# Access to midwifery services for Indigenous communities in Quebec

## Final Report

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We have feminized the presentation of results to reflect the predominantly female representation in this research. Only one man was interviewed during data collection.

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# Access to midwifery services for Indigenous communities in Quebec

## LIST OF ABBREVIATIONS

| | |
|---|---|
| AFNQL | Assembly of First Nations Quebec-Labrador |
| CISSSAT | Centre intégré de santé et de services sociaux de l'Abitibi-Témiscamingue |
| CBHSSJB | Cree Board of Health and Social Services of James Bay |
| CAALT | Centre d'amitié autochtone de La Tuque |
| CAATR | Centre d'amitié autochtone de Trois-Rivières |
| FNQLHSSC | First Nations of Quebec and Labrador Health and Social Services Commission |
| MSSS | Ministère de la Santé et des Services sociaux |
| NCIM | National Council of Indigenous Midwives |
| RCAAQ | Regroupement des centres d'amitié autochtones du Québec |
| UQTR | Université du Québec à Trois-Rivières |
| UQAT | Université du Québec en Abitibi-Témiscamingue |
| UQO | Université du Québec en Outaouais |
| VDNFC | Val-d'Or Native Friendship Centre |

# ABSTRACT

The ministère de la Santé et des Services sociaux (MSSS) has expressed its intention of implementing one of the measures included in the 2017-2022 action plan developed by the Secrétariat aux affaires autochtones (SAA), *Do More, Do Better: Government Action Plan for the Social and Cultural Development of the First Nations and Inuit*, a set of 119 initiatives organized in four strategic priorities. Measure 1.1.15 aims to "develop access to the services of midwives in non-treaty Aboriginal communities" (SAA, 2017, p. 47). In order to address this measure as well as the critical need to improve health care for Indigenous women, the MSSS approached the Canada Research Chair in Indigenous Women's Issues at the Université du Québec en Abitibi-Témiscamingue (UQAT) to conduct research on the access to midwifery services of Indigenous communities in Quebec. Conducted in collaboration with the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC), this research is the first step towards the implementation of this government measure (measure 1.1.15)[1].

The main objective of this research is to produce knowledge conducive to an improved access to midwifery services for Indigenous women and families in the said non-treaty communities in Quebec. The objective also includes an understanding of Indigenous women's needs in terms of culturally relevant and safe perinatal monitoring, the facilitating factors and the obstacles encountered in accessing these. The findings are intended, in particular, as tools for government and Indigenous authorities (Indigenous communities, FNQLHSSC, Regroupement des centres d'amitié autochtones du Québec [RCAAQ], etc.) in the deployment of midwifery services that are in line with the needs and aspirations of the various Indigenous communities in Quebec.

The health of Indigenous women in Quebec and Canada is marked by colonialism. Colonial policies have targeted Indigenous women in many ways, either through the control over their bodies, the devaluation of their roles within their societies, the eradication of their roles as educators through the mandatory attendance of residential schools, and the non-recognition of their place within their traditional land. Today, Indigenous women are affected by these numerous attempts at eradication. Indigenous midwifery knowledge, traditionally present throughout the Americas and elsewhere in the world, has been devalued in favour of biomedicine and the overmedicalization of pregnancies. Traditional birthing rituals have been stigmatized, and the Indigenous experience of motherhood has been adversely affected. As a result, pregnant women are faced with significant difficulties, of which the obligation of travelling long distances for pregnancy follow-ups and to give birth, and therefore isolating them from their families, their communities and their land.



[1] This research should also serve as support to implementation of the measures and recommendations included in the *2022-2027 Government Action Plan for the Social and Cultural Wellness of the First Nations and Inuit* developed by the Secrétariat aux relations avec les Premières Nations et les Inuit (SRPNI) as well as in the Plan d'action en périnatalité et petite enfance (PAPPE) 2023-2028 of the ministère de la Santé et des Services sociaux (MSSS) of the Quebec Government.

In the wake of the events surrounding the tragic death, on September 28, 2020, of Ms. Joyce Échaquan, an Atikamekw woman from the Manawan community, Joyce's Principle was developed to "guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health" (CNA & CAM, 2020, p. 14). Inspired by the United Nations Declaration on the Rights of Indigenous Peoples (UN, 2007), this principle brings back to the forefront the necessary recognition of and respect for Indigenous peoples' traditional health-related knowledge.

# Introduction

# 1. Nature of the research and objectives

## 1.1 Problematic issues: a portrait of Indigenous women's health

### 1.1.1 General health outcomes

Given the heterogeneity of this population group, it is complex to paint a general picture of Indigenous women's[2] health across Canada. However, inquiry reports (CERP, 2019; TRC, 2015; NIMMIWG, 2019) are unanimous regarding the inequities in health between Indigenous and non-Indigenous populations. In Quebec, the Institut national de la santé publique (INSPQ, 2014) observes that Indigenous populations are over-represented in terms of intentional and unintentional trauma, chronic diseases (obesity, diabetes and cardiovascular disease) and of certain transmissible diseases (sexually transmitted infections and tuberculosis). Indigenous women are more severely affected by chronic diseases than the rest of the Canadian population. For example, 46.5% of First Nations women report suffering from comorbidity, i.e., the coexistence of at least two chronic health problems, compared with 36.4% of First Nations men (FNQLHSSC, 2018). In 2006, 60% of Indigenous women aged 20 and over were diagnosed with a chronic disease, the most common of which were arthritis and rheumatism (O'Donnell & Wallace, 2011). For the Indigenous population as a whole, rates of adult obesity (26% for First Nations and Inuit, 22% for Métis) are higher than those of the non-Indigenous population (16 %) (GC, 2011). Indigenous women are also more prone to suffer from obesity than Indigenous men and to resulting illnesses such as diabetes (FNQLHSSC, 2018).

In Ontario, a study highlights the fact that Indigenous are at greater risk of developing diabetes than non-Indigenous women (4.2 % compared to 1.6 % [20 to 34 age group] 17.6 % compared 6.0 % [35 to 49 age group] (Walker & al., 2020). Similarly, a higher percentage of Indigenous women [4.8% for First Nations, 4% for Inuit and 2.2% for Métis] are diag-



[2] The use of the term "woman" may include transgender persons or those of non-binary gender. The term "Indigenous" includes First Nations, Métis and Inuit, and is used here for pragmatic reasons. In this report, it refers to the First Nations of Quebec.

nosed with gestational diabetes compared to the non-Indigenous population [0.5%] (Garner et al., 2010). These figures are all the more alarming given that the fertility rate among Indigenous women in Canada is higher than in the general population. In 2010-2011, for example, these rates were of 3.25 children per women living in territorial communities[3] and 2.20 per women living off-community, figures that exceed the average for Indigenous women, which stands at 1.63 children per woman. (HC & AFN, 2021). In this context, gestational diabetes therefore constitutes a major public health issue.

Finally, across Canada, in 2011, the life expectancy of First Nations women was of 77.7 years, therefore 9.6 years less than that of non-Indigenous women (Tjeokema & al., 2019)[4]. According to testimonies heard at the Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec (CERP, 2019), approaches to health care and the type of interventions performed in the health and social services network in Quebec fail to meet the needs of the Indigenous population, and the relationship with the system is quite challenging. In fact, many Indigenous women avoid points of service altogether (to which they are entitled) because they do not trust the health care system, and their negative experiences of control over their reproductive health (Basile & Bouchard, 2022; Labra & al., 2023). Furthermore, access to health care is often quite limited because of their geographic isolation and the considerable waiting time to receive care (CERP, 2019). Multiple factors undermine the health of Indigenous women, yet it is internationally recognized that colonialism is an inescapable social determinant of health (NCCAH, 2012; Labra & al., 2023; Smylie, 2008).

### 1.1.2 Impacts of colonization on health status

Indigenous women in Canada and Quebec carry a heavy burden in terms of health. These women, in addition to experiencing the determinants of health[5] that affect the Canadian population as a whole, are also plagued by Indigenous-specific determinants, such as culture, self-determination, and colonialism (Halseth, 2013). The history of colonization represents an important marker of vulnerability for Indigenous women. In particular, their exclusion from their nations' various decision-making bodies has meant that their roles in governance have been ignored (Basile, 2017). Colonial policies have also deeply impacted the role of women in the transmission of knowledge given that "[t]he transmission of teachings and cultural practices across generations of women has traditio-



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3 The expression "territorial communities" refers to communities located on First Nations territory, as the terms "reserve" or "Indian band" are no longer appropriate. According to TCPS 2 (2022, p. 169), "Territorial communities" have governing bodies exercising local or regional jurisdiction (e.g., members of First Nations who reside on reserve lands)."

4 Only the projected figures are available for the year 2017, and according to these, life expectancy for First Nations women is "between 78 and 80 years" (HC, 2015).

5 "Determinants of health refer to all the factors that influence a population's state of health, without necessarily being direct causes of specific problems or illnesses. Determinants of health are associated with individual and collective behaviors, living conditions and environments. There are disparities in the distribution of these determinants between different tiers of society, resulting in health inequalities" [translation] (INSPQ, 2021, p. 1).

nally ensured the strength and continuity of Aboriginal societies" (NCCAH, 2012, p. 2). The imposition of patriarchy within Indigenous nations has subjected them to roles of inferior status and limited worth, whereas this was not the case in the past. Therefore, "[h]istorical circumstances have shaped the current social, political and economic realities of Aboriginal women's lives, which in turn impact their physical, emotional and mental health" (Halseth, 2013, p. 6). The medicalization of pregnancy, the concept of risk and the policy of evacuating Indigenous women from their communities to give birth in "Southern" hospitals have had a devastating impact on them[6]. As emphasized by Dawson:

> the socially constructed risk discourse developed not in response to obstetrical emergencies but rather to scientific and technological advances, accumulated knowledge, and colonizing power. With advanced technology, pregnancy and birth became more of an anomaly with a narrower range of what is considered a normal pregnancy. With pregnancy no longer viewed as a natural process, the female body becomes inherently at risk (Dawson, 2017, p. 160).

The context shaping the lives of Indigenous women across the country explains the great disparities in terms of health affecting them. Therefore, "[n]ot surprisingly, [...] Aboriginal women experience a disproportionate burden of adverse maternity experiences, including the highest rate of gestational diabetes, birthing long distances from home, and postpartum depression compared to non-Aboriginal women" (Smylie, 2014, p. 2). This means that reproduction represents a risk factor added onto Indigenous women's general state of health (Halseth, 2013; Vang & al., 2018).

### 1.1.3 Indigenous women and perinatality

With regard to the medical conditions experienced by Indigenous women during the perinatal period[7], the literature most frequently addresses the issues of high-risk pregnancies, more specifically gestational diabetes (Chen & al., 2019; Gaudreau, 2009; Halseth, 2013; Pace & al., 2020; Smylie, 2014), stillbirths[8] (Auger & al., 2013; Gilbert & al., 2015; Sheppard & al., 2017) and infant mortality (Chen & al., 2015, 2019; Gilbert & al., 2015; Kaufert & O'Neil, 1990; Luo & al., 2010a, 2010b, 2012; Shapiro & al., 2018; Simonet & al., 2010; Wassimi & al., 2010; Xiao & al. 2016). In these documents, the issues previously raised regarding the many impacts of colonization



6 Pregnant Inuit women in Quebec and Canada may have to leave their communities for several weeks (average of 4 to 6 weeks) to give birth in a hospital. However, over 86% of deliveries by Inuit women in Nunavik take place in one of the region's villages offering perinatal services (Van Wagner & al., 2007).

7 The perinatal period covers the period "from the planning of the pregnancy or [under certain circumstances] from conception to the child's first birthday" (MSSS, 2008, p. 3).

8 Stillbirth is defined as fetal death occurring between 26 weeks (6 months) gestation and before or during delivery.

- and by extension the medicalization of pregnancy and childbirth - are approached solely from a medical perspective. These women, considered to be at risk, are subject to more stringent pregnancy monitoring (Gaudreau, 2009), and their geographic remoteness becomes an additional factor due to the lack of appropriate health services in this context (Cidro & Sinclair, 2021; Xiao & al. 2016). In other words, a majority of these Indigenous women must travel to a tertiary centre (high-risk pregnancy clinic) in order to access the follow-up required to address their high-risk pregnancy (Duquette, 2016).

### 1.1.4 Cultural safety in perinatal health care

Cultural safety[9] in health care is a model developed in New Zealand by a Maori nurse named Irihapeti Ramsden (Ramsden, 2002) that spread to Australia, Canada and the United States. This approach, widely documented in the literature originating from all three countries (Baba, 2013; Kruske & al., 2006; Lévesque, 2016; Lévesque & al., 2019a; Papps & Ramsden, 1996; Whitty-Rogers & al., 2006; Williamson & Harrison, 2010), encompasses a wide range of social justice issues, and applies not only to the healthcare sector, but also to education, social economy and homelessness, to name but a few (Lévesque, 2016).

It is imperative to take into account the various above-mentioned factors in the development of safe, culturally relevant health services for Indigenous women (IHWGRC, 2019; Hartz & McGrath, 2017; Lévesque, 2016; Williamson et Harrison, 2010). As noted by Halseth, "[i]mproving access to health care is an important step in addressing some of the health care needs of Aboriginal women. They have, up to now, not been well served by the health-care system" (Halseth, 2013, p. 12). Fortunately, various healthcare actors are getting involved to ensure the implementation of care services that meet the needs of Indigenous women, as is the case with the FNQLHSSC, Quebec Native Women (QNW), the Society of Obstetricians and Gynaecologists of Canada (SOGC), the National Council Indigenous of Midwives (NCIM) and the RCAAQ. As specified by Hartz and McGrath, "[a]ccess to culturally appropriate antenatal care, birthing services and maternal and child health services can reduce the risk of poor health outcomes for Indigenous mothers and their babies, children and families" (Hartz & McGrath, 2017, p. 50). In fact, among the range of strategies that could be deployed to offer culturally safe responses to Indigenous mothers and mothers-to-be, Indigenous midwifery services stand out in terms of the demands they generate.

### 1.1.5. Indigenous midwives: a need expressed by Indigenous women

A study of published literature carried out as part of this research indicates a desire for access to Indigenous midwifery services, as voiced by Indigenous women themselves and highlighted in the media in recent years. Across the country, Indi-



[9] "This approach took off in the early 1990s in the context of health care provided to the Maori population and deemed unsafe for patients because it did not respect Maori values and principles of life and well-being, reproduced discriminatory behaviors and attitudes, and denied the power and oppression relationships (past and present) between the Maori population and the New Zealand central state" [Translation] (Lévesque, 2016, p. 17).

genous women and associations are demanding better perinatal services in order to revitalize traditional practices related to pregnancy and childbirth, and to benefit from them (Alex, 2017; Baker, 2022; Wheeler, 2017; Williams, 2021). The literature consulted outlines the many advantages associated with midwifery practices in an Indigenous context, such as safer pregnancy monitoring, deliveries with fewer medical interventions and the important place of family during pregnancy and childbirth. As mentioned in selected newspaper articles, funding remains a key issue in meeting the needs of Indigenous women and ensuring the sustainability of midwifery services (CBC News, 2017a, 2017b; RC, 2017).

## 1.2 Research objectives

The main objective of this research is to produce knowledge that allow to enhance the access of women and especially families to midwifery services for Indigenous non-treaty communities[10] in Quebec. As specific objectives, this research aims to:

1) Describe the services offered in Indigenous communities and environments in Quebec in terms of family planning, pregnancy monitoring, delivery, postnatal care, including the revitalization of ceremonies and rituals related to the birth of a child;
2) Understand and analyze the experiences of Indigenous women and families, their needs in terms of perinatal services, facilitating factors, obstacles (deterrents) and desired improvements to access these services in Quebec, as described by participants working in Indigenous health departments and organizations;
3) Analyze the conditions for success (promising initiatives, innovative tools and resources, consideration of Indigenous knowledge) and the obstacles (shortcomings, unsafe practices, possible "birth alerts") encountered in accessing these services, when relevant;
4) Identify, describe and geographically locate certain Indigenous ancestral practices and promising practices (in Quebec, Canada and elsewhere in the world) in perinatality;
5) Illustrate the journey of Indigenous women when accessing perinatal health services by tracing the itinerary of Indigenous women through the healthcare system.

The aim of this research is to respond to the first stage of the development plan for access to midwifery services proposed by the MSSS. This research was conducted in collaboration with the FNQLHSSC. The ethics certificate was issued by the UQAT Human Research Ethics Committee on August 23, 2021 (Reference 2021-06-Basile S.).



[10] The term "treaty communities" refers to Indigenous communities that are signatories to the James Bay and Northern Quebec Agreement (JBNQA) or the Northeastern Quebec Agreement (NEQA), i.e., the Inuit, Cree and Naskapi communities. In opposition, the said "non-treaty communities" refer to all other Indigenous communities. These above-mentioned agreements guarantee health services to these three Peoples that other First Nations in Quebec do not have access to within their communities.

# 2. Methodology and ethical considerations

This research was conducted in accordance with the main tools and protocols framing research in an Indigenous context in Quebec, namely the *Assembly of First Nations of Quebec and Labrador Research Protocol* (AFNQL, 2014), the *Guidelines for Research Involving Aboriginal Women* (QNW, 2012), the *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans - TCPS2* (SSHRC & al., 2022) and the *Framework for First Nations Information Governance in Quebec* (FNQLHSSC, 2019). The distinctive approach adopted is characterized by the implementation of principles applicable in the context of this research, including the establishment of a close collaboration with a First Nations organization at the start of the research work, and the particular attention paid to the voices of the Indigenous women participating in the data collection.



## 2.1 Scientific committee and framing the research

From the outset, a scientific committee was set up to bring together the expertise needed to ensure that the research protocol developed met scientific standards. Over the course of the research, the scientific committee's mission evolved as the work progressed. As such, it has come to play a supporting role to the research team, through exchanges, discussions and the sharing of knowledge. The scientific committee held five virtual meetings between April 2021 and April 2022. The scientific committee was composed of ten people. One faculty member from the School of Indigenous Studies and one from UQAT's Unité d'enseignement et de recherche en sciences de la santé served on the committee. In addition, the head of the midwifery department of the Université du Québec à Trois-Rivières (UQTR) and a professor of the Social Sciences department of the Université du Québec en Outaouais (UQO) were also part of the committee. They were joined by a research officer and a manager from the FNQLHSSC as partners, four MSSS officials as observers, and the research officer from the Canada Research Chair on Aboriginal Women's Issues.

## 2.2 Research process

The qualitative method used for this research translated into the development of complementary methodological approaches that allowed to adequately meet the various research objectives. The research is divided into two areas: 1) a scoping review and 2) a field survey structured around data collection tools characteristic of an ethnographic survey

approach, based on semi-structured interviews and participatory mapping. From conception to completion, the research process benefited from the advice and guidance of the scientific committee.

### 2.2.1 Scoping review

The works of Arksey and O'Malley on scoping studies provided the research team with the tools required to meet research objectives 1, 3 and 4. Based on the six stages developed by these authors, a scoping review was carried out according to the following model: 1) identifying the research question; 2) identifying relevant studies; 3) selecting relevant articles; 4) charting the data; 5) analyzing the data; and 6) collating, summarizing and reporting the results (Arksey & O'Malley, 2005). The scoping review highlights weaknesses in the literature on the topic being explored. (Tricco, 2020). For the purposes of this research, we have catalogued as much of the existing literature as possible (articles, monographs, research reports, dissertations and theses, grey literature) on the realities of perinatal services and midwifery in Indigenous communities and environments in Quebec (which proves to be very limited) and in Canada (mainly written in English). For the last chapter of the report, the scoping review had to be extended to the international level, in order to list as many promising ancestral practices as possible. To facilitate the logistical processing of these references and data, reference management software (Endnote) was used.

### 2.2.2 Limitations of the scoping review

The scoping review was conducted over several months, allowing for the addition of new information over time. Despite this relatively long period of time, it became clear that there exists little literature on the topic of the experience of pregnancy and perinatal care among Indigenous women in Quebec, particularly for First Nations women in treaty and non-treaty Indigenous communities. A large percentage of the relevant literature focuses on Inuit women and communities (Nunavik), an area of study not a priori covered by this research. As it is essential to shed light on the contribution of Inuit midwifery in Nunavik and given the greater abundance of literature about these communities, it was decided to include this topic in the scoping review. With regard to the literature on Canada as a whole, several of the works listed address issues such as the evacuation of Indigenous women to hospitals for childbirth, Indigenous midwifery, cultural safety in perinatal health and the return of births to the territory. These texts were used to highlight the results of the interviews conducted.

### 2.2.3 Field survey and mapping

A field survey was conducted to understand and analyze the experiences in perinatal care of Indigenous women in Quebec (objectives 2, 4 and 5), using ethnographic research tools such as semi-structured interviews and participatory mapping. In doing so, it was possible to offer "a detailed and exhaustive description of a culture or social situation" (Laperrière, 1997, p. 327). All First Nations community health directors in the FNQLHSSC Network of Health and Social Services Directors were invited to participate. With regard to practices within the Movement of Native Friendship Centers of Quebec, the RCAAQ recommended contacting Friendship Centers that offer professional health services to Indigenous people who live or pass through urban areas. Three Centers were thus approached, two which have had a health clinic for several years (VDNFC

and CAALT), and one which has a clinic project in development (CAATR). Two other Indigenous organizations also took part in the research: QNW and NCIM. In several cases, the health departments preferred to designate a member of their team working at their health centres to take part in the interview.

As the participatory mapping exercise is quite voluminous, it has been included as an appendix to this report (see Appendix A). This exercise, carried out in conjunction with the field survey, enabled us to illustrate the journeys imposed on Indigenous women to access perinatal health services. The results of this exercise are 1) a schematic map of the typical journey of an Atikamekw woman and an Innu woman during an uncomplicated pregnancy, and 2) general maps of the itineraries of pregnant Indigenous women in Quebec.



### 2.2.4 Recruitment and data collection

Data collection was carried out in a single stage, i.e., individual interviews mainly conducted by videoconference (Zoom and Teams) due to the COVID pandemic and recorded with the consent of the interviewees. It was also possible to travel to three communities: Lac Simon, Manawan and Pikogan. Interviews in other communities were to be conducted in person also, but the resurgence of COVID at the time of the planned travel forced their cancellation. These semi-conducted interviews took place from late September 2021 to mid-March 2022 (see Interview Guide in appendix B).

The participants were approached in several stages. First, Professor Suzy Basile presented the research to health directors at a meeting of the Network of Health and Social Services Directors held by the FNQLHSSC. This presentation was followed by an information note, sent by e-mail in August 2021 by the FNQLHSSC to Network members, presenting the main information regarding the research (see Appendix C). Subsequently, personalized e-mails were sent to establish contact with each of the health authorities in the First Nations communities targeted by the research. In parallel with these initial approaches, Indigenous organizations were also contacted regarding their participation in the research. Throughout the fall of 2021, follow-ups were made, sometimes by the research team and sometimes by the FNQLHSSC, to ensure greater participation in the data collection. Initially, 33 interviews were planned, representing 31 communities and 2 Native Friendship Centres. Ultimately, 27 interviews were conducted, representing 19 communities and 6 Indigenous organizations, as well as 2 personal testimonies (see the table of Indigenous communities and organizations involved in the data collection in Appendix D). In all, 32 people took part in the interviews: this figure can be explained by the fact that, on some occasions, 2 people were present at the interview. Interviews were conducted mainly in French (22), with a few in English (5). As only one man was interviewed, it was agreed to feminize the names referring to the interviewees. Following the interviews, transcriptions were made in the language of use and sent to the participants so that they could validate the content and the accuracy of what was said. Out of respect for the anonymity of the testimonies collected, a coding system was set up as follows: COM+sequential number for First Nations communities, ORG+sequential number for Indigenous organizations (including three Native Friendship Centres) and TEM+sequential number for personal testimonies.

### 2.2.5 Limitations to the field survey

Several constraints limited data collection. The first stems from the fact that the research criteria involved only the so-called non-treaty communities. For the research team, this way of categorizing the Indigenous population in Quebec does not do justice to the diversity of nations that live on the land while also reflecting a colonial perspective towards these nations. Similarly, two of the said treaty nations, i.e., the Eeyouch (plural of Eeyou) and the Inuit, include midwifery services in some of their health centres. As a result, it would become useful to paint a comprehensive portrait of the situation in these communities, sharing their experiences as inspiration to other communities. With this in mind, the team turned to the testimony of a midwife who had previously practised in Eeyou Istchee (land of the people) to hear about her experiences.

Secondly, we quickly realized that health authorities, Indigenous organizations and their respective staff were overburdened by their numerous tasks and responsibilities. They also carried the added weight of a stressful health situation brought about by the COVID-19 pandemic sweeping across Quebec at the time of data collection. In this context, it was a privilege for all these people to be able to give us their time.

Thirdly, there are currently several projects under development in Quebec involving midwives and Indigenous communities, all closely or remotely linked to the MSSS. For example, the MSSS hired a midwife in winter 2020 to propose models for organizing perinatal services, including midwifery services, in certain non-treaty First Nations communities in Quebec. In Abitibi-Témiscamingue, in summer 2020, the Centre intégré de santé et de services sociaux de l'Abitibi-Témiscamingue (CISSSAT) hired a midwifery project manager responsible for the development of midwifery services for the region's population. This project manager also contacted Anicinabe communities in the region to gain insight into their needs. It's a similar story in Gaspé, where midwives in place were reaching out to Mi'kmaq communities to offer their services. In short, a strong enthusiasm for midwifery in Quebec, while positive for the province's Indigenous and non-Indigenous women, was manifesting itself simultaneously with this research work. This double request on the part of Indigenous health centres, whether in the community or within urban Indigenous organizations, increased the participant's workloads, in addition to creating confusion about the various initiatives.

### 2.2.6 Treatment and data analysis

The research team opted for an inductive approach. Inductive data analysis seems appropriate for this research, being defined as "[...] a set of systematic procedures for processing qualitative data, these procedures being essentially guided by the research objectives" (Blais & Martineau, 2006, p. 15). This type of approach is characterized by four stages: 1) preparation of raw data; 2) careful, in-depth reading; 3) identification and description of initial categories; and 4) further revision and refinement of categories (Blais & Martineau, 2006). To this end, the use of NVivo 10 software (QSR International) facilitated the digital organization of the data. This procedure enabled us to provide an exhaustive description of the situation regarding access to and quality of midwifery services for Indigenous communities in Quebec.

# 3.
# Content of the report

Highly enriching and insightful, the interviews conducted for this research inform on the multi-facetted realities of Indigenous mothers and represent the core of this report, which includes a presentation of the findings and a discussion on the available literature. The analysis is divided into five chapters:

**1.**
Scoping review.

**2.**
Perinatal services offered in Indigenous communities and organizations in Quebec.

**3.**
Perinatal services not accessible within Indigenous organizations.

**4.**
Midwifery services for Indigenous communities and organizations.

**5.**
Ancestral Indigenous practices.

Each of these chapters is broken down into sub-themes in accordance with the analysis of results obtained. A validation of the analysis of the results and the accuracy of the quotes was carried out with each of the research participants and corrections, if applicable, were made to the final version of the report available in French and English.

# Chapter 1.
# Results of the scoping review

The scoping review conducted for this research aims to answer three of the five objectives (1, 3 and 4) presented in the section Research objectives. This calls for an extensive examination of relevant literature, particularly as the first two objectives focus solely on Quebec, while the last one extends to Canada and elsewhere in the world. A total of 394 texts are listed: scientific articles, monographs, book chapters, newspaper articles, reports and documents produced by governments, as well as Indigenous and non-Indigenous organizations. Of these 394 texts, 69 were selected; they specifically address prenatal services in Quebec or ancestral Indigenous practices throughout the world. The scarcity of literature on the subject explains the very limited number of papers selected. Furthermore, in order to respond as adequately as possible to the first and third objectives, it was necessary to exclude studies predating the 1980-90s in order to ensure the most up-to-date description of the services available to pregnant women[11] and new mothers, the initiatives currently in progress and the obstacles that stand in their way.

## 1.1 Insight into contemporary midwifery practice

### 1.1.1 Midwives in Canada and Quebec

Whether practising in Canada or elsewhere in the world, midwives play an important role in providing prenatal care for women and their families. (RLSFQ, 2020a). A strong relationship of trust is created between mother and midwife, who also shares knowledge about pregnancy, motherhood and sexual health (Frame, 2014; RLSFQ, 2020a). In addition to providing locally based services, many positive effects are associated with midwifery, including a complete pregnancy monitoring service, a humanized and personalized approach, and a context of informed choice and of greater freedom for pregnant women. Compared to births attended by obstetricians, midwife-led births, including non-hospital births, are associated with lower rates of obstetric interventions and increased maternal satisfaction. Furthermore, these deliveries are not associated with an increase in maternal and neonatal complications (morbidity or mortality) (Couchie & Sanderson, 2007; Frame, 2014).



[11] When the term “pregnant women” is mentioned, it automatically refers to Indigenous women unless otherwise specified (non-indigenous women).

Having all but disappeared from the health care landscape, midwives reemerged in Canada during the 1990s[12] in response to the growing demands from women and families for more humane care during pregnancy and childbirth, but also in an attempt to achieve the goals of cost rationalization and accessibility of care. (Gref, 2018; MacDonald, 2007; Vadeboncoeur & al., 1996). Currently, the presence of midwives stretches across almost the entire country, with the exception of one province (Prince Edward Island) and one territory (Yukon), where midwifery services are still not available. Although the number of midwives in Canada more than doubled between 2007 and 2020, from 720 to 1,834, their services are not widely available in the provinces and territories where they are regulated (CAM, 2019). In Quebec, based on data from 2021, 230 midwives operate in 15 administrative regions out of a total of 18 regions. (RSFQ, 2020b)[13].



## 1.1.2 Indigenous midwives

Within Canada's vast network of midwives, Indigenous midwives are active in many parts of the country, as NCIM members if they so choose. As of 2016, 27 NCIM members were serving as midwives or student midwives in Nunavik[14]. This number is second only to Ontario, which currently has 57 NCIM-member Indigenous midwives across the province (Baker, 2022; Olson, 2016). The Six Nations of the Grand River Territory in Ontario is also home to the Tsi Nón:we Ionnakerátstha Birthing Centre, which has been providing a combination of traditional and modern midwifery services for nearly 30 years (SNHS, 2023).

While these numbers may seem rather low, it's important to remember that midwifery has always existed among Indigenous communities in Canada. As pointed out by Dion Fletcher: "[m]idwives have always existed, and hold an essential role to the childbirth process in Indigenous communities; it was grandmothers and other women in a mother's life who assisted them throughout pregnancy and in childbirth" (Dion Fletcher, 2017, p. 4), a finding supported by several other research studies (Bedon, 2008; Carroll & Benoit, 2014; Douglas, 2010; Olson & al., 2019; Routhier, 1987). The number of NCIM midwives is not higher, notably due to the imposition of colonial policies, as is the case with the determinants of health. Colonization interrupted the practice of midwifery, thereby undermining cultural practices and traditional knowledge related to motherhood and negatively affecting several aspects of Indigenous women's health (Dion Fletcher, 2017; Flynn & Brassard, 2012). Recent years have shown a revitalization of Indigenous midwifery in Canada, a practice that proposes a balance between traditional knowledge, access to culturally safe maternal health services and the return of births within the communities themselves (Baker, 2022; NCIM, 2023).

