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Relocating Childbirth:

the politics of birth place and Aboriginal midwifery

in Manitoba, Canada

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SUMMARY

The place of birth for First Nations is a contested issue in Canada today. For the past 30 years, the practice of removing women from communities to birth in urban centre hospitals, called maternal evacuation, has been a part of the dialogue between First Nation organisations, the Canadian state, policy makers, and Academics. Concurrent to the practice of evacuation, there is a movement to repatriate birth to First Nations through Aboriginal midwifery. This multi-sited ethnography is based on 15 months of fieldwork in Manitoba, Canada and follows the practice of evacuation and the establishment of an Aboriginal midwifery practice in one northern First Nation community. The ethnography reveals that both evacuation and returning birth is a complex, multi-layered negotiation of risk between various actors. From women and their families, doctors and nurses, midwives and other health professionals: the management of risk is at the forefront of this discussion. This study takes into account how risk is imagined, created and targeted in the practice of maternity care for First Nations in Manitoba. The concept of risk and risk management takes on multiple forms as the practice of evacuation moves from the community to the urban centre, from federal land to provincial land, from the hospital to the board room. Through participation observation in the places of birth and interviews with the range of actors involved in maternity care for First Nations, this ethnography reveals the messiness of the concept of risk, and identifies where these actors collude and conflict on the topic of evacuation and repatriation. The study also traces how the state has co-opted the language of risk on all sides of this debate and how the bodies of the First Nations mother and midwife becomes sites in which these contestations over risk, responsibility, knowledge and safety occur.

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List of acronyms and abbreviations

AFN	Assembly of First Nations
AMC	Assembly of Manitoba Chiefs
AMC-HIRGC	Assembly of Manitoba Chiefs Health Information Research Governance Committee
AMEP	Aboriginal Midwifery Education Program
BRHA	Burntwood Regional Health Authority
CAM	Canadian Association of Midwives
CFS	Child and Family Services
CIHR	Canadian Institutes of Health Research
CMA	critical medical anthropology
CMM	College of Midwives of Manitoba
CMRC	Canadian Midwifery Regulators Consortium
CPNP	Canadian Prenatal Nutrition Programme
C-section	Caesarean-section
EFM	electronic fetal monitor
HRA	health risk appraisal
Indian Affairs	Department of Indian and Northern Affairs Department
ICPD	International Conference on Population and Development
FNC	First Nations Centre
FNIH	First Nations and Inuit Health - Regional Office
FNIHB	First Nations and Inuit Health Branch - National Office
HREB	Health Research Ethics Board

ICM	International Confederation of Midwives
KOBP	kanaci otinawawasowin Baccalaureate Program
L&D	Labour and Delivery
LDRP	Labour, Delivery, Recovery, and Postpartum
MACHS	Maternal and Child Health Taskforce
MAM	Midwives Association of Manitoba
MANA	Midwives Alliance of North America
MIC	Midwifery Implementation Committee
MCH	Maternal Child Health
Medevac	Medical evacuation/transportation
MOU	Memorandum of Understanding
NACM	National Aboriginal Council of Midwives
NAHO	National Aboriginal Health Organization
NARM	North American Registry of Midwives
NAO	National Aboriginal Organisation
NHCN	Norway House Cree Nation
NHHS	Norway House Health Services Incorporated
NIHB	Non-insured Health Benefits
NMU	Northern Medical Unit
NPTP	Northern Patients Transportation Programme
NRP	neo-natal resuscitation protocol
OHIO	baby warmer
OOH	out of hospital

PEMA	political economic anthropology
RHA	regional health authority
SOGC	Society of Obstetricians and Gynaecologists of Canada
TAP	Treatment Access Programme
TBA	Traditional Birth Attendant
WRHA	Winnipeg Regional Health Authority
UCN	University College of the North
U of M	University of Manitoba

Acknowledgements

1. Introduction

This thesis brings together questions of birth place and Aboriginal midwifery through an exploration of the current reproductive practices in First Nation[1] communities in Manitoba[2], Canada. Locating birth is a complex task that moves from focusing on women's bodies and their location in space to the local actors who monitor the body and make decisions regarding what kind of maternity care women will receive. It also involves actors at the state level, whose funding for health services guides the implementation and provision of health care in specific places for specific groups of people, thus, creating a larger bio-political space in which women's bodies become objects of risk and risk management. The aim of this thesis is to understand how risks are created and managed within the multiple settings of maternity care for First Nations women in Manitoba by focusing on birth place and one attempt to re-introduce midwifery in the community of Norway House Cree Nation (NHCN) in the northern region of the province. The majority of First Nations women living in rural and remote reserves[3] in Canada are subject to what has often been referred to as maternal evacuation. This practice refers to the transfer of women late in pregnancy to give birth in urban, tertiary hospitals. The act of removal is regulated by the Canadian state and the process moves through multiple levels of jurisdiction and health systems[4]. At approximately thirty seven weeks in pregnancy, women are sent to an urban centre for "confinement"[5] until they give birth, after which they travel home. This thesis attempts to locate birth through the on-going practice of moving women from one place to another through a multi-sited ethnography of childbirth in Manitoba. In

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[1] I use the terms First Nations, Aboriginal, and indigenous interchangeably, moving from local to global definitions, whilst recognizing the importance of other community-based processes of understanding what it means to be Aboriginal. "Indigenous" is the broadest of these terms: it is used internationally to refer to "people who are the descendants of the original inhabitants of particular regions or territories" (Bent, Havelock, & Hayworth-Brockman, 2007, p. 2). The term "Aboriginal Peoples" is the collective name for all of the original peoples of Canada and their descendants, and may include the Cree, Dene, Annishnabe, Saulteaux and Métis Nations (National Aboriginal Health Organisation, 2008). Within the Canadian Constitution, "Indian, Métis and Inuit people are all recognized as Aboriginal" (Bent, Havelock, & Hayworth-Brockman, 2007, p. 1). The term "Indian", while still in use, is more outdated, it was the first name given to the original peoples in North America by Europeans, and is the term used in the Constitution of Canada and the Indian Act. In contemporary discourse, the term "First Nations" has replaced the word "Indian". However, "First Nations" is narrower in scope than both "Aboriginal" and "Indian": "First Nations" is not a legally recognized term, and it does not include the Inuit or Métis populations.
[2] Manitoba is one of 10 Canadian provinces. It is in the centre of Canada and is one of the three prairie provinces. It is 250,900 square miles with a population of just over 1 million people.
[3] First Nation reserves, or Indian reserves, are "a tract of land, the legal title to which is vested in Her Majesty, that has been set apart by Her Majesty for the use and benefit of a band". Therefore, all reserves are under federal jurisdiction. (Indian Act, s.2) The term "band" has also been replaced by the term "First Nation".
[4] The Canadian health care system is publicly-funded and guided by the Health Canada Act. In the Act, health care provision is delegated to the 10 provincial and 3 territorial governments. Provision for First Nations on reserve is provided under the federal system in reserve areas that do not have access to provincial services. This will be discussed in detail throughout the thesis.
[5] "Confinement" is the local term for the process of being sent to the city for childbirth. It is based on the medical term for the time period from the onset of labour to the delivery of a baby.

order to gain insight into the broader relationship between the Canadian state and First Nations, I am to unpack current reproductive practices as regulated by the federal state using childbirth as "an entry point into the study of social life," and viewing midwifery as a social cultural process (Ginsburg and Rapp, 1995, p.1). In current reproductive practices in First Nation communities, there is unequal access to maternal health services and choice in maternity care compared to the rest of the Canadian population, especially with respect to midwifery: because First Nations' reserves are considered federal land, there is little to no opportunity to access midwifery services in these communities. In the case of Norway House Cree Nation (NHCN)[6] , which serves as the case study for this thesis, jurisdictional complications prohibited access to midwife-attended births despite the presence of a state-funded midwifery practice in the community.

Risk emerged as a central concept in the debate surrounding place of birth in my fieldwork. Throughout this thesis, risk of childbirth moves from individual risks (located in woman's bodies) to the risks to the Canadian state (located at the level of populations), and the obligation of the Crown to uphold the rights of Aboriginal peoples as laid out in the Canadian Constitution. This ethnography argues that the current state of reproductive care in First Nation communities—state control over health care services, including what services are delivered and where these services are located—is inadequate for the realisation of Aboriginal peoples' rights as self-determining peoples. The ethnography traces how the state has co-opted the language of risk on all sides of the debate about childbirth and how the bodies of both the First Nations mother and Aboriginal midwife become sites in which these contestations over risk, responsibility, knowledge, and safety occur.

In order to fully address these multiple places and actors, the ethnography presented is based on fifteen months of multi-sited ethnographic fieldwork in the province of Manitoba, Canada. The ethnography reveals that the concept of risk and risk management is central to places of childbirth. The ability of certain actors to identify risks at particular times in particular places is essential to understanding why certain practices are allowed and others are not. The management of these risks is the action of making decisions and mitigating the consequences. Risk takes multiple forms as the practice of evacuation moves from the community to the urban centre, from federal land to provincial land, from the hospital to the board room. Through participation observation in these places and interviews with the range of actors involved in maternity care for First Nations, including midwives, doctors, policy makers, and pregnant mothers, this ethnography reveals the messiness of the concept of risk, and identifies where these actors collude and conflict on the topic of evacuation and returning birth to First Nations reserves.

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[6] With a population of approximately 7,000, Norway House Cree Nation is one of the largest First Nations communities in Northern Manitoba.

The current practice of maternal evacuation is the dominant way of managing the risk of childbirth. The impetus for this practice has been cited as the high infant mortality rates in Aboriginal communities in the 1960s and 1970s. (O'Neil and Kaufert, 2005) At the same time, however, midwives ask "what are the risks of this practice?" In this way, risk takes on multiple meanings situated in specific times and spaces from particular historical, social, and cultural contexts. Sending women to a tertiary facility to deliver their babies can be seen as an explicit practice of risk management governed by a notion of risk as 'manageable' through access to technologies and associated biomedical knowledge of caesarean section operations and blood transfusions. Conversely, sending women to a tertiary facility to deliver their babies alone, and thus removing women and their babies from their social and familial context, can be viewed as 'risky'. In order to address the social risks of evacuation, as well as a means to improving the continuing high rates of infant mortality and adverse birth outcomes in Aboriginal populations, Aboriginal midwives advocate for the return of birthing services to Aboriginal communities. (National Aboriginal Health Organisation, 2008) These overlapping frames of risk are co-opted by the Canadian state resulting in both a polarising and contradictory discourse of appropriate health care for First Nations.

In this thesis, four main spaces of childbirth emerged from the field. These are: birth as ceremonial practices located in people's home places; dislocation for birth through evacuation; relocating birth back to Norway House through midwifery; and childbirth in the policy setting. The first space I explored was the connection of birth and place through ceremonial teaching of elder Aboriginal women in Manitoba, along with the teachings of Aboriginal midwives about this connection. Next, I observed the practice of evacuation in the urban centre where Aboriginal women are sent for confinement. This includes boarding homes in the city where women during confinement, and in the hospital when they are delivering their babies. I concurrently followed the development of an Aboriginal midwifery practice in one northern First Nation community, NHCN. Finally, I followed the issue of midwifery in Norway House into the board room and policy setting. The ethnography reveals that both evacuation and returning birth is a complex, multi-layered negotiation of risk between various actors: from women and their families, doctors and nurses, midwives and other health professionals, the management of risk is at the forefront of the discussion. This approach takes into account how risk is imagined, created and targeted in the practice of maternity care for First Nations in Manitoba.

Evacuation and repatriation are polarising discourses that are often framed as follows: the midwifery discourse surrounding the return of birth to First Nation communities is characterised by the elimination of the practice of evacuation. The opposition to this position stems mainly from

obstetricians and nurses, who question the safety of rural and remote midwife-attended birth. However, this characterisation of the medical profession does not take into account the complex historical, political, economic, and social forces driving the policy of evacuation, and does not lend itself to an understanding of why this practice still persists. Furthermore, it may not take into account the plurality of choice and experience of women when it comes to their childbearing practices. In order to fully unpack the issue of birth place, it is important to understand women's experiences of childbirth when dislocated from their home places. Care must be taken not to discount the experiences of women, regardless of where they give birth. It is important to look at how some women will choose to be evacuated, and take care not discount these experiences by framing them within a negative discourse of the medicalisation of childbirth. As Lock and Scheper-Hughes (1996) note, "one of the biggest challenges for medical anthropology is to come to terms with biomedicine, to acknowledge its efficacy when appropriate while retaining a constructively critical stance" (p. 44) This thesis looks at the Canadian state as being composed of simultaneous and competing voices that both legitimise the practice of maternal evacuation, through their current practice of primary health care on reserve, and work towards returning birth closer to communities, through national policy initiatives.

It is important to note that I am also located within the context of this research. I was born in Whitehorse, Yukon with a First Nations father and an Irish-French mother, and identify myself as a citizen of the Tr'ondek Hwech'in First Nation. I attempted to become a midwife in 2004, entering and quickly exiting a bachelor of midwifery programme at the University of British Columbia. After this attempt at becoming a midwife, I began to work in the policy setting for the National Aboriginal Health Organisation (NAHO), and then during my Ph.D., as a consultant for multiple stakeholders, including the National Aboriginal Council of Midwives (NACM). I wrote various reports and policy documents, for both the federal government, the provincial government of Manitoba, and Aboriginal organisations. I was firmly ensconced in the policy world of Aboriginal midwifery and an active advocate for midwives before I began this work. This does not mean that I was opposed to hospital birth, or the associated technologies of childbirth. As a midwifery student who happened to be pregnant at the time, I felt pressure to birth naturally and to question the use of technology, and I riled against this prescription. I wanted to be able to choose my experience, insofar as I could, and not have to justify this to others. I had a homebirth with my first child, but not from a burning need to reject the hospital system, but because I had attended the homebirth of a friend and saw how peaceful it had been. Likewise, when I came into the policy setting, I did not want to fall into the trap of thinking that all First Nations women would want to have a midwife-attended birth in their

communities. However, I felt that women in these communities should have the right to choose their care providers and their birth setting.

About six months into my fieldwork, I discovered I was pregnant with my second child. At first, I thought working with pregnant women and midwives whilst pregnant was a good opportunity to 'embody' my own research. Given the low numbers of midwives in Manitoba, I struggled to find a midwife who would accept me into care. Luckily, one took me on as a client, and we planned for another home birth. This became a tricky point for me in my research, for I had to constantly re-locate myself within the field depending on who I was talking to: with midwives, my home birth was almost a given; in the hospital, I had to explain away my decision and emphasis my proximity to a tertiary hospital in case of emergency. However, my true perspective as a researcher was made clear to me in a discussion with a fellow anthropologist. As I joked that I was embodying my research, he replied, "No, you're not. If you were to truly embody your research, you would fly to Saskatoon [another prairie city several hundred miles away] a few weeks before you deliver, stay in a hotel alone waiting to go into labour, and then take the bus home with your baby afterwards." This seemed ridiculous to me. Who would voluntarily do this? The fact that the topic of my research was that very situation quickly brought my stance into perspective. While I did not want to prescribe location or experience of birth for First Nations women, I definitely thought the current practice of evacuation was unfair and that no mother should have to give birth in an unknown place without social support. With this in mind, I positioned myself as a "politically committed and morally engaged" anthropologist (Scheper-Hughes, 1995, p. 409).

1.1. Outline of thesis

In bringing together the place of birth and Aboriginal midwifery in the context of current reproductive practices of First Nations in Manitoba, I have organised this thesis into the following chapters:

Chapter one introduces the subject of the present thesis and provides a brief outline of the issues related to the topic.

Chapter two positions this thesis in the anthropology literature and other associated areas of study from which it draws. This chapter also clearly outlines the contribution of this thesis to the literatures.

Chapters three and four outline the historical development of midwifery and Aboriginal midwifery in Canada, and the historical relationship between First Nations and the Canadian state. These two chapters serve to locate maternal evacuation and Aboriginal midwifery within these processes.

Chapters five and six overview the methods and theoretical framework used in this thesis. These focus on multi-sited ethnography as a decolonising methodology, as well as the ethical issues that arose while conducting research with First Nations in Manitoba. The theoretical framework outlines some of the key works in risk theory and the anthropology of landscape that contribute to the understanding of the issue.

Chapter seven details the context of the fieldwork, including outlining the various settings in which the research took place, and the main actors involved in the process. This includes the community of Norway House, the urban centre hospital, and the government board rooms where meetings took place. The main actors include First Nations women who had been evacuated to the city, Aboriginal midwives, doctors, nurses, and policy makers.

Chapter eight is the first of four ethnographic chapters and focuses on the place of birth in the context of ceremony. The connection between birth and place is made explicit here by focusing on the teachings of elders, women who practice ceremony, and Aboriginal midwives.

Chapter nine outlines the current practice of maternal evacuation in communities. This chapter reveals the biomedical and social risks associated with evacuation, as well as the state's focus on managing and regulating evacuated women across various spaces and places.

Chapter ten looks at resistance to the practice of evacuation. It outlines both how women are agentive in various aspects of their evacuation, and work together with health care providers to change or subvert their experiences of evacuation. This chapter also looks at instances when women evade evacuation and end up delivering in their communities.

Chapter eleven, the last of the ethnographic chapters, tells the story of returning childbirth to Norway House Cree Nation through the development of the Kinosao Sipi midwifery clinic. This chapter outlines the development of the clinic, as well as the obstacles the midwives faced in starting their practice.

Chapter twelve delves into the policy fallout from the situation in Norway House midwifery practice, and the creation of multi-stakeholder committees to address the issue. This chapter details the negotiations surrounding midwifery, birth, and who is responsible for these in the context of the various levels of state present at the meetings.

Chapter thirteen concludes this thesis and presents the key findings and issues raised in the ethnography.

1.2. Notes on names

I have employed various ways of naming participants in my fieldwork. I used the real names of the Aboriginal midwives that I worked closely with: Darlene Birch and Carol Couchie, whom I refer to by their first names. I have used their names with their permission: as this story is about their life work, it is important to me that they be acknowledged as the key participants of this research. Additionally, I have used the real name of one staff member of the federal government, Dawn Walker. Dawn is also a well- known figure to those who work in Aboriginal maternal health care. She gave me permission to use her name. I also used the real names of the elders that I received teachings from. This follows First Nations practices of acknowledging who you received knowledge from and thanking them for it. For the evacuated women, I have chosen to use pseudonyms. Finally, I have chosen not to explicitly identify or give pseudonyms to some of the government staff I interviewed; I have simply referred to them by their position within the organisation.

2. Review of literature

In investigating maternal evacuation through a multi-sited ethnographic approach, some tensions in the analysis emerged leading me to circle around some recurring questions: is this thesis about childbirth or is it about midwifery? Is it about the Canadian state or indigenous peoples? Is it about policy or practice of maternal evacuation? Rather than potentially diluting the analysis, I came to realise that these tensions serve as points in which understandings about risk and governance emerge through the ethnography. In this chapter, I overview six areas of literature that I subsequently draw upon within my analysis of reproductive practices in First Nations communities: First Nations and the Canadian state; studies of maternal evacuation in Manitoba; studies of risk and reproduction; place of birth; anthropology of childbirth; and anthropology of midwifery.

2.1. First Nations and the Canadian state

According to Statistics Canada, in 2006, 1,172,790 people in Canada identified themselves as being Aboriginal (North American Indian or First Nation, Métis, or Inuit). Of these, 698,025 identified as North American Indians or First Nation, which is 3.9% of the total Canadian population. While proportionately small, the First Nations population is growing at a rate nearly four times faster than the non-Aboriginal population.   The fastest increase in the past ten years occurred in Manitoba. Aboriginal people in Canada are increasingly urban: of those who live off-reserve (60%), three out of four live in an urban centre. Winnipeg, the capital city of Manitoba, has the largest urban Aboriginal population at 63,380. The Aboriginal population is also younger than the non-Aboriginal population, with almost half (48%) of the Aboriginal population under the age of 24 compared with 31% of the non-Aboriginal population.

Birth outcomes for Aboriginal peoples in Canada are significantly worse across all than the non-Aboriginal population. (Smylie et al., 2010) In the Royal Commission of Aboriginal Peoples (1996), it was stated that "stillbirth and perinatal death rates among Indians are about double the Canadian average; among Inuit living in the Northwest Territories, they are about two and a half times the Canadian average". The Canadian Institute of Child Health (2000) compared the difference in Aboriginal post-neonatal mortality from 1979 to 1981 and 1991 to 1993, and found that the rates were three times higher than the national population. More recent data analysis show that this disparity continues. For example, in the infant mortality rate of First Nations in Manitoba between 1991 and 2000 is 10.2 per 1,000 live births as compared to a rate of 5.4 for the "non-First Nations" population in the province. (Smylie et al., 2010)

The Census shows that while overcrowding in housing decreased from 17% in 1996 to 11% in 2006, the state of the homes (ones needing major repairs) remained the same at one in four. Compared with non-Aboriginal populations, Aboriginal people were four times more likely to live in a crowded home, and three times more likely to live in a home in need of major repair. Crowding was more common on reserve, along with poor conditions of houses, with 44% of First Nations lived in homes in need of major repairs.

The Census also shows that Aboriginal children are more likely to live with a lone parent, a grandparent, or another relative. Aboriginal children are also twice as likely as non-Aboriginal children to live in multiple-family households. The Census notes that 29% of First Nations people said that they could speak an Aboriginal language, and that this was higher on reserve (51%). In 2006, 21% of children aged 14 and younger on reserve spoke an Aboriginal language. (Statistics Canada, 2008: p. 6-48)

In 2011, the Assembly of First Nations (AFN) produced a fact sheet on the quality of life of First Nations in Canada. This emphasises some other elements of life that widen the frame of the picture of First Nations. The 'quick facts', according to the AFN, are:

- One in four children in First Nations communities lives in poverty. That is almost double the national average.
- Suicide rates among First Nations youth are five to seven times higher than other young non-Aboriginal Canadians.
- The life expectancy of First Nations citizens is five to seven years less than other non-Aboriginal Canadians, and infant mortality rates are 1.5 times higher among First Nations.
- Tuberculosis rates among First Nation citizens living on-reserve are 31 times the national average.
- A First Nations youth is more likely to end up in jail than to graduate high school.
- First Nations children, on average, receive 22% less funding for child welfare services than other Canadian children.
- There are almost 600 unresolved cases of missing and murdered Aboriginal women in Canada. (2011: p. 2)

The AFN then places these facts—a combination of basic population measures (life expectancy, rates of illness) and social determinants (poverty, rates of incarceration, welfare funding, and suicide rates)—along with unresolved policy files in the following context:

> First Nations in Canada are affirming their rights and advancing plans to improve the quality of life for our people and communities based on First Nations rights, Treaties and increased responsibility. This effort will strengthen First Nation citizens and governments and position them to make the decisions that impact their future. (2011, p. 2)

The emphasis on different statistics begins to show that First Nations health and health care is a political process on many levels. From the viewpoint of the Aboriginal midwives I worked with, maternal evacuation is a part of the greater legacy of disruption and oppression experienced by indigenous peoples. Also apparent in the statement made by the AFN is that Aboriginal people are engaging in a political discourse of rights and responsibilities of self-governance and self-determination in relation to the Canadian state.

According to the Canadian Constitution (1982, Section 35(1)), there is a pre-existing Aboriginal or treaty right to continued use of the land for hunting, fishing, and trapping. This gives "priority to Aboriginal and treaty rights and states that the government must only infringe upon these rights only to the extent necessary to achieve a substantial and compelling objective" (Ross, 2001). How the government regulates resource development initiatives while not infringing upon Aboriginal and treaty subsistence rights has led to an intense examination of the nature of the relationship between Canada and its indigenous population. Court decisions such as *Sparrow* (S.C.C., 1990) and *Delgamuukw* (S.C.C., 1997) have attempted to address this through articulating the government's fiduciary duty to consult "meaningfully" and "adequately" with First Nations.   This fiduciary obligation was discussed for the first time in *Guerin vs. R.*, which explained it as "the ability of the Crown to make unilateral decisions that affect the rights of First Nations and encompasses a requirement of consultation where such decisions are being made" (Adkins and Neville, 2000, p. 3). It is said that this particular fiduciary duty is held "*sui generis* (of its own kind) in that it arises from the historical relationship between the aboriginal peoples and the Crown, and the powers over aboriginal interests which are vested in the Crown" (Adkins and Neville, 2000, p. 3). The articulation of the fiduciary duty is that the government holds the power to make decisions for Aboriginal people's interests, and because it holds this power to affect change for indigenous people, the Crown then has the duty to consult with them before such powers are exercised.

In order to address maternal and reproductive health rights, it is necessary to consider a number of international documents and their relationship to the Canadian context. In 1994, the International Conference on Population and Development (ICPD) met in Cairo, where "participating States recognised that sexual and reproductive health is fundamental to individuals, couples and families, as well as to the social and economic development of communities and nations". Further, the Commission on Human Rights subsequently confirmed that "sexual and reproductive health are integral elements of the right of everyone to the enjoyment of the highest attainable standard of physical and mental health" (Hunt and Bueno de Mesquita, n.d., p. 3). In the International Declaration on the Rights of Indigenous Peoples, Articles 23 and 24 reaffirm these rights. The

Declaration states that indigenous people have a right: "to be actively involved in developing and determining health, housing and other economic and social programmes affecting them"; "to their traditional medicines and to maintain their health practices"; and "to access, without any discrimination, to all social and health services" (United Nations, 2007).

This global discourse of reproductive rights is just now becoming part of the Canadian indigenous landscape. For example, in June 2011, the Society of Obstetricians and Gynaecologists of Canada (SOGC) published a policy statement regarding the "sexual and reproductive health, rights, and realities and access to services for First Nations, Inuit, and Métis in Canada" (p. 633). While SOGC's statement represents a change in the Canadian discourse about Aboriginal reproductive rights, it is vital that the discussion of rights to maternal health should not be considered new terrain on which the relationship between the state and indigenous people needs to be negotiated. Rather, the established rights of indigenous peoples' use of the lands and resources, and the obligation of the Crown to protect these rights, should form the basis of this discussion. As this thesis argues, the rights to maternal health and the rights to access to land are not mutually exclusive, but are an interconnected part of the indigenous landscape.

2.2. Studying maternal evacuation in Manitoba

Maternal evacuation is not a new topic for academics, including anthropologists. In 1982, Lorna Guse wrote about the evacuation of pregnant women in Manitoba. Her research remains acutely relevant: Guse's descriptions of women's experiences in urban centre boarding homes in the 1980s could be observed and rewritten verbatim today. In medical anthropology, most well-known are the works of Patricia Kaufert and John O'Neill (1990; 1993; O'Neil and Kaufert, 1995) on evacuation policy and the Inuit of the northern region of Manitoba (now Nunavut). Their seminal research on this topic began in the 1980s and became included in a number of important collections in medical anthropology, and particularly the anthropology of reproduction (Ginsburg and Rapp, 1995; Lindenbaum and Lock, 1993). Subsequent research on maternal evacuation in Manitoba followed, mainly through graduate student dissertations (Hiebert, 2003; Eni, 2005; Phillips-Beck 2010). Across Canada, numerous studies from various disciplines have focused on the multiple negative effects of relocation for birth, including "increased maternal newborn complications, increased post-partum depression and decreased breastfeeding rates" (Smith, 2002; see also: Klein, Christilaw & Johnston, 2002; Moffitt and Vollman, 2006; Kornelson and Grzybowski, 2004). Maternal evacuation has also emerged as a research topic in Australia, where the system of health care and similar historical relationships with the Aboriginal population. (Kildea, 2006; Ireland, Narjic, Belton, and Kildea, 2011)

Part of the impetus for this thesis is that there exists a plethora of research that has been conducted in support of ending evacuation practices and implementing Aboriginal midwifery, and yet the practice continues to be the cornerstone of Aboriginal maternal health care. (Smith, 2003) At the time of their work, Kaufert and O'Neil were working in the province of Manitoba without legislated midwifery care. In fact, much of their anthropological work was greatly influential in the drafting of policy and structure for midwifery care in the province. Likewise, their work and associated studies that highlight the negative aspects of maternal evacuation have been taken up by the federal and provincial governments, and has resulted in the implementation of policy directives aimed specifically at addressing this problem. Alongside this work in Manitoba to regulate midwifery, Aboriginal midwives began to come together as a unified voice at the national level. The yearly meetings of the Aboriginal midwives in Canada officially became NACM in 2010. Therefore, while the composition of the landscape of childbirth is very different from 30 years ago, Guse's (1982) depiction of a First Nation woman's experience of evacuation remains consistent with current practice. At the time of my fieldwork, the first provincially-regulated midwifery practice on a First Nations reserve was being implemented in Norway House. This thesis can be seen as a continuation of the study of evacuation, from its beginnings identifying evacuation as a unit of study, to the regulation of midwifery across Canada, and now to the implementation of midwifery in NHCN.

2.3. Studying risk and reproduction

A number of authors have explicitly made a link between risk and reproduction. (see Fordyce and Maraesa 2012) As Nikolas Rose (2001) remarks, "contemporary biopolitics is risk politics," and reproduction provides an important space "in which an array of connections appear between the individual and collective, the technological and political, the legal and ethical" (p. 208). Kaufert and O'Neil's (1995) work on the languages (epidemiological, clinical, or lay) of risk in childbirth is a significant contribution to the understanding of how risk is used in the debate of place of birth. Kaufert and O'Neil's languages of risk are telling; ultimately, however, they are limited as the authors do not take into account how these languages become co-opted and used by other stakeholders, particularly governments, in the debate around rural and remote birth. For example, women and their families are not solely confined to lay interpretations of risk, and often take up clinical and epidemiological explanations in regards to safe birth. Likewise, doctors and nurses do not solely rely on the clinical language of risk; rather, they are constantly negotiating of all conceptions of risk in maternal evacuation, including social or lay risks, within the clinical setting. This thesis seeks to understand how risk in evacuation is operationalised in the everyday life of the various actors in the multiple settings that maternal evacuation occurs. The ethnography uncovers

how risk is "formulated, deployed, experienced, embodied, and contested by cultural actors and their social networks" (Fordyce and Maraesa, 2012, p. 1). By doing so, the centrality and the 'messiness' of risk to the reproductive practices of First Nations are revealed.

Risk is not a singular concept, and within the context of maternal evacuation there are multiple takes on the definition of risk. It is important to unpack the concept of risk within this context. Risk is often categorised as "objective" risk from an epidemiological, positivist perspective, which is placed in opposition to "subjective" risks or risk perceptions. (Boholm, 1996, p. 44) In contrast to this division, I wish to begin with the premise that all risks are constructed, in so far as risk is the result of decision. As Beck (1999) explains: "Risks always depend on decisions.... They arise from the transformation of uncertainty and hazards into decisions (and compel the making of decisions, which in turn produce risks)" (p. 75). It is important distinguish risk from other notions of uncertainty, danger, and hazards in this context. In saying that risks are "made", I mean that risk is "not an intrinsic property of things"; rather, it is a "relational term that emerges out of contexts depending on shared conventionally established meanings" (Boholm, 2003, p. 175).   As Douglas and Wildavsky (1983) explain, "risk should be seen as a point product of knowledge about the future and consent about the most desired products" (p. 5). However, this is not to deny that intrinsic uncertainties, dangers, and hazards are present in childbirth practices. The potential of a woman to hemorrhage, the possibility of a stillborn baby, or the breakdown of a marriage during a woman's confinement were all cited occurrences in the practice of maternal evacuation during my fieldwork. The conception of risk as made recognises intrinsic uncertainties, dangers, and hazards, and asks how these are transformed into risks: if risks are the products of decisions, who is making them? How are risks created, realised, and managed in particular settings? How do the decisions that result in the creation of risk affect and guide the practice of evacuation, and consequently the return of reproductive health care to communities?

The focus on infant and maternal mortality is at the surface of debates about risk in the perinatal period, and is fundamental to the technocratic practice of maternal evacuation. As Weir (2006) explains:

> During the late 1950s the new post-World War II analytic epidemiology, "risk factor" epidemiology, [became] attached to the new concept of perinatal mortality. A cloud of risk factors drifted over the perinatal interval. Risk factor analysis was folded into the prior form of prenatal care that had existed since the 1920s, reconfiguring prenatal care as a standardised, risk-based regime serving the governmental objective of reducing perinatal mortality rates, each primary health care provider was to be supplied with a set list of risk factors to routinely assess women for risk at each prenatal visit. Risk techniques made possible not only the

analysis of perinatal mortality and morbidity, but its care-"perinatal care" as it begins to be called at this time-setting down a vast and detailed apparatus of pregnancy risk governance, effect at both the population and individual levels. (p. 58)

The issue with this risk discourse is that it:

…invite[s] dichotomous thinking, so a risk is either present or absent, leading to the implication that a risk-free state exists. This kind of woolly thinking reinforces the notion in maternity care that 'high tech' hospitals are safer environments to give birth in because they can set in place measures to reduce the risk and rapidly treat its effect if they do occur. (Walsh, El-Nemer, & Downe 2004, p. 120)

Risks are also permeable, and multiple risks addressing different conceptions of the body can be present in the same time and space. In the practice of maternal evacuation, the questions become: which risks take precedent over others? How is this decided? By whom and for what purpose? How are certain 'risk management' techniques (primarily biomedical management of pathological bodies) used to address or manage other risks (based on the social body/ body politic)? I wish to contribute to the literature on risks and reproduction in the context of maternal evacuation by addressing one of the gaps: the discussion surrounding risk and evacuation has been largely confined to the categorisation of risk as bounded objects associated with particular subjects; by contrast, I use risk objects as starting points to break down the assumptions that created them.

2.4. Place of birth

The debate around where childbirth takes place is central to maternal evacuation. In this thesis, two streams of understanding merge. First, alongside the focus on childbirth and midwifery in the anthropology of reproduction is a focus on place of birth through medicalisation and authoritative knowledge. (Jordan 1993, p. 36) The movement of childbirth from the home to the hospital is central part of these analyses. (Davis-Floyd 1992; Klassen 2001; Cheyney 2011; MacDonald 2006) This thesis engages with medical anthropological and medical sociological literature which examines place of birth within health care systems. In addition to this literature, within medical research, place of birth has long been a unit of analysis. There is now a substantial amount of research that shows maternity care located in, or closer to, rural and remote communities produces better outcomes for women and their families, as compared to centralised care in urban centres. (Klein 2002a, 2002b; Torr, 2000; Hutten-Czapski, 1999; O'Neil, 1995; Houd, Qinuajuak, and Epoo, 2004) There have been large studies comparing home birth and hospital birth in North America and internationally. (Janssen et al., 2002; Johnson and Daviss, 2005; Murphy and Fullerton, 1998) Most of these studies have shown that there are comparable outcomes in the home and hospital settings. For example,

Janssen et al. compared planned hospital and planned homebirths attended by regulated midwives in British Columbia, Canada by comparing perinatal outcomes. The study found that the home birth group were less likely to have epidural analgesia, be induced, and have augmented labours using oxytocin or prostaglandins, or episiotomies. Similar outcomes regarding perinatal mortality, Apgar scores, and meconium aspiration syndrome, or need for transfer for specialized newborn care were seen between the home birth and hospital groups. The study concluded that there was no increased maternal or neonatal risk associated with planned home birth with the care of a regulated midwife. (p. 315) Internationally, there has been numerous studies looking at the safety of providing choice of birth setting, including the home. In the UK, a national prospective cohort study compared perinatal outcomes, maternal outcomes, and interventions in labour by planned place of birth for women with low risk pregnancies. The study found that there were no significant differences of outcomes for any of the non-obstetric unit settings compared with the obstetric units. The study concluded that the results supported a policy of offering women with low risk pregnancies a choice of birth setting. (Birthplace in England Collaborative Group, 2011) Another study that looked at the relation between intended place of birth (home or hospital) in the Netherlands found similar results. They concluded that the outcomes for planned home births were at least as good as planned hospital births for low risk women receiving midwifery care. (Wiegers, Keirse, van der Zee, and Berghs, 1996)   Despite this evidence base, the discourse of the hospital as the safest place to give birth is still common amongst health professionals and the general public. For example, in the September 2011 issue of a popular Canadian magazine, the headline reads: "Don't try this at home", with the tagline "home births may need less intervention and cause fewer injuries for mom. But they may be riskier for babies" (Bochove, 2011: p. 68).   The disconnect between the evidence base in the form of large scale research on place of birth, and the continued debate over safety is important to emphasize to address the issue of birth place and midwifery in Manitoba.

However, this thesis broadens the analysis from the biomedical field to include other notions of space, place, and landscape. In the context of First Nations reproductive practices, the study of the movement of childbirth from home to hospital back to home begins to explore the role of place and dwelling as part of the broader indigenous landscape. The spiritual and close connection of indigenous peoples to the landscape is often referred to in broad, general terms, such as the connection to Mother Earth, with emphasis on the ability to be on the land for purposes of hunting, fishing, trapping as proof of this relationship. Likewise, the discussion of returning birth to communities tends to make broad statements about the importance of the connection of birth to the landscape without engaging deeper into what this really means.   In order to more fully reconceptualise the relationship, we can turn to Ingold's (2000) study of relatedness in his attempt

to understand what it means to be "indigenous" (p. 132). Ingold suggests turning to a "relational approach" in which "both cultural knowledge and bodily substance are seen to undergo continuous generation in the context of an ongoing engagement with the land and with the beings human and non-human that dwell therein" (p. 133). The relational approach is very helpful in connecting identity and place. From this, we can develop the understanding that

> ...to inhabit the land is to draw it to a particular focus, and in so doing to constitute a place. As a locus of personal growth and development ... every such place forms the centre of a sphere of nurture. Thus the generation of persons within spheres of nurture, and places of the land, are not separate processes but one in the same. (Ingold, 2000, p. 149)

In this context, we see how birth in home places for indigenous populations can constitute spheres of nurture, and how the displacement of people for childbirth is connected to the loss of these nurturing places that "constitute their identity, knowledgability, and the environments in which they live" (p. 133).

From this perspective, this thesis takes on a new understanding of place of birth and how it is situated within the political framework of First Nations and the Canadian state. Through this exploration, I find that within a First Nations cosmological framework the commonly perceived separation between the struggle for recognised rights to land and water, and the struggle for rights to control bodies and birth does not actually exist: they are, in fact, the same struggle.

2.5. Studying childbirth

Childbirth is more than just a biological act: it is, as Ginsburg and Rapp (1995) describe, "an entry point to the study of social life" (p. 1). Anthropologists now recognise that birth is "everywhere socially marked and shaped" (Jordan, 1993, p. 1). Along with understanding the importance of childbirth and childbearing practices for individual women and their communities, it is important to take into consideration how these practices are shaped by the state through its policies and controls. In this way, we take into consideration both how childbirth is "experienced" and how it is "constituted" in discourses of childbirth and childbearing practices (Jolly, 1998, p. 2). Childbirth enables us to see "how cultures are produced (or contested) as people imagine and enable the creation of the next generation" (Ginsburg and Rapp, 1995, p. 1).

The starting point to the study of childbirth remains with Jordan's (1978) *Birth in Four Cultures: A Cross-Cultural Study of Childbirth in Yucatan, Holland, Sweden and the U.S.* Although it is not to say that others did not discuss childbirth before her, this monumental study gave "new legitimacy to the study of reproduction in anthropology" (Ginsburg and Rapp, 1991, p. 320). Her detailed

ethnographic accounts described birth through a "biosocial perspective", which allowed her to study "each culture's birthways as a system that made internal sense and could be compared with other systems" (Davis-Floyd and Sargent, 1997, p. 3). Inspired by Jordan, a flurry of anthropologists began to study birth in "other cultures" through in-depth ethnographic studies of Benin, Egypt, Sierra Leone, Malaysia, Columbia, Mexico, India, Greece, and among the !Kung, the Efe, the Inuit, to name a few. From this point, anthropologists moved on to focus on other aspects of reproduction, such as miscarriage and stillbirth, abortion, and new reproductive technologies. (Davis-Floyd and Sargent, 1997, p. 5)

In the late 1970s and early 1980s, some anthropologists began to turn their gaze towards Western childbirth as a point of focus. This shift coincided with feminist scholarship on reproduction, and served to "legitimatise the natural childbirth movement" in the United States and Europe. Ginsburg and Rapp (1991) note how these studies became "increasing political over the decade of the 1980s" (p. 321). Critical readings of mainstream maternity care in North America exposed it as a "process that alienates women from their bodies, fragments the potential wholeness of the birth experience, and commodifies both women and babies" (McDonald, 2006, p. 239). As Emily Martin elaborates, in biomedical childbirth, the "body [is seen] as a machine and the doctor as the mechanic" (1987, p. 56). This critique of Western biomedicine and its treatment of pregnancy and childbirth are important in understanding the practice of maternal evacuation. How the model of biomedical, or what Davis-Floyd (1992) refers to as "technocratic", birth have pervaded the policies and practices around childbirth for indigenous peoples in Canada is at the same time glaringly obvious and subtly nuanced.

The focus of this thesis is the childbearing practices of First Nations women and Aboriginal midwifery in Manitoba, Canada. However, how does one define when childbirth starts and when it ends? Does it begin with the first contraction, or does it relate to the monitoring period of what is defined as the "perinatal" period that encompasses the time before and after birth? As McCourt and Dykes (2009) point out: "time is a fundamental theme in considering childbirth", for it addresses "social and cultural as well as physical reproduction" (p. 1). For First Nations women who are evacuated for birth, the perinatal period is well defined, and this study follows these parameters. Therefore, for the purpose of this study, childbirth is defined more broadly than the time in which a woman is in active labour and gives birth; it is defined as the time from which a pregnant woman is required to leave her community until she returns home (the perinatal period).

Such a focus on specific periods of time is not without its problems. While the anthropology of childbirth has become a well-respected unit of study over the past thirty years, it is important to ask

questions about choosing this event as the focal point of study, including in this thesis. In fact, one of the arguments in this study is that the current practices surrounding childbirth fragment, or remove, the experience of giving birth from the continuum of the experience of becoming, and being, a mother and part of many kin relations. The concern here is that focusing on childbirth as the unit of study serves only to increase this fragmentation and the disassociation of the event from the everyday lives of First Nations families. As Ivry (2010) observes, "anthropologists seem more fascinated with birth and other, often technologically oriented, reproductive dramas than with the process of gestation" (p. 5). I have attempted to address this by looking at the broader discourses that re-connect the perinatal period within the social and familial context, and further connecting these to broader notions of place and First Nations rights. By presenting current practices that occur in the perinatal period, and how decisions are made and for what purposes, the focus on maternal evacuation feeds directly into these broader connections.

Two concepts are useful in linking the perinatal period to broader structural influences: stratified reproduction and structural violence. Ginsburg and Rapp (1995) first employed the term "stratified reproduction," which is "the power relations by which some categories of people are empowered to nurture and reproduce while others are disempowered" (p. 3; see also Colen, 1986). Ginsburg and Rapp uncover hierarchical structures which seem "inevitable", and show how "institutions may intervene" into areas of reproduction "in the name of social need or national priorities" but do not acknowledge the impact of these "interventions on the lives of women and their communities" (p. 4). The concept of stratified reproduction can illustrate how social arrangements surrounding parenting can ultimately structure empirical knowledge and practices surrounding pregnancy and childbirth. (Ginsburg and Rapp, 1995, p. 13)

Paul Farmer's concept of "structural violence" explores how through the study of history, political economy, and biology we can uncover violence that is exerted systemically by everyone, either knowingly or unknowingly, in a certain social order. Simply put, the job of structural violence is to "inform the study of the social machinery of oppression" (2004, p. 307). Farmer explains structural violence as the study of "both individual experience and the larger social matrix in which it is embedded in order to see how various social processes and events come to be translated into personal distress and disease" (2005, p.29). The study of structural violence asks "By what mechanisms, precisely, do social forces ranging from poverty to racism become embodied as individual experience?" (Farmer, 2005, p. 29)

As Bourgois and Scheper-Hughes (2004) point out, there is a "need to disentangle the causes, meanings, experiences, and consequences of structural violence and show how it operates in real

lives", which includes "how victims become victimizers and how that hides local understandings of structural power relations" (p. 318). In the case of maternal evacuation, one of the main concerns from previous studies, which is relevant to this thesis, is the lack of social support for women when they have their babies. In terms of structural violence, the premise of evacuation is based on a state requirement to provide access to primary care (i.e. pay for it). First Nations become dependent on the allocation of these resources, most of the time because they do not have the economic means to finance their confinement. So in a way, the issue of evacuation is as much about economy as it is about the associated risks of childbirth.

It is also important to acknowledge that childbearing as social and cultural processes centres on the notion of belonging or "relatedness". This is seen as a move from the study of classical kinship forms to include "the implications and lived experience of relatedness in local contexts" (Carsten, 2000, p. 1). Strathern (1992) notes how kinship is both biological and social, and consists of the constitution of relationships as well as the interactions between relatives. (p. 5) As Bodenhorn (2000) observes of the Inupiat in Northern Alaska:

> Human beings bear children, just as children take life…. Parents are the ones who do the parenting, who love them. This role is not necessarily restricted to one set of people. Biological kinship is rarely denied, but the primary relationships, both in affect and in moral weight, are formed with those you are brought up with. (p. 141)

Strathern (1992) shows how new reproductive technologies affect thinking of kinship and relatedness, and the role of the father becomes unstable through the distinction between "biological" and "social" parenting (p. 24). While evacuation is not a new reproductive technology, the arrangement for childbirth focusing on the mother and the delivery of a baby also affects the social make up of those kin relations, at least by who is able to be present at the birth and who is not.

2.6. Studying midwifery

Aboriginal midwifery in Canada has not yet been critically examined within anthropological literature. Whilst the potential role of the midwife has been studied in the context of maternal evacuation (Kaufert and O'Neil 1993; Hiebert 2003), there have yet to be any in-depth studies of Aboriginal midwifery as a concept and symbol, and as a social and cultural process in Canada. This thesis engages with the practice of Aboriginal midwifery. It must first be acknowledged that the production of anthropological knowledge about midwifery and childbirth is often used for political purposes. (Jeffrey and Jeffrey, 2004, p. 265) The knowledge of midwives and their role is often used

on both sides of the debate regarding the medicalisation of childbirth. On one hand, the lack of technological knowledge is often used by those opposed to birth outside of the hospital setting. On the other, the role of midwives as respecting the psychosocial aspects of childbearing is emphasised. (Jeffrey and Jeffrey, 2004, p. 265; Lindenbaum and Lock, 1993) The Aboriginal midwives as subjects of this thesis were certainly engaged in the political tug-of-war regarding place of birth. I actively tried to resist the anthropological tendency to romanticise Aboriginal midwifery and thereby positing the "traditional as 'natural'"; rather, I sought to engage with midwifery as a social and cultural process taking into account the historical, political, and economic contexts within which Aboriginal midwives are currently doing their work (Jolly, 1998, p. 13; Lowis and MacCaffery, 2004, p. 7).

As an anthropologist working with Aboriginal midwives there is often the assumption that I work with traditional birth attendants (TBAs). When I say that most of the women I work with are registered midwives within the Canadian health care system, there is a hesitation and sometimes a question about what makes them "Aboriginal midwives", since they may be just employing "a watered down version of the biomedical model". When I have shown short videos of Aboriginal midwives using fetal dopplers[7] in settings that look very much like a hospital, people reject this image as "not really Aboriginal" or indigenous. As one person asked me, "have they [indigenous midwives] been trained in a traditional way, or are they just indigenous people who took midwifery training at university?" In the case of the women I work closely with, mainly from NACM, the latter is mostly true. There is a tension here between the 'traditional' Aboriginal midwife and their historical roots. As Fraser (1995) articulates in her study of African American midwifery in the southern United States, there is a need to "assert the separation between traditional [midwifery] and the more recent natural-childbirth movement" in that they have emerged from a "rather different racial, cultural, and class contexts" (p. 54) She also warns against retelling a history that "comes to have a creation story and then another happy ending as women rediscover their control over birthing and come to reassert the natural processes of their bodies against the unnatural technologies of hospital-based obstetrics" (p. 54). It is important to take these cautionary remarks when embarking on research with Aboriginal midwives. On one hand, Aboriginal midwives are not the same as the granny midwives 100 years ago, and some of the current Aboriginal midwives were explicitly a part of the home-birth movement that occurred in the 1970s and 1980s in North America. On the other hand, these revelations should not deter critical engagement with the current practices of Aboriginal midwifery in Canada. In fact, these differences should encourage

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[7] Fetal dopplers are hand held devices that listen to a baby's heartbeat.

further exploration of Aboriginal midwifery as it developed from its own particular social and cultural contexts.

