Consolidation of the connection to the land of Innu and Atikamekw women through pregnancy and childbirth

Our own teueikan (drum) is our placenta. It's sacred – Innu woman

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Je n'ai pas la démarche féline
J'ai le dos des femmes ancêtres
Les jambes arquées
De celles qui ont portagé
De celles qui accouchent
En marchant

Joséphine Bacon (2018), *Uiesh*.
Quelque part, Mémoire d'encrier, p. 6.

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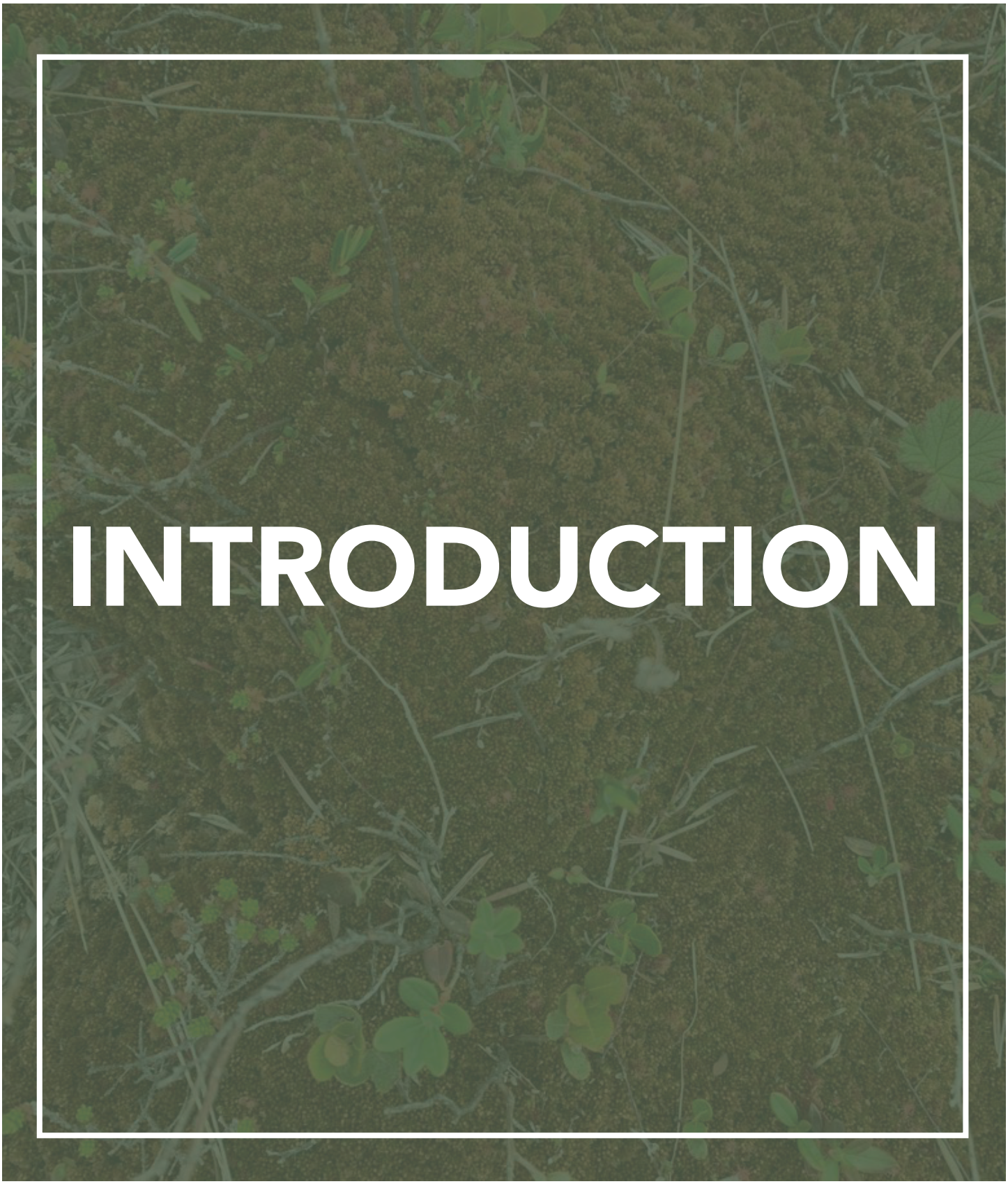
Abstract

This participatory research focuses on the consolidation of the connection to the land of Innu and Atikamekw women through pregnancy and childbirth. The stories collected have enabled us to better understand these women's experiences of motherhood, to document their traditional land-based practices and transformations in order to determine how these women have been influenced by colonial standards. In addition to suppressing the role of Indigenous women in the areas of governance within their respective societies, several government interventions have definitively accelerated the sedentarization that goes hand-in-hand with forced hospitalization. This undeniable erosion of the social system associated with life on the land has contributed to hindering the importance of births on the land and has also been instrumental in deep-seated changes in the territoriality of Innu and Atikamekw women. An analysis of participants' testimonies shows how the shift in practices to assist pregnant women, from the land to the community, and then from the community to the hospital, has led to the loss of midwifery practices and to the acceleration of an imposed biomedical vision of pregnancy. These multiple relocations of birthing environments have precipitated a gradual loss of control that pregnant women could exercise over their deliveries. Nevertheless, the connection of Innu and Atikamekw women to the land has not been lost, it has been transformed. The solutions proposed to revitalize this bond can be summed up by the reintroduction of midwifery practices, the revival of certain ceremonies and rituals, the transmission to younger generations of knowledge about significant places on the land, the preparation of traditional medicines and crafting of objects related to pregnancy and childbirth.

Key facts

- The consolidation of Indigenous women's connection to the land through pregnancy and childbirth is a topic that surfaced during a previous research project. Analysis of the data gathered at the time showed that land birthing experiences appeared to be strong, temporal, relational and identity markers for Atikamekw women.
- The main purpose of this research was to identify the practices that could help revitalize and consolidate the bond of Innu and Atikamekw women with the land.
- In 2020 and 2021, fifteen semi-structured interviews were conducted with Innu and Atikamekw women born between 1931 and 1966. Their stories allowed us to better understand their experiences of pregnancy and childbirth, to document their land-based traditional practices and their transformations, and to determine how these women were influenced by colonial practices.
- Many government interventions have definitively accelerated sedentarization and forced hospitalizations; they have undeniably contributed to the erosion of an entire land-based social system in addition to undermining the importance of land birthing and transforming the territoriality of Innu and Atikamekw women.
- Analysis of the narratives demonstrates that beyond the situational differences characterizing the paths of Innu and Atikamekw women, many historical elements converge, namely the transfer of support practices for pregnant women, from the land to the community, then from the community to the hospital.
- The takeover of this life stage under the guise of government policy, and above all, the methods used to implement such control (substitution and marginalization of midwife knowledge by the medical profession, medicalization of pregnancies, imposed travel to hospitals, etc.) have considerably influenced the possibilities for Indigenous women to exercise their free will and have altogether altered family empowerment as well as birthing support as practiced over millennia, with midwives as one of its cornerstones.
- These stories allow to understand that the gradual loss of influence by Innu and Atikamekw midwives goes beyond the simple absence of successors to receive their teachings and practices.
- The imposition of a biomedical vision of pregnancy embodied by the relocation of deliveries to hospitals supplanted the significance of these know-hows and, at the same time, hastened the gradual loss of control that pregnant women could exercise over their deliveries.
- Far from remaining passive despite the shift to hospital deliveries and the abandonment of certain practices, the Innu and Atikamekw women interviewed have instead become the guardians of their land-related knowledge and the practices associated with it.
- The stories of the Innu and Atikamekw women demonstrate that the connection to the land is not lost but has been transformed and that the strengthening of this connection for new generations necessarily requires the valorization of women's leadership in terms of life cycle, from birth to death, by way of childbirth.
- The reintroduction of midwifery practices, and the revival of certain ceremonies and rituals in the communities are identified as means for consolidating the connection to the land of Innu and Atikamekw women.
- The women we met have emphasized the need for informing younger generations about significant places and for passing down know-how on the preparation of medicines and traditional objects related to pregnancy and childbirth.



INTRODUCTION

Introduction

This research focuses on a subject that is relatively undocumented to this day. The relationship of Indigenous peoples to the land, their territoriality, has been the subject of some research in Quebec and elsewhere in Canada, but very little research has focused on the connection between Indigenous women and the land[1]. Over the past few decades, various colonial laws and policies have assigned ownership of Indigenous family territories to men and excluded women from decision-making bodies. And yet, before sedentarization, men and women shared responsibilities and decision-making in the management of their territory. Both men and women developed their identities through their relationship with the land. As part of her doctoral thesis in environmental sciences, Suzy Basile, now a professor at the School of Indigenous Studies at the Université du Québec en Abitibi-Témiscamingue (UQAT) and director of this study, found that birthing experiences on the land appeared to be strong, temporal, relational and identity markers for women and their families. During the thematic analysis of the interviews on "the role and place of Atikamekw women in the governance of land and natural resources" (Basile, 2017), the issues of pregnancy and childbirth, the role of midwives and birthplace emerged without any direct questions being asked on these topics. It was therefore deemed important to continue focusing on these themes through the lens of Indigenous women's governance and leadership, and also in terms of the creation and consolidation of the connection to the land in a contemporary context.

This qualitative research was funded by the Social Sciences and Humanities Research Council of Canada (SSHRC). Based on a participatory approach, it was conducted in close collaboration with and at the request of Innu women from the communities of Nutashkuan and Ekuanitshit and Atikamekw women from the community of Opitciwan. This request was voiced during consultation sessions with Indigenous women held by the Research Laboratory in Indigenous Women's Issues - Mikwatisiw. Data collection was carried out between May 2020 and December 2021, while validation of the results and a number of verifications were conducted during the fall of 2021, when sanitary measures related to the COVID-19 pandemic were relaxed. A total of 15 women participated in semi-structured interviews based on a biographical approach. Consequently, the women had the freedom to mobilize their own perceptions to describe their experiences. Given the advanced age of the women who have experienced pregnancy and childbirth on the land, it seemed urgent to document their knowledge, practices and values.

In keeping with one of the underlying principles of collaborative research in an Indigenous context, the research objectives were developed during consultations held by the lead researcher, during which important themes were raised by the Indigenous women consulted. The questions were co-developed by the principal researcher and the three women (two Innu and one Atikamekw) appointed as research leaders by their respective community authorities.

Research objectives and questions

The general objective of this research was to catalogue practices that could help revitalize and consolidate Indigenous women's connection to the land in Quebec. More specifically, it aimed to:

1. Identify the transformation, resistance and persistence of tradition through the consolidation of the connection to the land;
2. Demystify the operational mechanisms of colonialist institutions and protagonists, past and present;
3. Gather the elements of a traditional normative system that ensures the health and well-being of mothers and their children by consolidating the connections between family and/or community members and the land;
4. Create an interactive map of significant locations (birthing, plant gathering, burial of placenta)[2].