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12 The demand began to emerge in the 1980s, and the Puvirnituq maternity centre began operations in 1986.

13 It should be noted that in Quebec (with the exception of Nunavik and Nord-du-Québec), midwifery services are offered to healthy women, i.e., those with low-risk pregnancies. The scope of midwife practice is limited to pregnancy monitoring and physiological deliveries (without epidural or oxytocin), and they are governed by the Ordre des sages-femmes du Québec. Pregnant women who wish to be attended to by a midwife can also choose (depending on services offered in their region) the place of delivery, whether in a birthing centre, a hospital or at home (QG, 2008).

14 The case of Inuit midwives in Nunavik is unique in Quebec and Canada. This is discussed in the next section.

## 1.2 Present-day perinatal services

The first objective of the scoping review was to identify perinatal services offered in Indigenous communities and environments in Quebec. It should be noted that for the Indigenous population in Quebec, generalized and nurse-delivered perinatal services are found in Chapter 12 – Obstetrics of the *Clinical Practice Guidelines for Nurses in Primary Care* (FNIHB & GC, 2011). This document serves as a guideline for the provision of obstetric nursing care; however, it does not mention whether and how all Indigenous women in Quebec have access to it. In fact, very few texts address the services offered in Canada, even less so for the Quebec region. Among relevant documents, several refer to Nunavik, i.e., the Inuit population (plural of the term Inuk), while others focus on the Eeyou population (Cree of Eeyou Istchee) and the urban Indigenous population in general. Both Inuit and Eeyouch women can be accompanied by a midwife during pregnancy, delivery and the postnatal period. The Inuit model has been in operation in Nunavik since the 1980s, well before midwifery practices were introduced elsewhere in Quebec, while midwifery services offered in Eeyou Istchee by the Cree Board of Health and Social Services of James Bay (CBHSSJB) are more recent.

### 1.2.1 Perinatal services offered in Nunavik

The literature on Inuit maternal health is more extensive than that relating to First Nations. This is largely explained by the decades-old presence of maternity centres in three Inuit villages, and by the deployment of a midwifery training program in Kuujjuaq that is unique in the world (Douglas, 2010). A presentation of contemporary midwifery in Nunavik is a key element of this research.

The introduction of biomedicine to Inuit communities occurred later than among First Nations in Quebec. It was only after the Second World War that the Canadian Government stated to take a greater interest in the Inuit, despite their millennial presence, and extended colonization into the Arctic. During this period, Inuit health was perceived as being in crisis, setting in motion the government policy of forcing the Inuit into permanent by offering them access to health services, including perinatal services provided by nurse-midwives (Douglas, 2006). During this period, the first evacuations of pregnant women to urban centers in the south also took place, although initially on a rather marginal scale. Consequently, deliveries carried out in health centres began to appear throughout Inuit land. Most of the nurse-midwives assisting pregnant women came from the UK. Over time, the increased presence of biomedicine in Inuit territory and a decline in nurse-midwife recruitment led to a widespread evacuation of pregnant women to southern hospitals for childbirth (Douglas, 2010). Troubled by this excessive travel, the Inuit decided to take matters into their own hands and establish perinatal care facilities within Inuit villages. (Bedon, 2008; Douglas, 2010; Leibel, 2014; Tourigny & al., 1990). In 1986, the first midwifery service, the Inuulitsivik Maternities, was established in the village Puvirnituq, followed by birth centre projects in Inukjuaq in 1996 and Salluit in 2004. These initiatives bring childbirth back to Inuit territory, as descri-

bed by Epoo & al. (2021), an Inuk midwife[15] who practises in Nunavik and is an important voice in raising awareness of midwifery services for Inuit women and families:

> The story of how we reappropriated birth, along with the skills and common knowledge related to childbearing, parenting, and woman and child health, is more than the tale of a clinical achievement and the realization of a viable model for maternal and childcare in northern and remote regions. It also describes a journey towards bringing meaning, participation, and vision back into the lives of Inuit families (Epoo & al., 2021, p. 76).



Articles published by Epoo in collaboration with other authors depict the practices of midwives in remote regions while explaining the importance of bringing back deliveries to the North (CERP, 2018; Epoo & al., 2012, 2021; Houd & al., 2004; Van Wagner & al., 2007), as corroborated by other authors (Bedon, 2008; Chatwood, 2021; Douglas, 2010; Fletcher, 1995; Gref, 2018; Leibel, 2014; Macdonald & al., 2014; Tourigny & al., 1990). The Inuulitsivik Maternities are mainly staffed with Inuit midwives. As of 2018, 14 Inuit midwives were conducting births in this part of Nunavik. This explains the high rate of births in Inuit territory - 86% of all births. Of this percentage, 63% of births took place in the women's own village. (CERP, 2018). This return of childbirth to an isolated northern environment requires that Inuit midwives be qualified in the necessary emergency skills; this explains why these are acquired during the academic training of Inuit midwifery students (CERP, 2018; Epoo & al., 2012, 2021).

One of the characteristics setting the Inuit environment apart is the midwifery education program established in 1986 with student midwives training in their own communities and now recognized by the Ordre des sages-femmes du Québec for registration as a midwife (OSFQ) (CERP, 2018; Gref, 2018; Tourigny & al., 1990). In 2018, there were 17 Inuit graduate midwives and 10 Inuit student midwives (CERP, 2018). This education program is unique in Quebec and its modular competency-based curriculum is "consistent with clinical content of southern midwifery education programs" (ONSA, 2008, p. 33). It provides a culturally safe educational environment for students through its direct link to Inuit culture. The curriculum is co-constructed with community members, who participate in the program in several ways, notably by selecting midwifery students for training within their communities (Gref, 2018, p. 97; Van Wagner & al., 2007). Traditional knowledge coexists alongside western knowledge, and teaching methods reflect Inuit ways of learning, such as observation, storytelling, learning in Inuktitut (the Inuit vernacular) whenever possible, encouraging hands on practice and flexibility (CERP, 2018; Douglas, 2010; Epoo & al., 2012; Gref, 2018; Van Wagner & al., 2007).

Epoo and her collaborators describe the roles of Inuit midwives, explaining that within the health services offered in Nunavik, these health care professionals are responsible for monitoring the pregnancies of all Inuit women[16] (Epoo & al., 2021).

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[15] Brenda Epoo is also co-chair of NCIM, Canada's National Council of Indigenous Midwives.

[16] Which is not the case in the rest of Quebec, as previously explained.

During the prenatal period, Inuit midwives address a number of issues, including sexuality, family planning, domestic violence, child development and breastfeeding (Epoo & al., 2021). In short, the presence of Inuit midwives ensures that women receive comprehensive pregnancy and postnatal care, in keeping with Inuit values and culture, and all in Inuktitut.

The relocation of childbirth, the disconnect between newborns and their land of birth, the loss of traditional pregnancy and childbirth-related knowledge through the imposition of Western biomedicine, and the isolation of the pregnant woman from her community[17] are just some of the findings that stem from the colonial policies imposed on the Inuit (Leibel, 2014) and discussed above.

### 1.2.2 Perinatal services offered in Eeyou Istchee

The literature on services in Eeyou Istchee is limited compared to the information available on services in Inuk territory. This is due to the fact that midwifery health care has only recently become part of the services offered by the Cree Board of Health and Social Services of James Bay (CBHSSJB). Although Eeyou midwives have been present since time immemorial, right up to the 1940s, the medicalization of pregnancy and childbirth has changed the situation, with their role being gradually eclipsed by the arrival of nurses and subsequently doctors. (Basile & al. 2023; Cournoyer, 1987).

Until the early 2000s, deliveries still took place in Eeyou Istchee, but the practice had to be discontinued due to a lack of medical resources (CBHSSJB, n.d.). This change has led to the evacuation of late-term pregnant women to hospitals in other administrative regions, such as Abitibi-Témiscamingue (Val-d'Or Hospital) and Nord-du-Québec (Chibougamau Hospital), to give birth (CBHSSJB, 2018). This disconnect between birth and land has greatly affected the Eeyou population, who have been calling for the return of this practice for over two decades (Duff & Little, 2016). A project was developed to set up three birthing homes in Eeyou communities (Chisasibi, Mistissini and Waskaganish), staffed by midwives and birth assistants (people who support the midwives and take care of the birthing homes, not to be confused with doulas). This project is part of a deep-seated resolve to bring back to the forefront the transmission and revitalization of traditional knowledge, and to participate in the process of healing and decolonization (CBHSSJB, 2018).

CBHSSJB documents provide a global view of perinatal services offered in Eeyou Istchee. Services for pregnant Eeyouch women are grouped under the Awash (meaning "child") program, which supports parents from conception to school entry through home visits and a range of activities tailored to families' needs (Bonnier Viger, 2000, p. 221). Specifically, the Awash program encompasses prenatal and postnatal consultations, nutrition, breastfeeding support and sexual health, and is tailored for pregnant women and mothers (for the first year after childbirth), then for children from birth to age 9. (CBHSSJB, 2018). Finally, "in some communities, in addition to the Awash services, Eeyouch mothers can also benefit from integrated traditional support services for mothers and their children (Cree maternal tradi-



[17] Pregnant Inuit women in Quebec and Canada may have to leave their communities for several weeks (an average of 4 to 6 weeks) to give birth in a hospital.

tions) through the Waapimausuwin program offered by the Nishiiyuu service" (CBHSSJB, 2018, p. 34).

Introduced in September 2018 in Chisasibi, the midwifery program was designed with the active participation of Elders, through the Nishiiyuu service (CBHSSJB, 2016). This department is responsible for implementing traditional approaches and Eeyou mutual aid practices (CBHSSJB, 2018). In June 2019, the first Eeyouch babies were born on the territory thanks to midwifery services (Kitty & Little, 2019). By March 2022, some 78 births had taken place in the territory since the midwifery services were introduced (Quinn, 2022). In December 2021, the Chisasibi midwifery team inaugurated the birthing centre, enabling women to give birth in a safe place, surrounded by their families and traditional practices (CBHSSJB, 2021). The team is now in the process of setting up an educational program to train Eeyouch midwives (Quinn, 2022).



### 1.2.3 Perinatal services offered by the Val-d'Or Native Friendship Centre

Since 1974, the Val-d'Or Native Friendship Centre (VDNFC)[18] has been a leading defender of Indigenous rights and access to culturally safe services in urban areas. The Minowé Clinic was developed following the First Nations of Quebec Socioeconomic Forum held in Mashteuiatsh in 2006, "[...] a landmark event during which the Québec Government and First Nation leaders committed to work at improving the living conditions of Québec's First Peoples" (Cloutier & al., 2018, p. 40). Over time, and in keeping with a spirit of social innovation, the Minowé Clinic is transformed into an initiative translating a broad-based approach to cultural security in care, health and social services, a health centre project called Mino Pimatisi8in[19], including an Indigenous Health Clinic deployed within the organization.

The social perinatally component is part of the services offered by Mino Pimatisi8in[19] and includes several aspects, including perinatal teachings, awareness and prevention, physical examinations of mother and baby, pregnancy and birth monitoring, attachment, nutrition and childbirth recovery (Cloutier & al., 2018). In addition, Indigenous women and their newborns have the opportunity of building bridges with elders in the urban community, thereby facilitating the transfer of knowledge about childbirth and baby care. (Lévesque & al., 2019a). Blanchet-Cohen & al (2021) list the various activities offered to Indigenous women by the VDNFC team as a way of coming together to discuss their experiences of parenthood. Finally, it's important to note that the Mino Pimatisi8in Health Centre upholds a holistic vision which involves the whole family, and also represents a cultural safety approach anchored in the Indigenous environment (Blanchet-Cohen & al., 2021; Cloutier & al., 2018; Lévesque, 2016; Lévesque & al., 2019 a, 2019b; Vallerand, 2022).

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18 The VDNFC is the organization with the longest experience of providing health services within the Movement of Native Friendship Centers in Quebec.

19 "Mino Pimatisi8in is an Anishinabe word meaning overall, harmonious and balanced state of well-being, and more broadly, the quality of life of the Aboriginal population in its relationship to humans, living beings and the universe" (Cloutier & al., 2018, p. v). The number 8 is pronounced as a "w".

## 1.3 Conditions for success and obstacles to accessing perinatal care services

The conditions for success and the obstacles to accessing perinatal care services are largely under-represented in the available literature on the issues and realities of Indigenous women in Quebec, making it difficult to develop an accurate picture of pregnant Indigenous women's experiences and their perinatal follow-up.

### 1.3.1 Conditions for success: globally unique models

Among the literature that discusses perinatal health services for Indigenous women, two globally unique models garner attention (CERP, 2018; Douglas, 2010; Epoo & al., 2012, 2021; Gref, 2018; Houd & al., 2004; Kildea & Van Wagner, 2012; Van Wagner & al., 2007).

Firstly, it is the Inuit model deployed in Nunavik, which is characterized by the presence of recognized Inuit midwives who have graduated from training programs implemented within the Inuit communities themselves. Researchers who have studied this model speak eloquently of its success. They begin by mentioning the merits of the collaborative, community-based approach to health care development. The community-based midwifery training program and the integration of Inuit and Western knowledge into teaching and practice are also highlighted, as are the assessment of pregnancy risks from different angles (social, cultural and community) - and not just from a biomedical perspective - as well as the creation of an interdisciplinary perinatal committee. These elements shape the nature of these approaches, which include a place for the return of births to Inuit land, the revitalization of traditional Inuit knowledge, and the sense of trust and pride felt by Inuit women regarding pregnancy and childbirth.

Then, even though it has been in operation for a shorter period of time than the model deployed in Inuk territory over the past 40 years, the VDNFC urban model is also described as a success story in terms of the cultural safety put forward, the strong partnership between the VDNFC and the CISSSAT, the social innovation of this model and the scientific anchoring present within the program through the active participation of a research team (Blanchet-Cohen & al., 2021; Cloutier & al., 2018; Lévesque & al., 2019 a, 2019b).

### 1.3.2 Obstacles to accessing perinatal services

Indigenous women face many obstacles when it comes to accessing perinatal services. While the conditions for success are poorly documented, the same cannot be said about the barriers that stand in their way. Once again, it is difficult to find any Quebec-specific literature. While there is a greater body of English-language literature on Indigenous women's health, these have been excluded in the context of this scoping review, which focuses solely on Quebec.

Moreover, many of the obstacles mentioned cast light on the situation in Quebec. Notably, the experience of language barriers and communication difficulties experienced by Indigenous women (Couchie & Sanderson, 2007; Epoo & al., 2021; Sokoloski, 1995) or the inadequate fun-

ding of services (CSSI, 2018; Epoo & al., 2018, 2021; Vang & al., 2018) are trends that are ultimately visible in Quebec. The same applies to "birth alerts[20]" during pregnancy follow-ups and childbirth (Duchaine, 2021; QNW, 2021; Flynn & Brassard, 2012; Quinn, 2021; Shaheen-Hussain, 2021) as well as the mistrust of healthcare services (Basile & Bouchard, 2022; Blanchet-Cohen & al., 2021). We also note the lack of integration of Indigenous and western knowledge within perinatal health services (Kildea & Van Wagner, 2012) and systemic racism, discrimination and prejudice experienced by women when accessing services outside the community. These phenomena are present throughout Canada, including Quebec. (CERP, 2019; Basile & Bouchard, 2022; Flynn & Brassard, 2012; Kildea & Van Wagner, 2012; Sokoloski, 1995; Whitty-Rogers & al., 2006). Added to these are the evacuation of Indigenous women to hospital to give birth and the impacts this has on pregnant women (CBHSSJB, 2018; Couchie & Sanderson, 2007; Dawson, 2017; Jung, 2021; Kornelsen & al., 2013; Van Wagner & al., 2007). During these evacuations, the literature reports a lack of continuity (Kildea & Van Wagner, 2012; Sokoloski, 1995) and the lack of understanding on the part of healthcare professionals towards Indigenous practices and traditions (CERP, 2018; Couchie & Sanderson, 2007; Kildea & Van Wagner, 2012; Kornelsen & al., 2013).



# 1.4 Ancestral Indigenous practices: promising perinatal practices

The final section of the scoping review broadens the research spectrum, targeting not just Quebec, but Canada and the world, in order to identify, describe and geographically locate certain ancestral Indigenous practices and promising practices in the field of perinatality. Although Anderson (2011b) points out that there is a loss of traditional ceremonies and practices, it is still possible to find a few texts on the subject. Some practices are mentioned in publications, and the authors add nuance by pointing out the importance of not generalizing these practices to all Indigenous women and families, as they are above all conducted in the private sphere, making the subject difficult to document.

To simplify the presentation of the material, ancestral Indigenous practices from Canada and the United States are depicted jointly, since many of the texts focus on Indigenous nations living on the same territories. In fact, today's administrative boundaries in no way reflect the territory long shared by Indigenous nations.

## 1.4.1 A pregnant woman's world

From the outset, the researchers emphasize the importance of life for Indigenous nations, and the crucial role of the community in providing support and assistance to the pregnant woman (and even the pregnant couple) throughout the pregnancy and the first few months of the newborn's

[20] Over-reporting of Indigenous newborns to child protection. At the time of revising this report, the Quebec government had announced that it would end the practice of birth alerts and replace it with a prevention program (Carrier & Ouellette, 2023; MSSS, 2023).

life (Anderson, 2006, 2011b; Couchie & Sanderson, 2007; Douglas, 2006; Epoo & al., 2021; Tabobondung, 2017). A pregnant woman must follow a number of rules, including dietary restrictions, physical positions to avoid and the importance of staying active throughout her pregnancy, all to ensure her health and that of her baby (Anderson, 2011b; Dufour, 1988; Pernet & ICA, 2012; Sokoloski, 1995). Pregnant women still use certain traditional medicines, as advised by their elders. (Dawson, 2017; Lévesque & al., 2016). The *in utero* baby occupies a central place in the pregnancy process. According to the elders met by the authors, the emotions experienced by the mother are transmitted to the baby (Cook, 1986; Tabobondung, 2017).

Midwives have always played a central role among Indigenous nations. Births traditionally occurred with the assistance of an Indigenous midwife or a family member when no midwife was available[21] (Anderson, 2011b; Basile & al., 2023; Beaudet, 1983; Bedon, 2008; Carroll & Benoit, 2014; NCCAH, 2012; Churchill, 2015; Cidro & al., 2017; Dawson, 2017; Dion Fletcher, 2017; Douglas, 2006; Epoo & al., 2021; QNW, 2002; Finestone & Stirbys, 2017; Leitenberger, 1998; Olson & al., 2019; Pambrun & al., 2019; Routhier, 1987; Tabobondung, 2017; Van Wagner & al., 2007). In other words, Indigenous midwives are part of Indigenous cultures and have been recognized by them since time immemorial. What's more, their knowledge is transmitted among women, as explained by Pambrun and Bourgeois:

> Before this [colonization and medicalization], our communities always relied on midwives, keepers of the most sacred ceremonies of life and death, medicine people with a deep understanding of biology and the reproductive life cycle.
> Our midwives were some of the most brilliant Indigenous scientists, providing care through reproductive physiologic events of menses, pregnancy, birth, abortion, menopause, and using lifesaving skills when things deviated from the ordinary (Pambrun & Bourgeois, 2021, p. 102-103).

## 1.4.2 Birthing rituals

The importance of maintaining the connection to the land from the point of view of a baby's identity from the moment of birth is reflected in the resurgence of births on the land (also preventing the unnecessary evacuation of pregnant women) ( CBHSSJB, 2018; Cidro & Sinclair, 2021; Dawson, 2017; Epoo & al., 2021; Wiebe & al., 2015). The literature documents certain rituals still in practice such as ceremonies for the placenta (Anderson, 2006; Basile & al., 2023; Church & al., 2017; Dufour, 1988; Olson & al., 2019; Pernet & ICA, 2012; Simpson, 2006), the umbilical cord (Anderson, 2006; Dawson, 2017; Douglas, 2006; Olson & al., 2019; Pernet & ICA, 2012) and the naming of the baby (Anderson, 2011b; Dufour, 1988; Pernet & ICA, 2012; Simpson, 2006). Some authors mention that mothers need to stay at home for up to six weeks after giving birth,



[21] Anderson (2011a) and Douglas (2016) report the words of Elders who recall that women sometimes had to give birth alone.

to concentrate solely on caring for the baby (Anderson, 2011b; Dawson, 2017; Epoo & al., 2021). Elders, men and women, from Indigenous communities still play a key role in the transmission of traditional teachings and the practice of perinatal ceremonies. (Anderson, 2006, 2011b; CBHSSJB, 2016; Dawson, 2017; Lévesque & al., 2016; Lévesque, 2013; Pambrun & al., 2019; Viau, 2021).

### 1.4.3 Elsewhere in the world

It is worth noting that similar practices are being adopted by several Indigenous nations in other parts of the world. As mentioned previously, Indigenous midwives are also part of the pregnant women's support networks in Australia, New Zealand (Jones, 2012) and in India (called “dais”) (Sadgopal, 2009). Literature on the practices of Indigenous peoples in Australia and New Zealand reports similar rituals surrounding the placenta and umbilical cord. (Jones, 2012), in addition to mentioning the importance of giving birth on the land (Basile, 2017; Ireland & al., 2011; Jones, 2012; Kruske & al., 2006). Ireland and her collaborators (2011) also indicate that female elders and grandmothers take on an important role in the transmission of knowledge, and that traditional medicines, mainly the domain of women, are also widely used during the perinatal period. Finally, only one text locates placenta-related rituals and traditional beliefs and practices in Bolivia (Pinsonneault, 2012).

# Chapter 2.
# Portrait of available perinatal services

Analysis of the interview findings reveals the multifaceted realities of pregnant Indigenous women. Each of the subsequent chapters focuses on one of these dimensions, starting with the present chapter, which describes the perinatal services offered by Indigenous communities and organizations in Quebec.

## 2.1 Disparities in perinatal services offered in Indigenous communities and organizations

Several of the questions in the interview guide, developed for this research, relate to perinatal services offered to Indigenous women and families by community health centres, and by some urban Indigenous organizations. Because participants accurately describe the services to which pregnant women have access, disparities concerning prenatal services are revealed. Clearly, the provision of services differ considerably from one community to another, and from one Indigenous organization to another. For example, the community of Kahnawà:ke offers the widest range of prenatal services, given that, "except for the delivery and high-risk pregnancies, all other services are offered right here" (COM08).

However, all communities adjust their prenatal services to the needs of the population, as participant COM05 explains, "[…] we try to adapt our services to the needs of the community. […] We try to offer service to those living in situations of vulnerability within the community" [Translation]. This resolve to integrate existing services with community-based needs is a strategy acknowledged by several research participants. Actually, the idea is to enhance the experience of pregnancy from the very start, by providing women with early support. Indeed, "[…] we try to prioritize the pregnant woman. Making pregnancy tests a positive experience, being there for her. Bringing out the positive. That's where the attachment begins, with the maternal bond" [Translation] (COM09).

Moreover, the reality of dissimilarities in the prenatal services offered can also be observed at Native Friendship Centres, as this respondent explains:

> Friendship Centres offer a continuum of services, as well as being a community living environment where people can come together and feel at home. This includes numerous informal gatherings (community meals, cultural activities, family outings, language classes, etc.) in addition to a host of frontline services. […] In fact,

there are five centres that have a clinic, i.e., professional nursing and/or medical services in the centre. There are three centres where doctors come. [...] This definitely facilitates access to health services [Translation] (ORG02).

In fact, visiting Friendship Centres[22] facilitates access to perinatal care for women who initially come in for other activities. However, since Friendship Centres operate in different urban contexts, their means and resources differ from one place to another.

## 2.2 Present-day health care teams



Community health centres and Indigenous organizations in urban areas offering services are staffed by a number of health professionals who ensure that pregnant women's health care and monitoring needs are met as effectively as possible.

### 2.2.1 Shortage of doctors

To begin with, there are very few doctors in the health centres. Only four of the Indigenous communities consulted[23] have a doctor on hand to monitor pregnancies:

> A doctor is always available in the Matimekush-Lac John area. The dispensary is in the Innu community of Matimekush, and we're very close to Schefferville and the Naskapi community of Kawawachikamach, approximately 15 km away. A doctor is always available for all three locations. The doctor is with us two days a week for meetings and follow-ups [Translation] (COM14).

The fact that the same doctor attends to people from several communities alongside non-Indigenous women is also mentioned several times and reflects the geographic reality of remote regions. In Essipit, for example, the presence of doctors in the health centre ensures follow-up not only for Innu women from the community, but for all women in the region, since "the two doctors who are here in the community also follow, in turn, all pregnancies on the Upper North Shore. They monitor a lot of people" [Translation] (COM15).

Elsewhere, the limited presence, or even absence, of doctors can be explained by their reluctance to collaborate with community medical staff, as illustrated by this account:

> There is no "ordonnance collective" because we are only a local health centre, and we are only four nurses here [Timiskaming First Nation]. There are no doctors here. And no doctor wants to oversee our practice here [...]. No doctor wants to collaborate with us to get that sign off for us to all the prenatal visits with us here (COM03).

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[22] The Regroupement des centres d'amitié autochtones du Quebec (RCAAQ) represents and supports 10 centers located in the cities of Chibougamau, Joliette, La Tuque, Maniwaki, Montreal, Quebec, Senneterre, Sept-Îles, Trois-Rivières and Val-d' Gold, with points of service in Gatineau, Saint-Michel-des-Saints and Shawinigan.

[23] The community of Lac-Simon can be added to this number. A doctor travels to monitor pregnancies up to the 30th week of pregnancy. Thereafter, pregnant women must consult a doctor in the nearest town, about 30 minutes away.

Overall, retiring doctors also have a significant impact on communities, because once their retirement is announced, rarely do new doctors to take on the [retiring doctor's] patients at the health centre. Pregnant women are then referred to nurses, and when they need to see a doctor, they have to travel away from home.

> Usually, we refer them to the doctors who come here to Mingan. We have two [female] doctors who used to come here, but one is retiring, so she no longer takes on pregnant women, but there's one who comes here with an SNP (specialized nurse practitioner). We try to adapt as best we can so follow-ups can be carried out here at the health centre [Translation] (COM11).

The retirement of doctors and the absence of replacements, a situation common to most of the communities we met, have prompted some participants to express the need to develop a local approach. Despite some of the changes taking place in terms of service offer, the communities want to preserve what they have, as participant COM13 reports: "In recent years, the new ob-gyn doctors have decided to repatriate all appointments to the hospital [...], but we've still kept our way of doing things here in Wemotaci" [Translation].

### 2.2.2 Nursing personnel at the forefront of services

Maternal and infant health nurses are present in almost every Indigenous community and organization we met. One participant explains:

> There are health centres in Uashat and in Mani-Utenam. The same services are offered in both health centres, so both communities have access to perinatal services. Each health centre has a perinatal nurse [Translation] (COM02).

The nurses on staff are sometimes joined by a nutritionist, a social worker, a kinesiologist, a psychologist, a doula, a family visitor (accompanying pregnant women") and a mother's aide.

> Then, I have kokomijic [auntie or little grandmother]. Kokomijic is a position we created and named. Basically, they're family visitors. They accompany pregnant women and mothers with young children at home aged 0 to 5. They provide support and help. For example, they'll check with moms to make sure their children have received their vaccinations, or that they're registered with the civil authorities or on the band list. They'll help as needed. These family visitors are trained as family and social auxiliaries. I have three of them, then I have two who have that training, then the third is a new hire because we have a lot of births [Translation] (COM07).

Because realities differ from one place to another, the portrait of services is extremely diverse, as each health authority tries to respond as best it can to the needs expressed by its members. On the other hand, there is a common thread running through all of the strategies set up locally,

since the health teams present both in the communities and in the Indigenous organizations strive to develop a trusting relationship with pregnant women. This closeness is beneficial because it compensates for the lack of trust towards the health services[24], as mentioned by one participant: "Women who live outside the community call us to have their follow-up done by the health centre, instead of the CLSC, because the relationship of trust is there, the feeling of belonging is there" [Translation] (COM01). The creation of this trust-based relationship can also be seen in the strategy developed by the Friendship Centres:

> So that's what we always see at the Friendship Centre in La Tuque. Whether it's the nurse or the outreach worker, they come to see the person. They want to be accompanied by that person. A relationship of trust is established. And then, as soon as this bond of trust is created, well then, people really, really trust us, and then they do their follow-up [Translation] (ORG03).

Well-documented in the literature on Indigenous health care, the importance of this bond is central to the process of accessing quality, culturally relevant services (Cloutier & al., 2018; Lévesque & al., 2019a).

### 2.2.3 The special case of birth attendants

Access to birth attendants is relatively rare for pregnant Indigenous women. Occasionally, they are able to access the support offered by birth attendants through certain Indigenous organizations. Some people in Indigenous communities and organizations have tried to train as birth attendants, but this is sometimes complicated, if not impossible, due to the multiple roles they occupy:

> As a birth attendant, we had already taken the course with the FNQLHSSC [...], but it took up too much of our time. We, as birth attendants... Let's face it, I would have had to accompany the women [who were] about to give birth. I was already working 35 hours a week, plus going with them would have taken up too much time [Translation] (COM12).

In short, this type of service seems difficult to implement within Indigenous organizations, without additional resources and funding, for the time being.

## 2.3 Activity programs in Indigenous communities and organizations

Indigenous communities and organizations are committed to bringing Indigenous cultures to the forefront of their programs in order to meet the needs of their members. This is why some programs and activities are offered on a large scale, while others are limited to a single community or organization. The following sections present perinatal health projects underway in several Indigenous communities and Friendship Centres in Quebec.



[24] This lack of trust in Quebec's health and social services is widely reported in the literature (Basile & Bouchard, 2022; Blanchet-Cohen & al., 2021; CERP, 2019; Cloutier & al., 2018; NIMMIWG, 2019; Shaheen-Hussain, 2020).

### 2.3.1 Prenatal classes

Most Indigenous communities and organizations offer culturally safe prenatal classes, thanks in part to the presence of cultural aspects specific to each woman. Admittedly, the availability of prenatal classes has been disrupted by the pandemic[25]. Nevertheless, prenatal classes enable pregnant women to get together and discuss their respective realities, as well as being an important place of teaching and knowledge transmission for health professionals and elders. At the same time, "when the women do the baby wrap at the prenatal classes, it allows them to form a support network among themselves, among mothers" [Translation] (COM02). For the few Indigenous communities and organizations where there are only a handful of pregnancies per year, the teachings usually conveyed during prenatal classes are given in other ways, either during home visits or pregnancy follow-ups.

Prenatal classes become an opportunity to discuss ancestral Indigenous practices, as participant ORG01 explains: "[...] during perinatal groups, there are discussions about these ceremonies. After that, it's a matter of offering them the resources so they can experience them" [Translation]. For another participant, it's during prenatal classes that traditional medicines are explained, thanks in particular to the intervention of traditional knowledge keepers teamed up with a nurse so that "when they do the prenatal classes, they share the traditional medicine that a pregnant mom can use safely" [Translation] (COM08).

Besides traditional maternity knowledge, prenatal classes provide opportunities to learn about all aspects of maternity, while adapting them to local needs, as illustrated by the direction of the Olo (eggs, milk, orange juice) program on women's nutrition. Through this program, offered to all pregnant women who so desire, and not just those living in a context of vulnerability, women receive Olo coupons that allow them to choose foods at their local grocery store:

> Women make appointments and are given Olo coupons. We say Olo, but it's not Olo. We're not part of the CISSS. For us, it's eggs, milk, peppers or kiwis, and then we give them brown bread. They have a choice of four [foods] [Translation] (COM12).

