CONTINUITY AND CHANGE IN WEMINDJI CREE CHILDBIRTH EXPERIENCES AND PRACTICES: PAST AND PRESENT

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ABSTRACT

In this dissertation I explore Wemindji Cree childbirth knowledge and practices since around the beginning of the 20th century until this day, largely based on Wemindji Cree people's memories, stories and experiences. I analyze continuity and change in Cree childbirth following the chronological order of events during the medicalization process in the 20th century that resulted in Cree childbirth transfer from the bush to the local nursing station in the 1970s, and eventually to southern hospitals in the 1980s. I investigate and analyze how the Cree experienced new birthing environments and adapted to them, influenced and modified them.

An important part of the thesis is dedicated to exploring Cree compliance with the childbirth evacuation policy. I argue that this was an adaptive strategy in the form of *superficial compliance* (Kenny 1985), and thus a form of survival and resistance under the given colonialist policies. I employ Inuit concept of *ilira,* a particular kind of fear, born out of an authoritarian and unpredictable environment, and Foucault's model of panopticism to explain and clarify the reasons Cree engaged in superficial compliance tactics. Further, based on writings of Fanon, Coulthard and a case study in Wemindji, I show how superficial compliance can become normalized, automated and internalized, and that eventually, after realization of unjust realities, can evolve into resurgence movements that include demands for respect, truth and justice.

I argue that s*ociality, flexibility*, *reciprocity* and *self-reliance* are the essential continuous traits in Cree childbirth that helped Cree mothers and their families to cope with the challenges of the medicalization of birth, including evacuations, long waiting periods away from home and technocratic care. Cree families managed to create spontaneous temporary communities and support networks away from home for their mothers that created as much as possible *culturally safe* spaces around the mother, generating a supportive environment. By bringing family and community to births and getting hospital personnel to accept their presence, the Cree found ways to partly *indigenize* technocratic birth, and that is how they were able to cope with birth away from home for many years, before bringing it back to their communities in 2019.

Dans cette thèse, nous explorons les savoirs et les pratiques cris relatifs à l'accouchement, à partir du début du XXe siècle jusqu'à aujourd'hui, en nous basant principalement sur les souvenirs, les récits, et les expériences des Cris de Wemindji. Nous analysons la continuité et le changement dans le domaine des accouchements chez les Cris en suivant l'ordre chronologique des événements en lien avec les processus de médicalisation au cours du XXe siècle qui ont eu l'effet de diriger les accouchements cris de la vie en forêt aux postes d'infirmerie dans les années 1970, puis dans les hôpitaux du sud dans les années 1980. Nous investiguons et analysons les façons dont les Cris ont vécu ces nouveaux environnements d'accouchement, comment ils s'y sont adaptés, et comment ils les ont influencés et modifiés.

Une part importante de cette thèse est dédiée au conformisme des Cris envers la politique d'évacuation des accouchements. Nous avançons qu'il s'agissait là d'une stratégie adaptative du type « conformisme superficiel » (Kenny 1985), et donc une forme de survie et de résistance face aux politiques colonialistes de l'époque. Nous employons le concept inuit *ilira*, une forme particulière de peur issue d'un environnement autoritaire et imprévisible, ainsi que le modèle panoptique de Foucault afin d'expliquer et de clarifier les raisons pour lesquelles les Cris se sont engagés dans ces tactiques de conformisme superficiel. De plus, en nous basant sur les écrits de Fanon, de Coulthard, ainsi qu'une étude de cas à Wemindji, nous démontrons comment le conformisme superficiel peut devenir normalisé, automatique et internalisé, et qu'éventuellement, lorsque d'injustes réalités émergent, ce conformisme est en mesure d'évoluer vers un mouvement de résurgence qui amène avec lui des demandes de respect, de vérité, et de justice.

Nous proposons que *socialement*, la flexibilité, la réciprocité, et l'autonomie sont les traits constants essentiels aux accouchements cris qui ont permis les mères cries et leurs familles de faire face aux défis de la médicalisation des accouchements, des soins technocratiques, des évacuations, et des longues périodes d'attente loin de leur foyer. Les familles cries ont créé des communautés spontanées et temporaires, ainsi que des réseaux de soutien pour leurs mères qui étaient loin de leur maison, produisant ainsi autour de ces dernières des espaces *culturellement sécuritaires*, ainsi que des environnements solidaires. En invitant la famille et la communauté aux accouchements, et en amenant le personnel des hôpitaux à accepter leur présence, les Cris ont trouvé des moyens d'*autochtoniser* les accouchements technocratiques, et c'est ainsi qu'ils furent en mesure de faire face aux

naissances hors de leurs foyers pendant tant d'années, avant de ramener ces pratiques dans leurs communautés en 2019.

GEOGRAPHICAL LOCATIONS MENTIONED IN THE THESIS:

- Wemindji – Cree town approximately 1320 km north of Montreal in Quebec, eastern James Bay.
- Paint Hills – earlier name of Wemindji.
- Old Factory Bay – a bay with groups of islands near Wemindji that Cree used and are using for fishing and spring/summer goose hunting.
- Chisasibi – Cree town 243km north of Wemindji by road, eastern James Bay, Quebec.
- Fort George – earlier name of Chisasibi.
- Eastmain – Cree town 375 km south of Wemindji by road, eastern James Bay, Quebec.
- Nunavik – Inuit territory, the northernmost region of Quebec province about 260 km north of Wemindji by air.
- Val d'Or – French speaking town in northern Quebec, approx. 855 km by road south from Wemindji. Currently most pregnant women are evacuated to Val d'Or hospital.
- Moose Factory – Cree town on the southwest side of James Bay in Ontario. Formerly, most pregnant women from Wemindji were evacuated to Moose Factory hospital.

Figure 1. Map of the principal locations mentioned in the thesis.

CREE VOCABULARY USED IN THE THESIS[1]:

Awaash uti ishkwaashimunsh – baby's pillow (the placenta)

Awaash – baby

Iiyiyuuschii – the traditional territory and homeland of the Cree of northern Quebec

Iiyiyuu – people in Cree, this is how Cree refer to themselves

Ishkwaashimunsh – placenta

Iskwaau kaa uutinaat awaash – woman who attends birth (midwife) (literal translation – woman that delivers baby)

Napaau kaa uutinaat awaash – man who attends birth (midwife) (literal translation – man that delivers baby)

Kaahiipiwit – a thread to tie the umbilical cord (or to make nets)

Miichiwaahp – teepee

Miisiiwaapui – castor oil

Miyupimaatisiiun – being alive well (healthy)

Uuchimmauch – tallymen

Utispikun – amniotic sac

Suuhkw! – push! (during birth)

Waaspisuuyaan – Cree bunting bag/moss bag for the baby

ABBREVIATIONS

CBHSSJB - Cree Board of Health and Social Services of James Bay

CHR - Community Health Representative

CPS – Cree Patient Services

IRB Advisor – the Institutional Review Board

MSDC – Multiservice Day Center

MSSS – Ministry of Health and Social Services in Quebec

SERC – Surveillance, evaluation, research, communication team (Public Health sector at CBHSSJB)

WHO – World Health Organization

UN – United Nations

[1] Frances Visitor has kindly helped with the spelling of Cree words.

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CHAPTER ONE: INTRODUCTION

1. 1 Longing and pride

Sophia, a Cree Elder from Wemindji, remembers how she, with her mother, almost delivered a baby in the 1960s, in the bush.[2] She describes in detail how together with her mother, a Cree midwife, she prepared the teepee for birth – brought in the firewood and water, layered the moss bedding, and took out the white cotton thread for the umbilical cord. The birth did not happen. Probably it was a false labour, Sophia says, 'I think because she was cleaning beaver, and sometimes it's hard, especially on your lower back when pregnant.' Sophia thinks that the baby probably moved and was pressing down hard but was still not ready to be born. The baby was born later in Moose Factory at a different camp, and Sophia was not present then. When at the end of the interview I ask her if she had anything to add to all we had talked about, she says she wished she had seen the birth and delivered with her mom that one time: 'There's one thing I've missed it's… I've been there! I could have seen it! I wasn't scared or anything, I was interested in doing it' (Sophia, Elder 2014). What was then viewed to be an ordinary life event, today Sophia remembers as one special missed opportunity that will never come again.

Among the Cree with whom I work, I note a certain longing and sentiment attached to birth in the bush. Not only do people wish to deliver or to see birth on the land, but also they wish they had been born on the land. Elizabeth remembers asking her mother why she did not deliver her in the bush. Instead, in heavy labour, her mother left the bush to go to deliver in the clinic in town. Elizabeth adds: "Cause both of my grandmothers were there,[3] and I told her, 'You were already having contractions, why didn't you stay?...' Elizabeth thinks aloud: (…) people had already been going out… and I'm the 5th child, so they were, I think they were already in the mind-set of having children there… But I had to ask this question 'Why didn't you stay at the camp and wait for my birth?!' (Elizabeth Shashaweskum, young mother, CHR[4])

There's a pride in being born on the land. When people would learn that I wanted to talk about childbirth, the first thing I'd often hear was, "I was born in the bush!" and the conversation would flow—as happened when I met Sammy Blackned on the way to the

[2] http://hemisphericinstitute.org/hemi/en/enc14-5-minute-manifestos/item/2606-enc14-5min-kulchyski%20and/or%20https://www.questia.com/library/journal/1P3-11079721/bush-culture-for-a-bush-country-an-unfinished-manifesto

[3] Both of her grandmothers were experienced midwives.

[4] CHR – Community Health Representative – a mediator between the medical staff and community members at the Wemindji clinic.

community store.[5] We sat in the hall near the entrance, and he continued. He said he was born in 1973, and that probably he was from the last generation of babies born in the bush. His mother and all the women who participated at his birth, except his aunt, had since passed away. I asked him about the women who helped his mom. He said they were his grandmother and several of his aunties. Men were not allowed then, he said, because they were not allowed to see anything down from the waist of another women. "I was born in the afternoon, men were waiting outside the teepee and came in when they were invited to see me." Sammy said that most women at the time knew how to deliver babies because people were spread out widely on the land. Everybody had to know what to do if a baby comes. Even some men might have known how to do it—they must have known, he concluded.

There is also nostalgia attached to birth in the bush. And it is not only the act of birth that creates longing[6] (Stevenson 2014:137) – it is the whole experience of a place and life on the land, with all its challenges and its blessings, where Cree were miyupimaatisiiun ('being alive well') (Adelson 2006):

> They were miyupimaatisiiu because they lived in the Indian way, which was good for them… And the people said that's the reason why they were strong and healthy because they didn't use anything from the Whiteman. … That's why they were strong and miyupimaatisiiu, and that's what the elders knew. They were a kind of people, even if they didn't have anything much, they still would know what to do to keep well and strong in their lives. … And that's how it was, before Whiteman came. (Quoted in Adelson 2006:59, no name given of the person quoted)

In 2013, talking with AQ, a mother of three, about her second birth, which happened in the hospital in the 2010s, I asked whether her escort, her sister, was present in the delivery room. "Yes, she was there," AQ said. But then she switched the conversation abruptly and reflected on the fact that actually she herself has never witnessed a birth: "Yeah, she (her sister) was there. I kept telling her 'Take pictures! Take pictures!' but she wouldn't. I've never witnessed a child being born. Never! Well, just my son, because there was a big mirror there, but… you know… I was never there to witness another person giving birth. There was regret in her voice; she wished she could have seen a baby being born.

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[5] At the time, the community store was in the Community Hall because the store, together with the coffee shop, had burned down that year. The Community Hall was usually where feasts, weddings and community events take place. Inside the Hall, at the entrance to the store, there was a space with tables where people could sit down and have coffee or tea. It was a very much-needed space that replaced the burned down former Sam's Coffee Shop that had been in the same building as the store. People would sit there to spend time, talk and exchange news.

[6] Stevenson (2014:137) elaborates on a concept of longing in Inuktitut – *kajjarniq.* It is a time and place where everything feels right, and it is the moment to embrace and absorb in order to create longing for it in the future.

To witness birth for many Cree is an honour, a privilege. At the same time, being present at a delivery is a natural and ordinary place to be, a place one should be. For many years, first-hand experience of childbirth was - and for many Cree mothers still is - challenged by logistical, financial and bureaucratic procedures. Nonetheless, Cree continue to see birth as a family and community event, in which people should be able to participate in one way or another. In the days of bush-births, childbirth experience was common through observation, participation and presence. One of the Elders, Winnie Asquabaneskum, when asked about bringing birth back to the community, said that they should do it, because probably many people would be willing to come and watch (from the interview with Winnie Asquabaneskum, 2013). Many Cree want to watch births and to participate in the process. Mothers, more often than not, want to have as many people present during delivery as they can fit in the delivery room. Cree feel proud when talking about the births they've participated in or witnessed.

Today, in accordance with the federal evacuation policy, women from Wemindji, as from other remote Indigenous communities, have to leave their homes between 36 and 38 weeks of gestational age, and travel to urban centers to await for labour and birth (Lawford 2011; Lawford and Giles 2012a; Lawford and Giles 2012b). For many years, Cree have been disciplined (Foucault 1998) and limited by the colonial system. The medicalization of childbirth and the evacuation policy for birthing mothers are results of colonization. Colonial ways are expressed in power relations, social control and surveillance, colonial attitudes, modes of conduct and care (Allan and Smylie 2015, Stevenson 2014). Regardless of those challenges, faraway birthing locations, hospital regulations or modes of hostile and patronizing care, many Cree still end up in the deliver rooms assisting at births, providing much needed comfort, personal and culturally sensitive care for birthing mothers. Wemindji Cree are active participants in the Indigenous resurgence movement (for Indigenous resurgence movement see Coulthard 2014; Simpson 2011). They navigate within the limits of the biopolitical[7] infrastructure by stretching its boundaries—they silently and persistently continue with their long-standing birthing traditions, modifying some of them and adopting new ones. This thesis is a story based on Cree experiences of childbirth, how Cree childbirth has transformed and persisted in turbulent times, and how it is in the process of being brought back home to Iiyiyuuschii.

[7] Biopolitical – *"... a form of care and governance that is primarily concerned with maintenance of life itself and is directed towards populations rather than individuals"* (Stevenson 2014:3-4).

1.2 Structure of the thesis

There are nine chapters in this thesis, including the Introduction (Chapter 1) and Conclusions (Chapter 9). In this Introduction, I briefly discuss the ethnographic context of the Cree Nation of Wemindji, review the literature on Wemindji and Cree childbirth, and present the methods used in my ethnographic study. The second chapter is dedicated to situating childbirth stories in the historical context of political and sociocultural events in James Bay at the end of the 19th and in the first half of the 20th century, including: Cree ways of life, the introduction of the biomedical system in eastern James Bay, the medicalization of childbirth, and the establishment of the Wemindji settlement in 1959. The third chapter analyzes the effects of colonization on Cree childbirth, birthing mothers and their families, and engages theoretically the works of Kenny (1985), Fanon (2008), Coulthard (2014), as well as my own insights and research.

Chapter 4 is dedicated to the prenatal experiences of Cree mothers while living in the bush, and later, in town, in Wemindji. In this chapter, I discuss emergent themes from the prenatal stories in the lives of Cree women: forming a family, becoming pregnant, revealing the pregnancy to the family, and receiving family and/or biomedical professional advice and care during pregnancy. All these themes are analyzed in two parts along their location and time—the bush (roughly before 1959)[8] and Wemindji town (after 1959).

The following three chapters (5, 6 and 7) are organized in a chronological sequence and according to the location of Cree childbirth—birth in the bush (until about the1970s), birth in the local nursing station (from the 1970s until about 1980s) and birth at the hospital (from the 1960s until the present). The fifth chapter on the birth in the bush, focuses on Wemindji Cree Elders' stories and experiences, their memories and knowledge of Cree childbirth practices. Chapter 6 is dedicated to birth at the local nursing station, which constituted a transitional period from childbirth in the bush to childbirth in the hospitals. I look at the changing roles of midwives and their interactions and cooperation with nurses. I also examine women's experiences of childbirth in the nursing station when births there were a routine practice, and the emergency clinic births after the 1980s when the clinic was no longer considered by policy-makers to be a safe space to deliver babies.

Chapter 7 addresses hospital births, from the very early few evacuations remembered by the Elders in the early 1960s, up until today. I look at the main issues and themes that women

[8] Not all the families moved to town in 1959; many were still continuing life in the bush, where children were born until about the 1970s.

and their family members brought up in our interviews about their experiences of evacuation and childbirth in the hospitals. Chapter 8 is dedicated to the manifestations of Cree childbirth practices in the hospitals. The last chapter (9) is a summary of my findings, followed by a discussion in the form of cultural comparison of childbirth practices elsewhere. It ends with a look into current initiatives to re-matriate Cree birth and provide women with choices in birth location and care.

Figure 2. Wemindji from the air, 2006

1.3 Ethnographic context and anthropological research in Wemindji

Wemindji, in the northern part of Quebec, is one of nine Cree communities along the eastern James Bay coast. The population of Wemindji is approximately 1400, and growing steadily. Many Cree are employed at the nearby gold mine operated by Goldcorp[9] and at the hydroelectric power plant in Radisson, La Grande,[10] where they usually secure the lowest paid jobs. Wemindji owns the local construction business, which has been well established in the region since the 1990s. Regardless of wage labour, a large part of Wemindji Cree economy to this day involves hunting, trapping, fishing and gathering. Land is essential, not only for subsistence but also for the health and wellbeing of Cree. It is an essential part of Cree identity—hence topic of the political struggles and debates.

[9] Goldcorp is a gold production company headquartered in Vancouver, British Columbia. The company is engaged in gold mining and related activities like exploration, extraction, processing and reclamation.
[10] The La Grande is a hydroelectric power station on the La Grande River, and is a part of Hydro Quebec's James Bay Project.

Most research conducted in eastern James Bay has been on land use, Cree ways of life, hunting practices, economic development projects and politics in the region. Tanner (1979) conducted an extensive study on Mistassini Cree hunting and ways of life. A number of scholars have looked at Cree land use and harvesting practices, especially hunting and aspects related to it (Peloquin and Berkes 2009; Peloquin 2007; Sales 2008, 2015; Sayles and Mulrennan 2010; Scott 2018, 2013, 2007, 2006, 1986, 1983; Scott and Webber 2001). Preston dedicated his work to understanding Cree worldviews (2002). Morantz conducted ethnohistorical research on James Bay Cree social structure (1983a), fur trade (1983b), colonial history of the region (2002a), and on Inuit, Cree and Euro-Canadian interactions (2010). Much of the research on eastern James Bay has focused on the politics of resource extraction and economic development projects (Feit 1989; Nasr and Scott 2010; Salsbury 1986; Scott 2001, 2003, 2012).

Figure 3. Wemindji town: above - residential streets; below - the two daycare centres in the distance.

The Wemindji area was extensively researched during the joint Paakumshumwaau-Wemindji project (2005-2010) based at McGill, in collaboration with the Cree Nation of

Wemindji and a team of interdisciplinary researchers from various Canadian universities.[11] Both Wemindji Cree Nation and academics contributed to the research from the starting point to the final stages of the project (Mulrennan et al. 2019; Mulrennan et al. 2012, Mulrennan 2008). The goal was to establish protected land and marine areas managed by local Cree institutions, which was accomplished through dialogue and understanding between two different traditions of knowledge (Mulreannan et al. 2019). In the course of the project, various types of research took place in Wemindji – environmental, geographical, biological, archaeological and anthropological. Anthropologists and geographers, collaborating with community members, mostly looked at local environmental knowledge, land resource management (Mulrennan 2008; Mulrennan and Scott 2005; Peloquin and Berkes 2009; Sayles 2008, 2015; K. Scott 2008) and the community's approach to development (Labreque 2010).

Overall, most research in Wemindji has been based on experiences, perspectives and information provided by Cree men, and mostly conducted by male scholars. The former is probably the result of the latter. It is also noticeable that the large amount of above-mentioned research on Cree land use, hunting strategies and worldviews have largely omitted Cree women, whose vital roles in Cree hunter-gatherer economy are yet largely under-researched in the region. According to Desbien (2007:364), "In creating a gender-blind picture of the Eeyou traditional economy, scholars may have also skewed our understanding of the interdependence between male and female spaces and practices on the land."

There is some information about Cree women's experiences from the James Bay region in general, but close to none from Wemindji specifically. There have been a few studies conducted in western James Bay that focus on Cree women's perspectives. Among these is the work of one of the first female anthropologists, Regina Flannery, who did her fieldwork in Moosonee in 1933, talking with women about their lives. Flannery spent most of her time with Elder Ellen Smallboy, who was born in 1852. Flannery recorded her stories in a book Ellen Smallboy: A Glimpse into Cree Women's Life (Flannery 1995). Another study based on interviews with Cree women in western James Bay examined transmission of Indigenous knowledge and bush skills (Ohmagari and Berkes 1997). In the late 1970s, Sarah Preston conducted a study similar to Flannery's, during which she recorded a life story of a Cree woman, Alice, from the eastern James Bay, Rupert house (Waskaganish). Cath Oberholtzer (1930-2012) extensively researched Cree material culture in the area of eastern James Bay.

[11] The project was co-directed by Colin Scott (Principle Investigator) and Rodney Mark (chief of the Cree Nation of Wemindji).

She published and presented papers on different aspects of Cree artifacts related to women's lives and childrearing, such as clothing, moss bags, cradleboards, dolls, dream catchers, etc. (Oberholtzer 1994, 1997, 1998). Many of her papers related to childrearing items were read at the Algonquian Conference;[12] unfortunately, they were not published, and currently are difficult or impossible to get hold of. At present, Katherine Scott, an anthropology PhD candidate at McGill, is conducting a study under the employment of the Cree Nation of Wemindji as a Heritage Research Coordinator. She is documenting Cree cultural practices that involve women's chores, such as cooking (Stewart B., Stewart J., Stewart E. and K. Scott 2016), hide preparation and crafting.

About childrearing practices, there is some relevant information in the work of Susan Marshall. In her Master's thesis (1984), she extensively looked at biomedical and Cree medical systems in Chisasibi and Mistassini, where she concentrated on children's health care, including breastfeeding. In her later publications, she describes her research on traditional Cree knowledge from Chisasibi; part of that study is dedicated to childbirth, pain management, the postpartum period and breastfeeding (Marshall et al. 1989, Marshall and Chiskamish-Napash 1996). Her latest work (Marshall and Masty 2013) is a collection of stories from Whapmagoostui, where among many men there are a few Cree women who reveal their perspective on Cree life. Lynn Whidden has conducted research on Cree songs (2007). However, her study was mostly dedicated to men's songs and hunting songs. She recognized in her work that Cree women were shy singers and there is little known about Cree lullabies or songs that Cree women sang (2007:60-63).

Women and their stories have never been the centre of research in Wemindji. This thesis brings some balance to the pool of research in Wemindji and eastern James Bay by talking about women, their bodies and their experiences. That said, even though the act of birthing is restricted to women's bodies, the childbirth event has different but essential roles and challenges assigned to all members of the family and community—women and men, young and old. Therefore, all stories, experiences and expectations in childbirth narratives matter.

[12] Algonquian Conference has occurred annually since 1968 and is dedicated to the languages and societies of Algonquian peoples. The conference encourages participants publish their papers in the peer-reviewed conference proceedings "The Papers of the Algonquian Conference."

1.4 Methods

Before getting into the details about my fieldwork in Wemindji, I should say a few words about my background, since I believe it informed my methods. I grew up in Lithuania, a northern European country, occupied by the Soviet Union. That is to say, I have experience of an oppressive regime and limitations on freedom of thought, expression and movement. I have also experienced a passionate struggle and fight for the freedom of my nation, my family and all the people who surrounded me up until my early teens. I am also painfully aware of the challenges that come after oppression has fallen and the borders are open. The healing is long and difficult, and the process of learning to live with so much desired freedom after many decades of oppression is overwhelming. For years after the declaration of independence in 1990, Lithuania has had one of the highest suicide rates in the world. We also, infamously, have one of the highest alcohol consumption rates, according to the World Health Organization (https://apps.who.int/iris/bitstream/handle/10665/274603/9789241565639-eng.pdf). On the other hand, there were many positive developments in my country in politics, science, technology and society, not to mention having one of the fastest growing economies in Europe. That is to say, I know from experience that for a nation to stand on its own feet after oppression takes huge amounts of work, persistence, foresight, wisdom and belief in the future. I will never fully know the struggles and pain of Cree people caused by colonial politics in Canada, but when in the field, I could relate to their experiences of oppression and their desires for autonomy, protection of their lands, and reclamation of their traditions and practices, including those around healing and birth.

In Lithuania we love our forests and trees; lakes, streams and rivers. There's a tradition to plant a tree when a child is born; many Elders would teach that the tree is a sacred, living being, and thus has to be respected. As a child, I knew all my flowers, bushes and herbs in the gardens and fields, all my trees, berries and mushrooms in the forests, and all the fish in the lakes and rivers. Our stores were empty of food, but our forests, waters and small collective gardens provided healthy meals and traditional medicine. My grandfather was a fisherman and often took me on his day trips to the woods, fields and rivers. He taught me to clean and to prepare fish and was always full of observations and stories about how fish live and think. He taught me to cure and to cook fish and to use every single part of the fish, not wasting anything. My mother and my grandmothers taught me to harvest medicines in nature and to garden. I also learned to sew and to knit when I was five years old. Back in the day, there was

very little choice of clothing at the stores, thus my mother would make clothing for me and others in the family.

Cree harvesting recourses from the land, Cree stories about past and present life experiences, reminded me of my country and my childhood. In Wemindji, I could go for berries or mushrooms around town, collect herbal medicine, learn about local species of plants and trees, and compare their usage to the plants I know from home.[13] I could eat and prepare fresh fish and learn similar and different ways Cree go about their fishing and fish preparation. Handicraft skills from my childhood and my passion for knitting helped me connect with many elder Cree women in Wemindji who would gather in the Community Wellness Centre every week to work on their ongoing handicraft projects and chat. I also found that the Cree way of straightforward, less verbal communication with little need for small talk was familiar, comfortable and easy.

Thus, when in Wemindji, I could relate to elements of natural and social environments, modes of communication, stories of Cree lives, joys and struggles. And I suspect that my feelings of relatedness to the place, the people and their ways of life, were a big part of my drive, motivation and dedication to families and research in Wemindji.

Figure 4. The gifts of the land and waters in Iiyiyuuschii: white fish, trout, cranberries, blueberries, raspberries

[13] Even though Lithuania is not as far north as Wemindji, I found that the wild species of trees and plants are fewer but much the same.

When entering "the field" in Wemindji, I was not a total stranger to the place, nor was the place strange to me. I worked on Wemindji territory together with the stewards of the land as an assistant archaeologist and a member of Paakumshumwaau-Wemindji project through 2005 to 2008. Since then I've been visiting Wemindji on a yearly basis, mostly during the summers, and have kept close contact with some members of the family on whose territory we had been excavating, who were our guides on the land, and our team's research partners. However, it should be noted that as an archaeologist, I spent most of my time on the land, outside the town of Wemindji, where the dynamics of everyday life and the social environment differ greatly from life in the bush.

Many people I came to know better only once I arrived in Wemindji for my fieldwork in 2013. I was aware that my, and my children's, presence was noticed in town. People asked me questions and from the start assumed that I was a new teacher or a nurse. I spoke English with a different accent than everyone was used to hearing from the francophone nurses; thus, I often received questions about where I was from. Many were puzzled by my name, which was difficult to read and to pronounce, and then by my home country, which was unfamiliar. I felt that some people were more curious about my background, others less so, or not at all. In any case, I felt very warmly received and welcomed. My children did not lack attention and love from the community – people were bringing toys and asking if we needed any clothing, gifting us traditional foods and inviting to their homes, community events, ceremonies and feasts. We had regular visits in our home from people we knew well, and from those we did not at the beginning of the fieldwork. During the day, especially during the warm season, our house was full of children who were coming to hang out at our place. They happily tried the different dishes that were unfamiliar for them and participated in different play, arts and craft activities with my kids. All that is to say that I am aware that my identity, gender, skin colour, the fact that I had two toddlers in the field, and my personal qualities were among the factors that formed peoples' relationship to me and influenced the kinds of information I collected. However, I do not want to speculate or generalize on how I was perceived or what answers mothers and their families chose to provide me and which ones to keep for themselves. This work is a result of what people in Wemindji shared with me, as well as what I thought they tended to be silent about (for example, see section 4.2.4 Abortions).

The focus of my thesis, childbirth, came to me as I was visiting a friend from Wemindji in a Montreal hospital where she gave birth to her baby; during labour, she had been in an uncertain situation, sent from one hospital to another without clear answers to why and for

how long. This confusing process put considerable stress on my friend and consequently on her baby. Having recently given birth myself, and not without issues with the biomedical institutions, I wondered how women from Wemindji, who are evacuated over a thousand kilometres away from home, cope with those challenges. How do they see the current evacuation policy? Would they like the system to be different? How did they birth before the evacuation policy was put in place? How did the system become the way it is now? Why do women have to follow the evacuation policy? Finally, how do they want their children to be born and where? Those became the guiding questions at the beginning of my research and fieldwork. Later those questions were somewhat modified, expanded and guided by women's concerns and needs.

I conducted participant observation fieldwork in Wemindji in several stages through the period of 2013 to 2014, with a follow-up trip to Wemindji in the summer of 2016. Participant observation is a key to the practice of anthropology and it is a way of corresponding with people, dialoguing and learning (Ingold 2017). When living in the field, one immerses in the mode of participant observation and it is one continuous activity rather than many different events in which you chose to participate.

In 2013, I spent six consecutive months in Wemindji–from July to December. My main goal during this period was to talk with community members, mostly Cree mothers and fathers, about childbirth and their experiences related to it, as well as to collect stories and insights from Cree Elders. In 2014, having obtained Cree Board of Health and Social Services of James Bay approval to talk to their employees, I returned for the months of October and November to conduct interviews with the staff in the Wemindji clinic. At the same time, I caught up with the families that I had already interviewed in 2013 and collected more insights and stories. In the summer of 2016, I returned for June and July to obtain final consent from the study participants and to make sure that the information I had received, recorded, and analyzed was correctly understood and interpreted. In total, I conducted 52 interviews with Cree families and medical staff at the Wemindji clinic. 36 of those extensive interviews were conducted with Elders, women who gave birth to children, and men who participated in the births of their children or children of close family members. The other 16 interviews were conducted with the medical staff at the Wemindji clinic, including doctors, nurses, Community Health Representatives (CHR), the administrative staff of the Awash[14]

[14] Awash department - perinatal department in a newly built Wemindji clinic. It was established in 2009 and, according to the many women interviewed, improved perinatal care in Wemindji.

department and the then-director of the Wemindji clinic. By "extensive interviews," I mean an interview process during which I would talk with the same person several times over extended periods of time. On top of the scheduled interviews, during participant observation fieldwork, I had many unplanned casual conversations with families, Elders, young mothers and expectant mothers who shared their ideas, stories, memories and opinions on the subject that helped me understand and learn people's views on the current childbirth situation in the community. During my fieldwork, I was actively involved in community life, participating in community events and gatherings. I was also volunteering in the Wemindji Wellness Centre, participating in a Young Mothers Group, as well as in Kuhkums[15] & Friends arts and crafts activities.

Living in a research site while conducting participant observation often leads to close relationships between the interlocutors and the researcher. The field site 'boundaries' intertwine with everyday life and it may raise ethical issues, including questions about what is said on and off the record, or which actions and events can and cannot be used in the final report. In such circumstances, and in my research process, the consent of the interlocutors about the participation in the research was not a one-time event, but an ongoing process (except with the medical professionals, who signed an informed consent form during the one-time interview). As Lederman describes, in ethnography research "you're always developing relationships and gaining access to people. As people get to know you better, they're able to judge in new ways what to tell you or show you, and what to allow you to participate with them" (IRB Advisor 2006:105). Since I interacted with several mothers and families on a daily basis and had many conversations on the topics of interest to my work outside the scheduled interviews, I tried to make sure that women knew, which information will appear in my thesis. I paid particularly close attention to the sensitive stories. Those stories I read out loud together with women and left them with printed copies, so they could think about whether they want them to appear in my thesis or not. A number of stories and details were left off the record, and even so provided me with a better general understanding of the situation and with better insights into the data from my fieldwork. Thus, consent in fieldwork was an ongoing process, based on trust and respect on both sides. It allowed participants to decide what they want to share and adjust or withdraw the information they provided.

[15] Kuhkum – grandmother in Cree. Kuhkums & Friends group, in which the participants were usually Cree women Elders, gathered every Tuesday afternoon in the Wellness Centre for different arts and crafts activities – knitting, sewing, other creative arts and crafts activities, bingo games, etc.

The interviews I conducted during my fieldwork can be broken down into the following three categories: mothers or family members of the mothers (grandparents, brothers, partners), Elders, and medical staff.

1.4.1 Interviews with mothers and their families

My interlocutors were selected mostly through word-of-mouth. I talked to people I know, and those people talked to ones they know. Often, I was introduced or advised to contact one person or another who would have an interesting story or a recently born baby. I posted my research Information Sheets in different locations around the community - in the daycare, clinic, the Wellness Centre, and the Wemindji Community store, but I am sure that none of the participants came to talk because they saw or read the information posters. What worked in Wemindji was communication and building trust - engaging in community activities, volunteering, listening, learning, getting to know each other. Slowly people started talking more and more about their personal experiences, sharing their stories, pointing directions and giving insights. It was a long process, the pace of which I did not intend to hurry or pressure. I strongly believed that people should talk only when and if they were willing to share. Thus, before any scheduled interviews, I usually already knew the person in one way or another. I might have already conversed with her/him, participated together in some group activities, spent time with our kids playing, gone berry picking or collecting boughs,[16] enjoyed a meal together, spent time on the land or worked together on other projects. Often questions did not need to be asked, as people would offer up essential details when the time and place felt right to them. Sometimes the initial interview was only an introduction to a big story. The next scheduled or unscheduled meeting would reveal the same and other stories with more context, more depth and detail.

The scheduled interviews with women and men were semi-structured and/or unstructured, mostly conducted in a small office in Wemindji Wellness Centre. The Wellness Centre kindly provided me with a workspace that was temporarily not in use. Some of the interviews happened at participants' workplace or at my home–whichever location was most convenient to the interlocutor. All of those interviews were conducted in English and most of them audio-recorded. A few of the interviewees preferred me to take notes instead, which I did. I transcribed all the recorded interviews. There were a few questions for which I used a

[16] Cree use spruce boughs to cover the teepee floor. The boughs need to be changed as they dry and wear out. Many Cree build teepees in their backyard for various traditional activities, ceremonies and for preparation of traditional foods.

social media platform, such as, for example, posting a question on the Wemindji Announcements closed group Facebook page when trying to find out the year of the last baby born in the bush. Many people who were telling me their stories gave names of others whom they thought I should talk with.

The subject of childbirth is close to many people's hearts in Wemindji. Families are large; there are many babies being born every year.[17] Since people mostly know each other and are extended family members, nearly everyone knows about the new baby born in the community and congratulates, visits and celebrates. Birth is an important rite of passage; it is essentially a family and community event. People care about it and therefore were eager to talk and usually had a lot to say.

During my first six months in Wemindji (2013), I was together with my 3- and 4-year old children, who were attending one of the two Wemindji daycares. On the one hand, having two small kids in the field put considerable time constraints on my work - observation, note taking or participation in certain events, especially the evening events, was difficult. On the other hand, my children facilitated contact with Wemindji families, opened doors to their homes, helped build relations, friendships and trust among families through our shared experiences of parenthood and childrearing.

In the summer of 2016, I made a return trip to Wemindji to catch up with the families I had interviewed. The goal was to show them my writing, to clarify details, and to go through more sensitive stories to make sure that my interlocutors agreed with the format and the wording and to let people make changes they felt necessary.

1.4.2 Interviews with Elders

I have had access to a total of 13 interviews about childbirth experiences conducted with Elders, mostly in 2013. Ten of the interviews were conducted in Cree by Sarah Stewart from Wemindji, and the other three I conducted myself in English with some assistance from Elders' family members when interpretation became necessary. The 10 interviews that were conducted by Sarah were for the CBHSSJB project titled "Cree Birthing Knowledge," the goal of which was to video-record Cree Elders' childbirth stories and teachings to use as educational materials for expecting Cree families. Sarah Stewart was hired by the project to conduct the interviews. I signed an agreement with CBHSSJB that allowed me to participate

[17] During the last years, there was an average of 30 babies born in Wemindji yearly, with a few years coming up to as many as 35 or even 47 (Ministère de la santé et des services sociaux data bank).

in all the interviews with Sarah and to conduct my own research by contributing my questions that Sarah would ask the Elders in Cree. As a result, the ten interviews in the Cree language were video and audio-recorded and semi-structured, with Sarah interviewing and myself present. The three interviews that I conducted with Elders on my own were only audio recorded and took place in Elders' homes. Those were unstructured interviews conducted as open discussions about the Elder's life, childbirth experiences and knowledge. During one of those interviews, the Elder's family was present to help out with translation and interpretation.

Figure 5. Multiservice Day Centre (MSDC), where most Interviews with Elders took place.

Elders for the interviews were suggested by several community members, including Sarah herself and her sister Dorothy Stewart. The list expanded as people heard about the childbirth project. Most often Sarah would be the one to contact the Elders and ask whether they would like to talk about childbirth and what best arrangements could be made. They would agree on an approximate time and place to meet. All but one of the ten interviews were conducted at Multiservice Day Centre (MSDC),[18] since this was the most convenient location for many Elders. Our routine with Sarah and Cain Stewart, our cameraman, was to visit the MSDC in the morning, have some coffee, and see if anyone was willing to talk about childbirth. If people were willing to share their stories, we would go to a "meeting" room and record the interview. In addition to my questions for the Elders, Sarah had the main guiding questions provided by the CBHSSJB "Cree Birthing Knowledge" project. Interviews would last between half to one and a half hours. Later in the day Sarah and I would work together on

[18] MSDC – a place for Elderly and people with disabilities that has social workers on site with regular visits from therapists and biomedical staff. The centre organizes daily activities - including cultural workshops, mental activities (chess, puzzles, etc.), physical activities (yoga), physical therapy, etc.

the translation and interpretation of the material. We would listen to the recording and stop it every few sentences. Sarah would translate, and I would type. After translation of the interview, and a few days' time, we would go back to the MSDC and ask more questions to fill in the information gaps or to clarify the details. Such work took a few months.

I learned in the process that Sarah has a great knowledge of her community, its history and people. She is a local Cree, born in the bush where she spent her early childhood, moving to Wemindji the year it was established (1959). During all this time, Sarah was an invaluable source of information – she not only translated the interviews, but also provided me with much valuable information on cultural practices and details from her own experience; she also shared her cultural insights, explaining the many cultural references, Cree vocabulary, etc. Finally, Sarah and her sisters, Linda and Clara, and her brothers, Fred and Donald, facilitated my participation in the community happenings, kept me in the loop of the news and events in town, guided me through habits and routines of life in Wemindji, and helped me to feel included. For me, Sarah served as a gateway to the history of Wemindji and the Cree worldview. Her guidance throughout my time in Wemindji, especially while translating and interpreting the interviews, was invaluable. Ultimately, Sarah interpreted the 10 interviews and stories from the Elders and I put them in writing. I have somewhat edited the interviews by adding in additional information from the second and third conversations with Elders. Sometimes, in order to make the story flow without interruptions, I put Sarah's cultural references and comments in footnotes. Thus, the original words have gone through several transitions – translation, interpretation and editing (as little as possible), which means that some details might be lost in translation, or emphasis might have been put on different aspects of the story than the Elder intended.

The reader should keep in mind that the words on paper are not direct words of the Elders, except from the three interviews conducted by myself and marked with letters "dir.sp." (direct speech). All the names on the interviews with Elders are original names, with the exception of one person. Elders were asked whether they wanted to be identified in the final report, to which they said yes (except one person) and that they did not mind having their names on paper. Some made sure that I had all their names down properly, including their middle names, since there are several people with similar first and last names in the community.

1.4.3 Interviews with medical staff

In the summer of 2014, I conducted the interviews with the medical staff at the clinic. They were voice-recorded, semi-structured, one-time interviews arranged with the great help and support of the director of the Clinic, Greta Visitor, and the Awash department coordinator at the time, Karine Jones. The medical staff at the clinic were very helpful, willingly sharing a great amount of information about their experiences and their work and showing interest in the study of childbirth and the outcome of the study. I conducted interviews with all the staff present at the time in the Awash department providing pre- and post-natal services to mothers and their children, and with a few nurses working at the Current Services[19] who had experience with pregnant women or emergency births at the clinic. As a result, I conducted 16 interviews with 3 doctors, 7 nurses, 4 CHRs, the coordinator of the Awash program, and the then-director of the clinic.

In interviews with the medical staff, they provided their points of view on issues concerning childbirth and services to childbearing women and families in town. Juxtaposing their perspectives on episodes and events with Cree women's stories and narratives brought more understanding to what has gone or is going on, and where miscommunication or issues in caring for expectant women may lie.

1.4.4 A final note on methods

In this thesis, I provide many stories and interview quotes from women and their family members. The stories are essential and integral parts of this work, representing diverse voices and experiences of women and men. The direct words in Cree are beautiful, touching and carry a style of storytelling that I would not be able to convey in my own words. That is why I chose to use many and some might think long quotes from the interviews. Stories told to me by Cree families are unique in their content and form. Thus, especially in Chapters 5, 6, and 7, I rely on Cree oral histories, particularly personal accounts of events. I begin the history of Wemindji Cree childbirth practices in the second half of the 19th century, which is when the Elders' grandparents would have been born and so able to transfer their knowledge and experiences to their children and grandchildren, who are the Elders today.

[19] Pre-natal services and post-natal services for women and their children are provided in the Awash department, while Current Services are for the rest of patients in Wemindji. Some of the nurses working at the Current Services have experience with pregnant women or births, such as for example in emergency cases, and some of them rotate between the two departments.

Dorothy Stewart, a friend of mine and a Cree from Wemindji, once corrected me while we were discussing the manuscript on the collaborative work between Cree and archaeologists in Wemindji, where I was talking about revealing the past. Dorothy noted that maybe archaeologists reveal or reconstruct the past, but Cree, they remember the past. Her words stuck with me, and therefore, my sources of information here are Cree memories and Cree oral histories.

Oral histories or oral traditions can reach far back in time and may include useful aspects in regard to childbirth. However, stories may contain different characters – some may include mythological aspects of the past and present, others may be narratives of past events experienced by people in 'ordinary' life, or they may be personal life stories experienced by an individual (Damm 2005:76). I have concentrated on the analysis of personal accounts, narratives of personal experiences, and memories, because analysis of the stories beyond personal experience requires a different kind of approach, knowledge and methods.

Until very recently, there was an assumption that Indigenous oral tradition does not carry historical value (Cruikshank 1994, 1990; Marshall and Masty 2013:5). Instead, Indigenous history was created by journals and reports produced by missionaries and traders. In recent decades, it has been realized that colonial and archaeological records alone are insufficient sources of information with which to study the past. Oral histories slowly have gained recognition as valid historical resources. The early works promoting oral tradition and Indigenous histories were by Trigger (1980, 1982, 1984, 1997), Nabokov (2002), Preston (2002) Morantz (2001, 2002b), Cruikshank (1998), Cruikshank and Argounova (2000), Ridington (1988) and others. The question remains, however, how best to integrate or complement the two distinct traditions of knowing about the past and who is in the best position to do it? (Damm 2005; Habu, Fawcett and Matsunaga 2008; Nicholas 1997; Smith and Wobst 2005). Some anthropologists and archaeologists employ and discuss oral tradition in various ways with regards to history, and work on various collaborative projects with Indigenous communities (see 2001; Ferguson 1996; Castaneda and Matthiews 2008; Colwell-Chanthaphonh and Ferguson 2008; Marshall and Masty 2013; Mulrennan, Scott and Scott 2019; Mulrennan et al. 2012; Murray 2011; Paberzyte et al. (in press); Silliman and Ferguson 2010), while Indigenous academics and grass root activists work on their behalf to bring valuable Indigenous perspectives to the question of the past and Indigenous histories (Yellowhorn 1996; Nicholas 2010; Tonkin 1992).

As there are several different sources used in this thesis to discuss the past (Cree oral histories, social sciences literature), there are also different theories and concepts used (Cree, Inuit and social sciences) to understand Cree experiences. I do not try to impose the foreign concepts on Cree narratives, but I try to make sense of what I heard from people, and to find the answers to some questions that even Cree themselves were struggling find. Not everything we say or do have immediate and obvious explanation. Theories, insights and concepts that come from different peoples in different places, but similar political or sociocultural circumstances and talk to similar issues, can lead to enlightening disclosures and insights. Here, I employ those theories that I find relevant and helpful to understand some of Cree experiences and events in their lives. Anthropology is about bringing variety of perspectives together and about trying to make sense of the human behavior and experiences in the world we live in. Ingold (2017) writes: "no specialist, no indigenous group, no doctrine or philosophy already holds the key to the future if only we could find it. We have to make that future together, for ourselves, and this can only be done through dialogue" (p.22). Thus, I bring different sources of information, different theories and concepts to one table to have that dialogue through which I am looking for answers and trying to understand human actions and experiences.

I intentionally avoid using the term "traditional" in reference to Cree childbirth. Instead, I define it by place of birth– for example, bush birth or hospital birth. My reason is that the concept of "traditional birth" would require discriminating certain behaviours from others and deciding which ones are "traditional" and which ones are not. That would be a complicated and quite useless task, giving a static and unrealistic representation of the community. Tradition is complex, multi-layered, adaptive, constantly evolving and shifting. I believe that, even among Cree, there would be many arguments about what belongs to "traditional Cree birth" and what does not. Some of these discussions I witnessed myself, and therefore will not be the judge of what "traditional Cree childbirth" entails. For the sake of this thesis, tradition is considered as a continuous practice no matter where it is performed – bush, hospital, or clinic. While talking about childbirth, I will stick to the place of birth instead of creating packages of "traditional" and consequently "non-traditional" childbirth items or behaviours.

CHAPTER TWO: HISTORICAL CONTEXT

In this chapter, I will first provide an overview of Cree life in the late 19th and early 20th centuries in eastern James Bay;[20] and second, I will focus on the following outside factors that influenced Cree childbirth: 1) national policies that intervened in Cree ways of life; 2) the gradual medicalization of life in northeastern James Bay, and; 3) the development of the evacuation policy and medicalization of Indigenous childbirth throughout the 20th century.

In describing national and local contexts of the time, I rely primarily on academic publications and complement them with Wemindji Cree personal accounts of some of the events discussed.

2.1 Subsistence strategies and the fur trade

The main subsistence strategies for Cree living in eastern James Bay through the 19th and early 20th centuries were hunting and fishing. These had sustained the Cree economy for centuries and continue to play essential roles today. In addition to hunting and fishing, Cree were for centuries intensively involved in short- and long- distance trade with their southern and northern neighbours - other Indigenous peoples (Morantz 1983b, 2010; Wren et al. 2014). Cree became directly involved in the fur trade in 1668, when Englishmen sailed to James Bay and started establishing trading posts along the eastern coast (Morantz 2002). It is important to note that for a very long time the Cree were not dependent upon imported foods, and the fur trade was not in conflict with hunting for subsistence,[21] at least until the end of the 19th century (Carlson 2009; Morantz 2002a; Niezen 1998). Morantz (2002a:22) emphasizes that between the 1670s and the 1870s, Cree were active participants in the fur trade and "…that the fur trade, although managed by a few Englishmen, was in fact orchestrated by the Crees." Englishmen were dependent on Cree who "provided the labour, not only in supplying pelts but also transporting the goods and furs and maintaining the Englishmen at the post. They provided them with country food, firewood, clothing, male and female companionship and family life" (Morantz 2002a:22).

[20] The current day Elders, who were interviewed for this project, told childbirth stories and teachings, which they learned during their youth from their parents and grandparents. That is why I chose to start the discussion on the historical context of Cree life at the end of the 19th century – the approximate date when grandparents of the current day Elders were born, who were the main source of t childbirth knowledge for their children and grandchildren, thus, the Wemindji Elders today.

[21] Cree eat the animals they trap. They sell the furs, for example of beaver, but it is also a food source. Beaver and muskrat tails are also considered highly valued delicacies.

It is important to remember the often overlooked essential roles that Indigenous women played in the fur trade. Research from other Indigenous communities across Canada on the role of women in the fur trade reveal that Indigenous women were the diplomats, the peacemakers and the translators throughout the fur trade, especially during early contact (Baker 2018:104; Van Kirk 1984:9). They influenced the flow of trade so to secure what they found useful in making footwear (moccasins and snowshoes) and clothing, as well as products and equipment facilitating food preservation. At the trading posts, women were the main providers of food during winter months - snaring hare and partridge, providing dried fish and berries. Women repaired canoes and helped traders navigate the land and the waters (Baker 2018; Van Kirk 1984:10-11).

In the early part of the 20th century (mainly in the 1930s), the Cree in the Wemindji area experienced a decline in food resources and for many it was a time of misery and sometimes starvation. Migratory caribou[22] were almost entirely absent from the area for decades, and this cyclical decline in caribou happened to coincide with large influxes of White trappers using the area more intensely related to the advent of the railway across the southern edge of Cree territory, and increased use of bush planes after the World War I. Cree Elder Angus Mayappo from Wemindji recalls his childhood: "We lived with Sinclair Moses and his family that year and we shared a squirrel between two families. After the squirrel was cooked, I received the squirrel head to eat. I was told not to eat all of it and save some for breakfast" (from the interview with Angus Mayappo in Wemindji Turns 50, 2010:41).

2.2 Iiyiyuuschii from the 1850s to the early 1900s: The beginnings of colonial policies

At the end of the 19th and the beginning of the 20th century, not only the decline of the game and food resources started to influence the life of Cree, but also outside political shifts and rearrangements. In the climate of nationalism galvanized by the fear of a US invasion, Canadian provinces united to form the Dominion of Canada and a country of its own in 1867.

[22] Populations of migratory caribou, one of the important food resources for Cree, were always highly cyclical in this part of the subarctic. A complete cycle, from peak to peak, lasted about a human lifetime (for fluctuation of caribou in the region see Peloquin (2007) *Variability, change and continuity in social-ecological systems: insights from James Bay Cree cultural ecology*). A study by Loring (cited in Leacock and Rothschild 1994:193 and in Morantz 2010:50) found that every other generation of caribou undergo cyclical decline in their numbers. Daisy Atsynia Sr., from Wemindji, who was born in 1927, told a story about the decline of caribou that corresponds with these studies: "My father told me that there were a lot of caribou when he was young. Then there was not a single caribou around when I was a young girl. He said the caribou would be gone for a while but would be back later in life. And that's what happened, caribou are starting to be around here these days. That's one of the stories my father told me. It is one of my favourite stories" (from the interview with Daisy Atsynia Sr. in Wemindji Turns 50, 2010:84).

Thus, Canada is a young political formation, which came to be only when the grandparents of current day Elders were born. At the time, the Hudson Bay Company surrendered its trading rights in Hudson Bay and northeastern James Bay to Canada,[23] after which northern peoples of James Bay and Hudson Bay found themselves in the North-West Territories. In 1912, Quebec extended its boundaries into the Territories, adding James Bay and Hudson Bay to the province. Therefore, "…although they probably were not aware of it, in 1867 the northern peoples became the residents of Canada, and in 1912, of Quebec" (Morantz 1983b:35).

The concept of the "James Bay Cree" is a recent construct that was produced by political and social pressures in the mid-19th and the early 20th centuries (Morantz 2010, 1983a, b). The English name "Cree" (Cri in French) for Iiyiyuu[24] was given by outsiders. In 1863, peoples of eastern James Bay were mentioned in correspondence by missionary A. E. Watkinson and referred to as a "Cree speaking" population. At the very beginning of the 20th century, anthropologist Alanson Skinner referred to the same James Bay people as "Cree." It is assumed that Cree is an abbreviation of the name Kristinaux (also Cristinaux, Chritino, Kiristinon, Killistinaux, in Dickason 2002:120), a group of people who were known to French explorers and Jesuits in the 17th century and mentioned in their accounts. According to these accounts, Kiristinaux people lived on the North Sea, meaning James Bay (McMillan and Yellowhorn 2004). Before arrival of Europeans, peoples around James Bay referred to themselves differently, and identified with smaller groups than the present-day Cree (Morantz 2010, 1983a, b). However, through various state administrative and educational policies, the name Cree became well established (Morantz 1983a, b). In the second half of the 20th century, Cree identity was greatly reinforced by shared Cree experiences of Canadian and Quebec policies towards them. These included the enforcement of a sedentary way of life by the federal government, cultural genocide through the residential school system (Woolford 2015), political marginalization, and the unconsented exploitation of land. All of these violations led the Cree into an ongoing fight for the establishment of a nation-to-nation relationship with the Canadian government that includes their voices in political and economic decisions, especially when it comes to their territories and waters. Eastern James Bay Cree had to face these issues together and form a strong unity in order to deal with colonial politics. As a

[23] Since 1679, the British Hudson Bay Company had functioned as the *de facto* government in parts of North America, including the James Bay and Hudson Bay region, until the Hudson Bay Company sold the land it "governed" to Canada in 1869, after Canada declared itself a country.
[24] *Iiyiyuu* - this is how Cree refer to themselves, meaning 'people.'

result, Cree identity is a complex and multilayered formation. Nonetheless, today it is a recognized, proud and strongly rooted entity in the minds of the Cree of Quebec.[25]

During the end of the 19th century, despite political and historical events - such as shifting provincial borders around them - Cree continued with their daily life and were primarily concerned about getting food for their families and keeping themselves safe and sound (Morantz 2002a:71). Northeastern James Bay Cree did not experience much external government influence until about the 1930s. The first noticeable government involvement in the region was the establishment of "Beaver Preserves" by the Hudson Bay Company and the Department of Indian Affairs to combat the decline of the beaver population. Those Preserves were built on a pre-existing Indigenous framework (Berkes 1995, Feit 1994), and although Cree tallymen (uuchimaauch in Cree)[26] responsible for the Preserves (counting beaver lodges and making sure the quotas were met) were appointed by Hudson Bay Company officials, they were already recognized among Cree as senior hunters managing their family hunting grounds. Traditionally, uuchimaauch were respected for managing the land economy and were the ones to whom people would listen (Whiteman 2004; Scott 1986).

At the same time, the Department of Indian Affairs established a requirement to appoint one elected Chief and several council members for each trading post (Niezen 1998, Whiteman 2004), and in this way, intervened in local Cree leadership structures. James Bay Cree were more or less egalitarian communities who used to give respect to various community members with outstanding forest economy skills–the previously mentioned uuchimaauch (tallymen) (Morantz 2002a, 1983a, b, Niezen 2009:43). During winter, hunting groups consisted of two to four families that formed a local band (Tanner 1979). A number of those bands would gather during summer in one place to socialize, find spouses, and trade. According to Whiteman (2004:430), traditionally there did exist so-called Cree "chiefs" who would oversee "summer settlement," when bands would come together for summer gatherings (Morantz 2002a, 1983a, b). During the fall, bands would split again into smaller hunting groups and most of the year uuchimmauch were the responsible extended family leaders (Morantz 2002a, 1983a, b; Whiteman 2004). As a result, two different leaderships eventually emerged in Cree communities. The uuchimaauch remained the senior hunting group leaders

[25] There are nine Cree communities along the eastern coast of James Bay in Quebec, with a population of about 18,000 people. The largest communities are Mistassini and Chisasibi, with populations over 3300 people. Wemindji has a population of about 1400 inhabitants.

[26] Cree tallymen are senior hunters and trappers. They are in charge of traditional subsistence activities such as hunting, trapping, and fishing on their traplines. Traplines are more or less specified areas that divide Cree land.

managing the forest economy, while community chiefs were younger, often more educated in the Euro-Canadian system, English speaking, and skilful in negotiations with the outside world. To this day, many important decisions in Wemindji are made in consultation and agreement between the Elders, tallymen and the political leaders of the community.

2.3 Establishment of the Old Factory post (1935-1959)

The Old Factory post is the early Wemindji settlement, which in 1959 was moved from the Old Factory Bay to the current location of the village on the mainland. This trading post was established in the Old Factory Bay on one of the islands (Taawaasuu Minishtikw) in 1935 by independent Swedish trader Jack Palmqvist (Lofthouse 2013:32; Denton 2001:16). For many years, Old Factory was a famous place for fishing and goose hunting among the Cree. After the post was established, it quickly became the centre of activity for the coasters and inlanders[27] who were coming to spend their spring-to-fall goose hunting and fishing seasons there, meet other families, and get supplies. Some Elders who were no longer able to travel to their traplines would stay at the post throughout the year (Denton 2001). In 1937, on his boat "Venture," Jack Palmqvist brought Oblate[28] Catholic missionaries to the Old Factory, where they built their "Mission de l'Immaculee Conception Vieux-Comptoir" and opened a school for children, which was known as "Fresh Air University." People remember that the Catholic mission maintained a kitchen garden and kept some pigs. The journal of the Mission shows that the population registered at the post in June 1938 consisted of 362 people. Anglican missionaries arrived at the Old Factory Bay in 1940 and began a competition with the Catholics. The Reverend Redfern E. Louttit was in charge of the mission and of supervising the building of a church (Morantz 2002a:153). Both missions operated on separate islands, had their own schools and were in a contest of drawing Cree to their own churches (Lofthouse 2013). There is also some evidence of amicable interactions. For example, there is a record in the journal of the Oblate missionaries that an Anglican teacher named Hamilton came to get a haircut from Catholic priests (Lofthouse 2013:34).

[27] Cree who lived within a few days traveling distance to the trading posts were called "homeguards" or "coasters" by the company men. The ones who lived far inland from the posts were called "inlanders" (Morantz 2002a).

[28] The Missionary Oblates of Mary Immaculate is the missionary religious congregation in the Catholic Church founded by Saint Eugene de Mazenod in France in 1816. They arrived and established themselves in Quebec province in 1853.

After its establishment, the trading post was a great point of attraction and often served as a temporary campsite and, for some Cree, as a permanent settlement with two missions, their schools, a trading post, and a Hudson Bay Company store. At the end of the 1950s, supply boats found it more and more difficult to get in and out the bay because of the shallow waters, and the settlement had to be moved elsewhere. After surveying the coast, the Cree chose the current location of Wemindji (called "Paint Hills" at the time) and relocated there in 1959, while a few chose the present location of Eastmain instead. Today, Cree from Wemindji and Eastmain still gather every summer for an annual celebration in the Old Factory Bay to remember and celebrate the life on the islands (Figure 6).

Figure 6. The gathering on the Old Factory island in 2007: fish cleaning competition, evening dances

2.4 The beginnings of the medicalization of life in northeastern James Bay

The first "physicians" in James Bay were the missionaries. Christianity had become a part of Cree life before the 20th century due to contact with fur traders and missionaries. The Cree took from Christianity what they needed: "They embraced its spirituality, interpreting it in their own Cree way" (Morantz 2010:96). Missionaries had a great influence on Cree beliefs, medical practices and family planning (Niezen 1997), however, the effects of this interaction went both ways. Missionaries who worked in the region reported that they had to

adjust their own minds and to learn Cree ways in order to reach local people with their message (Carlson 2009:100-102). Carlson adds, that "if many Cree became Christians, it is likely because Christianity, in its turn, became very Cree" (2009:101).

Missionaries started to interfere more actively in the life of the Cree in the northern part of James Bay during the second half of the 19th century, and in the early 20th century, many Cree in northeastern James Bay became members of the Anglican Church. This religious shift occurred at the same time as Cree were confronting significant changes due to diminished numbers of hunted animals and widespread death from epidemic diseases in the different parts of James Bay: 1895 – whooping cough, 1900 – influenza, 1902 – measles, tuberculosis, etc. (Morantz 2002a:43). Most of these diseases were brought by European settlers, and since the Cree had not been exposed to them before, they had not developed immunities and required medication that they did not possess.

Morantz suggests that the decline in game, especially caribou, and the waves of epidemics might have challenged Cree beliefs in their spiritual world and pushed them towards the Anglican Church (Morantz 2010:31). In other words, local institutions were not able to cope with the challenges brought from the outside and Cree started to look for new ways and new tools to cope with them, engaging with the Anglican Church, or embracing biomedicine[29] when it became available.

One of the most influential Anglican missionaries was Reverend W.G. Walton (Carlson 2009:102) who arrived at Fort George (now Chisasibi) in 1892 and remained until 1924. He was ministering to the Cree and Inuit of Fort George, Great Whale River (Kuujjuarapik), and Old Factory (Wemindji). He was also the "sole physician" for the Cree (cited in Morantz 2010:30 from Curran and Calkin 1917:115). There are testimonies of Walton willingly trekking to far away locations to visit sick or injured people. According to the post journals, the Fort George men left all medical needs of people to Walton's care (Morantz 2002a:86).

Catholics arrived to Chisasibi in the 1920s, offering some medical services and their religion. The Cree accepted their medical advice and support but did not convert to Catholicism. They continued with their own religious beliefs and leaned more towards the Anglican Church and practices (Morantz 2002a:96). During my interviews in Wemindji, Elders briefly mentioned Roman Catholic missionaries who possessed medicines and were treating the sick. They also remembered getting castor oil from the Catholic missionaries,

[29] In this thesis, I use the term "biomedicine" to refer to conventional "Western" medical practice that is currently no longer "Western," but is global in knowledge production and practice, has its own institutionalized structures, and is dominant in most parts of the world (Kleinman 1995:25).

which some Cree midwives used during births (seeChapter 5). Today there is no Catholic church in Wemindji, but Sarah Stewart remembered that during the 1950s, Catholic missionaries were still there. Sarah said that as a child, she and others would run down to get candies from the missionaries during Christmas; however, it was only the missionaries themselves who were visiting their Catholic church on a regular basis.

In the late 1920s, Cree started to get an annual visit from an "Indian agent-doctor," along with an X-ray technician for tuberculosis scans on a "medicine boat," which would come to Eastmain, south of Old Factory (Wemindji):

> The X-ray technician used to come with a doctor on a boat and stayed for a week sometimes. The boat they used was referred to as the "medicine boat." The doctor also worked as an Indian agent and his nickname used to be "the doctor of the law." He also looked after the people who were on welfare. (From the interview with Willie Matches, Elder from Wemindji, in Wemindji Turns 50, 2010:77).

The first nursing station on the eastern coast of James Bay was built in Rupert House (currently Waskaganish) in the 1950s. People at other posts looking for biomedical treatment or medication continued to rely on the missionaries or the Hudson Bay store managers (Morantz 2002a:189; see also below).

2.5 The beginnings of childbirth evacuations from Wemindji

Apart from the missionaries, Elders from Wemindji remember that when the settlement was moved to the mainland in 1959, it was the Hudson Bay Company store manager that was giving out medication and telling people how to take care of themselves in case of diseases. Bill Woodrow, the first Hudson Bay Company store manager in Wemindji (Paint Hills at the time), remembers that when the nursing station was established in the early 1960s, he was finally relieved from his medical duties. According to him, it was his toughest job to treat 150 measles patients in and around Wemindji (Bill Woodrow in Wemindji Turns 50, 2010:92).

From the same time, Elder Margaret Mistacheesick told a story about her son's birth in 1960. After the birth in the bush, Margaret and the newborn were sent out to the Moose Factory hospital by the manager: "We were living across the river. It was Fall. The manager of the store was present at my son's John's delivery. When I delivered my children, I was OK. And when John was being delivered, the manager came and sent me out. The manager wanted to make sure I was OK. I never came back until December" (Margaret Mistacheesick, Elder,

2013). “Was it Bill Woodrow?” Sarah[30] asked. “We will call him that,” replied Margaret. Sarah laughed. Margaret did not remember the manager’s name, but Sarah thought it was Bill Woodrow who sent out Margaret with her baby, as it corresponded with the years when Bill Woodrow was on duty in Wemindji.

Wemindji did not have a landing strip at the time and small planes could land only on the water or on the ice of a well-frozen river, so Margaret could not come back earlier; she had to wait until the river was completely frozen. Since she had delivered her baby in the bush, the manager, who most probably did not have experience or knowledge about births, wanted to be on the safe side. He also might have had instructions to evacuate newborns with their mothers from the bush. This is the earliest birth-related evacuation I have recorded from around Wemindji. It does not mean that it was the first one in the area, but based on Wemindji Cree accounts, it seems that evacuations from and around Wemindji were closely tied to the establishment of the permanent settlement in 1959 and the opening of the nursing station in 1962 (see Chapter 6). The settlement enabled the emergence of governmental institutions through which it was easier to administer and regulate the Cree, who previously would have been scattered in a large territory and moving around. After 1959, many Cree, even if not settled permanently in Wemindji, would come to town from the bush to see their families, to get supplies, to receive medical help at the nursing station, and/or to collect their government allowances.[31]

2.6 The childbirth evacuation policy and childbirth medicalization in Canada: Federal policy shifts and attitudes towards Indigenous birth

In this section I will step back from local events in Wemindji to place them in the wider Canadian context. I will look at the development of the federal government policies towards birth, and especially Indigenous birth. I will begin by describing the wider medicalization context in the Western world, which was paralleled by the theory of Social Darwinism popular in Europe and in the minds of the settlers in North America at the time. General

[30] As mentioned above, Sarah Stewart was assisting me during the fieldwork and conducting Elder interviews in Cree.

[31] The Cree in James Bay began receiving family allowances from the federal government in 1945. These consisted of monthly payments in the form of credit at the Hudson Bay Company’s store, where families could choose food or clothing from the list approved by the Department of Indian Affairs. Allowances were also used by the federal government as a tool to force Indigenous children into residential schools. If the family would not let their children go to school, their allowance was taken away (Morantz 2002a:209).

medicalization trends and Social Darwinism informed the policies and actions of the Canadian officials towards Indigenous peoples and their birth practices.

The process of colonization of Indigenous birth went hand-in-hand with general tendencies to medicalize and "modernize" birth. According to Davis-Floyd (2001:S9), since the Industrial Revolution, Western society has striven to control nature. The more nature and our physical bodies were controlled, the more westerners feared those aspects of nature that are uncontrollable, such as death, aging, disease, and reproduction - especially childbirth. She argues that the Western world tends to believe that technologically altered natural processes become better, in that they become more predictable, more controllable, and therefore safer (Davis-Floyd 2001:S9). In this context, pregnancy and delivery risks are perceived as preventable with the help of biomedical interventions and technologies. Increased control of childbirth through biomedical interventions is often used by national governments as a preventative measure to "ameliorate outcomes of health," to reduce biomedical risks and/or to "modernize" society (For various examples, see Fordyce and Maraesa 2012).

The process of colonization in North America led to the partial loss of Indigenous traditional occupations and natural resources, increased reliance on "White" food, and an erosion of traditional and medical knowledge (Brown, Varcoe and Calam 2011). Periods of starvation and epidemics among Indigenous populations resulted in poor health in various parts of Canada. The Canadian government attributed Indigenous health problems to the lack of biomedical care and lack of contact of Indigenous peoples with "civilized" society (Brown, Varcoe and Calam 2011; Niezen 1997). Those ideas were consistent with the prevailing unilineal social evolutionary model at the time (Social Darwinism), in which all societies were believed to naturally evolve through the same unilineal stages of development, though at different times. Indigenous peoples were understood to be at the lowest or earliest - and English Victorian society the highest or most advanced - stages of development (see Spencer 1860, Morgan 1877, Tylor 1871). Many European countries justified their colonial actions and control over non-European peoples in terms of bringing "civilization" to "savages"/ "primitives" for the good of humanity (Trigger 1997). Not surprisingly, through the analysis of archival documents, Lawford and Giles (2012a, b; 2016) found that the goal of the Canadian government's policy of evacuation of childbearing Indigenous women was not solely related to improving the health of Indigenous peoples, but was mainly an attempt to assimilate and to "civilize" Indigenous populations. One of the methods of assimilation was to medicalize and institutionalize

Indigenous birth, while devaluing and erasing Indigenous childbirth knowledge and practices (Lawford and Giles 2012a:331): "Our research results point to the ways in which the evacuation policy was not just about good health, but rather also about furthering the colonial project of the First Nations' assimilation and civilization. We do not assert that these were the only driving forces that informed the evacuation policy, (…), we do, however, suggest that existing archives reveal their prominence in evacuation policy's genesis." The reasons Lawford and Giles connected childbirth medicalization policies to attempts to civilize Indigenous peoples were several. They found that the Canadian officials' interference with Indigenous childbirth coincided with the rise of Social Darwinism and the belief that Indigenous peoples were at the lowest stages of development. They also found that the attitude about "uncivilized" First Nations and their birthing practices was reflected in the archival documents, and various correspondences between officials and their reports. Vocabulary and wording in these documents reveal the "civilizing" goals of the policy makers through women's bodies and medicalization of birthing. Lawford and Giles (2012a) also claim that "…the government was well aware of the enormous role women played within their communities. Not only were First Nations women the bearers of life and nourishers of all generations, but they held unique knowledge bases that directly contributed to their communities' health and wellbeing. The government's deliberate disruption of First Nations women's roles and responsibilities is testament to its aggressive tactics and colonial goals" (335). The childbirth evacuation policy is not unique to Canada. It has also been implemented in other former British colonies, such as Australia. Today Australian Aboriginals and Torres Strait Islanders face childbirth-related issues similar to those of the Indigenous peoples of Canada (Callaghan 2001, Ireland et al. 2011, Kildea and Wardaguga 2009).

In some Indigenous communities, implementation of the childbirth evacuation policy happened earlier and, in some others, later. The literature shows that implementation of the evacuation policy in the Canadian North happened during the late 1960s and 1970s (Douglas 2006; O'Neil and Kaufert 1995). Lawford and Giles (2012a, b) found that the beginnings of the development and implementation of the evacuation policy related to Indigenous birth started about 70 years earlier. According to Lawford (2011), the question of Indigenous births in the bush was brought to the attention of Indian Affairs in the late 19th century, and from there, the policies started to be built up to control Indigenous birth in order to "civilize" and assimilate.

In 1896, Indian Affairs hired a Euro-Canadian midwife to provide services to Chippewas and Muncey First Nation in Ontario. According to Lawford, this is the earliest evidence in Canada's archives that relates directly to the provision of perinatal care for Indigenous populations, and therefore constitutes the beginning of the introduction of the Euro-Canadian biomedical childbirth model to Indigenous peoples (Lawford 2011:39).

