DECOLONIZING CHILDBIRTH: INUIT MIDWIFERY AND THE RETURN OF DELIVERY TO THE CANADIAN NORTH

by

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Abstract

Since the 1970s, the mandatory evacuation of Inuit women to southern Canada for hospitalized childbirth has resulted in many negative impacts on communities including a loss of culture in the form of traditional knowledge and midwifery practices, negative health and social outcomes due to emotional, physical, and economic stressors, and a loss of autonomy and decision-making in pregnancy and childbirth. Furthermore, it is part of a larger historical pattern of Western biomedicine enforced on northern populations as a method of colonization and assimilation. Using the framework of colonial governmentality, this research examines two Inuit midwifery programs currently operating in Inuit land-claim areas of Northern Canada—the Inuulitsivik Maternities in Nunavik, QC and the Rankin Inlet Birthing Centre in Rankin Inlet, NU. A social determinants of health framework is applied to identify the ways in which Inuit midwifery programs provide a holistic and culturally respectful childbirth option by addressing social determinants in a way that the mandatory evacuation system cannot. These programs address maternal health in a holistic community-based model, taking into account cultural and social determinants of health, and provide a viable way of returning birth to the North. This is a return of both the physical birth event and a restoration and revitalization of Inuit childbirth knowledge to the community. Inuit midwifery further works as a force for decolonization, taking into account the historical trauma of colonial medicine and providing a model for Indigenous midwifery systems across Canada.

List of Abbreviations Used

CAM	Canadian Association of Midwives
DEW	Distant Early Warning
IJIH	International Journal of Indigenous Health
IMR	Infant Mortality Rate
NACM	National Aboriginal Council of Midwives
NAHO	National Aboriginal Health Organization
NCCAH	National Collaborating Centre for Aboriginal Health
RCMP	Royal Canadian Mounted Police
SOGC	Society of Obstetricians and Gynaecologists of Canada
TB	Tuberculosis
TRC	Truth and Reconciliation Commission of Canada
UN	United Nations
WHO	World Health Organization

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Chapter One: Introduction

Since the 1970s, Inuit maternal health has been defined by the evacuation of women from remote communities to urban centres in southern Canada for the final weeks of pregnancy and delivery. These women are forced to give birth alone, separated from their families, communities, cultures, and traditions. With evacuation, women are stripped of their autonomy and birth is removed from community contexts. It is removed in a dual sense as the physical act of birth no longer occurs in the community and Inuit childbirth knowledge is subjugated to the authority of Western medicine (Paulette, 1990a, p. 78). This has had devastating health and social impacts on Inuit communities and has effectively medicalized pregnancy and childbirth, transforming a formerly non-medical problem into a medical issue that demands treatment under the supervision of physicians (Conrad, 1992, p. 209). Community resistance to evacuation has been consistent, with some women going so far as to conceal their pregnancies in order to deliver in the community (Dawson, 1993, p. 19). Evacuation policy has been extensively critiqued as damaging to the social, physical, and community health of Inuit and community resistance supports this critique, calling for a return of childbirth to the Canadian North.

Evacuation policy demands that all Indigenous women in remote and rural areas are evacuated to hospital for delivery at 36-38 weeks gestation (Health Canada, 2011, p. 6). This does not give consideration to non-medical risks, such as the social and economic implications of transferring women out of their communities, and additionally does not consider the emotional, mental, and physical health impacts of removing women from their support systems and cultures (Couchie & Sanderson, 2007, p. 251; National Aboriginal Health Organization [NAHO], 2004, p. 11). Evacuation largely ignores the social determinants of health. These determinants are defined by the World Health Organization (WHO) as the “conditions in which people are born,

grow, live, work, and age" which are "shaped by the distribution of money, power, and resources at global, national, and local levels" (WHO, 2018). Social determinants include factors such as race, gender, culture, and educational status which have a direct effect on physical health (Cockerham, 2007, p. 184). In southern hospital environments, these determinants are largely ignored as childbirth is increasingly medicalized and viewed purely as an obstetric event demanding the supervision of medical experts (Brubaker & Dillaway, 2009, p. 35).

Women are regarded as passive recipients of care, rather than active agents in the evacuation process. This stands in contrast to Inuit perceptions of birth which regard childbirth as a crucial event in the life cycle, worthy of celebration and typically considered a "communal responsibility" (Dawson, 1993, p. 17; Douglas, 2006, p. 121). Childbirth in Inuit communities is conceptualized as a pivotal moment, central to rituals determining the relationship of the newborn to family, community, and land (Dawson, 1993, p. 17). The individual health and well-being of mother and child are directly tied to the health of the community (Douglas, 2006, p. 121). Self-sufficiency and autonomy are further emphasized in Inuit childbirth, with women given control over all proceedings including labouring position and birth attendants (Dawson, 1993, p. 17). Women's self-sufficiency is central to birth, in direct contrast to the passive role of women in medicalized environments (Jasen, 1997, p. 385). Evacuation policy and medicalized childbirth stand in opposition to Inuit birth culture, and are part of a larger colonial legacy of the Canadian government "modernizing", "developing", and assimilating Indigenous Peoples through the use of "authoritative Western medical knowledge about childbirth" (Olson, 2015, p. 170). The development of this policy is inextricably linked with Canada's colonial intrusion into the North and evacuation has enabled the destruction and subjugation of Indigenous knowledge, including Inuit midwifery (O'Neil & Kaufert, 1990, p. 65).

Several attempts have been made to revitalize Indigenous midwifery including two programs operating in Inuit communities, the Inuulitsivik Maternities in Nunavik, QC and the Rankin Inlet Birthing Centre in Rankin Inlet, NU. These programs seek to place authority back into the hands of communities and attempt to be geographically and culturally accessible to Inuit women (Simonet et al., 2009, p. 548). They strive to return childbirth practices to communities by blending Indigenous knowledge and Western medicine, operating as an advocate for Inuit rights to health and self-determination (Douglas, 2010, p. 112; Olson, 2015, p. 169). Battiste and Henderson (2000) observe that Indigenous knowledge is "a complete knowledge system with its own epistemology, philosophy, and scientific and logical validity" (p. 41). It has multiple foundations including traditional, spiritual, and empirical sources (Martin-Hill, 2003, p. 3). This plurality enables Indigenous knowledge to engage in a holistic paradigm, acknowledging the multiple levels of well-being for individuals and communities including spiritual, physical, and emotional factors (Martin-Hill, 2003, p. 3). Since the colonial encounter, Indigenous knowledge has been consistently positioned against "modern science" as superstitious, irrational, and alternative; discredited on the premise that scientific evaluation must be based on and supported by empirical evidence strictly defined within Western scientific paradigms (Skye, 2010, p. 28). Indigenous knowledge and Western science are integrated in these midwifery programs, presenting unique challenges and debates which are explored throughout this thesis.

Based on secondary data and literature analysis, this thesis focuses on Inuit midwifery programs and their attempts to return childbirth to Inuit communities. Specifically, this thesis seeks to examine the evacuation of Inuit women to southern Canada for hospitalized delivery and resulting negative impacts, including a loss of culture in the form of Indigenous knowledge and midwifery practices, negative health and social outcomes due to emotional, physical, and

economic stressors, and the loss of autonomy and decision-making in pregnancy and childbirth. This thesis further aims to recognize historical factors, primarily the intersecting forces of Western medicine enforced on Inuit as a method of colonial assimilation and the 20th century medicalization of maternity, which each directly shaped maternal evacuation policy. The central research question guiding this thesis is: In what ways do Inuit midwifery systems provide a holistic and culturally respectful childbirth option for Inuit women by addressing social and cultural determinants of health in a way that the current system of evacuation to southern hospitals cannot? Sub-questions include: Are these programs able to return the physical birth act and a revitalization of Inuit childbirth knowledge to communities? In what ways are these programs addressing the social determinants of health crucial to Inuit maternal health including race/Aboriginal status, gender, and socioeconomic status as directly influenced by the fundamental health determinant of colonialism? And finally, do these programs provide a viable way of returning childbirth to the Canadian North?

Terminology

This thesis employs terminology outlined by NAHO adapted for use by the International Journal of Indigenous Health (IJIH). These guidelines are recommended for all researchers studying Indigenous Peoples in Canada (IJIH, n.d., p. 1). Although NAHO uses the term "Aboriginal" in their title and publications, as author I acknowledge the current shift in terminology away from the use of "Aboriginal" towards "Indigenous" (Joseph, 2016). NAHO acknowledges this shift and its importance in recognizing land rights and tenure along with adherence to the United Nations (UN) Declaration of the Rights of Indigenous Peoples (IJIH, n.d., p. 5). There is no single term used to describe Indigenous Peoples in North America, however the NAHO guidelines were prepared with attentiveness to definitions selected by

Indigenous Peoples themselves. Within this thesis, "Indigenous People[s]" is used to collectively refer to First Nations, Inuit, and Métis within Canada (IJIH, n.d., p. 2). "Aboriginal" is used only within direct quotes and when referring to titled concepts.

"Inuit" refers to circumpolar populations inhabiting Russia, Greenland, Alaska, and Canada and in this thesis refers specifically to groups inhabiting Canadian northern regions (IJIH, n.d., p. 6). The four comprehensive land-claims that involve territory inhabited by Inuit are: Inuvialuit Settlement Region (Yukon/Northwest Territories), Nunavut, Nunavik (Northern Quebec), and Nunatsiavut (Labrador) (IJIH, n.d., p. 7). Inuit do not live on reserves, rather they reside in communities or settlements and these terms are used accordingly (IJIH, n.d., p. 7).

The term "traditional medicine" is often used to describe a wide range of Indigenous health beliefs and practices (Martin-Hill, 2003, p. 6). However the term "traditional" is a colonial concept[1] that is not favoured by most Indigenous groups (Martin-Hill, 2003, p. 7). Excluding direct quotations, this thesis uses the terms "Indigenous/Inuit medicine" and "Indigenous/Inuit knowledge" in place of "traditional", respecting the preference of Indigenous Peoples. This applies to midwifery as well, which is referred to as Indigenous/Inuit midwifery as opposed to "traditional" midwifery. "Knowledge" and "medicine" are used in this thesis with the understanding that these terms represent a plurality, with no singular form of either existing.

The broadest definition of a midwife is "any individual who, by choice, assists a woman in the process of delivering her baby, and who consciously assumes some degree of responsibility for the health and well-being of mother and child" (Burtch, 1994, p. 6). This includes trained nurse-midwives, a variety of birth attendants across cultures, and obstetricians. In Canada, midwives are typically defined based upon qualifications and relationship to formal

[1] "Traditional" is regarded by many Indigenous Peoples as a British colonial term, introduced by academic and institutional scholars in order to "separate and prioritize beliefs that were not their own" (Martin-Hill, 2003, p. 7).

education systems. They are grouped into two categories: nurse-midwives and lay or community midwives. Nurse-midwives complete formal nursing education and are registered with nursing associations, receiving midwifery training from accredited programs (Burtch, 1994, p. 8). Community midwives practice outside the scope of legislation and registered associations (Burtch, 1994, p. 7). Community midwives may or may not have professional training or accreditation, and are frequently regarded as inferior and "dangerous" with comparison to nurse-midwives (Burtch, 1994, p. 7). Indigenous midwifery is diverse and varies across groups, cultures, and geographic regions. Indigenous midwives are defined as "women with specialized knowledge in prenatal care, birthing assistance and aftercare" (Martin-Hill, 2003, p. 9). They may incorporate specialized diets, massage, prayers, counselling, and rituals into their practice, emphasizing a holistic approach central to Indigenous medicine (Martin-Hill, 2003, p. 9).

Background & Context

The evacuation of Inuit women to southern hospitals for the final stages of their pregnancies and deliveries cannot be understood without first addressing the medicalization of pregnancy and childbirth. Medicalization is defined as the "process by which nonmedical problems become defined and treated as medical problems" (Conrad, 1992, p. 209). Under medicalization, only forms of health care that are rooted in Western biomedical science are accepted as valid. Medicalization has been examined sociologically as a "mechanism of social control through the medical gaze and surveillance" (Brubaker & Dillaway, 2009, p. 32). The medical gaze is a concept developed by Michel Foucault which suggests that as subjects of medicine, patients become defined by their conditions or illnesses (Barker, 1998, p. 1070). The medical gaze can be viewed as a mechanism of surveillance, with physicians coopting patients' autonomy in order to control the illness or condition affecting them (Conrad, 1992, p. 216).

Within a colonial context, including that of Northern Canada, the medical gaze has been used as a method of control, enabling the "colonization of bodies" (Duncan, 2007, p. 103). This involves mapping and defining certain spaces as unhealthy, collecting statistics to support this assertion, and introducing Western medicine to control these spaces (Duncan, 2007, p. 103). This becomes evident in the policies and practices of the Canadian government with relation to northern tuberculosis (TB) epidemics which are explored in Chapter Three.

Due to high rates of infant and maternal mortality across North America, childbirth became rapidly medicalized in the early 20th century. This involved redefining the natural processes of pregnancy and childbirth as "risky" and "pathological", subjecting them to "control and monitoring, which inevitably led to an intensification that could only be implemented within institutions" (Prosen & Tavčar Krajnc, 2013, p. 252). This applied to all North American women, Indigenous included, and a majority of births came to take place in hospital environments with mandatory supervision by trained professionals and experts.

The medicalization of maternity led to a devaluation of midwifery and birthing practices of Indigenous populations. Redefined as "incompetent", midwifery across North America began to disappear as physicians obtained a monopoly on authoritative childbirth knowledge (Skye, 2010, p. 31; Smeenk & ten Have, 2003, p. 154). Several scholars (Barker, 1998; Brubaker & Dillaway, 2009; Cahill, 2011; Smeenk & ten Have, 2003) have linked the medicalization of maternity with suppression of midwifery and alternative forms of childbirth knowledge. The idea that midwife-assisted births were unsafe spread to Indigenous health programs resulting in a need to regulate and control Indigenous midwifery (Lalonde, Butt, & Bucio, 2009, p. 958). Multiple studies (Dawson, 1993; Gatto, 2010; Jasen, 1997; Lalonde, Butt, & Bucio, 2009; NAHO, 2004; Skye, 2010) note the connection between medicalization and the devaluation of

Indigenous midwifery, including suppression of Indigenous knowledge. As medicalization necessitates that women deliver in hospitals, it creates dependence in Inuit communities on a medical system designed and directed towards bringing childbirth under government control (Jasen, 1997, p. 400). Evacuation and enforced medicalization directly reflect colonial policies and practices, such as residential schooling, which sought to bring Indigenous Peoples under the control of the state in an attempt to assimilate them.

Maternal evacuation policy was implemented for several reasons including changes in Canadian immigration policy that restricted the use of foreign trained nurse midwives, the definition of Inuit as "high-risk", and a desire to improve infant and maternal mortality statistics. In the 1960s, the Canadian government established Nursing Stations in northern communities to provide basic health care, staffed largely by foreign-trained nurse-midwives from the United Kingdom (O'Neil & Kaufert, 1990, p. 59). In the 1970s, a shift in Canadian immigration policy denied entry to foreign-trained nurses in an attempt to protect jobs for Canadians (Moffitt, 2004, p. 326). Several scholars (Chamberlain & Barclay, 2000; Douglas, 2010; Kaufert & O'Neil, 1990; Moffitt, 2004; Paulette, 1990a; Shaw, 2013) point to this change in immigration policy as a key factor in the ramping up of evacuations, as UK trained nurse-midwives were steadily replaced with Canadian nurses who were less familiar and confident in practicing maternity care. Canadian nurses "felt unprepared professionally and emotionally to provide intrapartum care without the assistance of a physician" (Chamberlain & Barclay, 2000, p. 117). As the number of nurse-midwives fell, a stipulation was introduced that primiparous women and those who had birthed four or more children would be evacuated (Shaw, 2013, p. 526). Pressure to transfer women south steadily increased until the early 1980s when official policy shifted to mandatory evacuation for all births (Kaufert & O'Neil, 1990, p. 432).

Northern communities were further defined as "high-risk", a categorization that continues to justify evacuation. Scholars including Chamberlain and Barclay (2000), Dawson (1993), Jasen (1997), and Shaw (2013) all point to the classification of Inuit women as "high-risk" as a central factor in the creation of evacuation policy. This "risk" status is defined not only in terms of remote distance and isolation, but also in culturally biased manners based on Western health models that do not take into account differing ideologies of health, wellness, and the significance of childbirth in the community (Chamberlain & Barclay, 2000, p. 117). The preoccupation with hospitalized birth focuses attention on the "alleged inadequacies" of Inuit childbirth practices and childcare (Jasen, 1997, p. 396). Statistics have been consistently used to assert that maternal and infant mortality in Inuit communities is high, despite the fact that statistics collected in isolated areas are often inaccurate due to population density and collection errors (Dawson, 1993; Kaufert & O'Neil, 1990). Risk is further defined in medicalized obstetric terms, largely ignoring social determinants including race/Aboriginal status, gender, and socioeconomic status, which significantly affect Inuit maternal health (Shaw, 2013, p. 526).

Statistics on infant and maternal mortality collected in Inuit communities were used to support the development of evacuation policy despite their questionable legitimacy due to small sample sizes and resulting susceptibility to reporting error, bias, and skewing (O'Neil & Kaufert, 1990, p. 59). Authors (Dawson, 1993; Douglas, 2006; Jasen, 1997; Morewood-Northrup, 1997; O'Neil & Kaufert, 1990) point to the use of infant and maternal mortality statistics to justify government intervention in Inuit pregnancy and childbirth. Improvements in statistics were seen as reflective of the governmental goal to provide health care for all, including improving women's access to medical facilities and physicians (Morewood-Northrup, 1997, p. 344). Statistics became an obsession of the Canadian state, with Jasen (1997) and Kaufert and O'Neil

(1990) arguing that infant mortality in particular became a metaphor for the "success and moral virtue of Canadian colonial penetration" into Inuit communities (p. 438). Douglas (2006) additionally argues that this obsession with statistics reflects a colonial approach to governing Inuit populations (p. 122). Olson (2015) further suggests that evacuation cannot be separated from the state's historical attempts to modernize and assimilate Indigenous Peoples through the use of Western medicine (p. 170). This is evident in the use of residential schooling, forced settlement, sanatoria TB treatment, and the establishment of the Inuit Disk List system which are explored in Chapter Three as tools of Western medicine used to "modernize" Inuit.

Evacuation policy has largely failed to improve infant mortality rates, which are still far from matching those of non-Indigenous Canadian populations (Lawford & Giles, 2012, p. 336). Framing evacuation as a solution to poor health statistics is therefore overly simplistic (Lawford & Giles, 2012, p. 336). Evacuation policy is not an effective solution to improving statistics, and it is debatable whether it has provided Inuit women with equitable access to health care services. Ultimately, this policy has had several negative impacts including poor health and social outcomes, removal of autonomy and decision-making in childbirth, and the loss of culture and Indigenous knowledge as part of a larger pattern of Western medicine imposed as a method of colonial assimilation. Approaching Inuit health from a purely statistical perspective ignores social and cultural determinants, including colonialism, which are integral to Inuit health.

Multiple studies (Couchie & Sanderson, 2007; Gatto, 2010; Lalonde, Butt, & Bucio; 2009; NAHO, 2004; O'Driscoll et al., 2010) discuss the negative physical and mental health impacts of evacuation including increased postpartum depression, generalized depression and anxiety, nutritional deficiencies, increase in premature infants and low birth-weights, compromised ability to breastfeed, increased smoking behaviour, and additional complications of

pregnancy and delivery. The social issues arising from evacuation have been covered extensively in the literature (Chamberlain & Barclay, 2000; Couchie & Sanderson, 2007; Dawson, 1993; Douglas, 2006; Gatto, 2010; Government of Nunavut, 2009; Kaufert & O'Neil, 1990; Lalonde, Butt, & Bucio, 2009; Morewood-Northrup, 1997; NAHO, 2004; NAHO, 2006; O'Driscoll et al., 2010). Several recurrent issues include: lack of social support, language barriers and culturally insensitive hospital environments, deterioration of family connection, separation from partners and children, and issues with reintegration of mother and child. Douglas (2006), Chamberlain and Barclay (2000), and Morewood-Northrup (1997) each mention the issue of land status as an additional stressor. Evacuation "breaks the first connection between an Inuk and the land", a connection with deep cultural and spiritual significance (Douglas, 2006, p. 125). Parents additionally worry that if children are born out of province they will lose their Indigenous status (Morewood-Northrup, 1997, p. 343; Chamberlain & Barclay, 2000, p. 117).

Evacuation policy removes any element of choice from pregnancy and childbirth. Several studies (Chamberlain & Barclay, 2000; Kaufert & O'Neil, 1990; Moffitt, 2004; NAHO, 2006) highlight anxiety surrounding choice in birthing. Inuit women express concern about their lack of choice in "place of delivery, the form of delivery and the amount and type of support they would receive during the labour and birth" (Chamberlain & Barclay, 2000, p. 120). Although evacuation cannot be forced and women must sign informed consent forms, there is a general sentiment of having no alternatives. Dependence on the medical system and a lack of opportunities for community birthing have convinced many Inuit women that hospital birth is the only option (Dawson, 1993, p. 23). Concerns about lack of autonomy are not dissimilar to those expressed in feminist critiques of medicalization which have pointed to the "usurpation of authority, choice, and control over women's reproduction" by a historically patriarchal medical

field (Brubaker & Dillaway, 2009, p. 35; Williams & Calnan, 1996, p. 1610). For Inuit women, however, there are additional concerns with delivering in hospitals thousands of kilometres from home in a medical system that carries historical trauma (Kaufert & O'Neil, 1990, p. 439).

By failing to provide space for births outside of hospitalized environments under the dominant biomedical model, evacuation has resulted in the suppression of Inuit knowledge and childbirth practices such as Inuit midwifery. The medicalization of birth is often perceived by Inuit a threat to their political and cultural autonomy (O'Neil & Kaufert, 1990, p. 65). The removal of childbirth from communities is highlighted by authors (Dawson, 1993; Gatto, 2010; Government of Nunavut, 2009; Lalonde, Butt, & Bucio, 2009; Morewood-Northrup, 1997; O'Driscoll et al., 2011; Paulette, 1990a; Tedford Gold, O'Neil, & Van Wagner, 2005) as a direct force in the destruction of Inuit knowledge and midwifery. Several scholars (Gatto, 2010; O'Driscoll et al., 2011; Tedford Gold, O'Neil, & Van Wagner, 2005) discuss evacuation policy as inherently colonial, part of a larger civilizing mission to undermine Inuit knowledge. The Canadian state effectively marginalizes communities and their involvement in health care "while making the local unfit for childbirth" (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 1).

Programs bringing Inuit midwifery back to northern communities have sought to address the negative effects of evacuation while situating themselves within a historical context, recognizing the intersecting forces of medicalization and colonialism. Inuit midwifery programs including the Inuulitsivik Maternities and Rankin Inlet Birthing Centre have shown promising results as they provide statistically safe care for mothers and infants, return childbirth and decision-making to communities in culturally appropriate ways, and incorporate Inuit knowledge in cooperation with Western medicine (Anderson, 2008; Blythe, 1995; Burtch, 1994; Carroll & Benoit, 2004; Couchie & Sanderson, 2007; Daviss, 1997; Daviss-Putt, 1990; Douglas, 2006;

Douglas, 2010; Epoo et al., 2012; Gatto, 2010; Government of Nunavut, 2009; Houd, Qinuajauk, & Epoo; 2004; Jasen, 1997; Kennedy & Carr, 2007; Kileda, 2006; Lalonde, Butt, & Bucio, 2009; Lemchuk-Favel & Jock, 2004; Morewood-Northrup, 1997; NAHO, 2004; National Collaborating Centre for Aboriginal Health [NCCAH], 2012; Simonet et al., 2009; Skye, 2010; Stonier, 1990; Tedford Gold, O'Neil, & Van Wagner, 2005; Van Wagner et al., 2007).

Several studies (Douglas, 2006; Epoo et al., 2012; Government of Nunavut, 2009; Kileda, 2006; Lemchuk-Favel & Jock, 2004; NCCAH, 2012; Skye, 2010) have shown that community-based midwifery produces statistically equivalent or improved outcomes to southern hospitalized birth. In one case study of the Inuulitsivik Maternities it was noted that rates of complications and interventions actually decreased when a majority of births occurred within the community (Douglas, 2006, p. 127). This reduction is attributed to the use of a unique community-based risk evaluation system that relies on a committee composed of midwives, medical staff, and community members (Douglas, 2006, p. 127). Risk is evaluated not only on biomedical factors, but takes into consideration a multitude of social and community factors (Douglas, 2006, p. 127). Since their creation in 1986, the Inuulitsivik Maternities have been the subject of many case studies and are highlighted across the literature on Inuit and Indigenous midwifery as a success in maintaining acceptable rates of maternal and infant mortality, reducing the number of medical interventions and birth complications, and decreasing the number of women evacuated to southern hospitals (Anderson, 2008; Blythe, 1995; Burtch, 1994; Carroll & Benoit, 2004; Couchie & Sanderson, 2007; Daviss, 1997; Daviss-Putt, 1990; Douglas, 2006; Douglas, 2010; Epoo et al., 2012; Gatto, 2010; Houd, Qinuajauk, & Epoo; 2004; Jasen, 1997; Kennedy & Carr, 2007; Kileda, 2006; Lalonde, Butt, & Bucio, 2009; Lemchuk-Favel & Jock, 2004; NAHO, 2004; NCCAH, 2012; Simonet et al., 2009; Skye, 2010; Stonier, 1990; Tedford

Gold, O'Neil, & Van Wagner, 2005; Van Wagner et al., 2007). Inuulitsivik is also acknowledged by WHO, Society of Obstetricians and Gynaecologists of Canada (SOGC), and the Institute of Circumpolar Health as an "excellent model of northern health care" (Lemchuk-Favel & Jock, 2004, p. 45). The Rankin Inlet Birthing Centre is also highlighted as a promising example of Inuit midwifery returning birth to communities (Blythe, 1995; Carroll & Benoit, 2004; Couchie & Sanderson, 2007; Government of Nunavut, 2009; Lalonde, Butt, & Bucio, 2009; Morewood-Northrup, 1997; NAHO, 2004; Skye, 2010; Tedford Gold, O'Neil, & Van Wagner, 2005).

In addition to providing safe health care, defined as an acceptably low rate of maternal and infant mortality, Inuit midwifery programs have returned decision-making, self-sufficiency, and the social and spiritual culture of birth to communities. Multiple studies (Couchie & Sanderson, 2007; Douglas, 2010; Kileda, 2006; Lalonde, Butt, & Bucio, 2009; Simonet et al., 2009; Tedford Gold, O'Neil, & Van Wagner, 2005) correlate the return of birth to the North with the alleviation of issues caused by evacuation, namely social dislocation, lack of autonomy and decision-making, medicalization of birth, language and cultural barriers, economic and social stressors, and negative mental and physical health outcomes. Midwifery programs show promising results and may provide insights for "culturally appropriate and cost-effective solutions to reduce maternal mortality rates" worldwide (Lalonde, Butt, & Bucio, 2009, p. 960).

The ability of midwifery programs to carve out a space for Indigenous knowledge and medicine is highlighted in several studies (Carroll & Benoit, 2004; Dawson, 1993; Douglas, 2010; Olson, 2015; Simonet et al., 2009). The incorporation of Indigenous knowledge does not ignore the achievements of biomedicine, but rather seeks to combine Indigenous health practices with Western medicine, bridging the gap between scientific and Indigenous knowledge and providing a space within the formal health care system for previously excluded knowledge

systems (Simonet et al., 2009, p. 548). Douglas (2010) argues that this blending creates a unique "non-modern hybrid" (p. 112). The revitalization of Indigenous knowledge is further seen as central to shifting the colonial narrative by alleviating dependence on southern authorities through legitimizing Indigenous culture and ways of knowing (Dawson, 1993, p. 22). This can be understood within the framework of the Two-Eyed Seeing model developed by Mi'kmaw Elders Albert and Murdena Marshall as a way to bridge Indigenous knowledge and Western science (Martin, 2012, p. 22). This concept refers to "learning to see from one eye with the strengths of Indigenous knowledge . . . and from the other eye with the strengths of Western knowledges . . . and using both these eyes together for the benefit of all" (Bartlett et al., 2012, p. 11). Two-Eyed Seeing emphasizes the "distinct and whole" nature of Indigenous knowledge and allows scholars to engage meaningfully in collaborative settings (Bartlett et al., 2012, p. 12). Utilizing this model in health research stresses the importance of social determinants and provides a framework that reflects on the health impacts of colonization, presenting opportunity for decolonization in health care (Martin, 2012, p. 29). This framework recognizes Indigenous knowledge as possessing integral information about health without denying the contributions of Western biomedicine, moving beyond simplistic dichotomies (Martin, 2012, p. 31; 38).

Purpose of This Study

Research on Inuit midwifery is broad and highlights successful case studies such as the Inuulitsivik Maternities and Rankin Inlet Birthing Centre. It is suggested across the literature that these programs are returning childbirth to northern communities in safe and culturally appropriate ways, however this success is often defined within the parameters of Western medicine emphasizing statistical outcomes. This research seeks to investigate how these programs address the social determinants of health, crucial to understanding Inuit maternal

health and unique in acknowledging colonialism as a fundamental health determinant. By analyzing medicalization through the framework of colonial governmentality, this research examines Inuit midwifery as a form of decolonization. In looking to the social determinants through a historically-rooted analysis, this research seeks to fill an existing gap in the literature, as none of the studies analyzed specifically highlighted the social determinants of health or how they are being addressed by Inuit midwifery. While many authors discussed factors which are integral to a social determinants approach, or noted the importance of social factors, no studies at present have dedicated considerable analysis to the social determinants related to Inuit maternal health. Furthermore, no studies at present investigate Inuit midwifery as a decolonial project.

As the Canadian government has recently allocated $6 million to fund and improve community-based Indigenous midwifery programs by 2022, this study is timely (CBC News, 2017). Health Minister Jane Philpott stated in a 2017 news release that "it is vital to support midwifery care, which will bring traditional birthing practices back to these communities, better support mothers and their babies, and build strong families" (CBC News, 2017). Although it is uncertain how funding will be allocated or how Indigenous knowledge will be incorporated in these programs, it is optimistic that the Canadian government is recognizing the value of midwifery in providing safe and culturally appropriate birth experiences for Indigenous women.