### 2.3.2 Breastfeeding support

The majority of participants mention that breastfeeding support is part of the services offered, both in urban areas and in communities. Activities promoting the benefits of breastfeeding and related teachings are widespread within health centres and Indigenous organizations. Home visits during the post-partum period are organized to teach women about breastfeeding and provide reassurance:

> With breastfeeding, I am trying prenatally to do all the teachings to normalize the colostrum feeding. To normalize what is the feeling about not having enough milk. Most of the mothers here stop breastfeeding because they think that they don't have enough milk. So, it is important to teach about those subjects and reassure them (COM03).



[25] The impact of the COVID-19 pandemic on perinatal health care will be detailed at a later date. With specific regard to prenatal courses, several participants explained that they had offered prenatal courses in remote mode, on the Zoom online platform.

Incentives are sometimes offered within the community to encourage breastfeeding women, as participant COM05 attests when she says:

> […] we advocate breastfeeding. We have a separate room if the woman wants to breastfeed. At the sports arena, there's a breastfeeding room. We want to encourage moms to breastfeed, but not everyone is comfortable. The mother's aide can even become a breastfeeding godmother. We can provide them with nursing pads, etc. [Translation].

In the opinion of several participants, this type of approach implemented by various members of health care teams has contributed to an increase in the practice of breastfeeding over the past few years, along with a notable improvement in the health of breastfed children. One participant confirms: "More and more women have been breastfeeding for (...) a few years now. Women of my generation are breastfeeding more and more" [Translation] (COM18).

### 2.3.3 Blood tests

Among services offered to expectant women, more than half of Indigenous health centres and organizations do blood tests. The numerous blood tests and gestational diabetes screening take place at multiple times in the pregnant woman's calendar. As members of the Kahnawà:ke community describe it, pregnant women can avoid having to travel outside the community when the health centre offers this service:

> But we do carry out blood tests within our community also, so the pregnant moms don't have to travel to have their blood tests done. We can do them at the clinic here. We do our own swabs; at 36 weeks they must do a special swab. [the doctor] does them here and we send them to [the hospital] to be analyzed. We are very fortunate to be able to do those services here (COM08).

### 2.3.4 Networking among pregnant women through activities

While prenatal classes provide an opportunity for pregnant women to get together, other activities are also promoted within the programs of community health centres and Indigenous organizations. Intergenerational gatherings sometimes feature on the calendars of certain Indigenous communities and organizations, allowing several generations of women to discuss perinatal issues. In doing so, "[t]hey have intergenerational activities with elders, parents and babies. There's a lot going on at the Centre d'entraide et d'amitié autochtone de Senneterre, not in the medical area as such, but everything related to perinatality" [Translation] (ORG02).

According to the literature on the subject, Indigenous women writers who focus on Indigenous womanhood frequently talk about the importance of Indigenous women coming together, helping each other and passing on traditional knowledge and skills at these gatherings (Anderson, 2006, 2011a; Corbiere Lavell & Lavell-Harvard, 2006; Tait Neufeld & Cidro, 2017). These networking practices through intergenerational activities also make it possible to collectively reconnect with the role of mothers and its importance in terms of knowledge transmission, a

collective functioning that the experience of Indian residential schools, for example, annihilate by breaking family ties over several generations.

## 2.4 Information corridors between hospitals and health centres of Indigenous communities or organizations

A few participants explained that hospitals in their region had set up agreements for the transfer of information on Indigenous women's deliveries and births to health centres and Indigenous organizations. In all the cases mentioned, these information corridors seem to work well and are appreciated:

> When a mother leaves the hospital with her newborn, and when she lives in Wendake, the health centre receives the information about the birth; the information is transmitted through the Loretteville CLSC [Translation] (COM01).

> With the hospital […], we have an agreement of information sharing, so we receive the woman's complete medical file. They transfer the information to us. So, if the woman attended her follow-ups or other exams, ultrasounds, for example, the nurse or nursing team can verify that the follow-up is normal, or if there are any complications [Translation] (COM13).

> Also, the VDNFC ensures that the information about women's pregnancy monitoring is transferred to the Indigenous Health Clinic of the VDNFC and the doctor. This step is taken to avoid a doubling of services [Translation] (ORG01).

To these are added other types of collaborations and good practices, such as training of nursing personnel, as explained by one participant: "This past week, we had a team that went to a training session on emergency delivery care at La Tuque Hospital. We do have a good working relationship with the nursing staff" [Translation] (COM13). Good practices are also pointed out by participants, especially by participant COM08 who mentions that "[the hospital] does respect and honour these types of practices and our traditions. […] They are very open to our culture at [the hospital]".

## 2.5 Pregnancy follow-ups offered to pregnant women

Pregnancy follow-ups are often carried out by a maternal and infant health (MIH) and appointments with a doctor complete the follow-ups:

> We use the same forms as the province for obstetric appointments, but the nurse takes the time to make a thorough assessment with the pregnant women and to conduct screening tests also. If the woman is experiencing any problems, it can be issues within

> the family unit, at home. Does she have a big family? Her lifestyle, alcohol or drug problems [or not] [Translation] (COM13).

Pregnancy tests are available in all health centres so women can use them directly on site with the assistance of the nursing staff. The nurse is often the one to guide the expectant mom towards the adequate services outside of the community, as explained by one participant:

> When I have a potentially pregnant woman, I will do an intake with her. If she is pregnant, I will take all the information. I will do the obstetrical history. She will have to decide where she wants to give birth: in Ville-Marie or in New Liskeard. From there, I refer her to the appropriate people, depending on where she wants to give birth (COM03).

In Native Friendship Centres, the reality about pregnancy follow-ups is just as diversified as in Indigenous communities. We point out that for the Friendship Centres consulted, perinatality and the development of health services are important sectors requiring much work and effort. For example, and this situation should evolve in the coming months, midwifery services are offered by an Anicinabe woman in Maniwaki. At the VDNFC, an Indigenous perinatal clinic opened in June 2021:

> It's a *walk-in* clinic for mothers and children aged 0-5. Three doctors work alternately at the clinics, which are held each Friday at the VDNFC, with or without appointment. So far, it's going very well. […] But it's *walk-in*. There are general follow-ups, but not pregnancy follow-ups [Translation] (ORG01).

Therefore, pregnant Indigenous women living in Val-d'Or must consult a doctor in one of the city's health clinics for their pregnancy follow-ups, but they can also turn towards the VDNFC perinatality clinic for certain needs, notably for gestational diabetes. At the Centre d'amitié autochtone de La Tuque, the Clinique Acokan has been in operation since 2015 and is in full swing. Another participant mentions that:

> Since last week, she [Atikamekw nurse] comes to the [Native] Friendship Centre and we will develop a service offer. […], in collaboration with the Wemotaci community, we intend to implement, for example, service trajectories, a service delivery relevant to those in transit, rather than just offering a service, we can make sure that it is a good service. Perinatality does take all of this into account [Translation] (ORG03).

Collaboration with the medical staff working with the neighbouring community's health centres is central to the mission of the Clinique Acokan. Indeed, Indigenous persons and families living in the city or in the community are extremely mobile (Cornellier, 2013; Lévesque et Cloutier, 2013), not to say hypermobile, as pointed out by participant ORG02: "[Here] we have statistics on our population's hypermobility, so pregnancy follow-ups must be done in parallel to moves and changes of location" [Translation].

## 2.6
## Postnatal follow-up offered to new mothers

When they return home with their newborns, new mothers have access to postnatal monitoring on the same follow-up schedule as elsewhere in Quebec. Nurses working at various health centres are responsible for this part of the perinatal services. Postnatal follow-ups are ideal times for teaching, prevention and breastfeeding support. Flexibility is at the heart of the follow-up program:

> It depends on the family's needs. It depends on the vulnerability factor: young parents, low level of education, low income... Closer monitoring will be provided to these families to give them the tools needed in order to reduce the placement rate [Translation] (COM05).

Depending on the communities, visits sometimes take place at home, sometimes at the health centre:

> After the delivery, we also have nurses visiting the home to see how the mom is doing, how the family is doing, how they are coping. We do the screening for post-partum depression on the moms on a regular basis during their visits with us. The nurses do home visits at least once or twice, depending on the needs (COM08).

However, home visits are not always welcomed, as participant COM12 notes:

> Basically, what we've noticed is that people are less comfortable with us going into their homes because many people live in the same house. [...] They're embarrassed to let us see their environment, so they prefer to come to the health centre. [Translation]

Aware of this reality, health centre professionals demonstrate great adaptability in meeting the needs of new mothers and their families, offering them the option of postnatal follow-ups at home or at the health centre, as they prefer. This pursuit for proximity is at the heart of the strategies implemented by these services.



## 2.7
## Need for proximity health services

Offering proximity-based health services is one way of improving the attendance of pregnant women at their follow-ups.

> If we're talking about medical services, GPs used to come to the communities to do pregnancy follow-ups. Even though Uashat is close to Sept-Îles, doctors would spend half a day in Uashat and half a day in Mani-Utenam, once a week, to do pregnancy monitoring and see the children at the walk-in clinic. When doctors stopped providing follow-up care at the health centre, we noticed a drop in the frequency with which women came

> to see the doctor for their pregnancy check-ups. In short, this had an impact, even though both communities are close to Sept-Îles [Translation] (COM02).

It is not clear from the testimony above why the physicians ended their practice at these two health centres. It would certainly be interesting to determine whether this was due to cuts in services, the doctors' preferences, or a shortage of doctors in the region. In order to respond more adequately to the needs of vulnerable families, the proximity approach is mentioned once again:

> The service offer is there, but I think we need to modify our offer to reach out to these people, as they need even more support. Often, it's not that they don't want to come, it's really the context. We need to reach out to them, rather than the other way around [Translation] (COM02).

This proximity approach is also promoted by the various Native Friendship Centres. In this respect, however, some work remains to be done in the area of perinatal care:

> The enthusiasm is there so that women can really be accompanied in the respect of their identity and culture, even during delivery. More and more, [Native Friendship] Centres are doing outreach work, in the home. They go out to people, community members and families. Of course, home births are still somewhat out of reach [Translation] (ORG02).

To this approach of openness and flexibility are added the culturally focused care practices that the various health centres make sure to deploy in their service provision, once again with the view of better meeting the needs of community members. With the hectic pace of day-to-day life, coupled with the constant demands placed on Indigenous people in key positions within organizations, it might be difficult to call into question the services offered. Cultural safety represents one of the solutions to be implemented to ensure better perinatal services, as this participant puts it when she says, "we talk a lot about cultural safety and trying to restore culture" [Translation] (COM02). This finding also emerges from the Viens Commission report, which states that the insertion of cultural safety is essential in the health care field (CERP, 2019). However:

> […]as the provision of specialized health and social services is very limited in both agreement and non-agreement communities, First Nations and Inuit members frequently have to turn to urban services, particularly in Montreal, in order to benefit from them. Over and above the organizational and financial challenges that this reality can generate, serious shortcomings in terms of communication and patient follow-up between communities of origin and urban services have also been brought to light. These shortcomings range from medical information being lost in the administrative maze, thereby limiting the quality of the follow-up carried out, to some people not returning to their communities or dying without their families ever being informed (CERP, 2019, p. 412).

## 2.8
## Impacts of COVID on perinatal health care

The COVID-19 pandemic has had considerable impacts on perinatal services for pregnant Indigenous women. The multiple measures deployed by community health centres and Indigenous organizations in urban areas to curb and manage the spread of COVID-19 mobilized all members of an already overburdened health care staff, with inevitable repercussions on the services offered to pregnant women. One participant mentions: "Services have slowed down a bit because of COVID. We are currently dealing with a lot of nurse shortages here in Listuguj" (COM19). Other participants explain that several activities that were taking place before the pandemic have had to be put on hold, including information meetings on breastfeeding and baby care, home visits, prenatal workshops, physical activity workshops and prevention activities. Beyond the activities for pregnant women, the development of new perinatal projects has slowed down, if not stopped altogether, as participant COM08 testifies about a proposed midwifery service in the community:

> Before COVID-19, [the doctor] wanted to get her colleagues at [the hospital] to entertain the idea of having a midwife; the midwife would go to [the hospital], a First Nation midwife, which are not recognized in Quebec, and [the doctor] would oversee the process, the delivery, but let the midwife take the lead. We were just into that but then COVID happened, and everything came to a halt.

Another participant explains that adding a new resource to the health care team has been put on hold since the pandemic: "One of the things we'd like to develop [...] would be to hire a maternal health educator who could go into the home with the visiting nurse. But right now, with the pandemic, everything is pretty much on hold" [Translation] (COM13). In addition to the difficulty of deployment and development experienced by some communities, there is also the issue of forging bonds with pregnant women, as mentioned by participant COM09 when she says that "[...] since COVID-19, it's been very difficult to establish relationships with the clientele." [Translation] However, this trusting relationship with pregnant women is a guarantee of success when it comes to women's attendance at pregnancy follow-ups, as NCIM reports, when referring to the type of services offered by Indigenous midwives (NACM, 2019[26]).



[26] This publication was released under NCIM's former name that changed in 2022, i.e. the *National Aboriginal Council* of Midwives (NACM).

# Chapter 3.
# Portrait of barriers to service accessibility

The previous chapter provides a portrait of perinatal services provided by community health centers and Indigenous organizations. As these services are not comprehensive, pregnant women and mothers have no choice but to turn to perinatal services offered outside their community. This situation raises a number of issues and challenges, not only in terms of continuity of medical follow-up, but also in terms of mobility, since travel is necessary.



## 3.1 Medical follow-up offered outside Indigenous community and organizations

The interviews conducted as part of the research enable us to identify perinatal services not available within Indigenous organizations.

### 3.1.1 Perinatal services not available in Indigenous communities

Medical follow-up, ultrasounds, HRP clinic[27] follow-up, childbirth and monitoring in the event of complications are not part of the services offered in Indigenous communities and organizations in urban areas. These multiple services are offered in Amos, Baie-Comeau, Bathurst (New Brunswick), Campbellton (New Brunswick), Gaspé, Havre-Saint-Pierre, Joliette, La Tuque, Maria, Mont-Laurier, Montréal, New Liskeard (Ontario), Québec, Roberval, Rouyn-Noranda, Shawinigan, Sept-Îles, Trois-Rivières, Val-d'Or and Ville-Marie.

The testimonies gathered reflect an important dimension, namely that of proximity as opposed to the geographical isolation characteristic of pregnant women's places of residence. For some Indigenous communities and Native Friendship Centres, where distance is not an issue, access to medical follow-up is relatively straightforward. This is the case, for example, for women living in Mashteuiatsh, an Ilnu community located a ten-minute drive from the Roberval Hospital, or for women who attend Friendship Centres located in towns with hospitals.

[27] Acronym for "high-risk pregnancy", the HRG clinic model offers women - both Indigenous and non-Indigenous - better access to the professionals involved in managing these high-risk situations, including general practitioners, obstetricians and gynaecologists, midwives, internists and nutritionists. In addition to rigorous pregnancy monitoring, these pivotal clinics contribute to patient awareness and information.

For others, distance is a real issue, as some pregnant women have to travel long distances and sometimes have to spend weeks away from home to give birth in hospital[28]:

> Our expectant mothers are followed in Joliette. [...] There is no medical pregnancy follow-up here in Manawan. [...] I was saying that pregnant women are followed in Joliette and are evacuated at 38 weeks of gestation to await delivery in Joliette [Translation] (COM07).

Ultrasounds, in particular, are recommended 2 times during pregnancy, generally around the 12th and 20th week of pregnancy. As no Indigenous community or organization offers this service, pregnant women must travel to another location[29]. In another example, pregnant women considered to be at risk, such as those developing gestational diabetes, need to be monitored more closely by doctors, requiring them to travel several times for their appointments at the HRP clinic.

The services available to pregnant women outside their community or Native Friendship Centre are the same as those available to all pregnant women in Quebec. No consideration is given to the Indigenous cultural dimension. This fact is compounded by the challenges and issues women face when travelling to access the perinatal services prescribed throughout their pregnancy.

### 3.1.2 Failure to attend pregnancy follow-ups

Testimonies show that some pregnant women consult their doctor very little, if at all, during their pregnancy. This lack of pregnancy follow-up, whether provided by Indigenous health centres and organizations or outside the communities, raises a number of issues. With regard to women in her community and the pregnancy follow-up provided by the health centre nurse, participant COM09 reports that:

> They come for their lab tests, but afterwards, they don't show up anymore. The nurse goes to see them, tells them it's important, the follow-ups, etc. She'll invite them, but they don't come. Maybe 10% or 5% are like that. [...] We have to work with them to value their pregnancy. Be proud of being pregnant, take care of yourself [Translation].

The statistical estimate proposed by participant COM11 is even higher:

> Here, maybe two thirds come to their appointments, are constant in their follow-up. Still, you've got maybe the one third who almost need you to hold their hand and say, "OK, no. You've got to come" and even then, they don't come [Translation].



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28 An entire section is devoted to the travel imposed on Indigenous pregnant women in the following pages.

29 One participant explained that ultrasound equipment was once available in Blanc-Sablon, on the Lower North Shore, but that today, all women in this region have to travel to Sept-Îles to obtain this service.

Without going into numbers, other participants echo the two previous testimonies. Participants ORG02 and ORG03 are particularly vocal about this alarming situation, for which they give concrete examples and offer explanations:

> Friendship Centre teams at La Tuque or at Maniwaki, for example, told me that some women see a doctor for the first time at their delivery [Translation] (ORG02).

The reality described by participant ORG03 is related to drug addiction:

> At [name of the community], drug dependency is widespread. Then, with many young girls, it's precisely in this clientele that there's going to be a lot of negligence, because the young girl is caught up in drug use. […]. These are people who are outside the healthcare system, and often these are the girls we go to see, who give birth in... because sometimes the nurse never knew the girl was pregnant. Then, she shows up one morning saying her stomach hurts, but no, she's about to give birth. These are also the realities we see in our communities [Translation].

The papers of Riddell & al. (2016) and Sokoloski (1995) are enlightening as to this infrequent attendance, if not complete avoidance, of pregnancy follow-ups. Riddell et al. writes about women in British Columbia that "First Nations mothers were less likely to have early ultrasonography, less likely to have at least 4 antenatal visits and less likely to undergo induction for indications of post-dates gestation and prelabour rupture of membranes" (Riddel & al., 2016, p. 40). Sokoloski (1995) goes further when she explains the reasons why women do not stick to their prenatal care, such as the family logistics of finding someone to look after the children, transportation issues, prejudices conveyed by health personnel, fear of medical procedures, difficulties in communicating with health professionals and the expeditiousness of medical appointments. The women Sokoloski met lived in an English-speaking town in the Prairies, but participants in this research also mentioned many of the same observations.

### 3.1.3 Reasons for missed appointments

Absenteeism from medical appointments is a common theme in the testimonies. Women have many reasons for missing them, but this is often misunderstood by healthcare staff:

> It's true that for some pregnant women, it hasn't always been easy to keep up with their follow-ups. They miss an appointment. The non-Indigenous person doesn't always understand why. They don't understand the notion of time is different here. You have to acclimatize to all that. In fact, the challenge we face is that families prefer not to go to appointments because situations arise [...] people don't show up for their appointments because of the family context [Translation] (COM02).

The "family context" referred to in this citation is also repeated in many other testimonies: "[...] there is a certain part of the clientele that will miss their appointments

because of their situation in the community. Family situation, finding a babysitter" [Translation] (COM13). Other reasons why pregnant women miss appointments include transportation, communication difficulties when making appointments and cultural factors unaccounted for.

> Sometimes, people don't take it into account, they'll say: "OK. Well, your next appointment will be at the beginning of September." "Yes, but for me, early September isn't just the start of school, like you. It's also hunting season, so I'll probably be out in the woods. Can we postpone it a bit? Can we do it earlier?" This is not taken into account. [...] There are a lot of obstacles for us to just go to a medical appointment [Translation] (ORG04).

Pregnant women's difficulty in attending their multiple pregnancy follow-ups can be summed up as follows: "It's not [so much] a disinvestment in one's child as a disinvestment in the healthcare system. That's what we see" [Translation] (COM02). This apparent disinvestment is rooted in the very workings of the healthcare system, which poses many challenges in terms of accessibility.

## 3.2 Challenges and issues in accessing perinatal services

A variety of challenges and issues intensify the journey towards access. The mistrust of Indigenous people towards the healthcare system is part of the findings highlighted in numerous government reports, such as those of the CERP (2019), the NIMMIWG (2019) and the Royal Commission on Aboriginal Peoples (RCAP). Pivotal in the journey of Indigenous women towards perinatality services, this mistrust is deeply embedded in many factors that surface during the interviews.

### 3.2.1 The reception of Indigenous women when accessing perinatal services

A major finding stands out during the interviews on the reception of Indigenous women in perinatal services. In certain cases, health authorities or nurses had not realized or we unaware of a poor quality of services or any problem in the service delivery. Yet:

> When a mother turns up for her appointment, surrounded by members of her family, this is very well received at the VDNFC. At the hospital, on the other hand, it's less welcomed because it's not understood. The concept of family is not understood in the same way, so women are not received in the same way. The extended family represents the family [Translation] (ORG01).

This lack of understanding by the medical staff of those present at an appointment or during childbirth, as mentioned by several participants, is combined with women's mistrust of the healthcare system, which seems to be at the root of the difficulties experienced at their arrival:

> In terms of reception [...], there's a mistrust of the health system on the part of community members. [...] There have already been cases

> where mothers didn't feel as welcome as they would have liked. They felt they were intruding. But these are not situations that are recorded. There are no official complaints [Translation] (COM02).

One of the women we met said that in the town where she lives, "it's not that the services aren't accessible, it's that they're not adapted. It's the way they're offered [that is problematic]" [Translation] (ORG01). Another woman explains the presence of these challenges and issues by colonialism:

> There are a lot of issues, but I think the biggest one is trying to access care in a healthcare system that is not designed for you. The healthcare system in Canada is not designed for Indigenous people. The healthcare system in Canada was actually an important tool of colonization (ORG06).

This last sentence appears abundantly in the literature concerning health and Indigenous people, notably in Gimenez (2012), Shaheen-Hussain (2020), Silver & al. (2022) and Smylie (2014). On perinatal health displacement, Cidro and Sinclair write that "the result for Indigenous peoples in Canada was an imposition of colonial policies and practices that transferred births and maternal care from the home to nursing stations and, subsequently, to hospitals located outside the community" (Cidro & Sinclair, 2021, p. 187). This relocation of deliveries from communities to hospitals will be presented and discussed at greater length in the next few pages. Moreover, the tragic death of Joyce Echaquan at Joliette Hospital in September 2020 has exacerbated the mistrust described above, as well as the fear of going to hospital for pregnancy follow-ups and deliveries:

> […] I can tell you that since the Joyce Echaquan business, unfortunately, I've had women who refuse to go to hospital, who want to give birth in the woods, and then put themselves and their baby in danger because they're afraid to go to hospital [Translation] (ORG04).

The situation of vulnerability of some Indigenous women sometimes makes them even more fearful of services:

> Of course, giving birth in a hospital, when you're in harmony with the medical environment and feel good about it, usually goes better. But if you're already skeptical and fearful, it's more difficult to feel at ease during childbirth, especially with non-Indigenous staff. It's a very vulnerable time. [...] Mistrust and fear of being monitored and documented, or distance and transportation issues, mean that women prefer to go without pregnancy follow-ups. It's a question of trust and financial resources [Translation] (ORG02).

The lack of trust can be explained not only by the way women are received in hospitals, but also by the existence of practices such as abusive reporting at birth, which unfortunately still seems to be widespread, according to the testimonies we have received.

### 3.2.2 Threat of birth alerts

Even though birth alerts and referrals to Youth Protection are considered to have been abolished in Quebec (MSSS, 2023), they were still in use at the time of the interviews, heightening Indigenous families' sense of mistrust in the healthcare system. The testimonies gathered describe the situation:

> This woman is reported because she didn't have a pregnancy follow-up. I'm not saying it's wrong to go without a pregnancy follow-up. What I'm saying is that if I choose not to have a pregnancy follow-up, I'll probably be reported [Translation] (COM09).

Another participant concurs:

> Often, they'll avoid talking about the pregnancy follow-up appointment or their experiences because they don't want to attract attention and be reported [to youth protection]. It's something that's been mentioned and that hangs over the women's heads [Translation] (ORG01).

In addition to this fear of being reported, birth alerts also represent an additional stress factor during childbirth. A Friendship Center who reported being recently involved in a case of birth alerts where Youth Protection promptly removed the baby from parental care less than 48 hours after birth due to lack of knowledge on indigenous realities.

Community health centres, Indigenous organizations and women themselves are mobilizing to prevent this type of situation. For example, "some women want to be accompanied to the hospital to make sure they are not discriminated against or subject to prejudice, so as not to have birth or baby alerts, just because they are Indigenous" [Translation] (ORG04).

In short, women feel discriminated against right from the start, and are continually afraid of losing their child, whether immediately after birth or later, a finding corroborated by numerous studies across Canada (Boutroy, 2020; Duchaine, 2021; Lawford, 2021; Quinn, 2021).

### 3.2.3 Prejudice and prevalent systemic racism

The testimonies gathered unanimously demonstrate the existence of certain prejudices experienced by women when accessing perinatal services, particularly during childbirth. For example:

> I have friends who look more Indigenous than I do, [they've] experienced judgments. Judgments about their ability to look after their children [Translation] (COM05).

> I've had women tell me that they've experienced prejudices about their delivery or other things, that they've never taken drugs, and then they're told: "Yes, you're taking drugs", or things like that [Translation] (COM12).

> Some women state that they face racism. I know that in Gatineau, the women face a lot of that stigma because of their race (COM16).

These words shape their experiences of pregnancy and are consistent with what Whitty-Rodgers & al. (2006) write about Mi'kmaq women in Nova Scotia who feel inferior because of the attitudes of health professionals. All these prejudices are part of a wider system characterized by the existence of systemic racism, i.e., racism inherent in the operation of the healthcare system and reflected in the practices of healthcare personnel, as expressed by one of the participants to this research:

> [h]opefully, people are increasingly starting to acknowledge the racism that Indigenous people experience in the healthcare system. Sometimes it's overt racism and sometimes it's a system of racism that people aren't aware of. The system wasn't made with the health and well-being of Indigenous people in mind (ORG06).

Another participant refers to the specific situation of teenage mothers who, "when they arrive in the public health system, [are] often looked at in a paternalistic way" [Translation] (ORG02). This participant added that a study of Indigenous people who live in cities and who use health services reveals that:

> [t]he figure was 58% when we asked: "Have you ever experienced racism or discrimination in the public network?" 58% answered "yes" out of 1,700 respondents. This shows that it's a fairly widespread experience [Translation] (ORG02)[30].

In some cases, solutions have been put in place to prevent Indigenous women from experiencing this latent racism:

> Yes, it's an issue. So, we work with a Indigenous Liaison Senior Advisor. When people experience problems, following the death of Joyce Echaquan, she's there to represent Indigenous rights. If there's racism, she'll make sure it doesn't happen again [Translation] (COM05).

While systemic racism is increasingly denounced, the entire healthcare system needs to be revisited so that women feel comfortable turning towards it during pregnancy. As Burns & al. (2019) point out, "cultural safety requires healthcare providers to critique the issues of institutional racism and discrimination in the healthcare system" (Burns & al., 2019, p. 143). While systemic racism is embedded in the workings of the healthcare system, it is relayed under the guise of specific acts that run counter to the most elementary respect for human rights, starting with respect for women's free and informed consent in the case of medical interventions. In this regard, a recent research report on the free and informed consent and imposed sterilizations of First Nations and Inuit women in Quebec reveals numerous shortcomings in obtaining consent for medical procedures (Basile & Bouchard, 2022). On the same subject, Shaheen-Hussain & al. (2023, p: 1763) add:

> A member of the Atikamekw Nation from the community of Manawan and the beloved mother of seven children, Echaquan was also a sur-



[30] Consult the publication by the Regroupement des centres d'amitié autochtones du Québec (RCAAQ, 2018).

vivor of obstetric violence. On the first day of the coroner's inquiry into Echaquan's death, her spouse, Carol Dubé, testified about these experiences, including how Echaquan had been pressured to undergo an abortion on more than one occasion, as well as a tubal ligation after the birth of their last child. In her 2021 report, coroner Géhane Kamel stated that "Echaquan's death could have been avoided" and concluded that the "racism and prejudice that Mrs Echaquan faced was certainly a contributing factor to her death". Accordingly, Kamel's first recommendation called for the Government of Quebec to commit to eliminating systemic racism. Disturbingly, Echaquan's experiences are not unique among Indigenous women in Canada.

### 3.2.4 Unsolicited medical interventions

Participants mention two types of medical intervention that impact women's access to perinatal services: caesarean sections and screening tests administered to newborns without parental consent.

In fact, several participants indicated that consent is not necessarily requested in the case of caesarean sections. For example, "One mother ended up having a C-section because they caught the gestational diabetes way too late. The baby was too huge" (COM03). Another participant notes that a second caesarean section is common among women who have already had one. Although the health centre encourages vaginal birth after a caesarean section (VBAC), pregnant women must go through a number of steps to obtain this right – however fundamental – to have control over their own bodies.

The second case involves Indigenous newborns. One of the participants discusses drug testing at birth, talking about her own experience during childbirth:

> I don't dare look in my own file to see if they've done it. They never came to ask for consent to do drug testing during my deliveries. I'm sure they do it without the parents' consent [Translation] (COM09).

This testimony, which raises the lack of ethics within practice, is echoed in the CERP report, which states that "unethical practices targeting women, and based on addiction-related prejudices, such as drug testing carried out without consent on Indigenous women who have come to give birth have also been brought to my attention" (CERP, 2019, p. 391). These experiences of pregnancy sometimes leave traumatic scars on women. One of the participants reports the reality experienced by a woman from the community:

> It was the same thing with another woman, her little girl was 8 or 10. It was a beautiful pregnancy. She went to every appointment, ate well. She did everything we told her to do. After giving birth, she breastfed her baby. She was told by the doctor, the physician, "We did the drug test on your baby, it's negative." This hurt her so much. She hadn't been told they were testing the baby. It hurt her so much. She was crying. She talked to me about it again, not at the hospital, but afterwards. "I was crying in the hospital;

> they did a drug test without telling me. I've never taken drugs in my life. I did everything I was asked to do." This is a lady who doesn't use drugs. "They dirtied me." They did. "Who do they take me for, it's disappointing" [Translation] (COM09).

These blood-testing experiences, carried out without the parent's knowledge or consent, fall within the broad spectrum of trauma inflicted on Indigenous families. In her article, Roy (2014) looks specifically at intergenerational trauma among Indigenous women in relation to motherhood. According to her,

> […] historical trauma and unresolved grief are reinforced and augmented with the trauma and despair stemming from present-day circumstances, including experiences of racism and sexism. In the context of health and social services, a lack of cultural safety contributes to oppression of Aboriginal peoples, and therefore to IGT [intergenerational trauma] (Roy, 2014, p. 14).