Untangling these explanations without juxtaposing the 'traditional' with 'biomedical', or TBA with midwife, is an ongoing struggle. As Davis-Floyd, Pigg & Cominsky (2001) explain:

> It has been difficult for anthropologists to write about midwifery in a way that avoids these value-laden polarities, however crude they are recognized to be. One reason for this is that the judgments embedded in them undergird many of the concrete efforts made around the world either to foster midwifery practice or to replace it with obstetrically managed systems. These are real political battles over the legitimacy of certain childbirth practices….midwifery (in whatever form it takes) is not neutral practice but, rather, something that is to be acknowledged, legitimated, revived, reinvented, co-opted, or combated, depending on what is perceived to be at stake. (p. 108)

The complex negotiation of these women as midwives and as Aboriginal midwives to practice in the settings they wish (i.e. northern and remote communities) has implications on a number of levels explored throughout this study. In this context, I would like to introduce the concept of the "postcolonial midwife"[8]. Drawing on Robbie Davis-Floyd and Elizabeth Davis's (1997) description of the "postmodern" midwife, the postcolonial midwife embodies this notion of the postmodern, but in an explicit engagement with the current health systems in place in Aboriginal communities. As Davis-Floyd and Davis describe (1997), postmodern midwives "are educated, articulate, organised, political, and highly conscious of both their cultural uniqueness and their global importance" (p. 319). In addition to embodying the "type" of midwife described here, postcolonial midwives are also required to unpack layers of inequalities in terms of access to care, and other social determinants of health. While the emergence of the postmodern midwife in Canada has been discussed by other authors (Bourgeault, Beniot & Davis Floyd, 2004; Plummer 2000; DeVries et al, 2001; MacDonald 2006), the constitution of the postcolonial, Aboriginal midwife is unique in that it becomes part of a greater dialogue with the Canadian state regarding indigenous rights and self-determination.

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[8] I use the term postcolonial specifically in the context of the present relationship between the Canadian state and First Nations people, and the mode of health care service delivery. I am aware of the vast literature that addresses postcolonialism and postcolonial theory (for example: Spivak, 1999; Ashcroft, Griffith, and Tiffin, 1998; Shohat, 1992); however, while these are noted, they are beyond the scope of this discussion.

3. Midwifery and Aboriginal midwifery in Canada

Midwifery as social and cultural processes in Canada must be understood within its historical context and in relation to the state. In this chapter, midwifery and Aboriginal midwifery and their historical development is discussed and placed at the centre of the debate over birth attendance and place of birth. This is due to the fact that midwives are the only health professionals in Canada who have out of hospital (OOH) birth as a part of their scope of practice. The development of Aboriginal midwifery as a concept and as a practice is also discussed in relation to the development of midwifery as a whole. The parallels and tensions between these two streams of midwifery are highlighted, and contribute to a better understanding of where the discussion of maternal evacuation and returning birth is situated within a broader discourse. I begin by defining who is a midwife and the Canadian model of midwifery care.

The International Confederation of Midwives (ICM) offers a lengthy definition of a midwife:

> A midwife is a person who, having been regularly admitted to a midwifery educational programme, duly recognised in the country in which it is located, has successfully completed the prescribed course of studies in midwifery and has acquired the requisite qualifications to be registered and/or legally licensed to practise midwifery.

> The midwife is recognised as a responsible and accountable professional who works in partnership with women to give the necessary support, care and advice during pregnancy, labour and the postpartum period, to conduct births on the midwife's own responsibility and to provide care for the new born and the infant. This care includes preventative measures, the promotion of normal birth, the detection of complications in mother and child, the accessing of medical care or other appropriate assistance and the carrying out of emergency measures.

> The midwife has an important task in health counselling and education, not only for the woman, but also within the family and the community. This work should involve antenatal education and preparation for parenthood and may extend to women's health, sexual or reproductive health and childcare.

> A midwife may practise in any setting including the home, community, hospitals, clinics or health units. (2009)

As indicated by the ICM definition, midwives are in part defined by how midwifery knowledge is obtained. It is important to note this aspect of the profession because it directly affected how midwifery became a regulated profession in Manitoba, as will be described below.

The ICM definition applies to midwifery in Canada, which is subdivided into three general types based on educational route: traditional/lay midwives, nurse-midwives, and direct entry midwives. The Midwives Alliance of North America (MANA) (2008) describes these types as:

> **Direct Entry Midwife:** A direct entry midwife is an independent practitioner educated in the discipline of midwifery through self-study, apprenticeship, a midwifery school, or a college-or university-based programme distinct from the discipline of nursing. A direct-entry midwife is trained to provide the Midwives Model of Care to healthy women and newborns throughout the childbearing cycle primarily in out-of-hospital settings.

> **Traditional/Lay Midwife:** The term "Lay Midwife" has been used to designate an uncertified or unlicensed midwife who was educated through informal routes such as self-study or apprenticeship rather than through a formal programme. This term does not necessarily mean a low level of education, just that the midwife either chose not to become certified or licensed, or there was no certification available for her type of education (as was the fact before the Certified Professional Midwife credential was available). Other similar terms to describe uncertified or unlicensed midwives are traditional midwife, traditional birth attendant, granny midwife and independent midwife.

> **Nurse-Midwife:** A Nurse-Midwife is an individual educated in the two disciplines of nursing and midwifery. (p. 1)

In Canada, the Canadian Midwifery Regulators Consortium (CMRC) (2006) has outlined the Canadian Model of Midwifery Practice. The key elements of the Canadian Model of Midwifery Practice are described as follows:

> **Health and Well-being:** Midwifery care in Canada is based on a respect for pregnancy and childbirth as normal physiological processes. Midwives promote wellness in women, babies, and families, taking the social, emotional, cultural and physical aspects of a woman's reproductive experience into consideration.

> **Informed Choice:** Canadian midwives respect the right of women to make informed choices about all aspects of their care. Midwives actively encourage informed decision-making by providing women with complete, relevant, and objective information in a non-authoritarian manner.

> **Autonomous Care Providers**: Canadian midwives are fully responsible for the provision of primary health services within their scope of practice, making autonomous decisions in collaboration with their clients. When midwives identify conditions requiring care that is outside of their scope of practice, they make referrals to other care providers and continue to provide supportive care. Midwives collaborate with other health professionals in order to ensure that their clients receive the best possible care.

Continuity of Care: Canadian midwives are committed to working in partnership with the women in their care. Midwives spend time with their clients in order to build trusting relationships and provide individualised care. Individual or small groups of midwives provide continuity of care to women throughout pregnancy, labour, birth, and up to at least six weeks postpartum. A midwife known to the woman is available on-call throughout her care.

Choice of Birth Setting: Canadian midwives respect the right of each woman to make an informed choice about the setting for her birth. Midwives must be competent and willing to provide care in a variety of settings, including home, birth centres, and hospitals.

Evidence-based Practice: Canadian midwives are expected to stay up-to-date with regard to research on maternity care issues, to critically appraise research, and to incorporate relevant findings into their care. (2006: p. 1)

While all of these elements are seen as important to midwifery care, the most compelling elements with respect to the return of birthing practices are continuity of care and choice of birth setting.

3.1. Midwifery in Canada

Midwifery is said to be one of the oldest professions. (van Teijlingen, 2004, p. 43) How 'profession' is defined warrants a discussion of its own; however, for the purposes of this chapter, the layering of midwifery with the notion of tradition and a deeply historical presence is important in the making of professional midwives in Canada. (MacDonald, 2006) The history of midwifery in Canada is often characterised in relation to the loss of the midwife in the mid-nineteenth century and the middle of the twentieth century. (Biggs, 2004, p. 18) This history centres on the medicalisation of childbearing practices across Canada. However, as Biggs (2004) notes, the decline of midwifery happened differently across Canada, at different times, and for different reasons. Likewise, the revival of midwifery services across Canada has also been uneven, depending upon a number of factors, including geography, economics, and politics. Understanding the concept of the 'neighbour midwife' and its link to tradition is particularly useful in the historical setting of Canada.

3.1.1. The decline of midwifery in Canada

The telling of the history of midwifery in Canada is intimately linked to the present profession of midwifery in the country. Therefore, it is difficult to formulate a summarised version of the history of midwifery in Canada without explicitly revealing the use of this history in the current argument for the promotion of midwifery care. The decline of midwifery across Canada is also difficult to summarise. Biggs (2004) points out that "often the history of midwifery in Canada as a whole is

equated with the history of midwifery in Ontario." The explanation for this is that "the debate there [in Ontario] over female midwifery was highly charged... and was eclipsed by the male obstetrical system early on" (p. 29). However, I would also add that the focus on Ontario may also coincide with the fact that Ontario was the first province to regulate midwifery in Canada (in 1994), and thus the dialogue of midwifery in its current form relies on this detailed historical anchor point.

The common narrative of the history of midwifery in Canada begins with the statement that Aboriginal peoples had midwives before the arrival of European settlers. (Carroll and Benoit, 2004, p. 264; Bourgeault et al., 2004, p. 4; MacDonald, 2004, p. 46) Most historical narratives leave the Aboriginal midwifery story with that very brief treatment, and go on to explore midwifery care in more detail/depth in the context of providing care to mainly Anglo-European women. (Biggs, 2004, p. 23) This form of midwifery narrative is often referred to as the 'neighbour', 'granny' or 'lay' midwife. (MacDonald, 2004, p. 46) As MacDonald (2004) describes, "she [the traditional midwife] was a natural, essential part of every community" (p. 46). The second part of the story is that there was a push to medicalise and modernise childbearing practices across Canada. Childbirth in a hospital setting, under the authority of physicians grew steadily and by the 1940s, and midwifery was "no longer an option for the vast majority of Canadian women" (MacDonald, 2006, p. 237). In mid-nineteenth century Ontario, the right to practice midwifery was restricted to medical practitioners (i.e. physicians), thus prohibiting midwives from attending births. (Burtch, 1994, p. 54) The effect of these policies is dramatically illustrated in birth statistics from the city of Winnipeg, Manitoba: in 1917, midwives attended 18% of the births; in 1925, midwives attended 5% of the births; and in 1945, midwives attended only 0.1%. (Mitchinson 2002)

While that the act of eradicating midwifery by physicians was explicit in Ontario, in other parts of Canada midwifery was either "endorsed or ignored" (Biggs, 2004, p. 18). Examples of supporting midwifery in New France, Newfoundland, and northern areas persisted until passed the 1940s. This is the case for most northern, First Nation communities. Plummer (2000) notes that despite the fact that in the 1930s and 1940s midwives were being outlawed from practicing in southern Canada, "non-native midwives were recruited to work in [northern] nursing stations" (p. 172). These northern midwives became a part of the effort of the state to "bring birth into nursing stations at least, and ideally, into hospitals" (Plummer, 2000, p. 172). In the case of northern nurse-midwives, during the 1970s, the Medical Services Branch (which later became renamed the First Nations and Inuit Health Branch (FNIHB)) set the criteria to determine if women should be flown out of the community to deliver in a tertiary hospital or stay in the community to deliver with the attendance of a nurse-midwife. During this time, all non-Aboriginal women in these communities were often

flown out to deliver their babies in urban centres, and it is interpreted by some that the policy of evacuation for all women was, in some ways, allowing Aboriginal women to receive the same care as the non-Aboriginal women in their communities. (Birch, personal communication, June 3rd, 2008) By the 1980s, this policy has expanded to include all pregnant women and nurse-midwives were no longer employed by the federal government. (Kaufert and O'Neil, 1995, p. 33)

This uneven history of the decline of midwifery in Canada makes it difficult to write a general history of midwifery in Canada without falling into a narrative of the disappearance of the neighbour midwife through the co-optation of birth attendance by physicians in Canada. As Biggs (2004) point out, the image of the tradition of the neighbour midwife is useful in understanding how the "concept of the neighbour midwife has become part of the folklore that has developed with the resurgence of midwifery in Canada"; however, it tends to "elide differences among women and mask the particular configuration of professional interests, regional politics, levels of industrialisation, class, race, and imperialist agendas (p. 22). MacDonald (2004) also notes how tradition became a "political symbol" in order to facilitate the creation of a new professional identity for the midwifery movement in Ontario in the 1990s (p. 50). It is important to note that while this common narrative is true in some places at particular times, the decline of midwifery happened differently across Canada. The absence of a narrative of midwifery in Aboriginal communities, other than a precursor to the main story, and mention of the role of nurse-midwives in the north mid-twentieth century, is a clear omission. Aboriginal midwifery will be discussed in detail below.

3.1.2. The rise of midwifery in Canada

The resurgence of midwifery in Canada can be marked by multiple, parallel movements. On the one hand, there was the organisation of nurse-midwifery and the rise of the home birth movement in Canada and the United States. On the other, the rise of midwifery is often located in the legislation of midwifery within the Health Acts of the various provinces. However, legislating midwifery means that there was a precursor to this act. When the role of the midwife became obsolete within the health care system, including the northern regions, there were two significant occurrences. First, many nurse-midwives were enveloped into the health care system, and began working on hospital labour and delivery floors as obstetrical nurses. Second, the community, or lay, midwives continued to work outside of the health care system in a private practice model.

In the early 1970s, the role of nurse-midwives in rural and remote settings was common; during this time, discussion began regarding integrating nurse-midwives into urban settings as well. At the same time, the "rebirth" of lay, or community, midwifery was gaining momentum (Bourgeault,

Benoit & Davis Floyd, 2004, p. 8), and from the community midwifery movement several consumer groups were formed in both Canada and the United States. Alongside this home birth movement was the international woman's movement that "sought to change consciousness around health issues, struggled to change established health institutions, and organised to provide health-related services to women" (Bourgeault, Benoit & Davis Floyd, 2004, p. 8-9). Both of these movements identified "the mistreatment of birthing women due to oppressive obstetrical practices" (Bourgeault, Benoit & Davis Floyd, 2004, p. 8-9). The involvement of the home birth movement into regulated midwifery practice contributed to the current model of midwifery care to include tenents such as "informed choice, choice of birth place, and continuity of care" (Bourgeault, Declercq & Sandall, 2001 p. 11). These tenents will be discussed further below.

In 1993, midwifery care in Ontario became "fully licensed, integrated into, and funded by the provincial health care system" (Bourgeault, Declercq & Sandall 2001: p. 7). This was followed by other provinces in Canada: British Columbia (1995), Alberta (1995), Quebec (1999), Manitoba (2000), Northwest Territories (2003), Nova Scotia (2009), New Brunswick (2010), Newfoundland and Labrador (2010), and Nunavut (2011). Midwifery is still unregulated in the Yukon Territory and Prince Edward Island. The impetus to regulate came from a number of factors. In Ontario, one of the contributing factors was the death of a baby at a home birth attended by a midwife in the early 1980s. The inquest into the baby's death brought the issue of home birth and the practice of midwives into greater public awareness. The inquest also brought home birth to the attention of the College of Physicians and Surgeons of Ontario. The College issued a directive to physicians who provided back up for home births to discontinue this practice. However, this did not stop the practice of home birth, but it meant that these physicians were no longer working with the midwives as back up. The inquest also drew attention to the "precarious legal environment within which midwives were practising" (Bourgeault, Declercq & Sandall, 2001, p. 12). The notion of litigious risk now characterises risk management in the maternity care setting and the legislation of midwifery can be seen, only in part, to be responding to this particular type of risk.

3.2. Aboriginal midwifery

As stated above, little has been written in depth about Aboriginal midwifery. What literature there is comes from the policy level, specifically reports written by National Aboriginal Organisations (NAOs) and therefore, tend to refer Aboriginal midwifery in broad terms and do not critically engage with Aboriginal midwifery as a concept or process. The generalising term 'Aboriginal midwifery' is both strategic and, like the history of midwifery in Canada, uses notions of tradition and community to communicate both the knowledge and historicised present of Aboriginal midwives today. This

serves explicitly to include Aboriginal midwifery in the on-going broader discussions of the relationship of the Canadian state to its indigenous populations and their associated rights.

The NACM (2012b) defines an Aboriginal midwife as a

> …committed primary health care provider who has the skills to care for pregnant women, babies, and their families throughout pregnancy and for the first weeks in the postpartum. She is also a person who is knowledgeable in all aspects of women's medicine and she provides education that helps keep the family and the community healthy. Midwives promote breastfeeding, nutrition, and parenting skills. A midwife is the keeper of ceremonies for young people like puberty rites. She is a leader and mentor, someone who passes on important values about health to the next generation. (p. 1)

The emphasis on the knowledge of a midwife—not only in the skills of midwifery, but also as a keeper of ceremonies and communicator of values—is an important aspect of the current understanding of Aboriginal midwifery. To consider more fully what is Aboriginal midwifery, I discuss the history of midwifery in Aboriginal communities generally before moving on to how this history becomes a part of the present day understandings and practices of Aboriginal midwifery.

3.2.1. The history of Aboriginal midwifery

The history of midwifery in Aboriginal communities often begins similarly to the history of midwifery in Canada as a whole: it is acknowledged that there were midwives in Aboriginal communities before the arrival of Euro-Canadians, and that the term midwifery was viewed in particular ways, by various nations. As Christine Roy, a midwife in the James Bay Cree area of Quebec explains:

> A long time ago, every community had midwives. At the same time, everyone, every woman and even every man, was taught what to do at a birth because the Crees were nomadic, and they lived on the trap lines and they were on the move all the time, so a birth could happen anytime, anywhere. Every adult had to have some basic skill, including the husband. Sometimes, a woman would go into labour and the only person there to help her was her husband, so they had to be taught. This was very important. At the same time there were women who gained experience, became more and more experienced, and really became the midwives. Sometimes people would go get them, but only if the birth seemed to be a bit more complicated. If the birth was going really nice and fast, they would give birth with the people that were around them, and if they felt they needed to, they would go and get the midwives. (NAHO, 2008, p. 14)

The presence of the granny midwife is very much a part of this dialogue. As the presence of midwives in Aboriginal communities is only a few generations back for most communities in

Manitoba, their lives are within living memory. At a gathering in Manitoba in 2009, an elder granny midwife, Florence Hamilton[9] explained her role as a midwife:

> I became a midwife at the age of 16, in the years of 1923 to 1982. I did this for 59 years until I was told not to do it anymore by a nurse that came to Wabowden. [I was told] if I did so I would go to jail. I was given this gift by my Aunt Emma Colombe. When my Aunt Emma was dying she called for me to come and see her. When I went to see her, she took my hand and held it. Emma said, "You have very kind and nice hands keep up the work that we have been doing". Then took both my hands together and said, "I will give you a blessing, whenever you're going to deliver a baby-pray, say 'Help me lord to do this work', and he said, "Always remember that, I will be with you always in delivering babies-you will never have any problems".

For Florence, becoming a midwife meant both being trained as an apprentice by her aunt, but also her aunt blessing her hands, and giving her this gift. From a different perspective, but also shedding light on the role of granny midwives, Chief Ovide Mercredi (2009) explains his birth with an Aboriginal midwife in Northern Manitoba:

> My first breath of life came with the helpful assistance of a qualified person trained in a Cree culture. What is the difference? Not likely too much in terms of the quality of care, as the old woman who delivered me was well aware of possible complications and how to avoid or care for difficult pregnancies. Barbara Sinclair was knowledgeable, experienced, and confident in her abilities. She may not have had the modern tools and technology available today but she was competent and capable having garnered that knowledge through oral traditions and by personal experience. Barbara had delivered many children into this world. For her it was a way of life. It was also spiritual and communal. Babies were not just delivered. Babies were prayed into this world. It was a sacred undertaking.

Being an Aboriginal midwife and spirituality are intimately connected in the history of Aboriginal midwifery. Alongside this, there is also an emphasis on the knowledge of Aboriginal midwives to deliver babies and deal with complications. Florence Hamilton relates a story of attending a breach birth in the northern nursing station:

> My good fortune is that I never lost a baby or its mother. I never ran into any kind of problems. The hardest delivery I had to do was my Grandson Dennis, he was born breech. The roads were closed and the planes couldn't fly…there was a nurse's aide at the nursing station. She called me to go and help her. My daughter Martha was in labour for three days. I was so tired and I needed sleep. I told my son in law, "I'll go and rest for a while". I lied down and fell asleep, and not long after my son in law woke me up. Alex said, "You better come now Mom, Martha is

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[9] Florence Hamilton shared this story at a gathering of the National Aboriginal Council of Midwives in October 2009 in Winnipeg, Manitoba. She passed away in July, 2010 at the age of 94.

really sick". I told Alex, "Don't worry son, you're going to have a red headed son, he is going to grow to be the size of you". Alex grabbed me and was crying, "Okay, God, I hope you're right Mom". When we got there the nurse was there watching her, when she had her pain instead of the baby working down it wanted to go up. I told the nurse I would hold her up on top (of her stomach) and you do the delivery and when she had another pain the nurse yelled and said, "I can't stay here! I don't know what to do!"

I let the nurse go and went to check my daughter Martha, and here was one foot sticking out. I told Martha, "Don't push." Then I went to go to the back and I put a lot of Vaseline on my hands and arms. I went inside to guide the other foot to be put together and when she had another pain, I told her, "Ok, push now". And then I felt for the elbows against the body. The elbows were sticking out. I used my fingers and held them to the body. After the next pain, my daughter pushed and the baby came, my son in law asked, "What is it Mom?" I told him, "I already told you what it was before it was born".

As mentioned, Florence recounts how she was told to stop practicing by the nurses working in her community in the north or else she would face going to prison. This incident coincides with the account of the decline of midwifery in other areas of Canada. However, this is not to say that there did not continue to be Aboriginal women working as midwives in this period of decline. Likewise, the rise of Aboriginal midwifery also coincides with the legislation and regulation of midwifery in some of the Canadian provinces. Darlene, an Aboriginal midwife central to this thesis, became a midwife during the community midwifery movement (discussed above).

3.2.2.   Contemporary understandings and practices of Aboriginal midwifery

The current configuration of Aboriginal midwifery in Canada differs from province to province to territory. The training of Aboriginal midwives and their approach to midwifery also ranges from midwife to midwife. However, they have established NACM in order to collectively and explicitly address broader issues of health and rights in Aboriginal communities. This new wave of Aboriginal midwives, while connected to the granny midwives of the past, has emerged in a variety of new forms.

NACM speaks to both the need for midwifery as part of an overall health strategy for indigenous communities, as well as midwifery as a way to address the historical inequality and relationship between indigenous communities and Western medical care. The mission of NACM is:

> …to promote excellence in reproductive health care for Inuit, First Nations, and Métis women. We advocate for the restoration of midwifery education, the provision of midwifery services, and choice of birthplace for all Aboriginal communities consistent with the U.N. Declaration on the Rights of Indigenous Peoples. As active members of the Canadian Association of Midwives, we represent the professional development and practice needs of Aboriginal midwives to the responsible health authorities in Canada and the global community. (CAM, 2011: p. 9)

In the preface to their core values, NACM recognizes the broad significance of Aboriginal midwives to the community at large. Aboriginal midwifery is not limited to birth attendance and care during and after pregnancy, rather, "the good health and well-being of Aboriginal women and their babies is crucial to the empowerment of Aboriginal families and communities".

> HEALING: Aboriginal midwives enhance the capacity of a community to heal from historical and ongoing traumas, addictions, and violences. Aboriginal midwives draw from a rich tradition of language, Indigenous knowledge, and cultural practice as they work with women to restore health to Aboriginal families and communities.
>
> RESPECT: Aboriginal midwives respect birth as a healthy physiologic process and honour each birth as a spiritual journey.
>
> AUTONOMY: Aboriginal women, families and communities have the inherent right to choose their caregivers and to be active decision makers in their health care.
>
> COMPASSION: Aboriginal midwives act as guides and compassionate caregivers in all Aboriginal communities, rural, urban and remote. The dignity of Aboriginal women is upheld through the provision of kind, considerate and respectful services.

BONDING: Well-being is based on an intact mother and baby bond that must be supported by families, communities and duty bearers in health and social service systems.

BREASTFEEDING: Aboriginal midwives uphold breastfeeding as sacred medicine for the mother and baby that connects the bodies of women to the sustaining powers of our mother earth.

CULTURAL SAFETY: Aboriginal midwives create and protect the sacred space in which each woman, in her uniqueness, can feel safe to express who she is and what she needs.

CLINICAL EXCELLENCE: Aboriginal midwives uphold the standards and principles of exemplary clinical care for women and babies throughout the lifecycle. This includes reproductive health care, well woman and baby care and the creation of sacred, powerful spaces for Aboriginal girls, women, families, and communities.

EDUCATION: Aboriginal midwifery education and practice respects diverse ways of knowing and learning, is responsive to Aboriginal women, families and communities and must be accessible to all who choose this pathway.

RESPONSIBILITY: Aboriginal midwives are responsible for upholding the above values through reciprocal and equal relationships with women, families and their communities. (2012)

Reflecting on the mission and values of NACM, it is clear that Aboriginal midwives draw upon midwifery's emphasis on birth as a healthy physiologic process, as well as recognising the need to uphold the standards and principles of exemplary clinical care. They also draw upon spiritual and sacred elements of birth, and identify themselves as keepers of the responsibility of keeping these spaces "safe" for women, their families, and communities. In this way, Aboriginal midwives balance their roles as primary health care providers in the current health care delivery systems, as well as their identities as knowledgeable, Aboriginal women. They also explicitly state the right of Aboriginal women to choose their place of birth and their care provider. The right to choose is important in the context of this thesis because it positions midwifery as a response to the current reproductive practices of maternal evacuation for First Nations in Manitoba.
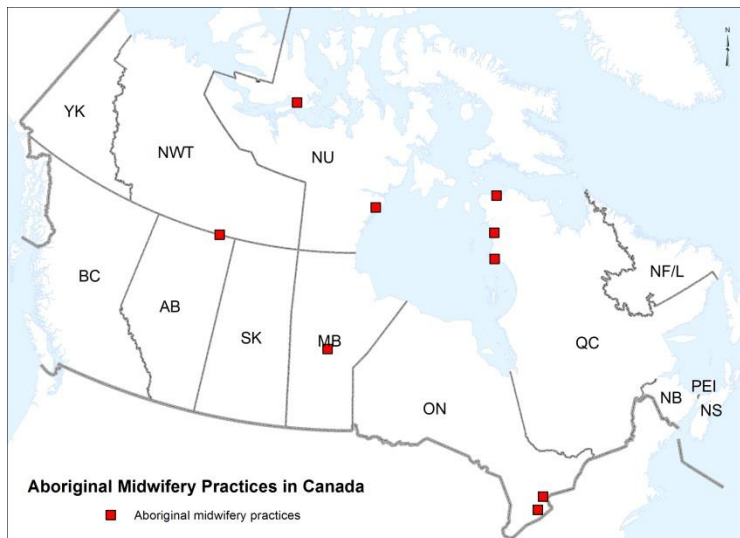
Figure 1: Aboriginal Midwifery Practices in Canada

There are currently only a handful of Aboriginal midwifery practices in Canada (see Figure 1), and they are all unique to their location and the relevant provincial or territorial legislation for midwifery. One of the first places Aboriginal midwifery was reintroduced through the health care system and was in the community of Nunavik, Quebec. The Innulitsivik Health Centre and its midwifery programme are recognised worldwide as a model of collaborative care that successfully provides women the opportunity to birth in their home communities. Since 1986, midwives have been the on-call primary care providers for maternity care for all women. This programme is located in three communities along the Hudson Bay coast. In 1983, 91% of women were transferred out of the community to give birth, which dropped to less than 9% in 1998. (Wagner, 2007, p.1) Midwifery education is a main component of the birth centres, and training Inuit women to become midwives has sustained the programme.

In 1986 in Ontario, the Six Nations of the Grand River opened their Tsi Non:we Ionnakeratstha Ona:grahsta' Six Nations Maternal and Child Centre. This birthing centre works under an exemption clause in the legislation of midwifery in Ontario in that stating that "aboriginal midwives providing traditional midwifery services to aboriginal persons or members of an aboriginal community" are exempt from the Regulated Health Professionals Act. This exemption allows Six Nations to use their own processes to identify who is a midwife; however, if a woman requires transfer to a health care facility outside of their centre, the midwife no longer has jurisdiction to provide care to those women in those facilities. British Columbia and Quebec also have exemption clauses for Aboriginal midwives in their legislation.

In the Northwest Territories, there is a midwifery practice in the remote town of Fort Smith. The midwifery programme was officially into its territorial health programming in 2005. Midwives, including one Aboriginal midwife, had been working in the community for many years in a private practice and chose to become a part of the local health care system. The clinic is a part of the health complex, and is not located on federal reserve land. (Becker and Paulette, 2008) A key feature of

the rural and remote Aboriginal midwifery practices is the presence of a perinatal committee composed of both midwives and doctors that review all midwifery client charts on a weekly or bi-weekly basis to review risk assessments and determine eligibility for birth in the community. (Wagner, 2007; Becker and Paulette, 2008)

There is only one urban, Aboriginal midwifery practice in Canada: an Aboriginal midwifery practice in downtown Toronto called Seventh Generation Midwives. There is also a birth centre in Rankin Inlet, Nunavut with primarily non-Inuit midwives working there. Finally, there is the Kinosao Sipi midwifery clinic in Norway House, Manitoba, which is central to this thesis and will be discussed in detail in chapter 11.

Whilst Aboriginal midwives work in other settings and practices, these are the only places where Aboriginal midwifery is explicitly being practiced. There are Aboriginal midwives in other communities across Canada currently in the process of introducing midwifery into their communities, including practices in Quebec, Ontario, and British Columbia.

3.2.3. Safety and birth outcomes in Aboriginal midwifery practices

In this thesis, the safety of an Aboriginal midwifery practice in a rural, remote First Nation community was called into question. A recent study comparing birth outcomes and primary care attendants in Nunavik, Quebec attempted to address the lack of research data around the safety of midwife-led maternity care in remote communities. While the results of the study were inconclusive, the authors note that "the results excluding extremely preterm births are more reassuring concerning the safety of midwife-led maternity care in remote indigenous communities" (Simonet et al., 2009). In remote areas, the SOGC recommends that midwives should be the primary providers of care for all pregnant women, since they are typically the health professionals with the most expertise in pregnancy-related concerns. (Couchie and Sanderson, 2007) The Society also recommends that midwifery should be an integral part of any changes made to services in Aboriginal communities, and those protocols for normal and emergency clinical care should be developed in collaboration with midwifery programmes. (Joint Working Group, 1998) The SOGC recommended that where present, midwives offer services to all pregnant women, regardless of risk status, and work in collaboration with nurses and physicians to ensure proper care for high-risk women. This will allow all women to receive the majority of their care in their home community, from a group of professionals dedicated to health promotion and the prevention of problems. (Roy and Couchie, 2007)

I now briefly look at the outcomes for current remote Aboriginal midwifery practices, as well as rates of transportation and transfer of care for First Nations and Inuit women who plan to give birth in their communities with midwifery services. It will be shown in this thesis that much of the resistance observed at the local and regional levels from FNIH to implementing midwifery services in communities stems from this fear of emergency transfer and transport.

An internal audit of the Nunavik maternities revealed that between 2002 and 2005 out of the 374 births planned for the birth centres, 92% took place in Nunavik. Of these births, "9.3% involved maternal transfer (antepartum, intrapartum, or postpartum), and 1% involved neonatal transfer" (Wagner, 2007). Of the maternal transfers:

> 7.8% were transferred to Montreal, and 1.6% transfers were to Puvirnituq. It is stated that the most common reason for transfer was preterm labour (14/42; 33%). However, 64% (n 9) of the women who were transferred for preterm labour without ruptured membranes delivered at term, often after returning to the north. (Wagner, 2007)

In Fort Smith, North West Territories, the rate of intrapartum transfer was 12% from 2005 to 2008. Of 58 women in total, seven were transferred for the following reasons: preterm labour (1), VBAC prior to referral (1), failure to progress (4), and breech discovered (1). (Becker and Paulette, 2008)

At the Rankin Inlet Birthing Centre, an audit covering the period of 1991 to 2004 revealed that between 1991 and 2000, there were 10 women who were transferred from Rankin Inlet during labour. The study showed that:

> ...fifty percent of the transfers during labour (5/10) involved preterm labour. Reasons for transfer were premature rupture of membranes with premature labour (4/10), premature labour with no PROM specified (1/10), failure to progress (1/10), pregnancy-induced hypertension (1/10), decreased fetal heart rate (1/10), lack of staff in Rankin Inlet (1/10) and unknown reasons (1/10). (Macauley and Durcan, n.d.)

During the period of 2000 to 2004, no cases of transfer during labour were recorded at the Rankin Inlet Centre.

3.3. Midwifery in Manitoba

Now that the histories of both midwifery and Aboriginal midwifery have been discussed, it is important to locate midwifery in the province of Manitoba in order to contextualise the Kinosao Sipi midwifery clinic, the subject of this thesis, in the history of midwifery practice in Manitoba.

Legislating and implementing midwifery in Manitoba was similar to the Ontario scenario; however, there are a few marked differences. Along with the same factors of the lay midwives and the nurse-midwives coming together to implement midwifery, a third group of midwives was also part of the development of midwifery in the province: these were the immigrant midwives. Kaufert and Robinson (2004) describe the coming together of three groups. The "unregulated or community" midwives, who had been "educated abroad or taken courses offered by US-based midwifery education," but were characterised by a deep commitment to a "model of midwifery care based on training by apprenticeship and through experience of attending to women as they give birth" (p. 206). Kaufert and Robinson trace the history of the community midwives to the home birth movement in the United States, and point out how these midwives, in calling themselves the "Traditional Midwives Collective" in 1985, drew upon the history of the "neighbour or granny" midwife in the history of the province (p. 213). The second largest group was the nurse-midwives, who had been mainly "educated in Europe" and trained "under the British midwifery model" (p. 206). They were also nurse-midwives who had been hired to work in northern nursing stations. After their contracts had been terminated by the Canadian government, many "drifted southwards, often finding work in hospital-based departments of obstetrics" (p. 206). The final and largest group of midwives were the "immigrant" midwives who had been trained in the "Philippines, China, and southeast Asia" and worked on the "periphery of the health care system" as "home care workers or nannies" (p. 207). This was because they "could not risk their immigrant status by copying the community midwives" and "provid[e] midwifery care outside the law," but nor could they work as obstetric nurses (p. 207).

Like Ontario, the push to legislate was motivated in part by an inquest into a baby's death. The two-year long inquest, which involved two midwives who attended the birth of twins and one of the babies died. At this time, the Manitoba government formed a Midwifery Implementation Committee (MIC) to transform recommendations from an early governmental committee that outlined the "essential characteristics of a made-for-Manitoba midwife" (Kaufert and Robinson, 2004, p. 205). Questions of structure of midwifery practice, including jurisdiction to attend "out of hospital" (OOH) births, educational requirements for registration, and also who should be receiving midwifery care were tasked to the MIC.

The result of the midwifery registration in Manitoba is that midwives were to work as employees of the province of Manitoba, hired by the various regional health authorities (RHA) across the province. In 2011, there were eleven RHAs; six of them had active and funded position for midwives (see figure 2). The Winnipeg Regional Health Authority (WRHA), encompassing the capital city of

Winnipeg, had 28.8 funded positions, the rural RHAs of South Eastman, Central, and Brandon had a total of 19.5 positions, and the northern RHAs of Burntwood and Nor-Man had three. However,
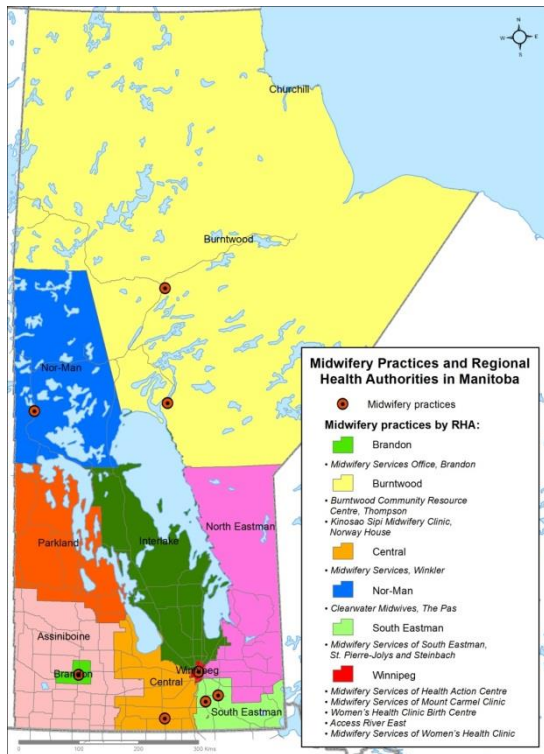
Figure 2: Midwifery Practices and Regional Health Authorities in Manitoba

despite having these midwifery positions available, there are consistently open and unfilled positions in each RHA. (Manitoba Health, personal communication, 24/04/2012).

In addition to their employment model, Manitoba midwives were given the jurisdiction to attend OOH births, including births that occurred in rural areas, inclusive of northern nursing stations and hospitals. Kaufert and Robinson (2004) outline the tensions that arose during the implementation process surrounding the issue of OOH birth. The MIC committee recommended the North American Registry of Midwives (NARM) as the basis for the development of the assessment process to register midwives. One of these conditions for eligibility to begin the assessment process was that the midwife

would have to have attended "ten home births as primary midwife" in the past ten years, while attended at hospital births was not required (p. 209). This was met by protest from the nurse-midwives and the immigrant midwives, as only the community midwives would have fulfilled this criteria. This resulted in the MIC recommending that "midwives as a group would still work in home and hospital settings, although not all midwives would work in both settings" (p. 211). This was significant in that it brought to the forefront the negotiation between "different visions of the midwife, different philosophies of midwifery care, and conflicting claims over who is (or is not) a true midwife" (p.211).

The other area that the MIC addressed was the rising critique of the racial inequalities that existed in the implementation of midwifery elsewhere in Canada. Sheryl Nestel (2004) critiqued the exclusion of visible minorities into midwifery in Ontario. This highlighted the tendency of midwives to serve a certain "type of population", especially in home births, of "largely white, largely urban, and largely highly educated" women (Kaufert and Robinson 2004: p. 216). In Manitoba, this accusation was actively avoided by establishing criteria for midwifery clients that included a provision that at least 50% of midwifery clients must come from "priority populations". Manitoba

Health defined these as "single women, adolescents (under 20 years of age), immigrant/newcomer, Aboriginal, socially isolated, poor, other at-risk women" (Manitoba Health 2002: p. 1). While the definitions of these populations could be explored in great detail, for the purposes of the history of midwifery in Manitoba, it is important to understand that there was an explicit attempt to address perceived, and potential, racial (and social) inequalities within midwifery practice. In the WRHA, midwifery positions were also placed in clinics and neighbourhoods known to have higher populations of immigrants/newcomers, Aboriginal, and socio-economically disadvantaged populations.

The link to evacuation and midwifery in Aboriginal communities was also made explicit by the MIC. In 1993, the Manitoba Midwifery Working Group included information on consultations with First Nations and Métis organisations in a report submitted to the Minister of Health. The main message in this report regarding Aboriginal communities and midwifery is that there was a need to "educate people living in Aboriginal communities to become midwives so that birth could take place closer to home" (AMEP, 2006, p. 8). In 1994, the Midwifery Implementation Council (MIC) emphasised ensuring access to midwifery care by Aboriginal populations, and the MIC conducted extensive consultations with Aboriginal women and organisations. The MIC consultation reports concluded that returning birth to communities is "the greatest factor promoting health and in strengthening both family and community ties" (AMEP, 2006, p.8). This intensive consultation and inclusion of the Aboriginal population in the building of regulated midwifery in the province in evidenced by its unique inclusion of a standing committee on issues related to midwifery care for Aboriginal women as part of the Manitoba Midwifery Act. This committee was given the name Kagike Danikobidan (meaning "always making grandparents"). (AMEP, 2006, p. 9) The struggles in the politics of birth place and midwifery in Manitoba were encountered, despite these intentions in setting up midwifery care in Manitoba. This thesis delves into the issue of Aboriginal midwives working in remote First Nations communities and their challenges to practice in Manitoba.

4. First Nations, health care, and the Canadian state

In this chapter, I wish to examine the historical role of the state in the development of First Nations health policies and practices. The focus of this thesis is birth place and Aboriginal midwifery, and it is important to fully realise the role of the state in this process. During fieldwork, and observing the struggles of the midwives to practice in a First Nation community, the question of the role of the state and their resistance to shifting birth place often arose. Why did they care so much about where babies were being born? What was at stake, and for whom? I believe that by situating the issue in the historical context begins to answer these questions.

We move from a discussion of the history of midwifery in Canada and the overarching theme of the medicalisation of childbirth and the movement of birth from home to hospital. In this section, we move through the history of the relationship between the Canadian state and First Nations within an agenda of modernisation[10]. The position of the Canadian state in regards to the maintenance of control of indigenous populations and their rights to will be shown to be explicitly modernist, and the implications of this view in relation to the risks posed by indigenous peoples to the aspirations of the state in terms of the global economy will give insight into the position of the state in regards to maintaining control over where and how people are born. While this may seem like a move away from the original topic of place of birth and Aboriginal midwifery, I argue that the current discussions surrounding birth are very much rooted in this notion of development and the ongoing negotiation of indigenous identity and modernisation. When delving into the politics of Canada and First Nations, childbirth is not at the top of the list. Rather, access to resources, defining rights to land and water, the role of consultation processes and the right to impede resource development come looming into the forefront of the issues. Rather than take these issues as disparate, I choose to see them as rooted in the same debate over rights, responsibilities, and the how the future of the Canada is imagined by both the state and its indigenous peoples.

4.1. The state and its citizens

The approach of this thesis to the state, citizenship, and policy requires explanation. The notion that the state is a discrete entity, or a "clearly bounded institution that is distinct from society… portrayed as a unitary and autonomous actor that possesses the supreme authority to regulate populations within its territory" can only take this discussion so far (Gupta 2001). Rather, engaging

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[10] Norman Long describes modernisation as "visualizing development in terms of a progressive movement towards technologically more complex and integrated forms of 'modern' society" (Long and Long, 1992: 18). Modernisation, then, is essentially an evolutionary idea, in which a society or culture moves along a linear continuum, and is usually measured by advances such as an "increase in income, participation in wage labour and growth in material wealth" (Young, 1995: 4).

with the state as "both an illusionary as well as a set of concrete institutions; as both distant and impersonal ideas as well as localised and personified institutions; as both violent and destructive as well as benevolent and productive" lends itself to deeper exploration (Hansen and Stepputat, 2001, p. 5). In this way, the state is in a "continuous process of construction" taking place through "a bundle of widespread and globalised registers of governance and authority" (Hansen and Stepputat, 2001, p. 5). We can then begin to "understand how 'the state' comes into being, how 'it' is differentiated from other institutional forms, and what effects this construction has on the operation and diffusion of power throughout society" (Gupta, 2001). In the case of reproduction, it is important to understand how, on one hand, the state uses it to "produce and reproduce its own mechanisms of status and control" (Unnithan, 2004, p. 3). The Canadian state does not just consist of the institutional structures and the laws and policy documents that come out of a central apex of power. Rather, its power and control over its citizens becomes enacted and practiced in everyday life. Recognising that the state intervenes and affects different subsets of its population in different ways is integral to this discussion. Aboriginal women, because of their marginalised position within the state, can be seen to be subjected to "top-down" impositions of health service delivery and health policy. (Fiske and Browne, 2008, p. 108) This fact has been pointed out in other settings that single out "poor women" as targets of these policies. (Pigg, 1997; Van Hollen, 2003; Unnithan-Kumar, 2004)

Citizenship can be viewed as being either formal or substantive. (Held, 1989, p.22) Formal citizenship is "the rights or entitlements afforded to individuals as 'citizens', as described in formal declarations, legislation, policies, or statutes", whereas substantive citizenship takes into consideration the ability of individuals or groups to "allow citizenship to become a reality in practice" (Salmon, 2007, p. 2). Citizenship has an uneasy history with respect to Aboriginal Peoples in Canada. Amy Salmon (2007) explains that:

> …as a colonial state, the institutional practices of Canadian nation-building have been founded upon the social, political, economic, and cultural domination of Aboriginal peoples and explicit efforts to limit or exclude Aboriginal peoples from both rights and recognition as "citizens". As official "wards of the Crown", Aboriginal peoples remain formally disenfranchised in their relations with the Canadian state." (p. 4)

Fiske and Browne (2008) show how the cultural construction of citizenship as "liberal notions of respect for diversity" and that the "assumption that citizens can – and do – shape government actions through participating in policy reform underlies a common view of democratic citizenship". They go on to show how within health policy reform, Aboriginal women, who remain ""on the margins of citizenship" become "discredited medical subjects" through the process of

"marginalisation and displacement" (p. 108). At the same time that these "rights" as citizens are being denied, according to Salmon (2007), the rights of indigenous people on an international level is being formally articulated with Canadian participation. Also, the rights of indigenous peoples are a part of a very different dialogue in comparison to other Canadian citizens, both as "wards of the Crown" and the duty of the Crown to fulfill its duty in taking care of them. I now wish to turn to a look at the creation of First Nations citizens from the perspective of the Canadian state through the process of defining First Nations identity.

4.2. Defining First Nations populations

Population statistics used to frame and define nations within nations are not neutral. The statistical profiles produced about groups of people become a part of the larger national discourse that create its citizens, and thus simultaneously produces and reproduces notions of belonging for some and exclusion for others. Often these statistical analyses focus on the bodies of women as indicators of health, however, more recently, the Canadian state has also adopted statistical profiles that address broader 'social determinants' of health and well-being, such as housing, education, income level, etc… into their profiles.

Before beginning to delve into the history of First Nations health care provision by the state, it is important to discuss how one becomes eligible to be included in the state category of "Aboriginal", and more specifically, "Indian". This complex process of being to be counted is firmly situated in the politico-historical relationship of the Canadian state and its indigenous inhabitants, and shows how the state has, and continues, to make First Nations relationships that produce offspring an on-going concern.

In this section, I wish to look at the State's defining of one the indigenous populations while recognising that this is a broad level of analysis that does not delve into the complexities of becoming, or being, indigenous. The role of the State in defining who qualifies to be "Registered Indian" and who does not can be seen as part of the colonial present for indigenous people in Canada today. First Nations continually cite this as "continued interference with and failure to acknowledge First Nations jurisdiction over citizenship matters" (Hurley and Simeone, 2010). It is important to establish the historical perspective of recognising indigenous identity by the state in order to contextualise the present intervention and control of the state over the childbearing practices of First Nations women.

4.3. Historical development of defining "Indians"

The Constitution Act of 1867, subsection 91(24), gives the federal government "full and complete responsibility" for Indians and lands reserved for Indians (Phare, 2009, p. 25). This subsection is called the Indian Act and remains "the principal expression of Parliament's jurisdiction" over its indigenous populations (Hurley and Simeone, 2010, p. 1). Along with this control over people and land, the Indian Act also defines who is a Registered Indian under the Act. Becoming registered means entitlement to a "range of legislated rights as well as eligibility for federal programmes and services" (Hurley and Simeone, 2010, p. 1). Therefore, there are implications for the state on who becomes part of their constitutional responsibility. This is a point of entry into the reproductive life of First Nations from the perspective of the state. The historical development of defining "Indians" is a process of negotiating rights and responsibilities embedded in social, political and economic processes that allow the state to intervene and define indigenous identity at an official level. This official identity prescription enters into family and social life in a myriad of ways. In this context, access to health services and the ways in which women relocate to give birth is, in part, shaped by this definition.

The earliest official definition of "Indian" came about through the Indian Protection Act of 1850, with the following four provisions:

> 1. All persons of Indian blood, reputed to belong to the particular Body or Tribe of Indians interested in such lands and their descendants.
>
> 2. All persons intermarried with any such Indians and residing amongst them, and their descendants of all such persons.
>
> 3. All persons residing among such Indians, who parents on either side were or are Indians of such Body or Tribe or entitled to be considered as such.
>
> 4. All persons adopted in infancy by any such Indians, and residing in the village or upon the lands of such Tribe or Body of Indians and their Descendants. (Miller, Lerchs & Moore, 1978, p. 36)

This Act was seen as controversial, and one year later, it was amended to include:

> All women, now or hereafter to be lawfully married to any of the persons included in the several classes hereinbefore designated, the children issued of such marriages, and their descendants. (Miller, Lerchs & Moore, 1978, p. 37)

This change was the first to differentiate "non-status" and "status" Indians, and introduce gender differentiation in gaining status. Miller, Lerchs & Moore (1978) also cite the 1857 Act for the Gradual Civilisation of Indians as a telling example of the government's preference to assimilate Indians rather than maintaining their distinctiveness in the legislation. The preamble to the Act states:

> Whereas it is desirable to encourage the progress of Civilisation among the Indian Tribes in this Province, and the gradual removal of all legal distinctions between them and her Majesty's other Canadian Subjects, and to facilitate the acquisition of property and of the rights accompanying it... (p. 27)

In 1869, a statute introduced the provision that if a marriage occurred between an Indian woman to an non-Indian man, the woman and her children would lose their status. The opposite was true for Indian men marrying non-Indian women. In this situation, the non-Indian women would gain Indian status. This was maintained in the 1876 Indian Act, and continues to be an issue to present day.

