

# Traditional First Nations Birthing Practices: Interviews With Elders in Northwestern Ontario

Terry O'Driscoll, MD, CCFP,<sup>1</sup> Lauren Payne, MPH,<sup>2</sup> Len Kelly, MD, MClin Sci, CCFP,<sup>1</sup>  
Helen Cromarty, RN, HBSn,<sup>3</sup> Natalie St Pierre-Hansen,<sup>1</sup> Carol Terry<sup>4</sup>

<sup>1</sup>Division of Clinical Sciences, Northern Ontario School of Medicine, Sioux Lookout ON

<sup>2</sup>Faculty of Health Sciences, Simon Fraser University, Burnaby BC

<sup>3</sup>Special Advisor on First Nations Health, Sioux Lookout Meno Ya Win Health Centre, Sioux Lookout ON

<sup>4</sup>Lac Seul First Nation ON

## Abstract

**Objectives:** Traditionally, First Nations maternity care was provided by community-based midwives trained through apprenticeship. Obstetrical practices and beliefs were integrated to provide holistic care. The Sioux Lookout Meno Ya Win Health Centre has a mandate to be a centre of excellence for Aboriginal health care. We undertook a literature review and performed a qualitative research study to understand some of the traditional practices in maternity care.

**Methods:** We conducted qualitative semi-structured interviews in English and Oji-Cree with 12 elders who had knowledge and experience of historical birthing practices in their home communities. Research team members included nursing and medical personnel and Anishinabe First Nation members. Interviews were analyzed and themes developed and verified by member checking and triangulation.

**Results:** The hands-on training for a community-based midwife often began in her teenage years with observation of childbirth practices. Practices were handed down by oral tradition and included prescriptions for healthy diet and moderate exercise during pregnancy; intrapartum care with preparation of clean cloths, moss, and scissors; the involvement of certain supportive family and community members; careful attention to the sacred handling of the placenta and umbilical cord; and careful wrapping of the newborn in fur. Complications, sometimes fatal, included retained placentas and stillbirths.

**Conclusion:** The provision of modern maternity care to Aboriginal patients should include acknowledgement of, and respect for, traditional birthing practices. Facilities providing care for these patients should consult with the relevant Aboriginal communities to understand their needs and initiate appropriate programming.

**Key Words:** First Nations, Aboriginal, traditional, obstetrical care, culture

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## Résumé

**Objectifs :** Traditionnellement, chez les Premières Nations, les soins de maternité étaient offerts par des sages-femmes issues de la communauté formées par stage d'apprentissage. Les pratiques obstétricales et les croyances étaient intégrées à l'offre de soins holistiques. Le *Sioux Lookout Meno Ya Win Health Centre* a le mandat d'être un centre d'excellence pour ce qui est des soins de santé des Autochtones. Nous avons mené une analyse documentaire et une étude qualitative en vue de comprendre certaines des pratiques traditionnelles dans le domaine des soins de maternité.

**Méthodes :** Nous avons mené des entrevues qualitatives semi-structurées en anglais et en Oji-Cree auprès de 12 sages qui disposaient de connaissances et d'une expérience quant aux pratiques d'accouchement historiques au sein de leurs communautés respectives. Parmi les membres de l'équipe de recherche, on trouvait du personnel infirmier et médical, ainsi que des membres de la Première Nation Anishinabe. Les entrevues ont été analysées et des thèmes ont été développés et vérifiés par contrôle et triangulation auprès des membres.

**Résultats :** La formation pratique d'une sage-femme issue de la communauté commençait souvent à l'adolescence par l'observation des pratiques d'accouchement. Ces pratiques étaient transmises par tradition orale et comptaient des prescriptions pour ce qui est de l'adoption d'un régime alimentaire sain et de la pratique d'exercices modérés pendant la grossesse; des soins intrapartum (préparation de linges propres, de mousse et de ciseaux); de la participation de certains membres de la famille et de la communauté à titre de soutiens; de l'attention rigoureuse devant être portée à la manipulation sacrée du placenta et du cordon ombilical; et de l'utilisation de fourrures pour envelopper le nouveau-né. Parmi les complications, parfois mortelles, on trouvait la rétention du placenta et la mortinaissance.

