The Innuulisivik Maternity Centre: Issues Around the Return of Inuit Midwifery and Birth to Povungnituk, Quebec

by Christopher Fletcher

Paper prepared as part of the
Research Program of the
Royal Commission
on Aboriginal Peoples

September 1994

Contents

Tables and Figures

Executive Summary

Seen from several perspectives, the Innuulisivik Maternity Centre provides medically responsive and responsible care in a culturally relevant way at the regional level. Clients of the Maternity Centre enjoy and appreciate the opportunity to give birth in their own region, although there is a feeling that low-risk pregnancies could be well accommodated in the community CLSCs (nursing stations). Inuit midwives and midwives in training face a rigorous training regime that is made more complicated by a lack of consistent funding for training material development and the extra demands on the time of midwives to provide education. Midwives in training first become maternity workers, responsible for infant and maternal care in the Maternity Centre and, if they have the interest and the ability, they enter training for midwifery. This system provides the only area in the hospital where Inuit employees can advance systematically from one position of responsibility to another.

The historical origins of the Maternity Centre are particular to the Nunavik region. Until the 1950s all births were assisted by traditional birth attendants. As nursing stations were built and permanent communities developed, foreign-trained nurse-midwives began to take on responsibility for birth assistance, often with the aid of traditional birth attendants. In the early 1970s federal health administrators decided that all births involving women from Hudson Bay coast communities should take place in a hospital milieu – in most cases, in Moose Factory, Ontario. While this policy reflected the medical ideology of the time and was perceived as the best option for women of the region, it produced individual, community and cultural stress and was implemented without consultation in the region. Women interviewed felt that the evacuation policy caused cultural deterioration, put existing children at risk during their mother's evacuation period, reduced family integrity, isolated mothers from their families during a critical period, and caused loneliness and sadness at what would otherwise be a time of happiness. The ethnographic accounts of childbirth practices and beliefs confirm that women isolated from their families and communities experience a form of coercive acculturation into western practices through the medical system. From this perspective the

evacuation of pregnant women can be seen within a larger context of assimilation as official policy toward Aboriginal peoples.

Dissatisfaction with this system among Inuit of the Hudson Bay region and a developing sense of the role of community-based health initiatives in provincial circles were the most significant factors in the successful planning and implementation of the Maternity Centre in Povungnituk. A cadre of politically astute Inuit women and non-Inuit health care providers and administrators, backed by regional consensus formed through community consultation, advanced the idea of the Maternity Centre and assured its development. This occurred despite official opposition by the physicians' union in the south. The Povungnituk Maternity Centre has been a catalyst for change, although that change has been slow in coming, in provincial law regarding midwifery. Midwifery pilot projects, supported in legislation by the province, have provided some movement toward recognition of the practice as a safe and viable alternative to physician-assisted birth. There is some possibility that, should midwifery be officially supported by the provincial government, norms in education and training implemented at the provincial level could complicate the training process in place in Povungnituk. Historically, cultural and linguistic differences have acted to exclude many Aboriginal people from a variety of careers where universal certification is imposed; this potentially could be the case with midwifery if provincial norms are instituted without considering the unique aspects of the northern Aboriginal milieu.

An important success of the Maternity Centre is the provision of culturally relevant and informed perinatal and maternal health education programs. Numerous maternal health indicators reviewed in the report show that clients are well served by the Maternity Centre approach and that these programs are being received and understood by the population. The Maternity Centre has developed expertise in providing culturally specific education and counselling programs to deal with nutritional deficiencies, STDs, toxoplasmosis, anemia and other health problems common in the population that present unique risks to pregnant women and the fetus. The pregnancy risk screening process used at the Innuulisivik Maternity Centre to identify clients in need of specialized medical care not available in the region clearly works. Situations requiring emergency procedures and/or medical evacuation of women in labour, unforeseen in the screening process, occur at a rate similar to that of other Arctic and

southern regions, indicating that the process in place accommodates the maximum predictability of pregnancy.

Ultimately the Innuulisivik Maternity Centre is a laboratory in which two different cultural perspectives on pregnancy and birth meet. A hybrid form of health care service delivery is evolving in which both culture groups provide differing perspectives. The Maternity Centre provides a model for co-operative management of health care that redresses perceived injustices of the past and contributes to a larger process of social and cultural renewal as well as the reacquisition of political power. The following recommendations are made based on the evaluation of the Innuulisivik Maternity Centre:

1. Health, illness and disease are culturally modulated elements of any ethnic or cultural group. Development of culturally relevant health services in Aboriginal communities should be considered as part of a larger process of cultural revitalization and renewal that is based on the reacquisition of control within those communities.
2. Community health efforts are best initiated and produce measurable results when the community or region controls and determines the shape and types of services to be developed.
3. Paramedical health careers should be encouraged for young Aboriginal people as a way of maintaining and strengthening cultural and social links while earning a living in a position of respect within their communities. Significant efforts have been made over the years to encourage Aboriginal youth toward professional health careers, with varying success. More emphasis on paramedical careers would encourage the development of a medically astute cadre from which doctors and nurses would emerge over time.
4. Culture-specific health knowledge and beliefs should be recognized as valid and become integral to health service philosophy in Aboriginal communities.
5. Improvements in community health take time, and health care planning should be long-term with specific goals determined through consultation with community members, professionals and paraprofessionals. Review of progress toward these goals should occur regularly with the same individuals.

6. Historical origins of chronic health problems should be examined and addressed in order to avoid repeating cycles of illness.
7. Midwifery should be recognized and promoted as a health career opportunity in Aboriginal communities.
8. Obstacles to the legitimization of Aboriginal approaches to health care should be removed where there are no demonstrable negative effects of those approaches (for example, healing circles).
9. Non-Aboriginal health care workers and traditional healers or other knowledgeable people should be encouraged to inform and learn from each other.
10. Opportunity for advancement within existing health care systems in Aboriginal communities should be encouraged for non-professional and para-medical personnel as a way to encourage effective participation in health care delivery and discourage high turnover rates.
11. Non-Aboriginal medical personnel should be given instruction in local Aboriginal culture, where possible, to improve their comprehension of local issues and perspectives and to discourage self-isolation within the community.
12. Part of the selection criteria for incoming non-Aboriginal medical personnel should be a demonstrable and sincere interest in promoting local health care initiatives and an awareness of the role of culture in determining health outcomes.
13. Maternal and infant health programs should be developed with culturally appropriate materials and approaches.
14. A research program focusing on Nunavik Inuit traditional birth techniques, beliefs and practices should be established. This program should include a comprehensive diffusion plan so that all community members may benefit and learn from the research. The research program should include opportunities for people from different age groups and cultures to share perspectives and knowledge.
15. Efforts should be made to have the Innuulisivik health centre designated as a teaching institution. This would, at least partially, relieve the chronic education funding problems in the Maternity Centre.

The Innuulisivik Maternity Centre: Issues Around the Return of Inuit Midwifery and Birth to Povungnituk, Quebec

by Christopher Fletcher

Introduction

There is perhaps no more fundamental issue to any people than birth. Three-quarters of the world's children are delivered by midwives outside of medical establishments. The culture-specific methods and experiences of birth and, in particular, the role of traditional birth attendants[1] have been the subject of research for some time. Comparative cross-cultural studies by researchers interested in pregnancy, birth and infant care — often with the goal of uncovering fundamental human behaviours common to all peoples (Mead and Newton 1967; Ford 1945; Jelliffe and Bennett 1962) — have given way in recent years to studies of the experiential nature of the same events in different cultures (cf. Jordan 1983; Hassan 1980; Dufour 1988). Studies that have sought to examine the interrelationship between western approaches to 'proper' birth methods and those of cultures in which those methods are relatively new and foreign, particularly among Aboriginal peoples in Canada, are few. (Kaufert et al. 1988; O'Neil and Gilbert 1990; Kaufert and O'Neil 1990; O'Neil, Kaufert and Postl 1990) There is a comparatively large literature concerning the feminist perspective on western birth practices and a literature concerned with alternative birthing methods. This study examines the reintroduction of Inuit midwifery, within a regional perinatal health program, into Inuit communities in the Hudson Bay region of Quebec. We examine the social, cultural and historical importance of Inuit midwifery within a southern-style medical centre and the strengths and difficulties experienced in the development of this program. A broad multidisciplinary approach is used to examine issues around birth from different perspectives.

In Canada most pregnancies were assisted by a traditional birth attendant or midwife until around the turn of the century. At that time there began a progressive medicalization of birth in urban centres. In rural areas few births were attended by physicians until some time later. In 'remote' areas, such as the Inuit-occupied portions of Canada, traditional birth

attendants practised until very recently and indeed still do on occasion. In all these areas responsibility for assisting normal healthy deliveries was transferred eventually from traditional birth attendants to foreign midwives to doctors. With this transfer of responsibility, the birth process was transformed from a societal event into a medical one. The medicalization of birth was a single aspect of a larger process by which medical services were initiated in these regions. These services were extended on the basis of the genuine need of people facing epidemic diseases for which they had little resistance and no remedies.

The initiation of medical services began a process that has seen an ever increasing importance of government in most aspects of the lives of Inuit. A theoretical perspective useful in interpreting these events is that of 'governmentality', whereby an *a priori* need of the western medical system is the ability to 'govern' its clientele in the broad sense, as an extension of the larger state apparatus; that is, because the medical services offered are an extension of the government, to receive those services is also to be governed. It is a process that at once creates a self-sustaining need to govern further and also reduces the group to identical atomistic elements based on the accumulation of 'facts' about them. (See Smith 1993 for an example of this type of analysis.)

In Povungnituk, all births were assisted by traditional birth attendants until the 1950s. At that time the Canadian government began to extend medical services to the Inuit through nursing stations in the newly established communities. Nurse-midwives (often from England) were engaged and began to assist women in delivering at nursing stations. In the early 1970s health administrators decided on a policy of evacuating all pregnant women on the Hudson Bay coast from their communities, usually to facilities in Moose Factory, Ontario. While motivated by a desire to provide the most up to date medical procedures for Aboriginal populations, this unilateral decision had a number of negative repercussions on the families affected and was seen universally by the Inuit as an unacceptable arrangement. When planning began in the 1980s for a new regional health centre in Povungnituk, local women's organizations and health care planners from the south began to assess the overall medical needs of the population and to look for better solutions to the issue of birthing and the participation of Inuit in the process. The concerns of local women mirrored an evolving philosophy in some circles that health services in Aboriginal communities should reflect

values associated with their cultures and should empower local people to take control of the services in their communities. From this grassroots movement was born the Innuulisivik Maternity Centre, where the vast majority of Inuit women living in Hudson Bay communities now give birth with the help of Inuit midwives and midwives in training. This is a unique arrangement in Canada and presents an example that could be adopted or adapted by other Aboriginal communities in the country.

This document represents a synthesis of a great deal of information collected about the Maternity Centre and about the cultural construction of pregnancy and birth. The information is presented in a way that highlights the questions and concerns of the community members who participated in the research. Most of the information was collected while the author was in Povungnituk under the auspices of the Royal Commission on Aboriginal Peoples, although some complementary information comes from previous research conducted with funding from different granting agencies and organizations.[2]

Data Collected

The research for this study was conducted in a manner consistent with the community-based research mandate and the ethical guidelines of the Royal Commission on Aboriginal Peoples. Local participation in the form of research assistance, community co-ordination, research direction and results verification was of paramount importance.

Interviews were conducted in June 1993 with all available medical, paramedical and Maternity Centre staff to gather perceptions on the functioning of the health centre and the Maternity Centre and on the interaction between the indigenous and non-indigenous culture. People of all age groups from outside the health centre were also interviewed on a wide variety of subjects related to the Maternity Centre and the history of birth policy as it affected them. Documentation from the health centre and other sources was collected and analyzed.

Priority areas were identified and detailed interviews conducted on these subjects. Consultation with project co-ordinators identified areas of interest that had not yet been subject to examination. Of particular importance to community members involved in this project was documenting beliefs and practices around pregnancy and birth specific to Inuit culture.

The Region and Its History

The Inuit occupy a vast territory, touching four countries: the former Soviet Union, the United States (Alaska), the entire northern portion of Canada and most of coastal Greenland. The Inuit language is remarkably homogenous, with relatively little dialectical variation across the territory. In Quebec and Labrador the Inuit formerly occupied all coastal regions from northern James Bay to the Strait of Belle-Isle in the Gulf of St. Lawrence. Among the Inuit in Quebec three regional groups were, and still are, recognized: the *Siqinirmiut*, who occupy the coast of Ungava Bay, the *Taqramiut*, who occupy the coast of Hudson Strait, and the *Itivimiut*, who occupy the Hudson Bay coast. (Dorais 1983) The *Qikiqtamiut*, a subgroup of the *Itivimiut*, occupy the Belcher Islands, part of the Northwest Territories. Before the 1930s several Inuit family groups occupied the interior more frequently than the coast and were called the *Nanamiut*. (Vézinet 1980) The term *Kupaimiut* Inuit is now used to designate Inuit from Quebec. Since the signing of the James Bay and Northern Quebec Agreement (JBNQA) the entire Inuit territory north of the 55th parallel is called Nunavik.[3]

Archaeology

The ancestors of the Inuit migrated initially from Siberia and Alaska, about 4500 years ago. In a few centuries these groups managed to occupy the entire Canadian Arctic to the coast of Labrador. The Hudson Bay, Hudson Strait, and Ungava Bay coasts were occupied continuously from that time until the arrival of Europeans. Three different periods of human occupation have been identified based on material remains: Pre-Dorset, Dorset and Thule. Pre-Dorset groups seem to have had a mixed economy based equally on inland and coastal resources. Later Dorset and Thule groups concentrated on marine resources, developing aquatic transportation and hunting techniques that permitted open-sea hunting of whales and other marine mammals. The technological evolution of these groups demonstrates an increasing adaptation to, and dependence on, marine resources. (McGhee 1978)

The first contacts between Aboriginal people in North America and Europeans date to around the year 1000 AD, when the Norse occupied the coast of Greenland and met Labrador Inuit on their westward excursions. Extensive contacts did not occur until the seventeenth

century in the southern portion of James Bay, the eighteenth century in Hudson Bay, and later in Ungava Bay. (Cooke and Holland 1978) The influence of whaling on the history of Inuit groups in Arctic Quebec is not particularly prominent, as the prevailing currents encouraged wind-powered boats away from the Quebec coast, and treacherous shoals further discouraged exploitation of these regions.