During the first quarter of the 20th century, the federal government was concerned with bringing birth from the bush into homes. The government proclaimed that they needed to fight the "old superstitions" and to educate Indigenous women about "proper care of children" and sanitation. The intention was for Indigenous women to adopt Euro-Canadian models of childcare, and eventually childbirth.

Following the trend of 'reducing risks in childbirth,' - meaning, controlling the birth process by biomedical interventions - the general policy in 1935 for all Canadian women recommended that all births should be attended by a physician and a qualified nurse. There was no limitation on where the birth should take place, but the policy stated that if a physician was not available for a home birth, the birth was to take place at the hospital (Lawford 2011:40). Traditional medicine and expert midwives and their knowledge were disregarded. There were no physicians or nurses available for bush births, therefore, in theory, birth had to be moved from the bush into homes or nursing stations, and eventually to hospitals. In practice, the situation differed from one place to another, as we will see later in the case of Wemindji.

By the mid 20th century, the Canadian government viewed Native midwives as particularly unsuitable to attend births because they did not possess biomedical knowledge, which government officials considered the only acceptable and safe standard of perinatal care. The federal government gradually replaced local Indigenous midwives with professionally trained midwives from Europe or Australia (O'Neil and Kaufert 1995). Ironically, at the same time as White urban "lay midwives" were striving to de-medicalize birth in Canada's South, promoting feminist ideas and advocating for women's choices in childbirth - including home birth - Euro-Canadian or Australian midwifes in the North were simultaneously seeking to control and medicalize Indigenous birth practices as directed by the government (O'Neil and Kaufert 1995).

According to Lawford (2001), the new policies had an immediate effect on Indigenous peoples–many Indigenous women in various parts of Canada followed these policies rigorously. Several Wemindji Elders I interviewed did not think they had a choice but to

follow those policies,[32] while others said they did not mind the hospital (see Chapter 7; for more on Cree compliance with evacuation policies, see Chapter 3).

In the 1960s, the Canadian Government made child and maternal health into their 'top priority' in the Indigenous healthcare sector. In 1967, the policy stated that it was acceptable to give birth in the nursing station with federally employed nurse-midwives, but that all primiparas (first time mothers), all gravida IV (fourth pregnancy) and over, and those with suspected complications, were to birth at the hospital attended by a physician (Lawford and Giles 2012a:334). Efforts were put into regulating who could attend births and where. Indigenous women were encouraged to go to medical institutions, and local traditional birthing practices were discouraged and demeaned by officials and/or biomedical staff who were sent to serve at the local nursing stations. By the early 1980s, official policy was against any births taking place in the remote local nursing stations (Daviss-Putt 1990:101).

2.7 The implementation of the evacuation policy in James Bay and Wemindji

In the early part of the 20th century, the federal government encouraged and expected Cree to give up their nomadic way of life and comply with national and provincial regulations, including those concerning healthcare. Since biomedicine considers childbirth a medical matter, Cree were expected to comply with protocols and procedures regulating childbirth as well.

In the 1940s, 7% of births in James Bay region took place at the hospital and by the 1960s the number was 91% (Robinson 1990:14). Wemindji does not fall within those averages in the 1960s, simply because the permanent settlement was only being established and people were still difficult to track down. The limited data that I collected suggests that before the 1960s, babies in and around Wemindji were mostly delivered on the land with only a few evacuation cases (Figure 7). There was no infrastructure to administer to people in the area before that time, and even though the trading post in Old Factory had been operating since 1935, most Cree were continuing a bush-based way of life throughout the year (Lofthouse 2013). According to Robinson, in the 1980s in James Bay, virtually all babies were delivered in a hospital setting (Robinson 1990:14). This time period is when Wemindji numbers start to catch up with the general childbirth hospitalization trend in James Bay and Canada - after 1963, the local nursing station slowly but surely became the place to go to

[32] The question of choice and methods of medicalization/colonization are analyzed in depth in Chapter three.

when in labour, and by the end of 1980s, the majority of women from Wemindji were birthing in southern hospitals.

Niezen (1997) has pointed out that dissemination of biomedicine has parallels with the spread of religion. Based on this idea, he establishes the concept of "medical evangelism". He argues that the spread of biomedicine and religion have four common identifiable traits:(1) each has the conviction that they provide access to vital knowledge; (2) each has a perceived need to change human behaviour; (3) both are universal and not restricted to various cultures, meaning any culture can embrace their truth and vital knowledge, and; (4) on the other hand, both have a tendency to be culturally intolerant of alternative local belief systems or healing practices (465). Niezen also identifies three main stages in which medical evangelism took place in eastern James Bay.[33] The first, or so-called "missionary phase," took place from about the mid-19th to the mid-20th century, when biomedicine and Christianity were complementary and worked together to change "irrational" Indigenous beliefs and healing practices. Missions, medicine and education acted together to convert the people. Looking back to the case of Wemindji, this is when missionaries became well established in the region, providing some schooling and medication to Cree. Thus, they were recognized as the first "physicians" in the region, later accompanied by the Hudson Bay store managers. Despite the largely intolerant, often imposing and complex fashion of the first stage of missionary evangelism in the region, I focus on the agency of Cree and argue that given the circumstances at the time, Cree chose their own belief or medical systems as they saw fit. They selected elements of those systems, altering them and using them to meet their everyday needs.

A different page of the story was opened in the first half of the 20th century, when the federal government started implementing the plan of "civilizing" and assimilating Indigenous people, in line with unilineal evolutionary models popular at the time. This corresponds to the second stage of medical evangelism as identified by Niezen (1997): when medical healthcare becomes institutionalized and centralized in the hands of government officials and biomedical professionals. Institutionalizing and medicalizing Indigenous birth was very much in line with the "civilizing" plan. It "modernized" the "savage" and "irrational" ways of birthing in "unsanitary conditions" and countered "old superstitions" (Lawford and Giles 2012). At the

[33] In this chapter, only two of the three stages of medical evangelism are relevant because I end the historical context analysis in the 1980s. This is when, according to Niezen, the third phase of medical evangelism begins, marked by the increasing openness of biomedicine to the Cree healing practices. This last stage, the indigenization of biomedicine and medical pluralism, will be addressed in detail in the last chapters of the thesis.

same time, assimilation policies coincided with the general trend of medicalization of human life. After the Industrial Revolution, as previously noted, the Western world started to believe that natural processes - such as birth, aging or death - needed to be controlled, so that they could become more predictable and therefore safer (Davis-Floyd 2003). Within this policy perspective, the only medical system suitable for the federal government to control nature with was the biomedical system; while Indigenous medicine, including midwives and their knowledge, were devalued and disregarded. By the late 1980s, after several policy shifts and consistent pressures, the government was successful in eroding the practices of Indigenous midwives and moving Indigenous birth from the bush to the hospital.

In the next chapter, I will look at some theories that potentially clarify the actions of colonized populations in the face of oppression. My goal is to answer the question, which I heard so many times from non-Indigenous and young Indigenous people: "So why did they go to the hospital? Why did they comply?"

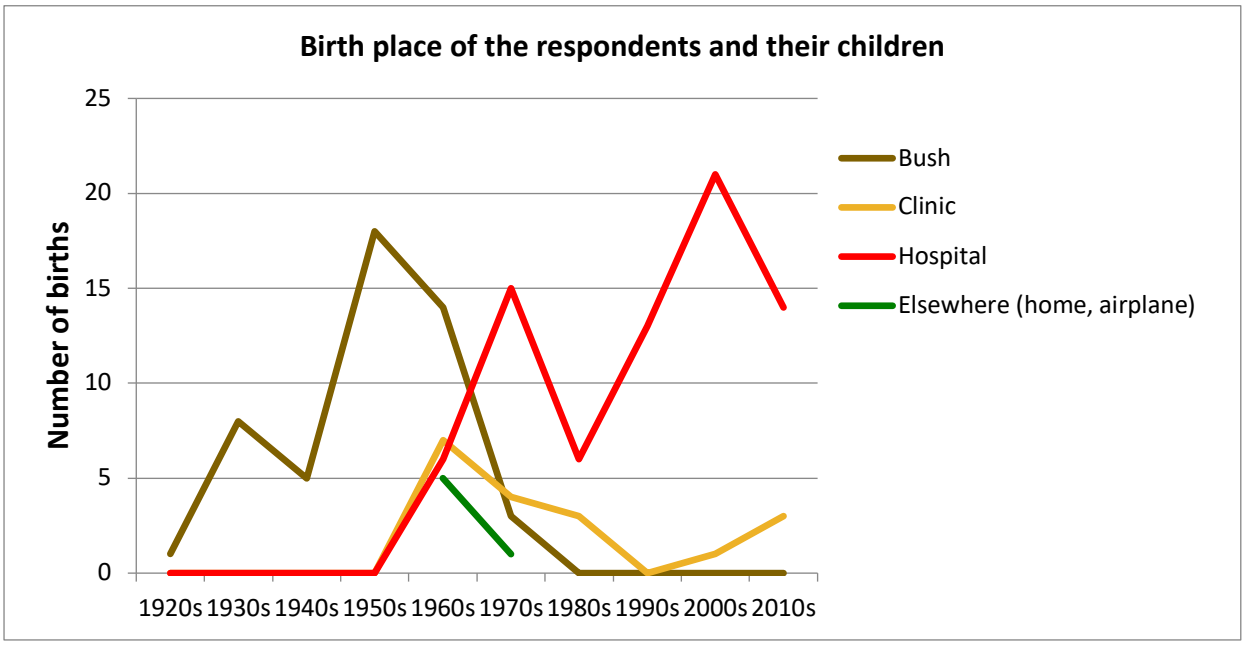

Figure 7. Birth place of the research respondents and their children from Wemindji

CHAPTER THREE: UNDERSTANDING CREE COMPLIANCE WITH THE EVACUATION POLICY

> "So how come no one thought about just going out onto the land?" he asked without looking at his father. His father lay on one side, leaning on his forearm and staring at the ground. "You get beat up good enough you don't breathe right," he said. "Meaning what?" "I don't know. All's I do know is that I was ten before we made it into town and then it was learnin' all about how to make my way through that."
>
> Richard Wagamese 2014, Medicine Walk

> It may be hard to understand why our Inuit men and women didn't protest the cold-hearted slaughter of the dogs that they not only depended on but also had a deep bond to. Just as one might wonder why parents allowed their children to be sent so far away to school, or why families would agree to move into settlements instead of living the way they had for generations. (…) To understand why our people followed directions that were clearly counter to their culture, their wisdom and their own self-interest, one needs to understand what we Inuit call ilira.
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> Sheila Watt-Cloutier 2015, The Right to Be Cold

In this chapter, I present and analyze a case study of childbirth in Wemindji in the early 1980s, which on its surface shows Cree conformity with the medicalization and evacuation policy for childbirth. It begs a question that I heard so many times from non-Cree and young Cree people–why did they comply? Why didn't they resist? In order to answer those questions, I tried to look for patterns in oppressed peoples' behaviour in the literature–can you find compliance, apathy and conformity in other places in the world when faced with oppression? Yes, you can, and those patterns are recorded by several scholars, such as Glen Coulthard (2014), Frantz Fanon (2008, 1963), Vincent Kenny (1985), Karen Lawford (2011), Karen Lawford and Audrey Giles (2012a, b).

Here I follow the sequence of colonization through the responses of colonized individuals to oppressive environments: 1) I discuss colonized peoples' adaptive strategies and their possible fears; 2) internalization of colonial rules; and 3) their break from the system of oppression – their resurgence. I employ several concepts and theories that help explain those processes and actions: complementary relationship (Bateson 1979), constriction (Kelly 1955), superficial compliance (Kenny 1985), ilira (Inuit concept of fear; Brody 2002), panopticism (Foucault 1995) and internalized colonialism (Coulthard 2014).

3.1 Colonialism at work: the evacuation policy in action

Most literature about the evacuation policy for Indigenous childbirth in Canada deals with Inuit[34] birth and their perspective on the issue. There is more limited work on First Nations' experiences (Brown et al. 2011; Lawford 2011, 2016, Lawford and Giles 2012a, b; Varcoe et al. 2013). It is noticeable that the literature on Inuit birth is mostly from the 1990s, about a decade after the evacuation policy was enacted in the remote areas.

Research on First Nations peoples' experiences is more recent, mostly from the second decade of the 2000s. Inuit (Hudson Coast and Strait) showed a strong resistance to the childbirth evacuation policy, which was supported by anthropologists and some medical professionals, especially in the 1990s (Douglas 2006; Jansen 1997; O'Neil and Kaufert 1990, 1995; Kaufert and O'Neil 1990, 1993; O'Neil and Gilbert 1990; Paulette 1990; Simonet et al. 2009; Van Wagner et al. 2007, 2012). An edited collection by O'Neil and Gilbert (1990) highlights Inuit resistance to the childbirth evacuation policy. It includes chapters by anthropologists, medical professionals and Inuit women voicing their concerns about the inadequacy of the policy, differences in the concept of 'risk' between Inuit thought and Western biomedicine, and the need for local birthing centres and locally trained Inuit midwives.

During my interviews in Wemindji, I expected to hear a similar kind of resistance in the stories of Elders when talking about birth transfers from the bush to the nursing station between the 1960s and 1970s, or the early transfers to the hospitals in the 1970s and 1980s. However, Cree Elders stories were somewhat different. Their thoughts about preferred place of birth were nuanced, and there was no obvious resistance expressed towards the evacuation policy. Wemindji Elders clearly distinguish between circumstances of the past and the realities of the present, and negotiate their stance on the best place for birth. If I had asked the same questions in the 1990s, would their replies have been different? If the same questions were asked of Inuit now, would their replies be different?

Lawford (2011) found that the evacuation policy (see Chapter 2) promoted by the federal government in the middle of the 20th century, had an "immediate and profound impact on the location of First Nations birth" (Lawford 2011:43). Various reports from physicians,

[34] The many different Indigenous peoples in Canada legally are divided in three major groups: First Nations, Métis and Inuit. First Nations are Indigenous peoples who mostly inhabit or have their traditional territories below the Arctic Circle (there are exceptions, for example Gwich'in); Inuit are Indigenous peoples who inhabit the northernmost territories of Canada and the tundra of the Arctic; and Métis trace their ancestry to First Nations and the early European settlers. Over time Métis emerged as a distinct people with their own identity and cultural traits (McMillan and Yellowhorn 2004).

nurses and agencies to the federal government recorded high and rapidly increasing numbers of First Nation births at the hospitals that indicated First Nations women's compliance with the hospital birth policy (Lawford 2011:43). For example, a doctor in Alert Bay, British Columbia wrote: "The Indian women from Alert Bay and surrounding districts today accept it as a matter of course that they should be admitted to hospital for confinement, and that is the situation which I found here when I took over six months ago" (St. John 1942 February 16, p.1, cited in Lawford 2011:43). Lawford found a similar situation in the 1940s and the 1950s in other places in Canada, like Alberta and Saskatchewan, where many First Nations' families viewed hospitals as the principal location to birth (Lawford 2011:43-44). However, Lawford does not suggest that this adoption of hospital birth was voluntary or welcome. According to Lawford, First Nations in Canada were forced into the biomedical childbirth model through coercion and marginalization (2011; Lawford and Giles 2012).

In northeastern James Bay, childbirth policies were set in motion somewhat later, but judging from my interviews with Elders, it seems there was a similar pattern of compliance among Wemindji Cree women, as described by Lawford. Some Wemindji Elders recognized that childbirth in the bush was difficult, and it was easier in the hospital, while others said they preferred to give birth on the land with a midwife. Many of them saw the benefits and drawbacks of both places. Everyone I spoke to had obeyed the evacuation policy, even though some Elders said they were not sure why they had to be evacuated when they had previously given birth to children on the land. But this is what they "had to do," they said, and so they followed through (see Chapter 7).

The two existing perspectives in the literature on women's compliance with the institutionalized birth policy are different: the biomedical staff writing reports in the mid 20th century seem to demonstrate a belief that women's compliance was voluntary, while Lawford (2011) and Lawford and Giles (2012a, b) write about forced compliance and the coercive methods that were used by governmental institutions to lure women to the hospitals to birth. I complement those two perspectives with a third one– superficial compliance. I argue that women complied with institutionalized birth policy superficially; it was their way of survival and resistance. A story from Wemindji that I present in the next section will be an example that will allow me to elaborate on the concept of superficial compliance as an adaptive strategy, and will help to analyze the questions "Why did they comply?" or "Why did they go to the hospitals?"

3.2 A case study: Elizabeth's birth story

I met Elizabeth in the Wemindji clinic when conducting interviews with Cree staff. Elizabeth worked as a CHR[35] at Awash department. After learning about my research topic, she eagerly shared the story of when she was born in the Wemindji clinic in the 1980s. She was the 5th child in her family. At the time of Elizabeth's birth, her parents were living in the bush throughout the year. Even though the Paint Hills (called Wemindji today) settlement was established in 1959, and the federal government strongly advocated a settled lifestyle, Elizabeth's family continued to hunt, trap and live on the land.

Her mother went into labour while the family was in and around their bush camp, including Elizabeth's grandmothers, who both were experienced midwives. During labour, Elizabeth's mother decided to go to the nursing station. Together with her husband she sat on a skidoo and drove about 25km into town:

> I was born here, cause my mom, we were in… it was in the spring camp, it's usually in the coastal area. My mom told me the story. She said she had contractions that morning, and we were still in camp, we still had some things to do, and to get ready for the spring. Like getting the wood, firewood ready, getting the water, all of those things. And she didn't come into town right away. She said only after a while she told my dad she had contractions. So they drove with the skidoo to come into town, and not long after we came into town… cause she was already having contractions… and one of her sisters came to the clinic to be there for the birth… and she said, she didn't mention the time, but she said not long after that, I was born.

In the clinic?

> Yeah.

According to Elizabeth and stories she heard from her family, the help her mother received at the station from the professional nurses was not efficient, and so she had to rely on another Cree midwife, Elizabeth's aunt, who came in to help her deliver:

> My aunt who was there when I was born, she said there was this nurse that was terrified, a new nurse. Like she was quite young, and she was panicking, and she started pressing my mom's belly. My aunt just slapped her, "Don't do that!" [Elizabeth laughs] So she (aunt) said she took over and told her, "You can go stand over there."
> She knew the nurse was panicking, not knowing what to do. It was her first… probably her first experience, cause she was a new nurse and she (aunt) said that the nurse was quite young, so she said, "I was the one being there and I helped with the delivery." Cause there was another nurse there.

[35] Community Health Representative is a liaison between community and medical staff at the clinic. CHRs are trained on the job and have to attend many different workshops to improve their professional skills and knowledge. Every pregnant woman or family with children have their CHR at Awash department and have regular appointments.

> In my family there's three of us that have orange hair and she (aunt) tells people, "I delivered her when she was born, if I had delivered more babies, they would have orange hair too!" [Elizabeth laughs]

Do you know how many people were with your mother in the clinic then?

> I think there was two nurses and my aunt.

Today Elizabeth wants to understand why her mother rushed to the nursing station. Elizabeth thinks her mother had all the best conditions to give birth in the bush, surrounded by her family and in the care of two experienced midwives. Elizabeth said she wished her mother had never left the camp and she had been born on the land, in the bush:

> So I said to my mom, "Why didn't you stay in the bush?!" Cause both of my grandmothers were there, and I told her "You were already having contractions, why didn't you stay?"

What did she say? Why?...

> I think it's because people were already more going out to town to go have their children, and out of town.[36] Like my older sister was born in 74… 75 somewhere around there, and she was born out of town. So people had already been going out… and I'm the 5th child, so they were, I think they were already in the mind-set of having children there. But I had to ask this question, 'Why didn't you stay at the camp and wait for my birth?! 'Cause my grandmothers were there…

3.3 Adaptive strategies: superficial compliance as a form of survival and resistance

It seems that Elizabeth's mother put in considerable effort, going against her own comfort during labour, so to comply with established rules and get herself to the clinic - even when there appeared to be no obvious bureaucratic/legal consequences for her had she not. However, the consequences for not complying with the rules may very well have been unknown or unpredictable, and such conformity could be a learned behaviour, one that evolves as a survival strategy in an environment of oppression. This oppressive colonialist environment could be described in Bateson's terms as a complementary relationship (1979). Bateson (1979) developed the idea that two groups or communities having continuous ties and contact with each other develop a relationship that is either complementary or symmetrical.[37] In daily language, these terms are generally perceived as positive, yet Bateson

[36] "… and out of town" – she refers to the hospital in Moose Factory.

[37] Symmetrical relationship – all forms of interaction that involve competition, rivalry, mutual emulation, etc., when actions of A stimulates similar actions of B, which in turn stimulates A and would continue to boost each other's reaction (Bateson 1979:192).

defines them very differently. According to his theory, in the complementary relationship, the actions of two groups are different, but mutually fit in a jigsaw fashion (Kenny 1985), meaning that if A is dominant then B is submissive, if A is exhibitionist then B is spectator, and if A is succouring, B is dependent (Bateson 1979:192). Such relationship patterns could be applied to the colonial relationship between the Canadian government and Indigenous peoples at the time. Kenny (1985) combines Bateson's complementary relationship dynamics with Kelly's (1955) notion of "constriction" to analyze Irish post-colonial character. Constriction is a sum of psychological tactics developed in complementary relationships while coping with a hostile, oppressive and authoritarian environment where individuals develop feelings of confusion, guilt, shame, inferiority, anger and frustration. The oppressed group constricts its interests and takes a near-sighted view of the world, dealing with only one issue at a time in order to reduce the range of elements that they find impossible to deal with as a whole (Kenny 1985).

Colonization creates a confusing and oppressive environment, where psychological constriction patterns start to emerge in a population. Kenny (1985) describes seven patterns that constriction may entail. One of them is especially useful in understanding Cree compliance with birth evacuation policies - a superficial compliance or pseudo-compliance. It is a safe tactic because superficial compliance reassures the oppressor that the power relations maintain the status quo. At the same time, superficial compliance creates a split within oneself, because external actions and signals do not correspond with internal experiences. The tactic of superficial compliance helps one to survive when open rebelliousness would most probably evoke immediate harsh measures from the oppressor. Thus, often the actors in oppressed systems employ external actions that superficially manifest compliance, and so are safe, yet leave such actors in a state of inner turmoil and disturbance.

Before looking into a few examples of superficial compliance in different sociocultural contexts, I want to bring up two different notions of fear that oppressed peoples feel towards oppressor and oppressive environment. I will particularly discuss the Inuit notion of ilira – a fear of unknown, mysterious and violent authority - and Foucault's social panopticism model, which refers to the fear generated by the perceived possibility of being visible/seen at all times.

3.3.1 Ilira

The Inuit concept of ilira describes a particular kind of fear that is born out of an authoritarian and unpredictable environment – a complementary relationship in this case. Ilira can be used to understand the actions of oppressed or colonized people in hierarchical complementary relationships, and clarifies the nature of superficial compliance by providing a glimpse into the experience of the colonized. In The Other Side of Eden (2002), Brody describes how he was learning various Inuktitut words for different kinds of fear, and tried to distinguish between the different concepts of fear (42-43). This led him to ilira.

In clarifying ilira, Brody's teacher, Anaviapik, told him how sometimes Inuit obeyed colonizers' demands and rules and did things that were not in the interest of Inuit. For example, he described a situation when the White policeman from the South came to town and gave orders for men to work very long hours, and everyone obeyed. The policeman also had sexual relations with women in town, who did not like him. "We felt ilira," Anaviapik explained to Brody (43). Ilira very accurately defines fear of someone in authority. Whatever or whoever causes ilira – "They are people or things that have power over you and can be neither controlled nor predicted. People or things that make you feel vulnerable, and to which you are vulnerable" (Brody 2002:43). Among those unpredictable authority figures that Anaviapik referenced were ghosts, domineering fathers, people who are strong but unreasonable, as well as White people from the South. If one can recognize the kind of fear associated with ghosts or violent parents, one can understand how colonized people felt in regard to colonists and their institutions. Brody continues: "The word ilira goes to the heart of colonial relationships, and it helps to explain the many times that Inuit, and so many other peoples, say yes when they want to say no, or say yes and then reveal, later, that they never meant it at all" (Brody 2002:43). Thus, although Cree might not have named that particular fear, they might have acted according to ilira.

3.3.2 Panopticism

If we return to the case of Elizabeth's birth, we might assume that the immediate consequences of disobeying the evacuation policy were not obvious. There was nobody around to witness disobedience. Reasons for compliance when there seem to be no immediate obvious repercussions could also be explained by Foucault's social panopticism[38] model,

[38] Panopticon – an architectural structure developed by Jeremy Bentham in the late 18th century that could be used in the construction of different institutions, where discipline and control are needed – prisons, schools, hospitals etc. In the case of prisons, a panopticon is a circular structure with an observation tower in the middle

where actors do not know if, when or how they might be caught in disorderly action. Foucault saw a modern prison (app. 1750-1830) as the point of departure for panopticism, where the prisoner cannot know when and by whom he/she is being watched. To Foucault, panopticism represents "transformation from the situation where the many see the few to the situation where the few see the many" (Mathiesen 1997:217). According to Foucault, panopticism forms a part of the new "modern" society that emerged in the late 18th and early 19th century.

Foucault transports the architectural panopticon model from the institutional setting to society at large: "In appearance, it is merely the solution of a technical problem; but, through it, a whole type of society emerges" (Foucault 1995:216). Actors in such a system are obedient because they are always visible, and "visibility is a trap" (Foucault 1995:200).

The panopticism model may be applied to colonial contexts where colonizer states discipline colonized subjects. In eastern James Bay, federal and later provincial governments,[39] disciplined Cree by making them into "civilized" citizens through various institutions. Watchmen in this system were government agents, employees of the Department of Indian Affairs, hospitals and schools, different church representatives, the Hudson Bay Company store managers, etc. A hint that Cree were aware of White officials 'watching' is the Cree threat to children who misbehave: "Stop! The White man will come and get you!" (Morantz 2002a:3-4). The saying assumes that the White man might be watching at any time, otherwise how would he know when you misbehave or when to "come and get you"? It demonstrates the mistrust, threat, and ilira Cree felt towards White people, who could be watching, taking notes, reporting, and later witholding family allowances or taking children away to boarding schools or foster homes. And it is true that Euro-Canadians, mostly White people[40] from the South, in one way or the other, were governing the Cree and their territories,[41] keeping track of their numbers and whereabouts. For example, in 1945 the federal government began distributing Cree family allowances based on the number of children in the family. Those allowances were essential to Cree families during the years of

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for the watchman. The watchman is then able to see all the prisoners at all times, while the prisoners can never see the watchman, so they do not know when or by whom they are being watched from the tower in the middle.

[39] Until the 1960s, the eastern James Bay Cree region was mostly the federal government's jurisdiction, managed through the Department of Indian Affairs. The Quebec government had a role as policy-maker regarding game and fish conservation in the region. It was only in the 1960s that the Quebec government started to show interest in James Bay territory, because of potential use of the region's natural resources (Morantz 2002a:221).

[40] A very small number of the officials or medical professionals may have been non-White. I happened to meet one of the nurses who came to work in James Bay in the 1980s from Britain and who was of Indian decent. This fact, however, does not make a difference in the perception of the Cree back in the day of the colonizer being a White Euro-Canadian.

[41] Since the establishment of beaver reserves in the 1930s, the officials from the Indian Affairs made annual inspecting tours of those reserves (Morantz 2002a:225).

starvation and different epidemics (1940-1950). They also allowed Cree to maintain their bush-based lifestyle (Morantz 2002a:209). Allowances were distributed by the Hudson Bay Company store manager in the form of credit for food and clothing at the store. As previously noted, these family allowances were used by the government to force children into residential schools - if parents did not send children to faraway schools, they would lose their family allowances altogether (Morantz 2002a:209, 213).

At the same time, Indian Affairs worked closely with the post/store manager, who distributed the allowances and had to manage funds rigorously. If the welfare was distributed too generously, the manager could be called into question (Morantz 2002a:210). Another example of the exercise of invisible power and discipline over Cree was the government Indian Agent who was a liaison between Cree communities and Ottawa. Indian Agents had the responsibility of organizing elections of band chiefs and tended to naturally favour government policies and directives (Morantz 2002a:223-224).

This is how the Reverend Scanlon characterized the Indian agent Lariviere[42] and his discipline and control over Cree in Mistassini: "…He knew so much about his immense region and its people, that he, in effect, controlled his superiors and their policy. They never questioned him … He was feared and respected by the Indians" (cited in Morantz 2002a:224). The Reverend added that the success Lariviere had in controlling the region was a result of his close cooperation with post managers (Morantz 2002a:224). Cree were watched by the federal government through the Indian Agent, who in his own turn engaged the post managers to provide him information. According to Reverend Scanlon, the managers greatly assisted Lariviere "in the work of improving the lot of the Indians" (Morantz 2002a:224).

In sum, many colonized individuals might have maintained expected and orderly behaviour at all times because they did not know when and who might be watching, whether it was a post manager, an agent or a nurse. Awareness of possible continuous observation by all or any of the government officials, including ministers, store managers, teachers or nurses could add to the reasons Cree engaged in superficial compliance tactics.

3.4 The manifestations of superficial compliance in different contexts

Superficial compliance suppresses internal thoughts and emotions, which then accumulate. Kenny (1985) suggests that superficial compliance is often accompanied by the

[42] Lariviere was an Indian Agent in Mistassini for over 40 years, from the beginning of the 20th century until about the 1950s.

feeling of need for unity within the suppressed group, and the need to find ways to express that unity to the members of the group. In other words, the members of the oppressed group feel a need to communicate their message of togetherness to each other, to let fellow group members know that they did not give up on their beliefs. That covert manifestation of unity and resentment can take unexpected and/or innocent shape: "There is a strong social need for people to appear unified as a group, and this can be manifested in ways such as dress, rituals, religious observances, etc." (Kenny 1985:73). For example, during the Soviet occupation of the Baltics, when the Lithuanian partisan resistance had died out (1960s), the population largely seemed to be following the rules of the Soviet system (superficial compliance): getting jobs required a membership in the communist party, going to school meant becoming a Little Octobrist[43] or a member of a Pioneer[44] movement, etc. Many people complied with those and other regulations, but resistance manifested in other unpredictable forms. In Lithuania, basketball matches became expressions of national pride and unity during the last years of the Soviet Union and maintained their role by becoming a national sport of Lithuania in the 1990s. The singing revolution[45] is another example of quiet resistance in the Baltics, where people would sing in gatherings songs ranging from folk to rock (Šmidchens 2014, see also documentary by Žickytė "How We Played the Revolution" 2012). While many manifested compliance externally, basketball or singing was the face of resistance that unified the community and expressed the inner experiences of the crowds.

Other forms of superficial compliance under Soviet occupation included social science publications. If we take a quick look at archaeological books and articles of the time, we might think that much of the material was following the Communist party's agenda because the texts contain political support and statements of praise for the Party and the Union. However, the researchers and authors had developed methods for coding their messages and expressing their protests against oppression. Readers, in the meantime, became well trained in recognizing these methods and strategies, and were able to discern ideas that belonged to the author and ideas that were imposed by the Soviet political system. For example, one of the

[43] Little Octobrist – in the Soviet Union all children between ages 7 and 9 were required to join Little Octobrist organization, based on the Soviet Union's political agenda. Children would have to wear a uniform and a Little Octobrist star on the chest, to signify that they are the members of the organization and comply with the behavioral and ideological rules.

[44] Young Pioneer – at the age of 9, Little Octobrists had to join the Young Pioneer organization for children ages 9 to 15, also based on the conduct rules and political ideology of the Soviet Union. The distinguishing symbols on the uniform were the red neck scarf and the badge on the shoulder.

[45] The "singing revolution" is a name commonly referring to the events and resistance that took place in the three Baltic states between 1987 and 1991 that led to the restoration of independence from the Soviet Union.

most adaptive methods in Soviet era Lithuanian archaeological literature was to avoid the topics that were politically sensitive or unacceptable (Luchtanas, lecture notes 2003). Such topics included the interpretation of archaeological data and theory building. The only safe way of disagreeing with an official position was to keep out of the discourse entirely and thus the silence was used as a statement of disagreement (Клейн 1993:82). In the long term, this interpretive and theoretical silence contributed greatly to the development of a strongly descriptive archaeological tradition in Lithuania (Paberžytė and Costopoulos 2009). Klejn titled this strategy "pose of silence," often accompanied by the "payment of tribute" (Клейн 1993:82). According to Klejn, "payment of tribute" expressed itself in separating the main text from politically enforced statements. The Soviet system and the classic ideas of Marxism were discussed apart from the main text in separate chapters, usually the introduction, the foreword and/or the conclusion. Similar and other strategies were employed in other social science publications. Thus, archaeologists who were externally exhibiting compliance employed different methods like the "pose of silence" and/or "payment of tribute" to express their protest and inner realities.

Another example of superficial compliance could be observed in the Canadian Arctic among Inuit. Stevenson (2014) developed a concept of cooperation, which she describes as a requirement of the Canadian authorities for Inuit to cooperate in biopolitics[46] in order to survive the tuberculosis epidemic. The Canadian government made an effort to keep Inuit alive and to control the spread of the disease apparently at any cost, and with little regard for the quality of life of Inuit people.[47] The Canadian biopolitical system that sees value in life itself, sees life differently than Inuit do. Even though Inuit live and engage in the biopolitical system, they have their own ways of expressing their inner realities. When the Canadian government assumed that starvation, perinatal deaths and tuberculosis in the Arctic were more or less under control, in the late 1980s, youth suicides erupted. Stevenson (2014) argues that suicide became a form of resistance against biopolitics: "In fact, one of the arguments of this book is that Inuit are never fully made into biopolitical subjects. They frequently fail to cooperate with the regime of life, and they live – or die – beyond its grid of intelligibility" (2014:70). Suicide became an Inuit expression of inner experiences of biopolitical life.

Even though at first glance Cree largely embraced the biomedical childbirth model and complied with the removal of birth from the bush to the hospital, we can observe the many

[46] Biopolitical – *"... a form of care and governance that is primarily concerned with maintenance of life itself and is directed towards populations rather than individuals"* (Stevenson 2014:3-4).
[47] Tuberculosis epidemic among Inuit occurred roughly between the 1940s and the 1960s (Stevenson 2014).

continuous or modified Cree childbirth practices that manifest in the hospital setting today. Those practices carried through the medicalization process are the manifestation of superficial compliance - Cree resistance and their wish to birth in their own ways. Throughout this thesis, I try to understand the inner experiences of Cree in childbirth and try to explore how some Cree birthing practices continued despite medicalization, while others were adapted to the new environments, and some others are currently being reconsidered, revived or adopted.

Before moving to other chapters analyzing past and present Cree childbirth practices that have persisted and changed, let's look at how colonialism can become internalized in the colonized subject over time, and how the colonized can finally break out of their oppression. This glimpse will provide even more insights into the superficial conformity of Cree actions during medicalization and the current resurgence movement.

3.5 Internalized colonialism

Superficial compliance explains some of the adaptive strategies of subjects in an oppressive system. After a long enough period, actions assumed through superficial compliance out of ilira, or out of fear of being watched (panopticism) can become automated, or normalized. As Elizabeth notes in her story above, her mother's actions were probably a habitual response that did not involve much rationalization at the time. In discussing colonial effects on colonized subjects, Coulthard (2014) notes how the anger and confusion of oppressed people can turn into resilience and eventually active self-conscious resurgence. He revives the ideas of psychiatrist, philosopher and revolutionary Franz Fanon (1925-1961), who analyzed the effects of colonialism and racism on Black people. Many of Coulthard's insights are based on Fanon's writings and are adapted to the Canadian context and its policies towards Indigenous people in Canada. Fanon observed and described phenomena in colonized nations that came to be known as internalized colonialism (Sardar 2008, Coulthard 2014:112), which manifests in automated actions and compliance with the colonial system. Superficial compliance eventually may become a condition of internalized colonialism. Colonialism requires the production of colonial subjects that "acquiesce to forms of power that have been imposed on them. "Internalization" thus occurs when the social relations of colonialism, along with the forms of recognition and representation that serve to legitimate them, come to be seen as "true" or "natural" to the colonized themselves" (Coulthard 2014:112-113).

When Elizabeth asked her mom, "Why didn't you stay in the bush?!", her mother replied that she did not know, she only did what everyone else was doing. In other words, she did what was expected from her and what was "normal" to do. At this point she might have assumed that colonial biomedical rules were "normal," "true" or even "better," In sum, the means and strategies of the colonizer in the complementary relationship are designed to produce subjects supportive of their own colonization through a combination of coercion and consent, while an adaptive strategy of the colonized in such oppressive environments is a superficial compliance, which later might become automated as internalized colonialism. According to Coulthard, normalization and internalization of colonial ways and views produce stagnancy, inertia and passivity in the colonized population (2013:113). If Elizabeth's mother was acting out of fear, then the social panopticism model and ilira might explain it, but if she acted out of inertia, because that was the norm, then her actions can be explained by internalized colonialism. That is exactly why Elizabeth's mom might not have found the answer to the 'why' question when she had to explain leaving the camp for the clinic. It was a norm. As Elizabeth says: "… they were already in the mind-set of having children there..."

3.6 Indigenous resurgence

Where is the breakthrough from the system? When and how do people become conscious of the injustice of their situation? Colonizers view the colonized as lesser and not worthy, and that's how the colonized gradually start seeing themselves. They devalue themselves and want to be "better," "Whiter," more "civilized." According to Coulthard, such a humiliating situation overwhelms the colonized, and negative reactions and anger emerge over time. Coulthard argues that this particular anger and resentment at some point start being expressed—individuals begin to externalize it (2013:114). That expression is a breakthrough point from internalized colonialism: "The colonized subject, degraded, impoverished, and abused, begins to look at the colonist's world of 'lights and paved roads' with envy, contempt, and resentment. The colonized begin to desire what has been denied them: land, freedom, and dignity" (2014:113). In contrast to the time when the group was exhibiting superficial compliance and expressing unity through covert ways (dress code, rituals, etc.), this time, when anger and resentment externalize, the protests are no longer covert. Inner experiences are being expressed externally. People start open demonstrations, blockades of roads, grassroots movements, etc. They realize that their current misfortunes are not due to their own

deficiencies: “After years of dehumanization the colonized begin to resent the assumed ‘supremacy of White values’ that has served to ideologically justify their continued exploitation and domination” (Coulthard 2014:114).

To exemplify Indigenous resurgence, Coulthard uses the example of the Indigenous “Idle No More” movement that erupted at the end of 2012 in Canada. It was sparked by the passing of omnibus Bill C-45, which Indigenous peoples saw as yet another threat to Aboriginal peoples’ rights and environments. The vision of the “Idle No More” movement calls "… on all people to join in a peaceful revolution, to honour Indigenous sovereignty, and to protect the land and water" (http://www.idlenomore.ca/vision). This movement started as an education campaign initiated by three Indigenous women and one non-Native ally – Jessica Gordon, Sylvia McAdam, Nina Wilson and Sheelah McLean (https://www.culturalsurvival.org/publications/cultural-survival-quarterly/being-idle-no-more-women-behind-movement). The goal was to provide information to Canadians about the impacts of Bill C-45 on Indigenous peoples, the environment and thus, all Canadians. This was followed by the hunger strike of Chief Theresa Spence of the Attawapiskat Cree Nation, who demanded a meeting with Prime Minister Stephen Harper and Governor General David Johnson to discuss treaty rights. Soon the movement spread via social media, where people began organizing themselves for “days of action” across the country. Many tactics of protest involved “flash mob” round dances, drumming in public spaces, prayer circles, education campaigns, conferences, teach-ins and public panels. As demands were not met and agreements not reached, more people engaged in more assertive forms of protest across the country – displays of marches, railway barricades, highway and bridge stoppages. At the end of January 2013, the “Declaration of Commitment” was secured after long negotiations between the Indigenous leaders and the Canadian government officials. The “Declaration of Commitment” had thirteen points, among which was a review of Bill C-45 in accordance with in-depth consultations with Indigenous peoples, a national inquiry into hundreds of cases of missing and murdered Aboriginal women, a promise to improve Indigenous education and housing, the full implementation of the United Nations Declaration on the Rights for Indigenous Peoples, and reform of the federal government’s land claims policy, etc. (Coulthard 2014:163-164). The movement is ongoing and continues to support environmental protests and Indigenous rights and sovereignty worldwide. As Jessica Gordon, the initiator of the movement, said, “A lot of people use it to motivate themselves and to feel, share in solidarity. They know they're not the only ones out there. Idle No More is still there, still

strong — people are finding different ways to use the movement and empower themselves and others" (from an interview with Jessica Gordon, December 2017 https://www.cbc.ca/news/indigenous/idle-no-more-five-years-1.4436474).

A short vignette by Indigenous (Michi Saagiig Nishnaabeg) scholar, writer and artist Leanne Simpson in the introductory chapter of her book Dancing on Our Turtle's Back echoes the process of resurgence, described by Coulthard, on a personal level. She describes one of her experiences of resurgence–getting rid of the feelings of shame and inferiority instilled by colonialism. She takes us through her emotions and thoughts as she walked on the 21st of June 2009 with a crowd of Indigenous peoples down the streets of Peterborough celebrating Indigenous Day. She felt joy, solidarity, unity, but at the same time, shame:

> (…) shame that is rooted in the humiliation that colonialism has heaped on our peoples for hundreds of years and is now carried within our bodies, minds and our hearts. It is shame that our ancestors–our families–did not rally hard enough against the colonial regime. It is shame that we were tricked into surrendering our life, land and sustenance during William Treaty[48] process. It is shame that makes us think that our leaders and Elders did not do the best they could." (2011:14).

Further on, Simpson continues with the realization: "To me, this colonial shame felt not only like a tremendous burden to carry, but it also felt displaced. We are not shameful people. We have done nothing wrong" (2011:14). This is when Simpson changed the perspective on that shame, which she realized was instilled by colonialism and that resistance had always been present; otherwise, she and her people would not be marching the streets celebrating Indigenous Day: "I began to realize that shame can only take hold when we are disconnected from the stories of resistance within our families and communities. I placed that shame as an insidious and infectious part of cognitive imperialism that was aimed at convincing us that we were weak and defeated people, and that there was no point in resisting or resurging" (2011:14). The shame initially felt and observed by Simpson parallels the devaluation of colonized and devalued individuals described by Coulthard. The resentment and realization that her people did nothing wrong, or, in Coulthard's words, the realization "that current misfortunes are not due to their own deficiencies" is an example of a personal resurgence, one of many resurgence stories colonized individuals may have.

[48] The Williams Treaties were the last historic land cession treaties in Canada, signed in 1923 by the governments of Canada, Ontario and by seven First Nations. According to the agreements, over 20,000 km² of land in southcentral Ontario were transferred to the Crown in exchange for one-time monetary compensations to Indigenous signatories. Chippewa and Mississauga peoples argue that the Williams Treaties also guaranteed their right to hunt and fish on the territory, but the federal and provincial governments disagree. The Treaty is the reason for current legal disputes and negotiations between the three parties involved. (https://www.thecanadianencyclopedia.ca/en/article/williams-treaties)

Among decolonization and resurgence movements throughout North America, James Bay Cree are no exception. There are various voices, initiatives and debates taking place among Cree to reclaim the ways of being Cree and to re-value various Cree practices and beliefs. Greta Visitor,[49] Director of the Wemindji clinic, said in an October 2016 speech to the House of Commons:

> …colonialists robbed Cree and the First Nations of their identity and of the sense of autonomy, the ability to believe that people have a voice and a choice. As a result, many people are filled with sense of apathy. I think, in order for our people to come back into balance and to take their rightful place in their society they have to come back to the basics, they have to re-embrace who they are as First Nations people, as Cree.

Here, Greta speaks of what Coulthard recognized as the signs of resurgence: the resentment, the wake-up call from the apathy, the urge to re-evaluate and to reclaim values and traditions.

In connection with resurgence movements and initiatives, various projects take place at the Cree Health Board. One of those projects, "Cree Birthing Knowledge," initiated in 2013, was directly concerned with Cree childbirth and the choices Cree mothers have or don't have in eastern James Bay. During the time of my fieldwork, the project was collecting Cree knowledge about birthing practices: recording stories and interviews with Elders, in order to pass their knowledge and experience on to younger generations. The goal was to establish local birthing centres in all eastern James Bay Cree communities with professionally trained Cree midwives, just as Inuit of the Nunavik region of northern Quebec did in the 1980s (Daviss 1997, Daviss and Davis-Floyd 2020 (in press); Douglas 2011; Epoo et al. 2020 (in press); Kaufert and O'Neil 1993; Kaufert and O'Neil 1990; O'Neil and Gilbert 1990). The process is still ongoing, with the training programs for Cree midwives being set in place, and administrative and logistic necessities being taken care of. Meanwhile, in September of 2018, the Cree Board of Health and Social Services of James Bay hosted a Blessing Ceremony in Chisasibi to mark the return of childbirth with midwives to the Iiyiyuuschii. Chisasibi will be the first town in eastern James Bay to re-welcome babies on the territory. Thus, the Cree are bringing birth back, reviving Cree birthing knowledge, exploring new ways of birthing, and aiming to give Cree families a choice over where and how Cree babies are born.

In conclusion, I suggest that the question 'Why didn't they resist?' is not relevant, because Cree did resist medicalization and the childbirth evacuation policy via their own ways and means. Superficial compliance was a form of resistance that was appropriate to the

[49] Greta Visitor currently is Assistant Executive Director for *Miyupimaatisiiun* department in Cree Board of Health and Social Services of James Bay.

circumstances. It was a way to survive in an oppressive environment – by manifesting compliance while keeping or suppressing inner thoughts and experiences to oneself. Perhaps some of the superficial behaviour became internalized/normative and perhaps, during the medicalization processes, some earlier Cree childbirth practices or beliefs were forgotten or altered, but through it all, Cree maintained their distinct ways of birthing, as we will see in the later chapters; and in a considerably new, institutionalized birth environment, they are in the process of reconsidering and re-evaluating various birthing systems and best-suited ways to birth for their mothers and their families. Simpson's insights echo my point about the presence of ongoing resistance among Indigenous peoples, including Cree and their ways to birth. She notes that resistance is too often misconstrued by defining what it is and what it is not:

> When resistance is defined solely as large-scale political mobilisation, we miss much of what has kept our languages, cultures, and systems of governance alive. We have those things today because our Ancestors often acted within the family unit to physically survive, to pass on what they could to their children, to occupy and use our lands as we always had. This, in and of itself, tells me a lot about how to build Indigenous renaissance and resurgence (Simpson 2011:16).

In the next section of my thesis, I begin exploring Cree childbirth in the order of sequence of birth, beginning with the preparations for family life – family planning and receiving advice and care before a baby is born. I look at the preparations for family life in the bush and at how these values and practices changed after the establishment of the Paint Hills (Wemindji) settlement in the 1960s.

CHAPTER FOUR: PREPARATIONS FOR CHILDBIRTH

In this chapter, I focus on Cree family planning and the advice women receive during their pregnancies. The two themes are divided into smaller sections, mainly based on location (bush vs. town) and roughly on time period. The way I chose to divide the time period for my analysis, before and after 1960, is based on a significant time marker – the establishment of the permanent Paint Hills settlement in 1959 (currently Wemindji). It should be noted, however, that the establishment of the settlement and the provision of a few plywood cabins for families did not initially do much to alter the pattern of people spending most of the year in the bush. As the population of the town grew and the economy of the village gradually provided more permanent employment, the ratio of primarily settlement dwellers, increased. Only after a long four decades process life in the settlement became the dominant way of life. Therefore, when I write for example about advice that women received in the bush, it was usually from before the 1960s—but it could also be from later, since initially only a small number of Cree spent more time in the settlement than in the bush.[50]

The first part of this chapter is about Cree family planning in the bush. The main questions explored are whom and when Cree were to marry. Elders often remembered the warnings given by their parents on the dangers of having children too close together. Thus, I also look at child spacing in the bush. The second part deals with changes in family planning patterns after the establishment of the Paint Hills settlement. In town, families started living close to one another, which created more opportunities for young people to socialize and to form loving relations. Indian Act policies started being implemented more rigorously, including the "marrying-out" [51] policy. This policy, in addition to teachings of the church, were among the main factors that played into significant shifts in family planning patterns and changes in Cree values on what is acceptable - and what is not - when it comes to creating a "proper" Cree family.

In town, the voices of single mothers and their experiences stand out, as well as stories of how women reveal, or not, their unplanned pregnancies to their families. The same question of whom to marry is still important; however, it is explored in a different light –

[50] It is important to note that despite living in the village today, nearly all Cree families go out in the bush for hunting, trapping or just spending time on the land. Time spent on the land is considered a medicine and helps healing from social and physical conditions. Families go to the bush for period of a few days, sometimes weeks and even months.

[51] By the Indian Act (1869), an Indian woman who married a non-status male legally ceased to be an Indian and lost all rights related to Indian status, as did her children (Van Kirk 2002:5).

under the influence and regulations of the "marrying-out" policy, and as a consequence, under the family's and community's judgement and pressure.

The last section of the chapter addresses advice women received when pregnant. First, I discuss advice that mothers were most often given while living in the bush, then, I discuss advice women receive during their pregnancies in town.

4.1 Family planning in the bush

When living in the bush, preparation for birth for Cree started in the early years of life, in the form of knowledge acquired from others. All family members had their part to play during birth at some point, depending on their age, experience and/or gender – some by guarding the fire during birth or providing food for the family, others by sharing their knowledge and advice, making baby clothing, assisting at birth or supporting the birthing mother with their presence.[52] Children learned about birth through their parents' behaviour and through different preparations taking place in their camp. If birth happened during the day, children were asked to go and play outside for long hours, but several Elders mentioned that as children, they'd felt something important was going on inside. Sometimes different sounds from the inside the miichiwaahp could be heard, like groaning or moaning. Even if most of the time children did not see birth, they were becoming more and more aware of the event of birth, and more conscious about preparations around it as they grew up. Slowly young people became ready to start their own families. When were Cree ready for their own family life, and whom did they marry? What was the order of things in the bush?

4.1.1 When to marry?

Most Elders in Wemindji said they did not remember their exact age at the time of their marriage,[53] but all Elders I talked to were married or started family life with their partner before they were twenty years old - the youngest being fifteen or sixteen years of age. Many Wemindji Elders said they never received advice from their family on when to start a family. A few said they married when they were told to marry, others said such conversation topics would never go beyond the warnings of not to have children before marriage: "Did you get

[52] For a complete discussion on participation in birth in the bush, see Chapter 5.

[53] Some Cree in the first half of the 20th century married according to Christian tradition, especially when the marriage took place during the summer at the Old Factory island where the trading post and missionaries were located. But in other cases, upon agreement of the parents, a woman would leave her household to go live with her partner/husband. Occasionally, it could happen that the daughter's husband would come to live with her group. The residency household after marriage was not strictly determined (Flannery 1935:81).

any advice from your parents when you should start a family or when you should have kids? No, they just warned us to not have any children before we were married or else…" (Mary Rose Visitor, Elder, 2013).

For Cree, being self-reliant, knowing how to manage the bush economy and a household were probably more important than being a certain age. However, Elder Daniel Atsynia remembered that his parents told him not to marry before he was 21, and not to have children until he was married (Wemindji Turns 50, 2010:80). The age of 21 did not seem to be a commonly accepted restriction for marriage at the time among Cree. It does not correspond with many other examples of Cree - especially women - marrying younger. Flannery (1938), who conducted research in Moose Factory in the 1920s, observed that Cree marry early.

A possible explanation for the 21-year barrier mentioned by Elder Daniel Atsynia might be the Euro-Canadian influence through the Indian Act, which implied that 21 is the age when one is officially considered an adult and can vote (see Niezen 1998:60). When the policy on age restriction for voting was introduced in the 1930s, Cree in Mistassini protested it because "A minimum voting age of 21 was inconsistent with the level of responsibility expected from those who were much younger" (Niezen 1998:60). According to Niezen (1998), during times of famine it would be the 10-13-year-old boys who would find food for their families, and most 16-year-olds were already fully autonomous hunters.

Thus, from the little information on marrying age in Wemindji before the 1960s, I deduce that there was no unanimous agreement about when a person should marry. Some Cree picked up a Euro-Canadian notion of a mature person and would advise children to wait until the age of 21, while generally, the main criteria for Cree to be ready for marriage was not the age, but the ability to carry out responsibilities that family life entailed. In both cases, Wemindji Elders emphasized that children were to be born after marriage.

4.1.2 Whom to marry?

One of the main concerns for Cree while living in the bush was to survive on the land and to "be alive well" (miyupimatsiun) (Adelson 2006). Thus, it was necessary to have a well-functioning household. It was important to have enough food providers for the family, caretakers for the elderly and the young, enough hands to complete chores in and around the camp, etc. Men and women would marry again if their partner passed away. As a result, many of the great-grandparents, grandparents, and parents of the current young generation were

married twice or three times and had children with different spouses, including occasionally children out of wedlock. One of my informants told a story about her great-grandparents who started living together when her great-grandmother was about sixteen, and her great-grandfather over 70 years old:

> It was her, my great-grandmother, who wanted to marry my great-grandfather, an elderly man, because she knew him since the day she was born. She loved him and respected him and wanted to take care of him. People knew families, they tried to make their best to survive, and they knew who's good at what. So my great-grandfather, who was over seventy, needed somebody to take care of him. So after, when his second wife passed, she was living with my great-grandfather as his third wife. As soon as he passed away, she married another one. People told her to wait for a year, but she wanted to get married as soon as possible, and she did very soon after that one year passed. She had kids with the previous husband [CW's great grandfather] and with the next one. (CW, 2014)

Niezen (1998) describes the opposite situation in Mistassini in the 1940s, when a young girl protested an arranged marriage with an elderly man, and her community turned to the chief for a resolution of the situation:

> There was a man who wanted to marry a young teenage girl. The man was about sixty-five or sixty-six and the teenage girl was only about eighteen or nineteen years old…. At the time [some people in the community] said, "That's a bit too old for this man to marry this girl." Everybody talked about it. Everybody put their mind to it…. Then the chief was the one who gave a direction, to make sure this didn't happen, and then everybody got together and they all agreed. In other words, no forced marriages for anyone" (p. 61).

Even though arranged marriages were favoured among Cree in the bush, and were in practice until the 1980s, the above case from the 1940s shows Cree flexibility at the time towards common practice and the ability to listen and to accommodate.

According to Van Kirk (2002), divorce and polygamy in many Indigenous societies were widely accepted practices. Some ethnographic literature confirms that Cree from the west coast of James Bay had polygamous marriages in the "old days" (Flannery 1995; 1935). Ellen Smallboy, from Moose Factory, remembers her grandfather having three wives – two of them sisters and the other unrelated (Flannery 1995:30). Carlson (2009) writes that at the end of the 19th century, many eastern James Bay Cree hunters had multiple wives and that couples separated amicably when these marriages did not work, which was a puzzle for missionaries

serving in the region. Reverend Walton[54] was wondering how and whether he should baptize 'illegitimate children' (Carlson 2009:127).

Even though the secondary sources suggest that there had been polygamous co-habitation among eastern Cree in the past (Flannery 1995, 1935), no such cases were remembered by Elders in Wemindji. Many seemed to be very surprised to hear of such a practice at all. When it comes to divorce, even if it might have been acceptable in the distant past (Carlson 2009; Flannery 1935), today it is not something taken lightly by most in the community. There are a few who believe that you're not supposed to (re)marry at all if you're divorced, unless your ex-spouse has passed away. Some Cree ministers in the recent past would refuse to marry divorced couples.

As in many other parts of the world, including Europe (Anderson 1986; Kuper 2009, 2008), cross-cousin[55] marriage was common among Cree (Flannery 1938; Rossignol 1938). In the 1930s, missionaries were astonished and attempted to eliminate such practices since it was considered "primitive" and "uncivilized" (see Rossignol 1938:28). According to Flannery (1937), "… they (James Bay Cree) marry early, and besides there is a fair amount of premarital freedom and license, and even some incest" (p.475). In the later article, Flannery wrote that the cross-cousin marriage among the eastern James Bay Cree "…is traditionally permissive and somewhat preferential, without being strictly mandatory" (1938:32). She also observed that the tradition was dying out and some young Cree objected to marrying cross-cousins, "…because under missionary or other White influence they had come to consider both cross and parallel cousins as closely related to them" (Flannery 1938:31).

There are some examples of first-cousin marriages in Wemindji today. From my personal communication with people in Wemindji, some are strongly opposed to such practices, while others do not see anything wrong with it. In one instance I was told about a young couple that were cousins who, while dating, conceived a child; however, they were forbidden to marry by their parents who were concerned about too close of kinship ties between them. In another instance, an informant was a child of first cousins, and sees no issue with it:

> There were two first cousin marriages in my family. I do not feel shame about it, even though some people look at it this way. My parents are happily married for a very long

[54] Reverend W.G. Walton was an influential Anglican missionary who arrived at Fort George in 1892 and remained until 1924. He was ministering to the Cree and Inuit of Fort George, Great Whale River, and Old Factory (see p.27 for his role in eastern James Bay).

[55] Cross-cousins are the children of a brother and sister, whereas parallel cousins are the children of two brothers or two sisters (Barnard and Spencer 2010:400).

> time, and they were the ones to choose each other, even though there was a lot of arranged marriages at the time. (CW, 2014)

In fact, during the second half of the 19th and the first half of the 20th century, most marriages in Wemindji were arranged marriages. This is how Elder Margaret Mistacheesick from Wemindji remembers her marriage and her father's arrangements with Mistacheesicks during one of the summers in the Bay:

> It wasn't up for the woman to make decisions when to make a family. I listened to my parents. I am not sure you gonna believe me what I am going to tell you - the man I married wasn't my choice. I only did what my dad told me. I even did not know which Mistacheesick I was gonna marry. We were in the bush for three years without coming back to the Bay. We would go to the coast in June (…) I was twenty years old when I got married. The last time I lived with my parents was that March. What I was thinking did not work. I promised my parents I would not leave them, but then my father chose a man for me. I was very sad. (Margaret Mistacheesick, Elder, 2013)

Summertime was a convenient season to have marriages. This season is when the inland and coastal families would meet on the island (Kaampaanii Minshtikw) in the Old Factory Bay while heading for the goose hunt and summer fishing camps, and where different celebrations and family arrangements took place. Tanner, who conducted his long-term fieldwork in the 1960s among Cree, describes summer gatherings in Mistassini:

> Summer is both the time of leisure and of lean supplies of bush food. (…) Summer is also the period of intense sociability, of courting, of adultery, of community feasts, of dances and of weddings. It is also interaction with White culture, with regular church attendance, and equally common beer parties. Unlike the winter, during this period there are occasional open expressions of interpersonal hostility. The very intensity of summer social life makes the stability of winter bush life which follows attractive" (1979:23).

According to K. Scott (2018 personal communication, unpublished paper), arranged marriage in the 1970s in Wemindji was still a norm. Young people had to follow the will of their parents to marry the person chosen for them, and they were not always happy about that choice. A few arranged marriages still happened in Wemindji in the 1980s.

In summary, a variety of family patterns existed around the current Wemindji area. While many families followed the arranged marriage pattern, others were free to choose their life partner. Polygamy, cross-cousin marriage and divorce were accepted practices in eastern James Bay that over time became less and less common.

4.1.3 How often to have children?

When it came to advice on having children, women mentioned that the first child should be born not too long after marriage, but the most important part was that women were often

warned to avoid having babies too often. There was a concern about a woman's health if she had one baby right after another. It was considered best to wait until the first one was at least one year old, and only then to try for another one. That suggests that child spacing should ideally have been around two to three years.[56]. Elders explained that a woman's body needs to completely recover after the previous pregnancy and birth, otherwise she might suffer, or the baby could be born unhealthy. Regardless, several Elders said that they did not follow that advice and had babies more often:

> When I first got married I did not have my baby right away. I got my baby two years after. I got married in 1952 and Gracie was born in 1954. After, when Gracie was born, after 4 years, another daughter was born. I was told not to have children too often, close together. I heard that, and I did it at first, but then, I did not care! [laughing heartily]. I had other children more often. (Mary Asquabaneskum, Elder, 2013)

> Parents would choose the husband for their daughter and once they get a child they would tell how many years apart to have a baby. Three years - sometimes they say. It takes long time for woman's body to clean up and restore. If she has a child within a year, this is how the special needs children are born. (Elizabeth Sashaweskum, Elder, 2013)

> Usually when the couple has a baby and she is around year old, they would try for another one. There was a woman who had children every year. The woman was not well, not healthy. When the woman has her baby and she is still losing blood, it's not right to have another one that soon. It has to clean up. Her blood was not good anymore. She was not doing too well. (Mary Ruth Georgekish, Elder, 2013)

It was also believed that sometimes the child gives parents a sign that she longs for a sibling. This is when the parents should try to have another one:

> Women are almost expected to have your baby–your first child–soon after you're married. They will tell you that your child will give you a sign when they are ready to have a sibling and that's what you watch. Like, let's say she is playful with another child or she always wants to play with another child. They tell you "She's seeking out the sibling, it's time to give her a sibling." (CN, 2013)

Two narratives of family planning emerge from the time when families were living in the bush. According to Wemindji Elders, the most common pattern was arranged marriages,

[56] I have not discussed contraception in the bush with Elders, thus I cannot claim for sure how they achieved the birth spacing. However, based on the context of the time (only basic occasional medical supplies from the traders or missionaries) and some literature about other First Nations' contraception methods in Canada, I assume that the contraception methods were abstinence, breastfeeding and Indigenous contraceptive medicines (Anderson 2011). According to Anderson, the contraception and abortion questions are very difficult and sensitive topics to discuss in Indigenous communities in Canada and there is very little research or information about them available (Anderson 2011).

when two families would reach an agreement about suitable partners, and time and place for the exchange. According to the younger Cree generation and secondary sources, Cree had a wide variety of ideas about family, marriage and life-long partnership, and were flexible in accommodating and respecting different situations.

The bush environment was favourable for both those families who were more restrictive about marriage options, and those who were more open to different arrangements. Young people had fewer chances to break the social rules imposed by their parents because people were spread out on the land, and only occasional interactions took place with only certain people. This situation enabled parents to limit their children's social interactions and to arrange partnerships accordingly. At the same time, again, a considerably wide variability of different partnerships and behaviours were commonly acceptable, like polygamy or cross-cousin marriage. If divorce or adultery happened, people were not necessarily unanimously stigmatized or condemned, and there was a mechanism in place to resolve such issues—conflict resolution. This mechanism was tightly woven into the bush-life yearly cycle, which allowed intense social interactions during the summers, and solitude, intensive work and sometimes calamity during the long months of winter (Tanner 1979). Until this day, the bush remains the place where Cree go to heal, to cleanse themselves, and to recover strength for the intensity of social life in town (Adelson 2006, Niezen 1998:31).

In the next section we'll see how Cree family planning changed after people started moving to town in the 1960s. What triggered those changes? What were the most prevalent family planning-related issues in town?

4.2 Family planning in town

4.2.1 Voices of single mothers: expectations and fulfilments

After the 1960s, more and more families spent longer periods of time in town and less in the bush. Simultaneously, the variability in family planning patterns was reduced. Throughout the 1960s and 1970s, parents expected their children to follow one plan: namely, arranged marriages in strictly the right order of events.

The changed environment (town vs. bush) presented young people with more opportunities to socialize, and with a wider choice of potential partners. However, the concept of a "proper" family or a suitable partner became narrower, and attitudes towards divorce and adultery less forgiving. Preference towards arranged marriages was already present among Cree before the move to town; however, the town setting and implementation of certain

Indian Act policies,[57] combined with teachings on Christian morals in the church, created an environment that facilitated the expression of judgement and stigma. Young people began forming friendships and love relations that parents were not able to control as much, and they started choosing partners whom parents would approve of, or in certain cases, disapprove. Such a situation created tensions among different generations. In this context, the voices of single mothers after the 1960s, and through the 1990s, stand out. Several women said they did not manage to fulfil their family's expectations; thus, their pregnancy experiences were difficult and painful.

Figure 8. The town of Wemindji (pictures taken between 2005 and 2008)

Marriah, now an Elder, but a single mom at the time, remembered her first pregnancy in the 1970s, when she was in her mid-twenties. She recalled her parents' condemnation and disappointment, judgement and lack of empathy from many in the community, in addition to long hours at work, and endless chores at home. All of it while living under her parents' roof. As we spoke, she paused several times, trying to hold back tears. Our conversation brought

[57] See the section below *The impacts of the Indian Act on Cree family planning patterns – whom to marry?*

back emotions and feelings she went through back then when she was rejected, hurt and mocked:

In the 70s did you have appointments in the clinic here, pregnancy follow-ups?

> It was… I didn't tell. My mom didn't know I was pregnant.

You didn't tell her?

> I was scared. No, she didn't know. But my sister knew, my older sister. And I… I guess my belly showed that I was pregnant. I went there at the clinic and I was already six months.

Why did you not tell your mother or the clinic before?

> Cause I was scared, I was… I guess I was kinda shy and ashamed. Ashamed that you're pregnant. No boyfriend… "where's the boyfriend?" There's nobody there. And when I went there [to the clinic], and the nurse… 'Why didn't you come?" you know, they didn't say that, they just told me, "You're six months..." So when my sister found out… she was the first one to ask me "Who's the father?" But I got a little bit angry with her, and I said "Oh, he's married." Right away it just came out. If I tell her he's married she would leave me alone. And so that's what she did. She didn't ask me any more questions. She didn't ask me who's the father or is he… So right away I told her he was married. But I don't know if he was, I didn't know… [chuckles sadly]. And all during my pregnancy, cause I used to do laundry and wash clothes all the time, and here I worked full time (…). Cause I really… nobody told me what's gonna happen. My mom didn't say anything, my sister, they didn't explain to me [about the delivery process].

Why? Why didn't anyone talk to you? Your mother knew very well how it goes…

> Cause it's a small community, everybody knew… Everybody knows, 'cause it shows that you're carrying a child. So I guess that's how they felt, they felt shame, like it's shameful to have that child, 'cause you're not married and I guess that's how the parents… the parents were like that. And most of them were religious kind, and you're just a… you're a shame. (Mariah, Elder, 2014, dir.sp.)

While being pregnant and having a full-time job to provide for her large family - parents and her siblings - Marriah was a shame. Several times during our interviews, she referred to the church. She said "the church is like that." If you happen to fall out of the norms or do not comply with the rules, you are shamed and blamed.

Throughout the years of epidemics and starvation in the late 19th and the early 20th centuries, Cree gradually embraced Christianity and transformed it to meet their own needs (see Chapter 2). Many Cree at the time became rigorous followers of the Anglican church, and remain so today. Niezen (1997) writes that when missions and biomedicine were fully

established in James Bay - around the middle of the 20th century - the influence of both was reinforced not only through the teachings at the church, but also through boarding schools and hospitals, where Cree behaviour was closely observed and corrected. While biomedicine concentrated on establishing its authority by weeding out traditional healing methods that compromised biocentric conceptions of well-being, the Christian Anglican church focused on changing Cree behaviour that was at odds with "proper" Christian conduct and values (p. 465). There was little space for diverse ideas and practices to thrive in a small town, where church and the government were in the process of shaping "civilized" individuals. In line with the three stages of medical evangelization[58] proposed by Niezen (1997), after the signing of the James Bay and Northern Quebec Agreement in 1975,[59] the political context became more open, and biomedicine gradually started accepting some aspects of Cree worldviews and practices. However, from the experiences of single mothers in Wemindji in the 1970s through the 1990s, it seems that recovery of the Cree variability of ideas about family or moral conduct was slow.

In the 1990s, judgement was still harsh of those who did not follow commonly established moral guidelines, and the consequences of falling out of the norm were difficult and long-lasting. AQ told a story from her years in high school in the 1990s. A couple of students were forced into marriage by their parents because of unplanned pregnancy. The boy was told he was to marry the girl as soon as he graduated. He figured if he never graduated, he would not be forced into marriage. As a result, he dropped out of school and never graduated, but had to marry nevertheless. "They still live together, but they have a very hard time..." (AQ, 2013)

CN described the time she got married in the 1990s. She was soon to enter her twenties and had had a serious boyfriend for a while. Her family was happy and supportive when everything was going by the customary plan. Expectations were high for CN. Her mother had

[58] There were three stages of medical evangelization in eastern James Bay, according to Niezen (1997) – the first was the missionary stage, from the mid-nineteenth to the mid-twentieth century, when Christianity, biomedicine and education were complementary and worked together to alter "irrational" Indigenous beliefs and healing practices. After the 1950s, the "civilizing" efforts were taken over by the federal government and reinforced through public institutions, such as schools, hospitals, band offices, etc., with the main goal to assimilate Cree into Western ways of life. The final phase began with the signing of the James Bay Northern Quebec Agreement in 1975, when local biomedical practitioners started to show some openness to Cree healing practices and worldviews (p. 464).

[59] The James Bay and Northern Quebec Agreement (1975) was a comprehensive land claims agreement among the Grand Council of the Crees, the Northern Quebec Inuit Association, and the federal and provincial governments. For more about the agreement, see the section on cultural comparison in the Conclusions chapter.

been a single mother in the 1970s as CN was a child born out of wedlock, and thus her family expected her to do better than that:

> When we told them [the families] that we wanted to get married, they didn't contest it. They always told me growing up that women should have their babies after they get married, which is weird, because see, my mom is a single mom, I was born out of wedlock. For her, I think, it was very shameful growing up in the 70s, having the baby in the 70s. (…) Our baby was born exactly 9 months after we got married, and I remember his grandmother saying, "That's exactly what you are supposed to do, she is born exactly when she's supposed to be born." So they were all counting like… "ah, like yeah, yeah, she was pregnant after…" you know, like… So everybody made sure, and we fit the profile. (CN, 2013)

CN continues her story, which within a few years shifted drastically and against the will of her family. She undertook a university degree down south and eventually divorced her husband, becoming a single mom. She tells of how difficult it was for her family to accept her decision, and how much she struggled to overcome feelings of guilt and rejection:

> I guess they were really disappointed [her family]. I went into therapy, and I really needed to talk to somebody about that. Because I was feeling guilty, I was feeling bad. But it felt worse to do something I didn't want to do any more. Cause it felt, it really felt like my life was over. That all I'm expected to do now is to keep having babies, and I didn't want to keep having babies! Cause I had cousins, I don't have siblings, I am the only child, so it was a lot of pressure. The norm in the community is - you get married young, you start your family right away and then you are expected to have 4 or 5 kids before you are thirty.