Research Methods

The methodology of this study is secondary data analysis using library and internet-based resources including books, peer-reviewed journal articles, compiled oral histories, organizational, NGO, and government literature and reports, ethnographies, and online resources including websites and newspaper articles. There is extensive literature available on Inuit maternal health, evacuation policy, and midwifery. This is not to say that the topic has been

covered exhaustively, but rather to validate the use of secondary data to complete this thesis as resources available are substantial, providing a quantity of literature with appropriate depth and breadth. The framework of colonial governmentality used in this thesis provides a previously unapplied method of analytically approaching the history and literature on Inuit midwifery. Case studies of two Inuit midwifery programs, the Inuulitsivik Maternities and the Rankin Inlet Birthing Centre, are presented in Chapter Six. These programs are analyzed to understand program structure, specifically if and how they are addressing social determinants of health. Sources were selected based upon availability with emphasis placed on using studies conducted by Indigenous and Inuit researchers and those that emphasized Indigenous voices within their research methods. When possible, authors were investigated to determine affiliations and relationships with universities, governments, and Indigenous groups. This was done in an attempt to situate sources within larger narratives and understandings of Western medicine, "modern" science, and the existing hierarchy of knowledges within academia.

Ethical Considerations

This research includes no contact with human subjects, constituting no direct ethical issues. However, as I am not an Indigenous person or member of any minority or racialized group, I believe it is important to recognize my positionality as researcher. There is a problematic history of Western researchers studying Indigenous Peoples with harmful outcomes. Academic research in particular is noted by Linda Tuhiwai Smith (1999) as a "significant site of struggle", where Western knowledge systems and their proponents have often clashed with Indigenous knowledge systems and scholars (p. 2). I seek to consistently recognize my role in this process as a researcher of European-settler descent conducting this thesis while studying at a formal academic institution. Within the university, I understand my position as the privileged

recipient of funding from the Killam Trusts, Social Sciences and Humanities Research Council of Canada, and the Nova Scotia Graduate Scholarship used to complete this research. I acknowledge the position and power that these scholarships give my research, and am aware of the hierarchy of knowledges situating Western knowledge as superior. I seek to use my privileged position to highlight pressing issues in Inuit maternal health while emphasizing the voices of Indigenous scholars and researchers throughout this thesis. I hope to shed light on the promising work of Inuit midwifery programs in returning childbirth to the Canadian North, but seek to do so while consistently aware of my outsider status, personally held biases, and the complex history of research through Western eyes.

In order to ensure that this research has as few harmful ethical implications as possible, I have shaped the methodology of this thesis to emphasize selection of sources and authors who are Indigenous or Inuit and scholars who prioritize Indigenous voices. This thesis seeks to gain a clearer understanding of Inuit maternal health, and it must be acknowledged that as author I cannot fully understand the lived experiences of Indigenous Peoples. I urge readers to think critically when reading this thesis and to realize that while generalizations may be made, it is understood that not all Inuit or Indigenous Peoples live under the same conditions, nor have they experienced the same relationship with the Canadian state or Western medical systems.

Limitations

As this thesis utilizes secondary data analysis, it relies on the research and data collection of other researchers. Most studies on the negative effects of maternal evacuation were complied in the late-1980s to early 2000s. At this time there was an abundance of interest and research on the topic, and articles compiled during this time period are referenced extensively in this thesis, particularly in Chapter Five. As author, I acknowledge that these sources are dated and that this

creates a limitation in the scope and applicability of this research. However, as evacuation has remained mandatory and dominant in Inuit maternal health care its impacts are understood to remain largely unchanged.

An additional limitation of relying on secondary data is that the prioritization of Indigenous and Inuit voices may not be present in available sources. Within the methods of this study, I have sought to mitigate this limitation by selecting studies that involve and incorporate Indigenous and Inuit researchers, midwives, and community members. In the 153 sources used, 52 (33.99%) had at least one Indigenous author or were written, compiled, or distributed by an Indigenous organization. When this number is adjusted to remove sources unrelated to Indigenous midwifery or health, such as those on medicalization, the midwifery model, or theory, 51 (45.95%) of the remaining 111 sources are Indigenous scholarship.

This research is limited geographically to analysis of Inuit midwifery programs operating in Inuit land-claim areas in the northern regions of Canada. While midwifery is practiced worldwide in developing and developed regions, playing an integral role in the childbirth cultures of many societies, regional limitations are necessary for this study in order to provide an analysis of Inuit midwifery programs within a unique historical context. As this thesis is written for the field of International Development Studies, it is noted that research on the revitalization and practice of Indigenous midwifery may have implications for the support of Indigenous midwifery practices not only in the nations within Canada's modern borders, but in multiple contexts worldwide as a solution to high rates of maternal and infant mortality and morbidity.

Chapter Outline

In Chapter Two the framework of this study, colonial governmentality, is outlined along with discussion of the social determinants of health with specific reference to Inuit maternal

health. This chapter further discusses Indigenous knowledge and specifically Inuit knowledge with a focus on health, pregnancy, and childbirth. The relationship between Indigenous and Western knowledge is examined and critiqued, looking to collaborative approaches and the use of a Two-Eyed Seeing model. Chapter Three discusses the use of Western medicine as a force for colonization. Emphasis is placed on the Inuit context and use of medicine to justify residential schooling, forced relocation and settlement, the Inuit Disk List System, and mandatory evacuation and sanatoria confinement for TB epidemics. Chapter Four outlines the medicalization of maternity in Western society and subsequent devaluation of midwifery. Debates in Canadian midwifery are examined and current midwifery practices, organizations, and associations are presented. Chapter Five examines evacuation policy and its development, arising largely from the intersection of colonial medicine and the medicalization of maternity. Policy development, proposed benefits, actual impacts and results, and community resistance are investigated along with the current state of Inuit maternal health. Chapter Six provides a case study of two Inuit midwifery programs—the Inuulitsivik Maternities and the Rankin Inlet Birthing Centre. The history and development of each program is presented, along with program structure and outcomes. The strengths and weaknesses of each program are compared and evaluated for their ability to return childbirth to communities, address social and cultural determinants of health, and incorporate Inuit knowledge. This chapter engages with critiques and debates surrounding the intersection of Indigenous knowledge and Western medicine and health systems. Chapter Seven concludes this thesis, presenting and discussing findings and recommendations.

Chapter Two: Colonial Governmentality & Inuit Midwifery as Decolonial Knowledge

The research presented in this thesis utilizes the framework of colonial governmentality. The central research question asks: In what way do Inuit midwifery systems provide a holistic and culturally respectful childbirth option for Inuit women by addressing social and cultural determinants of health in a way that the current system of evacuation to southern hospitals cannot? In order to answer this question, this thesis engages colonial governmentality to explore how the Canadian state has used medicine as a force for assimilation, modernization, and subjugation of Inuit. This chapter outlines colonial governmentality and introduces Indigenous knowledge—including Inuit midwifery—as a force for decolonizing the maternal health experiences of Inuit women. Indigenous and Inuit specific knowledge and medicine are presented, along with a discussion on historical Inuit midwifery practices. In order to answer the research question of this thesis, it is further necessary to define and discuss the social determinants of health most salient to Inuit maternal health including race/Aboriginal status, gender, and socioeconomic status. Finally, the intersection of Western and Indigenous medicine is explored with particular attention given to the use of a Two-Eyed Seeing Model.

Colonial Governmentality

This thesis explores the Canadian state's use of medicine as a tool for colonization, utilized to modernize and assimilate Inuit populations. This colonial application of medicine is approached through David Scott's (1995) framework of colonial governmentality. Colonial governmentality builds on Foucault's governmentality which concerns itself with how liberal states govern themselves and their subjects, and governmental attempts to establish "common good", defined as "obedience to the law" (Foucault, 1991, p. 95). The establishment of law-abiding society is not achieved through overt dominance, but rather through a multitude of

strategies that seek to shape society in a calculated way (Murray Li, 2007, p. 275). The objective is a society in which "people, following only their own self-interest, *will do as they ought"* (Scott, 1995, p. 202). Each state has a unique and complex form of power, aimed at a target population, through which it seeks to establish a self-governing society (Foucault, 1991, p. 103). The end goal is government that "operates at a distance", under which citizens are not aware that they are being controlled (Murray Li, 2007, p. 275). The insertion of Western medicine in the Canadian North was carried out at a distance, framed not in a manner of overt dominance, but rather as small projects which shaped Inuit society over time.

Scott (1995) expands governmentality attempting to better understand the political rationality that defined and organized colonial states (p. 204). Scott (1995) argues that colonial states sought to insert "modern" ideas, such as Western medicine, into societies under their control (p. 205). This modernizing power was not only expressed in the spheres of politics and economics, but worked to colonize knowledge and knowledge production, specifying which knowledges were modern and rational (European) and which were primitive (Indigenous) (Bhambra, 2014, p. 117). In the Inuit context, the goal was not solely to insert biomedicine, but to further assert the dominance of Western knowledge, seeking to suppress and ultimately destroy Inuit health practices including midwifery (Tester & McNicoll, 2006, p. 104). Modernization was set to be achieved through specific projects with colonial governmentality sorting populations into statistically quantifiable entities, or target populations, each with unique characteristics, needs, and norms (Duncan, 2007, p. 107). The structure of colonial power was conceived in a way so as to "produce certain governing-effects", necessitating and constructing society by defining it as statistically quantifiable through the use of censuses and collection of population data (Kalpagam, 2002, p. 38).

These colonial projects aimed at target populations, Scott (1995) argues, must be analyzed to discover the internal "discontinuities in which different political rationalities, different configurations of power, took the stage in commanding positions" (p. 197). What is essential is discerning targets of application and the specific fields governments seek to control (Scott, 1995, p. 204). Colonial governmentality recognizes the immense power of the state, but seeks to "decentre" it in recognizing that colonial powers were not totalizing or entirely successful in marginalizing resistance, rather they were part of a negotiated process (Scott, 1995, p. 192). Colonial governmentality allows space for Indigenous autonomy throughout colonization. While recognizing the undeniable impacts of colonialism, colonial governmentality presents a contested space—one in which Indigenous Peoples and knowledge did not cease to exist, but persisted and adapted. This framework directly refutes the "fatal impact thesis", which suggests that "indigenous cultures could not withstand or compete with the sophistication of European civilization", dying out or becoming substitute copies of colonial culture (Shilliam, 2015, p. 8). What Scott (1995) presents is a space in which Indigenous populations and knowledge both withstand and directly resist the colonial encounter in overt and subvert ways.

Colonial governmentality is applied to this research in order to conceptualize the Canadian colonial state and helps to explain both the historical and contemporary introduction of Western medicine in the North as a colonial project. Colonial governmentality further provides space for Inuit midwifery to be understood not as a restorative project, but as a form of Indigenous knowledge that existed before, during, and following colonial intrusion into Canada's North. Importantly, this approach does not diminish the agency of Indigenous Peoples to resist colonialism and allows space for the recognition of Indigenous knowledge and medicine as consistently present and active decolonial forces.

Indigenous Knowledge & Medicine

Despite being a target of assimilation under colonial governmentality, Indigenous knowledge and medicine have endured and persisted throughout the colonial encounter and continue to exist in a multitude of forms such as Indigenous midwifery. Indigenous knowledge has no established definition and Battiste and Henderson (2000) argue that demanding definition is symptomatic of Eurocentric thought (p. 36). Indigenous knowledge is more "local" than Western knowledge, which results in what Root Gorelick (2014) refers to as "many different but equally valid conceptualizations" (p. 46). Comprehensive definitions are therefore problematic in that they cannot contain the sheer diversity of knowledge that exists across Indigenous populations (Battiste & Henderson, 2000, p. 41). Without imposing a rigid definition, this research seeks to understand Indigenous knowledge through the framework provided by Battiste and Henderson (2000). This framework suggests that Indigenous knowledge expresses "the vibrant relationships between the people, their ecosystems, and the other living beings and spirits that share the land" (Battiste & Henderson, 2000, p. 42). It cannot be separated from Indigenous territories, nor from Indigenous Peoples (Battiste & Henderson, 2000, p. 42). All forms of Indigenous knowledge share six characteristics outlined as:

> (1) [K]nowledge of and belief in unseen powers in the ecosystem; (2) knowledge that all things in the ecosystem are dependent on one another; (3) knowledge that reality is structured according to most of the linguistic concepts by which Indigenous describe it; (4) knowledge that personal relationships reinforce the bond between persons, communities, and ecosystems; (5) knowledge that sacred traditions and persons who know these traditions are responsible for teaching 'morals' and 'ethics' to practitioners who are then given responsibility for this specialized knowledge and its dissemination; and (6) knowledge that an extended kinship passes on teachings and social practices from generation to generation. (Battiste & Henderson, 2000, p. 42)

Inuit specific knowledge stresses "the totality of knowledge" and is defined as practical and experiential teaching passed from generation to generation (Battiste & Henderson, 2000, p. 43).

This knowledge, understood as "truth and reality", is a system of respect and governs the use of shared resources (Battiste & Henderson, 2000, p. 43). Inuit knowledge is rooted in the language of the people, along with their spiritual life, health, and culture (Battiste & Henderson, 2000, p. 43). It is holistic, and cannot be separated from Inuit, existing with a dynamic, stable, and cumulative nature (Battiste & Henderson, 2000, p. 43).

Indigenous knowledge is a complete knowledge system with its own validity, originating from spiritual, traditional, and empirical sources (Battiste & Henderson, 2000, p. 41; Martin-Hill, 2003, p. 3). Indigenous ways of knowing are "dynamic, complex, and intricate" (Simpson, 2000a, p. 171). For centuries, Indigenous knowledge has been measured against Eurocentric norms and made a target of colonial assimilation (Simpson, 2000b, p. 189). Under colonial governmentality, existing knowledge systems form a barrier to the implementation of colonial projects, such as the insertion of Western medicine in the North. In order to realize these projects, it is necessary to colonize knowledge and knowledge production, subjugating Indigenous knowledge to the hegemony of Western thought (Bhambra, 2014, p. 117). This involves the often violent suppression and destruction of knowledge and knowledge creators that fall outside the dominant framework of Eurocentric knowledge. The present-day relationship between Indigenous and Western knowledge reflects this colonial history, with authority consistently granted to Western knowledge (Simpson, 2000b, p. 190).

Indigenous medicine is a specific form of Indigenous knowledge. There is, as with Indigenous knowledge, no universally accepted definition as it is pluralistic across populations with vast cultural and geographic diversity (Martin-Hill, 2003, p. 3). Indigenous medicine and health practices are varied, however each emphasizes a holistic approach and the "sacred connection . . . among people, the Earth, and everything above it, upon it, and within it" (Truth

and Reconciliation Commission of Canada [TRC], 2015, p. 163). Without seeking to impose a definition on Indigenous medicine, which risks minimizing its complexity, several common themes appear including elements of "diet, lifestyle, identity, knowledge of language and culture . . . herbal and ritual knowledge, and spiritual doctoring" (Martin-Hill, 2003, p. 2; 24). A holistic approach involves aspects of politics, economics, society, and culture that are shaped by Indigenous historical experiences and worldviews (UN, 2009, p. 157).

Elders note that Indigenous medicine is not disconnected from community, culture, and land; rather these factors are essential to maintaining health (Martin-Hill, 2003, p. 24; Skye, 2010, p. 30). Indigenous medicine addresses not only the physical and psychological, but includes elements of spirituality and metaphysics (Waldram, Herring, & Kue Young, 2006, p. 237). While modern Western approaches to health, such as evacuation, tend to focus solely on the biomedical condition of the human body, Indigenous medicine emphasizes the interweaving of everything "interconnected: mind, body, spirit, and emotions" (Skye, 2010, p. 30). Inuit medicine historically involved not only basic care for health issues and injuries, but knowledge of how to cultivate resilient bodies and strong minds (Martin-Hill, 2003, p. 10). Pre-contact medicine existed in Inuit communities as a formal, autonomous body of knowledge which utilized shamans in the healing process and emphasized the care and tending of the mind, body, and spirit (Bennett & Rowley, 2004, p. 219; Martin-Hill, 2003, p. 10). Health was never a personal matter, but was held within a "socio-cosmic order" where individuals were involved in physical and spiritual communities, with well-being dependent on relationships with human and non-human entities (Laugrand & Oosten, 2010, p. 243; 271). This involved connections to land and animals as part of the physical environment (Laugrand & Oosten, 2010, p. 243).

Due to the above noted hierarchy of knowledges, Indigenous medicine has typically existed outside the confines of dominant biomedical models and Western medical institutions (Martin-Hill, 2003, p. 3). Holding social and spiritual significance, Indigenous medicine became a direct target of colonial assimilation. This included the banning of ceremonies such as the Sun Dance, practiced primarily by Indigenous groups inhabiting the Great Plains and Canadian Prairies, and the Potlatch, an integral part of most Indigenous societies of the Pacific Northwest Coast (Martin-Hill, 2003, p. 6; Waldram, Herring, & Kue Young, 2006, p. 148). Indigenous medicine continued, however, "despite government repression and the introduction of early European medical services" (Waldram, Herring, & Kue Young, 2006, p. 152).

Inuit Midwifery & Childbirth Practices

Inuit were a historically nomadic population with childbirth carried out alone or supervised by available family members, often male partners (Daviss-Putt, 1990, p. 92). As colonial contact increased, permanent villages were established as projects intended to settle Inuit and uproot nomadic livelihoods and hunting patterns (Daviss-Putt, 1990, p. 93). Nomadic ways rapidly disappeared and a unique Inuit childbirth culture evolved, establishing midwifery as the standard of practice (Daviss-Putt, 1990, p. 93). As Inuit populations are diverse geographically, there is no consensus on childbirth knowledge or midwifery practice, however several common elements are noted. Communal decision-making was central, as knowledge was spread across society, and birth did not take place without a "high degree of community involvement" (Douglas, 2010, p. 114). Decisions further took into account the autonomy and desires of the pregnant woman (Douglas, 2010, p. 113; 114). Pregnancy and childbirth were recognized as communal, social, and spiritual acts directly connected to community, family, land, and nature (Daviss, 1997, p. 441; Daviss-Putt, 1990, p. 93). Male partners were involved in

pregnancy and were advised on what to expect throughout (Bennett & Rowley, 2004, p. 197). Pregnancy, labour, and delivery were understood to be natural phenomena, posing no inherent risk (Dufour, 1994, p. 35; Kaufert & O'Neil, 1993, p. 48). An Inuit Elder interviewed by Kaufert and O'Neil (1993) stated that: "Inuit people do not believe that having a child, being pregnant, birthing is a disease. It's not an illness. It's a way of life, a normal function of a human being" (p. 49). In stark contrast to the current medicalized evacuation experience, historical Inuit birth constituted a process connected to family, community, and land (Carroll & Benoit, 2004, p. 268).

Reflecting the conception of pregnancy as a natural process, pregnant women were given instructions regarding the "correct way" to do things that generally encouraged them to continue daily activities (Daviss-Putt, 1990, p. 92). This knowledge passed from grandmothers to mothers, generation to generation, and women were taught from a young age the signs of pregnancy and what to do during the gestational period (Bennett & Rowley, 2004, p. 197; Lalonde, Butt, & Bucio, 2009, p. 957). Pregnancy instructions vary across regions, but commonly emphasize that women should remain active, continuing tasks as long as the pregnancy proceeded normally (Okalik, 1990, p. 6). Women were allowed to travel, but were discouraged from lifting heavy objects or stomping pelts, additionally cautioned to avoid falling on their backs (Dufour, 1994, p. 21; Bennett & Rowley, 2004, p. 199). As a whole, women stated: "We were allowed to go on doing things normally" (Haulli, cited in Bennett & Rowley, 2004, p. 199). Different regions recommended special pregnancy diets, and overall, communal pregnancy knowledge signifies a larger philosophy of birth as a normal event in the life cycle (Daviss-Putt, 1990, p. 99).

Once established in settlements in the early 20th century, midwives became the primary birth attendants among Inuit. Women were trained for this role, chosen based on their capabilities and experience typically signified by having a large number of children and

possessing exceptional maturity (Daviss-Putt, 1990, p. 93; Dufour, 1994, p. 25). Experiential learning was emphasized as younger women attended births, learning directly from Elders through observation and hands-on training (Daviss-Putt, 1990, p. 93; Douglas, 2010, p. 114). Birthing positions depended on preference of the labouring woman, with kneeling and squatting favoured (Bennett & Rowley, 2004, p. 201). Women as a whole were confident and self-reliant in their ability to deliver, "dictated by their knowledge and intimate awareness of their bodies" (Dufour, 1994, p. 19). They were courageous, and took responsibility in labouring and birth (Carroll & Benoit, 2004, p. 267). Male partners attended births, sometimes assisting (Daviss-Putt, 1990, p. 97; Grieg, 1990, p. 43). Midwives were well respected in their communities, and remained connected to infants they delivered. This is evident in the customary gifts given to midwives; from boys a piece of their first hunt, and from girls a portion of their first independently cooked meal (Daviss-Putt, 1990). Midwifery was a shared communal knowledge, cared for autonomously (Okalik, 1990, p. 6). This knowledge continued through the colonial encounter, but with mandatory evacuation and enforced use of Western medicine, Inuit midwifery nearly disappeared. By the mid-2000s, Inuit Elders feared a complete loss of midwifery knowledge as pre-evacuation midwives were no longer practicing (NAHO, 2006, p. 15). The modern Inuit midwifery programs analyzed in this thesis seek to incorporate and centre Inuit knowledge in their practice, including these historic community conceptions of birth as a natural, non-medicalized process with spiritual connections to location and land.

A Social Determinants Lens for Indigenous Health

The social determinants of health are factors—such as socioeconomic status, race, gender, culture, and educational status—which have "direct causal effects on physical health and are not just background or secondary variables" (Cockerham, 2013, p. 184). Link and Phelan

(1995) identify social conditions as fundamental causes of disease and mortality (p. 88). To be a fundamental cause, a condition must influence multiple risk factors and disease outcomes simultaneously (Link & Phelan, 1995, p. 87). This means that social determinants do not influence only a few diseases, but rather affect multiple health issues through a multitude of risk factors (Phelan, Link, & Tehranifar, 2010, p. S29). This is tied with access to resources, health care and otherwise, which "can be used to avoid risks or to minimize the consequences of disease once it occurs" (Phelan, Link, & Tehranifar, 2010, p. S29). The health disparities present in Indigenous communities are inarguable, with reduced life expectancies, higher rates of infectious and chronic diseases, and mental and physical health outcomes that stand in stark contrast to those of the general Canadian population (Smylie, 2009, p. 292). These health inequalities are largely socially determined, produced in combination with historical factors such as colonialism (King, Smith, & Gracey, 2009, p. 76).

The health of Indigenous Peoples in Canada cannot be addressed without understanding the social, political, economic, environmental, and colonial context in which health is situated, with many researchers identifying the alarming health disparities of Indigenous communities as largely socially determined (Allan & Smylie, 2015; Inuit Tapiriit Kanatami, 2014; King, Smith, & Gracey, 2009; Martin, 2012; NCCAH, 2012; Smylie, 2009). The UN Declaration of the Rights of Indigenous Peoples states that addressing economic and social conditions is essential to improving Indigenous health (Mikkonen & Raphael, 2010, p. 42). Further acknowledgement of the "historical and ongoing colonization of Indigenous peoples" is required, addressing race and racism as social determinants in health care systems, education, justice, child protection, and legislative bodies (Allan & Smylie, 2015, p. 12). In contrast with the dominant medical model, emphasizing biomedical and behavioural risk factors, efforts are needed to address social

determinants from a communal, rather than individualistic, perspective (NCCAH, 2012, p. 41; Raphael, 2009, p. 3; Shah, 2004, p. 277). The holistic approach embodied by a social determinants of health framework works well with Indigenous knowledge and medicine (Mowbray, 2007, p. 34). Placing Indigenous beliefs, knowledge, and skills at the centre of health promotion, programming, policy, and service delivery is additionally identified as a step towards Indigenous self-determination and improved health outcomes (Smylie, 2009, p. 295). This insertion must be regarded critically, however, with consideration given to the continued colonization and subjugation of Indigenous knowledge.

The fourteen social determinants of health defined within a Canadian context by Raphael (2009) are: Aboriginal status, disability, education, employment and working conditions, early life, food insecurity, health services, gender, housing, income and income distribution, race, social exclusion, social safety net, and unemployment and job security (p. 7). Although defined separately, no social determinant can be considered on its own. Rather, they act in an intersectional manner, compounding the effects of one another. For Inuit women the determinants of race/Aboriginal status, gender, and socioeconomic status are highlighted within this thesis as they have a significant effect on Inuit maternal health. The overarching health determinant of colonialism is also explored as the health of Inuit women is intrinsically affected by "colonial policies and practices both past and present" (Allan & Smylie, 2015, p. 2).

Colonization as a Fundamental Health Determinant

In order to understand the social determinants most relevant to Inuit maternal health, the impacts of colonialism and enduring racist ideologies must first be addressed as an overarching health determinant (Allan & Smylie, 2015, p. 2). The health of Indigenous Peoples worldwide is "inextricably tied up with their history of colonization" (Mikkonen & Raphael, 2010, p. 41).

They share a collective history of genocide, dislocation, dispossession, violence, and racism that continues to the present in various forms including vast health disparities (UN, 2009, p. 167). Colonialism has been recognized as an underlying fundamental determinant of health, influencing and exacerbating the effects of social determinants (Allan & Smylie, 2015; Mowbray, 2007; Smylie, 2009). The dislocation of Indigenous People from their lands, livelihoods, and cosmologies, suppression of Indigenous languages and forced assimilation into Eurocentric society, and impacts of institutional racism each have implications for health (Smylie, 2009, p. 282). These colonial processes produce economic, social, and political inequalities while eroding cultural identity (NCCAH, 2012, p. 41). For Indigenous Peoples in Canada, four centuries of colonization have taken their toll on "physical, mental, emotional, spiritual, and cultural health" (Shah, 2004, p. 267). Colonialism is ongoing in the Canadian context, creating entrenched racism, a lack of self-determination, and social exclusion (Allan & Smylie, 2015, p. 2; 5). Racism and marginalization exert adverse and irreversible effects on health (Inuit Tapiriit Kanatami, 2014, p. 15). Within the Inuit context, forced settlement, compounded by the mass slaughter of sled dogs, fundamentally altered Inuit livelihoods (Allan & Smylie, 2015, p. 7). This targeted destruction and rupturing of Inuit nomadic lifestyles, accompanied by the forceful introduction of European societal norms and values, economic dependency on the federal government, and residential schooling has resulted in Inuit possessing "some of the most extreme health disparities in Canada" (Allan & Smylie, 2015, p. 7).

Social Determinants of Inuit Maternal Health

As Inuit women are forced to spend the final weeks of their pregnancies and deliveries in medicalized Western health systems, defined by systemic racism and mandated by the colonial state, the determinants of race/Aboriginal status, gender, and socioeconomic status intersect to

influence health outcomes. The existing evacuation model largely fails to address social determinants, but rather exacerbates their impacts in its colonial origins and current manifestation as a hyper-medicalized approach to health. The three social determinants identified in this analysis as most pertinent to Inuit maternal health are race/Aboriginal status, gender, and socioeconomic status. They are interpreted with the understanding that each acts independently and collaboratively to impact Inuit women's health.

Aboriginal status is closely tied with race and racism (Raphael, 2009, p. 7). Biological in origin, race is given its power as a health determinant through social construction (Cockerham, 2013, p. 139). Heavily influenced by colonialism, which enables the social construction of races including Indigenous Peoples as "inferior", racism marginalizes Inuit populations; creating social exclusion by rendering those who are indigenous to the land alien to the medical, legal, and social structures imposed upon those lands by the colonial state (NCCAH, 2012, p. 42; UN, 2009, p. 173). Racialized and Indigenous Canadians experience "a whole range of adverse living circumstances" that threaten their health (Mikkonen & Raphael, 2010, p. 47). Economic, social, cultural, and political variables converge along racial lines, reducing capacity for well-being (Cockerham, 2013, p. 157). Racism compounds social determinants and is directly related to conditions of underemployment and unemployment, poor quality housing, violence against women, targeted policing and disproportionate incarceration, and exclusion from full participation in the politics, economy, culture, and social affairs of Canadian society (Galabuzi, 2004, p. 247). Racism manifests in poor health outcomes through multiple channels including stress, social exclusion, poverty, food insecurity, and discrimination in access to health services (Mowbray, 2007, p. 35). Institutionalized racism is present in the Canadian health care system, often characterized by language barriers, absence of cultural competencies, lack of cultural

sensitivity and respect, barriers to access, inadequate funding for culturally relevant services, and an overall imposition of Western scientific norms (Galabuzi, 2004, p. 248). This is exacerbated for Indigenous Peoples, as they are not solely a racialized group, but have experienced centuries of colonialism that has sought to assimilate, modernize, and destroy Indigenous Peoples, their knowledge, medicine, and languages (Smylie, 2009). For Inuit, colonial medicine including forced evacuations for the 1940s-60s TB epidemic has created historical trauma associated with the formal medical system and particularly with evacuation-based treatment (Grygier, 1994).

Gender is a social determinant that, like race, must be conceptualized in relation to its social construction. WHO notes that gender works as a determinant through gender inequality, lack of decision-making power, unfair divisions of work, and unequal access to health resources (NCCAH, 2012, p. 38). Gender is shaped by "conditions, practices, and relations including relations of markets, power, and inequality" (Armstrong, 2009, p. 351). Gender differences have consequences for health, and women not only have added burdens of labour and reproductive capabilities, but also hold unequal position with relation to men (Armstrong, 2009, p. 352; 355). Women are often employed in lower-paying positions, are less likely to be working-full time, and have more responsibilities in childcare and housework which is often unpaid and unrecognized labour (Mikkonen & Raphael, 2010, p. 44). This is evident in Inuit households where women frequently play the "double-duty" of breadwinners and domestic labourers (Daviss-Putt, 1990, p. 107). Gender intersects with each of the social determinants identified by Raphael (2009) and is influenced by the overarching determinant of colonialism. Indigenous women are marginalized by racism, compounded by the historical and current processes of colonization (King, Smith, & Gracey, 2009, p. 81). Colonialism has directly shaped Inuit women's health and access to medical services, most evident in mandatory evacuation (Allan &

Smylie, 2015, p. 8). Indigenous women suffer lower educational levels and fewer employment opportunities, resulting in low socio-economic status (NCCAH, 2012, p. 52). This leads to them facing what the UN (2009) terms "multiple layers of discrimination" as they are simultaneously poor, female, and Indigenous (p. 174).

In medical sociology, socioeconomic status is regarded as the "strongest predictor of health, disease causation, and longevity" (Cockerham, 2013, p. 85). Hierarchical social stratification presents a pattern of inequality with those at the top obtaining superior resources for health while those at the bottom are left with almost none (Cockerham, 2013, p. 90). The power of socioeconomic status over health is explained by its interaction with other variables (Cockerham, 2013, p. 85). When socioeconomic status intersects with factors such as race/Aboriginal status and gender, its power is revealed as it magnifies the advantages or disadvantages attributed to these determinants (Cockerham, 2013, p. 85). Indigenous Peoples in Canada are disadvantaged with regards to socioeconomic status, intrinsically connected to the colonial dispossession of lands (Mowbray, 2007, p. 30). The forced settlement of Inuit into villages destroyed nomadic lifestyles and fundamentally altered livelihoods, hunting patterns, nutritional status, and overall health (Allan & Smylie, 2015, p. 7). Residential schooling further subjected generations of Inuit children to abuse—sexual, emotional, physical, mental, spiritual, and cultural—while failing to provide them with quality education (Allan & Smylie, 2015, p. 2). These colonial projects have had lasting impacts on socioeconomic status. Entrenched and institutional racism has further impacted access to food security, employment, education, and housing while permeating systems intended to provide social support such as health care, criminal justice systems, and child welfare systems (Allan & Smylie, 2015, p. 2).