The Historical Period (1600-1900)

In 1611 Captain Henry Hudson became the first European to arrive by sea in James Bay. He was followed by Captain Thomas James in 1631. Only Hudson encountered Indians; no mention of Inuit is made. The Hudson's Bay Company (HBC) started operations in 1670 and was established the same year at Fort Charles (Waskaganish) in Cree territory. Between the battles of the French and English, the operations of the HBC and other companies expanded inland and northward to the Great Whale River. In the first half of the eighteenth century, exploration of the Hudson Bay coast permitted the HBC to identify potential sites for posts. In 1750 the company built the first post on Hudson Bay on Cairn Island, in Richmond Gulf. The post was closed in 1759 because of poor returns. Contact with the Inuit was very limited at this time, although there were a number meetings with unfortunate consequences for Inuit and Europeans alike. (Francis 1979) It was not until the end of the eighteenth and the beginning of the nineteenth century that more permanent trading posts were established in the Hudson and Ungava Bay regions. In the northern portion of Hudson Bay it was not until the end of the nineteenth century that posts were established in Inuit-occupied territory.

The arrival of Europeans introduced epidemic diseases to which the Aboriginal populations had no immunity. Many families fell victim to epidemics, even though nomadism accorded some protection from contact. Periods of famine became frequent over the nineteenth century, further weakening the population. The lowest recorded population levels of Inuit in northern Quebec occurred between 1880 and 1920, when caribou populations decreased in the province and other northern regions around the world. (Graburn 1969) Other animal species also experienced population decline during this period, leading to numerous deaths among the Inuit. It became essential at this point for the traders and missionaries to

offer humanitarian relief in the form of food, as the Inuit population was no longer able to be self-sufficient.

The Recent Past (1900-1950)

The turn of the century marked the beginning of the evolution of the contemporary Inuit community in northern Quebec. Several unrelated events acted to change the lives and lifestyles of the Aboriginal populations. This period is characterized by the reduction of Inuit independence and autonomy, with a corresponding development of dependency on foreign-manufactured goods and government services. Following preliminary exploratory expeditions in the late 1800s, (Payne 1899; Bell 1885; Gordon 1887) which constituted the first sustained contacts between Inuit and southern Canadians in these regions, (Fletcher 1992) the Ungava Peninsula (Quebec north of the 55th parallel) and the interior James Bay lowlands were effectively claimed by the federal government as Canadian territory. Missionaries and traders established permanent dwellings, often in the same areas. In 1898 the boundary of Quebec was extended to include the portion of James Bay south of the Eastmain River to its head waters, and in 1912 the boundaries were extended again to include the entire Ungava peninsula, with the exception of Labrador. Despite the boundary extension, the provincial government did not have any real presence in northern Quebec until the 1960s.

The years 1903-04 marked the first Canadian Arctic patrol into eastern Hudson Bay for the explicit purpose of asserting sovereignty and establishing customs houses to deal with fur shipments to Europe. The Canadian Arctic Patrol would become an annual visitor in the North and establish the first relationship between the federal government and the Inuit of the region.

In the early 1900s the Hudson Bay Company began extending its network of trading posts northward from James Bay, southern Hudson Bay and the bottom of Ungava Bay. This was done partly to encourage the Inuit to participate more fully in the fur business – an effort to exploit the good market for fox fur – and partly to ward off competition from independent traders and from Revillon Frères. The First World War interrupted the commercial war and made supplying the posts difficult.

At the same time as the HBC was expanding, a generalized game shortage set in. The annual autumn/early winter inland caribou hunt by the Inuit became more efficient in the 1920s with the widespread diffusion of guns and repeating rifles, yet fewer and fewer caribou were available. (Audet 1979) By the 1930s caribou were rarely seen on the Hudson coast and were scarce in the interior. The HBC traders, whose posts were inundated with starving and ill Inuit, were forced to extend credit and could not recover loans from previous years. The growing missionary presence in the North also began taking on the responsibilities of social relief and medicine, although their own resources were limited. Despite all the changes, traditional activities and knowledge remained necessary to maintain the Inuit population.

The beginning of the Second World War was a disastrous time for the northern Aboriginal peoples, as fur demand plummeted, making catches, even in good years, almost without value. The HBC closed some posts to reduce losses and, in the posts that remained, goods were scarce. In particular, ammunition and other metal equipment, on which the Inuit were now entirely dependent, were hard to get. Large numbers of people began concentrating at, or near, the remaining posts and missions in the summer. They were encouraged by the possibilities of social relief and wage labour in the settlement and on the annual ship visit.

The missionary presence

The movement to convert Quebec Inuit began in the 1880s at Great Whale River with the establishment of a mission by Reverend E.J. Peck, an Anglican. While religious instruction and conversion took place in trading posts, tents and igloos, it was not until 1927 that a permanent mission was established north of Great Whale River, at Port Harrison, now known as Inukjuak. (Duhaime 1985) Other Hudson Bay coast missions were opened at Ivujivik in the early 1930s and at Richmond Gulf in the 1940s. The missions offered some medical services, education and relief for the destitute, which was increasingly necessary in the first half of the twentieth century. Until the 1940s, the church and, in some cases the HBC, were responsible for delivering government services in the region. The government subsidized mission education programs and supplied medical basics; both were very modest in scale. Informants in Povungnituk and other communities state that missionaries did not participate in delivering babies, as there were capable Inuit midwives in the communities.

Medical services

Missionary and trader reports at the turn of the century that disease was widespread prompted the government to include medical personnel on board the annual supply ship. In the early 1900s the annual Canadian Arctic Patrol vessel landed goods in the short ice-free season and usually carried out limited medical surveys and collected census data from the Aboriginal populations. (Vanast 1991) In 1922 the Eastern Arctic Patrol was established as the annual supply and scientific vessel. Medical personnel were authorized to evacuate the chronically ill to sanatoriums in the south, and increasing numbers of people were removed each year. Epidemic diseases such as smallpox, tuberculosis and measles were widespread from the 1930s well into the 1950s. This resulted in part from increased contact with non-Aboriginal people and in part from poor food supplies.

The medical visits encouraged people to concentrate around the developing settlements in the summer and also prevented their dispersal in the fall. People interviewed described waiting for the ship with a mixture of apprehension and excitement. It was possible that relatives returning from hospitalization in the south would be on the ship, but it was also likely that more members of the community would be evacuated because of illness. Duhaime (1985) estimates that at one point in some communities, one person in seven was evacuated. The increasing numbers of semi-permanent residents around the posts encouraged the extension of social assistance benefits on a par with those received in the south, particularly to families with one or more members being treated in the south, as well as to widows and the infirm.

The introduction of formalized medical services was a direct result of the new awareness brought about by regularized contacts between the Inuit and southerners. (Jenness 1964) A hospital established at Moose Factory on the Ontario side of James Bay was the staging ground for the first formalized services on the Quebec side of James Bay and Hudson Bay. In the 1940s the first systematic epidemiological studies in Aboriginal communities in James Bay and Hudson Bay were undertaken from the Moose Factory hospital. Social assistance payments and programs to eradicate tuberculosis had some success in reducing infant mortality.

The Contemporary Period (1950-Present)

The late 1940s and early 1950s saw a renewal of the sovereignty issue in the North, this time in a cold war context. A Distant Early Warning (DEW) station built in the 1940s at Fort Chimo was followed by construction of a radar control base, as part of the Mid-Canada Line, by the American and Canadian armies in 1955 at Great Whale River. The construction and operation of these bases provided the first regular wage labour in the North outside of trapping and seasonal employment at the trading posts. The greater visibility of the poor living conditions and dismal health record of Aboriginal populations, coupled with the developing role of government as a provider of social relief, encouraged the federal government to extend further services to the Inuit. Nursing stations were opened in several communities, and universal social assistance programs were extended to the Inuit. (Jenness 1964) These events marked the first sustained contact between government employees and the Inuit. The prevailing philosophy at this early stage in the contemporary period, on the part of the federal government, was cultural assimilation. Bureaucratic functioning demanded that each individual be associated with a community even if they were still living a traditional lifestyle. Federal day schools were built in many communities in an effort to harmonize Aboriginal education with Canadian standards.

The missionaries were gradually relieved of responsibility for education and health services and saw their influence in the communities reduced to some extent as a result. The communities were recognized as such, and municipal infrastructure began to be installed. Of primary importance was the facilitation of travel. Landing strips capable of handling small aircraft were quickly constructed. It was eventually realized that many of the chronic health problems experienced by Aboriginal populations were a result of poor living conditions. In an effort to improve conditions the government adopted a program of supplying prefabricated plywood housing with the intention of selling the dwellings to the Inuit at low prices over long periods of time. These houses, the now infamous 'matchboxes', while an improvement, posed new sanitary and health problems in the growing communities. These have since been replaced with modern, well constructed buildings administered by regional authorities. Overcrowding, and its health repercussions, have been reduced, although a high rate of

population growth has made it difficult to keep pace with the demand for new housing. Very few of the matchbox-type houses are still inhabited in Nunavik.

Also of importance in the early 1950s was the dawning realization in provincial political circles of the resource and hydroelectric potential of northern Quebec. In this period plans were developed for iron ore extraction near Fort Chimo, mining at Cape Hopes Advance, asbestos mining inland from Wakeham Bay (Kangiqsujuaq), and developing the hydroelectric potential of the Arnaud and Leaf Rivers. (Saladin d'Anglure 1984b) Few of the plans have come to fruition, with the exception of an asbestos mine near Wakeham Bay. They did, however, mark the turning point in the provincial government's interest in the region, culminating with present-day hydroelectric development of the major drainage basins of Great Whale River south to the bottom of James Bay.

The Contemporary Inuit Community

Today there are 14 Inuit communities in Nunavik (see Figure 1), with populations ranging from about 200 to 1200. (MSSS 1994) While all people live in a community, numerous locations around the coast and inland are used for varying amounts of time throughout the year as hunting and fishing camps. Residency in these camps fluctuates with the season and the availability of game. The length of stay can vary from a single day to several months, with occasional trips to town for supplies. The communities themselves are the centre from which land use activities radiate.

All communities have elementary schools and most have high schools administered by the Kativik School Board. These schools have some Inuit teachers and centre directors. Instruction is in Inuktitut until the second or third grade, after which it is in Inuktitut and English or French.

Each community has a nursing station with two or three nurses on staff. Kuujjuaq and Povungnituk have primary care hospitals, Inukjuak and Salluit have a resident physician, also working in the nursing station. For health services that cannot be provided in the communities or the regional health centres, patients are referred to Montreal. Some specialists make semi-annual trips to the communities and act as consultants while in the south.

Demography

The total Nunavik Inuit population in 1989 was 6,342 (KRG 1991) which, at an annual growth rate of 31/1,000 (Proulx 1988), would give a current population of about 7,500. The population of the Hudson Bay region served by the Innuulisivik health centre was 3,688 in 1987 (Proulx 1988) and is today closer to 4,500. The distribution by age of the entire Nunavik Inuit population is shown in Figure 2. People under 20 years of age make up 50 per cent of the population, while those over 60 account for 4 per cent.

Inuit Political Development

The co-operative movement, initiated in Povungnituk, was the first political expression of the Inuit in their relations with the Canadian government and society at large. The genesis of contemporary political activity in Inuit communities was the beginning of construction on the La Grande hydroelectric complex in the mid-1970s. While originally no negotiations took place before the project was started, a court injunction stopping work began the consultation process. The Northern Quebec Inuit Association (NQIA) represented Inuit interests in negotiations leading to the signing of the James Bay and Northern Quebec Agreement. Political authority was subsequently transferred from the NQIA to the Makivik Corporation. The JBNQA and subsequent agreements radically altered the political landscape of the North.

The Co-operative Movement

Although the first co-operative was formed at Kangiqsualujjuaq on the Ungava coast through the initiative of the federal government, the Povungnituk region is generally recognized as the place of origin of the indigenous co-operative movement among the Inuit. It grew out of carvers' societies encouraged by a former HBC manager and Oblate missionary, Father Steinman, which themselves grew out of the need to have tradable goods. (Steinman 1977) The indigenous co-operative movement was also a reaction against increasing welfare dependency and perceived bureaucratic waste in government. Community enthusiasm quickly made this novel form of co-operative highly profitable and spawned a growing political movement across the Arctic.

Figure 1
The Nunavik Region

Figure 2
Nunavik Population Profile

When the Neville-Robitaille Commission on federal-provincial jurisdiction transfer negotiations failed, the co-operative movement proposed establishing a regional government with limited autonomy. Viewed favourably in Quebec City, the idea was quashed by the federal government, which supported the establishment of the NQIA. (Saladin d'Anglure 1984b) The NQIA, created to represent Quebec's Inuit population, was recognized by the Société de Développement de la Baie James (SDBJ) under provincial mandate as the sole representative of Quebec Inuit in the negotiations surrounding the La Grande hydroelectric project. This ended, at least temporarily, the co-operative movement's role as political representative of the Inuit. The communities of Povungnituk, Ivujivik and half of Salluit formed the Inuit Tungavingat Nunami (ITN) to represent their interests and never recognized the NQIA as representing them. Povungnituk and Ivujivik have unextinguished land title around their communities (the situation with Salluit is complicated) and are known collectively as dissident communities. The co-operatives themselves live on primarily as commercial interests in all Inuit communities. They sell food and supplies in the communities and market carvings, artwork and animal products in the south.

The James Bay and Northern Quebec Agreement

Following extended negotiations, the Grand Council of the Crees, the Northern Quebec Inuit Association, and the federal and provincial governments signed the James Bay and Northern Quebec Agreement in 1975. (Quebec et al. 1980) The JBNQA has been the single most important element in defining the contemporary political life of the Inuit, in terms of both their relationship with the state and internally. The agreement contains provisions regarding land regimes, local government, environmental protection, health, education and justice. Entire communities have risen from the pages of the JBNQA, as has an administrative social class of Inuit.

With the signing of the JBNQA the Inuit elected to transfer all federal responsibility to the provincial government. The Inuit and Cree of Quebec were the first Aboriginal groups to sever the traditional linkage to federally supplied health care services. Each Inuit community is an independent municipal corporation with the same status as other Quebec municipalities. An elected mayor and community council administer the community resources and budget.

The community council of each municipality appoints a representative to the Kativik Regional Government (KRG). Based in Kuujjuaq, the KRG administers all activities in the territory north of the 55th parallel under the terms of the JBNQA. The Nunavik territory is subdivided into two administrative regions, one incorporating the six Hudson coast communities: Kuujjuaraapik, Umiujaq, Inukjuak, Povungnituk, Akulivik, Ivujivik, and Salluit on the Hudson Strait. The other includes the remaining eight Hudson Strait and Ungava Bay communities (Kangiqsualujuaq, Kuujjuaq, Tasiujaq, Aupaluk, Kangirsuk, Qoaqtaq, Kangiqsujuaq). The KRG also has regional authority over health, education, justice and employment. Its budget for these activities is supplied by the appropriate provincial or federal ministry. The Kativik Health and Social Services Council (KHSSC, more commonly known under its French acronym KCRSSS), under KRG jurisdiction, administers the two health centres in the Nunavik territory and the nursing stations in each community.