To this end, the following three main research questions, developed into several sub-questions, guided the approach:

- ◊ How has the connection to the land been transformed by government health programs (federal and provincial) and by the policies of the medical profession?
- ◊ To what extent could Indigenous women's connection to the land be updated to revitalize leadership and governance practices formerly associated with pregnancy and childbirth?
- ◊ What practices and provisions have been introduced to consolidate children's connection to the land since the shift to urban birthing?

The literature review provides answers to the first research question by presenting, among other things, the laws and government policies most influential in shaping Indigenous women's connection to the land in recent decades.

1 In this document, we will refer to First Nations women in Quebec as "Indigenous women".
2 This fourth objective was not carried out due to the highly sensitive nature of this type of information, the women interviewed were not ready to map out these sites.

The other two research questions are addressed in the three sections on the results of data collection with the participants.

Here is a short profile of Indigenous women in Quebec and of the Innu and Atikamekw communities participating in the research.

Summary profile of Indigenous women in Quebec

According to figures from Indigenous Services Canada (ASC), Quebec counted 104,453 Indigenous citizens (First Nations and Inuit) in 2021, or the equivalent of 1.3% of the total population (ISQ, 2022). An analysis carried out by the Viens Commission indicates that the proportion of men and women is almost identical in each Indigenous Nation in Quebec, since 50.1% of the Indigenous registrants are women and 49.9% being men (CERP, 2019)[3]. The median age of Indigenous women is 38,5 years (and 36 years for men). In comparison, the median age of non-Indigenous women in Quebec is 43 years (and 41,2 years for men) (CERP, 2019). According to Statistics Canada (Tjepkema *et al.*, 2019), the life expectancy of Indigenous populations is much shorter than for the non-Indigenous population. In 2011, the life expectancy for First Nations woman at age 1 was 77,7 years, i.e., 9,6 years shorter than for non-Indigenous women. The latest data available shows that Indigenous women have the highest fertility rate in Canada, i.e., 3.25 children per woman living in community and 2.20 children for women living off community. In comparison, the fertility rate of non-Indigenous women is 1.6 children per woman (SC & AFN, 2021).

In Quebec, 6,740 persons reported Atikamekw as their mother tongue (SC, 2023) while 7,725 persons declared Innu as their mother tongue, making them the two Nations whose languages are the most widely spoken in Quebec, right after the Eeyou (Cree) language and Inuit language (SC, 2022). According to 2021 Statistics Canada counts, the number of Atikamekw language speakers is slightly on the rise (between 0 and 10 %), while Innu language speakers are in a slight decline (between 0 and 10 %). In fact, most of the women we interviewed were unilingual Atikamekw/ Innu speakers or preferred to express themselves in their mother tongue. The women were between 54 and 89 years of age at the time of the interviews, being born between 1931 and 1966.

Summary profile of participating research communities

Here is a short presentation of the three communities[4] participating in this research project. It is important to point out that the transition from a nomadic to a sedentary lifestyle was a gradual one. On the sites that would become today's communities, houses were always built before, and sometimes well ahead, of the official establishment of the communities (Charest, 2017). For example, the three Atikamekw communities were created between 1895 and 1950 (Gélinas, 2002), but permanent Atikamekw settlement began in the 1960s-1970s (Poirier, 2001). Among the Innu, however, houses built before the 1920s gradually started to disappear for lack of maintenance. When the communities were created in the 1950s and 1960s, it seems that there were no houses left in these areas (Charest, 2021).

In those days, the houses built by Indigenous people were not necessarily occupied. Some would use them during the summer, either to live in or to store equipment. Others would have left these earlier houses to the elders to shield them from the cold weather (Maltais-Landry, 2017). The vast majority of families, however, continued to live in the tents they installed nearby while waiting to return to the land at the end of the summer (*ibid.*).

3 In the Report of the Public Inquiry Commission on the relations between Indigenous Peoples and certain public services (CERP), the Indian Register, the Register of Cree and Naskapi beneficiaries as well as the Register of Inuit beneficiaries were used to establish the number of Indigenous people residing in Quebec, the demographic profile specific to Indigenous peoples and the male-female ratio (CERP, 2019).

4 Here, the term "community" is preferred since the term "Indigenous community" generally designates a territory inhabited by a group of people who recognize a familial, cultural and historical belonging to an Indigenous nation (INSPQ, 2023) (consulted on April 11, 2023). In this report, the term "reserve" will be used in the historical context of colonization and sedentarization. It is defined as follows: "A reserve is a parcel of land where legal title is held by the Crown (Government of Canada), for the use and benefit of a particular First Nation" (ISC, 2021a) (consulted on November 2, 2021).

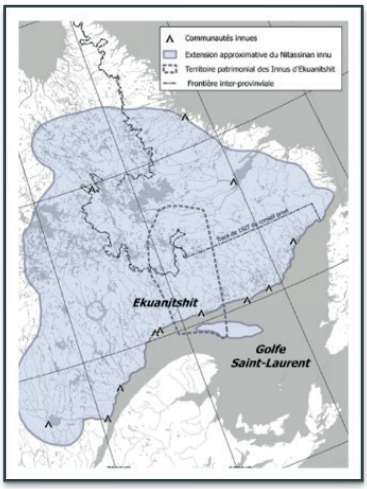


Figure 1. Ekuanitshit community.
Map source: Ouellet, 2018.

Ekuanitshit

Ekuanitshit was formerly called Mingan. It is also an Innu community located in the Côte-Nord region, 28 kilometres west of Havre-Saint-Pierre and 182 km from Sept-Îles. The community is accessible by road year-round. Founded in 1963, it initially occupied an area of 1,800 hectares which expanded to its current 3,838 hectares (9,483.9 acres). In 2023, 677 persons resided in the community and 45 off-community, for a total of 722 persons (CIRNAC, 2023).

Before concluding this section, let's recall that archaeological research carried out in *Nitassinan* (which means "our land" in the Innu language) attests to an Innu presence dating back 8,000 years in certain regions of the Côte-Nord (Ouellet & Richard, 2017; Plourde, 2003), and that the presence at other sites shows an occupation as far back as 3,500 years and reveals an occupation of the entire *Nitassinan* (Chevrier [1996] in Ouellet, 2018).

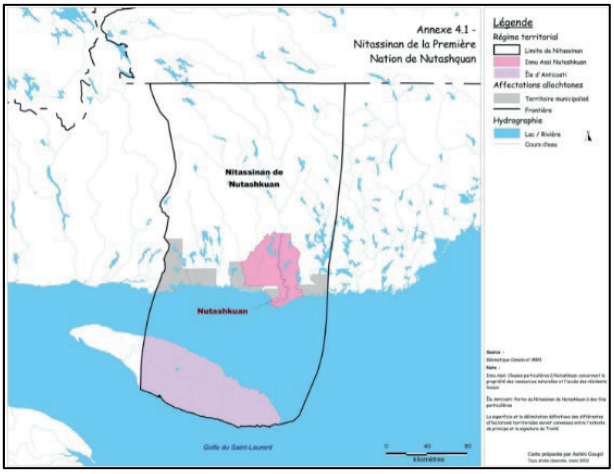


Figure 2. Nutashkuan community.
Map source: Les Premières Nations de Betsiamites, Essipit, Mashteuiatsh, Nutashkuan, Government of Canada and Government of Québec, BAPE, 2002 (created by Ashni consultant).

Nutashkuan

Nutashkuan is one of the Innu communities in the Côte-Nord region. It is located at the mouth of the Nutashkuan River, a few kilometres away from Natashquan and 336 kilometres from Sept-Îles. The community is accessible by road year-round. The community was officially created in 1953 on the site of the former Innu summer encampment (Maltais-Landy, 2017). The community occupies an area of 118,9 hectares (293,8 acres). In 2023, 1,152 people resided in the community and 105 off community, for a total of 1,257 persons (CIRNAC, 2023).

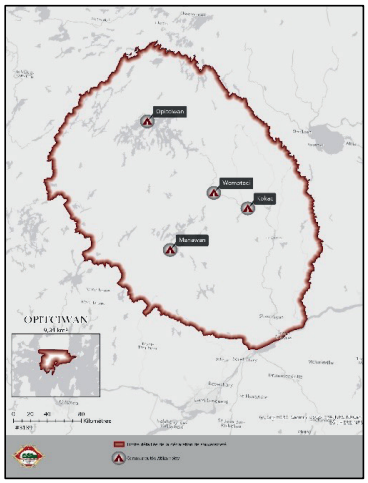
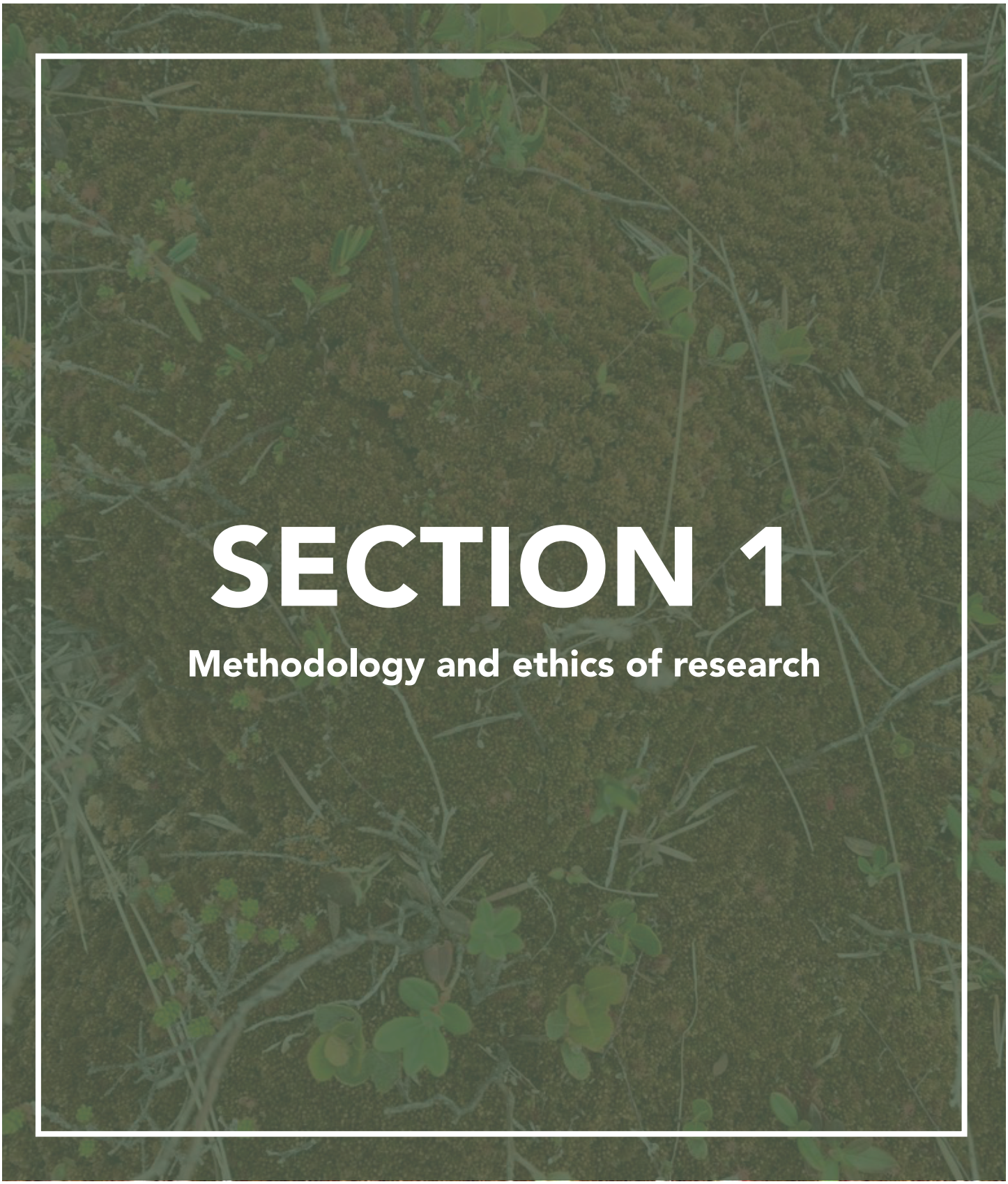


