SEVENTEEN

Heeding Warnings from the Canary, the Whale, and the Inuit

*A Framework for Analyzing Competing Types of Knowledge about Childbirth*

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Some of the elders leaned closer to the microphones at their table, as if the move might enable them to hear better. One stopped sewing her kamik (boot) and looked up. This was going to require more attention than they thought. It was true, then, what I was telling them, that a contingent of white apprentice-trained midwives was “taking birth back home” in the southern Canadian communities and that these midwives were about to become legally accepted. Such news, to this gathering of Inuit elders and young women from regions across the Northwest Territories back in 1985, was revolution. It was as if the Renaissance of Reason had occurred. But there was a silence in the room, as if one still had to be cautious about this sort of news. I wasn’t surprised by their skepticism. Just the day before, one of the elders had told me that it may be because of our simple naiveté that television’s trick photography has duped us into believing that a man has actually been sent to the moon.

In the years following that 1985 Igloolik meeting, I did whatever I could to spend time with Inuit elders and younger women who were trying to figure out what had happened to birth in their culture. Even before the miles of ethnographic videotape that I took, it had become obvious to me that a kind of culture shock in birth is upon the Inuit. A similar shock is felt by many of us who have discovered birth in the so-called developing world and then returned to North America. When the elders asked me why doctors think that they own birth, I tried to explain to them that some physicians believe, as preposterous as it may seem, that birth is a medical act. The elders regard it as a community, social, and spiritual act. The individual young Inuk woman thinks of it as her own personal act. Many southern Canadian midwives have come to regard birth as the supreme political act. The statistician sees each birth as one act of many. Everyone’s focus reflects his or her particular vested interest.
In searching for clues about what is considered to be authoritative knowledge in northern Canada, I have concluded, from the ethnographic literature and my own experience, that the Inuit treat the white people, or Qallunaaq, like children who need to be allowed to have their own way in order for them to learn their lesson and see their folly. The unfortunate problem is that white men, even more than children, usually get their way, the deed done, the lesson not always learned. My perception is that the Inuit see the Qallunaaq (pronounced “ha-loo-nuk”) as a people with a lot of attitude, needing to impose it on others; the Qallunaaq see the lack of combative spirit among the Inuit as a sign that they have accepted Qallunaaq authority. It was with apparent passivity that the Inuit stood back in the 1960s to allow white federal medical services to start the evacuation of all pregnant women away from their settlements, separated from their husbands, families, friends, and midwives for the “privilege” of a southern hospital birth under the control of white physicians. But over the ensuing thirty years the almost entire obliteration of their childbirth traditions became for the Inuit a focus of political, community, and personal outrage (O’Neil and Kaufert 1990).

Southern Canadian history tells us that miners used to take a canary with them into the mine shaft as a security measure because the weaker metabolism of the little bird would act as a sign that the buildup of gases was nearing incompatibility with life. The northern symbol of environmental danger is provided by the beluga whales that wash up on shore with highly toxic chemical residues in their systems. It is the purpose of this chapter to demonstrate that just as the canary can serve as a barometer of air quality and the whale of the integrity of the sea, the ability of a community to retain control over its birth culture is a good indicator of the life-force of that community. The vulnerability of indigenous childbirth systems everywhere is a warning sign that not only birth but also community life itself are at risk in this overly technologized time. The story of how one Inuit community in northern Québec is reclaiming both birth and community is a strong story of hope for us all.

ARRIVING AT THE ANALYTICAL FRAMEWORK

In 1975 and 1976, while Brigitte Jordan was studying birth in the Yucatan, Sweden, and Holland, I was becoming a midwife with the traditional midwives in Guatemala. Subsequently I worked in rural Alabama among black midwives; with traditional midwives and an obstetric team in Afghan refugee camps in Pakistan; and, like Jordan, with Dutch midwives in Holland. A practicing midwife for twenty years (I have served as primary attendant at over a thousand births and have participated in many more), I have
continually experienced firsthand the contradictions and tensions between traditional and medical definitions of reproductive risk and normalcy. So that I could deal with the constraints these tensions placed on being a midwife in various parts of the world, I began to develop, as a "mental survival" strategy, a vocabulary for analyzing what motivated people to manage birth so differently, and why attitudes toward childbirth were so polarized everywhere I went. I came to see that each player in the health care system, from the caregiver to the administrator to the recipient of care, creates and articulates his or her own system of logic and assumes that it is logical. These assumptions affect the individual's perception of what constitutes risk and what constitutes normalcy. Therefore, different types of people using different systems of logic will arrive at differing perceptions of how to manage birth. I came to see regularities in these competing rationales, and to classify them in terms of the types of logic being used. I have found that this system of classification constitutes a useful framework through which one can analyze the dynamics of these systems of logic interacting with each other in each act of birth. The types of logic I have thus far identified are as follows:

1. Scientific logic is based on evidence, not only from biology and physics, but from available epidemiologic knowledge—that is, from statistical analysis of health and disease or normalcy and risk patterns in birth.

2. Clinical logic is used by health care practitioners to assess the health and determine the treatment of the mother and baby at the office, home, or hospital visit. It varies according to the training, experience, knowledge, philosophy, and peer pressure of the practitioner dealing with the case. Unfortunately, it is sometimes presented by practitioners as, or assumed by their patients to be, scientific logic, even when there are no statistics or trials to back it up.

3. Personal logic is used when individuals and families make decisions about what they stand to lose or gain on a personal level from their birth plans and compromises. This also includes the personal logic of practitioners, whose careers may be positively or negatively affected by particular health care decisions.

4. Cultural logic is concerned with the development or demise of fundamental beliefs about how a given society should manage birth. This category can include traditional community logic and spiritual logic.

5. Intuitive logic is based on information directly apprehended by a person who has the ability to become familiar with and make decisions about a situation without necessarily depending on the other forms of logic. Some people have more of this intuitive ability than others.
I consider cultural logic to be a kind of common sense, and intuition to be a kind of uncommon sense. (See also Davis-Floyd and Davis, this volume.)

6. Political logic assesses the projected consequences of what will be said and done about birth plans and birth outcome by family, community, "public opinion," peers, other practitioners, and government policy makers. It is concerned with issues of who has the power to control childbirth and of what cultural institutions and values will be reinforced and perpetuated through that control.

7. Legal logic is based on concerns about liability should anything go wrong during the pregnancy or birth. Even though the notion of "informed consent" grew out of legal logic, it tends to undervalue "informed choice," as court battles are usually conducted by legal and professional experts, and lay opinion does not carry much weight. Legal logic—read "fear of liability"—is often the deep underlying basis for decisions made by birth practitioners.

8. Economic logic has to do with assessing cost benefits and risks. It is applied differentially, depending on whether one’s goal is to save or to make money from a given birth.

While I classify as types of logic the rationales people use to decide what actions to take and to justify those decisions, Jordan uses the term "authoritative knowledge." It is my perception that in our different disciplines, but traveling through similar geography, Jordan and I have developed the two terms "logic" and "authoritative knowledge" to label much the same thing. When I combine our perspectives, I can see that what kind of logic is considered to be authoritative in a given birth situation will depend on many factors. The story of how the Inuit in one village are reclaiming birth is the story of profound shifts in what kinds of logic, what systems of knowledge, they accept as authoritative.

The health care system in North America rarely has the time or desire to consider the implications of either of these terms, let alone to try to balance the eight types of logic described above. Technomedicine tends to look at decisions about birth in terms of levels of risk, rather than as decisions about choice of logic or about the conflicting claims to authority of different knowledge systems. Even when the medical system does acknowledge the existence of some of these categories, they are perceived as categories of risk—"the clinical risk," "the legal risk." These are the authoritative categories in technomedicine, whereas cultural and personal factors are rarely acknowledged as being at risk. For example, to send a mother by plane from the Northwest Territories to Montreal is seen as a triumph of decision making based on clinical risk—"the important thing is that the mother and baby are well." What this means is that they both physically
made it through the birth. If the mother is emotionally traumatized by the experience, if one of her children was sexually abused by a neighbor while she was away, if the fabric of community life was disrupted by her absence, these are simply less important than the all-important clinical rationale. It was to avoid all the biases of the term “risk” that I came to prefer the term “logic” as an umbrella for our understanding of risk, benefit, and normalcy. To call these various priorities “types of logic” frames them in a nonthreatening way and clarifies the need to recognize their competing claims to validity.