The Innuulisivik Health Centre

Povungnituk is the location of the Centre Hospitalier de la Baie d'Hudson, Innuulisivik Health Centre, and as such is the medical administrative centre for the eight Hudson Bay communities. All primary medical treatment not available from nursing stations in each community is undertaken at the CHBH. The community has a core of people who have considerable experience in dealing with the western medical system and its associated researchers. These include administrators, committee members, midwives, interpreters, translators and other professional and para-professional staff. The health centre is a product of the James Bay and Northern Quebec Agreement (1976) and as such has a unique administrative structure that assures local indigenous control of the health centre and its resources. The concentration of medical and para-medical personnel, Inuit and non-Inuit, makes it a particularly interesting centre for the study of intercultural organization of health services.

The hospital was established at a time when new approaches to community health were being developed and debated in the south. A movement away from the medicalization of birth was occurring and the pending construction of the Innuulisivik health centre provided an opportunity to put in place a system significantly different from the status quo. The lessons

gathered from the old federal system of health services in Moose Factory and Kuujjuaq were studied and a different philosophy adopted in Povungnituk.

Health Centre Structure

The Innuulisivik health centre is a 25-bed facility (4 are in the Maternity Centre) offering a range of first line medical services: general medicine, pediatrics, emergency medicine, obstetrics, gynaecology, radiology, dentistry, audiology and outpatient clinic as well as some chronic care services. Also contained in the same building are the department of social services, the Maternity Centre and the CLSC (nursing station) as well as general stores, the blood bank, laboratory, pharmacy, cafeteria and offices for administrative, finance and training personnel. There are no facilities for ultrasound, general anesthesia or surgery (except some dental). Patients requiring services not offered are referred to institutions in Montreal and are transported on regularly scheduled flights or by medevac in emergencies.

Employees of the health centre are unionized under a general agreement with the Confédération des Syndicats Nationaux (CSN), with the exception of the nurses and midwives, who are represented by the Fédération des infirmiers et infirmières du Quebec (FIIQ). The administrative structure of the health centre is shown in Figure 3. The Council of Doctors, Dentists, Pharmacists and Midwives (CDDPMW) is a professional management committee responsible for maintaining and regulating the quality of care, protocols, policies and orientation of professional services offered by the establishment. It has an advisory role to the board of directors and functions the same as in all other Quebec health care institutions, except that in this case the health centre decided to include midwives in the group. In 1987 the Innuulisivik had 131 full-time employees (some working in nursing stations in other Hudson Bay communities), of which 48 per cent were Inuit. In the space of five years this profile has changed significantly. In a recent evaluation of training and staffing needs (Innuulisivik 1992) 112 positions were filled by Inuit and 62 by non-Inuit, excluding physicians.

The Innuulisivik Maternity Centre

For the Inuit of the Hudson Bay region of Nunavik, medical intervention in birth began in the 1950s with the introduction of nursing stations staffed with foreign (usually British) nurse-midwives who assisted in births that occurred in the community. In the early 1970s the nurse-midwives were replaced by a policy of evacuating all pregnant women to Moose Factory, Ontario or, occasionally, Quebec City or Montreal to give birth. In the early 1980s planning began on a new regional health centre in Povungnituk. At the insistence of local and regional women's organizations, in conjunction with a guiding philosophy of community-centred and -directed health services, a birth facility was integrated into the health centre structure. The Innuulisivik Maternity Centre, as it is now called, is the only centre in Quebec offering midwife-assisted births. It is even more remarkable for other reasons: the role it has had in training Inuit women to be midwives; for delivering culturally relevant ante- and post-natal health care appropriate to the northern milieu; and providing this type of care at a regional community level where communities are still isolated and transportation and communication are still difficult despite modern methods. This section looks at some factors that resulted in the establishment of the Maternity Centre and at its operations.

The 100 per cent evacuation period

The policy of flying third-trimester pregnant women from the Hudson Coast communities to Moose Factory, Quebec or Montreal, beginning in the early 1970s and ending with the opening of the health centre in 1986, caused significant stress on the individuals, families, communities and culture affected. The experiences of Inuit women and families during this period in various regions have been documented by a variety of researchers. (Kaufert and O'Neil 1990; O'Neil, Kaufert and Postl 1990; Pauktuutit N.D.; Stonier 1990; Innuulisivik 1989) Interviews and discussions with people in Povungnituk reconfirm the findings of these researchers.

Figure 3
Innuulisivik Health Centre Administration

Even during this period about seven per cent of births took place in the Arctic Quebec communities. (Proulx 1988) Evacuation did not occur in these cases for a variety of reasons, including premature birth, uncertainty about the date of conception and transportation problems. Often the women in question intentionally misstated the date of their last menstruation so that they could deliver in their own communities. This placed them in the position of treating their pregnancies as a source of conflict between themselves and the medical services personnel in the communities; being pregnant meant eventual separation from the family or lying to the nurse. The social effects of being absent from the community for the last four weeks of the pregnancy were profound. The women worried that their other children would not be fed or taken care of properly in their absence. Husbands became distant from the birth of their own children and could not help or appreciate what their wives were going through. Some came to blame the extra stress of dealing with the spouses' absence on the women themselves. Some people attribute the increase in teenage pregnancy to the non-participation of the fathers in the entire pregnancy and birth process. They became irresponsible, in the words of one person consulted, because they never saw what it was for a woman to give birth; the woman just went away and came back with a child.

When asked about their experiences with childbirth in Moose Factory, women in Povungnituk were universally unhappy with the experience. Some described abject loneliness and confusion arising from language differences; others felt that it was simply ridiculous that after several successful births at the nursing station or in a tent or igloo that they were now deemed 'sick' and were sent to hospital hundreds of miles from home to give birth. However, some people who had spent extended periods in Moose Factory for treatment of tuberculosis had established friendships and social links in this community and had less problem adjusting to the waiting. It would seem likely that the association of tuberculosis treatment, from which many people did not return, and birth caused stress in the individuals concerned.

There is another link between the decision to evacuate pregnant women and tuberculosis. The evacuation policy came shortly after the decline of the last tuberculosis epidemic in Northern Quebec and may have been an attempt to maintain staffing and bed levels in Moose Factory. It was also partially a result of "difficulties in hiring certified nurse-midwives". (Proulx 1988, p. 56) Tuberculosis epidemics were partly responsible for the

construction of serviceable airstrips in the north and in a sense paved the way for the evacuation policy. Indeed the general structure of northern health services, oriented to bringing patients to southern cities for medical care, was established during the tuberculosis epidemics. Current efforts to develop community-based services are hindered by the inertia of a system oriented to the control of infectious disease epidemics.

This period of evacuated births was characterized by decreasing inter-generational contact, increasing intra-familial tension, abandonment of culturally prescribed pregnancy and birth practices, absence of maternal health education, poor maternal health, poor infant health, absence of medical follow-up of infants, high infant mortality (although lower than previously), and association of the birth process with fear and alienation.

Women in Povungnituk always questioned the 100 per cent evacuation policy, but for a long time felt they had no say in the way things were done. In discussions with Inuit women, it was stated that as a general rule people do not feel qualified to question the authority of foreign health care personnel. They respect them and their abilities so much so that they don't feel able to protest or demand explanation for certain decisions. (Interviews 6a and 6b) The feeling that one had no say in the decisions of health personnel and institutions was quite common and remains so to some extent with regard to southern institutions.

Origins of the Povungnituk Maternity Centre

Despite the profound respect and thankfulness most Inuit feel toward health care providers, they were nevertheless opposed to being obliged to leave their communities to give birth. This preoccupation was often discussed by the Povungnituk Women's Association, which played a significant role in promoting the idea of a maternity centre in Nunavik and seizing the opportunity presented by the pending construction of the new regional health centre. Their role included consultation with people in the communities to be served by the hospital centre and promotion of the maternity centre concept in the face of sometimes indifferent or hostile attitudes of health care planners with little or no northern experience.

Inuit concerns about the birthing issue and health in general were known to several key southern medical personnel, some of whom had previous experience on the Ungava coast as physicians and researchers. An evolving philosophy within southern academic circles of the

role of community health service delivery played a significant part in advancing alternative health service delivery methods. This philosophy supported the idea that for health services to have an effective and long-lasting impact on the population, responsibility for those services must be taken up by the population receiving them and moulded by the reality of the culture and lifestyle of those people. At the heart of this approach is a concept of community health that approaches health issues at the societal level rather than the individual level. (cf. Dufour 1989) The Arctic and indeed most Aboriginal communities in Canada have had a history of health care service delivery based on the immediate need to deal with epidemic disease, with little attempt to approach health as a holistic concept. In other words, health has been approached historically as the relief of illness rather than the maintenance and promotion of wellness. For some people in the community health field, who were associated with Nunavik health service delivery, the planned hospital centre for the Hudson Bay coast presented an opportunity to change this historical orientation.

A doctor who was intensely involved in the development of the Innuulisivik health centre described the origins of the maternity centre as being heavily influenced by his and other people's clinical experiences on the Ungava coast. They saw the hospital, established originally by the federal government, as paternalistic and unresponsive to the needs of the population served and almost entirely unconcerned with health promotion. Maternal, perinatal and infant health were poor, and almost no efforts were being made to educate people about health issues or to encourage individuals to achieve responsibility and control over their own health. In the 1970s successful community health programs involving Inuit community audiology workers (*siutilirijiit*) and dental care workers (*kigutilirijiit*) provided convincing evidence that community health initiatives delivered by Inuit personnel could be effective and efficient. The development of the Hudson Bay coast hospital provided an opportunity to make a fresh start and deliver a different kind of health service.

Once the implementation phase of the Innuulisivik health centre had begun, community groups and health professionals began a phase of consultations at the regional level. Regarding the maternity centre concept, three levels of meetings with community members were held in all the communities in the hospital catchment area. Adolescent women, mothers and grandmothers were consulted in turn and the local initiative was solidified. Their

wishes regarding a maternity centre were presented to the health centre planning committee. The committee included personnel who encouraged their activities, were sympathetic to their concerns, and who effectively promoted their position within the closed ranks of the medical community. A midwife from the south was hired to co-ordinate the planning and promote the interests of the women's group and its constituents among the various health care and bureaucratic elements. The political and personal resolution and commitment of key Inuit and southerners were responsible for the maternity centre taking shape. As is often the case, it was a question of the strong personalities of a few people, resulting from certain life experiences, that permitted the maternity centre idea to be implemented. When it was finally established, pregnant women began, once again, to give birth in their own communities or at least close to those communities where they most often have relatives and social networks to help and support them.

Operating procedures of the Maternity Centre

The Maternity Centre addresses perinatal health on a regional scale, delivering services, education programs and training in each of the Hudson Bay communities in the catchment area of the health centre. In most cases the woman comes into the nursing station in her community when she believes she is pregnant. She is given a pregnancy test, and if it is positive she meets with the nurse or doctor, if there is one in her community. If she chooses to have the pregnancy terminated she is referred to a special clinic in the south. If, as in most cases, she chooses to continue the pregnancy, various physical examinations and tests are conducted. Her case is entered into the file of active pregnancies at the Innuulisivik Maternity Centre.

Until the third trimester of pregnancy the woman sees the nurse, doctor or midwife (if she lives in Povungnituk) monthly for examinations or checkups. At about 28 weeks' gestation she has a second examination from a doctor and begins to visit the nurse or midwife every two weeks. At the same time the perinatal committee meets to evaluate the risks involved in the individual's pregnancy and to design a course of action for following the remainder of the pregnancy. If the woman is not from Povungnituk a conference call is arranged between the nursing station personnel and the perinatal committee in Povungnituk.

Figure 4
Process of Perinatal Care in Hudson Bay Region

In some cases where the risk is considered high, the woman will be referred to a hospital in Montreal for delivery (usually the Royal Victoria Hospital). If not, then at around 37 weeks' gestation the woman travels to Povungnituk and is billeted with a local family. Her husband and other family members may accompany her at a special reduced 'paternity' fare on Air Inuit. She visits with the midwife at the Maternity Centre for another checkup and is shown around the facilities if she has not already been there. When she goes into labour she is admitted to the health centre and comes to the maternity centre. If the woman is admitted during the day she is attended to by the Maternity Centre staff present (during the day the Maternity Centre is staffed by at least three people, midwives and midwives in training). If she is admitted at night, the midwife and midwife in training on call are brought in and assist in the birth. If there are unforeseen complications a doctor may be called in. If the complications are serious she may be evacuated by medical transport to Montreal or to Iqaluit in the case of a serious emergency.

If, as in most cases, all goes normally, the woman stays in the Maternity Centre for a day or two and is helped with child care by the maternity worker. The maternity worker also monitors the condition of the baby and alerts the midwife if she feels there are any problems. Breast feeding and child care instruction are given to the new mother at this time. The woman normally returns to her home community within three or four days. She will receive home visits, one and two weeks after giving birth, from the midwife, the nurse in her community or a maternity care worker. If problems are encountered she will be given counselling by the appropriate people or agency who then begin to follow the woman and the child. This process is shown in Figure 4.

Perinatal committee

Of particular importance to the functioning of the Maternity Centre is the interaction of its staff with the rest of the operations of the health centre. The perinatal committee of the Innuulisivik health centre meets weekly to assess the pregnancies of women between 31 and 34 weeks' gestation. The committee is composed of midwives, doctors and nurses and is charged with evaluating the pregnant woman's health and risks to it. This committee reviews each woman's file from a variety of perspectives to gain an overall view of her condition.

The committee makes the decision when necessary to send a woman out of the community for specialized testing and treatment as well as for delivery. A perinatal committee meeting was observed during the course of this study and notes taken on the following aspects: subjects discussed, meeting co-ordination, degree and style of participation of those present, amount of time spent on each dossier, conflicts and solutions arising during the meeting.

Present at the meeting were three midwives in training, three midwives, two physicians (one part-time, one full-time), two nurses, and two medical students. Five pregnancies were discussed; four of the women were residents of Povungnituk, and the fifth was from Ivujivik. This meeting was different from many in that there was no telephone conference with the nursing station to assess the pregnancies of women from other villages. In each case the woman's social status (marital, number of previous children, age, job, support network), history (abuse, adoptions, previous problems), and problems, if any, were discussed. Her situation on arrival for first pregnancy test was brought up if relevant, as well as her apparent mood and disposition toward being pregnant. The various laboratory results were related and missing information queried. Medical problems, current and past, were discussed and management methods discussed. The presence of toxoplasmosis antibodies and nutritional status were particularly important factors, as were estimated dates of conception and delivery.