Figure 3. Opitciwan community.
Map source : Conseil de la Nation Atikamekw, 2023.

Opitciwan

Opitciwan is one of the three Atikamekw communities in Quebec. Officially created in 1944. Located on the north shore of Gouin Reservoir, at 274 km of the closest urban center (Roberval) and is accessible by road year-round (CNA, 2022). The community occupies an area of 927 hectares (2 290,7 acres) with a population of 2,593 residents living in the community and 572 off community for a total population of 3,165 persons in 2023 (CIRNAC, 2023).

The Atikamekw territory is not limited to the Opitciwan area surface and that of the two other communities, Manawan and Wemotaci. *Nitaskinan* ("our land" in the Atikamekw language) covers the Tapiskwan Sipi (Saint-Maurice River) watershed in north-central Quebec. Oral tradition has it that, to escape the threat of epidemics and Iroquois raids, the Atikamekw stopped going to Trois-Rivières and its surrounding areas, retreating inland to the territories above the Tapiskwan River (Poirier *et al.*, 2014).



SECTION 1

Methodology and ethics of research

Methodology and ethics of research

This research centers on life stories told by Innu and Atikamekw women, and on their analysis. As such, it is based on a qualitative approach understood from an Indigenous feminist perspective. To avoid reproducing unequal relationships of power in the production of scientific knowledge, the research participants are recognized as holders of expertise and know-hows that must be co-constructed with the study's researchers (Anderson, 2011; Basile, 2017; NIMMIWG, 2019a; Kermoal & Altamirano-Jiménez, 2016). Our epistemological stance is motivated by a desire for a collective reflection on the effects of public policies on women and families to ensure that the results are relevant and useful for the participants and their communities.

This research project is based on the *Guidelines for Research with Aboriginal Women* (QNW, 2012) and also implements good practices in terms of ethics of research with Indigenous peoples (Asselin & Basile, 2012; AFNQL, 2014; SSHRC *et al.*, 2022). The band councils of each participating community granted approval for the conduct of the research and signed letters of support. The project was evaluated by the Human Research Ethics Board at the Université du Québec en Abitibi-Témiscamingue (REB-UQAT) and an ethics certificate was delivered to the lead researcher on March 25, 2020.

Research participants were financially compensated for their time, not for the knowledge they shared. All data collected is available to them to help defend their interests. The research results contribute to consolidating the connection to the land of these women and their families while promoting the recognition of their knowledge and practices about pregnancy and childbirth. In this regard, a particular focus was placed on any of the women's concerns about sharing this knowledge with researchers, and how it would be subsequently used in this study. Since their knowledge had been pillaged and usurped in the past, our approach aims to protect it from any repeat negative experiences. To this end, these issues were discussed with the participants prior to the interviews, therefore allowing us to develop a strategy for withholding or excluding certain sensitive information. This strategy was implemented while validating the results with the participants.

In parallel, literature indicates that many infants of Indigenous women in Quebec had died or gone missing without a trace from within the healthcare system (SAA, 2022). We were fully aware that recalling certain memories could be painful for some participants. Support services provided by a nurse, psychosocial worker or psychologist were organized with the local research collaborator. Following each interview, the lead researcher conducted a follow-up to ensure that participants were not left to fend for themselves, and that they benefited, if need be, from the support services available to them.

Participatory research

Participatory research means that the parties involved - researchers and participants - work together to achieve the common goal of producing new scientific knowledge (SSHRC *et al.*, 2022; Katz & Martin, 1997).

In this case, Innu and Atikamekw women contributed to the research process by helping to define the research topic. As already mentioned, the question of pregnancy and childbirth as practices for consolidating Indigenous women's connection to the land surfaced in a previous research project. This research was consequently developed in response to a request from within, namely from the women themselves.

Recruitment

The lead researcher began by canvassing her own network of contacts in each of the participating Nations. Recruitment was also facilitated through the involvement of a community coordinator assigned to the research team by each of the communities.

The main selection criterion for recruiting participants was their knowledge of pregnancy and childbirth as previously experienced either on the land or in the community. This knowledge could be related to their own pregnancies and deliveries prior to transportation to hospitals, or from their experiences as midwives or childbirth assistants. Their expertise had to be recognized within their communities. It was clearly expected that women meeting these criteria would be of a certain age. The snowball method allowed the research team to start by mobilizing elders and families having shown an interest in participating to the research, then to recruit more participants if needed.

An initial visit to the participating communities was used to promote the project and identify women who met the selection criteria. Already, some women expressed an interest in taking part in the research. Those who met the sample selection criteria were invited to a detailed presentation of the research objectives and stages, which also allowed us to validate the approach with them. Prior to the interviews, the consent form was given to the participants so that their respective interpreters could assimilate the content in their mother tongue and pass it

on to the participant. All those involved in data collection were financially compensated for their time. In the following weeks, in collaboration with the local research coordinator, the volunteers were invited in person, by e-mail, by Messenger or by telephone to schedule a time for the interviews.

Methods of data collection

The biographical approach was selected to guide data collection. This approach makes it possible to comprehend the logic of action that drives Indigenous contemporaneity by contextualizing the social practices studied (Guay & Martin, 2012). Consequently, rather than attempting to uncover social mechanisms, the research aims to present the different values that underpin the identity and actions of the participants (Guay & Martin, 2012). The discursive freedom offered to the participants enabled them to mobilize their own perceptions to describe their experiences. The concepts of *mino-pimatisiwin* (healthy life or "good life" on the land), *madjimadzuin* (translated by "life line") and *notcimik – nutshimit* (a term that refers to "the forest" or "the woods" as well as the place of origin and belonging) have guided the data collection process.

Semi-structured interviews with 15 women from Ekuanitshit, Nutashkuan and Opitciwan helped us to better understand their experiences of pregnancy and childbirth, to document their traditional land-based practices and transformations and to determine how these women have been influenced by colonial practices.

Target and participating population

Initially, a total of at least 12 women were identified to participate in the research (4 per community). In total, 15 women were recruited.

Table 1. Target number of participants and actual number of participants

Community	Target participants	Actual participants	Timeline of data collection
Ekuanitshit	4	5	Between May 19 and July 16, 2020
Nutashkuan	4	4	Between August 2 and September 2, 2020
Opitciwan	4	6	June 12, 13 and December 15, 2021
Total :	12	15	2020-2021

All interviews were conducted by Professor Suzy Basile, occasionally assisted by Sophie Cardin, master's student. For various reasons, and due to events beyond the control of the lead researcher and in consideration for the availability of the participants, data collection with the Atikamekw women of Opitciwan took place a few months after that with the Innu women. In the context of the COVID-19 pandemic, all interviews were conducted in person once sanitary measures had been relaxed. The women told their stories in their mother tongue, and were accompanied by someone, usually a family member, for translation.

Analytical methods and approaches

Prior to conducting a biographical thematic analysis of the life stories shared, these were recorded and subsequently transcribed in their entirety. The interpreters played an essential role in the transcription and validation process. A code was assigned to each of the verbatim: a letter according to the community of origin (E for Ekuanitshit, N for Nutashkuan and O for Opitciwan) followed by a sequential number. These verbatim formed a qualitative database that was analyzed using NVivo software. Themes were developed around the three research questions.

Table 2. Themes and examples of subthemes identified during data analysis

Main themes in relation to research questions	Examples of identified subthemes
Transformation of women's connection to the land	From giving birth in the tent, to the community, to the hospital Residential schools
Revitalization of leadership associated to pregnancies and childbirth	Expertise of midwives Postnatal support
Practices for consolidating the connection to the land	Ceremonies Choice of the child's name

Although some themes were identified at the outset, others emerged through an inductive process. Unlike the deductive approach, which seeks to confirm an initial hypothesis, inductive analysis allows us to account for life experiences in all their complexity and dynamics (d'Arripe *et al.*, 2014). It also allows the researcher to approach the phenomena with her own theoretical sensibility and background knowledge (Guillemette, 2006). An initial analysis of the results was validated with the participants, with the help of the three women responsible for monitoring the research in their respective communities. A final version of the research report was then submitted to the participants for final validation.

SECTION 2

The state of knowledge

The state of knowledge

For the purpose of examining the consolidation of Indigenous women's connection to the land, certain concepts and themes need to be mobilized, and are presented in this section. These include Indigenous feminism, the territoriality of Indigenous women, sedentarization and exclusion from the land, the importance of birth on the land and the medicalization of childbirth.

Indigenous feminism, an essential framework for analyzing the colonization process

By Indigenous feminism, we mean an analytical tool that provides an understanding of the various themes relating to the condition of Indigenous women by examining how racism and sexism, in particular, have created a distinct discrimination towards Indigenous women (Suzack, 2015). Indigenous feminism explicitly proposes a different outlook on two critiques: objections to colonialism and patriarchy (Belleville-Chenard, 2015; Green 2017). In Canada, Indigenous women first adopted this stance in the 1990s, by denouncing the lack of consideration over the impacts of colonization in the intersectional analysis of the status of women and by prioritizing approaches that take into account gender, ethnicity, race and colonialism (Archibald, 2009; Basile, 2017; Green, 2017; Pagé, 2014; Valaskakis, 2009). For example, many research projects have focused their attention on substance use among Indigenous women during pregnancy, much less attention has been paid to the effects of colonization on pregnancy and parenthood (Shahram, 2017).