### 3.2.5 Language and communication barriers

Within the Indigenous communities and organizations we met, some people speak French, while others speak English. Others speak the Indigenous language of the Nation to which they belong. This multiple linguistic reality is part of the Indigenous landscape in Quebec. Access to perinatal services must take this into account, which is not always the case, depending on where you are in Quebec. So, for some pregnant women, the experience of accessing care is tainted by a language barrier. In the words of one participant: "There are difficulties with accessibility and difficulty with communication. Because sometimes, they get a practitioner that is more comfortable in French, and [...] is an English community. So, they don't really understand. There is a language barrier" (COM03).

This language barrier has harmful consequences, particularly in terms of birth assistance and post-partum care. The language barrier can also have an impact on pregnancy follow-up, "especially for Indigenous women who speak English. [...] This barrier is one of the reasons why you don't feel like going to your pregnancy follow-up" [Translation] (ORG01).

In some cases, participants report that the language barrier is partly resolved by local initiatives that encourage the presence of English-speaking staff in French-speaking establishments, in order to meet women's needs, as is the case, for example, at the Ville-Marie Hospital in Abitibi-Témiscamingue. However, the COVID-19 pandemic has weakened this practice:

> They always made sure [in Ville-Marie] that they had one staff English on-hand. But that was before the pandemic. Everyone has been pulled. If I go back, I am sure they won't be as many staff and probably not the same staff (COM03).

For some women, the language barrier is compounded by communication issues. One participant points out that "when an Innu woman arrives, these people are extremely shy. And then there's the lan-

guage barrier. Sometimes they can't express themselves the way they want to. I've seen it. I've experienced it. They don't dare ask" [Translation] (COM02). Another participant explains:

> Aboriginal people need time to think and to reflect about the questions. They need time to ask questions. And there is not that time. It is always rush. They feel like they get no information. Multiple people have told me this (COM03).

Medical appointments are frequently rushed, which means Indigenous women don't have access to all the information they need. One participant spoke of the frustration experienced due to communication issues: "The women get frustrated because the nurses don't understand them, they don't understand the nurses" (COM16). Mistrust of services is also one of the feelings communicated by the women and briefly discussed later. Combining frustration, mistrust and trauma, this context is exacerbated by the need for many mothers and mothers-to-be to relocate, especially when they live in geographically remote areas.

## 3.3 Travel-related challenges and issues

To access perinatal services not available in Indigenous communities and organizations, pregnant women have to travel. Distances are sometimes short (a few minutes), sometimes long (several hours, even days). The challenge of transportation is frequently mentioned in the testimonies gathered, along with many other issues, such as the lack of accompaniment and interpreters, income, accommodations, family logistics, loneliness and stress. This section highlights all of these aspects identified by the participants with regard to Indigenous women.

### 3.3.1 Relativity of Distances and Means of Transportation

Depending on where they live, pregnant women will leave their communities sooner or later before their due date. Generally speaking, women who have to give birth far from home leave their community for three to six weeks, as illustrated by the case of women from the Matimekush-Lac John community, whose move to Sept-Îles is scheduled for the 36th week in the case of uncomplicated pregnancies. This procedure involves complex coordination for health centre staff, who must consider the weather, especially when air transport is involved:

> The transfer back home also has to be organized, depending on a difficult-to-predict hospital discharge date. The trip from Sept-Îles to here can take several days. They often return a week after giving birth. It also means flying with a newborn. [...] MedEvac Canada transports obstetrical emergencies to Quebec City. Sometimes this is done by Air Inuit (commercial flights) or Air Medic, depending on availability and weather conditions. We don't have a designated aviation service; Air Medic covers the entire Côte-Nord region. We are entirely dependent on weather conditions, and sometimes a plane cannot land or take off from Schefferville for several days [Translation] (COM14).

For other communities, the train is the most common means of transportation, due to their geographical remoteness, in which case "the train journey, once a week, takes approximately 10 hours (some have been stuck on the train for 17 hours)" [Translation] (COM14).

Communities closer to urban areas have less of a commute problem, as noted by the Wendake participant and the Wôlinak participant. "Here [in Wôlinak], we're used to travelling short distances by car. For us, it's next doors. The challenges... I don't think there's a distance issue" [Translation] (COM06). For others, the drive can take many hours, making travel more tedious, as participant COM13 explains:

> The biggest challenge I see is getting around, driving. Going to La Tuque takes at least 1 hour 30 minutes. If she has to go to Shawinigan, it's another hour. If she has to go to Trois-Rivières, it's another 2 hours. The challenge is the travelling, the transportation, the geography of the roads that make it a challenge [Translation].

Distance is not the only factor to consider when it comes to travel. Since public transport is not available in most regions of Quebec, women have to manage otherwise, regardless of whether they live in a community or a city:

> Transportation is an important factor in access to care (ability to get to appointments). [...] Even in town, transportation is an important issue. Plus, there's no public transit in Val-d'Or. [...] There are limitations related to transportation, even for members who live in town [Translation] (ORG01).

Indigenous organizations offer medical transportation services, but these vary from community to community. In one community, "they have access to medical transportation if they don't have their own vehicle or if they can't find a ride to get there. They are reimbursed if they take their own vehicle or someone else's vehicle at 22,5 cents per kilometre" (COM03). It would be essential to revise this amount upwards, considering that the Treasury Board rates are $0.68 per kilometre in 2023, and that many Indigenous communities in Quebec are located in forested areas with gravel access roads. Some health centres have a vehicle at their disposal, enabling them to offer health-related travel to community members who need it. When the transportation service is not available, such as evenings or weekends, patients use cabs, which are then paid for by the health centre. In certain situations, however, this option is restrictive, as participant COM12 points out when she says that with the cab, "they [pregnant women] can't fit all the children's car seats" [Translation], which complicates travel for pregnancy follow-up appointments, in particular. Native Friendship Centres sometimes try to offset this transportation issue, but this is unfortunately not possible for all of them, as specified by the following interviewee:

> I know that in Sept-Îles, the [Native Friendship] Centre has sometimes provided some accompaniment, because there are mothers from the Lower North Shore who have to go to Sept-Îles beforehand. I know that the Centre accompanies the mothers, helps with translation and so on. But the service isn't structured and formalized [Translation] (ORG02).

The medical transportation service is subsidized by Health Canada under the First Nations and Inuit Non-Insured Health Benefits (NIHB) program. The eligibility criteria for accessing the medical transportation service come from this program, both for pregnant women and for those wishing to accompany them. As participant COM07 points out, "all aides - escorts to travel - had to be medically required" [Translation]. Among the criteria established, participant COM09 criticizes the following:

> [...] they allow the dad only at the delivery, not during follow-ups. If there's room for the father, I allow him in the transport. It depends on the government's criteria. But when we have room, we try to get the dad on board [Translation].

Participant ORG03 is also critical of the NIHB program, which she feels discriminates against Indigenous people living in cities, as travel costs are not covered for pregnant women living in urban areas, compared to those living in a community. She explains:

> 'It's part of Health Canada's regulations. We know that, for several [years] now, they've been cutting more and more, funnelling the service more and more. We have far, fewer services than before. We now have to pay for medication that is no longer covered by Health Canada, the NIHB, they call it. [...] It's like discrimination on the part of the NIHB, Health Canada, to cut us off from these services when, as the Grand Chief of the Atikamekw Nation says, "You're Atikamekw no matter where you are in Quebec" [Translation].

As viewed by the participants we met, it is important to review the NIHB program's eligibility criteria by bringing back to the forefront the essential role of travel escorts in the support of pregnant women, and the allocation of funding for Indigenous people living in cities.

### 3.3.2 Logistical challenges: coordination, support and financial issues

Over and above the travel involved, giving birth far from one's community raises major logistical challenges, and foremost in terms of accommodations for women. Birthing homes are part of the service offered by some community health centres, as is the case for those who travel to Joliette, Sept-Îles or Roberval. During pregnancy, women often have to travel back and forth, both for follow-ups and for childbirth, as many of the participants put it. "It often happens that women have to go alone to give birth [...]. That's why we decided to hire a birth attendant" [Translation] (COM11).

Leaving with your partner (or family) also involves many challenges, especially during childbirth, such as your spouse missing work and children missing school, the distance from community and family, and the family logistics of babysitting. In short, "it's all about planning your absence from home. I think it's one of the biggest challenges for the pregnant woman. Leaving home, leaving the children, living with another family or finding a place to live over there" [Translation] (COM10). The woman has to find someone she trusts to look after the children while she's away, which can be quite a challenge, and is sometimes the reason for missed medical appointments.

> [...] when there's, how could I say, drug or alcohol use at home, it's difficult for the pregnant woman to leave the children. That's an important issue. [...] It's difficult for a pregnant woman to leave when there are problems of substance abuse, of infidelity in the couple during pregnancy, it's not easy [Translation] (COM17).

Experiencing childbirth alone place women in a highly vulnerable situation, accentuating the traumas discussed above, and also putting them at risk of possible obstetric violence:

> Violence perpetrated against women is the result of a patriarchal system permeated by multiple relationships of oppression. Obstetric violence can be all the more difficult, if not more frequent as consent is not always sought by the medical team, when such violence is experienced in a differentiated way depending on the woman's social position. [...] Their experience of obstetric violence is tainted by these unequal power relations, and they give us a better understanding of how they can manifest themselves (RNR, 2019, p. 22).

The cutbacks in support services in recent years explain one dimension of this deplorable situation:

> In the past, they were always accompanied. The husband was always allowed to accompany his wife, but not obliged to, depending on their decision, because it often took someone to look after the children at home too. So, if they wanted, they could be accompanied. [...] Then, over the last ten years or so, there's been a kind of tightening of expenses and all that. Pregnant women were no longer allowed to be escorted while waiting to give birth in Joliette. The father was only allowed to go in once she went into labour, at least to witness the birth [Translation] (COM07).

While some of the costs are covered by the Government of Canada's Non-Insured Health Benefits program (GC, 2020), the participants we met pointed out that accompanying escorts must eat at their own expense. Another added that "depending on her stage of pregnancy, she doesn't always have an escort. I say escort, but the term is accompanying person. It's not always paid for" [Translation] (COM13). Or again, "[a]dmittedly, with the spouse, there's the obligation to leave at 37 weeks of pregnancy. The spouse can't stay for three weeks. That's not covered. It's not covered by health services" [Translation] (COM17). In short, it seems essential to clarify with community health centres what financial resources are available to ensure that pregnant women are cared for and supported during their travels, particularly during childbirth.

The financial issue is of concern not only to the person accompanying the woman, but also to her. Indeed, "there's a part that Health Canada pays for, such as travel and accommodations. And then it's the pregnant woman who pays the other costs. [...] You have to have money to go elsewhere. to give birth" [Translation] (COM10). A participant adds:

> Some people live on welfare. That could be a financial issue for them, because it still takes money to go and live in the city, compared to when you're here or living with your parents. Over there, you stay in a hotel [Translation] (COM11).

This reality is experienced from the Haute-Côte-Nord to Abitibi-Témiscamingue, including the Gaspé Peninsula. All these women face the financial difficulties that unfortunately characterize part of their pregnancy. Even for women who live in the city, getting to the hospital is not always easy. For example, "there is no reimbursement of travel expenses for people who live in Trois-Rivières, and there is no medical transportation" [Translation] (ORG05), compared to other Native Friendship Centres offering this service, such as in Val-d'Or.

### 3.3.3 Increasing number of travel requirements

Participants representing community health administrations and organizations unanimously confirm that all women, at one point or another during their pregnancy, have to search for perinatal services that are not accessible within their own communities. None have the option of giving birth in a health centre. For some communities where several services are offered, two additional trips are generally required to perform the two ultrasounds prescribed in the pregnancy follow-up schedule. When medical follow-up is not provided by the Indigenous organization, it is done on a regular basis, first every month, then more frequently as the due date approaches. When asked about the number of trips required, participants were reluctant to offer a figure. On the whole, it varies between 12 and 16 trips for a normal pregnancy. These figures rise considerably in the case of so-called "at-risk" pregnancies, notably due to gestational diabetes. For example, "if your pregnancy's not going well, it's not going well. You're going to have one. You have to go to the HRP [clinic] once a week" [Translation] (COM12). The following comments demonstrate the complexity of these undertakings:

> If you have follow-ups once a month at the clinic; that you have to go and do your tests, blood tests, diabetes; two ultrasounds at the hospital; and if there's a follow-up at the HRP clinic [at the hospital] once a week. So, for 9 months of pregnancy, about 2 blood tests, 2 diabetes screening tests, we can say about 15 times plus the delivery, so 16 trips for a normal pregnancy. If there are complications and follow-up in a HRP clinic once a week from 30 weeks onwards, we add 10 trips to that. This means approximately 26 trips [Translation] (ORG05).

Given that the prevalence rate of gestational diabetes is higher among Indigenous women than among non-Indigenous women in Canada (Chen & al., 2019; Pace & al., 2020; Smylie, 2014), it seems fair to say that Indigenous women are subjected to a disproportionate amount of travel during pregnancy.

### 3.3.4 Being away from home, a source of loneliness and stress

Being away from home, often on their own, creates a host of worries, and therefore additional stress for women. The uncer-

tainty of their situation, which translates into a lack of control felt by the women, is linked to the fact that "Some get bored when they go to stay in Joliette. They never know how for how long they'll be away" [Translation] (COM07). Not to mention the travel involved, which in itself is a stress factor, compounded tenfold by weather conditions. Participant COM10 presents the experience of an Innu woman from the Lower North Shore:

> I think that for them [the women from the Unamen-Shipu community in La Romaine] it's even more stressful for the mother, in terms of travel. [...] For her consultations, going to Sept-Îles. She either takes the boat or the plane to Sept-Îles. [...] When she travels, she loses a week's work. It also depends on the weather. Costs too. Right now, she's away from home, and then she has to go back in two weeks. That's another trip [Translation].

The notion of distance and its repercussions are little mentioned by the health authorities and organizations we met. The available literature does, however, address women's feelings about relocating. Varcoe et al., who met Indigenous women in British Columbia during focus groups, write that "in one focus group all seven young mothers cried through most of the interview, describing the effects of giving birth outside their communities: loneliness, disconnection from the community, isolation from family and culture, and discrimination" (Varcoe & al., 2013, p. 5). The study by Lawford et al. concurs, clearly evoking the loneliness felt by Indigenous women in Ontario who leave their children at home:

> In northwestern Ontario, First Nations women who were evacuated to Sioux Lookout from their northern reserve communities described similar feelings: loneliness, disruption, and separation from their children and family support. Indeed, independent of the province in which they were located, First Nations women have unsurprisingly reported experiencing loneliness and disconnection when they are evacuated for birth (Lawford & al., 2018, p. 481).

The distances travelled by Indigenous women during their pregnancy are fraught with obstacles. An abundance of literature examines the policies of evacuating women to give birth, in force in Canada, New Zealand and Australia, among others (Brant & Anderson, 2021; Chamberlain & Barclay, 2000; Cidro & al, 2017; Cidro & Sinclair, 2021; Couchie & Sanderson, 2007; Dawson, 2017; Dietsch & al., 2011; Finestone & Stirbys, 2017; Hartz & McGrath, 2017; Kornelsen & al., 2010, 2013; Lawford, 2017; Lawford & al., 2019; Lawford & Giles, 2012; Silver & al., 2022; SOGC, 2012; Vang & al., 2018). On the subject of Tłı̨chǫ women in the Northwest Territories and the evacuation policy in place in this part of Canada, Dawson writes that "colonization became integrated into the lived experiences and rituals of birth and created birth places structured by the cultural values of the colonizer, whether saving souls or saving bodies" (Dawson, 2017, p. 161).

# Chapter 4.

# Midwifery services for Indigenous communities and organizations

This chapter provides an overview of midwifery services as perceived by the participants, both in terms of their potential and the difficulties involved in setting up this type of expertise.

## 4.1 The difficult access to midwifery services: between unfamiliarity and shortage

A description of the perinatal services offered in Indigenous communities and organizations, and those that are not accessible, highlights the scarcity of midwifery services, both in First Nations communities and in Quebec cities. Although there are midwives in some regions of Quebec[31], Indigenous women from communities not under agreement are rarely offered this service[32]. What's more, when informed of the practice, they find it difficult to access midwifery services, especially as midwives are already stretched to the limit and birthing centres are operating at maximum capacity. One participant explains the situation in her community: "[...] as the birth centre is always full and the waiting list is long, women who experience an obstacle when trying to access a midwife simply abandon the process" [Translation] (COM01). Participant ORG02 is also aware of this situation. She mentions that:

> Without a reserved birthplace, I don't think it would be realistic for more Indigenous women to go to birthing centres [...] Because yes, access to midwifery services would certainly be a good option, but I don't know if it's realistic in the short term. At the moment, it's 4%[33], but there have been requests everywhere for years, and there aren't many birthing centres opening every year [Translation].



31 In August 2022, no midwifery services were deployed in the Côte-Nord, Abitibi-Témiscamingue and Laval regions. (RLSFQ, 2020b).

32 This excludes Inuit women, for whom the service has been deployed in Quebec for the longest time, and Eeyouch women, as mentioned above.

33 This statistic refers to the total number of women who had access to midwifery services in Quebec, in 2021 (RLSFQ, 2021). In its 2008-2018 perinatal policy, the Quebec government planned that 10% of Quebec women would have access to midwives by 2018 (GQ, 2008), which is far from being the case.

For her part, participant COM03 reports some access to services, but in the neighbouring province of Ontario, and under very specific conditions:

> They can access midwifery services. If they have an Ontario healthcare card and an Ontario address, they can access midwifery services in Ontario. Sometimes it happens because they don't transfer right away their information and they go back-and-forth. It is the only time where I have seen someone access midwifery services around here.

When asked about the accessibility of midwifery services during the course of the research, participants expressed their views on several aspects of contemporary midwifery[34], including the benefits of midwifery for pregnant women, the lack of knowledge about the practice, the lack of pregnancy follow-up options and the implementation steps required to deploy midwifery services. One thing is certain: for participant ORG04, the practice of midwifery to meet the needs of pregnant women is more than essential:

> The need for community midwives is really important. It's a need. [...] The purpose is to ensure the well-being of women and children who will be born in the communities. To give them a future. Right now, it's precarious. The situation is precarious. For the total well-being of our families, we need to have these people in our communities. Pillars, I'd say. Because, it may not seem like much, but having midwives in the community... I wouldn't have given birth in hospitals each time if I'd been able to have a midwife [Translation].

This hope is directly in line with the recommendations raised by Varcoe & al. (2013), who indicate that the participants in their research would like to be able to experience their pregnancy follow-up with other health professionals:

> The women's recommendations varied depending on their communities and their individual experiences. […] Some [women] were supportive of the idea of expanding the range of providers, including doulas and midwives, including Aboriginal midwives, a direction advocated by other researchers and presently being championed by the National Council of Aboriginal Midwives in Canada (Varcoe & al., 2013, p. 6).

On the subject of doulas (or birth/labour attendants), it turns out that some of the pregnant women we met sometimes turn to this service in the absence of midwives. "A few years ago, some of our community members went to a doula training within the community, so we have a few doulas in our community and the next step was to get midwives" (COM08). Another participant adds:



[34] We feel it's important to use the term contemporary practice to refer to the current practice of midwifery in Quebec, so as not to confuse it with the traditional Indigenous practice experienced by Indigenous midwives. That said, we recognize that there are a few Indigenous midwives practicing in Quebec today, in particular among the Inuit, but also in the southern part of the province, and that these midwives skillfully combine traditional Indigenous knowledge with Western knowledge regarding the world of perinatal care and motherhood.

> For women who really want to be followed by a midwife, but are unable to do so, they often turn to labour attendants, who teach childbirth preparation and accompany women as they go into labour. They come to the home and follow women to the hospital. They stay until the baby arrives. They have a very human approach. It's a plus for the family because you have someone you can trust with you, who knows your needs and your vision [Translation] (COM01).

There is a widespread lack of awareness of the role of midwives among the general population of Quebec. This proves to be paradoxical, as the philosophy behind the action of midwives is directly linked to the notion of informed choice during pregnancy, medical interventions and the type of follow-up desired by the woman. This observation is highlighted by MacDonald (2018) when she discusses the midwifery model in Ontario from a feminist approach to "care". The fact remains that participants are poorly informed about midwifery, as participant ORG02 points out: "services in the public system aren't even known, so to think of midwifery services that aren't mainstream [general public], of course, they're not known. I've never heard of them either" [Translation]. Other participants have questions about the range of the practice, with one confirming that "[b]ut I've noticed that women have a lot of questions. It's still not widely known, even though it's 2021. There's a lot of ignorance about the role of midwives and the fact that they can provide these services" [Translation] (COM01). Another participant adds:

> I've also noticed that in order to use midwifery services, the pregnancy has to be "perfect", without any complications. For example, my baby is going to be two years old, and in my first pregnancy I had preeclampsia and high blood pressure. In my second pregnancy, I was monitored as if I had the same complications. I was followed in the high-risk pregnancy (HRP) clinic, even though everything was fine. I was followed as if the risks were high, as a preventive measure, according to the people at the clinic. Talking to other mothers, they tell me they've had the same complications, or diabetes, so it's hard to imagine giving birth with a midwife in a birthing centre if there are risks. We need to demystify what's possible and what isn't [Translation] (ORG05).

As brought up by participant ORG05, this work of demystification echoes that of participant ORG04, who suggests a Quebec-wide midwifery tour to reach out to community health centres, to the health services of city-based Indigenous organizations, and to Indigenous women. Finally, participant ORG06 sums up the situation perfectly:

> For many communities, it's been such a long time since midwives have been an active, normal and regular part of the community that the role of midwives is sometimes less known. It's not necessarily forgotten; some people do still remember what having a midwife represented.

## 4.2. The contribution of midwifery

Despite this lack of understanding about the role of midwives, it turns out that their role is positively perceived when participants are asked about the contributions of midwifery (both Indigenous and non-Indigenous) to the perinatal health of Indigenous women, particularly when it comes to women who are vulnerable.

> I think the midwifery approach could be appreciated by women with really complex backgrounds, who may have a history of abuse, violence or negative hospital experiences in their family or among their loved ones. Here again, they would need to hear about it [Translation] (ORG02).

In the opinion of many, midwives would provide better pregnancy monitoring to expectant mothers. Participant COM03 points out that this could help with screening for gestational diabetes, but also with women's childbearing history:

> I have also had experiences with mothers not getting the proper screening for gestational diabetes. Again, if a midwife was here, knowing the Aboriginal culture, knowing that they are more at risk of getting gestational diabetes, they would do early screening. They wouldn't be any unnecessary interventions. […] If there is someone, like a midwife, that can do the whole follow-up, and know exactly how their birth has gone. Because I ask the mothers, and often, they will either tell me exactly what happened, or the mothers will prefer not to say anything. Again, I just respect what their wishes are. If someone is there during the birth, they will know all the details.

Participant COM16, who is familiar with the services offered by midwives, lists all the positive aspects this would provide for women:

> Midwives are offering three visits in the first week [after delivery] and once every two weeks after that: [they are followed] for six weeks. It's a more personalized approach to care and with that personal approach, women will be healthier, their babies will be born healthier, with the knowledge that they will have the same person seeing them every single time during their pregnancy, when they give birth, and after the delivery. I'm happy to start filling that gap, especially for Indigenous women and their care.

To which participant TEM01 adds that:

> In fact, it would also allow to open up to... It also helps to avoid ... they avoid C-sections slightly more, that kind of thing. There's a certain percentage that means there are fewer C-sections in these cases. C-sections are only considered as a last resort. There are several stages before we get to that point. [...] I also liked breastfeeding with the midwives. They really encouraged this aspect, breastfeeding your child.

> I think that's also [what] they provide, to recommend that, to help women to be able to breastfeed [Translation].

The testimonies collected, which recount the many benefits of accessing midwife-assisted pregnancy care, are in line with Olson's words, which situate Indigenous midwifery in a much broader spectrum than women's perinatal health during pregnancy: "Aboriginal midwifery is not limited to birth attendance and care during and after pregnancy, rather, the good health and well-being of Aboriginal women and their babies is crucial to the empowerment of Aboriginal families and communities" (Olson, 2016, p. 5).

Because midwives can intervene directly in mothers' homes, introducing their services to Indigenous communities and organizations who so wish would also address the need for local health services. In fact, midwives would be called upon to travel around the community to be closer to women wishing to access their expertise. In so doing, their practice would help offset some of the problems highlighted in the previous chapter, starting with absenteeism from medical appointments and women's lack of perinatal follow-up.

At the same time, insecurities surrounding access to healthcare services and the ensuing obvious mistrust of the healthcare system, would also be mitigated owing to the presence to these health professionals, as expressed by several participants. Participant COM12 illustrates this point when she insists that women in the community "might feel safe because there wouldn't be, precisely, the sort of prejudice, you know, that people are labelled. [...] That would not happen. I think the women would feel reassured" [Translation]. All in all, the midwives' projected relational and cultural openness is perceived positively by the participants, since:

> It's a question of how you're received and how you receive the other person. It's about reciprocity. We feel this reciprocity with midwifery services. One learns as much as the other in the relationship that's created. It makes it easier to open up [Translation] (ORG01).

All of the above is in line with the need to include the concept of cultural safety in healthcare in Quebec:

> Sometimes the need may not be expressed, such as access to midwives, but if it were offered, people would embrace it. For me, this would be part of the current drive for cultural safety in health care. Previously, it was the midwives who were present. There were no doctors. Midwives are part of our customs, which we've lost [Translation] (COM02).

This thought was also conveyed by participant COM07, who believes that midwives would offer culturally safe services for pregnant Indigenous women, families and communities. The Centre d'amitié autochtone de Trois-Rivières (CAATR) is currently supporting such an initiative by exploring this avenue with the Nicolet birthing home, which is developing culturally safe tools.

## 4.3 Implementation stages

During the interviews, those we met were asked about the implementation stages of midwife services within the health centre or the Indigenous organization they belong to.

### 4.3.1 Logistics and material challenges

A number of issues were raised, such as financial issues, the needs of pregnant women, a review of services already offered, establishing communication with midwives and promoting awareness of these services. Many of the participants also pointed to other issues. For some, geographical remoteness is a factor to be taken into account when setting up services. For others, it's the close-mindedness of doctors and gynaecologists that is at the core of the situation, as participant COM13 explains when she says: "[...] what we know is that one of the doctors who is in charge of obstetrics doesn't want to hear about midwives" [Translation]. This situation refers directly to the history of biomedicine in Quebec and the medicalization of pregnancy and childbirth, which has contributed to the devaluation of midwifery among healthcare professionals (particularly doctors and nurses) and the general population (Laforce, 1987; Rivard, 2014).

Many of the people we met cited the lack of space at their facilities to accommodate midwives and introduce the service. This situation is particularly acute in several Indigenous communities:

> I think that would require infrastructure. We don't have room at the moment. We're very, very cramped in the health centre. We don't even have an observation room anymore. We have a room that we've turned into a doctor's office. As a result, we no longer have an observation room to monitor people. [...] We've run out of space. I have employees sharing the same office. [...] We also don't have any accommodations. It's full everywhere, everywhere [Translation] (COM07).

These words are reaffirmed in a number of testimonies gathered as part of the research, of which the following is a further example:

> In an ideal world, yes. Maybe not all the services as such, because we're not equipped for a complete midwife follow-up, and we're still 1.5 hours from the nearest hospital. It's a forest road, and it often takes longer to get to La Tuque because of bad weather or road conditions. So, there's the whole geographical aspect. There's also the health centre aspect, because we're short of space. We're overcrowded. We're aiming for a new health centre, but today, right now, full midwifery services, there would be challenges. Big challenges. Especially with the hospital in La Tuque [Translation] (COM13).

In the short term, it appears that lack of space is an obstacle to the implementation of midwifery services. Adequate funding is needed to move forward[35], as is greater openness on the part of perinatal health professionals currently involved in providing services to pregnant women.

Midwives who will be working with Indigenous women also need to be trained, as participant COM02 mentions: "I think it starts with the training of resources. If it's a non-Indigenous resource, it has to be someone who can easily work in the community" [Translation]. Fortunately, a few projects are under development to develop the offer, as participant COM16 explains:

> Starting in January [2022], I envision offering full midwifery services related to perinatal care, labour, birthing and post-partum. My objective is to provide services to the Indigenous women at the Maniwaki Native Friendship Centre. That includes all the women in Kitigan Zibi and the Indigenous women of the Maniwaki area; women who are from Rapid Lake, Lac Simon or any other Indigenous communities.

Some Friendship Centres are proactive in this area, as illustrated by the position of VDNFC, which "raised its hand first, a few years ago, to demonstrate an interest in developing a project to gain access to midwifery services" [Translation] (ORG02).

### 4.3.2 Educational path to becoming a midwife in Quebec

During the interviews, participants raised the issue of the schooling required to become a midwife in Quebec, one recognized by the Ordre des sages-femmes. The main educational path proposed is the bachelor's degree in midwifery offered at the Université du Québec à Trois-Rivières (UQTR, 2022). It's important to remember, however, that this is not the only possible academic itinerary. The educational program developed by and for the Inuit in Nunavik is also part of the offer available in Quebec, as participant ORG06 points out:

> [T]here are not many Indigenous midwifery services in Quebec, but also, at the same time, the oldest midwifery services in Canada, one of the first reemergences of midwifery happened in Quebec with the Inuit midwives in Nunavik and the amazing job they do. It's kind of interesting to think that that's the height of community-based midwifery in Canada and that they started so much earlier a reemergence of midwifery practices [than in the rest of Canada]. They have an excellent education program; they are training their own midwives; they are training them in their first language.

Referring to all Canadian university programs, this same participant emphasizes that:



[35] Indigenous Services Canada's First Nations Child and Family Services program should enable the funding of midwifery services in First Nations communities, in complementarity with the health services in Quebec in particular. According to the latest information received, the occupational classification "midwife" is not listed in the Treasury Board's financing formula as the profession is not recognized by the federal government. This means that the funding needed to implement these services in Indigenous communities in Quebec is not available.

> [t]here are very few university-based programs, and they are extremely competitive. These programs are Western-based. […] The educational and healthcare systems, in general, are modelled on a Western and colonial approach leading to limited opportunity for Indigenous midwifery education. That represents a huge barrier (ORG06).

Participant COM11 is also critical of the program. She considers the offer insufficient, pointing out that only one place is reserved for an Indigenous person. What's more, when Indigenous women decide to train to become midwives outside Quebec, it's not easy to obtain their licence, particularly because of language issues (second-language context between French or English, Indigenous mother tongue and the mandatory French language classes when they are unable to understand the courses dispensed in French). Fortunately, as participant ORG02 suggests, progress is being made in this direction thanks to the MSSS, which is attempting to remove the administrative barriers that arise in this specific situation. Unawareness of current practices is also a barrier to enrolment, as participant ORG04 indicates, with the following suggestion:

> A tour of Quebec by midwives to get women interested by saying: "I've been able to give birth six times. I'm capable of helping someone else. I can start by being a birth attendant. If I like it, it makes me want to go further, to go back to school". That might be a start, but you have to generate interest. Right now, there isn't any. So how can you want to do this job when you don't even know it exists? [Translation].

Beyond the lack of knowledge about the work of midwives, other obstacles stand in the way of promoting the expertise of these healthcare workers.