You think it's still a trend like this? A pressure like this?

> I see it with my daughter. (…) She is about the same age now. She has a serious boyfriend at the time I had a serious boyfriend, and there is a lot of pressure to get married. It's also maybe the social context is like that, and when you look at it, you think why not?... Yeah, because there is a big wedding, there's a lot of attention on you, and it's a big grand affair here in the community, and girls look forward to that. Getting that attention, and then once it's over it's like... now what?... So the next big thing is - have your first baby! Have all that attention again. So there is a strong pressure on young girls to either get married or have the kids right away.

I wonder how it feels if you're not even having a boyfriend and being single in the community?

> Yeah, and that must be a lot of pressure. Or even a single man, you're a bachelor and you have no kids? How come you don't have kids? You know… Yeah, there's something wrong with you. Let's say whether it's a woman or a man if you're over the age of 25 and you have no partner or no kids, people think there's something wrong with you. Either one - are you gay? Can you not have kids? What's wrong with you? And that's the impressions, rather than somebody just wanting to live their life differently and do something. (CN, 2013)

Another single mother in her thirties reflects on pressures she experienced all her life to have a "proper" family. She says that even if you have kids, have a job, and are doing well on your own, the pressure to marry is still there: "People like to tease me all the time - 'If you like eating traditional foods, get yourself a husband!' I am not looking for a husband! I am fine! When it comes, if it comes, it's OK. I do not want to go with any kind of man, I want a right one for myself." (AQ, 2013)

On the other hand, CN thinks that in contrast to a decade or two earlier, families are now more often ready to accept a single parent. Having children continues to be very important for many, even if they are out of wedlock. The family concept is starting to adjust to current realities of life:

> So the older generation of single people... it's almost like pressure, and then if there is no healthy ways to socialize, then it's socializing through drinking, cause you don't wanna be alone, you don't wanna be lonely, you don't wanna be different, you wanna be like everybody else. So that's why you have maybe women who are single and have children. Yes, they might have a partner in the community or they had a baby, but the family… the way they look at us – "well, at least she has kids." Or the guy, you know, maybe he has three kids with three different women, but he has kids. But if you're single and no kids… So it's important to have kids, whether you're married or not.

Does this come from Elders?

> Yeah... It's important… The family is very important.

What would they say about education today? If you weigh the family and the education? Is education important?

> I think the more they know the opportunities that the kids have, the more families encourage their kids to stay in school and to finish high school. And then very few beyond that encourage them to go out and get an education. It's more expected that after you finish high school you settle down. (CN, 2013)

People and their ideas clashed and competed in a newly established, densely populated town. Under the pressure of the Indian Act, and moral teachings at the church, marginal and alternative ideas had little opportunity to coexist in a small space. The lesser the variability of ideas, the lower became the tolerance for diversity. As a result, women suffered severe judgements when they did not meet expectations set up by their parents and community. Many young women were falling outside the boundaries imposed by their parents in the

1970s. Ironically, in the 1990s, women who experienced unplanned pregnancies and single motherhood themselves now expected their daughters "to do better than that."

In the next section, I will discuss the ways in which "marrying-in" and "marrying-out" policies undermined the flexibility of family planning patterns.

4.2.2 Whom to marry? - the impacts of the Indian Act on Cree family planning patterns

Arranged marriages in town were less and less common after the 1970s, but according to some women, there remained a persistent pressure from the families to marry a certain kind of person, the right person. CT talked about her experience in the 1990s when she was a single mom and dated a non-Native person. She also reflected on how the community's attitudes towards a "suitable partner" has changed over time:

> He was not Native. He was from [southern Canada], you know, no connection with anybody from where I was from. So that too was a little bit not happy... They were not happy about that, that he was from somewhere they didn't know where he's from. They didn't know who he was, they didn't know who his family is.

Usually do people in the community prefer Cree persons?

> Yeah, that you with the Cree, Cree married, like… there's some interracial but it was almost like… with me – my father was not Native and my mom never married, so that was hidden for a long time, because there was shame around that and it was not really acceptable to marry outside your community or much less to get pregnant by an outsider or a White person. So that's why I guess they reacted that way too, cause when I became pregnant I wasn't married, I was a divorced single mom…

Do you think today is less so?

> It's more and more accepted now, because now people travel more than they used to, we have the roads that we can access to go down South, whereas before, we didn't. Yeah, and I think more and more it's accepted now. But it's still a little bit… you know, it raises eyebrows when people see, still… Here some people are mixed up – Cree half black, Cree half Chinese, like… or Vietnamese in town, we have a few mixes like that, but other communities it's not so often you see it. I find now they are becoming more and more acceptable. Like we don't question now "Well, that's who they decided to marry, that's who they marry." But before it was... Even though this was in the 90s, I think it was still, you know, pretty hard for the family to accept it. (CT, 2013)

Intermarriage has a long history over the course of the colonial period in Canada. Van Kirk (2002) demonstrates that the fur trade and colonization were important factors in shaping Indigenous and non-Indigenous intermarriage patterns. At the very beginning of the fur trade,

Indigenous people were in favour of intermarriage with Euro-Canadians and their integration into Indigenous communities - these created socio-economic bonds that were beneficial for both sides (Lawrence 2003; Van Kirk 2002).

However, at the decline of the fur trade towards the middle and the end of the 19th century, settlers made intermarriage into a colonial tool, where Native women marrying Euro-Canadian men or non-status Native persons would lose their Native status. According to Van Kirk (2002), "… by the mid-nineteenth century, the process of intermarriage had become effectively colonized. Intermarriage was seen as a vehicle for removing Aboriginal women from their own cultures" (p.5).

Native status in the Indian Act was defined by patrilineal descent and was connected to band membership (Barker 2008). It meant that a woman's status and membership in the band was defined by her father's, or if she married, by her husband's. If her husband happened to be from another band, she would lose her native band's membership and would gain her husband's band membership together with the Indian status (if he is a status Indian). If a woman were to divorce a status Indian from another band, she would lose her status and could only reinstate it by marrying another Native status person by gaining membership to a band to which her husband belongs. If a woman married a non-status Native person, she and her children would become non-status as well.

According to Morantz (2002a), in eastern James Bay, the Department of Indian Affairs started compiling lists of registered Indians in the 1940s, and only one or two men at the posts were listed as non-Indian (245). There are no secondary sources on how "marrying-in" and "marrying-out" policies affected Cree in Wemindji, but a few stories from women in Wemindji show that families, and especially women, were affected.

JT from Wemindji described her situation in the 1970s. She married a non-status Native man from another community who was born out of wedlock, and according to JT, "He had lost his status because the year he was born the Indian Agent had declared that all children born out of wedlock would automatically be considered as non-status,[60] stripping him of identity as an Indigenous person." Upon marrying him, JT lost her status, and their children automatically were born as non-status Natives. She said, "We were dispossessed people in our own homeland…" All of them were able to re-instate their status in 1985, when

[60] "Under section 12(2), "illegitimate" children of status Indian women could also lose status if the alleged father was known to not be a status Indian and if the child's status as an Indian was "protested" by the Indian Agent (Lawrance 2003:13).

the Bill C-31 was passed.[61] JT added that, at the time she lost her status, she did not live in Wemindji, but had moved to a big city, and therefore did not experience all the issues that other Cree women did when they stayed in town as non-status.

In fact, the situation was difficult for families who stayed in eastern James Bay. Indigenous women married to non-status men were struggling with the consequences of losing their housing and their jobs in the communities. In 1972, George Legrady conducted a photography project in eastern James Bay, the goal of which was to shed light on the acuteness of issues of non-status Cree families. As an initial attempt, Legrady travelled to Fort George (currently Chisasibi, the next Cree community north of Wemindji) and took pictures of all non-status households. Most of the houses were home-made one-room shelters in poor condition, according to him, with a bed in every corner and a wood stove in the middle. The average number of people per household was eight to ten (K. Scott 2018, unpublished).

It is not difficult to imagine how such conditions and issues might constitute valid reasons for why divorce became unacceptable among Cree, or why outsiders and non-Cree individuals would not be considered the first-choice partners for a status Cree woman. According to Barker (2008:261), many First Nations status women refused to marry at all in the fear of losing their status, in case of divorce or if in a union with a non-status person.

The "marrying-in" and "marrying-out" policies were largely influenced by racist ideas of the time and the goal to assimilate Indigenous peoples into the White mainstream citizenry. Van Kirk (2002) notes that there were gendered nuances in this process and line of thinking. For example, a Euro-Canadian woman marrying a status Native person would become status Native, because in the eyes of colonizers "'Whiteness' could not prevail in the person of a woman" (Van Kirk 2002:7). And in those situations, when intermarriage between an Indigenous man and a Euro-Canadian woman took place, "Aboriginal men were seen to be usurping Euro-Canadian male prerogatives; and it was not acceptable for a White woman to be subordinate to an Aboriginal man" (Van Kirk 2002:6).

The Indian Act determined not only who was status Native, but also influenced people's decisions on whether they would stay in the community or would move to a big city. In the

[61] Bill C-31, an Act to Amend the Indian Act, was passed in 1985, but it was not uncontroversial among Indigenous people. The main concern for many bands was that many urban Natives, who had left the reserve a long time ago or had never lived on the reserve would claim their status and band membership. Many felt uneasy about reinstating statuses of long-lost band members and their children. Indian Act rules became partly normalized and thus status Indians living on reserves came to view Indigenous mothers (and their children) who had lost their status, and lived and grew up outside reserves, as outsiders and not Native any longer (Lawrence 2003:15).

long run, it would shift the community's views of who was local and who was considered an outsider who did not belong anymore. After the passing of Bill C-31 in 1985, many bands felt uneasy about reinstating statuses for those members who had left their communities a long time ago and now had children who had grown up in the cities. Usually, it was Indigenous women married to non-status men who would have to leave their communities and raise children outside of their home towns. Now that they and their children wanted to reinstate their status, they were not always welcomed by their bands of origin because, according to Lawrence (2003), on some reserves there are prevailing attitudes to preserve Native culture, and thus outsiders might be seen as threatening to community identity (p.15).

After the establishment of the settlements/administrative centres in James Bay, it became easier to implement Indian Act policies. As noted by Morantz (2002a), Indian Act policies reached eastern James Bay Cree later than other Indigenous peoples in Canada, and started to be implemented more rigorously only in the 1950s. While in the bush, Cree were free to choose which family planning pattern they would follow without much repercussion from the outside. After moving to town in 1959, choosing the "wrong" life-partner might have had serious consequences for women. It is still to be researched how much "marrying-in" and "marrying-out" policies affected Wemindji in particular, but a few accounts from Wemindji, and the situation described in the nearby Chisasibi community, suggest that Wemindji was not completely isolated from those policies, which in turn, shaped Cree family planning patterns and impacted families' lives.

4.2.3 Finding out about pregnancy and breaking the news to the family

When talking with women about their pregnancies in town, they said usually they found out about their pregnancy when they missed their period. Then they'd take a home pregnancy test or would go to the clinic for a consultation and/or confirmation. Then, there were other ways of finding out – I was told that children can tell very early that you're expecting. Cree say that "the kid knows":

> (…) My niece walked up to me telling me "there's a baby down there in your stomach" and I kept telling her, "No it's not." That's what I kept saying to her, "That's a lie!" She was telling me that I was pregnant, but that I didn't know. So I found out I was pregnant in May.

But so she knew already before?

> Yeah. She also told me I was gonna have a boy, and when I went to have ultrasound they said I was gonna have a boy. Well, they say that the kid knows when you are expecting. So she told me I was pregnant before I even knew I was pregnant, but I kinda figured there was already a possibility I was pregnant since I missed my period...

How old is your niece?

> My niece, she is 6 now, she wasn't even 2 yet. She was one of the babies that talked a lot, she was so buggy [laughing]. (CQ, 2013)

Among many other factors, the fact of being single, having an "unsuitable" partner or being too young complicated the situation for women when the news about a pregnancy had to be revealed to the family. When and how to do it? The feelings of fear and failure to meet family expectations often resulted in women hiding their pregnancies. More than half of the women I spoke with had one or more pregnancies that they were anxious about revealing, which resulted in hiding their condition or, in a few cases, denying it to themselves. Often this situation occurred for younger women seventeen to nineteen years old, but not always. Some women did not have a partner, were already a single parent, or had a partner that their family disapproved of. Such situations often resulted in delayed prenatal visits to the clinic, which women would avoid - not wanting to deal with the issue, or trying to contain the rumours before they themselves told the news to the family. Thus, the most common reason to avoid prenatal appointments was to hide the pregnancy from the family–or in a few cases, to avoid medical institutions.[62]

> "Keeping it to myself"
>
> I don't know where to start… I didn't tell anyone I was pregnant.

Ok…

> I told my boyfriend, but anybody in my family. I didn't say anything. I didn't tell the clinic. They didn't know when…

Why?

> I took one of my kids to the clinic, and there was a pregnancy test there on the counter. And I grabbed it and put it in my pocket. And I did the whole pregnancy test at home. It was in January that I found out that I was pregnant with my third pregnancy.

Why didn't you want anyone to know?

[62] For more on avoiding medical institutions, hiding pregnancies, and emergency births, see Chapter 6.

I wasn't married at the time, I was a single parent, and afterwards, I kept it to myself for a long time. And after a while, it was in April, the end of April, I started to have contractions, because I got stressed out...
(…)
I got called in [at the clinic waiting room], and I told them, "I'm pregnant and I am having contractions." And he looked at me, "Did you ever come to the clinic?" And I told him, "No, I never came." "And how far along are you?" "Must be 4 months pregnant." And he looked at me, "Why didn't you ever come?" "I wanted to keep it to myself"... (CE, mother of four, 2013)

"I didn't tell…"
Actually, it was in February that I went to the clinic and told them that I was pregnant. I didn't tell them that I was pregnant before. And… they were wondering why I got too big and I could feel myself growing too, my stomach. "Why didn't you come here when you found out?" they told me.

How far along were you when you went to the clinic, do you remember?

I think I was about three months. And they tried listening to the heartbeat but didn't hear anything; they gave me a pregnancy test. "Yeah, you're pregnant," and "We'll send you out in a couple of days to Chisasibi for an ultrasound," to find out how many weeks I am. And I just told them that July, maybe in July I'm gonna have this baby, I told them. "And how do you know?" "'Cause I know when I conceived!" [chuckles]. "Ok then, I'll send you to Chisasibi to make sure on everything." (CE, young mother, 2013)

Becoming an uncle

When did you find out that your sister was pregnant?

I don't know… Well, she didn't tell anybody right away, it was after goose break, after the spring that she told us that she was pregnant.

Do you know how far along was she?

Few months. She was able to hide it for a few months, maybe two months. She was scared to tell my parents.

And how did you react?

I was happy! I was one of the first people she told. She was still scared to tell my parents after she told me, but I told her, "They need to know, I tell them if you don't tell!" [laughing] I was excited to have a niece or a nephew! (BL, young man, 2013; he escorted his sister for delivery and witnessed her birth at the hospital)

The wrong boyfriend

And then you did the follow ups here… Did you tell your family?

Not right away. I kept quiet about it for a bit, because the relationship I had with [baby's name] father - my family wasn't supportive of it. So we kept quiet about it

for a little bit. Even though it was good news for us, but at the time with my family it wouldn't have been. We kept it quiet till after New Years.

How far were you when you told your family?

I was probably close to three months. (CL, young mother, 2013)

Sometimes, family members find out about pregnancy without a woman telling. Mothers say that their parents knew already, their family had the feeling, or that they found out through other channels.

"My mom knew…"

Were you nervous when you found out about your pregnancy or…?

My son? Yeah. Cause I knew my mom wasn't gonna be happy about it.

And she wasn't?

No. She didn't talk to me for a week when she found out. That was kinda hard.

You told her yourself?

No. My sister told her.

This is how you wanted it to be or…?

No! I didn't tell her to do that, she just told her. But I think my mom knew… I don't know how, but she didn't say a word. And my sister told her, "You gonna be a grandma again!" and my mom just sat there, she didn't say anything. (BA, 2013)

"My dad found out…"

When you found out that you were pregnant, who first did you tell? Were you nervous to tell your family?

Yeah, I was nervous. It's one of the hardest things you could tell your parents. But my dad found out. He figured it out before I said it, because he noticed a change in me. I had hard time telling my mom. I was trying to find out ways of telling my mom, and she sent me to the store, she went into my room to check what was wrong with me, and she found the book that I got from the clinic before I could tell her the news. So when I got home from the store, I had no choice but to tell my mom that I was pregnant, because she had seen the books that I had…

Was she OK with it?

> Well, eventually she was, at the beginning… not so much. I was 17 when I was pregnant with my first one. So it's hard to accept your child being pregnant at this age. (AQ, young mother, 2013)

Cousins' secret

Who did you tell first that you were pregnant?

> My best friend and who's also my cousin. She was the one that knew first, and we didn't say anything at first. I was scared, and she didn't wanna tell anyone else too, 'cause I told her 'What should we do? What should we do? [she whispers]

Were you scared?

> Yeah, to tell that I'm pregnant and I didn't know… It seemed that at first I didn't wanna accept that I was pregnant and I didn't know what to do, but at the end I had to tell.

So how long did you keep it secret?

> First time I went it was October… So I was probably… four months already and I didn't show too. I still wore the same clothes and the same… My parents were out of town… they hunt and trap, so they weren't in town from September or the end of August until December.

Who did you live with when they were in the bush?

> My cousin, my oldest cousin, so we stayed with her. Her husband and her children, but when… my son's father, he was the one that told his mom first. Then his mom called my cousin and we were living in a living room that weekend and me and my cousin we slept in a living room, cause we watched some movies that night, and that morning my cousin received that call from my son's grandma, and she says right away… She asks me if it's true, she tells me who's calling and what she was telling and right away we pulled the blankets like this [laughing and showing how they pulled the blankets over their heads], me and my cousin. I didn't say anything, and my cousin, who's my best friend, "Yeah," she says, "It's true..." So they send us to the clinic, both of us, me and my cousin. (CW, young mother, 2014)

The stories of women confirm the tension between the parents and their children in town when it comes to unplanned pregnancies. Parents seem to have different expectations and plans for their children and their children know it; therefore, revealing pregnancy becomes scary and stressful. In retrospect, young women understand their parents' disappointment and different plans for their future, but do not necessarily agree with their actions or points of view.

In some cases, peer mothers, a teacher or a counsellor play an important role in giving advice and support for young women, especially when they are not ready or scared and do not

know how to reveal their pregnancy to the family. Most young mothers I spoke with first revealed their condition to their closest friend, cousin, sibling or their teacher - a person outside their close family whom they could trust. Cree mothers often prefer somebody who speaks Cree, understands the sociocultural dynamics in town, and maybe has similar experiences.

For example, CB got pregnant while still in high school at 17 years old. She was afraid to tell anyone about it, especially her parents, and she said she did not know much about pregnancy or birth. There was still no Awash department[63] in Wemindji at the time, and services at the clinic were not very good, according to CB. There was a Young Mothers Group organized by the Wellness Department where women and mothers could join in. CB and others remember the late Shirley Otter, who led the group for several years. CB said that Shirley was a very special person who did a wonderful job in creating a safe, supportive and informative space for women. CB joined the group, and received most information about her pregnancy there, where peer mothers shared information and supported each other. Shirley was the first person CB told about her pregnancy. Shirley talked to CB's parents about the issue and consulted the family throughout the critical moments. CB said she is very grateful to Shirley for the way she dealt with this most difficult situation.

As we've seen in the examples above, in the current context and over the last several decades, women often have a hard time telling their family about their pregnancy and tend to hide it for a short while. This secrecy raises questions about the options that women have when they find out they are pregnant. Are abortions available? Are they accessible, and how often are they performed?

4.2.4 Abortions

According to medical staff at the Wemindji clinic,[64] there are many unplanned pregnancies in town. However, abortion is a sensitive topic in the community, and discussion of it is avoided, if possible. Often, when I asked women what they think about abortions, they'd tell me that they "do not believe in it." A very few said they considered it, and only one admitted that she went through with it. Several medical professionals at the clinic

[63] Awash department – opened in 2009 and is responsible for providing perinatal services and healthcare for children and teenagers up to adulthood.

[64] To preserve anonymity, I talk generally about the medical staff. I conducted interviews with 3 doctors, 7 nurses and the director of the Awash program, who is also a medical professional (see Chapter 1 Methods section). When I generalize "the medical staff," it means I summarize their prevailing point of view on the issue.

confirmed that women tend to refuse prenatal tests for genetic and chromosomal disorders, because "they do not believe in abortion." On the other hand, according to medical staff, when young girls show up for an appointment with an unplanned pregnancy, they often consider termination. To undergo the procedure, a woman has to travel to Val d'Or hospital, and it is unlikely the trip can be organized without her parents knowing, especially if she is high school age or/and still living with her parents. After her parents figure out the situation, in most cases, according to the medical staff, they convince her to continue with the pregnancy and to have the baby. As a nurse at Awash said to me:

> What I wanted to say about the position of the mothers, who don't want to keep the baby, who first get the news very like 'ah…' detached and don't want to go with the pregnancy… We have to give them some time to think, and very often they will talk about it to the members of the family and they will feel pressure from the members of the family to keep the baby, right? Because abortion is not welcome and is not well seen so they will feel a lot of pressure. Many young mothers come and tell me that they finally talked to their mother and she said that she can't do abortion, that it's really bad, and that the mother will say, "Well, I'm there, I'll help you, "and that way… So many times, they will cancel. I would say like nine times out of ten the woman who doesn't want to have a baby will keep the baby (Nurse at the Awash department, 2014).

> The thing is that down South it's 14 years old, the choice of keeping or not. After 14 years old, legally, they're allowed to take a decision regarding their health. So down South she could have come to the office and said, "I want to have an abortion, "and have it done. Here, with Cree Patient Services, they need an escort to get out of the community for medical reason. So… (Nurse at the Awash department, 2014).

Sometimes women are even more scared of their family finding out about the abortion than the consequences of unplanned pregnancy. Here is an excerpt from an interview with a mother who found herself in a very difficult situation, away from her family in a big city, divorced, already a single mom, a student without a job, and pregnant in an unstable relationship. She was sure that her family would be enormously disappointed; however, she said that abortion, even far away from home, was not an option for her because she was afraid of somebody finding out about it at home and so she decided not to proceed with it:

> Sorry, could I ask you?… The situation seemed so very difficult. Did you consider abortion or not at all?
>
> > Yeah, at first I thought I am already a single mom, I didn't really plan on this pregnancy. When I went to the health centre I asked what my options are. And they told me about abortion, but I was very concerned that somebody would find out I had an abortion. They told me there were some private clinics in the area...

Somebody, you mean from your family or…?

> Yeah, like from Cree Patients Services. Because as soon as somebody sees a Cree patient in an area, even if it's in the city, talk goes fast, "Oh, who are you, what are you doing here?, etc." So I wanted to avoid it altogether, it was something that I would never consider at the time... (JJ, 2013)

Charlene, a mother of five, remembers the insensitive and blunt way it was suggested that she terminate her pregnancy in Val d'Or hospital in the 1990s. She was told of a spina bifida diagnosis during the early stages of her second pregnancy. The doctor revealed the news by saying that Charlene's baby might not live long after the birth and suggested an abortion. Abortion would never ever have crossed Charlene's mind, no matter the diagnosis. Charlene felt deeply hurt and insulted by the doctor, not only by the inhumane wording the doctor chose to reveal the information, but also by the sheer suggestion of termination of the pregnancy:

> … when she came in, she (the doctor) told me "Your baby's gonna die on you, I think you should have an abortion." I was like "What? Who are you to tell me to have an abortion?!" I don't believe in that, and I told them no. "I don't care what you say, I don't care that you say my baby's gonna die, I'm still going on with this pregnancy," I told her. "I'm not gonna terminate my pregnancy because of what you think,"I told her. And they told me probably right after childbirth she's gonna die. And I was like "as long as I see this baby breathing it's gonna be OK with me." (…) It was pretty hard. The pregnancy with her was pretty hard, like with all this going in my mind "Oh, my baby's gonna die…" I was like – "I have to get that out of my head!" It was hard. (…) Once we got to Montreal we saw another specialist, and I told my boyfriend, 'I think it's time for me to tell him what the doctor told me in Val d'Or'. When I talked to the specialist, I told him what the doctor said to me, like "Your baby's gonna die on you, you should have an abortion," and I told him about it, and he was shocked! He told me "No! We can help your baby! Your baby's gonna be fine!" And that's when I knew I'm gonna give her name Joy, 'cause I was so happy when I found that out, that she's gonna be fine. That they would be able to help her. (Charlene, 2013)

This incident is not only telling about patronizing and insensitive biomedical practice, but also about Charlene's wish to have her baby no matter what and about abortion not being an option or even a consideration.

Briefly I touched on the subject of abortion with one of the Cree CHRs, who responded, "The numbers I don't know. Some mothers would tell me, but I would not put it in the notes. But I noticed that in the community they do not support the abortion. They prefer to have the child. Even though the woman is young, they would encourage her to have a child. I asked her, "Do you know the reasoning? Why?" There was a long pause. "I don't know...."

This is what another nurse at Wemindji clinic had to say about common perceptions of abortions in town:

> Birth control is much more open in the community than abortion. They're pro-life. Once you're pregnant, abortion is a big no-no. Usually it's very hard to get an abortion if you want one, 'cause you get judged and you get called bunch of names, apparently. But birth control is quite well settled and it's OK in the community. Preventing the family is OK, but killing a baby by abortion is… They get called like "baby killer" and stuff like that, so I heard. So that's very hard, 'cause they get labeled (Nurse from the Awash department, 2014).

The biomedical staff at the clinic try accommodating women the best they can to keep appointments and procedures confidential. The appointments for scheduled abortions and the follow-ups are handled at the Current Services department instead of the Awash in order to avoid spreading rumours in town about possible pregnancy. I asked one of the nurses at the Awash department whether it is often that women say they do not want to continue with their pregnancy:

> Yes. I mean I don't know statistically, but it happens quite frequently that the woman would say, "No, I don't really want to have a child," or "I'm not ready" or "I have one really young." You know it was not planned, it happens very much. More pregnancies are unplanned than planned.

What age do you think is the most common for that issue?

> I would think between 15 and 25.

So it's young mothers?

> Yeah, and that it's not planned, you know. Very rarely I see young mothers that come in and like "Oh, finally, I wanted to get pregnant and now I am!" It does not happen very often. (…) So we just tell them that we are here to support them whatever decision they make. That we are not here to judge. That abortion could be a good solution if that's what they decide. So if they want to go that way, we support them and they don't go to Awash department. Because there is a big… how should I say… As soon as you go to Awash department everybody knows you're pregnant. (…) They know that if they go to Awash, people will start talking and they gonna know that she's pregnant, and maybe she didn't want to tell people, and she was still in the reflection of if she's gonna have the abortion or not.

Is just the fact that she's sitting in that hall of the Awash department?

> (…) You know, people in the waiting rooms see another person going to Awash and people talk. It's a small village, people like to talk. So I know that is a big issue, because many women tell me that. (Nurse from the Awash department, 2014).

Apparently, not only in Wemindji is abortion a sensitive topic. Anderson (2011) notes that the subject of family planning and the use of contraceptives and abortifacient medicine are difficult to talk about in many Indigenous communities, and that uneasiness about the subject comes from long-standing fears of the Christian church. Given the colonial history of the region and the Christian church and missionaries' role in it, including residential schools, I do agree with Anderson's statement. However, it appears to me that in the current context, it is not a long-standing fear of the church that influences the decision-making, nor fear of talking about it as much as a normalized belief that abortion is a sinful subject and/or practice. There are other studies in the world showing the influence of the Christian church over people's views and state policies on abortion (Mishtal 2015).

In Wemindji, many people follow or strive to follow the teachings of the church, thus, views towards abortion are often tied into religious belief; however, young women also fear their parents' and community's condemnation - possibly more so than they are following personal religious convictions. There are other possible reasons for abortion being taboo. Collective memory of colonial experiences might also contribute to a strong reaction against termination of pregnancies, as - between 1928 and 1974 - medical professionals often coerced Indigenous women into abortions and sterilization in Canada (Stote 2015).

There is no direct evidence of how much coercive abortions and sterilization directly affected Wemindji Cree, but there are a few sources that provide the numbers of sterilizations performed in Moose Factory hospital on "Indians" between 1971 and 1974, when Moose Factory Hospital was a primary hospital for Wemindji Cree,[65] as well as other Cree from all over James Bay. During those few years, the sterilization number was 122 women and 1 man (Stote 2015). At the same time, Wemindji Cree might also be aware of coercive sterilizations and abortions in other Indigenous communities in Canada through social connections, stories and media (https://theconversation.com/canadas-shameful-history-of-sterilizing-indigenous-women-107876; https://www.theguardian.com/world/2018/nov/18/canada-indigenous-women-coerced-sterlilization-class-action-lawsuit; https://www.cbc.ca/news/politics/sterilization-indigenous-1.4902303, etc.).

Disapproval of abortions among Cree might also come from hunter-gatherer ways of life that favoured big families on the land and cherished every soul in a household. A considerable number of small children would not survive during the years of famine or

[65] Moose Factory was the prime hospital for Wemindji Cree until after 1975 (Torrie et al. 2005:207).

epidemics; thus, every life was appreciated and honoured. As they grew, children provided very much needed help in the household. The more children you had, the more providers for the family there were, and the more people you could rely on in difficult or unpredictable circumstances.

Love, care and appreciation of children is always evident in Elders' stories about the past and their conduct with children today. Families who are not able to conceive usually adopt children. In just a year and a half, a young family that I know adopted four children under the age of six, and that is not an isolated case. Just listening to Cree talk about children, observe children or interact with children, it is obvious that for them every child is special and precious, a blessing for the family.

According to the literature (Carlson 2009; Flannery 1938; Preston 1982a, b; Rossignol 1938) and accounts in Wemindji (see CW story at the beginning of the chapter), a few generations ago, Cree worldviews concerning family planning were quite flexible. As previously noted, polygamy, cousin co-habitation/marriage and intermarriage were acceptable. Cree were picking up, exchanging, and adapting various cultural patterns they found attractive or fit their lifestyle. Cree family planning practices and wedding traditions were gradually mixed with values and worldviews brought in by Christian fur traders and missionaries. As a result, there was a great variability of ideas about family planning while living in the bush. Some Cree were following more restrictive rules; others were flexible about their practices. But bush-life and wide-space allowed for a diversity of ideas and practices to coexist.

The change in population density of life in town altered the community's social dynamics. Even though some Cree continued living off the land and visiting town only occasionally, town life changed the yearly cycle of families living alone during long winters and gathering again to socialize during short summers. Life in town nearly year-round made it more difficult for alternative views and practices to coexist and for conflicts to be resolved among people.

While youth had more opportunities to form social relations in town, many were expected by their parents to hold on to the arranged, or at least approved, marriage scenario. Teachings at the church about Christian morals along with colonial legislation, particularly the Indian Act, restricted the flexibility of the concept of the family and normalized gender inequalities, rendering Indigenous women married to non-status men outsiders within their own communities. Inequalities based on gender and ethnicity became internalized and

normalized by some Cree,[66] resulting in great pressures and challenges for the younger generation–mainly harsh judgments and stigma in cases of unplanned pregnancies, "unsuitable" partners or single parenthood.

Abortion was and rarely is a solution for an unplanned pregnancy. Families usually strongly encourage a woman to continue with a pregnancy, regardless the circumstances, as most people in the community "did not, and do not believe in" abortion. Severe judgement of the younger generation lasted through the 1970s and into the 1990s, when marriage by choice, single parenting or intermarriages with non-Cree became increasingly acceptable again.

4.3 Advice during pregnancy

4.3.1 In the bush

There were lots of teachings and advice that expectant women would receive from their Elders and family when they were pregnant in the bush. Most often Elders said they were told to "take good care" of themselves. Taking good care involved numerous precautions to keep women away from injuries or getting cold. Women were advised to avoid physically demanding household chores or lifting anything heavy, as well as to keep themselves warm and dry, especially in their legs and feet. The following are excerpts from interviews with Elders about advice they received when pregnant:

Taking good care of oneself:

> I was not afraid of birth or scared of anything. In the old days, women were told to take care of themselves. They needed to take care, and if they listened, they did well, delivered well. (Winnie Asquabaneskum, Elder, 2013).

> Long time ago, in the bush, a woman was not allowed to do hard work, chores. Or lift something. She was told to take care of herself, especially when she loses blood.[67] When a woman does not take any advice or good care of herself it comes back really hard on her. She has to dress up warm too. If she does not do all that, she will not be able to take care of the baby. She will not be healthy after birth. She will need somebody to take care of her baby. (Mary Ruth Georgekish, Elder, 2013)

No heavy work or lifting:

> They used to give advice to all the women who were pregnant. She should continue working around wherever they're living, but not to get too exhausted. She could get hurt

[66] On mechanisms of colonization and internalization, see Chapter 3.
[67] "To lose blood" – to menstruate.

if she does this and that. She was told to do light work, not heavy. Women used to bring firewood, and a pail of water.[68] (Edith Visitor, Elder, Midwife, 2013)

Not getting cold, keeping legs and feet dry:

I would tell the woman, who is pregnant, that when her menstruation stops she should tell somebody she thinks she is having a baby. Whoever she tells this, they should tell her what to wear around her legs and her feet.[69] She should continue doing work, housework, but try not to lift anything heavy (…) (Elizabeth Sashaweskum, Elder, 2013)

Young mothers to be were advised to take care of themselves and to make sure they do not get wet in their feet and legs. (Daisy Atsynia Sr., Elder, 2013)

Do you remember if you got any advice from your Elders, your mother how to treat yourself how to behave when you're having a baby? When you're pregnant?

> Yeah, yeah. They used to tell me like… I guess they saw me doing things like getting water from the bank, you know, we used to get our water from the bank, cause we wouldn't have no running water... My aunt came up to me one time and she said, "You better take care of yourself, because when you're delivering that's easier, it is not as painful as losing it, having a miscarriage', she told me one time...
>
> My mother and my aunt, they told me to always keep my feet warm, not to get wet, because they knew I went to get water from the bank... They told me "Don't get yourself wet, because sometimes that's how some women used to get hard time with their babies, long time ago'. So I did that. For some reason I… even before I got pregnant I used to do that, 'cause I didn't like cold feet, I used to try to keep my feet as warm as I can. (AP, 2013, dir.sp.)

To my children I told about the past, how babies were born. How it was done. Like I told you. To take good care of yourself, dress warm, not to get cold. It is very hard if a woman catches cold, especially in the legs and your blood vessels are clogged. It is very hard. It never happened to me though. I followed advice of my mother and this is what I told my daughter. (Dollien Georgekish, Elder, 2013)

Yes, I got an advice, especially when I drank something - they told not to drink cold water. To drink lots of broth, fish broth, meat broth. (…) The births in the bush went well, but I was not allowed to do work. I had to take it easy. (Minnie Shashaweskum, Elder, 2013)

[68] Sarah added that they had to watch out and not to carry full buckets.
[69] Sarah commented that women did not have pants then, so they would make legwarmers from wool as the legs had to be kept warm when pregnant.

Advice that families gave to future mothers was relevant to the circumstances they lived in at the time, like for example "not to get feet wet." Many young girls would be bringing water from the stream or lake nearby, where they often got their feet wet. Therefore, it was important not to get wet, or if they did get wet, to change as soon as possible.

I asked women what would happen if feet got wet or cold. Many said that consequences of wet feet are generally related to heavy pains during menstruation or birth - the cramps might be stronger, the labour longer and complicated. It was also important not to get injured or hurt while gathering the firewood or boughs in the bush, cleaning the game or trudging through heavy snow to check rabbit snares. All of those chores had to be done, but they had to be performed carefully with extra caution. Elder Winnie Asquabaneskum noticed that earlier women were doing many chores around the camp and therefore the advice of taking good care and not hurting oneself was important. Nowadays, as she says, women do not do all of that anymore, therefore maybe some advice loses its significance:

> Long time ago women were always told to take good care of themselves, not to get hurt. Now women don't do that what they did in the past. Women worked, chopped the firewood outside where they lived. And then they did other chores inside: to clean the game, cook, feed the family. Today it is not like that... (Winnie Asquabaneskum, Elder, 2013)

If "today it is not like that," how is it? What advice do women receive during their pregnancies in town?

4.3.2 In town

Cree perceptions of a healthy pregnant woman did not change much in town; however, due to different circumstances and town realities, types of advice for women were prioritized and formulated differently. Family advice for pregnant women in town focuses on a few main points: 1) on proper diet, meaning traditional foods; 2) on regular sleeping routines; 3) on amounts of physical activity; and 4) on keeping oneself warm.

Easier access to store-bought food, including junk food and cigarettes, has prioritized advice for pregnant women about their diet and tobacco consumption. The interview with Elder Mariah reflects those changes. Mariah was born and grew up in the bush, and moved to town as a teenager, where she gave birth to her children in the 1970s. She compares healthy bush food with unhealthy store-bought items. Later in almost every other interview with mothers, women mentioned traditional foods as a healthier option for pregnant mothers instead of the foods from the store:

> If you smoke cigarettes they tell you not to, you know, to quit when the baby is growing inside you, to quit smoking. And to eat healthy foods, not junk. Sometimes you see the baby is… you gain more weight and the baby is heavy. It's hard on your lower back, so you have to watch what you're eating and not to fry your food, and to boil your food and to drink… not alcohol! Sometimes when you don't listen it hurts, you feel you hurt yourself and you hurt your baby. So you have to get to listen to your mother or other women that are elderly, to your midwives who know. Cause when you're in the camp in the bush, there's no store, no anything, only what you have…'cause you buy your supplies and you get to bring them to the camp, that's all you have. And there's the hunters, they kill beaver or whatever comes again or whatever they have. You eat what's healthy, that's more healthy than store bought food. So that's what I was told to eat more, even when I was here when I was pregnant (in town). (Mariah, Elder, 2014, dir.sp.)

Family advice and teachings are mostly shared by grandmothers and mothers, but sometimes some questions are easier to ask somebody who's similar in age, like aunts or cousins. Women seek different family members for different kinds of advice:

> The one thing that they (grandmother and mother) didn't tell me and I wasn't sure - it was regarding sexual relations with my husband during pregnancy. Was it OK, or we're gonna hurt the baby, because we were young too and we didn't know. Those kinds of questions I saved to ask some of my aunts, who were younger, that I didn't feel shy to ask, or one of my cousins, who already had babies, and my doctor. Cause it wasn't something I was gonna ask my grandmother or my mother, I was kinda shy about that. (CN, 2013)

Advice about physical activity varies from one family to another – some suggest to discontinue chores and to take it easy, while others encourage moving and staying active. CQ, a mother of two, said she mostly received advice from her father, who strongly encouraged her to stay active and eat healthy:

Was it a difficult pregnancy? Did you have any pains or morning sickness?

> With my first one everything was OK, I was active. My dad was saying that a woman should do everything instead of just taking things back, slow, taking rests, those kinds of things...

Your dad? So your dad was giving you advice?

> Yeah, cause still like, pick up heavy objects, like... they say... they don't really want women carrying things when you pregnant. He told me what used to happen before... like the woman would still do everything, so I was still cleaning, moving furniture, play basketball, I did everything, but I also watched what I ate. He made sure I was eating with protein instead of something without it, so they gave me mostly traditional food, so I didn't really show I was pregnant until I was ready to have my baby. Like I got bigger, but it looked like I was just gaining some weight until I was ready to have him. (CQ, young mother of two, 2013)

Figure 9. Traditional foods: blueberry-fish (trout) salad, rabbit, geese, bannock on a stick.

Lilly had her four children in the 1970s and 1980s. Her mother was also encouraging physical activity during pregnancy. So Lilly continued going on the land, fishing, skidooing with her husband, going snowshoeing or checking rabbit snares. Lilly was told that it is important to keep muscles trained, because it would be easier to give birth. Her mother encouraged her to eat wild meat and traditional foods. She also remembers her mother telling her not to be stressed or worried, because everything will go the way it should go, and stress would only make things worse for her and the baby. Lilly emphasized that she rigorously followed her mother's advice and she took care of her mind and her body, and never worried about things beyond her control. As a result, all her births went very well, she said.

Some Elders say that, in addition to not lifting heavy objects, pregnant women should refrain from strenuous physical activity like running or jumping. One of the Elders told a story about a girl who did not listen. She was running and jumping in the sports hall with her friends. Elders who were sitting around told her to stop, but she did not listen, and sure enough, she lost her baby during birth. The Elder also emphasized that young people tend not to listen anymore to what Elders have to say.

During the interviews, when we would ask Elders about advice they would like to give to pregnant women, the answer often was that young people do not listen anymore anyway. Sarah[70] and I would have to encourage Elders by saying that their advice might still be useful for the ones who do want to listen and to learn. In fact, all young mothers I spoke with expressed great respect for Elders, interest and appreciation for their stories and teachings, and especially for the care they received from their grandparents and parents during their pregnancy and birth. A few mothers even suggested involving community Elders in the prenatal care at the clinic by organizing storytelling evenings or various workshops, because there are some youth that are more comfortable listening to stories from Elders than asking questions of the staff at the clinic. Not all young families have their grandparents or parents alive or always present. Elders would provide an encouraging and supportive space for young mothers:

> I think they should get the Elders who experienced, you know, to talk to these young girls, to have more support, so they can have questions, like I asked so many questions when I was pregnant with my son. I spoke to everybody - all my aunts, my friends, my grandmother, anybody I could talk to about childbirth. So I wasn't that nervous, I was like preparing myself for the worst. I had my grandmother, she taught me so much, I took the advice of my grandmother rather than the clinics, you know, she's my

[70] Sarah Stewart and I conducted interviews with Elders. She was my translator and interpreter. (see Chapter 1 Methods section).

grandmother, she wouldn't make it up. It would be, something for people… Because some of them have hard time talking to nurses but, if they have the Elders or their parents or mothers, their aunts that they could talk to, like share stories, and their experiences... (AQ, 2013)

The degree of advice and the details young mothers remembered and shared with me reflect the important role of family, Elders and their knowledge for the younger generation:

"My grandmother was most helpful"

During your pregnancy did you get any advice from your Elders, your mother or…?

My grandmother.

Your grandmother? Do you remember what was the advice she gave you?

She would always cook and invite me, she would give me fish broth, she told me it's good for the baby. She would cook certain foods, she always made sure that I eat right. It was mostly traditional food that she encouraged that I eat. So I did a lot of that. If she would make rabbit and dumplings, she would encourage me to drink the gravy that went there, and the broth, so that's what I would do.

Did you also follow appointments at the clinic with the nurse?

Yeah.

Did you find it helpful?

No. Not really. My grandmother was most helpful. She had 10 children, so she was… because my entire family went in the bush before my son was born, so I stayed and lived with my grandparents. So she gave me a lot of ideas and told me that these are the things that I should do. She always made sure that I didn't nap too long, because she told me, depending on your sleeping habits this is how your baby's gonna be when it's born. See, if you don't sleep at night, your child is not gonna sleep at night, if you take long naps, your child's gonna do exact the same thing, so you gonna be frustrated, because your child just wants to sleep and when it's time for feeding your gonna have a hard time. I followed what she told me. (AQ, a mother of three, 2013)

Grandmother's advice: stay active, sleep and eat regularly

Did you get any advice from your family, from your grandparents about pregnancy?

With my grandmother yeah, she told me that I should be following a regular sleep routine, eating healthy, like three meals a day, and she also told me to make sure that I stay active - to continue walking.

Did she say any particular things about food?

> No, she just told me to eat regularly and to eat healthy. Another interesting fact she shared with me was… 'cause she asked me if I wanted to breastfeed my baby and I said yeah, that's something I wanna do. And she said that throughout the whole pregnancy I should play with the nipple to shape it, so it will be ready for breastfeeding when the baby is born. (CL, mother of two, 2013)

Mother's advice: "Wear a hat!"

Do you remember, when you were pregnant, did you get any advice from your family, from your grandparents or your parents? Like how to behave, what to eat, etc.?

> Yeah, my mother.

What did she tell you?

> She gave me advice how to take care of myself during my pregnancy. Like what to eat, also how to take care of my child when he comes.

Do you remember what specifically she would tell you?

> She has always told me to have wild meat, like traditional foods were the best. She always told me to wear a hat, because he was born in winter, so I was getting bigger and bigger as the weather changed, you know… She always told me, "Wear a hat!" (BA, young mother, 2013)

No junk food

Did you get any advice from your mother or your grandmother about pregnancy, or breastfeeding or anything like that?

> My grandmother, and my mom, and my sister. My sister was the one telling me that I should try breastfeeding and "If you don't like it, you can use the formula. But it's up to you." Same thing my mom told me. "Try the breast milk first cause its cheaper, you don't have to pay for the formula." So I went with the breast milk.

And anything about your pregnancy?

> It was mostly "Don't eat that much junk food," cause before I ate a lot. So I had to cut down on that. And try to eat regularly every day, I went hungry a lot though! (laughing). (AG, young mother of two, 2013)

Family advice continues to be essential, but sources of information have become more numerous and diverse in town. Women have more contact with their peers, they can get different literature to read, access information on social media and the Internet. Women also

receive biomedical guidelines during their prenatal visits to Wemindji clinic.[71] Selection and negotiation among different information sources can become complicated if that information is contradictory and plentiful. However, the women I spoke with seemed to be confident about when to give priority to which source of information, and to know quite well which advice suited them best for a particular issue or situation. It does make sense, because the more different sources of advice you have, the more likely you will be to get advice that you like or are comfortable with.

As we've seen earlier in the interviews, for the questions women were too shy to ask their mother or grandmother, they turned to their cousins or aunts. In the following excerpts, we'll see that women also bought books, which are useful in understanding the stages of pregnancy and fetal development and for following a doctor's recommendations. They combine various sources of information and care during pregnancies.[72] Combined care is beneficial to women. While, for example, several women said they took into account doctor recommendations about the appropriate amount of physical activity, family played a major role in them quitting smoking or developing a healthy diet:

> Do you remember if you received any advice from your grandmother or your mother while being pregnant or about delivery?
>
> > During the pregnancy, as I got through the stages, me being young, I bought a lot of books, "What to Expect, When You Expect," "Baby Development," so I had all those books and pictures. I am supposed to have this by that time etc., so I was more focused on the literature that I acquired.
>
> Were you worried during your pregnancy about something?
>
> > Yeah… I just wanted to make sure I knew what to expect, that what I was going through was normal. Like my mother and my grandmother would tell me, you know... "Sometimes you'll have a discharge" or "Keep yourself warm"... they were more conservative not to play sports, whereas the doctor would tell me it's OK to be physically active to go and play, whereas at home I was told "No, you need to be careful and you need to take it easy and you think about your baby before you want to go and do something that could be harmful." I quit smoking, I was a smoker at the time and I quit when I found out.
>
> Was it your decision or was it from your family?
>
> > It was more family pressure, and it was almost like, well… not a choice - I have to. And it was easy, because I was still young and I had not been smoking heavy

[71] For more information about prenatal visits, see Chapter 7.
[72] For discussion and references about combining different approaches to wellness see Chapter 8, Section Homogenization*, indigenization and medical pluralism*.

> that long. Just to meet the expectations to have a good pregnancy... 'cause I was told, if you have a healthy good pregnancy, then it won't be hard when it comes to have your baby.

Did you have morning sickness?

> It wasn't morning sickness, it was evening sickness. It was in the evenings the smells were uhhh… I went in the bush, we would go camping with the family, there was certain things I couldn't take. The smell like, when they cooked porcupine, something with the strong smell. So they wouldn't cook it in the house. But I was very much encouraged to drink fish broth, eat fish, the boiled fish, to eat traditional food, because it would be a lot healthier. So the food that we did prepare at home it was a lot of traditional food that they wanted me to take, even the stuff I didn't like! And I thought OK, I'll eat it because they wanted me to. My grandmother would say, "You need to make sure your blood is good. In Cree it's like... I think she was trying to prevent me from being anemic. Cause she always wanted me to eat a lot of protein. She didn't want me to have a lot of junk food, cause she told me that's from where your baby eats, what's in your blood, and I knew she understood what it took to make a healthy baby, and she was explaining it to me in her own way, even when to me, "Yeah, but the book says..." So I had it both, two ways.

Did you argue sometimes what's in the book and what she says?

> Yeah, we did, but her argument was, "The book didn't have the baby, I had the baby!', so it was true... [laughing] And when it came time, when I started labouring and how everything went, I just totally forgot about the book! I didn't want to look at the book, I just listened to what they (grandmother, mother and her aunties) told me![73] (…) (CN, 2013).

BZ, a mother of five, had a close relationship with her grandfather. He passed away when she was in her late teens, but she always remembered his teachings which helped her during labour and birth. BZ said that she had lots of injuries as a child, and this is when her grandfather taught her to cope with pain. He told her to never focus on the pain, and instead, to concentrate on details around her, like for example a spot on the wall or a scratch on the window. She recognized that the kind of meditation her grandfather taught her helped her a lot during births. She also remembers advice from her close family who were telling her to go to bed early, eat traditional foods, not to lift anything heavy and to discontinue physically demanding chores. However, she did not think that the chores at home would hurt her baby. In the old days, she said, her grandmother and her mother would continue with their work while pregnant, because in the bush the chores needed to be done, so she did not see why she

[73] For more information about family support during labour see Chapter 8.

had to stop moving, quit working or stop being active while pregnant. On top of that, BZ said that she got lots of books to read about pregnancy and childbirth, from which she got useful information about pregnancy and baby development.

Sometimes family and biomedical advice might be contradictory, but for the most part, recommendations concur and complement each other. This frequent concurrence was well illustrated by CN when she talked about her grandmother telling her to eat traditional foods because "You need to make sure your blood is good." It is also not uncommon for family members to encourage women to consult a doctor or a nurse:

> It happened during pregnancy that after having sexual relations I lost some blood and a little bit what looked like mucus, and I was worried that we did something to cause a miscarriage... and the only person at home at the time was my grandmother, and I told her and she told me, "It will sometimes happen and it does not mean that you are losing your baby, but go see your doctor anyway." She still believed that that the medical field had a place, so I did, and they did observe me, they (medical staff) told me, "Well, you are not dilated, "she [the doctor] said, "It might have been something at the entrance of your cervix, maybe remnants of the previous period, I don't know, but it did not affect the baby or anything." (CN, 2013)

In summary, the main advice in the bush for pregnant women was to take good care of themselves, which primarily involved avoiding injuries, slowing down with chores and staying warm and dry. Given that many activities in the bush and daily chores around the camp were physically demanding and somewhat dangerous, it made sense to warn women to be extra careful and mindful. In town, people move less and have easier access to store-bought food; thus, advice about a healthy diet became even more important, and warnings about injuries or too much physical activity less relevant. As people's lifestyles became more and more settled, many parents felt the need to encourage pregnant women to move more and to stay physically active and strong. In town, pregnant women receive the most advice from their mothers or grandmothers; occasionally advice on pregnancy comes from their fathers and grandfathers. Some women consult different family members for different pregnancy issues, and/or combine different sources of information for specific questions, like literature and biomedical recommendations. Prenatal biomedical and family advice often concur and complement each other, making prenatal care for women that much more effective.

Elders' experience and knowledge is appreciated by everybody I spoke with. Women might disregard one piece of advice or another, but they want to hear Elders' teachings. It is not only the information Elders give that is important for women, but also the comfort and

care they receive, and the safe environment that Elders provide, where women can ask questions and be reassured if in doubt or when in a difficult situation.

The following chapter is dedicated to childbirth in the bush, based on experiences and stories told by thirteen Wemindji Elders.

CHAPTER FIVE: CHILDBIRTH IN THE BUSH

This chapter is based on 13 extensive interviews with Cree Elders in Wemindji conducted mostly in 2013, and a few in 2014 (for more details see Methods Section 1.4.2 Interviews with Elders). These Elders were born between 1927 and 1950, and so were between 66 and 86 years old at the time of the interviews. Their stories contain events and practices that they witnessed during their youth. Many also recalled stories and teachings from their parents and, in some cases, their grandparents. Thus, the information received from the Elders today about childbirth practices in the bush could reach at least as far back as the second half of the nineteenth century.

Today's Elders have experienced an overwhelming number of changes during their lifetime, including the shift from a bush-based lifestyle to a settled life in town. The Canadian federal government has made great efforts to assimilate Cree into Euro-Canadian ways of life - through public institutions, such as schools and hospitals in partnership with the church. "Bureaucratic colonialism"[74], as Morantz (2002a) refers to it, continues to leave a mark on the region and its people.

Some of the Elders interviewed here went through residential schooling and took different wage jobs in the South or in the community. Others never went to school and stayed around town and in the bush. Some Elders settled in Paint Hills (currently Wemindji) while they were still teenagers or young adults in the 1960s and 70s. Others continued living in the bush, or stayed part-time in the bush and part-time in town. All these life events have formed people's different perspectives on birth, and all of these perspectives are important for painting a picture of Cree birth practices and experiences in the past.

In addition to Elders' stories and teachings, I also received some information about birth in the bush from the younger generation who have listened and learned from their parents and grandparents, even though they have not witnessed birth in the bush themselves. Most of the younger generation are born in the Wemindji clinic or in hospitals and have grown up in Wemindji town. Nevertheless, bush life continues to play an essential role for them in various ways. If asked, many young people today would say that their favourite food is from the bush, that the bush is the place where they spend much time with their parents or grandparents and have developed a special connection to their Elders and the land. Bush life for many is

[74]According to Morantz (2002a), bureaucratic colonialism is a type of colonialism in which the government highly interferes and disrupts the lives of Indigenous people through various administrative procedures, social engineering, education, health care system, without settlers/colonizers physically being present on the territory they colonize (p. 8).

associated with peacefulness and happiness, a place where one can leave the troubles behind and heal. Many young people eagerly wait for holidays from work or school to be able to spend time on the land, harvest bush resources, paddle up and down the river and have community gatherings and feasts in the Bay. Thus, the knowledge that the young generation has about the bush is plentiful, and the information they shared with me is equally important in the story of bush births.

I open this chapter with a number of stories about childbirth in the bush. These stories represent a variety of experiences, and at the same time, contain common elements, such as: the importance of grandmothers, mothers and daughters as midwives; ways of learning about birth; the presence and roles of family/community at birth; respect for Elders' advice and guidance; a quiet and self-reliant attitude towards labour and birth, etc.

The rest of the chapter contains eight parts that are divided into smaller sections. The first part is dedicated to Cree midwives, in which I discuss: 1) who could be a midwife, how she/he was chosen, and how one became a midwife. The next six parts more or less follow the order of the birthing process, discussing: 2) pre-birth preparations - arrangement of space, bedding and other necessities; 3) the different participants in birth, and their roles; 4) the process of labour; 5) the significance of the caul; 6) and of the placenta, and ; 7) care of the newborn, with special attention to breastfeeding . The last part 8) explores the most commonly mentioned birth complications in the bush and their causes as explained by the Elders.

All interviews with Elders, except for three, were conducted in Cree by Sarah Stewart. Questions for all ten interviews were provided by the team leading a Cree Health Board project titled, "Birthing Knowledge," and myself. It was a cooperative work and the data from the interviews was used both for the Cree Health Board project and for my PhD research. During our meetings and interviews, I communicated with Elders in English, as much as it was possible, and Sarah facilitated our conversations. I also asked additional clarifying questions whenever I felt it was needed. Later, Sarah translated the interviews and helped with interpretation of details, adding her own experiences and knowledge to the information provided by the Elders. Most of Sarah's comments are in the footnotes. One interview, with Elder Lilybell Natawepineskum, was conducted in English and Cree by myself, together with Lilybell's son George Natawepineskum - who interpreted and translated during the interview. The last two interviews with Elders that I conducted in English are marked with "dir. sp."

(direct speech) (for more details about the interview process with Elders please see Methods 1.4 in Chapter 1).

5.1 Bush birth stories

Because my mother told me what to do, I knew what I was doing

by Elder Mary Ruth Georgekish

When we first went hunting in Ontario, in 1959, we lived with my aunt and my uncle. My aunt was pregnant. She already had a child, not her child – she was taking care of a girl, her sister-in-law's. When she got sick[75] that night, we could not sleep. My husband Jimmy went to town to tell that the baby is on the way. He left that night I don't know what time. My aunt was sick[76] for a long time and finally she said she could not help herself, because the baby was ready to be born. She told me she feels like baby was coming out and she wanted to check if that was true. When I lifted the blankets and looked, sure the baby's head was showing. It looked like the baby was in the water, and the water has not busted yet. My aunt told me to bust the waters. I washed my hands with miisiiwaapui [castor oil] and broke the waters. The water busted strongly. My aunt was very exhausted from the birth. The birth took a very long time. Then I had to look after the baby and the girl, there were two little children to look after.

Jimmy arrived with the guy by skidoo. It was late in November, late in the evening. He came with the game warden. The game warden asked me, "Who was the doctor during delivery? "Me," I told, "I was the doctor." He asked me everything what happened, and what I did during the birth. I told him that because my mother told me what to do, and I had already delivered my sister, I knew what I was doing. I said I remembered everything what my mother told me. It was already in my head. They were very proud of me. It was my second baby that I delivered.

I tried to do the same as my mother did

by Elder Winnie Asquabaneskum

I never delivered any babies,[77] but I watched my mother, she delivered many. When a woman was delivering a baby, young people were not allowed to watch,[78] but I watched my mother. I tried to do the same as my mother did, I learned from watching her. I delivered a baby of my mother-in-law. It was my husband's brother, Fred Asquabaneskum. I did not know that my mother-in-law was pregnant at the time. The father [father-in-law] was gone. All the men were gone. I was not sure where they were gone. On that day I went to do my chores. And I was already carrying my daughter Alice myself. When I came back from checking my rabbit snares, I was told not to leave again. So I was outside chopping wood. I did not go far. Grandmother [the newborn's grandmother], Elsie Blackned, was in the teepee too. When I came back in the teepee,

[75] Getting sick – this expression was often used by Sarah when talking about start of labour or contractions.
[76] Was sick = was in labour.
[77] At the beginning Winnie says that she did not attend any births, probably because the baby whose birth she describes attending was already out when she checked. Later in the interview she acknowledges that she did attend one birth, except she did not have to do much, because the baby came out himself.
[78] Winnie got married when she was around 15 or 16, so probably what she meant by "young" is younger than that.

my mother-in-law was already lying down. Elsie had covered her with blankets. This is when I understood that my mother-in-law was ready to have a baby. When I came into the teepee, I undressed and I was asked to come closer by my mother-in-law. And when I lifted the blanket, the baby was already there! After, I cut the baby's cord and cleaned him up. That was the first and the only time I ever delivered the baby.[79] Look how tall he is now! [Winnie laughs].

They would often call on my mother to go deliver

by Elder Doreen Daisy Georgekish

I only watched, I never delivered a child. At that time, I was afraid even to watch. The bedding for the woman was done so that the woman can be half-seated. This woman got sick and I went to bed. But my father told me to watch my recently born brother, and my mother was already sitting with the woman. I got up and he told me to keep the fire going. That was my job. It got morning, dawn, she was still delivering, and it got into the day. And, I think, the next morning, finally, the woman delivered. And the baby was huge! The labour was long, they had to sit her up and they put the blanket at her back. She was exhausted and tired. My brother Abel was born a month earlier and the new baby was bigger than my brother! That's probably why it took so long, because the baby was huge. The men were killing a lot of beaver at the time. We had lots of food then. I guess that is why she was so exhausted too, because before delivery she had to clean a lot of beaver…

When my mother cut the cord, that's when I got really scared. I was scared because I saw the scissors to cut the cord. For the cord, she used a flour sack string. My mother delivered the baby, and once she did, she cleaned him up, she washed him. She put him in a waaspisuuyaan (bunting bag). She delivered another child of the same woman--it was a girl, and she did exactly the same thing. That was the only two times I saw her deliver a child. When we were at the Old Factory, they would often call on my mother to go deliver. I never went with her, because they never wanted children to go to deliver the baby.

My grandmother was a midwife

by Elder Dollien Georgekish

What can you tell us about birth?

I did not participate in birth, but I saw it. My grandmother was a midwife. She used to tell me what to do and what not to when I was expecting my first baby. My granny told me way ahead of time about everything--how it will happen--before I was ready to deliver. She told me everything when she found out I was carrying the baby. She told me always to do things so my baby will grow, but not too big. And it was going to be an easy birth if I listened to my granny. She told me always what to do and what not to do, so I do not have a miscarriage. She said if I do some extreme housework, it could cause a miscarriage, or if I overexercise myself.

When I was ready to deliver, she got everything ready, things she would need to use. Even the water. That morning when I started getting my contractions, my granny

[79] Later in the interview Winnie said she was about 16 or 17 when she attended Fred's birth.

told me to continue doing whatever I was doing and not to lay down until I am ready to have the baby. It was around 4 o'clock when I could not stand the pain anymore and my granny told me to lay. During that time when I was getting my contractions closer together, I was hoping that my uncle Edward would be there. He was gone, he was hunting ptarmigan. Finally, they told me he has arrived home. The contractions were often. And they told him to go and sit right beside me. It must have been around 5 o'clock that I have delivered my son.[80] My granny delivered the baby and she cut the cord with scissors. She used a cotton thread, size 10 I think.[81]

Did you have any celebration after the baby was born?

Yeah, my uncle, when he went off, he was ptarmigan hunting, and that is what we ate after he got home.

A few weeks after the baby was born she passed away…

By Elder Mary Rose Visitor (dir.sp.)

My mother had another baby, in February, but I am not sure exactly what year was it. I think I was 9 years old. We were living with my grandmother and my uncle--my grandfather already passed away. So there were only two families there. Usually when a woman has a baby they don't want her to move around, they want her to stay in bed for at least one month. She wasn't allowed to do anything, even sewing, you know. My grandmother told me that people have sore backs when they get tired, when getting up too early, doing work. And a few weeks after the baby was born, she [the baby] passed away, in March. It was a very sad day when the baby passed away. My dad had to build a casket. Cutting trees, you know, with the help of my uncle. And I went with him when they buried the baby, with my grandmother and my uncle. And my sister had to stay with mom, to keep the fire going. It was March, it was a lot of snow then. They had to use an axe to cut the hole in the ground; they had a very hard time… And at the end of March we moved from there. That place is all under water now. It's in a reservoir.

The plane crash

by Elder Mary Asquabaneskum

Right around where MSDC (Multiservice Day Center), this is where my son was born.[82] In a tent frame. Do you remember the plane that crashed? [She is asking Sarah.] Did you hear about it? The same day my son was born!

I guess you were shocked–that's why you had your baby? [Sarah laughs]

[80] It is interesting that Dollien mentioned time. Timing of birth is a result of medicalization of birth [see McCourt (2009) *Childbirth, Midwifery and Concepts of Time*] and it is claimed to be a foreign concept for Indigenous people [Becker (2009) *Management of Time in Aboriginal and North Midwifery Settings*]. However, a number of Elders mentioned time in their stories. Young mothers talked a lot about time in relation to childbirth–the due dates, the timing of contractions, length of labour, the time of birth, etc.

[81] Interestingly, it was not a flour sack thread - as with the rest of the other cases. She also said that she had not heard anything about using flour sack thread to tie umbilical cord.

[82] Her son was born in 1960, in current Wemindji town. A few families had already moved there in 1959.

Yeah. Only me and my baby were in the tent, everybody went off to see that plane! [laughing] He was already born when the plane crashed. My sister told that the plane has crashed to a tree. And everybody ran to the water. They saw the pilot landing down on the other side towards the water.

So who was at your son's birth?

My mother was there, my sister, other women and my daughter Gracie.[83] The other children were not there.

Birth in a spring camp

by Abraham Matches[84]

I was born in the bush, The Moar Bay at Poplar River, right at the mouth of it. It was a spring camp there. My grandmother was the one that… my father's mother (Louisa Kitchicappo), was the one that delivered me and gave me both names, she gave me all difficult names! [laughing] This was in the spring break, May, goose break. I even saw where the old camp was, the teepee. It was huge! I don't know how many families, at least 6-8 families were there.[85] It was in a mîchiwâhp [teepee][86], cause that's what they usually use in the springtime.

5.2 Woman who attends birth (iskwaau kaa uutinaat awash); man who attends birth (napaau kaa uutinaat awash)

5.2.1 Who is the midwife?

In the bush, most of the deliveries were performed by older women in the camp–experienced mothers and grandmothers. Some of the women were expert midwives, known widely in the region for their midwifery knowledge and skills, and they were particularly sought if birth turned out to be complicated. There were also family members (husband, sister, niece, etc.) who had everyday knowledge about birth, with little or no hands-on experience, but who happened to be there at the time of delivery. They assisted in births if no one else was around to do it, and so they were midwives nevertheless. That is why the translation for midwife in Cree is "a woman that delivers a baby" (iskwaau kaa uutinaat awash) or "a man that delivers a baby" (napaau kaa uutinaat awash), which implies that a midwife is simply a person who happened to assist at birth.

[83] Gracie was about four years old at the time.
[84] Abraham Matches was born in 1959, the year Wemindji was moved to its current location. He was eager to share his birth-in-the-bush story.
[85] Abraham tells about the camp he was born in during the goose break - a seasonal goose hunt in the spring. There were 6 or 8 families staying in one teepee, which means that the teepee they built was big, which means also that there were many people present during his birth.
[86] For the different types of Cree dwellings see Traditional Architecture of the Wemindji Cree (1996) by Fred Georgekish.

When Elders were asked about the midwives in the past, many replied that the midwife was a well-experienced and respected woman (iskwaau kaa uutinaat awash) or, at times, a man (napaau kaa uutinaat awash), who delivered many babies. The mother would choose a midwife some time before delivery. It was not unusual for Elders to suggest which midwife to choose. But it was always important for a birthing woman to have a good relation and connection with her midwife, otherwise the birth could go wrong.[87] For this reason, the mother eventually had the final say. Sometimes it would be someone from the family; at other times a woman wanted to have an expert midwife who was not a family member:

> I guess it was an important person for the woman who is delivering. She was a respected person–the one that was to deliver a child (Edith Visitor, Elder, midwife-expert, 2013).

> I heard that a woman would request a specific person to be there. The woman that she named would be the woman to deliver her baby. What they also said is that the woman to deliver the baby would be the one that the mother trusts the most. Even though her husband is not there, but the woman she requested is there, the birth is going to be good. For the baby too. (Elizabeth Shashaweskum, Elder, 2013)

When Elder Mary Rose Visitor had her baby, she said she requested Marion Stewart, who delivered many babies:

Did you know that the baby is coming?

> Yeah, I told my mother that I think I'm gonna get sick [go into labour]. I had backache and, you know, moving around. So she told me to get my bed ready and she called my grandmother, but the other lady was the one who delivered. Marion Stewart was the one that delivered. (…) I just felt like having her over, you know, it just popped out in my mind.

So you asked for her?

> Yeah. She delivered many other babies. She passed away over 10 years ago now. (Mary Rose Visitor, Elder, 2014 dir.sp.)

Marshall (1984) writes that it was an honour to be asked to be a midwife. She cites an interview with a Cree Elder from Mistassini recorded in the 1970s: "It was a big honour to be asked to help, especially to deliver a baby. The midwife would comb her hair and put on clean clothes out of respect for the woman and a new baby. It was a big occasion, like getting

[87] There was a strong belief that the birth might go wrong if the wrong person was in the room with the birthing mother, or if the most important person was missing during birth. See section 5.4 Participation in birth

dressed up for a wedding. The midwife was really excited to be a part of the birth" (quoted in Marshall 1984:64). According to Marshall (1984), a Cree midwife or healer was a person who deeply cared about others and was dedicated to helping out (p.60). Wemindji Elders mentioned that to be an expert midwife, one had to have a gift and certain qualities–one had to be strong-hearted and not afraid of blood:

Could you tell us about midwives in the past?

> The women that were there were the ones to deliver the baby. There were a few that tried to be a midwife, but a person who is scared won't be able to do it. (Dollien Georgekish, Elder, 2013)

While some women mentioned expert-midwives outside their immediate family who assisted for them in birth, others said that their babies were delivered by their own mother or grandmother. Marshall's observation in Mistassini in the 1970s is in accordance: "It was usually the grandmother, the oldest woman in the camp, who is the healer. Because she spent most of her time in camp, it was she who was on hand to help deliver the babies, and she who would decide how to cure the sickness" (Marshall 1984:62).

In other cases, a midwife was simply a person who was present at the time of delivery. Cree were out on the land in fairly small groups of two to three families throughout the year, and would only meet in summer for a short period of time (Tanner 1979; Morantz 2002a), thus it would not always be possible to have Elders or an expert midwife at birth:

> When the community was together, they would pick an expert, but if they were at their camp, the help would come from whoever was there. Sometimes it happened that if the midwife is not too far, she would come to deliver to the other camp. (Edith Visitor, Elder, expert-midwife, 2013)

Mary Ruth Georgekish told a story in which she delivered her sister when she was twenty years old. It was her first delivery. Her mother guided her through the process:

> The first time I attended birth it was my youngest sister Juliet. My mother told me what to do. Until the baby was born, she wanted me to get the blankets. My aunt Flora was there too, but she was scared. My mother said she would have the baby any time soon, so she told me to get the stuff ready and to heat the water, because she will need lots of water. She told me what to do and I delivered my sister! She told me not to cut the cord right away. First, I needed to clean it off, the stuff that was on the cord, because my mother wanted the blood to circulate. I had to get the blood out of the cord before cutting it. I used the thread to tie the cord (kahibiuts).[88] She told me to clean the baby

[88] I've asked what kind of thread it was and if it was used anywhere else in a household. Mary Ruth said that the same kind of thread was used to make fishnets.

and to wash her. After I cleaned the baby, I put castor oil (miisiiwaapui)[89] on the cord and wrapped the baby in the waaspisuuyaan [bunting bag][90]. Finally, the placenta came out and my mother asked me to check it. After, I was told to change the bedding, so it wasn't dirty with blood and wet. I put the baby on my mother.