In 1951, the Indian Act was revised and important changes were made to the document. One of these was the establishment of a centralised "Indian Register" (Hurley and Simeone, 2010, p. 5). The Act maintained the provision of loss of status for Indian women, and also introduced the 'double mother' rule, which stated that:

> ...a person registered at birth would lose status and band membership at age 21, if his/her parents had married after the coming into effect of the legislation in September 1951 and his/her mother and paternal grandmother had acquired status only through marriage. (Hurley and Simeone, 2010, p. 5)

For the next thirty years, this Act was opposed by First Nations advocacy organisations and through court cases, such as Lavell, but it was not until the Canadian Charter of Rights and Freedom in 1982 that propelled the government to change its discriminatory framework for deciding who is an "Indian". Entitled Bill C-31, the changes included:

- persons with acquired rights, i.e., entitled to registration prior to 1985, including non-Indian women married to Indian men and their children, retained full status (paragraph 6(1)(a));
- women who had lost status through the marrying-out provision or through an order of enfranchisement, and persons who had lost status at 21 through the double mother rule, regained status (paragraph 6(1)(c)); and
- persons with one parent entitled to registration under subsection 6(1) acquired status under subsection 6(2); persons with one parent registered under subsection 6(2) and one non-status parent were/are not entitled to registration. (Hurley and Simeone, 2010, p. 3)

This amendment to the Bill was heavily criticised mainly for the distinction between 6(1) and 6(2), known as the "second generation cut-off". It is at this point that determining Indian Status can become excessively complex. However, the point here is that while this Bill addressed the gender inequality from that point (1985) onwards, the reinstating of status to woman who had lost it meant that their descendants were subjected to the "cut off" in a different way than Indian men who had not lost their status at all. Hurley and Simeone (2010) explain this as:

> …the children of Indian men who had married non-Indian women before 1985 were registered under subsection 6(1) and, despite having the same degree of Indian ancestry as subsection 6(2) registrants, were able to transmit status to their offspring when they married out. Those offspring, registered under subsection 6(2), could in turn pass on status for at least an additional generation (25% descent). (p. 4)

Bill C-31 was amended on December 15, 2010 by Bill C-3. This bill was a result of the court case of McIvor vs. Canada, in which the Court of Appeal for British Columbia found the Indian Act to be unconstitutional. This Bill is said to ensure "that eligible grand-children of women, who lost status as a result of marrying non-Indian men, will become entitled to registration" (Aboriginal Affairs and Northern Development Canada, 2011).

From this discussion of the state defining First Nations people, two points become clear. First, the status of who qualifies to be registered as First Nations, in particular, in the Indian Register, is of importance to the Canadian government. This definition permeates into family life and the relationship between men and women and their offspring, and subsequently, shapes how these families are seen and dealt with by the state in terms of their continued obligation to ensure continued rights and access to resources. Secondly, there is an underlying discourse that permeates through the defining and re-defining of Indians, and this is one of civilising and modernising First Nations people. Throughout these various political and legislative processes, there is a consistent link between defining Indians and defining their lands, or territories, and how best to use them. This will be discussed in more detail in other sections, although it is important to note here that the very definition of "who" in the historical development of the Canadian state places the Indian in the context of a land and resource base, and continually emphasises the need to engage both the land and bodies of Indians in a more vibrant and advantageous economic state through the exploitation of both.

4.4. Projecting the future

Coinciding with changes in eligibility for registration, reports on population projection were produced by the Canadian government. A brief overview of these projections based on Bill C-31 and Bill C-3 will be examined and key points emerge regarding the position of the state in relation to the fertility, and childbearing practices, for First Nations.

The Department of Indian Affairs estimates that over 117,000 people have regained or acquired status since Bill C-31 came into effect. However, the "second generation cut off" provision in the Bill will "result in a rapid decline in the population entitled to registration" (Hurley and Simeone, 2010, p. 4). The projection goes on to report that:

> …those non-entitled to registration are expected to begin to outnumber those entitled to registration in about three generations. Projection trends suggest that sometime around the end of the fifth generation, no further children will be born with entitlement to Indian registration. (cited in Hurley and Simeone, 2010, p. 4)

Since Bill C-3 came into effect in January 2011, these projections have now changed. According to the federal government, this legislation resulted in approximately 45,000 new registrants. (Aboriginal Affairs and Northern Development Canada, 2011) The population projections reflected in the most recent report released in December 2011 shows that:

> …the Aboriginal identity population in Canada, estimated at 1.3 million in 2006, could reach between 1.7 million and 2.2 million in 2031. Aboriginal peoples would then represent between 4.0% and 5.3% of the Canadian population, compared to 3.9% in 2006. (Malenfant & Morency, 2011, p. 11)

The report also notes that the average annual growth rate of the Aboriginal population would "range between 1.1% and 2.2% from 2006-2031", whilst the non-Aboriginal population rate is projected to remain at 1%. Specific to First Nations, the report also notes that "the North American Indian population living on reserve would grow during the 25 years covered by the projections" and would increase to "between 511,000-585,000" from 361,000 in 2006 (Malenfant & Morency, 2011, p. 11). These numbers are based on Aboriginal identity reported in the Census combined with other measures, therefore, they do not directly constitute changes to the Indian Register in that the category of First Nations includes status and non-status individuals, however, one can assume that with the restrictions lessened for eligibility for registration, the increase in population has the possibility of affecting this number. This is where the focus on fertility and women's bodies come into play. Also, where the women are located is of interest since being on reserve has direct implications to the government's jurisdictional responsibilities.

While the study employs traditional demographic techniques of looking at fertility and mortality rates, the discussion of fertility in the report reveal a continuance of the modernist view of the Canadian state towards First Nations. The fertility rate of First Nations is higher than the non-Aboriginal population. The study shows that despite the fertility rate lowering since the 1960s, it still remains higher at 2.2% compared to 1.0% in the non-Aboriginal population. In the period of 2005/2006, the odds of bearing a child if you were First Nations woman was 1.49 compared to the non-Aboriginal rate of 1.00. Living on reserve and being a Registered Indian were also positively associated with this data. (Malenfant & Morency, 2011, p. 21) In relation to future fertility rates, the study asks the question:

> Do the cultural and socio-economic specificities that can be assumed to be related to Aboriginal peoples different fertility ensure that the fertility of these populations will exceed that of non-Aboriginal people on a lasting basis? Or, on the contrary, should we expect that in adopting a lifestyle that they share-increasingly so-with non-Aboriginal people, Aboriginal peoples will see their fertility behaviours become similar to those of the overall population? (p. 21)

Under the second assumption, the size of the decrease in fertility is a "function of the 'excess fertility' of each of the groups" and that the reduction will be greatest for "North American Indians and Inuit". Under this assumption, the gap between the two groups will be reduced by half. (p. 21)

The association between lower fertility rates and "modern" society has been critiqued by many authors (Kanaaneh 2002; Van Hollen 2003). This view that in order to progress, one must reduce their number of children is common from a modernist perspective. Adopting, or in order words, assimilating into, a "non-Aboriginal" lifestyle, means having fewer children in general, and in particular, fewer children under federal constitutional obligation.

4.5. Indian policy: modernising land and bodies

Early in Canadian state policy directed towards First Nations people, there is an explicit link between Indian bodies and land and resources, and the assumptions about appropriate "use" of both. Miller, Lerchs & Moore (1978) note that "changes in policy" were directed by "a change in social attitude" towards First Nations (p. 4). They emphasise that after 1850, two main objectives emerged in Indian policy. These were:

1. Protection of Indians from destructive elements of "white" society until Christianity and education raised them to an acceptable level, and
2. Protection of Indian lands until Indian people were able to occupy and protect them *in the same way as other citizens*. (p. 4, italics mine)

The role of the state in the lives of Indians was clearly articulated as one of "protector", especially when it involved "matters of land" (p. 5). Therefore, there was very much a philanthropic notion of taking care of the Indians, and ridding them of their savage ways, but also educating them in how best to use their territories. The state tried to implement a plan to turn the indigenous populations into agriculturists. This was regarded as mostly unsuccessful, as Lord Sydenham despaired in 1841:

> The attempt to combine a system of pupilage with the settlement of these people in civilised parts of the country, leads only to embarrassment of the Government, expense to the Crown, a waste of resources of the province, and injury to the Indians themselves... He occupies valuable land, unprofitably to himself and injurious to the country. He gives infinite trouble to the Government and adds nothing either to the wealth, the industry, or the defense of the Province. (Miller, Lerchs & Moore 1978: p. 17)

It is clear that both the bodies and the land of Indians were not being used to their full potential. As described above, active policies of assimilation and enfranchisement tried to remedy this problem. Therefore, Indians had not only become unsuccessful at bodily reforming into "citizens" of Canada, but also had become obstacles to the development (mainly resource-based) and the potential future of the country. Despite the fact that these discourses of Indian bodies and land took place over a century ago, these same threads remain running through state policy regarding indigenous peoples. As Miller, Lerchs & Moore (1978) compare two statements made by Ministers of Indian Affairs, they note that although the semantics had slightly altered, the message conveyed by both Ministers was essentially the same. In a House of Commons debate in 1880 Sir John A. Macdonald stated that government Indian policy was:

> ...to wean them by slow degrees, from their nomadic habits, which have almost become an instinct, and by slow degrees absorb them or settle them on the land. Meantime they must be fairly protected (Miller, Lerchs & Moore, 1978).

In 1950, Walter E. Harris stated that:

> The ultimate goal of our Indian policy is the integration of the Indians into the general life and economy of the country. It is recognised, however, that during a temporary transition period of varying length, depending upon the circumstances and stage of development of different bands, special treatment and legislation are necessary. (Miller, Lerchs & Moore, 1978)

Even today, discourses of stimulating job creation and Aboriginal participation in the economy (this is particularly prevalent in consultation processes regarding resource development in areas that may affect indigenous rights to use the land) continue as one of the main aspects of state engagement with First Nations. In Manitoba, this is particularly evident with respect to hydro-electric development in First Nations territories.

In Manitoba, hydro-electricity is the main source of industrial development. Manitoba Hydro is the Crown Corporation and the province's major energy utility. (Manitoba Hydro, n.d., p. 1) Manitoba Hydro generates almost all of its electricity from "self-renewing water power from 14 hydroelectric generating stations, primarily on the Winnipeg, Saskatchewan and Nelson rivers" and "have capital assets-in-service at original cost approaching $13 billion, making us one of the largest energy utilities in Canada" (ibid; p. 2). The majority of their revenue comes from exporting electricity to other Canadian provinces and the United States. They note that, "In 2010–11 export sales totalled $398 million with 84 per cent derived from the U.S. market and 16 per cent from sales to Canadian markets. Since 2002,our export sales have totalled $5.5 billion" (ibid, p. 2).

In the early 1960s, Manitoba Hydro proposed to build a mega-hydro project and was supported by both the federal and provincial governments. Because of this, the governments of Canada, Manitoba, and Manitoba Hydro "signed a series of agreements that set in motions the plans for a megaproject" (Wera and Martin, 2008: p.59). However, as Wera and Martin (2008) note, "missing from the set of interested parties were the Crees of northern Manitoba… [who] were unaware of the plans being made for them" (p. 59). The adverse effects of major hydro development in the north were "the final step in removing… the opportunity to fully support and sustain their [First Nations] traditional way of life" (Waldram 1999, 1988, 1987, cited in Wera and Martin, 2008: p. 59). The Churchill-Nelson project led to the "relocation of 450 persons and the Grand Rapids project displaced some 1250 residents" (p. 65). As Chief Ovide Mercredi stated in a meeting I attended, "Manitoba Hydro is our trauma".

In Manitoba, negotiations around water and rights to water are distinct from other areas of Canada, such as the James Bay, Quebec. As Martin and Hoffman (2008) explain:

> The approach of Manitoba Hydro, which continues to develop what might be called "business-only partnerships." … While many commentators and some FN leaders have argues that this type of deal is the best way to involve Aboriginal communities in the inevitable development of their natural resources while simultaneously generating revenues and employment for northern populations, other have criticised Manitoba for continuing a colonial tradition characterised by inherently exploitive relationships. (p. 3)

Contextualising the relationship of Manitoba Hydro and First Nations in Manitoba is telling in a number of ways. It reinforces the notions of modernisation that have been a thread throughout this historical overview of First Nations and the State. By developing only "business" partnerships with First Nations, it effectively is seeking to continue the modernising project through the facilitation of Aboriginal peoples' use of the land in more "profitable" ways.

4.6. Historical development of health care for First Nations

Bent, Havelock, & Haworth-Brockman (2007) trace the key events regarding entitlements to health services for Aboriginal Peoples, the first of these being the Royal Proclamation of 1763, in which King George III stated that "any lands within the territorial confines of the new governments that had not been ceded by the Indian people were reserved for the Indian people" (p. 9). This was important as it set the stage for treaties to be signed between First Nations people and the Crown. (Steckley and Cummins, 2001, p. 119) Eleven numbered treaties were signed between 1871 and 1906. Treaty 6 has become the most important treaty in relation to health services, as it included a provision that "a medicine chest will be kept in the house of each Indian Agent for the benefit of the Indian people" (Ray, Miller, & Tough, 2000, p. 143). The meaning of this clause was debated but eventually came to be interpreted as meaning "free medical care" to Indian people (Bent, Havelock, & Haworth-Brockman., 2007, p. 10). The treaties also created Indian reserves, the lands designated to Indian peoples.

The British North America Act of 1867 (BNA Act) established the country of Canada. In this Act, the provision of providing health care rested with the provincial governments, with the exception of Indians. This is explained by the fact that in Section 91(24) of the Act, the legislative authority over "Indians and the lands reserved for Indians" was the responsibility of the federal government. Also, since it was the Crown that signed the treaties with Aboriginal peoples and not the provinces, including the clause for a medicine chest, the contention was that the responsibility of providing health care rests with the federal government. (Bent, Havelock, & Haworth-Brockman, 2007, p. 12) In defining the status of registered Indians, the BNA Act resulted in the "loss of control over their organisation and governance and health and social structures" (Carroll and Benoit, 2004, p. 269). This also marks the point of departure from which the provinces constructed policies and programmes that differentiated from one another. The balance between the provincial approach to health care and the federal government's policies and programmes is a reality that has, and continues to face Aboriginal peoples across Canada.

In it the history of providing health services to First Nations peoples provided by the First Nations Inuit Health Branch (FNIHB), the provision of health care is explained in these terms:

> By the 1900s, First Nations and Inuit communities were decimated by smallpox, tuberculosis, and other communicable diseases, but little coordinated effort existed on a national level to address the health crisis. In 1904, the Department of Indian Affairs appointed a general medical superintendent to start medical programmes and develop health facilities. (FNIHB, 2007)

It is important to note that the Canadian government chooses this as its point of departure in its intervention of healthcare. It places itself in the paternalistic role of coming to the aid of communities in crisis, and while I do not wish to suggest that this was not the case, the rates of infectious disease at the term of the century are well documented. However, as Carroll and Benoit (2004) point out, it was the compounding of these epidemics with the "paternalistic government policy… which contributed to the weakening of Aboriginal peoples' health and well-being" (p. 269). It is interesting that this is the first image we receive of the government's role regarding the health of Aboriginal peoples. In choosing this point of departure, the historical summary provided by FNIHB contributes to "an understanding of Aboriginal society that reinforces unequal power relationships; in other words, an image of sick, disorganised communities can be used to justify paternalism and dependence" (O'Neil, Reading, & Leader, 1998, p. 230). This may be, however, taking this analysis a bit too far at this point. Therefore, while the tone of this statement is noted, we must look further into this history to fully realise this claim.

The Indian Act (1876 and 1958) prohibited "traditional healing practices and ceremonies", a restriction that was in place until the Act was amended in 1960s (O'Neil and Kaufert, 1995). Dickason (1992) notes that communities were assigned government appointed "Indian Agents", individuals who were "often without medical training", and who assumed "authority over local healers".

The Indian Act also clearly articulated its assimilationist intentions through its process of enfranchisement. It clearly spelled out how "Indians could acquire full Canadian citizenship by relinquishing ties to their communities…(including) giving up culture and traditions, and any rights to land" (Hick, 1998). Incentives to enfranchisement included the right to vote. There were also some circumstances in which enfranchisement was compulsory, this included "if an Indian became a doctor, lawyer, Christian Minister, or earned a university degree" (Furi and Wherret, 1996). The clause regarding earning a university degree was an amendment to the Act made in 1880, and a subsequent amendment in 1933 gave the government the power to enfranchise Indians without their consent. (Baines, 1996, p. 9) The issue of enfranchisement came to a head with the White Paper in 1969 in which it was proposed that the Indian Act be repealed and that the federal government no longer hold any responsibility to Indian peoples, and passing the administration of Aboriginal lands to the provinces. The justification of this was to "place aboriginal peoples on an equal footing with the rest of Canadian citizens" (Baines, 1996, p. 10). The White Paper did not see its fruition.

The issue of enfranchisement can be seen as a determinant of health in the way Aboriginal peoples were positioned where they were forced to choose between their cultures and communities, and their rights to participate as "formal" citizens in the Canadian state. Within the discourse surrounding disenfranchisement and assimilation, there is a constant reiterating of the need for Aboriginal peoples to "catch up" or be on "equal footing" with the rest of the Canadian population. This idea that Aboriginal peoples are somehow behind or need to become "modern" speaks directly to Escobar's arguments on the discourse of development that serves to "legitimise differential positions of power… within nations" (Van Hollen, 2002, p. 167).

In 1972, the Minister of National Health and Welfare tabled the Policy of the Federal Government concerning Indian Health Services. This policy stated that there were "no statutory or treaty obligations exist to provide health services to Indians" despite the interpretation of the 'medicine chest' clause of Treaty 6, which was used as the basis for the federal government's acquirement of the provision of health services for Aboriginal peoples as discussed above. Despite the claim that no prior rights to health were recognised, it stated that the federal government wanted to ensure:

> …the availability of services by providing it directly where normal provincial services (were) not available, and giving financial assistance to indigent Indians to pay for necessary services when the assistance (was) not otherwise provided. (FNIHB, 2007)

In 1979, a new Indian Health Policy was created. It dismissed the earlier attempts of assimilation and instead focused on three foundational pillars: community development, the traditional relationship of the federal government and "Indian peoples", and the Canadian health care system. (FNIHB, 2007) This coincided with other areas of the Department of Indian Affairs in which the approach to First Nations communities changed from being one of assimilation to "centres of community development" (Baines, 1996, p. 11). The timing of this change coincided with the agenda of international development on a global scale, in which the focus from social and economic development shifted to a broader goal of "fulfilling basic human needs, to improve the "quality of life" for those living in the Third World" (Van Hollen, 2002, p. 167).

From 1991 to 1996, the process of a Royal Commission on Aboriginal Peoples (RCAP) took place. Commissions "hold public gatherings, call for research, and issue position papers to unearth and define socio-cultural relations that are seen to be shaping the problem". It addressed the problems that Aboriginal people experience "with the justice system, and the federal government's reviews of the impact of the Indian Act on Status and non-Status First Nations women", and it was meant to "investigate the root causes of these and other social, economic, and political crises affecting

Aboriginal peoples" (Fiske and Browne, 2008, p. 16). According to Fiske and Browne (2008), RCAP "positioned Aboriginal women simultaneously as citizens holding Charter entitlements and as a special needs group" which points to how state policy and other official documents can serve to construct Aboriginal women (pg. 16). This point will be elaborated on further below.

In 1997, in response to RCAP, the Ministry of Indian Affairs issued the document Gathering Strength: Canada's Aboriginal Action Plan. The document is:

> an action plan designed to renew the relationship with the Aboriginal people of Canada. This plan builds on the principles of mutual respect, mutual recognition, mutual responsibility and sharing which were identified in the report of the Royal Commission on Aboriginal Peoples. That report has served as a catalyst and an inspiration for the federal government's decision to set a new course in its policies for Aboriginal people. (Government of Canada, 1997, p. 1)

The document emphasises building a new "vision" for the future that must include "the means for Aboriginal people to participate fully in the economic, political, cultural and social life of Canada in a manner which preserves and enhances the collective identities of their communities, and allows them to build for a better future" (Government of Canada, 1997, p. 5). RCAP and this subsequent policy clearly display the fundamental shift in position the Canadian government has made. The argument can then be made that the assimilationist policies of disenfranchisement are in the past, and that the current policies and programmes of the Canadian state do not accurately represent its relations with Aboriginal populations. While this acknowledgement of past wrongs is noted, however, it is my intention to show how many of the underlying assumptions of modernising Aboriginal peoples through its reproductive, mainly childbearing, practices still persist within the government policies and programmes.

It is must be noted, however, that even though these policy recommendations and subsequent action plan set out this plan for a bright future, the federal government has failed to act on most of the recommendations, including changes to "governing relations with Aboriginal people, in general, and, more particularly, with women" (Fiske and Browne, 2008, p. 16). This lack of action and emphasis on rhetoric is telling for the actions based on those words then become a separate matter. In the case of maternal evacuation, it is important to look deeper at the relationship between the "action" of evacuating women from their communities to urban centres for childbirth and the discourses surrounding this evacuation, which are often competing and contradictory, through government policies and programmes.

4.7. Mobility and the Provision of Health Services

The control of the government in moving people from their communities for medical treatment and other purposes is a recurring theme in the historical development of health care services for First Nations that warrants a deeper exploration. In this historical context, the treatment of tuberculosis and the residential school era bring much to light in terms of the current system of medical care and evacuation from the community. For without understanding the role of these movements in the last 100 years of First Nations-state relationships, the depth and complexity of the issue of maternal evacuation cannot be fully realised.

4.7.1. The Tuberculosis Sanatoriums

In 1998, in reference to TB sanatoriums, the Grand Chief Francis Flett stated that, "the rest of Canadian society must know what happened to our people, to learn about the pain and anguish we suffered at the hands of people who were charged with healing us" (McKinley, 1998). In the late 1800s, tuberculosis was "widely recognized to be the primary cause of morbidity and mortality among First Nations populations" (Daschuk, Hackett, MacNeil, 2006, p. 307). While the time period of infection varies across Canada, in each region it coincides with contact with Europeans. In Eastern Canada, First Nations were exposed "some 300 years ago", those on the West Coast, "200 years ago", on the prairies, "about 100 to 120 years ago", and in the North, "relatively recently, in the late 19th and early 20th centuries" (Grzybowski and Allen, 1999, p. 1025-1026). While looking the role of TB in Aboriginal history, it is also important to note that this disease is still very much an issue and a health concern for Aboriginal peoples today.

Tuberculosis was a "disease in which the emotional serenity of the patients, particularly if they are sick for a long time, is an important factor" (Grygier, 1994, p. 13). Treatment for TB in the last century included sanatoriums which "isolated infected patients and provided rest, nutritious food, fresh air... education and rehabilitation". Saskatchewan was the first province to provide free access to sanatoriums, and from the 1930s onward, sanatoriums were located in every province. In fact, by 1953, "there were 101 sanatoria and TB units in general hospitals with a total of 19 000 beds" (Grzybowski and Allen, 1999, p. 1026). In their history of TB in Canada, Grzybowski and Allen note that:

> Because of the misguided parsimony of the government with respect to the suffering of aboriginal people, aboriginal patients were rarely offered sanatorium treatment in the 1930s. However, after protests and investigation, care for aboriginal people improved, and by the end of 1953, 2627 aboriginal people and 348 Inuit were in sanatoria. (1999, p. 1026)

While the policy of treating Aboriginal peoples in TB sanatoria, as was the norm for treatment before drug therapy was introduced, was seen as a positive step in terms of accessing modern health care, the experiences of Aboriginal people being taken away from their communities still resonates within current TB research conducted with Aboriginal communities today. In a study done about TB in urban Aboriginal populations in Canada, the issue of the sanatoriums was brought up by participants, "despite not being explicitly asked about this topic" (Brassard et al., 2008, p. 197). In another study focused on current TB treatment, "no questions were asked directly about sanatoriums", however, eleven respondents mentioned sanatoriums in their responses. This suggests that the "stories about the old sanatoriums still influence people's thoughts about TB today" (Gibson et al., 2002, p. 43). Unfortunately, many of the stories told about sanatoriums are negative and traumatic. As one participant noted, "It was not a good time for me. I had to stay in the hospital … for nine months. I was lonesome for my parents, my mom, the kids, my sisters. I missed them a lot" (Gibson et al., 2002, p.43). In an article about an inquiry into treatment of Aboriginal peoples at a sanatorium in Northern Manitoba, one Chief remembers, "some stories the Elders report are that their people went there and never came back" (McKinley, 1998). In a letter to Indian Agent, Mr. E. Low, dated July 4th, 1949, Chief Cornelius Bignell from The Pas, Manitoba (now Opaskwayak Cree Nation) articulated his concerns over sanatorium treatment for his people. He wrote:

> The Indians feel so bad about the management that they begin to believe that they are being brought to this place to die... Too many persons have died and are dying too fast in such a short time. Very few leave the San (sanatorium) alive. (McKinley, 1998)

Intrinsic to this discussion is that by removing people from their communities for treatment led to a great mistrust of the both the intentions of the federal government in providing health services, and the appropriateness of Western treatment of illness for First Nations people. As Paul Hackett (2005) notes:

> Medical intervention for TB during the early part of the twentieth century were often heavy handed, and many of the policies favoured by the federal government, including the support of residential schools and changes to lifestyle associated with reserve life, promoted the spread of the disease among Aboriginal populations. (p. S19)

While it is not my intention to denounce the act of obtaining treatment and access to sanatoria for Aboriginal peoples, the argument for obtaining access to sanatoria for Aboriginal peoples coincides with the reasoning behind the beginning of the policy for maternal evacuation for childbirth. This can mainly be seen as an on-going attempt to modernise Aboriginal peoples, and get

them to catch up, or be on equal footing with the rest of the Canadian population. This is a current discourse surrounding Aboriginal peoples in Canada, and continues to pervade the policies and practices of the federal government. In this history, we have seen how the government, with the best of intentions to modernise and medicalise its indigenous population, effectively moved treatment of illness out of the community, and therefore, removed the authoritative knowledge of the community to effectively treat its people. As O'Neil and Kaufert (1990) explain:

> ... implicit in this treatment approach was the message that responsibility for decisions regarding the type and location of treatment for diseases was now entirely in the hands of the colonial power. In the name of medical care, government claimed the authority to disrupt family life and traditional patterns of social organization... Instead of viewing sickness as an event which, with the help of a healer (or midwife), resulted in increased social harmony and integration, illness was feared not only as a threat to life, but also a threat to social continuity and autonomy. Sickness facilitated the intrusion of the colonial power into the intimacies of family life and its paternalism was reproduced continuously in the highly emotional context of the medical encounter, the evacuation of the patient, and the breaking apart of families. (p. 56)

The role of removing, or relocating, Aboriginal peoples from their communities is a recurrent theme in the history of Aboriginal people and the state. While the above example of TB sanatoriums illustrates not only the removal of health care, and health knowledge from communities, the next historical example of residential schools will serve to understand the attempt of the federal government to also remove the indigenous identity of the Aboriginal population.

4.7.2. Residential schools

> Mr. Speaker, I stand before you today to offer an apology to former students of Indian residential schools… Two primary objectives of the residential schools system were to remove and isolate children from the influence of their homes, families, traditions and cultures, and to assimilate them into the dominant culture. These objectives were based on the assumption aboriginal cultures and spiritual beliefs were inferior and unequal… Indeed, some sought, as it was infamously said, "to kill the Indian in the child."… We now recognize that it was wrong to separate children from rich and vibrant cultures and traditions, that it created a void in many lives and communities, and we apologize for having done this... We now recognize that, in separating children from their families, we undermined the ability of many to adequately parent their own children and sowed the seeds for generations to follow, and we apologize for having done this. (Prime Minister Stephen Harper's Statement of Apology, June 11th, 2008)

Between 1870 and 1996, Aboriginal children were forcibly removed from their homes and taken to residential schools, whose aims were to assimilate them in into mainstream Canadian society. (Assembly of First Nations, 2008) This not only denied children the right to be raised by their own families, but they were also cut off from their "traditional knowledge systems, original languages, and traditional cultural practices" (Carroll and Benoit, 2004, p. 256). In 1920, the government mandated that every child between the ages of seven and fifteen attend a residential school. In 1931, there were eighty residential schools operating across Canada; in 1948, there were seventy-two; and by 1979, there were only twelve schools with almost 2,000 students. The last residential school, in Saskatchewan, finally closed in 1996. (Assembly of First Nations, 2008)

The schools are characterized by the "deliberate suppression of language and culture, substandard living conditions and second-rate education, and widespread physical, sexual, emotional, and spiritual abuse" (Smith, Varcoe, Edwards, 2005, p. 40). According to the Royal Commission of Aboriginal Peoples (RCAP):

> Aboriginal children learned to despise the traditions and accomplishments of their people, to reject the values and spirituality that had always given meaning to their lives, to distrust the knowledge and life ways of their families and kin. By the time they were free to return to their villages, many had learned to despise themselves. (1996, cited in Smith, Varcoe, Edwards, 2005, p. 40)

When looking at pregnancy and parenting in Aboriginal communities, Smith, Varcoe and Edwards. (2005) found that one needs to address the intergenerational impact of residential schools (IGIRS) in order to effectively address the current health policies and practices associated with maternal health. Participants in their study articulated the need to "turn it around" and that in order to adequately address the health care needs of Aboriginal parents, this "could be understood only in the context of their experiences of and efforts to change the IGIRS and related colonizing influences and structures" (p. 40). Indeed, it can be seen that part of the process of "turning it around" could be the return of the knowledge of birthing practices to communities and to allow the return of women to their homes for childbirth.

5. Theoretical framework

In this chapter, I outline the theoretical orientation of this thesis, and review some of the ways of thinking about risk, place, and knowledge that informed my analysis. I begin by placing my thesis research in the field of critical medical anthropology (CMA), and more specifically, the subfield of anthropology of reproduction. These two approaches supplied me with an understanding of bodies, and the important notions of embodiment and agency, all of which come to the forefront of my analysis. Next, I explore a more thorough understanding of risk, and its rise in the field of social sciences in order to take into account current thinking about risk within the study of reproductive practices.

5.1. Critical medical anthropology

This ethnography engages with a multitude of theories and approaches within the study of social anthropology. I propose to ground this thesis within the critical medical anthropological (CMA) discipline. That is, I want to take into account the political, economic, and social processes that shape individual experience and interaction within the topic of maternal evacuation. I do this by leaning towards a critical interpretative method that moves away from a Marxist reading of CMA and towards a more phenomenological, humanistic approach that centres on the body and embodiment. However, in the case of maternal evacuation, this approach is incomplete without the recognition of the primacy of place and its relationship to power/knowledge. Therefore, the discussion turned towards defining space, place and landscape.

CMA is also called political economic anthropology (PEMA) or political anthropology of health, and concerns itself with situating health within global economic systems, and links the social production of approach analyses the impact of global economic systems, particularly capitalism, on local and national health. There are generally two main approaches to CMA. One is rooted in political economy, drawing on dependency theory and Marxist theory. (Morsy 1996; Baer, Singer & Johnsen 1986; Morgan 1990; Singer 1989) The PEMA approach is often defined by its focus on the macro-level of analysis of health systems; however, Morsy (1996) explains that the strength of CMA is that it allows medical anthropologists to move beyond "ethno-medical conceptions but extends to issues of power, control, resistance, and defiance surrounding health, sickness, and healing" (p. 23). The other branch of CMA, sometimes called a critical clinical approach, moves away from an adherence to orthodox Marxism and looks critically at the clinical setting. This approach emphasises a "phenomenological and humanistic, yet politically informed, approach to sickness and healing" that draws on Foucauldian notions of biopower to analyse biomedical practices and the associated

power and authoritative knowledges that exist within the practitioner-patient relationship. (Morgan 1990: p. 945)

In attempting to look deeper into the issue of birth place and associated discourses of risk, I use CMA as the theoretical starting point. Therefore, this thesis moves from macro (health system organisation and the role of various institutions involved in the place of birth for First Nations women) to the micro-level of analysis (individual's experience and clinical encounters in childbearing practices). Understanding Scheper-Hughes and Lock (1987) notions of the "three bodies", or what they term as a "critical interpretive" approach is useful in this approach. As they explain:

> The task of a critical-interpretative medical anthropology is, first, to describe the culturally constructed variety of metaphorical conceptions (conscious and unconscious) about the body and associated narratives and then to show the social, political and individual uses to which these conceptions are applied in practice. By this approach, medical knowledge is not conceived of as autonomous but is rooted in and continually modified by practice and social and political change. (Scheper-Hughes and Lock, 1987, p. 44)

The discussion/act of bringing "the body" into scholarship raises the question of what is meant by "body." Scheper-Hughes and Lock (1987) define the body as "simultaneously a physical and symbolic artefact, as both naturally and culturally produced, and as securely anchored in a particular historical moment" (p. 7). Over time, however, scholars replaced "body" with "embodiment". Csordas explains this shift:

> ...the expression 'the body' has become problematised and replaced with term 'embodiment'. This change corresponds directly to a shift from viewing the body as a non-gendered, pre-discursive phenomenon that plays a central role in perception, cognition, action and nature to a way of living or inhabiting the world through ones acculturated body. (1999: p. xiv)

Despite the movement between the terms 'body' and 'embodiment', an exploration of both of these terms is warranted. There are two main theories of embodiment: that of Merleau-Ponty (1962), who elaborates "embodiment in the problematic of perception", and that of Bourdieu (1977, 1984), who "situates embodiment in an anthropological discourse of practice" (Csordas, 1990, p. 7). Bourdieu is important in this study of the body through his notion of habitus, which offers a "theory for understanding the relationships between social structure and embodied experience" (Seale, 1998, p.21). Bourdieu defines habitus as a "system of dispositions which is the unconscious, collectively inculcated principle for the generation and structuring of practices and representations" which happen through the body or bodily deportment (Csordas, 1990, p.11). Embodiment and habitus are important concepts for they draw the link between individual experiences and their relationship to "larger structures of power and domination in social life" (Seale, 1998, p. 22).

Scheper-Hughes and Lock (1987) lay out the three ways in which bodies may be understood: the individual body-self, the social body, and body as body politic. (p. 6) The individual body-self is understood as the "phenomenological sense of the lived experience of the body-self", while the social body refers to the "representational uses of the body as a natural symbol with which to think about nature, society and culture" (p. 7). The body politic refers to the "regulation, surveillance, and control of bodies (individual and collective) in reproduction and sexuality" (p. 7-8). Foucault's contribution to this topic highlights the connection between the three bodies: the "stability of the body politic rests on its ability to regulate populations (the social body) and to discipline individual bodies" (Scheper-Hughes and Lock, 1987, p. 8). As a result of this connection, anthropological explorations of the relations between the individual body and the body politic "inevitably lead[s] to a consideration of the regulation and control not only of individuals, but of populations, and therefore of sexuality, gender and reproduction-what Foucault refers to as bio-power" (Schepher-Hughes and Lock, 1987, p. 27). Bio-power is literally having power over bodies through "technologies, knowledges, discourses, politics and practices used to bring about the production and management of a state's human resources". Bio-power "analyses, regulates, controls, explains and defines the human subject, its body and behaviour" (Danaher, Schirato, Webb 2000, p. ix).

There are some cautions to taking a CMA approach to the issue of maternal evacuation. One issue is the positionality of the anthropologist within their research. CMA is often described as a form of "applied" research, and represents an "actively political, critical, and committed anthropology" (Scheper-Hughes, 1988). As Scheper-Hughes (1995) emphatically states, "If we cannot begin to think about social institutions and practices in moral or ethical terms, then anthropology strikes me as quite weak and useless" (p. 21). Kaufert and O'Neil (1990) explain that similar reasoning underlies their research: their objective in studying maternal evacuation is to "assist in change by providing a forum for all those engaged in the debate over the evacuation of the pregnant women-particularly for those who have been relatively the most powerless and unheard-the women of the communities" (p. 34). I believe that writing from a critical approach is necessary when one is witnessing what everyone else perceives as injustices. However, anthropologists should take care not to portray biomedicine and its institutions solely as negative or oppressive. Further, when studying birth and evacuation practices, anthropologists should not personify the evacuated woman as "powerless and unheard", thus reproducing women and women's bodies as passive agents in the process of evacuation. In order to address this fallibility, it is important to emphasize the concept of agency within this analysis.

The concept of agency bridges the division between the structures and institutions and associated power/knowledge, and is the "socioculturally mediated capacity to act" (Browner and Sargent, 2011, p. 205). Although agency as a theoretical concept has been widely discussed and debated, for the purposes of this analysis, focusing on agency addresses the critique of social theory, like Foucault's governmentality, that "construed human behaviour as shaped and defined by external constraint" (Browner and Sargent, 2011, p. 205). However, rather than create this dichotomy between external constraints and individual capacity to act, I adopt Bevir's (1999) explanation of agency:

> …agents…exist only in specific social contexts, but these contexts never determine how they try and construct themselves. Although agents necessarily exist within regimes of power/knowledge, these regimes do not determine the experiences they have, the ways they can exercise their reason, the beliefs they can adopt, or the actions they can attempt to perform. Agents are creative beings; it is just that their creativity occurs in a given social context that influences it. (p. 6)

The following ethnography draws on this explanation when looking at the experience of evacuation. Rather than posit women as powerless, their active negotiation of their experiences are described while acknowledging the limits set by the institutions that shape their experiences.

5.2. Place and landscape

Within this study of maternal evacuation, the role of "place" is central to the discussion. Therefore, it is useful to outline some of the thinking around place and space, and offer an approach to dealing with this added dimension of analysis. Working from the notion that pregnancy and birth are embedded within the political and social contexts of First Nations and the state, the question arises of how can we relate maternal evacuation to First Nations peoples relationship to the landscape and their associated rights? How do these broad ideas of rights to be in and from the land become actualised in practice and of being-in-the-world? Through an examination of both individual and collective engagement with landscape, the primacy of place within national and global discourses of rights to land and health emerges.

Landscape is a "one tool among others through which interrelationships between humans and nature, and between humans in social and situated communities, are produced and reproduced" (Lovell, 1998, p. 10). Landscape is process between space and place. Space can be defined as "an experiential domain that relates entities to one another in terms of position and movement"; place is "an experiential domain that marks and situates particular entities or bounded fields of situated entities" (Gone, 2008, p. 371). Space and place "require each other for definition" through the idea that "what begins as undifferentiated space becomes place as we get to know it better and endow it

with value"(Tuan, 1977, p. 6). That said, Casey (1996) notes how "place has a great a claim to conceptual primacy over space owing to the inescapable emplacement of embodied perception that remains the foundation of human knowledge and experience" (p. 14). In this vein, Basso (1996) emphasises the primacy of place through an exploration of Apache moral discourses that reference specific places in the landscape. More specifically, Stewart and Strathern (2003) define place as a "socially meaningful and identifiable space to which a historical dimension is attributed" (p. 4). They posit that landscape is produced through an interaction of place with community, and use "history and memory to explore the economic, political and social events that impact perceived visions of landscape and the perceived placement of people within these settings" (p. 1). History, memory, and place then become "transducers whereby local, national and global are brought into mutual alignment" (p. 2). In addition to history and memory, the concept of "belonging" becomes "fundamentally defined through a sense of experience, a phenomenology of locality which serves to create, mould, and reflect perceived ideals surrounding place" (Lovell, 1998, p. xv). These notions of history, memory, and belonging all contribute to understanding the issues being presented in this thesis, including the idea of being from and belonging to the land, the history of First Nations and collective memory, and the complex interaction between our bodies, both their presence and their absence (in the case of maternal evacuation) in particular spaces and places across the landscape. In this instance, the "body" is not the focus per se; instead, the focus lies in looking at "culture and experience insofar as these can be understood from the standpoint of bodily being-in-the-world". (Csordas, 1999, p. 143)

Hirsch's (1995) approach to the study of landscape is based on the concepts of foregroundness and backgroundness, and assists in connecting the places of maternal evacuation. He refers to the "foreground" as the "concrete actuality of everyday social life ('the way we are now')" and the "background" as "the perceived potentiality thrown into relief by our foregrounded existence ('the way we might be')" (p. 3). In this ethnography, the foreground frequently shifts between women who are evacuated from their communities to deliver babies, and women who are re-establishing the relationship to their environments through bodily interaction and ceremonial practice in the creation of meaningful places and memories across the landscape. The foreground is also the practice of ceremony at specific places and times. The background is both engaging with a historical notion of the "old ways" and moving back to them through ceremonial practice, as well as the perception of risk and safety for the future generations. The potential to once again be healthy and strong communities is played out against the notion of the continuance of unhealthy and struggling communities in the midst of environmental degradation and under state control.

An example of how these discussions of place and landscape are useful was during my fieldwork in the urban centre hospital. As an ethnographer engaged in an explicit multi-sited field study, a hospital where evacuated women give birth was a key site. In anthropological literature, the discourse of evacuation centres around the presence or absence of a tertiary hospital facility; yet, this "space" of the dialogue is rarely critically examined. In the discourse of returning birth to the community, the notion of the hospital is often characterised as an oppressive institution that limits choice and exposes women to unnecessary intervention. From one federal doctor's perspective, the hospital is necessarily "a black box because you don't really know what happens [and what] goes on there." (23/02/2010) In other words, the hospital in the discourse of evacuation is an exclusive place and knowledge of that place is limited to expert medical knowledge of the body and its treatment through technology. By framing the hospital in this way, it automatically excludes everyone else, including the "less medical" midwives, from commenting on treatment or management of risk in these settings.   From this perspective, the hospital is a bounded space of highly ordered, biomedical regulation: the black box in which the contents are "mysterious to the user" (Oxford, 2012). This view of the hospital as a "black box" presents significant limitations to the ethnographer working in the hospital setting, as it may limit one's ability to connect the goings-on of the hospital with the broader spaces and places in which the practice of maternal evacuation is present. Taking the opposite view, however, is also problematic: framing the hospital as a "microcosm of society" or "as continuations and reflections of everyday social space" may retract from acknowledging the space of the hospital as a "modernist institution of knowledge, governance, and improvement" (Street and Coleman, 2012, p. 5). A solution is found in Street and Coleman's conception of the hospital as "simultaneously bounded and permeable, both sites of social control and spaces where alternative and transgressive social orders emerge and are contested" (p. 4).

Next, another related field of thought must also be addressed: risk. At the beginning of this thesis, risk was identified as a central concept in the practice of evacuation. Therefore, it is important to acknowledge and address current thinking around the concept of risk, and relate it to the theoretical framework developed thus far.

5.3. Risk

Many theorists have traced the notion of risk and found its meaning and contemporary use has become increasingly common, so that it can now be applied to many different situations. Douglas and Wildavsky (1982) note that the meaning of risk has changed from an originally neutral concept that, in 19th century usage, took into account the probability of losses and gains, to one having only

negative associations. Within the literature, I have found many typologies of risk and ways of defining it. The following discussion briefly surveys these various approaches.

5.3.1. Objective and subjective risk

Objective risks are defined "according to statistical calculations of the probabilities of 'adverse' events" (Bohom, 1996, p. 64). The development of objective risk is closely associated with the emergence of modernity in the 17th and 18th centuries. (Lupton, 1999, p. 5) According to Giddens (1991), modernity can be defined as the "institutions and modes of behaviour established first of all in post-feudal Europe, but which in the twentieth century increasingly have become world-historical in their impact" (Giddens, 1991, pp. 14-15). As Lupton (1999) notes:

> Modernity depends upon the notion, emerging in the seventeenth century Enlightenment, that the key to human progress and social order is objective knowledge of the world through scientific exploration and rational thinking. It assumes that the social and natural worlds follow laws that may be measured, calculated and therefore predicted. (p. 5-6)

Therefore, the development of objective risk coincides with modernity and the development of objective knowledge. Hacking (1990) notes that the science of probability and statistics were developed to calculate the "norm" and identify "deviations from the norm", resulting in the belief that this practice would bring "disorder under control" (p. 1). This is important in understanding the emergence of risk as a science, and identification of risks became dependent upon those who can perform these calculations.

In the practice of maternal evacuation, the role of epidemiologists as calculators of risk takes precedence. Their positivistic approach to risk identifies dangers, or hazards, within equations of probability. Risk then becomes the product of "probability and consequences (magnitude and severity) of an adverse event" (Bradbury, 1989, p. 382). As Lupton (1999) explains, "risks, according to this model, are pre-existing in nature and in principle are able to be identified through scientific measurement and calculation and controlled using this knowledge" (p. 18). Therefore, the conclusion of the model is that risks exist, and it takes the expert to identify, calculate, and then mitigate them.

The critique of this type of risk calculus is that it is presented as value-free; rather than embedded within historical, economic, and cultural processes. This division between what is a 'real' and 'objective' risk versus 'subjective' or 'perceived' risk contributes to the prioritising of expert risk knowledge within the model. Implicit in these divisions is that one type of risk is real and the other is not.

When analysing risk in this techno scientific way, a type of linguistic imperialism emerges. As Hansson (1989) explains:

> …scientific 'linguistic imperialism' treats the word risk as a uni-dimensional, technical concept that refers to some numerical probability value, whereas in everyday popular usage the term has many other layers of meaning. (p. 107)

This contrasting of scientific and lay uses of the term is referred to by Giddens (1987) as the 'double hermeneutic' (p. 18). As Hayes (1992) explains:

> …at issue in the double hermeneutic is the translatability of concepts between scientific and lay language communities, and conflict over authority to declare the correctness of translation…. The double hermeneutic exposes ideological dimensions of the language of risk. (p. 403)

Recognising such limitations of the techno-scientific understanding of risk, scholars have embraced a socio-cultural theory of risk, which I turn to in the next section. This theory of risk highlights the breakdown of 'objective' and 'subjective' risks, and locates risk within broader notions self, society, and governance.

5.3.2. Risk and culture

Mary Douglas' writings are central to anthropological understandings of risk. Rejecting the techno-scientific understanding, she notes that risk "has [no longer] got much to do with probability calculations. The original connection is only indicated by arm-waving in the direction of possible science: the word risk now means danger; high risk means a lot of danger" (Douglas, 1992, p. 24). Douglas' previous writing about purity and danger, and pollution of the body underpin "her understanding of the cultural role and importance of risk in contemporary western societies", and in particular "the use of risk as a concept for blaming and marginalising an Other who is posing a threat to the integrity of self" (Lupton, 1999, p. 39-40). Described as the "cultural/symbolic" interpretation of risk, Lupton (1999) situates Douglas' writing on risk as a "functional structuralist" approach, in that she is interested in how "social and cultural structures and systems serve to maintain social order and the status quo and deal with deviance or divergence from accepted norms and social rules concerning behaviour" (p. 26). In this way, how risk is used to establish and maintain boundaries between the self and other, and how the body is used both symbolically in discourses and practices around risk. (p. 39)

In the context of First Nations populations, it is useful to think of risk in this way, in that it is a "contemporary western strategy for dealing with danger and Otherness" (Lupton, 1999, p. 36). In

emphasising the communal aspects of risk, rather than the focus on individual responses to risk, Douglas (1985) notes that:

> A community uses its shared, accumulated experience to determine which foreseeable losses are most probable, which probable losses will be most harmful, and which harms may be preventable. A community also sets up the actors' model of the world and its scale and values by which different consequences are reckoned grave or trivial. (p. 69)

Douglas emphasises the political use of risk "in attributing blame for danger threatening a particular social group" (Lupton, 1999, p. 36). Douglas and Wildavsky argue that risk is "intimately related to notions of politics, particularly in relation to accountability, responsibility and blame". She notes that risk is "a selective process" and that some risks are "ignored or downplayed" while others are not, and this is the one point of entry into the study of risk. (Lupton, 1999, p. 39) Douglas (1992) makes the distinction between presence of danger and the construction of risk. She notes:

> …the reality of dangers is not at issue. The dangers are too horribly real, in both cases, modern and pre-modern. This argument is not about the reality of dangers, but about how they are politicised. This point cannot be emphasised too much. (p. 29)

Douglas' contributions to thinking through risk and its politically constructed nature are important to understanding risk in the context of childbirth in First Nation communities. Through epidemiological means, First Nations have been constructed as a "high risk" population. This attributing of "high risk" status by the state can be seen as a way in which the state deals with the "otherness" of its indigenous population, and its justification for the continuance of control over it.

5.3.3. Cultures of risk and the risk society

Two prominent sociologists, Ulrich Beck and Anthony Giddens, have emerged as leaders in the development of socio-cultural perspectives of risk theory. While their thinking around risk is useful to some degree within the context of this ethnography, there are limitations to the 'risk society' in the context of maternal evacuation. However, since the writings of Beck and GIddens have proliferated the current thinking around risk, it is important to include consideration of these two scholars. In short, both are concerned with the treatment of risk in what they term late or reflexive modernity, and both position risk as a central component of these societies. Giddens (1991) explains the socio-cultural notion of risk, which emphasises the prominent role of risk in late modernity:

Modernity is a risk culture. I do not mean by this that social life is inherently more risky than it used to be; for most people in the developed societies that is not the case. Rather, the concept of risk becomes fundamental to the way both lay actors and technical specialists organise the social world. (p. 3)

Recognising the centrality of risk in modern life, Beck articulates the "strange paradox" of late modern society: risk is increasing "due to technology, science and industrialism" rather than lessening through "scientific and technological progress". This increase in risk is central to Beck's thesis of a "world risk society" or global risk society (Jarvis, 2007, p. 1). Jarvis (2007) explains:

Global risk society is distinct from industrial modernity for Beck in one crucial respect: [in the former], the 'social compact' or risk contract is increasingly broken down. Risks, because of their extensity and unknowability, are now incalculable and beyond the prospects for control, measurement, socialisation and compensation. (p. 17)

This macro-level of analysis of risk is useful in situating risk within the global political structures; however, for numerous reasons, it is difficult to apply this theoretical approach to the study of childbirth in First Nations communities.