### 4.3.3 Deconstructing the monopoly of the over-medicalization of pregnancy

An important element to emerge from the testimonies is the lack of options for women in terms of choosing a type of follow-up and health care professional. Participant COM02's testimony is enlightening in this respect, when she states that "it's not so much the intention as the opportunity to do it. The how doesn't arise automatically, because we don't have that service. We're not in a position to offer it" [Translation]. The impact of the limited range of services available in terms of support choices is a constant theme in the participants' testimonies:

> In Gaspé, we're used to having fewer services and not asking for anything other than what's available. […] We're so used to the classic journey: you get pregnant, you make an appointment with the gynaecologist, you give birth at the hospital and then you come home with the baby. There's no other way of doing things [Translation] (COM04).

This "classic" journey referred to by participant COM04 is also described by others:

> The current system is so deeply rooted in the community, so no, women don't ask for this kind of

> service. Women go to the doctor for their follow-ups [...]. You can't consider that they have any options when the only place to give birth is in Sept-Îles and to spend the last four weeks, at the very least, elsewhere than at home [Translation] (COM14).
>
> From the start, the hospital is the only avenue offered to us [Translation] (ORG05).
>
> When you're in hospital, you tell yourself that this is the norm. That's what's absolutely necessary. You have no other choice because otherwise you're in danger, it seems, whereas when you go with them (the midwives), it reassures you as a human being, as a woman [Translation] (TEM01).

All these citations refer to the medicalization of pregnancy in Quebec (and Canada) and the devaluation of Indigenous knowledge by colonialism. As Laforce explains, "[i]f doctors succeeded for a century in establishing and then stabilizing their monopoly, it was because the discourse of efficiency they transmitted was well integrated by women, who accepted it" [Translation] (Laforce, 1987, p. 203). According to participant TEM02, the discourse of risk, supported by biomedicine, also has an impact: "I think that, after that, the notion of risk is very much tainted by this, because there has been so much talk surrounding risk, and how their knowledge as Indigenous people is not as good" [Translation]. This observation is echoed by Routhier, who, in a rare text on the subject, describes the perinatal landscape as it relates to the Atikamekw women and midwives of Manawan:

> [...] the obligation for Native women to turn to official medical services for childbirth is inextricably linked to the process of colonization and sedentarization of the Indigenous peoples, and the phased transfer of pregnant women to hospital gradually destroyed the process of transmission of knowledge [...] Women's knowledge of midwifery, which had been passed down from generation to generation, was considerably impoverished (Routhier, 1987, p. 70).

Despite this reality, the elders' knowledge is not entirely forgotten, as the following participant highlights:

> When you don't know that you can choose your place of birth, it can't be an expressed need. In our discussions between elders, who either gave birth in the woods or were born in the woods, and younger women, we noticed a marked interest [Translation] (ORG01).

This mirrors participant TEM01's own account of childbirth: "[...] I wanted to experience childbirth to its fullest. I thought of my ancestors, I thought about my grandmother, I thought about the women who gave birth in their community. So, I thought about all those women [...]" [Translation]. The following section, on ancestral Indigenous practices, highlights the presence of Indigenous midwives in Indigenous culture and traditions, revealing that for some participants, even if the dominant discourse suggests that they have been forgotten, the situation is much more nuanced.

# Chapter 5.
# Ancestral Indigenous practices and maternity

This chapter offers a valuable insight into ancestral maternity practices through the narratives of the participants. These accounts are all the more essential as they contribute to the cultural survival of practices already undermined by assimilationist efforts, of which the medicalization of pregnancies and Christianization of Indigenous societies are but two aspects in a colonial context.



## 5.1 Ancestral practices: from colonial discredit to resurgence

Testimonies surrounding Indigenous ancestral practices related to perinatality suggest that, for many participants, these practices are no longer relevant today. This loss is due to colonization and an imposed Catholic religion, as emphasized both in the literature (Bourassa & al., 2005; Dion Fletcher, 2017; Hartz & McGrath, 2017; Smylie, 2014) and by the participants we met: "[...] because of religion, I think there was a lot of reluctance to embrace ceremonies that were presumably practised in the past" [Translation] (COM11).

Even so, some have noted the return of certain traditional practices in communities in recent years. For example, "eight years ago, I didn't see any. Now, there are more and more. In the last two years, they've started to come back" [Translation] (COM09). However, this revitalization of rites and ceremonies requires the involvement of knowledgeable people in the communities, as "we need to identify pregnancy-related rituals. What can we do? What used to be done? [...] We have to work on that, I'd say. All the more so to trace the origins of traditional knowledge" [Translation] (COM17).

In addition to this much-needed resurgence, participants readily explain the importance of ancestral Indigenous practices in the life of the community and of the pregnant woman.

> Throughout the year, the longhouse is a gathering place for families and community members. Everyone is welcome. There's always a meaning, or a theme, depending on the year's calendar, on the season. Various rituals are carried out according to the calendar [Translation] (COM01).

These practices bind the community together and serve as a reminder of the importance of nation and family culture, a core value in Indigenous cultures. Many of the participants consulted expressed a desire to return to their roots, seeing the resur-

gence of this type of practice as a way of "[...] bringing back cultural practices at the very moment of birth, and then the pride of Indigenous identity" [Translation] (TEM02). Rituals, ceremonies and traditional objects anchor the child's importance within the community of origin. One research participant stresses the importance of the ceremonies surrounding the arrival of a child "because birth is a ceremony" (COM16).

The revitalization of ancestral maternity practices is part of a broader movement of cultural affirmation in response to the assimilative consequences of the colonization process. Issues relating to Indigenous languages feature prominently in the testimonies gathered, as these languages are intertwined with traditional practices and enable their vitality and transmission. In this context, hearing the Indigenous mother tongue at birth not only revitalizes its practice, but also strengthens the bond between the child and its homeland, as emphasized in the literature on the Inuit (Epoo & al., 2021; TIMS, 2018; Van Wagner & al., 2007). This point is confirmed by several respondents, including participant COM08, who recounts that "At Anna-Laberge [Anna-Laberge Hospital], they also respect requests when you want the baby to hear the Mohawk language spoken first at birth, those present will not talk before we tell them that it is OK to do so."

Pride in one's identity is generally part of the discourse of the people we meet, particularly among urban-based Indigenous organizations.

> There's a reconstruction of identity that goes hand in hand with pride in being Indigenous. This pride is less and less concealed. It's valued. The child's place in the community is central. So, it's important for the child to be rooted in the land [Translation] (ORG01).

To contribute to the revitalization of Indigenous ancestral practices, Native Friendship Centres are actively pursuing a number of initiatives, so much so that "there isn't a single centre that isn't currently working on strengthening the provision of more traditional services" [Translation] (ORG02). Various resources are deployed to this end. At the VDNFC, for example, Anishinaabe storytelling on birth and pregnancy was introduced on National Indigenous Peoples Day in June 2022. Moreover, this revitalization approach is not limited to a quest for cultural preservation, but touches on broader social issues, all in a process of reparation for the harmful consequences of colonial policies. This is illustrated, for example, by the issue of abusive placement of Indigenous children by youth protection authorities, so that "[...] young parents have sometimes also experienced disconnect by going through the youth protection network. It's about recreating the bond between parents and children with culture and pride" [Translation] (ORG02). In short, the revitalization of ancestral practices is essential to the symbolic preservation of Indigenous cultures, far too long depreciated by assimilationist policies, as well as to the physical and spiritual well-being of the victims of these policies. In this sense, the revitalization of ancestral practices is a tool for decolonization, serving to repair the traumas suffered.

When the subject is explored in greater depth with the participants, they name a variety of traditional practices, actions and objects related to perinatality, sometimes very briefly, sometimes in detail. On some

occasions, these practices take place only within the family, in the private sphere, while at other times they are more widely practised within the community. In any case, the perceptions about maternity from the perspective of ancestral practices echo the words of several researchers, including Anderson (2006; 2011), Simpson (2006) and Tabobondung (2017), for whom these practices symbolize the deep connection felt with the community, but also with ancestors, kokoms (grandmothers) and the land. A recent study on the consolidation of Innu and Atikamekw women's connection to the land through pregnancy and childbirth (Basile & al., 2023) confirms that the crafting and use of traditional objects and the rituals associated with them require an in-depth knowledge of the land on the part of Indigenous women, in order to gather the necessary resources and pass on land-use practices. The same study confirms that midwives occupy a central place considering the breadth of their practice, rooted in the land in many ways. Incidentally, the interest shown by Innu and Atikamekw women in returning to this practice is one of the findings of this research.



## 5.2. An overview of ancestral maternity-related practices

In many communities, there is a strong interest in revitalizing ancestral practices such as the use of mickiki (traditional medicines), childbirth on the land, the first steps ceremony, the baby naming ceremony, the newborn ceremony, the burial of the umbilical cord and placenta, as well as the use of misaspison (cloth baby wrap) and tikinakan (wooden board baby carrier)[36].

### 5.2.1 Traditional medicines (mickiki)

Many participants referred to the use of traditional medicines during the perinatal period, but the realities differ from one community or Indigenous organization to another. For one of the communities consulted, traditional medicines are recognized and integrated into the health services offered:

> We have just opened our traditional medicine services. […] The nurse makes sure that there is no contraindication, no reaction to any medicine or combination of Western and traditional medicine. Our traditional medicine services are also available if the moms want them present at the birthing; they will go to [the hospital] and do a ceremony there (COM08).

Native friendship centers in Quebec are also taking steps in this direction. In the global context of the COVID-19 pandemic, plants and related knowledge have been used to support the immune system of several people:

> Medicinal herbs have remained in use. We saw that with the pandemic. They made baskets with medicinal herbs, among other things [Translation] (ORG02).

[36] Other practices mentioned, but by very few participants, include breastfeeding, the baby wepison (hammock), traditional baptism, newborn bellybutton care and craftwork.

For other participants, it's important to be thoroughly knowledgeable in this field, so as not to compromise the health of pregnant women by taking certain traditional medicines. It's important to know what is and isn't forbidden during pregnancy. Elders are invaluable sources of information on this subject, as one participant pointed out: "She [name of great-grandmother] used to tell us that there was a plant that was used precisely for women who didn't want to continue their pregnancy. But she never told me what the plant was" [Translation] (COM11).

### 5.2.2 Childbirth

When asked about traditional Indigenous practices, the people we met talked about childbirth in relation to the experience of Indigenous women of another era: "What I remember the lady saying, the elder saying, was that they didn't give birth lying down, they gave birth standing up or squatting. They weren't [placed] in a horizontal position. They were standing. Squatting" [Translation] (COM12). The scant literature on childbirth in Indigenous environments is consistent with these comments, as noted by Anderson (2006), Basile & al. (2023), Dufour (1988), Flynn & Brassard, 2012, Pernet & ICA (2012) and Sokoloski (1995), among others. Interviewees go further, saying that "[...] what we want is to revive this practice of midwifery and, above all, to bring back Indigenous knowledge of childbirth" [Translation] (ORG03).

### 5.2.3 The newborn ceremony

This ceremony is performed when the baby is still small, and aims to welcome the child into the family, as explained by participants TEM01 and ORG05, who have both experienced this ceremony:

> For the newborn ceremony, there were a few babies and we officially presented them to the people. Ours was in a tikinakan, and we went around to those present to introduce them, and they welcomed the baby, saying hello and addressing him by name. As we didn't have him baptized, nor did we have godparents, we chose people to accompany him in his life. They were the ones who held our baby and introduced him to people [Translation] (ORG05).

### 5.2.4 The first steps ceremony

The first steps ceremony is frequently mentioned by participants. While the practice declined in popularity at one time due to the presence of Catholicism among the nations according to one participant, it is now being revitalized in both urban and community settings. Two participants explain the first steps ceremony as follows:

> All of those who will have a role to play in the child's life are present (kukum, mushum, etc.). There may be other families, so they will come together to perform the ceremony at the same time [Translation] (COM05).

> From what I've heard, the child, until it takes its first steps, cannot be put in contact with Mother Earth. It's always in his parents' arms. [...] When the infant starts to walk, a ceremony must be performed. [...] That's when you put [the toddler] in contact with Mother Earth. The child is placed on the

> ground. He walks around something nearby [a tree], and you accompany him. Then the child goes back into the tent [Translation] (COM09).

### 5.2.5 The baby naming ceremony

As with the first steps ceremony, the baby naming ceremony is increasingly practised by Indigenous families. "The child is given a traditional name. This name is used when the child goes to the longhouse. Some also use it on a daily basis, but it's mainly in the longhouse" [Translation] (COM01). The same participant, speaking of the longhouse, adds that "[there] is always sharing afterwards, with singing and dancing. It ends with a meal. Everyone brings something to eat, and it's all shared together. These moments are truly uplifting" [Translation]. Or again, "giving traditional names to children is also coming back. Toddlers coming to the VDNFC are increasing called by their traditional names" [Translation] (ORG01).

At a time when birthing happened on the land, the place of birth became a strong marker of identity. Basile et al. (2017) point out that a traditional name (often in an Indigenous language) is part of a person's identity, often connected to place or family history. This practice is still widespread among many Indigenous peoples, particularly in Quebec. Another study on the consolidation of connections to the land mentions the following:

> [t]he question of giving an Indigenous name at birth seems to indicate a much-needed connection to the land. An increasing number of parents are choosing an Indigenous name for their child, rather than an English or French one. In the days of births on the land, this name was often connected to the birthplace. Assigning a name associated with the family's territory is another practice that helps consolidate the link to the land for younger generations. (Basile et al. 2023, p. 64).

### 5.2.6 The umbilical cord

Very few participants mention practices associated with the umbilical cord, even though it is mentioned in the literature by a number of authors (Anderson, 2011b; Dawson, 2017; Olson & al., 2019; Routhier, 1987; Simpson, 2006). Its disposal, which consists of placing a small, dried piece of cord in a pouch and burning the rest with the placenta, is highly symbolic and is reminiscent of the respect that Indigenous women pass on to the next generation. While apparently less common, the practice is nonetheless perpetuated under certain circumstances, which are explained here. According to the research participants, it is more likely to be experienced privately within the immediate family, which may account for a certain loss of recurrence. One participant recounts her own experience: "I was taught to keep my children's umbilical cords. I still hear other families doing it, but not many. It's disappearing, I think" [Translation] (COM09).

### 5.2.7 The placenta

Of all the ancestral Indigenous practices shared by the participants, the ceremony surrounding the placenta is most frequently invoked. This ceremony is gene-

rally described as follows: "Some people that I know keep the placenta and do a ceremony. They plant it under a tree. You give to the tree life and nourishment. In return, it is like a guidance tree for the growing child" (COM03). This ceremony highlights the importance of returning to the land following the birth of a child, creating a connection between the newborn child and the ancestral land. The placenta can also be used in other ways by women.

> [people] started, many of them, asking to preserve their placenta when they gave birth. Then they freeze it. They preserve it, and then they use it to make medicine. Medicine, sometimes, an ointment for, say, dermatitis or skin infections. They'll produce a placenta-based ointment [Translation] (COM07).

As with the other practices and ceremonies mentioned above, the placenta ceremony is being revitalized by the various Indigenous nations we have met.

> I remember delivering a baby and showing the placenta to the woman, and then to those closely huddled in the room. The women were so surprised, and then they were so happy to be able to see it, too. We showed them what it was, and what it was used for. I think there's much more to be done to raise awareness of the placenta ceremony, especially to reappropriate this knowledge [Translation] (COM013).

This has meant that some healthcare professionals working in hospitals have had to respect this movement by allowing women to retrieve their placenta after giving birth. For one participant, allowing women to dispose of their placentas themselves is truly part of a culturally safe service (COM06). Nevertheless, "[...] at the beginning, the first women who asked for it, the nurses, the doctor, they were reluctant to give it to them. But after that, the women insisted that it belonged to them" [Translation] (COM07). Incidentally, since 2017, integrated health and social services centres in Quebec have been required to comply with requests from women who wish to leave the hospital with their placenta (MSSS, 2017). Placentas are sometimes tested before being handed over to the women, as one participant testifies: "[...] they send it to the lab to have it analyzed, then package it and give it back to the mom, sometimes the next day or when she leaves the hospital if it is ready" (COM08). This MSSS policy specifies that some placentas must be sent to the laboratory, however, this does not mean that it can't be given back to the parents afterwards (MSSS, 2017). The implementation of this regulation certainly facilitates the process for women who wish to keep their placenta, but it is not always as straightforward as it should:

> [...] I heard that several young people had taken up this practice. My mother-in-law does this kind of ceremony with the placenta. When I gave birth, I asked that it be kept for me; the hospital had leaflets about it, but I don't think people were asking for it, I was one of the first. I got the pamphlet when I was already in labour, and even after I gave birth, I didn't have time to

> read it. When I got out of the hospital, I asked how I was going to get my placenta back and the nurse said, "They'll call you." A month later, I read in the pamphlet that I had to pick it up, and when we called, we found out they'd thrown it away. I didn't have time to read the leaflet and I wasn't told verbally because they weren't sure themselves how it worked. I must have been one of the first to ask for it in Trois-Rivières. I thought it was a shame because I wanted to do the placenta ceremony with my mother-in-law [Translation] (ORG05).

The placenta ceremony, in addition to connecting the child to Mother Earth, provides an opportunity for women to experience this practice among themselves. "We're hearing more and more about it. These are wonderful stories. Generally speaking, it's the women who probably know a little more about their culture and have started looking for women to perform these ceremonies" [Translation] (ORG01). One of the women we met experienced this ceremony following the birth of her daughter, and she recalls this moment between women:

> [...] I did it at the same time as the newborn ceremony. We took the opportunity to do it at the same time, yes. So, it's done. Basically, all you have to do is bury the placenta under a tree. I chose a cedar tree. It's a ceremony that takes place mainly between women. Among women who have [already] had their periods. It was very moving [Translation] (TEM01).



### 5.2.8 The misaspison

The misaspison, or baby carrier, "is a cloth with strings wrapped around the baby to put him to sleep. It stabilizes the baby" [Translation] (COM02). The misaspison is still widely used today, according to the many people who mentioned it in interviews. The kokom play an important role in the making of misaspison and its use by women and families.

> They are made by the kokom [...]. We tie it on the first day, when the baby arrives. [...] Instinctively, the baby will sleep a lot because it feels like it still is in its mother's womb. That's often the message our grandmothers pass down to us [Translation] (ORG03).

Sometimes, during activities organized by health centres, pregnant women make their own misaspison. "The get to form a support network among themselves, among mothers" [Translation] (COM02). In short, the comfort of the baby and the bonding with the mother are evoked when speaking of this practice: "They see that the baby is comfortable in there. I find they're much, much closer to their children, those who wrap up their babies" [Translation] (COM09).

### 5.2.9 The tikinakan

In addition to the misaspison, the tikinakan is also cited by several participants as a traditional object used in connection with perinatality and the baby:

> The tikinakan is a baby carrier made by a man and a woman. The man does the woodwork, and the woman makes the cloth to support the baby. She's also the one who

> shows how to wrap the baby in and why. It's coming back. You might not see a tikinakan in town like you would a baby sling, but families have a tikinakan at home. They [use it] in the woods [Translation] (ORG01).

Originally crafted for life in the forest, the tikinakan, although not used by women on a daily basis, is part of the cultural heritage with a strong symbolic meaning. Basile (2017) presents this traditional object, which is returning to the practices of young Atikamekw families. In fact, it was this (empty) object that was offered to the Pope during the visit of an Indigenous delegation in 2022, to remind him of the children who disappeared in residential schools during the 19th and 20th centuries in Canada. As a result, many have a tikinakan at home, and a return to its use is encouraged: "Me, my future grandchildren are all going to be in the tikinakan again. I don't have any grandchildren yet, but I can't wait" [Translation] (ORG03).

## 5.3 Accompanying women, the cornerstone of ancestral maternity practices

In addition to the variety of practices described above, there are a number of significant people involved in accompanying pregnant women and new mothers, specifically grandparents/elders, both male and female, and Indigenous midwives.

### 5.3.1 The place of kokom

The section on the importance of ancestral Indigenous practices highlights the community, the family and the place of children. Grandparents, specifically the kokom, are often seen as children's second parents. (COM02).

> There are young women who became pregnant, and their parents took care of the baby. I've seen a lot of that, that she stays with her parents and the parents look after the baby, and she continues to go to school. [...] It's really collective. It's really together. The family raises the child. That's what I see [Translation] (COM12).

The comments of Simpson (2006, p. 27) vividly describe the place of child and community in Indigenous cultures.

> Children are not viewed as helpless babies who need to be controlled, they are viewed as independent spiritual beings, who have many things to teach their parents. Children are gifts. They are leaders. They are gifts that require respect, patience, love, attachment, listening; gifts that require us to face our own conflicts, faults, and misgivings. In our culture, children have a lot of freedom to experience the world for themselves, they have few boundaries, and they learn the natural consequences of their actions under the careful watch of their mothers, fathers, aunties, uncles, and grandparents.

This citation helps us to understand not only the child's status within the family, but also within the community network. Indeed, as participant COM16 points out, "family is the biggest thing for us, most of us. I think it's one of the most important things to have."

In addition to being there for their grandchildren, kokom (and other women in the pregnant woman's circle) are first-rate resources and pillars for pregnant women. They advise and guide them during their pregnancy and are often present during childbirth. "They go to see their grandmother, their mother, their aunt, the other kokom. They'll go and see them, then they'll listen to these women instead of going to see the nurse, in fact" [Translation] (ORG03). Elders hold pregnancy and childbirth ancestral knowledge and know-how, which they pass on to the younger generations of women.

> I also see posts from friends of mine on social media, well, I've been sharing some about the young kokom in her forties that's very, very involved in the early pregnancy process and then in the early life of the newborn. There are many, many of them. It was like that in the past too, the kokom accompanying their daughter who was becoming a mother. They passed on their knowledge of how to look after newborn babies. These are truly ancestral practices [Translation] (ORG03).

The literature also mentions these comments made by participants. Despite the usurpation of their roles and responsibilities by imposing the mandatory transfer of childbirth to hospitals, many women want these practices to return to their communities (Basile & al. 2023; Flynn & Brassard, 2012). According to several authors, kokom wish to continue passing on their knowledge, assisting pregnant women at various stages of pregnancy and maintaining ancestral Indigenous practices (NCCAH, 2012; Dawson, 2017; Desmarais & al., 2005; Viscogliosi & al., 2017).

### 5.3.2 The role of Indigenous midwives

The presence and role of Indigenous midwives in First Peoples cultures and traditions is well documented. Not only were they present during childbirth, but they also passed on Indigenous knowledge about medicinal plants and reproductive health (Basile, 2017; NCCAH, 2012; Churchill, 2015; Cidro & al., 2017; NCIM, 2023; Olson & al., 2019; Routhier, 1987). Churchill emphasizes that "Although unique in their knowledge and practices, traditional Indigenous midwives have been depicted in stories as the ultimate multi-taskers" (Churchill, 2015, p. 44). Many of the women we met spoke of the ancestral presence of Indigenous midwives in the communities. "I think that midwives played a very, very important role here in terms of births and accompanying women. It was very, very precious, a woman who had just brought a baby into the world" [Translation] (COM07). Another participant adds:

> Before, it was the midwives who were present. There were no doctors. Midwives are part of our customs and traditions, which we have lost. [...] It's not that long ago. The last children to be born in tents happened about twenty years ago. The practice was marginal, but it was present. Women from the community were involved in the

> pregnancies and deliveries. It wasn't a recognized midwife with a diploma. It was Innu women who had learned through intergenerational transmission, handed down from mother to daughter. It's not that long ago [Translation] (COM02).

The loss of this practice is cited by other participants, who recall a not-so-distant past when Indigenous midwives were still widely present to accompany women during pregnancy and childbirth. One explains that "[...] in those years, before we had the road [the road leading to Manawan was built in 1973], most gave birth in the community with a kokom, with a midwife" [Translation] (COM07). At the same time, other participants believe that the last people in the community to be born in the woods are not that old, averaging 50 to 55 years of age, which puts these practices at less than 60 years ago. Another participant concurs:

> And when talking to community members, for example, my mother was born in a tent. She was delivered by an Atikamekw midwife. [...] I think she's 64. So, it's not that long ago, 64 years is not a century. So, my mother was born in a tent. She was delivered by an Atikamekw midwife, but this practice is kind of forgotten now [Translation] (ORG03).

The disappearance of Indigenous midwives can be explained in part by the medicalization of pregnancy and childbirth (Basile & al. 2023; NCCAH, 2012; Cidro & Sinclair, 2021; Dawson, 2017; Simpson, 2006) and by the evacuation policies forcing women to give birth outside their communities (Cidro & al., 2017; Kornelsen & al., 2013; Lawford, 2017; Lawford & al., 2019; Lawford & Giles, 2012). One participant also addressed the notion of risk, intrinsically linked to the medicalization of pregnancy:

> When health services started up again, I think the midwives withdrew, they stopped delivering babies, because of the medical procedures that could be used against them. Because, fundamentally, my grandmother was the community midwife. And when she talked about it, I understood that some thirty years ago, there might have been an advantage in still having midwives. It wasn't that she didn't feel up to it, but the risks she was taking were too great [Translation] (COM11).

This loss comes with the wish to revitalize this age-old practice in order to continue passing on Indigenous knowledge. "And then, what we want is to revive this practice of midwifery" [Translation] (ORG03). Especially since the knowledge and skills of Indigenous midwives were widely recognized, as one community respondent explained:

> They also told me that some women, some kokom, were really skilled. When a woman's placenta was stuck, there were kokom who were able to detach the stuck placenta. For instance, there were three kokom who were really good at doing this back in the day [Translation] (COM17).

Overall, it would appear that many refer to the presence of Indigenous midwives in their perinatal traditions and cultural practices. One participant expressed the wish that the birth of Indigenous babies be attended once again by Indigenous midwives:

> Having our babies born into the hands of Indigenous midwives surrounded by culture, tradition, knowledge, respect and celebration of Indigenous identity is the best start that we can give to our children to remember the strength and pride of being Indigenous and to see the strength of your community. I think it's a perfect start for babies (ORG06).

# Conclusion

This research focuses on the conditions of access to midwifery services for Indigenous communities in Quebec and is part of the wide-ranging project on the maternal health of Indigenous women. The study has allowed to document, with the help of the health authorities from participating Indigenous communities and organizations, some of the realities surrounding the perinatal experiences of Indigenous women in Quebec. Despite the scarcity of publications on the subjects in this province, the scoping review has allowed us to demonstrate that there are many discrepancies between Indigenous and non-Indigenous women in terms of health, and that the latter are at greater risk of developing certain episodic illnesses, such as gestational diabetes. This review also reveals how Indigenous women's reproductive health is undermined by a range of disproportionate problems before, during and after pregnancy. Among the causes identified in the available literature, colonization has been singled out as a social determinant for Indigenous peoples' health and as an important marker of vulnerability for women.

Although access to perinatal care services is largely understated in the available literature on the challenges and realities facing Indigenous women in Quebec, it is still possible to state that significant gaps still need to be bridged. Approaches to care in hospitals that don't meet their needs, and a difficult relationship with the healthcare system due to negative experiences, indicates that many Indigenous women avoid health services in Quebec altogether. Women with “high-risk pregnancies” due to various indicators (gestational diabetes, stillbirths, infant mortality, etc.) require closer medical monitoring. This need for close monitoring, combined with the geographical distance between urban service centres and their place of residence and the absence of local services, implies that women often have to travel far from their homes and on multiple occasions. The mapping exercise included in the appendix clearly demonstrates this reality. One of the proposed solutions for improving access to perinatal care services is the implementation of cultural safety measures, a wide-ranging concept that emphasizes the need to develop culturally relevant and safe health services for Indigenous women.

Midwifery services are among the strategies considered culturally safe for Indigenous women. Although funding for these services remains a major issue, midwifery services are a need identified by Indigenous women, in the literature consulted, in recent media articles and in the findings of the data gathered from the Indigenous communities and organizations we met. In Canada, the vital role played by midwives was undermined by the imposed overmedicalization in childbirth. Having all but disappeared, the practice made a comeback in the 1990s, largely because of rising demand in a context of cost rationalization and care accessibility. The role of Indigenous midwives has been damaged by the colonization process, which has contributed to the suppression not only of their social and community contribution, but also of their land-rooted knowledge and practices. However, a revitalization of their expertise is underway, in tandem with a pursuit for balance and complementarity between traditional and Western knowledge. The few existing models in Quebec can be found in Nunavik, where the introduction of Inuit midwifery services has

brought childbirth and pre- and post-natal care back to the north, and in Eeyou Istchee, where women can give birth in their own communities with the assistance of midwives. This return of childbirth to Indigenous land is particularly effective in preventing a disconnect between newborns and their land of birth, as well as the loss of traditional knowledge through its renewed transmission within families and communities, since such knowledge remains poorly documented, if at all. In addition, the model for implementing perinatal services within an urban Native Friendship Centre not only provides safe access to these services, but also enables Indigenous families to socialize and discuss with elders about their parenthood experiences. These initiatives contribute to the much-needed healing and decolonization process in an Indigenous context.



The data collection carried out within the framework of this research has made it possible to gather new information during meetings with 27 Indigenous communities and organizations in Quebec. The new data allowed us to provide a description of the perinatal services available to Indigenous women, to draw a portrait of the obstacles circumscribing access to these services, to describe the challenges facing the implementation of midwifery services and to present an overview of Indigenous ancestral maternity and birthing practices.

The main characteristic of perinatal services rests in their great diversity, with offers varying considerably from one Indigenous community and organization to another. Therefore, each service offer must be examined in its particular context. Only a handful of Indigenous communities or organizations receive visits from doctors or have succeeded in establishing effective information corridors between hospitals and their local health centre. Even fewer have the services of birth attendants or midwives, the latter being virtually absent from the service offer. Based on the data collected, there is nonetheless a strong resolve to align perinatal services with the needs of the community and/or the clientele of the Indigenous organization concerned, whenever possible. The pregnancy monitoring offered to women is broader, and encompasses social and cultural aspects, not just biomedical ones. Postnatal follow-ups are conveniently flexible, with visits made either at community health centres or at home, depending on the needs and circumstances. Nurses conduct pregnancy follow-ups for expectant or new Indigenous mothers who are frequently on the move, and who have little trust in the Quebec healthcare system. In this way, health centres are ensuring that community-based services with culturally oriented care practices are deployed to encourage regular attendance at pregnancy check-ups. This will also include prenatal courses encompassing culturally safe principles such as information on traditional medicines and birthing rituals, breastfeeding support and on-site screening such as blood tests (for gestational diabetes, etc.). According to survey participants, an additional challenge has overshadowed perinatal efforts: the negative impacts of the COVID-19 pandemic, which forced the shutdown of perinatal services in the Indigenous communities and organizations we met.