My mother told me I was a strong-hearted girl, not afraid of blood. She was proud of me! My dad finally came, and my little sister was already born. He probably was not far away. (Mary Ruth Georgekish, Elder, midwife 2013)

Figure 10. Waaspisuuyaan—Cree bunting bag made from flannelette and hides to wrap the baby used in the past and continues to be used today. Made by Edith Visitor, Elder, Midwife.

Elder Mary Rose Visitor remembered her sister's birth in the bush. Her family was camping with her aunt and uncle's family when her sister was born. Her aunt had to deliver the baby for the first time, because nobody else was around to help:

> My mother had a baby when we were in the bush. We were living with my uncle and my aunt. We were only two families. And I was supposed to be in school that year, but my dad did not want me to go, because my mother was pregnant, and we were in the bush. So, she was born on November 8th, 1958. A little girl. My sister and Alice were doing the chores, cutting wood and… you know. And we were doing the chores to keep the teepee warm. I did not see how the baby was born, I just helped her out to do this and that. My aunt delivered the baby, her first time it was. She said she was very nervous! There was nobody else around to help.

Did it go well?

[89] Castor oil was sold at Hudson Bay Company or at the Roman Catholic mission. Sarah remembers that Roman Catholic priests were around for some time. They would have medicine and give candies for people during Christmas.
[90] Waaspisuuyaan–a traditional Cree bunting bag made from flannelette and hides to wrap the baby.

> Oh yeah! It was our whole family there and my aunt, and my uncle. It was far… I think it was 144 miles away from Wemindji. We didn't see anyone until January. (Mary Rose Visitor, Elder, 2014 dir.sp.)

Many people in the community said that men were also delivering babies in the past, and they must have known how to do it, but it was difficult to find somebody who would remember a particular man, or any stories about napaau kaa uutinaat awash. Cree male midwives were also very briefly mentioned in the literature by Flannery (1995) and Preston (1982b). During the last of my visits to Wemindji, Sammy Blackened suggested, "Go talk to my aunt Frances Visitor, ask her about it, she will know the story." So I met Frances, and this is what I found out about napaau kaa uutinaat awash. Frances said she worked with Annie Whiskeychan[91] (1937-1997), who was Grand Chief Billy Diamond's[92] (1949-2010) sister. Annie and Billy Diamond's father, Malcolm Diamond, was a midwife, and she heard this story from Annie, which happened when they were living in the bush. Annie and her sister were both expecting babies at the time. It was Fall, and women had to be evacuated early to the hospital, because the float plane would not be able to land on half-frozen water later in the season; there were no runways or roads back then. When the medevac plane came, the two sisters did not want to go. They asked the nurses to leave them on the land because their father knew well how to deliver babies, but they were not allowed to stay. The nurses told Annie and her sister that their father was not trained to do the job.[93] Annie and her sister were evacuated against their wish to stay. Annie also mentioned that her father was well known in the area for his midwifery skills. At least once he delivered a breech baby and the birth was successful—the baby and the mother were healthy and sound. She said he knew how to turn the baby in a woman's womb so the baby comes head first (from a conversation with Frances Visitor, 2016).

I also found further information on Waskaganish First Nation's official website, where Billy Diamond told the story of his birth and his father being a midwife: "I was born on the shores of Rupert River about four miles west of the Cree Village of Waskaganish. It was

[91] Annie Whiskeychan (1937-1997) was an education consultant for Cree schools and did extensive work to develop Cree school curricula that meet the needs of Cree children and are more relevant to Cree ways of life. She developed language programs for schools, helped prepare an eastern James Bay dialect Cree lexicon, and did a lot of translation work from English to Cree and from Cree to English.

[92] The Grand Chief of the Grand Council of the Crees from 1974 to 1984. He was also a founder of Air Creebec company.

[93] It was around the 1960s. At that time, the government's attitude towards traditional midwives was demeaning - condemning them as dirty, unsanitary and not equipped to deliver babies. This attitude is well reflected in the statement of the nurses who said that Annie's father was not trained for the job.

called Rupert House back in 1949. There was no doctor or nurse at my birth, so my dad had to do the delivery." (Billy Diamond, http://www.waskaganish.ca/billy-diamond).

Frances stood up and started looking for something on her bookshelf. She said that there was another story about napaau kaa uutinaat awash–a man who delivered babies–in a small reader for school kids. After a thorough search she pulled out a small book, about 20 pages long, with many illustrations and short easy-to-read sentences on every second page of the book. The story was written by Edith Matoush from Nemaska; the illustrations were by Morley Stewart, an artist from Wemindji. It was titled "When my younger sibling was born on the trapline" (1998, see Figure 11). Edith Matoush recounted her experience of witnessing her sibling being born on the land and her father being a midwife:[94]

I was out of school after the first year. I was staying in the bush with my parents and siblings. It was winter. My father could not go hunting, because my mother was to deliver a baby any time soon. If he'd go somewhere for a little while, he would tell me to not leave my mother alone. The pains started. My father warmed up salted water and rubbed my mother's belly. The baby was born soon. I was alone with my father and my siblings, nobody else was around. There were no doctors and no nurses. It was my father who delivered the baby. My father was a midwife.

Figure 11. Illustrations by Morley Stewart (Wemindji) in a book "When my younger sibling was born on the trapline" (1998)

[94] The book is in James Bay Cree southern dialect. Frances was translating the sentences as we were going through the book.

Cree knowledge and experiences of childbirth were widespread, varying depending on age, sometimes gender, family size or number of families that people were living with while out on the land. Such knowledge was accessible to most, because birth was an everyday life event happening in every camp. Everyone had an idea of what to do, when to do it, and how to do it. Some women were experts who delivered many babies, others delivered only a few, and some assisted in deliveries or at least watched them.

Figure 16 is an incomplete list of Cree midwives whom people in Wemindji still remember and talk about. It contains the names that I was told, but I am sure that there are many more who were not mentioned. These midwives delivered babies in the bush until around the 1970s, and a few have helped deliver babies in the clinic (See Chapter 6 for more about clinic births).

5.2.2 Acquiring midwife skills

How would one learn to deliver a baby or become a midwife? As with so many other skills, Cree learn through watching, observing and participating: "I tried to do the same as my mother did, I learned from watching her." (Winnie Asquabaneskum, Elder, 2013). "I saw my mother and my granny delivering babies, and that's how I learned. I did not do it myself, I was watching." (Minnie Shashaweskum, Elder, 2014)

In several interviews, it was mentioned that younger children were not allowed to watch births, but older ones assisted with different tasks, like getting the water, keeping the fire going, or taking care of the infants. Tending the fire was the main task for young girls during deliveries. This way they could also learn about birth by being present.

Dollien Georgekish told a story about how her grandmother, who was a midwife, brought her to see a birth. Dollien thinks that the reason for her doing so was to show Dollien "what the woman goes through when she's having a baby." It was her life lesson from her grandmother. At the same time, she must have learned about the process of delivery and possibly gained some practical skills:

> When Sally Atsynia was giving birth to her daughter Rita, my granny was asked to go over there and she wanted me to go with her.[95] It was in Old Factory. At that time I was not married yet, and I guess that is why my granny wanted me to go see what the woman goes through when she's having her baby. My granny was asked by Sally to be there. Sally must have been sick [in labour] for two days. As soon as we arrived, Rita was born.[96] (Dollien Georgekish, Elder, 2013)

[95] Dollien was 17 years old at the time.
[96] A Cree belief was - and is - that if the right person shows up or is present at birth, the baby comes in no time (see section *5.5.2 Pain management)*.

Midwife-expert Edith Visitor described her first time delivering a baby. Edith's mother was an experienced midwife, but she told Edith that her hand was sore, and she could not deliver a baby on her own, so she took Edith along and guided her through the process. Edith became one of the most respected midwives in Wemindji and delivered many babies, including in the clinic when it opened in 1962:

> Yes, I was a midwife, my mother was there to tell me what to do. Her hand was sore and so she just told me what to do. She knew she will not be able to do it by herself, so she brought me with her and she guided me throughout delivery. I delivered Flossie (Winnie's daughter) in Moar Bay. It was in a teepee. It was spring. (Edith Visitor, Elder, midwife-expert, 2013)

Elder Margaret Mistacheesick told how she helped deliver a baby in the bush. She remembered that the delivery happened fast and nothing was ready; she did not receive much help and had to do it all by herself:

> Nancy [the baby's grandmother] was telling me to hurry up and when I went over, the baby was at the birth canal. I did not have time to take my coat off! If we would be gone for the snares, we would not be there to deliver the baby! [laughing]. It would only be my daughter Beatrice that would be present at birth. Nothing was prepared. Usually, when you know the baby is coming, you get things ready. Nothing was ready--thread, clothes… And she was yelling for me to hurry up!. . . [Nancy] was telling me to rush rush rush. I had some thread in my basket and this is what I used to tie the cord.[97] After I tied the cord, I cut the cord. I felt like I was doing (it) all on my own. I did not feel scared or anything. Here, I thought, she was gonna help me, and she was just yelling at me to hurry up! That was the first and the only time I helped to deliver a child. After, I got him all cleaned up. Now I have experience, and I think I could deliver a baby, as long as the mother is not having a difficult labour. I could deliver both of your kids! [Margaret laughing] (Margaret Mistacheesick, Elder, 2013).

Later on, I learned that Nancy, the grandmother who was rushing Margaret, was Margaret's half-sister, 16 years older than Margaret and, most importantly, remembered as an experienced Cree midwife. The fact that she left Margaret to deal with birth on her own suggests that the reason might have been to teach Margret to deliver babies and to give her a chance to practice delivery under supervision.

As previously mentioned, the first time Mary Ruth Georgekish had to deliver a baby, it was her little sister Juliet. Her mother guided her through the delivery. The second birth she attended was that of her sister-in-law's child. This time Mary Ruth was unsupervised. While her husband went to town to ask for help, Mary Ruth stayed to deliver the baby. Her husband

[97] It was a cotton thread that she used, not a silk one (she emphasized it), because the silk one can easily come undone.

came back with the game warden, but the help was not needed anymore as the baby was already born. The warden asked Mary Ruth how she knew what to do:

> He asked me everything what happened, and what I did during birth. I told him that because my mother taught me what to do when I delivered my sister, I knew what I was doing. I said I remembered everything what my mother told me. It was already in my head. They were very proud of me. (Mary Ruth Georgekish, Elder, 2013)

It was by being around deliveries in camps - helping out with small tasks and maybe even watching - that "strong-hearted" girls would learn about midwifery. Girls often found themselves in circumstances where they needed to apply their knowledge of birth and start practicing. Some were thrown into situations where there was nobody else to do the job, as with Mary Ruth; others had to take over because their mother or sister were not taking initiative. Those hectic situations were women's initiations into midwifery, with which women dealt confidently and competently. Some of those situations were brought about by life circumstances in the bush; others might have been deliberately arranged by their family or midwife-mentors.

5.2.3 Going to delivery – the midwife's equipment and preparation

Cree midwives would have a few necessary items ready for births. When I asked Elders what was in the "midwife-kit," they did not name particular items, but emphasized that all was organized, and put in one place: "Yes, my mother used to put her things together. She would prepare things, so she does not have to rush around looking for them." (Margaret Mistacheesick, Elder, 2013). Items that were generally mentioned in the birth stories by Elders were soap, scissors to cut the umbilical cord, a string to tie the cord, castor oil, some clean cloth or towels and, in some cases, clothing for the newborn.

During the time in Wemindji I attended weekly Kuhkums & Friends[98] arts and crafts activities. Women would bring their necessary sewing or knitting equipment, including handcrafted needle cases (Figure 12). Such needle cases were often included in the traditional midwife kit, because they contained thread and scissors. When talk around the table touched on the needle cases, midwives and births, one of the Elders remembered her mother keeping her midwife necessities in a tin cookie box−flat and round with a lid, or sometimes in a "jar with a lid that closes well."

[98] Kuhkum = grandmother in Cree. Kuhkum and Friends is an activity held by the Wellness Center in the Community Hall where Elder women come for different handicraft activities, bingo, and hanging out.

Figure 12. Handcrafted Cree needle cases with scissors, needles and threads. The cases are made and used today, but women agreed that this is more or less what midwives would grab on the way to births

Elders also mentioned that if a woman was well prepared, the thread, the scissors, the soap and other useful things were already there for the midwife to use. In those days, people would collect strings that could be used to tie umbilical cords and save them for later, so they were always on hand in any household. Midwives used several kinds of string to tie the cord. It was important that the string was the right kind, otherwise it could come undone and the baby could bleed to death. The thread had to be a strong cotton thread, not a slippery silk one. Elders remember most often using the string that was left from the bags of sugar or flour:

> Long time ago there was hardly anything to use for the birth. They used to tie the umbilical cord with a bag string. People used to keep those strings and to gather them. Once the cord is tied, they cut it. I heard that once the baby's belly button was bloody, blood came out from it, because the string came undone. There was nobody around, like a doctor, who could help the baby and the baby died. The strings long time ago were much stronger than today. Maybe they used the wrong string to tie the cord… (Daisy Atsynia Sr., Elder, 2013)

> To cut the cord they would use whatever we had. To tie it, we used a thread from the flour bag. We used to save the strings from the flour bags,[99] especially elder women. This string was strong. It was the best thing to use. If we wanted to have the birth now, we would not have those around anymore! [laughing] (Edith Visitor, Elder, midwife-expert, 2013)

Some midwives would use castor oil (miisiiwaapui) as an ointment for the umbilical cord. As previously mentioned, they would get it from the Hudson Bay Company or at the Roman Catholic mission that was around for some time at the Old Factory trading post. In one instance, it was mentioned that the midwife was using castor oil to clean her hands and nails before delivery. Others would use soap, some others would use only water or boiled water. Equipment that was going to be used during delivery was also carefully cleaned:

> Yes, I would clean my stuff, that's what midwives used to do. I saw them do it and that is what I did. With soap and water. My scissors, clean my nails... (Edith Vistor, Elder, midwife-expert, 2013).

> My mother, when she would get ready for delivery, would wash her hands and her scissors. And the string that she would use, she would make sure that it is clean, and she would clean her fingernails. (Elizabeth Shashaweskum, Elder, 2013)

Midwife Edith Visitor remembers that she would need different kinds of arrangements when heading to birth, depending on whether it was in the bush or in the clinic:

> When I was delivering at the clinic I did not take anything, because I knew they had things there, but when I was delivering in the bush, I would use whatever I had, and sometimes I would get things for the baby to wear, and one time I even had to breastfeed her baby before the mother could breastfeed it, because at the time I was breastfeeding my child. Sometimes, when the woman had the baby the first time, she did not have milk, and if she did, sometimes it took time for the milk to come (…) (Edith Visitor, Elder, midwife-expert, 2013).

In the bush, Cree midwives assumed many responsibilities—not only delivering the baby, but also making sure that the baby and the mother had support and everything they needed during and after the birth, including sometimes clothing.

[99] According to Edith, they would use this thread for everything in the household, even for sewing, because there was hardly any thread then.

5.3 Pre-labour preparations

5.3.1 Preparing the bedding

Right before birth, the inside of the dwelling would be prepared. It was the responsibility of the whole family to arrange the space and make sure that all necessary items were there for the birth. The bedding was a place for woman to lay down usually during the last stages of labour. It was a mattress made of canvas stuffed with goose feathers or sewn from different hides and covered with layers of moss and different cloths or blankets:

> They would make a mattress. They used canvas and put feathers inside. I saw other mattresses they used—rabbit skin mattresses. They used bearskin too. Even beaver pelt mattresses. When the skin is ripped somewhere, this is what they would use for the mattress.[100] They would also use the skin of beaver or rabbit for sitting on the boughs. (Doreen Georgekish, Elder, 2013)

Preston, who was doing research in Rupert House (Waskaganish), recounts that Cree used mattresses only after delivery. According to her, a Cree midwife or a husband would help to prepare a bed (a bearskin mattress with balsam boughs), which would be used only after the baby was born (Preston 1982a). Yet Elders in Wemindji said that the bedding was important both during and after delivery. Elders remembered that most often during the last stages of labour, a woman was half-seated or horizontal; therefore, the bedding was necessary.

There was a system in place to keep the mattress clean during labour. On top of the mattress, at the lower waist area there was a layer of moss covered with a clean cloth and used to keep the mattress from getting wet and stained. The cloth could be any clean fabric: towels, sheets or blankets. Sometimes there would be only old blankets or rags used to absorb the moisture, and no moss. Those two upper layers of moss and cloth would be changed as they became dirty, or right after birth. In one instance the midwife used plastic instead of moss, which she put on the mattress and covered with a clean blanket. Most often Elders mentioned only one layer of moss and cloth on the mattress. In one case, the layering on the mattress was thicker—there were three layers of cloth with two layers of moss in between. Some women would burn the dirty cloths afterwards, some others would wash them and reuse them:

> When they made a mattress, they put the moss on top of it and the cloth over it, and they would change it often. They would make sure the blood does not get on other things. When you change the cloth, you can still wash it and reuse it. (Doreen Georgekish, Elder, 2013)

[100] Sarah said that the rest of the hides, the ones that were whole and undamaged, they would send to the company (Hudson Bay Company).

> They used to put a mattress where the woman is gonna lay and deliver the baby. They would put moss where the baby would be delivered and they would put a cloth over the moss. When that is done, when she loses blood, it does not go through and that is why they used moss. (Margaret Mistacheesick, Elder, 2013).

> Long time ago they used to make mattresses with feathers, this is before we got the real mattresses,[101] Where they knew the baby would come out and it would get wet, they would put moss under and then some material over it, so the liquid does not go through on the mattress. Once the baby was born, they would change the moss and the material and they would put more moss and a clean cloth. (Edith Visitor, Elder, midwife-expert, 2013)

> Usually the birth would happen in the teepee. They would put moss under the blankets, only up to the waist. This is where they would lay the mother. Once the water breaks, it all goes into the moss, as well as the blood. They change the moss right away. I used to work in the hospital and I witnessed once the women gave birth they did not take the sheets, they did not change them right away as they were supposed to do. Midwives, they would change it right away when the baby is born. They would also warm up the moss on the pan for the mother. (Mary Ruth Georgekish, Elder, 2013)

The moss had to be prepared for the bedding early on. Women would gather big pieces of moss and hang them on the poles over a stove to dry. Once the moss was dry, they would pick out all the small sticks and branches and lay the moss in strips on the mattress. Sometimes it was mentioned that the moss was warmed up for the woman before she lays down, or when the bedding was being changed during delivery:

> Cause they used moss most of the time. We almost delivered the baby with my mom, so I knew a little… (…) I saw her, how she got the moss and she used to hang it on the poles where the stove was.

The moss would not fall? Would it be in big pieces?

> Yes, yes, and when it gets dried she would take the moss and remove all the branches and just use the moss… She had a cloth, it was clean, and what she did, she put the moss on the cloth, like strips, and then she made one layer and she put another one of moss. (…) and she put the moss with the cloth on it and just lay it beside the entrance where the baby is coming out, that's where she put it. (Sophia, Elder, 2014 dir.sp.)

Another important thing that was mentioned several times in interviews was a rope fastened horizontally on the poles of the teepee above the woman for her to hold or pull during delivery. There was some kind of soft rag wrapped on the rope where the woman could hold to prevent from blistering her palms when pulling hard. It was emphasized that

[101] It is interesting that Edith considers a "real mattress" the kind that is used today.

such equipment was especially important if the husband was not present. Otherwise he would be the one giving physical support to the woman and the rope would not be necessary, but even then, it could be in place, just in case:

> They make a bed so the woman has a sitting position. I also saw that they put something on the poles for the woman to hold on to. Especially when the husband is not there. When there were only women there, that was what they used to put for her to grab on to. Sometimes the woman who is delivering the baby would be alone with the midwife, so if she needs it, it's there. (Elizabeth Shashaweskum, Elder, 2013)

> Sometimes the men would be there during the birth, especially the husband. He would hold her hand. If no men were in the teepee, they would put a rope horizontally for the woman to hold on to it, when she feels a need. And they would put a cloth around that rope for her not to cut her hands. (Mary Ruth Georgekish, Elder, 2013)

> My husband was helping me when needed. They also put a rope for me to hold on to, my mother told me I could use that too. (Dollien Georgekish, Elder, 2013)

5.3.2 Arranging the birthing space, preparing baby clothing

Preparing the bedding was one thing, the other was to get the necessities for birth ready and to arrange the inside of the dwelling. The tasks included getting enough water, heating it up, getting the firewood to make sure the place stayed warm through the delivery, collecting moss if it hadn't yet been done, drying it, and protecting the teepee from the wind and cold - especially around the area where the bedding for the mother was prepared. Keeping the cold out meant covering the gaps between the teepee floor and the walls with some fabric.[102] The mother had also to prepare baby clothes and hang them in the teepee to make them warm. If there was not enough clothing for the baby by the time the woman went into labour, other women would be making some:

> They make sure that the firewood is plenty, you have firewood outside and you bring firewood to keep the stove going, not to let it get cold. Just to keep the heat inside the teepee. (Sophia, Elder, 2014 dir. sp.)

> Usually when there were young girls in the teepee, they used to tell them to watch over the fire. They would put the fabric to keep the cold away from the ground. (Elizabeth Shashaweskum, Elder, 2013)

According to Elder Elizabeth Shashaewskum, even when labour started, the woman could not lie down, but had to prepare the baby clothes – to take them out and hang them in

[102] Sarah remembers that her mother always kept the teepee warm by covering the gaps between the ground and the walls with boughs or fabric. She would tie a string from one pole to the other near the ground and would fix some fabric on it, especially around the place where you would put your head during the night while sleeping.

order for them to be warm for the baby. When she was done with all those necessary preparations, the baby was born in no time. The preparation process for birth was a ritual for the mother that was effective in helping her to prepare psychologically for the baby's birth, and also as a way to stay active through labour pains:

> When they know that the woman is pregnant, and is near her due date, they wanna look after her and ask her if she has pains and if she is feeling well. When she says she is near her delivery, they prepare a bed-like thing for her to lay down. They ask her if she prepared anything for the baby that the baby will need. The saying was that when the woman prepares all of this, her pregnancy will turn out good, because she has prepared everything. When the pains come, she would take the baby clothing out and hang it above, so the clothes would be warm for the baby. When she does all that, it does not take her long to give birth, maybe in an hour the baby is born. Usually when she has her baby, they ask her how she feels.
>
> The mother of the baby would make clothing from the flour sacks. Sometimes she would use flannelette for the lining. She would make the baby bunting bag too (waaspisuuyaan). She would dry moss way before she has her baby.
>
> Some mothers would know right away what they would need for the baby, so they would get ready. There was also saying that if the woman did not prepare the stuff like that, the birth will not turn out well, it might be a difficult birth. Sometimes she would only see the baby for a little while if she did not prepare what the baby needs. I heard my mother talk about it that a certain woman did not get her things ready, and sure enough, she did not see her baby that long[103]… (Elizabeth Shashaewskum, Elder, 2013)

Regardless of how things were supposed to be prepared in theory, reality sometimes was different and unexpected. Several Elders remembered stories when a mother or the family did not prepare what they needed for birth and everyone had to jump in and to rush when the labour started. All of those stories were told with laughter and in good spirits:

> There was another birth, Eric Matches, he was born in a teepee. I helped out with him too. At that time there were no men at the birth of Eric, only women. They were not in the teepee at the time, maybe out hunting? The mother did not get anything ready! The clothing for the baby to wear, nothing! While she was having her pains each and every woman was making different items for the baby to come [laughing]. The baby was born before the hunters came back.
>
> I heard the story that this woman was drying some moss and putting it away. She just made it to the teepee and she had her baby born at the doorway!
>
> What did they do when this happened?
>
> They just quickly made the bedding for her then. (Mary Asquabaneskum, Elder, 2013)

[103] Elizabeth means that the baby passed away not long after birth.

5.4 Participation in birth

As we have seen, Cree childbirth is a community event. It was, and generally is, open to family and community members. In the old days, birthing had many participants with different roles assigned to them, depending on their age and sometimes gender. The roles were somewhat flexible, because of the hunter-gatherer lifestyle in the bush, where families lived on their own on the land throughout the winter. Generally, everyone was welcome to watch or help at childbirth with the exception of small children, and usually men who were not immediate family members. These exceptions did not apply to Elders. The number of participants largely depended on the season of the year–during summer gatherings, when families were together, there would be more people at a birth, while in other seasons, there would be fewer.

If birth was taking place at night, nobody had to leave the dwelling. It would be divided into separate spaces (Tanner 1979), and each family would sleep or birth within their own family space. If the birth was happening during the day, the young ones usually were told to leave and play outside. Sarah Stewart remembers witnessing two births when she was around six years old during winter or early spring. There were four families together, and the men were out hunting. One morning the women dressed up the kids and told them to go out and play. They played a long time, Sarah said, and when they came back, they found a newborn baby. Adults asked the kids if they saw baby footprints in the snow when they walked in, because the baby came running in the snow barefooted. He came from a tree stump, the kids were told. Sarah said they were puzzled, and did not see baby footprints around the dwelling. Then they were told to go out again and find that tree stump where the baby came from. Sarah was laughing heartily every time she told the story—she remembered herself and other kids being tricked; they believed the tree stump story and went looking for it!

As children got older, they became more and more aware of pregnancies and births. Elders said at some point they were not that easily tricked anymore. Soon they could start participating in births with some small tasks. The main task for young girls during birth was to keep the fire going and to make sure the place stayed warm all through delivery. They would also have to bring buckets of water from the stream or lake nearby. Sometimes they had to take care of the infants and younger children in the camp. The older they got, the more closely they could participate in the birthing process by assisting a midwife and being able to see deliveries.

A husband was expected to give a birthing partner physical support and comfort when needed. However, often men would be out hunting and would be gone for days or weeks, and women would be left alone with children and Elders. If men were home, a husband would stay by his wife while the other men and young boys kept themselves busy outside the dwelling. Sometimes there were exceptions, and some Elders noted that other men apart from the husband were inside during birth, even if the birth took place during the day. "My husband was there, and some other men too during birth. Some women were there, some others were gone to pick the firewood. Kids were around, tied on the string.[104] My husband was helping me, supporting me." (Dollien Georgekish, Elder, 2013)

For birth to go well, a mother had to be comfortable with everybody present. She had a right to tell people to leave if anyone was bothering her:

> The mother had a right to say that she does not feel comfortable with the person during birth, and the person would have to leave. When there's a woman who is in labour, and she is not comfortable, it takes a long time for her to deliver a baby. When they notice that she is sick [in labour] for a long time, they would ask if somebody is bothering her. She would say the name of a person. The baby is usually born very soon after that person leaves. (Mary Ruth Georgekish, Elder, 2013)

The absence of a person that a birthing woman has requested or wished to have nearby during birth was also regarded as a cause of difficult labour. Sometimes the mother would request a person early on, and sometimes she would ask a person to come in when the labour was in progress. The person could be anyone the woman feels a special bond with, or somebody who she thinks might be knowledgeable and useful:

> (…) Sometimes the baby takes a very long time to be born. But when the mother would request a special woman, the baby would come much sooner. This is what happened to me when my son was born. My son was not coming out until I requested for somebody to be there. And then, in no time, my son was born. (Daisy Atsynia Sr., Elder, 2013)

> There was one difficult labour I heard of. But I've never seen one myself. It took a long day, then my mother came,[105] and the woman delivered. (Winnie Asquabaneskum, Elder, 2013)

[104] As previously noted, to tie the kids on the rope in a teepee was a safety measure--until a certain age kids were tied on the rope, so they would not get burned if they came too close to the fireplace. A woman from Wemindji told me that she remembers, as a kid, she was tied to a rope and did not mind. One day she was alone in a teepee while her grandmother was nearby picking firewood. Suddenly, a big fire started in the teepee; luckily, she was able to undo the knot of the rope and to escape.

[105] Winnie's mother was a midwife-expert.

If delivery took a long time, and especially if the woman was not feeling well, they would ask an Elder to come and sit with her. Elders were the ones to talk to the mother and to calm her down. They would know what to do and how to handle difficult situations, even if everyone else was stressed or scared. That Elder could be a woman or a man; gender did not matter:

> Usually the husband was present. If the labour is difficult the Elder is asked to come and sit with the woman. (Daisy Atynia Sr., Elder, 2013)

> During the day, when the woman is delivering, the children were told to go out and play but some men would be there. That's what I saw when I was young. Even myself I was told to go out and play. Elders were inside--men and women. The Elders would sit where the woman is, the men too. Some women would worry that she might not deliver. That is why the Elders were there. That's what they did. They told her not to worry what she was going through.

Would many women be worried?

> Yeah, the women would worry, the mothers to be... Even the midwife would worry sometimes, especially if she knows that the mother is worried. The Elders would talk to them. (Edith Visitor, Elder, midwife-expert, 2013)

When asked about which people would be present at birth in the old days, Elders often said that a woman's body at birth was never exposed as much as it is in the hospital today; therefore, anyone who wished to could attend:

> Who was allowed in the teepee during delivery?

> I was comfortable with all the people who were there. They say that if the woman is comfortable, the birth is easier. No kids were allowed. From the men, only the husband would be present. In the hospital the blankets are up. Here (in the bush), they would cover her.

> Were there any Elders present at the deliveries?

> Yes, Elders were usually present. If it is at night, everyone was there. They did not do what they do today at the hospital when the baby is born and people are present. They cover her up, they do not leave her uncovered. (Margaret Mistacheesick, Elder, 2013)

> Once the woman lay down, they would cover her up. They would not leave her wide open. (Mary Asquabaneskum, Elder, 2013)

In summary, the idea was to let everyone participate in birth as long as they wanted to be there and as long as the birthing mother felt comfortable. People could stay, help out, and watch. Usually women appreciated having family and community around during births,

because the more people around, the greater the support and care received by the woman and her baby.

5.5 The process of labour

5.5.1 Self-reliance during labour

During labour women were calm and patient, carrying on with their daily chores. Often women mentioned that they continued throughout the day without telling anyone until the last minute: "Some women would never tell that they were getting sick [going into labour]. Some did. (Daisy Atsynia Sr., Elder, 2013)

Preston (1982a, b) notes that keeping labour pains to oneself is an expression of Cree core values, which include self-reliance, emotional control and non-interference. According to Preston (1982b), "Childbirth in a Cree context includes withholding from the midwife information about the birth until it is actually taking place. This action is primarily to maintain self-reliance and to avoid interference with another until the last moment." (p. 125). Marshall (1984) maintains that, "The importance of self-reliance and individual competence to those Cree who spend a large amount of time in small isolated hunting groups is hence self-explanatory" (p. 54). In those circumstances, it would often happen that experienced women or Elders noticed that a woman was in labour before she spoke out. Preston's (1982b:171) analysis suggests that experienced midwives were supposed to notice signs of labour. Experienced midwives or family members could also understand the signs of labour before the woman herself did, especially if it was her first baby.

5.5.2 Pain management

Elders would often say that they had nothing in the old days for labour pains. Further into a conversation it would become clear that by "nothing," they meant none of the current biomedical pain relief methods, like nitrous oxide or epidurals. Otherwise, Cree had several ways to help women cope with labour, such as staying quiet, calm and confident, and by listening to the guidance of Elders and family:

> That's what I did--what I was told to do. During birthing, women were told not to yell and not to scream. That's what they told me, and I did exactly that.

Were you scared or nervous at birth?

> No, not at all. I was always told not to be scared, the Creator gave me to deliver a child and I should do that with confidence. (Mary Asquabaneskum, Elder, 2013)

There were several ways for others to help a labouring woman: 1) by applying heat compresses; 2) massaging; 3) using dried caul (see below); 4) being present; and 5) giving guidance and support. The most often mentioned pain relief method was the application of heat via a "sort of water bottle"[106] or a special rock wrapped in moss:

> Do you remember, was there anything used for pain? Like when your sister-in-law had pain in her back or when you had strong pains during labour, would people use something to relieve the pain?
>
> > I think what she used was a sort of the hot water bottle or a warm compress. I think that's what she used, sometimes she would just massage her lower back. No, she didn't give her any medication, cause she didn't wanna do more damage[107],[108]. (Sophia, Elder, 2014, dir.sp.)
> >
> > If I had any pains anywhere I would use a water bottle. You boil the water, you put it there and then you… or a rock, you heat it up and then you cover it with wet moss and with a cloth or a towel or something…and then you put it wherever you have the pain. And that really helped. (Margaret Mistacheesick, Elder, 2013)

A warm compress from rocks and moss was prepared by finding a suitable rock, heating it up, covering it with wet moss, and applying it to the painful area:

> (…) But in their time they didn't have the water bottle, so they used to get rock from the river, you know? They said, make sure that the stone or the rock is in the water all the time.
>
> Why?
>
> > Because it won't break when it gets hot. They put moss, you know, and they pour water on the moss and they wrap it around.
>
> First you heat it in a fire?
>
> > Yeah. Once you take it from the fire they… I remember you could see the steam from the rock… and they put moss all around and then they pour water on the moss and put the stone in it and wrap it, wrap it around.
>
> Do you know why the moss?
>
> > I don't know. That's how they did it.

[106] Any container that could keep hot water in it.
[107] An assumption here is that by giving medication you could cause more damage. Many Cree are aware that biomedical medicine might have unexpected side effects; thus, some try to avoid it if possible.
[108] Sophia is talking about early contractions of her sister-in-law (see Sophia's story in the Introduction, p.1) that happened in the bush. She referred to medication because, I suspect, she wanted to emphasize that back in the day, even if her mother might have had some from the missionaries or the store manager, she relied on Cree medicine and practice during births.

Maybe it's softer with the moss?

> They keep the moss moist so it won't burn you. They used to use a towel I think or something else, kind of a material to wrap the stone and the moss, then they put it. But they had to check the moss. If it's getting dry, you have to moisten it so you don't get burned. (AP, 2014 dir. sp.)

Most Elders said they did not see birthing mothers being massaged until after birth, but a few said that massage was used when contractions were very strong: "Yes, they would massage the area where the pain is, if the birth is difficult. They would massage the woman, they did not use anything else for pain" (Doreen Georgekish, Elder, 2013). Elder Mary Ruth Georgekish also mentioned a dried utispikun (amniotic sac/caul) being used to speed the labour and to relieve the pain. The caul was dried and kept in a safe place and used for pain when needed: "They used it (the utispikun/amniotic sac) when a woman is having a difficult time at birth. They would put it where the woman is the most sore, usually at the back (shows the lower back area). That's how a baby would be born soon. It would speed the birth, the birth would be easier (Mary Ruth Georgekish, Elder, 2013)[109].

An Elder or a family member having a special connection with a woman and talking her through the labour also provided pain relief. "The husband was usually present at birth. If the labour is difficult, the Elder would be asked to come in and would sit there during birth" (Daisy Antsynia Sr., Elder 2013).

When Elder Mary Rose Visitor (2014, dir. sp.) was giving birth at her parents' home in Wemindji, she had a midwife nearby. When I asked her about the pain, and how it was managed, she replied that her mother would talk her through the labour. Labour was less painful, easier, since her mother was there and she had the support she needed: "My mother was sitting beside me, holding my hand, talking to me, telling me to take deep breaths. I was lying down. They did not want me to move."

Emotional support from the family and/or the Elders is considered a medicine, and it is grounded in the wholesome Cree concept of "being alive well" (miyupimaatisiiun) (Adelson 2006). In order to be healthy and well, you have to have a healthy environment. Thus, to endure physical pain, a woman should have support and emotional comfort - people who bothered her had to leave, and the ones who were requested had to show up. Elders or family

[109] Caul has a strong symbolic meaning for Cree; thus, the healing and protective powers attributed to it makes caul an effective medicine for Cree (for more see 5.7 *Utispikun* (caul/amniotic sac).

who had wisdom, experience, or a connection to the mother were essential sources of pain relief, along with warm rocks, hot water bottles, and massage.

5.5.3 Labouring positions

A labouring woman was encouraged to move around and to prepare for the birth and the baby. When she could not stand the pain anymore, she usually would lie down. The most common position, according to Elders in Wemindji, was lying down on her back, especially in the last stages of labour. Often the bedding was prepared in a half-seated position. Some women remembered lying down on their sides, instead of on their backs, because it was easier to push the baby out: I couldn't lay like the doctor lays the woman when she is ready to deliver. I couldn't lay like that. I had to lay on my side (Dollien Georgekish, Elder, 2013).

Preston (1982a) wrote that the most common delivery position among Cree was kneeling. However, none of the Elders from Wemindji mentioned that position or remembered seeing it:

> Everything used to get set up. They would prepare the bedding where the woman is gonna be delivering. When the pains accelerate, the woman would lay down. First, she would sit up, but then, she would lay down when she could not handle the pain anymore. (Edith Visitor, Elder, Midwife, 2013)

Some Elders said that a woman always had to lie down during delivery, because they were afraid she might hemorrhage.[110] On the other hand, when the labour was difficult, there was a practice to sit her up and hold her upright. In that case, a woman would be squatting on her own feet. It made it easier for the baby to find its way out:

> I always saw women lying down when they would deliver. When the labour is difficult, they would sit her up and hold her upright. (Mary Ruth Georgekish, Elder, 2013)

> During delivery women would lay down. But some women during the difficult labour would sit. The only difficult one I know of, they sat her up. (Winnie Asquabaneskum, Elder, 2013)

5.6 Ishkwaashimunsh (placenta/afterbirth)

The placenta had a special place in Cree childbirth. All Elders had something to say about the placenta and emphasized that in the past it was treated respectfully. The literal

[110] Cree medicine for hemorrhaging in childbirth or heavy bleeding was beaver castoreum, which mix with water and drink. According to Elders, after such a drink "the blood stops flowing" (Marshall and Chiskamish-Napash 1996:28-30). The beaver castoreum drink was also used after miscarriage, when the woman was losing a lot of blood (p. 88).

meaning of the word placenta (ishkwaashimunsh) in Cree is "pillow"; Cree call it the "baby's pillow":

> I think they didn't throw it away like garbage, they just kept it… like, it's a sacred thing… You know, like when you sleep you have a pillow, and they say it's the baby's pillow–ishkwaashimunsh. That's how they call it–awaash ishkwaashimunsh. It was a sacred thing and they had to really take care of it. I think it was placed like in a burial or something. It's not to get the animals to it, bury it where it's safe. And they had to wrap it up so … the smell doesn't attract animals. But they didn't burn it or anything, it was just a burial. That's what the baby's pillow is–ishkwaashimunsh... (Sophia, Elder, 2014, dir.sp.)[111]

There were various practices for disposing of the placenta. Some Elders said it was buried in the ground, others that it was burned or tied up in a tree. Even though Elders could not remember the reasoning behind these different practices, it was clear that the placenta had to be handled considerately, and that the different ways for disposing of the placenta were meant to protect it from being treated disrespectfully by whomever came along, whether animal or human:

> I saw my mother wrap the placenta up and put it high on the pole and tie it--make sure that nobody gets into it. Other people would burn it. (…) People would not do exactly the same thing, some would burn it, some would hang it. (Elizabeth Shashaweskum, Elder, 2013)

> The doctors today throw it away. A long time ago it was almost sacred to the people, important. They'd wrap it and tie it on the long tree. They used to stand the long stick next to the tree to secure the placenta. They made sure it is secure. It stayed there until it deteriorated and there were worms in it. That's when they would burn it. People were not allowed to play with it, had to respect it and not to touch it. That's what the people did a long time ago. (Daisy Atsynia Sr., Elder, 2013)

> They used to look at it, if there was anything on it. Check it out, then it was burned. I do not know why they checked it out when the baby is born... The reason why they burn it is for it not to lie around. (Mary Asquabaneskum, Elder, 2013)

The most frequent complication of birth in the bush was when the placenta did not part after the delivery of the baby. In that case, a woman could bleed to death. No specific cases of death were mentioned, but women were well aware of this consequence, and several said that

[111] When my mentor, Dr. Robbie Davis-Floyd, read this part of my thesis, she was amazed, as when she was pregnant with her son, she did a visualization in which she entered the womb as a tiny person and swam around her son, and saw him lying with his head on the placenta, using it as a pillow! Despite her wide cross-cultural knowledge of birth, this is the first time she has ever heard of a culture that calls the placenta a pillow, and she was tremendously moved.

they had a hard time dispelling it. In those cases, various methods were used to help. Some midwives used a hand, others applied heat or massage:

> The first child I had myself--the placenta did not want to come out. My grandmother, she was a midwife then, and she was helping me. She moved the cord around, and finally, it came out. It did not take too long. I was OK then and I did not feel any kind of pain. (Edith Visitor, Elder, 2013)

> When my baby was born, the placenta did not want to come out right away. I don't know what my granny did with it after... She asked me where I was feeling pain and she told me to lay on that side. Soon after that, the placenta came out. She also asked me if I had a back pain when lying a long time on my back. She would help me turn on one side or the other. (Dollien Georgekish, Elder, 2013)

> My first delivery was difficult, and the only one difficult. The placenta would not come out and they had to press on it to bring it out. It was almost two days before they got it out. The midwife, she had to put her hand in and to bring it out[112] I had pains after, but they gradually went away. The other births were easier. (Margaret Mistacheesick, Elder, 2013)

> When the baby is born the placenta comes out. But sometimes it does not. It happened to me when my son Stanley was born. My granny managed to take it out. Granny told me that if she was not there, I would not make it alive. My granny used her hand. She pulled it out slowly with her hand. (Minnie Shashaweskum, Elder, 2013)

> When it did not come out, they made sure that it was not inside her. Sometimes it would inflate like a balloon. Sometimes the woman would say, "I have pain at the back on the side." If she says so, it may be stuck on something inside. When finally it comes out, the woman who delivered the baby would check on it. When it goes like that and it does not come out, the midwife would get the rock, heat it up and wrap it in a cloth and put it on the area where the woman complains about the pain. It might help the placenta to come out. (Elizabeth Shashaweskum, Elder, 2013)

> Sometimes the placenta would not come out right away. It was stuck somewhere. Whenever the woman said she has pain in a certain area, she would massage it and shortly after, it would come out. Sometimes when a placenta comes out, they would look at it, and it would show where it was stuck. I don't know what they did with it… The only time I heard talking about it is when it happened that it did not come out easily. If it takes a long time for the placenta to come out, and the woman still complains about the pain, they would heat the rock and would put it on that area where the pain is. I did not see my mother do it, but she mentioned it that she would do it. (Doreen Georgekish, Elder, 2013)

After the placenta came out, it was important to check it, but Elders could not remember what exactly it was checked for. When I asked the medical staff at the clinic about it, a

[112] In scientific terms, this is called "manual removal of the placenta" and is a skill that all birth practitioners must know (Kongnyuy et al. 2009).

family doctor who worked in Cree and Inuit communities for many years suggested that they might have been looking for tears. Obstetricians do exactly the same thing, she said. Looking at the placenta you can see if there are any pieces missing, which indicates that some of it is still in the womb and can cause heavy bleeding. The whole placenta must be out.

5.7 Utispikun (caul/amniotic sac)

There was something covering the baby's head–utispikun. That was the only thing my mother would save. My sister, the one I delivered, was wearing utispikun and my mother wanted to dry it. It is almost like a paper. She dried and she folded it… and made sure children do not get to it. It was said that they used it when a woman is having a difficult time at birth. They would put it where the woman is the most sore, usually at the back. That's how baby would be born soon. It would speed the birth, the birth would be easier. They used to cover it (utispikun) with fabric and keep it safe. My mother kept the one from my sister. It was sacred to her. Once my sister Grace made a joke – she said 'Bring it here! I will roast it on the stick in the fire!' [laughing]. (Mary Ruth Georgekish, Elder, 2013)

Elders often emphasized the significance and sacredness of utispikun. The caul has great significance in many sociocultural contexts (Rich 1976; Uchino 2016). Wemindji Elders explained various meanings and powers of utispikun—it eases difficult labour, relieves pain and protects people from drowning.[113] Utispikun had to be saved and kept in a secure place. It was said that kids were not supposed to get to it or play with it; it had to be respected. The caul was dried, folded, covered with clean cloth and kept in a special sack or box:

When the baby is still in the womb and the water breaks, the sac dissolves. But when the person who delivers the baby breaks the water, the sac is there, on the head of the baby. It was sacred, important to people. You stretch it out on the flat surface and you dry it. The women would keep that. My father had one, he kept it in his pocket. It is like a protection. My daughter Lillian has it too. I gave it to her and told her to carry it everywhere she goes. It is like a bag and it really dries fast. People thought it was one thing that cannot be destroyed, it was sacred to them. (Daisy Atsynia Sr., Elder, 2013)

A long time ago they used to dry it. And they kept it.. . . and after it's all dry, they keep it in a safe place. Usually the mother would keep it. I don't not know why they did that. I guess they just wanted to keep it… (Winnie Asquabaneskum, Elder, 2013)

I saw it. It looks like plastic. When the baby comes out they usually punch the sac for the baby to breathe. They used to dry it, and once they dry it, they fold it up. Sometimes the man would stick it in his wallet. Why do it?... I am not sure what the meaning is… (Mary Asquabaneskum, Elder, 2013)

[113] A similar belief about the caul protecting people from drowning was held in England among fishermen (around the 17th to 19th century) (Uchino 2016:36).

Several women said they gave the utispikun to their children, but were not sure if they kept it. One afternoon at the cultural camp,[114] I was talking to Elders about utispikun while helping to pluck geese. Elder Queenie Atsinyia said that her husband is 75 years old and he still has his utispikun. The next afternoon she brought her husband's utispikun to the camp. It was dried, folded and kept in an old Bible. It looked like a thin, old, yellowish paper with brownish edges (Figure 13). There were many people in the teepee, many Elders. The utispikun that Queenie brought made a big impression on everyone. It went around, everyone wanted to look at it. Some women came to me and said that Queenie's husband went through a lot, and probably the fact that he had his utispikun was what got him through difficulties in his life.

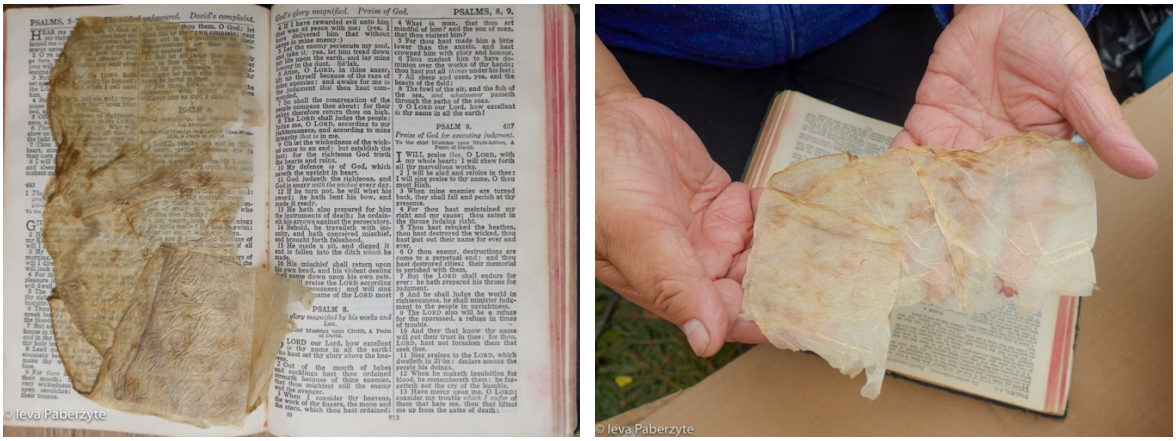

Figure 13. Freddie Atsynia's (born 1941) *utispikun* (caul/amniotic sac).

5.8 Caring for the newborn

After birth, it was time to take care of the baby. After being tied, the umbilical cord was cut with scissors.[115] It was advised to wait to cut until the blood circulated well. Mary Ruth Georgekish remembered that her mother told her to clean the cord first, to squeeze the blood out, to tie it, and only then to cut it.[116]

[114] Cultural camp is a recently built camp right outside Wemindji town in the bush on the mouth of the river, where the Elders spend time cooking, hanging out and doing traditional Cree activities. Community members come to participate, to eat bush food, to learn, etc. Many community events and activities are organized in the cultural camp.

[115] Scissors and other items used in birth, like thread, flannelette, canvas, or plastic were possible to get at the trading post from missionaries or traders. Some Elders mentioned that the scissors were carefully cleaned before with water, boiling water or water and soap.

[116] The formerly routine practice in biomedicine of immediate cord-cutting has now been scientifically discounted as evidence has become available showing that the newborn needs the blood and oxygen still flowing through the cord for as long as it keeps pulsating. The current evidence-based practice, affirmed by global guidelines for third stage management, is to wait to cut the cord until it stops pulsating (see Hutchon 2006; Raju and Singal 2012). This example of waiting before cutting the cord shows again that many Indigenous birth

As previously noted, the cord was tied with a special thread - a heavy cotton string from flour or sugar sacks, or sometimes a simple cotton thread that was thick enough not to break. Then the baby was cleaned, washed, put in a waaspisuuyaan (bunting bag, see Figure 10) and given to the mother. Sometimes, during birth, the baby could swallow some amniotic fluid, blood or poop/meconium; thus midwives and other birth attendants had to pay attention to the airway of the baby to make sure it could breathe easily. If needed, the airway was cleaned,[117]

> Sometimes when the waters burst, the baby would swallow some blood, or water, so they always would check if the baby can breathe. They check the mouth and the nostrils and they clean it right away. (Mary Ruth Georgekish, Elder, 2013)

> What they used to do once the baby appears from the birth canal, they used to get a piece of cloth and to cover the nostrils and the mouth, for the baby not to swallow the water. They used to say that it is not good for the baby's stomach to swallow the liquid. That's what the midwife used to do a long time ago. They covered the nostrils and the mouth. (Edith Visitor, Elder, midwife-expert, 2013)

Elder Mary Ruth Georgekish recounted in some detail how newborns were taken care of—the Cree used moss for a diaper, but would protect the belly button from infection by covering it with a cloth. For the belly button to heal, Cree used castor oil or bear fat. If the baby had stomach aches, it would be treated with a warm compress:

> They used heavy cotton thread to tie the umbilical cord, not the fine one, not to cut the baby's flesh when the baby moves. Castor oil would be used to clean the belly button. Sometimes when the baby would cry a lot and the belly button would pop up, it would look like a breast nipple. It meant the stomach is not working well. The baby was crying a lot then.[118] They would put the cloth on the skin and then the moss on the cloth. The moss did not contact the skin. The reason why they used the cloth is for the belly button not to get infected from the moss.[119] Even after the umbilical cord falls out, they would still use the castor oil to clean the belly button and would put a fresh cloth around the belly button, on the waist only. Sometimes when the baby cried hard they thought maybe the cloth is too tight on the belly button or the stomach. They would warm up the cloth and put it back on the stomach in order to soothe the pain. Sometimes, when the baby's belly button still does not heal and castor oil does not work, people would use

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practices—including the Cree practices of keeping the woman upright and moving during labour and using kneeling and squatting positions–were in fact evidence-based.

[117] Unfortunately, Sarah and I did not ask Edith or other Elders about how they would clean the airway.

[118] Sarah asked whether it was the air in the stomach and that's why the stomach was hurting, but Mary said no, it wasn't.

[119] I did not discuss infection or germs with Elders, nor how they knew that the wound can get infected. However, I suspect that through a long-standing practice of childbirth and handling of newborns, and from treating other wounds and witnessing infection, the knowledge and wisdom of what to do and what not to do, what causes harm and what does not, emerged over time - similarly to scientific knowledge gained through observation, trial and error.

> bear fat. They would put the bear grease[120] and warm up the cotton cloth to tie around the waist. (Mary Ruth Georgekish, Elder, 2013)

Mary Ruth emphasized that to prevent infection they would put the cloth on the belly button and only then used moss. Marshall and Chiskamish-Napash (1996) quotes Elders from Chisasibi who said they did not use the cloth on the skin, but moss only: "Moss is the best kind of medicine. We used to use this moss for babies, too. They never got diaper rash when we used this medicine. Nowadays, babies get diaper rash from the Whiteman's products, but in those days the skin was nestled in the moss with no cloth of any sort in-between" (Q.C.) (Marshall and Chiskamish-Napash 1996:63). Elders from Waskaganish remembered that diapers were prepared in ways very similar to the preparation of the bedding for the birthing mother. The moss was picked in the summer and hung up to dry. Later it was cleaned of stems, sticks or bugs, and stored for the winter in bags. When preparing a diaper, the moss was inserted between two layers of cloth and fitted on the baby. The kind of moss that was used for the diaper (awaashaschiish--Sphagnum moss) would also prevent diaper rash (Marshall et al. 1989:56).

5.8.1 Breastfeeding

Breastfeeding was a common practice in the bush. Elders in Wemindji said that all babies were breastfed. In addition to breast milk, it was not uncommon to offer a baby some water or fish broth, especially when the baby was feeling unwell. Sometimes water was offered to the baby right after birth, until the meconium was out. Occasionally canned milk was also added to a baby's diet. Elders emphasized that if a mother wanted to produce enough milk for the baby, it was essential for her to drink lots of broth:

> When the baby was born, the baby wasn't breastfed yet. They would collect the water, boil it, cool it down and give it to the baby, until the black stools are out. After that, the mother would breastfeed the baby. The mother would drink lots of broth, all kinds--fish, meat. Broth is good for the mother. (Mary Ruth Georgekish, Elder, 2013)

> They used to make a swing for the babies. If the baby cried, they would use the rattle (see Figure 14 and 15) and sing a lullaby, and the baby would stop crying. They would never use the bottle--babies were breastfed. Only if there was something wrong with the baby, for example the baby was crying a lot, they would warm the water and give it to the baby from the bottle. (Daisy Atsynia Sr. Elder, 2013)

[120] Bear fat and other animal fat (goose, moose) were also used to prevent chapping of the nipples when breastfeeding, or to heal them when cracked and sore (Marshall et al. 1989).

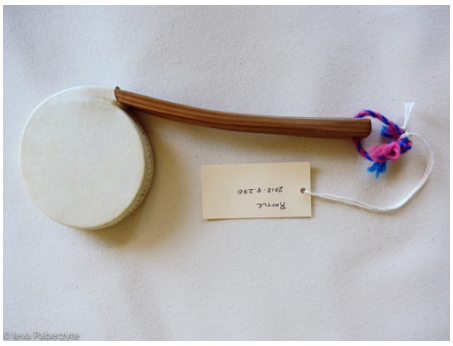

Figure 14. The kind of rattle used in the bush for babies to calm down and/or to stop crying. They are still made and used today by some families.

Figure 15. Some Elders and mothers are making different kinds of rattles for their babies today. One Elder showed me what she was using as rattles for her grandchildren—a tin candy box with coins and the medicine bottle with pins.

If for whatever reason a mother did not breastfeed, Cree would use a substitute of fish broth. The detailed recipe is cited in Marshall and Chiskamish-Napash (1996), told by an Elder from Chisasibi: "For a drink, fish is boiled. Pick out the back bones and boil them again, long and hard, until the water becomes white. Add more water as the water evaporates. It is ready to drink when it is cool (p. 22). Elders in Wemindji did not mention other substitutes for mother's milk, but in Chisasibi and Waskaaganish, Elders said they also used fish eggs that were boiled and beaten until fluffy, or animal brains (bear, beaver, rabbit, porcupine, caribou) for that same purpose (Marshall and Chiskamish-Napash 1996:22).

When a woman experienced discomfort in her breasts, and the milk would not come, a husband would use his mouth to try to suck whatever was clogging the milk. Elders talked about this practice, but a few young mothers remembered getting this advice from their grandparents and all of them agreed that the practice was helpful:

> My granny delivered the baby and she cut the cord with scissors. She used a cotton thread, size 10 I think.[121] After, when my granny did all that, she cleaned and washed the baby, dressed him and put him in a waaspisuuyaan (bunting bag). After she finished

[121] Interestingly, it was not a flour sack string, which was used by most at the time. Dollien said that she did not hear anything about the flour sack strings' use for umbilical cords.

> dressing the baby, she gave it to me to breastfeed right away. My milk was not coming right away, so my husband sucked on my breasts. Then it came out! [laughing]. (Dollien Georgekish, Elder, 2013)

It is clear that such custom traveled together with Cree Elders who had moved into a town, as exemplified in the following quotation:

> (…) The day after I went home, my breasts started to hurt and it was like the milk didn't wanna come out and my grandmother said to me, "It's because the thick stuff is almost finished and it's blocking." And I took a shower and I put compresses, but it's still not coming, and she told me, "Breastfeed your husband." And I was like "What?!" "I am telling you, you breastfeed your husband! You have to! He will be able to get it out." And I was kinda embarrassed....So I breastfed my husband and it hurt really bad and then all of a sudden it felt like a release that tingled from my head to my breast and then the milk was watery, so I said, "OK stop, stop! Bring the baby!" Whatever needed to come out came out. And there was a little blood too. I called my doctor, I told her what happened. She started laughing. "But that's good!" she said, "That's probably what they used to do back in the day and it's good your grandmother told you to do that!" She said, "Don't worry about the blood, it's probably busted, if it really gets heavy come and see us," but it stopped bleeding and I was able to breastfeed. So that was my breastfeeding incident. (CN, 2013)

Usually Elders did not remember how long they breastfed their kids, but according to the information from the interviews, the weaning age varied from about two months to two years. When canned milk became available, occasionally it would be given as a supplement to breast milk. Most babies were breastfed for longer periods of time rather than shorter.

> How long [did you breastfeed], do you remember?
>
> > About a year. I breastfed all of my kids. (Minnie Shasaweskum, Elder, 2013)
> >
> > Yes, I breastfed all of them. Brian was breastfed until he was almost 2 years old. That's when my father passed on… No, I did not have any problems breastfeeding. Later I fed them whatever we ate--fish, fish broth, and I made sure there are no bones there. Meat, I would cut it up in small pieces, I would give meat broth too. (Margaret Mistacheesick, Elder, 2013)
> >
> > My mother told me that it would be easier for me to breastfeed. You don't have to wash bottles all the time, you know. So even in the middle of the night, you just breastfeed. If the baby was crying or something…
>
> Any trouble with breastfeeding?
>
> > No. Well the first one, I had problem with the nipples. They gave me something to use and they told me to keep trying and it will not hurt anymore as much. It worked. (Mary Rose Visitor, Elder, 2014 dir.sp.)

> I breastfed my babies. All of them. But I used only one breast. When I was a small girl I had pus in my other breast, so I did not use it. I breastfed about two years. (Mary Asquabaneskum, Elder, 2013)

If the growth of the baby was somewhat supervised by biomedical staff, which happened more and more after 1962 when the clinic was built in Wemindji, breastfeeding was often interrupted by medical professionals. According to the biomedical standards of the time (1950s–1960s), formula was a valuable substitute for breastmilk, especially if the mother or the baby were sick or not gaining enough weight (Nathoo and Ostry 2009; Weaver 2009). The conclusion we could draw is that the more biomedicine intervened in postpartum care, the more often breastfeeding was interrupted at an early age:

> With Howard - I was breastfeeding him and the doctor said that the sooner he starts eating food, the bigger he will be. Look how big he is! [laughing] The doctor was right! I did not breastfeed the others long either...I breastfed only three of them. I found out later I had gall stones. The nurse told me not to bother with breastfeeding anymore. So I did not breastfeed anymore. (Minnie Shashaweskum, Elder, 2013)

> I only breastfed for 3 months and the milk stopped. I went to the doctor and the doctor told me to use a bottle. So I did, and I did not feel any pain, all went well. (Elizabeth Shashaweskum, Elder, 2013)

Did you breastfeed your babies?

> Yeah, only one I did not… Lindy was very small, always very skinny and I could not get him to feed. So I used the bottle and the doctor said it was because I did not give the bottle he was not gaining weight. In the Fall, they took him to the hospital. I could not go with him, but they took him to Moose Factory because he did not have enough weight. And then he came back when the ice was gone, that's when they brought him back… We were at the Old Factory when they got him back to Wemindji. He did not gain any weight! He was the same! [laughing]… He was one when he came back home and then he was having whatever we ate. He wasn't using a bottle anymore, he was using a cup by then. They took him in April, and they brought him in June. Yes, I was worried. At that time, you could not go with your children. They would not let you. He came back with somebody, with an elderly man, William Nattawapineskum. (Doreen Georgekish, Elder, 2013)

Marshall (1984) reports that bottle-feeding in eastern James Bay could be traced back to the presence of biomedical staff in the communities. During the 1960s and the 1970s, health professionals often discouraged women from breastfeeding. In the 1980s, health workers were trying to bring back breastfeeding, but they were not very successful and the numbers of breastfeeding women were still going down. Marshall also noted that there was a significant

difference between women who were going to the bush and the ones who were mostly staying in the settlement. The ones in the bush were more likely to breastfeed than the ones in town (p.164-165).

There was one exceptional story by a young mother, who was advised by her in-laws to stop breastfeeding in the summer because, apparently, breastmilk attracts snakes - which could get into a baby's mouth:

How long [did you breastfeed her]?

> Well, at 14 months. Breastfeed. Only breastfeed. Didn't give her bottles. I tried to give her bottles. I used to take the bottle to the daycare but she would just drink one ounce. And they told me to stop breastfeeding her because it was in the summer time. But I didn't listen.

Why did they say to stop breastfeeding?

> From CH family [in-laws], they saw something happen to a child long time ago and it might have carried it. Breast milk attracted snakes. And at one point one of the ladies that… long time ago, his father saw a snake go into a child's mouth in the bush. And he would always tell us not to breastfeed in the summer, to stop before summer comes. And my daughter was already one years old and she was still breastfeeding. And he kept telling me to stop breastfeeding, from my husband's side. And I asked him why. And that's when his story came out. "Cause snakes can smell the breast milk," he said. And that's when I started to slow down on breastfeeding, and about 14 months, I stopped. (CE, 2013)

5.9 Birth complications: deaths, miscarriages, premature births

There were three main reasons that Elders gave to explain complications during birth: spiritual, circumstantial, or caused by people because of their irresponsibility or incompetence. Elders emphasized that the mother had to behave properly during pregnancy "to take good care of herself" and to prepare accordingly. If she did all properly, the birth went well: "I was not afraid of birth or scared of anything. In the old days, women were told to take care of themselves. They needed to take care, and if they listened, they did well, delivered well." (Winnie Asquabaneskum, Elder, 2013)

Human mistakes could include, for example, using the wrong type of thread to tie the umbilical cord:

> The first baby I had, I lost her. I think the reason was that when they tied the cord, it came undone... When they changed her, she had blood down at her belly button. The day she was born, when they undid the bunting bag (waaspisuuyaan), they saw blood. When she was changed they tied her up again and they noticed that she wasn't doing

> well, so they undid her and that's when they noticed blood. A girl it was. (Doreen Georgekish, Elder, 2013)

As we have seen, circumstantial reasons could include the absence of a person the mother requested, the presence of the wrong person, etc. Spiritual reasons could include the Creator's will and His agenda, the reasons for which were not always known. Again, the most frequent complication mentioned for birth in the bush was when the placenta did not part, in which case the mother could bleed to death. Other complications included breech births, premature births, the cord wrapped around a baby's neck, miscarriages, etc. Nobody remembered multiple births, and if asked, often said that in the bush, multiple births never happened:

> Did you deliver any breech babies or twins?
>
> > When I delivered Flossy her little bum was showing. I was scared when I saw that. I guess she turned and her feet came out first. And then gradually she came out, but it took a while. I never saw twins and I even never heard about it. It was hardly any twins born at that time, only single births. (Edith Visitor, Elder, expert-midwife, 2013)
> >
> > Sometimes the baby is born and the cord is wrapped twice around the neck. Once it has the cord wrapped twice, they let the baby come out and at once unwrap the cord. I also heard that a child was born with his feet first. My mother made sure that the baby was not stuck and came out straight. (Doreen Georgekish, Elder, 2013)

A few Elders recalled cases of miscarriage in the bush. Women did not remember any special treatment of the mother who experienced miscarriage or any ceremonies that would take place. Mostly I was told that if a miscarriage or stillbirth happened during the last stages of pregnancy, the birth would take place as a usual live birth. "The healthy baby helps the mother to give birth," said Mary Ruth; thus it is much more difficult when the baby is not alive and the women still has to go through the same labouring process:

> A long time ago pregnant women were told to take care of themselves and try not to fall. If they fall or something else happened, that is how women miscarried. When the baby is fully-grown or almost, and a woman miscarries, midwives say that it is more difficult for a woman. The baby can't move, that is why it is hard. It does not find its way. The healthy baby helps the mother to give birth. That's when the woman loses lots and lots of blood. (…) It was the same procedure if they knew the baby is not alive.
>
> I saw this one time. It happened with my sister-in-law. The baby was the size of a big matchbox. The baby was fully developed. My mother told me that a woman loses more blood during miscarriage than during birth. It is pretty hard for a woman to go through miscarriage. Sometimes the woman does not make it herself. This happens because the

> woman did not take good care of herself when she was pregnant with the baby. (Mary Ruth Georgekish, Elder, 2013)
>
> I did not see any miscarriages, but I heard about it. The woman miscarried and lost her life. (Elizabeth Shashaweskum, Elder, 2013)
>
> Was there any special treatment for the woman who lost a baby, any ceremonies?
>
> > No, not that I know of. It is the same, they would tell you to take care of yourself… (Mary Rose Visitor, Elder, 2014 dir.sp.)

There was one story about premature birth in the bush that stood out in Wemindji. It was told by several different people from different generations in slightly different ways. I first heard it from the Elder Margaret Mistacheesick, the mother of the premature baby:

> One of my boys, he was born premature. He came out and waters did not break. He was so tiny! His due date was in March and he was born in January. We thought we cannot do anything with him… He was all covered… He was in water. We saw him moving and the midwife told my husband, "You should break the water!" We wanted to get John Sashaweskum to baptize the baby as soon as possible. We did not think he would survive. John came and he baptized the baby. He was not a priest or minister, he was just a person to do the prayers. It was very difficult raising him… A good thing --we had 10 cans of milk and we gave him the bottle[122]. (Margaret Mistacheesick, Elder, 2013)

A year later, Elizabeth Shashaweskum, a young mother and a CHR at the clinic, told me a birth story that fascinated her and that had been told many times in her family. Elizabeth's grandmother happened to be assisting Margaret during birth of her baby:

> Two of my grandmothers were there for the delivery of one of their sisters. (…) she (Margaret Mistacheesick) gave birth and they were in the camp in the bush, I don't know where though, and my… she gave birth prematurely and my mom said when the baby was born, he was still in the sac and they… broke the sac and took the baby… I remember my grandmother saying she was holding up her hands like this and she said "When I was holding the baby like this, the baby was this size, the baby was that small!" And the baby survived.
>
> And I asked "How did you?... What did they do?" And they said the baby wasn't able to breastfeed, cause the mouth was too small and the baby couldn't latch on and what they did was…give the baby cloth to suck on and also used a spoon to drip the milk into the mouth, but eventually when the baby grew, eventually the baby was able to breastfeed after. And my mom said around the same time, the same thing happened for another lady, they gave birth to a child in town and there were nurses there and the same thing happened, the child was born inside the sac, but they didn't break the sac and the child didn't survive. So what my grandmothers did when… they broke the sac and they knew

[122] Later in the interview, Margaret said that she breastfed all her children; the canned milk was additional for the premature baby.

what to do right away. And… so the child survived, and he's about 40 years old now. (Elizabeth Shashaweskum, young mother, CHR 2014)

Elder Lilybell Natawepineskum, one of the women helping out Margaret, said they were camping somewhere inland. It was winter. There were many people together, many families. "The baby was so small!" She showed her palms put together. The baby could not move at first, she said, but then the mother warmed the blankets and wrapped the baby, and then the baby started moving. They gave him water first, from a spoon, and after a few days the mother would breastfeed. "The boy grew up healthy and strong!" (notes from the interview with Elder Lilybell Natawepineskum, 2014).

Cree birth was a wholesome experience, based on the concept of "being alive well" (Adelson 2006), where the environment and the people present could influence woman's emotional and physical state during birth. The participation of the family and community meant "being well" for the woman and the baby during birth, and women had also their part to play –to prepare, to listen to their Elders, and to keep calm, quiet and confident. Self-reliance, non-interference, competence and confidence were the main values in Cree childbirth, as in Cree society in general; these essential qualities also applied to the role and behaviour of midwives, and to those surrounding and supporting the birthing woman.

Everyone was familiar with childbirth procedures and the roles they had to play in them. The northern environment and bush-based lifestyle influenced the Cree childbirth model, which had certain guidelines, but was flexible, responsive to the particular circumstances. For example, if the community was together, the midwife-expert was asked to help; but if the family was alone, it was the grandmothers, husbands or whoever was there that took over the role of midwife. I suggest that this trait of flexibility in Cree childbirth in the bush later facilitated Cree adaptation to birthing in the clinic and the hospitals, aspects of which will be examined in the following parts of the thesis.

Figure 16. The incomplete list of Cree midwives remembered in Wemindji during the time of my fieldwork

Elder Dollien Georgekish's grandmother. Elder Dollien Georgekish's mother – midwife-expert.
Lydia Ratt (nee) **Matches** (1913-?) midwife-expert. Her daughter - **Edith Visitor** (nee) **Ratt** (1936) – midwife-expert, delivered many babies in the bush and in Wemindji clinic.
Nellie Georgekish Jonah (?–1977) - midwife-expert. Her daughter - **Margaret Mistacheesick** (nee) **Visitor** (1935-2018) – delivered one baby. **Nancy Mistacheesick (nee) Jonah** (1919–2000) – midwife-expert. Nancy was also teaching Margaret Mistacheesick, her half-sister, how to deliver babies. Margaret's and Nancy's sister **- Maudie Ratt** (nee) **Mistacheesick** (1950) – helped deliver babies, one of them in the clinic.
Marion Stewart (nee) **Georgekish** (1893-1986) – midwife-expert. Her daughter - **Winnie Asquabaneskum** (nee) **Stewart** (1932) – delivered one baby.
Dinah Shashaweskum (nee) Gilpin (?-1993) - midwife-expert. **Caroline Matches** (nee) **Georgekish** (1916–late 1960s) – delivered at least one baby. **Elizabeth Georgekish** (nee) **Stewart** (1912-1986) – midwife-expert. **Jane Gilpin** (1906–the 1960s) - midwife-expert. **Louisa Kitchicappo** – midwife-expert. **Malcolm Diamond** (?–1980s) – midwife-expert from Waskaganish. **Mary Gilpin** (1906–1970s) – midwife-expert. **Mary Ruth Georgekish** (nee) **Visitor** (1933-2015) – delivered two babies. **Maryann Shashaweskum** (nee) **Mistacheesick** (1920-1996) – midwife-expert. **Sarah Gilpin** (nee) **Blackned** — midwife-expert, started delivering babies at the age of 14. **Sarah Stewart** (nee) **Shanush** (1909-1985) – midwife-expert.