By the time I reached northern Canada in 1985, I had already identified most of the components of this framework. It became useful for helping the elders sort out the various reactions to evacuation without invalidating anyone’s perspective, because it allowed those whose logic was being undermined to more clearly state their case. In northern Canada, the decisions about evacuation for birth are made in a highly political milieu; they play their part in an ongoing battle, subtle and overt, over which kind of logic will be authoritative and therefore which parties will control birth. The proponents of keeping birth in the settlements accuse those who advocate evacuation of using clinical reasoning at the expense of personal, cultural, spiritual, and economic logic. Evacuation proponents accuse those who want to stay in the settlements of not being aware of the clinical risks. Ironically, both sides accuse each other of not using scientific logic, as who decides what constitutes “good science” often depends on who has the most political power.

When using this framework, it is important not to operate out of preconceived or stereotypical notions about who will use what kind of logic. A physician rarely uses only clinical logic, or an Inuit elder only cultural logic. Many physicians attracted to the North have more hope and faith in restoring Inuit traditions than the Inuit themselves, and some Inuit leaders have more respect for the medical model than physicians. Such apparent incongruities remind us of the ability of all participants to adjust and change.

THE PRESENT SITUATION: A CASE STUDY OF ONE EVACUEE

In an earlier work (Davis-Put 1990:91–114), I described how evacuation was introduced and the social upheaval that it has caused in the Northwest Territories—the breakup of families, the loss of community knowledge about birth, and the health problems of women who must sit for weeks in southern cities waiting to go into labor, with strange food, little exercise, and no family support. The Northern Health Research Unit at the University of Manitoba has been diligent in providing intimate and honest reporting on the problem in Keewatin (Kaufert et al. 1988). In brief,
evacuation was implemented in the 1970s with the explanation that it would reduce risks, but without conclusive epidemiological research to back up that assertion. Although evacuation may have benefited high-risk mothers, it has created more problems than it has solved.

Consider the following typical situation. At age seventeen, Elisapee (a pseudonym) is pregnant with her second baby. The only time that she has been out of the settlement was when she was twelve—due to language communication difficulties, she was mistakenly sent out instead of her brother, who needed his tonsils out. She has been told that she has to fly to a southern Canadian city, a five-hour plane trip away, more than a month before her due date because her last pregnancy terminated at thirty-six weeks (clinical logic). She knows that she will be billeted by a white family whom she does not know, or stay in a transient center by herself for this period. With the encouragement of her mother, she had hidden her first pregnancy from the primary health care practitioner in the settlement, the Qallunaq nurse, because she was afraid to go and because her mother had told her that you couldn't get Arctic char, seal, or caribou to eat while down south, or go fishing (personal logic). Another woman in the settlement had also hidden her pregnancy, and the nurse had attended her birth, so Elisapee knew that the nurse could handle a delivery (clinical logic on Elisapee's part). The nurse, who is sympathetic to the plight of Inuit pregnant women, had obliged with Elisapee's first baby when they couldn't get a plane out on time, and "fortunately, everything went all right." This first baby, who has just begun to walk, is still nursing, and Elisapee's brother, who is three, is living with her because her mother has a heart condition. Elisapee doesn't want to leave the children at home, but neither does she want to take them down South where she will have to care for them in unfamiliar surroundings. When Elisapee's boyfriend is under stress, even though theirs is a dry community, he manages to get alcohol and becomes irresponsible and aggressive, and she worries about leaving the children in his care. This time she is unable to hide the pregnancy from the nurse and is flown out.

Five days after she arrives in the city, Elisapee, who is living in the transient center and feeling very lonely, finds out that her baby daughter back in the settlement has been in a skidoo accident. Shortly afterward, she gets a call from the nurse at the doctor's office in the city, who tells her that her hemoglobin is low (110 mg/dL) and that she should be taking iron (incomplete clinical logic; iron causes constipation and may actually be unnecessary, as a lowered hemoglobin may simply represent hemodilution,4 a normal condition of pregnancy). Elisapee, apart from feeling depressed, shows no symptoms that would indicate a need for iron: she is not lethargic, pale, or feeling tired. She tells the nurse that she is going home where she will get a better diet (community logic, which in this case is
supported by scientific logic). The nurse tells the doctor, who instructs the nurse (political logic—he thinks the nurse will be more persuasive) to tell Elisapee that if she goes home she could be risking her life, because she might have a postpartum hemorrhage (political logic to convince her to stay; medical clinical logic that is scientifically questionable). 6

Elisapee ignores the clinical and political logic of the physician and the nurse and takes the next plane home (intuitive logic). The nurse back home is very understanding but also quite nervous because she is worried about being faced with another premature baby (clinical logic, but the baby at this point will only be a week or so premature—scientifically, not much risk). Elisapee does indeed go into labor two days after arriving home, has the baby with the nurse, does hemorrhage, but feels fine. The nurse sets up an intravenous line and transports Elisapee by air back to the city (clinical, political, and legal logic). Ready to go home the next day, she cannot find a return flight and is forced to stay a week waiting for a plane.

None of this is based on economic logic. And through the entire process, the mother, according to her own report, has felt like a cross between a beached whale and a canary flying to and fro to save herself.

**AUTHORITY FIGURES: ANY LOGIC HERE?**

**Historical Authorities**

According to the literature of the explorers, historians, and ethnographers, traditional Inuit society had no formal authority. The elders explain that every person is an individual, and no one should speak for another person or carry great authority over another—an egalitarianism that is characteristic of many hunter-gatherer groups. The Inuit think that everyone’s needs should be respected, and I find that the elders see the white need for hierarchical power structures as immature. Historically, it appears that the Inuit did grant authority to entities that were feared, such as shamans. The shaman was the vessel through which one could know what the spirits were thinking and make the right choice to appease them. In fact, a good deal of time was spent appeasing the shamans (Graeburn 1972:355).

With the arrival of the white man, white men of power were incorporated into the same belief system. It is little wonder that the Inuit were reported to have disliked the explorer William Perry and at the same time almost worshiped him. This history helps us to understand why physicians and priests who were overbearing, threatening, or otherwise powerful were treated with respect and obeyed.

In the traditional childbirth of the nomadic hunter-gatherer days, power apparently inhered in the grandmothers and mothers, whose duty it was to remind the pregnant woman about the necessity of following
traditional taboos and rituals (Daviss-Putt 1990:92–95). In some areas, when the time came for birth, the laboring woman was taken to an isolation hut made of snow or skins where she gave birth alone, a practice that began to decline in the twentieth century. In Spence Bay, one of the oldest elders told us that in the old days the shaman used to wait near the isolation hut, chanting, while the woman was inside laboring. As Inuit nomadism gave way to larger groups of people clustering at given sites, the community began to share a more developed birth culture. In the 1950s, the government of Canada relocated many such clustering groups into permanent settlements. Traders, missionaries, nurses, and the Royal Canadian Mounted Police at various times influenced childbirth among the Inuit, serving as sources of information and sometimes dictating what choices would be available. The Qallunaat brought with them their own perceptions of what constituted risk and normalcy, and began to take over decision making in childbirth affairs with little resistance from the Inuit. The colonial attitude of political and religious superiority and authority extended even to birth.

I have . . . conducted an obstetrical clinic for the benefit of the old women in whose hands all obstetric authority lies. Little impression was made, but the important fact is that some impression, no matter how superficial, was made. Like religion it is true, they will shortly adopt the obedient attitude. (Bildfell 1934:5)

When such authority figures took over decision making in birth, they were not necessarily considered “wise,” but it was clear that they had to be appeased. In an interview with another elder in Spence Bay who had given birth during the 1960s, I found an exchange of the shaman of the old days for a new version of power: she had invited the manager from the Bay (the general store) to her birth! As is hinted in the following historical text, it is possible that the impending intrusion of such an authority figure was enough to cause the baby to come: “Two married women attended her but her delivery was long and painful. Her husband was hurriedly sent out to invoke our assistance, but the child was delivered almost as soon as he left the hut” (Jenness 1922:164).

Nurses and Midwives as Authority Figures

When I first arrived up North, I could not understand how a nurse who had worked for years with the Inuit could tolerate women being forced from their homes to give birth. But then I witnessed the stress of isolation and the overwhelming workload borne by the nurses and nurse-midwives who serve as the primary health care practitioners in Inuit settlements. Their specific responsibilities vis-à-vis pregnancy and birth are to do with pre- and postnatal care. It became clear that although the nurses then
selves would like to be responsive to what the Inuit desire, they receive no support from the government bureaucracy to do so; in fact, they are under extreme pressure to evacuate women for birth, because of the government's—and their own—fear of lawsuit should something go wrong in the settlement.