Central to Beck's and GIddens' arguments is the assertion that there are two macro-social processes that characterise late modernity: "reflexive modernisation" and "individualisation". Reflexive modernisation can be described simply as "the move towards criticism of the outcomes of modernity", and individualisation as "the breaking down of traditional norms and values" (Lupton, 1999). The process of reflexive modernisation is seen as a response to the changing role of the state in globalisation and the breakdown of lay people's confidence in expert knowledges. (Lupton, 1999, p. 81) Beck characterises globalisation as "a power-play between territorially fixed political actors (government, parliament, unions) and non-territorial economic actors (representatives of capital, finance, trade)", which results in the "political economics of uncertainty and risk" (Beck, 1999, p. 11). This results in a changing role of the state, in that it puts greater emphasis on individual citizens' responsibility to mitigate risk. As Jarvis (2007) explains:

...this becomes a 'domino effect' as the state retreats from its traditional responsibilities and downloads these on to its citizens, in the process increasing the risk individual's face by making their welfare the preserve of individual responsibility through self-provision. (p. 6)

It is at this point that the "risk society" thesis breaks down with respect to the study of maternal evacuation. While it may be true that the Canadian state is indeed in a state of "late" or "reflexive" modernity, especially in relation to its natural resources in a global economy, with respect to the relation between Canada and its indigenous peoples, "industrial modernity" (described by Beck and

Giddens as something which is supposed to be located in the past) is very much a reality. While according to the socio-cultural theory, risk has centralised itself within the political context in Canada; however, First Nations have themselves become a central component to the "risk society" (i.e. one of the risks), insofar as the presence of a group of people with inherent rights to land entrenched in the Constitution present a risk to the ability of the state to participate in the global economy of exporting natural resources, including water and oil. As this ethnography will show, rather than creating a state-citizen relationship like that described by Beck and Giddens, the Canadian state's continuance in governing all aspects of the lives of First Nations is critical in controlling risk to the state. Reliance of "expert knowledges" and the tools and technologies of modernisation become key to the maintenance of this control.

5.3.4. Governmentality and risk

Foucault's writing on governmentality is another entry point into exploring conceptions of risk. In the theory of governmentality, the starting point of analysis is the "ways in which the discourses, strategies, practices and institutions around a phenomenon such as risk serve to bring it into being" (Lupton, 1999, p. 85). Therefore, risk is studied as "calculated rationality" (Dean 1999). In this way, risk may be understood as:

> …a governmental strategy of regulatory power by which populations and individuals are monitored and managed through the goals of neo-liberalism. Risk is governed via a heterogeneous network of interactive actors, institutions, knowledges and practices…. So too, through these effects, particular social groups or populations are identified as "at risk" or "high risk", requiring particular forms of knowledge's and interventions. Risk, from the Foucauldian perspective, is a "moral technology". (Lupton, 1999, p. 87)

A Foucauldian approach to risk encompasses the role of expertise in the administration of populations and the regulation of individuals, which is somewhat neglected in the risk society school of thought developed by Beck and Giddens. (Peterson, 1997, p. 192)

Governmentality is the approach to social regulation that emerged in 16th century Europe: this marked the beginning of modern states' thinking of their citizens in terms of "populations", or a social body requiring intervention, management, and protection, to "maximise wealth, welfare and productivity" (Lupton, 1999, p. 24)). Features of populations such as "demographic estimates, marriage and fertility statistics, life expectation tables and mortality rates" became central, and the "body of both the individual and that of populations became the bearer of new variables" (Lupton, 1999, p. 85-86). Through governmentality, we are able to explore risk in the "context of

surveillance, discipline and regulation of populations", and also look at how constructions of risk encourage self-regulation. (Lupton, 1999, p. 24-25) As Foucault (1991) describes:

> The things with which in this sense government is to be concerned are in fact men, but men in their relations, their links, their imbrication with those other things which are wealth, resources, means of subsistence, the territory with its specific qualities, climate irrigation, fertility, etc; men in their relation to that other kind of things, customs, habits, ways of acting and thinking, etc; lastly, men in their relation to that other kind of things, accidents and misfortunes such as famine, epidemics, death, etc. (p. 93)

In line with this, Castel (1991) observes that when thinking about risk there has been a shift from focusing on "dangerous individuals" to an emphasis on "a combinatory of factors, the factors of risk" (p. 281). He notes that:

> …risk does not arise from the presence of particular precise danger embodied in a concrete individual or group. It is the effect of a combination of abstract factors which render more or less probable the occurrence of undesirable modes of behaviour (p. 287)

Castel argues that this change in focus leads to a far more subtle mode of population regulation and increases opportunities of state intervention:

> To intervene no longer means … taking as one's target a given individual, in order to correct, punish or care for him or her…. There is, in fact, no longer a relation of immediacy with a subject because there is no longer a subject. What the new preventive policies primarily address is no longer individuals but factors, statistical correlations of heterogeneous elements. They deconstruct the concrete subject of intervention, and reconstruct a combination of factors liable to produce risk. Their primary aim is not to confront a concrete dangerous situation, but to anticipate all the possible forms of irruption of danger. (Castel, 1991, p. 288)

This approach to the study of risk in the context of maternal evacuation is useful in that it provides an avenue through which we can break down the current discourses of risk and safety within the policy or practice. As discussed below, the regulation of the First Nations population is a clear objective of the Canadian state. In the particulars of evacuation, risk in evacuation is constructed as a myriad of biomedical factors, but also relates to First Nations as a "high risk" population as a whole.

5.4. Summary

In this thesis so far, the topic of place of birth and Aboriginal midwifery has been discussed in a number of ways. First, I presented an overview of the anthropological inquiry into childbirth and midwifery, along with a historical overview of midwifery and Aboriginal midwifery in Canada, with a strong focus on the notion of medicalising childbirth and the body, and contestations over knowledge within the birth setting. I then turned to a historical perspective on the construction of First Nations by the Canadian state, and the implications of providing health care services to First Nations through a constitutional obligation. This section described the state's explicit attempts to modernise both the land and bodies of First Nations. Finally, my discussion of critical medical anthropology, place, and risk forms the theoretical basis from which the rest of this ethnography is built.

6. Methods

This chapter outlines the methods used in this study, as well as issues of access and ethical clearance to conduct the research. This work is firmly grounded in an indigenous methodological framework, and uses multi-sited ethnography as a decolonising methodology.

6.1. Having an indigenous research agenda

In defining 'indigenous peoples', Linda Tuhiwai Smith (1999) traces the emergence of the term to the struggles of the American Indian Movement and the Canadian Indian Brotherhood. She traces the term's development to a global definition, in that it "internationalises the experiences, issues and the struggles of some of the world's colonised peoples". It has "enabled the collective voices of colonised peoples to be expressed strategically in the international arena" and to "come together… to learn, share, plan, organise and struggle collectively for self-determination on the global and local stages" (Smith, 1999, p. 7). This understanding of indigenous peoples speaks clearly to the political nature of research with indigenous peoples. Indeed, in this context, it can be said that "all research is implicitly political" (O'Neil et al. 1993, p. 229). Even the creation of ethical guidelines can be seen as a political act, and a "site of political struggle" for Aboriginal populations (Humphrey, 2001, p. 200). Therefore, the political nature of the research process is recognised and embraced as part of the ethical space that I was seeking to locate in my Ph.D. fieldwork.

The history of research within Aboriginal communities is not an easy one, and like many parts of indigenous peoples' histories, the process of doing research in Aboriginal communities is yet another thing that needs to be reclaimed. From the loss of land rights to traditional practices, from the loss of languages to family life, and values, the assimilation project of the colonisers of Canada paints a grim picture of the historical and present day realities from within which research practice takes place. The pejorative view of research is both historical and a part of the contemporary everyday reality of Aboriginal peoples engaging with researchers. For Aboriginal communities, the term "research" is "inextricably linked to European imperialism and colonialism" (Smith, 1999, p. 1).   This is clearly displayed by the fact that a "large portion of Indigenous culture and history consists of information recounted by researchers and anthropologists that is comprised of non-Native perceptions of Native people and culture" (Peacock, 1996). Because of this, research is sometimes viewed with "suspicion and hostility as something intrusive, exploitative, and unethical" (Ermine et al., 2004, p. 12). In turn, researchers, the embodiment of research, have been viewed as "intruders and predators inaccurately representing Indigenous ways of life" (Trimble, 1977; Maynard, 1974 cited in Ermine et al. 2004, p. 12). The frustration of Aboriginal people with this misrepresentation of themselves and their way of life is compounded when outsider research is:

> …given greater legitimacy than their own voices, turned around and used by western institutions to teach their own children in schools, colleges and universities or used to establish government policy and programmes, thus negating the words and practices of communities and elders. (Ruttan, 2004, p. 13)

For anthropologists, key areas of concern with research in indigenous communities have been the "lack of culturally appropriate ethical standards, lack of respect for community cultural beliefs, failure to conduct research that is responsive to community perspectives and needs, and misappropriation of Indigenous knowledge" (Brown 2005: p. 2). While this negative legacy may be hard for many well-meaning and politically engaged researchers to come to terms with, it is important to understand when beginning to think about research in indigenous communities. Charles Menzies (2001) points out that "to deny the colonial legacy by not adapting our research projects to accommodate Aboriginal concerns is to participate in the colonial project itself" (p. 22).

The role of specific disciplines, especially anthropology, in the colonial project is clear. Anthropology is probably the discipline that is given the harshest critique by indigenous communities. This is not to say, however, that anthropologists should give up on their work: confronting the realities of the discipline's colonial past, including looking at the reconfigurations of anthropology over time that specifically address this colonial legacy and the further opportunities within the discipline to improve, strengthens the discipline's ability to meaningfully contribute to the research concerns of indigenous communities. As Jacobs-Huey (2002)points out, "fundamental concepts (central to the discipline of anthropology) such as "native", "culture", and "the field" have been reframed by some scholars to represent the constructed and dynamic nature of notions such as "identity, culture, and place" (p. 791). This reframing of concepts in anthropology speaks directly to the concerns that indigenous communities have regarding themselves as subjects of research.

Along these lines, rather than disregard research as useless to indigenous peoples, indigenous and non-indigenous scholars have turned to new ways of thinking about and adapting research to address these issues of imperialism and unequal relations of power. Within this body of literature, self-determination for indigenous peoples is the central topic. Indigenous self-determination can be defined on the level of individual, community, and nation. The First Nations Centre (FNC) elaborates on the three definitions:

> …for an individual, [self-determination] includes freedom and the resources to make economic, health and personal decisions in one's own best interests. For a community, it is the ability to create an environment that supports the well-being of its members. For a nation, it is sovereignty over its lands, resources and its citizens, including the ability to govern itself according to its values, culture and traditions, and based on its legal, political, social, economic, and cultural systems, in order to

create an environment that supports the well-being and prosperity of its citizens. (2007: p. 11)

Self-determination on all levels is the heart of the indigenous research agenda. As Stevenson points out, for "ethical and moral research to occur [First Nations] and tribal organisations must move towards self-determination by the creation, development, and institutionalising of codes of research conduct and ethics" (2001, cited in Ermine et al. 2004, p. 265).

6.2. Multi-sited ethnography as a decolonising methodology

Multi-sited fieldwork is not the same as fieldwork in multiple sites. (Robben, 2007, p. 331) Fieldwork in multiple sites replicates the same study in multiple places; multiple-sited fieldwork is based on numerous connections, designed around

> …chains, paths, threads, conjunctions, or juxtapositions of location in which the ethnographer establishes some form of literal, physical presence, with an explicit, posited logic of association or connection among sites that in fact defines the argument of the ethnography. (Marcus, 1995, p. 105)

Multi-sited fieldwork is a powerful tool: it enabled me to follow the issue of maternal evacuation from the embodied perspective of women leaving their communities, and to follow the discourse of evacuation throughout the levels of policy and jurisdiction. Following these paths, I was lead into the community, women's ceremonies the small planes of Northern Canada, the boarding home where women stay in the city, the urban centre hospital, as well as into boardrooms in provincial and local regional offices. This methodology also led me to the national office of First Nations and Inuit Health (FNIHB) in Ottawa, where decisions and money filter their way to the regional offices in the various provinces.

Some of these paths were more obvious than others. For example, during a young women's ceremony, I was introduced to the sacred connection between birth and water. Following this path, I began meeting with and interviewing women who practice water ceremonies, enabling me to learn about the connection of women as "water carriers" to the importance of birth place for First Nations. I found this connection between birth, water, land, and indigenous rights that was not an obvious part of maternal evacuation, but contributes to the understanding of both the political aspirations of Aboriginal midwives, some community members, and, on another level, the national aims of indigenous peoples in Canada.

Multi-sited fieldwork is also a powerful tool in creating an indigenous research agenda. This method approaches fieldwork not as a study of indigenous peoples, but as a study of a policy that

affects the lives (including births) of indigenous peoples. The advantage in this respect is that multi-sited fieldwork allows/enables one to study in all directions, and thus to uncover and unpack an issue that addresses structural violence, indigenous rights, and self-determination. Therefore, using this method, I studied "down, up, sideways, through, backwards, forwards, away and at home" during my time in the field (Hannerz, 2006, p. 23).

6.2.1. Outline of fieldwork

This ethnography combines participant observation in communities, hospitals, boarding homes, and boardrooms. Over the course of 15 months of fieldwork, I spent time in one northern First Nation community, Norway House Cree Nation. In this community, I spent time with the local Aboriginal women, and in the federal hospital located in the community, including the hospital boardroom for a meeting of Kagike Danikobidan (Standing Committee for Midwifery Care and Aboriginal Women) and the provincial midwifery clinic located on the second floor. Each of these places can be seen as geographically as in the same space; however, the relationships and how power is constituted in each of these different spaces is diverse, and speaks directly to the issues that are created around the notion of returning birth to the community. I also attended over twenty policy meetings, and conducted participant observation in meetings of the Norway House Clinical Services Committee, the Norway House Steering Committee, the Manitoba Maternal and Child Health Strategy-Relocation Committee, Kagike Danikobian, the Winnipeg Birth Centre, and NACM. In Winnipeg, I spent over one hundred hours on the labour floor of an urban centre tertiary hospital, in both the Labour and Delivery ward (L&D) and in the Labour, Deliver, Recovery, and Postpartum ward (LDRP). I attended eleven births during my time there, ranging from low risk, 'normal' deliveries, to a forceps delivery and an emergency Caesarean-section. I also spent time in a boarding home in Winnipeg, where women from various communities come to stay and wait for their babies to be born.

I conducted 39 individual interviews with individuals from all of these different sites, and one focus group of six women in the boarding home. Most of these individual interviews were recorded; if they were not, notes were taken. The interviews were with pregnant Aboriginal women, fathers, grandmothers, First Nations political leadership, policy makers from both the provincial and federal governments, hospital nurses, nurses working in a remote federal health care centres (both hospital and nursing stations), Annishabe women who practice ceremony, doctors (including obstetricians and doctors employed by the federal government), midwives and Aboriginal midwives. The interviews ranged from very short (20 minutes) to longer (2 to3 hours). Some of the participants were interviewed multiple times, and almost all of the interviews involved individuals with whom I

spent time outside of the interview setting in one of the research settings. For example, I would attend the policy meetings as a student observer, and then interviewed key individuals from those meetings in order to understand their perspective of what was taking place during that particular meeting, as well as more generally.

I conducted a body mapping workshop with 15 women from NHCN. Body mapping is a "creative therapeutic tool that brings together bodily experience and visual artistic expression" (Art2Be, 2009). Body mapping began with the Memory Box Project dealing with HIV/AIDS in South Africa. The process of body mapping involves "drawing (or having drawn) one's body outline onto a large surface and using colours, pictures, symbols and words to represent experiences lived through the body" (Art2Be, 2009). While the majority of body mapping projects work within the field of HIV/AIDS, they can be applied in other settings, such as the practice of maternal evacuation. By engaging with a community on a project such as this, key insights into people's experiences of relocation can be used to explore "identity and social relationships" (Solomon, 2007, p. 3). It can also contribute to understanding of authoritative knowledge within this context. As Wienand (2006) points out, there must be a balance between the presentation of biomedical and local/indigenous understandings of health and illness (p. 9). She shows how body mapping workshops engage women with

> ...anatomical diagrams before drawing their pregnancies or internal organs, as well as referring to indigenous medical practices and plant remedies. By allowing both approaches to understanding health and illness, the workshops acknowledged 'To the members of all societies, the human body is more than just a physical organism, fluctuating between health and illness. It is also the focus of a set of beliefs about its social and psychological significance, its structure and function.' (Wienand, 2006, p. 9, citing Helman, 1990, p.11)

In preparation for the body mapping workshop, I re-worked the existing facilitator's guide to body mapping provided by Repssi (Solomon, 2007). I then spent one day in Thompson, Manitoba with Darlene and her midwifery student, conducting the workshop with them. We then discussed their experiences and they gave me their suggestions of how to better structure the workshop for the women in the community. I re-worked the guide and then travelled the next day to Norway House and conducted the workshop with the women there. After each one had completed their body map, I took photos of each map, and interviewed the woman about what she had drawn and written. In this way, both the map and the interpretation of the map by the woman became important sources of information and insight into their experiences of birth and evacuation.

One of the disadvantages of my fieldwork was that I did not follow a group of women through their experience from the community to the city and home again. Therefore, I encountered different groups of women in all of these different settings (the community, the boarding home, and the hospital) and spent time with each of these groups respectively. While these groups of women were not the same women in each setting, their situations, stories, and the challenges that they faced in becoming new mothers each contributed to my understanding of the issue.

6.3. Creating (or attempting to create) ethical spaces

In keeping with the notions of creating an indigenous research agenda and situating this project within the context of political spaces is the intertwining of these realities with the research ethics processes that needed to be undertaken. It must be recognised that because the act of research with indigenous communities is intrinsically political that it follows that the process of gaining ethical consent is also a political process. Willie Ermine describes this process as the creation of ethical spaces. He states that:

> The "Ethical Space" is formed when two societies, with disparate worldviews, are poised to engage each other…. The development of the ethical space will be a new enterprise in research and cross cultural interaction… The principle imperative of this new enterprise… is the realignment and shifting of the perspective, particularly from the Western knowledge perspective that dominates the current research order, to a new centre defined by symmetrical relations in cross-cultural engagement. The new partnership model of the ethical space, in a cooperative spirit between Indigenous Peoples and Western institutions, will create new currents of thought that flow in different directions and overrun the old ways of thinking. (Ermine, 2008, p. 193)

While these statements and discussions of creating ethical spaces are indeed important, they are almost prophetic in nature, and not necessarily grounded in the present day reality of ethics processes within indigenous communities and academic (and medical) institutions. While creating ethical spaces can been seen as a future goal for indigenous research, its presence was certainly not felt within the context of my research. In my experience, there emerged two very separate ethics processes that did not overlap or connect in any space or place: Western ethics and indigenous ethics. The emergence of ethical guidelines, such as the Belmont Report, recognised the need for ethically sound research involving human subjects, especially those who are vulnerable, including racial minorities. (Department of Health, Education and Welfare, 1976) In the Western academic tradition, the three main guiding principles for ethical research can be summarises as:

1. *autonomy* or independence of choice making,
2. *non-malfeasance* or doing no harm, and
3. *beneficence* or maximising the good (Weijer 1999, cited in Ruttan 2004, p. 2).

For indigenous communities, however, these guiding principles are seen as incomplete. (Ruttan, 2004, p. 2) The critique focuses on the idea that most ethical guidelines are created from a common value-base without recognising that the value-base of Aboriginal peoples may differ from that of the researcher or the people creating the ethical guidelines. (Letendre and Caine, 2004, p. 4) As Casteel (1996) points out, the ethical standard set forth in documents such as the Belmont Report may be "inappropriate" for use with people who have an "ethnically different perspective" (cited in Ermine et al. 2004, p. 225). Research ethics are also seen to address a smaller set of issues, and tend to exclude overarching themes of "setting research priorities, ownership and control of the research process, and outcome and dissemination" (Young 1995, cited in Letendre and Caine, 2004, p. 6). According to Letendre and Caine (2004), issues in research ethics most pertinent to Aboriginal communities are: proper consultation, community involvement, and ownership of data. (p. 6) The National Aboriginal Health Organization (NAHO) (2006) also stresses that "existing policies and statements concerning FN (First Nations) research ethics do not acknowledge the constitutional and statutory jurisdiction of FN culture, heritage, knowledge, and political and intellectual domains" (p. 3). It is suggested that any ethical statement needs to explicitly recognise these jurisdictions.

Another topic that is central to most ethical guidelines is one of informed consent. In the Belmont Report (1976), informed consent "requires that subjects, to the degree that they are capable, be given the opportunity to choose what shall or shall not happen to them", and that informed consent can be measured through its three elements of "information, comprehension, and voluntariness" (p. 7). In indigenous ethics, informed consent moves from the individual level, but does not exclude it, to the level of community, and is seen as an on-going process throughout the research project. In the Canadian Institutes of Health Research (CIHR) Guidelines for Health Research Involving Aboriginal Peoples (2007), this way of thinking about consent is described as follows:

> A process to obtain the free, prior and informed consents from both the community affected and its individual participants should be undertaken sufficiently in advance of the proposed start of research activities and should take into account the community's own legitimate decision-making processes, regarding all the phases of planning, implementation, monitoring, assessment, evaluation and wind-up of a research project. The requirement for community consent is distinct from the obligation of researchers to obtain individual consent from research participants. (CIHR, 2007, p. 4)

Understanding the complexity of the term 'community' is also important to the understanding obtaining consent. Community may involve political leaders, elders, or other appointed members of the community, and it is the task of the researcher, in collaboration with community members, to

identify whose consent is needed for a particular project. This way of approached informed consent also speaks directly to the issue of jurisdiction of Treaty and Aboriginal Rights, as mentioned by NAHO.

Since my fieldwork was to take place in a number of different locales and settings, my processes for gaining ethical consent were also numerous. Since I set out to focus specifically on First Nation experience of maternal evacuation, but not one particular community's experience of it, my first port of call for permission rested with the Assembly of Manitoba Chiefs Health Information Research Governance Committee (AMC-HIRGC). The AMC-HIRGC functions as the regional ethics review board for projects that are not specific to one particular First Nation, and therefore cannot enter into a research protocol with a particular community. The committee reviews research proposals on behalf of Manitoba First Nations and makes recommendations for further development. The AMC-HIRGC also "works collaboratively with health researchers to develop and implement health research projects" (Centre for Aboriginal Health Research, 2008). I contacted AMC-HIRGC in April 2009 in order to present my research proposal to the committee. Unfortunately, due to funding and time constraints, the meeting kept being delayed, and the committee did not actually meet until July 2009. While I was waiting for this meeting, I made contacts with local researchers at the University of Manitoba (U of M), working in the area of Aboriginal Maternal Health, and began working with their team on a volunteer basis. This gave me a chance to become engaged with researchers currently working in the field, as well as gain a sense of what the current initiatives were in the province with regard to research in this area. This engagement, which was not without its complications, provided an opportunity to "study sideways" by looking at issues of ownership and control of both study topics and geographical areas.

While I was waiting for the AMC-HIRGC to convene, I made a choice not to proceed with the other various ethics processes necessary for my research until I received consent from the indigenous organisation. In July, I made a presentation to the committee via conference call and was given their full support for the project.

At this point, I began exploring how to gain access to the hospital setting, as I really wanted to have experiential knowledge of that particular place in the complex "social life" of maternal evacuation. I soon realised that this was not going to be an easy task. I knew of one hospital in the city that took most of the northern women for labour and delivery, and one particular practice group of obstetricians who cared for these patients working in that hospital. Therefore, working from the hospital backwards, I found that there were two levels of ethics review I would have to undertake in order to be allowed permission. The hospital itself had a Research Review Committee, but this

committee would only review proposals that had been submitted to and approved by the Health Research Ethics Board (HREB) at the U of M. After emailing and receiving all of the necessary forms, I began to wade through the paperwork that was required. Firstly, much of the forms did not apply to my study since most of the research in the hospital is biomedical in nature. For instance, one question asked what pharmaceutical company was sponsoring my research. There was, however, a little tick box if your study was 'qualitative', so I checked that and moved on. Another complication of this process was that the only people allowed to apply to the HREB were employees of the WRHA and faculty members of the U of M. Fortunately, the academic I had been volunteering my time with agreed to be a co-investigator on my project. Her involvement in the actual research was minimal, although she assumed responsibility if something should be questioned or if an incident occurred.

When I received my first letter back from the HREB, it stated that my application had been "tabled" by the committee, and invited me to the next meeting to field questions directly from the board. It also listed eight issues. Most of these issues were technical, for example, clarifying participant numbers, consent forms, etc.; one, however, made me very worried. The letter stated that I had given "no evidence of the communities from which the participants had come were supportive of the project". I immediately panicked, since I had put a lot of emphasis on getting consent through the indigenous ethics process first. I set up a meeting the next day with the chair of the AMC-HIRGC to discuss this issue. When I met with her, she assured me that I had taken the correct steps in the process, and then asked if she could accompany me to the meeting.

I was scared and intrigued at the idea of attending a meeting of the HREB: until that moment, for me ethics boards had existed in some other removed space, where you never see the people or really know exactly how they operate. All of the academics I spoke to were also intrigued, as no one had ever been asked to attend a meeting before. In addition to the attendance of the chair of the AMC-HIRGC, I emailed Chief Ovide Mercredi and asked him for a letter of support. Chief Mecredi is a well-known chief in First Nations politics in Canada, having been the National Chief of the Assembly of First Nations, as well as a known media figure. He is out-spoken and respected by most facets of Canadian society. He responded to my request with the following:

> Hello Rachel
>
> I think the tabling (by the Health Research Ethics Board) of your research proposal is just another example of why Universities … fail to support research that is relevant and sensitive to our human condition as Indigenous Peoples. Colonialists are everywhere and they intend to maintain power over our people and use any means to suppress our story from being told. Do not give in to their pettiness.

> You have my unqualified support and I recommend you proceed within our communities and to other venues where you have already secured access to conduct this very important research. I will help you get the support of the Chiefs from Northern Manitoba who will immediately see the value to this research to the quality of life issues that the HREB will have no appreciation of whatsoever. The elite in Canada are out of touch, not that they ever were at any time in our history, with our reality and aspirations for fairness and justice in this country. As a black poet once wrote, "Keep agoin." (personal correspondence, 06/10/09)

After subsequent conversations with Chief Mercredi and my co-investigator, he agreed to also attend the HREB meeting. I emailed the HREB and indicated that both the chair of the AMC-HIRGC and Chief Mercredi would be attending the meeting. Very soon after this, I received both phone calls and email messages indicating that my proposal had been re-reviewed by the chair of the HREB and he felt that there were going to be no issues in approving my proposal, and therefore we were not required to attend the meeting after all.

My experience of gaining approval to conduct research in the hospital setting was important for two key reasons. One, it showed how control over medical spaces is almost entirely held in the domain of medical institutions, and that attempts to engage with these institutions as representatives of indigenous peoples is still fraught with political tensions. As Chief Mercredi describes, the HREB can be seen as a mechanism to "maintain power over our people" (personal correspondence, 06/10/09). Two, within this ethics process, the review ceased to be about the autonomy, non-malfeasance, and beneficence of the research project. Instead, it became a power play between two opposing ethical gatekeepers that ended not in the creation of an ethical space as envisioned by Ermine, but rather the maintenance of two separate processes that remained disengaged from one another.

While this dispute was taking place, I was also actively looking for funding to conduct the body mapping workshops. This also proved to be a difficult task. By November 2009, it became clear to me that a regional workshop was not going to take place. It was also becoming clear to me that one particular First Nations was engaged in the process of relocating birthing services back to their community, which was being met with multiple layers of obstacles. This community was Norway House. I spoke with Darlene in the community and presented the idea of conducting a body mapping workshop there. She supported the idea, so I began the process of engaging with the First Nation to gain permission for this to occur. I submitted my research proposal and my various ethics certificates, and had a meeting with the Chief of the community. He agreed to let me do the body mapping workshop, along with research on the political process of returning birthing services, but only if I would agree to conduct a financial analysis of the impact of evacuation of pregnant women

from the community. In his words, he allowed me to do the "fluffy stuff" if I would agree to provide a report detailing some "useful" research that the community could use to leverage against some parts of government that were unwilling to see birth return to Norway House.

Another challenge of my encounter with these ethics processes was the tendency of each separate ethics board to want to comment on, or control, each piece of my research process. While I went to the HREB in order to gain access to the hospital, some of their issues with my work focused on my entry into the First Nations boarding home. I had already been given permission to spend time in the boarding home from both FNIH, the owner of the boarding house, and from AMC-HIRGC, and felt that I did not need the permission of the HREB to begin conducting my research there. Likewise, in the hospital setting, after I had received my ethics approval and I had contacted the proper department in order to get the logistics of entering the facility worked out, I received a letter from the Director of Women's Health saying that she could not believe I had begun my research project (in general, not just in the hospital) without her permission. The lines I had drawn between my field sites, in terms of who controlled them, had become increasingly blurry, and negotiating my way through these sites became a substantive part of my fieldwork experience, as well as a very telling piece of the puzzle of the politics of First Nations women and birth in Manitoba.

7. Context

Up until now, this thesis has built upon existing literature to formulate its orientation and place within academic research. Now I wish to shift focus to my specific research. Before this, I will introduce myself and my position within the fieldwork, before outlining the various settings, actors, and the dispute surrounding place of birth and Aboriginal midwifery in Manitoba, and specifically in Norway House Cree Nation.

7.1. Positionality

Among indigenous peoples in Canada and the world, it is usual for people to greet each other and introduce themselves by stating where they are from. This location can be referred to by indigenous language, Nation, clan, community name, or region. In most areas of Canada, most First Nations people locate their origins by the name of the reserve from which they and their family are from and are registered (but not always) with the federal government. In my case, I always introduce myself as being a citizen of the Tr'ondek Hwech'in First Nation from Dawson City, Yukon. I describe myself as a citizen, rather than a member, of the Nation in acknowledgement of the self-governing agreement that our community signed with the Crown. Further, since the Yukon is a territory of Canada, not a province, there is no reserve system; therefore, I am unable to locate the Nation as separate from the greater non-indigenous community that surrounds it. Rather than being plunked down on an "out of the way" parcel of land like most reserves in Canada, our First Nation office is located on Front Street of Dawson City.

Dawson City is a unique town: originally a fishing camp and gathering place for our people, it became famous in the late 1800s during the Klondike Gold Rush (the word Klondike, stems from the word "Tr'ondek" which means the confluence of two rivers in our language). If one was so inclined, after visiting the First Nation office, you could wander up the streets to Robert Service's old cabin, or to Jack London's, whose cabin is just a few doors down. A few years ago, there was an archaeology dig at Tr'ochek, the original fish camp location before the Gold Rush took place. They had to dig through layers of Gold Rush materials before they reached the stone tools and bone arrowheads below. Some of the First Nations people in town were amazed that those artefacts were even found. It is as if there is a feeling among members of my community that those layers of things left over from the Gold Rush are too deep to find something that once belonged to our people.

There is a story that speaks directly to this notion of digging through the layers of indigenous-non-indigenous interaction in our community. It is said that our Chief at the time of the Gold Rush, Chief Isaac, was a medicine person and that he could see into the future. Once the Gold Rush began,

and suddenly the small fishing camp and gathering place of our people became flooded with gold-seekers from around the world, Chief Isaac saw a hard future for us. He knew we would lose many of our traditions, our ceremonies, and our language. He travelled to Alaska to visit our relations across the border, armed with his knowledge of our songs, our stories, and a ganhawk stick (a ceremonial item). He asked the people of Tanana to keep these safe for us. He said that our people would lose our way, that we would forgot these things, and that when we were ready, we would come back to find them. Chief Isaac's predictions of our future came true: we lost our language and a lot of our knowledge about who we are and where we come from (aside from our famous gold rush history) as the small fishing camp transformed to a town of 30,000 at its peak, and our people were subjected to the colonial practices of the Klondikers, including curfews for "Indians" in the town of Dawson City (they were not allowed to be in town after a certain time, so they either had to head for the hills, or go down the river) residential schools, and Anglican missions. In the early 1990s, almost a hundred years after Chief Isaac entrusted our Tanana relations with our culture, a group of Tr'ondek Hwech'in citizens made their way to Alaska to ask to for our songs. The people of Tanana said they had been waiting for us.

Our family locates its homeland further down river, 20 miles from the town, at a place called Twelve Mile. Once a camp with multiple cabins, there is not much there now, as the spring ice jams in the river took away any evidence of the camp decades ago. My father spent his childhood there, fishing for salmon in the summers, hunting moose and caribou in the fall, and trapping furs in the winters. We try to visit this place every summer, bringing our children there to see where their Papa grew up. He often regales us with tales of his childhood on the river; in a way, this makes me feel more "legitimate" in my identity as a First Nations individual (I also have a Indian Status card issued by the Crown under Bill C-31, which legitimises my claim in some, but not all, circles), and that much closer to where I come from.   I am also a member of the Wolf Clan. Although, for myself and my sister, this is a bit tricky: Clan is passed down the matrilineal line, and it is my father who is First Nations (my mother is a French-Irish second generation Canadian). The Nation has come up with a way of devising Clan when an individual's mother is not First Nations; however, according to that formula, I am from the Crow Clan. Yet, all of my family relations are Wolf, and I have also been told that I am from the Wolf Clan in a Shaking Tent ceremony in Manitoba, so I am sticking with it. I have also been given a traditional name in a Shaking Tent ceremony. This name comes from my husband's community, in the tradition of the Anishinabe people, which is far from my roots in the Yukon and the place of my fieldwork, but I have been told not to worry about this. My name is Leader of the Thunderbirds. I have also been told that I have a little bit of a "Windigocan" in me, which are the backwards people (not in a derogatory sense, but rather in a trickster figure way of

seeing things and doing things opposite to most people). This also makes sense to me, and maybe speaks to why I have chosen to complete my graduate studies in another country but do my fieldwork at home, rather than the more traditional way of going off into the unknown of the field in-between years of university study.

The reason I have introduced myself in this way is in keeping with our traditions of locating ourselves as indigenous people geographically in our home territory, but also to begin to discuss the complexities of identity, history, citizenship, and statehood for indigenous peoples in Canada today. My introduction also begins to speak to the idea that "where you come from" is not only tied to geographic locations but to also a complex set of relationships with people, places, stories, the state, and our interactions with them. In Mohawk, the term for midwife means "she who pulls the baby out of the water, out of the earth". It is this process of pulling something out from deep within the earth, from underneath all of these layers that is integral to understanding both the politics and processes surrounding birth that is the focus of this thesis. It is also the starting point for understanding both my position as a researcher conducting fieldwork, as well as the methods I have chosen to carry out this research.

7.2. The sites

The sites of my research can roughly be divided into two areas: the north and the south. This distinction is both geographically grounded and imaginary. These differences will be explored in the ethnography, especially in the context of the midwifery education programme, and the divide between northern and southern midwifery. The area of the north includes the community, or town, of Norway House Cree Nation and specific locations within the community, focusing mainly on the federal hospital and midwifery clinic. The areas of the south centre on Winnipeg, the capital city of Manitoba, specific locations within the city. These locations include the hospital, the boarding homes, and the board rooms.

7.2.1. The north

7.2.1.1. Norway House Cree Nation

In the 2006 Census, the population of NHCN was 4,070, of which the population of Registered Indians was 4,000. (Statistics Canada, 2007) The Norway House Cree Nation is located within the tradition of anthropological categorisation as being a part of the "Western Woodland Cree" or the

"Rocky Cree" peoples. The Woodland Cree "constitute a major branch occupying portions of northern Manitoba, Saskatchewan, and Alberta" (Lovisek, n.d.). According to archaeological evidence, the Western Woodland Cree have "occupied northern Manitoba since 1200 C.E. and were the original inhabitants of the Churchill drainage basin"; the Cree are descendants of "peoples who inhabited the boreal forest west of the Nelson River and Lake Winnipeg for centuries before the fur trade" (Lovisek, n.d).

The community of Norway House is located 456 kilometres north of Winnipeg, Manitoba, and is about 30 kilometers north of Lake Winnipeg on the eastern channel of the Nelson River. The Nelson and Jack Rivers flow through the community, which is situated on the shores of Playgreen Lake. Because of its location in the watershed, Norway House provided early fur traders with a multitude of travel routes. The Hudson's Bay Company built a trading post in Norway House in 1814, and hired craftsmen from the country of Norway to build it; hence the name. The first Methodist church was built in Norway House in 1840 by the missionary James Evans.

The landscape of around Norway House is Canadian Shield. The trees are short and scrubby, and rocky outcrops glide into the clear water, creating picturesque scenes of "Northern Canada". Bridges connect the different parts of the community, but to get in and out, you have to take a short ferry ride across the Nelson Channel. In the winter, they build an ice road across, thus for a period of time in the fall during freeze up, and in the spring during break-up, the only way to travel into and out of the town is by airplane. Norway House is divided into reserve and off-reserve land, and is made up of the First Nation community (on reserve), and the Métis community (off-reserve).

The economic base for the community is fishing, trapping, hunting and logging. The First Nation economy relies on various employers and there are approximately 1,000 jobs in Norway House, with the various forms of governments accounting for approximately 63.25% of these. The service sector accounts for 19% of the total employment. There are also seasonal activities including fishing, trapping, collecting wild rice, and traditional crafts. In 2004, there were 140 trappers, 52 commercial fishermen, and 32 guides who are seasonally employed.   (Wabanong Nakaygum Okimawin, 2004, p. 88) In 2005, the Manitoba Bureau of Statistics recorded that there was a 23.5% unemployment rate as compared to a 5.5% rate in Manitoba overall. The average total income in Norway House for 2008 was $14, 875 (approximately 9,000 GBP) while the Manitoba average was $22,057. (Manitoba Bureau of Statistics, 2008)

The majority of people (91% in 2005) lived in Band, or First Nation, housing. The water supply in the community varies, from several separate water systems providing potable water, to water

delivery via truck. In 2004, there were 232 houses with piped water, 658 houses with water holding tanks, 30 houses with water barrels, and three houses with no services. Similar discrepancies are shown in the sewage disposal systems, with 232 houses with piped service, 658 houses with trucked septic service and 33 houses with no service. (Wabanong Nakaygum Okimawin, 2004, p. 88)

While in the community, I stayed with one of the Aboriginal midwifery students in the student housing at the University College of the North (UCN), and at the local hotel. While I spent days driving around and picking up mothers and dropping them off, the majority of my time in the community was in the federal hospital.

7.2.1.2. The structure of health services in Norway House

Health service delivery in Norway House is based on a very complex structure of local, provincial, and federal resources. Norway House established a Health Integration Initiative through the organisation of the Norway House Health Services Incorporated (NHHS), a non-political entity whose aim is to create seamless, more cost-effective health service delivery system and thereby eliminate the fragmentation of services among various jurisdictions. The Initiative brings together NHCN, the Province of Manitoba, the Northern Medical Unit (NMU) of the U of M, the Burntwood Regional Health Authority (BRHA), the Norway House Mayor and Council, and the FNIH Manitoba Region. At the time of fieldwork, NHHS was composed of the community physicians clinic, which was jointly funded by FNIH and the Province of Manitoba, public health nurses that are hired by the NHCN through a transfer from FNIH, and Telehealth funded by both the Province of Manitoba through the WRHA and from FNIHB in Ottawa (since the FNIH regional office declined to fund the service). There are also physician and consultant services, which are hired by NHHS and funded by both the provincial and federal governments. The responsibility for filling these funded positions rests with the NMU. Physicians and consultants have privileges in both the clinic and the hospital.

7.2.1.3. Northern hospital

The current Norway House Indian Hospital was built in 1952. The first hospital was built before World War One by the Department of National Health and Welfare, and burned down in 1918 to 1919. A second two-story nursing station was built in 1925, and also burned down in 1952, at the time the current hospital was being constructed. At the time of fieldwork, the Norway House Indian hospital was an acute care facility, owned and operated by FNIHB of Health

Figure 3: Norway House Indian Hospital, 1952 (Glenbow Archives, NA-5075-1)

Canada. It was one of only two hospitals operated by this federal branch in Manitoba. The Indian

Hospital lost its accreditation as a hospital a few years before I began fieldwork, and while it is still

called a hospital, it now functions as an acute care facility.   The structure of the hospital is unique, in

that it is not governed by a board, but rather is governed directly by the Regional Director. The

hospital administration is employed by the Manitoba regional office (FNIH), and takes direction from

them, whilst still being a part of the larger federal division of FNIHB of Health Canada, whose

headquarters are in the capital city of Canada, Ottawa.

The history of providing Western biomedical care in the community is a long one, and as

Robertson observes (1994), "sickness has been a good business in Norway House since the hospital

was first built" (p. 197). Although rather negative in her descriptions, Robertson's observations of

the hospital in the early 1970s are interesting:

> A puny white clapboard two-storey structure with one doctor was expected to
> treat all the sick Indians of northeastern Manitoba…. [...] To the idealists, the
> hospital, perched on its barren rock, was a beacon of hope. To the cynics, it was a
> fortress…. [...] Norway House has been in a state of crisis and epidemic since the
> hospital opened. The alert is always sounding…. [...] The panic which is felt by the
> staff of a small, understaffed, and inadequate hospital is the middle of a plague has
> never decreased. Every Indian is seen as
> a potential patient, a source of infection,
> and Indians are bodies to examine,
> treat, cure. (pp. 198-199)

It is interesting to note that Robertson

pejoratively identifies the Norway House Indian

Hospital as the referral hospital where all the

women in the region were sent to have their

babies. The irony is great, since the focus of this

thesis is the struggle to allow birth to happen in

that very same place. Robertson describes the

process of childbirth at the hospital in the 1970s:

Figure 4: Nurse with Mother and Baby at Norway House Indian Hospital, 1952 (Glenbow Archives NA-5075-4)

> Almost every pregnant Indian woman in
> the region is flown in the [Norway
> House] hospital a least a month before
> delivery time (at public expense) and boarded in the community until the baby is
> born. She is then flown home with her baby. This kind of red carpet treatment
> certainly provides an incentive for women, married or not, to have children-one
> month's paid holiday by air. All this fuss and expense could be virtually eliminated

except in problem birth if there were enough nurses and trained midwives in the communities. (p. 199)

This description of evacuation conflicts with the current discourses of evacuation that frame it in purely negative terms. While Robertson laments the "fuss and expense" while equating evacuation to a "holiday" with "red-carpet treatment", the fact that Norway House was deemed a safe place for birth is fascinating in the current context of childbirth in Norway House.

At the time of my fieldwork, pregnant women from Norway House were usually sent to the hospital in Thompson, a larger northern town about a four hour drive away (approximately 300 kilometres), or to Winnipeg, the largest urban centre in Manitoba located 456 kilometres away by air (approximately one and a half hours flying time), or 800 kilometres by road (approximately 10 hours driving time). Choice is always limited to these two settings, and sometimes the location is decided by the obstetrician who visits the community once a month depending on the risk assessment of the pregnancy. (See Figure 5)

During the time of my fieldwork, a lack of physicians was cited as being a major problem in the hospital, and became one of the reasons for the hospital administration to reject midwifery services. One significant event affected the number of health professionals at the Norway House hospital. In 1999, a nurse was implicated in the death of an infant and forced to leave by the Chief and Council. As a show of solidarity, five doctors quit and left the Norway House hospital. Since then, there has been a lack of doctors in the community. In 2009, Chief Marcel Balfour apologised to the nurse and the doctors who left, stating that:

Figure 5: Routes of evacuation for birth for women residing in Norway House Cree Nation

> Apology is the first step in reconciliation and part of a number of strategies intended to create a positive and supportive environment to enable recruitment and retention of physicians, nurses and other vital health professionals. Reconciliation is a journey. We are proud to show today that politics no longer interferes with the provision of health care services in Norway House. The challenge now remains to begin our journey and implement strategies to commit to our on-going approach to health and get doctors and health professionals in Norway House. (30/09/09)

However, once midwifery was introduced into the community, the politics of providing health care once again came to the forefront of in negotiating the hospital space. I first visited the hospital in the midst of the dispute surrounding the midwifery clinic and this became one of the focuses of this thesis.

7.2.2. The south

7.2.2.1. Hospital

I conducted fieldwork in one of the two tertiary hospitals in Winnipeg, Manitoba. This hospital was the first one in Western Canada, founded in 1871 by the Grey Nuns to "meet the health care needs of the people of the new province of Manitoba" (St. Boniface Hospital, 2012, p. 1). The hospital tells the story of their founders:

> They came to teach. They came to heal. They came to comfort. Four intrepid French Canadian women came through the wilderness by canoe – their singular purpose to improve the quality of life for all within their reach. They struggled through hardship, poverty and prejudice. They resisted those who would have left them behind. Determined to reach the western frontier of Canada and deliver their own brand of fierce compassion…. The Grey Nuns stepped out of their canoe onto the shores of the Red River, and into the history of our nation, our province, our city and our hospital. (St. Boniface Hospital, 2012, p. 1)

The hospital's labour and delivery ward is divided into two sections: Labour and Delivery for high risk patients (L&D) and a low risk section called Labour, Delivery, Recovery, and Postpartum (LDRP). According to the hospital website, "the LDRP unit allows low-risk mothers to labour, give birth and recover in one room and have their baby by their side throughout their stay in hospital" (St. Boniface Hospital, 2012).. Birth for women with complications occurs in the Labour and Delivery unit (L&D): the "high-risk obstetrical services provide antenatal care and technology to women with complicated pregnancies", and after birth, mother and baby are transferred to the Mother Child unit.

The hospital also has a history of providing care to evacuated women from the North, and various attempts to ameliorate the practice of evacuation have occurred over the years. The same academics and health professionals that were instrumental in the regulation of midwifery services in Manitoba worked with the hospital to address the issue of evacuation. They begin a labour support programme in the early 1990s, and made promotional videos to sensitise the hospital staff to northern issues. However, these initiatives eventually faded away, and the hospital resumed a regular routine of women from the north delivering their babies there with no social support.

In most First Nation communities in Manitoba, the NMU supplies the nursing station with temporary health care staff to supplement the work of the federal nurses. Doctors in the province of Manitoba are consultants, and the obstetricians that work in the Northern reserves are contracted through the NMU. Each doctor is assigned an area, or a few communities, which they will visit on a bi-monthly basis. One practice group, located adjacent to the referral hospital in

Winnipeg, is one of the main clinics that take referral patients from Norway House. Figure 6 shows the number of women from Norway House that deliver in Winnipeg from 2004 to 2006. The data available confined analysis to these years; however, it provides insight into the number of babies being born in the city of Winnipeg.
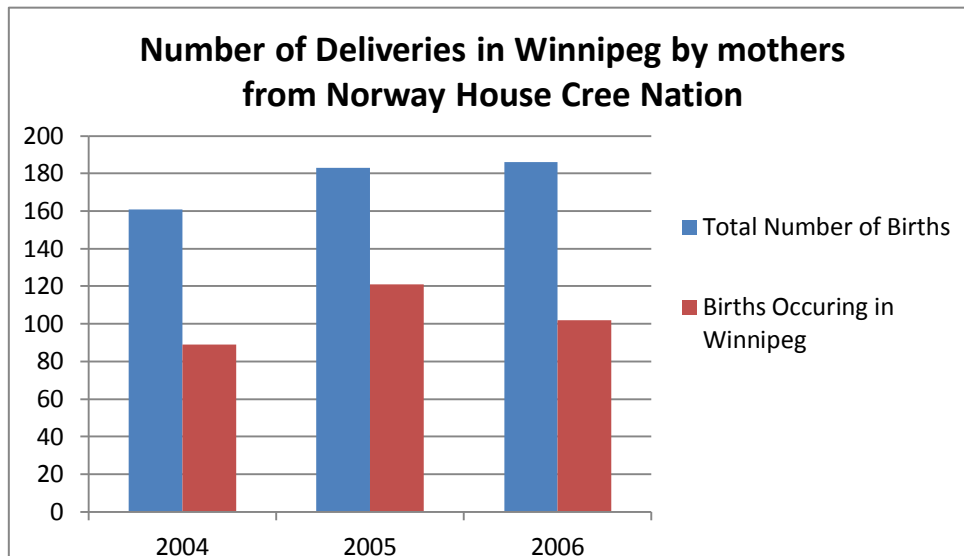
Figure 6: Number of deliveries in Winnipeg by moms from NHCN. (Winnipeg Regional Health Authority, 2009)

7.2.2.2.   Boarding home

There are seven medical boarding homes in Winnipeg that are currently used by northern patients accessing medical care in the city. The type of medical care is not differentiated between boarding homes, so the patients staying at them can range from woman in confinement to diabetics for dialysis. Some of the boarding homes are specific to certain communities, such as Norway House, whose members usually stay at the boarding home at 333 Maryland, or the Quality Inn. During my fieldwork, I spent time in one boarding home that was non-community specific. The boarding home has 80 single beds, with often more than one bed in a room, thus requiring women to share room. While I was there, there were no less than five women out for confinement at one time. These women came from various remote First Nations communities in Manitoba. There were hourly room checks, in which the patients are required to open their door to the security guard patrolling the home. Meals were provided. There were various common areas, some with pool tables and other games. There were pay telephones, although the manager confided that on occasion, she allowed the women to make long distance calls on the house phone.

My first impression of the boarding home was not a good one: the rooms looked old and cramped for space; I saw dried blood on one of the couches in the main lobby.; and I heard a suspicious

scurrying sound as I walked past one of the closets. However, after visiting a few times, my view softened. The women and families were able to gather in many of the common rooms. There was always coffee in the kitchen, and as Katie, one of the evacuated mothers, confided, the ladies in the kitchen let the pregnant women eat when they wanted, not just at the arranged meal times. In a field note, I remarked this change in my view of the home:

> My first visit to the boarding house was dismal. Left me feeling heavy, and like it was a dump. After only a few days there, I already see it differently. Things shift so easily. (24/11/09)

I came to see the boarding home as both a place of refuge for the women and a waiting room; a liminal space in the midst of the politics of the childbirth for First Nations women.