The Intersection of Indigenous Knowledge & Western Science

Within health research, scholars have recognized the similarities between Indigenous medicine and a social determinants approach in that both emphasize holism, considering health as connected to factors external to the physical body (Waldram, Herring, & Kue Young, 2006, p. 74). Parallels between Indigenous medicine and the social determinants model are present, with researchers calling for a convergence of these systems as a way of improving Indigenous health (Skye, 2010, p. 30). Some, such as Gorelick (2014), argue that while it has often been constructed as "pseudoscience", Indigenous knowledge and science are "as sophisticated and nuanced as western sciences" and should be taught alongside Western science in formal institutions (p. 43; 48). There is contentious debate, however, on how Indigenous knowledge can, or should, be incorporated into dominant Western systems given the existing hierarchy of knowledges that has subjugated Indigenous ways of knowing for centuries (Skye, 2010, p. 30). If integration is to be attempted in health programming, policy, and delivery, there must be extensive collaboration and discussion between practitioners, scholars, and researchers, both Indigenous and Western (Waugh, Szafran, & Crutcher, 2011, p. 258).

The foundations of biomedicine and Indigenous medicine are vastly different, with Indigenous medicine encompassing the spiritual while biomedicine positions itself as "positivist, based on a philosophy of scepticism" (Waldram, Herring, & Kue Young, 2006, p. 249). Most existing health systems are "monocultural", based solely on biomedicine and failing recognize the validity of Indigenous medicine (UN, 2009, p. 176). Biomedicine is rigid, rarely incorporating new ideas or concepts, and it is questionable if Indigenous medicine can be included in any meaningful way or if it will be dismissed outright (Waldram, Herring, & Kue Young, 2006, p. 250). If Indigenous knowledge is forced into an empirical Western model,

spiritual foundations will no doubt be removed as anything that is not empirically supported is discredited (Simpson, 2000b, p. 192; Skye, 2010, p. 30). If Indigenous knowledge and medicine are to be incorporated into health policy, service delivery, and programming, they must be situated at the centre, not the periphery, and must be integrated on Indigenous terms (Simpson, 2000b, p. 194; Smylie, 2009, p. 295). Many Elders fear the commodification of healing practices, and integration will need to "safeguard" knowledge from exploitation and commercialization (Martin-Hill, 2003, p. 14; 25; Waugh, Szafran, & Crutcher, 2011, p. 258).

Indigenous Peoples and their knowledge, medicine, and culture have been a specific target of colonial assimilation and racism for centuries (Simpson, 2000b, p. 189). It is rare that Indigenous knowledge is recognized or accepted within its own right, but rather it is consistently measured against Eurocentric norms (Simpson, 2000b, p. 189). An integrative health model, therefore, presents challenges in how to utilize and employ two knowledge systems when one has been subjugated and deliberately attacked for centuries. Leanne Simpson (2000b), a Michi Saagiig Nishnaabeg scholar, points to the challenge of integrating Indigenous and Western knowledge when one holds substantial dominance in society (p. 192). She asks: "How do you 'integrate' the experiences of the colonized into that of the colonizer?" (Simpson, 2000b, p. 192). One attempt at resolving this dilemma is the use of a Two-Eyed Seeing Model.

Two-Eyed Seeing Model

As briefly described in Chapter One, Two-Eyed Seeing is a framework established by Mi'kmaw Elders Albert and Murdena Marshall (Hovey et al., 2017, p. 1278). This model seeks to provide a unique way of engaging Indigenous knowledge and Western science, addressing some of the concerns noted above. Two-Eyed Seeing seeks to arrange different ways of knowing on an equal level, recognizing a diversity of perspectives without assigning them to a hierarchy

or “perpetuating the dominance of one over another” (Martin, 2012, p. 24). There are many ways of understanding emphasized, some European-derived and others Indigenous (Martin, 2012, p. 31). The strengths and weaknesses of each knowledge are noted in this model which seeks to employ the strongest elements of each, moving beyond reductionist dichotomies (Martin, 2012, p. 38). While originating in Mi’kmaq knowledge, this model presents itself as open for application across knowledge systems as the underlying goal is to combine different ways of knowing, emphasizing the strengths of each, and metaphorically “learning to see from one eye with the strengths of Indigenous knowledges and ways of knowing, and from the other eye with the strengths of Western knowledges and ways of knowing” (Bartlett et al., 2012, p. 11). When both eyes see together, the result is a respectful and collaborative intersection of knowledge (Bartlett et al., 2012, p. 11). In doing so, Two-Eyed seeing “resists the colonization of thought by co-creating a process . . . arriv[ing] at a new understanding of a shared research question and shared understandings of how to address that question” (Hovey et al., 2017, p. 1285).

The advantage of this system is its attempt to break down hierarchies of knowledge. Several scholars identify this as a way to meaningfully and respectfully share perspectives, identifying solutions to pressing matters affecting Indigenous and non-Indigenous populations alike (Bartlett et al., 2012; Hovey et al., 2017; Iwama et al., 2009; Martin, 2012). This model does not seek to merge systems, nor does it “paste” parts of Indigenous knowledge onto Western knowledge (Iwama et al., 2009, p. 5). Instead it creates a common ground, a binocularity and “field of shared strengths” (Iwama et al., 2009, p. 5). Two-Eyed Seeing is a decolonizing approach that demands reflection on the role of colonization in positioning Indigenous knowledge (Martin, 2012, p. 29). It requires reflexivity and an understanding of how knowledges have been subjugated through the colonial process (Martin, 2012, p. 32).

This model has previously been applied to health research in a study by Hovey et al. (2017) which sought to integrate Philosophical Hermeneutics and Haudenosaunee Decision Making in a diabetes prevention project in a Kanien'kehá:ka (Mohawk) community in Quebec (p. 1279). The scholars involved in this study felt that they were able to experience and apply Two-Eyed Seeing through a sharing of perspectives and "weaving back and forth" amongst the interdisciplinary research team comprised of Indigenous and Western scholars (Hovey et al., 2017, p. 1284). This study notes that Two-Eyed Seeing is not a reducible concept, but presents as a "complex and ongoing set of relational and personal sharing of ideas, ways of knowing, and understandings that affect [a] co-learning journey" (Hovey et al., 2017, p. 1285). This complex process may not produce consensus, but its strengths lie in creating a space for sharing and understanding between ontologically conflicting ideas (Hovey et al., 2017, p. 1284). Two-Eyed Seeing is gaining acceptance across health professions, including a research project on its applicability to Indigenous health by the Canadian Research Chair in Indigenous Peoples' Health and Well Being, Dr. Debbie Martin (Canada Research Chairs, 2017).

There are several challenges in utilizing this model, however. Diligence is needed in selecting the strongest elements from knowledge systems, and it is questionable if an equal field can ever be created when considering the centuries of sustained attack on Indigenous knowledge (Bartlett et al., 2012, p. 13). It is further questionable if this model can, or should, be utilized by Western researchers when considering the history of colonialism and existing biases[2]. When applied to health research, this model faces challenges in that Western scientific understandings

[2] Another question raised throughout this research process is if integration should even be the goal of health systems. While this thesis presents integration as a possible approach to improving Inuit maternal health, as author I recognize that integration into a pre-existing Western system falls short of a comprehensive solution. At its core, a fundamental overhaul of the dominant medical system is needed to properly recognize Indigenous knowledge and medicine, restructuring internalized hierarchies of knowledge and the colonized relationship between Eurocentric and Indigenous knowledge systems.

of health have made undeniable contributions (Martin, 2012, p. 31). As Indigenous knowledge and medicine are subjugated to Western models, they are posited on a continuum with Western science at one end and Indigenous knowledge at the other (Martin, 2012, p. 35). There is significant challenge in re-conceptualizing knowledges in a way that does not reinforce existing dichotomies (Martin, 2012, p. 35). Simpson's (2000b) question: "How do you 'integrate' the experiences of the colonized into that of the colonizer?" remains important when considering the Two-Eyed Seeing Model, in that while aspirational, this model faces difficulty in practice as Indigenous knowledge and medicine, including Inuit midwifery, are the targets of assimilation and continually regarded as subordinate to Western models (p. 192).

Conclusion

This chapter has introduced the chosen approach of colonial governmentality. It has further presented Indigenous and Inuit knowledge and medicine as decolonial forces, existing throughout the colonial encounter and to the present in a multitude of forms including Inuit midwifery. A social determinants of health lens, particularly relevant for application to Inuit maternal health, presents a model that works well with Indigenous medicine in that both recognize the role of factors external to the body—social, political, and economic—in producing health outcomes. While many scholars highlight the potential for Indigenous knowledge and medicine to be integrated into existing health systems, this cannot be done without acknowledging a hierarchy of knowledges which has consistently positioned Indigenous knowledge as inferior and subordinate to Western knowledge. Chapter Three discusses Western medicine and its use as a force for colonization and assimilation with particular reference to colonial medical projects in Northern Canada. This historical analysis is essential to framing and understanding the subordination of Inuit midwifery to Western biomedicine.

Chapter Three: Medicine as a Colonial Force

Medicine has been used throughout history as a tool of colonial governmentality, particularly in assimilating colonized groups. This involves the social construction of bodies as diseased and presenting Western medicine as the solution to this sickly condition (Waldram, Herring, & Kue Young, 2006, p. 195). This is particularly evident in the pathologizing ideologies surrounding Indigenous Peoples, socially constructing them and their bodies as inherently diseased. Under colonialism, the definitions of disease and health are "inextricably linked to larger structures of authority and power" (Waldram, Herring, & Kue Young, 2006, p. 291). Western medicine has been established as an authoritative force, given its power through its connection to dominant European scientific ideologies. In Canada, the construction of Indigenous bodies as "desperate, disorganized, and depressed" created the rationale for paternalistic policies resulting in dependency on colonial systems (Waldram, Herring, & Kue Young, 2006, p. 292). This is evident in the Inuit context with policies and structures such as residential schools, forced settlement compounded by the slaughter of sled dogs, the Inuit Disk List System, and government responses to the 1940s-60s TB epidemic working to assimilate Inuit on justifications of health. These projects and policies disrupted Inuit livelihoods and worked to discredit Inuit knowledge and medicine, creating dependence on colonial authority and providing the blueprint on which maternal evacuation policy was built.

The Colonial Medical Gaze

The "medical gaze" is a concept developed by Michel Foucault (1973) in *The Birth of the Clinic.* Foucault (1973) suggests that medicine is used for social control as bodies are constructed in a way that grants physicians complete authority over patients and their bodies (Conrad, 1992, p. 216). The medical gaze is a "plurisensorial structure" which touches, hears,

and sees the body in a certain way (Foucault, 1973, p. 164). The medical gaze has informed and consistently reinforces the medical model of illness. This is the idea that "illness is a biological condition that occurs exclusively within the sphere of the human body", and subsequently the physician must look no further than the individual to discover the origin and treatment of illness (Strohschein & Weitz, 2014, p. 4). This conceptualizes patients as their illnesses, essentially subtracting the patient from their condition and focusing only on the diseased body separated from any other human qualities (Foucault, 1973, p. 14). This process is called biological reductionism in which illness is noted as "an objective biological condition that is located within the body", separated from social and environmental contexts (Strohschein & Weitz, 2014, p. 4). It further reflects mind-body dualism, a concept developed by Rene Descartes that suggests bodies and minds are "uniquely different entities" with limited ability to interact with one another (Strohschein & Weitz, 2014, p. 4). This results in a system dominated by Western medicine which views illness, and treatment of illness, as located solely within the biological body, ignoring social determinants and the complex environment in which health exists.

Under the medical gaze, supported and reinforced by the medical model, biological reductionism, and mind-body dualism, the body becomes something necessitating the control of physicians within formal medical systems (Williams & Calnan, 1996, p. 1610). Modern medicine emerges as part of a larger structure of "disciplinary techniques and technologies of power which are concerned with the moral regulation and 'normalization' of the population through the medical regimen" (Williams & Calnan, 1996, p. 1610). The medical gaze, with elements of classification and categorization, has worked to construct certain bodies as diseased and in need of medical control (Burtch, 1994, p. 44). This has been specifically applied to Indigenous bodies. Under a European medical gaze, any knowledge systems outside the

dominant European framework are delegitimized (Waldron, 2010, p. 51). Subsequently, dominant Western scientific culture views Indigenous cultures, peoples, and worldviews through a Euro-Western lens, pathologizing their bodies as diseased and in need of scientific control.

The medical gaze is used by colonial states to both create and control target groups of colonized populations, such as Inuit, under the auspices of bringing health, hygiene, and sanitation to those in need. The introduction of modern medicine is a specific project aimed at a target population, a tool of colonial governmentality as described by Scott (1995). Within the South Asian context, James Duncan (2007) explores how colonial governmentality used moral and racist discourses to control plantation labourers, particularly over issues of hygiene and sanitation (p. 101). Through the colonial medical gaze, spaces are constructed as "pathogenic", helping to "justify the insertion of European modernity into those spaces" (Duncan, 2007, p. 103). Western medicine works as a tool of colonial powers, intending to meet economic and assimilationist goals (Duncan, 2007, p. 104). Issues of hygiene and sanitation are furthermore tailored to theories of racial difference, enabling the division of populations into subgroups with unique characteristics, norms, and needs to be addressed through modern medicine (Duncan, 2007, p. 107). Under colonial governmentality, disease is a "medico-moral complex" (Duncan, 2007, p. 128). This means that disease is understood and treated not only as a biomedical issue, but becomes part of a larger humanitarian mission with subvert goals of assimilation.

Medicine as a Colonial Force in Canada

The medical model has been granted hegemonic status globally, allowing it to operate as a powerful economic, cultural, and political force. Biomedical models and Western scientific thought remain dominant in an unconscious manner, working as "common sense" knowledge and setting the standard by which any alternative knowledge systems and forms of medicine are

assessed (Waldron, 2010, p. 53). The medical model is part of a larger system of cultural normativity, which asserts the superiority of Euro-Western thought. As such, when examining health systems and policies, particularly as they are implemented by colonial states, it is necessary to critically examine who is allowed to produce knowledge, which knowledges are regarded as superior/inferior, and how subordinated knowledges are positioned.

The historic use of medicine as a tool for modernization is evident in the Canadian context. Medicine has been used to assimilate and colonize Indigenous populations through a variety of policies and institutions (NAHO, 2004, p. 8). Although the Canadian government took almost no responsibility for Indigenous health in the 19th century, missionaries viewed medicine as a powerful Christianizing force and attempted to infiltrate the most personal aspects of Indigenous society, replacing Indigenous medicine, shamans, and healers with Christian spiritual leaders and Western medicine (Jasen, 1997, p. 390). Public health measures were extremely personalized, with reforms "aimed to change conduct and personal habits at the most intimate level" (Bashford, cited in Rutherdale, 2010, p. 6). Through the Indian Act, treaties, residential schools, forced relocation, and the outlawing of Indigenous medicine many aspects of Indigenous livelihoods were disrupted (Kral et al., 2000, p. 37). By upsetting food systems and forcing communities to live in close contact, food insecurity and malnutrition resulted leading to endemic disease (Dawson, 1993, p. 23). With communities weakened, health care became "a powerful converting device" for assimilation and modernization (Dawson, 1993, p. 23).

Indigenous People were subjected to the colonial medical gaze under which their bodies were conceptualized as inherently diseased (Kelm, 2005, p. 373). Issues of sanitation and hygiene were a focus of the colonial state, with Indigenous communities viewed as unsanitary and the Indigenous home "the locus of all infection" (Kelm, 2005, p. 390). Understood to be

"naturally inured to filth" on the basis of culture and worldviews, they were blamed for their own ill health (Kelm, 1998, p. 39). This strictly biomedical approach ignored social determinants, directly tied to the colonial policies principally responsible for Indigenous health issues at this time (Kelm, 1998, p. 40). The solution to Indigenous disease was to be found in Western science, standing in contrast to Indigenous conceptions of health and healing as outlined in Chapter Two. Indigenous medicine emphasizes holism and the complete health of mind, body, emotions, and spirit (Bennett & Rowley, 2004, p. 219; Skye, 2010, p. 30). The colonial medical model directly contrasted Indigenous medicine by focusing on disease eradication within a narrow biomedical framework. By framing the imposition of Western medicine as humanitarian, the colonial state created a moral basis for intervention (Kelm, 1998, p. 101). Under the auspices of saving Indigenous People through medicine, Canadian colonialism was justified, legitimized, and sustained (Kelm, 1998, p. 100). Medicine was further utilized as an "acculturative device", destroying elements of Indigenous society and discrediting Indigenous knowledge and medicine under the auspices of improving health (Kelm, 1998, p. 126).

Establishment of Northern Medicine

The introduction of Western medicine in Inuit regions came at a later date, and until the early 20th century, northern medicine was "conspicuous mainly by its absence" with Inuit populations being largely self-sufficient in health care (Brett, 1969, p. 521; Douglas, 2006, p. 121). Although Inuit were in contact with Europeans from the 11th century and had established relationships with outsiders through whaling and the fur trade, health care was provided on an "ad hoc basis" by military, missionaries, and government agents until after World War II (Smylie, 2009, p. 289; Waldram, Herring, & Kue Young, 2006, p. 16; 173). The Royal Canadian Mounted Police (RCMP) arrived in the 1920s, followed by Christian missionaries in the 1920s-

30s (Kral & Idlout, 2009, p. 316). Pre-World War II, two mission hospitals operated under the auspices of churches who recognized that illness and health could be utilized as "commodities. . . traded for the spiritual and economic loyalties of the Inuit population" (Douglas, 2006, p. 121; O'Neil & Kaufert, 1990, p. 55; Waldram, Herring, & Kue Young, 2006, p. 198). The Catholic and Anglican churches framed meeting medical needs as a humanitarian mission to "save" Inuit from themselves (Tester & McNicoll, 2006, p. 90-91). The Catholic Church was particularly explicit about its assimilationist goals, and medical services were one way of achieving Christianization and "civilization" (Anderson, 2008, p. 11). Churches did not seek to introduce formal medicine, however, and only after 1941 were health care systems established as large numbers of military and government personnel moved to the Arctic to build the Distant Early Warning (DEW) Line of meteorological and radar stations which operated as a detection system for Cold War aggression (Kral & Idlout, 2009, p. 316). The absence of health care was justified by the Canadian state due to difficulties in providing services with inadequate communication, a lack of transportation infrastructure, high costs, and the inability to secure trained personnel to serve a geographically dispersed population (Anderson, 2008, p. 72).

With an increased presence of military and government officials in the North, formal medical intervention began with physicians accompanying ships on the Eastern Arctic Patrol servicing missions and trading posts (Brett, 1969, p. 521; Douglas, 2006, p. 121; O'Neil & Kaufert, 1990, p. 55). The Department of Northern Affairs and Natural Resources was established in 1953, accelerating the introduction of Western medicine as it sought to provide health care, education, and a new economic system (Anderson, 2008, p. 11; Kral & Idlout, 2009, p. 316). Rapid social change occurred as Inuit were encouraged to join the wage labour system and relocate to permanent settlements with access to health care, education, and additional

government services (Anderson, 2008, p. 10). Medicine was part of a larger project of colonial governmentality to permanently settle, organize into quantifiable populations available for wage labour, and ultimately control Inuit for assimilationist and economic purposes.

The social change caused by settlement projects created instability with rampant food insecurity and overcrowded housing causing health issues, including high rates of infectious disease (Dawson, 1993, p. 23). The "Westernization" of Inuit is noted by Steenbeek et al. (2006) as creating a lower health status for Inuit than their pre-contact ancestors through settlement, increased disease exposure, crowded and unsanitary housing, malnutrition, and suppression of Inuit medicine including Shamanism and midwifery (p. 532-533). This led to an "unquestioning dependence" on the services and authority of the government, particularly for health care (Dawson, 1993, p. 23). A cycle emerged in which colonialism both directly caused disease and provided the only solution to it. Western medicine was introduced with assimilationist goals, attempting to replace "primitive" shamanistic practices, discrediting Indigenous knowledge in order to bring Inuit into the "civilized and modern world" (Tester & McNicoll, 2006, p. 104). Aggressive measures were taken to curb mortality and morbidity with nursing stations constructed in settlements providing extensive referral to southern secondary- and tertiary-level facilities (Paulette, 1990a, p. 77). Inuit became "objects of a colonial gaze", with specific projects developed to deliver modern medicine (Tester & McNicoll, 2006, p. 89). Post-World War II, residential schools, forced relocation, the Disk List System, and evacuations for TB sanatoria treatment were emphasized to modernize Inuit in the name of health.

Residential Schools

Residential schools were a tool for the colonization and Christianization of Indigenous Peoples (TRC, 2015, p. 43). Justified on the assertion that Indigenous People were "unclean and

diseased", advocates presented education as a means of saving children from the "insalubrious influences of home life" (Kelm, 1998, p. 57). By removing them from supposedly negligent and unclean parents, Indigenous children could be taught higher standards of hygiene (Kelm, 1998, p. 62). Strict Eurocentric gender norms and indoctrination into European religious systems had a dramatic impact on health and well-being (Carroll & Benoit, 2004, p. 269). Indigenous women were noted as contributing to infant mortality with their "unsanitary ways", and young women in residential schools were trained in domestic tasks in order to improve these outcomes (Kelm, 2005, p. 395; Kelm, 1998, p. 61). This undermined Indigenous women's health practices, birth rituals, and understandings of menstruation and reproductive health (Carroll & Benoit, 2004, p. 270). Physicians encouraged residential schooling due to this reinforcement of gender norms, thought to be helpful in restructuring unhealthy Indigenous communities, and further supported teachings on hygiene (Kelm, 2005, p. 395).

Schooling was positioned as a humanitarian mission (Kelm, 1998, p. 61). Ironically, schools were extremely unhealthy places with unclean water, poor ventilation, and improper sanitation (TRC, 2015, p. 94). Students were exposed to infectious diseases such as TB and were overworked, underfed, and subjected to physical, sexual, and emotional abuse (Kelm, 1998, p. 80). An estimated 25% of residential school students died, although accurate numbers will never be known as health records were routinely destroyed (Kelm, 1998, p. 64; TRC, 2015, p. 90). Residential schooling has had lasting intergenerational impacts. Consistent abuse combined with an undermining and belittling of Indigenous values, knowledge, practices, and peoples resulted in survivors experiencing a "disconnection or disassociation from painful feelings, low self-esteem, negative identity as an Aboriginal person, and lack of respect for traditional beliefs and practices" (Smith, Varcoe, & Edwards, 2005, p. 47). This occurred at a formative time for

children, and residential school teachings became encoded in Indigenous identity, beliefs, and behavioural patterns (Smith, Varcoe, & Edwards, 2005, p. 47). This has been subconsciously passed on to survivors' children, creating a cyclical pattern of trauma (Smith, Varcoe, & Edwards, 2005, p. 47; 53). With these horrifying impacts, residential schools are now recognized as part of a larger plan to "eliminate Aboriginal governments; ignore Aboriginal rights; terminate the Treaties; and . . . cause Aboriginal peoples to cease to exist as distinct legal, social, cultural, and racial entities in Canada" (TRC, 2015, p. 1).

Despite their later colonial encounter, Inuit were not spared the experience of residential schooling. Schools and hostels were established in Inuit regions starting in the 1950s with enforced mandatory attendance for children (Kral & Idlout, 2009, p. 317). A formal agreement between the Department of Northern Affairs and National Resources, the Indian Affairs Branch of the Department of Citizenship and Immigration, the Northwest Territories Council, and the Roman Catholic and Anglican churches established federal government responsibility for all schools in the North and partial funding for church-run hostels (Anderson, 2008, p. 82). Hostels were similar to residential schools but required fewer staff, allowing them to operate in dispersed communities with small student populations (Anderson, 2008, p. 82). Education was regarded as a "highly acculturative force" and by 1964, 75% of Inuit children were enrolled in residential schools or hostels (Anderson, 2008, p. 84; Kral & Idlout, 2009, p. 317). Due to small communities and a later, arguably more efficient, colonial encounter, the "per capita impact of the schools in the North is higher than anywhere else" in Canada (TRC, 2015, p. 67). The impact on communities was complex with some children traveling thousands of kilometres to attend schools while others remained close to families in relocated settlements (TRC, 2015, p. 67). The residential school experience was in no way universal, but due to high per capita attendance, the

impacts are “strongly felt in the north” (TRC, 2015, p. 67). In the 1970s, territorial governments were established and pushed for the use of day schools (TRC, 2015, p. 70). A majority of hostels and residential schools in northern areas were closed by the late 1970s, with some remaining in operation through the 1980s and the last hostel closing in the late 1990s (TRC, 2015, p. 69).

Although hidden for decades, the shameful and continuing impacts of residential schooling have come to light through extensive testimonies and the work of the Truth and Reconciliation Commission of Canada (TRC). The TRC recognizes that residential schooling was a system which failed to provide students with adequate education while simultaneously degrading Indigenous culture, subjecting students to physical, sexual, and emotional abuse, and undermining the health and well-being of generations of Indigenous People through malnutrition, overcrowding and overworking, exposure to infectious disease, and poor sanitation (TRC, 2015, p. 132). Instead of creating the robust healthy bodies, desired for wage labour by the colonial state, residential schooling created weak bodies, bringing death and disease to many and creating a lasting multi-generational impact (Kelm, 1998, p. 57). Psychological health was intrinsically affected, and has resulted in what Smith, Varcoe, and Edwards (2005) identify as a “downwards spiral of addiction, violence, and poverty” (p. 48). This historical trauma is noted as contributing to increased rates of suicide amongst residential school survivors (Smith, Varcoe, & Edwards, 2005, p. 39). Indigenous Peoples’ relationships with the Canadian state and society further became, particularly at the level of institutions, “a twisted experience of lies and captivity” (Couchie & Nabigon, 1997, p. 43).

Forced Relocation

With an increased government presence post-World War II, Inuit populations were “encouraged” through federal policy to relocate into permanent settlements (Smylie, 2009, p.

289). Towns were set up, and sedentary settlement was intended to deliver services such as health care, education, and welfare while enabling closer administration of Inuit (Bjerregaard & Kue Young, 1998, p. 31). Nursing stations were established in settlements to attract residents (Douglas, 2006, p. 122). Resettlement appealed to government officials as they hoped it would provide wage labour for projects such as the DEW Line, along with an increased number of Inuit utilizing health care services and schools (Anderson, 2008, p. 30). These were assimilationist goals to destroy Inuit livelihoods and hunting patterns by creating a wage labour economy, introducing Western medicine, and educating children in residential schools. With settlement each Inuk could be counted, creating the defined target population needed for efficient governmentality (Kaufert & O'Neil, 1990, p. 439; Scott, 1995). Groups that previously had little contact and did not share subsistence patterns or dialects with one another were now forced into close confines (Kaufert & O'Neil, 1990, p. 429). Areas chosen for resettlement often failed to have sufficient natural resources, leading to food insecurity and malnutrition (Anderson, 2008, p. 10). Housing conditions were generally poor, infectious disease spread quickly, families were separated, and Inuit became rapidly disorganized both socially and politically, leading to dependence on colonial systems (Kaufert & O'Neil, 1990, p. 430). There were further implications of relocation in destroying the connections to land integral to Inuit identity, and due to these and additional factors, resettlement was overall "ill-conceived and poorly executed" (Kaufert & O'Neil, 1990, p. 429-430; Kral & Idlout, 2009, p. 316).

The negative effects of settlement were compounded by, and in many ways directly led to, the mass slaughter of sled dogs by the RCMP (Allan & Smylie, 2015, p. 2; Møller, 2010, p. 42). Although historically denied, a 2005 Quebec Government investigation recognized the mass slaughter of sled dogs carried out by federal government officials as a method of retaining Inuit

in permanent settlements (Sled dog slaughter, 2011). This report investigated Inuit regions in Quebec, although it is likely that sled dogs were slaughtered across the North. The importance of sled dogs to Inuit was ignored by RCMP (Croteau, 2010, p. 121). Inuit earned their livelihoods from trapping, fishing, and hunting and sled dogs were essential to this subsistence living (Croteau, 2010, p. 7). The use of sled dogs "was always an integral part of the distinct culture of the Inuit" (Croteau, 2010, p. 7). As permanent settlements grew, a "dog issue" resulted with a significant increase in the dog population, rise in the number of stray dogs, and outbreaks of canine disease (Croteau, 2010, p. 111). The grounds upon which dogs were slaughtered included issues of health and safety, with government agents also believing that owners settled in permanent villages no longer needed dogs for subsistence (Croteau, 2010, p. 136). The final report of the Quebec investigation found that more than 1,000 dogs were arbitrarily killed without the consultation or consent of dog-owners (Croteau, 2010, p. 136). A separate investigation conducted by the RCMP denied all allegations, and stated that dogs were killed for "health and safety reasons in accordance with the law" (Croteau, 2010, p. 2). The impact on Inuit livelihoods was devastating, and created further instability and vulnerability within communities.

Inuit Disk List System

As Inuit came under greater government control, it became essential to count and record them, creating the target population needed for colonial governmentality. Attempts to register and statistically quantify Inuit were undertaken through the creation of the Disk List System in 1941 (Waldram, Herring, & Kue Young, 2006, p. 16). Under this system each Inuk was given a disk stamped with an identification number that they were to wear at all times (Anderson, 2008, p. 38). Disks were used to administer welfare services, crime records, statistics, family allowances, education records, hunting and trapping licenses, rights to consume alcohol, birth,

marriage and death records, and other data necessary for government administration (Anderson, 2008, p. 39; Smith, 1993, p. 64). Over time, the system evolved without legal basis to become equated with Inuit status (Smith, 1993, p. 64). The need for classification arose from medical personnel who required a method of patient identification (Smith, 1993, p. 49). Administrators needed the Disk List as they were uninterested in learning, spelling, or pronouncing Inuit names (Smith, 1993, p. 64). Inuit did not have a standard naming system or surnames, spoke little English, and administrators rarely spoke or were willing to learn Inuktitut (Grygier, 1994, p. 49). The use of the Disk List System, allegedly for medical purposes, constituted a direct extension of state power (Douglas, 2010, p. 114). What started as a system of patient identification rapidly evolved, growing into a "much more comprehensive, if not also much more insidious" method of information collection and administration (Smith, 1993, p. 49-50).