At that first Northern meeting I attended, I was introduced to a nurse-midwife who had worked for almost two decades among the Inuit. I asked her to point out to me the elders who were midwives. She said in a definitive way, "There are none." I realized that this ultimatum was for my immediate education. Regardless of the fact that the express intent of the Inuit Women's Association was to introduce me at this meeting to the elders who were midwives, I would have to recognize her authority: by Qallunaaq government standards, the elders who had done births were not really midwives. They were not medically trained, as this nurse-midwife had been in Britain, nor did they fit the international definition of a midwife, which says that you have to be recognized by your government. (The government of Canada did not recognize midwifery at that time, except for the nurse-midwives in the North.) What I refrained from telling her was that I had already worked as a midwife for a decade without formal recognition from a government, and that it was specifically because I had originally been trained by indigenous elders in Central America that I was trusted by the elders and invited to come.

Annie Okalik, one of the elders from Pangnirtung, laughed at me when I told her that I only had two children—to think that I could be any kind of midwife, when I had had so few! When the young, single nurse-midwives first arrived in the settlements, what authority could they have had? My impression is that they must have been accepted as authority figures who fit into the same historical script as the shamans and the white men of power. I doubt that the elders ever relinquished in their hearts their place at the side of the birthing woman, because they tell me that they are still willing to assist women during birth. But their credibility is being eroded by the bedazzlement of fancy technology. They are not sanctioned by the government to attend births anywhere in the North. They take the responsibility only if they are asked by the woman to attend her. None of the elders I have interviewed has any qualms about doing that; they tell me that if it is the woman's choice, they will do it. I view this willingness to take over where they left off as an indication that they have not been convinced, in the last forty years, of the superiority of medical, clinical logic.

The younger women often possess the same inner defiance that the elders express, but they have no experience of what birth used to be like in Inuit culture—only the impression they get from the elders that it was simpler, with less interference. These young women are products of this era, in which rumor holds that one can be put in jail if one refuses to be
evacuated to the South. Such fear augments the split reaction that, I have observed, is common to pregnant women in all countries when faced with the possibility of intervention that they do not want but are afraid that they need. To give an example, one day when I was visiting a woman—I'll call her Nina—in an Inuit settlement, we received news that her sister was going into labor, and Nina asked me to see her sister, even though she was headed to the nursing station. Nina wanted me to take over and do the birth, to save her sister a transport to a hospital, and to stand up for her right to give birth in the settlement. I found out when I got to the nursing station that this was a clear case of prematurity. The woman was only thirty-one weeks into her pregnancy, and I knew that if I were in charge I would set up an intravenous line and transport her to a hospital—the same treatment chosen by the doctor who happened to be in the settlement. Nina was still pressuring me to take over, but before I had time to explain that in this case it would not be good judgment for me to interfere (clinical logic), the doctor entered the room. Nina’s personality change was immediate and dramatic. She mentioned nothing more about staying in the settlement, but spoke with the physician in a friendly manner, relinquishing all authority to him and asking few questions about his care. I watched this woman turn from radical to submissive within a few minutes. This phenomenon is not uncommon when I transport white women in the South. Medical authority is a power that paralyzes women, compromising their ability to sort out their own logic.

POVUNGNITUQ: REVIVING THE BELUGA

In 1985 when I first started seeing scenarios like Elisapee’s, I could not fathom how the Northern communities could remain incapable of rejecting evacuation, nor could I see how the government could overlook a basic requirement of a vital community life: community ownership of birth. Anywhere else in the world that I had been, from Afghan refugee camps in Pakistan to the rural areas of South America and Thailand, at least a token effort is made to utilize and even upgrade the skills of traditional midwives. From speaking with Inuit women, I had learned that many still wanted to give birth at home or at least in their settlements. But after three decades of dependency on the nurse in the nursing station for all aspects of health care, most of the young women had become fearful about leaving the health professionals entirely out of the picture. These young Inuit women feel overwhelmed at the thought of tackling the federal bureaucracy and the mystique of the medical profession. However, unlike the beluga whales who are helpless to clean up the pollution, they are starting to hear that there are solutions.

An Inuit settlement in northern Québec, Povungnituk (glossed by the
was the only community with representatives at that 1985 Igloolik meeting who returned home and implemented a concrete plan to bring birth back to their homeland. In 1997, POV is still the only settlement that has been able to generate a viable answer to the loss of Inuit control over birth (see also O'Neil and Kaufert 1995). The rest of this chapter will be devoted to an explanation of the way in which the women of POV have detoxified their beached beluga—in this case, an apt metaphor for their dying traditional childbirth system—by demanding a better balance of the types of logic in our eight-category framework.

Much of the information in the following pages was consolidated during my last two-month visit to POV in February and March of 1994. An earlier visit to POV had been primarily concerned with research and video production; now I was sent on a return visit by the government of Ontario to be trained under new legislation that requires all midwives to be officially trained and certified. The irony was becoming customary to me: I had been “trained” by traditional midwives in Guatemala; later I was sent to Nicaragua to “train” traditional midwives who had forty years more experience than I; and now I was being sent for “training” to a program I had helped to initiate. My role during this training process was primarily that of an observer at prenatal and postpartum exams and during labor and delivery. As it turned out, I also served as a consultant, helping the POV midwives with the adaptation of a data form for clinical statistics.

As in the rest of the North, the pressures in POV to bend toward the Qallunaaq way are steady. The continued viability of the POV Maternity requires constant vigilance on the part of the Inuit midwives, as well as the awareness that the steps their community has taken are part of an important political process of reclaiming both birth and a sense of continuity and identity. It seems likely that the POV midwives will be well equipped to contend with possible future encroachments into birth in the settlements by white administrators. They are trained through an effective combination of apprenticeship and formal classroom teaching, and they are developing systematic knowledge about all the types of logic in our analytical framework and strong convictions about the need for an appropriate balance among them. The discussion below reveals the particular pressures brought to bear on the POV midwives by examining each type of logic in turn.

Political Logic: Taking Back the Power

In 1993 I wrote a paper entitled “Informed Choice in Childbirth: Is It Possible in the North?” with the help and advice of a woman in Cape Dorset, Akalayok Qavavao. Akalayok had been the deputy mayor of her settlement and one of the few women who had the strength to say no to the
health care system's plan for her evacuation: she handpicked some elders
who assisted her in a traditional birth at home. In the paper we raised
the question, "Does introducing the concept of informed choice impose
another white construct on an already colonized Inuit populace?" From
our review of the history of the Inuit relationship to authority figures, the
isolation huts, and the Inuit insistence on strict obedience to taboos, it was
not clear to us that such a plan would work in a traditional society in which
choice has never been part of the equation. The difficulty in demanding
choice, for a people who never knew that they were allowed to have it,
cannot be overestimated. You have to learn decision making and, even
more basic, realize that it is your prerogative to make decisions. To defend
your principles, you must be willing to speak out, to debate, often in a
language not your own, often in the face of political uncertainty and the
threat that what you say may later be used against you, or that your priori-
ties will be minimized once more.

When I was in POV in 1989 working on the research for a video about
the evacuation crisis, I searched for a reason why POV was able to over-
come the obstacles that have paralyzed other Inuit communities, rendering
them incapable of bringing birth back to Nunavik ("our homeland"). Mina
and Harry Tulugak, young leaders in the community, told me at the time
that POV has a reputation for not always saying yes to the white man. Harry
said that the people of POV do not allow things to get past them: "We ask
questions." It was in Povungnituk that one of the first cooperatives was
established, a store run by Inuit, bravely tackling the formidable competi-
tion of the Hudson's Bay Company monopoly. POV was also one of the
three communities that would not sign the James Bay and Northern Qué-
bec Agreement, refusing, as Harry Tulugak put it, to "sell for beads the
heritage that is rightly ours" (see also O'Neil and Kaufert 1995). 7

When the women of POV asked to have a maternity unit, which they
decided to call "The Maternity," I doubt that the world understood what a
marked revolution that represented. Here was a community, eight hours
by small plane from any hospital large enough to have cesarean section
facilities or a neonatal intensive care unit, making a political decision to
reject clinical logic to save the integrity of their cultural, personal, and
intuitive logic. In clear words and actions POV was willing to state that the
clinical risk of losing a baby was worth the benefit of returning birth to the
Inuit community.