7.2.2.3.   Board room

Next to the hospital, the board room is one of the coveted spaces in the politics of childbirth: this is one of the places where decisions are made; this is where people can decide to provide health services and to take them away. It is the one of the many places where different ideas about the risk of childbirth converge, and where the levels of the state become embodied through the various representatives around the table. Being "a fed" (i.e. representative of the federal government) versus "the province" versus "the region" versus "the community" prescribes the official position one is meant to embody, although personal opinion inevitably creeps into the conversation and becomes a part of the process. As I sat in many meetings, I noticed that board rooms are places where indigenous women are talked about and rarely seen. I find these meeting intense, and the performance of the various levels of the state fascinating. But I also find it frustrating to watch: watching their inertia, their planning to decide next time, to do more "research", to make no real decisions, and, on all sides of the various levels of the state, to commit to nothing but attending the next meeting for further discussion.   The meeting room is a tangible space where certain ways of behaving are acceptable and routinised; however, the space is permeated by teleconferences, and the dynamics of power often shift into these silent spaces of people listening in on the phone, and voices coming out of a speaker.

7.3. The actors

Trying to understand the organisation of health care services for First Nations is complicated; likewise, understanding the actors that provide these services and how they interact or do not interact with one another is equally complex. In introducing the actors, I do so by the various institutions they represent, because this is the way I have come to think of them. Certain people have transformed themselves in my mind from individuals into "the feds" or into "the Province" in the realm of policy. I see the health care providers as separate from all this. Although they are connected as contractors or employees of this system and have their own complex arrangements amongst themselves, they all interact with the "patients", so there is a tactile and a reality in their role in childbirth, more so than the abstract and the centring on the discursive in the policy setting.

7.3.1. First Nations women

In trying to define who I encountered in my fieldwork, especially within the category of "First Nations women", a complex notion of identity and First Nations politics comes to the forefront. Who are these women that are relocated from the North? Can they be defined through their First Nations status? Should they be? Why is this significant? Or are there other factors, such as socio-economic status (e.g. poverty), that must be pushed to the forefront of this analysis? In this section, I will attempt to identify the women that I encountered through my fieldwork, and answer these questions in order to accurately depict the women who are at the receiving end of the politics of maternal evacuation.

In the field, I encountered many indigenous women who were directly experiencing maternal evacuation at the time I met with them: they were in Winnipeg waiting to go into labour, delivering, or heading home with their babies. As noted above, I met women in the boarding homes and in the hospital; these latter encounters varied from brief visits while I was shadowing nurses, to being with women during their labour, the birth of their babies, and time with them after they delivered. In the hospital, the women I spent time with came from four different First Nations communities in Northern Manitoba. Unfortunately, my time spent with women in the boarding house did not cross over into their stay in the hospital, as was my original intention. This is because the logistics of connecting with women as they transitioned to the hospital proved to be very difficult. While women in the boarding house said that I was welcome to come with them to the hospital, this was never followed up on, and when it came time to deliver their babies, I did not hear from them. This is understandable, since "calling the anthropologist" is probably not first on a women's list of things to do when they go into labour. I found that women flowed through the system—boarding home,

hospital, home—quickly, so that the faces of the women were constantly changing for me, and that long term engagement with particular individual women proved to be very difficult. Despite this, however, I believe that the women I interviewed while in the city, and the births that I attended with some of them allowed me to understand with greater depth the experience of First Nations women relocated for birth.

My other encounter with First Nations women who were relocated for childbirth was through a workshop I held with fifteen mothers from Norway House Cree Nation: as discussed above, we explored pregnancy, relocation for birth, and mothering through a body mapping exercise. The women in this group had all recently (within the past year) given birth, and had been relocated for that delivery.

These instances in my fieldwork—the boarding home, the hospital, and the community—are the instances in which I encountered the group that would be considered central to my discussion; although upon reflection, I hesitate to the limit 'the group' to these women. The reality is that the women I encountered in other settings, such as the First Nations midwives at the NACM gathering and First Nations women at various governmental and inter-governmental committees, also had experienced evacuation for pregnancy and birth, and I cannot discount them or their experiences as outside of my realm of inquiry.

The evacuated women circulated and dominated discourses of evacuation in the policy circles I participated in. Again, these women existed for me as a category of "Other" for a long time before I actually encountered them during my fieldwork through my engagement on this issue at a policy level. While I met with midwives and a few women who recounted their stories of evacuation in public settings (conferences and meetings), it seemed we were always talking about the other: the evacuated women existed to us only as a concept that needed addressing. Too often the picture of evacuated women is dominated by discussion of efforts to manage, control, and educate them in the dominant public health discourses surrounding healthy pregnancy, birth, and mothering. In turn, they then become a group of women who are commonly portrayed as uneducated about these issues, unmanageable, and bad mothers. I tended to cling to this otherness a bit during my fieldwork, always thinking I did not spend enough time or get enough information from "them", even though I was consistently speaking with First Nations women who had experienced evacuation. Even after completing my research, I find it a constant struggle to separate the women I met from the construction of them in the discourse of evacuation.

Another group of First Nations women I encountered were older, elder women who practise traditional ceremonies of the Midewiwin. These women, some of whom were mentors to the Aboriginal midwives I worked with, possessed what they would term their communities' "traditional knowledge" regarding mothering, pregnancy, and birth. The time I spent with these women was steeped in protocol. They told me stories that I have connected to present reproductive practices of First Nations families and to Aboriginal midwifery in Manitoba.

7.3.2. The midwives

At the time of my fieldwork, there were two working Aboriginal midwives in northern Manitoba: Carol and Darlene. These two women have informed most of my observations and understandings of the struggles of Aboriginal midwifery in northern Manitoba. Both had been integral in the development of the KOBP; however, Carol had recently left her practice and her position in the programme, and at the time of my fieldwork was working as a consultant. Both Carol and Darlene are active members of the National Aboriginal Council of Midwives.

I met both Carol and Darlene in Vancouver at the Canadian Association of Midwives (CAM) conference in 2007. I met Carol again in The Pas, Manitoba while assisting with interviews for NAHO later that year. During my short stay in The Pas, Carol and I connected, and almost instantly we had a feeling of trust between us. I am not sure why, exactly, but I remember a moment during the taping of the interview where she said, "Ask Rachel, she knows." It felt like I had known her for years. A month later, I travelled to The Pas to a meeting of the KOBP on behalf of NAHO. It was February 2008, and I had flown into The Pas with all the government staff from Ottawa, and midwives from Northwest Territories, Quebec, and Winnipeg. Carol got very upset at the meeting, having not even been informed that we were all flying in, and she left her job soon after. I have this clear memory of Carol at that meeting: angry with tears in her eyes, sleep deprived as she was on call as a solo midwife in a northern community, and near her breaking point. In bits and pieces over the next years, I got to know Carol's story better: from our conversations on the phone, from the days she spent staying with me and my family in our house, from travelling to ceremonies with her, and from reading papers she had written and interviews she had given in other publications. (Couchie and Nabigon, 1997; Anderson, 2000)

Carol is from the Nipissing First Nation in northern Ontario, and grew up near Niagara Falls in Ontario. One day she showed me the tree she used to climb, near the walkway around the falls, where she used to sit and talk with all the tourists who would come to town. She was raised away

from what we would characterise as "traditional way of life". She explained that her path to midwifery was intimately connected to her recognition of her First Nations heritage:

> When I was thirty, I began to wake up as an Aboriginal person. I began to wake up as a mother, as a woman, but birth was always something that I was interested in[…] and then I was an elders' helper for Katsi Cook who is a traditional midwife and she had just had her twins, they were eighteen months, now they are nineteen now, so it was a long time ago. I had a friend who had had home birth, she was a non-Native woman, she was the person I was talking about that raised her kid older, so she had all her babies home birthed and breastfed lots and this kind of mothering really, really attracted me because it was very natural and I liked all the values. I mean I think I was a farmer in another life, like I could be a farmer's wife with chickens and cows and milking them and all that kind of thing so I like that, I think that was the thing that attracted me to midwifery, that it was very practical. It was all about being at home and letting things be natural and having skills that were part of everyday living. (15/01/10)

Carol did her midwifery training at a university in Ontario, before moving to northern Manitoba to open a solo practice in The Pas. In her early 50s, Carol was considered one of the elder midwives within NACM. Since I got to know her better after she left her midwifery practice in The Pas. She was a bit of a rogue in the political context. This happened, by her own acknowledgment, mainly

Figure 7: Carol working in her northern Manitoba practice

because of her outbursts at political meetings. She was very active within the midwifery scene at a national level; however, she had become *persona non grata* at the various policy and political meetings I attended. She had become excluded from many of the conversations because was a strong voice and advocate against the policy of evacuation and the state of maternity care in First Nations communities, and she was a passionate and emotional voice in the breakdown of the

KOBP. So although Carol was not present at many of the political meetings, she maintained her network, and was often someone I could rely on to let me know what was really going on.

Figure 8: Darlene in the Kinosao Sipi Midwifery Clinic

Darlene was one of two midwives working in northern Manitoba in the community of Norway House. At the time of my fieldwork, one of the midwives had left, making Darlene the only midwife working there. Her story and the context of her work in Norway House became the basis for this thesis. Darlene was a part of the "community midwifery" movement in Manitoba: before midwifery was regulated, she spent decades working as a "neighbour" or "community" midwife in rural Manitoba. I spent little time with Darlene in my first travels to The Pas. After the KOBP meeting, she asked if I would ride with her in her truck so we could chat a little on our way to the restaurant. A few months later, Dawn, a woman who worked for the federal government who I will describe below, called me and asked if I would be willing to travel to Australia in June 2009 for a conference and meeting regarding rural and remote birth. She asked me if I could ask Darlene to come as well, as Dawn had been very impressed with Darlene at the meeting in The Pas. So I ended up travelling with Darlene to Australia, where Queensland Health sent us on a whirlwind tour that included meetings with nurses and obstetricians, and flying up the coast to Palm Island to tour a community nursing station in the process of returning birth. We also visited kangaroo parks, held koala bears, shopped, went out for dinners, and spent over 20 hours on the plane ride home together.

Like Carol, I learned about Darlene through bits and pieces, and over time began to understand her commitment to midwifery and to returning birth to the northern First Nation communities. I don't know when Darlene first told me about her experience in a tuberculosis sanatorium at the age of five. When I conducted the body mapping workshop with Darlene and Audrey, her only remaining KOBP student in Norway House, she drew the story of her time in the sanatorium. The first picture she drew was her grandmother rocking her as a baby. Then the picture became a little girl in a bed, next to a window. Darlene explained:

> And this is when I was in the sanatorium, which you know was very formative time of my life, even though it was just a year. This was my rich internal life. You know, I spent a lot of time looking out the window because I was in a straightjacket, tied to the bed. So this is me in the bed. And this is my heart going out here to what I could see in the window, which was the river and the riverbank and the trees and the grass and wanting to be out there. (14/06/10)

Her memories of the hospital permeated into her life as a mother. She explained:

I didn't realise it until I was older. Yeah, when I was pregnant with my daughter I just didn't want her to be in the hospital. I guess that was the main thing about having her at home, was that feeling of protecting her from that experience of being in a hospital without her parents. I was just terrified that they were going to get her mixed up with another baby, or they were going to take her to the nursery and something was going to happen to her, and I wasn't going to be there, you know, that whole thing, so from my own experience of having that happen numerous times. (14/06/10)

Darlene had all of her children at home with her husband. She apprenticed as a midwife with community midwives, and then began to practice. She would often travel to small towns and stay with expectant mothers until their babies were born, with her children in tow. She is passionate about choice of birthplace for women.

Darlene was a part of an inquisition into the death of baby that is well known in Manitoba, and was one of the triggers for the regulation of midwifery in the province (this was discussed above in chapter 3). She told me this story very early on in our friendship, and I didn't connect it to the larger inquisition until much later. Darlene became a registered midwife in the province when regulation occurred, and so when I met her in 2007, Darlene was in the process of transitioning from an independent midwife to a regional health authority employee.

7.3.3. The state

The bifurcated health care system in place for First Nations meant that I was in contact with two distinct systems in relation to evacuation for childbirth. At the level of policy, the opposition of the federal and provincial governments was as clear as the table that divided them at meetings. My main entry into this policy realm was through someone very close to the "top" in Ottawa: Dawn. Dawn was a high level policy person at FNIHB, and a strong advocate for midwifery care within the federal system. At the time, she was a Special Advisor on Maternal and Child Health in Ottawa. She was intimately involved in the mechanics of the federal system, and was often brought into difficult situations to "sort them out". Early in her career, she trained as an obstetrical nurse, but had a long career working in the realm of policy in the federal system.

When I first met Dawn, I scheduled a meeting with her and a colleague about my new position at NAHO in the area of maternal care. I had been given a total budget of $500 for the year, and was concerned as I had seen a federal publication stating that we were holding a First Nations Midwifery Circle. I wanted to clarify with them what they thought I was doing, so that there were not expectations for me to be doing something I was not able to do. I was very naïve to the political dynamic and the depth of the politics of Aboriginal health in Ottawa, but I got along with Dawn. By

the end of the meeting, I had secured just under $100,000 to re-write a NAHO publication called "Midwifery and Aboriginal Midwifery in Canada." From that meeting forward, Dawn was one of my biggest advocates. She sent me to Australia, put my name forward for contracts, and desperately tried to get NAHO to keep me working with the government on their midwifery file by offering to increase their contribution agreements. I am still a bit in awe of how kind and supportive she was of me and my work. When I met her, Dawn was ill with cancer, although she continued to work tirelessly in the system until her death in the summer of 2011. I was able to interview her multiple times during my fieldwork. A few months before she passed away, Dawn emailed me all her midwifery files. She wrote, "It feels good to pass these along. I know they are in good hands."

Since much of my research is critical of the state and its policies, it may seem strange that one of my biggest allies was a part of, and represented, the system I am critiquing. I think that this speaks directly to the complexity and complications of the polarising discourse of returning birth, and how easy it is to fall into binary oppositions. In this thesis, I try to actively resist these temptations, however successful, to characterise the state in these ways.

The regional office of FNIH is not as intimately known to me. I sat in meetings and interviewed key actors, including the Regional Director, the Medical Officer, Hospital Administration, nurses working at the national level, regional nurses, and various staff of some of the federal programmes, such as Canadian Prenatal Nutrition Programme (CPNP) and MCH, but I did not form close relationships with any of these people. Despite this, my interactions with them were dynamic, and I felt they were candid with me about the subject in ways that was probably not in the best interest of the state. For example, I sat down with one of the directors and immediately, before I had pressed record, he said, "You know, I am not allowed to talk about the politics". I said that was fine and not to worry, but by the end of the conversation, his disdain for, and frustration with, Manitoba Health was clear. The tensions amongst federal staff were also illuminated through the interviews, with clear divisions between the on-the-ground staff in the northern community, and the regional and national offices.

From the provincial side of the policy realm, there were a few main actors that informed this study. I conducted formal interviews with two of these staff members. I gained their confidence, and was often called to come to meetings, or if I was not invited, they would call me afterwards and give me a rundown of what had occurred. The meetings I wanted to focus on were the clinical meetings regarding midwifery in Norway House; however, the complex issue of the KOBP programme often overshadowed the clinical components in most of my conversations.

7.3.4. Doctors and nurses

There are a few obstetricians who are primarily responsible for providing care to northern First Nations women through the NMU as consultants. Time with obstetricians is considered precious, as they, as a profession, seem not to have a lot of it. I remember after the delivery of a baby in the hospital one nurse confided to me: "I hope the doctor isn't too upset with me that I called him into the room too early." The doctor had come in to the room while the mother was pushing, and had to wait one contraction before the baby was born. I had kept my eye on the clock and he had been there for less than 15 minutes. So meeting with the obstetricians was difficult. One doctor, the obstetrician for Norway House, was welcoming in her emails and interactions, and one of the doctors who worked in the Arctic invited me along to some of her community visits. Unfortunately, budget and timing did not allow for this to take place.

There is one particular doctor who is well known in the province for serving one northern area of fly-in communities. Everyone spoke of him as an important man. However, he is a contradictory figure. People praised his dedication and his commitment to the communities, but they also described his tendency towards paternalism. When I ended up being in deliveries with him, he knew the women's names and their families, having probably been the doctor who delivered them as well. Nurses described his dedication to the communities and his skill as a doctor, especially using forceps. A medical student described his dedication to me, and commented that it sometimes borders on paternalism, but people always stressed that his intentions are good. He takes all his own call, so he is also known to be a bit ornery at times. I asked to meet him.

When the time came, a midwife led me to the basement of the hospital. Before she opened the door to the clinic, she paused and turned to me:

"Are you feeling brave?" she asked.

"Sure", I replied, "Why not?"

We entered the clinic and I was introduced to the nurse in charge. He had not arrived at the clinic yet, but would soon. The two women discussed how to get him to talk to me. I held my pamphlet about my research in my hand. They decided it would be best not to tell him that I was there, but have me wait in his office, so that when he came in to hang up his coat, I would be waiting, and I could try to get him to speak to me.

They led me to his office and closed the door. I sat in his chair, looking around, feeling incredibly nervous, and wondering what he would think when he came in to find me sitting there, ready to

pounce. I noticed a black and white photo of First Nations women sitting on a step, with a white doctor with them. I assumed this was him. The photo must have be decades old.

He came in and looked only slightly surprised to see me. We spoke for about 10 minutes, and he ended the meeting by agreeing to let me hang around in labour and delivery with him. At one point, he was visibly annoyed: so many graduate students have come through, asking for interviews, asking for his time and nothing changes. He still writes letters for each patient to FNIH, Non-Insured Health Benefits (NIHB), pleading to allow an escort so that women do not have to birth alone. He said: "There are two problems. Women need support with them, and we have to do something about diabetes". With that, he got up and walked out.

I met him a few more times—in the operating room, in the staff room in the hospital, in his clinic. Each time, I was forced to think about how it is not useful to pit midwifery against doctors: it is much more complicated, more intimate. I thought back to that black and white photo in his office, and it reminded me of an old family photo taken at my great-grandfather's cabin: a white man surrounded by First Nations people and their babies. Except in my photo, it is an Anglican priest, not a doctor, posing with them.

To try and summarise the nurses that I met and interviewed across my fieldwork sites is a difficult task. In one interview in the northern hospital, there were two nurses in the room with me for half of the interview. One had been a midwife in the Caribbean (where she was originally from) and was now hired as a Nurse Practitioner (a nurse with an extended scope of practice); the other was a First Nations woman from the community. The Caribbean nurse voiced her disapproval of evacuating women, while lamenting the lack of infrastructure and support for the births. The other nurse vehemently opposed birth in the northern hospital, and scoffed at the idea of social support being a deciding factor in place of birth. She said, "I want a doctor at my delivery so he can deal with complications. Who cares if my boyfriend is there?"

Nurses in the urban centre hospital were diverse. Their role in monitoring and managing the care they provided was prescribed by their hospital protocols, and the boundaries of what they could and could not do were well defined. Most of the nurses I worked with were sympathetic to the struggles of the First Nations women who had been evacuated. Upon hearing my thesis topic, one nurse commented, "Good. Maybe things will change." Some other nurses described the differences in care amongst the staff. One nurse said how she loves to provide more emotional supportive care, rather than just clinical care, and so when she sees a First Nations woman in L&D that has come down from the North, she requests taking care of that patient so that she can make

sure that woman has more support. Other nurses take a more clinical approach. I remember an instance in my fieldwork when a nurse was teaching me to read the electronic fetal monitor (EFM) tape, and she showed me how in this particular instance, the device was attached to an internal fetal monitor through the woman's vagina. She pulled back the sheets of the bed to show me the wire, thus exposing the bottom half of the 17 year old First Nations girl that it was attached to. The girl didn't even move, she kept watching the television, and I remember thinking to myself: "this is an example of how people sometimes are treated like 'bodies' in the hospital setting." Upon reflection, nurses were everywhere across the landscape of evacuation: from the nursing station to the hospital, to the board rooms.

8. Carrying water

In this chapter, I present findings that explore place of birth and Aboriginal midwifery through the connection between Midewiwin ceremonies, and the discourse of revitalising and renewing indigenous cultural practices in order to restore health to First Nation communities. This discussion is foregrounded in the act of women participating in ceremonies that re-establish the relationship between bodies, the land, and water. The "backgroundness" of this practice is the potential to be healthy again, the potential to be balanced, and, in essence, the potential to embody the "post-colonial" vision that has been articulated by the Aboriginal midwives. This is one of the paths that I followed during my multi-sited ethnographic research, although in the politics of place of birth and midwifery, it initially seemed divergent.

This path started with the midwives talking about ceremony and healing, and continued with my own participation in ceremony and the teachings around women, family, and how to live a good life. Darlene introduced me to one elder, Kathy Bird, at which point I began to interview elder women who practiced ceremonies. I gave them tobacco and cloth, and asked for these teachings. While the connections of ceremony to birth place are not explicit, and I cannot say that the women experiencing evacuation would think of their experiences in these terms, I felt that this path was the most important journey of my fieldwork. I felt like I was digging down and figuring out why all this mattered so much: what had been "lost" through the practice of evacuation, and how traditional teachings moved from what we had in the past to be able to comment on the present, and then reveal what our potential future could be. I found that by bringing the politics of childbirth into the discussion of revitalising ceremony, the issue of birth place and Aboriginal midwifery broadened to and contributed to indigenous rights. The ceremonies bring the body and bodily substance of childbirth into the same arena of negotiating the rights of land and water. Therefore, through participating in and studying these ceremonies, I found that not only reproductive rights are pertinent to birth place, but rights to land and water are a part of this dialogue.

This chapter details my path of discovering the connection of place of birth, Aboriginal midwifery, and broader indigenous rights. It is organized as follows: first, the ceremonies are contextualised; second, the experience of these ceremonies, including the teaching surrounding water and birth is discussed; third, the views of mothers and their perceptions of kinship and relatedness through birth is presented; and, finally, how these ceremonies relate to the relocation of birth through Aboriginal midwifery will be made explicit. From this discussion, we can go on to look at the current practice of maternal evacuation.

8.1. Midewiwin ceremony and the 'traditional'

The historical and political context of indigenous peoples is rife with traumatic events, such as relocation to reserve communities, residential schools, and the on-going assimilationist policies directed towards the 'modernisation' of indigenous peoples and their identities (as discussed above in chapter 3). There is an articulated loss of connection to the land and 'traditional' ways of being on the land. In my experience doing research in Manitoba, this loss is often mitigated through a return to, or a continuation of, practicing ceremony. The importance of returning to ceremonial practises lies in the fact that so much of ceremonial practice establishes and re-establishes the relationship of indigenous peoples, both individually and collectively, to the land and water. This relationship was seen through almost every ceremony I have ever participated, both inside and outside of my research, including women's ceremonies associated with pregnancy and birth.

As the use of the terms 'traditional' and 'ceremony' may raise red flags in anthropological modes of thinking, a brief explanation of what I mean in this context is necessary. In First Nations communities in Manitoba, certain 'contentious' terms are used quite freely to describe certain practices. This may be because of our long history of having anthropologists within our midst: being 'traditional' or practicing one's 'traditions' or 'culture' have become part of the common vernacular. The use of these terms, however, does not mean that these practices are static and not adaptive; rather, the process keeps going and does not "yield precise replicas of past performance" (Ingold, 2000, p. 147). In this way, "tradition is more than a badge of ethnic identity, it is a mode of engaging with the world" (Csordas, 2002, p. 163). In most instances, ceremony refers to the practice of what can be considered rituals of healing. Rituals are "an important part of the way that any social group celebrates, maintains and renews the world in which it lives, and the way it deals with the dangers and uncertainties that threaten the world" (Helman, 2007, p. 224). Csordas (2002) connects ritual healing and identity politics by focusing on "bodily experience" as an "experiential transducer" between the "religious and political domains" that allows us to look at these rituals through the "context of politics, or as the opening of a performative window onto larger political processes" (p. 162-163).

The women I interviewed about ceremony, including members of the Midewiwin Lodge, all actively practiced traditional ceremonies in some form or another. The Midewiwin Lodge/ceremony originates within the Annishnabe, and it was originally exclusive to them. In some of its current forms the ceremony welcomes indigenous peoples from across "Turtle Island" (North America); therefore, participation is no longer exclusive to Annishnabe. The Midewiwin ceremony has its roots in the aadizookaanag (sacred narratives), which was the Annishnabe's "explanation for the origin of

the world, and the behaviour of all things" (Angel, 2002, p. 4). These narratives told of Nanabozho, the hero and trickster, and his role in the "creation of a new earth". The Annishabe were told of:

> …the birth of the first people, how their descendants had been taught many things by Nanabozho so that they would be able to survive. They learned of the power of visions and dreams by which they could communicate with the manidoog, or spirits, and they learned to pay respect to their animal brethren with whom they shared their existence…. The most important of Nanabozho's gifts … was the institution of the Midewiwin, since practitioners were promised a long life if they followed its teachings. (Angel, 2002, p. 4)

The exact origins of the Midewiwin have been under scrutiny since the first explorers and missionaries encountered the ceremony. (Angel, 2002, p. 5) For the purposes of this discussion, the origin, or authenticity, of Midewiwin ceremonies is not a concern. Rather, it is important to understand how the Midewiwin fits into the lives of the people:

> The Midewiwin was an integral part of the [Annishnabe] cosmology… within the Midewiwin … special powers were gained as a part of a process that also taught them the meaning of life and death, their place in the universe, and the origins of the [Annishnabe] people. In other words, it was more than just another ceremony, for it provided an institutional setting for the teaching of the world view (religious beliefs) of the [Annishnabe] people. (Angel, 2002, p. 48)

The ceremonies of the Midewiwin are highly complex and layered with meaning. Depending on the level or degree in the Lodge, narratives are told with either more or less detail. As my friend, anthropologist Allice Legat, constantly tells me, "Elders will speak to the least knowledgeable in the room"; therefore, the knowledge given to me in these teachings can be seen as rudimentary at best. This being said, however, most scholars of the Midewiwin emphasise that historically "its central ritual was a healing ceremony meant to protect the [Annishnabe] (and practitioners from neighbouring tribes) from disease and to promote long life… the ceremony clearly addressed not only the health needs of the community, but also its spiritual and social condition" (Angel, 2002, p. 13). In present day, one of the ways the Midewiwin is practised is as the "Three Fires Midewiwin Lodge", which is described on their website as a "contemporary movement of the sacred Midewiwin Society" (Three Fires Midewiwin Lodge, 2011). They hold ceremonies and initiate members into different levels and degrees. The grandmothers whom I interviewed for this study all were initiated members into the Midewiwin Lodge. While my husband's family is Annishnabe/Saulteaux and my practice ceremony has been primarily with them, they do not participate specifically in these Midewiwin Lodge ceremonies and teachings. As my mother-in-law explains, "what we do is Midewiwin, but not in that way with the degrees." Therefore, my experiences in ceremony could be

on one level characterised as Midewiwin, although not it the formal sense of receiving the teachings of the Midewiwin Lodge.

8.2. The berry fast

On a cold and snowy morning in January 2010, I got up early to drive out to a reserve to attend a berry fast ceremony. I was in the middle of my first trimester of pregnancy, and I had to drag myself out of bed, fighting the lethargy and nausea that often consumed me. I had been invited to tag along by the midwife and midwifery student from Norway House, Darlene and Audrey. Audrey was bringing her pre-teen daughter, so that she might learn about the ceremony and perhaps participate. I got out of bed, stuffed into a plastic shopping bag my long, flowered skirt and a package of tobacco, both of which are required to participate in ceremonies. I quickly made oven-cooked bannock as my contribution to the feast. I was tired so I didn't measure correctly, and the bannock came out a bit burned around the edges and stuck to the pan. I was late, so I just placed a cloth over the pan, put on my winter coat and boots, and used oven mitts to carry the bannock out into the icy cold morning, and placed it on the floor of the car to cool down. I drove across town and picked up Audrey and her daughter, along with her daughter's friend; we met up with Darlene at the Tim Horton's coffee shop on the way out of town to grab hot drinks and doughnuts before the two hour drive.

I had heard/learned of the berry fast only recently, during one of my interviews with an elder, Margaret Lavallee. It is a rite of passage ceremony marking the beginning of menstruation. According to Margaret, a young girl abstains from eating berries for a period of time after her first menstrual cycle. The ceremony today was the celebration of the end of a young girl's one year berry fast. As Margaret explained:

> …so the mums and the grandmothers [in the community] knew that this girl would have to go on a berry fast from the time … of passage [when she started menstruating], which means that they would go on this fast….so she was always connected with the [her] grandmother, this young woman. If it wasn't the grandmother then it would be the aunties. It was only the aunties or the grandmother to teach this young woman of her moon time. And it was their responsibility, the grandmother and the aunties. So then sometimes they would only go on a fast for six months from the berry fast, maybe sometimes a year…. And those were the times where the young maiden[s] was looked upon because she was shedding blood and it was time for the men to look after [here]; they took it very seriously because this had to do with a cleansing time, a purification time. And so that all went together, all those teachings went together, as well as the berry fast, as well as the breaking of the fast, as well as preparing this young woman every month that she was going to shed blood. For what? It was for a preparation. So those young women, not only the young women but the young

men were taught that too because they went on a vision quest with the grandfathers and they were taught that the young maidens were preparing for womanhood and also the young maidens were told that your body is sacred, your body is very important that you take care of your body, and boys were also taught to respect that young woman. (2010)

This ceremony and the above description are telling of a number of things; it describes the rite of passage to acknowledge a girl's transition to womanhood during her first menstrual cycle; it also points to the family connections and the role of the extended family network in the teachings for the young woman, or maidens as Margaret Lavallee terms them, about her body and how to take care of it. Margaret's description references the role of men in this cycle, in that they also receive teachings about how to respect young women during their "moon times" and times in general.

Margaret's description of the berry fast ceremony presents it as a ceremony that occurred in the past—before changes such as residential schools and the introduction of Christianity—and thus lends itself to that image of what was practiced "before". However, the practice continues to take place, in a variety of forms: while it may not be as widespread as it was "before", it is still present, both in the words of the elders I spoke with, and in the very fact that I was driving north to attend a fast-breaking ceremony. The notion of bringing "past" ceremonies and understandings of our bodies into the present and future is a dominant narrative that will be explored in more detail below. In fact, this narrative of revitalisation is also seen within the movement of returning, or repatriating, birth back to communities. I discuss these ceremonies and understandings of the body within their discursive and embodied practices in order to gain a broader understanding of the implications of the connections and disconnections of bodies and place within the broader framework of maternal evacuation.

Returning to that cold morning in Manitoba, we pulled up to the ceremony, which was taking place at a hall in a small town near the reserve, and found lots of pickup trucks in the parking lot. We quickly grabbed our things and went into the room. This ceremony is not just for the fasting young woman, but for the community—for friends and family to celebrate her—and I was invited as a friend of the midwives who were invited by Kathy Bird, who was running the ceremony. I took a deep breath and set my semi-burned bannock on the table with all the other food, and took a seat. I knew no one from the community and I could feel their eyes on me, sitting timidly with my long flowered skirt hanging down over my jeans and boots.

The berry fast has been described by other authors, and this part that I am witnessing, the breaking of the fast, is part of a year-long ceremony that a young girl and her family undertake. Anderson (2000) details the whole process:

The ceremony starts with a big feast in the spring, where girls come together with their female family members as well as a number of women who are to play the traditional role of "auntie" to them. They are taken aside with one of the aunties, who teaches them how to make tobacco ties (offerings of tobacco wrapped in cloth), which they are to put out at a designated time each month. [...] The girls then hear from each of the aunties who have assembled, who encourage them and talk to them about some of the challenges they will face, both during the fast and as they enter the world as women....   ...the aunties will talk about patience, sacrifice, respecting their bodies, and taking time to build relationships. They are then offered the berries four times, and each time they are required to say "no." They must then offer the berries to their mother ... who recognises that they are saying goodbye to the child, and letting her proceed on her journey towards womanhood. Thus begins a thirteen-moon (month) period during which the young women are expected to refrain from eating berries or berry products…. At the end of this period, they come back to their circle of aunties, and are sent out on the land for twenty-four hours to do a fast (no food and no water). When they come off the fast, they are bathed in cedar-drenched water, dressed in their finest (often regalia), and introduced as the new women of the community to the aunties and family members who are attending the ceremony. (pp. 386-387)

One author's description of a young woman's breaking of her fast is similar to the ceremony I attended. The author recounts the experience of this young woman, Sabrina ("A journey into womanhood", 2005):

At the end of the year a celebration was held in which Sabrina was presented to her family. She braided her hair while aunties and grandmothers talked to her about the past year's teachings. A blanket was placed over her head and face and she was led from her room outside and around the circle of her family. At the end of the ceremony she was offered berries. She refused them four times, one for the Elders, one for the children, one for family, and one for everybody else. The fifth time they were offered she ate them. A large feast followed.

During the ceremony I attended, an auntie stood up and talked about the water. She poured us all some water to drink, and talked about the importance of taking care of the water. She spoke of birth water, amniotic fluid, and how we must take care of this water in our bodies. She told us of the importance of the water breaking when you are in labour. She also spoke of the ceremonies they do each spring, walking with water on the land, in order to keep that water healthy as well. The image of these women walking with pails of water immediately struck a chord, and I felt that a new way of understanding pregnancy and birth in the context of relocation has just opened up in front of me. I resolved to get in touch with the auntie who spoke about these things, and learn more about being a 'water carrier'. I feel my stomach, not yet showing or having yet felt anything inside me move, but I know she is in there, and I realise I am being a 'water carrier' now.

The notion of 'carrying water' has come to be fundamental in my understanding of the issue of birth place. The health of the water, both in the body and on the land/territory, is fundamental in the movement to revitalise and restore some kind of healing in indigenous communities. The berry fast touches some of these fundamentals. Josephine Mandamin, an Anishinabe grandmother who walked around the Great Lakes with a pail of water whom I had the privilege of interviewing, explains the connection of the berry fast with the land: "This teaching's [the berry fast] about the first blood that a young woman, when she sees her blood for the first time, she gives it to Mother Earth" (08/12/10).

There is also power associated with the menstrual cycle, or moon time, which comes clearly into focus in the recounting of Sabrina's experience of the berry fast:

> …while the teachings [of the berry fast] restrict some actions and promote others, they focus a young woman's attention on becoming aware of her power, the power granted to her with the coming of her monthly blood flow. From this point onward she has the capability of bringing new life into the world…. It comes with responsibilities toward future generations. (unknown, 2005)

The notion of power in the menstrual cycle is one of the common ways of thinking about referring to women's bodies in the practice of ceremony. In the next section, I explore the connections between our bodies and bodily substance, focusing mainly on birth and babies, and the land and water from which we come, through my conservations and interviews with elder women who are currently 'practicing their culture'. From these connections, the role of these ceremonies and what they are telling us can be placed in the current state of the practice of maternal evacuation.

8.3. Looking for our tissy buttons

At the berry fast ceremony, I learned that pregnancy is carrying sacred water. I asked Kathy Bird if I could visit her again and ask her some further questions. She gave me a phone number to set up an appointment at the WRHA. I found out that there is a clinic called the "Aboriginal Traditional Wellness Clinic", which Kathy runs at the Health Sciences Hospital in Winnipeg, Manitoba. I called the number and booked an appointment. I was instructed to bring tobacco and a gift, and to dress appropriately in a long skirt. It is interesting that an exploration that started in a First Nations community hall ended up in the halls of an urban centre hospital where Aboriginal woman go to have their babies. Suddenly, my connection between ceremony and the health care system did not seem so divergent.

On the day of my appointment, I found myself in the basement of one of the many hospital buildings. I went through a set of doors, and found another door that I knocked on and waited for an answer. Inside, I found three women preparing the room. There was a table set up with jars of all shapes and sizes filled with different herbs, and a lady was putting some in small, brown paper bags. Another woman was kneeling beside a bear skin and a burning smudge, setting out the ceremonial items. Kathy was organising papers and talking on her cell phone. I went in and sat down; I gave Kathy the tobacco, explained my research, got the necessary consents signed, and turned on my recorder. The first thing Kathy said to me explains her view of pregnancy and the body:

> I think the main thing that is important, and that we are trying to teach the girls and the young women is our own creation story, like where life comes from.... Our spirit comes from the Creator and … we need to nurture that respectfully and with dignity. So that is what we are trying to teach the young girls: who they are … and where we come from and how we walk upon the earth, and then we go back to the spirit world…. And that there are responsibilities all the way along there, and so that to us is what life is all about. So when that spirit starts, for us that happens right away, that already your baby has that spirit, and it doesn't come at birth, it is already there, from the moment of conception. So your body is moulding and shaping the body of your baby, to surround it and protect it, to protect that spirit. So that is why for us it is important to look after yourself all through your pregnancy.... And you want it to be healthy, and you want it to be well and everything to be okay. And there are a lot of teachings along with that. (04/05/2010)

In an interview with *Talking Leaves* magazine, Mohawk midwife Katsi Cook adds to this by describing a women's pregnant body as the baby's "first environment" (2000, p. 1):

> Our grandmas tell us we're the first environment, that our babies inside of our bodies see through the mother's eyes and hear through the mother's ears. Our bodies as women are the first environment of the baby coming, and the responsibility of that is such that we need to reawaken our women to the power that is inherent in that transformative process that birth should be. (p. 1)

Katsi also talks about the water. She says that "And we thank the waters. The waters of the rivers and the waters of our bodies are the same water…. It puts you in that state of relationship" (2000, pg.1).

In the basement of the hospital, in the Aboriginal Traditional Wellness Clinic, I saw the women who spoke about water at the berry fast ceremony. She is tending to the ceremonial items, so when I ask a question about the water, Kathy switches places with her. The woman begins to tell me about birth water:

> There is a spirit that comes, during that time when that water breaks, [and] washes that doorway for the new spirit to come. She is called *Seeimigaykwe*[11] [this means 'she who pours the water']. There is a song that goes with it, and you sing that song to welcome that spirit and encourage that spirit. Because that is a very painful passage for that spirit. It is hard …it is actually painful when you are coming through that doorway, and then you sing and you calm that little spirit, you calm when you sing that. When you are singing it is actually not you singing, it is that spirit, *Seeimigaykwe*, singing that song to that spirit. And it is very calming and soothing to the mother and also to that new spirit that comes through that doorway. *Seeimigaykwe* washes that doorway for the new spirit. (04/05/2010)

Thus, the body as environment and our relationship to the environment through our bodies is made clear in the context of pregnancy. As Kathy Bird elaborates:

> And then it [clarify] goes back to … how when we carry life, we carry it in that sacred water, that water keeps baby warm, that water protects baby, baby's skin … everything that is in that water is constantly being cleaned, our body is naturally doing that, and when it is time for us to give birth, what is the first thing that happens? The mucus plug comes out and the water breaks … usually this is what normally happens … and we say that it cleans the way out for the baby to be born…. So that whole connection of we female spirit and Mother Earth female spirit, and Grandmother Moon … it is all connected. (04/05/2010)

Communicating these teachings about water, pregnancy, and birth is as much a part of passing on traditions and ways 'of the past' as it is a comment on the current state of First Nations communities and a warning for the future of First Nations. Bringing people 'back' to practising ceremonial ways is seen as a healing process from the trauma encountered by First Nations peoples in Canada, as well as a way to both maintain our connection to the land and water, and to keep that

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[11] This is my spelling of the Cree word.

same land and water safe for future generations. In the next section, the practise of certain ceremonies—the foreground—connects the physical remains of childbirth with the land and water, thus establishing that baby's connection and place in the landscape. In the same sense, the absence of conducting these ceremonies becomes a comment on the current conditions of First Nations in Canada—the background—thus reinforcing the need to return to ceremonial practise in order to maintain balance and ensure a good future for our communities. As Kathy Bird concluded:

> Mother earth for us is a living spirit, a living being, and she provides us with food, clothing, shelter, and everything that we need to survive. Water, her blood is the water, and it flows through her body, under the earth in those veins. So that is her lifeblood. And water is cleansing. Water is sacred. Water is the lifeblood of Mother Earth, and she gives life, just as we, women, give life. She brings forth life, we bring forth life. We are like Mother Earth. And the blood that flows through our veins is like the water that flows through Mother Earth. And we are the caretakers of the water, because of that close connection…. that is why we are considered caretakers of water. (04/05/2010)

A ceremony that connects the foreground of ceremony with the background of conditions of life for First Nations in Canada is taking care of the umbilical cord after the birth of a child. When the umbilical cord is cut, the baby's remaining umbilical cord dries and falls off within the first few days after birth. Keeping this stump, or, as Kathy Bird refers to it, the "tissy button", is important for the future of the child. She explains:

> Once it dries up, you don't just … throw it away in the garbage. Our people always looked after those things. And there were ceremonies, little ceremonies, that they did for [a] girl's umbilical cord, and certain ones for boys. For us, back home [NHCN] it was for girls wrapping the umbilical cord with needles, thread, cloth, leather, and tying it in a bundle and putting it in a tree or stump or burying it, so that she would be able to sew, you know, to look after her family's clothing in a good way. That is what they did with the girls. With the boy's they put it in a little leather pouch with a bow and arrow or a little fishing rod … so that he would be a good provider of food for his family. (04/05/2010)

This small ceremony directly establishes the connection of the baby to the land. It also speaks to gender roles within communities, including how each gender is expected to take care and provide for family. The ceremony is of further importance because key to achieving a "good life" is development of the relationship between one's body and the earth. Kathy stresses this importance:

> Those things [umbilical cord stumps] were very essential for our survival. So they were never thrown away. They were looked after. And it was about respect: respecting life, respecting what Creator gave us. So they did that in a ceremony. They put all that away back to the earth. It is always back to the earth, because for

us, we are part of the earth, and the earth gives us life, and so that is what we do, back to Mother Earth. And again, it is close to where you live, the grandmothers say, so that you ground them. (04/05/2010)

For First Nations people, establishing one's relationship to the land is important. This individual relationship is first established at birth; shortly after, through little ceremonies, it is confirmed. The key point is that these ceremonies should take place close to one's home, where one "comes from". This raises the question: what are the implications, of giving birth far from where you "come from"?

From this perspective, evacuation not only removes social and kin support, but it removes the opportunity to establish one's relationship with the land from the beginning of one's life. On a more general level, one of the reasons given for social upheaval in communities is this loss of connection between body and the land. This teaching is explained by Kathy:

> They [the grandmothers] said that the reason today our youth are so scattered and so bewildered so much ... is because a lot of those things [tissy buttons] are being discarded in the garbage. They said, "So they are looking for their tissy buttons in the garbage". That is exactly the words they use.... So the more we get back to doing this, the stronger our youth are going to be. (04/05/2010)

The implication in this is that by restoring our connection to the land through ceremony, other structural issues will again come into balance.

Another ceremony that establishes the relationship between one's self and the earth is burying the placenta after birth. According to Kathy, the placenta is "what is connecting you and your baby". It is what is "nurturing, what is feeding, what is helping your baby grow" (04/05/2010). Like the tissy button, it is important that this is "looked after" and respected. Kathy explains the teaching around the placenta:

> Once they [the mother] had the placenta, and they brought it home. And usually it is the father that takes it and buries it. Puts it back to the earth with tobacco and gives thanks that it looked after his little one in a healthy way. It is a respect; it is about respect for where life comes from. And the other thing that the grandmothers said is that when that happens, the baby is grounded…. Our grandchildren's placentas are all buried near our house so that they are grounded in that place. So that is one of the things that we encourage young mothers to do, young parents to do, is to look after the placenta. (04/05/2010)

Like the tissy buttons, burying the placenta as soon as possible after birth is seen as very important. When birth took place in communities, the opportunity to bury placentas close to one's home was possible. Josephine explains:

> I remember my grandmother was a midwife and they would come in and get her at all hours of the night to go and deliver babies and what they would do right away as soon as the placenta was out, the natural thing is to bury it…. When the blood is the freshest from Mother Earth, because she needs that blood. (10/12/2010)

By burying the placenta in the earth, a place is created in the landscape to which the baby is both physically and metaphorically connected, thus contributing to the health of the child. In turn, giving the placenta to the earth also contributes to "her healing":

> …the placenta has to go back to Mother Earth because that's the way it was a long time ago. People are saying they want to go back to their old ways, that's one of the ways, help the Mother Earth with her healing, give back to her. It's all a cycle of life, birth, death. (10/12/2010)

In the current system of evacuation, obtaining one's placenta is not always a straight forward task. While some say that hospitals in Manitoba are good about giving women their placentas, others have not had the same experience. Josephine retells one woman's experience:

> Well what's happened here there was a woman who came from up North … and had her child, her baby, born and then when she left, her placenta wasn't given to her. They said it would be mailed to her. So it was mailed in a package and it got lost in the mail and when she got it, it was just a grey mass of dried up.... It was very disrespectful for her and for women to be disrespected that way when she could have, you know, it could have been given to her then and there at the hospital. (10/12/2010)

In another instance, she explains:

> …my other granddaughter who went through the situation where they wouldn't give it to her, they said they had to do tests on it and to probe, I don't know why they're probing the placenta, and then she was told that she would have to pick it up at the morgue…. She had to pay that and she did pay for it because she had to do a ceremony, she said when she got it, it was all white, no sign of any blood in it. (10/12/2010)

Negotiating access to placentas, and having babies (and their placentas) born far away from their communities, shows how evacuation for childbirth may affect aspects of their relationship to their home place for both the mother and the baby. In the cases described above, there is also an underlying commentary on how indigenous people are treated by the broader health care system and the state. The juxtaposition of picking up a placenta, something that is connected to life and gives the earth fresh blood, in a morgue, a place of death, creates an image of uncertainty for the current and future states of indigenous peoples. The metaphor of looking for our "tissy buttons" in

the garbage because the hospital threw them away is a powerful commentary on the current state of First Nations, as viewed by these grandmothers. Also coming out of the descriptions of these ceremonies are notions of responsibility and accountability.

8.4. Realising and managing risks through ceremony

These practices identify risks. As discussed above, the grandmothers noted that there is a risk to an individual if relationships to the land and water are not established at birth or subsequently maintained: when a baby is born and the ceremonies are not performed, and therefore the relationship to the land and water is not established, the result is a lack of connectedness to their home places or sense of identity.

There are also broader risks present here: the global risks of climate change and pollution are also connected to the maintenance of these relationships. The current "sickness" of the earth and the risks she faces are seen to be, in part, related to First Nations' lack of maintenance of their relationship with the land, and their loss of their notion of healing—not just healing of individual bodies, but the land and water—through these ceremonies.   Kathy relates:

> Our waters are getting so polluted. And the more Mother Earth becomes polluted, the more we are going to become polluted. The more sicknesses she is going to have, the more sicknesses we are going to have…. Even her breathing, even how she breathes, through her breath she cleans the air, and it is through the trees. And when we destroy the trees, we are destroying her lungs. So you know … that is why we as Aboriginal people … we always had respect for those things, and we always took care of those things…. We looked after those things…. We knew what to do and we had tremendous respect. And we need to learn those things again. We are teaching our children. That is why it is important for us to take these little ones out fasting, and that is why it is important we are doing that for those young women. We didn't have that opportunity to go fasting when we were young, because we got sent to residential school, and other things beyond our control. But now we have a bit more control, and we are trying to teach our children, our grandchildren, these things. To pick up that sacred bundle, it is a medicine bundle, those teachings of the grandmothers. (04/05/2010)

This passage brings to the foreground several important points. First, Katy identifies current risks, both to the body and to the earth in general, and points to the practice of ceremony as the way to manage these potential risks. Second, regarding knowledge and control, Kathy stresses that through ceremonial practice, not only is balance brought back to the relationship between bodies and land, but so is the knowledge associated with these practices. Third, Kathy acknowledges the control of the state over ceremonial practices in the past through residential schools. Finally, she acknowledges the possibility of change in the present and transformation through "a bit more

control". Carol, an Aboriginal midwife, echoes these same sentiments in the context of birth. For Carol, birth itself is the ceremony:

> Birth is the fundamental ceremony of our tribes. It is the most sacred ceremony that we have…. It just happens. So we have never lost it. It always happens, babies are always born, and women are always doing that, and they are caring for them. We don't have to get back birth because it has never left us, but we have to get back in control of that ceremony. We have handed over the control of that ceremony to other people, and it has to be brought back home to us. (NAHO, 2008, p. 58)

With this statement, Carol draws on the midwifery discourse that reterritorialises birth within women's bodies, as well as acknowledges the loss of knowledge and control in the birthing process. In order to explore these ideas further, I turn to examples of how Aboriginal midwives have constructed the women that they work with, and the potential future for First Nations in relocating birth place to communities.