Each case took roughly ten minutes to discuss. All participants in the meeting contributed except for the medical students and one nurse. Each woman's file was presented by a midwife or by a midwife in training with the assistance of a midwife. All cases but one were presented by Inuit personnel. In one case there was the unconfirmed possibility of twins. This led to a brief discussion between one doctor and a midwife. The doctor suggested sending the woman to Kuujjuaq for an ultrasound to confirm twins, while the midwife disagreed and felt it would be better for the woman to wait and use available techniques to assess for twins as the pregnancy developed. The doctor concurred. The midwives in training and Inuit midwife were able to fill in all relevant details about the social situation of each of the Povungnituk women. Their knowledge and opinions were called on in each case. In one case the issue of the woman's treatment of a previous child was brought up. The Inuit staff described how the child was being cared for by the woman and by her mother which seemed

to be adequate. The possibility of her adopting the coming child was raised. The suggestion of pregnancy through rape was raised in another file based on conflicting reports from the pregnant woman and her mother; again the Inuit staff were asked to comment. The meeting ended amicably and with consensus on all cases and issues.

What was particularly striking about this meeting was the input of social information that could come only from living in the community with the individual in question. Some of the non-Inuit staff present knew of the people and their histories but did not have the depth and current knowledge of the situation of these women. The role that the midwives and midwives in training play extends outside the maternity and health centres to become an encompassing form of surveillance of the situation of women and their lives. This is an opportunity that only a small community, were the midwives and clientele speak the same language, can offer. It is also subjectively one of the great strengths of the system in Povungnituk. Concern about each individual was sincere on the part of all people involved in the perinatal committee, and relevant social details, available only through intimate knowledge, were key factors in the decision-making process.

A second important element that became evident in observing the meeting was that despite the formal risk assessment procedure for the health of the mother and the child, the process is far more subtle and somewhat more subjective than it would appear. This is not a negative comment, as risk is assessed as a combination of elements that carry differing weights depending on their juxtaposition with others. A more formalized system could not easily incorporate this flexibility. As a result, the assessment of risk is highly responsive to the individual and is variable depending on their needs. The perinatal committee also serves to adjust the risk assessment module to conditions or circumstances in Inuit communities that would not be considered in southern communities where the risk assessment procedures were originally developed. For example, half of all low birth weight babies are delivered in the south; this proportion makes up 26 per cent of all evacuated births (Innuulisivik 1989) and shows that the screening procedures remain effective. Questions of the applicability of statistical health standards to different ethnic groups have long been raised. Appropriate and healthy birth weight in particular has been found to vary considerably (Llewelyn-Jones 1955,

cited in Mead and Newton 1967) and the validity of this statistical measure as relevant to Canadian Inuit populations has been questioned. (Murdock 1979)

The participants in the perinatal committee meeting seemed to place greater and lesser importance on various factors depending on their profession. The physicians seemed to rely more on medical tests and possible supplementary examinations, while the midwives tended to emphasize the individual's interests and experiences when assessing what more the tests could tell them. As a tool for evaluating pregnancies and courses of action, the perinatal committee presents a model that encourages effective participatory training for midwives and medical students while giving multiple professional perspectives to the client.

Training

A fundamental objective of the Maternity Centre, and indeed the health centre as a whole, is to train local people to occupy and control as many positions as possible in health care. In Nunavik, education of local health care personnel has been negligible. Most Inuit-occupied positions are either administrative (secretarial, financial, directorial) or at the basic services (interpreters, porters, housekeeping) end of the spectrum. There are no Inuit doctors or nurses (although several are in training in Kuujjuaq and one in Montreal). This is typical of the history of western medical services in the North and in many other Aboriginal communities in Canada.

At present the greatest obstacle to increased Inuit participation in and control of the health care system in their communities is education. Working in health care institutions in the North, whether they are nursing stations or the health centre, demands a certain level of second language skills that many people over the age of 40 don't have. Even many younger people have limited English and/or French skills. This is not surprising in a community that has always been and remains majority Inuit. It has however been close to 20 years since control over education was transferred to the North and a regional school board established. To the great frustration of many in the health services sector, there does not seem to be much progress in producing high school graduates, much less professionals in any field. The young people who do go through high school and continue on are almost never available for the jobs offered at the health centre because they are offered better jobs with the regional government,

school board or municipalities. As a result the health centre has caused the single greatest influx of non-Inuit into the community and with them values and needs that diverge widely at times from those of the Inuit of Povungnituk.

Despite these difficulties, several programs and departments other than the Maternity Centre – notably audiology, dentistry and patient care – have attempted to increase the participation of local people in the work force by developing training programs and redefining tasks. In the *aaniasiurtiapit nunaliit* position, the roles of interpreter, nurse's aide and community health facilitator are combined. The *kigutilirijiit*, or dental health worker, combines the skills of dental assistant and dental hygienist with that of interpreter and community health worker. The *siutilirijiit* performs a similar function with regard to audiology. All these positions require some training, and all three departments have experienced some difficulty in attracting and keeping qualified personnel.

Becoming a midwife

The first group of Inuit selected to be midwives in training found out about the job through postings put up around town – the usual method of announcing jobs and community events. Since then the community midwives have developed a two-tier system to select candidates for training. To become a midwife in training the candidate must first work as a maternity worker. Maternity workers are responsible for post-natal care and monitoring of the baby and mother. They provide some health education to the parents, do basic examinations of the baby and monitor the child's progress during the first few days of its life. The midwives depend heavily on the maternity workers to advise them on problems occurring with the child or mother and place great importance on the role of the maternity workers as frontline health workers. One midwife described how the maternity workers are able to monitor the baby's state of health very closely and that they had detected illnesses in the very early stages that might have gone unnoticed by the midwives or other medical staff because of their overloaded schedules and relative lack of familiarity with each individual baby.

Later, once a maternity worker has gained experience and demonstrated her skill and dependability, she can apply for a midwife in training position when an opening becomes available. If she is accepted she begins a new cycle of training and practical experience. This

system permits the individual to learn the basics gradually before beginning more intense training as a midwife. It also selects for people who are serious and dedicated to the position and provides one of the few opportunities for advancement within the health care system for Inuit.

Health Indicators of the Maternity Program

The Povungnituk maternity has undergone at least two comprehensive epidemiological and organizational reviews since it was opened. (Meyer and Belanger 1991; Carignan 1993) This section provides a brief overview of these studies and supplementary information gathered from other reports and during this study.

Infant Mortality

Drawing concrete conclusions about the efficacy of the Maternity Centre and its health programs on the basis of infant mortality and morbidity rates is difficult, largely because of a lack of sound data from the past and the lack of comparability of the data that do exist. A further complication in the data is that some deliveries occur outside the Nunavik region and have been ignored in the studies (except for Carignan 1993), which affects the results for those that did occur in the North. Other investigators (Kaufert et al. 1990) have reservations about the use of epidemiological data in the decision-making process in northern obstetrical policy. They warned about the effect of sample size in producing large variations in crude rates of perinatal mortality; the reliability of categorizing live birth, stillbirth and miscarriage and the effect of single errors on overall rate calculations; and problems in interpreting perinatality rates as causal rather than correlational. It has been suggested that infant mortality rates have been used as an ideological tool throughout the process of the medicalization of birth. (Kaufert and O'Neil 1990) Despite these caveats some general trends and differences can be discerned.

There is little doubt that infant mortality rates in all categories were higher in the past than they are now (Duval and Thérien 1982; Tremblay 1981) and that fertility rates have increased simultaneously (Tremblay 1985), although in the more distant past it is difficult to estimate what they would have been.

Infant mortality rates have fallen for a variety of reasons: the control and eradication of most epidemic diseases, increasing assurance of adequate food, improved housing and standard of living, improved sanitation, improved transportation networks, universal access to health care and antibiotics are all important factors. Despite these changes, the mortality profile in Inuit communities is distinctive and reflects the northern lifestyle and problems specific to these communities.

Fertility rates have likely increased as a result of changed nutrition and lifestyle, lower age of menarche (onset of menstruation), possible increased age at menopause, changes in the social control of sexual relations, and improved maternal health. These have likely been offset to some extent by the introduction of medicalized birth control and sterility resulting from pathology or incompletely treated or untreated sexually transmitted diseases. The end result of the change in fertility and mortality rates is that more children are being born and they are living longer lives.

In an evaluation of mortality in Hudson Bay coast communities between 1982 and 1986 (Proulx 1987), infant deaths accounted for 21 of 134 deaths. Prematurity and sudden infant death syndrome (SIDS) were the most common causes (7 and 4 deaths respectively), followed by meningitis and bronchiolites with three deaths each. In a corresponding evaluation from 1991-92, Affleck (1993) cites trauma (suicide, accidents, fire) as the single most important factor in mortality (46 per cent of all deaths) in the Hudson Bay communities. Infant deaths (0-1 year) were the second most important factor and accounted for 16 of 64 deaths (25 per cent) in this same period. Five were from SIDS, three were stillbirths, two died of viral myocarditis, four from congenital illnesses, one from congenital hydrocnecphaly and one from premature delivery. The figures do not represent epidemic levels of infant deaths, although the number of SIDS deaths is high, as it has been found to be in other Aboriginal communities (Proulx 1988), and could possibly be lowered somewhat through post-natal education via the Maternity Centre. Comparisons between the time periods of these studies cannot be made with statistical confidence. Table 1 presents a synthesis of data available on infant mortality rates in Nunavik, the Northwest Territories, Greenland Inuit communities, and Quebec as a whole for comparison.

Table 1
Infant Mortality Rates, Inuit-Occupied Regions and the Province of Quebec

	Northern Quebec 1965-1970 est. (1)	Ungava region 1974-78 (2)	Northern Quebec 1974-79 (3)	Hudson region 1982-86 (4)	N.W.T. 1983-85 (4)	Green-land 1979-1983 (4)	Hudson region 1989-1990 (5)	Quebec 1983 (4)
Infant Mortality per 1000 live births, 0-1 year	136.5	69.5	57.3	33.7	28.0	37.0	33.4	7.4

Source: Adapted from Proulx 1987. (1) Normandeau 1979; (2) Tremblay 1981; (3) Duval and Thérien 1981; (4) Proulx 1987; (5) derived from Affleck 1993 and Meyer and Belanger 1991 (9 infant deaths/269 total births between 1989 and 1990).

While caution is encouraged in drawing conclusions from these data, it can be said that the infant mortality rate has been declining over time but is still several times higher than that of the province as a whole.

Maternal Health Indicators

An equally important measure, and one that is related more directly to the operation of the Povungnituk Maternity Centre, is maternal health. This is often expressed statistically by the presence of risk factors in the pregnant woman's medical and social history and by frequency of medical intervention in pregnancy and birth. One of the implicit goals of midwifery is to de-medicalize pregnancy and reduce unnecessary intervention by providing continuous care and evaluation of the mother during her pregnancy. (Quebec Alliance of Practising Midwives 1989)

In Kuujjuaq, an evaluation found that high turnover rates of physicians and nursing staff contributed to unnecessary medical interventions during pregnancy and delivery. (Bouchard 1990) In Povungnituk, continuity of care is a prime objective of the Maternity Centre and is assured by the presence of midwives and midwives in training who are subject

to comparatively lower rates of turnover than other medical personnel. Rates of illness and complications in pregnancy rise with delays in the first prenatal visit. The time of first visit on average has dropped from 15 weeks' gestation at the opening of the Maternity Centre to 13 weeks. (Innuulisivik 1989) Between 1989 and 1991, 76.6 per cent of women had their first visit before the 15th week of gestation. (Carignan 1993)

There are several highly represented risk factors within the population served by the Maternity Centre. Anemia during pregnancy is a common problem; 55.9 per cent of women suffer from it. In response nearly all women are prescribed iron and/or vitamin supplements. Low haemoglobin and low haematocrit on the first visit of the pregnant woman to the Maternity Centre are common, at 31.7 per cent and 68.6 per cent respectively. These figures increase during the pregnancy to 54.2 per cent and 89.9 per cent (Carignan 1993), although all women returning for a second pregnancy within two years show improved haemoglobin rates. (Innuulisivik 1989) At least one sexually transmitted disease, another risk factor in pregnancy, is present in 41 per cent of the population. Cigarette smoking is very common during pregnancy, with 83.5 per cent of women smoking, 25 per cent of them consuming more than 10 cigarettes per day; however drug and alcohol consumption are quite low, at 5.2 per cent and 4.9 per cent respectively. (Carignan 1993) There have been no cases of fetal alcohol syndrome babies in several years, although subtler developmental problems associated with alcohol consumption have been noticed in this population. (Hodgins 1994)

Between 1989 and 1991, 350 babies were born at the Povungnituk Maternity Centre. Only about 15 per cent of pregnant women from the Hudson coast communities were sent to southern hospitals for complications during pregnancy and delivery. Of the 350 babies born in Povungnituk, a midwife assisted in the birth of 321 (91.7 per cent). The great majority of these births proceeded without the use of analgesics or anesthetic (87 per cent and 72.9 per cent respectively) and damage to the perineum, tears, and episiotomies were relatively rare (33.8 per cent, 30.6 per cent and 4.9 per cent respectively), which contrasts markedly with the figures for the province as a whole, as shown in Figure Table 2.

Age is another important risk factor during pregnancy. Women younger than 20 or older than 35 years have a higher potential for complications during pregnancy, according to

southern-based risk assessment methods. (Kaufert and O'Neil 1990) Between 1989 and 1991, 30.3 per cent of women delivering were under 20 years of age and 3.2% were older than 35.

Despite the relatively high rates of a number of maternal and fetal health risk factors – STDs, anemia, low haematocrit, low haemoglobin, and smoking – the Maternity Centre is able to deal effectively with the births that take place, with little evidence of negative outcome for the child or the mother.

Figure 5
Maternal Health Indicators: Povungnituk and Quebec

Derived from Carignan 1993.

Contemporary Health Issues

As shown in the previous section, there are certain behavioural and health indicators specific to the population served by the Maternity Centre. In this section these and other health issues related to pregnancy in the Hudson coast communities are examined.