POV went even farther than establishing a facility where women could
have babies close to home. A decision was made not to duplicate the prob-
lem of the past by hiring only white midwives to take care of the births,
thereby perpetuating the dependency on the South. (When such prac-
titioners head south and there is no replacement for them, the births fol-
low them south again.) Instead, the people of POV had the foresight and
enthusiasm to immediately begin to train community-chosen Inuit women to be more than just aides, to be primary caregivers who would be entirely responsible for a woman's care, consulting with medical practitioners only when necessary. At present there are two to three white midwives (one of whom acts as coordinator) working on the training of the Inuit midwives. There are two fully trained Inuit midwives, two more about to be given that status, and two more about to start training. They are assisted by a dozen part-time "maternity workers," whose job is to stay with the woman postpartum, taking vital signs and informing the midwives of any abnormalities. The POV Maternity is a small wing of a small primary-level hospital, which has a basic laboratory and a staff that includes nurses and three to four general practitioners.

Thirty years before, without any overt policy statement, the Canadian health care system had eliminated Inuit ownership of birth simply by rewarding the nurses for evacuating and criticizing them if they did not, and by the default system of not maintaining nurse-midwives in the settlements. Now POV used similar strategies to bring birth back to the community, step-by-step. Although POV did not hide its undertakings, it also did not broadcast its new policies loudly in circles that might try to stop the repatriation. The Maternity was established after a survey was taken up and down the coast asking women what birth choices they considered ideal. It was decided from the start that the Maternity would operate under a midwifery model—a paradigm of childbirth that values the integrity of the natural process of birth, nurturant emotional and physical support of the laboring woman, mutual connection and respect between patient and practitioner, and non-hierarchical relationships among the practitioners themselves (see Davis-Floyd 1992; Rothman 1982). At the very beginning, the first director general of the Maternity, a white administrator, was replaced by an Inuk woman because of his lack of support for a midwifery model. Since then there have been consistent attempts to ensure that it remains an Inuk-held position, and commitment to the midwifery model has remained strong.

Peer review is done with a "perinatal committee" that reviews all decisions of potential concern, with input from community midwives as well as the nurses and physicians. For example, the last time I was there, a case was called up at the perinatal committee involving a physician attending a woman in a settlement a couple of hours away from POV who had made decisions and performed interventions prior to transporting the woman to the POV Maternity, without consulting the midwives. It became clear at the committee meeting that in the future it would be in the best interests of all involved for consultation to be carried out in advance with the midwives who would be receiving the mother. Povungnituk is one of the few places in the world where physicians have to consult with midwives before imposing an intervention.
It is still sometimes difficult for Inuit midwives to say what they really think during perinatal committee meetings. These meetings have full agendas, move along rapidly in English, and require facing intimidating personalities. By and large, however, the Inuit midwives and student midwives excel in presenting their own cases and making critical suggestions about the cases of others. They have a special role on this committee because they are often the ones who really know what is going on behind the scenes. It is they, for instance, who keep an eye on the exposure of intimate details of a woman’s private life in this small community while still providing enough information not to compromise her care. White practitioners, who may not be aware of the intricacies of community life, do not always share the same sensitivity to issues of confidentiality.

Scientific Logic

The POV Maternity is making contributions to the study of some diseases and effects of contaminants that are more prevalent up North than in other settings, for example, toxoplasmosis and PCBs. The present coordinator of the POV Maternity, Qallunaq midwife Colleen Crosby, would like to do some practical randomized controlled trials; only half in jest, she says, “We need to determine the effect of skidoo rides within a week of delivery on a mother’s perineum.” Although science is taught to the midwives, it would not be true to say that scientific logic is highest on their priority list. When the POV nurses and midwives travel south to give presentations about the Maternity, the white midwives present the graphs and statistics, and the Inuit midwives tell the stories. Their skepticism of scientific logic is understandable; it was claimed to be the rationale for removing birth from the settlements in the first place, since health care officials assumed that statistics on complications and perinatal morbidity and mortality that were too “high” would be corrected by transporting every woman to a hospital. Scientific logic was also invoked to convince people in the early settlement days that raw meat was unhealthy, carried disease, and should always be cooked. Then anemia became a problem, one of the speculations being that the vitamin C in the raw meat was one of the nutrients that not only prevented scurvy but also helped the assimilation of iron. Such history creates warranted misgivings about white man’s science as authoritative knowledge. In POV, some of the women now generalize that good food is “country food”—Inuit food such as seal, caribou, walrus meat, and Arctic char—and categorize white man’s food as junk food. It is eaten, but not considered to be healthy. Unlike other aboriginal populations of Canada, Inuit women were not convinced by medical practitioners to start their babies on supplemental milk. They still believe breast milk is best, a belief that science has ultimately confirmed (although the scare of contain...
inants may alter this somewhat). The fact that the Inuit all along had a "hunch" that avoiding evacuation, Qallunaat food, and neonatal milk supplements would be beneficial suggests why Inuit women feel less need to "prove" things scientifically, and have more affinity for cultural and intuitive logic.

Acquiring accurate perinatal statistics in the North is made difficult by the small numbers of births in each settlement; there can be significant fluctuations in the numbers from year to year and from one settlement to another that make statistical analysis problematic. For example, if a community has two perinatal deaths one year and four the next, it appears that the mortality rate has "doubled"; if no babies die the following year, there appears to have been a dramatic decline when in fact these may be statistically meaningless fluctuations. It took me over a year, involving phone calls to midwives, epidemiologists, statisticians, and various government departments, to finally bring together the closest that we can get to the correct data on perinatal deaths (see tables 17.1, 17.2).

In table 17.1 it appears that the stillborn rate has gone up and the early neonatal death rate has gone down since the Maternity opened, but this may simply be a result of random fluctuation. Also, the information I obtained on deaths for the same years from the Bureau de Statistique du Québec (see table 17.2) shows two fewer early neonatal deaths, for a tally of six rather than eight in the years 1982 to 1986, and one more in the years 1987-1991 (7 deaths rather than the 6 shown above). Also suspect is a stillborn rate of 1.5 per 1,000 for the years 1982-1986 in table 17.1 because it is unusually low compared to other years and to other Northern settlements. Recording systems are far from ideal and highly suspect; should a woman be transported and her baby die, the same number of deaths theoretically should be recorded by the hospital, the settlement from which she comes, and the Bureau de Statistique du Québec, but discrepancies do exist. Thus in table 17.2 note (in round and square brackets) that different agencies report a different number of deaths for the same time period. I had constructed table 17.1 before the information in table 17.2 was put together at my request by Brian Schnarch at the Nunavik Regional Board of Health and Social Services. It compares neonatal death rates in POV and its sister settlement Kuujjuaq, which takes care of women living on the Ungava coast using physicians rather than midwives, but, like POV, without cesarean section facilities or a neonatal intensive care unit. Stillborn rates could not be retrieved for table 17.2.

From the data in tables 17.1 and 17.2, it is not possible to conclude definitively that the perinatal death rate has gone down since the Maternity opened, or that it has gone up significantly when compared to either the pre-Maternity period or to the physician-attended births of Kuujjuaq. I can accurately say that keeping the births in POV results in fewer interventions
(although actual statistics are not yet available, the lack of need to transport everybody already affirms that) and happier mothers, apparently without compromise to overall safety. The fact that accurate statistics are so hard to come by reveals a large hole in the original rationale to evacuate; statistics would have been even harder to come by at the time that the evacuation decisions were being made.

Accurate science sometimes demonstrates that what cultures and women do intuitively is what they need the most; in many cases, cultural and scientific authoritative knowledge are congruent. The entire Inuit population could be scientifically considered high-risk because of their high incidence of postpartum hemorrhage, sexually transmitted diseases, and socioeconomic problems. But the midwives believe that, given these

<table>
<thead>
<tr>
<th>Number of births</th>
<th>656***</th>
<th>682**</th>
</tr>
</thead>
<tbody>
<tr>
<td>Stillborns (defined as a death of a fetus weighing 500 g or more)</td>
<td>1*</td>
<td>5**</td>
</tr>
<tr>
<td>rate per thousand</td>
<td>1.5/1,000</td>
<td>7.3/1,000</td>
</tr>
<tr>
<td>Early neonatal deaths (deaths between birth and the sixth day of life)</td>
<td>8* ( \text{in Table 7.1} )</td>
<td>6** ( \text{in Table 7.2} )</td>
</tr>
<tr>
<td>rate per thousand</td>
<td>12.2/1,000</td>
<td>8.8/1,000</td>
</tr>
</tbody>
</table>


**These figures come from the addition of (a) deaths reported 1989–1991 and published in Susan Chatwood, "Indications for Transfer for Childbirth in Women Served by the Innuit Health Centre" (Master's thesis, Department of Epidemiology Biostatistics, McGill University 1995), and (b) deaths reported 1987–1988 and quoted in Chatwood's thesis, from F. Meyer and D. Belanger, Evaluation of Perinatal Care and Services: Hudson Bay and Ungava Bay, Pregnancies and Births in Two Inuit Populations of Northern Quebec (Department of Community Health, Centre hospitalier de l'Université Laval, April 1991).