Carol led a session at a meeting of the National Aboriginal Council of Midwives in 2009 in Winnipeg, and asked the participants to draw the realities they face in their daily work, and then to visualise a "landscape of a happy, healthy community, where the healthiest babies possible are being born, and the best births are happening, and what that looks like" (02/11/09). This process drew forth images of kinship, landscape, and granny midwives. The student midwife held up a colourful drawing with hands and rainbows. She explained:

> My Granny said when she was at a birth she would feel … a lift when you touch the baby. What you are feeling is God, God's presence when you feel this … his love. These are her hands. And the rainbow reminded me of my grandmother. The rainbow represents her, the grannies-the helpers. The house is surrounded by family. You feel the love when you first touch that child. It is his work and you are feeling his presence. Her spirituality too, whether it is the Creator or God that is what she is trying to tell me about. The houses are the community. Those are her hands there; the energy she would feel is his work. The warm light in the house … the house is so warm because of the family … you are surrounded by people, you are not strangers. (02/11/09)

The importance of support and family was also articulated by another midwife. Instead of drawing, she has decided to write words down instead. She reads from her paper and says:

> I wrote: I see a young girl in the arms of her mother, her family, and her community. She is considered precious, and when she decides to have a baby it is with a man who respects and cares for her. Together they are guided through the pregnancy and given the necessary preparation for parenthood. At birth time, the

young woman is supported and honoured and gives birth her own way. She is aware and active. By doing so, she discovers her strength as a person and as a woman. She mothers her baby closely, and breastfeeds and is given continued support and teachings. She feels whole before and after birth. She is blessed. (02/11/09)

This image of being whole and being surrounded by supportive family was in direct contrast to the previous exercise in which the midwives drew the realities they face in their daily work.

In the same exercise, the return of birth to communities—to the land—was articulated by one midwife who described what her ideal birth experience would be. She explained that she had thought about it on many occasions before this exercise. She elaborates:

So I always think of the perfect birth as having all the senses aligned…. The drum is there for our listening, the wind is whirling outside-it's the breath, it's the breathing … the pine and cedar and sage, the medicines are there for the prayers, maybe there is a sacred fire going so you can smell the fire. And touch again, singing and drumming you in. Love, everyone's heart, all the spirits are there with you … the ancestors, the star people, the grandmother moon is there with you. Your midwife is there beside you and your family is sitting beside you, and it is a really safe place. And the four directions … have some significance in your mind … what position you give birth in. Whether you are facing the east or the north. It is really beautiful, and all of your senses are all awakened so you bring your baby into that safe place. (02/11/09)

In this description, the emphasis on safety and support extends into the connection of birth and the environment. After the session, I asked this midwife about her thoughts on the connection between birth and the land. She replied:

I think we always went back to identifying with the land.... you know, that whole romanticised vision of Mother Earth taking care of us, and all that... well I don't think it is all that romanticised.... It really is a deep part of it. It is for real. Whether it is the Inuit women, or the women down in Oneida in my community … it is that tie. It is right through Grandmother Moon, right through every fibre of your being, right through your feet, to the very planting in the ground.... That's it. Right through your baby. Every fibre and every cell yearns for that land, and the smells, and the wind and all of that. So, to me, that is your identity, and your relationships, and your language. (02/11/09)

Through these descriptions, the collective vision of Aboriginal midwives becomes clear. They clearly articulate the historical place of midwifery in their communities and relate this to the system of dislocation that has been perpetuated through state policy. They also collectively visualise a healthy community through notions of safety, support, knowledge, and responsibility. Their ability

to articulate these relationships has led Aboriginal midwives to become a symbol of movement towards healthier communities, and self-determination for Aboriginal peoples. This collective naming of risks and subsequent actions contributes to Douglas and Wildavsky's (1983) understanding that actors within specific types of social organisation identify and mitigate risks in similar ways. Their view provides an option for the future which rests upon the knowledge and practice of ceremony in home places. The views articulated by the elders in this chapter also engage with Beck's risk society on one level, in that they acknowledge the increase in global risks, however, the elders see this not as a breakdown in trust of scientific knowledge and the increasing individualisation of the neo-liberal state, rather these increased risks are an indication of the loss that has occurred between individual and collective bodies of people to the land and water. The response to these risks is based both on individual and collective action through the practice of ceremony. For Aboriginal midwives, this action begins with where and how people are born.

9. Current state of maternity care for First Nations in Manitoba

The current practice of evacuation is detailed in this chapter. The crux of evacuation is the movement of women from one place to another for childbirth. Implicit in this practice is the idea that women are being transported from an unsafe environment (high risk) to a safe environment (low risk). Here, the relationship of the body to the administrative and jurisdictional powers that maintain the practice becomes clear. In this practice, women move from one health care structure—the federal, on-reserve system—to another—the provincial health care structure of regional health authorities and their system of service provision (see Figure 7 for the structure of this movement). The aim of these movements is central to Western medical birthing system. The goal of this system is to get women into a hospital to deliver their babies.   As Smith-Oka (2012) points out that "in the modern birthing system, the movement of women through the process becomes central to the idea of modernity", and "the facilitation of motion as well as the prevention of motion are integral to understanding modernity" (p. 104).   Birth, within this system, is "unpredictable and uncontrollable" (Davis Floyd, 1992, p. 2). This view of birth necessitates intervention into birth in order to mitigate possible emergencies. Managing birth within the system is a constant negotiation of trying to control the 'uncontrollable'. Smith-Oka (2012) builds on this by pointing out that birth is even more uncontrollable "in the spaces between structures" meaning the "places outside the formal structured areas for obstetrical care, such as waiting rooms or hallways" (p. 104).

Figure 9: Governance structure of evacuation

This chapter focuses on both the structures of obstetrical care within evacuation—mainly the urban hospital— and the places in-between—in particular, travel from the community and in the boarding home in the city. This chapter will show how the administrative structures try to maintain, and, in some cases, gain control over these in-between spaces of evacuation and consequently make women as risk objects in the practice of evacuation. This chapter remains within the boundaries of the practice of evacuation; the next chapter moves to an examination of forms of agency and resistance within current maternity care practices. The latter will be done by looking at the interactions of mothers and their families with doctors and nurses, as well as Aboriginal midwives intervening in the process of evacuation. Other layers of resistance and forms of agency emerge through these movements from one place to another, both in terms of who controls health care each setting and the authoritative knowledge associated with that place.

9.1. Evacuation as biomedical risk management

In the current state of maternity care, the dominant risks, according to Western science, centres on the body as pathology, or the body as a potential site for risks to occur. This form of risk management can be classified as a technocratic approach to managing birth. As Walsh, El-Nemer, & Downe (2004) comment, this approach:

> …sees birth as risky until proven otherwise. The model super values morbidity and mortality outcomes over all others, especially the psychosocial, and monitors outcomes by measuring what goes wrong. (pp. 118-119)

In the context of evacuation, because the focus is on getting women to the hospital, the technocratic approach is clear. Evacuation focuses on maintaining control over women in the perinatal period. The emphasis on risk management is locating the body within certain spaces in order for the proper management to occur, which is manifested in two forms: first, seeking to get women into the hospitals for their labour and delivery; second, once the women are there, managing childbirth. The result of this type of management is that it transforms the mother into the object of risk that must be controlled in order to ensure the safe delivery of the baby. This chapter will explore the practice of evacuation from these two processes of locating bodies.   I will look at the issues surrounding the premise of evacuation, primarily biomedical risk management.

Biomedical constructions of risk happen on various levels: one, at the level of population through epidemiological means, and the other in the clinical encounter between medical practitioners and patients. The other risks that result from these biomedical risk management practices are constructed as social risks and too, are managed within the clinical encounter, as well as outside of this setting. All of these risks enter into the policy setting, and decisions are made as to what risks take precedence over others and how best to manage them. This is done mainly through approval for funding certain practices and not others. For the purposes of this thesis, understanding the importance of first the epidemiological construction of Aboriginal peoples as a high risk population is important. Through the clinical encounter, we can see how biomedical risks are identified and managed by the health care providers, the women and their families, and the policy, or health care system.

9.1.1.   Risk in the clinical setting

Within discourse of health, healing, and health care in Canada, biomedical constructions of risk are well established. The dominant model of risk in biomedicine is epidemiological, and from this perspective risk is "the estimated excess frequency of occurrence of an event in a population and is

usually presented as a statement of statistical probability" (Becker and Nachtigall, 1994, p. 507). In relation to this, risk factors can be defined for a population; however, Becker and Nachtigall (1994) note that this does not mean "causality" or predict outcomes (p. 507). For Aboriginal peoples in Canada, as noted in Chapter 2, the epidemiological data for this population is consistently placing Aboriginal peoples in a high risk category. For example, in an advertisement of the Hill Times, the parliamentary newspaper distributed to politicians on Parliament Hill in Ottawa, Canada, there was a photograph of indigenous woman smiling into the camera holding a newborn baby. The words above her head read: "Canada can be a pretty safe place to give birth… unless you are Aboriginal" (September 21, 2009: p. 25). The advertisement was placed by the Society of Obstetricians and Gynaecologists (SOGC) and cites that infant mortality rates for Aboriginal peoples are three to seven times higher than the rest of the Canadian population. In this advertisement, the direct connection is made between being high risk with being Aboriginal. It is important to understand how these broad population-based interpretations of data become a part of the individual clinical encounter.

Within the discipline of epidemiology, the relationship of assessing risk in populations to assessing risk in individuals is fraught with tensions. It is important to note that "epidemiological views of risk" for groups "affect medical intervention and clinical decision-making" for individuals (Becker and Nachtigall, 1994, p. 507). Physicians place risk "within a medical ideology, as an intrinsic part of the practice of medicine" (p. 507). They see two types of risk assessment as key parts of routine medical treatment. These are:

> (1) the epidemiological construct of relative risk used to help make diagnoses and guide the choice of diagnostic tests, and (2) weighing risks and benefits when a test or procedure may have its own adverse outcome. (Becker and Nachtigall, 1994, p. 508)

Michael Hayes (1992) describes health risk appraisal (HRA) as a "method to help physicians practise preventive medicine by focusing prospectively on the avoidance of premature mortality" (p. 401). In this practise, the focus in on an individual's

> …health-related practices, habits, lifestyle, personal characteristics, and personal and medical family history [which] are compared with data from epidemiologic studies and vital statistics in an attempt to project the individual's risk of death over some future period. (Hayes, 1992, p. 401)

This attributes the risks to individual behaviour, and thus focuses on modifying the individual's action to account for the risk. This is especially important when considering the monitoring and surveillance of pregnant mothers. This management of risk takes the form of health promotion programmes, such as the Maternal Child Health (MCH), CPNP (Canadian Prenatal Nutrition

Programme), and FASD (fetal alcohol spectrum disorder). These programs are available on reserve and funded through the federal government. The biomedical management of risk through placing the onus on the individual mother to have a health pregnancy speaks to Foucault's notion of self-regulation and discipline. On the other hand, by labelling Aboriginal women as high risk, the continuance of control over these women in the perinatal period becomes an issue that must be dealt with at the practitioner and state level. The presence of these health promotion programmes then becomes contradictory in the practice of evacuation. For instance, the World Health Organisation's (WHO) definition of health promotion is "the process of enabling people to increase control over, and to improve, their health" (Hayes, 1992, p. 403). The WHO definition adds that "determinants of health are embedded in social structures and therefore beyond the individual's control, in addition to determinants over which the individual may have control" (Hayes, 1992, p. 403).

As shown in this chapter, evacuation for birth overrides the emphasis on health promotion's individual regulation for health pregnancies and relies on biomedical risk management. This management is exclusive knowledge, as Handwerker (1994) remarks:

> ….evidence based medicine purports to reduce or eliminate risks by the appropriate use of diagnostic aids and the implementation of effective treatments...In this way, risk is constructed exclusively in clinical terms and its management becomes a scientific matter. (p. 118)

This chapter also reveals the tensions between the framing of biomedical and social management of risk. In describing their own experiences of childbirth, the mothers seemed more interested in talking about being mothers, rather than becoming them. This coincides with Howes-Mischel's (2012) ethnographic work in Oaxaca, Mexico around risk and reproduction. She notes that:

> While public health institutions draw together tropes of risk and responsibility to motivate specific bodily practices and frame women's bodies as requiring their intervention, women talk about safety, love, and modernity and frame their bodily practices within a long-standing logic of care. (Howes-Mischel, 2012, p. 124)

With the descriptions given by the mothers I interviewed and Howes-Mischel's (2012) work in mind, this chapter attempts to bring together notions of biomedical and social risks within the practice of evacuation, and consequently, the management of evacuation by the state.

9.2. Getting women to the hospital

In most rural and remote First Nation communities, the nursing station is the first place women commonly seek prenatal care. Although some women do not access prenatal care, the women I spoke with had all gone to the nursing station for such care.

The FNIHB Clinical Guidelines for Nurses providing primary care (2000) indicate that women should be seen prenatally "up to 32 weeks gestational age: every 4 weeks; 32-36 weeks gestational age: every 2 weeks; and 36 weeks until delivery or evacuation: weekly" (pp. 12-14). The guidelines also indicate that "need for follow up will vary depending on risk factors", and that for referral purposes, medical staff should "Arrange for transfer to hospital for delivery at 36-38 weeks gestational age (sooner if a high-risk pregnancy)" (FNIHB, 2000, pp. 12-14). Deciding when to transfer to the city for confinement is a decision-making process between the nurses and the consulting obstetrician. Often there is some negotiation between the women and the nurses as to when they will leave for confinement. One of the pregnant women at the boarding home explains:

> I think some of them [women] would want to stay home till they are close to their due date. But the nurses are the ones that are scared to deliver the babies back home, so that is why they try and send them out early. That is how those nurses are back home. They want us to come out because they don't want to deliver. (16/11/09)

There are risk factors that often lead a woman to be sent out for confinement earlier. A consulting obstetrician explains that the main risk factors that lead a woman to be sent out early are "diabetes on insulin or hypertension. Those are the two biggest ones" (18/08/10). One woman I met in the city had been sent out early. She explained, "One of the doctors decided to send me out. I was bleeding at first and they didn't like that so they sent me out" (16/11/09). Another woman I met at the boarding home told me that:

> I was supposed to come for my appointment only and they told me to stay here. I was supposed to have just a prenatal check up with [the doctor] and then they told me I was here for my confinement and I've probably been here for three or four weeks already. I [brought] only one pair of clothes only. I had to get my boyfriend and my mom to pack my clothes and send them to me [on the bus]. I am happy I am getting induced tomorrow so that I can go back next week or this week. I think I was 32 or 33 [weeks] when I first came out here, and now I am 38. They said that I was, I don't know, GT diabetes or something like that, and my baby was too big. They said they were going to induce me the second week I got here, but my tests came out normal. I tried to ask to send me back home but they told me 'no'. (16/11/09)

This mother also explained that even though she was happy to be induced the following day, she was also really upset because her boyfriend and her mother would not be able to come to the city for a few more days. She explained, "They don't get their cheques [social assistance] until Wednesday and can't catch the bus to Winnipeg until then" (11/16/09). It was her second pregnancy, but she had no children: she lost her first baby late in pregnancy, and ended up having to deliver a stillborn at the nursing station in her community. When she told me about being alone to have her first baby the next day, she began to cry. From this example, we can see how social risks are being managed along with the biomedical management of a high risk mother: while the doctor kept her in the city in order to manage her risk of complications due to gestational diabetes, the risk of delivering without her social support was concurrently being negotiated by the mother. In this case, as in most, the biomedical risk takes precedence.

How the women are sent to the city is dependent on a number of factors. The foremost factor is their "status". The federal government is responsible for transportation of Status or Treaty Indians out of the reserve. The responsible department is the Non-Insured Health Benefits programme of the FNIHB. This programme was described to me by a FNIHB director as being "run like any other health insurance company" (10/02/10). The FNIHB plays a big role in the evacuation of women because their medical staff makes a number of key decisions regarding the experience of confinement. These decisions include: how a woman will be transported to the referral centre, how she will return home, if she will be allowed an escort to accompany her, and, if so, how long the escort will be allowed to stay with the woman. Some communities, like NHCN, have a local programme that administers the NIHB funding. The programme in Norway House is the Treatment Access Programme (TAP). Non-Status women get subsidies for transportation under the Northern Patients Transportation Programme (NPTP), which is provincially funded. The guidelines for transportation state that the method of transport (airplane or bus) is "by the lowest cost travel option that is medically appropriate" (Bartel and Mann, 2010).

Regarding an escort, TAP does not allow for an escort to accompany women when they are first sent out for confinement; rather, an escort is allowed to travel to the city a few days before the woman's due date. One mom describes her experience of being sent for confinement alone: "[I was] scared like 'cause I didn't know anyone in there. But then when the baby's dad came, I was just so happy that I wasn't alone" (15/06/10).

Once transported to the city, expectant mothers usually stay in a boarding home. These boarding homes are of interest to both the provincial policy makers and the medical health care providers. From their perspective, once transported to the city, the women become the

"responsibility" of the WRHA; therefore, "keeping track" of them becomes bifurcated between the parallel health systems (federal and provincial). One Manitoba Health director explained the difficulty of this process:

> …in terms of looking after the women who come down from the North, that's the WRHA's responsibility. However, we realise that with the federal jurisdictional issues and the transportation and where the women out for confinement are located while they wait, while they're out for confinement, that can be two to ten weeks, in which time the WRHA was having some difficulty locating where those women were, being able to provide them with the pre- and post-natal services that they would like to provide them with because women were in boarding homes or if they were full, they're in hotels or they might be staying with family or friends, some of them I understand were not staying anywhere, they just wanted to hang on the streets…. (16/11/10)

In a meeting of the Maternal and Child Health Taskforce (MACHS) Relocation Committee, it was noted that FNIH prefers "to place expectant mother in boarding homes as they can 'keep track' of their location this way" (Manitoba Health, 2010). The woman is also required to notify FNIHB of all appointments they have when they are in the city. MACHS also notes that:

> Women leaving the community are supposed to be given small cards that describe who to call, with an envelope containing all pertinent information. However, it is noted that women often arrive without this information. (Manitoba Health, 2010)

In particular, how the women spend their time in the city before their babies are born is of importance to policy makers and medical staff, but they disagree somewhat on where this time should be spent: FNIH likes to have women in the boarding homes because they are easier to "keep track" of, while the medical staff sometimes prefers that this be taken one step further and admit the women into the hospital early. One student doctor explained to me:

> …[the doctor] tries to get the women into the hospital as soon as possible. Any excuse he can find to get them into the hospital full time. If they leave the hospital, [the doctor] will drive up and down the streets looking for them and bring them back (08/09/09).

From this discussion of the perinatal period prior to childbirth, a certain construction of First Nations women begins to slightly emerge. The emphasis on "keeping track" and "managing" the women during this time reveals the notion that the women need monitoring and management during this period. There is a lack of information regarding where non-Status women stay when they relocate for birth. This gap was identified by the MACHS Relocation Committee and further research at the provincial level was recommended.

Another form of state surveillance can be present in the governance of childbirth in the perinatal period for First Nations women: this is the inclusion of Child and Family Services (CFS). The intervention of the state through CFS presents itself as a 'Birth Alert' for the expectant mother. A Birth Alert applies to:

> expectant mothers considered by agencies to be high risk in relation to the care they will provide for their newborn infant. The practice in Manitoba is to issue alerts to track and locate these high-risk expectant mothers. (Government of Manitoba, 2009, p. 8)

One expectant couple I spent time with, Nancy and Paul, were dealing with a Birth Alert for their delivery. Nancy's first baby was in care (meaning she had been taken by CFS and placed in another home which, in this case, was Nancy's mother's home), and Nancy had been notified that her second baby, a boy, would also go directly into her mother's care. The Birth Alert specified that apprehension would not take place directly after the baby was born. It was arranged with the social worker that Nancy and Paul would be able to travel back to their community with the baby, and at that point he would be taken into care. Upon their return, Nancy and Paul have committed to attending a drug and alcohol treatment programme. Another mother told me about her experiences with CFS:

> They checked up on me all the time. It was okay. Every time I have a baby that is who comes and sees me. CFS or social workers. They ask me lots of questions and check out the babies to see if there are any abnormalities or something like that. But there is nothing wrong with my babies. Then they come the next day and tell me it is okay and I can take my baby home. It is CFS back home that tells them in the city and then they come and check it out. (16/11/09)

Again, the emphasis here with CFS's activities is to locate and keep track of expectant mothers and monitor their behavior. The complexities of the apprehension of babies are not discussed in detail here, however, it is important to understand that this aspect of becoming a mother is present for some of the women who are experiencing evacuation.

9.3. In the hospital

In the issue of birth place and First Nations, the hospital emerges as a central location in the discussion: the safety of the hospital, the distance to the hospital, and the ability of the hospital to provide emergency care form the basis for the justification of the continuation of evacuation. Doctors from the RHAs and the federal government both agree that this is the safest and best place to give birth. The discourse of evacuation centres on the presence or absence of a tertiary hospital facility for childbirth, and within this, the hospital space is rarely critically examined. In the discourse

of returning birth to the community, the notion of the hospital is often characterised as an oppressive institution that limits choice and exposes women to unnecessary intervention; the hospital is an exclusive place, and knowledge of that place is limited to expert medical knowledge of the body and its treatment through technology. One federal doctor sees this oppressiveness and exclusivity as inherent to the institution: the hospital is necessarily "a black box because you don't really know what happens [and what] goes on there." (23/03/10) From this perspective, the hospital is a bounded space of highly ordered, biomedical regulation: the black box in which the contents are "mysterious to the user" (Oxford, 2012). However, framing the hospital in this way automatically excludes everyone else, including the midwives, from commenting on treatment or management of risk in this setting. In my research I was adamant that I should be allowed inside this black box to observe birth and women's experiences of evacuation from this contradictory space.

The following two stories come from my experiences in LDRP and L&D of the hospital in Winnipeg. These stories are presented here as a way of seeing and understanding two women's experiences of delivering in this setting. In both stories, the women, Arlene and Cindy, came from remote, northern communities to deliver their babies. Both of these stories show the range of risks that are created, realised, and subsequently managed in the hospital setting. While the intention is to manage the biomedical risks of pregnancy and birth, in Arlene's case, the lack of complications or intervention highlights the social risk of not having social support or family with her for her birth. In Cindy's case, her birth quickly became an emergency, and the hospital responded by performing an emergency C-section. The hospital in these two births became constructed in different ways: in Arlene's case, the hospital became a part of the constraints for her to experience birth in a familiar and supportive environment; for Cindy, the presence of the operating room probably saved her baby's life. These are dramatic moments, and within the discourse of evacuation, these two stories could be seen as sitting in opposition to one another: one defending evacuation, and the other condemning it.

9.3.1. Arlene's story

Arlene has been in the labour and delivery floor's triage for six hours. Triage is meant to be a place that women pass through on their way to one of the wings, and not a place where a woman stays for long periods of time.

"She has been here for six hours?" I ask the nurse. "Are there no beds in LDRP?"

"Yes, there are lots of beds, but they aren't taking her," the nurse replies in an exasperated tone. "Sometimes they forget they are a labour and delivery ward, not just a postpartum."

I go back through the curtain to the small space where Arlene has been labouring. She stands for each contraction and moves her hips in a circular motion.

"I didn't sleep last night," she says, "and I came in this morning." It is now just past three o'clock.

"They put this in me," she says, pointing to the IV stand attached to her through a needle in the back of her hand.

She gets another contraction, and I stand beside her with my hand on the small of her back. She begins to move her hips in circles again, and I tell her how that is a good thing to do to get the baby to move down.

Two nurses come into the room, and they say they are finally moving her to a room in LDRP. I carry her bags.

Once in LDRP, two nurses come and introduce themselves to Arlene. They are both in their mid-twenties: one is a nurse in LDRP, and the other is a student on one of her final shifts in the ward. They speak with us briefly and leave the room.

This is Arlene's second baby. She is from the far north, and had her first baby in a northern community. This is her first time in Winnipeg.

Arlene is focused on her contractions and her breathing. They start to get more intense after a few more, and at one point, she begins to grunt a little— a tell-tale sign that she may be transitioning into the 'pushing' phase. At this point, I get a bit worried that the nurses have not come in yet, so I make my way to the desk down the hallway and tell them that I think she is progressing fast, and say she is starting to want to push. They spring into action and come into the room with the birthing cart, with its sterilised tools wrapped up in blue paper. When the nurse checks her, she is only six centimetres dilated. Arlene has another contraction while the nurses are there, and I turn my focus away from the nurses, and back on her as I once again place my hand at the small of her back and begin to speak to her softly, telling her that she is doing great, and that her contraction is almost over.

A nurse begins to tell Arlene about different options for pain relief. Arlene says she doesn't want anything. The nurse keeps talking, and lists off her options, from nitrous-oxide gas, to fentanyl in her IV, or an epidural. Arlene asks if she can have the IV taken out, since it was put in by mistake. The

nurse reads the chart and confirms, that yes, the IV was a mistake, but she decides not to remove it until after the birth, "just in case". The nurse reads something in the chart and turns to Arlene.

"The chart says you tested positive this week for a STD," the nurse asks her, "but it doesn't say which one. Do you know what you tested positive for?"

Arlene shakes her head 'no' as another contraction begins.

From my point of view, sitting with Arlene during her labour and increasingly intense contractions, I think that things are going well. She is clearly progressing, her contractions are getting stronger and closer together, she is making the signs that she is transitioning. I am surprised that they offer Arlene an epidural, since I don't really think that she will be in labour long enough to get it, but I am not a trained nurse, midwife, or doctor, so I keep all of these thoughts to myself.

Arlene is adamant that she does not want any kind of augmentation. She keeps saying it, and says no each time the nurse asks.

The nurses leave, and Arlene and I are again alone in the room. I stand next to her as she sits on the bed in between contractions. We hear a baby cry in another room: that brand new, first cry of a baby. It is one of the nicest parts of the labour and delivery floor.

"Huh," Arlene scoffs, "She's lucky."

We laugh at that, and I tell her that her baby will come soon too.

Time is funny when a woman is in labour. It either passes very quickly or very slowly. We have been in the room for an hour and a half, and it seems like no time has gone by. I go out to get Arlene water and ice from the machine outside her room, another blanket from the warmer, and stand with her during each contraction, with my hand on her back and talking softly into her ear.

As the minutes pass, she no longer wants to stand up during a contraction. Instead, she stays on the bed, moving her legs, trying to find something to push against. Even though not much time has passed, I really think that Arlene will have her baby soon, so I go out to the nursing desk again to find the two nurses assigned to Arlene. I tell them I think she is getting close. They don't jump up as quickly as they did the first time, seeing how I was wrong then, but they come into the room as Arlene has another contraction. I go to her again, and do the same thing I have been doing for each contraction. The contractions are getting longer and harder.

During the contraction, the nurse says, "Do you want nitrous oxide? It doesn't have a lasting effect."

Arlene shakes her head, no, but she cannot say more than that, since she is in the middle of a hard contraction.

"I will go get the nitrous for you," the nurse leaves the room.

"You don't have to take anything you don't want to," I tell Arlene when the nurse is gone.

She comes back quickly into the room, just as Arlene begins to contract again. The nurse comes to the bedside and thrusts a mask in her face. Arlene shakes her head no, so the nurse hands it to her to hold onto.

The other nurse checks her again, and says she is fully dilated and goes to call for the doctor. They put Arlene's legs in the stirrups, and get the bed ready for the delivery. They open the bed up so that the doctor can get close in-between her legs and they attach a plastic bag to the bottom of the bed to catch any excess fluid from the birth. The nurse unfolds the blue paper covering the birthing cart, and waits for the doctor to arrive.

The doctor comes in with a resident, and they put on their gowns and masks. The resident doctor takes her position in-between Arlene's legs to deliver her baby. I am holding Arlene's leg in place, as it keeps falling off the stirrup.

With the next contraction, we all see the baby's head with its shock of black hair emerging. A few moments later, a little boy is born. Arlene smiles with relief. They take the baby to the OHIO (baby warmer) next to the bed, and check him to make sure that all is well. He is fine, and once the placenta is delivered, the resident and the doctor quickly leave the room. I realise I never even looked at them, and have no idea who they were.

Soon afterwards, while her baby boy is sleeping soundly under the warmer beside her, she asks if there is a telephone she can use. The nurse tells her no, that she will have to wait until she is allowed to walk down the hall to the pay phone, and then she will need a calling card- which she doesn't have- to use it. I tell her I have a mobile that she could borrow. She takes it from me and dials a number.

Arlene, who up until this point, has smiled and remained relatively calm throughout her labour and delivery, begins to dial a number on the phone. As soon as the person answers, a stream of words in her indigenous language come pouring out of her, and she is crying. She talks for a few minutes and then quickly hangs up.

She looks at me. "Just one more?" she asks, holding up the phone.

"Yes, yes, of course," I say.

She dials again, and the same thing happens. She begins to speak her language, and tears begin to stream down her face.

The nurse had put the baby in a bassinet near the window a while before, and he has become cold, so they place him under the warmer with a thermometer sticker on him. The nurses say they are going on break, and that another nurse will be with us for the next while.

After eating, Arlene wants to be closer to her baby, who is still quietly lying under the warmer. She moves to get up to see him, and I get up to help her as the IV gets tangled by the bedside. She says she hates that needle going into her, and she wants it taken out.

The new nurse comes in, and when she sees Arlene on her feet, she quickly runs to her side and scolds her for getting out of bed. She turns to me and says, "Next time she does this, press the call button. It is difficult, especially with ones like these, who think they can do everything."

She says that she might as well change the sheets of the bed, now that Arlene is out of it, and as she is changing them, she asks Arlene, "Do you smoke?"

Arlene says yes, as she is looking down and holding her baby's hand in the OHIO.

The nurse then begins to tell her about the dangers of smoking, and the affect it will have on her and her baby's health. In my head, I know these messages are important; yet, I can't help but think how inappropriate it seems. Arlene is all by herself, she just gave birth to a little baby boy, and now she is being lectured about the dangers of smoking.

She picks up the baby and begins to nurse him. The nurse comes in and sees that Arlene is nursing, and quickly brings over a sheet of paper and a pencil. It is a chart to record when she feeds her baby and for how long. I mark down the first feeding on the chart for her.

Arlene is getting sleepy, and so I tell her I will leave her to sleep with her baby. I say I will come back and visit tomorrow.

She smiles and replies, "I will be waiting for you."

9.3.2. Cindy's story

I can hear Cindy moaning as the shift changes in the main hallway of L&D. The nurses are crowded around a large, flat screen television mounted on the wall. The nurses coming off nights and the nurses beginning days mingle in the updates of each patient. The NIC (Nurse in Charge)

reads down the list, adding small comments to what is already written there: mostly stuff about the number of pregnancies, status of Group B Strep (positive or negative), rubella, centimetres dilated, and the amounts and types of medications the women is currently on. I can't hear or understand most of it.

A young nurse in her early twenties is going to be Cindy's nurse for the day shift. Cindy's moans are audible in the hall, and nurses exchange amused glances each time she cries out. I follow the nurse into her room.

She is in Room 6. It is dark; she is on the bed with a nitrous oxide mask covering her face. Her mother is curled up and sleeping in the chair in the corner with her coat over her head. Cindy is 19 years old, and she is from a northern, fly-in community.

The tracings are pumping out heartbeats and contractions. The contractions are not adequate, according to the nurse as she unfolds the stack of paper. The nitrous oxide tank is empty, and a nurse goes to get another one. Cindy has had a failed epidural, and right now, her pain relief consists of fentanyl being administered through her IV, and the nitrous oxide gas. She is struggling, though, and crying out during each contraction.

The nurse leaves to get more medication from the dispensary. I find a stool and sit down next to Cindy. With each contraction, Cynthia tenses, moans, and cries out. I put my hand on her leg and say, "deep breaths", and "it's almost over, and then you can rest", even though I have no idea where she is at, or what is happening with her labour.

Cindy gulps into the nitrous oxide mask.

The nurses come in again, looking at the fetal monitor. They take her temperature. Cindy is hooked up to an IV stand, with an internal fetal monitor connected through a wire inside her vagina, a catheter, a blood pressure cuff on her ankle, and a finger clip. With the next contraction, Cindy cries out again. The nurse holds her hand and rubs her leg. She walks back to the counter edge to prepare the fentanyl to be injected into Cindy's IV. Cindy cries out again.

"Calm down," the nurse says, "You can do this. You are in control here."

When the nurse walks out, I lean over to Cindy and say, "Don't worry, you can make as much noise as you want, you are the one in labour."

I hold Cindy's hand during every contraction. I talk to her in a low, calm voice, and I tell her she is doing a great job.

The nurse comes in with a foil package with three Tylenol. Cindy has a fever, and they are going to try and bring it down. Cindy thinks that they are for pain relief, and asks if the Tylenol are T3s (paracetemol with codeine added). They say no, that they are regular strength, and Cindy cries, "these aren't going to help me at all!" They explain that it is for her fever, not for pain relief.

"The baby's heart rate is really high," the nurse whispers to me.

The resident doctor comes in to assess Cindy. She looks at her chart and her tracings. They are going to need to do a C-section. They are going to call Cindy's obstetrician and see what he says. He tells them to wait until he gets there. The baby's heart rate is rising, and I can feel the tension of the nursing staff rising along with it. I sit with Cindy and continue to hold her hand. She squeezes my hand as hard as she can during contractions, and I am reminded of all those sitcoms on television, in which the father's hand gets crushed by the mom in labour. It hurts, but I don't really mind. I am focusing on Cindy, and helping her through her contractions in the only way I know how—by sitting with her and telling her she is going to be okay.

The nurses come rushing in and out, checking her temperature again and making notes in the charts. The resident comes in again and looks at the EFM. The baby's heart rate is racing. She goes out again, and finds that all of the operating rooms are currently occupied with other C-sections taking place. The obstetrician arrives, the same one that I cornered in his office, and suddenly a flurry of activity begins.

An emergency C-section is deemed necessary. The nurses run to set up, I remain seated with Cindy. Her mom gets out of the bed as another nurse explains Cindy/her daughter is going to have a C-section, but that the mother can't come in, since it is an emergency situation. I tell her I will come out of the operating room as soon as I can, and let her know how things are going. The anesthesiologist comes into the room as asks me who I am. I say an "anthropology student", and he tells me to wear my ID on my green scrubs shirt pocket, instead of clipped to the bottom of my shirt. I quickly move my ID, which happens to be my University of Sussex student card slipped into a plastic card holder, and get out of his way. We begin to wheel Cindy out of the room, and the Nurse in Charge yells over to me, "Rachel, take her temperature quickly, will you?" I immediately say, "I can't." I am not a nurse, or a medical student, and it is at times like these that I wish I would have continued with my midwifery degree so that I could have some practical skills to contribute to this scenario. We are rushing down the hallway, from the darkness of the room to the bright fluorescent glow of the main halls of the labour floor. At the door to the operating rooms, I grab a surgical cap and mask from the dispensary box on the wall, and quickly put them on as I walk alongside Cindy.

She is still crying and moaning. For a second time, I feel as if I am in a television show, except this time, it is one of those hospital dramas like ER.

In the operating room, I wonder if I am going to be okay. I have never been in surgery before, and I wonder how I will react. My main focus at the moment is not to get in anyone's way as they are rushing around. The anesthesiologist tells me not to touch anything with the blue paper, because that is sterile. Now that he knows I am a student, anthropology or otherwise, he is happy to explain these things to me. They are going to put Cindy to sleep, since the previous attempts at giving her an epidural had failed.

"Rachel, move up here and hold her hand," the nurse says. They are transferring her to the operating table and Cindy begins to cry in huge sobs. I move forward and hold her hand again.

"Stay there with her," the nurse advises. I move aside and hold Cindy's other hand, as they place the mask on her face. They put up a curtain only halfway, and I can see over it and watch them prep Cindy's belly.

The neonatologists come in and stand along the wall next to the OHIO, getting ready for the baby. A student comes into the operating room to assist the obstetrician. The obstetrician slowly makes the incision, and at a crucial moment of getting the baby out, he yells at the student to push on the fundus. She stares at him blankly and doesn't move.

"The fundus, the fundus", he repeats sternly.

I want to reach over the curtain and press on the top of Cindy's stomach— the fundus—but I know it isn't my place. The anesthesiologist leans over and does it instead. It is the student's first C-section as well.

Once the baby is out, the neonatal doctors grab it immediately and place it on the OHIO. They hold a tube of oxygen up to its face; they lift up the baby's arms and move its lifeless body, trying to get the baby to breathe. Finally, they have to intubate the baby. This is means a tube is put down the baby's throat. The obstetrician is methodically finishing the operation, closing up the uterus and the layers above it, but his eyes keep going back to the baby, and watching it. It is a little girl.

"How is that baby doing, doctor?" He asks the neonatologist.

They manage to take the tube out, and the baby is breathing on her own. They bundle her off to the NICU (the Neonatal Intensive Care Unit), and I find out later that the baby had to be intubated again once she arrived there.

I realise I have been holding Cindy's hand tightly the whole time and haven't let go.

9.3.3. Discussion

In a discussion of returning birth to a First Nations community, Arlene can be seen as a prime candidate to stay in the community for delivery: she had a normal first pregnancy and delivery, and had no risk factors that would necessitate being in a tertiary facility. For one of the obstetricians who support moving "low risk birth" to Norway House, the risk equation leans in Arlene's favour to stay in the community. At the time of my fieldwork, there was a free-standing birth centre being built, and many obstetricians were opposed to this centre. Yet, at the same time, some of these obstetricians supported returning birth to Norway House. One obstetrician compares birth in the North with the birth centre that was being built in the city. She states:

> I am not overly thrilled about the clinic that is being set up here in Winnipeg. Meaning, we have an LDRP unit that will provide exactly what these patients want, right: it's a private room, your own bathroom, nice view out the window, their midwives can do their entire care, and yet if you need help it is minutes away. And really it's in the city, so what are they giving up? When I look at a place like Norway House or I look at a place like Rankin Inlet that has a midwifery run centre, I see a very different risk benefit discussion. In Winnipeg, the benefit to me does not outweigh the risk: the risk is small in terms of not being in a hospital. The risk is small and I don't understand what the benefit is, so you're in a building that's twenty minutes from here instead of here. (02/09/10)

From this obstetrician's point of view, the hospital is still seen as the safest place to give birth; however, when you add the iatrogenic effects of evacuation as risk management, the argument for returning birth outweighs the chances of an adverse birth outcome. According to the obstetrician, birth outside the hospital, especially when you have access to a hospital close by, is not seen as a good option. In this case, risk is measured in terms of proximity to the hospital.

Considering Arlene's case from the perspective of biomedical risk, her birth was uneventful. Yet, Arlene's birth highlights a few important points. One, it highlights the social isolation of a woman who was sent away to have her baby. The first contact she had with someone familiar was filled with emotion and tears: something she never revealed to me or the other nurses during her labour and delivery.

Cindy's experience of birth is the sort that is held up as a reason not to deliver away from a facility without C-section capability. In the context of this thesis, Cindy's birth is important for a few reasons. First, it demonstrates that these biomedical risks are present. As Carol said to me:

> …When everything goes wrong and people are really sick, and women are at risk of dying or babies dying, like the sort of bad stuff that people talk about—what happens at birth—it's the obstetricians that care for those people, obstetricians and paediatricians. So midwives can't do their work in a modern context without them, we know it. But obstetricians can't do their job well without us. (15/01/10)

What both Cindy's and Arlene's births show is how little room there is for negotiating one's experience of birth within the hospital setting: the nurse told Cindy that she was in control, but Cindy was hooked up to machinery both through IVs and vaginal monitors with no way of moving around, much less feeling in control of the situation; likewise, Arlene was given an IV that inhibited her movement and experience of labour and birth as she tried to manoeuvre in the hospital room. The routinisation of monitoring and administering interventions in the hospital both mitigated and produced risk in this setting. While in the case of Cindy the risk of fetal and maternal death were given precedence and overtly negotiated, the nurse's insistence that she was in control was in response to mitigating a different kind of risk—one that is grounded in the notion of emotional safety. Arlene's initiative in moving around after birth, and breastfeeding without assistance or guidance, were also construed as a threat to her own safety in the hospital setting. She was to be watched closer because she "thinks she can do everything". The other aspect of her delivery that struck me was her insistence of having no augmentation during labour, and the nurse's equally forceful insistence on her receiving some kind of pain relief.

9.4. Locating the social risks of evacuation

In addition to locating women, managing the social risks of relationships and relatedness are woven into the process of evacuation and managing biomedical risk. The preoccupation of the health care system with who is present for evacuation in biomedical terms of health care professionals attending the birth and public health nurses managing women outside of the hospital setting has been outlined above. However, women experiencing evacuating identify and emphasize the social risks of not having a supportive network. In this section, the management of social risks will be discussed in two ways. First, the views of First Nations mothers in Norway House will be discussed in terms of relatedness, and in terms of the importance of a broad and complex family network, and their presence at birth. Second, I will relate a story told to me by a midwife in Winnipeg about her encounter with a woman who had recently experienced evacuation. From this, we can see how the biomedical and the social risks of evacuation are inextricably linked.

In this section, I draw from the experiences of young women that were communicated in a workshop I held in NHCN. I will draw out some important points about pregnancy and childbirth that emerged from the workshop process, including how women perceive the "creation of the next

generation". The workshop used body mapping as a tool to elicit narratives of pregnancy and childbirth in the context of evacuation for delivery. The key focus that emerged from the workshop was the focus on relationships. While the women had the choice of where to place certain topics on their body map, I suggested that place their "support system" outside the outline of their body tracing. However, once they began to draw or write about their support,

Figure 10: Mother working on her body map in Norway House (15/06/10)

everyone chose to put these names or pictures inside their bodies. Topics such as where you come from, your vision for the future, and the journey of evacuation remained outside their bodies in the drawings, but their families and loved ones were placed inside the tracing of their bodies. Along with people's names, one woman listed her support as "mother, sister, grandmother, boyfriend, friends, grandfather, and cuzins". Another wrote: "We all grew up together with our parents … and raised 15 kids in total. It is a blessing". One woman describes how she felt after had her baby: "tired, stressful, a handful, baby blues, homeless, lonely by yourself, mostly the lockdown". But at the end of this list she wrote that she had a "supportive family". One woman, even though she was in her early twenties, said that she often fostered other children from her community, and she was seen by the other woman as a knowledgeable person that they could rely on for advice and support. She wrote on her map, "I love keeping kids and babies even though I have my own".

Parents and other deceased relatives were also written inside the women's body maps. The names were placed within the outlines of their bodies, some with drawings of flowers and grass, often with a RIP, or, on one body map, a depiction of a child that had passed away with the words "Never forgotten". When I asked what the most important part of the body map was, one mother replied:

> My family, my pregnancies, and my kids. Everybody's kids. We don't know how many kids my mother's kids have, because I don't know how many kids each of my sisters' [have]now. I know it is a big family. My grandpa and grannie have been together for 75 years and they have 26 kids together but most of them are adopted. So there must be 230 grandchildren and great grandchildren. Family is important to me and we are going to keep making it bigger and bigger. (15/06/2010)

The other point that all the women emphasised was the love and emotion that they held for their children. While this may seem a bit of a given point (i.e. all mothers love their children), in this

context, it is an important one to make. Discourses of pregnancy and childbirth in First Nations communities are often focused on disparity, poor outcomes, and apprehension (this thesis being no exception), but the main point of focus that these young mothers wanted to communicate was their love for their children.

One mother at the body mapping exercise spoke about the people who were able to attend her birth. She had been evacuated for her birth to Thompson, Manitoba, a four hour drive away. She left on the medical transport (medevac) plane, and her family followed, driving in the car and arriving at the hospital a few hours after her. When I asked how many people were at her birth, she replied: "My nanny, Violet, Verna, my parents, and my little sister, and my uncle." She describes what it was like leaving alone on the plane and explains the support she drew from her family members at that time. She said: "I felt scared, crying lots. My uncle was just sitting right beside me, holding me, and saying, 'You'll be alright; you'll be okay. Don't worry.'" When she delivered her baby, she had her support with her: "I had a lot of help during my pregnancy [delivery]. There were two nurses, and my parents over there, and then finally my baby came out. I started crying, I was like: "'Oh my god! I did it!' I thought I wouldn't make it. It was hard."

For some women, the role of their husband or partner at the delivery is very important. One young mother explained:

> [I was] scared like 'cause I didn't know anyone in there. But then when the baby's dad came, I was just so happy that I wasn't alone…. After I had her I felt better. I get to hold her in my arms. Her dad was just crying. He finally said, 'I love you babe.' Because when I was pregnant, people were saying it wasn't his, and stuff like that. But he stayed with me, even though people were saying, 'that's not your kid!' And when she came out … when he was helping me push, and she finally came out, and he said, 'I love you babe,' it was the first time he ever said that to me. (15/06/2010)

The women in the body mapping workshop also emphasised the role of their partners or husbands at the birth of their babies. This importance is also reflected in Midewiwin ceremonies. When I interviewed elder Josephine Mandamin, the role of the father in childbirth came into focus when she spoke of the importance of having balance between men and women. She is a water carrier, and in her ceremony she explains this balance in the water ceremony and relates it to becoming parents:

> Because in taking care of the water, there is always supposed to be a man walking beside us. So we talked to them [men] about responsibilities, men's responsibilities to the women. For them to walk beside the women for the work that they do, and give life. Women give life, they are the carriers of life, and the

men also have a part in that. They plant the seed in the womb of the woman so once that is done their responsibility does not end there. They also have to be a part of taking care of that water of life that they had planted the seed in…. We need to work together in the work that we are doing as Annishabekwe, caring for the water. (Mandamin, 2010)

When speaking with Josephine, she elaborated on this unity between men and women in the water walk, and commented on the current state of First Nation communities in the process. She explained:

Well, we, that's part of our life story or our story as Anishnabekwe people, we're supposed to walk in balance and a woman who walks alone with water has to have that balance with the fire of the man who has that strength, that physical strength to walk with her…. It was nice to have somebody walk with the staff beside me or beside a woman so the woman walks the water and the man walks the staff and that's a good balance and it makes the walk a lot more easier. And that's part of life too when we have partners walk with us in our work, it makes the work a lot more lighter and that balance. If there is no balance, there is upheaval in our families and in our communities when there is no balance. (10/12/2010)

The potential upheaval of families is present in the practice of evacuation. A midwife in Winnipeg told me a story of her encounter with a woman who had been evacuated from the north. She explained:

I was meeting at the Union meeting downtown ... we had come out of this meeting and there was this beautiful young woman sitting on a bench. It was the middle of January so it was pretty freezing. I walked past her and I got in my car, and I swung by the building again and she was still there. So I rolled down my window and said, "Are you okay? Do you need a ride somewhere?" She said that would be very nice and she got in the car ... when she got in the car, she took a baby out of her amauti[12]. I didn't even realise she had a baby on her back. I said, "Are you okay? Is there anything I can do for you?" She said, "Well, you can listen to my story." So she told me her story.

Her story was that she had come down a few weeks before. At 36 weeks she came down to [the hospital] and she had been here for a while, and her partner had come down. He was here for a while as well. She had the baby, and then she was put on the plane to go home [but her] partner had no money to get home himself. So she went home … her partner [did] not because they didn't get the approval for him to come with her, but he came down anyways and then didn't have the money to go back. He said he was going to work or get the money from friends and then be right back home. She waited for a month and he never did come home, so she decided to come down and get him and see what was going on. And she found out

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[12] An amauti is a parka worn by Inuit women with a large hood to carry babies in.

he was living with another woman. She had nowhere to stay and she had no money to get home either. She was stuck, and he didn't want anything to do with her. She was saying that this wouldn't have happened, that they shouldn't have come down [for the birth].

It is just one example of what happens, I guess. (27/02/10)

This story highlights the negotiation of risk to relationships that becomes a part of the experience of evacuation. The woman's perception that evacuation caused the breakdown of her relationship is telling of how the risks of evacuation are framed by some women experiencing the practice.

9.5 Summary

This chapter followed the trail of maternal evacuation and outlined some of the key institutions that govern the experience of confinement. From the CMA perspective, this chapter brings together all levels of analysis, including the structural, the clinical encounter and individual experience of childbirth in order to understand the current configuration of maternal evacuation. Bio-power, the regulation of bodies through technologies, knowledge, policies and practices, becomes integral to this configuration. This chapter introduces a "heterogeneous network of interactive actors" involved in the monitoring and management of pregnant women during the perinatal period, including health professionals working in various jurisdictions and overlapping systems of health care, policy makers in various committees, including the MACHS Relocation Committee, hospital institutions, and advocates for reform in maternity care. (Lupton, 1999, p. 87) The effects of this controlling of women in the perinatal period is that as a population, they become defined as high risk. As the federal Medical Advisor stated, "We are dealing with a high risk population in a high risk environment" (23/02/10). This labelling of First Nations women as high risk allows for particular forms of interventions and knowledges to govern this population. In this chapter, the increased surveillance of First Nations women in the perinatal period is one of these forms of intervention. Therefore, maternal evacuation is not only a form of biomedical risk management, but also a moral technology used by the state to maintain control over a high risk population.

The prominence of place also emerged from this chapter. Governance, in terms of provision of health care, was clearly defined. Where bodies were located in space was of great importance to everyone involved in evacuation. Where responsibility began and ended was clearly defined for the various health care systems. Once a woman left the reserve, she was no longer a federal responsibility. Likewise, according to the MACHS Relocation Committee, a woman was only of interest once she arrived in the physical space of the WRHA. A preoccupation of locating women

between these spaces was seen through the interviews with the policy makers, and also with the health professionals who are responsible for providing care in these various settings. Power to govern these spaces was apparent by the WRHA and the FNIH Regional Office, and inversely, the insistence that the "other space", either provincial or federal, was not in their jurisdiction also seen as a powerful tool to delineate responsibility for providing care.