**Conclusion :** L'offre de soins de maternité modernes aux patientes autochtones devrait comprendre la reconnaissance et le respect des pratiques d'accouchement traditionnelles. Les établissements offrant des soins à ces patientes devraient consulter les communautés autochtones en question afin de comprendre leurs besoins et de mettre en œuvre une programmation appropriée.

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## **INTRODUCTION**

First Nations communities in Northwestern Ontario provided their own intrapartum care until the late 1970s, when medical evacuation from remote communities became commonplace. Little is known of their traditional maternity care. We set out to document available information by interviewing First Nations elders who had been involved in maternity care. We were particularly interested to learn how these practices might inform the development of hospital-based cross-cultural maternity care.

Aboriginal women in Northern and remote areas commonly travel out of their home communities at 36 to 38 weeks' gestation to give birth in larger urban or regional centres.<sup>1-3</sup> There is a lack of capacity for obstetrical care in these women's home communities. Their primary care is provided by nurses at outpost stations with visits by physicians every few weeks. This is viewed by many as a dangerous clinical environment in which to give birth because of the lack of local obstetrical resources.<sup>4,5</sup> Despite their success in reducing morbidity and mortality on an epidemiological level,<sup>6,7</sup> programs for evacuating women for delivery have contributed to negative psychosocial consequences, including loneliness, worry, anxiety, depression, loss of appetite, and increased smoking behaviour.<sup>8</sup> The Society of Obstetricians and Gynaecologists of Canada recently recommended that Aboriginal communities and health institutions should work together to change maternity programs to include culturally appropriate hospital care and to develop care resources closer to home.<sup>9</sup>

The Sioux Lookout Meno Ya Win Health Centre in Northwestern Ontario has a catchment population of 28 000, of which 82% are Anishinabe First Nations.<sup>10</sup> Like many rural maternity centres, this facility attempts to provide care "close to home."<sup>11</sup> A further mandate of the Centre is the development of culturally appropriate care across the complete spectrum of hospital services, including maternal child care.<sup>12</sup> The Centre's obstetrical population is widely distributed geographically and has relatively high-risk pregnancies, with double the provincial rate of gestational diabetes and Ontario's highest rates of adolescent pregnancy and smoking.<sup>11</sup>

## **METHODS**

### **Literature Search**

A search of Medline, HealthSTAR, Embase, SWAB, AMED, PsycINFO, and CINAHL from 1960 to 2009 was undertaken using the MeSH terms "health services," "indigenous," "Indians, North American," "Canada;

pregnancy," "prenatal care," "maternal welfare," "infant, newborn," "maternal health services," "medicine, traditional," "complementary therapies," and "spiritual therapies." Thirty articles were retrieved, and we included 29 relevant to our interest in actual birthing practices and associated beliefs.

### **Interviews**

We conducted interviews in four remote communities in Northwestern Ontario, two of which are accessible only by fixed wing aircraft. The communities have populations of 600 to 1200, and all are over 400 km from a tertiary care centre. Interviews took place in either a nursing station or a community centre. Twelve participants were chosen by key informants and snowballing techniques. All were women aged between 50 and 80 years.

Semi-structured interview questions were developed in consultation with our First Nations advisor. Permission was obtained from each participant as well as the community health directors and First Nations chiefs. The interviews were conducted in English, sometimes through an Oji-Cree interpreter, and were audiotaped and transcribed.

The interviews were analyzed by five investigators, including two First Nations members of the research team, using qualitative techniques of immersion and crystallization. Triangulation of content and theme analysis were achieved through discussions of the findings with key informant First Nations non-participants and clinicians providing obstetrical care in the region and by referring to previous studies in the area. Trustworthiness was ensured by having three investigators perform theme analysis and member checking independently.

Ethics approval for this study was provided by the Meno Ya Win Research Review Committee.

## **RESULTS**

### **Literature Search**

The literature regarding Aboriginal traditions and childbirth often discusses the loss of both the traditional knowledge and the community involvement of traditional local midwives. Some authors advocate the "rebirth of traditional midwifery" across Canada as a potential means to bring birth closer to Northern communities.<sup>9,13-18</sup>

Some remote community-based programs have been successful when the right resources, triaging, and local expertise were available. In Nunavik, the Inuulitsivik midwifery service is a successful midwifery-based model for

returning birth to the remote Hudson coast communities. Assessment and treatment involve physicians, midwives, and community personnel.<sup>13</sup>

An earlier study in our region described Nishnawbe Aski Nation traditional midwifery practices based on interviews with 19 traditional midwives.<sup>14</sup> They described seven roles of the traditional midwife: teacher, healer, caregiver, nurturer, dietician, deliverer, and “do-dis-seem” (the midwife becomes a spiritual partner of the child through a cutting of the umbilical cord).