Nutrition and toxoplasmosis

Of particular importance to the health of women and babies in the North are high rates of anemia and low birth weight. Both these can be solved in most cases with proper nutrition. After recognizing this problem, the Maternity Centre introduced a maternal nutrition program to encourage women to eat healthy foods that are high in iron. The most immediate and palatable food sources are part of the traditional diet of the Inuit, based largely on caribou, marine mammals and fish. Counselling women to eat these foods in greater quantities has a negative side, however. Some animals carry a virus that causes toxoplasmosis, which can

result in birth defects. If the woman has been exposed to the virus before becoming pregnant, there is no threat to the child, as the mother has already developed antibodies. As a result of changes in diet following the introduction of imported foods and changes in cooking methods, some women have not been exposed to toxoplasmosis before becoming pregnant. All women are therefore screened for toxoplasmosis antibodies. Those who do not have them are given extra counselling on food preparation techniques that kill the virus. Overall the traditional diet is far healthier for the mother and the fetus than imported high-carbohydrate foods.

Sexually transmitted diseases

From the epidemiological evaluation it is obvious that sexually transmitted diseases are a significant problem and risk factor in the general population in the North. The effect of these diseases on pregnancy is subtle in most cases, but they present some risk nonetheless. They are also an important and growing factor in female infertility and sterility. Problems hampering the control and treatment of these illnesses include lack of awareness or education and incomplete compliance with prescriptions for medication and abstinence periods. One-quarter of all cases of drug-resistant gonorrhea in the province of Quebec are found in Kuujjuaq. (Hodgins 1992) This is an alarmingly high incidence given the small size of the community. The community health education role of the Maternity Centre is an obvious place to start to treat this problem, and indeed they do offer education to pregnant women on these subjects. At some point these programs should be extended to the non-pregnant portion of the population.

AIDS

The effects of acquired immune deficiency syndrome (AIDS) have not yet been felt in northern communities to any great degree. This does not mean that there are no HIV-infected individuals or that the disease does not have a foothold in the population. AIDS has the potential to devastate the northern population in the same way that previous epidemics have done, except that it will most likely be young adults, rather than the very young and the old, who fall victim. The Maternity Centre has a critical role in helping educate the population about methods to prevent this disease. In June 1993 an AIDS conference was held in Kuujjuaq

with representatives from all communities, including some of the Maternity Centre staff, participating. They must now be given the means and support to develop programs and teach people how to avoid infection. Few prevention issues are as important in the northern health field at the moment.

Smoking

Cigarette smoking is a serious factor in health risk during pregnancy (and the rest of the time as well). More than 80 per cent of pregnant women smoke at least occasionally, which is far too many. Again the role of the Maternity Centre staff in public health education should be facilitated in reducing this health risk.

The Maternity Centre Staff and Community Health Initiatives

The midwives in Povungnituk are the only practising Inuit health professionals in Arctic Quebec and have developed a positive reputation in the population. They have the respect of the population and experience in developing and delivering health care information. They are role models for many and are sought out frequently for information and help by community members while on the job and at home. This causes them considerable stress at times, as they feel they are always perceived as midwives and health workers rather than just people with jobs. While this does cause some concern to them and their families, it also places them in a position of being able to effect positive change. The following anecdotal account shows the potential for the midwives to improve community health through their own experiences and example.

Five years ago in Nunavik it was very common to see all members of a family over about 14 years of age smoking (often simultaneously) around the rest of the children in a family. In the last year or two, however, it has become increasingly common to see people with young children smoking in the furnace room of their house. This is true in Povungnituk and in all the other communities in Nunavik. When asked about this change, one of the Maternity Centre staff said that she had started it. When asked to clarify, she said that when she learned about the link between smoking and children's illnesses through her training, she realized that this must explain why her kids so often had colds. She decided to smoke in the

furnace room with the window open. She felt that her children's health seemed better very quickly and went on the radio to explain what she had done. Other people began to do the same, and word got around quickly. That this behavioural change can be seen in all communities in Nunavik is testament to the communication networks that exist between these communities and, perhaps, the importance Inuit attach to their own experiences and those of others, particularly respected people, in learning. As a lesson in community health service delivery, it is quite revealing.

Part of the role of the Inuit midwives is translating ideas from western medicine into practice in their own communities. This is a very difficult task – far more difficult than translating words from one language to anther, and is a skill that should be developed for the benefit of all. Their advice on appropriate ways to present health information and programs to the general public is invaluable. Their role as community health program facilitators should be acknowledged and enhanced.

Health Policy Issues in Nunavik

In the larger political context the Innuulisivik health centre is a direct result of the James Bay and Northern Quebec Agreement, which provided for regional administrative control over health, among other issues, through the Kativik Conseil Régional de la Santé et des Services Sociaux (KCRSSS). In 1976, when the JBNQA was signed, representatives from Povungnituk refused to participate on the basis of political differences with the NQIA. Despite the opposition of Povungnituk and Ivujivik, they were effectively represented by the NQIA, as it was the legally recognized body representing Inuit in the negotiations leading to the JBNQA. The choice of Povungnituk as the site of the Hudson Bay health centre, while based on a variety of criteria, was made largely as a means of drawing Povungnituk out of its dissident role and into the mainstream. Despite the dissident status of the community, the health centre was built in Povungnituk and has been a significant benefit of the JBNQA in terms of its economic role, the services provided and, most important, the opportunity for true local control over decision making in the health fields. The Maternity Centre has set a national precedent in its promotion of Aboriginal-controlled and -delivered health services.

Policy Issues Affecting the Maternity Centre

Were it not for the unwavering insistence and commitment of local political representatives and health care planners in the south, the Maternity Centre would never have been established. In Quebec, midwifery has faced entrenched opposition from the very conservative Corporation des médicins, the professional body representing physicians in the province. The province lags behind other parts of the country in this regard; indeed Canada and South Africa were until recently the only two countries in the world with laws preventing midwifery. (Quebec Alliance for Practising Midwives 1989) Other than the Povungnituk Maternity Centre, no midwife-assisted birthing centres of any sort are operating in the province; home births are done clandestinely, and midwifery is still in the wilderness. In Povungnituk the local will exceeded the ability of the Corporation des médicins to control and prohibit midwifery. The Maternity Centre was a local initiative undertaken without the consent of the Corporation des médicins (although they were kept fully informed by medical personnel) and far enough away from the urban political centres that it was ignored. In the words of a doctor working in Povungnituk at the time,

> If we had waited for the official approval of the government, these things would never have happened. How it came about was that the people in the community had a strong will to bring it about, to bring back some control to the Natives, and there were some doctors who were part of the medical establishment that were strongly in favour of it. (Interview 3a)

Three factors are responsible for the establishment of the Povungnituk Maternity Centre: exceptionally strong local initiative, key supporters from the medical and paramedical community, and geographic isolation from the centres of power.

Some movement around the midwifery issue has occurred in the south since the opening of the Povungnituk Maternity Centre. In 1990, Bill 4, *An Act respecting the practice of midwifery within the framework of pilot projects*, was enacted in Quebec City, providing for a maximum of eight midwifery pilot projects to be established in hospital centres and/or community service centres in the province. (Quebec National Assembly 1990) The objective of the bill is to "authorize, on an experimental basis, the practice of midwifery within the scope of pilot projects". It further requires that committees be established to determine

standards of competence and evaluation of midwives who apply and a board of assessment to determine whether midwifery should be permitted in the province.

This bill was vigorously opposed by the Corporation des médicins, which sent out letters to all physicians in the province discouraging participation in the pilot projects. To date only Povungnituk has received funding as a result of this bill, putting it in the unusual position of becoming a pilot project after more than five years of operation. This bill poses some potential problems for the Povungnituk Maternity Centre as well as for other future Aboriginal-controlled maternity centres in the province. It represents the first attempt at governing the practice and hence will not be the last. The Povungnituk Maternity Centre has benefited from the government's laissez faire attitude and was able to establish its protocols and procedures independently and in response to local conditions and realities. It has therefore been responsive to those needs. As one of the original midwives in Povungnituk said, "We did not feel the outside there, even if they feel us now." (Interview 10a, translation from French) With the establishment of province-wide norms, the Maternity Centre in Povungnituk may find itself in the position where the people it has trained and certified do not meet provincial norms, and training programs may lose their ability to be flexible and responsive to the needs and abilities of individual trainees.

The Povungnituk Maternity Centre is no longer an experiment; it is established, operating and still carried by the will of the population. This determination will likely carry it through any government attempts to change it, but not without significant stress on the individuals and the structure. Regarding Bill 4, a midwife stated,

> It was a concern [imposition of government norms], but they haven't started that yet either. Also, if the pilot project fails, we are carrying on. A pilot project has an evaluation, in that you are going to continue or not. We are going to continue, and we made that clear to them. (Interview 3b)

The concerted efforts of the community to establish the Maternity Centre resulted in their achieving a goal but also, by the nature of the action, established some core institutional problems that will not be resolved until the political climate in the south changes to permit the inclusion of midwifery in mainstream medical politics and economics. The basic problem is funding for training and educational programs. This applies to the midwifery program and to the health centre as a whole.

The Maternity Centre has, since its inception, insisted on teams of certified midwives (from provinces or countries with formalized midwifery training programs) and local midwives in training. The midwives in training receive on-the-job training supplemented by academic instruction by the certified midwives. Funding for the educational component of the Maternity Centre has always come largely from the global budget of the health centre and as such has been restricted by the vagaries of medical economics. While there is strong support for the maternity training program at all levels of the health centre structure, training funding must compete with all the other necessities of the health centre's operations. For example, it is not possible to hire someone dedicated solely to the preparation of educational material for the midwives in training. As a result the practising midwives must do their best in their available time to create and teach these modules. The task is complicated by the unpredictability and high demands of the job and by the linguistic and cultural differences between midwives in training and midwives from the south. The training demands that the midwives in training not only master English as a second language but medical terminology as a third. The possibility of government norms and tests further complicates the training issue.

Certification has been a continual problem in the northern Aboriginal milieu. The requirement for uniformity in many job positions, through unions or government accreditation, has the effect of shutting out many Aboriginal people. For linguistic, cultural and historical reasons, many Inuit are unable to get the appropriate competency certificates or other recognition for jobs ranging from construction to teaching. It is a serious policy issue that has repercussions in the health centre environment.

Efforts to secure training and educational funding have been hampered by provincial bureaucratic distinctions between health and education. According to administrators at the health centre, efforts to secure funding from the ministry of health have failed because the ministry has no mandate for training in regional health centres and even less for midwives. Efforts at the ministry of education have been thwarted because the Innuulisivik health centre is not an educational institution but a hospital. Attempts to have the Innuulisivik health centre accredited as a teaching hospital have so far not been followed through on by the provincial government. The Kativik School Board (KSB), mandated to deliver education in Nunavik Inuit

communities under the JBNQA, does provide some funding to the health centre, but its mandate is limited mainly to institutional primary, secondary and post-secondary education, so that very little development of on-the-job educational programs has taken place. Until midwifery is accepted and funded at the provincial level, very little funding for training will be available.

Culture and the Maternity Centre

The ability to give birth close to or in one's own community with the assistance of people from that community has multiple meanings for the clientele. First, women give birth in their own culture. At least some of the people present at the birth share language, history and experiences with the pregnant woman. Second, the birth has become, once again, a social phenomenon that can be attended by the husband, the grandparents, other children, friends and adoptive parents. This better reflects the way births were attended before the evacuation policy was introduced and allows the generations before and following the pregnant woman to learn from and inform each other. Third, the entire pregnancy is experienced close to family and friends who are able to help the woman; she does not experience isolation and the associated fear, loneliness or frustration as a result. Fourth, as is implied by the factors already mentioned, the ability of the family and the individual to learn and to be responsible for their own health is greatly enhanced by the repatriation of the birth process to Povungnituk and a regional approach to perinatal care. The size of the population served and the Maternity Centre staff's awareness of the individual's social, personal and medical histories permits a holistic approach to her pregnancy. In effect the medical-midwifery system in place is also brought into the social construction of birth and places a significant emphasis on promoting a global approach to women's health that was not addressed previously. The family has regained responsibility in the process, and the woman has regained some autonomy with regard to decisions about her own health and the birth.

In conversation with midwives and other women in Povungnituk, it was often stated that they felt that in some way their culture had been disturbed by the evacuation policy in particular and by the western medical system in general. These feelings can be grouped under three types of effects on culture: abandonment of culturally prescribed practices, non-

participation of elders in the pregnancies of younger people, and absence of transmission of knowledge between family and community members. This has had repercussions, according to people interviewed, for a wide spectrum of social behaviour – abuse of women, neglect of children, passivity toward personal and prenatal health, and a general decline in the respect of community members for one another are all seen as linked partially or entirely in some way to the period of evacuation for birth. These changes are undoubtedly not attributable solely to the medicalization of birth; they are part of a larger process of political, economic and social change, of which the medicalization of birth is one aspect.

Cultural Context

We face a dilemma in describing the cultural context of the Inuit belief system as it relates to the cultural comprehension of health, pregnancy and birth. Most Inuit are Christians – some families have been for three or four generations – yet they also maintain a belief system that incorporates a worldview indigenous to their culture. Visual and ritual representations of traditional beliefs are nearly non-existent – there are no ceremonies one could point to as being 'traditional' – yet the privileged outsider is occasionally permitted insights into a way of understanding the world decidedly different from his or her own.

Most academic researchers who have attempted to describe the Inuit cosmogony or worldview have avoided the problem of modernity and syncretism by treating culture as if it were in stasis and by consciously weeding out and ignoring references to foreign beliefs. (Dufour 1988; Therrien 1987; Saladin d'Anglure 1977, 1980a, 1980b; Merkur 1991) Elderly informants are generally sought out because they are the most knowledgeable but also because they are the least influenced by views from the outside. Some work has begun on the interrelationship between western medical services, Christianity and cultural belief systems among the Inuit with regard to mental health beliefs. (Kirmayer et al. 1993a, 1993b; Fletcher 1993)

Wenzel (1991) proposes that the Inuit have an essentially eco-centric view of the environment and the place of human beings within it. This is to say that, rather than viewing the world and events as they relate to the self (ego-centric) or to the larger community (socio-centric), the Inuit tend to view experience as a part of the larger natural world of which they

are a part. Therrien (1987) and Therrien and Dufour (1992) demonstrate the place of the human body within a metaphorical context where the language of the body is placed in a larger cosmological framework. In this configuration the natural and human spheres, the animal world and the celestial, the visible and the unseen all intersect in the ethno-semantics of the human body. Saladin d'Anglure (1986) has documented the cosmological underpinnings of the Inuit worldview and the symbolic relationships between human beings, animals and the cosmos as demonstrated in Inuit belief, thought and mythology. He has further developed an interpretation of the 'troisième sexe' phenomenon in the cross-sex socialization of some Inuit children.