Childbirth as risk emerged as central to the practice of evacuation. From a biomedical perspective, birth is not predictable or controllable, but access to certain knowledge and technology located in a tertiary hospital becomes critical to managing risks of childbirth. At the clinical level, place became important in that decisions regarding which risks are "acceptable" and which are not depend on who is able to make decisions within the health care setting. Most often, this falls on to the health professional (nurse or doctor) who has the authority to make clinical decisions regarding the care provided.

Negotiation of social risks by women and their families was negotiated throughout the process of evacuation. It was shown that through the process of evacuation, the biomedical risks of childbirth were consistently given precedence over the mitigation of social risks by the health care system and policy makers. This coincides with Hamilton's (2012) observation that biomedical maternity care "continues to place objective medical risk over women's subjectively defined risks, leaving women to cope with their own risk in their own ways" (p. 73). In the next chapter, some of these ways of dealing with woman's own risks will be explored.

10.   Negotiating risks in evacuation

This chapter looks at how women, their families, and their care providers work together to change various aspects of the experience of evacuation. This discussion builds upon Bevir's (1999) description of agents as "creative beings", and shows how women and their care providers are actively engaged in negotiating how evacuation is experienced within the boundaries set out for them by administrative structures (p. 6). Since evacuation is about facilitating movement of women, the primary place where women and care providers try to "work" the system centres around the timing of these movements; they also seek to initiate medical interventions. Their aim is to change the timeframe of events and control who is participating in evacuation. In these scenarios, exercising agency should not be equated with an ideological articulation of resistance, but rather a pragmatic approach to dealing with the challenges of evacuation. (Lock and Kaufert, 1998, p. 11) These forms of pragmatism are seen in the negotiation of when a woman leaves the community, when a women goes into labour, and how she is transported back home. On the other hand, the evasion of evacuation can be viewed as an act of resistance, creating two types of subjects. One is a non-compliant patient and consequently, in the view of a system that supports evacuation, a bad mother. The other is a woman actively negotiating other risks (other children, relationships, etc.) before the potential biomedical complications of childbirth.   This framing of women as bad mothers coincides with the literature that demonstrates how responsibility for the unborn child is placed on the mother, and any action that is perceived as putting the baby at risk results in the making of non-compliant patients in need of regulation, rather than looking at the structural factors that influence certain reproductive behaviours. (Armstrong, 2008; Kaufert and O'Neil, 1993; Hamilton, 2012; Tsing, 1992)

Nurses, doctors, and policy makers often use this framing of non-compliance in justifying the continuance of evacuation practices. However, in this chapter, I find that this focus on women's actions is often directly related to risks to health care providers in the communities. On the other hand, Aboriginal midwives articulate acts of resistance through their own knowledge, and their practice of attending to the social and biomedical risks of childbirth; they, therefore, approach dealing with so-called non-compliant women in a different way. Aboriginal midwives frame evacuation as a colonial practice, and, in doing so, offer an ideological, post-colonial vision for maternity care services located in First Nations communities.

This chapter serves two purposes. First, to demonstrate that current maternity practices are actively negotiated experiences that include the management of biomedical and social risk, and that this includes the cooperation of actors in the health systems and the women and families

experiencing evacuation. Second, this chapter looks at the construction of women as non-compliant and the response of Aboriginal midwives to the creation of risky mothers by the health systems trying to regulate where childbirth takes place. I move on to looking situating midwifery in Norway House in chapter 11.

10.1.   Agency within the practice of evacuation

Many women who are sent out for evacuation are knowledgeable about the specific guidelines for the practice, and actively try to subvert the no-escort policy. These women are willing to be evacuated, but they want to define when they should go. For example, if a women presents in early labour at the nursing station, she will be medevaced out of the community if she is less than four centimetres dilated. Therefore, some women choose to stay in the community until their labour starts, in hopes of getting sent out on an emergency flight. This is because if she is in labour, the guidelines will then allow for an escort to accompany her for the birth. A nurse at the nursing station explained:

> Yeah, this week we had mothers at 39 weeks in the community refusing to go because they're not allowed an escort…. What some of them have started to do too is to stay in the community and get medevaced. If they get medevaced they can take an escort…. [the mom] still doesn't win because we will medevac them as long as they come in and they are not four centimetres. (29/10/10)

Within this scenario, the nurse also describes the tensions of arranging the transportation for the women:

> …sometimes Life Flight [the medevac service] doesn't want to come and then we have to argue back and forth, it's such a waste of time…. Honestly, it really drives me nuts. Sometimes you know you wonder about the care agreements that they have with First Nations people. I mean there are abuses, I understand, they need some regulations, but sometimes things have to give and you have to draw the line somewhere and say, well, you know, so whatever the rules are, it cannot apply in this situation. Because I don't think they are that flexible sometimes…. Access to like a Life Flight, you always have to be convincing people about the fact that you know, I need you. (29/10/10)

She also describes how when examining a woman, she will often bend the four-centimetre rule if she thinks the woman will not deliver immediately:

> That is tricky for me, because I can always say they are three when they are four. If I have a primagravida [first pregnancy] in front of me and she's three centimetres or she's four centimetres, it [labour] will take at least ten hours, I am hoping, if she is not contracting heavily, I'd send her.   I think I am a good judge of when people

will deliver. I think I would, but I will tell you when I see a woman without examining her if she is really active or if she's not, she's going to deliver tomorrow. I don't need to put my fingers inside the woman's vagina to know that she's going to push that baby out for me in five minutes. (29/10/10)

Another woman I spent time with in the urban hospital explained how she and her husband got around the "no escort" rule. He had a doctor's appointment for his eyes, and timed his appointment so that he could join her in the city for her confinement. He kept postponing his appointment until after their baby had been delivered, and then they travelled back to the community together the next day.

In subverting the no-escort policy, women and their health care providers are actively negotiating different risks. In this scenario, women are taking the chance that they will be able to be medevaced out of the community so that they will have an escort with them. This particular nurse at the northern hospital is also negotiating risk on a number of levels. She uses her knowledge of labour and birth to bend the rules about the four centimetre dilation rule so that women can be sent out; at the same time, she is engaged in a negotiation with the medevac team in order for them to respond to her call for a flight.

While in the city, women's wait to have their babies often results in trying to start labour artificially. Women are often induced at their due date in order to facilitate a quicker return home to their community. This is known as "social" or "geographic" induction since there is no medical reason for the induction to take place. This intervention

> …may be offered to reduce the woman's time away from home once in a referral community awaiting the onset of labour. This is particularly relevant for women with other children at home or women who have travelled significant distances for intrapartum services. (Kornelsen et al., 2007, p. 583)

This practice was prevalent in the urban hospital where I conducted fieldwork. Like the nurse deciding whether or not to send a woman who is four centimetres dilated, social induction becomes one way of negotiating risk on behalf of the patient. As one obstetrician described:

> ...the standard of care right now for general pregnant women is minimum ten days overdue before we would consider induction, 41 [weeks] plus 3 [days]. And that just goes along with good evidence that says the vast majority of women left alone are going to deliver on their own and if we start inductions we're increasing the chance that we are going to have to intervene in other ways: increasing the assisted vaginal delivery rate, increasing the Caesarean-section rate and all its complications. Again this becomes weighing your risks and benefits because in a woman who has been here for three weeks and has two young children at home,

she wants to go home.   And so for all of our Northern patients, they hit their due date, well first of all we start sweeping their membranes at 38 weeks, at 38 and 39 and 40, and they hit their due date and we put them on the induction list, and the reason for induction is "wants to go home" and the staff does their very best.   I mean obviously we can't put that person ahead of a gestational, hypertension, whatever, but they try very, very hard to get them in and get them delivered and get them home.   And again … we are increasing that patient's risk for further intervention and complication but for her again, the benefit far outweighs that risk. (18/08/10)

In this situation, we can then see how increasing risk through intervention in childbirth is being constantly negotiated against the social risks that are also a part of the experience of evacuation. The interplay between these forms of risk depends on who has the power to make the decision (the health care provider or the woman) and how the decision is framed (informed on the part of the health provider, and irresponsible and in need of management on behalf of the mother). This creation of biomedical risk through induction can be seen as an iatrogenic effect of evacuation as risk management.

After the baby is born, arranging transportation back to the community is a priority for most mothers. As discussed above, this is done through FNIHB and the mode of transport is decided upon based on guidelines of what is "medically appropriate". This often means that a woman who has had a "normal" delivery will be sent home on the bus, which for Norway House is a fourteen hour ride. Some women and medical staff, however, also know these guidelines and ways to work around them. One midwife recalls a situation with a northern woman who had just delivered. She had a small tear, and in accordance with the current best practices, the midwife chose not to suture the wound. She described how the family seemed disappointed:

…the nurse and her mother informed me that if she had stitches that she would then be able to fly home and it would be paid for, whereas, if she didn't have stitches in her perineum or her vagina then she would have to take the bus home. (02/09/10)

The midwife then put one stitch, and she related how the family cheered, because they knew the woman would then be able to fly home with her new baby instead of taking a fourteen hour bus ride with a newborn.

10.2.   Evading evacuation

While the majority of First Nations women go through the system described above, there are also instances when women evade evacuation completely and deliver in the community. Discussion of "when evacuation does not work" reveals how women become the objects of risk within this practice. The occurrence of women sneaking back into the community is common across most communities that have a policy of evacuation for birth. As the nurse at the federal hospital relates, "Oh, yeah, I delivered babies in [a First Nations community in northern Ontario], I delivered a baby in [another First Nations community], I delivered babies in lots of places." Another federal nurse explains, "It still happens, it's always going to happen". In another province, a federal nurse commented that:

> We are seeing an increasing trend of increased births at the nursing station due to women not wanting to go out for confinement at 36 weeks, which is understandable, but puts everyone at risk. (16/03/10)

The administrator at the federal hospital in Norway House acknowledges these regular occurrences:

> Oh it happens all the time. Yes, because childcare is an issue. Or something is happening that's important with the family…. This one lady … she walked in and the baby was just [what?] … they just got her on the table to catch, to catch the baby. 'What are you doing back? We put you on the plane … you were sent out the other day.' Oh, they sneak back in. (23/03/10)

One mother who I met in the boarding home told me her story of delivering in the community after she returned after being evacuated:

> I had my baby back home but she was delivered by one nurse only. It was too late to send me out because my water busted. I was playing bingo back home, and I didn't know what was happening to me. I didn't know what was happening: I thought I was just peeing myself. It was too late to get medevac. Plus there was a blizzard, and the nurse had to call the doctor out here, and they were delivering my baby by the phone. My mom was there, and my dad, and my husband. It was hard because they didn't give me any painkillers or anything like that. She was 35 or 36 weeks when I delivered her. So she is slow. She is nine years old and she is in grade four. She still has, she can't talk. Well she can talk, but some people don't understand her. But she is doing okay. (16/11/09)

The risk of delivering with a nurse unfamiliar in obstetrics is a regular occurrence in the nursing station. One nurse describes how the risk to her job plays an important part in these situations:

> …It's pretty scary to be a nurse and having a license to protect and always having sort of thoughts in the back of your head that you're going to make mistakes and if

you do make a mistake, the system is not set up to support you. It's set up to punish you. So for instance if you have a breech baby unexpectedly then if you panic, or you potentially do something that could cause harm to the mum or baby, and there is an actual adverse outcome, you are the one that is going to be dealing with that issue in terms of the College of Registered Nurses and not the woman.... The onus is not on the woman at all, it is entirely on your practice. That's why we have so much fear when it comes to delivering babies in the nursing stations. (17/12/10)

She describes this consideration as having a "protective layer" around her practice. She describes one instance of an adverse outcome when delivering a baby in a nursing station:

I've got into situations where the baby didn't survive. In my role at that time, I was not the one actually delivering the baby, it was another nurse. My role was entirely to steer that woman through that loss. And in trying to deal with it, we acknowledged that there was a life precious to her and so on and so forth, but at the same time, comforting her. I'm thinking about could we have done things differently? Could we have saved this baby? Maybe if we tried this and tried that and if we were quick enough to get the doctor out there, the Life Flight, maybe the baby would have survived. Did I make a mistake? I'm thinking about my charting. So you can't be in the moment, be in an entirely supportive frame of mind when you're dealing with an adverse outcome because you're also dealing with an adverse outcome that affects your practice. (17/12/10)

This nurse's explanation of managing biomedical risks and social risks alongside managing the risks to her practice as a nurse is revealing and important in this discussion. The litigious nature of obstetrical practice and the fear of litigation are very prevalent in the discussion of place of birth. As the Norway House Hospital Administrator said, "everyone is worried about liability. It's the big issue but nobody really wants to say that" (12/03/10). Therefore, managing biomedical risk also encompasses managing professional risk as a health care provider. The experience of delivering in the north is seen as highly risky for women and their babies, as well as the health care providers.

The exclusive obstetrical knowledge of doctors is consistently brought forward in this setting as well. One doctor told me the following story:

The last baby that I delivered was a lady who went into the nursing station in premature labour. I flew up on the Life flight jet and she was four centimetres, so we loaded her up to take her out. We were in the air and she started to feel like pushing, so we landed and we landed at Norway House. And I was all ready to incubate the baby and we had the incubator ready and stuff like that because she was premature. And the baby came out and the baby was fine. And the woman had a retained placenta and she was bleeding, and I went to Norway House Hospital with her because there was additional staff there and you just can't do anything on those planes. And so the doc that was in Norway House Hospital said

to me, 'Well, I've had additional obstetrical training, I can take out her placenta but how would we put her to sleep?' And I said, 'Well, I've had additional anaesthetic training so I can put her to sleep if you can.' So I put her to sleep, he took out her placenta, she stopped bleeding and her haemoglobin was—like she would have died if it would have been another hour or something like that, so it was very narrowly averted. (23/03/10)

These narrowly averted dangers coincide with Kaufert and O'Neil's (1990) description of the "clinical language of risk" in evacuation practices. The role of doctors and their advanced technical knowledge is highlighted as integral to the saving of women who refuse to be evacuated for birth. Despite the positioning of biomedical obstetrical knowledge of dealing with the complications of childbirth, doctors and nurses are also actively trying to mitigate the social risks of the practice of evacuation. As one obstetrician relates:

I believe every labouring woman should have one support person down here with her for labour. I can understand that maybe they [the government] cannot afford to have someone down here for weeks on end, but if she has to be here for a prolonged period of time then at least let someone come down for weekends and bring her children if she has them. If it were me and I were a patient and you told me I had to be away from my kids for a month, I would be a very non-compliant patient. (18/08/10)

A nurse working in a federal nursing station also relates how she openly discussed negotiating risk with one woman who had returned to the community after being sent out:

I actually dealt with one woman when I was in [a remote First Nations community] over the summer who returned home [after being evacuated].... She just wanted to return home to visit her family. Understanding her situation and actually taking some time to talk to her, she was able to re-leave the community again, not being evacuated, but left on a scheduled flight with a better understanding of what we [nurses] had to deal with when we deliver babies.... Because we sat down, we had a really good conversation. I heard her story and she heard mine, and we were able to meet in the middle. Most practitioners won't give them that time. They will not even sit down and say, hey, can you tell me what's going on in your life? Okay, is there any way I could help you. It's just like, out the door, you have to go, no choices, no discussion. (17/12/10)

In this section, it has focused on the relationship between health care providers and women experiencing evacuation. The body became the site upon which risk was negotiated during evacuation, and the biomedical, social and professional risks of evacuation were discussed in relation to the action of subverting or challenging the practice of evacuation. The role of biomedical technical knowledge also emerged as an important part of mitigating the potential risks of childbirth. In the final section of this

chapter, midwives are introduced as primary health care providers who have knowledge of childbirth and as decision makers within the birthing process.

10.3.   Midwifery and the governance of childbirth

In Darlene's words, evacuation is framed in negative terms. It is a system that needs to change.

> Like the image of a path with its tributary trails, the current experience for women and families is bound to fail and is destined to change because it is not the main path. Evacuation was a solution that was never connected to reality, never grounded in the body experience. It was a reactionary idea based on false authority and fuelled by money and unsustainable practices and resources. (11/05/10)

In the previous chapter, it is noted that midwifery did not figure prominently into the current practice of evacuation. This is for a number of reasons. As discussed in chapter two, midwives in the province of Manitoba are provincial employees hired by the Regional Health Authorities (RHAs). The model of care of midwives makes it difficult for them to care for women being relocated for childbirth on many levels, both ideologically and operationally. The main aspects of the model of care that do not fit with evacuation are continuity of care, choice of birth place, and evidence based practice. (CMRC, 2006) As employees of RHAs, midwives are required to serve the population of their particular RHA. Midwives are also unable (with some exceptions) to work in other RHAs; therefore, they are unable to move to the urban centre with their client if the client is required to relocate for childbirth. The exceptions for this rule are in places that are relatively close to an urban location (i.e. South Eastman RHA and WRHA), where midwives in the rural communities have gained access to provide care in the urban tertiary facilities. (personal communication, 2010) The movement of evacuated women across RHAs leaves the midwife unable to provide care for them as they move to another RHA to give birth, but it also affects their ability to provide continuity of care. For example, in Darlene's midwifery practice in Norway House (which will be discussed in detail in chapter eleven), she is required to arrange transfer of clients (and thus transfer of care to obstetricians regardless of risk status) for childbirth in the city. She is able to provide prenatal and postpartum care, but this continuity is interrupted by the removal of the women from the community for birth. In 2009, Darlene was able to arrange the transfer of her clients to urban midwifery practices in Winnipeg; however, the midwifery workforce is so strained, and so many patients are turned away from midwifery practices in Winnipeg due to lack of midwives, that this practice of transferring care to a midwife was not sustainable. The justification for this was that midwives were turning away so many women in their own region that they should not be accepting

patients from other regions. Thus, in the current practice of evacuation, midwives are largely outside of the structures of governance for birth.

The role of the Aboriginal midwives in the current context of evacuation is one of ideological resistance to, and critique of, the practice. While the current practice of evacuation excludes midwifery, the role of the midwife in critiquing and providing a vision for the future is central to the movement to return birth to rural and remote First Nations communities, and to cease the routine practice of sending women to the city to have their babies.

10.4.   Midwives' views of current maternity care

Returning to the visioning sessions of NACM in 2009 (discussed in Chapter 8, Section 4), the midwives were instructed to visualise and draw "the most difficult things that come up in your work with birthing women" (02/11/09). Through these descriptions, the views of evacuation and how women are situated within the system is made clear. After a few minutes of contemplation and sketching, each midwife presented and explained their drawing to the group. Through these descriptions, the impacts of current reproductive care and the intervention of the state was articulated by the midwives. An Aboriginal midwife from Ontario describes the current situation for Aboriginal women in her community that goes along with the elders' views of the challenges youth are currently facing, and ties this back to the birth:

> What I see in the communities I am working in right now is the apprehension of most of the babies, the apprehension of the whole next generation. I am talking about Aboriginal babies, babies from our community.... I call it the trail of tears. I see the trail of tears in my work every day. This woman is in a hospital bed, because most of the time it is a hospital birth. And she is saying, "Help me somebody they are going to take my baby away from me. Birth does not feel safe for me and I am overwhelmed by my fear of pain". And there are the arms of someone they don't know … the baby is in the arms of someone they don't know, and they don't know where that baby is going to go. And the fear of not knowing, fears with the birthing process as we all know, the stress, and it is broken. The whole circle is broken. She is feeling ragged and overwhelmed with not knowing what is going to happen. The women I work with they tell me that they are broken…. Even before they have had their babies their bodies are numb due to the emotional, spiritual, sexual, and physical violence they have experienced in their lifetime. So they can't see the beauty, they don't know that there is beauty in birth; they don't know the sacredness of birth, because they can't see it because they are so shut down. (02/11/09)

The second midwife, a student, held up her picture of a braid. She explained that she started to think about how her grandmother used to braid her hair when she was a little girl, and make the

braid so tight that it hurt her. In the room, her grandmother, an elder midwife, is sitting and smiling at her grand-daughter as she speaks about this time. She drew the braid to explain what she sees in her work as a midwife:

> There is a disconnection, like long ago families used to be so tight and the men would support the women. Now it seems like everything is loose and coming undone and it is falling apart…. I found for myself that there was this disconnection. And there is that disconnection, even with the government and the communities…. They are not working together to keep things tight. Everything is coming loose. Long ago when my grandma did deliveries, everyone knew what their title was. Everyone knew that they knew that she was the midwife. There was no doubting her or whatever, they knew she knew what she was doing and they would call on her … now what I see when I go to the hospital … it is almost like the nurses were like, "oh, you know the midwife was here" … there is a disconnect between the midwives and the doctors and nurses…. You get a sense that they are only being polite, they are not really connecting … midwives have to prove themselves, their standards, that they are in line with the doctors. This is what I have been getting the sense of, and I have only been doing this for four years. The first thing that comes to mind is the sweet grass braid. And then how do we get that back? How do we get that connection back and have it tight? (02/11/09)

Another midwife explains part of her drawing:

> Here is the woman. This could be a hospital that she is going to give birth, so she is not able to stay in her own community. But it is not just about evacuation, she is tired. She is going through this wall. There is a wall that exists between life in the community and the outside life. And there is a wall that divides and there is no understanding between a lot of people that don't live in the community. They don't know what goes on, what life is like there. And she has to go through that wall, she has to go to the city to give birth, and those are her footsteps. And she is tired, because as you say, she is carrying the weight of the responsibility for her family and for birth. This is her husband, or her partner, here, who is sitting here and basically he is depressed. But when I wrote down what my concerns are, I put down family violence, homelessness, poverty, lack of choices for women (especially around birthing), but when I thought about all of those things, the thing that is the most important is the oppression of the women. And it is not just the oppression by the government, but oppression in her own relationships…. I see a woman who is trying to take care of him, she is trying to take care of the kids, she is trying to manage financially, and she has no choices. When she is working so hard and she has no choices. And basically to me, that means she is oppressed… I think for me, that is what a lot of it comes down to. It is the oppression of women. It is everywhere. I just see it everywhere. (15/01/10)

Through these descriptions of the issues that Aboriginal midwives face working in their communities, a few common threads emerge. The images of disconnection, of walls, of oppression come together in these drawings. The midwives link the lack of midwifery knowledge in the communities to the historical and current structural inequalities that exist in the community. The image of disconnection, or "things coming loose", occurs on many levels. There is a disconnection between women and their families, their health, their history, and their identities. As one midwife points out, this disconnection also exists within the bodies of the women they work with. The issue of relocation then becomes more complex than just birth place, rather, in the words of one midwife, birth must be relocated within women's bodies as a safe place as well as a physical shift of birth environment.

Midwifery in the context of evacuation is also explained in terms of the position of midwifery, drawing both on the historical role of the midwife and questioning the current practice. Carol explains her view of evacuation and the disconnection to midwifery:

> There was one Inuit woman interviewed and said that it was a blow to the self-esteem of all women that the midwives no longer did their job. And that always struck me big because I felt, it made sense to me to begin with because when someone's job is taken away, it's just like a hunter or like a trapper, we talk about all these things about residential schools, and it's like midwifery is kind of forgotten and so I see this sort of taking the job of midwives and removing birth from the community into the hospitals as something that's akin to colonisation. (15/01/10)

She also explicitly equates evacuation to practices of modernisation ant the attempts of the Canadian state to modernise First Nations through the medicalisation of childbirth.

> Most non-Native people and maybe even many Native people would see this as something that is just about modern life. But I am not convinced, and I don't think I ever will be convinced that we needed to have modern life that much. That modern life could have integrated itself just like everything else that happens in our environment or in our society, there needed to be an integration of the two, and our midwives needed to be invited to work with doctors and the doctors needed to come into our communities and see what we did. There needed to be, like in an ideal utopian world, there should have been an exchange of knowledge— not we're better than you, we can do it better than you. (15/01/10)

Carol also goes on to question the safety in the practice of evacuation and the opposition of physicians to birth in a rural and remote setting. She also talks about the same concerns of having a lack of knowledgeable staff in community health care settings when women present in labour. She says:

> When physicians… like I've been to their universities and I've learned their science and you can't even give them their own science, they'll still argue, they feel so possessive of this territory or of this thing. And they use safety as an excuse. Even

when there was no research to begin with that it was safer, every day we're finding more and more research saying that it's not safer and in my gut I cannot believe, as a woman who's attended over 600 deliveries, in my gut I know it's not safer. Because when you take away everybody in the community that knows anything about delivering a baby, in a place where there's no one, like there's no hospital… and you have pregnant women up till they are 37 weeks, how can that be safe? It's hit and miss on who is good in obstetrics. I'm not saying that all the nurses are doing a bad job in obstetrics, that is not true, there are nurses that work in nursing stations that are really, really good at it and they know their stuff. There are also nurses that are really, really good at trauma, heart attacks, managing diabetes, like these are hug skill sets and nobody on any given day can have it all. You need to have midwives so that there's always someone there that knows that… And it's usually not the same person who holds those two skill sets because they are so vastly different. (15/01/10)

Carol both questions the current management of risk in the practice of evacuation, and also positions midwives in an important role in First Nations communities. In the next chapter, I will turn to the implementation of midwifery services in NHCN, one of the only places in Canada at the time of fieldwork that was actively attempting to have midwives work with the federal system of providing primary care.

10.5   Summary

In this chapter, it was shown how both health care providers and woman actively negotiate how maternal evacuation takes place. When a woman is sent out for confinement, the presence of an escort, the induction of labour, and postnatal interventions (i.e. suturing), can be seen as factors upon which biomedical and social risks are debated. When a woman evades evacuation to deliver in the community, multiple other risks emerge. It was shown that some woman have developed strategies to subvert or participate in the decision making regarding their pregnancies and deliveries. These strategies focus on the lack of obstetrical knowledge and capacity in the community to attend deliveries, and the consequences of possible litigation in this process. Subverting or evading evacuation leads to women being framed as 'irresponsible' or in need of more active management.

In this chapter, the body becomes the site upon which these risks are negotiated. In this way, Beck's (1999) observation that risk is produced from the transformation of danger and uncertainty into decisions. (p. 75) Decisions on moving bodies from one location to another, or to intervene into labour and postpartum care use the body as the focal point for these negotiations. This focus on the physical body also demonstrates how the process of evacuation becomes one that could be seen in terms of stratified reproduction. In this chapter, having to negotiate induction, sutures, and birth without proper obstetrical care are issues that some First Nations women face during the perinatal period that can be seen as absent for those who are not required to relocate for birth.

In this chapter, Aboriginal midwives' opposition to evacuation are also overviewed through their constructions of the current state of maternity care for First Nations women, and the challenges that are currently faced in communities. Carol also questions the safety of evacuation as a risk management technique. By doing this, she positions midwifery as the re-introduction of safe practices to maternity care.

11.   Postcolonial midwifery in Norway House

So far this thesis has gone through the practice of maternal evacuation and the associated risk management practices conducted by all actors. Now I turn to the issue of returning maternity care practices, particularly childbirth, to NHCN. The timing of my fieldwork was fortuitous: during my time in Norway House, the debate about returning birth to the community and its consequences was being played out, and all actors—including First Nations leadership, federal health officials, provincial health officials, and midwives—were actively engaged in dialogue. One of the issues of the debate was the inability of midwives to practice in Norway House, and is the focus of this chapter. It is shown that through the obstacles faced by the Kinosao Sipi Midwifery Clinic, midwives became the centre of the risk debate. Analysing the debate, I argue that it shifts from the state's initial preoccupation with managing irresponsible and non-compliant patients to an attempt to manage midwives and challenge their knowledge of childbirth. This assessment coincides with Cominsky's (2012) argument that, in the context of safe motherhood policies in Guatemala, "the midwife is [seen as] the greatest risk factor in the reproductive process" (p. 82).

This chapter is structured as follows: first, the development and collapse of the KOBP in Norway House is discussed; second, the story of one woman's attempt to give birth in Norway House with the midwives is told. The political fallout from this attempted birth sets the groundwork for the remainder of this thesis. The story highlights how the biomedical risks of childbirth in a remote setting were combined with certain notions of the risks associated with midwifery. For example, how lack of access to technology became combined with the notion of risk of midwife-attended deliveries. This combination of risk reveals itself in the everyday functioning of the clinic in the federal hospital; therefore, I first review some of these obstacles faced by the midwives in their clinic, before going on to look at the discourse of risk of childbirth in Norway House. I also identify how particular places and spaces become governed in First Nation communities by the federal government, and how perceptions of control over health care in the community extends beyond the physical space of the hospital onto the entire reserve land. In the next chapter, risks and implications of birth in Norway House are discussed at a broader political level. The movement from the midwifery clinic to the board room also signals a shift from a focus on the embodied enactment of risk management of childbirth to the disembodied discourses at the level of the state.

11.1.　　　　Governance of birth place

The FNIHB National Office played an important role in the development of the midwifery programme in Norway House. This section outlines FNIHB National Office's part in the process in order to contextualise the fall-out that occurred once the midwives began their practice. At the federal level, a few key actors emerged as the main drivers and supporters of midwifery and returning birth to communities. One of these was Dawn, a senior official, who was introduced in chapter 7. While Dawn maintained the federal line of "we do not hire midwives" and "we are not responsible for primary care", Dawn was very supportive of midwifery in Norway House. She can be considered responsible for the creation of the Maternal Child Health (MCH) programme and a policy directive at the senior management level of returning safe birth closer to communities in 2005. The main elements of this policy directive of "Returning Safe Birthing Closer to Communities" are:

> Return: to exemplify that birthing was and has always been in the communities;

> Safe: to indicate that birthing in the communities will meet safety standards in place; and

> Closer: the recognition that not all communities may be able to support a birthing services but that options would be developed for women to give birth as close to their home as possible. (Desjarlais, 2008: p. 3)

When speaking of the midwives in Norway House, Dawn said: "The midwives are wonderful, wonderful midwives, I mean I would trust them with my life, or my daughter's life". (25/11/09) On a structural level, Dawn stated that the even though the federal government was not in the business of hiring midwives, it was "supportive of midwifery because that is our official position" (25/11/09). Yet, she confessed that from her position and above (i.e. the Deputy Minister and Minister of Health), everyone was individually supportive of returning birth to the community.

It is important to note that the distinction Dawn makes between the personal view of state actors and the state's official position. Her department's policy initiative, which was based on the personal view of state actors but did not overtly contradict the official state position, enabled Dawn and her staff to fund research on the topic of birth and midwifery, and to organise conferences and meetings between all stakeholders. According to one of Dawn's staff members, they "used that [the MCH programme goals] as a way to try to nab some of the money, try to direct some of the money under the MCH programme to fund some of this work" (25/11/09). The effect was a push at the national office to try to advocate for midwifery to be included in various dialogues. Since the MCH programme was a part of the health promotion realm (part of the Community Programmes division versus the Primary Health Care division), and maintained the stance that midwives could not be hired by the federal government and hired only nurses to deliver these programmes. However,

when the opportunity to fund the Aboriginal Midwifery Education Program (AMEP) in Manitoba came through the Aboriginal Envelope of the Health Care Transition Fund, these federal employees jumped at the chance to provide support for the project. This fund was established by the Government of Canada in order to support provincial and territorial efforts to reform their primary health care system. The objectives of the Aboriginal Envelope were to:

- promote more productive and cost-effective primary health care service delivery to Aboriginal peoples through integration of existing services and resources; [and]
- improve the quality of primary health services delivered to Aboriginal peoples, including cultural appropriateness of services. (AMEP, 2006, p. 12)

This initiative enabled the FNIHB employees at the national office to move from supporting primarily health promotion activities to support changes to the delivery of primary care on First Nation reserves. The following section details the development of AMEP, which later became the kanaci otinawawasowin Baccalaureate Program (KOBP), in Norway House, and its subsequent breakdown.

11.2. kanaci otinawawasowin Baccalaureate Programme and the midwifery practice in Norway House

On 13th December 2004, Manitoba Health issued the following press release which proclaimed that the "first Aboriginal Midwifery Education Program [was] to be established in Manitoba—Program to provide traditional aboriginal and western methods of practice" (AMEP, 2006). The Minister of Manitoba Health, Tim Sale remarked:

> I believe that the process of birthing, the process of giving life, when it is honoured and rooted in community, is the very foundation of healthy communities and healthy life. (AMEP, 2006, p. 17)

The press release included remarks from the National Chief of the AFN and the Grand Chief of the AMC supporting the programme. The National Chief Phil Fontaine stated:

> It is extremely important that expectant mothers have the right to deliver their babies in their own communities, in their own homes, rather than a sterile hospital environment, far removed from their families. I applaud the Government of Manitoba for taking this innovative step, which is really the rediscovery of First Nations traditional practices. (AMEP, 2006)

This programme, to be launched in two communities, one in Norway House and the other in The Pas, was part of the larger project of building midwifery in the province of Manitoba.

From 2004 to 2006, AMEP was developed with the overall goal to "establish a comprehensive and sustainable midwifery programme in Manitoba that reflects a blend of traditional Aboriginal and western methods of practice, and the necessary support systems, for persons of Aboriginal ancestry". (Peters, 2006, p. 1) Manitoba Health was the lead organisation for AMEP, and partner organisations included Manitoba Advanced Education and Training, UCN, BRHA, NOR-MAN RHA, FNIH Regional Office, NHCN, College of Midwives of Manitoba (CMM), and Kagike Danikobidan. (Standing Committee on Issues Related to Midwifery Care to Aboriginal Women) The approved contribution was 1,690,927 Canadian dollars. It is important to note that all of the actors involved in the later controversy of birth in Norway House were part of this initial proposal to fund a midwifery education programme with the explicit intention of bringing midwifery, and childbirth, back into remote First Nation communities.

In 2007, AMEP was handed over to the UCN and became the kanaci otinawawasowin Baccalaureate Program, meaning "sacred midwifery" in the Cree language. Two sites were chosen for the programme: The Pas and Norway House Cree Nation. Since a midwifery education programme was being established in Norway House, an accompanying midwifery clinic was simultaneously set up. The Pas had existing midwifery services in the town. The site of Norway House is the focus here, since the committees that were subsequently formed focused the debate around birth in this community.

One of the midwives explains the process of choosing the locations for the midwifery education programme:

> Developing KOBP, they went to lots of different communities to try and find the right place. So we were looking at things like birthing populations—was there enough babies being born to sustain a midwifery practice, support of governance, the women, the communication, and transportation? The university has a centre and what kind of technology they had for distance education. A number of communities put forward proposals. The good things of Norway House, they had hospital so it shouldn't be too different there, they had a tri-partite agreement, between the federal government, the provincial government, and the community. We had elder support, support of the women. So we went ahead. (02/10/2009)
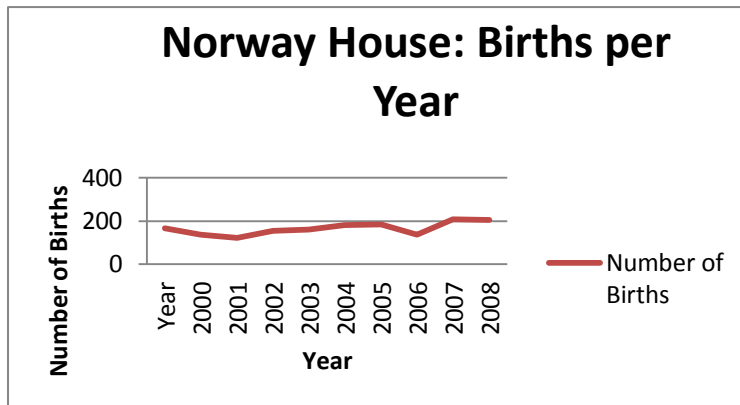
Norway House: Births per Year

Figure 11: Norway House Births per year

Additional considerations for setting up a midwifery clinic in Norway House centred on the population characteristics of the community. At the time, projections estimated that the population would double by the year 2020. Like other Aboriginal communities in Canada, the population of Norway House is young, with 44% under the age of 19. (AMEP, 2006, p. 14) The birth rate was also a factor in the decision to bring the KOBP to Norway House. The following table shows the number of births in the community by year from 2000 to 2008. (NHCN, personal communication, 2009) The range of total births per year was between 122 and 208. The birth rate is expected to increase to 240 to 260 births per year by the year 2020. (AMEP, 2006, p. 14) Many First Nations had applied to have the KOBP in their community; however, because of all of the above considerations, AMEP thought Norway House was an ideal place to begin both the education programme and midwifery practice.

While Norway House was accustomed to dealing with complex funding arrangements for delivering health services (similar to the arrangements discussed in chapter 8), the introduction of community midwifery services proved to have some unforeseen complications and consequences. The following story of Frieda's attempted home birth in the community illuminates the breakdown of KOBP and midwifery services in Norway House, and the political fallout that involved all levels of state and health regulators. I interviewed Frieda at the body mapping workshop in Norway House[13], about six months after her baby was born. From Frieda's story, one can begin to understand the challenges that the midwives working in Norway House confronted, and how their presence in the hospital became a risk to providing health services in the community.

11.3.   A room for birth: Frieda's story

Frieda was going to have a baby. It was her third pregnancy. She was born and raised in the community of Norway House, and is a member of the Norway House Cree Nation. After three weeks of prenatal
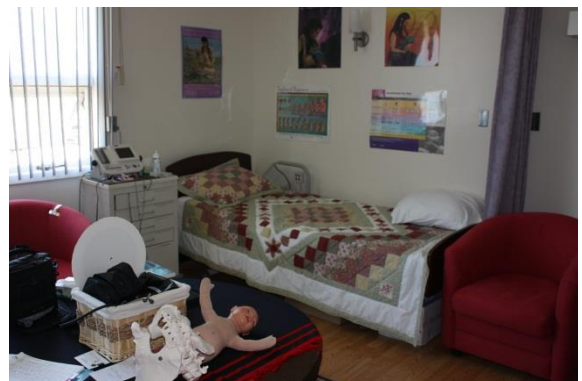

Figure 12: Kinosao Sipi Midwifery Clinic

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[13] Interview date: 15/06/2010

visits at the First Nations clinic, Frieda heard that midwives had opened a clinic upstairs in the hospital, so she went there to check it out. She climbed the stairs, and walked past the Nurse in Charge desk, down to the end of a long blue hallway. The Kinosao Sipi midwifery clinic (See Figure 12) was the last door on the left. Frieda liked having her appointments with the midwives. "It was nicer. You get those hour visits, rather than rushed out of the clinic ....with the midwives, it was like any questions I had about anything, they were there to talk to me. They would explain things more".

In the second trimester of her pregnancy, the midwives asked Frieda a question. They asked her where she wanted to have her baby. Frieda though the choices were either Thompson or Winnipeg. Yet, when the midwives asked Frieda about where she would like to give birth, another option came into focus. There was the possibility of staying in Norway House, the possibility of staying home. Frieda had previously birthed in Winnipeg and Thompson, and because of her experiences there, neither option was particularly welcome. When she told the midwives of these experiences, they began to talk to her about the option of birth in the community.

Frieda had her first baby in Winnipeg. She spent a month in the city before she had her baby. She travelled there alone in the final weeks of her pregnancy to stay at a medical boarding home located in downtown Winnipeg. She didn't know anyone in the boarding home, and she did not know her way around the city, so she spent most of her time alone in her room, watching television. "I was out for about a month on my own in Winnipeg.... I was just in the room, by myself, and calling my husband and saying, 'I want to go home' and stuff like that. I was just alone", Frieda explained, "I had to wait for my husband for two weeks for him to come down." In Norway House, TAP allows escorts to travel to the referral city just before the expected due date. In Frieda's case, 'TAP ... said I wasn't allowed to have someone ... just until the week before, just at the delivery part'.

Frieda's experience in Winnipeg was a lonely one, and she was reluctant to repeat the experience for her third pregnancy. Now Frieda also had her other children to consider when thinking about going out for confinement. She didn't want to leave her kids, especially since she had been away for a month the last time she gave birth in Winnipeg. Further, her birth experience at the tertiary hospital also contributed to her reluctance to return to the city. She explained:

> *The reason I didn't want to go back there is because after the birth ... I don't know ... you know when you get off the bed, after they clean you up and everything. Everything starts slowing down. I kind of stood up, and then a gush of blood came out and soaked my legs, and the nurses were like, "oh, you're okay", and put me back in bed. I said, "What about my feet?" You know, like the bloody splatter? So they just put me in bed and said, "It's okay, it's okay". So I couldn't do much after that.... Plus it was too far to go there again.*

For her second birth, Frieda chose instead to go to Thompson, a town four hours away. Although this place was closer to her home in Norway House, her experiences in that setting were no more positive than the first. When I asked her to describe this birth experience to me, tears immediately spring to her eyes. She explained:

> Well, I don't know what the word would be … it was like, late at night, and the people taking care of me were kind of arguing with the doctor right in front of me. He was arguing with her and stuff like that. One of the nurses … this exam they do, and she was really rough…. I kind of had to grab hold of the bed, and started to sweat it was so painful, and she asked me to put my hands underneath my back and lift up, and after I did that, she kind of just did that again, and it made me cry. I was telling [the midwife] about this. After the birth there she kind of just grabbed the cloth and rubbed me really hard on me, like after they clean you up and stuff. It still hurts when I think about it.

Frieda tried to file a complaint with the hospital, but was told that she needed a record of each time the nurse entered the room. She did not have this information, and so, discouraged, she did not take the process any further. Therefore, when the midwives asked her where she wanted to deliver, the option of staying in Norway House was very appealing. She explains:

> The reason I wanted to stay home is that I didn't want to go out [to Winnipeg] by myself, and I didn't want to go to Thompson in case I had that nurse again. I was telling [the midwife] about it and she talked about home birth, and I just kind of, I don't know. I started thinking about it more, and I wasn't too sure about where to go, and we started talking about it more.

Once she decided to stay home, the midwife wrote a letter to the Chief and Council to notify them they were planning a birth in the community. Frieda explains, "they didn't respond, so we just started planning … like what we need to get, like medicines and stuff. And transportation, you know, just in case. All that stuff". Then a week before Frieda's due date, the midwives received a letter from the Burntwood Regional Health Authority, who also called Frieda at home.

> [The midwife] gave me a call that evening and told me they were unable to have it, have the home birth. I can't remember exactly what it said. She just told me it wasn't good news. The BRHA stated that it wasn't possible because the hospital wasn't running … like the medevac…. When she called me there, I was kind of disappointed and crying.

Darlene, her midwife, explained this situation from her perspective:

> The struggle was then to have births in that community…. [Frieda] was interested. [We decided] we won't struggle with FNIH about giving birth in their facility. This woman was interested in having a home birth, so we thought, okay, we will get

everything organised and we will have this home birth in Norway House. (02/10/2009)

Because of the numerous obstacles, that will be discussed in detail below, that needed to be overcome by the midwifery clinic, their immediate solution was to not try to deliver the baby at the hospital. By removing the hospital from the equation, the midwives thought that they, provincial employees working within the regional jurisdiction of Burntwood (albeit on federal reserve land), would be able to move forward without complications. This, however, was not the case. According Darlene:

Well, we were up front about it with everybody. We talked about it in a meeting, and well you have never seen FNIH act so quickly. FNIH wrote a letter within two days…. …they will not allow it. Of course,[we responded,] we are not going to have birth in your hospital, we are going to have a birth in the community. (02/10/09)

However, despite the fact that the birth was not being planned to take place in the hospital, FNIH Regional Office contacted the BRHA, who then sent a letter to the midwives, stating that this birth was not to take place within the community:

FNIH contacted our employers, the RHA, about why we're not allowed. Number one: transportation which was paid for by FNIH. And number two: [the] hospital emergency back-up from Thompson which is the RHA we were hired out of. (02/10/09)

Therefore, because FNIH controlled the transportation in and out of the community, it had the jurisdiction to stop the birth from taking place. The situation was at a standstill—there were women who wanted to deliver in their community; midwives, whose main job it is to deliver babies, were in the community employed by the RHA and ready to deliver in the community; and a midwifery clinic housed within the Norway House Indian hospital run by First Nations and Inuit Health—but births were stopped from taking place.

Frieda ended up travelling to Thompson to deliver her baby. As an exception to the rule, one of the midwives was allowed to travel with her, and attend to her in the hospital. She was happy to have the midwife with her there:

It was much more calmer. It wasn't so busy, like people running around you. She was there, she gave me that support. She was helping my husband too…. Plus with the pushing, like the nurses and the doctors they are like, "PUSH! PUSH!" and she [the midwife] was like, "push when you need to".

When Frieda told me this story of her birth experiences, it was not the first time I had heard about her or the birth of her third baby. Frieda's attempt at home birth in Norway House travelled

through all levels of policy and government, and spurred intergovernmental committees and meetings to resolve the issue of planned births in the community.

11.4.   The Kinosao Sipi Midwifery Clinic

In order to contextualise Frieda's story, we must go back to the development of the Kinosao Sipi Midwifery Clinic in Norway House. As mentioned above, the clinic was established as part of the delivery of the KOBP at UCN in the fall of 2007. The figure below (Figure 13) shows the complex governance of the midwifery practice. The confusion surrounding birth services in the community began at the time of the midwifery clinic's founding: questions surrounding who was responsible for funding what aspects of the clinic, opposition to rural and remote birth, and safety of midwifery services all surfaced in the process. In this section, the development of midwifery services in

Norway House Indian Hospital

The midwifery clinic is housed in a federally-run acute care facility, and governed by the First Nations and Inuit Health Regional Office in Winnipeg, Manitoba

Burntwood Regional Health Authority

Employs one midwifery position in Norway House

Kinosao Sipi Midwifery Clinic

First Nations and Inuit Health Branch, Ottawa

Funded AMEP **(laterKOBP)** through the Primary Health Care Transition Fund

Manitoba Health

Funds midwifery positions across Manitoba **through the RHAs**

Figure 13: Structure of Kinosao Sipi Midwifery Clinic

Norway House will be discussed in terms of access to space, decisions made in those spaces, and the structures, or lack thereof, that inhibited attending births in the community.

According to the FNIH Regional Office, the Kinosao Sipi Midwifery Clinic was never a clear part of the midwifery education programme. A federal doctor explains that the FNIH Regional Office thought that KOBP in Norway House was an education programme that "wouldn't have a clinical component" (23/03/10). He explained that when "they found out that the midwives wanted to see patients and provide care and stuff like that, some of the people here kind of were concerned about that" (23/03/10).

The Norway House hospital administrator also did not have a clear idea of what the intent of the midwifery clinic was. She was charged with providing space in the hospital for the midwives. She explains:

> I was instructed by the then Director of Nursing … to find a room in this hospital for the midwifery programme. It wasn't explained what it [the programme] was.... It [the programme] just wasn't thought out in a way that it should have been. It was just kind of a room for them. It was kind of an office. So then there was all the fighting and trying to get a contract in place and differences of opinions about midwifery, and the old stigmatisation about birthing and it was awful. (12/03/2010)

Dawn believed that the misunderstanding at the regional level (FNIH) should have been cleared up when funding was allocated to develop the education programme. She explains:

> I don't think other people who reviewed the proposal understood the implications of funding the education programme, particularly [the] Manitoba Region. Our regional office had to sign off; I mean they had to approve that that amount of money was going into midwifery education with the concept of returning birth closer to communities. So when they signed on for that funding, that should have reinforced the policy dialogue. I mean the policy dialogue as I've often said since then is: you approve the funding, we're in. If we [the Region] hadn't approved the funding for the education programme, then we could have said 'we're not ready to go down that route', but because we did, we knew very early in the game that we were moving towards a midwifery practice within a regulatory framework in the Province of Manitoba. (25/11/09)

The midwives worked for the BRHA. It is important to understand relationship between the BRHA and Manitoba Health for it has implications for midwifery services in Norway House. Manitoba Health does not provide on the ground services: their role is to develop policy and planning, and to fund services; the RHAs are the operational, primary care providers. A Manitoba Health employee explains this relationship:

> Manitoba Health is the funder so ... in their global funding, between Burntwood and Manitoba Health, there would be a decision made if this is what they [Manitoba Health] wanted their priority [to be]. Sometimes Manitoba Health, through the deputy [health] minister, you get your priority dictated to you in a way. And if we ask an RHA to take something on then it's usually up to us to make sure that the money follows, and if they want to initiate something new, they ask for it in the annual estimates so the funding [will be considered], and if that requires more staff, all that funding has to follow the request. (16/11/2010)

In the case of midwifery in Norway House, it was initially established in the community through the support of Manitoba Health as the primary applicant for the Primary Health Care Transition Fund

for AMEP. The RHAs were required to follow this direction by hiring midwives through their regional mechanisms. Other health professionals that work in the Norway House community clinic and hospital are also hired by the province through the RHAs, as well as the federal governments. Therefore, juggling of funding for health care professionals is not unusual; rather, what was novel in the establishment of the Kinosao Sipi Midwifery Clinic was the introduction of midwifery services into the community. As detailed below, this introduction of regulated midwifery practice through the provincial government (Manitoba Health to BRHA) to the federal hospital (Aboriginal Health Transition Fund to local FNIH) was fraught with misunderstandings and inconsistencies throughout these levels of government.