The term “midwife,” however, is subject to many interpretations that vary across cultures. In the Mohawk community, the term for midwife translates to “she is pulling the baby out of the earth,” among the Nuu-chah-nulth of British Columbia it means “she who can do everything,” among the Ojibwe it translates to “the one who cuts the cord,” and in Cree communities midwives are “the ones who deliver.”<sup>16,19</sup>

Informants from a 1995 study with Cree, Sauteaux, and Ojibwe First Nations peoples expressed feelings consistent with the historical practice of having older, experienced women as attendants during birth, although physicians could appropriately be involved for management of medical complications.<sup>20</sup>

Pregnancy among indigenous communities of North America is largely governed by a varying set of practices that women have historically followed; some of these practices may be helpful and some may be harmful. Beneficial practices, as normally outlined by community elders, more generally relate to remaining active, eating naturally, and maintaining a positive emotional demeanour.<sup>7,13,14,20,21</sup>

The process of childbirth itself is also shaped by a number of practices and taboos that vary across North American indigenous cultures. Common to many populations, including the Mi'kmaq of Nova Scotia, Inuit populations, and other Canadian Northern Aboriginal communities, is the belief that a mother should make very little noise during labour because her noise may discourage the baby from coming out or indicate a lack of courage or concentration.<sup>7,21–26</sup> Knots were not allowed during pregnancy in some Native American and Inuit populations, especially during childbirth, when all knots including hair ties and shoe laces were to be untied to decrease the possibility of nuchal cords at delivery.<sup>13,21,24</sup>

Breastfeeding was viewed as the normal practice for many North American indigenous populations and lasted for at least two years.<sup>21,27</sup> Besides mother's milk, the first food

given to infants among the Alberta Woodland Cree was a soup or broth made from meat or fish and introduced between two months and one year of age.<sup>28</sup>

The practice of keeping the umbilical cord in a small bag as a sacred object was common in many communities.<sup>23,27</sup> Among the Chippewa, this container would be attached to the cradleboard for the child to play with and was later dropped on a hunting trip to help the child become a good hunter.<sup>27</sup>

The care of a mother after childbirth was seen as important to ensure the wellbeing of the child and the family in general. Care of the mother often took the form of isolation after birth and provision of natural remedies.<sup>24</sup>

## Interviews

Participants described a way of life in which pregnancy care was an integrated part of community life. Women delivered wherever they were when they went into labour, usually in a teepee or cabin. Community members with experience in delivery, most often women, were called upon to act as midwives.

Typically, midwives in a remote First Nations community were taught by older women. They learned by watching and helping, beginning in their teenage years. The gathering for a birth began by the midwife calling elders and some of the younger female community members to accompany her to the labour. Midwifery experience was passed from generation to generation through younger women watching and learning from their elders. The community-based midwife needed to have a calm character and was expected to come to a woman in labour with the necessary supplies: scissors, clean cloths, soap, moss, and thread for tying off the cord. She would be “prepared, willing and courageous.”

Midwives were often involved in prenatal care. They would see the pregnant woman every month for the first five months of pregnancy and subsequently every two weeks. Once the midwife determined that the fetal head felt engaged, it was assumed that the delivery was 7 to 10 days away. Pregnant women were encouraged to eat and sleep well and to get regular exercise but to refrain from overly strenuous work. An active lifestyle was believed to help with delivery and maternal and neonatal health. The recommended diet limited fatty foods to prevent too much weight gain.

Traditionally a midwife and one or two helpers attended a labouring woman and prepared a bed of boughs or moss as a temporary delivery bed. The mother would deliver where she was living: in a bush camp, a teepee, or a house. The midwife

## Three Anishnabe infants in their tikinagans (traditional cradle boards)



Sioux Lookout Meno Ya Win Health Centre. Used with permission.

would have the labouring woman wash herself but continue to wear a dress. Warm water was heated on a stove and everyone involved washed their hands. Moss bundles were arranged on the floor and the scissors were heat sterilized.