In this section we summarize some of the findings of the culturally oriented discussions and present a brief analysis of these findings. The focus is on describing the experiences and values associated with them in order to provide documentation that interested community members can refer to. Most of the information in this section comes from interviews conducted in Povungnituk, although some comes from interviews conducted previously by the author in other communities in Nunavik. These are identified in the text. It is not our intention to present the material in this section as outmoded curiosities from a previous time but to demonstrate that, despite outward appearances to some, a vital and viable culture-specific belief system surrounds the birth process among the Inuit.

Sex change of infants during birth

According to several informants, young and old, it is possible for the sex of a child to change during the birth process. Other academic researchers have written about this phenomenon from different perspectives (O'Neil 1995; Saladin d'Anglure 1977, 1986) and from different Arctic locations (Iglulik, Keewatin) which suggests that this is a pan-Arctic phenomenon. This process occurs during a particularly long and difficult delivery. The child, often a boy but occasionally a girl, is resisting birth until at some point it abruptly changes sex, after which the birth proceeds quickly and with ease. In Povungnituk the people interviewed were not able to name this phenomenon, nor did they recognize the term used for it in other Arctic Quebec communities – *sippiniq* – although several had experienced it and others were aware of it.

Several people in Povungnituk had experienced *sippiniq* while giving birth, and several people in the community were said to have been born in this way. An elderly woman described her experiences, which are paraphrased below.

> The baby was taking a very long time coming out and I was in a great deal of pain. I thought this baby was trying to kill me. Then I felt a strong thump on my lower abdomen (left side) [At this point the woman demonstrated the sensation by tapping my arm firmly with three fingers]. After that the baby came out quickly and it was a girl. When it was inside me it was a boy. (Interview 7b-8a)

Her child, now a middle-aged woman living in the community, was socialized by her family as a boy, quite probably because of the birth experience of her mother. She spent most of her childhood learning hunting skills with her father, not the skills of her mother as would usually be the case. This cross-sex socialization has also been remarked on by other northern researchers and is associated with another cultural trait linked to name sharing between generations (discussed later). It was not possible to interview the daughter because of other events happening in the community at the time.

Sippiniq – fetal and infantile memories

The observations of the elderly woman were very similar to those of others in Povungnituk and elsewhere. In Kangiqsujuaq (Fletcher 1990-93), it was reported that the sex change was not only felt but could be heard by others nearby as a sharp crack sound. This interviewee (who 20 years previously had discussed *sippiniq* with Saladin d'Anglure, who subsequently published an account of it) described how it was possible for the sex of a boy to change until shortly after the birth. To stop this from occurring the penis of the child should be held and pulled lightly as soon as he exits from the mother. Children who experience *sippiniq*, becoming boys during the birth process, may be distinguished latter in life by a receding hairline (widow's peak), although not everyone with this condition is *sippiniq*, as the infusion of non-Inuit genes into the North can also result in similar balding patterns.

In a mythological account of *sippiniq* (Saladin d'Anglure 1977), the remarkable story of a woman's birth experience is recounted. The woman describes the womb as an igloo with the tools associated with men on one side of the entrance and those of women on the other.

The birth was perceived as leaving the igloo with some difficulty and at the last moment grabbing the woman's tools, causing her to be born a girl. In Povungnituk, prenatal and immediate birth memories are common although not ubiquitous. Several people remember being in the womb of their mother at various times during their fetal period. Most of these memories describe the warmth and darkness of the womb. Some describe the sensation of moving down a tunnel toward a light that is outside the mother, and others still describe the sensation of exiting the mother's womb into the hands of the traditional birth attendant. Some people have intimate recall of details around their actual birth. The faces and identities of people aiding and witnessing the birth are recalled. The texture of the material they are born onto, a fur or cloth, are also remembered, as is the intense cold felt by some born in winter.

Name-sharing traditions

A central tradition in Inuit communities throughout the eastern Arctic is intergenerational name sharing or *saunik*. This tradition is characterized by giving infants the name or names of people in the community with the understanding that they will take on certain characteristics of the personality of the people they are named after. Researchers have referred to this as the name soul. (Graburn 1969, Merkur 1991) The names may come from elders, alive or recently deceased, or from those who die young through accidents or other means. It is also extended to some non-Inuit who become close friends with certain people or families. In most cases the intention of name giving is to perpetuate the memory, personality and skills of an elder through the newborn. In the case of an infant named after a recently deceased child or young adult, the intention seems to be more one of permitting the young dead person to continue his or her life through the birth of another. It may also be considered a cultural mechanism for dealing with grief resulting from the loss of a community member. (Fletcher 1994)

Through time, names are recycled from one generation to another, permitting history to permeate the lives of those in the present. A child named Alaku, for example, would share this name with someone at least one generation before him or her, who in turn would share the name with a member of an even earlier generation. The personality of the elder *saunik* is transmitted to the younger through the name, thus achieving a certain continuity through time. In contemporary Inuit communities this practice is used in most births and, in some cases, is

used to help the mother deliver a healthy child. In Kangiqsujuaq (Fletcher 1990-93) traditional midwives would, with the counsel of the pregnant woman's family, name a child before it was born if the mother was ill or the fetus apparently unhealthy. This is said to encourage the child to be born healthy because it knows that it is wanted, and it is already infused with an identity and personality through its name. These accounts show clearly that Inuit perceive the fetus as possessing a full range of conscious mental ability once it has been named.

On a similar theme, Guemple (1994) examines the reincarnation beliefs inherent in the name soul complex of the Hudson Bay Inuit. He finds that the practice is based on the belief that there exist a finite number of souls, which are continually reinvoked in physical form through the naming of children.

The name given a child plays a large part in determining his or her social relationships with others in the community and is incorporated into the complex kinship recognition structure of the Inuit. An older elder person who has a child named after him or her will greet the person as *Saunik* and vice versa. Since more than one child can be named after a single individual, they will share the same namesake and some personality traits, and they too address each other as *Saunik*. However, two people with the same name from different individuals do not address each other as *Saunik*, as they do not share the same namesake, just the same name.

When the younger person's *Saunik* is dead, the family addresses the living *Saunik* with the kinship term appropriate for the dead person. Hence a newborn named Robert, after his grandfather, will be addressed as husband (*ui)* by the deceased Robert's wife, father (*Ataata*) by his children, grandfather (*Atatsiaq*) by his grandchildren and so on. Because names often come from outside the extended family, and kinship terms are used as if there were a biological link between the *saunik* and the family, there is the effect of intergenerational mixing and interfamilial kinship recognition where none exists, often resulting in confusion for the outsider.

Guemple (1994) discusses the relationship between naming and the Inuit concept of the soul. In his formulation, with which I concur, the Inuit see the world as containing a finite

number of souls that can be neither exhausted nor added to but that are transferred continually between the young, the old, the dead and newborn and, in special cases, usually associated with shamanism, between species. Animals have their own finite quantity of souls, and recycling occurs within each species. Even disease, which releases souls through death, has a constant presence in the cosmos that gravitates from species to species and region to region. The name soul from an Inuit perspective is not reincarnated as much as repeatedly introduced into new individuals through the name. Unlike western concepts of soul, based on the existence of unique and individual souls, at death the Inuit soul simply loses its physical manifestation for the time being but continues to exist in close proximity. This is getting a bit beyond the scope of this paper but there is, according to the Inuit, an invisible world inhabited by a panoply of peoples that occasionally intrudes on the present world through possession and dreams.

By removing birth from the control of Inuit and from the community, through evacuation and medicalization, the responsiveness of the name-sharing tradition to help grieving families cope with loss and to infuse the newborn with personality was affected to some degree. In some cases a deceased elder will be reborn, in a sense, within days through the naming of a newborn child. When the mother was away, often for weeks, giving birth, the name would have to be decided either before she left or on her return. The tradition was affected and as a result the cultural organization of birth and the continuity of the personality were also affected.

The Sanajiik

Another aspect of the birth process particular to Inuit communities that was disrupted by medicalization is the role of the *Sanajiik*. There is no direct equivalent in western traditions to this role. It is one that carries obligations for the person who is the *Sanajiik* and for the child as it grows up. It could be roughly equated to the role of godparent.

It is the responsibility of the *Sanajiik* is to cut the umbilical cord joining the child and its mother. This person was usually, but not always, someone other than the traditional birth attendant. The *Sanajiik* was chosen by the family of the pregnant woman based on mutual

trust and friendship. It was a high honour to be asked to be the *Sanajiik*. This person would be present during labour and birth and would be involved in helping the pregnant woman to relax. Often an older woman who had experienced several births herself, the *Sanajiik* would be able to offer help to the woman in labour based on her own experience. Once the baby was born the *Sanajiik* would tie and cut the cord, often talking to the child while doing so. Normally this person would address the child repeatedly using the term a *Sanajiik* uses to address the child or children they have assisted with (*Angusiaq* for a boy or *Angnaliak* for a girl). Only a *Sanajiik* would use this term. This action would join the child and the *Sanajiik* in a lifelong relationship by which the *Sanajiik* would actively participate in teaching the child the skills they would need to survive and the child in turn would be obliged to share preferred portions of their first kill of each animal food species with his or her *Sanajiik* and/or give some form of gift for each important occasion in his or her life. The *Sanajiik* relationship is one of the many mechanisms that determined and defined interpersonal relationships among Inuit. It was also perhaps one of the most important in the life of the child, because of the role of educator taken on by the *Sanajiik* and the expectations and obligations imposed on children when they passed certain milestones in their personal development.

With the medicalization of pregnancy, first in the nursing stations and later in distant hospitals, the *Sanajiik* role and relationship were seriously eroded. Few young people participate actively in the relationship, and many older people who are *Sanajiik* feel that this practice has been forgotten for some time. They cite other influences as also having an effect on the relationship, in particular the creation of villages with large numbers of people and compulsory education. The relationship was more viable and the role of the *Sanajiik* more important when people lived in smaller family groups and occupied different camps in different seasons. With the opening of the Innuulisivik Maternity Centre, the practice has been re-established to some extent. Many young people are not aware of the full role of the *Sanajiik*, nor are many people chosen to cut the cord. Often the expectant mother expresses no preference as to who the person should be, preferring to leave the decision to the midwives.

Participation of elders in birth

In the past elder men and women were regularly consulted on all aspects of pregnancy and maternal and infant health. With the encroachment of western society and institutions, the reliance on elders declined significantly. Many older people themselves say that they have little role to play given the apparent capacity of white people to cope. Others feel that through the 1950s and 1960s they were actively discouraged by white people and government policies from practising many traditional aspects of their culture. This extended to most aspects of life, including keeping dog teams, hunting practices, choice of place to live as well as participation in births. It should also be noted that this was a period of severe stress for the Inuit throughout Arctic Quebec. Epidemic disease killed young and old alike. Families were broken up as people were evacuated to the south on the Eastern Arctic Patrol ship for treatment, returning only a year or more later, if they returned at all. Food was scarce, as many hunters and/or their wives were absent or incapacitated, and emergency relief was provided through the Hudson's Bay Company posts and the churches. Many older people who were interviewed cite these factors as influencing them to devalue their own culture and to rely more on the abilities of white people to provide for them. Their decreasing participation in birth and increasing reliance on non-Inuit medical personnel were part of a larger problem of social disruption. Since the 1970s people have begun to reassess the strengths of the traditions of their culture and have created the means to further the discussion throughout the Inuit territory.

One of the objectives of the Povungnituk Maternity Centre was to renew the involvement of elders in the birth process. It was hoped that they would again begin to share their knowledge and experiences with younger people, which would in turn contribute to revitalizing the Inuit traditions around birth. In reality this is one of the few frustrations experienced by the Maternity Centre staff. Elders seem to be reluctant to participate and share their knowledge. Several factors may account for this. The Maternity Centre itself is contained within the health centre, although it has a separate entrance. The hospital centre is viewed by many as a non-Inuit institution. It is not part of their domain, and they see little reason to go there unless they happen to be sick. The reliance on non-Inuit medical personnel is another. People are aware that Inuit midwives are working in the Maternity Centre, but in

discussions and interviews it was often stated that they are very competent and do not seem to need the help of others. Maternity Centre staff have spoken on community radio, asking people to participate, but to little avail. At present there are three middle-aged and older women from the community who do participate on a regular basis. Two of these women were interviewed.

Knowledge of Elders Relating to Pregnancy and Birth

This section relates information gathered from some elders with regard to practices surrounding pregnancy and birth in the past. Previous sections have presented supplementary information. The information here is nowhere near complete, but it touches on some of the principal issues. Elderly interview subjects were eager to provide information on the subject of birth practices and beliefs, often stating that ignorance of traditional methods caused unnecessary hardship for some women. Their frequent insistence that this knowledge be better distributed suggests that some form of comprehensive research and diffusion program would be appropriate in the near future.

Food and nutrition

Specific foods were 'prescribed' to pregnant mothers, often ptarmigan and loon, as were specific portions and preparation methods for meats. It is recognized that good nutrition has always been of fundamental importance to the pregnant woman. Non-traditional foods, particularly 'junk' foods are seen as having a very noticeable and negative effect on the pregnant woman. Elders say that pregnant women are much bigger today than they were in the past and that the baby is carried differently, more 'forward'. Babies are larger than in the past, which can cause difficulties during labour. Bad foods plus the apparent general laziness of young people, at least in the eyes of some elders, contributes to overly large pregnancies and babies. In Kuujjuaraapik in 1992 (Fletcher 1990-93) one woman stated that she believed that children were developing much faster than before. The children were bigger and become adults at an earlier age. She also felt that despite changes in physical development that, people were now weaker than those of her generation and took an exceptionally long time to become adults in a social sense.

Changes in babies times extend beyond their development and include the way they smell. Inuit handle their children a great deal and express affection through kisses given with the nose (*Kuni*). This involves pressing the nose against the baby's flesh, inhaling and pulling the face away to relieve the suction. This technique is coupled with an appreciation of the baby's odour. Some elders say that babies today have an appreciably different odour than in the past. This is likely a result of the diet of the mother, which changes the quality of the breast milk taken by the baby.

Prescriptions and prohibitions during pregnancy

A very detailed set of rules and practices were taught to expectant mothers; some of them are reproduced in Table 2.

Table 2
Rules and Practices Associated with Pregnancy in the Past*

When a woman's belly began to swell with pregnancy the elders would explain certain rules to her:

1. On awakening in the morning she should immediately go outside. This made the labour period shorter.
2. She should not clean her hands by scraping them with an ulu (woman's knife) or knife. To do so would make the woman dry when the baby came and cause tears.
3. When stretching a seal skin on a frame the rope should not be wound around the hands as this would cause the cord to be around the baby's neck.
4. She should never place anything bowl-shaped on her head as this would make the placenta stick to the baby's head.
5. They were not to put their head or arm part way through a hole or doorway because this would make the baby present and retreat back and forth at the vagina before being born or the baby would be born arms first.
6. She should not walk backwards or the baby would be born in breech position.
7. The woman's bed should always be facing the doorway, never sideways or the baby would be transverse inside her.
8. If something like sewing was started it should be finished in the same session so that the labour would not be long.