The Disk List System was generally ineffective, with administration issues apparent from the start and many Inuit simply refusing to wear the disks (Waldram, Herring, & Kue Young, 2006, p. 205). Administrators and policy makers were so frustrated with the system that it outlived any usefulness it may have possessed (Smith, 1993, p. 63). The use of this system was a powerful extension of colonial power, though, in that it was the first "direct state-to-individual link" enabling mass collection of data and intensive surveillance of Inuit (Smith, 1993, p. 44). The Disk List System was essential to creating a target population "in order to meet state interests of governance" forming the delineated population necessary for colonial governmentality (Smith, 1993, p. 44; Scott, 1995). All Inuit interaction with government from the early 1940s to the late 1970s was done through this system before it was replaced by "Project Surname" in 1968 (Anderson, 2008, p. 39; Smith, 1993, p. 63). Project Surname encouraged

Inuit to select and register family names with standardized spelling, a further attempt at categorization, assimilation, and control (Anderson, 2008, p. 39; Smith, 1993, p. 63).

Tuberculosis Epidemic & Forced Evacuation to Southern Sanatoria

The most overt use of medicine as a force for colonization in Canada's North was the forced evacuation of Inuit to sanatoria in southern Canada for TB treatment. Rapid social change, accelerated by residential schooling and permanent settlement, led to an increased dependence on store-bought goods with poor nutritional quality, residence in sub-par overcrowded housing, increased contact with non-Inuit peoples, poor sanitation, and alcoholism (Hodgson, 1982, p. 503; Møller, 2010, p. 39). While settlement was intended to improve the health of Inuit, in reality it accelerated the spread of TB while failing to provide adequate health care services (Hodgson, 1982, p. 503). Outbreaks of TB were a result of, and fuelled by, settlement compounded by the cultural, social, and economic upheaval Inuit experienced at this time (Smylie, 2009, p. 289).

TB rates in northern regions increased throughout the 20th century and were noted by missionaries and civil servants who called for additional health care resources (Anderson, 2008, p. 72). The Canadian government, however, was complacent about medical treatment for Inuit prior to the end of World War II and accepted no "legal or moral responsibility" for Indigenous health (Hodgson, 1982, p. 503). With an increased presence of government and military personnel constructing the DEW Line, concern for Inuit health intensified as appalling conditions were revealed and the threat of contagion could no longer be ignored (Hodgson, 1982, p. 505; 509). International criticism of Canada's failure to address TB mortality rates in the North grew, creating an aggressive governmental response (Jasen, 1997, p. 395). In 1945 the Advisory Committee for the Control and Prevention of Tuberculosis Among Indians was created and given the authority to do whatever was needed to eradicate and prevent TB (Grygier, 1994,

p. 63). What evolved was a harsh policy of mandatory evacuation to southern sanatoria for treatment and a general refusal to construct health care facilities in the North (Anderson, 2008, p. 72). Treatment in sanatoria was the standard approach to TB in Southern Canada at the time, and although proposals were presented, any attempts to create a TB sanatorium in the Arctic were rejected under the assumption that specialists could not be obtained to work at such facilities, the number of cases would to drop within five years, and the central purpose was to remove infectious sources from their communities (Grygier, 1994, p. 73). The methods used to eradicate TB throughout the 1940s-60s included X-ray screening to detect active infection, removal of patients from communities via evacuation to southern sanatoria to stop the spread of disease, and immunization of as much of the population as possible (Grygier, 1994, p. 66). This approach was strictly biomedical and failed to identify or address the social determinants and community conditions that led to rampant TB infection (Grygier, 1994, p. 63).

Large-scale screenings began in 1945 utilizing coastguard ships that ran yearly patrols to screen and evacuate infected patients (Bjerregaard & Kue Young, 1998, p. 103). Inuit were treated like cattle with entire communities rounded up and herded onto ships, rushed through diagnostic procedures as fast as possible with little to no explanation, and held on ship if found infectious, unable to return to shore to say goodbye or make any necessary arrangements (Bjerregaard & Kue Young, 1998, p. 104; Waldram, Herring, & Kue Young, 2006, p. 202). Male household heads were denied the opportunity to select someone to care for their dogs or hunt for family subsistence, and mothers were unable to organize childcare or arrange for someone to process and sew skins needed to clothe the family (Grygier, 1994, p. 96). Once evacuated, patients spent on average two and a half years in treatment and many died, their bodies never returning to the North (Bjerregaard & Kue Young, 1998, p. 104; Grygier, 1994, p. xxi). At the

height of the epidemic, approximately half the Inuit population had been institutionalized with 75-80% receiving treatment in southern sanatoria (Bjerregaard & Kue Young, 1998, p. 104).

In sanatoria Inuit were met with strict daily regimens and forced detention of any "recalcitrant patients" (Hodgson, 1982, p. 507). It was a culture shock with language barriers, a complete change in diet and lifestyle, and full immersion in Western culture, practices, and concepts as "defined by the medical establishment" (Grygier, 1994, p. 183; Hodgson, 1982, p. 508). Inuit were denied money for incidentals or personal items, and were provided no information on family back home or their own condition and treatment (Grygier, 1994, p. xxii; Hodgson, 1982, p. 508). Due to administrative difficulties and the failure of the Disk List System, health care officials often could not locate hospitalized Inuit or produce accurate patient records (Grygier, 1994, p. 75). When deaths occurred, records were poorly kept and families were notified only through government officials (Grygier, 1994, p. 123). No information was provided on cause of death, burial location, or date of passing and messages were often received years after the death occurred (Grygier, 1994, p. 128; Waldram, Herring, & Kue Young, 2006, p. 202). Evacuation came to be recognized as a death sentence and Inuit initially resisted TB screening and treatment by hiding from ships and running away from sanatoria (Tester & McNicoll, 2006, p. 103). Over time, however, resistance collapsed as Inuit became convinced that sanatoria treatment was the only treatment option (Tester & McNicoll, 2006, p. 103).

Return to communities was poorly facilitated with individuals dropped in the wrong settlements, luggage lost, and a failure to notify family members of arrival (Grygier, 1994, p. 118). Many found it difficult to integrate back into Inuit society and could not adapt to their former lifestyles after years of living in southern Canada (Jasen, 1997, p. 395). Children presented a particular challenge as they often lost their language skills, did not want to leave a

familiar environment, and returned to unknown family members (Grygier, 1994, p. 125). Having lost much of their identity and culture, they came back as strangers (Moffitt, 2004, p. 326) To Inuit, the evacuation of children is regarded as a form of kidnapping, with children "lost forever" (Grygier, 1994, p. 128). Many died and a large number were adopted by southern families or placed in government care without the consent or notification of parents (Smylie, 2009, p. 289).

Although many were cured, the process of evacuation posed a direct threat to the social and cultural autonomy of Inuit and is historically regarded as a "socio-cultural disaster" (Hodgson, 1982, p. 506; Møller, 2010, p. 38). Although framed as a humanitarian mission, the Canadian government recognized the potential hospitalization had for culture change as a positive by-product of treatment (Waldram, Herring, & Kue Young, 2006, p. 203). Hospitalization became "synonymous with civilization and Christianity" (Grygier, 1994, p. 61). It was assumed that sanatoria would introduce Inuit to the desirable benefits of modern Canadian culture (Grygier, 1994, p. 177). TB treatment was part of a larger attempt to modernize and assimilate Inuit, with Western medicine and culture change understood to be interrelated (Waldram, Herring, & Kue Young, 2006, p. 202). Evacuation not only introduced Inuit to Euro-Canadian culture, but in separating families and kinship systems it undermined social cohesion (Waldram, Herring, & Kue Young, 2006, p. 204). Evacuation-based institutionalization was not the only option available at this time for TB treatment, but was emphasized as it enabled the modernization and control desirable to the Canadian colonial state (Hodgson, 1982, p. 508).

Inuit lost control of health care through TB evacuation (Møller, 2010, p. 39). Through the epidemic Inuit became fully dependent on government services, demoralizing and disrupting communities (Kaufert & O'Neil, 1993, p. 38). This approach to disease carried with it the implicit message that decisions on health care were entirely in the hands of the state (Waldram,

Herring, & Kue Young, 2006, p. 199). In the name of health, colonial powers "claimed the authority to disrupt family life and traditional patterns of social organization" (Waldram, Herring, & Kue Young, 2006, p. 199). Illness came to be constructed as a threat to Inuit autonomy and social cohesion as it facilitated intense colonial control (Waldram, Herring, & Kue Young, 2006, p. 199). Inuit perceptions of disease, illness, and hospitalization are intensely affected by colonialism, and evacuation carries with it a legacy of bitterness overshadowing Inuit relationships with and towards medical systems (Hackett, 2005, p. S19; Møller, 2010, p. 43; Waldram, Herring, & Kue Young, 2006, p. 202). TB evacuation provided a prototype for maternal evacuation and memories of this experience "thread through the discourse on childbirth" with opposition to evacuation "emotionally coloured by memories of people sent south with TB, never to return" (Gatto, 2010, p. 9; Kaufert & O'Neil, 1993, p. 39).

Conclusion

By tracing the introduction of Western medicine, it becomes apparent that it has been consistently used by the Canadian state as a method of assimilation, intended to modernize Inuit and bring them under government control through the use of targeted projects. Through mandatory education in residential schools, forced resettlement and slaughter of sled dogs, categorization and classification under the Disk List System, and forced evacuation and sanatoria confinement, it is clear that medicine has been consistently utilized by the Canadian state as force for colonial governmentality. Medicine has justified the intense surveillance and control of Inuit, creating a legacy of mistrust through "authoritative and inhumane" treatment (Bjerregaard & Kue Young, 1998, p. 104). This historical trauma is integral to understanding present-day resistance and responses to maternal evacuation policies.

Chapter Four: Medicalization of Maternity—Implications for Canadian Midwifery

Over the course of the 20th century, biomedicine gained an unparalleled cultural authority across the Western world (Barker, 1998, p. 1067). Under this scientific hegemony, pregnancy and childbirth were no longer understood to be natural processes; rather they were conceptualized as medical events, demanding the supervision and control of physicians (Conrad, 1992, p. 225). The medicalization of maternity granted a monopoly over childbirth and childbirth knowledge to physicians, leading to the almost complete demise of North American midwifery (NAHO, 2004, p. 7). Although midwifery has resurfaced in Canada, biomedicine still "reigns supreme and midwives suffer under its disciplinary effects" (MacDonald, 2007, p. 4). To situate Inuit midwifery within the larger narrative of midwifery in Canada, this chapter investigates the medicalization of maternity to determine how this force worked in conjunction with colonialism to devalue non-scientific knowledge systems including Indigenous medicine and midwifery.

Medicalization & the Cultural Authority of Biomedicine

Medicalization is the "process by which nonmedical problems become defined and treated as medical problems, usually in terms of illnesses or disorder" (Conrad, 1992, p. 209). This process engages the medical gaze and occurs on multiple levels (Conrad, 1992, p. 216; 211). Conrad (1992) defines these levels as the conceptual, institutional, and interactional (p. 211). On the conceptual level, medical vocabulary is used to define the health problem or issue that is medicalized (Conrad, 1992, p. 211). At the institutional level, organizations and health care systems adopt a biomedical approach to treating identified problems (Conrad, 1992, p. 211). Medicalization occurs at the interactional level as physicians work directly with patients, defining their problems as medical and treating them with biomedical interventions (Conrad, 1992, p. 211). This process has expanded and encompassed "many problems which hitherto were

not defined as medical issues" including: menopause, pregnancy and birth, aging, baldness, and unhappiness (Williams & Calnan, 1996, p. 1609; Brennan, Eagle, & Rice, 2010, p. 11).

Increasing pharmaceutical technology and biotechnology have facilitated the rapid extension of medicalization (Conrad, 2005, p. 5). Crucial to medicalization is the exclusion of psychological, economic, political, and social factors, including the social determinants of health, in favour of defining disease as resulting solely from pathologized processes within the patient (Brennan, Eagle, & Rice, 2010, p. 11; 16). Under the medical model, the focus is on treating the diseased body with science, failing to situate physical health within the context of larger social and political structures. Medicalization is a sociocultural process that involves the active engagement of society (Brennan, Eagle, & Rice, 2010, p. 11; Conrad, 1992, p. 211; 219). It is a negotiated process, and cannot be conceptualized as entirely hegemonic. Patients are not merely "passive or active, dependent or independent, believers or sceptics", but rather engage with medicalization in a complex combination of these roles (Williams & Calnan, 1996, p. 1619). Demedicalization occurs simultaneously, creating a medicalized-demedicalized continuum on which certain conditions, including maternity, constantly shift (Halfmann, 2011, p. 189; 202).

With the emergence and rapid rise of biomedicine in the 20th century, a cultural authority was granted to scientific medicine (Barker, 1998, p. 1067). This authority enables and fuels medicalization, as science is permitted to define what conditions are medical and create public acceptance of this definition (Barker, 1998, p. 1067). The medical profession has grown, gaining a position of cultural, economic, and political influence and power (Jordan, 1997, p. 57). This is a global power, and the superiority granted to scientific "ways of knowing" has allowed the dismissal of all other knowledge systems (Jordan, 1997, p. 56). This occurs through the construction of alternative knowledge systems as ignorant, backwards, and naïve (Jordan, 1997,

p. 56). All forms of Indigenous knowledge are seen as exotic, superstitious, primitive, fraudulent, and harmful (Waldram, Herring, & Kue Young, 2006, p. 127). The creation of authoritative knowledge is a social process that reinforces and reflects existing power structures, working in a way that the general public comes to understand the existing social order as natural (Jordan, 1997, p. 56). For Indigenous Peoples, the construction of authoritative knowledge has resulted in devaluation of Indigenous knowledge and medicine, as discussed in Chapter Two. Within the context of Canadian midwifery, medicalization and authoritative biomedicine have undermined and almost destroyed the practice, including many forms of Indigenous midwifery.

The Medicalization of Maternity

Women are noted as being particularly vulnerable to medicalization, with gender and gendered societal roles being central to this process (Conrad, 1992, p. 222). Their increased subjugation to medical authority is thought to be largely due to unequal social positions and the possession of external markers such as menstruation, childbirth, and lactation (Prosen & Tavčar Krajnc, 2013, p. 263). Women visit doctors more than men, often due to these reproductive health markers, and gender inequity across many societies leads to an increased vulnerability "to the expansion of medicine" (Prosen & Tavčar Krajnc, 2013, p. 264). In the early 20th century, few women consulted physicians during pregnancy (Baillargeon, 2009, p. 1). By the 1960s, this had changed dramatically and it was unthinkable for a woman not to see a doctor throughout her pregnancy (Baillargeon, 2009, p. 1). This medicalization of maternity is defined as the "transformation of the pregnancy, birth, and newborn care into matters that required medical attention or the mediation of medical science" (Baillargeon, 2009, p. 2). With the rise of obstetrics and gynaecology, women across the Western world were expected to submit to physician authority for prenatal care and particularly for assisted delivery (Barker, 1998, p. 1074;

Jasen, 1997, p. 391). This manifested in Canadian society along class, gender, and ethnic lines and was legitimized on a "broad range of preconceptions and prejudices totally unrelated to scientific objectivity . . . aimed first and foremost to dominate an area that previously was the preserve of women" (Baillargeon, 2009, p. 5). The campaign for medicalization was intended to reduce high rates of infant and maternal mortality, and gained support by manipulating mothers' anxieties and fears (Baillargeon, 2009, p. 105; Prosen & Tavčar Krajnc, 2013, p. 252). Infant mortality was understood as a marker of society's development and civilization, targeted in the name of modernization (Jasen, 1997, p. 394). Medicalizing maternity was therefore incorporated into a larger colonial agenda of modernization, attempting to realize goals of development through the control of reproduction (MacDonald, 2007, p. 8).

Through medicalization, pregnancy came under supervision and delivery required the assistance of trained professionals (Gallagher & Ferrante, 1987, p. 379). Childbirth was no longer a domestic event, but rapidly moved away from pre-scientific understandings to become a biomedical event located in a "medical space" (Barker, 1998, p. 1071; Conrad, 1992, p. 225). By reducing birth to physical and biological characteristics, childbirth authority is seized from pregnant women and placed into the hands of medical professionals (Barker, 1998, p. 1073; Brubaker & Dillaway, 2009, p. 34). The pregnant woman's body is defined as "uncontrollable, uncontained, unbound, unruly, leaky, and wayward" (Prosen & Tavčar Krajnc, 2013, p. 256). Medicalized maternity in Western industrialized countries begins early in pregnancy, transforming it into a constant at-risk condition necessitating medical monitoring through technological interventions (Benyamini et al., 2017, p. 1; 2). This definition of maternal risk is subjective, using scientific terminology to medicalize maternity at the conceptual level and transform it from a natural process into a disease (Cahill, 2011, p. 335; 339). Now dangerous, "a

crisis controlled and remedied only through the art of medicine", the hospital becomes the safest place to regulate pregnancy and delivery (Cahill, 2011, p. 334; Dawson, 1993, p. 15).

Hospitalized birth involves a high rate of interventions including ultrasound, electronic fetal monitoring, episiotomy, forceps and vacuum delivery, anaesthesia, and caesarean section in both low- and high-risk pregnancies (Shaw, 2013, p. 523; Smeenk & ten Have, 2003, p. 153). The focus is mechanical, not emotional, and ignores social determinants by defining patients solely as their physical conditions (Kaufert & O'Neil, 1990, p. 435). Women are forced to give birth in circumstances and positions that are ideal and convenient for medical professionals, but not particularly healthy or conducive for women themselves (Shroff, 1997, p. 17). These interventions have come to be accepted as routine, de-legitimizing the innate birthing capabilities of women (Shaw, 2013, p. 527). Physicians have obtained a knowledge monopoly, defining what is normal and abnormal along biomedical lines while any alternative knowledge systems are discredited (Smeenk & ten Have, 2003, p. 154). Birth across Western countries has become "technocratic", managed by professionals using technology to diagnose and regulate delivery (Kitzinger, 2005, p. 2). Almost all births in North America now take place in hospitals, involving a variety of biomedical interventions with notably high caesarean rates (Davis-Floyd & Sargent, 1997, p. 11). Although enjoying a brief resurgence in the 1970s, midwifery only accounts for a small percentage of births in North America and is subject to a hegemonic medicalized birth culture (Davis-Floyd & Davis, 1997, p. 319; Davis-Floyd & Sargent, 1997, p. 11).

Medicalization of maternity has coincided with reduced infant and maternal mortality. The Global North has unquestionably better infant and maternal mortality statistics than the Global South, achieved in part through medicalization (Kitzinger, 2005, p. 7). Biomedicine has undoubtedly been instrumental in saving many lives, and the introduction of emergency medical

services and hygienic delivery has notably contributed to improved outcomes (Cahill, 2011, p. 355; Shaw, 2013, p. 523). There is controversy, however, over whether medicalization has singlehandedly reduced mortality or whether this can be attributed to large-scale improvements in sanitation, hygiene, and diet (Burtch, 1994, p. 86). While infant and maternal mortality have certainly improved in countries where medicalization has occurred, this has gone hand in hand with a decline in fertility rates (Baillargeon, 2009, p. 239). Biomedicine subsequently cannot be given all the credit for these reductions, as it is "difficult to specify which of these two phenomena, medicalization or contraception, contributed most" (Baillargeon, 2009, p. 239). The medicalization of pregnancy, including extensive prenatal monitoring, is particularly questionable in its contributions as Barker (1998) notes that falling maternal mortality is "almost entirely attributable to the elimination of postpartum infection", connected to delivery practices but not prenatal care (p. 1068). While the achievements of biomedicine including research and training, improved clinical care, and reduced mortality cannot be ignored, it must be acknowledged that medicalization has pathologized maternity, restricting women's authority and creating iatrogenic effects (Burtch, 1994, p. 94; Kitzinger, 2005, p. 7).

Through the medicalization of maternity, bodily autonomy and authority are restricted destroying women's abilities to manage their own health (Barker, 1998, p. 1073). Women's natural capabilities to labour and deliver have been taken away, placed in the hands of physicians (Shaw, 2013, p. 533). The steady erosion of women's bodily autonomy, choice, and control occurs simultaneously with medicalization as medical supervision and techniques are applied to pregnancy in a way that "intrudes upon the mother's own competence" (Cahill, 2011, p. 335; Gallagher & Ferrante, 1987, p. 379). Arguments about safety justify these restrictions and subject pregnant women's bodies to an unequal distribution of power in the physician-patient

relationship (Barker, 1998, p. 1074; Cahill, 2011, p. 335). The discourse surrounding pregnancy and childbirth becomes a false dichotomy between delivering healthy babies and allowing women control over their bodies (Prosen & Tavčar Krajnc, 2013, p. 267).

Feminist critiques primarily focus on the cooption of women's autonomy and decision-making by patriarchal medical systems (Shaw, 2013, p. 523). The hierarchy of physician-patient relationships places women in passive roles, disempowering them and creating dissatisfaction with pregnancy and delivery experiences (Shaw, 2013, p. 529; 532). Lacking control over what was previously conceived as a natural process, women become estranged from the reproductive capabilities of their own bodies (Williams & Calnan, 1996, p. 1610). This dissatisfaction with medicalized birth stems from a lack of informed decision-making, with notable restrictions in choosing the birth location and the use of medical technology and interventions during pregnancy and delivery (Benyamini et al., 2017, p. 6; Prosen & Tavčar Krajnc, 2013, p. 265). This cooption of autonomy is particularly notable for Inuit women who are affected by multiple levels of power inequities. The cultural hegemony of Western knowledge over Indigenous knowledge reinforces the medicalization of childbirth as Indigenous midwifery and health systems are discredited (Martin-Hill, 2003; Waldram, Herring, & Kue Young, 2006). Inuit women are further disadvantaged in health care access due to factors including their remote location in the North, gender inequity, established racism and cultural barriers in the Canadian health care system, and low socioeconomic status (UN, 2009, p. 174). Each of these social determinants and factors compound to particularly limit Inuit women's autonomy in health care decisions, including childbirth, and policies enforcing mandatory evacuation further subject Inuit women's autonomy to health care system with colonial roots and associated historical trauma.

In addition to compromising women's autonomy, several scholars question the excessive use of biomedical interventions in pregnancy and labour. Medicalization is noted as leading to an increasing and unwarranted number of cesarean sections (Prosen & Tavčar Krajnc, 2013, p. 258). The overuse of interventions in pregnancy and labour including episiotomy, Pitocin to induce labour, epidurals to relieve pain, a lack of consistent care throughout the prenatal, delivery, and postpartum period, emphasis of the lithotomy delivery position, and "the overarching ideology that birth is a medical event" are noted as contributing to substandard care and may result in iatrogenic effects (Burtch, 1994, p. 55). Iatrogenesis refers to effects on patients resulting from excessive or unnecessary interventions administered by medical personnel which have an overall negative or "sickening" outcome (Burtch, 1994, p. 5). Iatrogenic effects of interventions are noted throughout the literature on medicalization, particularly highlighting the increasing rates of unnecessary caesarean sections (Bourgeault, Benoit, & Davis-Floyd, 2004; Burtch, 1994; Kitzinger, 2005; Prosen & Tavčar Krajnc, 2013).

Devaluation of North American Midwifery

Prior to rampant medicalization and societal acceptance of hospitalized birth, a majority of women delivered at home assisted by family members or midwives (Rutherdale, 2010, p. 62). The practice of midwifery—women assisting women in childbirth—is thought to constitute "the oldest, most traditional, and culturally widespread health care activity" (Connor, cited in Dodd & Gorham, 1994, p. 103). Globally, midwives continue to attend a majority of births, delivering an estimated 80% of the world's babies and comprising an integral part of almost every country's maternal health systems (Burtch, 1994, p. 3; Shroff, 1997, p. 15). In North America, however, midwives almost disappeared in the 20th century as midwifery knowledge was subjugated under medicalization and the authority of biomedicine (Burtch, 1994, p. 3).

Throughout the late 19th and early 20th centuries the medical profession worked to declare midwifery illegal in order to gain control over childbirth (O'Neil & Kaufert, 1990, p. 62). By the 1940s, midwifery was "no longer a maternity care option for the vast majority of Canadian women" (MacDonald, 2007, p. 29). A crucial shift occurred in who was allowed to possess childbirth knowledge, with physicians gaining a monopoly over maternity care while midwives were discredited (Barker, 1998, p. 1071). Medicalization was crucial to this near demise of North American midwifery (Olson, 2015, p. 170; Shaw, 2013, p. 525). As pregnancy and childbirth were defined as risky, demanding physician intervention, midwives were displaced (MacDonald, 2007, p. 28). Physicians declared midwifery unsafe, but underlying motives were economic (Burtch, 1994, p. 223; O'Neil & Kaufert, 1990, p. 62). Cutthroat competition emerged as an over-supply of physicians faced opposition in maternity care provision, and eliminating midwives became essential to protecting the interests of the emerging medical profession (Bourgeault, Benoit, & Davis-Floyd, 2004, p. 30; Burtch, 1994, p. 12).

The devaluation of midwifery reflected patterns of male dominance over women in both medical and general societal spheres, a patriarchal takeover in which a predominantly male profession sought to displace a predominantly female one (Burtch, 1994, p. 12; MacDonald, 2007, p. 28). Male physicians exploited and built upon class, race, and gender advantages (Dodd & Gorham, 1994, p. 6). Midwives threatened male authority and the medical profession resisted training and education for women, particularly midwives, by subscribing "to the general belief that most women were not intellectually capable of a scientific education" (NAHO, 2004, p. 7; Shaw, 2013, p. 525). This successfully limited midwifery in North America while the European medical establishment, following some initial resistance, came to embrace midwifery education and training (NAHO, 2004, p. 7).

There was a concerted effort to discredit midwifery and any non-scientific birth knowledge systems, including Indigenous medicine and midwifery (Olson, 2015, p. 174). Physicians claimed that midwives were unsafe, "dirty, ignorant, and incompetent", and in the case of Indigenous midwives this built on existing racist colonial claims regarding substandard hygiene and health (MacDonald, 2007, p. 28). Public opinion was shaped by medicalization to believe that midwife-attended births were hazardous, overlapping onto Indigenous health policies (NAHO, 2004, p. 7). Colonial systems of oppression supported the authority of Western medicine and were an integral factor in the devaluation of Indigenous midwifery (Shroff, 1997, p. 16). Colonization "is the first cousin to patriarchy", and exacerbated the medical control and suppression of Indigenous midwifery across Canada (Couchie & Nabigon, 1997, p. 44). Particular attacks to discredit Indigenous midwifery were tied to the expansion of colonial policies and power (Bourgeault, Benoit, & Davis-Floyd, 2004, p. 33). By dismissing any non-scientific knowledge as ignorant and dangerous, biomedical approaches gained dominance (Barker, 1998, p. 1071). Medicalized birth was seen as "modern", and efforts to replace Indigenous midwifery were undertaken in the name of development (NAHO, 2004, p. 7). Non-scientific knowledge was rapidly discredited and women, including Indigenous women, slowly came to believe in the superiority of medical knowledge (Jordan, 1997, p. 61).

Current Practices in Canadian Midwifery

Canada and the United States are the only industrialized countries where midwifery almost entirely disappeared (NAHO, 2004, p. 8). In Canada, modernized midwifery with formal accreditation was not allowed to develop in part due to provincial medical acts that granted physicians monopoly rights over childbirth care and attendance (Dodd & Gorham, 1994, p. 6; O'Neil & Kaufert, 1990, p. 62). The failure to endorse any formal education system for

midwives further allowed the practice to "die of neglect" (Dodd & Gorham, 1994, p. 6). Until the mid-1990s, Canada was the only Western industrialized country that did not legally permit midwives to practice (MacDonald, 2007, p. 4). In most countries, midwifery is legally recognized if not respected (Shroff, 1997, p. 15).

Contemporary Canadian midwifery arises out of grassroots social movements including feminism and the women's health movement that emerged in the 1970s (MacDonald, 2007, p. 4-5). This time period was marked by diminishing trust in professional authorities, including physicians, leading to a rise in demand for home births and midwifery (Bourgeault, Benoit, & Davis-Floyd, 2004, p. 7). A small yet vocal group of childbirth activists formed and challenged medicalization of birth, calling for a renewal of North American midwifery (Bourgeault, Benoit, & Davis-Floyd, 2004, p. 8). By the mid-1990s, Canadian midwifery began to resurface and receive public and governmental support (Bourgeault, Benoit, & Davis-Floyd, 2004, p. 10). Through the 1990s, midwifery was legalized in almost half of provincial jurisdictions, and midwifery legislation currently exists in all provinces and territories excluding the Yukon and PEI (Bourgeault, Benoit, & Davis-Floyd, 2004; NACM, 2016, p. 8). Canadian midwifery emerges as an intricate blend of "indigenous, local, provincial, national, and international models of . . . maternity care" (Bourgeault, Benoit, & Davis-Floyd, 2004, p. 10). Depending on province or territory, midwifery forms a "patchwork quilt" of regulated and unregulated arrangements with certain regions granting Indigenous midwives exemptions from regulation (NAHO, 2004, p. 9). Midwifery is slowly gaining government and public support as it provides statistically safe, low-cost, and nurturing maternity care (Davis-Floyd & Sargent, 1997, p. 14).

Canadian midwifery has been extensively critiqued as unsafe, with issues of public safety and competency surrounding most modern debates on the issue (Paterson, 2011, p. 484). Debates

often draw on contradictory discourses including feminism, neoliberalism, expertise and safety, and the dominance of medical science (Paterson, 2011, p. 487). Additional critiques emerge regarding the cost effectiveness of midwifery services. Cost-saving was described as "key benefit of midwifery services" throughout the legislative debates of the 1980s, and midwifery is often critiqued as a cost-cutting shortcut of the government in their failure to address physician shortages and rising health care costs (Paterson, 2011, p. 484). Additionally, while some claim that midwifery is feminist in that it restores autonomy in the birthing process, others argue that emphasizing "natural" birth reinforces gender performativity and problematic ideals of the female body, pregnancy, childbirth, and motherhood (MacDonald, 2006, p. 240). The idea that women must aspire to "natural" births, however defined, instead of using the modern medical system limits female autonomy in its own way (MacDonald, 2006). Modern Canadian midwifery has sought to address many of these critiques by emphasizing informed choice throughout the birthing process which does not exclude the use of pharmaceuticals and biomedicine if required or desired by the labouring woman, including the option to have a midwife-assisted delivery in a hospitalized setting (MacDonald, 2006, p. 244; 251).