CHAPTER SIX: BIRTH IN THE CLINIC

The era of routine births in the clinic was only a short, transitional phase in the development of the evacuation routine for Cree women. Most births in the clinic/nursing station took place in the 1960s, at which point some births were also still happening in the bush. In the 1970s, births in the bush became less frequent and more births were transferred (out of the communities) to the far-away hospitals. For some women, especially those who had already given birth in the clinic, bush birth remained a valid option until the late 1980s. For some Cree women it took longer than others for the evacuation policy to become a "normalized," routine procedure. As the mindset of women and families gradually shifted, the routine evacuation practice became increasingly well-established.

In this chapter, I present the experiences of Cree mothers who gave birth at the community's clinic, as well as some of the staff who assisted in those births. I look at midwives' roles during clinic births, and their collaboration with nurses in the 1960s, and I discuss the period during which Cree midwives no longer accompanied women for clinic births. I also consider the reasons for occasional emergency births at the clinic today. This transitional phase of clinic births illustrates the rapid change and adaptations of Cree childbirth practices in the bush to a new more medicalized environment.

6.1 Collaboration of midwives and nurses at the nursing station (1962-1980)

The waters in the bay gradually became shallower[123] and so the supply boats found it increasingly difficult to get in and out of the Old Factory Bay. Thus, in 1959, the Old Factory settlement/trading post moved to the present-day Wemindji location, called Paint Hills at the time (Denton 2001; "Wemindji Turns 50" 2009). The first public building in town was a school, built in 1961; and the second was the nursing station, established in 1962 ("Wemindji Turns 50," 2009). This is where the first clinic births took place.

The peak period of births in the nursing station was from the time of its establishment, until about the beginning of the 1970s (see Figure 7). Later, more and more births took place in hospitals (see Chapter 7) outside the community, and births in the bush were completely discontinued. Women who remembered births in the clinic did not express particular

[123]There is a rebound of the earth's crust in the James Bay area, caused by the weight of the glacier from the last Ice Age - about 8000 years ago in the Wemindji area. Since then, the land in James Bay has been rebounding at a continuously reduced speed. Initially, the upward movement was about 6.5 metres per century, while today it is about 1.4 – 2 metres per century (Pendea 2011; Pendea et al. 2010). The "growth of the land" is observed and described by Elders in their stories (Denton 2001:5-6).

dissatisfaction with the staff nor the fact that they had to go to the clinic to birth. It seems that birth in a new biomedical facility with Euro-Canadian nurses was quickly accepted as a norm. Whenever I asked about the nurses and how competent they were, Elders would mostly say that the nurses did a good job, were known in town, worked there for a while, etc. Instead, complaints were directed - not at the health practitioners - but towards the beds at the clinic, which were hard and uncomfortable for labour.

It is significant that, in the early days of the nursing station in Wemindji, Cree midwives were usually allowed to deliver or to assist the nurses. Judging from the stories of Elders, at least one or two people who were close to a birthing woman were allowed in the delivery room. The rest of the family and friends would usually wait outside the room. I did not encounter a single story in which a Cree midwife was asked to leave the birthing room or to step aside during birth. If that ever happened, Elders did not mention it during the interviews.

Cree midwife, Edith Visitor, who assisted clinic births, shared a few recollections from her experience. In her stories, Edith concentrated on the fast progression of the births and the necessity to hurry up to the clinic. She also mentioned some details about the staffing of the station, from which we learn that at the very beginning (early 1960s), there were no biomedical professionals at the clinic, but the manager's wife who was performing medical duties:

> There were many children I delivered… One kid really rushed me–Carlene Kakabat. She was born at the clinic. There was no nurse at that time. But the manager's wife was sort of a nurse [It was in the early 1960s, at the very beginning of the establishment of the nursing station]. She was in the clinic, but she was with the other patient. She was not there where the mother was to deliver. The mother yelled. When I checked her, the baby was already out. She yelled for the nurse. The nurse came running into that room. It was the first time I saw a baby born that fast!
>
> Another child… My sister Mabel was delivering Pauline [it was in the 1970s] I did the same thing–I just came out from nowhere. The nurses were already working at the clinic at that time. I was not in town. I was in the bush getting firewood. Somebody came to get me. I was told that I was needed at the clinic. And whoever went to get me brought me back to town. I did not get a chance to eat, just quickly changed my clothes.

Resonating with what I have noted previously (5.4 Participation in birth) regarding the importance of women's chosen birth companions, Edith continued:

> As soon as I walked in, the baby was born. The nurse was the midwife this time. I only helped the nurse. (Edith Visitor, Elder, midwife-expert, 2013)

Edith Visitor also remembered that it was somewhat convenient to deliver babies at the clinic, because she did not need to take anything with her. The clinic had all that was necessary for births:

> When I was delivering at the clinic, I did not take anything because I knew they had things there. But when I was delivering in the bush, I would use whatever I had.

Regardless of the presence of the nurse in the clinic, or the manager's wife, Cree families considered it important to have Cree midwives in the delivery room. Most of the women describing labouring or birthing at the station would say that a midwife was with them. She would show up, or would already be there when they arrived. When a woman was in labour, the news spread quickly in the community, and people made sure that midwives knew about the delivery.[124] The ones available or closest to the woman would come, or would be brought by someone to the clinic. As midwife Edith Visitor recalled, sometimes she would attend the delivery herself, and sometimes she would be watching or helping the nurse - but she would be there.

Since usually only one or two people could fit in the delivery room, Cree midwives took over several separate Cree customary roles (see Chapter 5) during births in the nursing station. Women could not have a husband, an Elder, an important person and a midwife beside them in the clinic room. Thus, a Cree midwife had to be ready to play many parts–she became the Elder who shared her wisdom and support, the significant person who comes in and helps the birth move along, and the midwife who made sure everything went well for the woman and her baby.

The fact that Wemindji nurses allowed family members or Cree midwives in the delivery room did not align with the government's approach at the time, which strongly condemned the practices of Indigenous midwives, viewing them as unsanitary and unequipped to deliver babies (Lawford 2016; Lawford and Giles 2012a; Lawford and Giles 2012b; Lawford 2011). I am left to wonder if the Wemindji nurses actually appreciated the presence of experienced Cree midwives at the clinic. Nurses might have had theoretical training, but it is possible that they would not have had much actual experience in childbirth - especially compared with Cree midwife-experts, who had been delivering babies in the bush for a significant part of their lives. Such an arrangement worked for the women giving birth as well–if the nurses appeared perhaps less trustworthy, less experienced, or busy with other

[124] Population estimates in and around Wemindji town in the 1960s was ca. 240, and in the 1980s ca. 500 (Eades 2014:238).

patients - Cree midwives covered for them. Thus, the women did not feel abandoned or lacking care. Besides, the family and community were right behind the door.

Lizzie gave birth in the early 1970s. She shared her experience of labouring in the clinic and described the details of the clinic premises at the time (also see Figure 17, 18):

> … I guess I was overtired or overworked and… I called the clinic, I called the nurse, she told me to come right away. It was Spring, I remember the day [laughing]. I walked over there, cause it was just… I didn't have pain or… just a lower back, a little bit, and the stains. But it scared the nurse. And when I went there they asked two women to be there with me, my older sister, the one that's noisy, the noisy sister [laughing] and Edith Visitor. So both of them were there at the old clinic right down the bank. So I walked to the clinic, I didn't get the transportation. When I was there they told me to rest and the nurse checked if I was bleeding, but I didn't have anything, just the back pain a little bit. And I was like that lying there on the bed, they didn't want me to walk. I think it got worse when I laid there, cause my back was hurting, because I was lying on the bed, and it was hard, the mattress was hard. The next morning I didn't feel anything!

So your sister and Edith stayed with you?

> I don't know if they stayed all night, 'cause I finally fell asleep. The nurse was there too, the night shift. That's where they stayed, they had an apartment at the clinic. They had their living room, the kitchen, their own two bedrooms and they had their groceries downstairs in the basement and a big room for gathering or meetings. And they had two or three examining rooms and I was there in one of them. And there was a bed there, and it was hard. So the next morning I was told to… they had to send me by plane, medevac. I was on a stretcher. I didn't feel anything, I didn't feel like pains or labour pains, or anything, I was OK, I could have walked. But I was… I regretted I should have gone to Moose Factory instead.[125] I regret that, that I was sent to Fort George, that's where my daughter was born… she was born in two days.

Did you try to argue or to ask them about Moose Factory or to stay at the clinic?

> No no, I didn't wanna argue or anything, they were professionals, they were thinking about my baby too.

Was the nurse nice, good with you?

> Yeah, they were nice and in Fort George they were nice. I had a good nurse over there. And the doctor who delivered (Lizzie, Elder, 2014, dir. sp.).

[125] Lizze explained later that she had some family working at the Moose Factory hospital at the time and that is why she was hoping to go give birth there, where her family would support her.

Figure 17. The old clinic (back side and front entrance) in November 2014 – the place where many Wemindji babies were born. The building has since been taken down.

Figure 18.The old clinic site after was taken down and the housing unit for the nurses next to it.

Figure 19. The view from the clinic site and the river bank a few meters down. One of the long-time Wemindji nurses said that when she arrived to Wemindji in the 1980s and saw the clinic location, she immediately fell in love with the place.

While the peak of births in the clinic was in the 1960s, in the 1970s the numbers started to decrease, primarily because more and more women were evacuated to give birth at the hospitals. The decision of whether to evacuate a woman in the 1970s likely depended on the confidence of the nurses at the station, as women reported varying experiences. Among the 33

women I interviewed, 11[126] gave birth to their children in the 1970s. Two of them gave a total of 4 births in the clinic and were not evacuated to the hospital (Figure 20). In both cases, Cree midwives, family and nurses were present. The births went well and the women were released home soon after.

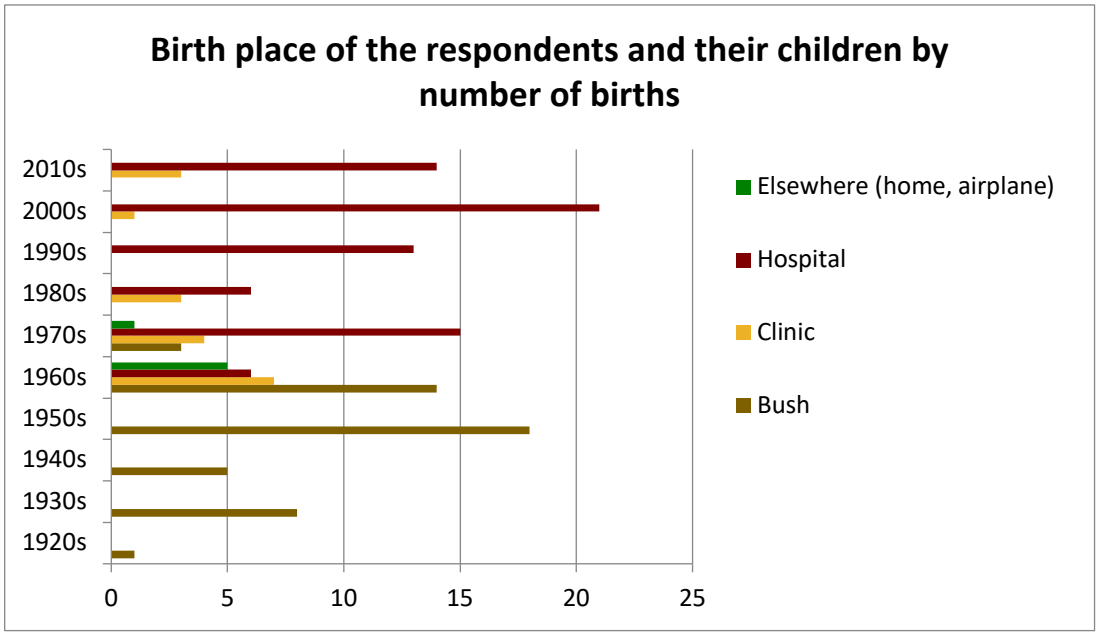

Figure 20. Birth place of the respondents and their children by number of births

Lillian Georgekish was one of the women who gave birth in the nursing station to her firstborn, without any issues, in 1976. However, the experience of her second birth, in 1978, was very different. She was shoved on the plane by the nurses in the middle of her pushes and gave birth in the air, instead of being allowed to deliver at the clinic. At the time, government recommendations allowed births at the station if the pregnancy was not complicated and if the birthing woman was not a primipara (first-time mother) (For details on government recommendations, see Section 2.6, The childbirth evacuation policy and childbirth medicalization in Canada). According to those recommendations, Lillian was a good candidate to birth at the clinic. It was Lillian's second pregnancy and according to Lillian, it was healthy and easy, without biomedical risks. Lillian said that one morning she started feeling pains and her water broke. Together with her husband, she went to the clinic. There were two nurses and two Cree midwives at the clinic, Marion Georgekish Stewart and Edith Visitor, who helped her. The birth was advancing fast and Lillian felt the need to push, but the

[126] One of the 11 women gave birth in the hospital because she was temporarily living in the south when her child was due.

nurses kept asking her to "hold it." Lillian said she did her best not to push the baby, but at the same time she was not sure how to "hold it"; she felt a strong urge to push. The medevac plane came in after awhile and they took off. Her daughter was born in the air during the flight to Chisasibi hospital.[127] Lillian remembered she did not hear anything of what her husband or the doctor were saying, because it was so loud on the plane. The only thing she saw was her baby cry, but she could not hear her. When they landed in Chisasibi, the pilot was excited. He said he had no idea what was going on during the flight, but he was very happy to know the baby was born on his plane. The news spread quickly about the girl born on the plane. Lillian remembered receiving many "White people" coming to visit her and her baby at the hospital. "Some kids and nurses came in just to see my baby! I did not know any of those people!" [laughing heartily] (Lillian Georgekish, 2013).

Recently, Angela, a woman who was born on that same plane celebrated her 40th birthday; her birthday wish was to fly in the bush plane as she had when she was born. Her wish came true, but the story did not end there. After her flight with a bush pilot, Angela posted on Facebook:

> "A blessed and interesting day indeed! 40 years ago my mom gave birth to me on a bush plane. Today, the only wish I had was to fly in one, and my wish came true. Our pilot actually knows the pilot from 40 years ago. His name is Daniel Lalancette. He is retired now but sent these articles (see Figure 21) and said that he would be delighted to meet me in person! I will visit him with my family soon. Thanks everyone for the birthday wishes, it sure was a good day!! ✌️❤️✈️"[128]

It is difficult to know why the nurses didn't want to deliver Lillian's baby at the station and called for the emergency evacuation, when it was quite obvious that she would not make it in time to the hospital. A small piece from a newspaper at the time, about the baby being born on the Beaver plane (see Figure 21), says that the plane came to the emergency call together with a doctor and a nurse from Chisasibi hospital. When they arrived to Wemindji, they decided to not attend the birth at the clinic, but to take Lillian on the plane to the hospital in Chisasibi. There is no reason given for their decision in the article, and Lillian herself did not have an explanation either. The fact that the evacuation was so rushed may suggest that the biomedical staff from Wemindji and Chisasibi preferred to transfer birth responsibilities elsewhere, maybe to a better equipped location and/or staff. A few years later, Lillian delivered yet another baby at the Wemindji nursing station without complications.

[127] The flight from Wemindji to Chisasibi is about 30 minutes, including take off and landing.
[128] Angela has kindly given permission to use her Facebook post in this thesis.

Accouchement d'un bébé indien dans un petit Beaver!

Expérience fantastique vécue par un pilote de Girardville!

DENIS LALANCETTE, DE GIRARDVILLE, mène une vie passionnante, comme pilote dans le Nord du Québec. "Je ne vivrai jamais assez longtemps pour oublier ce vrai baptême de l'air survenu dans mon petit appareil Beaver, ces jours-ci! Dans un Boeing, ça peut encore aller assez bien, mais dans un minuscule appareil, faut l'faire", de commenter, encore tout ahuri, M. Denis Lalancette, de Girardville, que l'on voit ici aux commandes de son avion. (Paul-Etienne Gosselin, pour L'Etoile du Lac, à Girard-

Par Paul-Etienne Gosselin

M. Denis Lalancette, un pilote bien connu de Girardville, se souviendra très longtemps de ce voyage en avion qu'il fit ces jours-ci au village indien de Point Hills.

Son aventure commença alors que l'on retint d'urgence les services d'un appareil de type Beaver, à Fort George, sur la Baie James.

Et c'est alors que le pilote Denis Lalancette, qui travaille là-bas depuis deux ans, accompagné du docteur Marcel Moreau et d'une infirmière, se rendit au village indien de Point Hills, pour l'accouchement de Mme Liliane (Henri) Stewart.

Cris de bébé

A l'arrivée du médecin, le docteur Moreau décida de

avec la patiente. Mais quelle ne fut pas la surprise du pilote Lalancette, lorsqu'il enleva ses appareils écouteurs durant l'envolée, d'entendre les cris du bébé naissant! Une adorable petite indienne faisait ainsi son baptême de l'air, avant de recevoir son vrai baptême!

Un «curé de l'air»

M. Denis Lalancette, qui compte déjà quelques années d'expérience comme pilote, était loin de penser qu'il vivrait un jour une telle expérience, d'autant plus que l'espace est plutôt restreint, dans ce genre d'appareil... M. Denis Lalancette est pilote pour Fecteau division Fort George. Il viendra-t-il spécialiste des "baptêmes de l'air" et devient-on un jour le "baptiseur" lui-même du sermon

Figure 21. A newspaper clipping about the birth on the plane during the flight from Wemindji (Paint Hills at the time) to Chisasibi hospital. (Taken from Angela's Facebook post, with her consent, in 2018)

The 1970s was a transition period, when Cree births from the clinic and the bush were being moved to the hospitals. The latest date for a bush birth that I came across in my research in Wemindji was 1973. At this time, many birth evacuations were already planned ahead, but if a woman was in early labour or had not had prenatal care, she would be heading for the nursing station. At the station, biomedical staff could arrange emergency evacuation or delivery at the clinic, depending on the situation and their experience. By the early 1980s, national policy was against any births taking place in the local remote nursing stations (Daviss-Putt 1990:101), thus only emergency births were supposed to take place there.

6.1.1 When the clinic was closed or too far to reach – home births

During the 1960s and 1970s, a few births happened in women's homes in town. These women said they did not have time to go to the clinic, or that the clinic was closed during the holiday season. They delivered with their family and a midwife:

<u>I could not make it on time</u>

> The other time, I could not make it on time to the clinic. I was late. Our house was next to Nelly's. I was on the way to the clinic, but I did not make it. The baby was born at Nelly's and Charlie's place. Nelly's mom delivered her baby at home too, and the nurse came in much later. (Minnie Shashaweskum, Elder, 2013)

Birthing in parents' house

> My second one was born here in Wemindji. We were staying with my parents, we didn't have a place of our own. And I was supposed to go to Moose Factory two weeks early, but he was born two weeks early. He was born on August 9th. There was the old lady who delivered my baby, cause the nurses were all out on holidays. The clinic was closed. And I had a hard time, and I lost a lot of blood, so they had to take me to Chisasibi hospital. But not on that late evening, because the weather was up and the doctor had to come from Chisasibi. I don't remember some of the time, I was blacked out.

Who was the lady who helped you deliver?

> It was an old lady, Marion Stewart.

Did you know that the baby was coming?

> Yeah, I told my mother that I think I'm gonna get sick [go into labour]. I had backache and, you know, moving around. So she told me to get my bed ready and she called my grandmother, but. . .Marion Stewart was the one that delivered.

Any special equipment?

> Scissors, cloths… boiled water they put too. I was losing too much blood after the baby was born, they could not get the placenta out. After I got to Chisasibi it went out. I got already sick in the evening and it took all night until it was 3pm in the afternoon. Marion Stewart, I felt like having her over, you know, it just popped out in my mind.

So you asked for her?

> Yeah. She delivered many other babies. She passed away over 10 years ago now.

Were you stressed delivering at your parents' house? Did you have your family with you?

> Yeah, my relatives came around. I think it was five or seven people in the room. I did not mind. Marion told me not to get embarrassed or not to worry, everything's gonna be OK. It wasn't her first time and she told me that I had to listen to what they told me.

What would she do to relieve the pain?

> My mother was sitting beside me, holding my hand, talking to me, telling to take deep breaths. I was lying down. They did not want me to move.

Did they give you something to eat or to drink?

> Not until the doctor with the nurse came in by a small plane.

Do you remember when they came in?

> I think it was two hours after the baby was born, cause I blacked out and they had to give me blood. The pilot gave me his blood. The doctor and the nurse were there, and they found that donor, he was just sitting outside on a skidoo. And after that I saw him, he told me "My sister!"… a White guy [she is laughing]. I saw him once I went on the plane. One time I went to Timmins I saw him there. Right away he recognized me. He was talking to his wife– "This is my sister, I gave her blood!" (Mary Rose Visitor, Elder, 2014, dir. sp.)

6.2 Normalization of the evacuation and decrease of births at the clinic (1980-2000)

In the 1980s, women's narratives about clinic births started to change as evacuation became a national policy (see Chapter 2) and the nurses were expected to attend only emergency births at the clinic. During this period, biomedical staff were often portrayed by women as stressed and unprepared for clinic births; women talked about panic, inexperience and incompetence among the medical staff, as well as uncomfortable beds and space unequipped for births. However, delivery at the clinic for some Cree women in the beginning of the 1980s still seemed to be a valid option, especially if they had already delivered children in the clinic before. During the late 1980s to the early 1990s, the Cree mindset gradually changed, and the routine evacuation procedure became well established and normalized among Wemindji Cree families. In the 1990s, over 90% of births took place at the hospitals in the region of Iiyiyuuschii, compared to 62% in 1983 (MSSS, Births data bank 1983 to 2011).

Many Cree midwives passed away during this period, and there was no opportunity for them to transfer their skills to the younger Cree generation because births in the bush did not happen after the 1970s. Thus, usually there was no longer a Cree midwife-expert to accompany women, but more often it was a close family member who sometimes had some experience with births, and sometimes did not.

Elizabeth was born in the 1980s at the clinic and her birth story is a good example of a family member (Elizabeth's aunt) assisting in clinic birth and helping out the nurses (for the detailed discussion of Elizabeth birth story see Chapter 3). Elizabeth's aunt had knowledge about births, but no hands-on experience. Nevertheless, according to Elizabeth's story, her aunt turned out to be more knowledgeable and more self-confident during birth than one of the nurses.

Another birth took place in the clinic in 1983. Lilly had an evacuation date scheduled, but nobody was able to take her to the airport, so she missed her flight and did not make it to the hospital. Before the dawn, Lilly started feeling pains and went to the clinic with her sister

and her mother, where eventually she gave birth with the nurse. Afterwards, she was flown to Chisasibi hospital where she stayed for three days. Her biggest complaint was that the bed in the clinic where she had to labour was very hard and uncomfortable. It was an examining table, not even a bed.[129] The clinic was not equipped for deliveries. (From the conversation with Lillian, 2013)

BZ remembered when her sibling was born in the clinic in the 1980s. She was 5 or 6 years old at the time. One morning she woke up, had her breakfast, and was told to get ready to go to the clinic with her aunt. They went to the clinic and sat in the hallway with some others from her family. Soon after, she heard the baby cry. BZ remembered that there was lots of running around and the nurses seemed very nervous and stressed. (From a conversation with BZ, 2013)

According to a mother who gave birth in 2000, the staff in the clinic were so stressed during the birth of her son that they tried to get rid of her by sending her home in heavy labour, and finally by leaving her to labour alone with her mother in a small clinic room, showing up only at the last minute:

Can you tell me how it happened? Was it an accident or was it planned?

> It was an accident, I guess. [laughing] I was supposed to leave on Thursday… or on Tuesday. He was born on Friday before.

So he was born early?

> Two weeks early, yeah. (…)

So how did it start? How did you go into labour? Did you feel anything?

> Ahhh, I don't know. I just felt my contractions.

And you went to the clinic?

---

[129] The use of beds in birth is related to the movement of births to hospitals and is tightly connected to the medicalization of childbirth. The change in birthing support/furniture is also connected to changes in the culture of birth. The birthing seat/stool was in use for many centuries in different parts of the world, since long before Christ (De Jonge 2007:11; Dundes 1987). Initial introduction of a supine position in labour is attributed to the French obstetrician Francois Mauriceau, who, in his practice, replaced the birthing chair with the bed in the 17th century (De Jonge 2007). He did not recommend the flat lithotomy position, but a reclining labouring posture. The stool/chair in labour was still in use until about the 20th century in some parts of the world, which later was changed in hospitals to an obstetric table and an obstetric bed (Dundes 1987; Jowitt 2012). The flat dorsal position first began to be used by obstetricians in the US in the 19th century (Dundes 1987). According to several scholars and birth practitioners (Asher 1974; Dundes 1987; Atwood 1976; Jowitt 2012), the lithotomy position was introduced for the convenience of obstetricians. Davis-Floyd (2003) analyzes this position as a "symbolic inversion" of the woman in which she is "down" and the doctor is "up," mirroring the authoritative status of the physician and the cultural coding of high status as "up" and low status as "down."

Yeah. And they sent me home. “There’s nothing we can do,” they told me and “The baby is not gonna be born until the 8th or 9th.”

And? But it didn’t stop?

No. And I went home, it was 7 in the evening when I went to the clinic on the 4th and they sent me home. They told me that the contractions gonna stop.

Did they give you any medication?

No. And I went home and at 3 in the morning I started to have pains and we went in the clinic, we walked to the clinic, me and my mom. It was 7 in the morning we went there. And they sent me home.

Again?

Yeah. They told us,“Medevac will be here at around 10:30.” Come back at 10:30. And we went there at 9, 9:30am. And I gave birth at 11 o’clock.

So when you went to the clinic in the morning you were already in heavy labour?

Yeah.

What did they do? Did they understand that there will be no evacuation?

I think they were panicking. The doctor was supposed to leave that day.

Do you remember how many nurses were there? A doctor?

There were three nurses and a doctor.

So what did they do with you?

I couldn’t lay down, I was standing and holding my mom. I was nervous too, that was my first baby too.

Did they explain anything to you, how it’s gonna happen?

No, just my mom told me... They couldn’t stay in the room. The nurses couldn’t stay.

Why?

Cause… maybe they were nervous.. . The doctor came after, at 11 o’clock.

She came after the baby was born?

No, ten minutes before.

Was it a good delivery? Was the baby healthy, all went well?

Yeah. After, we went to Chisasibi, we stayed there for a day. Monday we came back.

Right away you went to Chisasibi? With medevac?

Yeah.

And your mother?

No.

You went alone with the baby?

Yeah. My mother drove to Chisasibi.

So they just checked you and they let you go again?

Mhm.

How did you like this experience?

I liked it, because I didn't want to go to Val d'Or…

So in a way you liked that it was here and you didn't have to go for two weeks away?

Yeah. When I had my second baby it was hard for my first-born, to leave him.

Where did you leave him?

With my mom. (CK, 2013)

6.3 Reflections of nurses on occasional local births

NQ is an experienced nurse who first came to Wemindji in the early 1990s and worked there, and in other Indigenous communities, for over 20 years. She confirmed that many nurses were scared of births, but for her it was a delightful experience. Every time a woman delivered at the clinic, it lifted spirits–everyone would be excited, especially Cree staff;[130] people would smile, the clinic would be full of family and friends. For her, those were the most rewarding moments of the job. And then she added: "I am stressed when there's a cardiac arrest or things like that–delivery is a happy event for me! It's so wonderful to do a delivery at the clinic! It's a happy event to have a baby at home."

[130] Some Cree were Community Health Representatives (CHRs), who facilitated communication between the biomedical staff and the clients/patients, and held administrative positions; no doctors or nurses were Cree.

Note that NQ codes a clinic birth as "at home," meaning that birthing in the community is birthing at home; many Cree felt the same. When NQ started working in Wemindji, women were not allowed to have a scheduled birth at the remote nursing stations anymore. Thus, the births were not planned nor expected by the staff–they were local emergency births. When asked about complications, NQ said that in most cases even emergency births went well. And when they did go well, she did not see the need to send women out for evaluation, which they had to do routinely:

> I did not understand why the doctor had to send the women with the baby away after birth. If all is well, no need to send her out. If I was to decide, then no evacuation. But some doctors felt insecure, they wanted to make sure. In uncomplicated cases, which were most of them, I did not see a need for that. (NQ, nurse, 2015)

NQ remembered that she and the doctor were mostly worried about neonatal care after birth. She recalled rigorously going through the details in the books together with the doctor to make sure they were well prepared for when the baby comes. After some reflection, she added:

> We don't take chances of anything anymore, it was different before. It changed a lot. It was a gradual change, same down south. We are following the guidelines they follow down south. The young specialists are very insecure... and respond to every single small thing. All becomes overwhelmingly medicalized. The problem is, they need to follow the protocol. Many are afraid for their license to practice, to lose it. Me, I had one good doctor, I often consulted her and we went with the feeling. We closely observed, we did not make drastic decisions. We felt comfortable. Young nurses are very insecure, scared.

NQ's words are echoed in research (Klein et al. 2011), which found that young obstetricians are much more prone to use interventions during births than experienced professionals. Here is what another nurse at the clinic had to say:

> As you can see, we don't have a lot of those cases. When we do, because we don't have a lot of exposure, we're not really at ease… If something goes bad, it's really hard on everybody around. We might be losing a mother and a child, which is pretty hard on the family and everybody around. If it's the second or the third baby, usually it goes pretty good. First one—we never know… but second, third with high risk pregnancy… oh, wow wow wow… What will happen?! And after that, if you start to bleed, have a breech, baby doesn't want to come down, you have meconium coming out–we are in deep shit. We need C-section–forget it! We don't, we cannot. We will not." (nurse at Wemindji clinic, 2014)

6.4 The reasons for and circumstances of recent clinic births (2001-2013)

In the first decade of the century there were very few births at the clinic. Evacuation became a routine procedure, and nurses made sure women were evacuated at least two weeks

before their due dates. Women who have pregnancies with certain biomedical risks are evacuated even earlier. Nurses and doctors in Wemindji do everything they can to avoid deliveries at the clinic, and so any birth there is an emergency. Emergency births take place if women, for some reason, do not show up for prenatal appointments and so have not had a medevac arranged in advance, or if the birth is before their due date. In all these cases, biomedical staff will still try and arrange an emergency evacuation, but sometimes weather conditions restrict medevac flights or the emergency team does not have time to arrive, and so the birth will happen at the clinic. In a few instances, when weather conditions were bad, the staff urged close family to drive labouring women to Chisasibi hospital by road.[131]

JT told us how she delivered before her due date, but had to labour on a bumpy access road on the way to Chisasibi hospital in her father's car. It was winter, with stormy weather, so the medevac plane could not land. Her father had to drive JT from Wemindji to the James Bay highway, where she was picked up by an emergency vehicle. The gravel access road from Wemindji to the highway is about 96km long. JT said that the trip on the access road while in labour was terrible, bumpy all the way. On the other hand, she said she was happy to have her family with her. Her mother and her boyfriend were beside her all the times. She liked that she did not need to be evacuated down south. She said if she gives birth again, she wouldn't want to leave her older son and to stay for weeks away from home.

Nurse Tim remembered another case of early delivery. There was no time to evacuate the woman, as she was already pushing when she decided to inform the clinic:

> That was a very fast delivery. I think she was something like 36 weeks pregnant. Between 36 and 38. And I think she was scheduled to leave the village the following days or weeks. So it was in the evening. I received a call from a husband saying that his wife was feeling for pushing so...

Already pushing? Not just contractions?

> Yeah, yeah pushing, they said already pushing. So I just asked a few questions in terms of, do you know how many weeks she is and so on... He said hurry up we don't need to talk! [laughing]. So I just told them to take directions to the clinic while I was dressing and going. And by the time I reached the clinic, I think they called me twice. I had to tell them, "Stop calling me or otherwise I'm never gonna make it!' [laughing] It was the old clinic at that moment, next to the river [the new clinic was built in 2009].
>
> When I opened the door, I saw she had strong contractions. She went inside and asked, "What should I do?" So I told her to remove her underwear and get set on

[131] The James Bay highway was built in the 1974 and the current access road, connecting the highway with the community, in 1995. Today it takes about 3 hours to drive to Chisasibi from Wemindji.

> the table, and by the time I turned around and prepared few things, mainly the clamp for the cord… she was already kinda pushing… we could already see the head! So getting a few warm blankets while delivery was going on. Fortunately, it was a nice delivery, she pushed two three times and hop! Nice little healthy baby comes up! We took the time to wrap the baby, had the father cut the cord and stuff like that… So it was nice for that, but you never know....
>
> The baby was wide awake, routine treatment done, secretion, aspiration, stuff like that, but the baby was breathing on its own. Doctor came in. She gave me a lot of instructions for follow up, in terms of temperature, things like that. But we don't have any warm rooms, we don't have any tools like that so… because the baby seemed fine to me, I didn't want to disturb too much the baby, so we used a kangaroo technique. I just put the baby on the top of the mother with the blanket over it, and she tried to breastfeed, if the baby wants to... So it went good and in the morning we got the flight and they had the mother and the baby transfer.

Transfer to Chisasibi or to Val d'Or?

> I don't remember… I think she went to Val d'Or. Because still, there's no resource in Chisasibi, so if there were any kind of complication you would be stuck up there. So I think she went to Val d'Or, but it was more for routine checkup, because everything was done, the placenta was out. I was not able to assess the placenta--lack of experience--but the doctor did that part, I think. But still, just to make sure we sent her down… That was a nice delivery in fact. Yeah… I still remember the name of that kid! (…) In fact, a few years ago they invited me to his birthday! And the latest news that I have he is a fine kid, doing very well. (Tim, nurse at Wemindji clinic, 2014)

Some women do not show up at the clinic while pregnant because they want to withhold that information from their family and don't want to spread rumours (see Chapter 4). Others keep away from the clinic to avoid biomedical interventions, including evacuation from their hometown for birth. Research in Canada and Australia confirms that some Indigenous women hide their pregnancies in order to avoid evacuation and deliver at home (Douglas 2006; Ireland et al. 2011, Vang 2018:1860). Several biomedical professionals at the Wemindji clinic suggested that occasionally that could also be the case in Wemindji. They said that women have no choice but to go through more and more medicalized pregnancy and delivery experiences, unless they decide to never show up at the clinic. This is what one of the long-time doctors in James Bay had to say about prenatal care:

> Now the visits seem to be getting heavier. When we see a woman who doesn't have much health problems or whatever, we're surprised and happy, of course! But sometimes I'm wondering with all the recommendations--to be on insulin, ultrasounds, if they are diabetic they need to get ultrasound at 20 weeks and they also need to see an ophthalmologist, and then all those recommendations… I

> think… I feel that sometimes for some women they feel it's too much. And what might be happening is that some women say, "Oh, I'm not gonna go at all."
>
> It was one lady that I delivered here a couple of years ago, it was her fourth baby and she knew she was pregnant, but she didn't wanna… somebody in her family spent a lot of time in the hospital and she just didn't want that for herself. My impression was that she really didn't wanna be bothered with all that being sent out for whatever… and you kinda wonder if there is an optimal number of tests and follow ups that we should do... This whole obstetrics thing is getting more medicalized. Even when they come for the first visit you have to start talking about prenatal testing. Technologies have gone up quite a bit. All kinds of prenatal tests to look for the different pathologies where you get some probabilities of illnesses…

Do you have women refusing those tests?

> Usually it's the nurse that gives the talk for their first visit, and one of the questions we ask them, "So if you knew, would you stop the pregnancy or not?" And a lot of women say, "Well I wouldn't," so they don't bother with the testing. I'd say that not an insignificant number decline the testing, which to me makes sense--if you're gonna take whatever comes, then why bother? Because with the testing they don't get yes or no, it's probabilities, and probabilities lead you to more testing and more things, and in the end you're not really sure. Also, you get more worried, so…

So in general you'd say the regulations get tighter and more medicalized all the time?

> Yes, yeah… I get that feeling, I get that sense. Maybe with reason too, but… (doctor at Wemindji clinic, 2014)

Clinic nurse Tim echoes the doctor's view that women often have no choice but to undergo all the tests and to be evacuated for births, unless they never show up at the clinic. However, Tim seems to think that recently the pressure from the families is very strong for the women to go see the specialists, and women give in. According to him, the most recent emergency births happened at the clinic because women did not know they were pregnant:

> In fact, what the problem is, women don't have a choice, they don't have the options. They are transferred. The only way to do delivery in the community is if they refuse the follow-up and they kinda hide. It happened! Some women completely refuse.

Do you know such cases?

> With names to put on, no I don't, I know some were kinda hiding. But at some point, they get so much pressure, if something happens it's gonna be your fault, then at some point, I think they kinda break. Those who had delivery, it's because they didn't know. It happens for some reason that some women come to the clinic with pains and, "Oh surprise, you're pregnant, it's gonna be a delivery!" It

> happens here, it happens anywhere, in Montreal or whatever. So there are few cases like that, I know it happened. There are few with social issues, drinking, stuff like that, don't wanna go and don't care about their pregnancy, sad to say, but that's kinda my interpretation.
>
> But I know for sure some women if they were asked or had an opportunity to deliver in the community, even with some risk, they would probably choose to stay. But as I told you, there's so much pressure put on, because the medical staff do not wanna deal with delivery… Delivery from my experience is something magical, it's incredible, it's wonderful, but if… sorry about the word… but if shit happens it's sad. And you don't wanna lose the newborn, you don't wanna lose the mother, so that's why it's always… (Tim, nurse at Wemindji clinic, 2014)

There was a case of delivery at the clinic when a woman had never shown up for prenatal appointments. Paul, another nurse at the clinic who helped with delivery, thought she knew she was pregnant, but for some reason did not want to come to the clinic:

What was the reason of this emergency? Nobody knew she was pregnant?

> In town they had to have an idea, maybe… But nobody told the Awash[132] department that she was.

Did she know she was pregnant?

> Of course she knew! The baby is kicking in your belly, you know… You were already pregnant, you know!…

Sometimes there might be cases they don't know…

> Well, they might ignore it, anesthetize themselves, but I think it was not the case. I really think she knew.

Do you know why she did not tell?

> … She didn't want to… I think she wanted to keep it for herself. I didn't explore the reason why, because it was not the job at the time. The job was–let's deliver that baby! And it was a happy ending. Baby was healthy, everything went well, the placenta came out. (…)

Were there any other people, her relatives, her friends around?

> Yeah, yeah, yeah! When they knew, people showed around and it was really funny because it was a really big surprise for everybody! (…) It was really a nice experience for this.

Were they evacuated later?

[132] The Awash ("child" in Cree) is the perinatal department in the clinic that takes care of pregnant women and their children up until 9 years old.

> Yeah, to Chisasibi. It was useless to send her down [to Val d'Or] just for two or three days after, to make sure everything was fine. (Paul, nurse at Wemindji clinic, 2014)

In this particular case, we cannot know whether the woman was hiding her pregnancy on purpose or if she really did not know, but there are cases when women do not know. And as the staff at the clinic mentioned, it is not something specific to Wemindji or Cree; it happens everywhere:

> It's not unheard of, even in other cultures, and some women would even bleed every month, even if they are pregnant, not necessarily a heavy period but… and often they have relatively stocky build--you're so busy with life that you don't feel it, and they maybe do not wanna be pregnant… Even at the time I was doing deliveries in Chisasibi, I had one woman like that, and it wasn't her first baby. So you know it can happen. Say your head is somewhere else and… many women are aware, but I don't think its unheard of, and it's not something that's specific to the Cree, I've heard stories of other peoples too to have it. (doctor at Wemindji, 2014)

I was told by staff and families of several pregnancies that went undetected in Wemindji because women got pregnant while on Depo shots,[133] or continued to menstruate while pregnant. A couple of such cases ended in stillbirths at the clinic. In one particular case, the pregnancy was said to have been undetected because of the negligence of the staff, who for some reason did not do a pregnancy test for a woman who showed typical pregnancy symptoms. According to the woman's family and biomedical staff currently working at the clinic, instead of doing a pregnancy test, the nurse took a woman's word for it—when asked if she could be pregnant, the woman answered no. AP, a mother and a grandmother, shared her personal and painful memory about her daughter's pregnancy and the loss of her grandchild.

A loss story

> She used to complain about backaches all the time. She told the nurse. They never really checked her. They never did any tests on her, you know. She complained a lot about back pain and the nurses… Whenever she went to see the nurse, they never did tests. Did not check if she was pregnant. They always gave her pills.

Did she know she was pregnant?

> No, she didn't. Me too. I didn't, I guess I wasn't aware. She got very sick once. I called the nurse. She said, "We can't see her." She suggested to give her some

[133] Depo-Provera is a birth control injection received every 3 months. Depo shots are one of the most popular contraception methods in Wemindji.

Tylenol. “I can see her tomorrow,” she said. I tried to help her, you know, massage her on her back. She said it wasn’t helping her really. So I called a nurse again. It was Saturday. She said, “We can’t see her now.” It was after hours. “We can’t see her,” just the usual Tylenol and, “Wait till tomorrow,” she said. I was getting mad!

I tried to comfort her, I couldn’t really sleep during that night, I kept waking up. She was making noise, sounds, you know--I guess because of the pain. In the morning I called the clinic again. It was Sunday. The nurse said that she can’t see her, she has to wait till one o’clock, she told me. I was getting so so mad, you know?... Finally at one o’clock I called again. And she told me that… well Saturday she told me to come and get pills, so I did. I went to pick up the pills. So Sunday… I took her to the clinic. And I guess the nurse that saw her checked her up, and we didn’t hear anything.

And then my husband said that the nurse told him… like there were no planes at that time flying, because of the weather, I think. So the nurse asked him if he could drive her to Chisasibi hospital. So he did. And during that time, I guess, when he took her, drove her to Chisasibi, I guess the water broke. I think it broke when it was here, but I am not sure. Well anyway, when she got to Chisasibi, her water was gone. All the water was gone. And she was told that she was pregnant and she had the doctors examine her. They took her to the delivery room and it was already dead inside her. I don’t know, I felt so bad, not realizing, you know…

Did you go by car to Chisasibi?

No. I flew later. That’s when I found out that she was pregnant.

But she still had to deliver the baby…

Yeah, yeah… It was stillborn. And they did like an autopsy on him, and he was… there was nothing wrong with him. It says that the water broke early, I guess he was dehydrated.

Did you participate in the delivery?

No, it was already, when I got to the hospital.

How long did she stay in the hospital then?

I don’t know, 4 or 3 days. Came back. They took the body to Montreal for autopsy. But when it came back it was sti… [AP did not finish the sentence, tears rolling down her face. We take a moment.] We were supposed to dress it up, you know, but we couldn’t. It was already smelly… [covering her face]. And I held it in my arms when we went there… and my husband was there too. We held him in our arms… our boy was dead.

One time after that she [her daughter] got online, you know, we asked for legal advice.. It was, I don’t know how many years after, she asked the lawyers. They told her that she could have done something, sue the nurses that were there. But

> now… I think they said 3 years after, you can't do anything anymore. (…) Yeah, well. They said after that, the head nurse informed them to always to check whenever the young girl goes to the clinic and complains of something, they should do the test, cause you know…

After that, did the nurse come to you? Did she talk to you? Maybe she apologized?

> No. No… (AP, 2014)

The next evening, AP and I went for a walk around town. It was late and already dark. We passed the cemetery. I was contemplating asking, when AP showed me a little cross and the grave of her grandson. She said we could come visit later, during the daytime when there's more light. I asked if they gave the name for the baby. AP said they gave him the name of the doctor who delivered him and a Cree name. She said the doctor at the hospital was French, so it was a French name. AP continued her story while we walked. When I came home, I tried to write it down from memory:

> You know, the body… we did not receive the body back for a long time. Probably two weeks. And the minister was mad. He was mad because we could not dress it up. The little body was already smelly and decomposing. So we covered it in blanket that people donated to us. We covered him and closed the little coffin."

Why did they not send him back earlier?

> Because they did not have my daughter's signature. Whenever they sent him away from Chisasibi hospital, she was not in a state to sign anything, they just asked her and she said OK to everything. So they sent him to Val d'Or. Next thing we know, they sent him to Montreal. Because they said they did not do autopsies in Val d'Or.

Why did they send him to Val d'Or in the first place?

> I don't know… And in Montreal they said they could not send him back because they did not have the signature. The doctor should have known better!

When I talked to the staff at the clinic, some of them vaguely remembered a few details of the case: others remembered better. Many staff were new and were not present at the time of the incident. One of the biomedical staff did not mind sharing the details, and encouraged me to write the story since, as she saw it, the medical system had not done justice to the family. She said the nurses who took care of the young woman were not working at the clinic anymore and one of them had already passed away. She remembered that in the patient's charts it was noted that the woman came several times to the clinic and complained about her condition—back pains, sensitive abdomen and strange movements in her stomach. During one of her first

visits, the woman was asked if she was maybe pregnant, and when she said no, the nurse continued prescribing her painkillers without paying close attention or examining her properly. After the baby passed away, the patient's charts were opened and facts were checked. The details of the case became known to all the biomedical staff at the clinic. It was recognized that the case was gravely mishandled. There was a meeting requested, where details of the case were discussed and there was a strict requirement set in place to pay better attention to women and perform pregnancy tests when they are in their fertile age range and show pregnancy symptoms.

Figure 22. Wemindji cemetery

Despite experiences such as the one above, in general, clinic births were mostly remembered positively by women that I spoke with. When I had an opportunity to ask, women said they were happy to deliver at the clinic, because they did not need to leave their family and their home for long periods of time, even if the beds were hard or the staff sometimes was not very well prepared. Their children were also proud to say they were born in their hometown, Wemindji. Elders, who were birthing at the clinic in the 1960s, did not have or did not express any major complaints about the care they received during births. If sometimes the nurses were not very experienced, Cree midwives were always there to cover for them. Biomedical staff and the midwives did not compete, and at least from the accounts

of the Elders, it looks like they cooperated and both did what needed to be done during births. Over time, midwives passed away, and there was no one to take over their knowledge and their skills in the clinic room. Thus, by the 1980s, nurses and the doctors found themselves alone with birthing women. As the evacuation policy became more established, the nurses became less and less equipped to deal with deliveries because they were not expected to have them at the station anymore. Therefore, deliveries at the clinic became occasional, but also stressful events for the family - and particularly for young or/and inexperienced staff. Since the late 1980s and the 1990s, all births were, and currently are, rigorously planned to take place in Val d'or or Montreal hospitals according to a routine evacuation schedule.

The next chapter describes the evacuation process and hospital births as, revealed through stories of Cree women, some of their family, and the biomedical staff at the Wemindji clinic.

CHAPTER SEVEN: HOSPITAL BIRTHS

Since around the 1970s, Cree women have not had a choice of where they give birth and are routinely evacuated to birth in hospitals down South. Women's stories of evacuation experience presented in this chapter take place primarily in three locations: the local Wemindji clinic, where women have prenatal appointments; the cities (Val d'Or and sometimes Montreal or Moose Factory), where women are waiting for births; and in the hospitals in the cities, where births take place. This chapter draws on the themes and issues that Wemindji mothers brought forward in the interviews when talking about their birth evacuations, revealing a range of experiences.

Even though the first evacuations around Wemindji started in the 1960s, it took some time before the policy and practice was well established in the 1980s (see Section 2.6 The childbirth evacuation policy and childbirth medicalization in Canada: Federal policy shifts and attitudes towards Indigenous birth). Childbirth evacuation policies for all remote Indigenous communities were gradually implemented by the Canadian governmental and biomedical authorities, disregarding local Indigenous knowledge, experiences, practices and beliefs (Brown et al. 2011; Douglas 2006; Kornelsen et al. 2011; Kornelsen and Grzybowski 2004; Chamberlain and Barclay 2000; Daviss 1997; O'Neil and Gilbert 1990; Stonier 1990). Evacuation time and place of birth was, and is, determined by current biomedical safety standards and bureaucracy - women are evacuated on the dates decided by clinic medical staff and Cree Patient Services.[134]

Biomedical standards of safety are closely connected with interpretations of the concept of risk; a topic discussed by a number of social scientists (for ex. see Beck 1992, 1995; Giddens 1990, 1991, 1994; Lock 1993; Lock and Nguyen 2010; Lupton 2013). These biomedical standards of safety and perceptions of risk do not always accord with Cree perceptions of healthy and safe birth. Further, what Cree mothers see as risky may not be considered a risk by biomedical standards. Perceptions of risk may, and often do, differ between the actors who are located in different contexts and may bring competing or complementary logics to understandings of risk (Lupton 2013:44). For example, research conducted among Inuit by Kaufert and O'Neil (1990, 1993) on the risks associated with childbirth, revealed that Inuit perceptions of risk are at odds with epidemiological and

[134]Cree Patient Services (Wiichihiituwin) "organizes medical appointments, transportation, meals and lodging for Cree beneficiaries who need to travel outside *Iiyiyuuschii* for medical services." http://www.creehealth.org/cps

biomedical approaches (for a more detailed discussion of Inuit and Cree birth, see Chapter 9, Section 9.2.4 The Cree and the Inuit models of birth).

According to Lock (1993), discrepancies between diagnostic taxonomies and subjective experiences of illness has major consequences for patients' wellbeing (141). Even though childbirth is not an illness, in biomedicine it is perceived as a condition requiring biomedical care and assistance because it involves biomedical risks. In biomedicine, risk is often assumed to be "...an objective reality that can be measured, controlled and managed, again, usually using mathematical models to measure and predict risk" (Lupton 2013:20). Such an approach to risk disregards subjective perceptions and life experiences of the people who experience these risks and, as already stated above, who might actually disagree on what aspects of their lives - or, for example, aspects of childbirth - they perceive or feel to be risky.

According to a sociocultural perspective (Beck 1992, 1995; Giddens 1990, 1991, 1994; Leslie and Young 1992; Lupton 2013; Lock 1993; Young 1982), "risk is never fully objective or knowable outside of belief systems and moral positions: what we measure, identify and manage as risk are always constituted via pre-existing knowledges, and discourses" (Lupton 2013:43, see also Good 1995; Good and Good 2010; Lock and Gordon 1988; Lock et al. 2000). Thus, neither biomedical nor Cree approaches to risk in childbirth are value-free. Pre-existing realities shape the reproduction of meaning and knowledge about risk through socialization and common experiences. This means that perceptions and definitions of risk are constantly changing according to changing realities and the production of new, incoming information (Lupton 2013:43).

For many hundreds of years - before encountering new Canadian policies on childbirth in the early and especially middle of the 20th century - Cree perceived childbirth primarily as a social family and community event. The idea of childbirth as something carrying biomedical risks and in need of biomedical professional care is relatively new to Cree. Therefore, it is interesting and important to learn a current Cree approach to childbirth. How do Cree mothers see and experience childbirth today in a medicalized setting?

In this chapter, Cree mothers speak about their lived experiences and tell what provokes anxiety or stress and what feels risky to them. At the same time, I want to understand how they deal with those anxieties and risks, and what they perceive to be a safe and comfortable birth (see Chapter 8 for more on Cree strategies in maintaining culturally safe birth in biomedical settings).

I argue that Cree women coped considerably well with evacuation in the past, and for the time being, they cope well enough with the medicalization of birth - so long as they are accompanied by others from their own community. Thus, the "riskiest" birth for many Cree mothers is to birth alone without family/community support. The presence of community and/or family - providing emotional support, Cree childbirth knowledge and experience - reduces the risks that women otherwise face in the evacuation (for example, being left alone in an unfamiliar environment, language barriers, boredom, loneliness, fear, stress, etc.) and helps create a culturally safe space for miyupimaatisiiun birth. In other words, Wemindji Cree have managed to develop a system within a colonial and biomedical framework which works quite well for them, given the circumstances. However, respondents of the research - including Cree Elders, young mothers and their families - agree that the women have to have a choice over where and how their children are born. Many mothers today want to combine biomedical and Indigenous knowledges and practices, choosing the elements from each that they find useful. For example, a woman might like to have a family and/or community member with them during a birth in the southern hospital. Or, if ever birthing in the community, to have biomedical advice and/or care available. Whenever in biomedical care, Cree mothers express a wish to not be stereotyped, to be listened to and heard by the professionals and administrators. Thus, they want better communication, which also involves staff's respect of Indigenous childbirth knowledges and practices, including a more individual approach towards the mothers and their families during perinatal care, as well as a better understanding of the impact of colonialist policies and current sociocultural realities in Cree communities.

This chapter is divided in three main sections. In the first section, I discuss prenatal appointments, which mostly took - and still take place - at the Wemindji clinic Awash department, where administrative and biomedical staff, together with the Cree Health Board, are working hard to provide quality care to families. In the second section, I discuss the various preparations made before and during evacuation–mainly the arrangement of evacuation dates and flights, the conditions in the boarding homes in the cities, and the most common issues women face during the evacuation period while they wait to deliver. I also look at the different ways women make "homes away from home" while they are away from the community, and how they overcome loneliness and boredom in a city where "there is nothing to do." The third part deals with women's hospital parturition experiences. I investigate stories told by the Elders who were the first to experience hospital births in the

early 1970s and 1980s, and I share their thoughts on the best place to birth. Then I present issues brought forward by Cree mothers while talking about hospital births and postpartum stays at the hospital.

7.1 Prenatal appointments at the clinic in Wemindji

The establishment of the Awash department in a newly built Wemindji clinic (2009) (Figure 23) was a significant event in perinatal care in town. According to many mothers, with the establishment of the department, the services for families in Wemindji started to improve. The implementation of the services to women and their children was gradual. In 2010, the department hired a second nurse and started offering services, not only for pregnant women, but also for their newborns. A few years later, it started taking care of children up to five years old. Currently, the Awash department provides pre- and post-natal care for women and their children, until nine years of age. At the time of the interviews (2013-2015), the Awash department had two permanent nurses, several replacement nurses,[135] four CHRs who were local Cree, a nutritionist and a community worker who provided support and advice for women dealing with social issues. At the same time, there was always one doctor in the clinic whose office was not in the Awash, but in the Current Services department; however, she/he was always on site, if needed. Pregnant women usually have only a few appointments with the doctor – in the beginning of their pregnancy, in the middle and at the end of their term. All routine follow-up work is done by the nurses and the CHRs at the Awash. For different routine and optional pregnancy testing, women are sent out to Val d'Or hospital.

Figure 23. Miyuupimatsiun Centre (clinic) in Wemindji, built and opened in 2009.

[135] The director of the department at the time noted that they always hire the same replacement nurses, if possible. So even if they do not stay in the community permanently, they are familiar with the place and its personnel.

A CHR is a local Cree person who facilitates communication between the medical staff and Cree mothers. She follows a woman throughout her pregnancy and postpartum; gives her essential biomedical information about the pregnancy, birth and baby care; helps the mother to make her birthing plan; often provides moral support; and facilitates communication at the clinic between non-Cree biomedical staff and the mother. Together with the nurse, CHRs do postpartum visits to the mother's home after she returns from the hospital. CHRs play an important role for mothers, and were mentioned by women in a positive light. They were a stable, non-changing element in women's - and their children's - perinatal care. CQ, a young mother, said she appreciated that during her pregnancy and after, she was followed by the same CHR, and that she could talk to her before seeing a doctor or a nurse: "I noticed that they (biomedical staff) are more helpful here (in Wemindji), because of the CHRs. Cause we see the CHR before you see the doctor or a nurse (CQ, mother of two children in her twenties, 2013).

Tracy, a CHR working in the Awash department since its establishment, confirmed that as the department has been running for a while now, women know more about CHR's role in perinatal care and the kind of support they can get from them. Mothers are coming forward with more open questions and are using their services generously:

> When it first started, they did not know what the program is, they did not know they could come and talk to us, but now it's really different. They know their CHRs, they'd call them up, "Oh I need this, oh, can you tell the nurse…" I think it's a good program for the moms. (Tracy, one of the four CHRs at the Awash, 2014).

Tracy described her work and the ways in which CHRs make efforts to accommodate women -to meet their needs, and provide information - but also to leave space for women to make their own decisions, and most importantly, not to judge, but to support them:

> We listen to their needs and see if we can help in their situation. If it's social, we ask social to intervene; nutrition--tips on nutrition. Sometimes the doctor asks us to do teaching on iron [deficiency]. We touch base on drinking, smoking, abuse. Some (mothers) would admit, some won't. Sometimes I feel it's too much on the first meeting… like "Do you smoke? How much do you smoke? Do you drink?"... We do give information and teachings, trying to build a link with the client, but if you're like that right away, then they close up. So you do it slowly, bit by bit, eventually they open up. […] (Tracy, one of the four CHRs, 2014).

Our interview continued about the third prenatal visit to the Awash:

> It's touching back on smoking, drugs, but some of them would say that they do smoke, that they do marijuana, stuff like that. It helps them if I ask and encourage—"Oh, it's good that you cut down!" I would not say like, "Oh, quit quit quit!," but I give them

> "Yay! You cut down!" You encourage them, not condemn them (Tracy, one of the four CHRs, 2014).

The personalized approach in prenatal care from the team (a CHR, a nurse and a doctor) at the local clinic is important to Cree mothers. The difference in care in a big city hospital was noticed and described by CN, a Cree mother in her 30s, who happened to live in Montreal during one of her pregnancies. She preferred and valued more the personal approach of the prenatal appointments in the community clinic over the cold and technical treatment in the southern hospital:

> I didn't have the same care that I had in the community. It was very clinical. It was always in waiting rooms with the number. You are a number, you know, "Number 42, come in!" You go in, you're checked, they ask some questions, they do a pelvic exam and everything, and, "Ok, we'll see you back in 8 weeks" or, "We'll see you back in four weeks..." So... I felt it very clinical. Nobody really asked 'So how are you doing? How are you feeling?

Did it bother you?

> Yeah, it kinda bothered me, I felt like I wasn't being taken care of the same way I got the care at home. (CN 2013).

Similar preferences in maternal care have been noted elsewhere (Oster et al. 2016; Vang et al. 2018), when medical staff report that strong relationships and trust with Indigenous mothers and their families are essential in providing effective prenatal care. Taking more time to know mothers and their individual situations, and building authentic relationship with each individual are important to achieve better pregnancy outcomes. This involves more time and flexibility in regards to place and timing of the appointments, having the same care provider throughout the pregnancy, and often transcending the formal patient-care provider relationship to move towards a more personal approach, etc. (Oster et al. 2016). According to some research (Vang et al. 2018:1859; Canales et al. 2011, Towle et al. 2006), women's trust and positive experiences of care are directly related to the amount of time that providers spend with them during appointments. According to Vang et al. (2018:1860), patient and care provider communication can be characterized as instrumental and affective. Receiving and providing information are the instrumental ways to care for a patient, while providing support, encouragement, showing genuine concern and being friendly, constitutes affective care. Affective, individualized care is exactly what is important in interaction with Indigenous patients (Vang et al. 2018:1860).

Wemindji Awash department makes efforts to inform women about their birthing options and provide women with tools to make those decisions while birthing at the hospital. Women have some choices over how to birth, but, according to biomedical staff at the clinic, they are often not informed about those choices. Together with women, nurses and CHRs prepare birthing plans in which women indicate their preferences –whether they want to be induced after their due date, whom they want to see in the delivery room, whether they want to have music during delivery, if they want to birth standing up, lying down or in a bathtub, etc. (See Appendix 1). Women bring their written birthing plans to the hospital, carefully prepared in consultation with biomedical professionals at the Awash department, to give these women a stronger voice. The plan could also be used as a tool to seek justice, should a woman's preferences be disregarded without a valid medical reason. According to the nurses at the clinic, women are happy to know they have a variety of choices in birth at the hospital and they eagerly pursue them. One nurse from the clinic gave the detailed description of the many different choices Cree mothers make in birth:

> They are often times like, "Oh, yeah, I didn't know I could do that," cause there's different positions. They think that delivery is only in the lying position. Well no, there's sitting and there's squatting, there's on your knees, there's a bunch of different positions. And Val d'Or are open to it. So that's good. They [the labouring women] are like, 'Ah!..." And then you explain different positions, what are the risks, and sometimes they don't tear as much on the side, and if there's stress in the body then just having your legs open, it depends… So there's different options and they're like, "Ah, I didn't know…"
>
> It's surprising sometimes how they are very shy and… but then you look at their birth plan and they want to touch the baby when it's crowning, they want the husband to take pictures, videos!… So yeah, OK, cool! So it's like the whole another world. It's nice for them to be able to choose. We do it [the birthing plan] with them throughout the pregnancy and at the end we give them a copy and we tell them to give it to the nurse when they get to the hospital. (Awash Nurse at the Wemindji clinic, 2014)

Such birthing plans were introduced because many women were coming back from Val d'Or hospital dissatisfied with the experiences, saying that they were pushed around or coerced into medical procedures. The staff at the Awash department in Wemindji felt they needed to take a stand to reduce such incidents and to provide information that would allow women to know their choices and their rights. During my interview with the director of the Awash department, she remembered some incidents that signalled the necessity of the birthing plan:

> When the mother came back she said… cause we are always questioning after birth, what do you want to do about birth control, things like that, and it happened

> one time that the mother said "Oh they gave me the Depo shot [Depo-Provera--birth control] and I didn't want it.

She didn't want it, but she didn't say?

> No, she said it! She said to them!

And they still gave her the shot?

> Yeah, they said, it's a doctor's order and you have no choice.

This is a human rights violation…

> Yes! So that's why! I jumped up this high when I heard that! And we said we are going to start something like a birth plan so that we can inform the women first. And then when they come back, if they have something in writing that they say they don't want contraception when they leave the hospital and they are forced into it… We will be able to right away call with that feedback and say, "Who was the nurse working this shift? you know… and then you can go to the commissioner of complaints and do something about it. (Director of the Awash department, Wemindji clinic, 2014)

While the department is working hard to improve their services for the women and their children, there are always challenges and places for improvement. At the time of my fieldwork (2013-2016), there were no Cree nurses or doctors working at the clinic. Both non-Cree staff and Cree women talked about sociocultural tensions and miscommunications at the clinic. For some Cree women the language barrier, the sometimes overly patronizing tone, the tendency to fill-in silent moments, and the loads of new information make it difficult to open up or to ask for information from non-Cree professionals. Non-Cree medical staff recognized that they often face communication challenges with their clients. Professionals mentioned that communication is different in the North, yet it was difficult to pinpoint the problem. Most of them mentioned that Cree women's emotional expression is different: they are much more reserved and more silent; they have a less verbalized manner of communication, which is difficult for them to read and comprehend. Several staff mentioned women being sensitive, and that you need to carefully compose and choose what you want to say, and you do not always know how to do it best. This situation is echoed in other research looking at the interactions of care providers with Indigenous mothers in other communities. These studies also report misunderstandings between mothers and professionals rooted in cultural differences in communication styles, medical beliefs and values, as well as systemic racism

and negative stereotyping of Indigenous peoples (Bourassa et al. 2004; Browne and Fiske 2001; Greenwood et al 2018; Vang et al. 2018:1859).

It was my observation that only a few of the medical staff at the clinic are actually involved in community life outside of their work. The majority tend to keep close to their colleagues and live segregated lives within the Cree community without much interaction with Cree or non-coworkers outside their working hours, thereby making it more difficult to connect with people, to earn their trust or gain any insight into local dynamics and communication patterns. The separate housing for medical staff, concentrated on one or two secluded streets in town, further reinforces a segregation between the community and its medical personnel. A recent study in Canada (Oster et al. 2016) suggests that medical personnel often feel they have a great lack of Indigenous sociocultural understanding and that the training they receive about Indigenous communities, if any, is insufficient and inadequate to be able to work with Indigenous peoples effectively. The medical staff in this study also noted that reading or learning from the seminal material or online is one thing, but it makes a big difference when they are able to learn from first-hand encounters with First Nations peoples, and learn from the real-life experiences, stories and teachings told by Elders and other community members. When working in the community, many professionals said that they felt embarrassed about not knowing much or enough about the place and its people. They felt shy and did not know whom to approach in the community about appropriate cultural protocols or cultural knowledge and understanding (Oster et al. 2016:5). During my fieldwork in Wemindji, a few medical professionals asked if I could point them to literature they could read about Cree worldviews and especially Cree understandings of health and perceptions of risks in childbirth. I see this situation as a vicious circle–non-Indigenous biomedical staff do not receive appropriate training and do not have much knowledge about or sociocultural understanding of Indigenous communities, their historical context and the ongoing impacts of colonization, nor a knowledge of the community they are going to work in. As a result, they feel uncomfortable and keep to themselves and their co-workers, who are mostly non-Cree. In this way, segregation is reinforced and ongoing. As Oster et al. (2016) suggested, biomedical professionals need to acquire an appropriate cultural understanding about Indigenous peoples, and in addition to completing competence training, efforts need to be directed toward partnering with Indigenous communities to enable them to share their real-life experiences, worldviews and stories with biomedical personnel. If medical professionals are going to work in a particular community, it is important to include in their training the characteristics

specific to that community, since all are unique. The maternity care system has to be more flexible in accommodating individual needs and more open for collaboration and mutual learning for both the biomedical staff and Indigenous families (Oster et al. 2016:7).

7.1.1 Ultrasound testing and due dates

Ultrasound testing often came up as a theme in the interviews with women about prenatal visits. One topic stood out–the due dates established by the ultrasound. Today the ultrasound screening is performed in the Val d'Or hospital or in Montreal. As a rule, women want to spend the least possible time in boarding homes and to have their partner or family nearby while in evacuation and during birth. This is when ultrasound tests become important. Due dates established by ultrasound testing determine the date of a woman's evacuation and also the date of eligibility for an escort, which is one week prior to the due date. If the ultrasound estimated due date is too early, a woman will then have been evacuated earlier than necessary and have a longer time in evacuation waiting before the baby is actually born. On the other hand, if the estimated due date is late, then the escort may not arrive in time. Thus, sometimes women are left to labour alone without their family's support. This is the risk that most Cree mothers do not want to take. Some women are more vulnerable than others when left in such a situation, which is especially hard on young first-time moms.

BA said that her labour started earlier than her official ultrasound due date. Her mother or family did not have time to come to support her:

> I lost some blood, it was during lunchtime, we were sitting at the table [in the boarding home with other Cree patients]. I kept having pain on this side, I was going like that a lot [she shows leaning on one side] I didn't know I was going into labour and someone told me, "I think you're going into labour," cause she's seen me go like that all the time. And then, I remember, cause nobody was there [she means nobody from her family], I was allowed to have an escort, but nobody was there [she emphasizes again that she was alone], cause my due date wasn't until the 29th, so it was too late to ask someone to come, cause I was gonna ask my mom to come, but it was that evening that I started my contractions and I called my mom and I cried, because I didn't know what to do. So I went to the hospital after lunch.

What did your mom tell you?

I don't remember really, I just remember crying a lot… (BA 2013).

One young mother, whom I met at the Youth Centre in Wemindji, described how confusing it was that during her pregnancy the due date was shifted several times according to the ultrasound tests: "At first they told me it is in January, then, they told me it is in

December, and finally he was born in November!" She never made it to Val d'Or hospital, because she went into labour at home in Wemindji, and later was medevaced to the Chisasibi hospital. Because of the stormy winter weather, the medevac plane could not land, so her father drove her on the access road[136] (see Figure 24) to James Bay highway (see Figure 25), where the emergency vehicle picked her up. She said she was happy to have her family beside her all the time, and in retrospect she was glad she was not evacuated to Val d'Or, although the trip on the bumpy access road in her father's vehicle was very uncomfortable during labour pains.

Figure 24. Gravel access road that connects Wemindji to James Bay highway

Figure 25. James Bay highway

[136] The access road from Wemindji to James Bay highway is 96km and was built in 1995, making Wemindji accessible by car all year round (see Figure 25).

Some women felt that their insights and knowledge of their own bodies were disregarded, their concerns not taken seriously, nor even discussed. CZ recalled that from the very beginning she was sure her ultrasound dates were way off. Her pregnancy was carefully planned; she knew when she conceived and so kept the count of the days and the weeks:

> Cause me and my husband planned it [the pregnancy], and I counted how many weeks I was, and here I told them the date, the conceiving, the last period, so they wrote it down, but once I had my ultrasound, they changed the due date. I kept my date and they kept the other date. They didn't take my due date.

What was the difference, do you remember?

> It was… I said she would be born on the 7th. And they said she would be born later, on the 28th or 26th.

Oh, so it was like three weeks difference...

> I still believed that she would be born on the day I kept. So they would keep looking at the ultrasounds and when it was time to leave… and once I got to Val d'Or I was worried. I went to Cree Patient Services and I said I would need my escort soon. And they looked at my arrival date and they said, "No, it's too soon. According to the ultrasound it's too soon." And I said, "No, I believe my baby will be born on the 7th. And they said no, you can't, you have to wait. And so this is when she was born. On the 8th. It was the date I was targeting. […] I'm happy my sister was there, but my husband never made it. […] When the departure came, the Cree Patient Services, they apologized, saying, "Oh, we are sorry we didn't believe you, according to the ultrasound…" I remember that.

How did your husband feel about this?

> He was like, "They should have taken your word in the first place!" (CZ 2014)

As biomedical technologies become more and more a part of human reproduction (Franklin 1998), it is important to remember that those biomedical technologies are not autonomous - they are the product of historical, cultural and political contexts (Lock and Kaufert 1998; Rapp 1999) and are operated by professionals who interpret the data. On the one hand, biomedical reproductive technologies may be experienced as enabling and resourceful, but on the other hand, they might be useless and/or harmful (Lock and Kaufert 1998; Inhorn 2006), causing anxiety and stress, as we saw in the last example, where ZC clearly knew that she did not need an ultrasound test to know her due date. The fact that she might need to birth away from home without her partner caused anxiety and stress, the outcome which she was trying to prevent from the very beginning by keeping careful record

of her conception date. As stated above, birthing alone and away from home is the risk that most Cree mothers most want to avoid. Anxieties and stresses caused for different reasons by the use of reproductive technologies have been widely demonstrated elsewhere (Davis-Floyd 2003; Franklin 1998; Inhorn 2006; Lock and Kaufert 1998; Rapp 1999).