In her doctoral dissertation, Basile (2017) points out that, despite the denunciations of recent decades, "relations between the State and Indigenous peoples remain 'colonial' in nature, and that the examination of Indigenous women's place in this system has become imperative in order to fully grasp the dynamics driving governance among First Peoples and specifically Indigenous women" (Basile, 2017, p. 5). It has been clearly demonstrated that before colonization, Indigenous Nations were largely based on egalitarian relations between genders, each exercising social and economic power (Basile, 2017; Lévesque *et al.*, 2016; Kuokkanen, 2019; Ohmagari & Berkes, 1997; Rude & Deiter, 2004; Van Woudenberg, 2004;). It was the paternalistic ideologies on which colonial laws and policies were built that disrupted the male-female relationship in Indigenous societies. This is true of the *Indian Act* that has "reinforced racist and sexist policies in many ways, and as a consequence, diminished the power and resources available to Indigenous women in Canada" (Shahram, 2017, p. 17).

The term 'deep colonizing' is used to refer to the structural effects of laws and policies that erase the power and presence of Indigenous women in certain areas in which male knowledge overrides that of women (Rose Bird, 1996). These structural impacts stem from the implementation of various tools conducive to the appropriation of First Nations territory, and in which settlement in reserves plays a fundamental role.

The territoriality of Indigenous women

The connection between the land and First Peoples, and especially the relationship between land and womanhood, is still under-researched. Studying the relationship to the land from the point of view of First Nations women sheds light on Indigenous women's knowledge systems which are still heavily influenced by colonization (Kermoal & Altamirano-Jiménez, 2016). It is this connection with the land that establishes the fact of being Indigenous and the fact of being a woman. The connection to the land thereby informs us about identity and social organization (Kermoal & Altamirano-Jiménez, 2016). In effect, for Basile (2017), the notion of connection to the land refers to the relationship that First Peoples have with the land and nature; it is the relationship at the origin of First Nations language, culture and economy (Basile, 2017). First Nations generally prefer saying that they belong to the land, as opposed to the land belonging to them. This ontology-based view explains, in part, the conflicts and misunderstandings between governments, industries and First Nations regarding land protection and management (Basile, 2017; Friedland, 2019). In addition to colonial laws and policies, economic development has also contributed to the dispossession of Indigenous peoples in general and Indigenous women in particular. Studies on the subject indicate that:

> Demonstrably, Indigenous peoples' connection to the land is poorly understood, not to mention jeopardized by the exploitation of natural resources (Bélisle & Asselin 2021; Carlson *et al.* 2015; Notzke 1994), industrialization (Newell 2015; Tobias & Richmond 2016) and the exclusion of Indigenous rights (Ahrén 2013; GITPA 2015; Mackey 2014) (Basile *et al.*, 2022, p. 9, Translation).

A study conducted by the Tłı̨chǫ Nation in the Northwest Territories shows that Tłı̨chǫ knowledge and identity intersect on ways of understanding and experiencing the land, especially during significant life events such as childbirth.

> Historically, Tłı̨chǫ women gave birth on the land wherever they were travelling at the time. Giving birth on the land required an intimate knowledge of women's health, plants, medicines, and the environment for both

> the baby's and mother's survival (…) It was therefore considered crucial that both Tłı̨chǫ women and men had knowledge about childbirth in order to safely deliver a baby and to survive on the land (…) The elders we spoke to described birthplaces as important for both the mother and the baby, which connect them directly to the land and these specific areas (Olsen & Kuntz, 2016, p. 7).

For the Navajo in the United States, attachment to the land is also significantly connected to the place of birth and the ritual celebrated there.

> This attachment to place initially established during the prenatal stage of life and reaffirmed at every subsequent step on the path to full Navajo personhood is solidified shortly after birth through burial of the umbilical cord. This act anchors an individual to a particular place. This sense of anchoring, and the spiritual and historic nature of the connection to one's home, is implicitly understood in the Navajo world (Schwarz, 1997, p. 43).

Indigenous women clearly held an important position in the family group; they were vested with decision-making authority and recognition that have gradually been taken away from them over the past few decades. The literature shows that in Canada, the *Indian Act* has played a decisive role in the restructuration of gender relations and in the subordination of women to men, particularly as it imposed a model of patriarchal rights and institutionalized discrimination against Indigenous women (Anderson, 2009; Basile, 2017; Boyer, 2009; Nahanee, 1997; Van Woudenberg, 2004). The following quote clearly demonstrates the deliberate nature of these attempts: "The disappearance of Indigenous women's footprints on the land is not only the result of inaccurate historical descriptions but is also the consequence of contemporary political actions and power struggles" (Van Woudenberg, 2004, p. 83, Translation).

This disappearance "of Indigenous women's footprints on the land" represents an erasure of the power that these women have always exercised within their society, in one word: their leadership. And this process of invisibilization is not just the result of forgetting women's contribution to the historical narrative of their people's colonization. This oversight was also facilitated through a number of means, of which forced settlement plays a key role. As such, the disappearance of Indigenous women's 'footprints on the land' must be understood as the erasure of their presence on the traditional lands they have inhabited since the dawn of time, a modification of their territoriality by external forces.

The concept of territoriality refers to the objective and subjective relationships that individuals maintain with the land (Desmeules & Guimond, 2018). Beyond accounting for systems of land tenure and resource management, the concept of territoriality also refers to the knowledge, values, epistemological and ontological principles, as well as forms of authority and responsibility that underpin and shape Indigenous Peoples' relationship to their land (Bishop, 1986; Poirier, 2001; Scott & Morrison, 2004). Studies in the field also assign to this relationship a fundamental role in the makeup of Indigenous identity (Bonnemaison, 1981; Di Méo, 2002, 2004) :

> Through identification with a particular territory, by engaging with it through their practices and language, by valuing it and even defending it, individuals or communities forge their singular identity (Lussault, 2013). The land, as a background for specific practices, is the bearer of referents and symbols that shape an individual's or group's concept of self-identity. (Desmeules & Guimond, 2018, p. 301, Translation).

The land is at the heart of Indigenous people's identity, as it is the "place of origin", an integral part of one's self-identity as an "Indigenous person" (Basile, 2017). Another study also demonstrates that for the Atikamekw, Nitaskinan and land-based activities are understood as being essential to overall well-being in terms of physical, mental, emotional and spiritual health:

> As highlighted by Béland (2021), *Nitaskinan* is an essential element of the Nehiromowin[5] identity, because it is in the territory that underlies the roots of traditions and culture. It is in the territory where youth build their identity. Going on the land is an opportunity for the Nehirowisiw to get out of the community, which is based on political and legal structures that do not represent them. On the land, they can exercise their self-determination and practice their cultural identity (Périllat-Amédée *et al.*, 2021, p. 54-55).

This relationship is very much alive and adapts to changes without being distorted. Therefore, Indigenous peoples can work towards the exploitation of natural resources while maintaining their identity-related relationship with their territory since "traditions and contemporary development are not incompatible" (Desmeules & Guimond, 2018, p. 306, Translation).

Studies on territoriality are often gender blind (Basile, 2017; Van Woudenberg, 2004). Yet, the knowledge required for care in general, and for pregnancy, childbirth and afterbirth care in particular - areas more specifically handled by women - confirms that they were just as familiar with the land and the management of its resources as men (Dawson, 2017; Van Woudenberg, 2004). Indigenous women's connection to the land cannot, however, be essentially reduced to a utilitarian knowledge, since it is expressed in all areas of human life, including spirituality (*ibid.*). On this point, Dawson (2017) sums up the spirit of this connection perfectly: "Birth on the land, therefore, reflected the interconnected nature of humans, animals, and spirituality" (Dawson, 2017, p. 153).

5 The term Nehiromowin refers to the Atikamekw language. Nehirowisiw should be used to designate the People or the individual.

Sedentarization and exclusion from the land

Paul Charest's monograph (2021) on the sedentarization of Innu communities offers insights into this process in the cases of Ekuanitshit and Nutashkuan, two of the three communities taking part in the research. We learn that "concomitantly, as if to free up territories for exploitation by large industrial companies, five new reserves were created between 1949 and 1969", including Natashquan/Nutashkuan in 1954 and Mingan/Ekuanitshit in 1963 (Charest, 2021, p. 220, Translation). According to the literature, several government interventions have definitively accelerated the sedentarization of groups associated with these communities or reserves:

> Those of the federal government, through the creation of permanent settlements, their institutions and management systems; those of the provincial government, to encourage the creation of major industrial complexes to exploit the territory's forestry, mining and hydroelectric resources, through the granting of resort leases, outfitting operations, hunting and fishing licenses, and in particular the system of beaver reserves (*ibid.*, p. 221, Translation).

Factors to which:

> We can add a greater access to the interior of Innu families' hunting territories for non-Indigenous peoples through the construction of new roads and railroads associated with industrial developments. All these developments had a marked effect on the nomadic activities of the Innu, and accelerated the process of sedentarization, as evidenced by the archives and other documents consulted (*ibid*., Translation).

In parallel, from the mid-twentieth century onwards, the government began to divide the territory into lots for allocation to Indigenous household heads, generally men. In many Nations, including the Atikamekw and Innu, once married, women left their family clan to join their husband's clan and occupy his father's family territory (Basile *et al.,* 2017; Nadon-Legault *et al.*, 2022). Historical documents refer to an erroneous view of the role of Indigenous women, restricting them to performing "domestic" tasks and staying at the camp, while men were considered to be the hunters and warriors (Desbiens, 2007; Kermoal & Altamirano, 2016; Van Woudenberg, 2004). This probably reinforced the paternalistic notion that Indigenous men held the role of head of the family, and that stewardship of the family territory fell to them without regard for women. However, "women could also contribute to subsistence by hunting and fishing in the camp's vicinity. If need be, they also cut wood" (Charest, 2021, p. 144, Translation) and their role was undeniably complementary to that of the men (Lévesque *et al.,* 2016; Venkataraman, 2021). The same applies to the care and support of pregnant women and, more generally, to the health of these societies, traditionally under the responsibility of women (Van Woudenberg, 2004). Several researchers have denounced the exclusion of Indigenous women from decision-making circles and the non-recognition of their traditional roles, knowledge and responsibilities by colonial policies (Basile, 2017; Brodribb, 1984; Kermoal & Altamirano-Jiménez, 2016).