Midwifery as Demedicalization

Midwifery is noted as a force working against excessive medicalization, seeking to restore autonomy and decision-making in pregnancy while reducing unnecessary interventions (Dawson, 1993, p. 24). Midwifery seeks to break down patriarchal control, positioning women and their bodies as capable and shifting the narrative on birth towards something women do, rather than something that happens to them (MacDonald, 2007, p. 9). Birth is conceptualized under the midwifery model as a natural phenomenon, challenging "essentialized understandings of the body, birth, and gender" (MacDonald, 2007, p. 9). This model shares many conceptions of

health, medicine, pregnancy, and childbirth with Indigenous medicine (Dawson, 1993, p. 24). Both understand birth as a holistic process, focusing on social determinants, emotional well-being, and factors outside the strictly biomedical sphere (Shaw, 2013, p. 532). A "humanized" birthing experience is emphasized in the midwifery model, taking multiple values into consideration including women's emotional states, values, beliefs, dignity, and autonomy (Prosen & Tavčar Krajnc, 2013, p. 260). Midwifery is noted as a force for demedicalization, seeking to shift the place of maternity on the medicalization/demedicalization continuum and "opening spaces in which to discuss alternatives to medicalized pregnancies and births" (Benyamini et al., 2017, p. 2; Paterson, 2011, p. 500). Considering the history of medicalization and its contributions to the colonization of Indigenous Peoples in undermining their knowledge and medicine, it is crucial to evaluate how health care professionals can work to address birthing women's desires and needs (Shaw, 2013, p. 522). This includes studying midwifery to see if it offers a more holistic approach, aligning with Indigenous medicine and providing a suitable alternative to evacuation-based maternity care in Indigenous and Inuit communities.

Canadian Midwifery Organizations & Associations

Legislative regulation for midwifery exists in every Canadian province excluding PEI and the Yukon (NACM, 2016, p. 8). PEI has passed legislation, although it has yet to go into effect, while the Yukon has appointed a Midwifery Advisory Committee as of September 2017 to discuss and strategize for legislation within the territory (Goodwin, 2018; Government of Yukon, 2017). The Canadian Association of Midwives (CAM) is the organization which nationally represents midwives and the midwifery profession (CAM, 2017). CAM states that "midwifery is fundamental to maternal and newborn health services" and strives to provide every Canadian woman with "access to a midwife's care for themselves and their baby" (CAM, 2017).

CAM supports the National Aboriginal Council of Midwives (NACM), established in 2008 and operating as an umbrella organization under CAM similar to provincial and territorial midwifery associations which hold voting seats on the CAM board of directors (NACM, 2012; NACM, 2017). NACM is made up of over 100 Inuit, First Nations, and Métis midwives, Elders, and students from across Canada (NACM, 2016, p. 4; NACM, 2017, p. 4). The NACM supports eleven Indigenous midwifery practices and strives to see "Aboriginal midwives working in every Aboriginal community" (NACM, n.d., p. 4; NACM, 2017, p. 5). It works to improve midwifery service provision in Indigenous communities and on reserves, increase the number of Indigenous midwives in Canada, increase access to Indigenous midwives, and eliminate "institutional barriers that limit access to culturally safe care" (NACM, 2016, p. 22). NACM endorses Indigenous midwifery as a form of culturally safe care which empowers families, contributes to intergenerational healing, helps to fulfill the callings of Indigenous midwives, and supports the "traditional role of the midwife for the community" (NACM, 2017, p. 7).

Conclusion

The medicalization of maternity throughout the 20th century led to the near-demise of midwifery as a practice in North America. This worked in conjunction with colonialism to discredit the value of Indigenous medicine, knowledge, and midwifery while asserting the dominance of Western science. By conceptualizing pregnancy and childbirth as strictly biomedical events, demanding the supervision of physicians, medicalization was a key force in the creation of maternal evacuation policy for Inuit women. The next chapter will explore the development of evacuation policy and its effects including negative health and social impacts, restricted autonomy and decision-making in childbirth, and a loss of Inuit childbirth knowledge.

Chapter Five: Inuit Maternal Health & Evacuation Policy

In the space of three decades, the location and options for childbirth in Inuit communities changed drastically. The transition from nomadic lifestyles to permanent settlements in the 1950s and 1960s shifted childbirth from an Inuit midwife-assisted event—birthing on the land with the assistance of other Inuit women—to a medically controlled event supervised by foreign trained nurse-midwives in nursing stations (Daviss-Putt, 1990, p. 92; Douglas, 2006, p. 116; Paulette, 1990a, p. 77). Nursing stations were established in Inuit settlements throughout the Canadian North in the 1960s to fulfill a government responsibility to provide medical care and "apply the biomedical model to pregnancy" (Douglas, 2010, p. 114). Nursing-station births continued throughout the 1960s and early 1970s and nurse-midwives, typically recruited from the UK, were responsible for providing maternal health care with the assistance of consultant physicians (Paulette, 1990a, p. 77). A majority of Inuit women delivered in community nursing stations with evacuation recommended for all *primigravidae*[3], *grand multiparae*[4], and any patients with significant history of obstetric or antenatal complications (Baskett, 1978, p. 1003; Paulette, 1990a, p. 77). This rapidly transitioned in the late 1970s and early 1980s to mandatory evacuation for all women, regardless of how many children they had delivered, risk status, or obstetric history (Kaufert & O'Neil, 1993, p. 35).

The intersection of colonialism and medicalization of maternity worked to pathologize Inuit pregnancy as high-risk, demanding state-mandated control and intervention. Maternal evacuation policy and its widespread implementation rapidly resulted in nearly all Inuit women delivering under the control of physicians in southern Canadian hospitals by the mid-1980s (Daviss-Putt, 1990, p. 92; Douglas, 2010, p. 115). Although this undoubtedly benefitted women

[3] A woman who is pregnant for the first time (Lawford & Giles, 2012, p. 334).
[4] In the context of this policy, a fourth or subsequent pregnancy (Lawford & Giles, 2012, p. 334).

with high-risk pregnancies, who would have encountered adverse birthing outcomes in regions without emergency obstetric care, the overall result of evacuation is noted to have "created more problems than it has solved" (Daviss, 1997, p. 446). This chapter explores the origins and current implementations of maternal evacuation policy. It is necessary to critically examine the historical development of this policy, particularly the use of statistics to justify its expansion. This chapter further discusses the adverse effects of evacuation including negative physical and social health outcomes, a removal of autonomy and decision-making in pregnancy and childbirth, and a loss of culture and knowledge in the form of Inuit midwifery before providing an overview of the current state of Inuit maternal health.

Maternal Evacuation Policy & Current Implementations

The maternal evacuation policy present in annual reports and government documents from 1969 until 1977 stated:

> We have continued the policy that sees all primigravida and grand multiparae (fifth or subsequent infants) evacuated to a hospital for delivery as are all complicated pregnancies and anticipated complications. Provided no complications ensue at the birth of the first infant or if all else is well, second, third or fourth babies are delivered in nursing stations. (National Health and Welfare Canada, cited in Kaufert & O'Neil, 1990)

Criteria for evacuation were not officially altered through the 1970s, however there was a gradual but steady decline in the number of births occurring in nursing stations as physicians and nurse-midwives faced increasing pressures to evacuate (Kaufert & O'Neil, 1990, p. 432; O'Neil & Kaufert, 1990, p. 61). This shift to mandatory evacuation for all women was implemented in the late 1970s and has been maintained in the Health Canada Clinical Practice Guidelines (Lawford, 2016, p. 153). These guidelines were developed to assist community health nurses providing primary care in isolated, rural, and remote Indigenous communities (Lawford, 2016, p. 153). The Guidelines state that federally employed medical staff and nurses must "arrange for

transfer to hospital for delivery at 36-38 weeks' gestational age according to regional policy (sooner if a high-risk pregnancy)" (Health Canada, 2011, p. 6). This is a blanket policy, applied to all Indigenous women living in remote or rural areas of Canada regardless of obstetric history, but has been most heavily applied to Inuit women due to their location in extremely remote areas (Lawford, 2016, p. 152). Although constituting only one sentence in a chapter on obstetrics, this policy has justified the maternal evacuation of nearly all Inuit women (Lawford, 2016, p. 153).

Maternal evacuation policy has been extensively and efficiently implemented. Inuit women receive prenatal care in local health centres or nursing stations, often visiting with a doctor once or twice throughout their pregnancy (O'Driscoll et al., 2010, p. 129; Olson, 2015, p. 177). Women typically leave their communities at 36-38 weeks gestation, earlier if significant complications are detected, and await delivery in hospital accommodations, hostels, or billeted with local families who may or may not be Inuit (Daviss-Putt, 1990, p. 105; Dawson, 1993, p. 19). Historically, there has been no provision of escorts or accompaniment for evacuated women unless they are under eighteen or disabled (Olson, 2015, p. 177). Women were required to travel alone, often hundreds of kilometres from their home communities, to wait the final weeks of their pregnancies and deliver in a strange environment with a completely different culture and first language (Morewood-Northrup, 1997, p. 347). This experience of delivering alone, without social support, far from their homes and culture has been identified as negatively affecting physical and emotional health (O'Driscoll et al., 2010, p. 25). Lack of accompaniment was consistently identified by scholars and health professionals as "extremely unhelpful", and in April 2017 Health Minister Jane Philpott announced that "Ottawa will pay for someone to travel with Indigenous women who need to leave their communities to give birth" (Canadian Press, 2017, para. 1; O'Driscoll et al., 2011, p. 129). This provision for accompaniment is

commendable, but only addresses one issue resulting from widespread maternal evacuation and it is yet to be seen if, or how, this will alleviate physical, emotional, and economic stresses upon evacuated women, their families, and communities.

Although evacuation may be necessary for particularly high-risk pregnancies, for women with no complications or obstetrical history evacuation creates negative physical and social health effects (O'Driscoll et al., 2010, p. 25). As women deliver separated from partners, children, family, and community support the connection between infant and family, infant and community, and infant and land is broken (Gatto, 2010, p. 3; Jasen, 1997, p. 397). This has drastically affected the way Inuit women, their families, and communities experience childbirth (Olson, 2015, p. 177). Delivering in southern hospitals additionally comes with the challenges of language barriers, structural, individual, and interpersonal racism, and distrust resulting from negative incidents with the biomedical Western health care system (NAHO, 2006, p. 15). This intrinsically affects the way that Inuit women interact with the health care system and the quality of care they receive. These issues are further compounded by a shortage of Indigenous and Inuit health care workers and a general lack of culturally appropriate care (NAHO, 2006, p. 15). Evacuation has further contributed to a decimation of Inuit knowledge and midwifery, and directly compromises the autonomy and decision-making abilities of Inuit women.

Origins of Maternal Evacuation Policy

Maternal evacuation policy has several origins. This includes remote and rural status with a general lack of transportation infrastructure, difficulties staffing health centres and specific challenges in hiring midwives due to the increasing medicalization of childbirth and devaluation of midwifery as a profession in Canada, changes to Canadian immigration policy that prevented the recruitment of foreign trained nurse-midwives, and an attempt to improve high infant

mortality rates[5] (IMR) reported in the 1950s and 1960s. Beneath this overt reasoning for maternal evacuation, however, lies the subvert use and interpretation of questionably valid statistics to define Inuit as a "high-risk" population, justifying colonial assimilation and attempts to bring Inuit maternity and childbirth under government control and medicalization.

The Canadian North is extremely large with a geographically dispersed population. It is simply not possible to have hospitals and medical staff based in each isolated community as the population numbers are not high enough to support these centres, and operational costs would outweigh any benefits (Morewood-Northrup, 1997, p. 334). The rural and extremely remote status of Inuit communities has been used to justify evacuation, and difficulty in staffing and retaining medical personnel in nursing-stations and health centres, a lack of transportation infrastructure, harsh climate conditions, and cultural and language barriers further support evacuation (Lalonde, Butt, & Bucio, 2009, p. 956; NAHO, 2006, p. 1; NCCAH, 2012, p. 9). Due to remote rural status, medical professionals consider it generally unsafe for Inuit women to give birth in their communities as emergency health services are unavailable should complications arise (Chamberlain & Barclay, 2000, p. 117). There is a lack of medical staff willing to work in remote areas, with difficulties in recruiting and maintaining physicians and nurses (Lemchuk-Favel & Jock, 2004, p. 34). Medical supply and equipment shortages compound this issue, as they make the North a difficult and stressful work environment (Lemchuk-Favel & Jock, 2004, p. 45). Nurses who form the backbone of northern health care systems often suffer "high levels of stress, dissatisfaction, and burn-out" and there is a noted shortage of Indigenous and Inuit health workers in these areas (Bjerregaard & Kue Young, 1998, p. 69; NAHO, 2006, p. 15).

[5] The infant mortality rate (IMR) is calculated as the number of deaths within the first year of life, divided by the number of live births, multiplied by 1000.

In the 1960s and 1970s nursing stations were staffed primarily by foreign trained nurse-midwives, often from the UK (Moffitt, 2004, p. 326). As midwifery training was not available in Canada due to increasing medicalization and the devaluation of midwifery as a profession, there was a reliance on nurse-midwives to staff these centres and provide maternity care in remote areas (Blythe, 1995, p. 14; Jasen, 1997, p. 397). Nurse-midwives formally introduced government and medical institutions into Inuit communities and their role can be understood as legitimizing "a certain set of ideas about pregnancy and the body", medicalizing maternity in the North (Olson, 2015, p. 170; O'Neil & Kaufert, 1990, p. 59). Nurses and nurse-midwives were instructed to discourage Inuit birthing and midwifery practices, pushing for delivery in the nursing station and increasing evacuation through the 1970s (Douglas, 2006, p. 122). Part of their mandate was to specifically replace Inuit midwives, working to reduce the use of Inuit medicine (Jasen, 1997, p. 397).

Although they initially delivered low-risk women in nursing stations, the shift to mandatory evacuation and a change to Canadian immigration policy resulted in the replacement of nurse-midwives with Canadian nurses who possessed no midwifery training (O'Neil & Kaufert, 1990, p. 64). This immigration policy change in the 1970s denied entry to any foreign-trained nurses, including nurse-midwives, to protect jobs for Canadian nurses (Moffitt, 2004, p. 326). This shift directly contributed to an increase in evacuations as Canadian nurses were trained in a medical model that demanded all births take place in hospital and were not confident in providing delivery services (Douglas, 2006, p. 124; O'Neil & Kaufert, 1990, p. 64). They were unprepared, both professionally and emotionally, to provide obstetrical care without physician assistance (Chamberlain & Barclay, 2000, p. 117). High rates of staff turnover and a shortage of nurses wiling to work in remote communities compounded this issue (Morewood-

Northrup, 1997, p. 346). This change to immigration policy, exacerbated by the medicalization of maternity and lack of respect for the midwifery profession in Canada, led to an absence of midwives—Indigenous or foreign-trained—in Inuit communities. This justified the transition to mandatory evacuation as nursing-station delivery was no longer supported nor recommended without the presence of nurse-midwives.

A further justification for evacuation was the Canadian government's obsession with improving Inuit IMR, with a decline in these rates viewed as "public proof of the virtue of government policy" (Kaufert & O'Neil, 1993, p. 38). Throughout the 1950s and 1960s, IMR was understood to be an indicator of the government's ability to provide health care to Inuit populations, with the solution to less than ideal rates found in the medicalization of childbirth (Douglas, 2006, p. 122; Morewood-Northrup, 1997, p. 344). The clinical reasoning behind the shift to nursing-station births, and later hospital births and mandatory evacuation, was the understanding that midwife-assisted deliveries were unsafe and an improvement in IMR depended upon the provision of sophisticated obstetric services (Dawson, 1993, p. 20; Douglas, 2006, p. 124). As late as the 1990s, when questioned about the rationale behind evacuation northern medical staff pointed to IMR (Kaufert & O'Neil, 1993, p. 46). Coupling this response to infant death with health professionals' fear of liability and general feelings of helplessness working in remote areas without emergency services, evacuation has received continued support from the medical community (Daviss-Putt, 1990, p. 101).

Throughout the 1950s and 1960s, Inuit IMR was inarguably high, however the collection, calculation, and interpretation of statistics in areas with small populations are particularly vulnerable to skewing and misinterpretation (O'Neil & Kaufert, 1990, p. 59). Inuit infant mortality statistics have been criticised in subsequent decades for being of poor quality, misused,

and misunderstood (Kaufert, Moffatt, O'Neil, & Postl, 1990, p. 5). Accuracy and interpretation are of certain note, as when calculating IMR once the numbers are calculated into a rate the size of the original numbers is often forgotten (Kaufert, Moffatt, O'Neil, & Postl, 1990, p. 6). The loss or miscalculation of a few births or deaths can therefore drastically change the calculated rate (Kaufert, Moffatt, O'Neil, & Postl, 1990, p. 6). Definitions of stillborn/miscarriage are subjective and often result in reporting inconsistencies (Kaufert, Moffatt, O'Neil, & Postl, 1990, p. 7). In a study comparing collected figures for the Keewatin Region, NU by Kaufert, Moffatt, O'Neil, and Postl (1990), vast differences and mistakes in recording were found even when infant deaths were reported at the same hospitals and nursing stations (p. 7). While the recording of a single death may not make a significant difference in regions with large populations, it can dramatically change a rate in Inuit areas (Kaufert, Moffatt, O'Neil, & Postl, 1990, p. 8).

Aside from difficulties in reporting, there are also challenges in the interpretation of statistics. While mortality rates in nursing stations are higher than in hospitals, the initial interpretation that nursing station births are dangerous is faulty logic as infant deaths in nursing stations are more likely due to congenital anomaly, premature birth, or other inevitable complications that are not dependent on birth location (Kaufert, Moffatt, O'Neil, & Postl, 1990, p. 8). Additionally, the initial IMR collected in Inuit regions throughout the 1950s and early 1960s, although high, does not provide social or historical context. These were the years directly following forced settlement into permanent communities which led to infectious disease outbreaks, poor housing conditions and sanitation, deteriorating nutritional status and food insecurity, and generally poor Inuit health (O'Neil & Kaufert, 1990, p. 59). This coincided with famine due to changing migration patterns of Inuit food sources (Kaufert & O'Neil, 1993, p. 38; O'Neil & Kaufert, 1990, p. 59). While the IMR was no doubt high during this time, it cannot be

understood to properly reflect pre-contact mortality (O'Neil & Kaufert, 1990, p. 59). The failure to obtain accurate statistics and interpret them in a way that considers societal, political, and historical factors reveals significant flaws in the rationale for evacuation (Daviss, 1997, p. 456).

IMR became a symbol of the success or failure of the colonial state's civilizing mission (Gatto, 2010, p. 9). The Canadian state was disturbed and frustrated by the "hard core of mothers" who managed to evade nursing-station care, blaming them for high infant death rates (Jasen, 1997, p. 396). The "alleged inadequacies" of Inuit maternal and child care were given full credit for mortality statistics, and controlling these rates demanded an increase in contact with formal Western medical systems (Jasen, 1997, p. 396). In using statistics to justify intervention, the state transferred its responsibility and the "impact of poor housing, infectious disease, tuberculosis, the demoralization of famine, and relocation" onto Inuit women (Jasen, 1997, p. 398; Kaufert & O'Neil, 1990, p. 439). By defining risk in strictly physical, scientific terms and ignoring political, social, and historical contexts, the state successfully placed blame for poor health outcomes onto the physical body of Inuit (O'Neil & Kaufert, 1990, p. 54). As Inuit women are further subject to colonial constructions of gender and race, they become pathologized as "sick" and at risk for adverse maternal health outcomes (Dawson, 1993, p. 20). By defining Inuit as high-risk, assimilation and modernization are justified as the state is granted the power to control and medicalize Inuit maternity (Chamberlain & Barclay, 2000, p. 117; Jasen, 1997, p. 400; Kaufert & O'Neil, 1993, p. 51).

Risk is constructed on biomedical knowledge, largely ignoring social determinants and factors that Inuit may consider of higher consequence (Gatto, 2010, p. 10). Inuit women may be more focused on the risks posed to their families and children by evacuation, fears about their absence and childcare, domestic violence, economic hardships, issues with reintegration of infant

and mother, and other factors including previous interactions with the established medical system such as historical TB evacuation (Gatto, 2010, p. 10). For Inuit, being without knowledge is "to be at risk", and in this context evacuation itself may pose more risks than remote rural delivery with an absence of emergency obstetric services (Kaufert & O'Neil, 1993, p. 49). Evacuation has further played a key role in the larger colonial agenda of northern health care (O'Neil & Kaufert, 1990, p. 55). Extensive TB evacuation, explored in Chapter Three, provided the model under which to evacuate pregnant women and carries with it significant historical trauma (Gatto, 2010, p. 9). The mandatory evacuation model forces Inuit women to subject themselves to the powerful control of both the colonial state and the hegemony of biomedical science and medicalized maternity (Dawson, 1993, p. 15). Birthing is understood as a crucial way of assimilating and civilizing Indigenous populations "into the colonial world" (Lawford & Giles, 2012, p. 332). While the provision of Western health care has undoubtedly improved some areas of Inuit health, the "ways in which the government displaced and dismissed . . . birth practices, how it achieved its goals, and how these factors contributed to the larger colonial project" cannot be dismissed (Lawford & Giles, 2012, p. 330).

Health & Social Impacts of Evacuation

The removal of pregnancy from community contexts, both in eliminating the availability of and option to use Inuit midwives and the actual physical relocation of pregnant and birthing women to the South, has multifaceted impacts for the health of Inuit women, infants, families, and communities (Gatto, 2010, p. 3). The separation of birth from the community is defined by "a lack of dialogue between communities and the institutions that govern them, as well as the divide between the widely held collective memory of an Inuit history of birthing in the North and the imposed southern approach to childbirth" (Tedford Gold, O'Neil, & Van Wagner, 2005, p. i).

The childbirth event, which historically held a significant cultural role for Inuit as described in Chapter Two, has been replaced by a biomedical model that relies on the separation of families, steals "the power of the birthing experience" from Inuit women, and weakens "the health, strength, and spirit of [Inuit] communities" (Van Wagner et al., 2007, p. 384). This has led to negative social and physical health outcomes for women, infants, families, and communities, the compromising of women's autonomy and decision-making in pregnancy and childbirth with particular implications for location of birth and connections to land, and a loss of culture and knowledge in the form of Inuit midwifery.

Evacuation to southern hospitals includes extended stays of several weeks to months in hospital residences, hostel accommodations, or community housing, constituting a major culture shock for Inuit women who are without familial or partner support and alienated from their culture and language. This results in increased psychological and physiological stress (Morewood-Northrup, 1997, p. 347). Childbirth in this context is noted by the SOGC (2010) to be a disruptive and isolating event that weakens, rather than strengthens, familial and community connections (p. 1186). Indigenous Elders, when referencing evacuation policy, have stated that they believe many societal ills affecting their communities result not only from social determinants and external factors, but also from the "disconnection that results from being born in unfamiliar territories, far from the bonds of our loving families and community supports" (Gatto, 2010, p. 8). Multiple studies by a wide range of scholars including health researchers, Indigenous and Inuit scholars, and social scientists have reinforced these assertions, highlighting the negative physical and social health impacts of evacuation.

Some of the noted physical health impacts of evacuation include: an increase in premature and low birth-weight babies, general maternal and newborn complications, postpartum

depression, compromised ability to establish breastfeeding, unnecessary interventions in childbirth and resulting iatrogenesis, higher rates of induced labour, forceps delivery, and caesarean sections, increased alcohol/drug use and smoking behaviours, and heightened risk of gestational diabetes and toxaemia (Couchie & Sanderson, 2007, p. 251; Daviss-Putt, 1990, p. 104; Dawson, 1993, p. 21; Kaufert & O'Neil, 1990, p. 432; Morewood-Northrup, 1997, p. 347-350; NAHO, 2004, p. 11; NAHO, 2008, p. 55; NAHO, 2009b, p. 13; O'Driscoll et al., 2010, p. 25; Stonier, 1990, p. 62). These physical health issues are frequently reported in evacuated women who are admitted in general good health (NAHO, 2008, p. 55). The high rates of obstetric interventions are in part due to the medicalized and technocratic childbirth culture dominant in southern hospitals, but are further increased in women who have been evacuated. Women who are past their due dates and anxious to return to their families are frequently induced in an effort to reduce maternal anxiety (Morewood-Northrup, 1997, p. 347). Higher rates of alcohol/drug use and smoking behaviour are noted as a reaction to stressful and isolating environments (Morewood-Northrup, 1997, p. 347). Nutritional status may also decrease in evacuated women as they reside in unfamiliar environments with a different diet, notably lacking access to "country foods", and may experience a lack of appetite as a result of heightened stress and anxiety (Daviss-Putt, 1990, p. 104). Compromised nutritional status in the final weeks of pregnancy may affect the health of both mother and infant (Daviss-Putt, 1990, p. 104).

There are multifaceted social impacts of maternal evacuation, principally resulting from isolation. Extreme loneliness at being separated from family and community is frequently reported, as women experience social and emotional disruption (Baskett, 1978, p. 1004; O'Driscoll et al., 2011, p. 130). Many women experience anxiety and depression related to this isolation, and repeatedly note how stressful it is to leave their homes (O'Driscoll et al., 2011, p.

128). Childbirth is an emotional and pivotal event in the life cycle, and experiencing it without social support is noted as a traumatic experience for Inuit women (O'Driscoll et al., 2011, p. 128). Isolation is compounded by cultural alienation (Grieg, 1990, p. 43). Living for weeks or months in an unfamiliar climate, surrounded by strangers with vastly different culture, language, foods, and traditions is distressing (Chamberlain & Barclay, 2000, p. 118; Dawson, 1993, p. 19; Houd, Qinuajuak, & Epoo, 2004, p. 239; Kaufert & O'Neil, 1993, p. 41; Stonier, 1990, p. 61). Accustomed to living in a highly social community, Inuit women are forced to "accomplish birth in a place where scarcely anyone [is] familiar" (Kaufert & O'Neil, 1993, p. 41). Inuit criticisms of evacuation often highlight the vast differences in birth philosophy, with Inuit viewing childbirth as a natural process while medicalized systems view it as a biological process demanding physician control (Kaufert & O'Neil, 1993, p. 41). Delivering in southern hospitals also requires increased contact with a health care system plagued by institutional racism including language barriers, a lack of cultural sensitivity and respect, and an overarching imposition of Western scientific norms (Galabuzi, 2004, p. 248).

Evacuation is noted by multiple scholars and studies as contributing to domestic issues within marriages and partnerships, family households, and Inuit communities at large (Chamberlain & Barclay, 2000; Daviss-Putt, 1990; Dawson, 1993; Gatto, 2010; Government of Nunavut, 2009; Morewood-Northrup, 1997; NAHO, 2006; O'Driscoll et al., 2011; O'Neil & Kaufert, 1990; Stonier, 1990). Separation of partners at the time of delivery alters relationships between men and women (Stonier, 1990, p. 62). Mothers want the presence of their partners throughout the late stages of pregnancy and delivery and note a general lack of support in hospital settings (Chamberlain & Barclay, 2000, p. 121; NAHO, 2006, p. 10). Inuit men traditionally played a role in pregnancy and childbirth, taking responsibility for provision of

proper nutrition and country foods during pregnancy and the postpartum, and sometimes assisted in the birth process (Stonier, 1990, p. 62). With evacuation, men lose their understanding of birth, and are denied the opportunity to participate in perinatal events and care (Stonier, 1990, p. 62). By removing the presence of a partner, evacuation is perceived as a factor contributing to increases in family and domestic violence (Dawson, 1993, p. 18; Stonier, 1990, p. 62).

Evacuation further compromises bonding between families and infants (Dawson, 1993, p. 18; Government of Nunavut, 2009, p. 7). Reintegration presents a challenge to returning mothers as siblings and partners often experience difficulty connecting with the new baby, blaming the infant for maternal absence (Chamberlain & Barclay, 2000, p. 119; Paulette, 1990b, p. 46). Fathers are given additional childcare responsibilities when mothers are evacuated (Daviss-Putt, 1990, p. 106; Dawson, 1993, p. 18; Gatto, 2010, p. 8). Unaccustomed to domestic duties, they may struggle with this responsibility and an increase in the alcohol intake of male household heads is noted with evacuation (Morewood-Northrup, 1997, p. 348). Children suffer without their mothers, with some women separated from nursing toddlers at the time of evacuation (Daviss-Putt, 1990, p. 106). School problems, increased illness, insomnia, and attitude and behavioural issues are reported in children whose mothers are evacuated (Blythe, 1995, p. 15; Dawson, 1993, p. 18; Stonier, 1990, p. 62).

Economic stressors exacerbate each of these social issues. There is no funding by government health services for childcare, which falls on families to cover (Gatto, 2010, p. 11; NAHO, 2006, p. 15). Fathers often miss hunting or work to care for children, with some even losing their incomes if they are required to stay home for full-time childcare (Daviss-Putt, 1990, p. 107; 109). Without the mother's income, family resources are often severely compromised (Chamberlain & Barclay, 2000, p. 120; Daviss-Putt, 1990, p. 109). Inuit women frequently play

"double-duty" in the roles of domestic caregivers and breadwinners, and without their income there is severe strain on financial resources (Daviss-Putt, 1990, p. 107; Dawson, 1993, p. 18). Additional costs include long-distance phone calls and travel costs associated with attempts to reunite for the birth (Chamberlain & Barclay, 2000, p. 120; Daviss-Putt, 1990, p. 109; Gatto, 2010, p. 11; Morewood-Northrup, 1997, p. 347; O'Driscoll et al., 2011, p. 128). While changes in policy allowing an escort to accompany evacuated women may alleviate some of these domestic and economic issues, childcare expenses and familial separation are still expected as providing one escort will not reduce the multitude of stresses placed on families. It is evident that the social determinants of socioeconomic status and gender play a key role in exacerbating the negative effects of evacuation. Operating in a medical system defined by systemic racism, with limited economic resources, and carrying the responsibility of being breadwinners and providing domestic labour in gendered roles, Inuit women are harshly affected by evacuation.

Restricted Autonomy & Decision-Making in Childbirth

By mandating that every Inuit women give birth in a hospital setting, women lose control over their bodies and decision-making in childbirth. By evacuating all women regardless of risk or obstetric history, making local health centres and nursing-stations unfit for childbirth by staffing nurses inexperienced in midwifery and delivery care, and undermining the knowledge and profession of Inuit and Western midwives, the Canadian state has removed all choice in the place, timing, and process of childbirth (Kaufert & O'Neil, 1990, p. 439; Lawford & Giles, 2012, p. 333). Inuit women's choice is either to evacuate or give birth with young, inexperienced, and unwilling nursing staff in local health centres (Kaufert & O'Neil, 1993, p. 35; Lawford & Giles, 2012, p. 333). Whereas they previously had no ability to choose to access medical intervention, Inuit women now have no choice to refuse it (Daviss, 1997, p. 469). If they refuse to be

evacuated, they must sign forms "declaring they are staying in the community against the advice of the nurse in consultation with the physician" (Moffitt, 2004, p. 327). Those who refuse may also be labeled as "noncompliant" or "irresponsible", a decision that may compromise future health care experiences when nursing stations are often the sole source of care for women and their families (Kaufert & O'Neil, 1993, p. 35).