***Calculated from the information sent by Proulx on deaths, as it was nowhere to be found in the actual literature.
<table>
<thead>
<tr>
<th>Year</th>
<th>Hudson (&lt;7 days)</th>
<th>Ungava (&lt;7 days)</th>
<th>Hudson (7-28 days)</th>
<th>Ungava (7-28 days)</th>
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<td>1</td>
<td>1</td>
<td>1</td>
</tr>
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<td>1</td>
<td>0</td>
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<tr>
<td>1978</td>
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**Note:** N = Public Health Department, (N) = Ministry of Health and Social Services, or MSSS, [N] = Bureau de la Statistique du Québec, or BSQ.

*Note that there may be missing deaths in any or all years. This is related, in particular, to deaths occurring outside of the region that often do not end up in Northern records.

—Public Health Department data from 1975-1986 were vigorously collected from available sources including the MSSS, nursing stations, the Kuujuak, Moose Factory, and Puvungnituq hospitals and elsewhere. Nonetheless, particularly for Hudson between 1975 and 1978, the completeness of the data is suspect.

—Public Health Department data from 1987 to 1994 were collected from hospital archives on the two coasts and are likely missing several deaths occurring outside of the region. (See next point.)

—Data in round brackets ( ) from 1987 to 1993 are based on MSSS data and include deaths occurring anywhere in the province. Coding is based on mother's residence. As a result, this source is, since 1988, usually more complete than regionally collected data.

—Data indicated in square brackets [ ] were provided by the Bureau de la Statistique du Québec and are based on the same MSSS data as reported in round brackets. Minor discrepancies between MSSS and BSQ data in 1990 and 1992 are explained by the removal of duplicate records from the BSQ data which remain in the MSSS data.

—We recommend that, for virtually all purposes, the higher value from either the BSQ or the Public Health Department records be used as the best estimate. This applies to each cell individually. Do not use multicell totals from just one source. This recommendation is based on the assumption that, in any given year, the BSQ data will include all of the Public Health Department records or vice versa. In other words, for any given year, we assume that there are not records which are exclusive to the Public Health Department and simultaneously records exclusive to the BSQ.

source: Brian Schnarch, Public Health Department, Nunavik RRSSS. Revised May 7, 1996.
risk factors, increased community input on each individual birth works better than blanket evacuation. Colleen Crosbie is attempting to convince the staff to use the Midwives' Alliance of North America (MANA) data form to tally and analyze birth outcomes in a more systematic and detailed way than their statistics are currently collected. (For a detailed explanation of this data form, see Johnson, this volume.) Using the MANA form will enable researchers to compare POV outcomes to those of other provinces and states in North America, including Mexico. We simply modified the form slightly to accommodate such distinctions as a diet that includes walrus flippers and raw caribou.

The POV midwives find it ironic that science, which originally was assumed to provide the logic for evacuation, may turn out instead to show that it is better to avoid evacuation.

**Clinical Logic**

When the city physician told Elisapee that she might lose her baby if she returned home, he was probably operating out of genuine fear based on his prior clinical experience. He would probably not have taken the time to explain to her exactly how statistically significant his fear was, nor would he necessarily have known.

The elders, meanwhile, have their own clinical biases. They say, for instance, that they did not have as many interventions—inductions, episiotomies, transfers—in the old days, and why are they needed now? One of the unfortunate results of near-total evacuation is that the elders have no opportunity to learn who really could benefit from evacuation and who would benefit more from staying home. The result has been that sometimes those who have refused transfer have been the very ones who most needed to go: those with high blood pressure, or diabetes, or a history of stillbirths. The elders can also be as adamant as physicians about the "right" position for birth: in Dorset it is on your knees, supported in the back and on the sides by three people; in Fangnitung it is lying on your side. Clinical logic is influenced by prior experience.

Thus it seems fortunate that both the Inuit and the Qallunaq staff at the Maternity in POV give themselves permission to throw out their former sacred cows of maternity management. For example, it has been scientifically shown that smoking increases the risk of postpartum hemorrhage. In the South, the Qallunaq would most emphatically counsel a pregnant woman to stop smoking. In POV, they proffer that advice, but one of the realities of life is that barely an hour after birth many women are wheeled out to the garage for a smoke. The women consider it to be social therapy, and there is a concern that abrupt nicotine withdrawal in heavy smokers
immediately postpartum would be more harmful than continuing to smoke. Those of us who arrive in POV unaccustomed to giving routine oxytocin injections (to avoid postpartum hemorrhage) to low-risk women are rapidly converted to giving the injection with almost every birth. Meanwhile, Inuit midwives diligently accept modern medical training; they learn to draw blood, read lab results, and do clinical reasoning the Southern, Qallunaalik way.

At the POV Maternity, flexibility seems to be the key to clinical success. Job definitions and organizational structures can change according to need in ways that are not always possible in the established pecking orders that entrench themselves in Southern training and clinical settings. For example, while I was there I served as note-taker during some of the births. The coordinator realized how much better it was to have someone other than the student midwives writing notes during a woman’s labor. She resolved that henceforth the maternity workers would take the notes, so that the student midwives would be free to concentrate on being “with woman” during labor and birth. For another example; the “risk factors” that used to be listed on the front page of the mother’s chart are now called simply “factors,” because the POV Maternity explicitly rejects the medical approach in which every woman is labeled according to her potential risk, with no mention of social factors and special wishes that she may have for her birth.

To date, the Inuit student midwives do not hunger for the theories and details of clinical practice in the same way that the more competitive Southern white midwives do. Inuit midwives do not seek to be “right” about clinical details to prove their expertise, nor do they seek out conferences that focus on such details. (Akinisie Qumaluk says that she prefers gatherings where traditional practices will be discussed.) But in their thoughtful, unpreoccupied way, they are legitimately proud of triumphs demonstrating their clinical skills. Leah Qinajuak discovered a heart murmur that was missed by a physician in Montreal and a first trimester toxoplasmosis conversion on lab results that had been overlooked by the Qallunaalik midwives. I remember a comment made in 1989 by one of the Inuit women in a nearby settlement after Akinisie had made a presentation to them: “I never knew that Inuit could know so much.” This is no longer a “surprise” in the Kativik region of Quebec served by the POV midwives.

Cultural Logic

Historically, the Inuit obeyed the laws of nature and of land, community, family, and tradition. This interwoven knowledge system guided their lives to the extent that health and disease were considered the result of abiding
by or transgressing the social and spiritual order. Since these factors were interdependent, how a woman’s pregnancy and birth transpired would reflect her overall relationship to her cultural and physical environment.

In the 1980s, the obstacles to working with the elders and young women to salvage the former intricate balance and make it congruent with the contemporary Inuit world seemed insurmountable. I also realized that it was going to be difficult to obtain grants to develop programs that would challenge evacuation. In order to get funding, it was politically correct only to collect stories about what birth used to be like, and never hint that we might consider returning birth to the community. We first proposed a study of the history of "traditional midwifery." It became clear that the government was not going to fund something that acknowledged that there had indeed been a functional midwifery system among the Inuit. The letter of response from the federal health minister, Jake Epp, stated, "Birth is safest in the hospital. We cannot fund this project at this time. We wish you every luck in your endeavor." When we used the phrase "traditional childbirth" instead of "traditional midwifery," we got a grant. Even national Inuit organizations find it difficult to receive funding if they threaten the established health administration.

In a similar vein, in the Northwest Territories, where evacuation is still the rule, birth traditions that do not present a threat to the medical system, such as taboos about behavior, eating, and drinking, are not frowned on by health practitioners. In both rural and urban hospitals, even various positions taken in labor and birth can now be negotiable. But the most important cultural factors, such as the Inuit concern about loss of cultural identity from not being born on the land in one’s own territory and their concern that the elders have lost to the Southern doctors the prerogative of being proprietors of the authoritative knowledge about birth in their community—these are the areas that the health care system cannot seem to face and act on.