Access to perinatal services for Indigenous women in Quebec faces other major challenges. Among the obstacles identified, the majority of Indigenous women have no choice but to seek perinatal services outside their community. While access to these services may be fairly straightforward for some women living close to urban centres, those from remote communities still face considerable struggles to access

services. The amount of travel required, and the lack of cultural elements offered to expectant Indigenous women partly explains their absence at their follow-up appointments. Furthermore, they also contend with a host of major contextual issues, such as transportation from remote communities, the care of other children during their absence, the enduring prejudices they are subject to on the part of medical staff, miscommunication in a second-language context, and the difficulty of juggling a calendar of cultural activities while orchestrating medical appointments. Added to these recurring problems are the following stress factors, especially during delivery: perinatal services in urban centres often still ill suited for Indigenous women and their families, with reported cases of medical staff unable to comprehend the presence of extended family members at pregnancy follow-ups and during childbirth, or threats to call child welfare authorities. These challenges are heightened by unsolicited medical procedures such as C-sections, newborn screening tests and very little consultation time with doctors during medical appointments, often carried out expeditiously. Finally, women have identified issues specific to forced travel, starting with the mounting number of trips for appointments, a major problem in itself compounded by the absence of support and interpreters, the experience of urban exile several weeks before giving birth, additional living expenses, limited urban accommodations, loneliness and stress caused by factors unrelated to one's state as a pregnant woman.

When asked about their perceptions and experiences of midwifery services, some participants state that despite their scarcity, the services were necessary for Indigenous women, while others disclose that they know very little about midwifery practices. The philosophy underlying this practice, related to the notion of informed choice during pregnancy, of preferred medical intervention and type of follow-up, is viewed positively by Indigenous health services and organizations accompanying pregnant Indigenous women. Among the benefits associated with this practice, participants specifically cite a reduced number of C-sections, the promotion of breastfeeding and an increase in pregnancy follow-ups. In order to mitigate Indigenous women's obvious distrust of the healthcare system in Quebec, midwives could help prevent negative experiences, prejudice and stigmatization targeting Indigenous women. They could reclaim their traditional place and take on a new role as “agents of cultural safety” for Indigenous women. Clearly, the loss of their traditional role is largely due to the overmedicalized pregnancy care facilitated by the introduction of a rhetoric of risk justifying the monopoly of the biomedical model. Consequently, this dominance was instrumental in undermining the credibility of Indigenous knowledge and has contributed to its disappearance, creating the impetus to deprive women of the choices needed to access midwifery services no longer available. Their implementation is mainly confronted by the geographical remoteness of many Indigenous communities, a dire shortage of space for facilities and accommodations within the communities, and an ideological closed-mindedness of physicians towards the practice of midwifery. Solutions are put forward to encourage the development of midwifery practices, including a training program for Indigenous women inspired by the Inuit approach to midwifery in Nunavik as well as Quebec-wide information and awareness tours in Indigenous communities and organizations to help demystify the practice and foster its return.

While the ancestral practices of Indigenous midwifery have all but disappeared in the communities that took part in the research, some of them still endure and are now valued within Indigenous families. Discredited by colonialism, they have long been perceived as "less good", even dangerous. Yet, this research demonstrates that some practices have not only survived but persisted such as the use of traditional medicines and various birthing positions, ceremonies marking the arrival of the newborn, its first steps, the Indigenous naming ceremony, the respectful disposal of the umbilical cord and placenta, as well as the use of ceremonial objects such as the misaspison and the tikinakan. These practices are part of a movement to revive sacred rituals, cultural practices and positive identity and pride in being Indigenous. This resurgence is also part of a broader movement of cultural affirmation among Indigenous peoples. This includes, foremost, the importance of calling upon Indigenous languages as a means for restoring a sense of pride in identity damaged by colonialism. Because the revitalization of identified ancestral practices is essential to preserving Indigenous cultures, it also becomes a decolonization tool, allowing to consolidate women's connection to the land. As such, the return of midwives is pivotal: with practices once rooted in the land, they can also be catalysts for the return of birthing to the land while providing culturally safe support and guidance. This research also highlights the fact that accompanying Indigenous pregnant women is a cornerstone of the sought-after improvement in services. Today, this assistance is often provided by kokoms who play an active role in childcare, are often present at births and act as guides to young pregnant women and mothers. In so doing, they compensate for the role of midwives, whose practice is not so distant in memory. The findings of this research clearly translate as follows: a firm resolve to revitalize this age-old practice which would undoubtedly contribute to the return and transmission of Indigenous knowledge about the world of motherhood.

Finally, according to research participants preoccupied by the need to accompany pregnant women beyond pregnancy follow-ups, and despite the lack of training and on-site equipment, Indigenous women want “to give birth differently", naturally, at home or on the land. They are asking that birthplaces be recognized and valued, and that control over birthing be reclaimed. They want a safe place to give birth (e.g., a birthing centre or hospital in the community or nearby) and, finally, the presence of Indigenous midwives to offer complete support, from prenatal classes to postnatal care. As mentioned by one participant, the spiritual nature of this momentous event - the arrival of a child - needs to be valued and celebrated once again “... because birth is a ceremony” (COM16).

# Recommendations

In light of the results of the literature search and the analysis of the stories gathered, the research direction has formulated the following recommendations, based on the opinions and recommendations heard during the interviews. The following recommendations are all of equal priority, and the order in which they are presented does not necessarily represent the importance to be accorded to them. The proposed recommendations are intended to meet the needs of Indigenous women and families, and to enable them to have a choice when it comes to pregnancy and childbirth. This research shows that pregnant Indigenous women have no choice in their preferred type of follow-up care and with which healthcare professional.

## 1) Decolonization of services

Indigenous midwifery services must be developed in keeping with Indigenous peoples' quest for self-determination and ownership of services, and with efforts to decolonize health services so that Indigenous women have access to reproductive and sexual justice, and to health services free from racism and discrimination.

## 2) Culturally safe programs and environments for Indigenous families



The rapid demographic growth of Indigenous communities in Quebec makes it essential to develop more programs for the families who support pregnant women and their babies. Implementing these programs requires the investment of additional financial and human resources.

- Review the eligibility criteria of the Non-Insured Health Benefits (NIHB) program to ensure that pregnant Indigenous women and those living in urban areas receive safe accompaniment (by funding the father's transportation costs in particular, when necessary).
- Review the Treasury Board's codification of funding formulas to recognize the practice of midwifery in Quebec's non-agreement communities.
- Review transportation compensation rates, taking into account Treasury Board rates, the condition of access roads (mostly gravel) to Indigenous communities, and the remoteness of some of them.
- Invest in infrastructures (adequate facilities and accommodations) that would allow for midwifery practices within Indigenous communities, such as birthing homes.
- Draw inspiration from the health clinics set up within certain Native Friendship Centres (Val-d'Or and La Tuque) in Quebec to create additional points of service for pregnant Indigenous women.
- Provide adequate funding for perinatal care and proximity services to counter the lack of perinatal follow-up through the development and deployment of programs designed by and for Indigenous people.

– Provide adequate funding for the installation of equipment to offer remote pregnancy monitoring (telemedicine), given the significant Internet connectivity limitations in certain regions of Quebec.

## 3) Information campaign on the right to consent

The lack of awareness about the rights surrounding childbirth (the right to be accompanied, to choose the birthing position, to recover the placenta, to bring certain cultural objects, etc.) must be the subject of an information campaign so that pregnant Indigenous women can make an informed choice.

– Produce documents, web videos and radio capsules in French, English and relevant Indigenous languages.

– Encourage participation in gatherings, meetings, training and all relevant activities organized by and for Indigenous women to promote the right to consent and to all information relating to maternity and perinatal care.

## 4) Information campaign on midwifery practices within Indigenous communities and organizations

The lack of knowledge about the role and services of midwives, as well as the right to have access to them, remains a major obstacle to their implementation in the Indigenous context in Quebec (except for certain agreement communities).



– Undertake an information tour of all Indigenous communities and organizations to raise awareness of midwifery and its benefits.

– Offer educational programs that value ancestral knowledge about maternity and bring midwifery back to Indigenous communities.

– Draw on programs and services available in Nunavik and Eeyou Istchee to raise awareness of the opportunities for implementing such services.

– Facilitate the return of births to communities that express the need, as the place of birth is a strong marker of identity.

– Encourage the management of maternity-related services by midwives to enable Indigenous women to remain close to their culture and environment, thus avoiding the sometimes long, premature and/or inconvenient journeys to urban facilities for access to perinatal services.

## 5) Deployment of cultural safety in perinatal health services

Cultural safety measures must be deployed within the various health service facilities in Quebec. healthcare personnel must be trained to:

– Harmonize perinatal health care by including Indigenous and Western knowledge in this field.

– Take into account the historical and contemporary traumas experienced by Indigenous peoples, and more specifically by Indigenous women, to better understand the origins of their mistrust of healthcare services.

Healthcare personnel must be trained to:

- Include knowledge about Indigenous practices (rituals and cultural objects) in training programs for midwives, gynaecologists, doctors, nurses, etc.
- Allow new Indigenous physicians trained in Quebec to choose to practise in their community or region of origin when assigning internships, externships and residencies.
- Offer more places reserved for Indigenous candidates in the Bachelor of Midwifery program, while expanding the program's international profile and intercultural component to include internships in Indigenous communities in Quebec.
- Offer more internship opportunities for future healthcare personnel in Indigenous communities.
- Practise in Quebec despite training acquired outside the province for linguistic reasons in particular, since the training program is not available in English, even though this is the language spoken (second language or not) by many Indigenous women in Quebec.

## 6) Calls to action and recommendations from previous commissions of inquiry and research on maternity and perinatal care issues



The numerous calls to action and recommendations formulated in recent works by inquiry commissions, research organizations and national and international bodies must be implemented.

- Implement the numerous calls to action issued by the Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec: listening, reconciliation and progress (CERP), the National Inquiry into Missing and Murdered Indigenous Women and Girls (MMIWG), the Truth and Reconciliation Commission of Canada (TRC) and the Royal Commission on Aboriginal Peoples (RCAP) on the health needs of Indigenous Peoples (see Appendix E).
- Implement two of the recommendations (nos 26 and 27) of the research report on the Free and informed consent and imposed sterilizations among First Nations and Inuit women in Quebec published in 2022, which deal respectively with the training of doulas and midwives in First Nations and Inuit communities, and the adequate funding of university training in French and English, which includes a cultural component in its curriculum and offers places reserved for First Nations and Inuit students.
- Adopt le Principe de Joyce's Principle which aims to guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, therefore including perinatal services.

- Implement the recommendations (nos h and i) of the United Nations Special Rapporteur on the rights of Indigenous Peoples included in his latest report to the Human Rights Council (UN, 2022) on the recognition of Indigenous women's knowledge of obstetric care, maternal health and promoting the hiring of midwives.

## 7) Future research

The findings identified in this report should serve as an anchor for future research and the development of maternal health care that meets the needs of Indigenous women. The following research topics were mentioned:

- Trauma experienced by Indigenous women related to delivery and childbirth.
- The revitalization of traditional birthing practices in an Indigenous context.
- The impacts of the displacements of Indigenous women in Quebec, drawing parallels with the experiences of Indigenous women in other parts of Canada.
- Reasons for the limited mention of the work of obstetrician gynaecologists (specialists who play an important role in pregnancy) by research participants.
- Case study with Indigenous midwives in training or in practice in Quebec.
- Detailed mapping for certain nations or communities.

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# APPENDIX A

## Cartography of the travelling imposed on pregnant Indigenous women

As cartography can be used to illustrate relationships to the land, this tool offers a unique representation of Indigenous territorialities characteristic of women's travels during pregnancy. By drawing lines between the various places that have defined their experiences of maternity, their narratives contribute to the reappropriation of a space, a territory, within which their movements are often problematic. Therefore, by reclaiming the geographical grammar of the places they travel to, Indigenous women take a form of control over the hypermobility imposed on them. In this respect, participatory mapping is a tool for emancipation, starting with the people we met in the course of the research on access to midwifery services for Indigenous communities in Quebec (Basile & al. 2023), and then for all Indigenous women who have or will experience pregnancy. Given that reconstructing and locating collective narratives of pregnancy travels contributes to this emancipation, communicating the result of this mapping is an act of empowerment (Desbiens & al., 2022), for the communities and Nations concerned. We are therefore witnessing a counter-mapping, a reversal of the so-called colonial map, the one that helped enforce the doctrine of terra nullius (land without a master) and the erasing - both symbolic and spatial - of the presence of Indigenous peoples from the territories they have occupied for millennia (Brocca & Genay, 2021). This reversal is reflected in the application of previously unpublished data from the life stories of Indigenous women, who have rarely been asked to recount their particular experiences of the land.

During the interviews conducted for this research, participants took part in a participatory mapping exercise, explaining the typical journey of pregnant Indigenous women in their respective communities. The focus here is on the numerous trips imposed on Indigenous women, especially in terms of evacuation policies **to give birth** in a hospital. In addition to these often-extended trips to give birth, there are also the numerous displacements imposed in order **to access a complete pregnancy follow-up**. The testimonies gathered speak of approximately fifteen trips on average, sometimes over long distances, a tedious undertaking in the context of a pregnancy that generally lasts 40 weeks. During this period, Indigenous women are confronted with numerous issues, such as the disconnect with their land and family network, the care of other children during their absence, the persistent prejudices they face, their mistrust of the health system, fears of birth alerts and incomprehension of their needs due to the language barrier

(second-language context), the absence of support and Indigenous language interpreters, their exile to the city requiring additional expenses, and finally, the loneliness and stress they may feel.

The maps presented therefore reflect the "**ideal travel itineraries**" for pregnancy follow-ups and childbirth that many women are unable to make, for the reasons outlined above. As a result, their health and that of their unborn child is jeopardized by the absence of favourable conditions for accessing comprehensive perinatal services. Consequently, the lack of access to midwifery services is a major drawback.

## Methodology

Using a Google map, participants were able to pinpoint the various locations and travel itineraries that pregnant women need to make to access pregnancy follow-ups and deliver their babies. This cartographic data was then passed on to two mapping specialists, geographer Danny Bisson (Progigraph, Quebec) and Professor Matthieu Noucher (Centre national de la recherche scientifique, France), who each illustrated, in their own way, the journeys of pregnant Indigenous women. Their contribution enabled the creation of two types of maps: 1) typical route maps showing the travels of women from two Indigenous communities in Quebec, and 2) general maps tracing the travels of pregnant Indigenous women from 14 Indigenous communities in Quebec.

## Cartography No. 1

The detailed information of data collected provided insight into the lives of pregnant women in two communities: the Atikamekw community of Wemotaci (located north of the town of La Tuque, in the Haute-Mauricie region) and the Innu community of Matimekush-Lac John (located near the town of Schefferville, in the Côte-Nord region). The Wemotaci community was chosen because of the high level of accuracy of the data collected, while the Matimekush-Lac John community was chosen because of the regular presence of a doctor in the community, which partly explains the lower number of trips required of pregnant women. It should be noted that the data represent the **typical** journey for the monitoring of a so-called "normal" pregnancy. Pregnancies involving gestational diabetes, for example, require a greater number of days away from the community and travel for pregnancy follow-ups (approximately a third more in terms of days and travel). This cartography does not include the transfer of files between the communities where women may have started a pregnancy follow-up and moved to during their pregnancy.

**Atikamekw community of Wemotaci**

The first map (figures 1 and 2), that of Wemotaci (accessible by road and train), has **27 circles** representing **27 days**, explained as follows:

- 10 red circles which represent the number of days dedicated to pregnancy monitoring, including the transit time from Wemotaci to the town of La Tuque (115 kilometers of forest road).

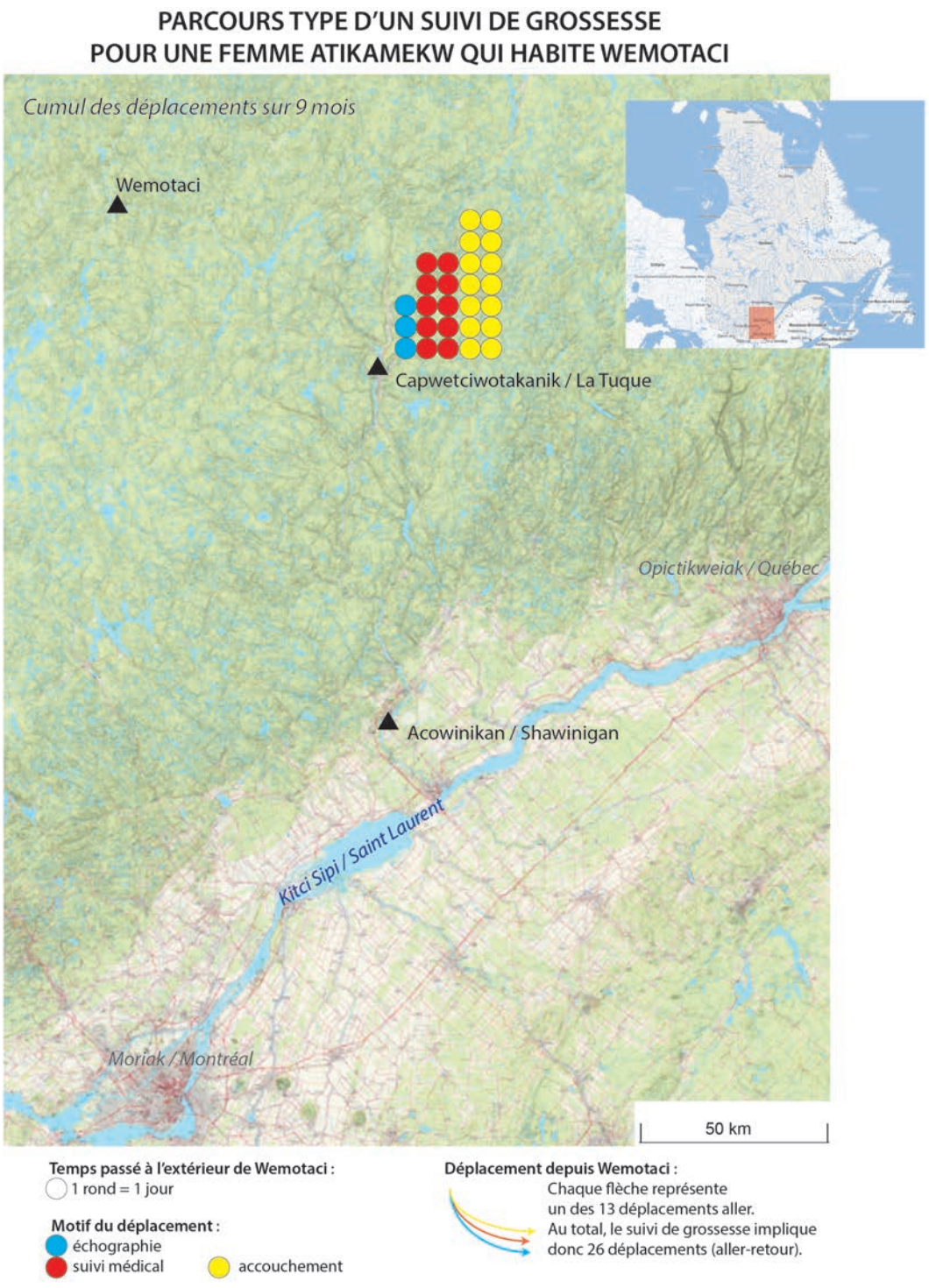
- 3 blue circles which represent the days dedicated to ultrasounds in La Tuque.
- 14 yellow circles which represent the number of days devoted to childbirth (including the waiting time before childbirth and the post-delivery period).
- The arrows (red, blue and yellow) represent the 13 one-way trips that a pregnant Atikamekw woman must make, therefore 26 trips in total.

**Innu community of Matimekush-Lac John**

The second map (figures 3 and 4) of Matimekush-Lac John (no access route), includes **36 circles** representing **36 days** explained as follows:

- 8 blue circles representing the number of days devoted to pregnancy follow-ups (including 2 ultrasounds) requiring air travel (1 h 15 or more, depending on weather conditions) or train travel (10 hours/1 time per week) to Sept-Îles.
- 28 yellow circles representing the number of days devoted to delivery (including waiting time pre-delivery and post-delivery period).
- Arrows (blue and yellow) representing the 3 one-way trips (by plane) an Innu woman must undertake, for a total of 6 trips.

**Figure 1: Typical journey for a pregnant Atikamekw woman from Wemotaci-1**




**Fonds de plan** : Gouvernement du Québec. / **Données** : entretiens auprès de la communauté atikamekw. / **Entretiens** : Frédérique Cornellier et Suzy Basile, UQAT. / **Cartographie** : Matthieu Noucher, CNRS.

**Figure 2: Typical journey for a pregnant Atikamekw woman from Wemotaci-2**

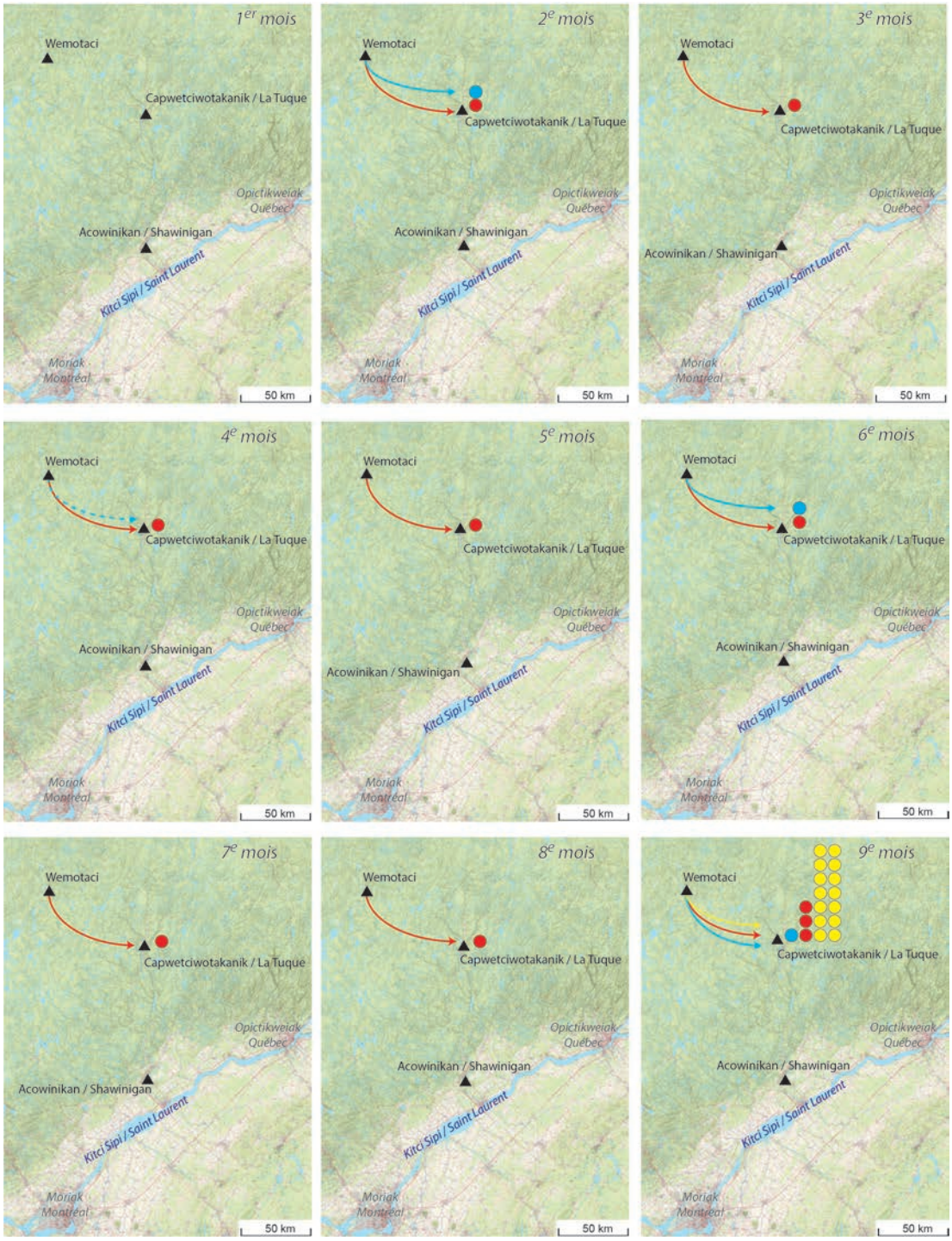


**Figure 3: Typical journey for a pregnant Innu woman from Matimekush-Lac John-1**

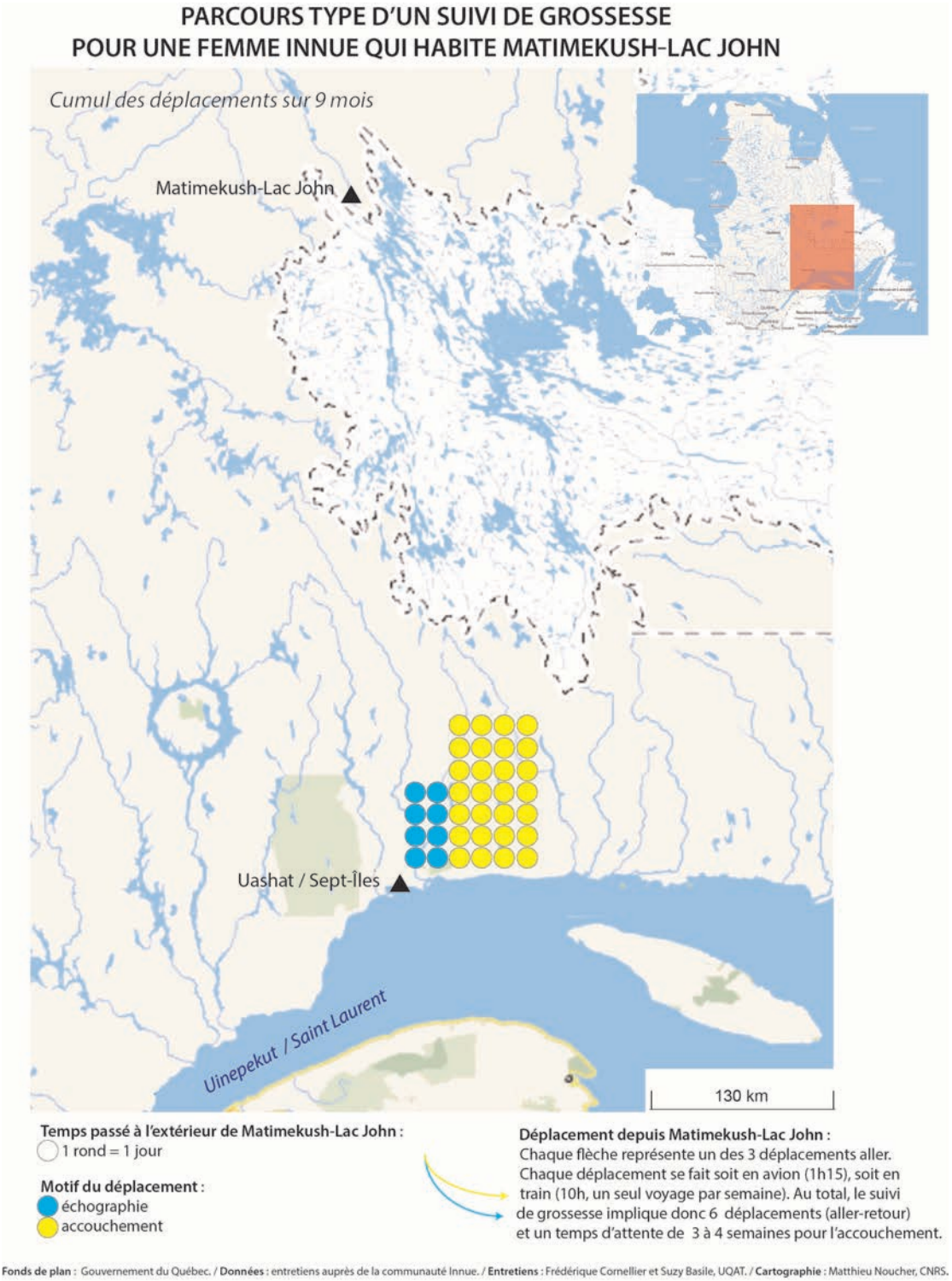
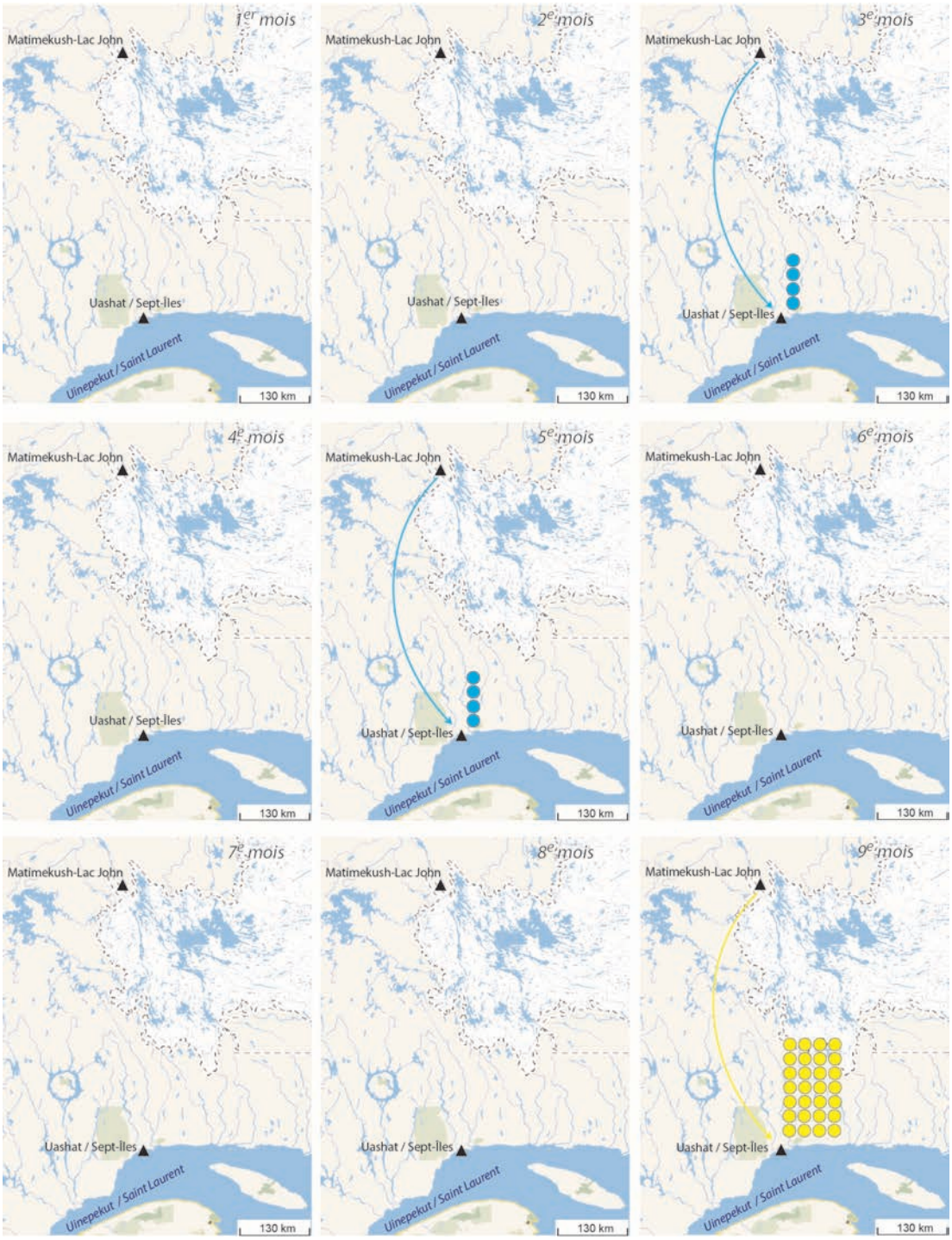


**Figure 4: Typical journey for a pregnant Innu woman from Matimekush-Lac John-2**



## Cartography No. 2

The first map (Figure 5) indicates the geographical location of the 19 Indigenous communities and 3 Native Friendship Centres in Quebec taking part in the research. The next series of 13 maps (Figures 6 to 18) represent the trips imposed on pregnant Indigenous women from the communities taking part in the research. They are listed in alphabetical order, first by Nation and then by community name. The maps include:

- Yellow dots representing perinatal service facilities, such as health centres in the communities, clinics in the relevant Native Friendship Centres and hospitals in the various regions.
- Arrows representing the straight-line routes (as the crow flies) that pregnant women must travel in order to access perinatal services. Bear in mind that some communities are not accessible by road, but only by boat or plane, while others are also accessible by train.
- Blue arrows representing the journey for pregnancy follow-ups.
- Green arrows representing the journey for uncomplicated deliveries.
- Red arrows representing the journey for deliveries with complications.