Once evacuated, the birthing process is further subjugated to physician control and women are unable to decide on the form of delivery, amount and type of support they receive, and positions taken during labour and delivery (Chamberlain & Barclay, 2000, p. 120; Kaufert & O'Neil, 1993, p. 41). This may contribute to a "feeling of violation" (Daviss-Putt, 1990, p. 106). Choice in the location of birth has additional implications for Inuit as connections to the land are integral to Inuit identity (Gatto, 2010, p. 8). Birth out of territory breaks the initial connection between an Inuk and their land and many women state that they only consider children born up North to be "real Inuit" (Douglas, 2006, p. 125; Olson, 2015, p. 175). There is further concern that land claims and Inuit status will not be respected for children with out of territory birth certificates, a threat to the "long-term cultural identity and survival" of Inuit (Chamberlain & Barclay, 2000; Daviss-Putt, 1990; Morewood-Northrup, 1997; O'Neil & Kaufert, 1990).

The loss of female autonomy in pregnancy and birth is noted across feminist critiques of the medicalization of maternity, power, and patriarchy; but for Inuit women it carries further implications of colonial relationships (Kaufert & O'Neil, 1993, p. 41). Maternal evacuation is not only an extreme form of mandatory medicalized birth, but one that is enforced by a colonial state responsible for the destruction of Indigenous knowledge, birth practices, and medicine. This has been carried out through institutions and policies such as residential schooling, forced relocations and settlement, and historical TB evacuation and cannot be simply understood as a

"health policy" (Lawford, 2016, p. 154). Evacuation constitutes a key element of the colonial state's civilizing mission, and the destruction of Indigenous and Inuit birthing knowledge and midwifery is a "purposeful and intentional policy outcome" (Lawford, 2016, p. 154). This is a political issue for Inuit, and evacuation represents dependency on colonial systems understood to be contributing to deterioration of health services at a community level (Daviss-Putt, 1990, p. 108; Kaufert & O'Neil, 1990, p. 439).

Loss of Inuit Culture & Knowledge

By removing childbirth from the Inuit community, Inuit midwifery and childbirth knowledge have been compromised. Communities have "lost birth as a significant and celebrated part of the social fabric and life cycle" (Epoo et al., 2012, p. 283). The breakdown of knowledge and practices, including support and sharing between older and younger generations, has been a direct result of maternal evacuation (Paulette, 1990a, p. 78). Inuit Elders note that they have not seen or heard of births taking place in their communities for years, and young women are no longer familiar with childbirth practices having never experienced or watched birth before they deliver in southern hospitals (Jasen, 1997, p. 398; Paulette, 1990b, p. 46). This loss of knowledge concerns many Inuit as it has created further dependency on colonial structures and is understood as a threat to political and cultural autonomy (Daviss-Putt, 1990, p. 107; O'Neil & Kaufert, 1990, p. 65). Loss of knowledge constitutes a loss of competence, creating a state of vulnerability and risk (O'Neil & Kaufert, 1990, p. 65). Elders note that childbirth knowledge has nearly disappeared in many communities, as little knowledge is formally recorded and many Inuit midwives are no longer alive or practicing (NAHO, 2006, p. 15). This rich component of Inuit culture has almost been completely destroyed as midwifery is consistently devalued, with additional stigma associated with Indigenous health knowledge and practices (Dawson, 1993, p.

16; Government of Nunavut, 2009, p. 5; Morewood-Northrup, 1997, p. 349). By replacing Inuit knowledge and midwifery with a Euro-Canadian biomedical model, colonial assimilationist and civilizing goals are promoted (Lawford & Giles, 2012, p. 335). Evacuation is not solely a medical mission, but fulfills colonial goals of abolishing Inuit and Indigenous childbirth practices, midwifery, medicine, and knowledge while simultaneously breaking connections with the land (O'Driscoll et al., 2011, p. 127).

Inuit Resistance to Evacuation

Since its implementation, Inuit have protested evacuation policy, pressing for reversal throughout the 1980s with objections centering primarily on "the issue of family disruption and the medicalization of childbirth" (Bjerregaard & Kue Young, 1998, p. 88; Douglas, 2006, p. 126). The predominant method of resistance for Inuit women is to hide their pregnancies or mislead medical staff about due dates in order to deliver within their communities (Daviss-Putt, 1990, p. 92; Dawson, 1993, p. 19; Jasen, 1997, p. 398; Kaufert & O'Neil, 1993, p. 35; Paulette, 1990a, p. 80; Shaw, 2013, p. 526; Tedford Gold, O'Neil, & Van Wagner, 2005, p. 9). Stories of escape and deception, women resisting evacuation in every way possible, tend to highlight the desperation and struggle of pregnant women attempting to restore their autonomy (Jasen, 1997, p. 398). One example highlighted in an article by Jasen (1997) tells of a woman in her ninth month evacuated to northwestern Ontario for delivery who "wanted so badly to be back home to have her baby that she managed to get part way back on a skidoo" (p. 398). Nurses and Inuit women have collaborated in resistance by officially planning evacuation but preparing for local birth in the nursing station, however these are relatively isolated acts of "individual political resistance" (Kaufert & O'Neil, 1993, p. 41). These incidents were also mainly reported when nurse-midwives worked in communities. Planning an "accidental birth" today has more

challenges and risks due to the destruction of obstetrical capacity and infrastructure in communities with the removal of nurse-midwives (Dawson, 1993, p. 19). Whereas nurse-midwives could handle accidental births in the 1970s, this is no longer a viable option as today most staff is young, inexperienced, and "unwilling to provide anything other than emergency obstetric care" (Daviss-Putt, 1990, p. 92; Dawson, 1993, p. 19; Kaufert & O'Neil, 1993, p. 35).

Resistance has been stunted in many ways by fear of discipline for non-compliance. Dependence on the existing health system has made local communities unfit for childbirth as they no longer possess the resources or birth attendants needed for safe delivery (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 10). Although they cannot be forced to evacuate without providing written consent, Inuit women feel that they have no alternatives (Dawson, 1993, p. 23). Their options are to deliver locally without resources or to evacuate. Compared to women in southern Canada who possess a plethora of birthing options including home birth, midwifery, doula assistance, or hospitalized birth, Inuit women are severely restricted in delivery options. There is also a fear amongst young women of birthing locally without physician care (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 11). The cultural authority granted to biomedicine has been accepted by many, and while younger women may still share the same defiance as their elders, they have no personal experience of Inuit childbirth pre-evacuation (Daviss, 1997, p. 450). They are products of a new era, one that fears discipline and in which popular rumours circulate that they can be jailed for refusing evacuation (Daviss, 1997, p. 450). Medical authority paralyzes women, compromising "their ability to sort out their own logic" (Daviss, 1997, p. 450). This amplifies existing low self-esteem of a population that has experienced decades of colonial assimilation, racism, and harsh medical authority (Daviss-Putt, 1990, p. 99).

Current State of Inuit Maternal Health

Today, Inuit maternal and infant health is undeniably worse than that of the general Canadian population (Paulette, 1990a, p. 76). While keeping in mind the earlier discussion on faulty, misunderstood, and misinterpreted statistics collected on small populations, the fetal and infant mortality rates of Inuit regions is reported at 2.66 times that of Canada as a whole (Luo et al., 2010, p. 237). Studies admit limitations in small sample sizes and incomplete data on "maternal and medical risk factors", including social determinants (Luo et al., 2010, p. 241). Across all health indicators, however, there are large disparities between Inuit/Indigenous and general Canadian populations, largely resulting from the massive economic, cultural, and social changes they face as a result of colonialism (Epoo et al., 2012; Luo et al., 2010; Moffitt, 2004; Paulette, 1990a; Skye, 2010). A long history of inadequate health services, injustice, and systemic racism, all "inherent to the process of colonization", have compromised Inuit health (Epoo et al., 2012, p. 284). In terms of reproductive health, Inuit have younger ages at first pregnancy, increased rates of anaemia, preterm labour, postpartum hemorrhage, sexually transmitted infectious, birth defects and major malformations, and higher IMRs (Daviss, 1997, p. 456; Epoo et al., 2012, p. 284; Lauson et al., 2011, p. 364; Luo et al., 2012, p. 332).

When discussing infant mortality statistics, which remain the primary rationale for evacuation, it is worth noting that the IMR found amongst Indigenous populations in Canada is "consistent with the rate found among the lowest income groups in urban Canada" (NAHO, 2009b, p. 6). Specific location of delivery, therefore, may be less important than social and economic factors. Infant mortality is defined as death within the first year of life, and the mortality and morbidity in Inuit areas is highest age one month to one year (Stonier, 1990, p. 62). Results of studies throughout the 1970s showed that it was actually safer to be born in Inuit

communities than to live there for the first year of life, and issues of postnatal education, health services, and support are critical (Baskett, 1978, p. 1004). While IMR is used to justify evacuation, it is connected to larger structures and risk factors than delivery location. Postpartum factors including low breastfeeding rates, overcrowded living conditions with poor ventilation, exposure to smoking and infectious respiratory diseases such as TB, and additional social and socioeconomic factors are more responsible for high IMR than the physical location of delivery (Lauson et al., 2011, p. 365). Most Inuit communities lack substantial postnatal services, including breastfeeding support, and there is a "virtual void" of health education on topics of sexual and reproductive health (Health Council of Canada, 2011, p. 10; Stonier, 1990, p. 62).

Evacuation has not achieved the goal of Inuit health "catching up" to general Canadian standards (Lawford & Giles, 2012, p. 336). The main reason for this may be the lack of a comprehensive approach, which is needed to address health needs throughout all phases of pregnancy, childbirth, and the postnatal period (Government of Nunavut, 2009, p. 5). Focusing solely on the birth event has not produced desired improvements in IMR, and this may be due to the fact that this response largely ignores social determinants responsible for poor health outcomes in Inuit communities (Lalonde, Butt, & Bucio, 2009, p. 957). Social and economic conditions including poverty, food insecurity, poor quality housing, and the multi-generational social and cultural effects of colonialism are contributing to infant death (Lalonde, Butt, & Bucio, 2009, p. 957; NAHO, 2006, p. 2; Paulette, 1990a, p. 76). The specific site of birth has a minor impact when considering these factors, and improving infant and maternal health requires improvements in the general social and economic conditions of communities (Lalonde, Butt, & Bucio, 2009, p. 957). Inuit women are subject to the social determinants of systemic racism, evident in health care that is not culturally appropriate and that fails to provide relevant services

in accessible languages, socioeconomic status which compounds the economic costs and stress of evacuation, and gendered norms which subject them to the patriarchal authority of the medical profession and double duties of working and providing domestic and childcare labour (NAHO, 2006, p. 15). If significant improvements are to be made in Inuit maternal and infant health, these social determinants must be addressed with increased attention focused particularly in areas of "education, infrastructure, transportation, and gender equity" (Gatto, 2010, p. 9).

Conclusion

Evacuation policy needs to be re-evaluated as it has not achieved its stated goals of reducing infant mortality and improving maternal health in Inuit communities and further originates from racist colonial medical practices of assimilation. The adverse impacts of evacuation are severe for Inuit women, their families, and communities. In addition to producing negative physical and social health outcomes, compromising women's autonomy and decision-making in childbirth, and destroying Inuit knowledge and midwifery practices, evacuation fits within a larger agenda of colonial medicine. Evacuation policy reflects structures of colonial power and assimilation, seeking to delegitimize Inuit birthing practices with modernizing goals. While women of high-risk may benefit from biomedical hospitalized birth and evacuation, alternatives are emerging for low-risk women and those without history of obstetrical complications (Couchie & Sanderson, 2007, p. 251). The revitalization and reinstatement of Inuit midwifery services in several northern communities provides an interesting alternative to evacuation. The next chapter explores two of these Inuit midwifery programs, evaluating their strengths and weaknesses and examining their ability to provide a viable alternative to evacuation.

Chapter Six: Case Study—Inuulitsivik Maternities & Rankin Inlet Birthing Centre

There have been several efforts to reinstate Inuit midwifery in Northern Canada. This chapter examines two programs—the Inuulitsivik Maternities in Nunavik, QC and the Rankin Inlet Birthing Centre in Rankin Inlet, NU. These programs seek to provide an alternative birthing option for Inuit women, mitigating the negative effects of evacuation by offering midwife-assisted delivery in northern communities. The establishment of Inuit midwifery programs, including recruitment of Inuit women into the profession, has the potential to improve birth outcomes, contribute to self-determination efforts, and create new models of community-based care (NAHO, 2008, p. 58). These programs strive to return birth to communities in location of delivery and renewal of childbirth knowledge. They grant Inuit greater control over the design and quality of health care programming, and seek to incorporate Inuit knowledge into their practices, resulting in a synthesis of biomedicine and Inuit knowledge (Carroll & Benoit, 2004, p. 264). This chapter discusses each program individually, outlining history and background, program structure, and outcomes, before comparatively analyzing how each program returns birth to communities and addresses social and cultural determinants of health.

The Inuulitsivik Maternities: *History & Background*

The creation of the Inuulitsivik Maternities cannot be understood without first considering the implications of the 1975 James Bay and Northern Quebec Agreement. This treaty was signed by the Inuit and Cree residing in Quebec and gave rise to a unique model of health care funded by both the federal and provincial governments, providing local Indigenous groups with the ability to self-administer health care services (NCCAH, 2012, p. 101). Through this agreement, Nunavik was able to negotiate a certain level of political autonomy and self-governance with regards to health care, resulting in a distinct level of assertiveness when it

comes to interactions with southern authority (Douglas, 2010, p. 115; Epoo et al., 2012, p. 285). While services are provincially managed, Nunavik possesses the ability to develop programs "based on Inuit governance and a commitment to the education of Inuit health care workers" (Epoo et al., 2012, p. 285). The Inuulitsivik Maternity first opened in Povungnituk, Nunavik, QC in September 1986 and is a key example of one of these programs (Daviss-Putt, 1990, p. 110). The Maternities have since opened two additional birthing centres, one in Inukjuak in 1996 and another in Salluit in 2004 (Douglas, 2006, p. 126; Epoo et al., 2012, p. 283). The Maternities operate as a "midwifery-led collaborative model of care" using midwives, nurses, and physicians as a multi-disciplinary team (NACM, n.d., p. 7). The community-based Maternities provide midwifery services and run the first formal Indigenous midwifery-training program in Canada (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 12).

Prior to the opening of the Maternities there was an existing tradition of Inuit midwives assisting births at the Povungnituk Hospital, with Inuit women expressing desires to incorporate this practice into a formal system (Douglas, 2010, p. 115). The Maternities were developed through community consultation carried out by Povungnituk hospital director Aani Tulugak, an Inuit women elected by the community, and Swiss-trained midwife Johanne Gagnon (Daviss-Putt, 1990, p. 111). They conducted extensive questionnaires and public surveys in villages along the coast, holding meetings with local organizations, committees, health workers, and women's groups to "determine the needs and expectations of the population, to compare the risks of having births in the North with those in the South, to establish resource people and networks, and to determine the criteria for the selection of local midwives" (Daviss-Putt, 1990, p. 111; Stonier, 1990, p. 63). Throughout consultation and program development, dialogue with local health care providers was prioritized to understand the risk and potential for adverse outcomes as

a result of birthing at such a distance from tertiary care (Van Wagner et al., 2007, p. 386). The safety of women and infants was a priority, however considerations were not solely biomedical, but considered a variety of community concerns surrounding birthing. Consultations discovered a "strong desire to reclaim the birth experience" with communities advocating for an end to blanket evacuation through the reinstatement of Inuit midwifery (Epoo et al., 2012, p. 283; Van Wagner et al., 2007, p. 385). Detrimental effects of evacuation, both social and health, were a key motivation (Stonier, 1990, p. 61). Despite the perceived danger of birthing in remote areas the potential benefits were understood to outweigh risks (Van Wagner et al., 2007, p. 386). The decision to create the initial Maternity was not naïve, but was deliberate, informed, and initiated by Inuit in a bottom-up community driven manner (Stonier, 1990, p. 63).

It its initial years, southern-trained midwives were hired to staff the Maternity and develop a training program to provide local women with midwifery education tailored to the specific needs of Inuit communities (Douglas, 2010, p. 115). By the 1980s, Inuit midwives who had practiced pre-evacuation were aging and eager to pass on their knowledge in the role of advisers to the Maternity (Epoo et al., 2012, p. 284). Consultation with Elders, Inuit midwives, and Inuit women of childbearing age was consistent throughout program development with midwifery students selected by their communities for training (Van Wagner et al., 2007, p. 386). Recruitment of local students was deemed essential to creating a sustainable model of care provided in Inuit language, within an Inuit cultural framework, that incorporates and respects Inuit knowledge (Epoo et al., 2012, p. 285).

Program Structure & Components

The three birthing centres that comprise the Maternities serve a population of approximately 5500 people along the Hudson Bay Coast (Couchie & Sanderson, 2007, p. 251).

The Maternities provide care to around 200 women annually, all of whom see a physician once early in their pregnancy and receive consultations from specialists as needed, with primary care provided by midwives (Epoo et al., 2012, p. 286). The initial Maternity operates out of the Inuulitsivik Health Centre in Povungnituk, a 21-bed hospital with four additional beds reserved specifically for the Maternity (Stonier, 1990, p. 65). The Maternity wing is an annex of the Health Centre, "considered a separate place for healthy people", reflecting Inuit conceptions of birth as a natural process (Stonier, 1990, p. 65). The model is an integration of Inuit knowledge and biomedicine, seeking to combine the two in order to provide the most effective and appropriate health services (Inuulitsivik, 2017, para. 1). These models co-exist, and both contribute something unique to the provision of maternity care.

The Health Centre has a blood bank and laboratory facilities with the ability to give blood transfusions, induce and augment labour, and admit newborns in the case of complications (Van Wagner et al., 2007, p. 387). There is access to ultrasound and health workers skilled in uterine evacuation, however the Maternities are unable to provide C-sections (Stonier, 1990, p. 65; Van Wagner et al., 2007, p. 387). Consultation with specialists is carried out via phone, electronic communication, or transport to Montreal (Van Wagner et al., 2007, p. 387). The Maternities operate in three languages: Inuktitut, French, and English (Epoo et al., 2012, p. 289). By providing services in multiple languages, patients receive better care as they are "more likely to be understood, respected, and accurately assessed" (Epoo et al., 2012, p. 289). Patients feel comfortable interacting with health care services in their own language, and are able to more accurately express their desires. Inuit women particularly value this as their childbirth experiences under evacuation have been dominated by a lack of autonomy and decision-making.

The specific objectives outlined by the Inuulitsivik Maternities are:

> 1. To bring birth back to the North; this entails not only minimizing the number of unnecessary transfers to the South, but also revitalizing the common knowledge and community involvement around the birth process.
> 2. To provide high quality services to childbearing families through the perinatal period. Education and care extend also to areas of family planning, sexuality, gynecological health, familial violence, and newborn and young child development, care and feeding, both at the individual and community levels.
> 3. To foster the progressive autonomy of women and the community in self-health care, particularly as related to childbirth and pregnancy.
> 4. To put the responsibility for organization and provision of women's health care services in the hands of Inuit women, which entails, at a preliminary level, the training of local midwives. (Stonier, 1990, p. 63)

Inuit women as midwives and maternity workers provide all primary care (Stonier, 1990, p. 65; Inuulitsivik, 2017). Emphasis is placed on cultural appropriateness, taking into account feedback from the community, Inuit staff, and Elders regarding childbirth practices and services (Blythe, 1995, p. 74). With Maternities operating in the three largest communities of the Hudson Bay coast, 75% of the population "has access to intrapartum care in their home community" while women from smaller communities must travel to one of the main birth centres (Van Wagner et al., 2007, p. 386). They spend the final weeks of their pregnancies with relatives or in boarding homes in Povungnituk, Salluit, or Inukjuak and attend weekly prenatal and clinic classes (Stonier, 1990, p. 65). While these women technically must leave their home communities to deliver, as with evacuation south, it is a vastly different experience. Women are followed throughout their pregnancies and deliveries by "people who understand the language and the customs" and access care on Inuit land, in Inuit language, provided by Inuit women (Inuulitsivik, 2017, para. 2; Van Wagner et al., 2007, p. 386). They are often able to stay with family members and deliver with their partners, relatives, and friends nearby (Van Wagner et al., 2007, p. 386).

Inuit midwives form the backbone of the Maternities conducting most births and providing well-women, maternity, and newborn care with assistance from southern midwives, nurses, social workers, and physicians operating in a multi-disciplinary model (Douglas, 2010, p.

115; NAHO, 2008, p. 48; Van Wagner et al., 2007, p. 386). Midwives are assisted by part-time Inuit maternity workers who observe women throughout their pregnancies and play a key role in the postpartum period, taking note of vital signs and reporting any complications (Daviss, 1997, p. 453). The objective of the Maternities is to provide "high quality care through the promotion of health at the community level" (Stonier, 1990, p. 63). Health promotion is a key component of returning responsibility and autonomy over health to Inuit communities (Stonier, 1990, p. 63). Midwives carry out this promotion, educating communities on issues of women's health, family planning and sexual health, familial violence, and newborn/child development and nutrition (Blythe, 1995, p. 15; Gatto, 2010, p. 12; NAHO, 2008, p. 33). Midwives care for their patients from puberty to menopause providing information and access to contraception, STI screening and treatment, uterine and cervical cancer screening, and breast exams (Inuulitsivik, 2017, para. 4). A preventative approach is emphasized with significant consideration given to social determinants (Blythe, 1995, p. 74). Particular efforts are taken towards combatting the evacuation of teen mothers by addressing social determinants such as poor nutritional status that place them at higher risk for adverse outcomes (Blythe, 1995, p. 74).

An unusual risk-evaluation system is integral to the Maternities' operations and organizational structure (Douglas, 2006, p. 127). This evaluation takes the form of a Perinatal Committee that makes the decision whether a woman can deliver locally at the Maternities or should be evacuated south (Daviss, 1997; NAHO, 2004; NAHO, 2008; Stonier, 1990; Van Wagner et al., 2007). It is always chaired by a midwife and consists of a minimum of two doctors, two midwives, two midwives in training, and one member of the Inuit Women's Association (Stonier, 1990, p. 65). Each member of the Committee is equally weighted in decision-making, with no one member granted more authority than another (Douglas, 2006, p.

127). Physicians within this model must consult with midwives prior to imposing any interventions or evacuation and community representation is included to ensure that the Maternities provide relevant, culturally appropriate care (Blythe, 1995, p. 90; Daviss, 1997, p. 453; Daviss-Putt, 1990, p. 112). The Committee meets weekly to conduct chart reviews and make birth plans using a holistic evaluation of risk (NAHO, 2008, p. 48; Stonier, 1990, p. 65). Screening is a "social, cultural, and community process rather than simply a biomedical one" (Couchie & Sanderson, 2007, p. 252; Stonier, 1990, p. 66; Van Wagner et al., 2007, p. 387). The health services provided at the Maternities support the assertion that pregnancy and childbirth are healthy life events, and efforts are taken to de-medicalize the process (Stonier, 1990, p. 63). Risk is so differently determined at the Maternities that risk factors are not listed as such on charts, but are simply labeled "factors" (Daviss, 1997, p. 459). This Committee is noted as playing a central role in creating community trust, ensuring that staff share the workload, and creating wiser and safer decisions on evacuation (Stonier, 1990, p. 65). Additional responsibilities of the Committee include reviewing cases in the postpartum period, establishing policies and protocols, maintaining the philosophy and organizational goals of the Maternities, ensuring quality and standards of care, compiling statistics and essential data, and conducting internal evaluation of services (Stonier, 1990, p. 65).

The Inuulitsivik Midwifery Education Program is an academic and clinical midwifery education program for Inuit women of the Hudson Bay Coast (NAHO, 2008, p. 33). Inuit women are nominated by their communities to train at Inuulitsivik (Stonier, 1990, p. 63). The applicant's personal characteristics are considered, as they must possess not only clinical skills, but also the ability to provide compassionate and skilled care as a community leader and role model (Epoo et al., 2012, p. 290). As a community-based model, this selection process involves a "high degree

of cooperation" between health care workers and the communities they serve, noted as essential to the success and utilization of midwifery services (Blythe, 1995, p. 74; Stonier, 1990, p. 63).

The Midwifery Education Program uses a modular competency based curriculum, consistent with that of southern midwifery education programs but adapted to the realities of northern practice (NAHO, 2008, p. 33). Expertise from Quebec midwives, Inuit Elders, and Inuit midwives is blended to form a program "reflective of northern needs, context, and culture" (Lemchuk-Favel & Jock, 2004, p. 46). Classroom education, hands-on apprenticeship training, and a mentor/mentee system between students and the Maternities' midwives form the backbone of this program (Daviss, 1997, p. 451; 462). Apprenticeship skills emphasize hands on learning and students take part in all aspects of midwifery work throughout their training (Epoo et al., 2012, p. 287). Storytelling and oral methods of teaching are utilized, adhering to Inuit education models of showing rather than telling (Daviss, 1997, p. 462; Van Wagner et al., 2007, p. 388). Ways of teaching and learning include clinical and structured modules designed to be culturally and geographically relevant to remote regions (Epoo et al., 2012, p. 288). Emergency management training is provided to expand skills that may be necessary in emergent situations that arise without access to tertiary care, and students become proficient in crucial decision-making as they participate in the stabilization, transfer, and evacuation of patients (Epoo et al., 2012, p. 288; NAHO, 2008, p. 33). This allows them to gain experience advocating for their patients as they work closely with medical staff including social workers, physicians, nurses, youth protection workers, lab personnel, and sonographers (Epoo et al., 2012, p. 289).

The incorporation of Inuit knowledge is a central component of this midwifery education program. There is an understanding that learning takes place not only in a clinical or academic setting, but rather is a holistic experience encompassing the home, community, and land (Epoo et

al., 2012, p. 288). Students are encouraged to seek out Elders and learn from them, asking them to share their wisdom and attend births (Epoo et al., 2012, p. 288). Elders frequently accept these invitations, supporting women through the birthing process and assisting the Maternities in reviewing taboos, traditions, and childbirth practices (Daviss, 1997, p. 469). Students are trained to act as liaisons between patients and the health care system, seeking to combat the institutional racism frequently experienced by Inuit women (Epoo et al., 2012, p. 289).

To graduate, midwives must have followed pregnancy, birth, and postpartum care for a minimum of sixty women, attend at least forty births as second attendant, have a minimum of 1240 supervised clinical hours, and pass structured clinical written exams for each module (Carroll & Benoit, 2004, p. 273; Epoo et al., 2012, p. 289; Van Wagner et al., 2007, p. 389). They must further be certified in Emergency Skills, Neonatal Resuscitation, and CPR (Epoo et al., 2012, p. 289). Midwives are registered after graduation with the College of Midwives of Quebec where legislation recognizes Inuit midwives working at Inuulitsivik, although their licenses are only valid for practice within Nunavik (Carroll & Benoit, 2004, p. 273; Inuulitsivik, 2017, para. 5; Skye, 2010, p. 33). Ten students are expected to graduate from the program in the next several years, continuing their work at the Maternities (Inuulitsivik, 2017, para. 5).

Outcomes

The Inuulitsivik Maternities are regarded as a resounding success at returning childbirth to Inuit communities in a culturally respectful way, addressing the social determinants of health, and incorporating Inuit knowledge as an integral component of their practice (Anderson, 2008; Carroll & Benoit, 2004; Daviss, 1997; Douglas, 2006; Douglas, 2010; Epoo et al., 2012; Houd, Qinuajuak, & Epoo, 2004; Kileda, 2006; NAHO, 2008; O'Driscoll et al., 2011; Simonet et al., 2009; Stonier, 1990; Van Wagner et al., 2007). This model is considered a "champion" of

Canadian Indigenous midwifery, noted by NAHO, the SOGC, WHO, Institute of Circumpolar Health, and additional Indigenous and global health organizations as a successful model worthy of replicating in Inuit communities and other regions suffering from a lack of health care resources globally (Anderson, 2008, p. 79; Epoo et al., 2012, p. 292; NAHO, 2008, p. 48).

In 1983, evacuations accounted for 91% of births, but with the use of the Inuulitsivik Maternities this had fallen to 9% by 1998 (NAHO, 2008, p. 48). Between 1986 and 2006, 80% of women in Hudson's Bay coast communities delivered in Nunavik (Van Wagner et al., 2007, p. 387). Today, this rate is 92.2% of deliveries occurring in Nunavik, with only 7.8% of women transferring to Montreal (Inuulitsivik, 2017, para. 2). The Maternities report a significantly reduced rate of interventions such as forceps use, drugs to induce labour, episiotomies, and caesarean sections (Daviss, 1997; Epoo et al., 2012; Houd, Qinuajuak, & Epoo, 2004; Kileda, 2006; Stonier, 1990). Infant mortality rates have fallen from 8.6% to 3.6% as of 2006, and several thousand births have safely occurred at the Maternities since 1986 (Kileda, 2006, p. 392). There are fewer premature and low birth weight deliveries reported, with rates of complications and birth interventions decreasing significantly when "the majority of births began occurring at the Maternities instead of in Southern hospitals" (Douglas, 2006, p. 127; Houd, Qinuajuak, & Epoo, 2004, p. 239). A preventative and holistic approach to health emphasizing social determinants and collaborative decision-making has been central to achieving these outcomes (Stonier, 1990, p. 66). Through the provision of pre and postnatal care, screening, education, and holistic health promotion activities, the Maternities provide services that are regarded as effective and safe, with statistics "among the best anywhere in Quebec, including those of non-Aboriginal midwives working in southern regions of the province" (Carroll & Benoit, 2004, p. 273; Stonier, 1990, p. 63).

The Maternities have created a new birth culture which is not entirely Inuit nor entirely southern (Daviss, 1997, p. 464). Returning birth to the community has been crucial to the process of reconciliation and healing of wounds left by authoritative colonial medicine (Van Wagner et al., 2007, p. 390). Birth in the community facilitates a return of autonomy over birth location while simultaneously promoting respect for Inuit knowledge and medicine (Van Wagner et al., 2007, p. 390). It is a reclamation of not only childbirth location, but of knowledge; noted as a powerful way to preserve and regenerate Inuit medicine and midwifery proving "their compatibility with acceptable biomedical perinatal outcomes" (Douglas, 2006, p. 127). The Inuulitsivik Maternities are a model that establishes birth in remote communities as statistically safe, in many cases producing better outcomes than evacuation south (Van Wagner et al., 2007, p. 390). It is a sustainable, community-based model with an impressive level of communication and collaboration between Inuit midwives, Western health care providers, and Inuit communities providing accessible, holistic care suited to the needs of Inuit women (Simonet et al., 2009, p. 548; Van Wagner et al., 2007, p. 390).

The Rankin Inlet Birthing Centre*: History & Background*

In October 1990, the Northwest Territories Minister of Health announced a midwifery pilot project for Rankin Inlet[6] (Morewood-Northrup, 1997, p. 349). This decision was supported by the Inuit Women's Association, Keewatin Inuit Association, Native Women's Association, Dene National Organization, Northwest Territories Women's Secretariat, academics at the University of Manitoba, Pauktuutit, Northern Medical Unit, Canadian Confederation of Midwives, and the Ontario Midwives Association (Douglas, 2011, p. 181; Morewood-Northrup, 1997, p. 349). A two-year pilot project was developed in collaboration with the Keewatin

[6] While formerly part of the Northwest Territories, Rankin Inlet is located on Hudson's Bay in Nunavut which officially separated from the Northwest Territories April 1, 1999.