It is noted that biomedical knowledge or expert knowledge is often taken-for-granted; it has a privileged status and is often considered to be evidence based and factual (Davis-Floyd and Sargent 1997; Inhorn 2006), even when it was well-established that biomedical knowledge together with biomedical technologies are products of historical and sociocultural circumstances (Lupton 2013; Inhorn 2006). According to Inhorn (2006), "biomedicine is now the default and almost prestigious form of women's health care, replacing many earlier systems of healing" (356). Thus, it has become hegemonic, which Inhorn (2006) explains - taking from Gramsci (1971) - is a domination achieved through consent rather than force (356). Medicalization of childbirth is the result of both: by force, making midwifery illegal and/or unacceptable by administrative sanctioning; and partly by consent, as women became convinced that biomedical birth may have many benefits (Inhorn 2006). According to Lupton, "Lay people are often aware of their dependency on expert knowledge when it comes to disputes about risks" (Lupton 2013:151), and they are aware of their lack of agency to challenge expert knowledge (Wynne 1996; Michael 1996), but even then, lay actors often resist or challenge experts or technologies, as was the case with CZ – she knew when her baby would be born without experts telling her, and as she states, "I kept my date and they kept the other date." This illustrates how mothers build their own expert knowledges (Wynne 1996); or, in Jordan's terms (1997:55-79), "authoritative knowledges," - the knowledges that count.

7.2 Pre-labour preparations

Pre-labour preparations take place in a very different environment than they did when birth took place in the bush or in the nursing station in Wemindji. Today, not only women have to take care of themselves and to be "alive-well" (miyupimaatisiiun) when expecting a baby, but they have to put energy and thought into planning their evacuation and appointments out of town. They need to arrange childcare at home and secure an escort for their evacuation. While talking to one of the CHRs, I asked about the main concerns women express or communicate about their preparations for births and this was her reply: "If I put everything together in one word it would be 'stress'. […] To balance their family, her

pregnancy, when she leaves to Val d'Or, when and where she has to place her children, what to do if the father is out of the picture… So they have to deal with all those issues." (CHR 2014).

When children were born in the community, women were getting ready for the act of birth by making a comfortable space and bed for their birth, preparing clothing for the newborn and taking care of their bodies and minds (see Section 5.3 Pre-labour preparations). Today, women devote large amounts of that time and energy to worrying or/and planning their evacuation. This involves household care, childcare, finding an escort, securing/saving finances for the trip, arranging their time and space in evacuation, etc. Finally, they have to face the waiting time during the evacuation, which is a challenge in itself spending the last weeks of pregnancy away from home. Cree women's experiences are echoes by a number of research on Indigenous women's birth evacuations in Canada (Cidro et al. 2017; Cidro and Neufeld 2017; Kornelsen et al. 2011; Olson 2017).

In the next section, I primarily discuss two subjects: evacuation logistics (flights and boarding conditions), and how women pass the time and deal with the challenges of waiting for births while away from home.

7.2.1 Departure dates and flights

In the early days of the evacuation policy (the 1970s), before the airstrip was built in Wemindji in the 1980s, evacuation flights were constrained not only by weather conditions (strong winds, fog, storms, etc.) but also by seasons since planes could only take off or land on water or on a well-frozen river. For these reasons, mothers with their new babies would sometimes have to wait for the right temperatures and good weather conditions to be flown back home from the southern hospitals, and they'd often have to leave early, long before the birth and twait for the delivery in the South. AP, a mother to four children, and now a grandmother, remembers her evacuation in the beginning of the 1970s:

> Was evacuation arranged by the clinic? Was it the nurse who told you that you should leave by this date?
>
> > Yeah, yeah. I had to go because there wasn't going to be planes because of the freeze up. Because it was getting cold. And they told me I have to go before it freezes up, because later I wouldn't be able to go out.
>
> And what kind of plane? Was it a small float-plane?
>
> > You know those bush-planes, I don't know how you call them… Otter?

Did you go alone?

Yeah.

And there were no other women going with you?

No. They sent me to Moose Factory.

How did you like the flight being pregnant? Were you used to going by plane?

Yeah.

How long does it take to go by a small plane like that?

> I am not sure… Well, he had to land somewhere… Eastmain. Cause we had to stop in two places I think, to go to Moose Factory. So when I arrived in Moose Factory in Moosonee, that's where the plane landed, I had to go by helicopter!

Wow, what an adventure!

It's the first time I got on the helicopter!

How did you like that?

> It was scary, because it was all glass! I felt like I am going to slip off! [laughing] I was OK then. I wasn't really scared, you know... (AP 2013)

When the airport was built in Wemindji in the 1980s, getting to it posed an issue for some women because the airport was a few kilometres away, and there were few motorized vehicles in town. Lillian remembered she had the evacuation flight booked for her by the clinic; however, she could not find the way to get to the airport, so she did not make it. The next day her son was born in the Wemindji nursing station, after which she was medevaced to the Chisasibi hospital.

Air Creebec is a Cree airline that has served communities on the coast since the beginning of the 1980s. On one of my flights from Wemindji, I was skimming through the Air Creebec magazines and I found a story about a birth on one of their planes:

> Roger Steve Myles Jolly is the only person who was born on an Air Creebec flight. His mother, Shirly Jolly of Waskaganish, was on her way to hospital in Val d'Or on August 27, 1987 when Roger decided he could not wait to get to the hospital – or even to the airport. Roger was born while the airplane was in the air between Waskaganish and Val d'Or. He was named Roger because that's what his mother heard the pilot say when he was talking on the radio.[137] Roger said Myles was the name of the pilot and Steve was

[137] "Roger" is pilot talk for "OK."

> the name of the doctor at Val d'Or. Roger was given a lifetime pass on Air Creebec and uses it about six times a year. (…)" (Air Creebec magazine 2013, December)

AQ, a mother from Wemindji, also remembered how she went on the passenger plane while in labour in the 1990s:

> So I went into labour here, I went to the clinic… I woke up in the morning and I felt really different and I told my mom. I went to the washroom and I realized that I have lost my plug and I called the clinic, went to the clinic and they told me, "Well, you gonna have your baby soon." So I had to go home, pack my stuff and fly to Val d'Or. And he was born the following morning.

Did you have an escort with you?

> No. Back then [the 1990s] you didn't get an escort.

So you were alone labouring and you were on the plane?

> Yeah… The stewardess didn't realize that I was in labour until we landed in Waskaganish. She happened to see me timing my contractions, so she asked me if I needed a doctor or a nurse to come on board and I said "No, I am fine." So when I got to Val d'Or I was still in labour. It wasn't that bad. They didn't want me to eat or walk. And they weren't prepared for me. Because usually they send you down South at 38 weeks to get checked and to make sure that everything is OK. But I was early. (AQ 2013)

Today, in theory, the labour should not happen on the plane because the medical staff are supposed to make sure that women leave at least two weeks before their due date, and if a woman is in labour already, she is sent out on the medical emergency plane. In case an expectant woman near her delivery date wants to take a passenger flight, she needs to show the medical form signed by a doctor who performed a checkup the same day and confirmed that the woman is not in labour and is okay to fly (see Annex 2).

There are times when the flights get cancelled because of the weather conditions. Women who had their evacuation date delayed said they did not mind and were actually glad to leave a day or two later. CL remembered that her flight was cancelled twice:

> Because with the airline company--after 37 weeks and 4 days they don't want any woman flying. So you have to leave before that. And the airline company has this paper that needs to be filled out by the doctor that says I'm OK to travel. So that's why the nurse gave me the date. She called and she said, "CL, you leave July 17th," I think… And I said, "OK." I was already on maternity [leave]. So I started to get ready preparing my bags, cleaning the house, getting the crib ready. So the day came, she called me that morning, she's like, "CL, I'm sorry but there's no plane today, so you're not leaving today." "Ahh, that's good, I don't mind staying an extra day at home." So then the next day I get a phone call again, "CL, there's no room on the plane so we have to delay your flight to the next one." I was like, "Fine, that's OK with me!" Cause I wasn't really up

> for leaving early. And I was maybe 37 and 6 days when we left. They kept updating my paper every day [laughing]. But for other women, it did not seem to them like I had to stay long in Val d'Or, because of how far along I was when I left. But there're other women at different circumstances, so they have to leave earlier. Some that are GDM [Gestational Diabetes Mellitus] they leave at 36 weeks. And they're out there for four weeks before the baby is born. They don't like that... (CL 2013)

The evacuation date for women is finalized and covered by the Cree Patient Services. The person from the clinic administration who is arranging the flights calls women to inform them about the trip and their housing arrangements in Val d'Or or Montreal. The usual departure date is about two weeks prior to the due date. Women with higher risk pregnancies often need to leave earlier, depending on the doctor's decision. Many women said they were not happy with the evacuation dates; they thought they were too early. If they asked to change the dates, the requests usually were not approved.

Several nurses at the clinic admitted that the early departure dates are an issue for many women, but the dates cannot be easily changed. Val d'Or hospital and the Cree Patient Services schedule all prenatal appointments at the hospital according to the due dates and their own hospital schedule. This is how one of the nurses at the Awash department described the process:

> For the regular pregnancy at 32 weeks, we send a file to the nurse in Val d'Or, so then she could arrange all the booking for the delivery and plan which date. When she knows which dates, she sends us the request of appointment and with that request of appointment there's a date of departure. Then AL [a person working in the Wemindji clinic administration] books the flight.

And there's no negotiation with the mother herself which date is better for her?

> Well… We all know when we follow her, we tell her, "We know you're gonna be leaving around 36, 37 weeks." We know it's going to be during that time, so it's pretty much Val d'Or that decides when she arrives, and yeah…

And if the mother asks, "I want to go a few days later" or…

> Well… maybe sometimes we could move dates, but it doesn't really happen. The women usually are like, "OK, that's the date" and…

And so the decision is mostly from Val d'Or?

> Yeah. The reason they want the women to be there at 37 weeks is that it's term, right? Term is 40 weeks, but we know it's plus or minus two to three weeks. So after 37 weeks there could be a delivery. So that's why the woman has to leave so early. For sure it's an issue for some who have two or three children already, it's a long time far from their family. (Awash nurse at the Wemindji clinic, 2014)

On the other hand, another nurse at the Awash department had a less strict perspective on evacuation dates and said the staff tries to accommodate women and to be more flexible. She also remembered one recent case, where the staff and the clinic tried their best to accommodate a young mother's needs:

> Is there any chance of women saying, "No, I don't want to go Friday, I want to go next Wednesday or Saturday or?…
>
> > Yeah, it happened often. And especially when it is a wedding or… we try our best to help them with that.
>
> And this is the responsibility of whom, to organize the trip?
>
> > We send everything to CPS, they usually organize all the follow-ups and when the patient is supposed to leave. All of that. However, if the patient says, "I want to leave on this day instead of that day," we call the CPS and try to arrange it with them. We try our best to give them what they [the women] want. (…) Unless there's a risk. Some time ago we had a 16-year-old who was supposed to give birth between Christmas and New Year's, but there was a period when there was no plane. And she didn't want to leave because she didn't want to be alone for Christmas or New Year's, I don't remember exactly.
> >
> > But it was in that period and she didn't want to go, and by the time we could organize the flight she would have been 39 weeks pregnant. It's too late and we really tried, we really wanted to accommodate her, but at the same time there was a lot of risk staying here in the village, especially during that time. For one, there was no plane for a certain amount of time, and you never know the conditions of the weather, so if she suddenly goes into labour and she's here and there's no flight, there's no way that the plane's going to come, you know it's going to have to be done here, which puts everybody… you know, it's a risk. We don't… we're not equipped…
>
> When did she go?
>
> > Finally, the compromising… At first she didn't want to go, the family didn't want her to go, they wanted her to stay. We explained the risks and they still wanted her to stay, and I didn't feel comfortable. I spoke to the director of the department, she went to the clinic director, to try to organize something with CPS so that this child who's having a child could have some of her family with her down there. And finally, they agreed to pay. I think it was five tickets for the time being, yeah… So it was nice. We got that organized with CPS and at the same time, […] we were going to make her sign the form saying, "You know the risks, this is what could happen if you stay, and if you give birth here this is the reality and now it's your decision." But finally, they decided to go. So she was with four of her family members during the holidays.
>
> The delivery went well?

> No. So it's a good thing she wasn't here, 'cause she had quite a few complications after. (Awash nurse at Wemindji clinic, 2014)

There are rules and routine procedures in place for evacuation, but the two views of different nurses demonstrate that there is some flexibility and variability in staff members' approaches to those procedures and regulations and, among the staff, different ways to apply those same rules. The last case also demonstrates how important it is for families and women to be together during birth. The family's presence provided safety for the birthing mother, as well as assurance for her family. The biomedical risks from the mother's - and her family's - point of view then became secondary. As the nurse recalled: "We explained the risks and they still wanted her to stay, and I didn't feel comfortable." This is when the personal approach and care became important – it reduced anxieties and thus risks for both the biomedical professionals and the family.

7.2.2 Boarding homes and Friendship Centres

While waiting for births, women stay at the boarding homes or Friendship Centres (Figure 26), where they are provided meals and a bed. The majority of mothers with whom I spoke preferred smaller boarding homes over the big Friendship Centres. Women's experiences in boarding homes varied, but overall, Montreal boarding homes -before ongoing reforms - had a bad reputation, while Val d'Or boarding homes varied from one place to the other. Also, women preferred Val d'Or over Montreal because it has the advantage of being closer to Cree communities in eastern James Bay. In Val d'Or, women could meet Cree from other communities and often somebody they knew from their own town because Val d'Or is not only a destination for health problems or births, but also a place to go shopping, and it is a midway stop when driving south from the northern communities to the big cities.

Figure 26. Friendship Centre in Val d'Or

Several boarding homes in Val d'Or were known for being nice, clean, with a friendly staff and serving good food or - even better - Cree food. One particular place stood out in the interviews. Several times Robbie Tomatuk's boarding home was mentioned as the best place for patients in Val d'Or. Robbie was Cree himself and received patients from Wemindji and Eastmain, his home communities. In 2010, Robbie passed away and his place was closed. Robbie's place was like "home away from home" for many Cree:

> I liked staying there, because of the environment, cause it's more our culture and everybody was speaking our language, especially him, he was speaking Cree, so it was much more comfortable. (Elizabeth Shashaweskum Jr. 2014)

> It was just like… it's your own home. That's how I felt. You had everything that you needed. Everything, the food, the food that you liked to eat. That's what he had. He knew what patients liked. (CE 2013)

What made Robbie's home so special for the mothers? The ones who stayed there emphasized the familiar elements of home at Robbie's place, like fCree language, Cree food and the Cree way of being ("cause it's more our culture"). Families also appreciated quietness, comfortable beds and personalized rooms, which reminded them of somebody's home rather than a hotel with identical rooms. BL described his experience when he escorted his sister for birth and had to move from Robbie's home to a Friendship Centre when Robbie passed away:

> It was nice, it was like home away from home, but after he died, my sister had to move to the Native Friendship Centre, which doesn't feel like home, it feels like you're staying in a hotel. They have a sink in the room and two single beds. The beds are hard.

So you have to share your room with somebody when you don't have your escort?

> Yeah. And the beds were really hard! […] The rooms were really small, about the smallest offices here. And there could be a party in the next room, it could be very loud and noisy.

Do you know about other places for patients in Val d'Or?

> Yeah, there are other places, but they are not Cree. Robbie was Cree, he was from here. (BL 2013)

Robbie's boarding home provided women with a familiar cultural space that allowed them to be themselves, comfortable and relaxed without putting too much effort into expressing themselves or trying to understand others. CZ remembered that the place was very homey and the people staying there were much more open than in a big Friendship Centre:

You went to Val d'Or… Where did you stay?

> It was at the Friendship Centre, and I stayed there and there were a lot of Aboriginals staying there, some pregnant ladies, but we hardly had any link or communication between us. The staff was OK. But I wanted to transfer to a boarding home--it was an aboriginal guy running it and people there I know. So I asked if I could be transferred to that boarding home. So they said, "OK, yes." And I packed and I told Friendship Centre that I moving into the other boarding home. […]

How was in the other boarding home? Was it better?

> It was better, it was more homey. We would like… it's almost like a big trailer and there's a living room, kitchen and everybody had their rooms or they would share.

Did you share a room or you had your own room?

> I had my own room downstairs but I shared after when there was more patients. I found it very homey there. I would talk to people, they would talk to me, 'cause they were very open. But I don't know what it was in Friendship Centre, everyone was so closed (CZ, 2014)

While a majority of women preferred boarding homes, a few said they did not mind staying at the Friendship Centre, mainly because the Friendship Centre's security would keep the doors open late at night, while boarding homes would lock up at 11pm at the latest. One mother added that she appreciated a more active social life at the Centre and could meet many more people than in the boarding homes for patients.

Women who give birth in Montreal are the ones who have higher risk pregnancies. Out of 36 mothers (or their family members) that I interviewed, there were only four women who stayed in Montreal boarding homes during their pregnancies. Three women said the place in Montreal was OK and did not dwell on the subject, but went on to more pressing issues for them, like loneliness and tiring waiting times. One mother went into a little more detail and said she did not like Montreal boarding homes because they were dirty and crowded:

And how were those homes? Did you like them?

Well… not really, because I usually seen bugs.

Bugs?

Yes. Where I stayed one time, there was, you know, where the fridge is, there were ants in that area. We did not want to eat much in that place.

Did you make food for yourselves or they provided food?

Yes, they provided, but we did not want to eat there, we usually made it for ourselves. And we changed the sheets, they were dirty when we arrived.

How full was the place?

It was crowded. (AM 2013)

While only four mothers whom I interviewed stayed in Montreal boarding homes during their late pregnancies, many people in Wemindji have stayed there at some point in time as patients or escorts, and the feedback many gave was not positive, to say the least. On the community's Facebook page, there were different stories and complaints being posted about separate incidents and bad conditions. People complained about noise, expired food, unsanitary facilities, but also about disrespectful staff, patients being ridiculed, insulted and mistreated. According to some people, food, drinks and toilet paper were hidden and locked away in the evenings, and bathrooms were not allowed to be used after hours. People felt insecure sleeping during the night because the door locks in some rooms were broken. Some elderly patients said that in those homes they were treated as they had been in residential schools "back in the day." In May 2016, the Cree Health Board announced changes. Kathy Shecapio was the first Cree to be appointed as the Director of Cree Patient Services and soon after that, in July 2016, Cree Patient Services released the following announcement: "Starting July 1, Cree Health Board patients and escorts travelling to Montreal will stay at the newly-renovated Espresso Hotel. Current boarding homes will become private lodging. The quality of your stay in Montreal will improve."

7.2.3 In evacuation: waiting for births

Regardless of accommodation quality or type, the majority of women said that the waiting in the evacuation - away from home, their family and community - was a big challenge. Janeja and Bandak (2018:1) describe waiting as "a particular engagement in, and with, time." Being compelled to wait elicits diverse attitudes and evokes a variety of responses. Waiting does not affect everyone in the same way and is experienced differently (Auyero 2012:27). One can become frustrated, anxious, stressed, bored, irritated, and on the other hand, waiting can evoke creativity (Janeja and Bandak 2018). Waiting can shift from being passive and purposeless to active and purposeful - and back again; thus, waiting is unstable (Janeja and Bandak 2018:16; see also Auyero 2012:31). It has been importantly noted (Bendixsen and Hylland 2018; Jeffrey 2018; Janeja and Bandak 2018) that waiting is shaped not only by the ones who create the conditions of waiting, but also by the ones who wait. Generally, Cree mothers cannot control the duration of their waiting, but they can take control over the quality of their time passing. In the context of waiting, control over one's time and space is an important factor (Janeja and Bandak 2018:20). The capacity and experience of being able to act and being acted upon are pivotal to a sense of well-being and agency (Jackson 2002, 2005; Janeja 2010; Janeja and Bandak 2018). Thus, some element of planning and a sense of control over one's situation is important. Even though women report that waiting was long and challenging, that they felt lonely and bored - eventually, women actively and creatively invented ways of passing time and/or rearranging their waiting space. In this way, women take control over the time on their hands to make it less boring, lonely and stressful, but also more meaningful. In the following section, I discuss the main challenges women face during the waiting times in the evacuation and how they deal with those challenges.

7.2.3.1 Challenges of waiting: loneliness, longing, boredom and financial concerns

The time mothers spend waiting for birth in the evacuation seem long, no matter whether it is a week or a month. According to Janeja and Bandak, clock time and experience rarely coincide (2018:18). Unexpected or unpredictable waiting can be experienced as frustrating and long, while on other occasions time seems to fly, when, for example, experiencing activity flow (Csikszentmihalyi 1990) or making important decisions (Janeja and Bandak 2018). Thus, "Social time is not to be equated with measurable time units, but

rather as an experiential dimension of social life, which can only partially be measured by the watch and clock time" (Janeja and Bandak 2018:18).

CL, a young mother, left the community at almost 38 weeks of her pregnancy and had to wait for over a week in the boarding home, which felt long for CL, although other mothers did not think so, because they had to wait even longer:

> But for other women it did not feel like I had to stay long in Val d'Or, because of how far along I was when I left. There are women in different circumstances, so they have to leave earlier. Some that are GDM—they leave at 36 weeks. And they're out there for four weeks before the baby is born! They don't like that. No…" (CL 2013)

Mothers who stayed only a couple of days often acknowledged that they were lucky and that their evacuation was short compared to other women. AQ left Wemindji on Thursday and had to go straight to the hospital from the Val d'Or airport. She came back with the baby on Sunday the same week: "I wasn't there long, which made me very happy, cause some people stay for a very long time..." (AQ 2013). Regardless of a short stay, AQ said she felt lonely and bored in the hospital because she was alone and had nobody to talk to. Loneliness during evacuation was expressed by many women who did not have their families to escort them, but especially by first-time young mothers or those with long waiting times in Montreal. I asked CZ about her evacuation for her first birth, when she had just turned 18:

Were you nervous about it [evacuation]?

> No, but once I was there and all kicked in, I felt alone, I felt… nobody was there I knew.

You went alone?

> Yeah, 'cause I turned 18. So I didn't have any escort. (CZ 2014)

Escorts for teenage mothers are covered by the Cree Health Board for the whole length of the evacuation, but for women 18 and over, the escorts are covered only one week prior their due date. Thus, CZ was considered an adult and did not qualify for the escort for the whole period, but only for the standard one week before her due date.

Distance also played a role in women's experiences. AQ, who waited for birth in Montreal for seven weeks, said she wished she had been in Val d'Or because it is closer to home and there are always people you know:

> I was in Val d'Or for two days, but they noticed I had contractions and so I was medevaced to Montreal so they could keep an eye on me. They told me that it's better to have twins born, if they gonna be born early, in Montreal. The best hospitals are there.

Where did you stay?

> In a boarding home.

How did you like it?

> The bed was small, but I didn't mind, I was OK with it. I just missed everybody from back home very much, because it's so far… […] A good thing about Val d'Or, it is not that far, there's always people from here that you see, but for Montreal, you hardly get to see anybody. It's just too far... to drive or to… (AQ, mother of three children; the birth she is referring to took place at the beginning of the 2010s, and the interview in 2013.)

Missing and worrying about their children is one of the most difficult challenges for women who already have young children and have to leave them behind. When mothers are away, children most often stay with the grandparents or extended family, and sometimes siblings are placed in different households. If children have to be sent to relatives in other communities, they miss school. Even when kids stayed with family, several mothers said they were worried. One of the main reasons women ask to delay their evacuation dates is that they do not want to leave their children for such a long time:

During your births, where would you leave your kids? Who would take care of them?

> My parents.

Were you still worried about them?

> Yes. That's why I asked if I could leave a bit later instead of early and I wouldn't leave the kids that long. (CE 2013)

Not all women necessarily worried about their children being in their grandparents' care, but it did not stop them from missing their children greatly.

Separation is not easy for children either. CK remembered asking her youngest daughter if she wanted another sibling and that was her daughter's reply: "No! They gonna take you away to Val d'Or!" (CK 2013). The current evacuation system has no place for children in birth. CL remembered that her stepson was very excited about having a sibling and wanted to participate in the process as much as possible and leave with his stepmother to wait for his sibling to be born; CL had to explain him that it was impossible:

> My partner, when I was pregnant, he had a son, an older son, that we were raising together. And he was so excited about the baby, he wanted to be at the hospital, but I had to tell him, "I really cannot take you with me, because I am going to Val d'Or. How am I going to pay for that extra seat, the plane ticket, what's going to happen to you when I go into labour, nobody will be to watch you over there..." (CL 2013)

In 2014, Tracy, one of the four CHRs at the Awash department, confirmed that some women want to take their children with them, but she advises them against it, unless they have a babysitter with them: "Some of them want their kids there. But we keep telling them, "You can't have your kids there unless you have the sitter. You can't take your child to the emergency, who's gonna watch your child?" AQ, a mother of three, suggested that having family homes in Val d'Or and Montreal, where everybody would be welcome to visit and where women could bring their children, would be a good solution:

> Do you have a sense what is the biggest issue for mothers when talking about evacuation? Or is it usually fine?
>
> > I think it's when we leave home... Because we don't have an escort right away. We only have it one week before the due date. The Cree Health Board pays only for one week. But for some people, they have to stay longer and they don't have an escort. And it feels lonely; you miss everybody back home, especially if you have children. That's I would say is the hardest, leaving your kids. It is a big issue. One thing they could do is build a house or buy a house in Val d'Or where you going to have your babies, where people could come visit you, because in these boarding homes you have to share a room with somebody... You don't always have your own space.
>
> So ideally women would like to move their families over there?
>
> > Yeah! To have your family there with you, you know... There is one lady that gave birth and she has four daughters and they are teenagers, and she requested that they all be there when she delivered, because she does not want her kids to be young mothers. And I thought that is such a good idea, especially if you have four daughters. And that's what she did, she had all her four daughters there, when she delivered.
>
> The Cree Health Board does not pay for that?
>
> > No. It just pays for one. So, it is expensive if you do bring your family. (AQ 2013)

AQ implied that for women it is not only hard to leave their children, but that they also want their children to participate in birth, to see birth and to learn from the experience about birth, and about what it takes to have a child. Family members and community seeing and participating in birth was an essential part of Cree birthing practices in the bush (for birthing practices in the bush, see Chapter 5; for current Cree birthing practices, see Chapter 8).

Separation from children and families during evacuation is also a reason why women want to have local birthing centres. I asked CQ whether she thought birthing centres in Cree communities would be a good idea. She responded, "It would be easier, you wouldn't have to be away from your kids and your family. That's the hardest part, leaving your kids behind. […] I had hard time. I was medevaced. It was too sudden for me, I even didn't have time to say bye to my son. I think it would be easier if we'd have birthing centres. (CQ 2013)

On top of being lonely and missing their families and children, women said they often feel bored because, "There is nothing to do in Val d'Or." Waiting may often go hand-in-hand with boredom. Coleman suggests that while waiting is an activity, boredom is a state (2018:47). Various research suggests different descriptions and definitions of boredom (Gerritsen et al. 2014; Danckert et al. 2018; Eastwood et al. 2012; Nederkoorn et al. 2016). Generally, boredom is described as an emotion that signals dissatisfaction with whatever lies in front of us as options of engagement; at the same time, boredom can be a drive to find some satisfying activity (Danckert et al. 2018). Researchers have associated the state of boredom with stress (Thackray 1981, Mains 2007), anxiety, depression (Mains 2007), hyperactivity and different impulsive behaviours like gambling, overeating (Havermans et al. 2015), alcohol, drug use (Gerritsen et al. 2014), and even self-inflicting pain (Nederkoorn et al. 2016, Wilson et al. 2014). On the other hand, boredom can also evoke creativity (Janeja and Bandak 2018:20). The two major factors that are most often referenced in causing boredom are monotony (nothing to do) and constraint (having to do something we do not want to do) (Danckert et al. 2018:108). However, Danckert et al. argue that while monotony and constraint greatly increase the chances of boredom, there is a third factor that is crucial–our ability to formulate an object of desire for engagement (Danckert et al. 2018:108). Boredom becomes problematic only when an individual adopts maladaptive behaviours (like impulsive gambling, overeating or alcohol use) in an attempt to find something satisfying. Thus, there are significant outside factors that increase the occurrence of boredom, like monotony and constraint, and there are personal qualities that enable or disable us to find our ways out of it. Some situations are more challenging than others, and some require more self-control and self-regulation to respond to boredom, to formulate that object of desire for engagement. Pregnant women in evacuation are constrained by several factors: their environment (Val d'Or city, boarding home or friendship centre) and the waiting time (the due date/onset of labour), which rarely can be accurately predicted or controlled. Nearly all women said that there is nothing to do in Val d'Or, which is a description of monotony. Or if

you want to do something interesting, like go to the movies or to eat at a restaurant etc., you need to have the financial means, which not many families have (another constraint).

Expenses, expected and unexpected, were mentioned as an issue by most women. Some arrange to have escorts for the whole period of evacuation, and thus have to pay from their own pockets. But families also mentioned that generally there are a lot more opportunities to spend money down South. There are shopping malls, restaurants, local transportation costs, groceries, medicine, and clothing, which all add up. There are gambling places and easily accessible alcohol[138] on top of loads of free time. Women revealed that some partners or husbands fought their boredom by gambling and drinking, which resulted in considerable financial losses and stress for the families.

7.2.3.2 Embracing the waiting and dealing with the challenges

Whether women like it or not, they have to wait out the evacuation until their baby is born. Eventually, many women take control over the quality of time they have on their hands and find a variety of ways to deal with loneliness, boredom, and financial constraints. One of these is by building a strong supportive community of women. Young mothers and Elders said that mothers have always been taking care of each other when away from home. It is an unwritten rule since the beginning of the evacuation policy. Elder Margaret Mistacheesick briefly remembered her evacuation for birth in the 1970s: "We did not stay in the hospital all the time. There was a home there. Her name was Daisy Gunner. There were other pregnant women there too. When one would get sick (in labour) the others would go visit her. We always took care of each other" (Margaret Mistacheesick, 2013). Her words were echoed by young mother Elizabeth, who said that the same "rule" stands today:

> Even nowadays, if let's say there's a woman there, and she's pregnant, and she's about to deliver, and they [other Cree mothers or Cree patients] are from Wemindji, and they're in the same boarding home, or they know she is there, they're going to go to the delivery room or to go visit her and offer her help or if she has any questions or...

Even if they don't know each other well?

> Yeah. If they know they are from Wemindji, this is what they do.[139] (Elizabeth Shashaweskum Jr., 2013)

[138] Wemindji is a dry community.
[139] For more on community support during evacuation and birth, see 8.3.4 Community support.

Cree mothers spend time together, look out for each other, create bonds and prepare for the births. Sometimes the preparation means shopping together for baby clothing. Other times it is finding a birth companion, or as mothers often refer to the person–a birthing coach. A birthing coach is a person who accompanies a mother to the hospital and assists her during labour. It is especially important for mothers who do not have an escort. Several women told stories of how they found themselves in the role of a birthing coach or how they chose one for themselves while waiting for birth during evacuation. (For more about the birthing coach, see Section 8.3.1 The birthing coach)

One year was particularly special, in that many babies were born to Wemindji mothers, and thus, women were very happy to be waiting for births in evacuation together. CL described the community feel away from home, which made the situation relaxed and pleasant:

> And there was lots of us from Wemindji! There was a baby boom in Wemindji. That year was the biggest population growth. We had 51 kids born that year! I don't know why that was... […] So it was funny, 'cause I knew a lot of women from Wemindji there [in Val d'Or]. And we would all go in the afternoon for walks together with our husbands. There was a place where we could play mini-golf, so we went there, we went bowling together. I mean, it was so boring in Val d'Or, there was nothing to do, so we tried to find different activities to do together. And when somebody didn't show up, we said, "Ah, she went into hospital, it's her turn," you know? "Oh, look, it's her…" There was five of us together, but there was four who were already there, so nine all together. When one would come out, the other one would go in, sometimes two at the same time! Until we got close to our date, there was three of us with the same due date. I don't know… We didn't plan it! Something in the water that year! [laughing] (CN 2013)

Despite complaining of boredom in the evacuation, women at one point or another engage in an active form of waiting, fighting that boredom and trying to find an "object of desire for engagement" in one way or another. As CN mentioned, together with their husbands/partners and fellow mothers, women spend time together, go for walks or bowling. Others go to see places around town or shopping for their baby. Some others engage in the maintenance of the boarding home or doing handicrafts:

> Were there any activities that you could do in town when waiting for birth?
>
> Then, when I was there, nobody told me about anything like that. So I didn't… it was just me and my mom, we would do things, go for walks and go walk somewhere, go shop, it was just… Mostly I did a lot of walking when I was there. (Elizabeth Shashaweskum Jr., 2014)

> I stayed in a foster home, patients' home. And it was really good. Especially the host, I really liked her. […] The food was good and… I was there for a looong time… and I would clean up the place. And she was like "You're at it again?!" She would be so surprised for me doing the dishes. But it made the time go faster! (Charlene, 2014)

> In my time I felt lonely staying over there for two weeks, I couldn't go anywhere like we do around here. You get bored staying in the house when you cannot do your chores and somebody's doing it for you. All I had to do was knit while waiting. (Mary Rose Visitor, Elder, 2014, dir.sp.)

As Rapport (2018:31) has put it: "One develops a habit around certain spaces, certain activities, certain objects, certain accoutrements—a table, a game, a cup of tea, a vest—and that habit delivers a sense of security, certainty, comfort, pleasure, relaxation, recreation." Mothers in the evacuation period try to recreate some of their habits that make them feel at home, such as washing dishes. At the same time, women were creating temporary "homes" for themselves and creating new or altered habits around boarding homes with people who are in a similar situation of waiting. It was been noted elsewhere that waiting and boredom can create novel forms of sociality, rituals and gendered sociabilites (Janeja and Bandak 2018; Jeffrey 2010). Similarly, expectant Cree mothers in evacuation create a social support system within its own rituals to overcome the passing of time away from home.

Some mothers plan their evacuation well ahead of time to make their evacuations less lonely, boring or stressful. They might bring an escort for the whole period of their evacuation, which means they have to cover lodging and meals for the escort until one week before their due date; after that the escort's expenses are covered by Cree Patient Services. It was CL's first birth and she wanted to have somebody with her all the time. She saved money and asked her grandmother to come with her:

Did you have an escort with you all the time?

> Well, yeah, I did a little planning. [child's name] father… we knew that because of my due date, which was in August, and with his work schedule, he wouldn't be available to come with me. So we planned that my grandmother would be my escort. Because at the time she was the one very supportive, cause of the strained relationship with my parents. She came with me right when I left. I was maybe 38 weeks and 5 days. […]

And all your trip, was it covered by Cree Health Board?

> Mhm. Well, for the escort, when I asked if she could leave the same day that I left, they (the CPS) said yeah, they would pay her travel for her to fly out. But the boarding expenses, I had to pay. They told me they cover only seven days before the due date. That's when they would start paying. Because that's how they do it. The escort only flies out a week before the due date.

Was it very expensive, her boarding?

> Yeah, a bit. But I knew I wanted her to come with me right away, so I saved up for it and I was able to pay. (CL 2013)

In one exceptional case, a family saved for their own accommodations in Val d'Or, turning the last weeks of their pregnancy into a family holiday. They rented an apartment for the summer in Val d'Or and the father of the baby took parental leave from his job. All was thought through and planned thoroughly:

> So I went at the end of May to Val d'Or. My due date was mid-June... After one week, my husband came to join me. He had leave from work, parental leave. And that summer, that month, we were in Val d'Or. We rented an apartment from one of my aunts. It was empty. Otherwise, I had to stay in a home with other patients, boarding house.

Did you have to cover the rent yourself?

> Yes. If I went on my own, I had to cover it myself, so that's what I did, I paid her rent for that unit instead of staying in a crowded house with other women, other people waiting for… you know. And if you're there [in boarding homes], you don't have privacy, often you have to share your room with somebody you don't know–I actually wanted to have a relaxed time during the last weeks of my pregnancy. (CN 2013)

Many women recognize that the evacuation puts financial constraints on the family. Some women, when in Val d'Or, save money by walking places instead of taking public transportation. Several admitted that when they went into labour they did not have money to pay the taxi, so they walked to the hospital.

The waiting period sometimes becomes particularly worrisome for women—in a few cases, partners engage in gambling and/or drinking while waiting in Val d'Or—such behaviour has both emotional and financial consequences for the family. In those cases, women find different ways to deal with the issue. One of the mothers said she requested her partner to leave, which he did:

> During all those two months, did you have somebody with you at some point? An escort?
>
> > I had my boyfriend with me. For a while, off and on. But I couldn't really relax with him there, and I told him, "It's better if you go home and stay home. It's just gonna cost us too much." And he went back. (2013)

Another mother convinced the Cree Health Board and the medical staff to allow her to birth in Chisasibi,[140] in a dry community, where her husband could not access alcohol and she could stay with her relatives. At the time (the 1990s), only women from Chisasibi were given a choice to birth in the local hospital; therefore, a mother from Wemindji had to put a lot of effort into convincing the Cree Patient Services to allow her to have that option.

In special cases, such as, for example, a complicated birth or a medical condition, the family needs to stay in the hospital or near the hospital for long periods of time. The Wemindji community raises money to support mothers and babies in need. Charlene remembered the community's donations for her when she had to stay in Montreal close to a hospital with her newborn daughter for a few months:

> Cree Patient Services covered everything, but with us buying stuff or using taxi we were running short on money. I called over here [Wemindji, I spoke to my mom 'cause there was a respected Elder here, his name was John Matches […]and I told my mom to speak to him because I wanted help from the community--like for somebody to walk around with the little box and just put some money in there. That's what he [John Matches] spoke on the radio about and that he thought it was a good idea for the community to do that, like to walk around and to take donations. They really wanted me to… they (community) wanted to help. (Charlene, 2014)

Schwartz (1974) distinguishes between two forms of waiting–waiting for and waiting on. Waiting for is to be stuck in a queue where one has little power, for example in bureaucratic processes or institutions (Janeja and Bandak 2018:21). Similarly, women in evacuation are waiting in the boarding homes and usually have little power over the place and time of their waiting; therefore, they mostly wait for the birth and the time they can go back home. Waiting on is choosing when to wait and when to act (Janeja and Bandak 2018:21). It is when you can claim your agency and decide to momentarily put aside waiting and when to engage again. The next example shows the extent to which mothers go to fight boredom and to take control over their situation. CS changed her waiting mode from waiting for into waiting on by deciding to self-induce her labour:

> I was sooo tired of waiting for me to go into labour! I went to the pharmacy, I went to buy castor oil and drank the whole bottle!

Were you a full term already? At 40 weeks?

> No, no. I think I was 38, I'm not sure.

[140] This story was from the 1990s when a few births were still happening in the Chisasibi hospital, but services were restricted for women from Chisasibi only.

How did you know about castor oil? Who told you about this?

> My boyfriend heard it from somebody. And we were like, "We should do it, we should do it!"

Did you tell your doctor you did that?

> No!...

So you drank that bottle? And did it start?

> Yeah, my contractions started, and he was born at 3:44 in the morning. (CS 2014)

7.3 In the hospitals: delivery and postpartum stay

Most of the birth stories I collected came from Val d'Or, some from Moose Factory (Ontario) and Montreal hospitals, a few from Chisasibi. The Val d'Or hospital, which is about 855 km south of Wemindji by road, is currently the principal hospital for Cree from Wemindji. If a pregnancy is considered high risk, women are referred to hospitals in Montreal. Elders' stories about hospital births came from Moose Factory because the primary hospital for Wemindji Cree was located there until about 1983. Before 2000, a few births from Wemindji took place in Chisasibi hospital. While Chisasibi women with normal pregnancies could choose to schedule birth in the Chisasibi hospital until 2000, women from Wemindji were referred to Chisasibi only in cases of emergency, or sometimes to be checked after emergency births in the Wemindji clinic. Based on women's stories, I learned that the approach of the professionals to birthing Cree women in Chisasibi was more attentive and personalized than anywhere else. Women who gave birth in Chisasibi were satisfied with the care they received, even though the hospital could not offer epidurals nor perform C-sections. The number of births in the Chisasibi hospital was constantly reduced, and the obstetrics department was eventually closed in 2000.[141]

[141] Throughout the course of my fieldwork I asked medical professionals about the reasons that births were discontinued in the Chisasibi hospital. Some had worked there and attended births. Nobody had a very clear idea about the reasons but gave me several possible explanations: 1) That at that point in time there were only a few permanent physicians at the hospital and many replacement physicians who were very uncomfortable doing births. The permanent physicians were not enough to cover all births taking place in the hospital, thus at some point the hospital decided to send all expectant women to Val d'Or; 2) When family doctors were required to do deliveries, they had to take an extra insurance, which was expensive and so one more inconvenience/deterrence for professionals who were already difficult to convince to come work that far north. and; 3) The third reason mentioned was a lack of resources.

7.3.1 Early births in the hospitals (1965 - 1970s): Elders' experiences and their points of view on the best place for birth

The initial goal of this section was to explore Elders' experiences and views on different locations to birth and to draw conclusions on the best birthing place, according to these Elders. Yet the central point the Elders made was that women should be able to make their own informed decisions about where they want to birth, and thus they have to have choices available to them. They agreed that the "best place" to birth is an individual decision.

These Elders had widely varied memories and experiences, as well as differing individual preferences for the best birthing place. Many Elders experienced births on the land, in the clinic and in the hospital, and their stories conveyed a complex picture–there were many voices among these Elders, but also nuance and variation within each voice. Their experiences of birth differed depending on circumstances. Some Elders felt better giving birth on the land, some others said it was best in the clinic or easier in the hospital. At the same time, Elders distinguished between the realities of the past and the present, identified different advantages and disadvantages of all places, and revealed that the negotiations between birth in the community and the hospital are ongoing. Elders often returned to their thought that nowadays there are doctors who should be consulted when deciding about the birthing place, and that hospitals have a lot of useful technology that was not available back in the day. Again, the Elders' consensus was about the choices that should be provided for women, and that the women themselves are in the best position to make the choice of the best place and ways for their babies to be born.

Elder Dollien Georgekish had ten children. All of them, except two, were born on the land with a midwife. Sarah and I asked her to describe the differences between birth in the bush and in the hospital. She remembered that the births in the hospital took a very long time compared to her other births in the bush:

> I had children born on the land and in the hospital. Two of my children were born off the land. I think it is easier to be born on the land. My daughter Patricia was born in the hospital. I got a needle and it took a very long time for her to be born! Sheryl was another one who took a long time, but they did not give me anything for the birth that time. When you're in the hospital trying to have your baby they move you around. And when you're having your baby on the land, once they tell you where to lay or which way to lay, they don't move you after that.

What do you think of bringing back birth to the community?

> It would be good if the person delivering would be an expert. I guess you have to have a gift to be a midwife… (Dollien Georgekish, Elder, 2013)

Dollien did not reply with a straight yes or no to the question about bringing birth back to the community; rather, she emphasized the need for an expert to be beside the birthing mother. She added that the person assisting not only has to have experience, but also has to have a gift. Dollien's reply reflects the complexity of the current quest to find the most suitable solution for Cree mothers–yes, for her it was easier to birth on the land, but she had an expert beside her, her grandmother, who not only had plenty of experience, but also had a gift for midwifery. Where would you find such an expert today?

Doreen gave birth in Moose Factory hospital in 1969. She did not feel very comfortable over there. Even though her sisters were living in Moose Factory, she was used to living on the land, and all of her previous children had been born in the bush with a midwife:

> Do you remember the first time you gave birth in the hospital? Did you have a choice to stay on the land?
>
> > I did not have a choice to stay. I did not know why they sent me over there when I already had my children delivered here. I felt embarrassed too, because it was a doctor, a man, delivering my daughter. Because all the other times it was a midwife.
>
> Was there anyone from your family with you?
>
> > When I had my children on the land, the Elders were there, but when I was in the hospital, I did not have anybody. My sisters were living over there. They weren't beside me when I delivered, but they came to visit me in the hospital.
>
> How long did you stay at the hospital?
>
> > I am not sure, but I think about a week.
>
> How long were you away from home?
>
> > I left here in February and I came home in March.
>
> What do you think is the difference between hospital birth and birth in the bush?
>
> > When a woman had a baby in the bush, she was not allowed to get up right away, maybe for about a week, and in the hospital they make you get up very soon.
>
> What do you think about bringing back birth to the community?
>
> > It would be good to bring back the birth, but it would not be me delivering the babies! [laughing] I think that would work, but then we do not know, some

> women tend not to listen… Women used to deliver well when they listened and when they did not use anything.
>
> Where did you prefer to give birth?
>
> It was best when midwifes delivered the babies. (Doreen Georgekish, Elder, 2013)

Childbirth in the bush was a collective family and community experience, but women and their babies shared the main responsibility in birthing. Women were in charge of their own labour process and birth environment. The birthing mother would choose her midwife, and would tell people to come and to leave if they made her feel uncomfortable or annoyed. Community, family and midwife were there to support the mother and the baby in their choices. In the hospital, the main responsibility is assumed by medical professionals and it is they who strive to control the labour process and environment. In the technocratic birth model (Davis-Floyd 2001), the woman's and baby's roles are greatly diminished; women are often not listened to, nor heard. Doreen, after giving birth to her children in the bush, was suddenly stripped of her responsibility and considered incompetent in birthing, even though she knew she could do it well on her own, because she had done it before: "I did not know why they sent me over there, when I already had my children delivered here [in the bush]." At the same time, there is an underlying recognition that what was back then in the bush is not the same today. As Doreen noted, "It was best when midwives delivered the babies," but she recognized that life has changed since then.

Elder Minnie Shashaweskum gave birth in the hospital in the 1970s. After giving birth to her children in the bush in the 1950s and in the clinic in the 1960s, she found herself in a similar situation as Doreen, where her competence and knowledge of birth were disregarded. The responsibility was assumed by the medical staff, who did not listen to Minnie:

> When in Moose Factory, I stayed at my relatives.' I knew I was gonna have my baby soon and I told them. The ambulance came to get me to the hospital, to pick me up. But the doctor said I was not ready, even though I knew I was ready, because I had children before! They checked me in the delivery room, and said I'm not ready. They brought me back to my room. I kept saying I am ready to give birth. They brought me back again to delivery room to check, and again they said I was not ready. And surely I delivered my baby in my room! [giggles]
>
> Were you worried at all during delivery?
>
> No. I knew that the Almighty was watching over me.
>
> Where did you feel best to birth?

I did not mind any place.

Would it be good to bring back birth to the community?

It would be OK. I'm sure somebody could do the midwife work. (Minnie Shashaweskum, Elder, 2013)

Minnie knew her baby was ready to be born, even though the doctors were telling her the opposite. Elder Dollien Georgekish confirmed that the mother knows when it's time, and that she should help her baby to be born when it's ready; in describing the advice she would give to young mothers during birth, she said, "I would tell them to try to help their child to be born when it is ready. They would know when the baby is ready to be born, and that is when they should help the baby" (Dollien Georgekish, Elder, 2013). Here we return to the Cree Elder's view that it is the responsibility of both the mother and the baby to manage delivery. The mother and the baby are an intimate team, where both are working hard to help each other during birth, and they are in charge of labour—the mother helps out the baby, and the baby helps out the mother. This is one reason why it is extremely difficult when there is a miscarriage or a stillbirth, because the baby is not doing its part, the mother has to take over:

> When the baby is fully grown or almost, and a woman miscarries, midwives say that it is more difficult for a woman. The baby can't move, that is why it is hard. It does not find its way. The healthy baby helps the mother to give birth. (…) My mother told me that a woman loses more blood during miscarriage than during birth. It is pretty hard for a woman to go through miscarriage. (Mary Ruth Georgekish, Elder, 2013)

In the hospital, the tight connection and collaboration between the mother and the baby were disregarded, as the medical staff members assumed that they were in control of births and women's bodies. Women who had already delivered babies in the bush knew their bodies and how to birth, and mostly continued doing what they had to do, sometimes feeling indifferent to the place of delivery. They concentrated on the birth, their body signs and the baby - no matter the surroundings. As Elder Minnie said, she did not mind any place to birth, because, I assume, she was self-reliant and self-sufficient in birth. Even if the "intimate strangers" (Davis-Floyd and Cheyney 2009)–the biomedical staff around her–did not know what to do, she did. Over time, for many women, the medicalization of birth resulted in being less knowledgeable about their bodies, and less sensitive towards the signs their body gives them. This might be one of the reasons why some women are not aware of their pregnancies.

Elder Mary Rose did not give birth in the bush herself, but she delivered her baby in Wemindji with a midwife at her parents' place, and she was present at births in the bush as a child. She said that it was OK for her to birth at the hospital because she already knew some

people there; she had worked in Moose Factory hospital, so she was familiar with her birthing environment and had some of her family in town:

> My first baby was born in 1968. I had him in Moose Factory. They usually sent people early, two weeks early. Especially with the first child. And it took about four days in labour! He was 10 pounds! I guess that's why... I stayed in the hospital for over ten days, because I had stitches and they infected.[142] They didn't let me out of the hospital until completely healed. I stayed with… my grandmother was staying in Moose Factory with my aunt. My aunt worked in Moose Factory.

How did you feel in the hospital?

> It was OK, because I knew most of the people that worked there. I worked there before. The other babies were born the same place, in Moose Factory. Only one-- we stayed in Montreal, my husband was working there.

Did you prefer one hospital over the other?

> No. (Mary Rose Matches, Elder, 2014)

Often the waiting times of the evacuation and postpartum period in the hospital were more stressful and lonelier for Elders than the birth itself. Later in the interview, I asked Mary Rose if it would be a good idea to have a birthing centre in the community; she replied, "Yeah. In my time I felt lonely staying over there for two weeks, I couldn't go anywhere like we do around here. You get bored staying in the house when you cannot do your chores and somebody's doing it for you. All I had to do was knit while waiting. (Mary Rose Matches, Elder, 2014). Even though Mary Rose had some family in Moose Factory and she knew the hospital and some staff members and said she was OK to give birth there, she admits that she felt lonely, and that it would be a good idea to have a birthing centre close to home.

In reference to the emphasis on women's individual birthplace choices, Elder Margaret Mistacheesick said that there are advantages and disadvantages in the bush and in the hospital; therefore, women should have choice and they would know best what they and their baby need:

What about the hospital? Did you have any family there?

> There were no relatives there, only a doctor who delivered. My son was born on May 10th and I left home in April. (…) We did not stay in the hospital all the time. There was a home there. Her name was Daisy Gunner. There were other pregnant women there too. When one would get sick [go into labour] the others

[142] The stitches for perineal tearing during birth.

> would go visit her. We took care of each other. There were Cree women from all over James Bay.

What would be the difference between the bush and the hospital birth?

> It was harder in the bush to deliver compared to the hospital. They have things to use in the hospital. Even in the bush they had things to use though... When the woman is ready to come home from the hospital, they gave you some stuff too.[143]

Do you think it would be good to bring back birth to the community?

> Yes. The woman would know if she wants her baby to be born here or in the hospital. (Margaret Mistacheesick, Elder, midwife, 2013)

Mary Asquabaneskum delivered her children on the land, in the clinic and in the hospital. Sarah asked Mary where preferred to give birth; she replied:

> It is better to have children in the hospital. It is warmer. Long time ago they had babies in the teepee and even once, I heard, the baby was born outside. In the hospital, they have everything to use, in the bush they only had scissors to cut the cord and the string to tie it.

What do you think of bringing back birth to the community?

> I would not think anything about it. It would not be me delivering the baby! (Mary Asquabaneskum, Elder, 2013)

Daisy Atsynia Sr. had her two children in the bush. She never delivered in the hospital, but she thinks that today it is easier for women: "It is easier when they have babies in the hospital today, because we did not have anything what doctors are using now. It would be

[143] Sarah explained that earlier they would provide baby items in the hospital to departing mothers. Currently a "baby-boxes" program is starting to be implemented by two groups (https://babyboxcanada.org/ and http://www.babyboxco.com/) in Canada. They claim to follow Finland's example of providing baby-boxes, implemented in the 1930s and still ongoing. However, the feedback on the Canadian initiative is controversial, since it is sponsored by different companies who are able to advertise their products through give-a-ways. The Finish program was started years ago in order to prevent complications and mortality in childbirth and postpartum, and to support women and families in difficult situations: http://www.theglobeandmail.com/life/health-and-fitness/health/canadas-baby-boxes-wont-bring-pregnant-women-into-health-care-system/article30105424/ In Finland, mothers today are provided with a box in which babies can sleep, including the bedding and a mattress. The content of the box consists of many different items for the newborn and the mother - bodysuits, a sleeping bag, outdoor gear (snowsuit, mittens, warm bonnet, etc.), bathing products for the baby, personal care items for the mother and the baby (bra pads, nail scissors, toothbrush, digital thermometre, nipple cream, condoms, lubricant, sanitary towels, bath thermometre, hairbrush) nappies, a hooded bath towel, wash cloth, muslin squares, a picture book, teething toy, etc. The companies can submit the newborn items to government officials who test and evaluate them, and the program does not accept corporate sponsorship. The program is seen as a symbolic investment in the future of children. https://www.kela.fi/web/en/maternity-package-2018 The two organizations in Canada offer a box with different newborn products depending on the many different companies who sponsor the program.

difficult to bring back birth to the community… For some people it would be very difficult to stand the pain." (Daisy Atsynia Sr., Elder, 2013)

In the late 1980s and early 1990s, Inuit women in northern Quebec, were raising their voices about childbirth evacuation and were advocating strongly for local birthing centres. They were saying that living up North always involves certain risks, which are a part of Inuit life, and that they were ready to accept those risks, including the unpredictability of childbirth outcomes, because that was how their babies had been born since time immemorial (Kaufert and O'Neil 1993). Inuit of Puvurnituq were successful in achieving this goal of "re-matriating" birth.[144] After decades of evacuation policies, and realizing that outside care providers always leave at some point, Inuit created a maternity centre and brought in a US-trained professional homebirth midwife, Jennie Stonier, to train local Inuit to become professional midwives. They chose a homebirth midwife as their teacher because they understood that their new local midwives would have to have all the skills required to attend out-of-hospital births, as "the Maternity" does not have caesarean capabilities. Should a C-section be needed, it can take two-to-eight hours to fly a labouring woman to a southern hospital.

Despite this risk, the Puvirnituq Maternity has been running successfully for over two decades and its statistical outcomes, which are closely tracked, are consistently very good. The Puvirnituq model is now spreading across the Nunavik region. These communities largely agreed that birthing on their own land in their own communities reflects and strengthens their core values. They consider that overall gain to be worth more than the (rare) loss of a mother's or a baby's life (Daviss 1997). In a recent chapter, "To Bring Back Birth Is to Bring Back Life: The Nunavik Story" (Epoo, Moorehouse, Tayara, Stonier and Daviss 2018) Inuit midwives of Puvirnituq describe their maternity care program and the pride they take in creating and maintaining it in their own words.

Today, Cree do not say that they are ready to embrace biomedical risks when there is a possibility of birthing in the southern hospitals with the latest technologies in place and the staff competent to deal with complications. Cree Elders are aware of several biomedical risks and conditions that could interfere with a "normal" pace of childbirth, such as diabetes, breech babies, gestational diabetes, postpartum bleeding, addiction issues, etc. Yet at the same time, many would like to see babies born in the community surrounded by their families.

[144] The Rankin Inlet Birthing Centre and Innuulitsivik Health Centre.

In sum, there were not only varying preferences for birth place among Cree Elders, but also nuance and variation within each voice. If at one point an Elder would talk about the bush and say that home is the best place to be born, a few minutes later she'd say that the birth should be "safe" in accordance with current biomedical standards. This excerpt from the interview with Elder Elizabeth Shashaweskum demonstrates the complexity of Elders' views:

What do you think of bringing back birth to the community?

> I would suggest that the doctor should examine the women fully and if she is healthy to have her baby in the community. Some women have diabetes, that's why I said that. She needs to be examined by the doctor first. When a woman has diabetes, sometimes she loses a lot of blood. If the woman were not diabetic, it would be good if she could deliver her baby here, but if she were diabetic, it would be hard. They might not know what to do here. (…)

At the end of the interview Sarah asked Elizabeth one last question 'Is there anything more you want to say about birth?' Elizabeth thought for a while and then replied:

> They should really think of having birth back over here. Here at home. The doctor has to make sure that the woman is healthy and the baby is gonna be healthy, and that she is not diabetic, and both are doing well. Then she should try to have baby in the community, and to make sure that the doctor is nearby. (Elizabeth Shashaweskum, Elder, 2013)

Apparently, more risk-averse than Inuit of Nunavik, Cree Elders approach the birthing place decision with caution. They perceive birth as a complex and individual experience. As Elder Winnie Asquabaneskum said, "It would not be me delivering the baby!"– assuming that every woman has to decide for herself. On the one hand, Elders would like to see babies born in Wemindji—to come and watch, support and participate; on the other, many rely on the current biomedical standards of safety and so on the discourse of biomedical risks. Risk is not a static objective phenomenon; it is continuously constructed and negotiated (Lupton 2013:44), as we clearly see in the replies of Wemindji Elders, where they continuously negotiate the best place and ways to birth as their and their community's life circumstances change. The recognition of changed circumstances today, from the days when babies were born in the bush, is reflected in every interview we conducted with Elders. No matter how much longing and attachment they have for the old days or ways, they believe that women today should have all available resources to make their own informed decisions and choices in birth, including Indigenous and biomedical knowledge, local birthing centres, hospitals and biomedical technologies.

7.3.2 Common issues women faced in the hospitals

Despite the wide variabilities in women's hospital birth experiences, rarely did I hear a hospital birth story that did not include some misunderstandings or issues that left women in disappointment or sometimes even distress. Only a few stories stood out as issue-free, happy birth experiences. Significantly, positive birth stories differed from the rest in that the women had their family nearby and the staff paid attention to those women's needs, communicated with them, and accommodated them accordingly.

The main issues that stood out in the interviews about hospital births centred around disrespectful and patronizing behaviour of the staff towards women and their families, as well as a lack of communication or miscommunication. Some women felt they were pressured into different medical interventions and procedures or, were not really sure why certain procedures and interventions were necessary. In this part of my work I particularly look into cases of epidurals and C-sections. Nevertheless, nearly all mothers and their partners/escorts expressed appreciation for the biomedical staff's knowledge and skills. Women tended to trust professionals and rely on them more so during labouring and birthing than during the postpartum stay at the hospital.

The postnatal period in the hospital presented its own issues for women. Most of the mothers I spoke with were eager to leave the hospital as soon as possible. Yet, often the medical personnel would make them stay for a few days by refusing to discharge them. The same issues of disrespect and miscommunication manifested strongly during the postpartum stay. Staff did not explain why they were to stay in the hospital; mothers felt they lacked support or that the support they received was inadequate. Several mentioned that the staff insisted on baby formula feeding and disrespected their breastfeeding choice. Some spoke about not being able to sleep or relax because of too many people and too much noise in the postpartum rooms, as well as frequent disturbances for various tests and exams. Women also mentioned hospital food, describing it as tasteless, often looking not fresh, and as always the same or unappetizing. The interviews revealed that Cree mothers felt more confident during the postpartum stay and confronted the staff more often in comparison to their labouring and birthing experiences, when women relied more on the medical staff's recommendations and authority.

I asked some nurses at the Awash department in Wemindji what they were hearing from the women about their hospital births. The nurses' replies confirmed women stories:

> A lot of our pregnant ladies when they came back from Val d'Or were upset of how the delivery went. That was a common occurrence... […]

What were the most common reasons, why women were not happy about their delivery experiences?

> From one, what they said is that they didn't feel that the team was very nice to them, that they didn't accept their family. That they felt they were pushed around. And the other thing is they were given Depo-Provera without their consent. It's the shot for birth control.

What about breastfeeding?

> Oh yeah, that's the other one. They felt that they were pushing a lot for formula, not breastfeeding. So that was the main concern as well, 'cause here . . . we're very pro-breastfeeding, but then over there they are not, they give the formula right away. Like it would be easier, that kind of thing… (Nurse at the Wemindji clinic, 2014).

7.3.2.1 Health care models and the prevailing approach to childbirth in Val d'Or hospital

There are three basic health care paradigms identified by Davis-Floyd (2001, 2003, 2018a, 2018b): the technocratic, humanistic and holistic models, all of which greatly influence childbirth and perinatal care. According to Davis-Floyd, technocratic healthcare reflects society's deeply held belief that technology indicates progress and is a tool to control nature. The main value underlying the technocratic paradigm of medicine is separation. It is assumed that issues are better understood and more efficiently solved when they are separated from the larger context. Therefore, in childbirth, the mother's body is separated from her mind or her surroundings; the distinct parts of her body can be manipulated and "repaired" as it becomes necessary. In the technocratic model, bodies are viewed as machines and birth is seen as a mechanical manufacturing process that should proceed according to strictly established standards and it can be "repaired" or altered if it deviates from that standard. In technocratic care, biomedical professionals assume the sole authority and responsibility in delivering the baby.

The humanistic approach is the middle ground between the technocratic and holistic models of care. It arose in reaction to technocratic model in an effort to humanize health care. The humanistic model stresses the importance of the caregiver and client relationship and strives to provide individually responsive and companionate care while using biomedical technologies available at the hospitals. In this model, decision-making and responsibility of

the delivery of the baby is shared between the mother and the professional. Humanism in childbirth recognizes that women's emotions during labour can affect the progress and the outcome of birth; thus, humanistic professionals tend to listen to women's needs and are open to alternative childbirth methods if they are in line with their biomedical knowledge and practice. The mother's body is regarded as an organism - integrating body, mind, and emotions—a view that can positively affect the outcome of birth. In the humanistic model, the mother and the professional are a team and share the responsibility in delivering the baby (Davis-Floyd 2001, 2003, 2018a, 2018b).

The holistic care paradigm emphasizes the oneness of the body and mind, meaning that there is no body separate from the mind, it is one entity. That "bodymind" entity is seen as an energy system. Not only does a holistic approach emphasizes the oneness of the "bodymind," it also affirms the unity of the practitioner and the client–"the observer and the observed are not separate, but are energy fields in constant interaction with each other" (Davies-Floyd 2001:S17). Primary authority and responsibility lies with the client, who is considered the protagonist of her birth in both the humanistic and holistic paradigms; the practitioner is a team member. Midwives and birth professionals with holistic approaches seek to work with "the energy" during birth, which means they try to feel how best they can empower birthing woman, to make her most comfortable and most able to give all her powerful energy to birthing. The holistic approach encompasses a variety of healing modalities, such as Chinese medicine, naturopathy, acupuncture, homeopathy, etc. The holistic model minimizes but does not reject the use of high technology and its practitioners employ it when an individual need arises (Davies-Floyd 2001, 2003, 2018a, 2018b).

Out of the three ideologies of health care described by Davis-Floyd, the holistic approach is the one that corresponds best with Cree beliefs about health, health care and healing. According to Adelson (2006), from a Cree perspective, miyupimaatisiiun (health) or "being alive well" "has as much to do with social relations, land, and cultural identity as it does with individual physiology" (2006:3). Thus, "being alive well" or being healthy is a holistic concept in its broadest sense. Good healthy pregnancy and birth derive from the holistic Cree paradigm of miyupimaatisiiun. As a result, the environment, including surroundings (land/clinic/hospital/room), the participants in birth (midwife/practitioner/family/friends), the language spoken (Cree/English/French), the food provided (Cree bush food/non-Cree food) all greatly matter to the birthing mother. The quality of environmental factors determine what obstetrician Ricardo Jones (2009) calls the

psychosphere of birth, affecting emotional safety and comfort levels, and influencing the outcome of birth and its aftermath. In the bush, all responsibility to deliver the baby lay with the mother and her baby. As in the holistic model of care, the Cree midwife was just one member of a large supporting team (family and community). The mother was the main decision-maker about her environment during birth - and was able, as we have seen, to request a certain midwife and to say who should come and who should go. The mother's control of the birth environment and the birthing space echoes the main principle of oneness and connectedness of the holistic paradigm, which defines the "bodymind" as an energy system in a constant interaction with all the other birth participants.

The two examples below show two different models of care experienced by a Cree mother CN during her hospital births in Chisasibi and Val d'Or. The two experiences in different places allowed CN to clearly distinguish between the two models of care. She indicated that the Chisasibi hospital's staff had a humanistic approach to childbirth, while Val d'Or hospital was clearly technocratic.

> Chisasibi
> They told me that it was gonna be a little bit hard [to push the baby], because of the way the baby was positioned. She was upside down, her head was down, but her back was the other way around, so it was pushing the wrong way on my pelvis. So they told me, "It's taking too long like this." So they pushed me on the side and they said, "There's a reason why animals give birth like this, because it's easier, so don't worry about this,"and it's true--I was on my side and it was a lot easier to push down. (…) I had my aunt standing in front of me so she was holding one of my legs and the other one I was pushing against the bar and so I had… my doctor was there, and she had a resident doctor, a doctor that was in training, and… it was two female doctors, which… I was kinda glad, because I think I would have been nervous my first child with the male doctor.
>
> And I could see my family in the window and they were smiling and they didn't look worried, so that helped me focus. I think my mom was kinda scared, because she wasn't sure if there was something wrong when they pushed me on the side. So they took the time to explain it to her too, that sometimes it's a lot easier like this and it doesn't always has to be one position to give birth.
>
> Within thirty minutes she was born and it was like a big relief. She [the doctor] told me that I had to wait. She kept rubbing my belly and I keep thinking, "It's OK it's OK, my baby is born, now they are cleaning her." She [the baby] was crying, I was crying, they were getting ready for my husband to cut the cord… (…) and the doctor said, "We gonna take care of the baby and I'm also gonna take care of you,"so I said OK, and then she started rubbing me on my belly and she said, "You gonna feel something you gonna need to bring back." It was the placenta, it

was still not coming out. And in my mind I'm like, "What?! What is coming out?" I didn't understand.

Cause you didn't know about the placenta?

Yeah, I thought maybe… you know when you have your period and there's some blood clot, I thought this is what she meant. And then, I felt it like... she said, "You can push if you feel, it's going to help," because I wasn't frozen, I didn't have an epidural, I could completely feel it detach and come out. And it did, and she says, "Do you want to see it?" And my mom said, "No!" And I said, "Yeah!" I wanted to see how it was. So she had it [the placenta] in her hand, it was like a football or a brain. So she stuck her hand in it and she went like that and she said, "You see this is the bag where your baby was in," and she said, "See on this side it's rough and the inside is smooth, this is where the baby was, it's on the smooth side." So it was nice she showed it to me and explained it to me. My husband and I were looking at it and I said, "Well, what do you do with that?" And she said, "We send a piece to the laboratory just to make sure everything is ok, and the rest is incinerated." I said, "OK." I was really glad she took the time to explain it!

And she said, "I'm just going to make sure that everything is OK, I'm going to check you inside to make sure everything came out," so she did. She said, "I'm going to freeze you now. . . I need to give you three stitches." She said, "I didn't have to cut a lot, but I had to cut you." And it was very nice, cause it felt that she was not in a rush, she took the time and explained everything. And out of my four kids that's the only time that ever happened. And this was when we were in Chisasibi (CN 2013; she gave birth in the Chisasibi hospital in the beginning of the 1990s).

Val d'Or

So it was my husband, two nurses and the doctor and… at the hospital they were very professional, very kind to us, but what I noticed was--I felt very rushed, like we had to hurry up and no time to waste. It wasn't as caring and talking to and calming as my other experience, it felt very… They were very professional, very good, you know at their job, but it was very clinical, very not personal. I think it was because he [the doctor] was so busy with all these babies; for him it was just another birth, just another routine, but for us it was so special, you know, to have our baby born and it was a boy and we were just so happy, cause everything was OK, he was OK, he was fine and they did those tests, the Apgar, he was at a ten… But for the staff there, I could tell for them that there's somebody else waiting that needs their attention too. So that's why in the hospital like that it felt like cattle--one after another. (…)

Was it mostly French speaking-staff?

Yeah. Because I could speak French, I could understand and respond, but for my husband--he didn't speak it, so I had to tell him what they were telling me and because of the suddenness… they thought they were going to go on the shift change at midnight and I was right in the middle of giving birth when they wanted to do a shift change, so I could tell and I could feel that it was maybe inconvenient for them, you know, the rushing… that's why they were rushing maybe. And they

> really wanted to help the baby out, I said, "No, just give me time to push." It was like, "Is the baby stuck?…" And I felt that that's why he did the episiotomy this time, when they cut a little, because all I needed was two stitches after. (CN 2014, gave birth in Val d'Or hospital in the 2000s).

In Chisasibi, CN felt the doctor's and staff's personal concern and care towards her, her family and her baby. She felt listened and heard. The staff in Val d'Or put pressure to rush the birth process and did not explain to CN or her husband the interventions or the procedures during birth. In the technocratic care model, the staff assumes the authority and responsibility for births; thus, in Val d'Or they might have not even perceived a need to communicate with the mother. The busy hospital schedule, inconvenient timing and language barrier added to the hastiness of the process. Even though CN recognized that the staff was professional and polite, she felt that it was very clinical and that "it felt like cattle—one after another".

Although women's experiences varied in Val d'Or, and some women described practitioners as flexible and accommodating, my interviews about childbirth in Val d'Or suggest that the technocratic model described by CN is the prevailing form of care during childbirth in this hospital.

7.3.2.2 Cases of epidurals

As mentioned above, technocratic practitioners hold the authority and assume sole responsibility for the childbirth process. They decide when and which medical interventions will be used in labour. Even with the same biomedical guidelines and standards, intervention rates vary greatly across the country, as well as from one institution to another (Chalmers et al. 2009; Sadler et al. 2016). Women's stories from the Val d'Or hospital revealed that a number of women experienced pressure from the professional staff to go through certain medical interventions or procedures, which women felt they did not need, did not want or did not receive information about, and thus did not understand their necessity. Women mentioned interventions such as epidural, C-section, induction, episiotomy, continuous fetal monitoring, etc. Some Cree mothers resisted certain interventions during labour and birth, especially if they were more experienced, received advice from their family and/or had continuous support. Some mothers did not know they had other choices or options. Even if we assume that such medical interventions were necessary, the examples below demonstrate that the quality of the interaction and communication between the staff and Cree mothers was lacking or inadequate:

Did they give you any pain medication?

> They gave me epidural.

At what point, do you remember?