---

* Collected by Akinesie Qumaluk, Povungnituk, Quebec.

9. If she should lie around or take a nap the labour would be long.
10. At the first labour the woman should not scream or moan or she would do so for all subsequent labours.
11. The woman should never speak of or stare at other people's oddities, like a big nose or strange face. If she did the baby would have an even bigger nose, etc.
12. When eating the woman should finish and then lick her plate so that the baby would be beautiful.
13. When labour began the elders were told to come. Once they were inside they would prepare the labouring bed quickly so the labour would be fast. People were happy and joyous labour had begun.
14. The best part of the meat was saved for the pregnant woman.
15. If the labour was difficult then it was time for the male midwife to come.
16. Every newborn was greeted by everyone, even other children, with a handshake. The other children were told a new baby "had arrived".
17. Every newborn was given a piece of chewed meat as a symbol of welcoming. It was a joyful occasion.
18. A woman in labour should not wear a ring on her braids as that would cause the cord to be around the baby's neck.
19. To bring the placenta out a woman would use her left ring finger to gag herself. The placenta will expel after.
20. The placenta was put in cloth and buried in rocks.
21. Sand rocks or snow in a cloth were used to prevent hemorrhages.
22. Caribou or whale sinew was used to tie the cord. Never thread, as it would become infected.
23. Moss from the tundra which was a little burnt would be used to care for the cord.
24. When the baby was born it was held upside down and given a slap on the back to begin breathing.
25. The woman was not to make bubbles with gum, blow up a balloon or inflate anything because this would prevent the membranes from rupturing.
26. The woman should not chew gum or animal brains otherwise there would be vernix on the baby.
27. If the labour was long the woman should get up, go outside and return inside very quickly to make the baby come.
28. Tears were not sutured, they would heal on their own.
29. To make contractions easier the woman was given a box to lean over and ropes to pull on.
30. During pregnancy the woman should never have cold legs because this causes hemorrhaging.
31. The woman's breasts were to be kept warm so the nipples would not crack and the breast would be kept more healthy.
32. When women breastfed it helped to space the children from 2 to 3 years.
33. Even if the woman was not hungry she was to drink broth when she was breast feeding.

There are undoubtedly many others rules not included in this list and variations between communities on some of the rules. Even so, they were and to some extent still are important mechanisms for women to care for themselves and for their babies during their development and provide a communal and individual sense of responsibility for the birth process. They were intended to encourage a simple and healthy birth and to maintain the mother's health. According to elders and young people, these rules are less and less adhered to. This, according to some people, creates more hardship for the mother and the baby. One young person described her ambivalence to some of the rules and consciously broke one of them. Her subsequent complicated delivery demonstrated to her that the rules remain valid.

Complications during delivery

Traditional birth attendants who helped deliver babies before there were nursing stations and foreign medical personnel stated that most labours were quite uneventful. Their principal role was to comfort the woman in labour and wait for the baby to arrive. Once it was 'caught' by the traditional birth attendant, the baby's mouth and nose were cleared of fluid by placing the mouth over them and sucking the fluid out. The *Sanajiik* would tie and cut the umbilical cord and the baby would be placed on its mother's breast.

Occasionally there would be complications, which they were quite capable of dealing with. Often the traditional birth attendant would check the position of the fetus before and during labour. In some cases it was obvious that the baby was not in the right position and it would be manipulated from the exterior into a better position. During the birth, if the fetus was not positioned head-first, a combination of external and internal manipulation would be used to correct the position. The traditional birth attendant would place one hand inside the woman and the other outside and gently rotate the baby. One traditional birth attendant who was particularly good at external manipulation said that at times he was afraid that one of the limbs of the child would break during the manipulation, but that this never happened. (Interview 10a)

Normally after the baby was born the placenta would be expelled with relative ease. Occasionally, however, it would not, which could cause serious difficulties. If the placenta was slow to expel, the traditional birth attendant would place his or her fingers in the

woman's mouth. This would make her gag, causing a muscle contraction similar to that experienced during birth, encouraging the placenta to be expelled. Once it was expelled the placenta was disposed of in a specific manner. In Povungnituk, the placenta was carefully buried and surrounded by large stones. This was to ensure that the dogs would not eat it. Elders in Povungnituk emphasized that it was very important to dispose of the placenta properly. One woman (interview 7b-8a) stated that the placenta, because it was part of a person, was like a human being, although not completely. It was buried in the same manner as a person but without the same feeling. It was considered very bad for the dogs to eat the placenta because they would develop a taste for human flesh and become dangerous. There are mythical links between the placenta/fetus and dogs (Blaisel and Arnakak 1993) that may underpin these proscriptions.

In Kangiqsujuaq (Fletcher 1990-93), the placenta was treated in a similar fashion, although it could be disposed of in two different ways depending on the wishes of the mother. Once it was expelled, the placenta would be placed in a bag made of animal skin or, in more recent times, of cloth. If the woman who just delivered wanted to wait some time before becoming pregnant again the placenta would be wedged very tightly between two rocks. If the woman wanted to become pregnant again soon, the placenta would be suspended from a cliff face so that it was open to the air. In both cases it was emphasized that dogs should not be able to get at the placenta. In Povungnituk people did not recall this custom, which may be explained in part by the mainly flat terrain of the region. Regional variations in birthing practices are common throughout the Arctic (O'Neil et al. 1990) and a source of pride and interest among Inuit regional groups.

Summary

Throughout the interviews and discussions it became evident that Inuit consider the fetus and newborn to be fully conscious beings in the sense that they are able to exert conscious influence over people and their surroundings. This comes in part from the reincarnative capacities of name giving and also from a different perception of the formation of individual personalities. They experience and remember sensations and are able to comprehend them in a concrete manner. They are not perceived as intellectual voids in need of filling, as children in

western traditions are. The fact that people have distinct memories of events that occurred before and shortly after they were born and were able to recall their thoughts and feelings about their environment at and before birth confirms this.

The implications for the practice of midwifery in Inuit communities is that the midwife is not only serving the mother and having an influence on the quality of her life but is also serving the child who, from the point of view of the Inuit, has the mental capacity to remember and, by extension, be affected by what he or she experiences before and during birth.

Analysis

In essence this report is about integrating two different cultural perspectives on the events leading to the birth of a child. Both views serve a single purpose – to begin to integrate the child into his or her respective culture, essentially from the point of conception. In southern society the fetus is exposed to a specialized medical system designed to increase the likelihood of successful birth. This complex system surrounding pregnancy and birth reflects well the society into which the child will be born. For society to function we must all place our faith in strangers who know things we do not. The immediate family is expected to instil in the child what they feel are appropriate values within a broad range of possibilities, only the extremes of which are not accepted by society at large. Medicalized birth reflects the culture in which it is used.

In Inuit society there was very little such specialization until quite recently, and birth reflects a different cultural perspective; the child's health and development are the responsibility of a large web of related and proximal individuals, all of whom are known to the mother or the family. The identity of the fetus is at least partially that of some other member of the group and a direct reflection of relations that occurred before its conception. Children are born into a society where they will be intimately associated with those most directly involved in their perinatal care and a culture that values lifelong reliance on and obligation to certain people because of unique elements of their shared personal relationship.

Both Inuit and western cultures understand the biological process of birth in a similar way: fertility, conception, gestation, parturition and development are recognized as universal

processes that necessitate the active participation of the pregnant woman and those around her to be successful. What they do not share is the same vision of the role of birth in forging social ties and in the creation of the individual's identity. The Povungnituk maternity project is therefore as much about creating new forms of identity as it is about training midwives.

In the ethnography detailed above we have described prenatal and immediate post-natal memories, sex change in infants while leaving the birth canal, personality inheritance through the name, and the 'rules' a woman was to follow during pregnancy to assure a healthy baby. All these aspects are either challenged by the western medical model or potentially affected by hospital delivery. If we take the phrase quoted by O'Neil and Kaufert — *Irniktakpunga* and assume that its literal translation, "I make a boy", carries the same meaning in English[4] as it does in Inuktitut and combine this with the memories a person may have of the people who were present at the birth and of the person who catches him or her, it does not seem unreasonable to assert that to be truly born, from a cultural perspective, an Inuit person must be born in an Inuit context. A child is 'made' by the traditional birth attendant, and midwives are sought out for their skill. It is he or she who touches the child first on its entry into the world, providing the baby with its first sensation outside its mother's womb. The ability of some people to remember these experiences, sometimes quite vividly, reinforces the notion that this is a particularly meaningful experience. This is not to say that an individual delivered in a hospital does not exist, but that their arrival is somewhat ambiguous. They may have experienced a variety of foreign objects next to them, they may be affected by medication given to the mother, and they may come out of the womb into the hands of a doctor who is one of several people in the room who are not Inuit and not cognizant of the culture.

The generalized feelings of distance and disrespect between people described in interviews that have resulted from medicalized births imply that these are not Inuit values and responses. Is it because the infant has not been brought into the world in a manner that respects the Inuit understanding about the nature of being human. The rupture in the process of becoming a true Inuk begins for these children with their first breath. Perhaps this is just a complicated way of saying that people became alienated from one another because of birthing policy, but then again perhaps it is worth going beyond platitudes about the causes of social

problems in these communities and to look deeper at meaning to understand better. The community of Povungnituk is certainly looking for answers.

Conclusions and Recommendations

Although the Maternity Centre has many strengths, perhaps the most significant of which is involving Inuit directly in the delivery of health services, it is only one aspect of a larger system that exists to serve this population and does not respond to or solve all problems in the community. There are a number of continuing social problems in Povungnituk and in the other Inuit communities of Nunavik. The ability of people to deal with these situations is limited by a lack of resources and trained individuals and, more important, by a lack of cultural relevance in the roles and interventions prescribed by the way the various health and social services agencies are organized. The Maternity Centre and its innovative training program should serve as a model for programs in other areas. For example, the social services department and the justice system are seen by many people as mysterious and unresponsive to the needs of people and families. A system in which local people are trained to occupy community positions (which exists to a certain degree) and, more important, define the scope and intervention methods of these positions would be a logical extension of the Maternity Centre learning experience.

This points to the need for greater co-operation between the various institutions and administrations in Nunavik. The school board, nursing stations and the health centre(s) should be working together to develop training programs. The regional administrations, which are currently pulling in most of the well educated young people, should examine ways of steering some of those people into health-related careers. The health centre should be looking for innovative ways to make the jobs attractive and meaningful to those occupying them so that they will stay in them longer.

The Inuit staff of the Maternity Centre have an important role in the development of community health programs. AIDS, STDs, smoking and nutrition are all important issues in maternal and infant health but they also are equally important to the rest of the population. The role of these women as examples and facilitators of community health care is of

paramount importance and should be capitalized on by others in the health professions. They should also be given training and support to develop their skills.

The Maternity Centre itself has shown success in all regards. It has responded socially and culturally in an appropriate manner, providing effective perinatal care at the regional level. Repeated independent epidemiological evaluation has also affirmed its success in improving the health of the clientele. The social and cultural health improvements are less quantifiable but tangible nonetheless. The next logical step is to deal with the distribution of services and capabilities to the communities that do not have a hospital, as was originally planned. By themselves hospitals do not create healthy populations, but when health is treated as a social phenomenon and dealt with in a culturally appropriate manner, communities become healthier. It has been adequately demonstrated that birth belongs in the North in Inuit communities; it must now be branched off to the other communities and their nursing stations. According to various research (for example, O'Neil et al. 1990) and the information in this report, there exist no insurmountable physical, financial, medical or epidemiological reasons to prevent the return of low-risk births to nursing stations. The monitoring and evaluation model for pregnancy risk assessment developed in Povungnituk has been shown to be successful and appropriate to the population and milieu. The barriers that now exist are structural and educational.

Many women and their families in the North once again feel responsible for their pregnancies and capable of dealing with them, and the will to deal with them in their home communities is growing. In Salluit there have recently been several births in the nursing station, at least one of which was intentional on the part of the mother, who underestimated her gestation so that she would not be sent to Povungnituk. This is highly reminiscent of the reaction of some women faced with evacuation to Moose Factory and suggests that the policy and practices of the health care system in the North are not responding quickly enough to the needs and capacities of the population they serve.

At the regional and national levels the Povungnituk experience provides several important lessons that should be considered in the development and implementation of health services, particularly in the context of health service transfer to Aboriginal communities and organizations:

1. Health, illness and disease are culturally modulated elements of any ethnic or cultural group. Development of culturally relevant health services in Aboriginal communities should be considered as part of a larger process of cultural revitalization and renewal based on the reacquisition of control within those communities.
2. Community health efforts are best initiated and produce measurable results when the community or region controls and determines the shape and types of services to be developed.
3. Paramedical health careers should be encouraged for young Aboriginal people as a way of maintaining and strengthening cultural and social links while earning a living in a position of respect within their communities. Significant efforts have been made over the years to encourage Aboriginal youth toward professional health careers, with varying success. More emphasis on paramedical careers would encourage the development of a medically astute cadre from which doctors and nurses would emerge over time.
4. Culture-specific health knowledge and beliefs should be recognized as valid and become integral to health service philosophy in Aboriginal communities.
5. Improvements in community health take time; health care planning should therefore be long-term, with specific goals determined through consultation with community members, professional and paraprofessionals. Review of progress toward goals should occur regularly with the same individuals.
6. Historical origins of chronic health problems should be examined and addressed in order to avoid repeating cycles of illness.
7. Midwifery should be recognized and promoted as a health career opportunity in Aboriginal communities.
8. Barriers to the legitimization of Aboriginal approaches to health care should be removed where there are no demonstrable negative effects of those approaches (for example, healing circles).
9. Non-Aboriginal health care workers and traditional healers or other knowledgeable people should be encouraged to inform and learn from each other.