It should be noted that the Chief and Council of the First Nation are not a part of this debate over health care provision. This is because the onus to deliver health services to the community is shared between the provincial and federal governments. While the Chief and Council can advocate on behalf of the community for certain services, it is up to the respective governments to sort out delivery of services they commit to. The councillor that held the health portfolio in NHCN was adamant that the community wanted to have births occur in the community, but his role in the process was limited. As the federal administrator explains: "Then we had a lady who was involved from the community … and she wanted the band [NHCN] to be a signatory on this MOU [Memorandum of Understanding]. No! No! No! Because we are delivering the services to them. They can't". (12/03/10)

11.5. **Obstacles to midwifery practice**

This section looks at the marginalisation of the midwives in Norway House from the perspective of the workings of the hospital. The practicalities of setting up the new Kinosao Sipi Midwifery Clinic within the hospital setting illustrate the misunderstandings of the FNIH Regional Office and the hospital regarding the role of a contemporary midwifery practice in the current context of health care service delivery. The failure to integrate midwives into the hospital was shown in numerous ways: including nursing staff not calling the midwives, and midwives' inability to access records, lab work, other supplies, and transportation for patients. Through these exclusionary practices, some federal employees' views of midwifery are explicitly revealed.

Among hospital staff, a justification for excluding the midwives from health service delivery was that they were unfamiliar with working with midwives, and that there was lack of knowledge amongst nurses of what a midwife does and her place in the overall health care system. The hospital administrator explains:

> ...we were always fighting over something…. We never had a midwife in this hospital and of course because it's different from a regular hospital... [...] So we had to figure out a way to allow admitting privileges for a midwife. The nurses weren't used to having a midwife come in. Can we take direction from a midwife? Everybody was trying to figure that out. (12/03/10)

Darlene identifies access to patient records as one important aspect in her struggle to establish the clinic in the hospital:

> We were given a room in the hospital to establish a clinic, but because they were a federal hospital and we were provincial employees we were not allowed to access patient records. (11/03/10)

The reasoning behind this records protocol, however, was contradictory: doctors and nurses, all/many of whom were provincial employees, continuously accessed patient records in the hospital. However, after six months in negotiation, FNIH and the BRHA finally signed a MOU to allow midwives to access records and to begin seeing clients to perform pre- and post-natal care. Subsequently, the midwives developed their own charts, which were kept separate from the other hospital charts.

Despite the improvement of gaining access to, and use of, patient charts, the midwives continue/continued to be restricted in their charting in ways that other hospital-based health care providers are not. For example, the midwifery charts cannot be taken out of the hospital at any time; however, by midwifery standards of practice, postpartum home visits are a routine part of

care. Therefore, the midwives are required to photocopy the obstetrical record and postpartum referral form, and then chart when they return to the hospital. Further, charts could not be accessed after hours by the midwives. Darlene explains: "They [the charts] can only be accessed by NMU and FNIHB nurses working in the hospital who have the door code" (13/03/10). Yet, all other health practitioners have access to the midwifery charts and will/would sometimes pull them to review the files. There are also complications in how midwives chart as compared to others in the hospital. After birth, the baby remains on the mother's chart for six weeks postpartum. In the hospital charting, the baby has its own chart after birth. This can lead to some confusion. Darlene explains:

> We've been running into this situation where if someone goes in post-partum into emergency or into the clinic downstairs, they don't ever think to look in the midwifery chart because they assume, oh, she's had her baby, everything's in the larger charts, the baby's and the mother's chart, whereas we have it within that client's midwifery chart still for at least six weeks. So there's still issues around the charting. (12/03/10)

Darlene also wonders when the federal hospital might start to engage in discussing these issues with the midwives: "I don't know what would have to tip the scale, what number of clients might tip the scales, if we start to deal with half of the women in Norway House, maybe then they're going to click to okay, well maybe we need to figure out more about what they're doing and how they're doing it". (12/03/10)

Another difficulty of setting up the Kinosao Sipi Midwifery Clinic included not being able to order lab work, prescribe medications, or authorise transportation. The pharmacy was an independent, privately-owned facility, so getting that sorted was relatively easy; however, there was still resistance from hospital staff to allow the midwives to access certain supplies (e.g. latex gloves, etc.), often called consumables. On the day that I arrived at the midwifery clinic in Norway House, the midwives had just been told that they were no longer allowed to use the hospital's supply of consumables, because, again, they were not employees of FNIH. Darlene explains that they "fussed about silly things, like gloves—who is going to pay for those things?" Darlene points out that these supplies would be "used anyways if those women were getting care downstairs" by the FNIH and NMU nurses, whose use of gloves would not be questioned regardless of where the funding for their employment came from.

Finally, another ongoing issue was the hospital's resistance to calling the midwife when one of her clients presented in emergency at the hospital. The midwives had not been integrated into the policies of the hospital, and therefore did not get put on the nurses' call list. Darlene explains:

…the problem of us getting called when our clients come in [is] because they haven't revised their policies and their medical bylaws, so there's nothing that clearly states to the nurses that they can call us when it's our client or that they should call us. So their usual routine is [when] someone comes into emergency, they call the doctor on call, and if they're not available, they call the nurse practitioner. And nowhere in there does it say if it's a midwifery client, you should call the midwife. It's just like whoever's on call that['s] who they'll call. So that still needs to be changed so the interim solution is that they have a list of our clients, and that we tell our clients that they have to let them know when they go in that they are our clients. So that's the solution until the policies are changed. But it makes me uncomfortable. (13/03/10)

Near the end of my fieldwork, a doctor began to work for FNIH Regional Office did a review of the situation in Norway House. He acknowledged these exclusionary practices and related that:

…in fact I criticised our system because we had not directed the nurses who work in midwifery to collaborate appropriate[ly] with the midwife services, and that was a huge, huge disservice that I think everybody has to take some blame in…. And so what ended up happening, and even today I think it's still there, I just don't have the time to follow up, it's particular that the culture at Norway House seems to have no confidence in this concept of midwifery in general, and that culture, I'm talking about the medical culture, and the nursing culture, I'm not talking about the culture as far as you talk to community people. (21/10/10)

Through these challenges, Darlene has continued to work providing prenatal and postnatal care at the Kinosao Sipi Midwifery Clinic, and since the time of my fieldwork, provides midwifery care to over 50% of the community.

11.6.   KOBP goes south

Through the everyday practices of the medical staff at the Norway House hospital, midwives were excluded from practices there. This had a large impact on the implementation of the KOBP within the UCN: one of the significant impacts was that student midwives in Norway House were unable to gain the required clinic experience. When I left for my first year of doctoral studies in 2008, there were nine midwifery students in the programme; when I returned six months later, there were only two students left. While the stakeholders organised themselves into meetings and committees to address the challenges surrounding midwifery service delivery in Norway House and to try to save the education programme, there were plans underway to expand the midwifery education programme to Winnipeg.   UCN made this announcement at the CAM conference in the fall of 2009. As Darlene recounts, the announcement was "initially met with celebration and later with mixed reactions and many questions by the midwives in attendance" (01/12/09). Carol put it a little more bluntly and remarked, "It felt like Columbus had landed all over again!"   Through these

words, Carol explicitly brings an element of colonialism into the dialogue, and thus relates the politics of midwifery to the broader political context of First Nations in Canada.

As the KOBP was struggling with issues of clinical placements, retention of students, understaffing, and mismanagement by UCN, the plan to expand to southern Manitoba highlighted the divisions between Aboriginal midwifery in the north and urban midwifery in the south. Darlene wrote a letter to the midwives of Manitoba and expressed her concern. She first pointed out that the origin of the KOBP, and its emphasis on training midwives who are from rural and remote communities in a culturally-sensitive way. This meant that the KOBP was "designed for Aboriginal students who are interested and willing to live, study and work in northern Canada" (01/12/09). Darlene also pointed out that on 30th March 2009, Manitoba Health issued the following press release:

> This programme will meet the needs of Aboriginal and northern students while benefiting northern residents and strengthening their home communities…. Over the next few years, additional training sites will be established in other northern communities by UCN. (Manitoba Health, 2009)

The establishment of a southern programme led to many questions. In her letter, Darlene asked:

> How is the goal of providing midwives for the north being addressed? Should the southern programme retain the name kanaci otinawawasowin, the vision statement, etc? How will the southern expansion affect relationships with northern communities? What will become of the current KOBP programme sites in The Pas and Norway House? (01/12/09)

Darlene also asked the other midwives:

> We need to ask ourselves honestly how many non-Aboriginal midwives who are educated in the south will choose to work in remote First Nation communities? The experience in Manitoba since the beginning of legislated practice is that very few midwives are willing to relocate to the north. Most positions in Norman and Burntwood RHAs are unfilled, filled by locum midwives or by new graduates from Ontario who soon move on to southern practices. The only non-urban northern midwifery practice is in Norway House. This experience is not unique to midwifery. It is the situation with nurses and physicians as well. The most sustainable solution is to educate people from these northern communities who are willing to stay and serve their communities. (01/12/09)

The risk of losing the KOBP in Norway House was urgent, and the inability of the midwives to function in their clinic within the federal hospital was directly tied to the decline of the programme.

In this situation, the tensions between northern and southern midwives in this scenario also emerged, and return to the notion of the "made-for-Manitoba midwife" (Kaufert and Robinson, 2004, p. 5). With so few midwives working in the north, and the number of unfilled positions for midwives, the made-for-Manitoba midwife becomes one that resides and works in the southern part of the province. In the next section, I delve further into these questions by delving into the policy realm of midwifery; in particular, the committees that were formed to address the issues of the KOBP and bringing birth back to NHCN.

11.7.   Summary

In this chapter, the social organisation of the Norway House Indian hospital was challenged by the introduction of midwifery services. It was shown that within the northern hospital setting, the established status quo in dealing with the risk of childbirth centred on the removal of women from the community. Douglas' observation that social and cultural systems serve "to maintain social order and the status quo and deal with deviance or divergence from accepted norms and social rules" is helpful in understanding the midwifery situation in NHCN (Lupton, 1999, p. 39). The presence of the midwives in the northern hospital was viewed by the health professionals and the FNIH Regional Office as diverging from the accepted norms and social rules regarding risk management of childbirth. In this way, the midwives were viewed as challenging these accepted norms, and thus, were regarded as deviant. In terms of authoritative knowledge, the midwives were also viewed as challenging the status quo of doctors and nurses biomedical knowledge regarding the risks of childbirth. The unfamiliarity with midwives, and their capacity to make decisions regarding the care of pregnant women was seen as threatening to the nurses and hospital administrator. The Medical Advisor's questioning of the ability of midwives to manage childbirth and as primary health care providers was also a response to the midwives' presence in the federal hospital. In this way, the midwives became the focus of the debate over childbirth in the community.

As mentioned in chapter 5, Douglas also emphasises the political use of risk in blaming particular actors for threatening a social group. She also points out that in the process of making decisions, and thereby creating risks, some risks become downplayed or ignored, while others are given prominence. In the next chapter, this will be explored in more detail. I wish to turn to the meeting room in order to better understand how risk is created and operationalised within the political setting.

12.   Risky states and risk to the state

This chapter focuses on the meeting room and the associated policy discussions surrounding place of birth and Aboriginal midwifery in Norway House. The role of the parties involved establishing and funding of the KOBP was outlined in the previous chapter, as well as those actors involved in prohibiting midwives from attending births and practicing within the federal hospital. I would like to return to the role of the state and in the reproductive practices of First Nations. The role of the FNIHB National Office and other parties signed on to the KOBP, advocating the return of birth back to Norway House seems counter-intuitive to notions of modernity that were outlined earlier in this thesis. The push of the state to medicalise and modernise First Nations into modern citizens appears incongruent with this attempt to return birthing practices to the community. In this chapter, I delve into the risks presented by state officials in the discourses surrounding birth in various settings. The modernist intentions are still present at the federal, regional, and local levels of the Canadian state. These intentions are seen mainly in the federal hospital staff and the FNIH Regional Office's insistence that the hospital was not equipped to deal with complications, and that doctors needed to be present for childbirth in the remote setting. However, a bit deeper exploration into the explanations for not wanting to have birth in Norway House reveals other risks: notions of accountability and responsibility overtake notions of risky mothers and risky midwives when examining how federal state actors characterise current childbirth practices in the community. The risk then becomes who is responsible for adequate health care delivery? What is at stake? What are the repercussions of allowing midwives to attend births on reserve? This chapter uncovers these questions in the context of Norway House and the Kinosao Sipi Midwifery Clinic, and looks at the broader implications of this dialogue to the relationship between First Nations and the Government of Canada.

12.1.   Objecting to birth and midwifery in Norway House

While the federal government, embodied by its staff in various settings, usually employs prescribed position statements, this certainly was not so in the case of childbirth in Norway House. In this chapter, I explore the various positions put forward by different federal actors within the negotiation of returning birth. These discussions reveal the disharmony between the various levels of the state, and also how personal beliefs and opinions enter into the official state discourses. It also reveals the complexities of the federal government, and how the official state becomes "both an illusionary as well as a set of concrete institutions; as both distant and impersonal ideas as well as localised and personified institutions; as both violent and destructive as well as benevolent and productive" (Hansen and Stepputat 2001).

The state's objections to birth in Norway House conflated the risks of childbirth and the risks of midwifery. At the outset, as outlined in the previous chapter, the perception of supporting a midwifery programme in the community was viewed very different from allowing birth, and therefore, some aspects of midwifery practice, to occur on the NHCN reserve. This lack of support came directly from the governing body of the federal hospital: the Regional Director and his Medical Advisor. The Medical Advisor did not believe that birth in a rural community attended by a midwife was safe. He expressed his opposition in terms of the lack of women's ability to have a "technocratic" birth in the hospital: access to appropriate technology, including C-sections, blood transfusions, and epidurals were reasons that elective birth in the community was deemed too risky, despite current guidelines in place by both the College of Midwives and the Society for Obstetricians and Gynaecologists, which specifically state that rural childbirth does not necessitate immediate access to these technologies.

The way in which the Medical Advisor and other medical staff presented their opposition to birth in Norway House—which was always in terms of access to technology—gave their arguments authority and credibility within both the policy and practice setting. The Medical Advisor related: "The ideal thing is to be thirty to sixty minutes away from a hospital that can do C-sections, that's the ideal thing" (23/03/10). A nurse from the federal hospital told me that another doctor working in the federal hospital said that the only way he would support birth in the community is if they had C-section capability in the hospital. Another doctor working for the RHA stated that he would be supportive of birth in Norway House only if there was a plane on the ground, 24 hours a day, ready to transport women to a tertiary hospital. The latter two cases are not possible: bad weather often delays or limits transportation out of the community, and the closest place with C-section capability is a three hour drive away. Lack of epidurals is also cited as a reason not to deliver in the community. As the hospital administrator commented:

> [It is] three hour, three and a half hour, trip over horrible roads to Thompson, so what are you going to do? I wish people understood that, and [that] they don't have the drugs on board either, so it's not a comfortable birth if you're giving birth here. I mean, I wouldn't want to [give birth here] either. (12/03/10)

The Medical Advisor, who once worked for emergency medical services, also had a negative view of community birth, but he acknowledges that his view may be tainted by the fact that he was only called to emergency situations:. He reflects:

> All the women in normal births just go through the system, you never even see them, so you do get a skewed perspective. But at the same time I think it is a useful perspective because you know what the bad things are that can happen that

you kind of have to plan for and I think some people if they're not familiar with that. (23/03/10)

After Frieda tried to have a homebirth in with the midwives, and after the KOBP was being lost down the jurisdictional abyss, Dawn was called in from the FNIHB National Office to help sort out the situation in Norway House. As she explained:

> I think … the [Medical Advisor] was giving personal opinions to our [FNIH] regional staff and [they were] taking that as policy. So our regional staff presented that as the reason not to do birthing. I mean we didn't have close Caesarean-section back up, we didn't have a physician on staff, all these things, none of these things are within any sort of guideline, none of the reasons our regional office was concerned, are validated in any research. And they were basing it on personal opinion. When push came to shove and they were questioned at the meeting in October, they had to say that they have no jurisdiction over midwives, and, in fact, they are supportive of midwifery because that's the official position. So our [national] office kind of got the boat out of the water. (25/11/09)

Dawn's retelling of the situation illustrates a disconnect between bodies of the federal government: whereas the national office was aware of accepted practices and guidelines on childbirth in rural and remote communities, the regional office was relying on misinformation from individual physicians that were unsupportive of birth in the community. When Dawn flew to Winnipeg to attend a meeting, she first went to the regional office. She said that they were so adamantly against birth in the community, and that their argument was so persuasive, that she was almost convinced that she was indeed mistaken, and that birth in rural and remote areas was, in fact, an unsafe practice. She said she walked across downtown Winnipeg to the Manitoba Health office and thought about how the work she had been doing at the federal level for the past decade was misguided and not evidence-based. She felt terrible. But then she arrived at the meeting, where everyone there confirmed that there was, indeed, no basis for the objections of the FNIH Regional Office to rural birth, and that in fact, she had been correct all along. (25/11/09)

At the local level, the hospital administrator was also not happy about midwifery being introduced into the hospital. From her perspective, there was no funding or protocols about how to work with midwives to support the hospital staff's cooperation. She explains:

> Yes, it was just a nightmare. We'd be on the phone and this lady was very, very French, and it was very difficult to understand and she was having trouble with what we were saying, and no money, and I've had no operating money. … Yeah, and I'm supposed to be you know, making this silk purse out of nothing like what do you expect of me, you know? But it's just getting ridiculous…. Yes, I suppose your theory it sounds good, but where? You know, we're stuck! We're stuck in

limbo! And then when I get annoyed, you hear, "oh you're going to do this programme" and [I ask], "where am I going to do that? There is no space. It's crazy. No space and no money to do it. (12/03/10)

Despite the fact that the midwife was hired and paid for by the BRHA, the perception of no federal funding for midwifery was seen as a major problem at the hospital. The hospital administrator goes on to explain that:

> How do you expect to make a programme … work with no dollars? That is silly. Nice you got all this lip service. And yes we support this, oh great. Show your support. Give some money and also take a look at the real issues. The underlying issues if you want to have a success. Don't just do it because you want it. Oh well, we tried and it didn't work out. Oh well. Which often times I've seen. I've been around long enough to see programmes sometimes they throw money at it. Oh well, it didn't work out. We tried. (12/03/10)

She also points the finger at the national office for pushing the midwifery programme forward:

> But I don't mean to say it in any other way because it's political. [It's a] wish for someone who wants to see this happen and wants to support it: well women and choices. That's great, but not at this time until you get the real issues resolved. Someone is pushing it … within the federal [government]. That's what I believe. Cause someone's pushing this very, very hard…. [But] we've been trying to say this over and over again. "Not now. We're in no shape. This is the not the community to pick, you know?" I think you need to face the reality. (12/03/10)

The perception of the dissonance in the federal government was not lost on their provincial counterparts. One Manitoba Health employee observes:

> At the national level they tend to hedge a bit more, but at the local level they are very clear that they're not [supportive of midwifery]. So then we have to decide how do midwives work with [FNIH Regional Office]. But, you know, we haven't let that stop putting a midwife into Norway House, just because FNIH's not hiring. We could say well then fine, we won't have a midwife in Norway House, but we haven't done that, we've funded it through the RHA, told the RHA it needs to be in Norway House, that was a provincial negotiation direction and wouldn't necessarily have been the RHA's first choice, but again addressing population health needs, so putting a midwife, finding a midwife to specifically be in Norway House, the province went ahead and did that. (17/03/10)

Insight into the role of the provincial government and their relationship to the RHA responsible for employing the midwife is also gleaned from in the above discussion. The directive from the province of Manitoba to the RHA to fund a midwifery position in Norway House was not particularly welcome. However, since the directive came from the province, they had to post the position there.

The Manitoba Health employee explains how the BRHA did not want to put the midwifery position in Norway House, just as the FNIH Regional Office did not want to implement midwifery in the federal hospital, but was essentially forced to by the FNIHB National Office. While these internal struggles in the government systems are cited as issues, the struggles between the federal and provincial governments is also blamed for the confusion surrounding midwifery in Norway House. One federal employee points to jurisdictional issues with the province as a source of problems for midwifery:

> The other thing that gets compounded in all this, particularly in Manitoba, [is that] the Manitoba government has a different impression of their role in First Nations than do other Provincial governments. In Manitoba you will often hear the Manitoba official[s] talk[ing] about people who live on reserve as federal people. "Those are federal lands, those are federal programmes, those are federal children," I find that really hard to listen to. You don't hear that in any other Province…. And so this issue of midwifery gets caught up in that. (25/11/09)

As demonstrated through this discussion, there are clearly tensions between all levels of the state in on the issue of bringing birth to Norway House; however, the struggles around midwifery are part of a larger matrix of relationships and power struggles at all levels of the state. One provincial employee somewhat bluntly explained the situation: "Between Manitoba Health and the RHA, it is a pissing contest. Between Manitoba Health and FNIH there are so many issues already, we are constantly fighting with them". According to Dawn, the issue

> …begins to then get tied up in bigger issues than midwifery because now you've got Burntwood, Norway House, and FNIHB who have got a litany of problems between the three of them, of which midwifery is but one more. So then it became really difficult to develop, and I don't know whether communications fractured relationships, or relationships were never formed. There were requests for meetings, meetings never happened, and then finally it came to a head and the Province called a meeting. (25/11/09)

The meeting in question formed two sub-committees: one was to address the clinical component of returning planned births to Norway House, called the Norway House Clinical Services Committee, and the second to address the KOBP. The sub-committee's terms of reference explained that the

> …the purpose of the Clinical Midwifery Services in Norway House Working Group is to achieve accessible and safe midwife-assisted birthing in Norway House. The group will identify solutions to real and perceived barriers to providing midwifery services in Norway House. A team approach is required to address issues such as

transportation, standards of care, human and facility resources, planned and available urgent care, and other clinical components. (06/10/09)

As the practice of maternal evacuation continued, the debate and discourse of risk and safety regarding place of birth and the case of Norway House began to escalate within the political and policy circles of all levels of governments and institutions.

12.2.   In the board room

In order to explore the policy realm further, I outline the meeting room of the Norway House Clinical Services Committee, and the complex power relations that existed within it. First, I describe the space and one of the discussions that took place; then, I outline how states and their interests become to be represented through the presence of certain individuals in the room.

12.2.1. Meeting of the Norway House Clinical Services Committee

"What kind of births are we talking about?" the voice on the speaker phone demanded. There is silence around the table. Another disembodied voice comes out of the speaker and answers, "They are all the same."

I am in a meeting of the Norway House Clinical Services Committee, a multi-agency group of 'stakeholders' that have come together to try and solve the 'problem' of midwifery in Norway House Cree Nation. There are representatives from the federal government, including the federal hospital in the community, the regional office, and the national office in Ottawa. There are representatives from the provincial governments, the regional health authorities, the College of Midwives, and the nursing and physician regulatory bodies. Half of the people are sitting around the big oval wood table, sitting in oversized leather desk chairs that are squished in around the perimeter. We all have notebooks or printed meeting agendas in front of us, pens poised, and some of us are sipping cold coffee out of Styrofoam cups. A man is quickly typing on his blackberry, and then proceeds to set it down and close his eyes. There is a big speaker phone, sitting spider-like in the centre of the table. Here is where the voices from the other half of the people who do not attend the meeting in person permeate the room. Some have called in from the North, some from Ottawa, others from a few blocks away, and even some from a few offices down the hall. Some of the voices dominate the call, others are silent the whole time, with the mute button pressed, in their own conversations with the group that nobody is meant to hear. I have attended the meetings in various ways, including sitting with just one person in their office, watching them scramble for the mute button so that they can talk back to the speaker without anyone hearing. Today, I am here in the room.

This is one of the places where decisions are made. This is where people can decide to provide health services, and take them away. This is where the levels of the "state" become embodied through the various representatives around the table. Being a "fed" versus "the province" versus the "region" versus the "community" prescribes the official position one is meant to embody although, personal opinion inevitably creeps into the conversation, and becomes a part of the process. In these board rooms, indigenous women are talked about and rarely seen. I find these meeting intense and the performance of the various levels of the state fascinating. But I also find it frustrating to watch: watching their inertia, their planning to decide next time, to do more "research", to make no real decisions, and on all sides of the various levels of the state, to commit to nothing but attending the next meeting for further discussion.

"What kind of births? How many? Will there be complications?" the voice demands again. It belongs to a doctor working for the federal government. It is a midwife who answers that all births are the same. Both are aware that their questions and answers have subtle commentary about the risks associated with childbirth that is not necessarily being spelled out in the meeting room. When the doctor demands to know what kind of birth it will be, his stance is that birth is unpredictable, and that complications can arise unexpectedly. In fact, later in an interview with me, he describes birth events as "not a normal, predictable curve, it's full of peaks and valleys and different stuff happens" (23/03/10). By demanding to know what kind of birth it will be, he is, in essence, saying that we can never really know, so the risk of a planned, elective birthing programme in Norway House is too great to be acceptable. By answering that all births are the same, the midwife on the line is fully aware that some births are considered higher risk than others, however, by stating that "all birth is the same", she is also acknowledging that risks are present at any given time. However, from her perspective, understanding and knowing that risks are present and using the mechanisms in place, for example, the midwifery protocols set out by the College of Midwives, is seen as mitigating the risks adequately to make them acceptable. So before me there are two very different versions of the risks of childbirth, how to best mitigate these risks, and what is deemed 'acceptable'.

Two main themes emerged from these meetings. First was the persistent lack of knowledge about midwifery from the various actors around the table. Second, was a focus on the need for a doctor to be present at birth in Norway House. These two objections to midwifery practice in the north served to stall the process of moving forward with midwifery and birth in the community. As stated above, objections to midwifery were often couched in terms of reliance on technology to mitigate risks of childbirth complications. In this instance, however, while those objections

remained in place, objections to midwifery came through a lack of understanding of midwifery in the policy setting.

The lack of knowledge of midwifery through the work of the committee was apparent at many levels, including the legal. Darlene observes:

> Once they [the FNIH lawyers] got together it was so elementary, asking questions like, "Do midwives have insurance?" Never mind trying to figure out how to work with a RHA employee, they were still at the point of trying to approve midwives as professionals. This has been done already. We have standards. We are autonomous. We have a College. That was done a long time ago. They were way back at that point of trying to figure out if midwives were okay or not. (12/03/2010)

During one of the meetings, one of the provincial employees suggested that perhaps the midwives could come back with their standards of practice to show to the group. Afterwards, one of the federal doctors vented his frustrations:

> One of the things that the province wanted to do, I got very frustrated because [she] … I don't know her, I don't dislike her, nor do I like her, I don't know her— but she's a player that I see on this. She had suggested that Darlene go over the protocols for midwifery and I thought to myself, I thought, 'how stupid .... how stupid is that, you've been on this issue for five years and you don't know the protocols? Everybody who's involved, you don't know the protocols? Then clearly you've not done your homework and why are you on this committee? Why are you going back five years? It's not going to do anything. If you don't know what a midwife does, and can and can't do, then why are you on this committee?' And that's what I asked the Province, I said that is bullshit…. I am not going through that. Go home tonight, and go on Google, find midwifery, and do your own investigation. Because I'm not going to do that … and so that's what I told them, it's not going to happen, not going to happen. (21/10/10)

The level of knowledge of midwifery from the various state actors was clearly an issue, and comes into play when the actors agreed to meet and discuss midwifery implementation in Norway House. Resultantly, movement towards resolving these issues is stalled, and frustration is raised amongst group members. As one midwife comments: "it is like the group has amnesia. We go through the same thing over and over again at each meeting." (11/03/10) The lack of progress in resolving the issue is also related to what one doctor terms as "system inertia". He explains:

> Number one it's in inertia, it's an organisation, the system's inertia about Norway House, and I think that the Province of Manitoba, it is the government, it is Norway House itself, it is NMU, it is the docs, it is all those involved having inertia. (21/10/10)

Along with this, the perception by some of the federal staff that midwives were "non, or less, medical, and are focused on the uncomplicated deliveries, and if they run into trouble it's kind of passed along the system" (23/03/10). The Medical Advisor explained:

> "My understanding has always been you would have the midwives but then you would have a doc who has some experience who can provide some back up if something goes wrong, what if the baby is born and they're not breathing. If there is somebody there who can incubate and ventilate them often they'll survive, but if someone doesn't know how to do that then they die. (23/03/10)

However, there was disagreement about these risks at the federal level. Another doctor explained:

> So there had been an environment in FNIH and in Norway House and in all the players who relied on [name of doctor], who made an assumption and they all hung their whatever on it—the assumption that midwifery requires a physician to be in attendance. And so I think the block for midwifery was the fact that people got hung up on that and that a dialogue and a discourse with all the players involved said that if we don't get physicians into Norway House you can't have midwifery. And in my small, small little analysis and on site and my interviews, that was completely wrong. (21/10/10)

The presence or absence of doctors attending births was a part of the political process of delivering health care in the community. In order to understand the connection to doctor attendance, I now go back to the federal government's dialogue on how births are currently handled in the federal hospital. Going back to how women evade evacuation and the handling of birth in these situations highlights the lack of safe practices currently occurring in the federal hospital. From this discussion, it is demonstrated how the issue becomes much broader than childbirth in Norway House, and encompasses issues of responsibility and accountability in relation to the Canadian state and First Nations.

12.3.   A place of safe and unsafe birth

There is no "elective birthing programme" at the Norway House Indian Hospital, but inevitably, women present themselves at the hospital in active labour, and if they do not meet the criteria for transportation, they give birth in a small room, attended by the nurses on shift. This will be discussed in more detail below. The room has a bed in the middle, with metal stirrups attached on each side, waiting for women's legs to be strapped on to give birth in the supine position. There are neo-natal resuscitation protocol (NPR) guidelines taped onto the wall. When the midwife Darlene showed me this room, she casually mentioned how someone should really change that poster, because the guidelines were out of date. My first impression of this room is that it is cold and

sterile, with tiled green walls and the buzz of the fluorescent lights flickering above us. If you were to go back to the nursing desk and follow that hallway to the end, you would find the door to the Kinosao Sipi Midwifery Clinic. Inside, you would find a large room, with a low, circular table. Around it sit two, worn comfortable chairs. There is a large window looking out to the trees surrounding the building. In one corner is a traditional examination table, covered with the standard white paper. In the other corner, there is a single bed covered in a patchwork quilt. Along one wall is a row of cabinets and a desk with a computer. On the counters there are medical supplies you might find in any ordinary examination room. There are also jars on the counter, filled with dried herbs, such as rosehips, that one of the midwives had picked and dried the summer before. There are posters on the wall of drawings depicting indigenous women and their families, with sentences like, "I love to hear my mother's voice", "My mother takes me for walks before I am born", "I feel loved and wanted by my whole family", and "Breastfeeding: the natural and traditional way given from the Creator for the Children of the Earth". Inside this room, just down the hall from the other, women are not allowed to give birth, according to the "owners" of the hospital, the federal government. The risk of delivery by a midwife in the federal hospital is deemed too risky to be acceptable. Since the rooms are located only feet from each other, this does not seem to make much sense. In order to understand this, it is important to look at what the arguments are for not allowing birth to take place in the midwifery clinic, and then pose these arguments against what is currently happening in the "room down the hall" when a women comes in to deliver at the hospital. In these descriptions, shifts dramatically from one focused on women's bodies, babies, and knowledge of midwives, to risk of responsibility, acceptable standards, and, ultimately, potential litigation against the state.

Despite the regularity of unplanned births in the hospital, the federal government maintains that it is not responsible for it, and when the midwifery clinic opened, there were very specific notions, including C-section capability and blood transfusions, of what would be acceptable if planned births were to occur. The issue with midwifery was not that birth was going to occur in the hospital, since birth is always occurring there, but rather it was that planned birth was going to take place. This signals a shift from trying to the state's preoccupation with regulating 'non-compliant' women to the state's responsibility to provide an acceptable standard of primary health care.

In order to ensure so-called quality of health care, federal protocols and medical bylaws are in place for a health service delivery facility on the Norway House reserve. The protocols and bylaws ensure that the nurses and doctors in the hospital are not liable for specific actions if they are following the rules set out for specific instances in the health care setting. However, because the Norway House hospital does not "do deliveries", there are no protocols or bylaws to guide medical

staff through these circumstances. One of the reasons for the lack of direction is that the doctors and medical staff are managed by the NMU, who are provincially funded, but their transportation costs are paid by the federal government. Thus, there is a lack of clarity regarding is responsibility for the functioning of the hospital. Consequently, there is a lack of protocols surrounding birth and a lack of a basic call schedule, both of which are considered essential in providing quality services. As a federal doctor explains:

> …there are certain professional standards and there's like a code, and this is the bylaws, right, so the medical staff decide what's reasonable…. So it's the medical staff bylaws, it's the call schedule … who do you call in the event of a delivery, well [the] nurses should have a call schedule that says on this day who's on call and who you call first but they don't because the Northern Medical Unit doesn't make one up for us…. So we often don't know if there's going to be even a doctor or not. (23/03/10)

The hospital administrator adds to this:

> Policies haven't been written in one hundred years here. None of our staff has been updated so why would you? So there's no need to update now, just keep the status quo as I was told. Well there is some of the stuff from 1980. It's outdated and different [standards] apply. (12/03/10)

This adds yet another layer to how the federal government is currently running the hospital. The administrator is acknowledging that the policies of the hospital are not up to date, or up to the current standards of care that is received in Canada. However, she has been told by her superiors to maintain the "status quo"; according to her, this situation means that there is a "lack of quality of health care in this community…. There is no time and for follow up and the continuum of care that needs to happen…. It's a reaction to everything now we're in a crisis mode all the time." (12/03/10) Another federal nurse explains:

> The management structure at First Nations and Inuit Health is entirely, entirely crisis-oriented, clinical oriented, there's very little policy work, very little partnerships that are in place to deal with these kind of issues. Management structure is supposed to be supporting you in the field but doesn't. So that is where the problem lies in that the health care and the structure that exists right now is so crisis-oriented that it fails to deal with a lot of the issues. The policy issues that are there and have been there for a long time and things just don't move when you are in crisis mode. (17/12/10)

In terms of birth in the community, this means that if a women presents in the hospital in labour (a monthly occurrence), the stance of the hospital in terms of standards may be called into question. As the federal doctor relates,

That's the whole thing if you're doing it as an elective programme, there's certain standards that you need and if it's an emergency you do the best you can, you know, so the people in that hospital don't expect to do deliveries, they do the best they can.
(23/03/10)

This lack of standards of care, as well as the tensions between the medical staff and the various organisations can be seen in the description of one birth that occurred in the community. The doctor explains:

…You know the baby got some narcotics and they shouldn't have, the forms weren't filled out properly, anyway, just stuff like that…. If you're running a programme, the approach you want to have is like a quality improvement approach which means: let's sit down, let's look at this, let's look at what happened and let's try and do better next time. But if people are going to come in and say you did that wrong, you did that wrong, you did that wrong, especially if it's [the regional health authority] coming in and criticising us, you know my feeling would be more, "Well I don't want to do any more of these [births] then or you guys can do it!" And that birth too, anyway, they said the woman should not have got a shot of Demerol. Well it was the NMU [provincial] doc that gave the shot of Demerol and again [they] don't take any responsibility for the NMU docs or their activities and when you look at it, the woman was four centimetres, and then four hours later she was six centimetres, so they gave her a shot of Demerol. Forty minutes later she's pushing because she's fully dilated, you know, that's obstetrics, right, that's just what happens. (23/03/10)

The other issue that comes up when talking about births in the community is that the doctor at the hospital will often not come in to attend to the women in labour, leaving the nurses, who are sometimes inexperienced with labour and delivery, to deal with the birth situation. As the hospital administrator explains:

The doctor, we only have one doctor, the resident doctor here he, two weeks ago, there was a lady giving birth. It was, I believe, her fifth baby and the placenta wouldn't discharge. He would not come. He would not help for anything and so we have this extended role of nurse, the nurse on the phone with Winnipeg trying to figure out what to do for her [the mother]. The baby came out fine but the placenta's stuck so now what do we do you do? It's a real case to bleed out and those are some of the things you know. He [the doctor] won't come. We're phoning. Please, please come to help things. "No! No! It's not my case." Well maybe it's not your case but hopefully [you will] get up here anyway! We don't care. Like this isn't a time to be silly about things, but he won't come. Never did go. It wasn't his case. It wasn't on file. So he's busy doing other things. (12/03/10)

The federal doctor also comments on this situation by stating, "The last delivery they had at the hospital, the doctor, who's the only doctor there, and I don't blame him, he didn't want to be involved in it." (12/03/10) Even though the doctor refused to attend the delivery, the lack of physicians in the hospital was clearly a problem that needed to be addressed. And in terms of standards of care, the administrator explains that:

> The doctor we have right here now is on a conditional license. He's failed his doctor [exam], his license … five times now. The other doctor that comes in half time to fill in, he's the same, in the same boat [and] that's why he can only practice um two weeks a month. We don't have qualified [doctors]. We do have some aspects [of quality care] and in other aspects no, you've got a doctor responsible for a community of 6,000 people and he hasn't passed his exams. (12/03/10)

In addition to the doctor refusing to come to a delivery, the hospital likewise refuses to call the provincially-funded midwife who lives in the community and works down the hall. The explanation for this lack of inclusion of the midwife into the "emergency care" of a woman in labour is that she is not federally funded, or recognised in any of the policies of the federal government. From these explanations of what happens if a women presents in labour at the federal hospital, it is clear that the system works in "crisis-mode" and depends on working in that mode in order to absolve them from any responsibility to achieve a minimum standard of care in their facility. By simply, "doing the best they can" because they are not supposed to be responsible for birth, the arguments they put forward for not having a midwifery programme quickly breaks down, since they themselves are engaged in a much, by their own admission, "riskier" way of managing labour and delivery in a remote setting.

In the Norway House Clinical Services Committee, the opposition to an elective, midwifery-led birthing programme at the federal hospital focused on issues of "safety" in terms of access to technologies, as well as the ability of the hospital to meet these standards (and thus avoid possible litigation in the process). However, by looking at the current birthing practices in the community, issues of liability seem to be more plausible then if safety measures were set into place. (12/03/10) The focus on liability is a recurring theme in obstetrics, although according to Enkin (1994), the "exaggerated medical response to the perceived threat of a lawsuit can be counterproductive.... It should not be forgotten that the commonest cause of malpractice litigation is bad practice" (p. 213).

This represents a shift from the discussion about birth and access to technology, and moves towards a discussion of the state's ability to provide adequate care for women in their facilities. The argument of the doctors and nurses on what is an accepted risk becomes one about the risk of the state and not the risk to women in childbirth. A technocratic view of birth becomes the dialogue in

which these risks to the state are covered, leaving the focus on the "non-compliance" of women, their evacuation from their communities, possible complications of birth, and questioning the skills and knowledge of midwives, in a setting where the "acceptable" standard of care is no standard at all.

12.4   Summary

In this chapter, the risks of childbirth in a remote setting and midwives' knowledge were challenged by the federal hospital staff and the FNIH Regional Office. These risks were presented as objective risks by these actors using epidemiological data and doctor's expert knowledge. Around the meeting table, the network of heterogeneous actors came together to openly debate the issue of midwifery in Norway House. Like evacuation, these meetings were one strategy of the various levels of government to maintain regulatory power over birth place.   Where this group diverged from the governmentality defined in the evacuation process is that they were dealing with a divergent form of knowledge and alternative interventions into the birthing practices of the identified high risk population. The maintenance of control over this deviance was seen in a number of ways. These included the committee's insistence on naming who should be present at birth (e.g. insistence that a doctor is present) and the continued lack of knowledge about midwifery and midwifery scope of practice. When looking deeper into the current practices in the Norway House Indian hospital, the risky practices that were occurring around childbirth in the hospital brought to light other risks to the state in the return of childbirth. These risks had to do with the risk of the federal government admitting responsibility to providing adequate standards of health care in the community, and thus fulfilling their Constitutional duty to First Nations. In this way, the body became the symbol used by the state to maintain control over the lack of services provided in the community. In this chapter, the risks of place of birth shift direction, and in turn, provide insight into the broader issues of the relationship between the Canadian state and First Nations.

13.   Conclusion

This thesis has brought together birth place and Aboriginal midwifery in the context of current reproductive practices in Manitoba, Canada. Using multi-sited ethnography, the issue of maternal evacuation was explored from multiple angles in multiple places. Within these settings, negotiating and managing risk emerged as the central foci of all of the actors involved in the process of both evacuation and the return of birth to a First Nation community. How risk was defined and by whom was questioned throughout the study and the consequences of these risk management practices were explored. To conclude, I will highlight the contributions to broader themes in anthropology, including theoretical, methodological and applied contributions.

13.1.   Reproduction, risk, and the state

This thesis clearly sits at the intersection of scholarship on risk and reproduction. Renewed and growing scholarship on the concept of risk in reproduction has recently emerged within the anthropology of reproduction. (see Fordyce and Maraesa, 2012) This thesis contributes to the development of this field in a number of ways. Rather than confining understandings of risk to objective and expert knowledges, the ethnography revealed the messiness of the concept of risk, and how evacuated women's bodies and the bodies of midwives become the sites in which decisions regarding the acceptability of risk occur. Therefore, in the context of maternal evacuation, it is not only the bodies of women that are moved from site to site, but risk also circulates and changes in the movement between different spaces and places for childbirth.

The thesis also brought into focus how the state uses risk as a tool for the management of current maternity care practices, and as an explanation for the resistance to changing these current practices. The evacuation of women for the perinatal period is at the surface an overt form of risk management that centres on a technocratic approach to childbirth. However, the multi-vocal and complex negotiation of risk at the state level emerged in the ethnography and extended itself into discussions of the jurisdictional responsibility to provide adequate health care services. By focusing on the multiple forms of risk cited by state officials, the resistance of the Canadian state to provide these services was revealed. In this way, the thesis broadens its discussion beyond birth place and midwifery, and touches on wider notions of responsibility and accountability in the relationship between the Canadian state and its indigenous population.

Drawing further into the relationship of the Canadian state and indigenous peoples, this thesis also brings childbirth into discussions surrounding the defining of indigenous peoples, the state project of modernising bodies and the land, and the rights of indigenous peoples. Understanding

the potential for indigenous people to become a risk to the state in terms of resource development and access to land sheds light on the persistent intervention of the Canadian state into the reproductive lives of First Nations. Being a registered Indian has direct implications for the Canadian government through its constitutional responsibility to provide for these populations and the associated rights that come with being identified as a Registered Indian. This process of identification also has direct impact on how women and their families experience maternal evacuation through differential access to funding and decision making regarding the most appropriate and cost effective way of providing maternity care.

The thesis also explored risk in terms of space, place and landscape. The importance of place of birth was explored in multiple ways and four main spaces of childbirth were identified. The first was birth as ceremony, and by using the image of carrying water, elder women and Aboriginal midwives connected the experience of being pregnant with the on-going engagement with the indigenous landscape. This exploration was simultaneously individual and collective, tangible and symbolic, and spoke to mitigating risk for not only future generations of indigenous peoples, but the future of the global population as well. The second form of space identified was the dislocated space of maternal evacuation. The circulation of women into and out of multiple dislocated spaces became a way in which we can understand how risk shifts depending upon the social organisation and networks of the various places in which evacuation occurs. The permeability, or unboundedness, of these places became apparent as we followed the path of the evacuated women. The hospital was simultaneously portrayed by various actors as a bounded space where exclusive knowledge and practices occurred, yet at the same time, the ethnography revealed how the women's experiences in the hospital were constructed in part by the broader network of actors involved in maternal evacuation. The third space that was explored was the relocation of birth to NHCN. The shift from birthing in the urban south to the remote north marked both physical and ideological shifts in the practice of childbirth. The complexities of starting a midwifery practice on a federal reserve were revealed, and how the state inhibited her practice was shown in the everyday practice of the federal hospital, as well as the prohibition of her birth attendance. From the fallout of this practice, the decisions regarding the risks of midwife-attended births in Norway House moved to the policy setting. From here, the risks of women and midwives were consistently brought forward as reasons not to allow the midwifery practice to function. However, when looking closer at the current practice of attending births in the federal hospital, the responsibility for birth, and the consequences of having to provide adequate care became the focus of the objection. Thus the landscape of childbirth becomes an interaction between the foreground of evacuating women, barriers to midwifery practice in Norway House, and the continuance of the disconnection between home

places and birth places. Yet, the background of the landscape of childbirth is made up of a renewal of ceremonial practices, the potential of birth in the First Nation community, and the potential of the Canadian state to recognise and fulfil its constitutional duty to indigenous peoples. Aboriginal midwives are a pivotal link in the interaction between these background and foreground realities and potentialities. As Carol stated, "we need to have a postcolonial vision of what our families could be." Aboriginal midwives, through their knowledge of birth and their role in the health care system as autonomous care providers articulated this vision.

13.2.   Developing a multi-sited, postcolonial methodology

The methods employed in the thesis are multi-sited. Following childbirth across geographic and social spaces allowed for a deeper understanding of the process of evacuation, and the connections and disconnections between the various spaces and actors. However, this method was also chosen for another set of reasons. Starting from my own position as a First Nations anthropologist, my interest was not only in the experience of mothers and their families when experiencing dislocation for birth, but also the broader structural implications that fueled this practice. My interest in indigenous rights and the duties of the Crown to First Nations also guided this undertaking. In following this multi-sited method, the state ceased to be a monolithic, oppressive institution, rather, the struggles of the state actors to follow policy directives, implement programs in the health centres, and regulate their own practices as health care providers all came together in the issue of childbirth. By shifting focus between the families experiencing evacuation, the state officials, and the health care professionals, a greater understanding of the complexities of the practice of evacuation emerged.

The account of my ethics approval process also highlighted the political aspects of conducting research with First Nations in Canada. By recognising the implicit and explicit political aspects of the research process, the tensions between First Nations organisations, the systems of health care and academic institutions become clear. Rather than glossing over these political manoeuverings, these served as points of analysis and ways of thinking about the topic. Multi-sited ethnography allowed me to engage with these politics of these spaces, especially in the permissions to gain entry to them.

The groundwork for this thesis was also laid far in advance of the actual undertaking of it. My position as a research policy analyst and the opportunity I had to engage with Aboriginal midwives and conduct research on this topic in the policy setting was invaluable to this work. I continually actively engaged with the midwives on the possible directions of my dissertation topic before I began the degree. For my purposes, this engagement was critical in positioning my research as a

postcolonial, and indigenous research project. While remaining actively engaged on theoretical and methodological levels, it was also important that this work speaks to health policy and current maternity care practices in Canada.

13.3.   Implications for Health Policy and Practice

The policy and practice of maternal evacuation was analysed from various angles throughout this thesis. The study points to the unsafe practices involved in the current practice of evacuation, including the impact on the social isolation of women for labour and delivery. Conversely, it also explores the experience of health professionals and women when childbirth happens in the rural and remote areas without the necessary obstetrical care, including midwifery. This analysis of the policy and practice of evacuation and repatriation shows that multiple forms of risk and present and acted upon in different ways in the various settings. By focusing on the management of women throughout the process, the ethnography showed how other risks that are being managed are ignored. This leads to even riskier practice when dealing with rural and remote birth in First Nations communities. This thesis points to the need for a critical re-examination of how risk is understood and managed within the process of evacuation, as well as in the process of repatriating birth back to communities.

In this thesis, I also have introduced the concept of postcolonial midwifery. Postcolonial midwives, in the context of this thesis, were midwives working within the health care system in Aboriginal communities. Their presence and work as primary care providers for pregnant women and their babies in the community were in direct conversation with broader issues between the state and communities. The concept of postcolonial midwifery is an important one in the development and support of midwifery practice in Canada. Midwifery, in its current forms of regulated practices across Canada, is still relatively a newly recognised health profession. By understanding the challenges of access for First Nations people, and the barriers to practice in First Nations communities, the opportunity to incorporate understandings of postcolonial midwifery into the growing profession is important. The ethnography focused on the implementation of the Kinosao Sipi midwifery clinic in Norway House in order to understand the challenges of postcolonial midwifery in First Nation communities. Adding to the literature surrounding maternal evacuation and midwifery in Canada, this thesis also presented a unique moment in the history of midwifery in Canada. This experience of midwifery implementation will contribute to future planning for midwifery care for First Nation communities in Canada and beyond by pointing to the fundamental aspects of delivering health services, negotiating risk, and providing adequate care for mothers and families at the time of birth.

13.4. Summary

Maternal evacuation and repatriating birth follows childbirth through various spaces. This ethnography linked these various spaces of childbirth through the intersections of risk and responsibility, and power/knowledge. Through these spaces, 'risky bodies', both of pregnant women and of midwives, became the focal point for negotiating these intersections. Locating bodies in the in-between spaces of evacuation became a preoccupation of the state in the management of evacuation. At the practitioner level, acting upon bodies, through medical procedures such as induction and suturing, become the site of managing multiple risks, including the social or relational risks of evacuation. At the population level, the categorisation of Aboriginal bodies as 'high risk' also serves to justify current practices. However, in addition to bodies being sites of risk management, the ethnography speaks to the broader social and relational implications of reproduction. Through this focus on the perinatal period, the ethnography shows how the actors involved in these processes "imagine and enable the creation of the next generation" (Ginsburg and Rapp, 1995, p. 1). Potential futures become articulated in the process of evacuation and returning birth. As Darlene commented, "I have grandchildren now, and now I see how life goes on through your children and into your grandchildren, and that continuity. So now when I see a baby, I see a future." Childbirth then becomes a place where multiple futures are negotiated: the relationship of the Canadian state to indigenous populations, the relationship of the people to the land they inhabit, the role of postcolonial midwives working in First Nation communities, and the intimacy of having babies and growing families and relationships. As one mother remarked, "Family is important to me and we are going to keep making it bigger and bigger."

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