> They gave it to me around 4:30pm. I didn't feel anything [she did not have painful contractions], but they kept pushing me. I got so irritated, so I just took it. Even though I was telling them I don't feel my contractions, I don't feel pain and I don't want it, they just... I gave in, 'cause I was so irritated by them. (CQ 2013, gave birth in Val d'Or in 2000s)

Was it difficult? Painful? [talking about labour]

> Yeah… No… I took a needle [epidural].

Did you ask for it or they offered?

> No, they just gave me, because it was too long the labour, they said.

Did they say you should take it because the labour was too long?

> Yes. My water has already broken, it was taking too long, they said.

So they said that the needle will help to speed the labour?

> Yeah... But it didn't! [laughing] (CZ 2014, gave birth in Val d'Or in the 1990s)

Did you have epidural, the painkilling?

> Yeah.

Did they offer or you asked for it?

> I don't remember asking for it, but I was told, "You gonna be more relaxed with this.". And I didn't really know what it was. They made me sit up and they put something in, and after, I didn't feel anything. It wasn't a choice. It was just like... "It's gonna help you relax." (CE 2013, gave birth in Val d'Or in the 2000s)

Epidural anesthesia is a popular pain relief method during childbirth–a medical intervention with both benefits and drawbacks. It can completely or partially reduce labour pains for the mother, yet its side effects include a drop in blood pressure, slowed labour, numbness of the body, difficulty pushing out the baby, and increased possibilities of other interventions like forceps, vacuum extraction, etc. (Chalmers et al. 2009; Zwelling 2008). The World Health Organization (2000) and Health Canada (2000) recommend not to use epidural anesthesia as a

routine pain management method during childbirth. Epidural is recommended to be reserved until all other measures have proved ineffective. The Society of Obstetrics and Gynecologists of Canada (1998) recommends that "Women requesting epidurals should be partners in a thorough discussion of the procedure, its risks and benefits, and the expected outcome" (in Chalmers et al. 2009:15). Based on my interviews with Cree mothers, I find that there was a lack of communication during birth, or that the communication was inadequate. A number of women were left without explanation of the particular reasons for the epidural, its side effects, or alternative pain management options:

> Was your daughter also born without painkillers or did you have a needle?
>
> > They had to give me a needle. I didn't really want it, but the doctor insisted.
>
> Why? What did she say?
>
> > Because I was… I think I was 38 when I had her and doctors thought I was too old … I prefer without it… When they put me on the delivery table my water didn't break yet and the doctor told me that the baby was ready to be born, so he had to break my water. He was standing in front of me and he had some kind of stick and it splashed on him! [laughing] I didn't have any… no pains, I guess it's because they gave me the needle. I didn't have any pains when she came out. They told me to push but it felt like I wasn't pushing, because I was numb.
>
> So you didn't feel your legs, you didn't feel anything?
>
> > I didn't, and I was going like this [showing how she tried to push]. But I could feel when the baby came out! I could feel it! It started to cry. It was kinda… I don't know… It felt weird. All I felt it was coming down and coming out. (AP 2013, gave birth in Val d'Or in the late 1980s)

AP gave birth in the 1980s; however, "being old" has never been an evidence-based medical reason to impose epidural, and especially if the mother did not want one. Knox et al. (2018) looked into why sometimes professionals favour labour with the epidural and why they might insist on it. Sometimes, according to the professionals, an epidural provides a feeling of safety on their parts, in case a woman requires a sudden surgical intervention. Labour without epidural is less predictable and more challenging for the staff and demands more intensive care, more coaching and more presence (Knox et al. 2018). More intensive support conflicts with systemic and organizational barriers and very busy schedules. Sometimes the staff have to care for the very sick, which requires more attention and diverts care from the low-risk birthing women who can be put on an epidural and thus require less personal, hands-on

support and monitoring. The "interventionist," technocratic culture in high-occupation units treating higher-risk clients is another factor in high rates of epidural use. Other reasons mentioned were staff's difficulty in witnessing pain, and thus their urge to offer easy and quick pain relief. At the same time, professionals reported that some units did not have labour support equipment needed for women without epidurals (a portable electronic fetal monitor, baths, birthing chairs or stool), or that the equipment they had was not functioning properly (Knox et al. 2018).

After several stories from women about questionable cases of epidurals in Val d'Or hospital, I asked the nurses at the Wemindji clinic Awash department whether they had heard any complaints from the mothers about forced epidurals. They responded that they had not heard any complaints and/or were quite certain that Cree mothers wanted to have epidurals and usually accepted them without hesitation: "They're all for the epidural. Often, they'll take it–from what I hear. No concerns that were verbalized (Nurse at the Wemindji clinic, 2014).

On the other hand, during my interviews with women, I got the impression that epidural was not taken lightly by many, especially if women were advised by their mothers, grandmothers or their peers. Time after time the chats appeared on Facebook among Wemindji mothers sharing their experience of epidurals and long-lasting back pains after birth, which they often associated with the epidural. Several women I spoke with refused epidural altogether; a few waited until the very last minute when they could no longer stand the pain; others said it was a hard decision to make; and a number took it because they could not stand the pressure from the staff, as described in the quotes above. In one case, a woman revealed that her boyfriend was very annoying during labour, and she could not concentrate. That was the only time out of her five births that she requested an epidural and said that she did not like the experience–she could not feel her contractions or her pushes and she could not control her birth. Sometimes, mothers who had birthed with epidural said they wished to experience birth without it. Below are excerpts from the interviews with women or their escort about their thoughts or experiences on epidurals:

> "What was the whole point of taking that thing?"
> At two o' clock we got to the delivery room and I could not relax, I could not sit down, I could not lie down, I was afraid that something will happen to my body. I was trying to relax, and I couldn't! They told me I was at five centimetres. "Your gonna have your baby at about 7 o'clock in the morning," she said. And my brother and my sister-in-law said, "Just call us when the baby is ready." And at 3:30am I asked for an epidural. Didn't get it until 10 to 4am. After I got an epidural the baby was ready to push. I kept telling them that I could feel the pain like something is moving there, I couldn't explain

it, and they told me not to move and they made me sit like this. And I kept telling doctor, “Can you check me first?” “After epidural,” they kept saying. She didn't check me. After the epidural went in, I didn’t feel anything. At 4:05am she checked me, and she said I was ready to push!

So there was no point in having the epidural?

> Yeah… and I didn't know how to push afterwards. (…) And I kept telling my sister-in-law, “How do I push, how do I push, I can't feel anything anymore?!” And she asked me, “Did you get an epidural?” “Yeah”, I told her. “You won't feel anything then.” And my brother said to me, “What was the whole point of taking that thing?” He said it right in the delivery room [laughing] (CE 2013, gave birth in Val d’Or in the 2010s).

<u>“It took her awhile to decide… But at the end she took it”</u>
Did she get painkillers?

> Yeah, she got epidural.

Do you remember around what time?

> I can’t remember… I was too excited! [laughing]

But was it far in the labour process or was it at once when you came to the hospital?

> I think it was around 8 or 7 pm.

Ok, so it wasn’t at once, it wasn’t that you entered the hospital and she got it.

> Yeah, they wait for you and then they say that they have to give an epidural at a certain time. They can’t do it early, or they can’t do it later.

Did they ask her if she want it or…?

> Yeah, they asked if she wanted it. It took her awhile to answer if she wanted it. Cause she heard of the side effects and what can happen--if they made just a little mistake she could be paralyzed. So it took her awhile to decide if she wanted it or not. But at the end she took it. (BL 2014, brother who escorted his sister to birth to Val d’Or hospital, birth took place in late 2000s)

<u>No to epidural</u>
Did you have painkillers, the needle?

> No, no no no no no. I had no epidural.

Did they ask you if you want one or not?

> Yeah. I said no. [emphasis on ‘no’].

Why did you say no?

> Because I heard horror stories about epidural. [laughing]

From whom?

A lot of people say it hurts when they punch you, give you your needle or… I didn't want it. I didn't want it at all. So it was all natural. He was born drug free. (…) If I'd have a choice, let's say if I had another child and if it was safe for me to deliver naturally, again, I wouldn't go for the epidural (AQ 2013, gave birth in Val d'Or hospital in the early 1990s)

"I did not want it"

> The nurse put a monitor on me, I think this was the worst pain I've ever felt with the third. Cause I remember the doctor told me to walk around to make it faster and I only… the long hallway that I walked I walked once and I came back and I tried to go again but that was the time I felt really really... it hurt!... like I had to [she shows the breathing]... control my breathing and like I was always focused on one thing like, on the wall and counting like to ten. It was sooo painful!

Did they offer you an epidural?

> Yeah, but I didn't…

You said you don't want it?

> Yeah, I did not want it (BA 2013, gave birth in Val d'Or hospital in the early 2010s).

"… because of my mom, she talked to me a lot how the labour is"

> We went to Val d'Or. I had a natural birth too. I didn't have any epidural or…

Do you remember if they offered you an epidural or any other medication for pain?

> Yeah, they offered and I said no. It was probably because of my mom, she talked to me a lot about how the labour is and about delivery, and what to expect, and I also wanted to do it naturally, so I refused. (CW 2014, gave birth in Val d'Or hospital in the late 1990s)

"I kept on remembering what my mom told me"

Was it really painful? Did they give you painkilling?

> I didn't take painkillers. The only thing I took was that mask thing. That's the only thing I took.

Was it laughing gas?

Yeah, some special gas to make me relaxed. That's the only thing I took, I didn't take any…

Did they offer you epidural or anything else?

No.

And you didn't want it?

No.

Was it very painful?

Yeah, it was very painful, she was my first and… of course it was painful! [laughing] But I kept on remembering what my mom told me, like during my pregnancy she told me, "When you get into labour don't cry, 'cause if you cry the pain's going to be worse." That's what she told me, and it was stuck in my head. And I'm glad I didn't cry. But after, when I saw her [her baby], that's when I started crying. It was like after I saw her, all the pain just went away. (CS 2014, gave birth in Val d'Or in the 1990s)

"She told me, "Better to do it natural."
Did you have an epidural?

No, I didn't want it.

You didn't want or they didn't offer?

I don't know if they offered…

But you didn't want it anyways?

No, and I know my mom wasn't really supportive of it. She told me better to do it natural, so I can experience how it really is. (BA 2013, gave birth in Val d'Or hospital in the end of the 1990s)

7.3.2.3 Cases of C-sections

Several Cree mothers I spoke with were suspicious and cautious about C-section cases in Wemindji. Very early on in my study, I heard from some Cree women that C-sections became very common at some point in time for Cree women in Val d'Or hospital. One informant (DC) said she thought they wanted to control Indigenous population growth–that is why they started performing more and more C-sections. DC said some time ago there was a doctor in Val d'Or who would always encourage natural births. He was liked by Cree women and would say that Native women are very good at birth, because they are patient, quiet and

concentrated throughout deliveries; they know how to deliver babies. The doctor who replaced him had a different approach and started performing a lot of C-sections. This was when DC delivered her baby, in early 2000: "I did not like him. He did not talk to me at all [during her hospital labour]. It was difficult when everyone spoke French only. I would request a translator, but they would not find one, and if they did, they still did not speak that good English." The doctor insisted that DC's baby was too big to be born vaginally and they performed a C-section. When, after the birth, DC found out the actual weight of her newborn, she realized that the C-section had been unnecessary because she remembered that her first baby was even bigger and heavier, and she did not require caesarean then. DC added, "Some other woman who gave birth with this doctor were telling me that he wants to cut on Native population, that is why he does C-sections most of the time." (DC 2014, gave birth in Val d'Or hospital in the early 2000s)

Studies suggest that previous caesarean is an important determinant of an overall increase in caesarean rates, because there is a higher possibility of the subsequent births also being caesareans (Vogel et al. 2015; Young et al. 2018). Biomedicine does consider only a limited number of C-sections safe to perform on a woman, and it is a common practice to encourage another C-section after having a prior operation (Lawrence 2010; Feldman et al. 2010), especially when the due date of the following delivery is in less than 18 or 24 months. Cree women are aware of those facts:

> My mom talked a lot about what to expect. I would ask her questions what to expect, how's the delivery, where the women give birth, what do they do, and she would tell me all of those things and… She told me, "Try to have natural birth and also, not to get C-section, because when women tend to get a caesarean they are more likely to get another caesarean when they get another pregnancy" (Elizabeth Shashaweskum Jr., 2014).

There are historical grounds for fearing that White medical personnel have tried to decrease or control the Native population, and people remember. For decades, Canadian policies were aimed at actively assimilating Indigenous people and trying to reduce their numbers:

> It is now clear that the federal agency responsible for the health of Native Americans abused its power to administer policy upon Indian women and used sterilization as a population control measure in the face of the high birth rate of Indian children and the perceived inability of Indian women to use other forms of birth control (Smith cited in Stote 2015).

One of the current stories on the news in Canada in the Fall of 2018 was a class-action lawsuit launched in 2017, in which at least 60 Indigenous women alleged that they underwent forced sterilizations over the past 20 to 25 years in Saskatchewan, the most recent being in 2017 (https://www.cbc.ca/radio/thecurrent/the-current-for-november-13-2018-1.4902679/indigenous-women-kept-from-seeing-their-newborn-babies-until-agreeing-to-sterilization-says-lawyer-1.4902693). Earlier, policies included not only sterilization, but also coercive abortions and indiscriminate prescription of contraceptives (Stote 2015), which medical staff from Wemindji clinic had witnessed recently in Val d'Or hospital as well, where a woman was injected a Depo shot without her consent (see interview in 7.1 Prenatal appointments at the clinic in Wemindji).

It is also true that Iiyiyuuschii is now the region in Quebec with the highest rates of C-section, showing a significant difference from the rest of the province. C-section rates in Iiyiyuuschii increased from 21.3% in 1988-89 to 30% from 1990-1991 to 2014-2015 (an annual average of 98 cases per 328 deliveries). In the same period, the C-section rates in Quebec as a whole increased from 18.5% to 24.1% (MSSS, Med-Écho databases published in the report of SERC team of the Public Health Department, presented in an Annual Assembly in 2016). The WHO states that where C-section rates are substantially higher than 10-15%, the negative reproductive health outcomes may outweigh the benefits (Davis-Floyd et al. 2009). A recent study by Jiangfeng et al. (2014) confirmed that a population-level caesarean section rate above 10–15% is unjustifiable from an evidence-based perspective. Depending primarily on practitioner preference and population risk levels, C-section rates can vary widely among regions and among hospitals. For that reason, Robson (2001) and Robson et al. (2013) suggested that C-section rates should not be considered in isolation from the factors in that particular region or group of people and that: "It is not that a caesarean section rate is high or low but rather whether it is appropriate or not, after considering all the relevant information" (2013:298).

There was no strict consensus among medical staff in the Wemindji clinic about increasing numbers of C-section among Wemindji mothers. Some said that the general trend to perform C-sections is on the rise everywhere and therefore they have also gone up in the region:

> I'm thinking maybe the C-section rate is going up too… A fair number of Cree women end up getting C-sections.

What do you think, why are the numbers high? What is the reason?

> I think it's a general trend everywhere that we'll see. Now they're trying to decrease the rates of caesarean, but there are a number of women here that have really big babies too… (Nurse at Wemindji clinic, 2014)

Others agreed that women could be easily talked into this procedure by professionals, and that sometimes it is more convenient for the doctors to plan a birth than to wait for spontaneous delivery:

> We have quite a lot of women coming back with C-sections… If we're lucky, I'd say 30% had natural birth, but after, there's always the questioning about the hospital, right? Do they do everything that they could for the natural birth to be done? Or do they easily push the mother to have epidural? For instance, let's say a woman starts her labour and she gets the epidural and the labour slows down, right? Then they push with some oxytocin but then the contractions are not normal, they are pushing the baby and the baby's heart goes down and then they say. "Oh, we need to do a C-section", you know…
>
> For many hospitals, many gynaecologists, having labour for 24 hours is way too much. But that is a normal timing of a delivery for a first pregnancy; it is 24 hours. So we shouldn't be all excited after 14 hours that we need to do a C-section! But that's how it is. I'm sure that if we would have some birthing centres here, we would probably have a higher rate of natural births without C-section, and maybe less complications, but if there is emergency that is not related to that, because there is a breach position or a woman has bleeding postpartum… we don't have an operation room accessible in a reasonable time that could be let's say… 30 min. There would be higher risk for some problems, but probably the women would be happier if all goes well. But it is a hard decision to make… (Laura, nurse at Wemindji clinic, 2014)

Laura's observation seconds a very commonly observed pattern of medical interventions in childbirth described by Davis-Floyd (2001): in order to control the childbirth process, professionals use electronic fetal monitoring, which does not allow women to move and at the same time disrupts and slows down the labour. Consequentially, Pitocin[145] is administered to speed up the labour process, and finally epidural, to help women deal with the intense strong pains caused by the Pitocin. This well-known "cascade of interventions" often results in distressed babies and dysfunctional birth that needs a "second punch" of technological interventions in order to save the baby and the mother (episiotomies, forceps, C-sections, etc.) from the negative results of the previous interventions (Davies-Floyd 2001). As a result, what is often perceived as women's bodily dysfunction—yet was caused by medical interventions–often leads to a need for more medical interventions –an iatrogenic[146] effect

[145] Pitocin is a brand name drug. It is the synthetic version of oxytocin, a natural hormone that helps a uterus contract during labour.
[146] Iatrogenesis: disease, illness, or harm that has been caused by medical intervention by medical professionals (Illich 1975); the term comes from the Greek words "physician" *(iatros*) and origins (*genesis*).

caused by the interventions (Davis-Floyd 2001). The stories of two young mothers - CL and AG - exemplify Laura's observations:

CL's birth story

I went to go tell my grandmother, "You know, my water broke, we gonna be going to the hospital sometime today." And because she was a little worried cause the first thing that came was my water, 'cause I didn't have any contractions or anything, she wanted me to go to the hospital, but I was saying, "No no no, I wanna go walk", and she said, "No, I want you to see the doctor." That's why we went. I ended up being admitted. But they wouldn't let me walk around, they left me on the bed. They had me strapped to the fetal monitor.

Did you tell them that you wanted to walk?

Mmhm. They told me no, because they wanted to monitor the baby.

Did they explain why they wanted to monitor the baby?

No. And while I was laying there, because the contractions hadn't started, they gave me medication to start the contractions, and then I had to stay in bed because of my IV. It was through IV.

Did they induce you at once?

No, they waited a bit, maybe an hour, two hours. The contractions slowly started coming more regularly, but I wasn't dilating. When I first went, they told me I was at two, and then after induction and contractions started, they checked–I was at three and I stayed like that for a long time, maybe five hours. Then the doctor came in and they asked me if I wanted to take an epidural, and I said, "No, I am doing very well managing the pain."

Were you feeling fine with those contractions?

Mmhm, and he said, "Well, you know, you are not dilating, baby is not dropping–we think epidural, because the muscles will be more relaxed, the baby will drop and everything will dilate." But it just… I saw it… I said. "Well, OK, I try it." And I took the epidural and after that, nothing progressed–everything stopped, my contractions slowed down... Then that night, maybe about two o'clock in the morning, because nothing was progressing, and the doctor said, even if it did start to progress and that I would went through the vaginal delivery, it would be painful, because it would be a dry birth, because I lost all the water, all the fluid I have lost, he suggested a C-section. So I agreed. Because at this point I was getting tired and not knowing what's going on, and I was really starting to swell up too at my feet, my legs.

I agreed, "I said OK, prep, get it ready." They told me a paediatric nurse will be coming to see me, to go through my birth plan and I had told her that I wanted to exclusively breastfeed, no formula, and she said that with the C-section it would

have been hard for me to start breastfeeding right after the birth. And I said, "Ok, I agree to give the formula, but if you give it, please give it in a cup, no bottle, I don't want him to use the pacifier either." So she explained, "OK well, we'll give the pacifier but just to check the suction.' (CL 2013, gave birth in Val d'Or hospital in the early 2010s).

This is, unfortunately, an often heard hospital birth story; it demonstrates the failure of CL's attendants to practice according to the evidence, which would have required them to send her home until the active phase of labour, defined as starting at 6 cm, kicked in (WHO 2018). An evidence-based perspective shows that she was never really in labour—or rather, was in the "latent" stage of labour, which can safely proceed for many hours or even days until active labour kicks in. The same holds true in the following story:

AG's birth story
And they had to… you know how they make the contractions come harder? That's what they had to do to me, cause I was not feeling my contractions.

So they induced you? Gave you the medicine that makes it go faster and stronger?

Yeah.

When did they do that? Right away or after awhile?

After awhile. Sometime in the afternoon. Cause I was not dilating or anything either.

So you went to the hospital around seven or eight in the morning you said?

Yeah, seven. They told me to walk around for a bit.

And then they induced?

Yeah. So contractions started, and they brought me to the other, to the delivery room, and once contractions started to get stronger I grabbed my husband's hands and I squeezed. His fingers started to go blue, you know, how you… That's what was happening. I could not take it anymore, so I asked for the epidural and it slowed down my dilation. So at 1:41 at night that's when I got the C-section.

Did they tell you why and did they give you options?

Well they asked if I wanted to wait and I was just getting eager to meet my son, so I asked for C-section.

But did they tell you that you could wait or they told you it is better to do a C-section?

> They said it would be better to do a C-section. But I still had the option to wait. (AG 2013, gave birth in Val d'Or hospital in the early 2010s).

There were other examples when women agreed to C-sections, because otherwise, they were told, something might happen to their baby. When BB got to the hospital in the morning, she had already been in labour for several hours. The doctor told her to walk a little, and after a short while she [the doctor] said that a C-section was her best choice. BB strongly suggested that she did not want a C-section, and wanted to continue to labour. But the doctor insisted that it was for the sake of the baby, because the baby might be tired. BB said she did not have a choice, because she did not want anything to happen to her baby:

> […] So she told me, "I think you have to have a C-section, I'm afraid the baby might… what do you call that… the baby might be tired."

Hmm… Because contractions were for a long time?

> Yeah. I had like 14 hours of contractions. So she told me to have a C-section.

Did they check the heart rate or how did they know?

> No. She just said, 'I'm afraid the baby might get tired, so that's why I want to give you a C-section'.

Ok.

> First I didn't want to, but after, I said OK, because I wanted to meet my baby, I didn't want anything to happen to my baby. (BB 2013, gave birth in Val d'Or hospital in the early 2010s).

A long-time nurse who had worked in several Cree communities and hospitals in the area revealed that she knew of cases in which doctors would plan an induction or a C-section because they were going on holiday. She said that C-sections are not cheap, but they are more convenient for sure (from the interview with a nurse at the Wemindji clinic, 2014). A few nurses said they believe C-sections are performed only when necessary and that the numbers were not that high anymore:

> From what I understand they [Val d'Or Hospital] don't offer C-section for nothing. I'd say they have a reason for offering C-section. I think where the problem lies is just the communication. I think that might be the reason, and the women on the other end not understanding, cause "the baby who's tired"… there could be so many reasons – is it because the heart rate dropped, is it because… you know, what's the reason? They didn't understand it for x y z reason probably, maybe because of the barrier of the

> language, I don't know. But from what I hear, they don't offer C-section out of the blue unless it's really needed. Because the risks are a lot higher [with C-section], especially that they're overweight[147], and just the complications of the C-section itself and add the GDM (Gestational Diabetes Mellitus), it just adds to the problem. I highly doubt that it's offered for fun. One must have a good reason for that. (Nurse at Wemindji clinic, 2014)

There is no agreement in the literature about the underlying causes of generally rising C-section rates worldwide, and this "caesarean epidemic" has become a major and controversial public health concern (Betrán et al. 2018, Barčaitė et al. 2015, Davis-Floyd 2009). Different researchers talk about various causes for increased rates of C-section deliveries. Jiangfeng et al. (2014) says that some of those factors can be notable changes in society where mothers are becoming older and there is an increased prevalence of obesity in many parts of the world. As mentioned earlier, previous C-sections increase the number of women who have to choose between another C-section and VBAC (vaginal birth after C-section), and thus increase the number of elective C-sections (Young et al. 2018; Vogel et al. 2015; Barčaitė et al. 2015). There is some research demonstrating that even if C-sections are costly, they are more convenient for the biomedical staff, easier to plan and requires less time than a vaginal spontaneous delivery (Jiangfeng et all 2014). Also, different medical institutions - as well as medical professionals - have different practices in management of spontaneous labour, with some using more medical interventions than others. Some researchers have demonstrated that generally unnecessary medical interventions in childbirth are performed more often on vulnerable populations–for example, less educated, low-income women or teenage mothers (Chalmers 2011:280). Others, however, show that C-sections are performed more often in private facilities and thus among more educated and high-income women who request a procedure for various non-medical reasons (fear of labour pains, fear of pelvic floor damage, urinary incontinence, reduced quality of sexual functioning, etc.) (Boerma et al. 2018). Breech babies today most often are also delivered by caesarean (Jiangfeng et al. 2014). For those and other reasons, C-sections tend to be performed more often, even though the operation is not always beneficial and can actually be harmful to a woman's and/or newborn's wellbeing when used without medical indication (Chalmers 2011; Chalmers et al. 2010; Betrán et al. 2018; Lawson 2011; Sandall et al. 2018).

[147] When a woman is overweight, a C-section scar does not heal as well and it is more difficult to clean and care for the wound properly. That is why there are a number of infections, according to medical staff.

Cree women in Wemindji do not want to end up with C-section. As one Elder said, "Every mother, young and old, wants a natural birth." (Sophia, Elder, 2014). Regardless, when it came to women's personal experiences, only DC and a few others thought that maybe C-section was unnecessary for them. Generally, women said that in their case, they trusted the doctor and followed his/her advice, and that the doctor did a good job. They rarely criticized or doubted practitioners' decisions during birth, as opposed to the care they received during their postpartum stays.

7.3.2.4 Postpartum stay: miscommunication, coercion, explicit and implicit bias

CB stayed in a hospital with her baby for a week after birth because she lost quite a lot of blood during the delivery and her son had jaundice. They were in a room with four beds. "It was not good for me," she said. "There was a woman whose baby was crying all the time and other people were moving in and out." CB said she started feeling "baby blues" right after birth and that the hospital environment made it worse. She felt much better after coming home, and her condition improved significantly (CB 2013, gave birth in Val d'Or hospital at the end of 2000s).

Many women described the days after birth in the hospital as the most unpleasant part of their births. Apart from miscommunication with the staff, Cree mothers said they experienced authoritative, patronizing and disrespectful treatment, noisy and crowded postpartum rooms, food that was not fresh or not tasty. Women did not receive the support they needed, were kept in the hospital for long periods of time without explanation, and were pushed into feeding formula to their newborns, etc.

Right after birth is the time when many mothers want to be with, and need the help and support of their family and community. Instead, they are isolated in an unfamiliar and often hostile environment without appropriate affective care. Such separation is particularly the case for women with high risk pregnancies and births who must deliver their babies in Montreal. Those women who need their family most - who often need to stay longer in evacuation because of their medical condition - are those farthest away from their essential support system.

The following story was told by CE, who gave birth to twins in Montreal in the beginning of the 2000s. Being away for a long time was very difficult for her, especially because she had to leave her other children in Wemindji and did not receive appropriate help and support after birth, resulting in her twin newborns being kept away from her while in the

hospital. CE did not have an escort, and the long stay away from home caused her lots of distress:

> And they didn't give me my kids back in the room [after delivery], they kept them in the nursery [the staff told her that she would not be able to take care of the two alone].

Did you have anyone in the hospital with you?

> No. I was there alone. But one of my aunts was leaving Montreal hospital and her escort was there, and she came by, came and helped me, and then they brought the twins in the room once she was there. But they had to take them back when she left, I didn't have an escort at the time. They sent back my escort, because he was drinking. That's why. We [she and her twins] were in the hospital for six days. And the nurse, she used to work here [in Wemindji] way before, she wanted to keep me in that hospital for two months with the babies! She was one of the nurses I didn't like, I think she was racist or something… And I kept telling her, "I want to go home, I want to see my other kids, I want to bring my kids home," and I kept pushing and pushing for it. And finally, they agreed that I could go home.
>
> The doctor who delivered the babies came and she told me that I could go home, that things were going well. "Can you tell the nurse of the Cree Health Board that I could go home?" "Why, you really want to go home?" "Yeah, I know I have premature babies, but I really want to go home, I want to stay in my home town." "Ok, I'll talk to her." And they talked to her [the nurse from Cree Health Board] and she [the nurse from the Cree Health Board] called me and she came back to the hospital and she told me, "I'm gonna keep you here for a month, in town [Montreal], but out of the hospital," she said. And I told her, "I'm not going to have the help that I need here, but at home, that's where I'm going to have help. At home!" And she started to understand the situation and we got released that day, and we flew home the next morning. I had to feed the kids before though, before the airport. I prepared the bottles and everything. My mom came to Montreal to escort me and we came home. Once we got off the plane my family came out of the airport, they grabbed the babies! And we walked in and there was so many!… I couldn't see everybody in there! There were a lot of people there. Some people who wasn't my family, but they came to see the twins, how small they were!... The first one was 4 pounds.

How many weeks were they when they were born?

> 32 weeks.

How long did they keep you in the hospital till they finally released you?

> Six days. They were one week old when we came back. The nurse told me [the one in the hospital from the Cree Health Board], "I'm sure I'm gonna see you in a couple of weeks." Like she was so sure that she will see me, or see one of the twins… And she never did!

You never went back?

> We never went back. We stayed home. Everything went very well (CE 2013, gave birth in Montreal hospital in the early 2000s).

Several other women complained that they did not get released from the hospital for long periods of time without explanation. The standard practice is to keep women two to three days after birth, while Cree mothers said they were held five days, a week, and over. Some women were persistently demanding to be released, others were quiet but sad and distressed to be held for so long. Women cannot have the same care and support in the hospitals after birth as they receive at home from their family and community.

Did you have an escort with you?

> Yeah. My husband came one week before the baby was born. And we stayed in the hospital for eight days after the baby was born.

After when the baby was born? Were there some complications?

> I don't know.

But eight days after the birth, it's quite a long time?

> Yeah...

Were they checking on the baby, on you?

> Yeah. They always would hold the baby in the nursery, give her a bottle and they didn't respect me with breastfeeding. They always gave from the bottle.

Did you ask them not to give the bottle?

> Yeah.

And what did they say?

> They kept giving her the bottle.

Did they say why?

> No. And I talked to the nurse from Wemindji. There's Cree Patient Services. I told her, "What's going on, why am I not being discharged or…" and the next day we were discharged.

Did you get an explanation why they kept you so long? Why they were giving the bottle?

> No, nothing. (CK 2013, gave birth in Val d'Or hospital in the middle of the 2000s)

According to the nurses at the Wemindji clinic, possibly the staff at the hospital do not see a "proper" bond between the mother and the baby, and thus assume psychosocial issues. Possibly the staff do not know how to explain their perceptions to women and so they end up keeping Cree mothers in the hospital for prolonged periods of time without proper explanation, causing even more distress for the women. It becomes a vicious cycle– because of the post-partum distress they show in the hospital, the biomedical staff are hesitant to release women to go home. The longer the women are held in the hospital, the more distressed they feel:

> They usually stay in the hospital for a couple of days, two to three days. The reasons might be psychosocial. Probably they don't see an attachment, the good bond between the baby and the parent. If the parents aren't so much adequate with the newborn's needs and care, if the father and the mother do not have a very good relationship… Sometimes they'll bring a social worker and stuff and they'll keep them longer. I think communication is an issue… Another thing with Val d'Or—a lot of the nurses, they do not speak English, so that's another big issue and that was brought up often by the patients here and it's, you know, they don't understand.

Misinterpretations? Miscommunications?

> Yes, absolutely. Yes. There's a lot of judgement too. A lot of times when they [women] come home they tell they felt judged, not understood, culturally or otherwise, and a lot of times staff didn't speak English or very little English, so the communication is very poor. So if they are kept for five days in the hospital for x y z reason and they don't understand why… well it's probably because there was a miscommunication of some kind, so that's kinda sad. Here we accept them the way they are, but over there, there's lots of frustration because of the big families, no respect for the rules, and since they get a lot of Cree women—well, Val d'Or gets all the coastal Crees, there's a lot of frustrations… on both sides. So the care isn't probably the best... (Nurse at the Wemindji clinic, 2014).

A few women said that because of the long stays at the hospital after birth, they have missed important family events, usually weddings. One case was particularly painful for the mother (BB), because her grandfather passed away when she was in the hospital with her newborn. After the C-section, BB was kept for a week; doctors were doing different tests on her and her baby. She was not sure why so many tests were necessary, she just wanted to go home. Eventually BB found out that the staff mixed up the blood test results, and probably that was the reason they did not want to discharge them from the hospital:

> And I asked my aunt if she could be there for an hour [with her newborn in the hospital], cause I wanted to go shopping, cause I wanted to buy something for the Christmas and stuff… And she said OK. When I came back he [newborn] was on the blue light and I told her, "Oh my god, what are you doing?!" You know when some babies have yellow eyes or [she is talking about jaundice]… they have to put them under the blue light? And the nurse came, and she told me they got the wrong blood. They mixed up the blood tests. And after I was so… arghh… so mad!…

So he was actually fine? He did not have jaundice?

> Yes! He was fine! I kept looking at his eyes to see if he has that [jaundice]. He was fine when I left. They told me they got the wrong blood. So they released us then and he got another appointment in the morning to test him to make sure, and he was fine! He was released. And I had my appointment on the 27th. Just to check on the scar [C-section scar]. And they told me I was OK. So the next day on the 28th… home… Finally! That was the day when my grandpa was buried, on the 28th.
>
> So I just went to the church... just to see the body... and came back home with my baby. That morning [the morning her grandpa passed away], on the 26th, like three something AM I was changing him, his diaper, and I asked my sister, "Can you hold him?" and she said OK. When she was holding him, my baby was looking up in one spot [emphasis]. This is when I knew that my grandpa was looking at him before he left. The next day when one of my aunts came and told us the bad news, I told her I already knew it, because... When I told them about my baby, that he was looking up, and she told me it was a sign. And, you know, they [her family in Wemindji] kept calling us, "When are you guys coming home?"... and… "I don't know," I told them, "I'm having appointment on the 27th in the morning, so maybe on the 28th, if they release me." They said "OK, call us in the morning if you are coming home." (BB 2013, gave birth in Val d'Or in the early 2010s).

Many Cree mothers said their baby feeding choices were disrespected, their competence about breastfeeding was disregarded, or that they did not receive proper breastfeeding assistance. In the story below, the mother was a CHR from Wemindji Awash department and was working in a breastfeeding clinic to consult and help mothers who have difficulty breastfeeding; thus, she was knowledgeable and confident about her choices. In the hospital, she was treated with disrespect, not taken seriously, and completely disregarded as a professional:

How did you find those two days in the hospital after the birth?

> That part was the most unpleasant part of my stay. After he was born they told me I couldn't breastfeed for a few hours. It's 'cause of medication from the C-section and that I agreed to, I knew, and I kept saying, "OK, just give him a cup, no

> bottle." And the nurse that was working that night shift agreed that it would be confusion if they gave him the bottle. So at 10 or 11 that morning they brought him and they said he needed to feed. OK, right away he latched on, he was eating very well, he was good and then only because the first milk came, you know, the colostrum and he was feeding well, breastfeeding every two hours, but then after the colostrum, the other milk didn't come. So I tried maybe 12 hours him dry sucking and it was painful. And the nurse kept saying, "No, you got to give the bottle, he needs to eat, he's losing weight." And I said, "I know they lose 10 % of their birth weight, so it's fine that he's losing weight. I need him to keep going on the breast more often to make the milk come." And she was saying, "No, he is really hungry, he needs to eat." And I said, "No, I know what I am doing."

Did you tell them that you work in a breastfeeding clinic?

> Yes, I did, but she wouldn't believe me. She kept trying to take me into this room to make me watch a DVD on breastfeeding. And I said, "No, I am not going to watch it, I watched it at work like ten times. And I know what the DVD is about, and I know what I need to do." I was talking on the phone with one of my coworkers and she asked me, "In the drinks that they bring you from cafeteria, do they bring you a hot beverage?" and I said, "No. My tea is already cold when it gets here." So she suggested that I try something like hot chocolate or a hot compress on the breasts and at the time one of my friends was in Val d'Or for business, so I called her and I said, "Would you be able to bring me some hot chocolate from Tim Horton's? I need something hot to drink." She said, "Yeah, sure!" and she showed up with two! [laughing]. And I drank it, and I did hot compress, and I massaged, and eventually it came. Once it came, he was very happy, he did very well, he start gaining weight. But the nurses were so insistent-- "Give the formula! Give the bottle!" And I was like, "No, I am not, I am going to hold to what I want, and no bottle."

You stood your ground so well! For some other people it would be very difficult, especially for a young first-time mom…

> Yeah… And you know, the day we were discharged, a nurse comes in, and she's holding like a six-pack formula! And, "This is for the baby." And I say, "No no, the baby is not gonna take formula, he's all breast milk." And she's like, "No no, it's just for him, I know you are having breastfeeding trouble." And I was, "No, I am not having trouble!" Anyways… She put the milk in my bag.

What did you do with it?

> I brought it home, but I didn't use it. (CL 2013, gave birth in Val d'Or hospital in the 2010s).

Other women were inexperienced in breastfeeding or had less information about it, and said they did not receive much help from the staff:

Did the breastfeeding go well?

> No. It didn't. I think it's because looking from now, it was the lack of knowledge how to do it.

Did they help you with it?

> I think it was still language barrier and I remember they put me in a place in a nursery room, it was a really small area, there was a chair and a poster there and a curtain. They told me to sit there, and I sat there and they expected me to breastfeed, but that was the only support I had.

Oh wow… not much of a support…

> Yeah [laughing]. I remember that curtain--"chick" [she makes a movement with her hand to show how they closed the curtain in front of her face and she laughed].

So he didn't latch?

> No. I had cracked nipples by the time I got to Wemindji. So he only breastfed for a month. And went straight to formula after that.

Cause you couldn't handle it anymore?

> Yeah… (CZ 2014, gave birth in Val d'Or hospital in the late 1990s)

Distrust and disregard of Cree mothers' choices and standpoints are rooted in the technocratic mindset of the hospital, but in some cases, also in the prejudice and stereotypes held by the staff. The following story of CL from the late 1990s exemplifies some of the discriminating "rules" that the staff held against Cree and their families in Val d'Or hospital.

> I wanted to have fresh air one time and it was really nice in the evening and I asked the nurse, "Can I go outside for the fresh air with my boyfriend?" And they said, "No, the security is downstairs." I was like… it was like 9:30… and I asked her, "Why?" She says, "Because Native women, they would leave in the middle of the night, leave their babies and go drink." And they assumed I'd do the same thing! So she said, "OK, if you take the stairs and take the back door you can have a fresh air there on a balcony," she said. And I didn't find the balcony. Me and my boyfriend went looking for the balcony and we couldn't find the balcony. There were like five floors, cause we were on the fifth floor, we went all the way down to the floor and it says, "If you open this door the alarm will go off." So we didn't go. And we went back up to the second floor and it said there again. And I said to my boyfriend, "Maybe not, if we're still in the building, we're on the second floor, it won't probably trigger the alarm." So I opened the door and the alarm rang! [laughing hard] And we ran upstairs, it was crazy! And that night I started a fever! I think because of all that running [laughing]. Just for a fresh air! [laughing]

How did you feel when the nurse told you like that?...

> I said… I was in awe… Not every woman is the same! It's like they labeled Aboriginals like… It's insulting! It felt like we're in lockdown or something.

So you didn't get the fresh air…

> No… [laughing] I got sick instead! (CZ 2014)

In the report about health care disparities in Canada, Allan and Smylie (2015) demonstrate that the same issue of prejudice, stereotyping and implicit bias[148] in healthcare institutions continues to prevail today. This finding was confirmed by the Wemindji clinic administration, who said that recently they confronted the biomedical staff at the hospital with Cree women's complaints about being pushed around and disrespected. The hospital professionals admitted that they are somewhat biased and that they do have less patience with Cree families. When recently the Awash department decided to establish a birthing plan for Cree women, they called Val d'Or hospital to inform them about the initiative and to hear what the hospital staff had to say. While Cree women felt they were being pushed around in Val d'Or hospital, this is what the hospital staff told the Awash department about their point of view:

> They [Val d'Or Hospital] have a policy of having two people per delivery room, while Crees are very family, so it's not two, it's 20, which is really hard for them to deal with because well, if there's emergency, you have to get out of the way, and they want to help, but they can't help and… So no respect of the rules. When everybody else has to respect them, the Crees apparently don't care. The nurses are telling them no more than two, but then they have to call security, it's just a big… a lot of frustrations on their side. And Crees don't listen and so they're less patient. They openly said, "We are less patient, because… yeah… They don't respect our rules and if anything happens we want to care for them but it's so hard you know, twenty people in the room." So that was their main, main concern. (Administrative staff from the Wemindji clinic, 2014)

On top of explicit bias, Allan and Smylie (2015) found that Indigenous peoples face a lot of implicit bias in the Canadian health care system and healthcare institutions. "'Implicit bias' refers to attitudes and stereotypes that occur unconsciously and inform our thinking, beliefs and behaviours" (Allan and Smylie 2015:41). Implicit bias occurs involuntarily, beneath the level of conscious awareness. There is a growing amount of research that demonstrates how implicit bias in medical institutions can impact medical staff's interaction with patients and even treatment decisions. The quality of interaction and communication with patients may influence the overall outcome (Allan and Smylie 2015:41). Thus, miscommunication and implicit bias are not trivial issues in perinatal care; they are major

[148] Implicit bias is an unconscious stereotyping that informs our beliefs, our thinking and our behaviors (Allan and Smylie 2015).

factors in Cree mothers' wellbeing and safety. Even though mistakes and mistreatment may happen in perinatal care to everyone, Allan and Smylie (2015) demonstrated that Indigenous populations are more vulnerable in being stereotyped and categorized in biomedical systems, thus increasing the number of adverse effects on their wellbeing. As we saw, it was also confirmed by the staff themselves that they have less patience with Cree families. The implicit biases could be recognized in the examples above. They demonstrate the staff's assumption in those particular cases that the mothers in their care were less suitable parents or less responsible mothers, in need of assistance or not having enough knowledge on feeding or caring for their baby. This resulted in not listening and not hearing what women had to say or what needs they actually had for themselves and their newborns to be well. Approaching mothers as individuals and truly listening to their needs might help to avoid biases that one holds and is not aware of (Good and Hannah 2015).

Vang et al. (2018), who conducted research on Indigenous high-risk pregnancy, identified three main factors effecting the interactions between women and health care providers: evacuation-related stress, hospital bureaucracy and stereotyping (p. 1863). The psychosocial effects of evacuation play into interactions because mothers arrive to the appointments feeling stressed and overwhelmed. Bureaucratic procedures in large southern hospitals, such as long waiting times for multiple specialists, different paperwork and etc., are draining for many women. Vang et al. agree with Allan and Smylie (2015) and others (Bourassa et al. 2004; Browne and Fiske 2001; Greenwood et al. 2018) that stereotyping of Indigenous mothers and families are strong in biomedical systems and have long been so. Health care providers believe that certain traits, such as, for example, non-verbal communication styles and reluctance to share information is rooted in Indigenous culture; thus, instead of trying to connect with women and gain their trust, many professionals adopt a strategy of "doing their thing" or, in other words, doing whatever needs to be done professionally, without much explanation or questioning (Vang et al. 2018:1866). My fieldwork confirms these findings, and illustrates that all three factors play a role in women's and practitioners' interactions, as well as in women's overall childbirth experiences in southern hospitals.

The "cultural safety" concept/care model was developed by Dr. Irihapeti Ramsden (2002), a Maori nurse, to address health disparities among Indigenous peoples in New Zealand. When biomedical staff are learning about cultural sensitivity or cultural competence, often the focus is on "cultural differences" and culture is often understood in a very narrow

sense, involving types of clothing, traditional foods or ceremonies (Churchill et al. 2017). Instead, the cultural safety model requires health professionals to consider how social, historical and sociopolitical contexts, as well as structural and interpersonal power imbalances, shape and impact health and health care experiences. Practitioners are required to reflect on their own biases, beliefs and attitudes, their own history and life experiences, and be aware of the ways in which all these shape and impact their care practices (Ramsden 2002). The important part of the cultural safety approach is its concentration, not on practitioner's knowledge about differing cultural practices, but on self-awareness and reflection, understanding colonization and its harms to Indigenous people, recognition of the professional and institutional power imbalance between themselves and their Indigenous patients. The cultural safety approach requires recognition from the biomedical professional that other ways of knowing are valid and that it is a birthing mother who makes decision about what care is appropriate for her during childbirth (Allan and Smylie 2015:35). In this model, it is the recipient of care who determines whether the care is culturally safe, not the provider (Baker and Giles 2012).

Based on the lived experiences of Wemindji Cree mothers, I argue that the "riskiest" birth for many Cree women is when they are left to birth alone, far away from home and without the presence and support of their family and community. Most Wemindji Cree still view childbirth as a social and family event; for them, the birthing environment is only safe when family and community members are present. Their presence reduces risks and anxieties during evacuation. The waiting times are experienced as shorter, easier, less lonely and less boring when women are in a supportive and caring community of their own. The hospital births are experienced as less stressful and less painful with the presence and guidance of the mothers, grandmothers, aunties, cousins or even neighbours. Thus, regardless of their marginalized position in the Canadian and biomedical system, Cree mothers and their families control their own lives and create their own worlds, reflect on their realities and find ways to improve their situations, developing their own support systems - like spontaneous fellow mothers communities in the boarding homes and/or a support team of relatives, friends and/or neighbours in the birthing rooms (for more about Cree ways of birthing in the hospital, see Chapter 8 Manifestations of Cree Birth in the Hospitals).

On the other hand, Cree have adopted and accepted many standards of biomedical risks and respect and usually want to hear biomedical advice. As Lupton (2013) points out,

perceptions and definitions of risk are constantly changing according to changing realities (43). Such changes are very clearly reflected in the interviews with Elders, who responded about their preferred place to birth in the past, and what they think is the best place to birth today - recognizing the different realities of now and then. The Elders agreed that the mothers-to-be have to decide for themselves about where and how to birth, often adding that the mother's decision has to be made in consultation with the biomedical professionals. This confirms that a number of biomedical risks have been adopted by Cree over time, and the younger generation of Cree mothers eagerly want to use the available biomedical knowledge and technologies. Despite the variations in their hospital experiences, which sometimes included injustices, lack of choice and communication, and impersonal care - especially during their postpartum stays - Cree women largely express respect and gratitude towards biomedicine.

In the following chapter, I turn to Cree ways of adapting to birthing in the hospitals and finding their own ways to create healthy and safe births far away from home.

CHAPTER EIGHT: MANIFESTATIONS OF CREE BIRTH IN THE HOSPITALS

Even though today, Cree rely on biomedical services and go to the southern hospitals to deliver babies, they seek to own their births. Current Cree birthing practices[149] stem from practices in the bush, and from the holistic concept of being alive well (miyupimaatisiiun), in which the environment has significant influence on the outcome of birth, and the mother with the baby are in charge (see 5.9 Birth complications and 7.3.1 Early births in the hospitals). When Cree women began birthing in local nursing stations, and then far-away city hospitals, they brought elements of Cree birth with them and continued to maintain some of those elements within biomedical institutions. That is not to say that Cree birth was ever static; it was, and is, changing over time - like any other birthing model. However, before Cree women started birthing in hospitals, their model of birth (for details see Chapter 5. Childbirth in the bush) was considerably different from the biomedical technocratic model of birth.

Some elements of Cree birth are not well received by biomedical professionals, since Cree core values and understandings of healthy birth and care during birth are considerably different from technocratic care values and hospital policies. For example, as noted in the previous chapter, the staff at Wemindji clinic often receive complaints from Val d'Or hospital that Cree family members and friends come and go during labour as they please, while according to hospital policy, only one or two people are allowed in the birthing room with the mother. However, participation in birth is an honour and a privilege for Cree, as well as a necessary support for the mother–the more people are able to participate in birth, the more comfortable and safer the Cree mother usually feels. Different people in Cree birth play different roles, therefore the presence of various participants is important. On the other hand, for the medical professionals, many people in the delivery rooms represent a threat to a mother's and baby's safety, since they can obstruct professionals' work - especially if an emergency situation arises.

Thus, some Cree practices are often perceived as disrespectful of professional knowledge, and a source for frustration and sometimes conflict. However, Cree in no way seek any conflict or mean disrespect; rather it is a cultural strategy to maintain their support system by performing their roles and duties during birth to create a healthy, safe and supportive environment for the mother and the baby.

[149] For the sake of this thesis, Cree childbirth practices are earlier or later acquired practices that Cree routinely employ in the event of childbirth.

8.1 Homogenization and indigenization, medical pluralism

Cree and technocratic models of care in childbirth, with their widely varying core values of holism vs. separation[150] (Davis-Floyd 2001), differ considerably; however, those medical procedures that are evidence-based, and traditional Cree practices often agree with and complement each other. Cree often combine biomedical recommendations with advice given by their family and friends (see Chapter 4). The same goes for some medical professionals - especially the ones working at Wemindji clinic, who know more about local history, people and their everyday environment than the specialists working in Val d'Or or Montreal. A similar synthesized pattern of choosing healthcare advice has been observed elsewhere (Baer 2004; Cant and Sharma 1999; Carruth 2014; Cosminsky and Scrimshaw 1980; Hoyler et al. 2018; Kleinman 1978, 1995; Lock and Nguyen 2010; Ovesen and Trankell 2017; Saethre 2007; etc., Ovesen and Trankell 2010). As health care professionals medicalize Cree childbirth, Cree indigenize (Kleinman 1995, Appadurai 1990) biomedical birth by introducing new elements into the biomedical system and adopting biomedical elements for their own needs.

In analyzing general global/intercultural interactions, Appadurai points out two trends−cultural homogenization and indigenization (Appadurai 1990:295). Cultural homogenization is a general term that describes the spread and infusion of ideas from metropolises to marginalized, peripheral societies. Indigenization has two different aspects to it: one is appropriation by locals of newly spread ideas, knowledges, commodities or technologies to fit local sociocultural contexts and needs[151] (Appadurai 1990:295; Kleinman 1995:24); and the other is the influence of local practices and beliefs on the dominant homogenizing trends−the flow of ideas from the local and marginalized to the dominant groups. Important in the process of indigenization is the agency of the marginalized groups, who are not portrayed only as though passive, helpless victims−Americanized, medicalized or homogenized−but as also having the ability to selectively choose and adopt various technologies or practices of the dominant group, and even to influence the dominant trends. Researchers recognize that local communities continue to innovate and create change, regardless of the homogenizing pressures they experience (e.g., colonization, medicalization, etc.) (Sahlins 1999). Kleinman (1995) introduced the concept of indigenization to

[150] Separation – describes biomedical treatment of the body as separate from the mind and environment it is in.
[151] For example, as previously demonstrated, when living in the bush, Cree would use cotton flour bags to make baby clothing, and the strings from flour bags were commonly used to tie the umbilical cord.

biomedicine, which was later discussed, observed and built upon by others (Hoyler et al. 2018; Lock and Nguyen 2010; Ovesen and Trankell 2017, etc.).

In discussions about the indigenization of biomedicine, it is impossible to avoid the notion of medical pluralism—the coexistence of two or more medical systems discussed by many (Baer 2004; Cant and Sharma 1999; Carruth 2014; Cosminsky and Scrimshaw 1980; Saethre 2007; Kleinman 1978, 1995; Lock and Nguyen 2010; Ovesen and Trankell 2017, etc.). In general, and especially in earlier research, scholars concentrated on the conflicts among coexisting medical systems (Baer 2004; Ovesen and Trankell 2017; Saethre 2007:96-97). However, in some cases it was noticed that focusing only on conflict and dichotomy is counterproductive (Saethre 2007). For example, in Australia, certain interventionist programs were implemented to ameliorate Aboriginal health, based on the assumption that Aboriginal medicine and biomedical systems are fundamentally incompatible. Such policies and interventions did not solve persistent health disparities among Aboriginal populations. According to Saethre (2007), persistent focus on only the distinctiveness and conflicts between two medical traditions oversimplified a complex issue and ignored other important determinants of health disparities, such as social conditions, gender concerns and individuals' experiences of illness (2007:108). Similarly, in my research I found that many practices in Cree childbirth complement biomedical knowledge, and it is often a personal approach of nurses to mothers and their social realities, and respect for Indigenous childbirth practices that create a positive outcome in perinatal care, rather than a fixation on the differences in childbearing. In recent years, more research has concentrated on the intersections and complementary nature of biomedicine and Indigenous medical systems, their dialogues and compatibility (Baer 2004; Carruth 2014; Cosminsky and Scrimshaw 1980; Giovannini et al. 2011; Hall-Clifford 2015; Hoyler et al. 2018; Saethre 2007). For example, Hoyler et al. (2018) discuss what they call the "syncretic health-care landscape" in Guatemala, where they see traditional medicine and biomedicine as one overlapping system. In this example, biomedical professionals often use both biomedical and Indigenous medical knowledge on a case-by-case basis that considers individual circumstances (Hoyler et al. 2018:3).

In the following section, I discuss Cree practices that were carried from the bush to the hospitals that help women and their families to maintain a healthy and culturally safe birth environment, while observing how Cree adapt to the evacuation policy and indigenize the biomedical/technocratic model of birth.

8.2 Quiet and self-reliant labour

In accordance with, and as expressions of, their cultural values, Cree women tend to keep things to themselves sand conduct themselves calmly and quietly during labour and delivery. As we saw in Chapter 5, these core cultural values include: self-reliance, emotional control and non-interference. Women observed and learned such values when delivering babies in the bush, and many still adhere to these values today. Several women said they would not tell anyone that their labour started and would wait until the last minute, or until somebody else would notice they're in labour.

DC remembers that while she was staying at a boarding home in Val d'Or waiting for her birth, there was another Cree woman who was also pregnant and waiting. One day DC noticed something strange "on that woman's face." DC asked if she was doing OK because she looked like she was in a lot of pain. And the woman said that yes, she was in pain. "How long?" DC asked her. She had been experiencing contractions for 24 hours, but had not told anyone, not even her mother-in-law who was her escort. They quickly took the labouring woman to the hospital and the baby was born very soon (from the interview with DC, 2014).

Other women also narrated stories of following the "no-tell" cultural trait:

BA gave birth in Val d'Or in the 2000s

> …We were eating at the restaurant, and I remember I lost some blood, but I didn't do anything. I knew it was close, but I didn't have any pain or anything, so just waited. I was just thinking we should finish our shopping before [laughing]. So we just ate, we were shopping, and that night we went home. […] But when we went to bed, it was like 15 minutes after, laying there, trying to sleep, I felt contractions coming. They were like 10 minutes apart and they were getting stronger and stronger, and I told my husband, "I think I'm going to give birth soon."

They hurried to the hospital and her baby was born in a few hours.

CQ gave birth in Val d'Or in the 2010s

> ...We went shopping, we wanted to have a movie night. We were standing where the chips were in one of the stores in the mall. And I started to get sweaty again, my back was killing me, I kept going leaning against the wall. And my boyfriend's mom said, "Let's take you to the hospital, I think you're going to have your baby tonight or tomorrow."

CZ gave birth in Val d'Or in the 1990s

> ... I didn't tell anyone that I had contractions, it was 7 o'clock in the morning. I just kept going throughout the day.

Why didn't you tell your mom?

> I am not sure. I think it's just… I thought "Oh, maybe it'll stop." And then we went to the store, we went to Wal-Mart. And they noticed my face, "Is there something up?" they asked. And it was around five o'clock. So all throughout the day I had my contractions off and on.

So your mom noticed your face. It's not that you told her?

> No. Yeah, she noticed. And then she said, "OK, let's go rest, let's go back to the boarding home." So we went, and they were starting supper, and I felt hungry. I thought I will go have supper too. And it was before six, and they made me a plate and I was sitting down and thinking that I was hungry, and I took the first bite and I didn't want to eat. I felt hungry, but I didn't want to eat. I felt nauseous. So I didn't eat. Then I went back into the room. And my mom sent the lady to check up on me. I looked at the time and started counting how long it lasts and how long in between and they were like five minutes apart. And I told my mom, "I think I'm gonna go to the hospital, to go check."And she said, "OK." And she didn't know I had them throughout the day. So she said, 'OK, I'll stay behind" and I went with a friend. […] And they put the straps on me to see how far contractions are, but it didn't take long after when he was born, and my mom was surprised [laughing]. He was born around seven in the evening.

Elder Minnie Shashaweskum, as mentioned in Chapter 7, repeatedly told staff she was ready to deliver, but they did not take her seriously and her baby was born in a labouring room. Her conduct before reaching the hospital followed the "no-tell" behaviour pattern described above. Minnie laboured at home until the last minute, until she knew she was ready to deliver. She came to the hospital in an ambulance, needing only to push her baby out. Moreover, when the biomedical staff disregarded her competence and her knowledge of her body and birth, she continued with a quiet and self-reliant delivery on her own without staff support. Elder Minnie also noted that one of her other babies was born at her neighbours' place in Wemindji, because she did not have enough time to go to the clinic: "The other time, I could not make it on time to the clinic. I was late. Our house was next to Nelly's. I was on the way to the clinic, but I did not make it. The baby was born at Nelly's and Charlie's place" (Minnie Shashaweskum, Elder, 2013). In the 1970s in Wemindji, the walking distance from house to house or to the clinic, which was located on the riverbank in the town centre, was not greater than five to ten minutes, depending on where you were located. Again, Minnie waited to tell anyone until she knew she was ready to push, and that is why she did not have enough time to walk to the clinic.

While there was variation in women's self-conduct during birthing, the "no-tell" trend was evident at one point or the other throughout many women's pregnancies and/or labours.

Self-reliance and self-sufficiency continue to be valued traits that persist in the context of contemporary Cree birth.

8.3 Shifting roles during birth

In the bush, family and community members had defined roles to fulfill during birth according to their age, gender and experience (see 5.4 Participation in birth). Due to medicalization, traditional birth roles were altered or removed, and today not everyone is sure how to support a woman during birth, especially given that people rarely get to see births anymore in comparison to the days in the bush, and so do not get opportunities to practice. In the context of their northern environment and former nomadic lifestyle, Cree learned to be highly flexible in different life situations, including birth. The flexibility of Cree birthing practices in the bush, as described in Chapter 5, facilitated Cree adaptation to birthing in the clinic and the hospitals. For instance, the roles of participants in birth in the hospital became easily interchangeable. If in a bush birth the midwife-expert was not around, the grandmothers, the husbands or whoever was there would take over the role of the midwife. Contrary to current circumstances, Cree families then had easy access to births. They had the opportunity to watch births, participate in births and gradually learned to be part of births all their lives; thus, Cree were ready and well prepared to take over different responsibilities in childbirth, when needed.

When women started giving birth at the clinic, families' access to birth became largely restricted in the delivery room. The already-skilled Cree midwives were the ones to first adopt several traditional Cree roles during clinic births. Such midwives had become Elders—important people who shared their wisdom and support, who were requested by women and, once they entered the room, the "baby was born in no time" similarly to childbirth in the bush. Their presence in the birthing room at the nursing station gave great assurance to the family, who would gather inside and around the clinic anticipating the news. These home-town clinic births made it possible for Cree midwives and families to be nearby for the women and the babies. However, the more that birth took place behind closed doors, the less familiar or knowledgeable Cree became about the birthing process, and midwives had no way to pass their practical skills on to the younger generation.

As we have seen, the evacuation policy displaced Cree birth from the home environment. Usually only one or two family members can participate in hospital birth. If the family cannot make it down south, usually another Cree person (from Wemindji or another

eastern James Bay Cree town) takes over the responsibility of supporting a woman during hospital birth. The roles of participants in birth then continue to be very flexible and interchangeable–family or community members easily and willingly step in with whatever knowledge, skills or means they have to keep the birthing process fluid. While in the bush, and even in the clinic, these roles were usually filled by a competent person, one who was "trained for the job," today they are most often filled by someone who happens to be at the right place at the right time. Sometimes these people have some qualities or skills required for birth, but not necessarily. Having several family and/or community members at birth continues to be essential to labouring women's sense of wellbeing—of "being alive well."

8.3.1 The birthing coach

A "birthing coach" was mentioned by Cree mothers several times in their hospital birth stories—many Cree mothers seek someone not just to be there, but also to actively coach them through their technocratic hospital births. A birthing "coach" is a Cree person, chosen by a mother to guide her through labour and parturition. Unlike in the bush, where they had more freedom of choice, in Val d'Or or Montreal, the designation of a birthing coach is highly coincidental. Most often a birthing coach is another experienced woman, who may be a family member, a friend or another pregnant mother from the same boarding home. The birthing coach has many responsibilities, depending on whether a woman has her partner or family with her in the evacuation. Elsewhere, doulas serve in this capacity,[152] but doula services are currently not provided in northern Quebec. The doula advocates for her client's birthing plan and provides her and her partner with both emotional and physical support. Similarly, the Cree birthing coach attends to woman's needs (food, beverages, massage, advice, etc.), talks her through labour, supports her emotionally, and if able, helps translate or interpret conversations between the mother and the staff, since not all Cree women or Quebecois staff are comfortable in English - especially in vulnerable and stressful situations. To become a birthing coach one has to be at the right time and place, feel a special bond or connection with the mother, and have some experience with birth. None of our interviewees

[152] There are a number of Indigenous women in Canada who went through or are undergoing doula training and offer services that incorporate Indigenous ceremonies, sensitive support and personalized mother-centered care (Indigenous Doula Collective http://www.cbc.ca/news/indigenous/indigenous-doula-collective-supports-mother-centred-birth-1.3546977 , Manitoba Indigenous Doula Initiative http://www.cbc.ca/radio/unreserved/when-indigenous-healing-practices-meet-modern-medicine-1.3530072/traditional-birth-indigenous-doula-program-includes-ceremony-for-expectant-mothers-1.3533712).

recognized a partner or a husband as a birthing coach. However, I suspect that the choice of a birthing coach has less to do with gender roles and more to do with the coach's level of experience.

BA met her birthing coach in the boarding home. They have remained close friends since then:

> [Talking about the boarding home in Val d'Or] I liked it, 'cause there was a Cree man who was running the place and there was some people form Wemindji there, staying there too. Some people from Eastmain that I met. One of the ladies was my coach in the delivery room. And we stayed close friends after. We are still in contact today. […]

Was she also pregnant?

> No. I think she was there with her mom. Escorting her mom.

So it just happened that she was there?

> Yeah. Or I think she was escorting her sister, 'cause her sister was pregnant too. […]

So you asked her to come with you to the hospital?

> Yeah.

She was with you during labour and delivery?

> Yeah. She was my coach. (BA 2013, gave birth in Val d'Or in the 1990s)

Elizabeth had her mother coach her through birth. Her mother's presence and guidance made Elizabeth calm and concentrated. During a regular hospital checkup, the doctor said she could see Elizabeth's contractions even though Elizabeth did not feel anything. She was told that she could not leave the hospital:

> I was with my mom. And she reassured me, "Sometimes that's what happens. All women are different." So I wasn't worried. I was hungry and I told nurses I hadn't eaten my supper yet, 'cause I came here. So they gave me something to eat. After I finished eating, that's when I started to feel my contractions, just a bit, and I felt every contraction after, but they weren't strong and so that night I stayed in the hospital. My son was born 6:54 in the morning. They broke my water about four o'clock.

Do you remember why they had to do it?

> I don't remember why… Oh, they said to speed up my labour. So my labour would go faster. My mom told me, "Your contractions will be much stronger once

> they break your water." So after they broke my waters my contractions were much stronger.

Did you mind or was it OK for you?

> I guess it was that my mom was there and she was telling me how to relax and try to… every time I had a contraction she'd tell how to not to tense up and after to relax and to get my rest. 'Cause once I start pushing it would be much more work. She told me, "We don't know how long you going to push or how long it will last." So she would tell me to try to relax and that helped me a lot. […]
>
> I remember my mom sitting there. She was sitting in an armchair. It was looking so comfy! [laughing] And I was thinking to myself, "Oh, I wish I could sit on that comfy chair!" But everything went well, I didn't push for a long time it was… my son was 9lb 5oz when he was born. It was natural birth.

Do you remember if they offered you an epidural or any other medication for pain?

> Yeah, they offered, and I said no. It was probably because of my mom, she had talked to me a lot about labour and delivery and what to expect, and I also wanted to do it naturally, so I refused. (Elizabeth 2014, gave birth in Val d'Or in the 1990s)

BZ reflected on her experience as a labour coach. She had come to Val d'Or a month prior to her due date. While waiting for birth, she went to her friend's delivery in the hospital and coached her through labour. Her friend was very nervous and kept saying that her baby was "stuck." BZ sat beside her and talked to her, made her compresses, massaged her back, moistened her lips. According to BZ, there was a nurse in the corner of the room, but she was of no use. BZ explained to her friend about different kinds of pain and how it should feel when she's ready to push. She introduced some Cree words to the medical staff and asked them to use Cree words during delivery, such as "suuhkw!" which in English translates as "push!" She said that even a few Cree words made a difference and helped her friend to relax and to push the baby out.

Right after delivery, the baby did not make a sound, did not cry, and the staff looked worried. According to BZ, nobody took a minute to explain what was happening –"They were all on the baby." BZ had to ask the staff several times to talk to the mother and explain the situation. When the doctor eventually did so, they had difficulty understanding each other. BZ translated and clarified the doctor's explanations to her friend. They were glad to know that there was nothing to worry about, and the baby was healthy. "I have a special connection with the child. He knows me, he probably knows the story too. Every time he sees me, he smiles at me. Nobody knows it, but I know the connection is there" (BZ 2013, gave birth in Val d').

BK remembered how she was asked to help out at birth in the hospital in the role of birthing coach:

> (…) And then I witnessed a birth. In March. I don't know how old she is now…

Oh, so tell me about it!

> I was just only to take her to the hospital, 'cause she asked me to take her. She came to wake me up at one AM in the morning, to come drive her to the hospital [they were in a Val d'Or boarding home]. So I got up and took her to the hospital. She asked me to stay. So I helped her with her delivery.

Is it somebody from Wemindji?

> Yeah.

How was the delivery?

> I was telling her how to breathe and when to push.

Where did you learn these things? From your own experience?

> Yeah. The nurse that was there when I was delivering [her child's name] was telling me how to do it. But she wasn't there when I had my other children.

So that delivery with your friend went well?

> Yeah, she said she found it easier with this delivery than with her first one. Her husband was also there and there was another woman that was pregnant, we all went in the delivery room with her to support her. (BK 2013 delivered in Val d'Or)

Even with her husband and a friend accompanying this woman, she nevertheless awakened BK in the middle of the night and asked her to come and stay during delivery. Apparently, she perceived BK as trustworthy and reliable—someone who could offer her experience and knowledge. Her choice also speaks to the fact that many Cree women prefer a number of people beside them at birth. When far away from home, Cree find ways to request, welcome and appreciate support, and they are willing and honoured to participate and to provide support for each other during childbirth.

8.3.2 Family support

Family support for Cree is not only important emotionally, but is also recognized as a medicine or pain reliever. Close family members, an Elder or a midwife talking a woman

through labour was one of the main methods to relieve pain and anxiety during births in the bush and remains so in the hospital.

CN gave birth in Chisasibi hospital in the 1990s. She remembered having to choose between going to Val d'Or hospital, where epidural and emergency C-section were an option, or delivering close to her family, but without the option for epidural or emergency C-section. She said the decision was difficult to make, but since her pregnancy was healthy and birth was expected to be uncomplicated, she chose birthing with her family in Chisasibi over going down to Val d'Or alone:

> That's because in Chisasibi you were still able to give birth at the hospital. And I think she was the last group of kids that were born at the hospital in Chisasibi. I don't know why they stopped it, but it was nice to be there, because I had my mom there, my aunties there, my grandma… (…) The downside of that was that I couldn't get an epidural.

Did you want an epidural?

> Oh yeah!… [laughing]. Some people prefer natural, and what they did for us was laughing gas. They put on a mask. But when you're in full labour, it doesn't help! At least it didn't help me. And she was my first. So, yeah… (…) It was hard, I was in labour for 23 hours. So it was long and this is why halfway through I really wanted just to be over, and I wanted an epidural, 'cause they told me that it would take away the pain, but they couldn't give it to me! They gave me the gas from the mask and it didn't work. But what really helped me calm down was having my mom, my grandmother, my aunties there to tell me that what I was going through was normal and all women who have babies, this is what happens. So it helped me calm down. If I had been in Val d'Or, I wouldn't have had them with me. I think that helps just as much as the medicine that they give you.

In our 2013 interview, I asked CN if she were to choose again, what would she do? She replied, "I would prefer it to have with the family, without the epidural. Because once your baby is born, you forget about all the pain, you're just so happy, you know, everything is OK."

When several family members are present at birth in the hospital, they build a support system for the mother and each other. They find where they fit best, or sometimes, their parts are assigned by the mother. CN wanted her closest people - her mom, her husband and her auntie - to be beside her during delivery. She realized that her auntie would also be very good at providing reassurance to her mom and her husband, who were very nervous at their first child's and grandchild's delivery:

Who did you choose to be there with you in the delivery room?

> My mother, my husband, and my auntie that's closest to me. My auntie was there to help my mom calm down too. 'Cause my mom was very nervous, it was her first grandchild and my husband was nervous, 'cause he kept walking around the bed and he wasn't quite sure where he's supposed to stand or what he's supposed to do. He kept asking, "What do I do? What do I do? Where do I stand?" They told him, "Just stand beside her, hold her hand and be calm."

The rest of CN's family were standing in the observation room, from which they could watch the birth, and this made a great positive influence on CN. Usually, the more people that stay and support a Cree mother, the stronger and the more confident she feels:

> So the delivery room looked like operating room with the big lights, it was kinda scary, and my doctor was in a surgical outfit, so I was worried that something was wrong. She said, "No, it's to make sure everything is sterilized," and she told me, "You're only allowed three people with you," and then there was an observation room and they asked me if I would agree to have people in the observation room. And of course I said yes, because my grandmother was there, my aunties they wanted to see, to make sure everything was OK and they [the medical staff] did everything OK… They [her grandmother and aunties] were like super biased, you know, [laughing]. So I said, "Yes, I want them here!" I didn't want them to go.