Maltais-Landry (2017) explains that in the 1950s, in order to protect *Nitassinan* ("our land" in the Innu language) and particularly the declining beaver populations, the Innu asked the government to undertake a safeguard program, based on the model developed by the Cree/Eeyouch, namely beaver reserves. Instead, "the government proceeded to divide *Nitassinan* into individual registered plots. Trapping 'plots' were assigned to families. [...] Today, each family refers to its plot as 'my land'" (Maltais-Landry, 2017, p. 63, Translation). The objective of setting up beaver reserves was "on the one hand, to repopulate these regions with beavers, whose numbers had declined alarmingly in the 1920s due to overhunting, and on the other hand, to 'rationalize' the exploitation of this species by relying on the system of family hunting territories already in place" (Charest, 2021, p. 816, Translation). However, it was "no longer a question of respecting the traditional system of tenure, but rather of putting an end to a situation considered chaotic by assigning each person their own territory" (*ibid.*, Translation). Indeed, the highly mobile Innu hunting activities, impervious to fences, barriers or boundaries, disturbs the land-use planning practices promoted by the province's territorial order in which spatial entities, such as beaver reserves and all types of hunting grounds, must be strictly delimited.

The system of beaver reserves on Innu land in Nutashkuan was implemented by the Quebec government in 1955, with the collaboration of the federal Department of Indian Affairs, two years after the creation of the Ekuanitshit reserve territory (1963). The implementation of this system was the culmination of a long legal and legislative process, preceded in particular by the creation of private hunting and fishing clubs, vacationing activities, the creation of zecs, etc., and leading to the upheaval of the "traditional exploitation system of territories and resources by Innu families" (Charest, 2021, p. 832, Translation). This process can be summed up as follows:

> The invasion of Innu hunting grounds by steadily increasing numbers of non-Innu, facilitated by government measures of all kinds, led the Innu to visit these areas less often, as they could no longer live there adequately, and consequently drove them to stay on the reserves for longer periods of time (*ibid.*, Translation).

The compulsory enrolment of Innu children in day schools also contributed to a decline in women's use of the territory. At that time, half the children attended the Sept-Îles-Maliotenam residential school, and the other half the Longue-Pointe-de-Mingan day school. Those attending

the residential school came from families still living a nomadic lifestyle, while "attendance [at the day school] led mothers to stay at the Mingan settlement even before it became a reserve" (Charest, 2021, p. 270, Translation).

As in Ekuanitshit, it was proposed to establish a reserve near the village of Natashquan as early as the end of the nineteenth century, a recommendation agreed to by the then nascent indigenous authorities and then officially formalized in 1963, although camps, tents and gradually houses were already standing on the same site. And again, as in Ekuanitshit, children's schooling began even before the official creation of the reserve since "as early as 1950, schooling began in a tent school provided by Indian Affairs" (Charest, 2021, p. 273, Translation). This period is characterized by increasingly forceful federal government medical programs and policies, of which the restructuring of the Indian Health Service in 1945 to capitalize on the mobility of doctors, nurses and dentists in the region (Lévesque, 2021). At the same time, several stakeholders are accelerating the sedentarization of people in Natashquan/Nutashkuan. In that respect:

> The 1950s-1960s were marked by several events: the opening of the coastal and inland territory to mining; the first cohort of school-age children leaving for the Maliotenam residential school; the establishment of the reserve and construction of the first houses in 1954; the arrival of a resident missionary in 1958, followed by the construction of a chapel in 1962 (Charest, 2021, p. 275, Translation).

The sedentarization process had the same effect on the women of Nutashkuan as on those of Ekuanitshit, since "mothers and their school-age children stopped going to the land because of compulsory schooling" (*ibid.*, p. 276, Translation).

For the Atikamekw, the major changes in land use are mostly related to the creation of reserves, the children's mandatory attendance at residential schools (Basile *et al.*, 2022) and the use of paid labour, primarily in forestry (lumberjacks, log drivers) and as hunting and fishing guides (Gentelet *et al.*, 2005). Over the course of the twentieth century, the Atikamekw territory became "not only a transit route but also a prospecting ground for future industries" (Gentelet *et al.*, 2005, p. 11, Translation). In the specific case of the Opitciwan community, the construction of dams (notably the La Loutre dam) and the flooding of the land for hydroelectric development caused the community to move twice. The loss of access to land and resources for subsistence inevitably meant that the Atikamekw had to turn to other sources of income. The competition that developed between the Atikamekw and the Euro-Canadians for control over the territory created an imbalance of power that tested the Atikamekw's great flexibility and resilience (Poirier, 2001). In fact, before the introduction of government policies and programs, each family identified with a part of Nitaskinan. In a study by Basile *et al.* (2022), it was shown that wildlife management was the responsibility of the territory chief (often also head of the family), while the camp was managed by the women. Complementary roles were essential for nomadic life on the land, and the role of the woman was just as important as that of the man. This balance was disrupted by the pressures of colonization.

To this day, Indigenous women remain legally excluded from decisions concerning their land, and they are virtually never called upon to take part in consultation activities (Basile, 2017; Maertens & Basile, 2022). It can be said that "generally speaking, women are still rarely involved in consultation processes concerning development projects taking place on their lands; they want to be more actively included (Basile 2017; Nadon-Legault, 2020)" (Maertens, 2022, p. 150, Translation). Basile (2017) explains that by having a marginalized role in their own society, Indigenous women are rarely invited to join in the search for solutions on effective territorial governance. Women's knowledge is most often ignored in land-related consultations (Basile, 2017).

For Indigenous feminists, decolonization will only be achieved with the return of Indigenous women to all levels of governance - community, regional and national - and in all areas, including territorial issues (Basile, 2017; Coulthard, 2014; Kermoal & Altamirano-Jiménez, 2016b; Kuokkanen, 2019; Simpson, 2012). Demonstrably, "through colonialism, male-centred values were imposed and used to shape institutions, laws, policies, and legislated discrimination which have had continued and long-lasting negative effects on the health of Indigenous women" (Shahram, 2017, p. 16). We therefore need to break down this male monopoly to make a greater place for women.

In a work focusing on the Ekuanitshit Innu and the Romaine hydroelectric project, Desmeules & Guimond (2018) point out that Northern Quebec has developed around a deep ignorance of the northern world. This obliviousness is rooted in specific representations, including the existence of "a *terra nullius*, a vast wild and uninhabited space, a pool of inexhaustible resources for the needs of the South [... so that the] material and figurative appropriation of the North has reinforced the dispossession of the communities that have lived there for centuries, even millennia" (Desmeules & Guimond, 2018, p. 298, Translation). Among the Atikamekw, a study shows that:

> In the early 1970s, the Atikamekw became politically organized. In 1979, the Conseil des Atikamekw et des Montagnais began a comprehensive land claim process that, to this day, has not led to an agreement (Poirier *et al.* 2014). Since then, Nitaskinan has continued to be subject to logging, road development,

> resort activities, hydroelectric and high-voltage line development, and mining exploration by outside interests (Basile *et al.*, 2022, p. 10, Translation).

Lastly, although the Atikamekw and the Innu have experienced sedentarization in different ways, these two neighbouring peoples have a similar relationship with the land, which is reflected in their great ability to adapt despite the upheavals in their ways of life:

> The sedentarization of the Innu and Atikamekw, formerly nomadic groups, has led to changes in reference markers and spaces, with major consequences for their cultures, lifestyles and traditions. Because the land occupies an important place in the structuring of Indigenous societies, and also in the strategies of social actors, sedentarization upends their social, symbolic itineraries (Gentelet *et al.*, 2005, p. 33, Translation).

Among the social practices most affected by these upheavals in lifestyles are land births which play a pivotal role in the construction of connections with the land.

The importance of birth on the land

Indigenous knowledge and practices surrounding childbirth generally belonged to the feminine sphere (Basile, 2017; Begay, 2004; Dagenais, 1982; Lévesque *et al.*, 2016; Olson & Kuntz, 2016). Women are the essential driving force in the transmission of traditional medical knowledge. In Nutashkuan, for example, "women are considered to be the ones who know and apply traditional medicine" (Dagenais, 1982, p. 247, Translation). In fact, in most traditional Indigenous societies, the essentialization of maternal qualities forms the basis for the complementarity of male and female genders (Anderson, 2009; Arnaud, 2014; Seraphim, 2014). The fundamental role of women is therefore to nurture and care for the nation, a role still greatly valued even within contemporary Indigenous societies (Bousquet & Morissette, 2014; Brunschwig, 2015; Seraphim, 2014). In the past as today, the ability to give and care for life has bestowed great power onto women within their own families and communities.

In a cosmological conception of Anishinaabek social organization, *madjimadzuin* refers to the 'life line', the 'human Milky Way' or the 'moving life', that is, the continuity of existence, the chain connecting great-great-grandmothers to great-great-granddaughters (Anderson, 2011; Nahwegahbow, 2017; Well Living House, 2021). An Anishinaabe member of the Wasauksing First Nation told us that the life line was connected to the celestial body and to the stars of the Milky Way (Jenness, 1935). It is this astral kinship that sustains the earth. In the same way, the roles and obligations of each person within the family form a human chain that ensures the continuity of life. Women play the leading role in *madjimadzuin*, as they are the givers of life and the transmitters of culture (Anderson, 2011; Nahwegahbow, 2017). The concept of *human Milky Way* reflects, in part, the organization of social and biological reproduction by women. Studying this concept helps us understand the unique nature of female roles and knowledge in Indigenous societies. However, "overall, men and women's 'jurisdictions' worked together as part of a system aimed at ensuring balance and well-being in the community" (Anderson, 2011, p. 99).

In research on Naskapi traditional knowledge and practices, four organizational principles of knowledge systems were established: (1) differentiation between male and female spheres; (2) complementarity of spheres; (3) transfer of teachings from one sphere to the other as a preventive measure; (4) integration of the two knowledge systems in an egalitarian manner (Lévesque *et al.*, 2016). This organizational model provides a better understanding of the role played by men in pregnancy and childbirth on the land. And indeed, although birth-related knowledge and practices generally belonged to women, men played a complementary role during pregnancy and childbirth, for example by providing firewood and game (Charest, 2021; Lévesque *et al.*, 2016). To ensure the safety of women and children when deliveries took place during travel on the land and in the absence of midwives or other women to support the mother, the teachings also had to be known by men (Basile, 2017; Lévesque *et al.*, 2016; Routhier, 1984; Olson & Kuntz, 2016; Well Living House, 2021).