In contrast, Pungnituk not only has confronted the latter two issues, it has also tackled some that are more subtle—for instance, the differences in Qallunaq and Inuit perceptions of time, the importance of professionalization, and education.

**Time.** In a land of long nights and, as the season changes, long days, the nine-to-five job and taking birth control pills—actions that must be performed on schedule, by the clock—become problematic and require vigorous adjustment on the part of the Inuit to a time frame that is irrelevant to their cultural and geographic reality. One of the legends about the Qallunaq describes them as people who are always in a rush, obsessed, ambitious, boorish, and with an agenda. Such character traits are excused with the explanation that "the boat their mother put them on leaked and
they had to frantically bail it out—that is why they are always in a hurry and have too much to do” (Kurelek 1976:88). To a woman in labor it can seem incongruent to accept the authority of a health care practitioner who is always looking at his or her watch. One elder told me that she thought the actual purpose of such behavior was to slow down her labor, that the doctor’s diagnosis that her labor was too slow was actually a treatment.

For the midwives and maternity workers at the POV Maternity, the constant focus on work hours and time is a strain on families, as it is anywhere in the world. But the midwives at POV are finding ways of accommodating both Western schedules and their own needs for unscheduled time with friends and family. When Mina and Leah suggested that the midwives have one week off a month, it was put up for discussion and agreed on. The Inuit midwives themselves see their responsibility to make sure that the Maternity runs smoothly and is properly staffed, but they find ways to do this while maintaining their traditional priority on family and friends. This is the Inuit Way.

Professionalization. At a time when the need for “professionalism” is the battle cry in southern Canadian midwifery circles, it is of interest to me that it is not a term I have ever heard used among the elders or young Inuit midwives. Between 1992 and 1994, the introduction of legislation in the provinces of Ontario and Québec required that midwives who had been practicing for many years be “professionally” evaluated. Because most of the white midwives who have been employed at the Maternity in POV are either from Ontario or Québec, the Inuit midwives were able to witness firsthand the problems resulting from the new testing and evaluation process, which was designed under a European model of midwifery care that in some important ways was not responsive to the very real ideological and practical differences between European and Canadian midwifery.11 As a result, some of the women whom the Inuit midwives considered to be the best Qallunaq midwives in Québec were found lacking according to the newly introduced criteria.

Additionally, despite the fact that she had been working as a midwife for over five years, Inuit midwife Akinisie’s application for licensure was initially turned down in Québec because she did not have a secondary school education. By the time the government got around to reconsidering Akinisie’s request, the Maternity had already realized that the evaluation process was inappropriate and had withdrawn Akinisie’s application. External validation and the ability to call oneself a licensed professional, so important to the Qallunaq midwives, seemed to the Inuit to translate into license to consider oneself “above” instead of “with” women. Mina’s direct observation of the evaluations was that they rewarded intrusiveness rather than sensitivity to women. As I listened to Akinisie, Mina, and Leah express their
concerns, they began to appear to me like three mother beluga whales, riding the tops of the waves with watchful prudence, aware of the dangers of swimming too close to polluted shores.

Midwifery Training: The Inuit Way. Akinsie says that modeling is the key to training and being a good midwife. This seems to be a part of every aspect of Inuit teaching. Inuit show rather than tell. (I recall watching a team of men who were showing me how to make an igloo in Iqaluit. They went about their work in almost complete silence, stopping once to apologize for the quality of the snow, explaining, "It usually fits together just like Legos," and again to welcome me, once it was done, to the "White House.") The system of midwifery training at the POV Maternity does include class work, but the major method is what Jordan and North American midwives label "apprenticeship" rather than "didactic" learning. It is not apprenticeship as I knew it in Central America—that is, a system by which the apprentice evaluates herself (rather than being tested by the teacher/expert), can see for herself how well she is doing, and takes on new tasks as need and abilities arise. It is not the system of apprenticeship that Jordan describes where "knowledge acquisition occurs, for the most part, without active teacher intervention" (1978:193). Each Inuk student is assigned a Qallunaat midwife teacher, formal classes are given, and written tests are conducted. However, most of the learning is directly acquired through hands-on experience, and the midwives' responsibility to the birthing women and direct sanction or censorship by them is strong. The midwives are embedded in and constantly accountable to their community. For example, Akinsie believes that correct comportment should extend to one's entire life, that midwives have to be models, good mothers, caring, smart. The integrity of the person who is the professional is as important as the instruction they give. Character is the major factor taken into consideration, and the Maternity likes to ask the community: Who do you want as midwives? Who do you consider to have enough integrity to be worthy of the training? Not who had the best marks in high school or who can persuade women to accept interventions. Their apprenticeship takes place not only through their hands-on learning at the Maternity but also in the constant access to the community's broader knowledge base provided by their frequent interactions with the elders and the other women.

Within the Maternity itself, once hired, the talents of each midwife are channeled as they are perceived by the coordinator, the midwife herself, and the other members of the team of midwives. Leah was put in charge of the training and organization of the maternity workers. She is also very capable of standing up to the administrators and physicians; she is being groomed for leadership. Akinsie has a lot of clinical experience and is good at public presentations. Mina is the critic, analyst, and protector of
women's confidentiality. Nellie has become particularly adept at dealing with women who need refuge from potentially dangerous family situations. Of course, all of the midwives do all of these things. It is just that some have focused on certain aspects more than others. Professionalism and appearances are not as important to them as strength of purpose and dedication to women and community-centered birth.

Finding one's niche in the evolving culture of the POV Maternity does not just involve the Inuit. Colleen Crosbie, the coordinator, is one of the rare Qallunaaq who has maintained a special intimate relationship with the women of the Maternity, and has stayed there longer than any other southern midwife. They call her "Mom." At perinatal committee meetings, she is able to say the things that need to be said that other people might not want to say; she is forthright and strong-minded but consistently careful to make sure that the Inuit midwives understand that it is their Maternity and they make the rules. Whoever has to fill her shoes in the future will have a difficult task, but one hopes, should she leave, the Inuit midwives will be ready to take over many of the roles that she has played, because of the care she has taken to hand over authority to them whenever possible.

One of the problems the Maternity midwives encounter when they try to relearn lost birth traditions is that the elders conduct no deliveries at the Maternity. In a culture in which demonstration is the key and it is not considered polite to ask an elder a direct question, their expertise is not easily transferable if one cannot watch them in action. Elders are freely invited to the Maternity to act as support for women in labor, and once in a while an elder will be asked to review the traditions and taboos. It is possible that the real key would be to allow elders to conduct births with one of the Inuit midwives present. Still, the Maternity is inside the hospital, and there the elders seem to feel outside of their domain. The answer may be to invite them to work with a trained Inuit midwife in a home birth situation where they would feel less inhibited to share what they know. Mina says that if she has another baby, she would like to have it at home. Memories and storytelling about preevacuation days might flow more easily in such a context.

One of the experiences that most brought home to me how important cultural traditions are to the women happened one day when Mina was in the midst of charting clinical and social health "factors." A young pregnant Qallunaaq woman walked in for her appointment. Mina dropped what she was doing to enthusiastically demonstrate for this white woman the various Inuit taboos: "You shouldn't be standing in that doorway. And don't tie your kamiks [boots], tuck them in at the back." Far more interesting than charting, it was a chance to offer something that was hers, from the Inuit store of knowledge, to this Qallunaaq woman.
In sum, the midwives of POV have created their own midwifery culture, which is neither entirely Qallunaq nor wholly traditional Inuit, but which serves a vibrant group of parents determined to keep birth in their homeland and to benefit from the most appropriate pregnancy and birth care for their community.

Legal Logic

With the appalling Canadian legacy of Inuit and other native land claim disputes, it should not be surprising that Inuit families fear what being born or not being born on their land means to their rights to own it. There are those who believe that evacuation of pregnant women has been a government plot to take away land claims, and that belief has certainly been one of the factors stimulating the return of birth to the community.