10. Opportunity for advancement within existing health care systems in Aboriginal communities should be encouraged for non-professional and para-medical personnel as a way to encourage effective participation in health care delivery and discourage turnover.
11. Non-Aboriginal medical personnel should be given instruction in local Aboriginal culture, where possible, to improve their comprehension of local issues and perspectives and to discourage self-isolation within the community.
12. Part of the selection criteria for incoming non-Aboriginal medical personnel should be a demonstrable and sincere interest in promoting local health care initiatives and an awareness of the role of culture in determining health outcomes.
13. Maternal and infant health programs should be developed with culturally appropriate materials and approaches.
14. A research program focusing on Nunavik Inuit traditional birth techniques, beliefs and practices should be established. This program should include a comprehensive diffusion plan so that all community members may benefit and learn from the research. The research program should include opportunities for people from different age groups and cultures to share perspectives and knowledge
15. Efforts should be made to have the Innuulisivik health centre designated as a teaching institution. This would, at least partially, relieve the chronic education funding problems in the Maternity Centre.

Notes

This research would have been impossible without the co-operation, participation and insight of many people in Povungnituk and the staff of the Innuulisivik Maternity Centre. Akinisie Qumaluk and Colleen Crosbie were particularly helpful in guiding this effort, and their help is greatly appreciated. So too were all the people interviewed who will, as agreed, remain anonymous. Aani Tulugak and André Corriveau are also thanked for permitting this research to be conducted and facilitating the process. John O'Neil, from the University of Manitoba, Northern Health Research Unit, co-ordinated the project with skill and patience.

1. We use the term 'traditional birth attendant' in this document to indicate indigenous midwife; 'midwife' is used to indicate individuals of any ethnic background with formalized training and certification as midwives.

2. Northern Scientific Training Program, Department of Indian and Northern Affairs, 1991 and 1993; Fonds de la Recherche en Santé du Québec, 1992-1993; Bourse de l'Université de Montréal, Département d'Anthropologie, 1990; Canadian Airlines International, 1990.

3. In this document we use 'Nunavik' in referring to events in this territory after the signing of the *James Bay and Northern Quebec Agreement* and 'Northern Quebec' for events that occurred before the signing.

4. Assuming common meaning between languages is difficult at best. I may say "I made my bed this morning" with the implicit understanding between me and the listener that I did not in fact construct a bed but simply covered an existing bed with sheets. Another meaning may be attached to the term *Irniktakpunga* that non-Inuit are not aware of.

References

Affleck, Ewan. 1993. *Report on Mortality: Nunavik's Hudson Coast 1991-1992*. Povungnituk: Innuulisivik Health Centre.

Audet, René. 1979. "Histoire du caribou du Québec-Labrador et évolution des populations". *Recherches Amérindiennes au Québec* IX/1-2: 17-27.

Avataq Cultural Institute. 1993. *Tumivut: The Cultural Magazine of the Nunavik Inuit*. No 4.

Bell, Robert. 1885. *Observations sur la côte du Labrador et la baie d'Hudson*. Rapport des opérations à 1882-1883-1884. Ottawa: Ministère de l'Intérieur, Commission Géologique et d'Histoire Naturelle et du Musée.

Blaisel, Xavier and Jaypeetee Arnakak. 1993. "Trajet rituel: du harponnage à la naissance dans le mythe d'Arnaqtaaqtuq". *Études/Inuit/Studies* 17/1: 15-46.

Bouchard, Françoise. 1990. "Having a Baby in Northern Quebec: Lessons for the Future". In *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives*. Ed. John O'Neil and Penny Gilbert. Winnipeg: Northern Health Research Unit, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

Carignan, Ginette. 1993. *Pregnancies and Births Among the Inuit Population of Hudson Bay 1989-91*. Quebec: Département de santé communautaire du Centre hospitalier de l'Université Laval.

Cooke, Allan and Clive Holland. 1978. *The Exploration of Northern Canada. 500 to 1920: A Chronology*. Toronto: Arctic History Press.

Dorais, Louis-Jacques. 1983. *Les Tuvaalummiut: histoire socio-économique de Quaqtaq: Québec arctique*. Quebec: Ministère des Affaires Culturelles.

Dufour, Rose. 1988. *Femme et Enfantement: Sagesse dans la culture Inuit*. Quebec: Les éditions Papyrus.

Dufour, Rose. 1989. "Prêtez-nous l'oreille! Anthropologie de l'otite moyenne chez les Inuit". Doctoral thesis. Département d'anthropologie, Université Laval.

Duhaime, Gerard. 1985. *De l'igloo au HLM: Les Inuit sedentaires et l'Etat providence.* Collection Nordicana no. 48. Centre d'études nordiques.

Duval, B. and F. Thérien. 1985. "Demography, mortality and morbidity of the Northern Quebec Inuit". *Circumpolar Health 84*. Ed. R. Fortuine. Seattle: University of Washington Press.

Fletcher, Christopher. 1993. "Inuit concepts of mental health: Uitsalik/Nuliatsalik and Uuttullutaq". Paper presented at the Canadian Association of Medical Anthropologists annual meeting. York University, Toronto.

Fletcher, Christopher. 1992. "1884 – A Meteorological Station at Kangirsujuaq". *Tumivut: The Cultural Magazine of the Nunavik Inuit* 3. Montreal: Avataq Cultural Institute.

Fletcher, Christopher. 1990-93. Personal Archives.

Fletcher, Christopher. 1994. "'It's My Sister's Birthday": The Inuit name sharing tradition and culture specific responses to the death of a child". Paper presented at the 2nd International Conference on the Healing Process. Montreal, 9 September 1994.

Ford, C.S. 1945. *A Comparative Study of Human Reproduction.* Publications in Anthropology, No. 32. New Haven: Yale University.

Francis, Daniel. 1979. "Les relations entre Indiens et Inuit dans la baie d'Hudson, 1700-1840". *Études/Inuit/Studies* 3/2: 73-83.

Gordon, Andrew R. 1887. *Report of the Hudson's Bay Expedition of 1886 Under the Command of Lieut. A.R. Gordon, R.N.* Ottawa: Department of Marine and Fisheries.

Graburn, Nelson H.H. 1969. *Eskimos Without Igloos*. Boston: Little, Brown and Company.

Guemple, Lee. 1994. "Born-Again Pagans: The Inuit Cycle of Spirits". In *Amerindian Rebirth*. Ed. Antonia Mills and Richard Slobodin. Toronto: University of Toronto Press.

Hassan, Riaz. 1980. *Ethnicity, Culture and Fertility: An Exploratory Study of Fertility, Behaviour and Sexual Beliefs*. Singapore: Chopmen Publishers.

Hodgins, Stephen. 1992. Director, Community Health, KCRSSS, Kuujjuaq. Personal communication.

Hodgins, Stephen. 1994. Director, Community Health, KCRSSS, Kuujjuaq. Personal communication.

Innuulisivik Centre. 1989. "The Innuulisivik Maternity: A Community Based Perinatal Service on the Hudson's Bay Coast". Internal document.

Innuulisivik Health Centre. 1992. "Summary of the Five Year Plan". Internal document.

Jelliffe, D.B. and F.J. Bennet. 1962. "World-wide care of the mother and newborn child". *Clinical Obstetrics and Gynaecology* 5: 64-84.

Jenness, Diamond. 1964. *Eskimo Administration II: Canada*. Technical Paper 14. Montreal: Canada Arctic Institute of North America.

Jordan, Brigitte. 1983. *Birth in Four Cultures: A Crosscultural Investigation of Childbirth in Yucatan, Holland, Sweden and the United States*. Montreal: Eden Press.

Kaufert, P.A. et al. 1988. "Obstetrics in the Keewatin: Changes in the place of birth 1971-1985". *Arctic Medical Research* 47/suppl.1: 481-484.

Kaufert, Patricia A. and John D. O'Neil. 1990. "Cooptation and Control: The Reconstruction of Inuit Birth". *Medical Anthropology Quarterly* 4/4: 427-442.

Kaufert, Patricia, Michael Moffat, John O'Neil and Brian Postl. 1990. "The Epidemiology of Obstetrics in the Keewatin District: Methodological Issues". In *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives*. Ed. John O'Neil and Penny Gilbert. Winnipeg: Northern Health Research Unit, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

Kirmayer, Laurence J., Kathryn Gill, Christopher M. Fletcher, Yeshim Ternar, Consuelo Quesney, André Smith, Nadia Ferrara and Barbara Hayton. 1993a. "Emerging Trends in Research on Mental Health Among Canadian Aboriginal Peoples". Draft research study prepared for the Royal Commission on Aboriginal Peoples.

Kirmayer, Laurence.J., Ellen Corin, André Corriveau, and Christopher Fletcher. 1993b. "Culture et maladie mentale chez les Inuit de Nunavik". *Santé Mentale au Québec* XVIII/1: 53-70.

KRG (Kativik Regional Government). 1991. "Schooling, Vocational Training and Economic Activity in Nunavik". Employment and Training Department.

Llewelyn-Jones, D. 1955. "Premature babies in the tropics". *J. Obstet. Gyneac. Brit. Emp.* 62: 275-279. Cited in Mead and Newton 1967.

Mead, Margaret and Niles Newton. 1967. "Cultural Patterning of Perinatal Behaviour". In *Childbearing: Its Social and Psychological Aspects.* Ed. S.A. Richardson and A.F. Guttmacher. Baltimore: Williams and Wilkins.

McGhee, Robert. 1978. *Canadian Arctic Prehistory.* Toronto: Van Nostrand, Reinhold.

Merkur, D. 1991. *Powers Which We Do Not Know: The Gods and Spirits of the Inuit.* Moscow, Idaho: University of Idaho Press.

Meyer, François and Diane Belanger. 1991. *Évaluation des soins et services en périnatalité Hudson et Ungava. Volet épidémiologique, grossesses et naissances dans deux populations inuit du Nouveau-Québec.* Département de santé communautaire du Centre hospitalier de l'Université laval.

MSSS. 1989. "Ministère de la Santé et des Services Sociaux, Registre des Autochtones". Internal document.

Murdock, A.I. 1979. "Factors associated with high risk pregnancies in Canadian Inuit". *Canadian Medical Association Journal* 120: 291-294.

O'Neil, John and Patricia Kaufert. 1995. "*Irniktakpunga!*: Sex Determination and the Inuit Struggle for Birthing Rights in Northern Canada". In *Conceiving the New World Order: The Global Stratification of Reproduction.* Ed. F. Ginsberg and R. Rapp. Berkeley: University of California Press [in press].

O'Neil, John and Penny Gilbert, ed. 1990. *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives.* Winnipeg: Northern Health Research Unit, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

O'Neil, John, Patricia Kaufert and Brian Postl. 1990. "A Study on the Impact of Obstetric Policy on Inuit Women and Their Families in the Keewatin Region, N.W.T." Manuscript. National Health Research and Development Program, Health and Welfare Canada, #6607-1441-57.

Pauktuutit [Inuit Women's Association]. N.D. "Ikajurti -The Helper: Midwifery in the Canadian Arctic". Video.

Payne, F.F. 1887. *Eskimo of Hudson's Strait.* Proceedings of the Canadian Institute. Series 3, volume 6: 213-230.

Proulx, Jean-François. 1987. *Mortality Among the Inuit Population of Hudson Coast 1982-1986.* Povungnituk: Innuulisivik Health Centre.

Proulx. J.-F. 1988. *Towards Healthy Communities on Hudson Coast.* Povungnituk: Innuulisivik Health Centre.

Quebec Alliance of Practising Midwives. 1989. *What is the Future for Quebec Midwives?*

Quebec et al. 1980. *La convention de la baie James et du Nord Québécois et les conventions complementaires nos. 1, 2, 3, 4, 5 et 6.* Quebec: Éditeur officiel.

Quebec National Assembly. 1990. *An Act Respecting the practice of midwifery within the framework of pilot projects.* Quebec: Éditeur officiel.

Saladin d'Anglure, B. 1977. "Iqallijuq ou les reminiscences d'une ame-nom Inuit". *Études/Inuit/Studies* 1: 33-63.

Saladin d'Anglure, B. 1980a. "Petit-ventre l'enfant-géant du cosmos inuit. Ethnographie de l'enfant et enfance de l'ethnographie dans l'Arctique central inuit". *L'Homme* 20/1: 7-46.

Saladin d'Anglure, B. 1980b. "Violences et enfantements inuit ou les noeuds de la vie dans la fil du temps". *Anthropologie et Société* 4/2: 65-100.

Saladin d'Anglure, B. 1984a. "Inuit of Quebec". In *Handbook of North American Indians.* Volume 5: 476-507. Washington, D.C.: Smithsonian Institution.

Saladin d'Anglure, B. 1984b. "Contemporary Inuit of Quebec". In *Handbook of North American Indians.* Volume 5: 683-688. Washington, D.C.: Smithsonian Institution.

Saladin d'Anglure, B. 1986. "Du foetus au chamane: la construction d'un 'troisième sexe'". *Études/Inuit/Studies* 10/1-2: 25-114.

Smith, D.G. 1993. "The Emergence of 'Eskimo Status': An Examination of the Eskimo Disk List System and its Social Consequences". In *Anthropology, Public Policy and Native Peoples in Canada.* Ed. Noel Dyck and James B. Waldram. Montreal: McGill-Queen's University Press.

Steinman, André. 1977. *La Petite Barbe*. Montreal: Éditions de l'Homme.

Stonier, Jennifer. 1990. "The Innuulisivik Maternity". In *Childbirth in the Canadian North: Epidemiological, Clinical and Cultural Perspectives*. Ed. John O'Neil and Penny Gilbert. Winnipeg: Northern Health Research Unit, Department of Community Health Sciences, Faculty of Medicine, University of Manitoba.

Therrien, M. 1987. *Le Corps Inuit (Québec Arctique)*. Marseille: SELAF.

Therrien M. and R. Dufour. 1992. "Le corps Inuit: Corps physique, corps social et corps cosmique". Paper presented at Canadian Association for Medical Anthropology Annual Meeting, Montreal.

Tourigny, André, Judy Ross and Pierre Joubert. 1991. *Évaluation des Soins et Services en Périnatalité dans la Région de la Baie d'Hudson: Volet Organisation*. Département de santé communautaire du Centre hospitalier de l'Université Laval.

Tremblay, Normand. 1985. "La fécondité dans un village inuit". *Études/Inuit/Studies* 9/1.

Tremblay, Normand. 1981. *Natalité et Mortalité Chez les Inuit de la Baie d'Ungava*. Collection Nordicana No. 44. Quebec: Centre d'études nordiques, Université Laval.

Vanast, Walter J. 1991. "'Hastening the day of extinction': Canada, Québec and the medical care of Ungava's Inuit, 1867-1967". *Études/Inuit/Studies* 15/2: 55-84.

Vézinet, Monique 1980. *Les Nunamiut. Inuit au Coeur des Terres*. Quebec: Ministère des Affaires Culturelles.

Wenzel, George. 1991. *Animal Rights Human Rights: Economy, Ecology and Ideology in the Canadian Arctic*. Toronto: University of Toronto Press.