Though the teachings about childbirth were known by all, pregnancy and childbirth were the responsibility of midwives (Anderson, 2011). They possessed unquestionable 'authority' within their communities, but since Indigenous societies were complementary, their expertise was more a matter of respect than power (Routhier, 1984). Younger midwives acquired their skills gradually through experiential training by attending many births, then assisting in the gathering and preparation of medicines with the older midwives (Anderson, 2011). Attending residential schools and relocating childbirth to hospitals greatly influenced the transmission of midwifery knowledge (Anderson, 2011; Basile, 2017; Routhier, 1984). Numerous written sources inform us about the specific teachings of midwives, including a wide range of medicines that act (or not) on fertility, gestation, contractions, recovery from childbirth and breastfeeding (Anderson, 2003, 2011; Basile, 2017; Begay, 2004; Havard & Laugrand, 2014; Routhier, 1984; Olson & Kuntz, 2016). Citing Navajo customs, Begay (2004, p. 559) points out that childbirth practices were learned by observation as part of a sex education that took place outside formal courses so that "it was part of the total system of life in which knowledge was acquired without institutional instruction", while institutionalization of childbirth caused by the takeover of this stage of life by public and government authorities has diminished the family's responsibilities and role in supporting women in childbirth (Begay, 2004). The following quote illustrates

this phenomenon:

> The gift of birth should not (in most cases) require a healer or medical practitioner, only a supporter (…) pregnant women have been pathologized and birth medicalized to such an extent in Euroamerican societies that this reconceptualization of birth, not as a procedure but as a sacred gifting process, is a necessary rearticulation (Finestone & Stirbys, 2017, p. 179).

Pregnancies and births are fundamental spatiotemporal markers in the life of Atikamekw women in Nitaskinan, the Atikamekw territory (Basile, 2017). Indigenous societies attach great importance to birthplaces, even if the federal government has intentionally invisibilized and immaterialized these sites (Lawford, 2011) ignoring the customary and spiritual aspects binding women to the land (Kermoal, 2016). Generally, birthplaces located on the land carry the surname of the person who was born there, and these surnames are known and remembered in family toponymy (Anderson, 2011; Bouchard & Lévesque, 2017; Éthier *et al.*, 2019; Olson & Kuntz, 2016). For example, in the family of Métis elder Maria Campbell, the birthplace of her cousin Jenny in a blueberry patch on the side of a hill, has always been known as 'Jenny's berry patch' (Anderson, 2011, p. XV). Stories about these name places are then passed down within families. Accordingly, the Tłı̨chǫ Birthplace Mapping project (2016) involved documenting the traditional knowledge surrounding childbirth on the land, in order to entrust it to the next generation. Mapping was used to connection elder's stories and oral Tłı̨chǫ narratives to the landscape and to birthplaces (Olson & Kuntz, 2016). The participants described the relational aspect of these places, mentioning that they are important "both for the mother and the baby which connect them directly to the land and these specific areas" (Olson & Kuntz, 2016, p. 6).

To better understand the importance attached to the moment of birth, we can refer to research carried out by Rachel Olson, Charlotte Moores and Kathleen Cranfield and published in their book entitled *Born into my grandmother's hands: honouring First Nations' birth knowledge and practice in North Yukon* (2019) as well as the works by Kim Anderson, of the Métis Nation and Professor at the University of Guelph, published in her book *Life Stages and Native Women : Memory, Teachings, and Story Medicine* (2011). Anderson focuses on women's life cycle teachings in the traditions of the Métis, Cree, Ojibway and Saulteux Nations. She emphasizes the importance of celebrations and rituals in the construction of gender identity. Her work illustrates how the rhythm of these cycles orchestrates community and family life in Indigenous societies, within a framework of intergenerational complementarity. Roles and responsibilities evolve along life stages with each of them punctuated by a rite of passage. Coming into the world is the first rite of passage, it is a pivotal, spiritual and sacred moment (Anderson, 2011; CWEIA, 2018; Simpson, 2006). A woman's first birthing is a fundamental ceremony since this event ensures her passage to adulthood (Anderson, 2011). Similarly, "by giving birth to a new person, the woman is spiritually joined to both the past and the future", therefore, childbirth is a fundamental moment of cultural identification and spiritual connection (Begay, 2004, p. 556).

For the Atikamekw, the relocation of women's birthing sites has contributed to changing the name of the place of origin (Basile, 2017). For example, during the interviews conducted by Atikamekw researcher Suzy Basile, the women she interviewed who had been born in a hospital sometimes referred to their place of origin by the name of the community in which they grew up or lived. In fact, the term *notcimik*, in the Atikamekw language, (*nutshimit* for the Innu) used to talk about the forest, the woods or the land (Basile, 2017; Éthier & Poirier, 2018; Wyatt & Chilton, 2014), can also be translated by the expression 'the place where I come from' (Basile, 2017). This term can therefore refer to their origin, place of birth and/or belonging. *Notcimik* describes a place where you can be in symbiosis with nature, and this relationship with the land, plants and animals ensures a sense of well-being and renewal (Basile, 2017). Being on *notcimik* from birth reinforces the attachment and relationship between children and the land (Éthier *et al.*, 2019).

In addition to displacing the place of birth, the medicalization of childbirth has also limited the ritual surrounding the disposal of the placenta (Basile, 2017; Éthier *et al.*, 2019; Jérôme, 2008). Actually, many Indigenous peoples attach great symbolic importance to both the placenta and the umbilical cord. In the Māori society, "the term *whenua* means both 'placenta' and 'land' and because of the great respect shown by the Māori to both, the placenta is burned" (Basile, 2017, p. 185, Translation) or it is buried to establish a 'home place' for the newborn child (Simmonds, 2017). Same practice in French Polynesia where the policies of evacuation of deliveries to urban centers jeopardize its perpetuation (Saura, 2020). In North America, the way to dispose of the afterbirth varies greatly from nation to nation, community to community and family to family, but is often accomplished through a traditional ceremony (Anderson, 2011; Basile, 2017; Havard & Laugrand, 2014; Olson *et al.*, 2019) Among the Atikamekw, as among the Anicinapek (Bousquet, 2016), the placenta is generally buried at the foot of a tree on the land to consolidate the spiritual connection between the child and this territory (Basile, 2017). This practice takes the form of a ceremony called *otepihawson*, which translates as 'returning the heart to the land' (Jérôme, 2008, p. 10, Translation). In addition to its spiritual significance, the place where the placenta is returned to the earth marks a presence and a sense of belonging to the territory (Éthier *et al.*, 2019). In Atikamekw customary law, the placenta is buried on the family hunting ground (Éthier *et al.*, 2019). *Otepihawson* ensures the

development of a relationship between the individual and their social and natural environment and is an integral part of the ritualization of childhood in the Atikamekw Nation (Jérôme, 2008). However, this ceremony has long been impracticable owing to the medicalization of childbirth. In fact, the placenta was considered to be biomedical waste in Quebec until 2017 (MSSS, 2017). So, for several decades, many women were denied the request to retrieve their placenta following a hospital delivery (Basile, 2017; Éthier *et al.*, 2019). An Atikamekw woman tells us:

> For women, it's a sacred ritual now making a comeback. Many young women wish to bury their placenta on the land at the foot of a tree, but in most cases, hospital doctors do not support this practice for medical reasons (the placenta must be sent to laboratory). This has led to conflicts between the families and the hospital's medical staff (A14) (Basile, 2017, p. 166, Translation).

Exploring the themes of pregnancy and parenthood through the prism of Indigenous feminism shows that "a connection exists between the advancement of colonization and practices designed to control the bodies of Indigenous women (Olson 178)" (Finestone & Stirbys, 2017, p. 181). In addition to depriving Indigenous women of the right to choose with whom, where and how they wish to give birth, the control and the institutionalization of births have contributed to alienating Indigenous women from their spirituality: "Overall, birth was a time for women to honour and celebrate the 'prodigious power' they held as life givers (Corea 303)" (Finestone & Stirbys, 2017, p. 179).

This dispossession of the right to decide for oneself is largely explained by the gradual process of medicalizing childbirth. "Physicians were relegating Indigenous knowledge of childbirth to the past, as something not quite up to the standard of scientific and technological advances of the medical profession; they framed Indigenous birth methods as 'risky' by comparison" (Finestone & Stirbys, 2017, p. 180). Canada and Quebec are no exception to this pattern.

A historical look at the medicalization of childbirth

In First Nations communities in Canada, the medicalization of childbirth took place in two stages : the federal government started by marginalizing the role and knowledge of midwives, then used coercive pressure on First Nations to adopt the Euro-Canadian biomedical model (Lawford, 2011). In her thesis submission, Karen Lawford (2011), Indigenous midwife and associate professor at Queen's University, demystifies the evacuation policy that applies to First Nations pregnant women living in isolated or rural communities in Canada. As a precautionary measure, women are sometimes evacuated at 36 weeks of pregnancy (Lawford, 2011). Ekuanitshit, Nutashkuan and Opitciwan, the communities involved in this research, are no exception to this practice of evacuating pregnant women, and therefore to the forced relocation of birthplace from the community to the hospital.

The situation of Innu and Atikamekw communities in the early 1980s is well documented in a profile on their healthcare services commissioned by the Conseil Atikamekw Montagnais (CAM) and prepared by physician Louise Dagenais (Dagenais, 1982). This report mentions that, at that time, there were no resident doctors in the communities, a shortcoming alleviated at best by itinerant medical staff made up of various specialists, and at worst by trips to the nearest hospitals for curative care. We also note the presence of a nurse-run dispensary in each community. However, this profile points first and foremost to the inadequate management of the supervising nurse at Opitciwan in the early 1980s. It would appear that she did everything in her power to limit birthing possibilities in the community, in favour of evacuating pregnant women to Roberval or La Tuque (Dagenais, 1982). This policy of compulsory evacuation from the 32nd week of pregnancy (7th month) raises a number of problems, not only in terms of the physical and psychological comfort of pregnant women, but also in terms extremely limited communication with hospital nursing staff due to the language barrier (*ibid.*). The same is true of Ekuanitshit and Nutashkuan, where pregnant women at 32 weeks of gestation are systematically evacuated to the Jean-Eudes hospital in Havre-Saint-Pierre (*ibid.*), a transfer deemed as being premature by the author of the CAM report (*ibid.*).

This evacuation policy was not always described as such. Consequently, it should be understood as a set of state-implemented laws, standards or actions designed to achieve certain predefined purposes which attest to the federal government's intention to govern, impose its will, influence individuals and control pregnancies and childbirth as part of a larger strategy to assimilate and civilize First nations peoples (Lawford, 2011). One of these end results is the downgrading of midwives' roles to benefit and overvaluation of doctors' and nurses' expertise. In Quebec, the Collège des médecins is probably one of the institutions most involved in the process of dismantling midwifery practices. Starting in the mid-nineteeth century, in collaboration with Canadian medical associations and the legislature, the Collège succeeded in eradicating and/or subordinating its competitors from the medical care market in order to appropriate "a monopoly over most diagnostic and therapeutic activities" (Goulet, 2004, p. 43, Translation). At that time, while the Collège was fiercely attacking the validity of certain practices such as those performed by healers and bonesetters, midwives and nurses were being downgraded to the status of auxiliaries (Goulet, 2004; Routhier, 1984). Midwives in rural areas remained exempt from medical supervision for a longer period (Goulet, 2004), but the intensification of medicalized childbirth in the 1940s and 1960s eventually led to the end

of 'natural' childbirth throughout the province (Routhier, 1984).