Women often delivered quietly and rarely in lithotomy position. Usually she was “sitting on a moss mattress ... or lying sideways.” Having the mother remain modestly covered and quiet was thought to encourage the baby not to be afraid to come out.

At birth, the newborn was dried off, wrapped in rabbit fur, and wiped clean around its mouth. The placenta was often referred to by participants as “sacred.” It was wrapped in birch bark or cloth, carefully handled, and subsequently taken out into the forest and buried or hung in a tree.

Retained placenta was often described as a life-threatening complication that was sometimes beyond the scope of the local attendant. One participant, describing a woman with a retained placenta, said “they couldn’t take it out, she was bleeding too much.” Two women attended by study participants died in

childbirth because of “trouble with the placenta.” Stillbirths were also attended, but participants found these to be very stressful: “I couldn’t deliver a baby after that.”

All participants remarked on the need for saving the umbilical cord stump when it fell off. The cord was considered very important, and when it detached it was placed in a moose hide and often attached to the baby bag so that the baby would not cry for its loss.

Breastfeeding immediately after delivery was the norm both for practical and emotional reasons; one participant noted “that is the only way you can attach to your baby, to really love your baby.” If breastfeeding was not possible, fish broth was fed to the infant from a pouch made from a jackfish stomach.

The use of a traditional cradle board, a “tikinagan” (Figure) was standard both for safety reasons and because it was thought to strengthen infant legs. Moss was used during delivery as a disposable material, but also inside the tikinagan as a natural diaper. A certain type of soft moss was picked during the summer and kept for winter use.

When asked about hospital-based care, the elders regretted the loss of traditional teaching and practices. Some felt a return to community-based deliveries was desirable, while others acknowledged the safety net that standard medical care provides for complicated pregnancies or large babies. They also felt that there were roles for the involvement of elders in hospital-based maternity care: to attend deliveries, to encourage breastfeeding and a healthy lifestyle, and to speak of the traditional teachings.

## **DISCUSSION**

The participants in this study described maternal–child care that was community-based and informed by a set of beliefs and practices. Knowledge of these practices was handed down by oral tradition and trans-generational apprenticeships.

The general beliefs in health, active lifestyle, and diet echoed other published studies.<sup>13,14,20,21</sup> Breastfeeding was identified as vital, and in the region of the study it was supplemented with fish broth when needed. Quiet demeanour during labour was also valued in other First Nations, as both a sign of stoicism and a strategy to “not scare the baby.” A theme common to our study and others was the importance of saving and honouring the umbilical cord remnant and keeping it close to the child as it grew up.<sup>23,28</sup> Unique to our study was the emphasis on the sacred treatment of the placenta.

Interestingly, the use of the tikinagan (cradle board) for infant safety was often mentioned as promoting leg development, despite its association in medical circles with a predisposition to hip dysplasia.<sup>29</sup>

Participants regretted trends away from traditional teachings and practices, as well as negative changes in health status and self-care. When asked about the role of hospital care, there were suggestions for the institutional incorporation of some of the traditional influences.

The research questions elicited rich descriptions and consistency between participants. Reliability of the findings was achieved with triangulation and member checking, but transferability of the findings may be limited due to the sampling methods used. Our findings may also be limited by the variation in terms used by different interpreters.

Returning childbirth to all small, remote communities without in-community midwives or physicians may never be feasible. Efforts to bridge the gap created by hospital care might require a concerted effort to integrate elders’ teachings, First Nations community members, and doulas

into current hospital-based maternity care. Suggestions for change included involving elders and community members more actively in maternity care and teaching in order to support women away from their home communities. The ability to support simple traditions such as keeping the placenta and umbilical stump may require a change in practices for hospital caregivers.

The Sioux Lookout Meno Ya Win Health Centre has established and instituted a cultural orientation program for all hospital personnel. It has a robust Oji-Cree interpreter service and a developing traditional foods and medicine program.

## **CONCLUSION**

Traditional indigenous birthing practices were once robust and highly integrated into community life. Some knowledge of traditional practices has already been lost as maternity care has become distanced from the community. We are aware of the need to learn from and honour the past while providing modern obstetrical care to our First Nations patients. This will require tertiary care and regional hospitals currently providing obstetrical care to First Nations women to consult with these communities to understand their needs and initiate appropriate programming.

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