It is important to remember that, as demonstrated in the research report, the geographical location and available perinatal services are characterized by great disparity, and no Indigenous community can be compared to another, even if they are situated in the same region. Finally, Quebec's administrative regions do not necessarily correspond to the territories traditionally occupied by the Nations. For example, Indigenous women from the same Nation are referred to health centres in different administrative regions, further proof that a colonial geography has been imposed on them.

### References:

Basile, S., Cornellier, F. & Comat, I. (2023). *Access to midwifery services for Indigenous communities in Quebec*. Université du Québec en Abitibi-Témiscamingue.

Bracco, D. & Genay, L. (2021). *Contre-cartographier le monde*. Collection Espaces Humains.

Desbiens, C., Gagnon, J. & Hirt, I. (2022). « Un monde-carte: pouvoir colonial et *empowerment* des femmes autochtones cartographes ». *Revue d'études autochtones, 51*(2-3): 39-52. https://id.erudit.org/iderudit/1097375arCopiedAn

**Figure 5: Geographic location of Indigenous communities and Native Friendship Centres participating in the research**

**Figure 6: Travel itineraries of pregnant women from Anishnabeg communities participating in the research**

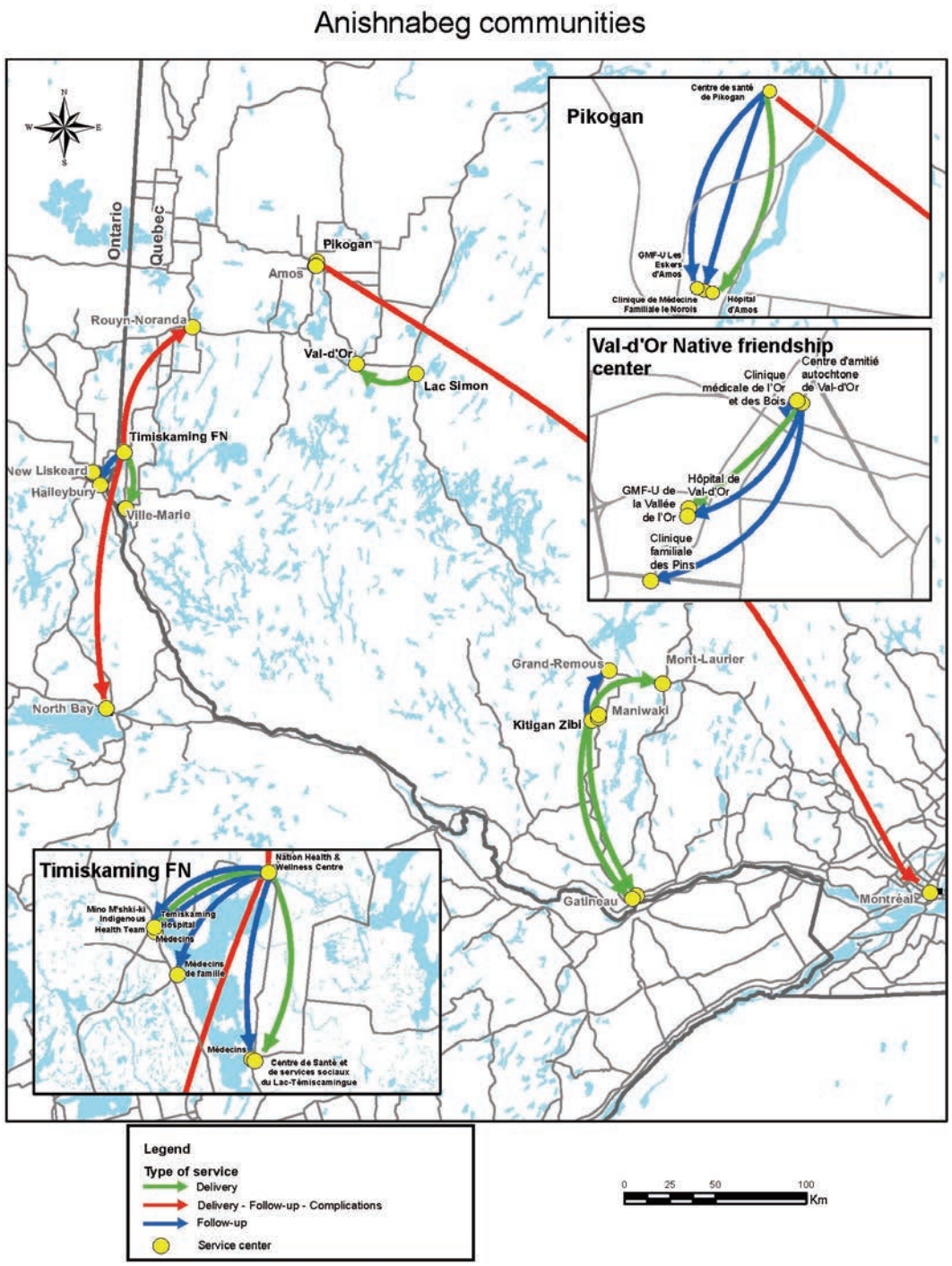


**Figure 7: Travel itineraries of pregnant women from Atikamekw communities participating in the research**

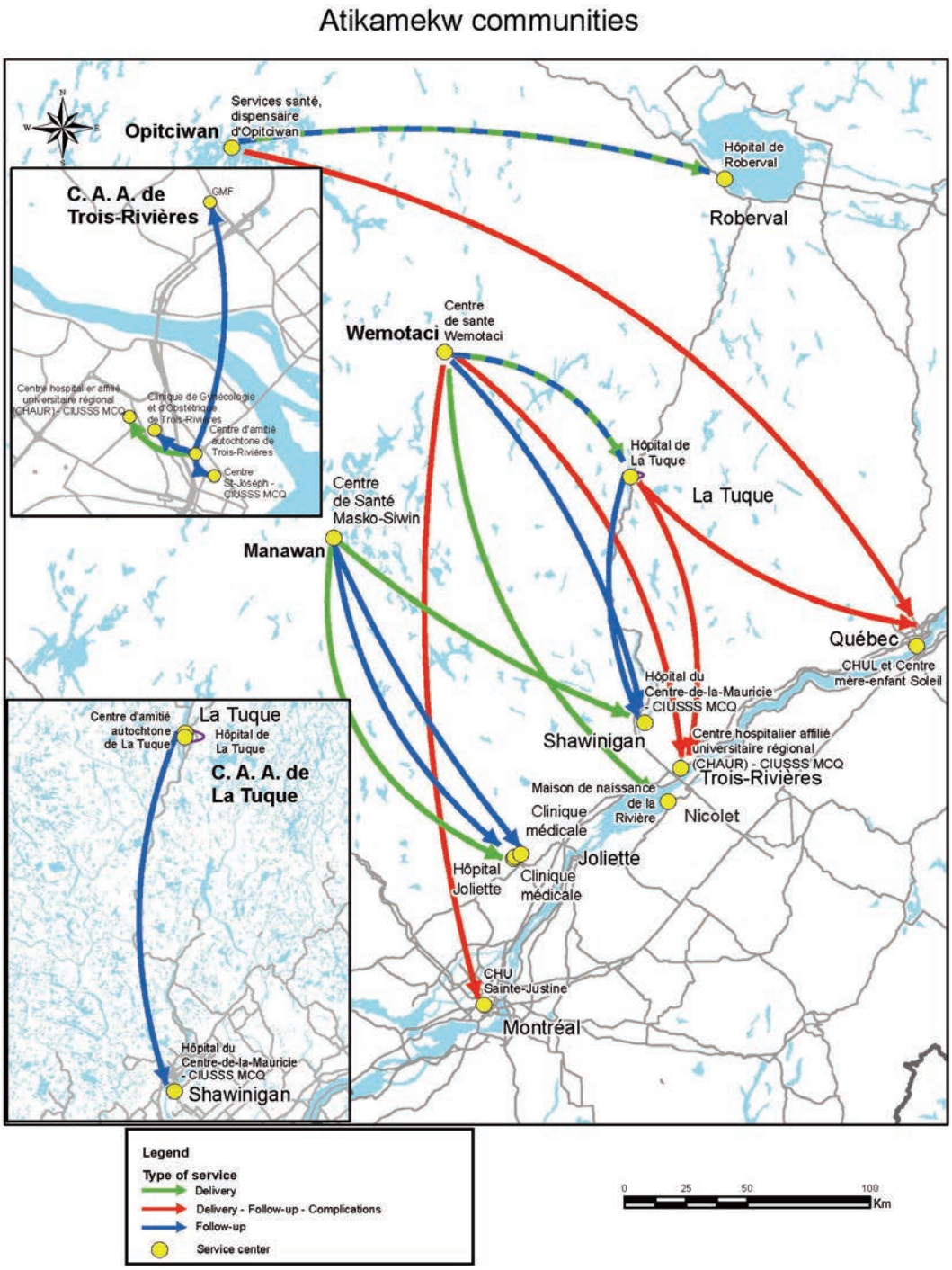


**Figure 8: Travel itineraries of pregnant women from the Wôlinak Abenaki community**

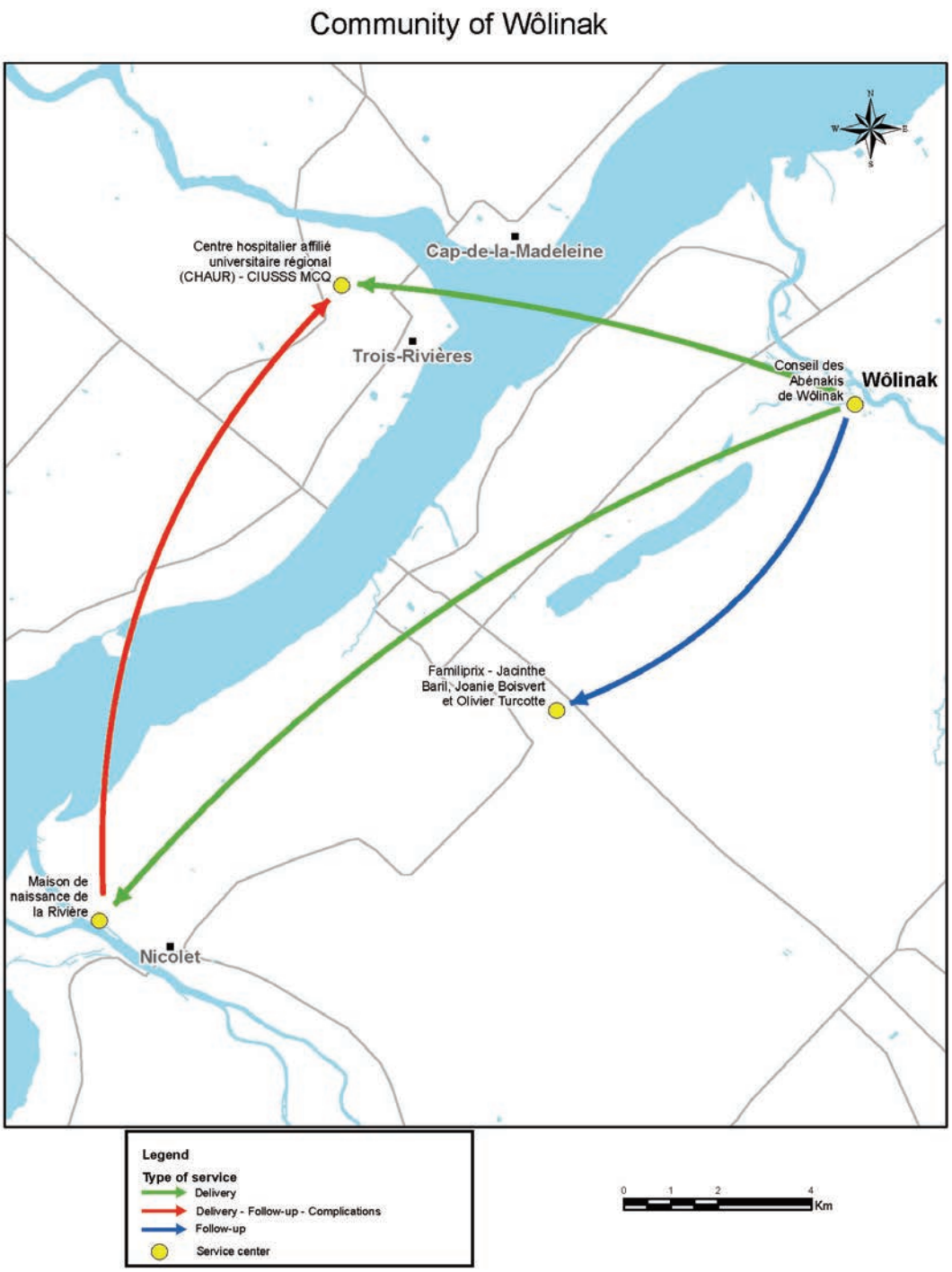


**Figure 9: Travel itineraries of pregnant women from the Wendake Huron-Wendat community**

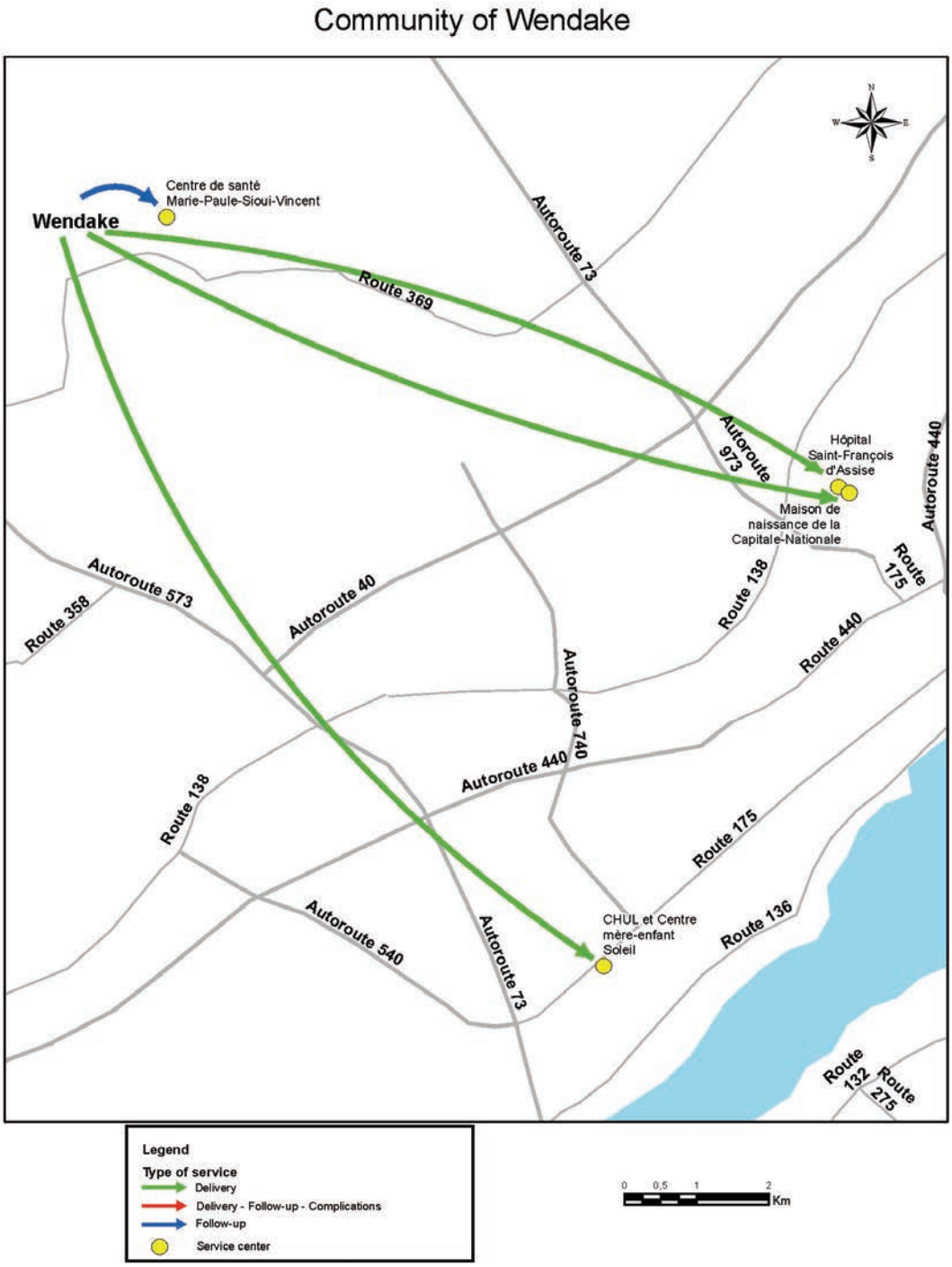


**Figure 10: Travel itineraries of pregnant women from the Mashteuiatsh Innu community**

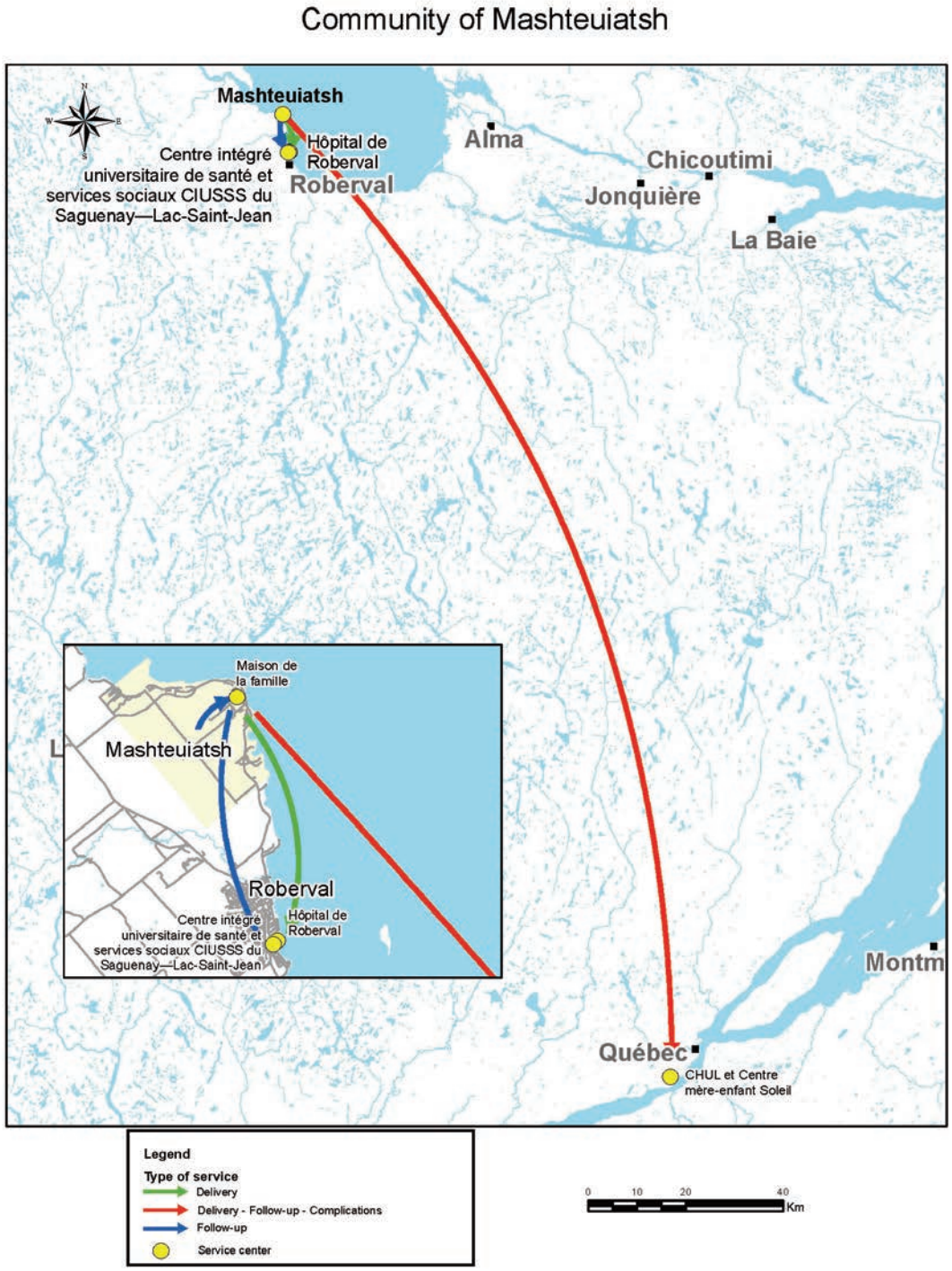


**Figure 11: Travel itineraries of pregnant women from the Ekuanitshit Innu community**

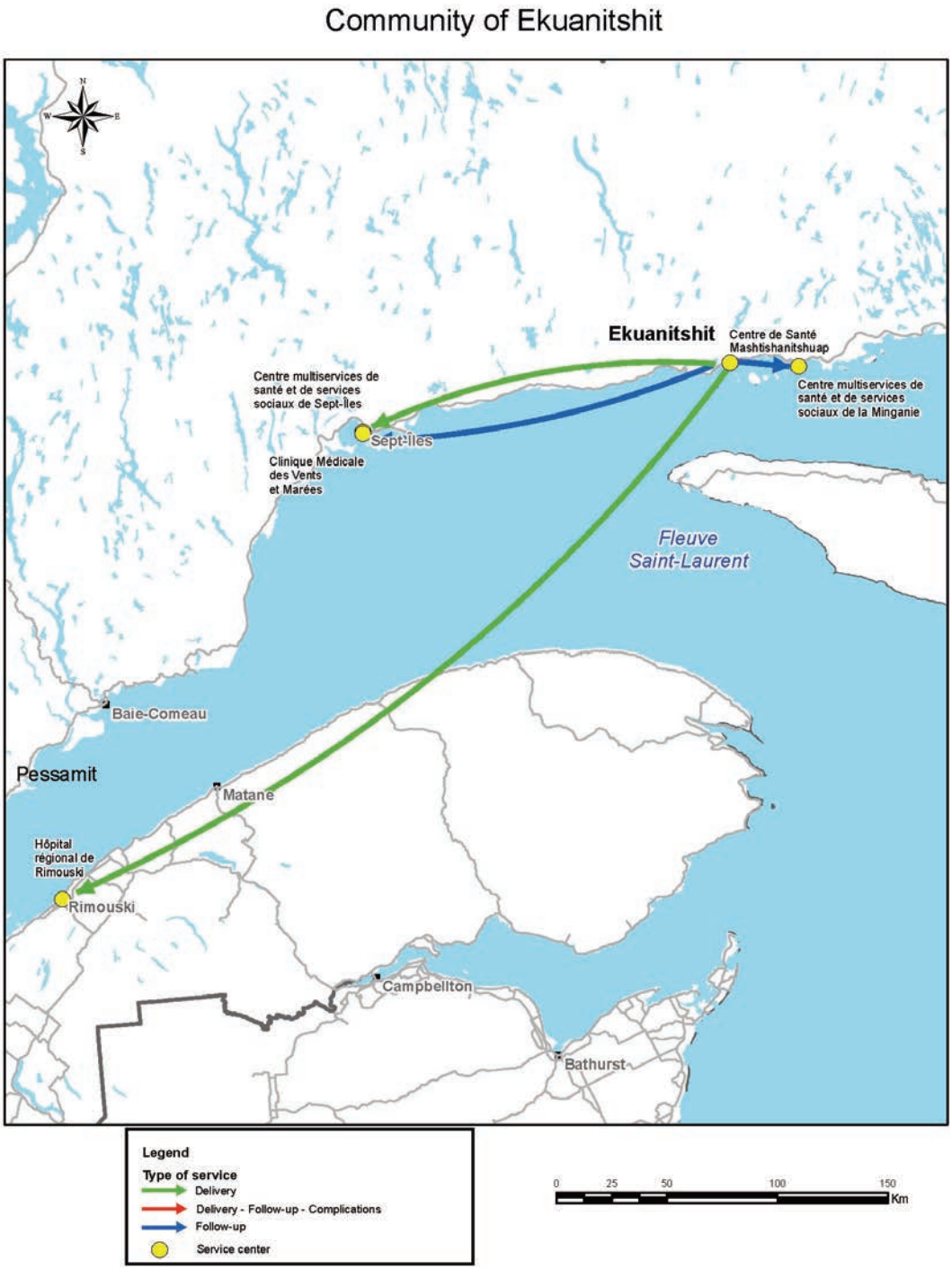


**Figure 12: Travel itineraries of pregnant women from the Essipit Innu community**

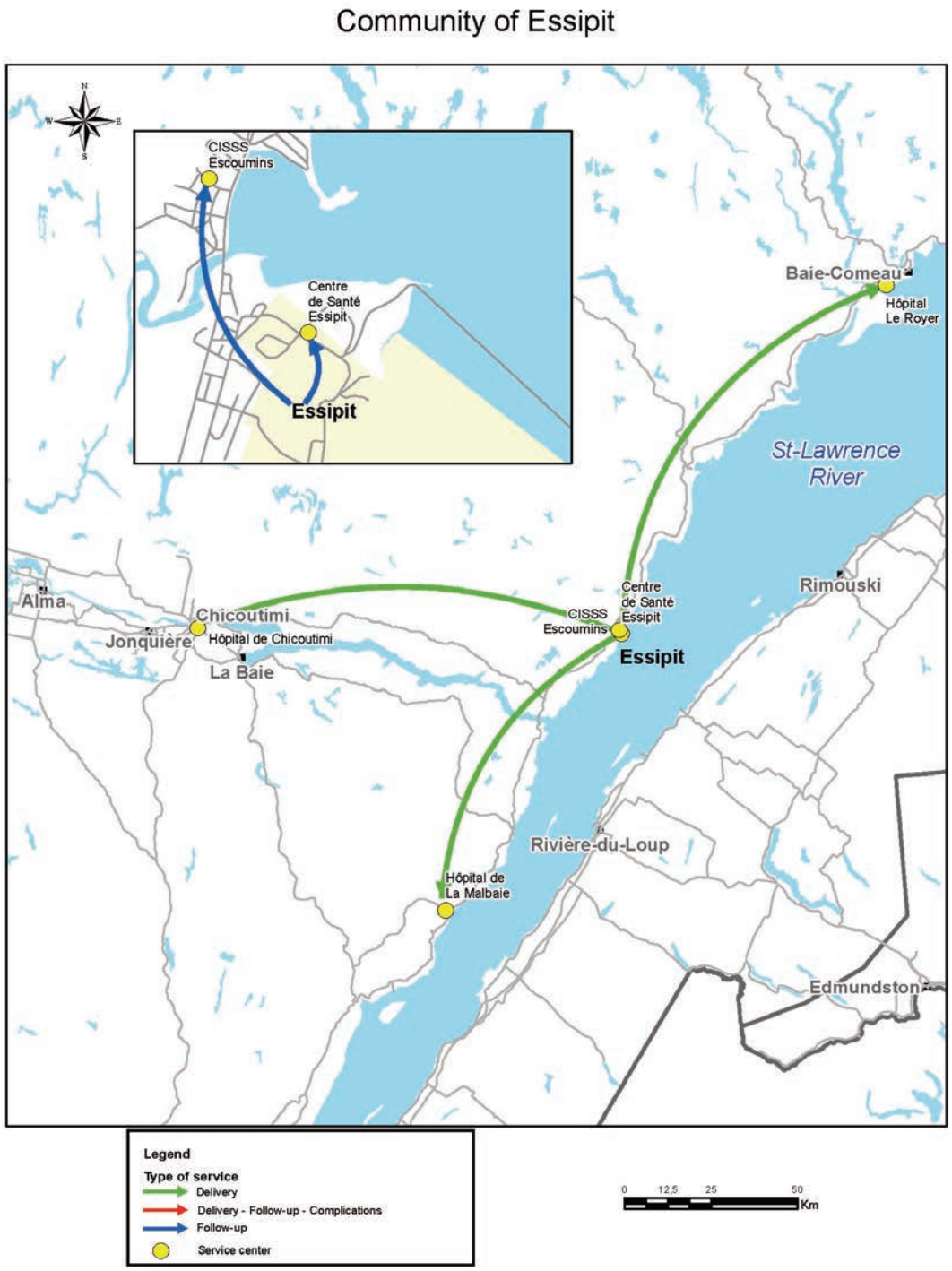


**Figure 13: Travel itineraries of pregnant women from the Matimekush-Lac John Innu community**

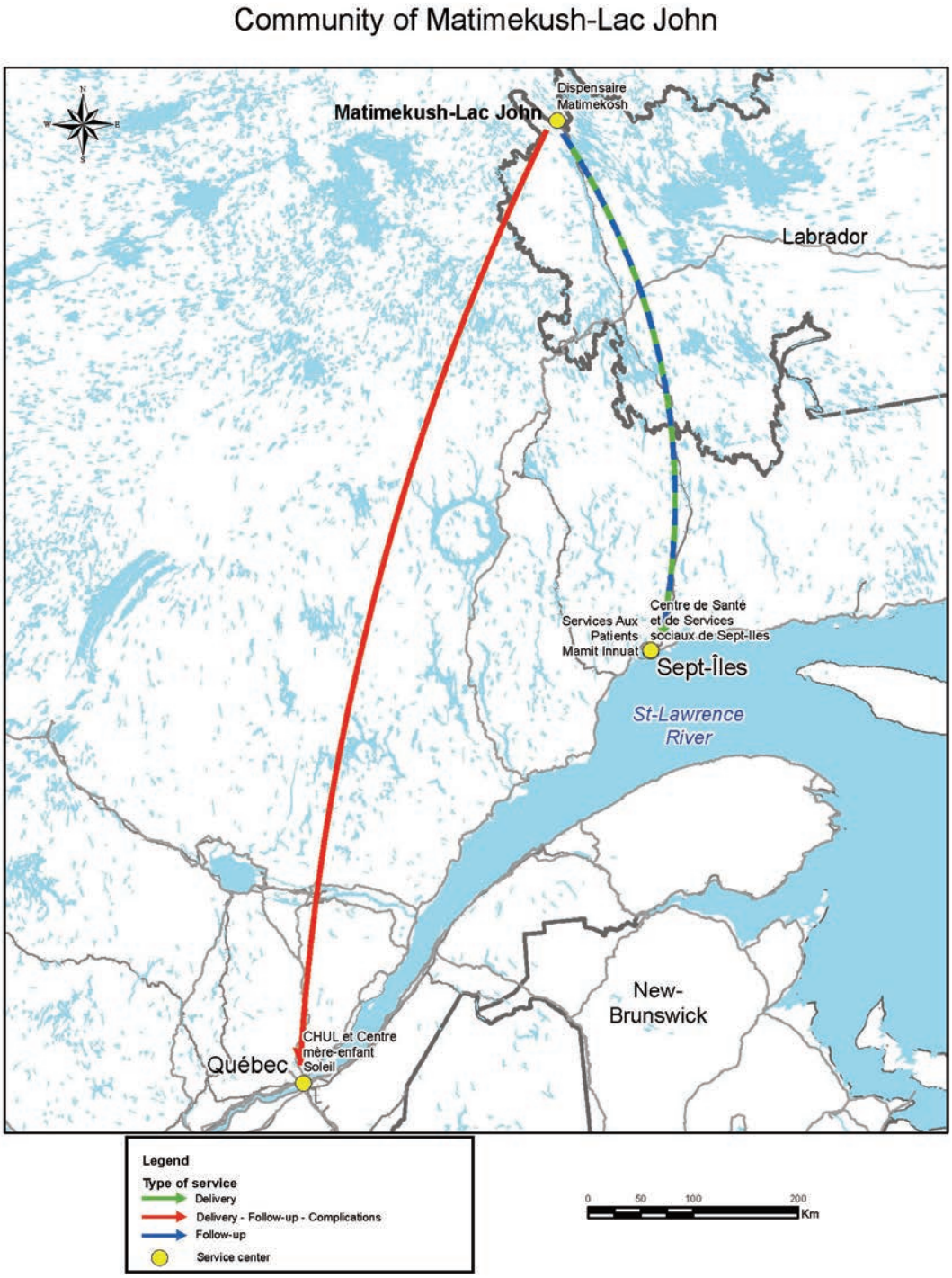


**Figure 14: Travel itineraries of pregnant women from the Nutashkuan Innu community**

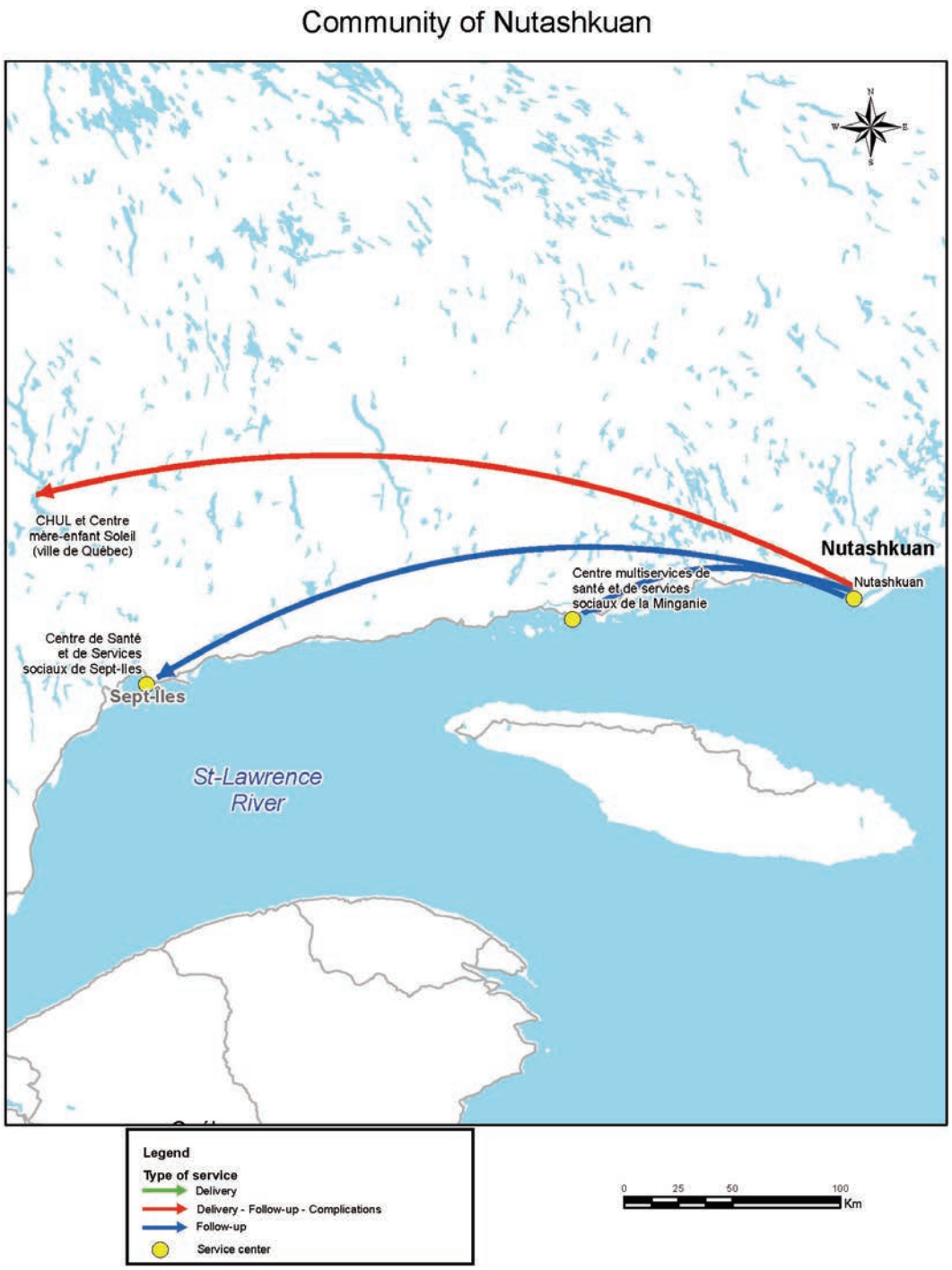


**Figure 15: Travel itineraries of pregnant women from the Pessamit Innu community**

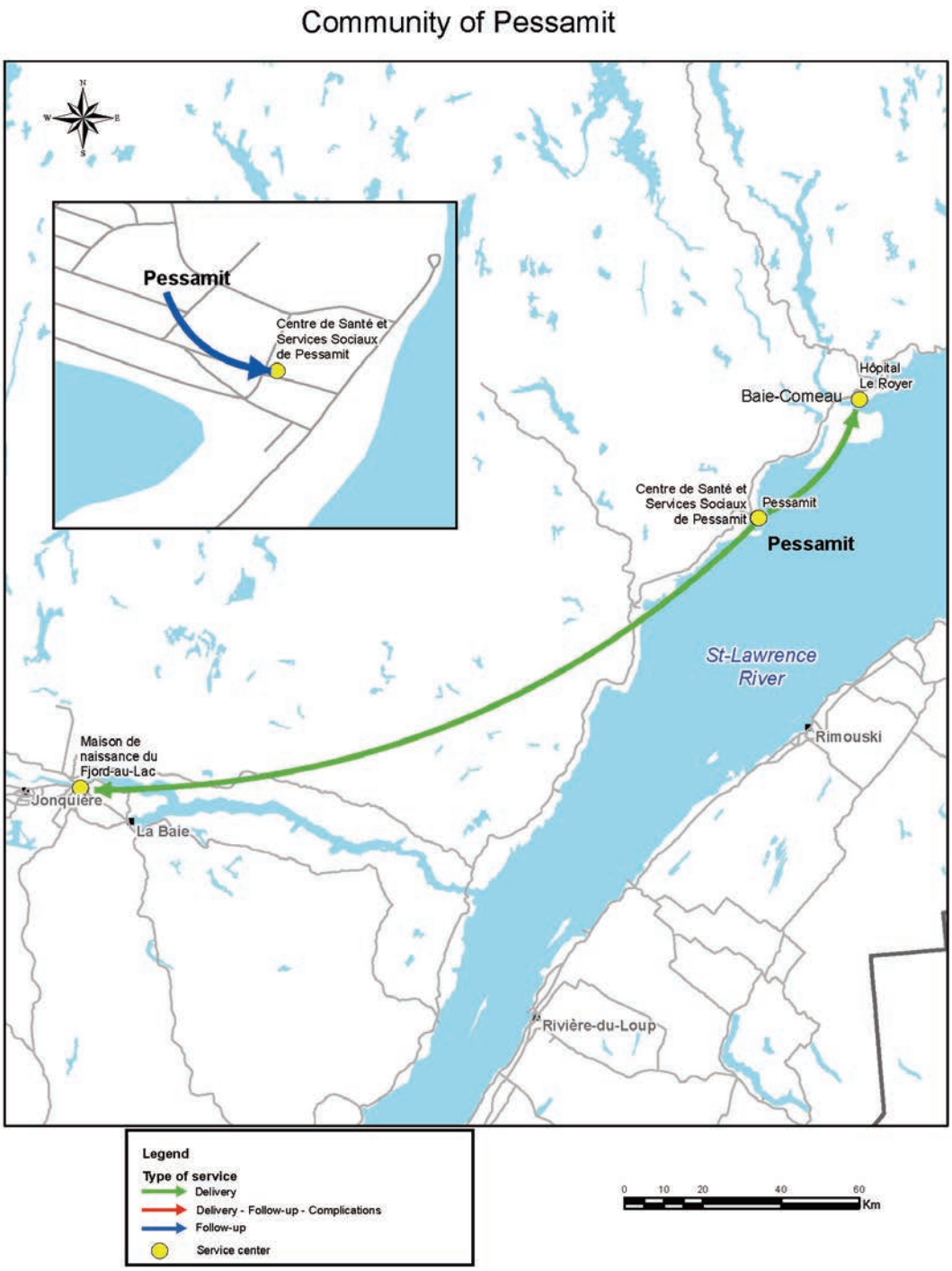


**Figure 16: Travel itineraries of pregnant women from the Uashat mak Mani-Utenam Innu community**

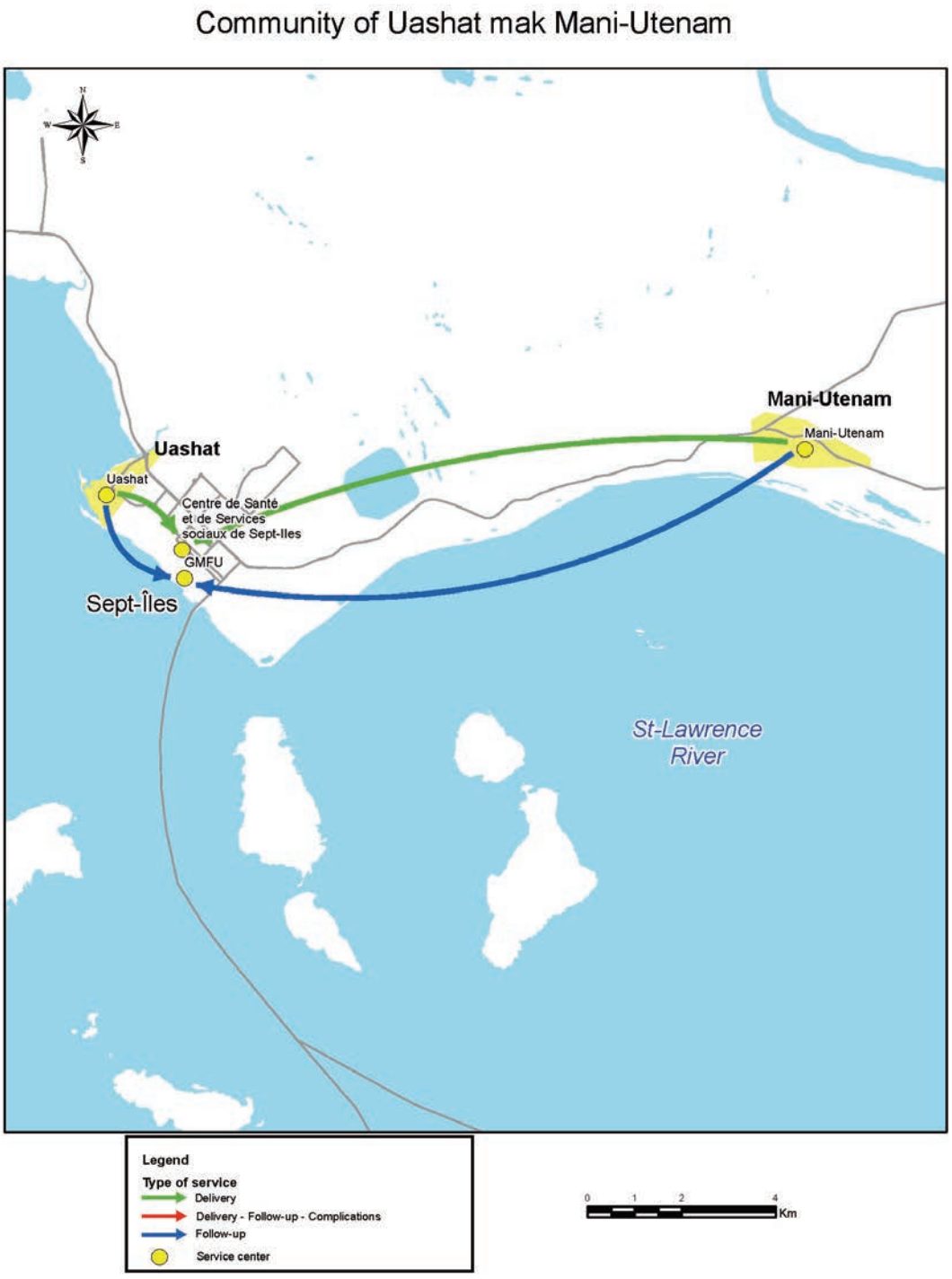


**Figure 17: Travel itineraries of pregnant women from Mi'kmaq communities participating in the research**

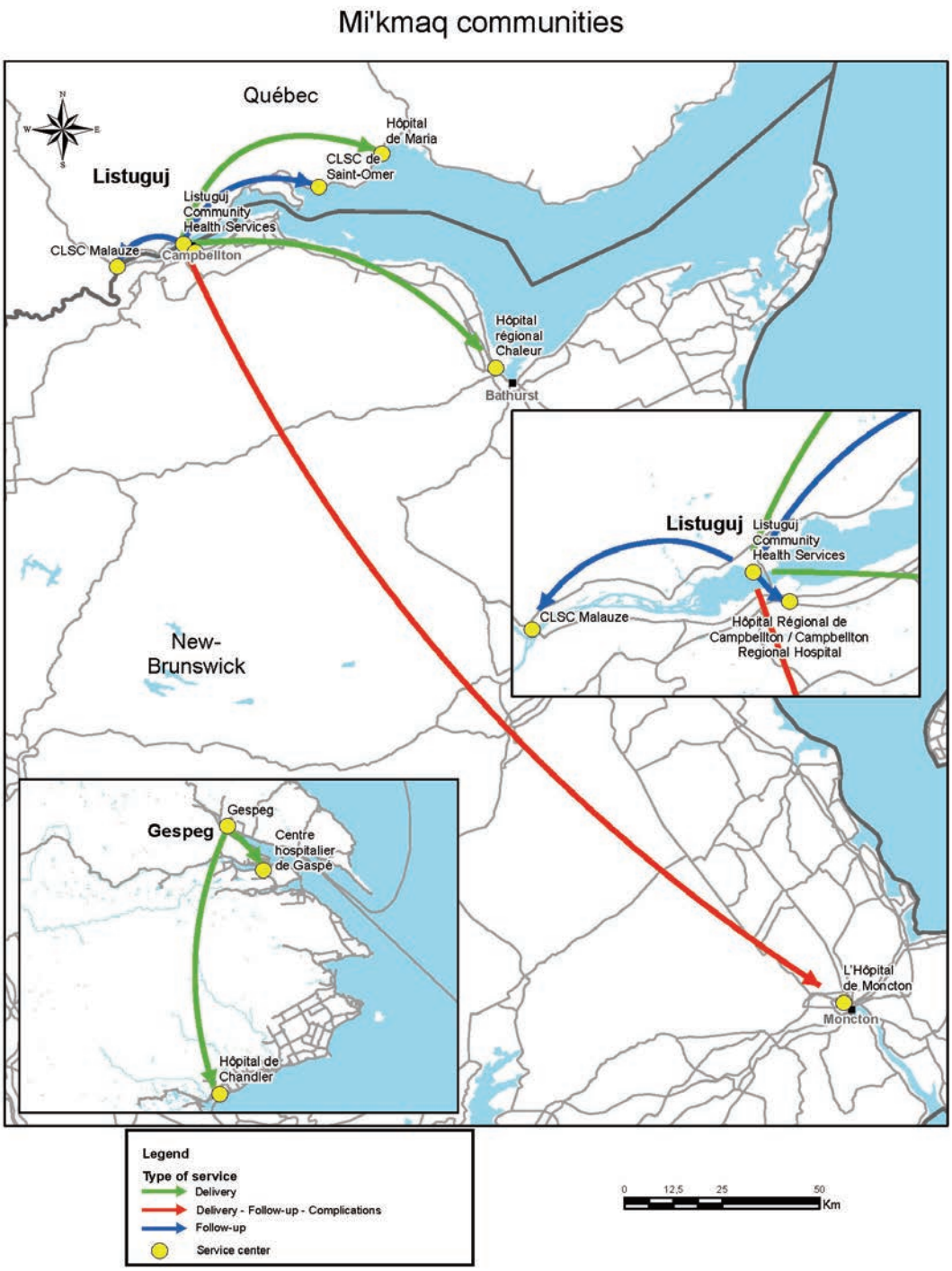
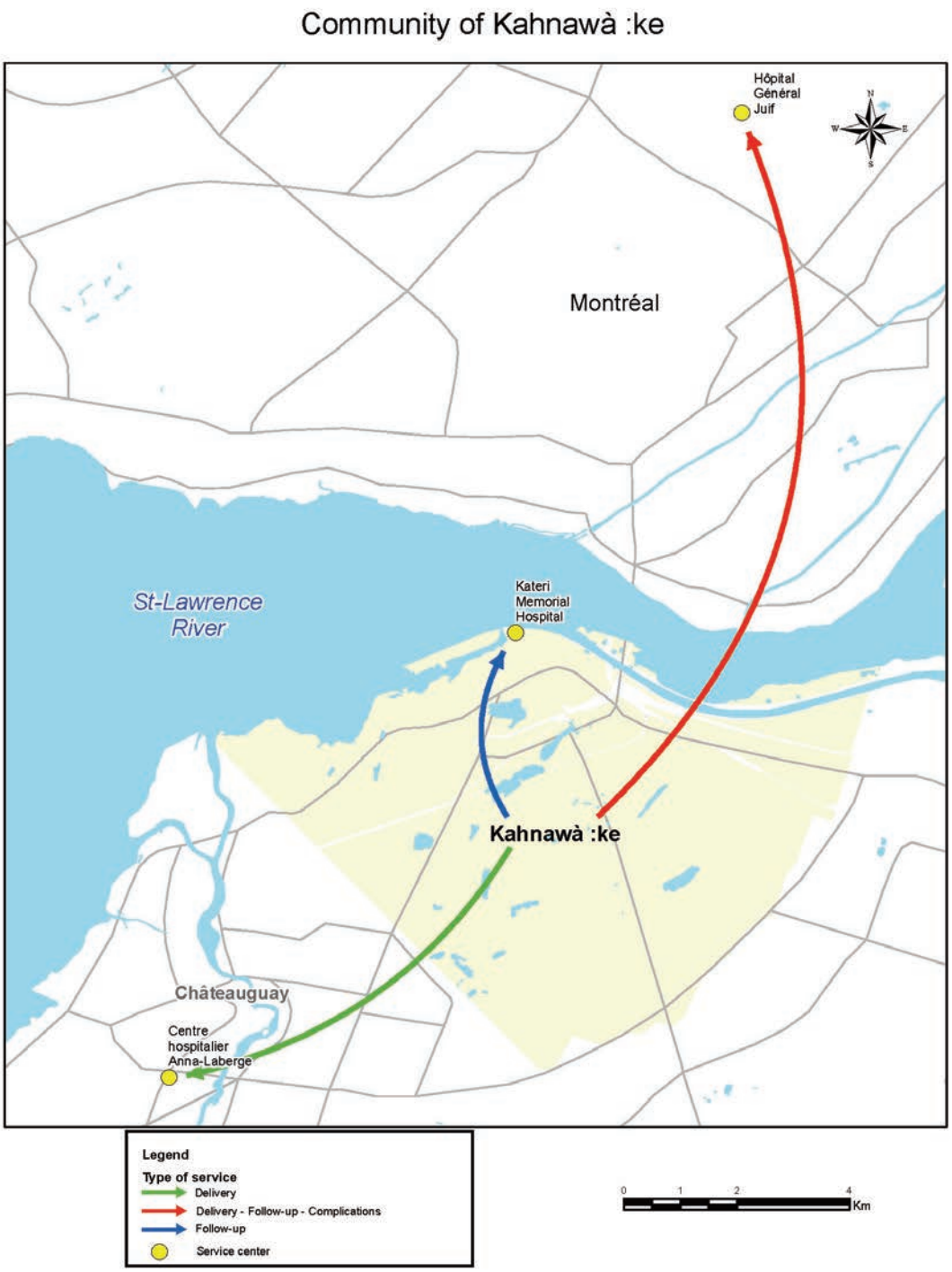


**Figure 18: Travel itineraries of pregnant women from the Kahnawà:ke Mohawk community**



# APPENDIX B
## Semi-structured interview guide

### Access to midwifery services for Indigenous communities in Quebec

| | |
|---|---|
| Presentation by the Canada Research Chair on Indigenous Women's Issues research team | Name and institution |
| | Presentation of research objectives |
| | Presentation of consent |
| | Request for permission to record interview |
| Identification of person interviewed | What is your name, surname or traditional name? |
| | Where do you come from? / Your community of belonging? |
| | Where do you live? |
| | What is your occupation? |
| | How many years have you occupied this position? |
| Perinatal services | Can you share with us what perinatal services are offered in the community/by your organization? |
| | Are there any midwifery services in or near your community? What are they? |
| | Is access to midwifery services a need expressed by pregnant women in the community (and/or those attending the health centre or your organization)? What have you heard? |
| | In your opinion, is the implementation of midwifery services in the community realistic? What would facilitate and/or hinder the implementation of this service? |
| | Can you share with us the kind of perinatal services desired in your community/organization? In what ways do women want to access these services? |
| | If these services had been put in place, how do you think they would have helped the women and their families? |

| | |
|---|---|
| | What perinatal services should a pregnant woman in the community receive, but which are not accessible in the community (e.g., ultrasound)? |
| | In your opinion, how could access to perinatal services offered by midwives compensate for the unavailability of certain perinatal services in the community? |
| | In your opinion, what needs to be put in place for these services to be offered in the community/by your organization? What needs to be addressed? |
| | In your opinion, do pregnant women want to give birth here, in the community? Why is this important? |
| | Why do you think it's important for women to be able to choose where they give birth? |
| | When women mention this preference, is their choice respected by the nursing staff? |
| Cartography (Using Google Earth) | Can you explain the steps a pregnant woman must take to access perinatal services outside the community (e.g., travel, making appointments)? |
| | What challenges and issues does a pregnant woman face in accessing these out-of-community services, and in ensuring that her follow-up is conducted adequately (time required, level of stress)? |
| | Approximately how many of these trips are made during the prenatal as well as the postnatal period? |
| | Do you have any idea of the costs involved? Who pays for these costs? Is there a reimbursement policy, and if so, is it easily accessible to mothers and families? |
| | Using a Google Earth map, track travel routes based on the stage of pregnancy and type of follow-up required. |
| Ancestral Indigenous practices | Are there any ancestral Indigenous practices (e.g., ceremonies or rituals surrounding pregnancy, childbirth and the arrival of the baby, etc.) that are still performed today and experienced not only by pregnant women, but also by members of the community? |