The development of modern medicine has meant an increase in life expectancy, thereby contributing to the increased notoriety of physicians (Goulet, 2004). The predominant role played by this medical profession in the development of today's healthcare system certainly ensures that standards of care are higher, but it also shapes a deep male-dominated model of reproductive health. In the early 1980s, in Quebec as elsewhere in the Western world, "it is the male doctor, but above all the OB/GYN male specialist, who is the expert in this field: as a phenomenon specific to our contemporary industrialized societies, control of reproductive functions has been transferred from women to men (Oakley, 1976, 1978)" (Laurendeau, 1987, p. 174, Translation). Although the disappearance of midwifery is a widespread phenomenon in both non-indigenous and Indigenous societies, it is necessary to distinguish between the processes applied and the consequences generated.

In an article examining childbirth among Atikamekw women in Manawan, anthropologist Marie-Josée Routhier describes this transition of birthing locations. Beginning in the 1940s, the Atikamekw started to give birth in hospital as a result of pressure exerted by nurses and agents of the Department of National Health and Welfare (DNHW)[6] (Routhier, 1984). In the 1960s, many Atikamekw women continued to give birth in Manawan with the help of midwives. However, the introduction of new notions such as "high-risk pregnancy", "complications" and "danger" caused great confusion among Atikamekw women, prompting some to look to hospital services as a preventive measure (*ibid.*). The bafflement experienced by the first to give birth in hospital comes from the many contradictions they faced: avoiding complications by accessing medical care while foregoing their way of life, their network of solidarity and security, and going into exile in an environment alien to their own culture (*ibid.*). Despite strong initial resistance, the ongoing confrontation with religious and medical discourse succeeded in making Indigenous women feel guilty and helpless. Left "clueless about their needs"[7], Atikamekw women must resign themselves to trusting the medical and nursing teams during pregnancy and childbirth. Over time, this rendered traditional practices surrounding First Nations pregnancy, childbirth and childcare unnecessary(Lawford, 2017).

Yet the hospitals serving the Innu and Atikamekw communities involved in the research have received many complaints. For example, "the wishes of mothers to breastfeed their babies are not respected" in the hospitals (Roberval and La Tuque) receiving the Opitciwan community population (Dagenais, 1982, p. 113, Translation). Forty years later, the Viens Commission report (2019) reminds us that, all too often, complaints lodged by Indigenous people against healthcare services in Quebec have been ignored. Medical professionals perform certain procedures without ascertaining that the patient fully understand their implications. Poor communication between community resident nurses and hospital staff regarding the follow-up records of evacuated patients often mean that nurses accompanying patients will only have incomplete paperwork or have trouble tracking down file updates.

One of the main characteristics of the healthcare model developed in Canada over the last century is that of hospitalocentrism (Desrosiers, 1999; Gaumer & Desrosiers, 2004). This rationale has led to the concentration of care in a number of hospital centers, in clear opposition to a range of care being broadly distributed across a variety of health services located in different establishments (Desrosiers & Gaumer, 2004). From the 1950s until the transfer of responsibility in 1979, the federal government was responsible for the deployment of on reserve health centres (Lévesque *et al.*, 2018). Paradoxically, at the very time when the latest advances in medicine were moving towards accessibility through the development of community health services, Indigenous women were being still forced to give birth in hospital to receive the care their condition required (Routhier, 1984). Concentrating care for pregnant and parturient[8] women in hospitals ensures proximity between obstetrics and other specialized medical units, with the objective of reducing infant and maternal mortality rates (Lawford, 2011; Routhier, 1984). That being said, First Nations high infant mortality rates cannot be attributed to midwives, since the number of stillbirths were relatively low (Routhier, 1984). In fact, among the Atikamekw, infant mortality increased considerably with the introduction of cow's milk and the relocation to poorly insulated, hard-to-heat federal housing with no access to drinking water (Dagenais, 1982; Routhier, 1984). Based on figures taken from the MSNBES and Quebec regional directorate annual reports, we can see that "among Quebec Indians, the mortality rate for infants is 26.1, lower than that for Canadian Indians, which is 37.5. However, it remains twice as high as the Quebec average of 11.9" (Dagenais, 1982, p. 342, Translation).

Data collected by Statistics Canada between 1989 and 2008 also show that, at the dawn of the twenty first century, maternal and infant mortality rates are higher among First Nations than in the rest of the population (Gilbert *et al.*, 2015). According to a study conducted by the United Nations Population Fund (UNFPA, 2017), perinatal and maternal mortality is higher among women from Indigenous populations. Even if these women do not constitute a homogeneous group, this phenomenon can

6 Former designation. Under the responsibility of Department of Mining and Natural Resources up to 1945.
7 Godbout Commission, cited in Lévesque *et al.*, 2018, p. 12.
8 This term refers to a woman who is in labour.

be explained by the many obstacles they must overcome to access medical care, despite their greater exposure to health problems (UNFPA, 2017).

In Canada, observable health-related disparities between each of the First Nations and the non-Indigenous population can be attributed to jurisdictional shortcomings and conflicts between the provincial and federal governments (Lévesque *et al.*, 2018)[9]. While hospitals and CLSCs fall under provincial jurisdiction and are located in cities (Gaumer & Desrosiers, 2004), on-reserve health services are federally funded but self-governed as stipulated in the Indian Health Policy adopted in 1979 (ISC, 2021b). Yet, health funding allocated to band councils is insufficient, being based on historical expenditures that vary according to the number of registered members, rather than actual needs (Lévesque *et al.*, 2018). Therefore, access to healthcare for an Indigenous person varies considerably depending on (1) their Indian status; (2) whether they belong to a treaty or non-treaty nation; and (3) their place of residence and domicile (Lévesque *et al.*, 2018).

In addition to physical health, the mental health of Indigenous women, during pregnancy and following childbirth, is also at greater risk than that of non-Indigenous women (Roy, 2019). This may be due in part to the transmission of intergenerational trauma stemming from the colonial past (Roy, 2019). Another important factor is the stress caused by the women's isolation after their evacuation to hospital. Since Health Canada does not cover travel and accommodation costs for relatives of these women, support is limited (Dagenais, 1982; Lawford, 2011; Routhier, 1984). The management of family responsibilities by those compensating for the absence of the mother evacuated to the city can be added to this financial and organizational burden (Lawford, 2011). A study in Nursing Science on childbirth experiences of Mi'kmaq women in Nova Scotia reveals that women often feel unprepared at the time of giving birth (Whitty-Rogers *et al.*, 2006). This feeling is essentially based on the lack of information about the physical process of giving birth, but also about parenthood and motherhood, causing stress, fear and anxiety that can be detrimental to the woman's health (Whitty-Rogers *et al.*, 2006).

Indigenous women's power is linked to their kinship and spiritual ties. They are women, but also mothers, grandmothers, sisters, wives and so on, and occupy various spheres of power through their respective positions. Not only do they fulfill their family roles, but they also help strengthen alliances (Basile *et al.*, 2022; Van Woudenberg, 2004). All of these facets contribute to the creation of territories through an interplay of relationships we call territoriality. The history of medicalized childbirth demonstrates how policies such as forced hospitalization can serve to deconstruct the importance of land birthing, and by doing so, deeply transform the pregnancy-related territoriality of Indigenous women, a role held in great esteem by Innu women in particular (Mailhot, 1983), and ultimately exerting a negative influence on their identity.

Traditionally, aunts, grandmothers and midwives have accompanied mothers at every stage of pregnancy and childbirth, whereas today, women are often frightened at the moment of giving birth and find themselves isolated from their natural support network once they are hospitalized (Begay, 2004; Simpson, 2006). To better understand how the medicalization of childbirth leads to a decline in the health status of Indigenous peoples, it is important to reconsider the notion of health. For Algonquian peoples[10], *mino-pimatisiwin* represents the individual and collective health and well-being within the community (Anderson, 2011). This holistic notion describes a state that equates to 'good life', to a 'full and fruitful life' and to 'healthy living' (Hart, 2020; Nahwegahbow, 2017; Radu *et al.*, 2014). It refers to the growth and healing of the physical, mental, emotional and spiritual spheres, reflecting the values of respect and sharing, both of which are directly anchored in the land (Guay & Delisle L'Heureux, 2019; Hart, 2020). This term does not contradict the notion of health as defined by the World Health Organization (WHO), i.e., "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (WHO, 2019, p. 1). However, the *mino-pimatisiwin* concept has the advantage of being more encompassing and better representing the Indigenous vision of health and well-being, precisely because it involves relationships with humans, non-humans, ancestors and the environment. In this respect, the connection to the land is deeply structuring for individual and collective well-being, and its construction traditionally begins with births on the land (Labra *et al.*, 2023).

9 However, a special land regime is applicable to three Nations in Quebec (Cree, Naskapi and Inuit) pursuant to their signing of the James Bay and Northern Quebec (JBNQA) and the Northeastern Quebec Agreement (Lévesque *et al.*, 2018, p. 13). These three communities are therefore designated as "treaty communities" in contrast to "non-treaty communities" in reference to all other First Nations communities in Quebec.

10 The Algonquian peoples of North America are a group of First Nations from Canada and the United States who share a similar linguistic and cosmological tradition. This term was developed by linguists and ethnologists to group together certain Indigenous groups who share some similarities in their social organization. In Quebec, it refers to the following peoples: Eeyou (Cree), Anishinaabe (Algonquian), Atikamekw Nehirowisiw, Innu, Naskapi, Wolastoqiyik (Maliseet), Mi'kmaq and Abenaki.

SECTION 3

Living and learning on the land

Living and learning on the land

The life stories shared by the women we met (n=15) documented the phases that led to their sedentarization in the communities, and consequently to the transformation of their relationship with the land. This first part of the results revisits the importance of going on the land, not only in shaping the identity of the participants and of those around them, but also in the transmission of knowledge traditionally associated with pregnancy and childbirth, and of which the midwives were the guardians. Because of the somewhat different historical trajectories of Innu and Atikamekw women despite some key commonalities, their stories will be presented successively. The choice of distinct presentations also applies to the next two sections (sections 4 and 5).

Innu women's connection to the land

Seven of the nine Innu women interviewed were themselves born on the land or under a tent in the newly established community pursuant to the sedentarization process. Only one gave birth to two of her children on the land, while the seven women had their first children in a tent or at home in the community, and the last ones in hospital. One woman had her only child in the hospital. All of the women interviewed had spent their childhood on the land, and had witnessed the deliveries of other women, including their own mothers, aunts and sisters. Their stories demonstrate that their connection to the land involves not only these highly significant moments, but also all the activities, myths and knowledge associated with these life stages in specific places. Their attachment to these places is still very much alive, and while some have been able to return since settling permanently in the community, others have never done so, but continue to nurture vivid and far from nostalgic memories of them.