While the Inuit communities understand well the land claims issue, other areas of legal logic are less comprehensible to them. Trying to fathom why a physician or nurse would be concerned that an Inuit woman would sue them if something went wrong with a birth merely demonstrates to the Inuit what a different set of rules they live by. What the Qallunaq fear, as expressed by one administrator at the Northern Obstetric Conference in Churchill in 1988, is that even if the Inuit themselves do not think of it, "some white lawyer" some day is going to convince an Inuk woman to sue a practitioner. Inuit women are always puzzled when I mention this; they tell me that Inuit communities simply do not work that way. Searching for a way to explain to the Qallunaq how Inuit people maintain law and order, the Inuit Women's Association came forth with a publication that identified the closest Inuit parallel to "legal logic." This publication stated that the traditional method of dealing with unacceptable behavior was "by either ignoring the behavior entirely and withdrawing from the situation, or by mocking, shaming, and gossiping about the person who is acting inappropriately" (Bolt 1990:6).

The settlements are so small (800 to 1,000 people) that if a Qallunaq acts inappropriately, everyone knows it, and he or she will ultimately be run out of town. Usually the person leaves voluntarily. One can stay if one has the correct attitude; experience is the only teacher. It rarely occurs to anyone to bring legal action, as social sanctions seem sufficient.

When the Inuit settlements were established in the 1950s and 1960s, the Qallunaq legal system assumed many of the responsibilities of traditional law. Canadian law enforcement agencies like the police and the court system acted as the main mediators in disputes (Bolt 1990:9), and many women came to believe that if they stayed at home or demanded that the nurse do the birth in the nursing station, they might have to face crim-
nal charges. They know better now in POV. Should an attempt ever be made again to remove birth from the community, its people will not be convinced that it is "legal."

Personal Logic
The Inuit midwives, student midwives, and maternity workers hold a special position at the Maternity that is difficult for any Qallunaat to fill. They have grown up in the community and know the fears and frustrations of the women they serve. They have lived through similar experiences. In this small community that has no halfway house to provide a refuge from family violence, the "family" at the Maternity becomes a haven for pregnant women who need special help. The Inuit midwife's role has naturally evolved to include particular responsibilities of safeguarding informed choice and confidentiality. The following case illustrates the difficulties involved when the Inuit midwives try to preserve a delicate balance between personal logic and clinical and scientific logic.

A woman who had come to the POV Maternity from another settlement had changed her plans about breastfeeding; with the encouragement of the Inuit midwives, she had decided to do it. On the ninth day postpartum the baby had still not gained back its birth weight, and the midwives suggested that the mother try waking the baby up every two hours to nurse. The next day the baby had gained, and the mother's flight home was arranged for two days later. Unfortunately, the following day the baby's weight dropped again and the decision was made to keep her. Both the Qallunaat and the Inuit midwives involved realized the mother might be feeling as though she were imprisoned in POV, but they were concerned about letting the baby go home because the primary health care practitioner there, a Qallunaat nurse, had other commitments and would not be immediately available.

Qallunaat midwife (Q.M.) to mother (speaking through a translator): You're not going to be able to go home because the baby needs to be watched.

[The grandmother does not agree with this decision and comes to the mother's defense.]

Inuit Student Midwife (I.S.M.) to Q.M.: They'll do the same thing at home as here.

Q.M.: But they'll have to do more. It hasn't been enough.

[I.S.M. to mother: The student midwife explains to the mother and grandmother that the problem is probably happening because the mother had a hemorrhage and is not quite strong enough yet to produce all the milk the baby needs. She explains that sometimes they use a feeding tube in such situations. The mother begins to cry.]

I.S.M. to Q.M.: We shouldn't have told the mother she could go, and then take it back.
Q.M. to mother: If you go, you might have to come back. We want the baby finished, ready to be gone.

Grandmother: The baby was born at 36 weeks, and is probably behind in weight because of that, and will gain according to when it was born. Probably in a month it will be OK . . .

Q.M.: If it was small-for-dates, we are even more concerned. Usually a baby that comes early will be okay in three or four days, with a supplement.

Grandmother: Is the baby going to die?

Q.M.: No, but it could suffer damage, yes. It could become very sick. If it does not grow at all, it will suffer brain damage. We’re not worried for today, though.

Grandmother: This is just a baby that was born too soon.

Q.M.: But babies that are born early grow fast, usually, but [turning to student midwife] if that’s what she thinks, what can we do?

Grandmother: It’s too soon to weigh the baby.

Q.M.: When should we weigh her? We can weigh her on Saturday. Maybe if we see the baby up until Sunday, maybe the nurse-midwife in the community will follow her when she gets home, during the week.

Grandmother: We can get the supplement here?

Q.M.: Yes. If the baby wakes up, we supplement after the next nurse.

Both the Qalluuaq and the Inuk student midwife realized the personal, political, and cultural risks of coercing the mother and grandmother to stay against their will. The decision to go or stay belonged to them. The student midwife recognized that the risk of making the mother feel that a decision not in her or her baby’s best interests was being made for her, against her wishes, was greater than the actual risk to the baby, if the baby received special care at home. By the next day, the baby had gained weight but the young mother had stopped breastfeeding. The Inuk student midwife was upset because she felt that the mother had stopped breastfeeding because the midwives had been so adamant about keeping her in Pov. To avoid such a problem in the future, at the next Friday meeting of all the midwives and students, it was decided that (a) one should never tell a woman that she can go home until it is known for sure that she can; and (b) the skills of the Inuit maternity worker in the community, where the Qalluuaq nurse may often be unavailable, should be utilized to allow women from that settlement to go home earlier.

**Intuitive Logic**

Having an intuition about a situation does not necessarily mean that one will act on it. Intuition is a highly personal and fragile phenomenon; when it clashes with the kinds of logic more accepted by the powers that be, the tendency to follow the "more sensible" approach of clinical logic often
takes over in decision making. To allow oneself to follow one’s intuition requires peace of mind, strength of conviction, and a safe environment (see Davis-Floyd and Davis, this volume).

The elders from the various regions have told me that they have had premonitions of problems regarding certain women, either because they know the woman’s family life is problematic or because she has unresolved emotional issues. Transgressions of pregnancy taboos create additional concerns.

Elder Annie Okalik from Pangnirtung told us the following story several years ago. She said she was attending a mother who was unconscious and bleeding terribly after a birth, and the gathering of women realized that the only thing left to do was pray. Annie intuited that it was important that they pray out loud, and the women began to do so in a lilting chant. Annie chuckled as she was telling the story, noting that the mother came around, saying that she felt she was drawn back into the room by a desire to “join in the ruckus.”

I have on occasion tried to get the elders and the new midwives to talk about intuitive experiences by sharing with them some of my own. The first time that I remember doing this was with an Inuit elder by the name of Ooksuralik with whom I stayed in Cape Dorset in 1989. I described to her a long labor that I had attended of a first-time mother.

I got concerned that the mother was holding something back that might be impeding the birth. When I sensed that something was wrong and some obscure thing was holding us up, I asked the mother to tell me about images from the distant past that she might be thinking of, sitting here in her bathtub. Sure enough, she had one—she immediately recounted the memory of a childhood incident involving her favorite doll, which had fallen out of a third-story window. As she watched it fall to the ground, she felt absolutely no compulsion to go down and pick it up. She was feeling the same way now, and so we spent the rest of her labor helping her to become motivated to “go down and pick up her baby, to get it out.”

I remember Ooksuralik staring at me intently as I was telling the story. She finally said, “I had no idea that a Qallunaq could think that way.”

The Inuit do not believe that the Qallunaq can think intuitively because the main types of logic to which whites have demonstrated commitment are clinical expertise and intervention, concern about legal liability, and an arrogant claim to scientific truth. Why share your innermost knowing with someone who may laugh at you or who does not have the psychological maturity to understand you?

The POV Maternity is an environment that creates a feeling of safety, an atmosphere in which intuition can freely flourish. Colleen often asks the midwives and birthing women, “What do you really feel is the right thing to do here?” It’s difficult to say whether the Inuit midwives follow their
intuition more than the white midwives do, but it seems clear that Inuit women are highly intuitive. I do not see it as my place to go into more depth about intuition and how it is used in the POV Maternity, but I have asked Mina to write down her own experiences with intuition, and we need, together, to address this type of experience in future publications.

In a culture in which a remarkable number of people remember being born, and having dreams about a person who has recently died is one way to know you may name your baby after her or him, it stands to reason that intuition would be respected as a valuable source of authoritative knowledge. It would be encouraging to think that as the Inuit midwives feel increasingly comfortable with clinical and scientific logic, they will also increasingly give themselves permission to cultivate and act on the intuitive. In this effort, they will no doubt be impeded by the Western privileging of other kinds of logic.