Later, when talking about the pushing stage, CN remembered how helpful the family's presence was: "I could see my family in the window and they were smiling, and they didn't look worried, so that helped me focus." The grandmother and the aunties behind that glass window not only provided emotional support for CN, but also ensured her safety. CN explained that they were there to make sure that no mistakes were made by the staff. Even if CN talked about her family in a slightly mocking way, saying they were "super biased" about birth, meaning having their own strong opinions on how birth should progress and be attended, she still wanted them there and she trusted them. Their smiling faces reassured CN that the process was normal and that she was taken care of properly. CN knew that if anything bad happened, her granny and her aunties would take action. So, instead of worrying, she was able to concentrate and focus on birthing.

The following excerpt illustrates another collective family effort to keep AG and her baby safe, comfortable and under the best-suited care at all times:

> Before the time that I left, I thought that my husband's gonna come with me, but he was working. He wanted to stay and work and to save money for when I come down when it comes time. So my mom came with me. And when it came time to go to the hospital, my husband stayed with me and my mom had to leave. He came a week before the baby had to be born. (AG 2013, gave birth in Val d'Or in the beginning of the 2010s)

Later in the interview I asked AG about her labour, and that is when it became obvious that her family near and far was involved and followed the process rigorously:

So how did it start, the labour?

> My water broke six o'clock in the morning. I was lucky I did not get anything on the bed though. So I rushed to washroom to go change and my dad was calling my sister in panic [laughing], asking if I was able to eat or should we go to the hospital right away.

Oh, so your dad was there too?

> Yeah.

And your boyfriend?

> Yeah.

When did your dad arrive?

> Few days before the water broke. My sister had said I could have went for a walk and kept walking around until… at least to go few hours after, 'cause it did not all come out at once, it was gushing out once in a while, but we still went.

AG kept mentioning different people showing up during her labour at the hospital, so I asked:

Who did you have in the hospital with you?

> My parents were there, and my husband, and my in-laws came. My parents went to have lunch and my aunt came to check on me once in a while.

Did you feel good that you had all your family around you?

> Yeah, I did!

The hospital did not mind that you have everyone in there?

> They said, "Just as long as you are comfortable."

In the operation room was it only one person?[153]

> Yeah.

Who did you choose?

> My husband, or I gave him an option – "If you don't wanna be there, then send my mom in." He said, "No, I wanna go, I wanna see him," so he came in there. (AG 2013, gave birth in Val d'Or hospital in the beginning of the 2010s).

[153] AG had a Caesarian-section birth. See the birth story in Section 7.3.2.3 *Cases of C-sections*, p.211.

AG's parents, siblings, in-laws and aunties were all involved in the delivery, each at their own time. AG's sister, who was not able to make it to Val d'Or, gave advice on the phone. AG's husband was there for physical and emotional support (later in the interview AG talked about holding his hand throughout the labour and squeezing his fingers until they went blue), and her auntie and parents made sure that someone was always beside her, attending to her needs.

It is quite common that family members come around "accidentally" when birth happens. For one or another reason they turn up without much planning. I emphasize again that the crowd of people around or nearby during labour makes Cree women comfortable:

Did you have your family in the room with you?

> Yes, there was my mom, my boyfriend, his mom and his dad.

And your sister, you said earlier she was taking money from the ATM?

> She was in the waiting room along with her sister and our little brothers. [laughing]

Oh, so there were many people! How did you choose who's gonna be in the room with you?

> Oh yeah, there was also my cousin's girlfriend! I wanted them to be there and they all asked me to be there. They [the cousin and his girlfriend] asked if it was OK.

And you said yes?

> Yeah, of course! (…) especially because it was for the both sides of the family--it was their first grandchild.

The doctor and nurses were OK with it?

> Yeah, they were OK with it. Because it was a big room.

They didn't mind?

> No. (CQ 2013, gave birth in Val d'Or in the late 2000s)

BL escorted his sister for her birth. It was the first time he saw a birth. He remembers that the delivery room in the hospital was packed with people and it was a lot of fun:

> Everything went well. It wasn't what I imagined it at all.

Oh yeah? I'm interested to hear. What was your impression?

She didn't act like she was in so much pain. She was laughing through her pushes! [laughing himself]

Really?

I had a lot of family in there that were there for Christmas shopping too [the birth took place right before Christmas].

So there were many people in the delivery room? Do you remember how many?

It was me, her, the two nurses, the doctor... [counting] There was ten of us in the delivery room.

Was it mostly family? Friends?

Yeah, family. Just family.

And she was okay with that?

Yeah, they asked her, "Are you okay with all these people in here watch you deliver?" and she said, "Yeah!"

And the doctor was OK with it too?

Yeah, it was a big delivery room. There was nobody in his way or... (…) The nurses were good, they were talking to us in English. Santa came to visit the baby in the room! It was OK, the doctor was… they made it really fun in the delivery room for us. The doctor started even a baby pool for us. Trying to guess at what time the baby is gonna be born and… it was a lot of laughs in the room. And then a lot of tears after the baby was born. [laughing]

Happy tears?

Yeah! (BL, young man who escorted his sister for birth 2013, his sister gave birth in Val d'Or hospital in the 2010s)

BZ said she had her 15-month old daughter sitting on the edge of her bed all through the labour and delivery: "We did not have anywhere to leave her. She was sitting on my shoulder, chatting, wobbling, playing with my hair." BZ's husband was also in the labour room, and the nurses told him to take the child away when they'd go to the delivery room, but both of them stayed with BZ. According to her, the delivery happened fast and there was no time for her husband and her daughter to go. BZ said she could not find a babysitter for her 15-month-old daughter; that's why they were all together at the hospital. If the father had left with the child, he would have missed the birth; he did not want to miss it, so he stayed throughout delivery regardless of the staff's request that he leave.

There were also cases when Cree mothers executed their decision-making power–long entrenched in Cree birthing traditions–and requested certain people to leave or refused their presence at the delivery:

> And then my sister pops by. It was… I found it really annoying [laughing].

Oh yeah?

> 'Cause while you're trying to concentrate on your contractions, while they are monitoring and putting that thing on… and I would say, "Sshhhhh… and I would want quiet, and they would talk lower and I'd be like, "Shhhhhhh!!!"

So who was in your room? Your friend, your sister, your boyfriend and your mom?

> In the delivery room?

Yes.

> Just my boyfriend.

And when you were in labour?

> My sister and her friend.

Your friend or her friend?

> Her friend.

So for you it was annoying?

> Yeah.

They wouldn't concentrate on you, but they would talk?

> Yeah [laughing]. And after the monitoring was done the nurse asked me, "Sit on the wheelchair, we'll take you to the delivery room and get you prepared." I said, "I don't wanna sit, I can walk!" [laughing] "OK, when you're ready." OK. I was waiting for the contraction to start. Once it ended, I would walk to the delivery room. And as they were preparing me and getting the stuff ready and the doctor came in and there were two knocks at the door and my sister and her friend looked in and said… Oh no, the nurse knocked and said, "These two ladies wanna join, can they come in?" And I said, "No!" [laughing].

It's good, it's your time, it's your baby.

> Yeah. And then a few minutes later that's when they knocked again and my boyfriend came in. So me and him was the only people at birth. (CZ 2014, gave birth in Val d'Or in the 2000s)

There was some discrepancy between Cree families' and the Awash department's experiences and observations about having a lot of people in the delivery rooms in Val d'Or. While Val d'Or hospital staff reported to the Awash department that Cree did not respect hospital regulations about the number of people during birth, Cree mothers in their interviews rarely said that the medical staff did not allow their family. Women said that usually the staff would ask them if they were OK with such a big number of participants, and if the mother said yes, the staff did not mind "because it was a big room." This might be an example of the indigenization of biomedical model of birth, of miscommunication between the mothers and the staff, or both.

A family's absence during birth is especially hard for young first-time moms. When family was not around, their birth stories sounded very different, showing emotional distress, loneliness, sadness and boredom.

AQ remembered her son's birth in the 1990s. She was in early labour and took a passenger plane to Val d'Or. From the airport she went straight to the hospital. Her family was worried, because they could not get information about what was going on with her until about midnight.

How was the delivery?

> Well, it wasn't that difficult. My water, it couldn't bust, it didn't bust, so the doctor had to come in and bust my waters for me. And as soon as they busted my water, my contractions became stronger and stronger. I was just… yeah, I was in pain, but I was mostly bored. Because I had nobody to talk to, I had nobody there. It was just me the doctor and the nurse. Everybody else spoke French so, so I had nobody to…

Oh, they spoke French around you?

> Well, it's a French town, it's French hospital, they didn't really have people that spoke English. I didn't really say anything to them. My mom… I wasn't able to call my mom until around midnight. 'Cause I landed in Val d'Or around 6pm. And I wasn't able to contact my mom, and she called around, trying to find me in Val d'Or. So eventually they did come… some of the ladies that went to Val d'Or to go have their babies came to visit me. I was strapped to the bed, I wasn't allowed to do anything, I had to stay in bed... And finally, after midnight I had visitors. (AQ 2013, gave birth in Val d'Or hospital in the 1990s)

BA remembered her first childbirth. She was young and inexperienced. Her family could not make it in time, because labour started earlier than expected:

> I lost some blood, it was during lunchtime, we were sitting at the table, I kept having pain on this side, I was going like that a lot. I didn't know that I was going

into labour and someone told me, "I think you are going into labour," 'cause she's seen me go like that all the time. I was allowed to have an escort, but nobody was there, 'cause my due date wasn't until 29th so it was too late to ask someone to come. 'Cause I was going to ask my mom to come, but it was that evening that I started my contractions and I called my mom and I cried, because I didn't know what to do. So I went to the hospital after lunch.

What did your mom tell you?

I don't remember really. I just remember crying a lot...

You didn't expect it so early?

No… I know, the day before I went into labour I was walking a lot and it was heavy snow and I was wearing big boots and my parka and walking a lot and that's probably helped me to start my labour too, and I went to the hospital and my friend came. I don't know if she came with me or she came later, I don't remember... (…)

How long did you stay in the hospital after he was born?

I think I stayed there for three days and I came home.

Do you remember anything about those three days? How was it for you in the hospital? The food? The nurses?

I remember I cried one night 'cause I was lonely, 'cause I didn't have family there. Actually, I stayed there for ten days total.

In Val d'Or?

Yeah.

So you stayed a few days in a boarding home, four days in the hospital and again boarding home?

Yeah, one night in the boarding home after the hospital.

You were happy to come back home, I guess…

Yeah, very much.

When you gave birth, your family, they couldn't come visit you or…? Why didn't anyone come?

Hmm... I don't know. I think it was too far, they already had... most of my siblings had families too, kids, and they couldn't really leave, my parents did not drive there, 'cause they were working and my labour started earlier than it was planned. (BA 2013, gave birth in Val d'Or in the 1990s)

In both cases above, women did not have their family around, which made them very sad. However, when family is not around, as we have seen, others from the community take over the responsibilities of caring for mothers. In the case of AQ, the women from the boarding home came to check on her after AQ's mother contacted them in Val d'Or and told them that her daughter had just flown in from Wemindji and had gone straight from the airport to the hospital. Community women went looking for her, even though it was very late at night. In the second example, a woman who stayed with BA at the same boarding home came to escort BA to the hospital and eventually became her birthing coach during delivery. Even though they missed their family, young women were never left alone. Thus, the hospital's policy, which states that only close family can participate or visit during birth, does not accord well with the Cree model of birth as it fails to account for Cree mothers' need to birth in community. Yet my interviews showed many instances of flexibility on the part of the hospital staff, and it is remarkable how Cree women so often manage to birth in community despite the official hospital policy.

8.3.3 The role of the partner/husband - "What do I do? Where do I stand?"

The partner's/husband's role has been greatly diminished through medicalization. No wonder many men I spoke with revealed they were nervous and did not know what to do during delivery, even though they were eager to participate. In the bush, the role of the partner/husband had been to give woman physical support and emotional encouragement and comfort. Today, when active physical support is less needed because of the staff and facilities in the hospital, many men feel useless and lost. The evacuation policy and the medicalization process severely diminished the partner's role. The escort policy banned men from the delivery rooms for several decades. Thus, it is no surprise that Cree fathers and often Cree men in general feel uncomfortable in birthing spaces, not knowing how to assist. Men eagerly talked about birth during casual conversations, but shied away from the interviews, saying they did not have enough knowledge or things to say about it, even though some of them continued asking questions about the research and sharing their experiences in casual random settings. Many were very eager, proud and honoured to participate in birth. I asked BL, a young man in his twenties who escorted his sister to birth, how he felt about that. Did he like the idea of participating in birth? He responded, "I was very happy!... But scared at the same time, like… 'cause I didn't know what to do when she went into labour. I had to call my

mom. She was in church when I called her. I said, “BM is in labour, what do I do?!” [laughing] (BL, 2013).

AK is a father of four. His children were born in southern hospitals and he participated in all four births. He shared his experience:

Was there anything you did not like about the hospital or maybe you liked it?

> To me it was OK. I mean professionals, they have done this before, if something happened it would be treated right away, and the other thing is sometimes they have to make sure that the baby is OK, like blood tests, you know… Especially, it was my first time, I was very nervous! I walked home after when the baby was born, I guess after few hours, just to make sure the baby and my wife were OK, so I walked home from there. I must have walked for two hours to get home. In the middle of the night. This was what?… one o'clock in the morning.

You did not stay to sleep at the hospital?

> No, they did not allow us.

What year was it?

> It was 78... And they wanted me to cut the cord! But I didn’t have the guts to go…" [laughing]. (AK, 2013)

Several men I spoke with said they would be happy if Cree children were born closer to home. Women together with their doctors would have to decide the safest place for birth, but men agreed they would be happy if there were a choice of birthing centres in Cree communities. This way it would be possible for men to be more involved and able to participate. AK, the father of four, named a few reasons why he thought that a local birthing centre was a good idea:

> It would be nice to have midwives here, ‘cause not everybody has work, especially the young couples. They are getting younger and younger, so they can’t afford to go.[154] And the other thing is, yeah, especially the new mothers now they get younger, so they need somebody to encourage them, to talk to them, what to expect. And over there they don’t have family or friends to talk to. […]
>
> It would be nice to have midwives, because it costs. Everything! Not only to transfer patients to Val d’Or, it’s also the husbands or boyfriends. They want to be a part, they want to be there too, to see their children being born! And sometimes it’s not the case. And the thing is, I know it’s expensive--you have to put up for a foster home, plus meals and everything. So by the time the baby is born and everything… And the other thing I have heard from older women was that… Today, once the baby is born, maybe

[154] AK means that even if the trip is covered by the Cree Health Board, it usually involves a lot of extra expenses on the part of the family.

> two days later they have to leave the hospital. In the old days the mother wasn't allowed to lift anything or do anything for at least two or three days. And they used to wrap some kind of cloth on the stomach, so they get their figure back. Nowadays they don't do that anymore when in the hospital. The other thing is, earlier, once the baby is born they used to wrap the baby in a waaspisuuyaan[155] [see Figure 10], so everything would be straight and tight. Now you don't see that anymore. Maybe a few ladies would use them.[156] (AK 2013)

AK mentioned a few reasons for bringing back birth to Cree communities. Firstly, he was concerned about young mothers not having support they need; secondly, he thought that young fathers cannot always participate in birth when it is far away from home, mostly due to financial constraints; and finally, he expressed concern about changing Cree childbirth practices that result from evacuation and medicalized birth--women have to travel long distances a few days after birth, babies cannot be wrapped in the waaspisuuyaan because they have to be in a car seat when leaving the hospital, etc.

I talked to a few Cree employees involved in various social programs at the Wellness Centre in Wemindji. They revealed that they are struggling to find ways to engage young fathers in learning about birth and about raising children. There were attempts to establish social support programs for young families and fathers in particular, but those programs did not succeed. Social workers tried going to young families' homes to show videos about how to take care of newborns and babies, and organized support groups at the Wellness Centre, but young fathers would not show up for the events. According to some people, the evacuation policy is deepening the problem of detachment of young fathers from their children. They cannot always make the trip to participate in birth, and later, it is more difficult for them to be engaged in caring for their child.

8.3.4 Community support

As often mentioned in the interviews with Elders and mothers, Cree women have been taking care of each other from the early days of the evacuation policy. Nobody was left alone; every woman was taken care of. Margaret Mistacheesick briefly remembered her evacuation for birth in the 1970s: "We did not stay in the hospital all the time. There was a home there. There were other pregnant women there too. When one would get sick [in labour] the others would go visit her. We took care of each other" (Margaret Mistacheesick, 2013).

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[155] Cree bunting bag/moss bag for the baby.

[156] From my personal experience of several years in Wemindji, many women are using *waaspisuuyaan* for their babies. Apparently, they were used less in the 1980s or 1990s, but today most women with whom I had interviews used a *waaspisuuyaan* for their babies—another good example of the re-indigenization of birth.

Elizabeth, a young mother from a family of nine, remembered the 1980s, when she was a child and all her siblings together with their father would wait at home for news about their mother when she would go to deliver in Val d'Or. Other women would call and give the news about her mother and the newborn. She reflected on the continuity of this practice–fellow mothers taking care of each other and reporting news to the family:

> The other mother that was there, that was in town having her baby at the same time as my mother, she was the one that called and said, "Oh, you have a baby sister!"

So who would usually call?

> It's usually… if there was woman from town that was there, they usually go and be there for the woman that didn't have somebody there. So they would go to the hospital and be there for that woman. A woman was there when my sister was born, and she went with my mom. When my sister was born, she called. Even nowadays, if let's say, there's a woman there, and she's pregnant, and they're about to deliver, and they're from Wemindji, and they're in the same boarding home, or they know they are there, they going to go to the delivery room or to go visit them and offer them help or if they have any questions.

Even if they don't know each other well?

> Yeah. If they know they are from Wemindji, this is what they do. 'Cause I remember my sister. There was a lady there, she had her husband… she came with him, but my sister was there for the delivery too. Even though we were not really close to them, but we know that family, we know them, 'cause it's a small community. And especially the women that are there, the elder women. They all go and see… you can see that on Facebook too! [laughing] "Oh, we went to see how the baby is" or… "I went to see mom…" and they'll say "I went to visit," or, "They're in labour." Some people would stay then in the delivery room and so on… (Elizabeth Shashaweskum Jr., 2014)

Women happily remembered times when they delivered their babies around some festivities that took place in Val d'Or and many people from Wemindji and other Cree communities came down. AQ, a young mother pregnant with twins, was referred to have a C-section in Montreal. Yet, she strongly insisted on having the operation in Val d'Or instead, closer to her family and community. Her main concern was that in Montreal she would feel lonely, and she would not receive the help and support she needed. Finally, permission was granted.

> I had people wanting to be there when the twins were born. There was this lady… 'Cause they would tell you, "OK, only your family can come in." So this one lady, she's from here and she came and she said she was my grandmother, 'cause she wanted to be there! She is not my family. [laughing]

So there were people visiting you?

> The next day there was tons of people that came in from Wemindji! Because there was something going on in Val d'Or when the twins were born. So there was lots of people! So that's what I was hoping for, instead of having my babies in Montreal. I would have been stuck there!... (AQ, 2013)

BK described her son's birth in the 1990s. He had to be medevaced from Val d'Or right after his birth to Montreal for immediate treatment. She could not go with her newborn, so someone from Wemindji escorted him. This escort was not a family member nor a close friend:

> He stayed in Montreal for two days and then they brought him back.

Oh… so he was only few days when…?

> He was only few hours. They sent… I didn't see him. I only saw him when they put him on my stomach and then they took him away after.

Oh, so that must have been stressful for you?

> No, it was not. Somebody went with him, I couldn't. Because I lost too much blood and the person called me to tell that they were coming down. So my son went with somebody from Wemindji. They couldn't send me because I was bleeding too hard.

And it was an emergency case--that's why they sent him there?

> Yeah. He was born 1:30 in the morning and they sent him to Montreal at three o'clock.

And when did they bring him back?

> Two days later. It's after that they found he had too much secretion in his lungs.

Did they explain the reasons to you?

> That he had asthma. They gave him puffers at once there at the hospital, and I had to continue when I came home.

After delivery, did you know they were going to send him to Montreal?

> Yeah, they told me right away. The Cree Patient Services came down to see me. They came to tell me that they were medevacing him to Montreal. Well, at first they told… but then they found room at the Children's Hospital. That's where they sent him.

Did you want to go with him? Or you were OK that he goes alone?

> Yeah, I was okay he goes. He didn't go alone, he actually went with somebody, somebody went with him. I was at the same boarding home.

Was it family?

> No. Just someone from Wemindji. Because they were already going to Montreal. And they came back with him too. (BK, 2013)

I kept asking BK if she knew the person who escorted her baby, if she knew why they sent him away without her, did she want to go with him, did she feel stressed or worried, but BK seemed not to understand my worry; she said several times that she was not stressed, and she emphasized: 'He didn't go alone, he actually went with somebody, somebody went with him.' That the escort was just "somebody from Wemindji" shows the amount of trust community members have in each other. It is a common practice in Wemindji to escort someone who is not a family member. People trust one another and provide essential mutual help. Such help and reciprocity is appreciated, but it is not extraordinary; rather it is the ordinary way things work in Wemindji.

In this chapter I focused in on the ways Cree adapt to birthing in the hospitals and create a healthy and safe birth away from home. Since family' and community participation in childbirth is the most important consideration for mothers to birth safely, Cree maintain support communities and networks for mothers in southern cities. Because of the realities of evacuation, Cree family and community roles in birth are shifting and adapting to the contemporary environment. Responsibilities in providing support during the last month in evacuation and during childbirth are fluid and interchangeable–family and community members easily exchange their tasks at birth and find ways of supporting the mother and each other. They step in whenever they can and wherever they can be useful, even those who have no relevant knowledge nor skills–they simply learn "on the go." An especially noticeable role has been taken on by the mothers themselves who, from the very beginning of the birth evacuation policy, have been taking care of each other - in boarding homes, as birthing coaches, doula-ing fellow mothers through labour and birth.

CHAPTER NINE: CROSS-CULTURAL COMPARISON AND CONCLUSION

9.1 Cross-cultural comparison

9.1.1 Human childbirth – a biosocial process

In this thesis, I argue that sociality, combined with flexibility, reciprocity and self-reliance, are the essential traits of Cree childbirth that have helped Cree mothers and their families cope with the challenges presented by the medicalization of birth, including evacuations, long waiting periods away from home, and coldly technocratic, often demeaning care in the southern hospitals.

Trevathan (1997, 1999, 2011) reveals through her research that sociality is an important trait of human birth and is largely an outcome of human biology. Humans have considerably more difficult births in comparison to other mammals due to the "obstetric dilemma" (Cheyney and Davis-Floyd 2019), Stoller 1995, Trevathan 2011)–a term used to describe conflicting evolutionary pressures on human pelvic shape. The human pelvis needs to be narrow front to back and wide enough side-to-side to allow bipedalism, and at the same time, the birth canal has to be wide enough and rounded to accommodate and allow the human infant to pass through (Cheyney and Davis-Floyd 2019), Stoller 1995, Trevathan 2011). The competing selective pressures resulted in an obstetric evolutionary compromise called sexual dimorphism, meaning that women's pelvises are wider than men's to allow the births of large-headed infants. The female human pelvis is nevertheless not as wide as those of the higher primates, and so human babies have to maneuver through a series of "cardinal movements" to work their way through the narrow birth canal.

The complexity and relative difficulty of human birth may have resulted in certain cultural adaptations that facilitate the birthing process (Cheyney and Davis-Floyd 2019). For example, mothers almost always seek assistance in births. Trevathan (1997, 1999) called this condition "obligate midwifery." She observed (1997) that before the medicalization of birth, childbirth cross-culturally tended to be a social event with community and family present to assist women in birthing. There are only a few exceptions to this of places where women tend to give birth alone (for example, the Rarámuri—see below). Trevathan named three important differences in the mechanisms of birth in humans and other primates that favour social childbirth: (1) human babies usually emerge facing away from the mother, which makes it difficult to reach down to catch the baby, to clean the airways or to remove the umbilical cord

from the infant's neck; (2) humans give birth to altricial[157] infants who need extensive care right after birth, while mothers may be exhausted after long and difficult labours; (3) long and difficult human birth involves powerful emotions on the mother's part – anxiety, fear, excitement, tension, joy, uncertainty, etc.–and these might have triggered mothers to look for assistance during births to help overcome psychological challenges (Cheyney and Davis-Floyd 2019). Those three mechanisms and elements of human birth might have resulted in childbirth being typically a social event in need of sociocultural interventions and adaptations.

The Wemindji Cree seem to be no exception in this human trend toward highly social birth. It is clear from the interviews that today sociality is the most highly valued part of Cree women's labour and birth experiences, and it is this very trait that helps Cree cope with the challenges presented by medicalization and evacuation policies established throughout the 20th century. Cree birthing mothers coped well with birth in the bush because they were surrounded by family and/or friends, and for the time being they appear to also cope well enough with medicalized birth, as long as they are accompanied by others from their own community. Throughout the colonization and medicalization processes, Wemindji families maintained this sociality, which has facilitated their adaptation to changes and new environments in birth. This finding has important cross-cultural implications. Thus, in this chapter I will look at several other models of birth that have very similar or very different features in comparison to Cree birthing. Such cross-cultural comparison places Cree birth in a wider context of other birth models and provides a deeper and more detailed understanding of Cree ways of birthing.

9.1.2 Rarámuri and Cree models of birth – social vs. solitary

The Rarámuri birth model makes an interesting comparison with the Cree model of birth because Rarámuri birth is, in some ways, the very opposite of Cree birth, primarily in its solitary nature. However, many underlying traits and culturally held values in birth among the two peoples are quite similar. The primary method of birthing for Rarámuri, an Indigenous peoples living in the Sierra Madre mountains of northwestern Mexico (also known as Tarahumara), has been solitary or "unassisted" birth inside or outside their homes. Rarámuri highly dislike and deeply fear hospitalized births (Miller 2020, in press).

[157] An altricial infant is one who depends entirely on the mother or caregiver for survival (Cheyney and Davis-Floyd 2019; Trevathan 1999).

Midwife and anthropologist Janneli Miller, who has studied the Rarámuri for 13 years, writes that Rarámuri learn about birthing through observation and some conversation, but emphasizes that their primary mode of learning is non-discursive (Miller 2020, in press). Cree ways of learning about birth, especially when birth was taking place in the bush, were mostly through participation and observation, and thus also in a non-discursive manner. Today, not everyone is able to witness births anymore. However, even when births are taking place in the hospitals, the habit, the urge or tradition of the participatory and observational mode of learning is strong among Cree. When talking about bringing births back to the community, Cree Elders mentioned that people want to watch births and that is one of the reasons why women should be allowed to choose birth in the community.

Watching births at first seemed to me an unexpected and interesting reason for re-matriating Cree birth, but now I think that it is an important continuation of the Cree mode of learning about births; the act of watching is the process of learning and the way of making sure that the knowledge of childbirth is transferred and spread among people. I suspect that learning is an implicit meaning behind the act of watching. When it comes to learning through participation, Cree are also engaged. Today, they find themselves in hospital rooms with the birthing mothers in different kind of roles (see 8.3 Shifting roles and responsibilities during birth), and often they are thrown into action in the midst of events, taking on participant responsibilities without second-guessing or questioning. The "sudden initiation" to the birth attendant role is also part of a continuous Cree practice of learning about birth (see 5.2.2 Acquiring midwife skills). Some people are more, others less, prepared for their participatory roles in childbirth today, but they learn in the process, through practice and sometimes support from other Cree in the birthing rooms. All in all, apart from the advice given by close family members, information from the books or biomedical staff (see 4.3 Advice during pregnancy), similarly to Rarámuri, Cree continue learning about births through non-discursive ways.

When it comes to young children's participation in birth and their learning about the process, Rarámuri and Cree methods echo each other. During birth at home, Rarámuri tend to ask younger children to leave the house and play outside. Nevertheless, Miller notes that "…young girls are acutely aware when their mothers deliver. Girls observe the behaviour of their mothers and imitate it when their time comes" (Miller 2020:5, in press). Further, Miller writes that older Rarámuri children might sometimes accompany or assist their mothers at birth (2020:5). Cree Elders also revealed that when they were small kids, usually they were

asked to play outside during births. The older they got, the more aware they were becoming of the important event taking place inside the dwelling. As Cree girls matured, they were allowed inside and were responsible for keeping the fire going to keep the place warm. Sometimes they were also taken by their mothers or grandmothers to assist in births. In this way, Cree girls were able to participate; similar to Rarámuri, they observed from an early age and imitated when their time came.

Self-reliant, calm and quiet birthing, including the "no tell" trait during labour, is another shared element between the Cree and Rarámuri birthing models. Miller (2020:7, in press) writes that "Usually a woman continues her work when she first experiences contractions. At some point, perhaps when contractions force her to catch her breath, she tells her husband and shoos the children out of the house," Cree mothers, while in the bush - and today, when in the southern boarding homes - often do not tell anyone about the onset of labour until other women notice. The advice of Cree Elders was to continue with the daily routines and chores, including preparation of bedding, baby items, clothing, etc., until it was time for the baby to come out. As described in Chapter 5, for the Cree, self-reliance, non-interference, competence, confidence and calmness were, and are, the main values in childbirth, as they are for the Rarámuri.

Another common belief shared by both the Rarámuri and the Cree is that babies have their own agency in birth and its outcome. Miller cites her interview with Isabel:

> I ask Isabel if he (her husband) helped her with the babies. "Well, he wanted to, but sometimes he couldn't. The last one, the girl, she was born when Ramiro was out of the house. The baby did not want to come. When Ramiro went out, the baby came right away. I think the baby was shy. She just did not want to come out if Ramiro was there (2020:7, in press)

Cree, similarly to Rarámuri, believe that the baby does hard work during birth and that they, together with the mother, are a team in the birthing process (see 5.9 Birth complications: deaths, miscarriages, premature births). Rarámuri not only allot agency to the baby, but also prescribe her a character. Isabel tells that her baby was shy and did not want to show up when her (baby's) father was in the room. Furthermore, Miller says that for Rarámuri the outcome of birth depends on women's individual behaviour combined with that of the unborn child (2020:11, in press), which echoes the Cree perspective that the baby works together with the mother as an intimate team.

According to Miller, "Knowledge about how to assist women in childbirth is common to all members of Rarámuri society" (2020:6, in press), which was also an important trait of

Cree births until they were transferred to the local nursing station behind closed doors, and eventually completely removed from the communities in the 1980s. Rarámuri do not have a word for "midwife," because all members of the society know how to assist (2020:6 in press). Similar to the Rarámuri, the Cree individual attending birth could be anyone who is around to help, including a father who never attended births before or a grandmother who is more experienced and might be known in the region for her skills. The difference here lies in the fact that Rarámuri mothers did not, and do not, necessarily seek assistance for births and many birth unassisted, often outside their home, in a solitary quiet place.[158] Cree mothers, on the other hand, have always looked for assistance and considered the presence of family and community essential for a healthy birth environment. At home or in the hospital, Cree have always had a whole support system set up during births with different people interchanging their roles and creating culturally safe spaces for the mother and the baby during birth. When Cree birth was taken away from the land, the presence of the family and community in the south became the most important factor that allowed Cree mothers to have considerably safe births away from home and to face the challenges of the technocratic hospitals. The Rarámuri are not allowed this kind of community support in the hospital.

As Miller shows, Rarámuri core values centre on independence, modesty, individuality, a cooperative and egalitarian society, reciprocal economic relations among kin, and a distrust of outsiders; these core values are reflected and enacted in their birthing practices. Thus, to lose their ways of birth would be to lose key aspects of their culture. Cree core values differ in some aspects, but not others. Cree core values centre around community, family and the land. Similar to Rarámuri, Cree also rely on independence/self-reliance and modesty (keeping things to oneself until the last minute, birthing patiently and quietly). Cree are also known for being an egalitarian society in terms of social hierarchies and gender roles, which has changed somewhat through processes of colonization (see 2.2 Iiyiyuuschii in the second half of the 19th, beginning of the 20th century: The beginnings of colonialist policies and 4.2.2 Whom to marry? - the impacts of the Indian Act on Cree family planning patterns). Reciprocity among Cree and their environment is another great value discussed not only in this thesis, but elsewhere as well (Feit 2004; Nadasty 2007; Scott 1989). However, distrust of outsiders does not seem to be a trait that Rarámuri and Cree share. Cree have engaged in trade with many different Indigenous and non-Indigenous people for hundreds of years (Wren et al. 2014) and

[158] The Rarámuri tendency to birth in privacy with only one or two people by their side seems akin to the current preferences of Euro-Canadian "freebirthers" who choose to birth with their partners or no more than one or two close people by their sides.

whatever distrust they have towards outsiders today, I see as an outcome of colonization and a result of the hostile and destructive policies against Cree of the colonizers and southern governments.

Rarámuri strongly resist hospitalization for births, while Cree more passionately speak about the choices that should be provided (community and hospital births) and the quality of care that should be culturally appropriate in whichever place Cree mothers decide to birth. The main difference between the Rarámuri fear of hospital birth and the general Cree acceptance of it seems to have much to do with sociality, community and cultural safety. Rarámuri women, who are used to solitary births with minimal assistance from only the most trusted kin, are expected by the state government to birth in hospitals surrounded by hostile strangers, with no support, no translators, and no respect for their practices; they are culturally and personally unsafe. For Cree mothers, translation/communication can be an issue in the hospital, but their birth companions provide them with respect and cultural safety as much as they can, given the circumstances, and sometimes a few hospital caregivers - much to their credit - allow and provide space for them to do so because they have come to understand the benefits. It is telling that the Cree women I interviewed who had major issues with their hospital births were usually the ones who gave birth unescorted, alone - just as most Inuit women had to do during evacuations (see below).

Miller also shows that the dangers Rarámuri face in the hospitals are much greater to them than the dangers of giving birth alone without skilled attendance. Disrespect, maltreatment, and flagrant "obstetric violence" (D'Gregorio 2010) due to rampant racism characterize almost all staff treatment of Rarámuri birthing mothers. For the time being, the Rarámuri do not have much opportunity nor power to "indigenize birth," whereas Cree, insofar as they achieve their goal of having as many "right people" as possible at their births, do have both the opportunity and power to change hospital birth culture and to include their ways—so even as the technocratic medical system changes them, they also change it, indigenizing it in accordance with their cultural values on flexibility and "being alive well." In other terms, Cree often manage to generate and maintain a sense of cultural safety in birth by surrounding themselves with a supportive team of their own, whose members can bring their shared knowledge to bear on how best to give birth.

9.1.3 Cree and Inuit models of birth

Because, as described in Chapter 3, both Inuit and Cree are Indigenous groups who have experienced similar political pressures from the government, including decades of forced evacuation for births, their coping systems and strategies in response to the medicalization of birth are ripe for comparison. Before going into details about the different strategies of Inuit and Cree in the politics of birth, one must be familiar with their historical context and understand the long path the two neighbouring peoples have gone through to be able to create their different models of perinatal care and birth.

Cree and Inuit from Southeastern Hudson Bay (Nunavik) lived side-by side for centuries and, according to some researchers (Morantz 2010) and local oral histories, their relations were often hostile in the past. However, Euro-Canadian attempts to dominate the region through a mercantile system and colonial policies united Cree and Inuit to stand against very similar challenges and similar threats (Morantz 2010). According to Morantz (2010), Inuit and Cree responses to the challenges imposed upon them by colonization somewhat varied. For example, when White traders came to the region in the late 17th century, Cree chose to participate in the fur trade, while Inuit resisted such engagement for a century after the Hudson Bay Company first established a post on their lands (Morantz 2010:111). Both Inuit and Cree embraced Christianity brought by missionaries in the late 19th century and adapted it to their own needs. However, when the federal government, in the first half of the 20th century, started aggressively imposing socio-economic services, Inuit took up wage labour, while the Cree largely stayed away, preferring to maintain their hunting and trapping subsistence economy to feed their families (Morantz 2010, 2002a). The Canadian federal and provincial governments were far more aggressive with their policies of colonization of Inuit and Cree than the previously encountered traders or missionaries. Using the power and resources of the state, governments put strong efforts into coercing Inuit and Cree into a Western value and knowledge system and its administration (Morantz 2010, 2002a). Their policies and administrative decisions required Inuit and Cree to move into residential towns to start leading a settled lifestyle. Cree and Inuit children were taken away from their families to attend residential schools, and welfare programs and wage-labour were introduced in the communities, resulting in the decline of subsistence hunting, trapping and fishing activities and making people dependent on the programs and short-term jobs (Morantz 2010, 2002a). Finally, colonial medicalization processes led to the development of evacuation policies for birthing mothers and for individuals with infectious diseases, many of whom

never returned home. Cree and Inuit traditional territories have been used for exploration and natural resources extraction without consultations or warnings to Inuit or Cree, disturbing and/or destroying the natural habitats of the game that many were and are dependent upon for survival.

Thus, when the opportunity came around, Inuit and Cree united and took the opportunity to demand that southern governments develop a Nation-to-Nation relationship that included restoration of greater Indigenous autonomy over their regions and protection of their lands and their lifeways. In the early 1970s, the Bourassa Quebec government announced its plans for the construction of a $6 billion project on the La Grande River, which was an essential source of subsistence (water, fish, hunting territories with wild game) for Inuit and Cree (Morantz 2011, 2002a; Niezen 1998). Both peoples emerged from those negotiations with the controversial James Bay and Northern Quebec Agreement (JBNQA) in 1975, which was the first comprehensive settlement of Indigenous land claims in Canada (Niezen 1998). The Cree and Inuit had to meet the governments halfway–by allowing the construction of the La Grande power plant on their lands, they gained administrative inclusion of the northern Quebec region into the Quebec provincial system, more regional autonomy, and monetary compensations (Niezen 1998:3, Rostaing 1984). In the agreement, the Cree negotiated a plan for their Regional Authority (the Grand Council of the Crees), autonomy in education (Cree School Board), health care (Cree Board of Health and Social Services of James Bay) and the Income Security Program, which guaranteed income to hunters and their families who spend most of their time hunting, fishing and trapping in the bush (Niezen 1998:3).

Similarly, Inuit negotiated the regional authority (Kativik Regional Government), autonomy in education (the Katavik School Board), in health (Nunavik Regional Board of Health and Social Services), justice and other economic policies (Watt-Cloutier 2015:90). This was the point at which Cree and Inuit began planning their own health policies based on their own priorities for health and educational reforms. Regarding health and wellbeing, Cree and Inuit had very similar goals, but took different strategies in achieving them. The main goal for both was to revive and maintain traditional activities, which take place on the land, to reclaim traditional lifeways, identities and thus, the wellbeing of their people.

Both Inuit and Cree had to operate within certain limitations; for example, the changes and distributed funding had to be approved by the Quebec provincial government (Niezen 1998:97). As stated by Niezen (1998:96), “The legal parameters within which Cree health

administrators were required to work in the early years of implementation of the James Bay Agreement left comparatively little room for the development of culturally appropriate policies and practices." The Cree Board of Health was compelled to work within already existing frameworks and thus found it a difficult time to accommodate Cree wellbeing practices within that system. The Cree took gradual steps in the sector of health by slowly adapting the system to their needs.

On the other hand, Inuit, faced with similar impediments and limitations, decided to make big reforms in the healthcare sector, including "bringing birth back" a priority. A number of Inuit women, supported by Elders and community members, demanded this focus because as one Elder from Salluit in Nunavik, Evie Saviadjuk, put it, "to bring birth back to the communities is to bring back life" (Epoo et al. 2019). The Inuit community of Puvirnituq, and most of the Hudson coastal communities in Nunavik region, have re-matriated birth back to the communities by building Maternity Centres staffed with skilled Inuit midwives[159] (Epoo et al. 2020, in press). Inuit believed that bringing birth back would help to resolve other issues such as mental illness, youth suicide, addiction and violence. Douglas (2006) wrote that, "An essential component of traditional Inuit health is their connection with the land, which functions as an important part of Inuit identity. One of the most important components of this connection is birth within the community, and hence on the land itself" (p.125). Inuit saw the evacuation policy for births established by the federal government in the 1970s as yet another government plot to take them away from their lands, or take the lands away from them, and thereby to take away their identity and their ways of being. Bringing birth back for them was the means of maintaining their cultural integrity and ownership of the lands and of being Inuit.

The land is an essential value for both Inuit and Cree. I witnessed many Cree mothers and families bringing their young children and newborns to live on the land for several weeks at a time, as well as many people going to the bush to heal from various addictions, mental illnesses or social conflicts in town. Life in the bush for Cree is a powerful medicine. In the Regional Assembly meeting in 2018, the Wemindji community presented their three primary goals in the healthcare sector: "traditional knowledge and land based healing" is one of them (see http://www.creehealth.org/sites/default/files/2018-Assembly-Community-Priorities_0.pdf). Even after the establishment of the Paint Hills (Wemindji) settlement and

[159]Hudson coast has 3 Maternity centres that serve 7 villages on the Hudson coast and Strait. On the Ungava coast, there is one Maternity centre in Kuujjuaq, but currently no Inuit midwives.

the medicalization process, a large population of Cree, to this day, continue using the land for their subsistence and for healing–for "being alive well" (miyupimaatisiiun).

However, Cree chose a different strategy from Inuit to secure and preserve their connection with the land. While Inuit decided that bringing birth back on the land would help work towards ensuring the well-being of the people, Cree chose to improve health and well-being by encouraging Cree to continue their traditional bush activities, providing hunters' families with income and first-aid supplies and training. The leading causes of death in the 1970s among the Cree population were accidents, poisoning, trauma and suicide (Niezen 1998:98). Many of those deaths were attributed to the lack of immediate first-aid in far-away locations in the bush. Thus, the Cree Health Board started a "bush kit" program to prevent fatal traumas and lifetime injuries for families, emphasizing that staying on the land and continuing land subsistence activities are vital for Cree wellbeing. Bush kits contained a bush radio to reach out for help, and first-aid-kits. Cree personnel were trained as first-aid instructors; volunteer hunters were trained in first-aid courses (Niezen 1998).

However, the "bush kit" program had a dual effect – on one hand, it supported the bush lifestyle and decreased deaths caused by accidents; on the other hand, it increased Cree dependency on the biomedical system and influenced the decline of Indigenous healing knowledge and practices. The "bush kit" program acted to replace, rather than complement, Cree medical knowledge. So while many hunters were appreciative of the bush kit program, they also raised concerns about the impacts of the program on Cree traditional medical knowledge and on declining self-reliance of those out on the land (Niezen 1998:101).

Regarding birth, both Cree and Inuit believe that babies should be born within their community surrounded by family. Thus, in addition to the land, community is another deep value for both. Inuit of Puvirnituq decided to bring birth back to their community over 30 years ago, and did so successfully, with excellent outcomes (Epoo et al 2020). The Cree healthcare institutions were working on other priorities, like the "bush-kit" program in the health care sector, however, Cree did not leave their birthing mothers alone down south but rather managed to bring community to wherever Cree mothers were evacuated to birth. Even before the official "escort" policy was established by the Cree Health Board in the early 2000s, Cree were organizing themselves and creating spontaneous support networks for the mothers in faraway southern locations. As previously shown, mothers usually stayed with other Cree women in someone's home or in boarding homes for Cree patients. Women cared for each other, accompanied each other to birthing rooms, and secured hospital spaces around

the mother that would generate a supportive psychosphere (Jones 2009) to make the experience - as much as possible - comfortable and culturally safe. Fellow mothers called back home and kept the family members who could not be there in the loop of events. Throughout the colonization and medicalization processes, Wemindji Cree families have held on to specified sociality in childbirth, which reflect and enact their deep values of reciprocity, self-reliance and flexibility in adapting to changing environments, shifting roles and responsibilities in childbirth. Cree families have managed to create spontaneous temporary communities away from home for their mothers that work effectively.

One large advantage that Cree have had over Inuit in terms of nurturing sociality in childbirth has been their geographical location–Cree communities are closer to the southern hospitals than those of Inuit. The trips are shorter and require less time and less expense for Cree, meaning more Cree are able to come to Moose Factory, Montreal and especially Val d'Or to be with their birthing mothers. In the 2000s, the Cree Health Board also began covering one-week expenses for the trip and the housing for the escorts accompanying mothers. Inuit, on the other hand, have not have an official "escort" policy until recently.[160] Before the establishment of the policy of birthing in community Maternities (birth centres) with midwives (1986), pregnant Inuit mothers were flown out alone to Moose Factory or Montreal, which were considerably longer trips than for Cree from James Bay, and they had to cope with strange foods, long waiting times and being cared for by "intimate strangers" (Davis-Floyd and Cheyney 2009). Cree, by bringing family and community to births, have found different ways to reclaim hospital rooms as their own birthing spaces, often against hospital regulations, and that is how they have been able to cope with birth away from home for many years, before bringing birth back to their communities in 2019 (see below 9.3 The Cree Birthing Initiative and the ways forward).

Bringing birth back is part of a resurgent movement of Indigenous peoples and is increasingly regarded as essential for Cree, Inuit and many other First Nations across Canada.[161] The differences between Inuit and Cree lie in their varying situations, strategies

[160] Currently the NRBHSS has an escort policy for all medical evacuees and also specifically for pregnant women.

[161] Bringing back birth is on the way in Alberta (https://www.cbc.ca/news/canada/edmonton/it-really-works-alberta-maternity-group-calls-for-midwives-in-indigenous-and-rural-communities-1.4635999), Saskatchewan (https://www.cbc.ca/news/canada/saskatchewan/indigenous-maternal-health-research-university-of-saskatchewan-1.4516115), and Manitoba (https://www.cbc.ca/news/aboriginal/bringing-birth-back-to-remote-manitoba-first-nation-1.2703154). Babies are born with Indigenous midwives incorporating Indigenous practices in Ontario, Tsi Non:we Ionnakeratstha Ona:grahsta' Maternal and Child Centre located on the Six Nations of the Grand River Territory (http://www.snhs.ca/bcBackground.htm).

and priorities. The sociality trait, including specified sociality, has helped Cree mothers to deal with the evacuation policy and to build the spontaneous support networks they have needed for their births, aided by their geographical proximity to southern hospitals. Thus, bringing birth back has not been as great a priority for them as it was for Inuit mothers, who were unable to build such networks and had to be completely alone during the evacuation period—"strangers in a strange land"—sometimes for as much as a month or more, leading to extreme anxiety for these women and to social disruption back home due to their long absences.

This comparison has clear implications for the evacuation policies of the future, should they continue to be followed: clearly, all evacuated Indigenous women should be allowed and supported to be escorted by as many people as possible from their own community, and, like the Cree, should be housed together in home-like places[162] where they can form spontaneous support systems. Organically formed spontaneous support networks can be great sources of information on the variety and specificity of needs of birthing mothers from differing sociocultural backgrounds. Via such networks, mothers and their communities can show what they need and work to fulfill those needs themselves, rather than being told what they need for safe and successful births and having to accept technocratic care.

9.2 A summary of my findings

In my introductory chapter, I discussed the Cree relationship with childbirth in terms of "longing and pride," where longing was attached to an experience of childbirth in a particular time and space where everything felt right (when/where Cree were miyupimaatisiiun); it was a moment to embrace and absorb in order to create longing for this kind of time and space in the future. This place and time for Cree were when Cree lived, birthed and died on the land, in the bush. Today, Cree know that their lives and the world around them have changed in many ways, and they embrace the changes and adapt to them, but birth in the bush for many is associated with that feeling of "being alive well" (Adelson 2006). The longing they created back then is in their hearts, even if they understand that it is not going to be the same, nor would most choose to have children in the bush today. The Cree who were born in the bush are very proud to share their stories, and many Cree would love to be born on the land, or in the community today. Cree feel honoured to witness births, to participate in births and are

[162] Most mothers preferred small housing units where it felt like someone's home, rather than big Native Centres, where it felt like staying in a hotel.

eager to watch births. As in the past, today Cree birthing continues to be a family and community event no matter where it takes place.

After briefly describing Cree society in its past and present forms, including the continuous Cree relationship with the land, I reviewed research done in the eastern James Bay Wemindji area, noting that most studies around Wemindji were based on experiences, perspectives and information provided by Cree men, and mostly conducted by male scholars; thus, the subjects of birthing and childrearing were largely omitted. I reviewed works that have some information about Cree women's experiences from eastern and western James Bay, and presented the research of female scholars who worked, or are currently working, in the region. Finally, I reviewed research relevant to Cree childbirth and Cree childrearing. In the last section of the introductory chapter, I described my thesis structure and the methods of my ethnographic research in the Cree Nation of Wemindji.

Chapter 2 zeroed in on describing the historical context around the life of the Cree throughout the last century—their hunting and gathering lifestyle in the bush; the encounters with colonialists; their gradual movement from a mobile lifestyle to life in settlements such as Wemindji; the beginnings of their medicalization, including that of birth; and of the early implementations of the government-decreed birth evacuation policy.

In Chapter 3, I argued that Cree compliance with the evacuation policy was an adaptive strategy of superficial compliance–a form of survival and resistance in which people outwardly comply with colonialist policies while not compromising their underlying values and beliefs. I employed the Inuit concept of ilira - a particular kind of fear, born out of an authoritarian and unpredictable environment - to explain and clarify the reasons Cree engaged in superficial compliance tactics. I also used Foucault's model of panopticism to show how fear might also arise from the knowledge of potentially being watched at any given moment, as Cree may have felt, given the circumstances of the time, which might have also resulted in forms of superficial compliance. Further, based on writings of Franz Fanon and Indigenous scholar, Glen Coulthard, I argued that superficial compliance eventually becomes normalized, automated and internalized; and that later, after realization of unjust realities, internalized colonialism evolves into resurgence and demand for respect, truth and justice. We can observe this process in Canada today in the form of grassroots movements, protests and various initiatives, as in bringing back birth to Indigenous communities and providing women with choice in location and varying ways to birth.

Chapter 4 addresses family planning, both in the bush and in town, comparing the older practices with their contemporary counterparts. I found that flexible family planning patterns were gradually becoming more and more restricted, particularly after the move to the settlement in 1959. Cree bush lifestyle and wide spaces facilitated and supported a diversity of ideas and practices about family planning among Cree, while the change in density of the town population altered the community's social dynamics, making it more difficult for alternative views to coexist and to resolve conflicts. Teachings at the church about Christian morals and colonial legislation, particularly the Indian Act, restricted the flexibility of the concept of the family and normalized gender inequalities. Inequalities based on gender and ethnicity became internalized and normalized by some Cree, resulting in great pressures and challenges for the younger generation that lasted through the 1970s and well into the 1990s, when marriage by choice, single parenting or intermarriages with non-Cree became increasingly acceptable again, as they had been in the bush. In Chapter 4, I also looked into advice women received when being pregnant in the bush and later in town. Women received most advice about pregnancy from the older and/or more experienced women in their family; and occasionally from their fathers and grandfathers. When in town, some women consulted different family members for different pregnancy issues, and/or combined different sources of information for specific questions, such as literature and biomedical recommendations. Prenatal biomedical and family advice often concurred and complemented each other, making prenatal care for women that much more effective.

Chapter 5 took us on a journey back in time through birth in the bush. Cree bush birth was based on the concept of miyupimaatisiiun "being alive well" (Adelson 2006), where the environment was believed to significantly influence women's emotional and physical state during birth. The mother was responsible for birth and had control of her birthing environment. Through the stories of Elders, I found that they believed that the baby also played an important role in birthing by working its way through the birth canal and, in this way, helping the mother. The Cree term for "midwife" translates as "a person who attends birth"–a woman (iskwaau kaa uutinaat awash) or a man (napaau kaa uutinaat awash). These terms indicate that childbirth knowledge was widespread among Cree and everyone knew more or less how to help the birthing mother if the need arose; therefore, midwives among Cree varied significantly in their skills and levels of experience. If the most experienced midwife, usually an older woman or a grandmother, was not around, the mother was attended during labour and birth by whomever was there, and that attendant would be considered a

midwife nevertheless. In the chapter I also discussed various roles Cree family and community members played and the responsibilities had during birth. The environment and the bush-based lifestyle influenced the Cree childbirth model, which had certain guidelines for different family and community members, but was flexible, depending on the circumstances. Cree childbirth in the bush was a social family and community event characterized by the display of Cree core values of self-reliance, modesty, flexibility and reciprocity.

In Chapter 6, I looked into the establishment of the nursing station in Wemindji and the transfer of Cree births to the station. I explored the roles of Cree midwives and nurses during births in the clinic until the late 1980s, when Cree births were transferred to the southern hospitals. I found that Cree midwives were unofficially collaborating with the nurses, undertaking many traditional roles of birth participants in the bush, and providing a great comfort and sense of security for Cree mothers and their families, anticipating the news behind the closed doors of the birthing rooms. Unfortunately, under such circumstances the learning experience through watching births and participating in births, which are the principal ways of knowledge transmission among Cree, was discontinued and midwives had no means to pass their practical skills on to younger generations. Interestingly, such collaboration among Cree midwives and the nurses in Wemindji was not in line with the governmental rhetoric and policies of the time, which viewed Indigenous midwives as unsanitary and unequipped to assist in births. However, in Wemindji, during the first decade of clinic births, Cree midwives not only played a major role in births for the mothers, but for the nurses as well. Based on the stories of women, nurses had yet to acquire practical skills; thus, they learned from the Cree midwives as well as sharing responsibilities during births, which, I supposed, alleviated the nurses' stress and greatly influenced positive birth outcomes.

I also examined the different reasons for and circumstances of emergency births that take place at the Wemindji clinic today, based on the stories of Cree families and the medical staff at the clinic. The opinions of the biomedical staff and the families largely echo each other. Apart from premature births, interlocutors mentioned that they wanted to keep their pregnancies to themselves and so avoided prenatal services until their labour started. The reasons for this avoidance differed – no partner, "unsuitable" partner and/or a wish to evade town gossip. Some biomedical staff suspect that some women want to avoid the over-medicalized and stressful processes of the follow-up appointments and tests altogether, and

thus show up at the clinic only during the onset of labour. Some Cree women claimed they did not know they were pregnant until they started having labour pains. The staff confirmed that this could also be a valid reason for mothers showing up late in pregnancy for appointments or eventually emergency births.

Overall, with a few exceptions, clinic births were mostly remembered positively by women that I spoke with, elderly and young. The main reason was that women were happy to give birth to their children in the community, even if beds were hard or the staff was not always well-prepared. This speaks to the fact that Cree wish their children could be born on their land.

Chapter 7 focuses on Cree mothers' experiences of the evacuation and births in hospitals. Based on women's memories and stories, I conclude that, from the Cree perspective, the riskiest birth is to have to birth alone, without family and community support. Keeping this perception of risk in mind, I focus on the three main themes in women's birth stories:

(1) prenatal appointments, which women found increasingly helpful after the establishment of the Awash department (2009) in Wemindji clinic;

(2) routine evacuation procedures for births throughout the 1980s and today; here I emphasize the challenges and effects that waiting during the evacuation period have on women. I reveal women's coping strategies, which centre on creating spontaneous support communities for each other in the boarding homes where they wait for births;

(3) epidurals, C-sections and unpleasant postpartum stays, which, after introducing the three models of birth identified by Davis-Floyd (2001)—the technocratic, humanistic, and holistic paradigms (2001) - I analyze as parts of the prevailing technocratic model in Val d'Or hospital. Regarding the use of epidurals, I found that biomedical staff assume that women want them and often try to convince them, subtly or overtly, that they need one, while Cree women reveal that the use of epidural during birth for them is not an easy choice. Several women expressed that they prefer birthing without it or having alternative ways of dealing with labour pains, such as nitrous oxide, having family members nearby, while maintaining the full sensibility of their bodies, especially during pushing. Regarding caesareans, women in Wemindji want to avoid them as much as possible. However, due to complex reasons, including miscommunication or lack of communication and strictly technocratic care in the hospital, James Bay Cree women end up with a relatively high number of caesareans at Val d'Or (around 30%–double the WHO recommended limit of 15%). On the other hand, women

largely expressed their tendencies to trust practitioners' choices in regard to birth and C-sections, and rarely criticized or doubted professionals' decisions during birth. Contrary to that acceptance during labour, during the postpartum stay Cree mothers were much more confident in themselves and more critical about their needs not being met. They recognized when they did not receive proper care or help and pointed out the mistakes the staff made in communication or in prescribing medication or treatment they did not need. They also noted the patronizing environment, the demeaning attitudes staff often held towards women and their families, and the inadequate and crowded facilities in the hospital for mothers and newborns.

Chapter 8 focuses on the continuities and changes in Cree childbirth practices in the hospitals and how Cree have managed in varying ways to adapt and maintain their own ways of birthing in an alien technocratic environment. I show how Cree not only take advantage of biomedical technologies and services, but actually manage to push the boundaries of the hospital regulations and to influence–to partially indigenize–the biomedical staff's routine practices. Cree humanize and indigenize their birth experiences via companionship and occasionally through strategic interaction with hospital staff (such as, for example, teaching practitioners Cree words to make the birthing mother feel more relaxed during labour). They accomplish indigenization of the technocratic institution in large part by working to ensure that the labouring woman has at least one labour support companion of her choice by her side throughout, and often by getting hospital staff to allow far greater numbers of people in the delivery rooms than usual, thereby enacting and preserving their high cultural value of giving birth in community and satisfying community members' desires to witness birth.

Over the last 60 years, Cree childbirth underwent the full circle of transitions, from being taken away from the land and community by colonial and medicalization processes, to being re-matriated by Cree initiatives back home, on the land. It is important to note that even if Cree are longing for bush births, they do believe that today the circumstances are different and they are eager to use all the knowledges (biomedical and Indigenous) and technologies available in birth. Thus Cree, exhibiting their core value on flexibility, take a very pluralistic approach to childbirth today and give priority to women's individual choice and decisions in birth. Perceptions and definitions of risk are continuously changing over time, according to changing realities (Lupton 2013:43), and those changing realities and perceptions of risk in childbirth are clearly reflected in my interviews with the Wemindji Elders. Even though many

Elders long for births in the community, they agree that the place and manner of childbirth is an individual decision and every woman has to decide for herself about how and where she wishes to birth, because what was available back then in the bush, or two decades ago in town, is not the same today. Elders often add that such decisions on the mothers' part have to be made in consultation with biomedical professionals, confirming the Cree pluralistic approach to childbirth - they are eager to use the biomedical knowledge and technologies available and to combine them with Cree ways of birthing. Thus, during these transitions, Cree childbirth practices, values and perceptions of risks in childbirth have changed and adapted to the shifting circumstances, yet some traits and values remain the same. I argue that sociality and flexibility combined with reciprocity and self-reliance are the essential traits carried from the bush to the local clinic and to the southern hospitals, and these traits have helped Cree mothers and their families cope with the challenges posed by the medicalization of birth. Throughout these transition periods, Cree childbirth has remained a social, family, and community event and sociality is what creates a miyupimaatisiiun (being-alive well) birth environment for Wemindji Cree mothers.

9.3 The Cree Birthing Initiative and the ways forward

Today, Wemindji Cree birthing location preferences seem to vary widely. Yet, as previously stated, they all have in common the desire to be accompanied by family and community members. The strong consensus among Cree is that women have to have choices, and every Cree I talked with showed great interest in giving birth in the community or being participants in births. Therefore, even though Cree did not generally express as strong an opposition or dislike for evacuation policies as have Inuit or Rarámuri, my questions about creating a birth centre in Wemindji or in nearby Cree communities were always met with great enthusiasm, because, again, Wemindji Cree believe that Cree women have to be able to choose. Therefore, the Cree Health Board project to bring birth back to the Iiyiyuuschii is well on its way. The Blessing Ceremony of bringing birth back to Cree women and families in James Bay was held in Chisasibi in September 2018. Cree women from eastern James Bay communities who have low-risk pregnancies, according to biomedical standards, will soon be able to choose a professional midwife's care and birth on the Iiyiyuuschii territory.

The Cree of eastern James Bay have always hoped to bring births back to the communities. Initiatives to do so have been proposed by the Cree a few times, but never did these materialize for various reasons, including opposition from several biomedical staff

members working in the region (personal communication with the biomedical staff and various employees at the Cree Health Board). According to the staff at the Cree Health Board, the last such initiative faded in the early 2000s.

At the beginning of the 2010s, another attempt to re-matriate birth was launched, which is currently proving to be successful. Cree demands to bring birth back to the communities in James Bay have been strengthened by the policy statement of the SOGC (Society of Obstetricians and Gynaecologists of Canada) released in December 2010, supporting the return of birth to remote Indigenous communities. The policy was endorsed by the Indigenous Physicians Association of Canada, the Canadian Association of Midwives and the National Aboriginal Council of Midwives (Lalonde 2014). According to Andre Lalonde, MD, FRCSC and Professor of Obstetrics and Gynaecology, who was consulting with the Cree Health Board throughout the birth re-matriation process, the aim of the Cree Health Board has been to return safe and healthy childbirth to Cree communities, to support early access to quality and culturally safe prenatal care, and to reduce the socio-psychological and economic stress for the women and their families. As a result, at this time of writing (May 2019), there are now three birthing centres ready to start accepting low-risk mothers to give birth—one each in Chisasibi, Waskaganish and Mistassini. There are three non-Cree midwives in Chisasibi ready to attend community births. At the same time, there is an agreement in place with the University du Quebec a Trois Rivieres School of Midwifery to start training Cree midwives to eventually take over midwifery practice in James Bay. Like Inuit of Nunavik, James Bay Cree are successfully moving towards self-determination in birth. Many Cree women very soon will have a choice of their birthing place (home, birthing centre, southern hospital) and the kind of practitioner they want to attend them (midwife, OB).[163]

In a public presentation by Andre Lalonde about the Cree Birthing Initiative, he stated that in order for the Initiative and maternity care to be successful, they must be informed by cultural/traditional knowledge; thus, the southern hospitals serving Cree women need to rearrange their spaces for the birthing mothers and their families, as well as provide cultural training for the biomedical staff serving Cree communities (Lalonde 2014). This requirement is strongly supported by many other studies around the world (Bryne and Morgan 2011; Davis-Floyd et al. 2009; Mullany et al. 2010; WHO 2012). Miller stresses the need for such a requirement with her findings among Rarámuri:

[163] The choice will be limited for women who have high risk pregnancies according to biomedical standards. In those cases, women will have be evacuated to birth in the hospital.

> …programs intending to improve maternal and perinatal health must ensure that all maternal health care services are culturally appropriate. If not, they may actually make things worse for mothers and babies. As noted in the 2009 UN Report on the State of the World's Indigenous Peoples, an intercultural health care system that recognizes and supports local indigenous health systems has a better chance of achieving successful interventions (UN 2009). The traditional Tarahumara method of delivering alone or with a family member has been deleteriously impacted by externally generated efforts to change these practices. Services intended to reduce mortality and morbidity at birth actually increase them, due to their disregard of locally cogent values and practices [. . .] it is essential to take into account local practices even when those practices run counter to widely held notions (2020, in press).

Thus, as Miller insists, it is essential to listen to pregnant women, the Elders and the community. As sociality is one of the main traits of Wemindji Cree birth, hospitals and birthing facilities have to make space for Cree families to be present and participate, in order to generate what Davis-Floyd (2018a) has called the "smooth articulation" of knowledge systems. It is also important to have a close collaboration among all the professionals (midwives, nurses, doctors) working in the local clinics, birthing centres and in the southern hospitals for training, evaluation, smooth and easy transfers of clients/patients when necessary, and overall culturally safe and respectful care.

In order to have a pluralistic approach in birth and perinatal care, to be able to integrate traditional knowledge into the biomedical system and to create culturally safe spaces for Cree mothers at the birthing facilities, biomedical professionals and/or midwives have to propagate an open birthing knowledge system (Davis-Floyd 2018b), in which the practitioner is not afraid to step out of the comfort zone of her routine medical practice when she sees that her practice is not culturally appropriate. To be effective and successful, practitioners have to be always changing their professional routines in accordance with the constantly new information flowing into the field of knowledge of birth from science and other knowledge systems, including Indigenous birthing practices and traditions. According to Davis-Floyd et al. (2018), an open-minded professional, whether an OB, a nurse or a midwife will practice informed relativism. She will compare different knowledge systems and will choose what works best in a particular situation for the particular individual: "… she will seek to practice according to the highest moral and ethical standards, which involve giving compassionate, woman-centred care responsive to the needs of the individual, regardless of what 'the system' dictates" (2018:9).

Childbirth will likely continue to be medicalized for decades to come, yet even medicalized maternity care can become decentralized, with more emphasis placed on creating

smaller clinics or birth centers in communities where they are needed. It is a well-established fact that women everywhere want care in their communities (Davis-Floyd et al. 2009; Daviss and Davis-Floyd 2020, in press). The Cree, Inuit, and the Rarámuri, among many others, teach us the importance of localized, individualized, and culturally safe care. The Cree in particular show us how to indigenize even medicalized birth, making it not a one-way technocratic hierarchy in which power flows from the top down, but rather a more flexible, collaborative, and culturally pluralistic approach of smooth articulation—a two-way street on which each model complements and enhances the other. The colonized and oppressed can indeed change the hearts, minds, and cultures of the colonizers and oppressors, generating hope for a more interwoven and egalitarian future for us all.

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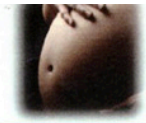
APPENDIX

Appendix 1. Birthing plan for Cree mothers to fill and bring to the hospital given at the Wemindji clinic. It is filled together with the CHR and the nurse during prenatal appointments over a period of time.



Birth Plan

Birth Plan:

A birth plan is a way of communicating with the nurses and the doctors who care for you in labor. It tells them about the kind of labor you would like to have, what you want to happen and what you definitely want to avoid. Be flexible – the best birth plans recognize that things don't always go as planned.

Full name: _____ Partner's name: _____

Today's date: _____ Due Date: _____

Community: _____ Hospital name: _____

Please note that I: (RN to fill out)

- ☐ Have group B strep
- ☐ Have Rh incompatibility with my baby
- ☐ Have gestational diabetes

My delivery is planned as:

- ☐ Vaginal
- ☐ C-section
- ☐ VBAC (Vaginal birth after c-section)

If I go past my due date and there are no health risks for me and my baby, I would prefer:

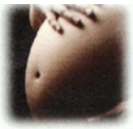
- ☐ Not to be induced
- ☐ To be induced

I'd like present… (max 2 people at a time)

☐ Partner: _____	☐ before labour	☐ during labour
☐ Parents: _____	☐ before labour	☐ during labour
☐ Other children: _____	☐ before labour	☐ during labour
☐ Other: _____	☐ before labour	☐ during labour

During labor I'd like…

- ☐ Music played (I will provide)
- ☐ The lights dimmed
- ☐ The room as quiet as possible
- ☐ As few interruptions as possible
- ☐ As few vaginal exams as possible
- ☐ Hospital staff limited to my own doctor And nurses (no students, residents or Interns present)
- ☐ To wear my contact lens the entire time
- ☐ My partner to film and/or take pictures
- ☐ My partner to be present the entire time
- ☐ To stay hydrated with clear liquids & ice chips
- ☐ To eat and drink as approved by my doctor
- ☐ Facial compress



Birth Plan

I'd like to spend the first stage of labor:

- ☐ Standing up
- ☐ Laying down
- ☐ Walking around
- ☐ In the bathtub
- ☐ Birth ball

Unless medically advised or on an epidural

For pain relief I'd like to use:

- ☐ Breathing techniques
- ☐ I would prefer laboring without pain medication. I will ask you if I would like something for pain. Please do not ask.
- ☐ Epidural
- ☐ Bath
- ☐ Protoxyde d'azote (AKA Funny gas)

To be done by partner or accompanying other:

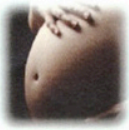
- ☐ Acupressure
- ☐ Distraction
- ☐ Massage

During delivery I would like to:

- ☐ Semi-recline
- ☐ Lie on my side
- ☐ Be on my hands and knees
- ☐ I would prefer my water not to be broken during labor
- ☐ Lean on my partner
- ☐ Use people for leg support
- ☐ Use foot pedals for support

As the baby is delivered, I would like to:

- ☐ Wait to push until I feel the urge even if I'm fully dilated
- ☐ Push as directed
- ☐ I'd like to be able to try any position comfortable during pushing
- ☐ Use the mirror to see the baby crown
- ☐ Touch the head as it crowns
- ☐ Use whatever methods my doctor deems necessary
- ☐ Help catch the baby
- ☐ Let my partner catch the baby



Birth Plan

I would like an episiotomy:

- ☐ Rather than risk a tear
- ☐ Not performed, even if it means risking a tear
- ☐ Performed only as a last resort
- ☐ Performed with local anesthesia (Unless epidural)

Immediately after delivery, I would like:

- ☐ _____ to cut the umbilical cord
- ☐ To see the placenta before it is discarded

If a C-section is necessary, I would like:

- ☐ To make sure all other options have been exhausted
- ☐ To stay conscious
- ☐ My partner to remain with me the entire time
- ☐ My hands left free so I can touch my baby
- ☐ The surgery explained as it happens
- ☐ My partner to hold the baby as soon as possible

I would like to hold my baby:

- ☐ Immediately after delivery (unless medically advised)
- ☐ After being wiped clean and swaddled

I would like to breastfeed:

- ☐ Immediately after delivery
- ☐ Later
- ☐ Never

I would like my family members: (max 2 people at a time)

_____

_____

- ☐ To join me and my baby immediately after delivery
- ☐ To join me and my baby in the room later

I would like my baby's medical exam & procedures:

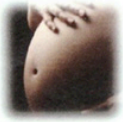
- ☐ Given in my presence
- ☐ Given only after we've bonded

Please DO NOT give my baby:

- ☐ Formula
- ☐ A pacifier

I'd like my baby's first bath given:

- ☐ In my presence
- ☐ In my partner's presence
- ☐ By me
- ☐ By my partner



Birth Plan

I'd like to feed my baby:

- ☐ With breastmilk exclusively (∅ formula)
- ☐ Only with formula
- ☐ Mixed
- ☐ With a cup if supplements are necessary

I would like to:

- ☐ Receive support from a lactation consultant

If my baby is not well, I'd like:

- ☐ My partner (or other) and I to accompany him/her to the NICU or to another facility
- ☐ To breastfeed or provide pumped breastmilk
- ☐ To hold him/her whenever possible

Special needs:

Have you had a past experience that may affect your labor or birth?