| | What are these practices, and can you describe them? |
| | How important are these practices (ceremonies or rituals) to the community? |

| | |
|---|---|
| Additional questions | Would you like to share any other information about the services that are offered, or should be offered, to pregnant women in your community or who attend your organization? |
| | What convinced you to take part in this research? |

# APPENDIX C
# Information note

## Note to First Nations community health departments and Indigenous organizations in Quebec

**Research on access to midwifery services for Indigenous communities in Quebec**

The Canada Research Chair on Aboriginal Women's Issues at the Université du Québec en Abitibi-Témiscamingue (UQAT), headed by Professor Suzy Basile, is drawing on its expertise in research with Indigenous peoples to conduct research on access to midwifery services for Indigenous communities in Quebec. This research is being carried out in close collaboration with the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC).

The objective of the research is to pinpoint the information needed to improve Indigenous families' access to midwifery services, through a review of the literature, a review of the services offered, a profile of the experiences lived by Indigenous women and families, the identification of conditions for success and obstacles, a description of certain ancestral practices and a mapping of the perinatal experiences of Indigenous families.

Your participation in this project is invaluable, as it will enable us to gather the data needed to paint as accurate a picture as possible of the current situation regarding access to midwifery services for Indigenous communities in Quebec. You will be contacted shortly by Frédérique Cornellier, UQAT research officer. Thank you for your collaboration.



For additional information, please contact:

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Suzy Basile, Professor, School of Indigenous Studies, UQAT suzy.basile@uqat.ca

Frédérique Cornellier, Research Officer, UQAT, frederique.cornellier@uqat.ca

# APPENDIX D

## Table of Indigenous communities, organizations and individuals involved in the data collection

| INDIGENOUS COMMUNITIES | NATION/LOCATION |
|---|---|
| Essipit | Innu |
| Ekuanitshit | Innu |
| Gespeg | Mi'kmaq |
| Kahnawà:ke | Mohawk |
| Kitigan Zibi | Anishnabe |
| Lac Simon | Anishnabe |
| Listuguj | Mi'kmaq |
| Manawan | Atikamekw |
| Mashteuiatsh | Ilnu |
| Matimekush-Lac John | Innu |
| Nutashkuan | Innu |
| Opitciwan | Atikamekw |
| Pessamit | Innu |
| Pikogan | Anicinabe |
| Timiskaming First Nation | Anishnabe |
| Uashat Mak Mani-Utenam | Innu |
| Wemotaci | Atikamekw |
| Wendake | Huron-Wendat |
| Wôlinak | Abénaki |

| INDIGENOUS ORGANIZATIONS | |
|---|---|
| Centre d'amitié autochtone de La Tuque | La Tuque |
| Centre d'amitié autochtone de Trois-Rivières | Trois-Rivières |
| Val-d'Or Native Friendship Centre | Val-d'Or |
| Quebec Native Women | Kahnawà:ke |
| National Council of Indigenous Midwives | Montreal |
| Regroupement des centres d'amitié autochtones du Québec | Wendake |

| INDIVIDUALS | |
|---|---|
| Non-Indigenous women | Montreal |
| Atikamekw women | Centre-du-Québec |

# APPENDIX E

## Calls for action and recommendations of inquiry commissions and government action plans on the health needs of Indigenous Peoples

| Themes addressed | **References**<br>CERP: Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec<br>RCAP: Royal Commission on Aboriginal Peoples<br>TRC: Truth and Reconciliation Commission of Canada<br>NIMMIWG: National Inquiry into Missing and Murdered Indigenous Women and Girls<br>Government Action Plan for the Social and Cultural Development of the First Nations and Inuit 2017-2022 (SAA, 2017)<br>Government Action Plan for the social and cultural wellness of the First Nations and Inuit 2022-2027 (SRPNI, 2022)<br>Action Plan in perinatal and early childhood care (PAPPE) 2023-2028 (MSSS, 2023) |
|---|---|
| Children | NIMMIWG (Qc), 2019:20<br>Action Plan (SRPNI, 2022): 3.3; 3.7 |
| Collaboration | RCAP, 1996: 3.3.6; 3.3.12; 3.3.21; 3.3.22<br>Action Plan in perinatal care 2023-2028 (MSSS, 2023): 2.3.1 |
| Cultural safety | CERP, 2019: 24; 25; 74; 75; 76; 78; 81; 84; 85; 90; 96; 97<br>CRPA, 1996:3.3.8; 3.3.15; 3.3.16; 3.3.22; 3.3.24<br>TRC, 2012: 22<br>NIMMIWG, 2019: 7.1, 7.2; 7.4; 15.4<br>Action Plan (SAA, 2017): two recommendations<br>Action Plan (SRPNI, 2022): 3.7; 3.8; 5.4; 5.5<br>2023-2028 Action Plan in perinatal care: 2.3 |
| Education | CERP, 2019: 24; 25; 26; 87; 102<br>RCAP, 1996: 3.3.14; 3.3.16; 3.3.17; 3.3.18; 3.3.19; 3.3.23<br>TRC, 2012: 23; 24<br>NIMMIWG (Qc), 2019: 8; 9<br>NIMMIWG, 2019: 2.5; 7.4; 7.6; 7.7; 11.1; 15.4<br>Action Plan (SAA, 2017): one recommendation |

| | |
|---|---|
| Funding | CERP, 2019: 76; 79; 82; 84; 86; 88; 90; 93; 97; 99; 100<br>CRPA, 1996: 3.2.1; 3.3.3; 3.3.13; 3.3.14<br>TRC, 2012: 21<br>NIMMIWG, 2019: 2.5; 3.6; 7.7; 7.8<br>Action Plan (SRPNI, 2022): 2.1; 2.8; 4.9 |
| Health programs | CRPA, 1996: 3.3.1; 3.3.5; 3.3.24<br>NIMMIWG, 2019: 7.3;<br>Action Plan (SAA, 2017): three recommendations |
| Language | CERP, 2019: 12; 15; 16; 18 |
| Legislation, regulations and agreements | CERP, 2019: 12; 74; 78; 80; 82; 83; 85; 86; 89; 91; 92; 95; 98; 101; 104; 105; 106<br>CRPA, 1996: 3.3.1; 3.3.3; 3.3.5<br>TRC, 2012: 19<br>NIMMIWG, 2019: 1.1<br>Action Plan (SAA, 2017): two recommendations<br>Action Plan (SRPNI, 2022): 1.6; 2.8; 3.6; 5.1 |
| Medical transport and accommodations | CERP, 2019: 77; 103<br>2023-2028 Action Plan in perinatal care: 2.3.3 |
| Policies | CRPA, 1996: 3.2.1; 3.2.10; 3.3.2; 3.3.12<br>TRC, 2012  18; 20;<br>NIMMIWG, 2019: 1.6; 3.6<br>Action Plan (SAA, 2017): two recommendations |
| Proximity perinatal care | Action Plan (SRPNI, 2022): 3.4<br>2023-2028 Action Plan in perinatal care (MSSS, 2023): 2.3 |
| Rights | RCAP, 1996: 3.2.10<br>NIMMIWG, 2019: 3.1; 7.1 |
| Resources | NIMMIWG, 2019: 7.4; 7.5 |
| Traditional knowledge | CRPA, 1996: 3.3.18; 3.3.21; 3.3.23<br>NIMMIWG, 2019: 7.4<br>Action Plan (SAA, 2017): one recommendation |
| Working conditions | CERP, 2019: 107<br>RCAP, 1996: 3.3.13<br>TRC, 2012: 23<br>NIMMIWG, 2019: 7.8<br>Action Plan (SAA, 2017): two recommendations |