Economic Logic

According to one estimate, every time the Maternity midwives do a birth in POV, they save Québec taxpayers approximately $10,000 Canadian (about U.S.$7,000). This figure includes the cost of the plane trip to a southern city, living expenses for a month or more before going into labor, and the often highly technological southern hospital delivery. Because of our Canadian system of comprehensive insurance for health care, individual hospitals and practitioners do not particularly benefit from these high costs. But in the United States, where hospitals and practitioners do profit directly from the high cost of birth, it is questionable whether the savings generated by birth centers such as the POV Maternity would be welcomed.

CONCLUSION

I began by stating that there is a tension between traditional and modern definitions of reproductive risk and normalcy. This chapter has presented an analytical framework that classifies and illuminates the types of logic that compete in most birth settings around the world—a framework useful for showing how some types of logic are given undue authority while others, such as cultural or intuitive logic, are devalued or simply ignored. Traditionally, to the Inuit, birth seemed a natural event, a time for serious reflection and examination of the woman's spiritual and social integration with her community, as upon this hung the success or failure of the birth itself. Today, medical services in most of northern Canada have made birth into an entirely secular affair for which the mother is allowed little responsibility. Traditionally, Inuit women had some small degree of choice about where and with whom to give birth, although those choices were constrained by survival needs and tradition-based customs and taboos. Since
the 1960s, their choices have been severely restricted in another way by
the medical takeover of Inuit birth. Up until the 1950s, Inuit women had
no access to modern medical information and intervention. Today, in most
places, they have no choice to refuse it. Traditionally, in many areas, they
were put into isolation huts to give birth. With evacuation, they are isolated
from their families but exposed to the medical team in the delivery room.
Before evacuation, they listened to the elders and the shaman. After, they
listened to the doctor. It would be tempting to say that things have not
changed much, that evacuation has merely imposed a different authority.
But, in fact, evacuation changed things so drastically that it has become
one of the greatest affronts to Inuit identity.

The POV Maternity has tried to make a shift in this picture. It is trying
to leave behind the pattern of women’s victimization in whatever setting,
and to balance competing ideologies in a viable way. The women of POV
do not buy into the medical myth that more technology equals safer out-
come. They balance the clinical risks of harming mothers and babies with
the risks of personal trauma and cultural and spiritual assimilation, and
find that when the personal, the spiritual, and the cultural are prioritized, less
overall harm occurs. Thus scientific logic now undergirds their personal and
cultural choices. Through the process of reclaiming birth as a part of com-
community life, Inuit women not only have created more choices for them-
seives but also are coming to learn what choice means. While I realize
that anthropologists may have a different perspective on this issue, as a
midwife—one who is committed to support women’s choices—I can only
celebrate such a development.

I have come to see the Inuit experience of evacuation as an example of
what can happen when one type of logic gains priority over all the others.
The clear need we can observe in Inuit birth for balance among our eight
categories of logic sheds light on events elsewhere. As a southern Canadian
midwife, I can say that in the South we are not usually brave enough to
allow a mother to refuse intervention even if her intuition tells her that
the intervention is not needed, because we are so conscious of our legal
liabilities. It seems evident that the more fragile types of logic—the cul-
tural, personal, and intuitive forms—are the canaries/beluga whales of our
eight-category framework. Even when they are backed up by science, they
are undervalued in relation to clinical, legal, and political logic, toward
which Southern childbirth is heavily skewed.

There seems to be no system of checks and balances to reconfigure this
framework in the South. Yet the Southern system, elsewhere referred to as
the “Western” system, dominates worldwide. Our typology of logic could
enable policy makers to avoid more mistakes like the evacuation crisis that
hit northern Canada. Yet given the current realities and priorities of West-
ern technocratic life, institutionalized respect for the more vulnerable
types of logic seems very far away. The World Health Organization has been diligently attempting for more than ten years to propagate public health models “liberating what people already know about health and illness, and legitimizing this knowledge” (North American Working Group on Health 1989; see also Wagner, this volume). Their efforts have been hampered not only by the technomedical establishment but also by the reality that indigenous people have been told for so long that they don’t know anything about health care, they often make health care decisions as if they believe it.

Ten years after initiating the Maternity, POV13 remains the only community in northern Canada to have reclaimed birth, not only geographically but also into the hands of its own midwives.14 Being made to believe that one’s own logic is inferior and unworthy could have sapped the life force of POV, as it has in other communities. Realizing that evacuation was adding to the continuum of dependency on white man’s logic and that the Inuit community had been robbed of its own authoritative knowledge over a basic human function was an important step for the people of POV. An equally important step is the realization that as birth returns to the community, “progress” is not synonymous with adopting the logic of the Qallunaaq.

NOTES

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1. At a workshop for consultants working in the “developing world” held in Oslo, Norway, prior to the International Confederation of Midwives’ Congress in May 1996, I took issue with the term “developing.” It is becoming increasingly problematic to apply “developing” to countries that may be heading toward a “goal” that at this point the so-called developed world has supposedly reached, when in fact, parts of the “developed” world should more appropriately be labeled “overdeveloped.” A policy maker from Gambia suggested that we’re really talking about the “Haves” and the “Have Nots.” Perhaps the politically correct term would be “financially challenged.” Others used “industrialized” and “nonindustrialized.”
But all these commodity and financial terms are found wanting when trying to figure out where the rich oil-producing countries fit; there, in spite of wealth, there is still underdevelopment in meeting basic human needs. The United States, too, while rich in commodity and monetary gain, is sorely lacking in social and health reform. Until we can find more appropriate terms, however, it looks as though “developing” is the word to use here; quotation marks seem to be the operative form of protest.

2. “Inuk” is the singular form of “Inuit,” which is the name this group of Arctic people call themselves. They have explicitly rejected the label “Eskimo,” which was given to them by other native American groups and which means “eater of raw meat.”

3. In the north, the term Qallunaat is spelled in various ways depending on the place. Here I use the spelling used in Povungnituk.

4. A hemoglobin level below 110 mg/dL is considered anemia by the World Health Organization.

5. Hemodilution refers to the fact that the amount of blood in a pregnant woman’s circulation increases as pregnancy advances; it is therefore normal for the hemoglobin to drop.

6. It is true that postpartum hemorrhage can pose greater risk if one has no hemoglobin reserves, but low hemoglobin does not cause postpartum hemorrhage. Whether such a hemorrhage would be life-threatening when the nurse has intravenous equipment is debatable. Postpartum hemorrhage is a frequent occurrence among the Inuit and is tolerated quite well by them. It is managed in home births much the same as in the hospital, with injections of syntocinon (an artificial hormone, a variant of pitocin). There have been a number of postulations about the reason for the high rate of hemorrhage. One is the fact that about 85 percent of the pregnant women are listed as smokers, and there is a known correlation between smoking and postpartum hemorrhage. There has also been an association suggested between the low rate of coronary heart disease and the fact that there is a component of sea mammal meat that acts as a natural anticoagulant. Could it be that this same factor, then, causes women to bleed more easily?

7. In the 1970s the Canadian government tried to expropriate the land in the James Bay area to build a hydroelectric plant. The people of FOV refused to sell their land.

8. Toxoplasmosis is an intracellular parasite transmitted to humans via raw or poorly cooked meat, as well as by cat or bird feces. It is prevalent in sea mammals. If acquired during pregnancy, it can cause serious congenital abnormalities in the fetus.

9. PCBs are organohalides (toxins) that remain stable when ingested in the body, are not metabolized, and accumulate in fat cells.

10. Pitocin is a synthetic form of the natural hormone oxytocin, which stimulates both the frequency and the force of uterine contractions and is often used to stop a hemorrhage. It is given routinely by some practitioners, but many midwives do not give it unless there is a need. The laissez-faire attitude of the Southern midwives was brought into check when they first began realizing how frequently, by Southern definition, Inuit women had hemorrhages (>500 ml and >1,000 ml of
blood loss). More study needs to be done and more precaution taken, however, regarding increased routine use of this "active management" of this stage of labor with medication, not only in the North but also in "developing" countries.

11. See Introduction, note 14, this volume, for more information.

12. How much credibility Inuit women give to these taboos is hard to know and may vary from one person to the next. But they do serve still as important markers of community membership and respect for connection with the past.

13. Editors' note: We have been informed by the author of this chapter that in 1996, Puvungnituq changed its name to Puvirnituq.

14. In Rankin Inlet, a project is under way to return birth to the community. However, the births are being attended by nurse-midwives, with no program yet for training Inuit midwives.

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