Regional Health Board, provincial Department of Health, and Northwest Territories Government with Rankin Inlet selected as project location due to the presence of an airstrip with a medical evacuation plane, a resident physician, and a sizeable prenatal population (Morewood-Northrup, 1997, p. 349). Extensive lobbying by Inuit women requested a midwifery project to return birth to the community and mitigate negative impacts of evacuation (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 2). The Centre was conceived under the auspices of improving infant mortality and morbidity rates, involving Elders and Inuit midwives in health care provision, improving physical and psychological health supports, and limiting family disruption and evacuation (Morewood-Northrup, 1997, p. 349-350). Further motives included reducing government expenditures, revitalizing "skills, experience, and knowledge" of Inuit midwives, and ensuring land claims and territorial status (Morewood-Northrup, 1997, p. 350). The Centre was intended to return childbirth to the community by providing maternity services and holistic care in the areas of sexual health, family planning, familial violence, and newborn/child feeding and development focused at individual and community levels (Morewood-Northrup, 1997, p. 350).

A committee comprised of two Health Board staff, the regional physician, an Indigenous community member, and a nurse-midwife from the Northwest Territories Department of Health was established to design and develop the project (Morewood-Northrup, 1997, p. 350). Funding was approved in 1992 and the first project-coordinator, a non-Indigenous nurse-midwife, was hired in January 1993 (Morewood-Northrup, 1997, p. 351). Two non-Indigenous nurse-midwives recruited from Ontario were hired to staff the project in August 1993 (Morewood-Northrup, 1997, p. 351). An Inuit maternity worker with no previous midwifery experience was selected from the local community, and while Elder Inuit midwives were consulted, they did not wish to actively participate in the project but were willing to be placed on an advisory committee

(Morewood-Northrup, 1997, p. 351). The Centre officially opened on November 22, 1993 and continues to operate from the Rankin Inlet Community Health Centre (Morewood-Northrup, 1997, p. 351). In 1995 it was established as permanent program, selected for expansion into a regional service in 2002 with the Nunavut government pushing for development of local training and increased hiring of Inuit (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 2).

Program Structure & Components

The Centre's staff consists of three southern midwives, one Inuit midwife, two Inuit maternity care workers, and a clerk interpreter (Rogers, 2014; Tedford Gold, O'Neil, & Van Wagner, 2005, p. 2). The Centre operates primarily in English, although Inuit midwives and maternity workers are able to provide translation and services in Inuktitut as needed. The Centre is established on the principles of: "health promotion, community support, and seeing the birthing process as a normal life event" (Morewood-Northrup, 1997, p. 350). Holistic care strives to involve the entire family and community in childbirth (Morewood-Northrup, 1997, p. 353). Prenatal, delivery, and postnatal care are provided by midwives directly consulting with physicians (NAHO, 2008, p. 51). The Centre operates out of the community clinic with a birthing unit located in the Kivalliq Health Centre (Rogers, 2014, para. 18). When staffing allows, midwives rotate through local communities visiting women in their homes to discuss birth options, provide prenatal care and education, and refer to physicians as needed (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 11). Women from outside the community must transfer to Rankin Inlet at the time of delivery and stay in boarding houses or with relatives. Inuit maternity workers are utilized in this program to support midwives in their day-to-day activities and incorporate Inuit knowledge into the program (Morewood-Northrup, 1997, p. 352). The maternity workers are encouraged to consult with Inuit midwives and Elders, although it is not

entirely clear how this consultative process works in practice (Morewood-Northrup, 1997, p. 352). The Centre existed with a questionable legal status for 15 years until the Midwifery Profession Act of Nunavut was passed in 2008, providing a territorial legislative framework for midwifery (Government of Nunavut, 2009, p. 13; NAHO, 2004, p. 12; Tedford Gold, O'Neil, & Van Wagner, 2005, p. 2).

Through the use of a Perinatal Committee women of "low or no risk" are selected to deliver in the community while all moderate to high-risk women are evacuated (Morewood-Northrup, 1997, p. 351; NAHO, 2008, p. 51). Only "low-risk" births occur at the Centre, with risk determined through clinical evaluation and consultation with an obstetrician-gynaecologist in Winnipeg (Douglas, 2011, p. 181). There is no community involvement on the Perinatal Committee, with evacuation decisions made through a strictly biomedical process taking no cultural or social factors into consideration (Douglas, 2006, p. 128). Risk is defined in biomedical terms using a standard medical risk scoring method based upon factors including first delivery, smoking and drug use, and high multipara (Douglas, 2006, p. 127-128). A majority of women are evacuated south under this model as the Centre can only accept low-risk second to fourth births as outlined in the Clinical Practice Guidelines (Douglas, 2011, p. 181; Douglas, 2006, p. 128). Low-risk women can electively choose to evacuate, and a majority continue to do so preferring to deliver in the South than under the care of midwives in the Centre (Rogers, 2014, para. 22). Less than half of all births in Rankin Inlet occur at the Centre, and at times staff shortages have demanded that all women evacuate (Douglas, 2011, p. 181).

Directly recruiting and training Inuit women from the community as midwives could address staff shortages, however this has yet to be implemented. While midwifery education has been available since the mid-2000s through the community midwifery program at Arctic College

in Arviat, there is no direct recruitment or hands-on training offered at the Centre (NACM, n.d., p. 7; Rogers, 2014, para. 6). Arctic College has graduated several midwives, but training is limited and small in scope (Rogers, 2014, para. 1). The Centre hired its first Inuit midwife trained through this program in 2014, but a majority of the Centre's staff continues to be southern-trained and non-Indigenous without the cultural or language competencies desired by the community (Rogers, 2014, para. 3). Despite originating from Inuit women's lobbying, the Centre continues to be a government project with little community involvement or input, directly threatening its existence and sustainability (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 12).

Outcomes

The Centre reports healthy birth outcomes with an average of 50 babies delivered annually (Government of Nunavut, 2009, p. 9; Morewood-Northrup, 1997, p. 354; Rogers, 2014, para. 24). Positive outcomes are noted by the Nunavut Government in returning birth to the community, providing culturally relevant and holistic care, and improving maternal and newborn health while reducing government expenditures (Government of Nunavut, 2009, p. 9). Despite these reported outcomes, the Centre's services are continually challenged by poor recruitment and retention of staff, lack of training for midwives at a local-level, and a lack of midwifery services available outside Rankin Inlet (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 2). The community desire for Inuit midwives to be the primary health care providers at the Centre has never been fulfilled, as "no comprehensive midwifery training program has ever been provided to local women" (NAHO, 2004, p. 12). The failure to provide this community-based education compromises the Centre's effectiveness (Skye, 2010, p. 33).

It is questionable if the Centre has successfully returned birth to the community and further uncertain if it has done so in a holistic and culturally appropriate manner. Douglas (2011)

argues that the Centre is fundamentally "a southern institution located in the Canadian Arctic" (p. 182). By using strictly a biomedical risk evaluation system, staffing primarily southern-trained midwives on rotating fixed contracts, and failing to provide or support training of Inuit midwives, the Centre is unable to gain community trust or provide services that address the specific health needs of Inuit women (Douglas, 2011, p. 182). While the Centre has returned some births to the community, a majority of women still evacuate due to "risk" or choose to deliver in the South, suggesting a distrust of the services provided at the Centre (Douglas, 2011, p. 180). Social and cultural determinants of health are not emphasized in this model, with risk narrowly defined within the confines of biomedicine. It is unclear how Inuit maternity workers, midwives, Elders, and community input are incorporated into the program, and it appears that the Centre operates as a top-down model reinforcing the authority of Western medicine. The Centre remains "limited in its relationship with the Inuit population", has largely failed to become an Inuit institution as it lacks the community connections and involvement necessary support the return of both delivery and childbirth knowledge (Douglas, 2011, p. 184). In its structure and operations, the Centre becomes yet another state-implemented project, carrying forward the trajectory of Western medicine utilized as a tool for colonial governmentality in the North.

Comparative Evaluation of Programs

Each of these programs provides what are considered statistically safe outcomes in remote communities and are used to support the assertion that childbirth in northern communities can be carried out by community-based midwifery programs (Couchie & Sanderson, 2007; Kileda, 2006; NAHO, 2009b; NCCAH, 2012; Skye, 2010; SOGC, 2010). Each program has received support from professional bodies and organizations including the SOGC (O'Driscoll et al., 2011, p. 127). The SOGC, on evaluation of Indigenous midwifery programs including the

Centre and Maternities, "supports the return of the birthing experience to all remote and rural Aboriginal communities" and is attempting to use its influence to facilitate conversations between communities, governments, and health care professionals regarding the restoration of Indigenous midwifery in remote communities (Lalonde, Butt, & Bucio, 2009, p. 960; O'Driscoll et al., 2011, p. 127). Studies suggest, however, that the success and sustainability of Indigenous health programs is dependent upon the community's sense of control over programming (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 12). In order to succeed they must originate from community approaches and perceptions of care (Tedford Gold, O'Neil, & Van Wagner, 2005, p. 12). Returning childbirth to Inuit communities must take into consideration social and cultural determinants of health with success evaluated not only on statistical outcomes, but cultural acceptability and accessibility (Simonet et al., 2009, p. 549). Inuit concerns about health programming centre largely on regaining and maintaining a high level of community involvement (Douglas, 2010, p. 114). When evaluating programs such as the Inuulitsivik Maternities and Rankin Inlet Birthing Centre, it is necessary to examine if they are able to return a significant number of deliveries and ownership over childbirth knowledge to Inuit and if they are able to do so in a way that addresses social and cultural determinants of health.

Ability to Return Childbirth to Communities

The return of childbirth is not solely about deliveries taking place on Inuit land but has further implications for community control over health (Kaufert & O'Neil, 1993, p. 49). Returning childbirth to the North is a return of physical delivery and of "reproductive knowledge back to the communities from which it has been taken" (Olson, 2015, p. 171). It is a decolonial process, combatting dominant narratives of Western medicine as superior, granting Inuit women autonomy over their bodies, re-defining of maternity as a natural process, and challenging

colonial systems of evacuation. The Inuulitsivik Maternities have been successful at returning birth in both a knowledge and physical sense, with a majority of births taking place in its regional centres under the direction of Inuit midwives (O'Driscoll et al., 2010, p. 26). Births are taking place on the land, negating the profound anxieties surrounding land claims and status. There is a physical return of the birth event and reclamation of Inuit childbirth knowledge through the use and extensive training of Inuit women from the community. Inuit women are the primary decision makers, health care providers, and voice of the Maternities.

The Rankin Inlet Birthing Centre, in contrast, has only returned a limited number of births to the community and has done so through the use of southern-trained midwives, failing to integrate Inuit knowledge and midwives (Douglas, 2011). While a small improvement may be noted in returning the physical birth event, there has been little to no return of Inuit childbirth knowledge. The vast difference in ability to return birth to the community is largely due to the definition and evaluation of risk used in each program. While the Inuulitsivik Maternities take a multi-disciplinary approach to risk evaluation, incorporating community voices in the process and considering a wide variety of risk factors including social and cultural determinants of health, the Rankin Inlet Birthing Centre follows a strictly biomedical risk evaluation supported by the Clinical Practice Guidelines. This results in a majority of births from Rankin Inlet evacuated south. The level of respect given to Inuit midwives, Elders, and community members is significantly different between these two programs with the Maternities prioritizing Inuit women, their voices, and their capabilities in selecting and training local women. The Centre, in contrast, has prioritized the hiring of southern-trained midwives while failing to support or initiate local training opportunities for Inuit midwives. In doing so, the Centre reinforces colonial ideologies by failing to adequately support and validate the use of Inuit midwives and knowledge

within its practice. It further fails to adequately address the historical trauma and colonial roots of evacuation, in that a majority of women are still evacuated under this model.

Ability to Address Social & Cultural Determinants of Health

The midwifery model is based on principles of treating maternity as a normal condition through a "woman centered and holistic" approach that seeks to honour community conceptions of health and well-being (Brubaker & Dillaway, 2009, p. 37; Burtch, 1994, p. 53). Midwifery resists medicalization, and while both of these programs, whether staffed by Inuit or southern-trained midwives, consider social determinants of health and seek to provide holistic health care, the Inuulitsivik Maternities go much further than the Rankin Inlet Birthing Centre in achieving this (Shaw, 2013, p. 531). The Maternities embody a well-rounded perspective of health, incorporating Inuit and Western health practices in a model reflective of Two-Eyed Seeing with no one model granted authoritative power over another (Inuulitsivik, 2017, para. 1). This is evident in the Maternities' multi-disciplinary risk evaluation model, which grants members equal decision-making power (Daviss, 1997, p. 453; Douglas, 2006, p. 127). While the Rankin Inlet Birthing Centre considers risk factors along strictly biomedical lines, adhering to the Health Canada Clinical Guidelines for evacuation, Inuulitsivik Maternities take into account cultural and social determinants of health on a much wider spectrum. The Maternities have proven reduction in interventions, reducing medicalization and iatrogenesis (Daviss, 1997; Epoo et al., 2012; Houd, Qinuajuak, & Epoo, 2004; Kileda, 2006; Stonier, 1990). The Rankin Inlet Birthing Centre has yet to provide such outcomes working within its medicalized framework and only providing midwifery services to biomedically defined "low-risk" women.

The programs sought by Inuit women incorporate Inuit knowledge creating a "unique kind of midwifery which takes into account the elements of the past and combines it with present

midwifery practices" (Grieg, 1990, p. 43). While both programs seek to incorporate Inuit knowledge and birthing practices in their operations, it is evident that Inuulitsivik Maternities are more successful than the Rankin Inlet Birthing Centre at prioritizing and emphasizing the recruitment and training of Inuit women as midwives. This directly acknowledges and seeks to influence the social determinant of race/Aboriginal status. Inuit women face institutionalized racism in the Canadian health care system, and particularly in the evacuation based model which removes them from their communities for the birth event which must take place in southern hospitals under the care of southern health care workers (Galabuzi, 2004). By providing care in Inuit communities, in Inuit language, by Inuit midwives, racism and the colonial legacies of northern medicine are addressed. By reducing evacuation, each of these programs additionally addresses the social determinants of gender and socioeconomic status. Although Inuulitsivik proves more successful at this, in that a larger portion of births are taking place in the community, both programs reduce the number of women evacuated and in doing so, allow women to remain in their communities reducing many of the economic stresses caused by evacuation such as flight costs, long distance-phone calls, and childcare (Chamberlain & Barclay, 2000; Daviss-Putt, 1990; Dawson, 1993; O'Driscoll et al., 2011). It further reduces gendered stresses for women, related to childcare provision and domestic duties (NAHO, 2006). Inuit women's choice in childbirth and delivery is also restored by providing them with the option of midwife-assisted delivery within their community or southern evacuation. In providing these options, Inuit women's ability to make crucial decisions about their physical bodies, health care, and childbirth location is expanded in dramatic ways.

Creating midwifery programs in which Inuit health workers, their voices, and their knowledge are centred has implications in the process of decolonizing the health care

experiences of Inuit women, addressing the overarching health determinant of colonization. Community-based midwifery practices in Inuit communities must consider the expertise, experience, and knowledge of Inuit women and include these at the core of their practice (Tedford Gold, O'Neil, & Van Wagner, 2005, p. i). Programs will not thrive, nor be utilized, unless they incorporate Inuit knowledge. This is evident in the vast disparities in utilization and number of births taking place at Inuulitsivik Maternities and the Rankin Inlet Birthing Centre. In order to successfully provide effective services, programs must consider and respect "cultural traditions, knowledge, and beliefs as well as the importance of community participation in the decision-making and implementation processes" (Lalonde, Butt, & Bucio, 2009, p. 956). Colonialism has created dependence upon Western health care systems and highly medicalized evacuation models (Dawson, 1993, p. 23). Inuit women face significant institutional racism in the Canadian health care system, and providing culturally respectful health care in midwifery programs requires that women receive services in their languages, from their people, on their land. Inuulitsivik Maternities have been able to provide these services and work to combat dependency on colonial systems by returning birth and childbirth knowledge to the community in an Inuit-centred model. The Rankin Inlet Birthing Centre has provided a southern-biomedical model of midwifery with little community input, limited language competencies and culturally respectful services, and few opportunities for Inuit women to work in the program or utilize its services, furthering dependence on authoritative Western knowledge and colonial institutions.

Conclusion

It becomes apparent in the analysis of these programs that the Inuulitsivik Maternities provide an exemplary example of a community-based Inuit midwifery program that successfully returns childbirth to northern communities in a holistic and culturally respectful manner. The

Rankin Inlet Birthing Centre, while seeking to achieve similar goals, has failed to achieve comparable results. While the intended goals of each program are similar—to mitigate the expenses and negative effects of evacuation while providing local, midwife-assisted childbirth as an option for Inuit women—they have achieved these goals in vastly different ways. While Inuulitsivik constitutes a bottom-up, community-driven program seeking to train Inuit women to carry forward the practices of Elder Inuit midwives who came before them, Rankin Inlet Birthing Centre has taken a top-down approach in transferring a southern-biomedical model to the North and failing to incorporate the community, Elders, or Inuit midwives in the process. Despite these noted weaknesses in the programming structure of Rankin Inlet Birthing Centre, each program provides the option of midwife-assisted birth to Inuit women, reducing the number of evacuations taking place and contributing to Inuit self-determination efforts and the creation of community-based models of care (NAHO, 2008, p. 58).

Chapter Seven: Conclusion

The Inuulitsivik Maternities and Rankin Inlet Birthing Centre provide midwife-assisted delivery options for Inuit women in remote northern communities. Through the historically rooted analysis provided in this thesis, it becomes evident that medicine in the North, and particularly mandatory evacuation for childbirth, originates from colonial projects of governance seeking to assimilate and "civilize" Inuit (Dawson, 1993, p. 22). As such, it is impossible to approach northern medicine without addressing its historical trajectory and resulting trauma. When considered within this context, it becomes evident that the return of childbirth—in the contexts of both physical birth and restoration of Inuit knowledge—is not simply about providing a wider variety of delivery options, but constitutes an attempt to decolonize health care experiences rooted in the assimilationist and civilizing mission of the Canadian colonial state.

The research question guiding this thesis asks: In what ways do Inuit midwifery systems provide a holistic and culturally respectful childbirth option for Inuit women by addressing social and cultural determinants of health in a way that the current system of evacuation to southern hospitals cannot? While this research has discovered that both midwifery programs are able to address social determinants and provide holistic maternity care better than mandatory evacuation, the Inuulitsivik Maternities emerge as a stronger model. When critically examined, it becomes evident that the Inuulitsivik Maternities are successful at returning childbirth as a both physical birth act and additionally revitalizing Inuit knowledge and midwifery practices. Through the use of a locally-sourced midwifery training model and incorporation of Inuit voices at all levels of operation, including a holistic risk-evaluation model, the Maternities constitute a bottom-up, Inuit-led, and Inuit-based midwifery system. The Maternities have been extremely successful and are a model lauded by organizations as worthy of replicating (Anderson, 2008;

Carroll & Benoit, 2004; Daviss, 1997; Douglas, 2006; Douglas, 2010; Epoo et al., 2012; Houd, Qinuajuak, & Epoo, 2004; Kileda, 2006; Lemchuk-Favel & Jock, 2004; NAHO, 2008; NCCAH, 2012; O'Driscoll et al., 2010; O'Driscoll et al., 2011; Simonet et al., 2009; Skye, 2010; Stonier, 1990; Tedford Gold, O'Neil, & Van Wagner, 2005; Van Wagner et al., 2007).

The Inuulitsivik Maternities are not simply a midwifery program, but a decolonial project seeking to return knowledge and autonomy to Inuit women. While a decolonial political agenda is not explicitly claimed by the Maternities, the Inuulitsivik model incorporates many elements of Two-Eyed Seeing as its midwives practice an integration of Inuit knowledge and Western medicine (Inuulitsivik, 2017, para. 1). No one model is granted authority over another, combatting the generally accepted hegemony of Western biomedicine. Through their training program, there is a determined effort to alleviate dependence on southern health care providers. By placing childbirth knowledge and authority back into the hands of the community, while simultaneously respecting the advances of biomedicine, Inuulitsivik constitutes what Douglas (2010) describes as a "non-modern hybrid", fusing holistic and communal conceptions of Inuit medicine with the advances of biomedicine (p. 112). Inuit midwives provide birthing services incorporating Inuit conceptions of medicine and health to Inuit women, in Inuit language, on Inuit land. By doing so, Inuulitsivik midwives combat the historical trauma of evacuation-based medicine and provide holistic care that takes into account the social determinants of Inuit health.

In contrast to Inuulitsivik, the Rankin Inlet Birthing Centre has not been particularly successful at returning a significant number of births to the community, nor at supporting a revitalization of community-held childbirth knowledge. By relying on southern-trained midwives, failing to provide support or training opportunities for Inuit midwives, and using a strictly biomedical risk-evaluation model, the Centre constitutes a top-down project,

transplanting a southern biomedical model into an Inuit community (Douglas, 2006; Douglas, 2011; NAHO, 2004; Skye, 2010; Tedford Gold, O'Neil, & Van Wagner, 2005). While it has provided some expansion of birthing options and returned a small number of births to the community, the Centre has not been successful to the same extent as Inuulitsivik, nor has it embraced a decolonial approach to midwifery. The Centre fails to address social or cultural determinants of health at the core of its programming structure, provide a holistic or culturally appropriate model of care, or address the colonial roots of northern medicine. Instead of challenging dependence on southern authority and biomedicine, the Centre reinforces this dependence and in doing so carries forward colonial ideologies of northern health care.

Recommendations

- **Holistic Social Determinants Approach to Inuit Health**

It becomes evident throughout this research that a statistical and purely biomedical approach to Inuit health is problematic. Statistics collected in the Canadian North are often inaccurate due to small population density and collection errors, resulting in problematic interpretations (Dawson, 1993; Kaufert & O'Neil, 1990). The use of IMR to justify mandatory evacuation ignores the fact that it is safer to be born in an Inuit community than to live there for the first year of life, with infant death highest from age one month to one year (Baskett, 1978; Stonier, 1990). This is directly connected to issues of poor health care access, support, and postnatal education combined with poor quality housing, food insecurity, and sustained poverty in Inuit communities (Lalonde, Butt, & Bucio, 2009; NAHO, 2006; Paulette, 1990a). In order to improve maternal and infant health outcomes, large-scale improvements to the general social and economic conditions of communities are required (Lalonde, Butt, & Bucio, 2009, p. 957). Addressing the social determinants of health is central to this, as the health of Inuit cannot be

addressed without understanding the social, political, economic, environmental, and colonial contexts in which health is situated (Allan & Smylie, 2015; Inuit Tapiriit Kanatami, 2014; King, Smith, & Gracey, 2009; Martin, 2012; NCCAH, 2012; Smylie, 2009). A holistic, life-cycle approach must be implemented, addressing health from a communal perspective (NCCAH, 2012; Raphael, 2009; Shah, 2004). This fits with Indigenous perspectives of health as involving physical, mental, and spiritual components (Bennett & Rowley, 2004, p. 219; Laugrand & Oosten, 2010; Martin-Hill, 2003; Skye, 2010; Waldram, Herring, & Kue Young, 2006). This requires stepping away from the dominant medical model, diminishing biological reductionism and mind-body dualism, and focusing on health as part of a larger social and cultural process.

- **Increased Support and Resources for Inuit Midwifery in Canada**

Inuit midwifery programs provide health care within a holistic framework, addressing social determinants frequently ignored in the evacuation model. There is a need for increased attention, resources, and training support for Inuit midwifery in Northern Canada to improve infant and maternal health outcomes. Through the analysis provided in this thesis, it becomes evident that Inuit midwifery programs are successful in their current implementation and combat many of the negative effects of evacuation in a cost-effective manner. These programs have received endorsement from Indigenous organizations including the NACM and NAHO along with professional health care organizations including the SOGC (Epoo et al., 2012, p. 292). Despite this support, and a proven effectiveness in providing a "safe and viable alternative" to evacuation, a majority of northern women continue to be evacuated for delivery (Epoo et al., 2012, p. 292; Kileda, 2006 p. 391). A lack of human resources has been a constant challenge in establishing midwifery in the Canadian North, however this can be addressed through the provision of local training programs such as those at Inuulitsivik which recruit and utilize local

women in their practice (NAHO, 2009a, p. 145). While the government's recent allocation of $6 million to fund community-based Indigenous midwifery programs is hopeful, it is still questionable how this funding will be allocated or if programs will be Indigenous-led or provided in a top-down manner (CBC News, 2017). Support for Indigenous and Inuit midwifery further addresses the Truth and Reconciliation Commission Call to Action #22, which calls for "those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices" and to support the use of these services, particularly when requested by Indigenous patients (NACM, 2016, p. 3).

- **Community-Based Midwifery Models**

If Inuit midwifery programs are to succeed, they must be community-based and originate from the specific needs and desires of each community. No "one size fits all" model will work in implementing Inuit midwifery as each region has its own unique health care needs (Carroll & Benoit, 2004, p. 281; NAHO, 2008, p. 62). The support of the community is essential to providing effective services that address the particular wants, desires, and social determinants of each group. As such, "women, community leaders, and elders all need to be involved in promoting the return of birth" (SOGC, 2010, p. 1187). The roles and contributions of Elders, Inuit women, and community leaders within this framework should be defined and decided by these individuals themselves so as to maintain autonomy and control over programming. Such an approach will recognize the importance of place, use holistic models, incorporate Inuit knowledge and medicine, and will work to develop local capacity in the training of health care workers (Tedford Gold, O'Neil, & Van Wagner, 2005, p. iv). Holism is emphasized in Inuit medicine, and is vital to the success of midwifery programs (Health Council of Canada, 2011, p. 23). If successfully implemented as bottom-up community-based programs, Inuit midwifery will

grant women autonomy and active participation in their own health care, reducing the need for and alleviating many of the negative effects of evacuation (Bouchard, 1990, p. 26).

- **A Two-Eyed Seeing Approach to Inuit Midwifery**

Inuit midwifery programs should not only be community-based, but should furthermore seek to integrate Inuit knowledge in a Two-Eyed Seeing model. This model emphasizes the respect and acknowledgement of a variety of perspectives without perpetuating a dominance of any one over another (Martin, 2012, p. 24). This has particular relevance for Inuit midwifery as a decolonial project in that it allows midwives to integrate Inuit knowledge and medicine with the benefits and advances of biomedicine in a way that does not reinforce the hegemony of Western knowledge. By using a Two-Eyed Seeing model it is possible to find "workable solutions" to pressing health issues (Hovey et al., 2017, p. 1279). Inuit midwifery, operating within the context of colonialism, is "part of a larger concern for legitimizing cultural patterns and alleviating dependence on perceived authorities" (Dawson, 1993, p. 22). Two-Eyed Seeing provides a model for achieving this as it allows for a respect and appreciation of Western medical advances while acknowledging colonized relationships between Indigenous People and the Canadian medical system (Couchie & Nabigon, 1997, p. 46).

There is an understanding in models using an integrative approach, such as Inuulitsivik, that Western biomedicine can increase the safety of births, but that using this medicine in collaboration with Indigenous knowledge and medicine provides a holistic and appropriate health care system better suited to the needs of Indigenous Peoples (Dawson, 1993, p. 23). Midwifery programs should ideally seek to resolve the tension between Inuit medicine and biomedicine, "creating a hybrid form of health care" in which "Inuit use the tools of biomedicine, but within a framework of the traditional and communal authorities that lies at the

core of their culture" (Douglas, 2006, p. 128). Continuously, though, it must be asked whether this blending is possible when consideration is given to the continued hegemony of Western science. As Simpson (2000b) asks: "How do you 'integrate' the experience of the colonized into that of the colonizer?" (p. 192). And if integration is to be achieved, who should be at the forefront of this movement? This is a delicate balance, but Inuulitsivik provides a hopeful example of a functioning health system that incorporates and values Inuit knowledge while utilizing the scientific achievements of biomedicine (Skye, 2010, p. 34).

Inuit midwifery has the ability to provide holistic and culturally respectful childbirth options for Inuit women. This reduces dependence on evacuation, rooted in colonial practices of assimilation and control, and provides a well-rounded approach to maternal health care that takes into account the specific social determinants of health affecting Inuit women. These programs provide a promising model of health care provision in remote northern communities, Indigenous communities across Canada, and resource-constrained areas globally (Lalonde, Butt, & Bucio, 2009, p. 960). The return of delivery to the Canadian North constitutes a larger project of Inuit self-determination, a return of women's autonomy, and a resistance of assimilationist medicine and medicalized childbirth. Inuit knowledge and midwifery are active decolonial forces, combatting medicine utilized as a tool of colonial governmentality. By giving Inuit women the ability to deliver on their land, in the presence of their families, friends, Elders, and communities, a decolonial process of healing and reconciliation begins.

References

Allan, B. & Smylie, J. (2015). *First Peoples, Second Class Treatment: The role of racism in the health and well-being of Indigenous peoples in Canada.* Wellesley Institute. Retrieved from http://www.wellesleyinstitute.com/wp-content/uploads/2015/02/Summary-First-Peoples-Second-Class-Treatment-Final.pdf

Anderson, E. (Ed.) (2008). *Canada's Relationship with Inuit: A history of policy and program development.* Ottawa: Indian and Northern Affairs Canada.

Armstrong, P. (2009). Public Policy, Gender, and Health. In D. Raphael (Ed.) *Social Determinants of Health: Canadian Perspectives, 2nd Ed.* (pp. 350-361). Toronto: Canadian Scholars' Press.

Baillargeon, D. (2009). *Babies for the Nation: The Medicalization of Motherhood in Quebec 1910-1970.* Waterloo: Wilfred Laurier University Press.

Barker, K. K. (1998). A Ship upon a Stormy Sea: The Medicalization of Pregnancy. *Social Science & Medicine, 47*(8), 1067-1076.

Bartlett, C., Marshall, M., Marshall, A. & Iwama, M. (2012). Integrative Science and Two-Eyed Seeing: Enriching the Discussion Framework for Health Communities. In L. K. Hallstrom, N. Guehlstorf, & M. Parkes (Eds.) *Beyond Intractability: Convergence and Opportunity at the Interface of Environmental, Health and Social Issues.* Vancouver: University of British Colombia Press. Retrieved from http://www.integrativescience.ca/uploads/files/2012-Bartlett-Marshall-Iwama-Integrative-Science-Two-Eyed-Seeing-enriching-discussion-framework(authors-draft).pdf

Baskett, T. F. (1978). Obstetric care in the central Canadian Arctic. *British Medical Journal, 2*(6143), 1001-1004.

Battiste, M. & Henderson, J. H. (2000). *Protecting Indigenous Knowledge and Heritage.* Saskatoon: Purich Publishing Ltd.

Bennett, J. & Rowley, S. (Eds.) (2004). *Uqalurait: An Oral History of Nunavut.* Montreal & Kingston: McGill-Queen's University Press.

Benyamini, Y., Molcho, M. L., Dan, U., Gozlan, M., & Pres, H. (2017). Women's attitudes towards the medicalization of childbirth and their associations with planned and actual modes of birth. *Women and Birth*, (Article in Press). doi: 10.1016/j.wombi.2017.03.007

Bhambra, G. K. (2014). Postcolonial and decolonial dialogues. *Postcolonial Studies, 17*(2), 115-121. doi: 10.1080/13688790.2014.966414

Bjerregaard, P. & Kue Young, T. (1998). *The Circumpolar Inuit: Health of a Population in Transition.* Copenhagen: Munksgaard.

Blythe, J. (1995). *Maternal-Child Health Care Programs for Aboriginal People: A review of the literature.* Ottawa: Minister of National Health and Welfare.

Bouchard, F (1990). Having a Baby in Northern Quebec: Lessons for the Future. In J. D. O'Neil & P. Gilbert (Eds.), *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives* (pp. 23-26). Winnipeg: University of Manitoba.

Bourgeault, I. L., Benoit, C., & Davis-Floyd, R. (Eds.) (2004). *Reconceiving Midwifery.* Montreal & Kingston: McGill-Queen's University Press.

Brennan, R., Eagle, L., & Rice, D. (2010). Medicalization and Marketing. *Journal of Macromarketing, 30*(1), 8-22. doi: 10.1177/0276146709352221

Brett, H. B. (1969). A Synopsis of Northern Medical History. *Canadian Medical Association Journal, 100*(11), 521-525.

Brubaker, S. J. & Dillaway, H. E. (2009). Medicalization, Natural Childbirth, and Birthing Experiences. *Sociology Compass, 3*(1), 31-48. doi: 10.1111/j.1751-9020.2008.00183.x

Burtch, B. (1994). *Trials of Labour: The Re-emergence of Midwifery.* Montreal & Kingston: McGill-Queen's University Press.

Cahill, H. A. (2011). Male appropriation and medicalization of childbirth: an historical analysis. *Journal of Advanced Nursing, 33*(3), 334-342.

Canadian Association of Midwives. (2017). *Mission and Vision.* Retrieved from https://canadianmidwives.org/mission-vision/

Canadian Press. (2017, April 9). Ottawa to pay for travel companion for Indigenous women giving birth away from reserve. *CBC Politics.* Retrieved from http://www.cbc.ca/news/politics/indigenous-women-pregnancy-reserve-escort-policy-change-1.4063082

Canada Research Chairs. (2017). *Canada Research Chair in Indigenous Peoples' Health and Well-Being.* Retrieved from http://www.chairs-chaires.gc.ca/chairholders-titulaires/profile-eng.aspx?profileId=3767

Carroll, D. & Benoit, C. (2004). Aboriginal Midwifery in Canada: Merging Traditional Practices and Modern Science. In I. L. Bourgeault, C. Benoit, & R. Davis-Floyd (Eds.), *Reconceiving Midwifery* (pp. 263-286). Montreal & Kingston: McGill-Queen's University Press.

CBC News: Indigenous. (2017, June 23). Federal government announces funding for midwifery services in Indigenous communities. *CBC News: Indigenous.* Retrieved from http://www.cbc.ca/news/indigenous/new-funding-for-midwifery-services-in-indigenous-communities-1.4174188

Chamberlain, M. & Barclay, K. (2000). Psychosocial costs of transferring indigenous women from their community for birth. *Midwifery, 16*(2), 116-122. doi: 10.1054/midw.1999.0202

Cockerham, W. C. (2007). *Social Causes of Health and Disease*. Cambridge: Polity Press.

Conrad, P. (1992). Medicalization and Social Control. *Annual Review of Sociology, 18,* 209-232.

Conrad, P. (2005). The Shifting Engines of Medicalization. *Journal of Health and Social Behaviour, 46*(1), 3-14.

Couchie, C. & Nabigon, H. (1997). A Path Towards Reclaiming Nishnawbe Birth Culture: Can the Midwifery Exemption Clause for Aboriginal Midwives Make a Difference? In F. M. Shroff (Ed.), *The New Midwifery: Reflections on Renaissance and Regulation* (pp. 41-50). Toronto: Women's Press.

Couchie, C. & Sanderson, S. (2007). A Report on Best Practices for Returning Birth to Rural and Remote Aboriginal Communities: Society of Obstetricians and Gynaecologists of Canada Report. *Journal of Obstetrics and Gynaecology Canada, 29*(3), 250-254.

Croteau, J. (2010). *Final Report of the Honourable Jean-Jacques Croteau Retired Judge of the Superior Court Regarding the Allegations Concerning the Slaughter of Inuit Sled Dogs in Nunavik (1950-1970).* Retrieved from http://thefanhitch.org/officialreports/Final%20Report.pdf

Davis-Floyd, R. E. & Davis, E. (1997). Intuition as Authoritative Knowledge in Midwifery and Home Birth. In R. E. Davis-Floyd & C. F. Sargent (Eds.), *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (pp. 315-349). Berkeley: University of California Press.

Davis-Floyd, R. E., & Sargent, C. F. (Eds.) (1997). *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives.* Berkeley: University of California Press.

Daviss-Putt, B. A. (1990). Rights of Passage in the North: From Evacuation to the Birth of a Culture. In M. Crnkovich (Ed), *"Gossip" A Spoken History of Women in the North* (pp. 91-114). Ottawa: Canadian Arctic Resources Committee.

Daviss, B. A. (1997). Heeding Warnings from the Canary, the Whale, and the Inuit: A Framework for Analyzing Competing Types of Knowledge about Childbirth. In R E. Davis-Floyd & C. F. Sargent (Eds.), *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (pp. 315-349). Berkeley: University of California Press.

Dawson, J. M. (1993). Native Childbirth in the Canadian North: Are Midwives the Answer? *NEXUS: The Canadian Student Journal of Anthropology, 11*, 15-26.

Dodd, D. & Gorham, D. (1994). *Caring and Curing: Historical Perspectives on Women and Healing in Canada.* Ottawa: University of Ottawa Press.

Douglas, V. (2006). Childbirth among the Canadian Inuit: A review of the clinical and cultural literature. *International Journal of Circumpolar Health, 65*(2), 117-132. doi: 10.3402/ijch.v65i2.18087

Douglas, V. (2010). The Inuulitsivik Maternities: Culturally Appropriate Midwifery and Epistemological Accommodation. *Nursing Inquiry, 17*(2), 111-117.

Douglas, V. (2011). The Rankin Inlet Birthing Centre: community midwifery in the Inuit context. *International Journal of Circumpolar Health, 70*(2), 178-185. doi: 10.3402/ijch.v70i2.17803

Dufour, R. (1994). Giving Birth in an Igloo. In M. O'Neill & F. Saillant (Eds.), *Born up North: The evolution of birthing practices in native communities of Northern Canada* (pp. 19-40). Toronto: University of Toronto Centre for Health Promotion.

Duncan, J. (2007). The Medical Gaze and the Spaces of Biopower. In J. Duncan, *In the Shadow of the Tropics: Climate, Race and Biopower* (pp. 101-144). Hampshire: Ashgate Publishing Limited.

Epoo, B., Stonier, J., Van Wagner, V., & Harney, E. (2012). Learning Midwifery in Nunavik: Community-based Education for Inuit Midwives. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 10*(3), 283-300.

Foucault, M. (1973). *The Birth of the Clinic: An Archaeology of Medical Perception.* New York: Routledge.

Foucault, M. (1991). Governmentality. In G. Burchell, C. Gordon, & P. Miller (Eds.), *The Foucault Effect: Studies in Governmentality* (pp. 87-104). Chicago: University of Chicago Press. (Original work published 1978).

Gallagher, E. B. & Ferrante, J. (1987). Medicalization and Social Justice. *Social Justice Research, 1*(3), 377-392.

Galabuzi, G. (2004). Social Exclusion. In D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives* (pp. 235-251). Toronto: Canadian Scholars' Press.

Gatto, B. (2010). *Taking Action: Thinking out of the Box: An Action Plan on Maternal-Infant Care for Aboriginal Families.* Native Women's Association of Canada. Retrieved from

https://www.nwac.ca/wp-content/uploads/2015/05/2010-NWAC-Action-Plan-on-Maternal-Infant-Care-for-Aboriginal-Families-Report.pdf

Goodwin, N. (2018, January 18). Midwives waiting on proclamation to begin offering services on P.E.I. *CBC News: Prince Edward Island.* Retrieved from http://www.cbc.ca/news/canada/prince-edward-island/pei-midwives-waiting-on-proclamation-to-offer-services-1.4492956

Gorelick, R. (2014). Indigenous sciences are not pseudosciences. *Ideas in Ecology and Evolution, 7*(43), 45-55. doi: 10.4033/iee.2014.7.11.c

Government of Nunavut Department of Health and Social Services. (2009). *Nunavut Maternal and Newborn Health Care Strategy 2009-2014.* Retrieved from http://cwrp.ca/sites/default/files/publications/en/NU_Maternal_strategy_2009.pdf

Government of Yukon. (2017, September 27). *Government of Yukon takes steps towards regulated midwifery in Yukon.* Retrieved from http://www.gov.yk.ca/news/17-195.html

Grieg, M (1990). The Pauktuutit (Inuit Women's Association) Perspective. In J. D. O'Neil & P. Gilbert (Eds.), *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives* (pp. 43-44). Winnipeg: University of Manitoba.

Grygier, P. S. (1994). A Long Way from Home: The Tuberculosis Epidemic among the Inuit. Montreal & Kingston: McGill-Queen's University Press.

Hackett, P. (2005). From Past to Present: Understanding First Nations Health Patterns in a Historical Context. *Canadian Journal of Public Health, 96*, S17-S21.

Halfmann, D. (2011). Recognizing medicalization and demedicalization: Discourses, practices, and identities. *Health, 16*(2), 186-207. doi: 10.1177/1363459311403947

Health Canada. (2011). *First Nations and Inuit Health Branch (FNIHB) Clinical Practice Guidelines for Nurses in Primary Care—Chapter 12: Obstetrics.* Retrieved from https://www.canada.ca/content/dam/hc-sc/migration/hc-sc/fniah-spnia/alt_formats/pdf/services/nurs-infirm/clini/adult/obstet-eng.pdf

Health Council of Canada. (2011). *Understanding and Improving Aboriginal Maternal and Child Health in Canada.* Toronto: Health Council of Canada.

Hodgson, C. (1982). The social and political implications of tuberculosis among native Canadians. *The Canadian Review of Sociology and Anthropology, 19*(4), 502-512.

Houd, S., Qinuajauk, J., & Epoo, B. (2004). The outcome of perinatal care in Inukjuak, Nunavik, Canada 1998-2002. *International Journal of Circumpolar Health, 63*(Sup. 2), 239-241. doi: 10.3402/ijch.v63i0.17909

Hovey, R. B., Delormier, T., McComber, A. M., Lévasque, L., & Martin, D. (2017). Enhancing Indigenous Health Promotion Research Through Two-Eyed Seeing: A Hermeneutic Relational process. *Qualitative Health Research, 27*(9), 1278-1287. doi: 10.1177/1049732317697948

International Journal of Indigenous Health. (n.d.). *Defining Aboriginal Peoples Within Canada.* Retrieved from https://journals.uvic.ca/journalinfo/ijih/IJIHDefiningIndigenousPeoplesWithinCanada.pdf

Inuit Tapiriit Kanatami. (2014). *Social Determinants of Inuit Health in Canada.* Ottawa: Inuit Tapiriit Kanatami.

Inuulitsivik. (2017). *Midwives.* Retrieved from http://www.inuulitsivik.ca/healthcare-and-services/healthcare/midwives

Iwama, M., Marshall, M., Marshall, A. & Bartlett, C. (2009). Two-Eyed Seeing and the Language of Healing in Community-Based Research. *Canadian Journal of Native Education, 32*(2), 3-23.

Jasen, P. (1997). Race, Culture, and the Colonization of Childbirth in Northern Canada. *Social History of Medicine, 10*(3), 383-400.

Jordan, B. (1997). Authoritative Knowledge and its Construction. In R E. Davis-Floyd & C. F. Sargent (Eds.), *Childbirth and Authoritative Knowledge: Cross-Cultural Perspectives* (pp. 55-79). Berkeley: University of California Press.

Joseph, B. (2016, September 21). Indigenous or Aboriginal: Which is Correct? *CBC News: Indigenous.* Retrieved from http://www.cbc.ca/news/indigenous/indigenous-aboriginal-which-is-correct-1.3771433

Kalpagam, U. (2002). Colonial Governmentality and the Public Sphere in India. *Journal of Historical Sociology, 15*(1), 35-58.

Kaufert, P. A. & O'Neil, J. D. (1990). Cooptation and Control: The Reconstruction of Inuit Birth. *Medical Anthropology Quarterly, 4*(4), 427-442.

Kaufert, P. A. & O'Neil, J. (1993). Analysis of a Dialogue on Risks in Childbirth: Clinicians, Epidemiologists, and Inuit Women. In S. Lindenbaum & M. Lock (Eds.), *Knowledge, Power & Practice: The Anthropology of Medicine and Everyday Life* (pp. 32-54). Berkeley: University of California Press.

Kaufert, P., Moffatt M., O'Neil, J., & Postl, B. (1990). The Epidemiology of Obstetric Care in the Keewatin District: Methodological Issues. In J. D. O'Neil & P. Gilbert (Eds.), *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives* (pp. 5-11). Winnipeg: University of Manitoba.

Kelm, M. E. (1998). *Colonizing Bodies: Aboriginal Health and Healing in British Colombia, 1900-50.* Vancouver: University of British Colombia Press.

Kelm, M. E. (2005). Diagnosing the Discursive Indian: Medicine, Gender, and the 'Dying Race'. *Ethnohistory, 52*(2), 371-406.

Kennedy, H. P. & Carr, C. (2007). Global Perspectives on Women's Health: Policy and Practice. *Journal of Midwifery & Women's Health, 52*(4), 321-322. doi: 10.1016/j.jmwh.2007.03.010

Kileda, S. (2006). Risky business: contested knowledge over safe birthing services for Aboriginal women. *Health Sociology Review, 15*(4), 387-396.

King, M., Smith, A., & Gracey, M. (2009). Indigenous health part 2: The underlying causes of the health gap. *The Lancet, 374*(9683), 76-85.

Kitzinger, S. (2005). *The Politics of Birth.* London: Elsevier Ltd.

Kral, M., Arnakaq, M., Ekho, N., Kunuk, O., Ootoova, E., Papatsie, M., & Taparti, L. (2000). Suicide in Nunavut: Stories from Inuit Elders. In J. Oakes, R. Riewe, K. Koolage, L. Simpson & N. Schuster (Eds.), *Aboriginal Health, Identity and Resources* (pp. 34-44). Winnipeg: University of Manitoba.

Kral, M. J. & Idlout, L. (2009). Community Wellness and Social Action in the Canadian Arctic: Collective Agency as Subjective Well-Being. In L. J. Kirmayer & G. G. Valaskakis (Eds.), *Healing Traditions: The Mental Health of Aboriginal Peoples in Canada* (pp. 315-334). Vancouver: University of British Colombia Press.

Lalonde, A. B., Butt, C., & Bucio, A. (2009). Maternal Health in Canadian Aboriginal Communities: Challenges and Opportunities. *Journal of Obstetrics and Gynaecology Canada, 31*(10), 956-962.

Laugrand, F. B. & Oosten, J. G. (2010). *Inuit Shamanism and Christianity: Transitions and Transformations in the Twentieth Century.* Montreal & Kingston: McGill-Queen's University Press.

Lauson, S., McIntosh, S., Obed, N., Healey, G. Asuri, S., Osborne, G., & Arbour, L. (2011). The development of a comprehensive maternal-child health information system for Nunavut-Nutaqqavut (Our Children). *International Journal of Circumpolar Health, 70*(4), 363-372. doi: 10.3402/ijch.v70i4.17840

Lawford, K. & Giles, A. (2012). Marginalization and Coercion: Canada's Evacuation Policy for Pregnant First Nations Women who Live on Reserves in Rural and Remote Regions. *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health, 10*(3), 327-340.

Lawford, K. (2016). Locating Invisible Policies: Health Canada's Evacuation Policy as a Case Study. *Atlantis, 37.2*(2), 147-160.

Lemchuk-Favel, L. & Jock, R. (2004). Aboriginal Health Systems in Canada: Nine Case Studies. *Journal of Aboriginal Health, 1*(1), 28-51.

Link, B. G. & Phelan, J. (1995). Social Conditions as Fundamental Causes of Disease. *Journal of Health and Social Behaviour,* (Extra Issue), 80-94.

Luo, Z., Senécal, S., Simonet, F., Guimond, E., Penney, C., & Wilkins, R. (2010). Birth outcomes in the Inuit-inhabited areas of Canada. *Canadian Medical Association Journal, 182*(3), 235-242. doi: 10.1503/cmaj.082042

Luo, Z., Wilkins, R., Heaman, M., Smylie, J., Martens, P. J., McHugh, N. G. L., Labranche, E., . . . & Fraser, W. D. (2012). Birth outcomes and infant mortality among First Nations Inuit, and non-Indigenous women by northern versus southern residence, Quebec. *Journal of Epidemiology and Community Health, 66*(4), 328-333.

MacDonald, M. (2006). Expectations: Natural Bodies and Natural Births in the New Midwifery in Canada. *Anthropology Quarterly, 20*(2), 235-256.

MacDonald, M. (2007). *At Work in the Field of Birth: Midwifery Narratives of Nature, Tradition, and Home.* Nashville: Vanderbilt University Press.

Martin-Hill, D. (2003). *Traditional Medicine in Contemporary Contexts: Protecting and Respecting Indigenous Knowledge and Medicine.* National Aboriginal Health Organization. Retrieved from http://www.naho.ca/documents/naho/english/pdf/research_tradition.pdf

Martin-Hill, D. (2010). Traditional Medicine. *Journal of Aboriginal Health, 6*(1), 2-5.

Martin, D. H. (2012). Two-Eyed Seeing: A framework for understanding Indigenous and non-Indigenous approaches to Indigenous health research. *Canadian Journal of Nursing Research, 44*(2), 20-42.

Mikkonen, J. & Raphael, D. (2010). *Social Determinants of Health: The Canadian Facts.* Toronto: York University School of Health Policy and Management.

Moffitt, P. M. (2004). Colonization: A Health Determinant for Pregnant Dogrib Women. *Journal of Transcultural Nursing, 15*(4), 232-330. doi: 10.1177/1043659604268959

Møller, H. (2010). Tuberculosis and Colonialism: Current Tales about Tuberculosis and Colonialism in Nunavut. *Journal of Aboriginal Health, 6*(1), 38-48.

Morewood-Northrup, M. (1997). Community Birthing Project: Northwest Territories. In F. M. Shroff (Ed.) *The New Midwifery* (pp. 343-356). Toronto: Women's Press.

Mowbray, M. (2007). *Social determinants and Indigenous health: The International experience and its policy implications.* World Health Organization. Retrieved from http://www.who.int/social_determinants/resources/indigenous_health_adelaide_report_07.pdf

Murray Li, T. (2007). Governmentality. *Anthropologica, 49*(2), 274-281.

National Aboriginal Council of Midwives (2012). *History of NACM.* Retrieved from http://aboriginalmidwives.ca/about/history-of-nacm

National Aboriginal Council of Midwives. (2016). *The Landscape of Midwifery Care for Aboriginal Communities in Canada.* Retrieved from https://canadianmidwives.org/wp-content/uploads/2017/03/NACM_LandscapeReport_2016_REV_July18_LOW.pdf

National Aboriginal Council of Midwives. (2017). *Rooted in Our Past, Looking to Our Future.* Retrieved from https://canadianmidwives.org/wp-content/uploads/2017/03/NACM_SituationalAnalysis_2017_Low-resolution.pdf

National Aboriginal Council of Midwives. (n.d.). *Restoration and Renewal: Aboriginal Midwifery in Canada.* Retrieved from http://aboriginalmidwives.ca/sites/aboriginalmidwives.ca/files/pamphlet-three-double_panels.pdf

National Aboriginal Health Organization. (2004). *Midwifery and Aboriginal Midwifery in Canada.* Retrieved from http://www.naho.ca/documents/naho/english/publications/DP_aboriginal_midwifery.pdf

National Aboriginal Health Organization. (2006). *Exploring Models for Quality Maternity Care in First Nations and Inuit Communities: A Preliminary Needs Assessment.* Retrieved from http://www.naho.ca/documents/it/2006_Maternity_Care_Inuit.pdf

National Aboriginal Health Organization. (2008). *Celebrating Birth: Aboriginal Midwifery in Canada.* Retrieved from http://www.naho.ca/documents/naho/english/midwifery/celebratingBirth/Midwiferypaper_English.pdf

National Aboriginal Health Organization. (2009a). *A Case Study of the Irnisuksiiniq—Inuit Midwifery Network.* Retrieved from http://tools.hhr-rhs.ca/index.php?option=com_mtree&task=att_download&link_id=7774&cf_id=68&lang=en

National Aboriginal Health Organization (2009b). *Birthing Through First Nations Midwifery Care.* Retrieved from http://www.naho.ca/documents/fnc/english/Midwifery.pdf

National Collaborating Centre for Aboriginal Health. (2012). *The State of Knowledge of Aboriginal Health: A Review of Aboriginal Public Health in Canada.* Retrieved from https://www.ccnsa-nccah.ca/docs/context/RPT-StateKnowledgeReview-EN.pdf

O'Driscoll, T., Payne, L., Kelly, L., Cromarty, H., St. Pierre-Hansen, N., & Terry, C. (2010). Traditional First Nations Birthing Practices: Interviews with Elders in Northwestern Ontario. *Journal of Obstetrics and Gynaecology Canada, 33*(1), 24-29.

O'Driscoll, T., Kelly, L., Payne, L., St. Pierre-Hansen, N., Cromarty, H., Minty, B., & Linkewich, B. (2011). Delivery away from home: the perinatal experiences of First Nations women in northwestern Ontario. *Canadian Journal of Rural Medicine, 16*(4), 126-130.

Okalik, A. (1990). A Good Life. In M. Crnkovich (Ed),*"Gossip" A Spoken History of Women in the North* (pp. 3-9). Ottawa: Canadian Arctic Resources Committee.

Olson, R. (2015). Restoring the Connection: Aboriginal Midwifery and Relocation for Childbirth in First Nation Communities in Canada. In M. Unnithan-Kumar & S. K. Khanna (Eds.), *The Cultural Politics of Reproduction* (pp. 169-189). New York: Berghahn Books.

O'Neil, J. & Kaufert, P. A. (1990). The Politics of Obstetric Care: The Inuit Experience. In W. Penn Handwerker (Ed.), *Births and Power: Social Change and the Politics of Reproduction* (pp. 53-68). Boulder: Westview Press.

Paterson, S. (2011). (De)Constructing Midwives and Pregnant Women in Ontario, Canada. *Canadian Journal of Political Science, 44*(3), 483-505.

Paulette, L. (1990a). The Family Centred Maternity Care Project. In M. Crnkovich (Ed), *"Gossip" A Spoken History of Women in the North* (pp. 71-87). Ottawa: Canadian Arctic Resources Committee.

Paulette, L. (1990b). The Changing Experience of Childbirth in the Western N.W.T. In J. D. O'Neil & P. Gilbert (Eds.), *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives* (pp. 45-50). Winnipeg: University of Manitoba.

Phelan, J. C., Link, B. G., & Tehranifar, P. (2010). Social Conditions as Fundamental Causes of Health Inequalities: Policy Implications. *Journal of Health and Social Behaviour, 51*(Extra Issue), S28-S40. doi: 10.1177/0022146510383498

Prosen, M. & Tavčar Krajnc, M. (2013). Sociological Conceptualization of the Medicalization of Pregnancy and Childbirth: The Implications in Slovenia. *Revija za Sociologiju, 43*(3), 251-272. doi: 10.5613/rzs.43.3.3

Raphael, D. (2009). *Social Determinants of Health: Canadian Perspectives, 2nd Ed.* Toronto: Canadian Scholars' Press.

Rogers, S. (2014, June 23). Nunavut's oldest, newest birthing centres bring new life to Nunavut. *Nunatsiaq Online.* Retrieved from http://nunatsiaq.com/stories/article/65674nunavuts_oldest_and_newest_birthing_centres_bring_life_into_the_territ

Rutherdale, M. (Ed.) (2010). *Caregiving on the Periphery.* Montreal & Kingston: McGill-Queen's University Press.

Scott, D. (1995). Colonial Governmentality. *Social Text, 43,* 191-220.

Shah, C. P. (2004). The Health of Aboriginal Peoples. In D. Raphael (Ed.), *Social Determinants of Health: Canadian Perspectives* (pp. 267-280). Toronto: Canadian Scholars' Press.

Shaw, J. C. A. (2013). The Medicalization of Birth and Midwifery as Resistance. *Health Care for Women International, 34*(6), 522-536. doi: 10.1080/07399332.2012.736569

Shilliam, R. (2015). *The Black Pacific.* London: Bloomsbury Academic.

Shroff, F. M. (Ed.) (1997). *The New Midwifery: Reflections on Renaissance and Regulation.* Toronto: Women's Press.

Simpson, L. (2000a). Anishinaabe Ways of Knowing. In J. Oakes, R. Riewe, K. Koolage, L. Simpson & N. Schuster (Eds.), *Aboriginal Health, Identity and Resources* (pp. 165-185). Winnipeg: University of Manitoba.

Simpson, L. (2000b). Indigenous Knowledge and Western Science: Towards New Relationships for Change. In J. Oakes, R. Riewe, K. Koolage, L. Simpson & N. Schuster (Eds.), *Aboriginal Health, Identity and Resources* (pp. 186-195). Winnipeg: University of Manitoba.

Simonet, F., Wilkins, R., Labranche, E., Smylie, J., Heaman, M. Martens, P., Fraser, W. D., . . . & Luo, Z. (2009). Primary birthing attendants and birth outcomes in remote Inuit communities—a natural 'experiment' in Nunavik, Canada. *Journal of Epidemiology and Community Health, 63*(7), 546-551.

Skye, A. (2010). Aboriginal Midwifery: A Model for Change. *Journal of Aboriginal Health, 6*(1), 28-37.

Sled dog slaughter harmed Inuit, Quebec acknowledges. (2011, August 8). *CBC News Canada.* Retrieved from http://www.cbc.ca/news/canada/sled-dog-slaughter-harmed-inuit-quebec-acknowledges-1.992772

Smeenk, A. & ten Have, H. (2003). Medicalization and obstetric care: An analysis of developments in Dutch midwifery. *Medicine, Health Care and Philosophy, 6,* 153-165.

Smith, D. G. (1993). The emergence of 'Eskimo Status': An examination of the Eskimo disk list

system and its social consequences, 1925-1960. In N. Dyck & J. B. Waldram (Eds.) *Anthropology, Public Policy, and Native Peoples in Canada* (pp. 41-74). Montreal: McGill-Queen's University Press.

Smith, D., Varcoe, C. & Edwards, N. (2005). Turning Around the Intergenerational Impact of Residential Schools on Aboriginal People: Implications for Health Policy and Practice. *Canadian Journal of Nursing Research, 37*(4), 38-60.

Smylie, J. (2009). The Health of Aboriginal Peoples. In D. Raphael (Ed.) *Social Determinants of Health: Canadian Perspectives, 2nd Ed.* (pp. 280-301). Toronto: Canadian Scholars' Press Inc.

Society of Obstetricians and Gynaecologists of Canada. (2010). SOGC Policy Statement: Returning Birth to Aboriginal, Rural, and Remote Communities. *Journal of Obstetrics and Gynaecology Canada, 32*(12), 1186-1188.

Steenbeek, A., Tyndall, M., Rothenberg, R., & Sheps, S. (2006). Determinants of sexually transmitted infections among Canadian Inuit adolescent populations. *Public Health Nursing (Boston, Mass.), 23*(6), 531-534.

Stonier, J. (1990). The Inuulitsivik Maternity. In J. D. O'Neil & P. Gilbert (Eds.), *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives* (pp. 61-74). Winnipeg: University of Manitoba.

Strohschein, L. & Weitz, R. (2014). *The Sociology of Health, Illness, and Health Care in Canada: A Critical Approach.* Toronto: Nelson Education.

Tedford Gold, S., O'Neil, J., & Van Wagner, V. (2005). *Examining Midwifery-based Options to Improve Continuity of Maternity Care Services in Remote Nunavut Communities.* Canadian Health Services Research Foundation. Retrieved from http://www.cfhi-fcass.ca/SearchResultsNews/05-03-01/70b861bd-b67a-421b-af31-e4eaa806ddd7.aspx

Tester, F. J. & McNicoll, P. (2006). Why Don't they Get It? Talk of Medicine as Science. St Luke's Hospital, Panniqtuuq, Baffin Island. *Social History of Medicine, 19*(1), 87-106.

Truth and Reconciliation Commission of Canada. (2015). *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada.* Retrieved from http://www.trc.ca/websites/trcinstitution/File/2015/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf

Tuhiwai Smith, L. (1999). *Decolonizing Methodologies: Research and Indigenous Peoples.* London: Zed Books.

United Nations. (2009). *State of the World's Indigenous Peoples.* New York: United Nations. Retrieved from http://www.un.org/esa/socdev/unpfii/documents/SOWIP/en/SOWIP_web.pdf

Van Wagner, V., Epoo, B., Nastapoka, J., & Harney, E. (2007). Reclaiming Birth, Health, and Community: Midwifery in the Inuit Villages of Nunavik, Canada. *Journal of Midwifery & Women's Health, 52*(4), 384-391. doi: 10.1016/j.jmwh.2007.03.025

Waldram, J. B., Herring, D. A., & Kue Young, T. (2006). *Aboriginal health in Canada: Historical, Cultural, and Epidemiological Perspectives.* Toronto: University of Toronto Press.

Waldron, I. (2010). The Marginalization of African Indigenous Healing Traditions within Western Medicine: Reconciling Ideological Tensions & Contradictions along the Epistemological Terrain. *Women's Health and Urban Life: An International and Interdisciplinary Journal, 9*(1), 50-71.

Waugh, E. H., Szafran, O. & Crutcher, R. A. (Eds.) (2011). *At the Interface of Culture and Medicine.* Edmonton: University of Alberta Press.

Williams, S. J. & Calnan, M. (1996). The 'Limits' of Medicalization?: Modern Medicine and the Lay Populace in 'Late' Modernity. *Social Science & Medicine, 42*(12), 1609-1620.

World Health Organization. (2018). *Social Determinants of Health.* Retrieved from http://www.who.int/social_determinants/sdh_definition/en/