Identification to the land

Birth and death sites are strong markers of territory and identity. A part of the identity of the Innu women we met is anchored in these sites, as well as that of their children, who were born there and are now adults. As one participant puts it:

> *"I recently saw a lady who wanted to go and see where she had given birth. One of her grandsons took her there. But she's very old, 85, I think. She was there for four days, she wanted to see, she walked around, and it reminded her of a lot of things. She had given birth to one of her children there. A death had occurred there too. And she saw it all. She was very happy to go there" (E3).*

Other participants speak of the pride associated with these births on the land:

> *"I'm proud of that. I talk about where I was born on the land. In the Innu language, the name of the land where I was born is Pitapeu. It's very, very remote and it means 'salt water that's green' if you translate it into English" (N1).*

> *"My brother is constantly saying: "I was born in the woods", it means he's very proud of that" (E2).*

Because their journeys lasted for weeks and sometimes months, the Innu way of life on the land nurtured close ties between members of the extended family. The nuclear family model was non-existent. Women travelled to the land with their husbands and children, to be joined eventually by grandparents, siblings, sisters-in-law and brothers-in-law with their own children - in other words, extended families living together in the same camp. Some participants describe their social organization. With the help of an interpreter, the first explains it as follows:

> *"Some people used to spend a year in the woods. With her father, her mother and her two brothers, she says there were six people who went into the woods. She says she took good care of her mother and grandmother. [...] She says that when they went into the woods, there were other people in camps. When they went for a walk, to prepare the camp, she picked up spruce boughs every time. Then she'd set up the tents" (E2).*

Other women tell us:

> *"There were two very old women who were with us when we went into the woods. There were three tents. They were the ones who carried all our sustenance provisions" (N4).*

> *"Yes, they were families grouped together, like my grandfather's. My mother's mother, everyone was together, they were in groups with several tents" (N2).*

This way of life required a full range of knowledge and know-how in terms of clothing, food, health care, travel, shelter and so on. For women, all the knowledge surrounding pregnancy and birth absolutely needed to be mastered as well as adapted to the resources available on the land.

Knowledge and know-how surrounding pregnancy

The women knew all there was to know about pregnancy and childbirth, and how to help the new mother in the days following delivery. The recovery period was rather short. When the time came to give birth, if the family had arrived at their camp, the birth would take place there with the help of the mother, sister or, if necessary, the father would go and find a woman in a nearby camp. Participants explain the essential role of midwives:

"The Innu would follow the Natashquan River and then cross into other territories, into other small rivers to get to their respective lands. When a pregnant woman was close to giving birth, they would return to the great Nutakuan River to find a midwife. A midwife was needed so that these women could give birth on the land" (N2).

Another woman relates this with the help of her interpreter:

"She was roasting a porcupine. After preparing her porcupine, she quietly returned to her tent. She didn't expect to give birth [right away]. She woke my father in the night.

She said to my father :

"I think I'm going into labour." Then my father said: "I'm going to get my mother (her mother-in-law)". She said, "Never mind, don't ask your mother." But her mother-in-law came. Her contractions didn't last, only an hour, and she gave birth" (E2).

She adds:

"But [for] the other [children], she says she gave birth in Mingan with two midwives. She says she gave birth only once upriver of La Romaine, farther north" (E2).

Another participant recounts:

"In those days, some women gave birth in the winter, and we were very worried that they would catch cold. But midwives knew what precautions were needed. For two or three days, the wood stove was always burning. It had to be fully loaded at all times, so that the mother who'd just given birth didn't catch a chill. The Innu tent was under watchful eyes and was covered to provide a little extra insulation so that the mother wouldn't catch cold. These were the kinds of precautions that were taken" (N1).

Furthermore, if childbirth occurred while the family was on its way to their territory or to the summer gathering site, everyone would stop for a few days at the place where the mother gave birth, and then set off again. One woman recalls how childbirth was everyone's business:

"Of course, there were a lot of births on the land, people were always on the move. If there was a birth, people gave birth. When they left, it was (for) six months. If you gave birth within the six months [...] someone would assist with the delivery. The elderly woman, the woman who was there would help deliver the baby. Yes, there are important places for them [referring to older women who had given birth on the land]" (E3).

As soon as the mother could, a few days after delivery or, for some, the very next day, she resumed her daily activities:

"They only stayed in the tent for three days after giving birth. Immediately afterwards, they returned to the land, many miles away" (N4).

One woman tells us:

"We had to wait for about four days in the same place when the woman gave birth. Time to recover. Then, the very next day, my aunt started working, she got up, she stayed in her tent and then my grandmother often went to cook, bring food and take care of the baby. The mother would sleep, then I'd say, "Go and get some water, you'll put some water here close by, we're going to heat up some water for the baby, we're going to wash him a little bit." We'd have to heat up the tiny sheets [and] they'd swaddle him" (N3).

Various techniques were used to make baby diapers, including the use of sphagnum moss, *masseukuashkamau* in innu language, known for its antiseptic properties:

"They had to look for rotting stumps, crush them into powder, then put a square of cotton, then put it near the stove to dry the stump powder. They used the moss too. When it was all dry, they put a layer on top and shaped it like a kind of bag, they used it as a diaper" (N3).

Another woman adds:

"In those days, we didn't have diapers. They gathered moss in the plains. That's what we used to make diapers" (N4).

Figure 4. Moss. Photo by Sylvie Basile, 2023

Additional knowledge relates more specifically to plant or animal based medicinal treatments:

"She told me there was a plant; it's useful for childbirth. To induce or accelerate, I think. She told me that when I was young. But I don't remember the name [of the plant]. But for pain, for contractions, it was beaver kidneys. It was probably soaked in water, as she used to tell me. She would give it to drink, and it would numb the pain. It took away the pain, it was a form of anesthetic" (E1).

A participant adds, with the help of her interpreter:

"She also says that they used porcupine skin as a pacifier for the baby. They gave it to her little brother, and he survived. They used it so he wouldn't go hungry" (E3).

After the delivery, the placenta – *Uatshishtun-ishkueu*, meaning "woman's nest" in Innu language, or *tatuashun,* the "baby bag" (like a "pillow" for some women) was buried near a tree or burned. From our interviews, however, it seems that this process was not the subject of a spiritual ceremony among the Innu:

"When they gave birth in the tents or on the land, the women put them [the placentas] in the fire" (N4).

"I think they said they burned it. Yes, they burned it. They didn't throw it away, they burned it. That's what I learned. I didn't see my sister when she delivered my baby, what she did with it. But they burned it. They didn't leave it lying around for the animals to eat" (E1).

Only one of the Innu elders explained that the placenta ceremony was sacred:

"In the tradition of the Innu nation, in the whole culture, the teueikan (drum) is highly revered, it's a sacred object that women can't touch or play. It's only for men. But our own teueikan is our placenta. It's sacred. That's why the placenta is sacred. That's why we can't leave it just anywhere, and why we have to burn it. So that it's not just anywhere. You have to give it to the fire as an offering" (N1).

Women also sometimes had miscarriages. Midwives also held the know-how to deal with these situations.

"I knew I was 2 months and a few weeks pregnant. I was in a canoe with my husband, and at one point I had a backache and a stomachache, and I didn't tell anyone. I was losing a lot of blood and my husband heated some wine for me, I think. I was very cold; I didn't really know what was wrong with me and my husband didn't know what was wrong with me either. He heated up some wine, and I thought that I'd get better with that. At night, that's when it really hurt. There was a kukum (grandmother) who came to help me with one of her friends who was the same age as me. They started putting resin on my belly to stop the bleeding. They changed my clothes and made sure I didn't lose too much blood. I was starting to turn pale and confused. I'd lost too much blood and miscarried in the tent. The next day, I laid down in the tent, as the kukum didn't want me to move. I lay in the tent all day. Two days later, we set off again to continue our journey, and I was taken into the canoe, swaddled in lots of blankets because I was cold. I was still bleeding, losing a lot of blood and getting weaker. At some point, my husband carried me on his back. I didn't want anybody to see me on my husband's back. My husband didn't want me to walk a lot or move around a lot. So, he carried me on his back to arrive after portaging to continue canoeing" (N4).

This meant knowing the territory and its resources to get by when needed. Solidarity between family members and the exercise of women's specific knowledge about pregnancy and childbirth were essential to everyone's survival.

The difficult transmission of birth-related knowledge

Knowledge about pregnancy and childbirth was not passed on to children; it was a taboo yet the subject of many myths. One participant shares what she was told about her own birth:

"When I was little, my mother told me: "You […], we found you in the firewood basket, there in the trail while gathering broken branches." So, that's where I was found, it seems. I believed it" (N2).

"When I asked her where I was born, she answered, well a bit like a fairy: "Suddenly, in one of the firewood boxes. That's where we heard noises then we saw you move around. You were running all over and your grandmother […] tried to catch you and that's how you were born" (N2).

Another participant tells how they hid information about a pregnant woman:

"I asked my grandmother: "Why is [she] so big? How come she has trouble walking?" They [the adults] never talked about it. It was very taboo to talk about this with children, and then I said: "What's in her belly?" [Grandmother answered] "Stop talking about that! You shouldn't ask that kind of question." It was not proper to talk about it in front of children. […] They'd rather have us believe that the baby was going to come from a tree stump and had hibernated there" (N3).

She goes on:

"I asked my grandfather: "What's happening in there?" He answered: "We're waiting for a baby very soon." "Where will it come from?" He said: "He'll run through the snow then into the tent". All sorts of things they had us believe" (N3).

A third participant explains why she was looking for a newborn:

"At breakfast, [name of a lady] said: "You gathered spruce boughs yesterday, but you didn't see a baby hiding in the bark? He was there!" After that, she closely examined each bough to find a baby [laughter]. She told her friend: "Hey, did you see a baby?" "No, I didn't" [laughter]. Grandmother said: "You've been in the woods too long looking for spruce." They searched long and hard for a child in the bark" (E2).

These myths endured and were adapted with the onset of home births when Innu families settled down. The same participant adds:

"I didn't know that my mother gave birth here, and I didn't know that my mother yelled out when she gave birth. After the birth, my grandmother came to show me my little sister. We used to play outside all the time, and then my grandmother said to me, "You didn't see a child outside under the stairs when you were playing?" I said, "No!" [laughter]. I didn't know she was pregnant. She gave birth here, in her house" (E2).

The taboos surrounding childbirth have also contributed to a loss of knowledge about pregnancy and birthing. They also led to a loss of trust in midwives among younger generations, while the presence of nurses and doctors was on the rise in communities. Participants talk about the lack of information:

« Je me souviens quand j'étais jeune, j'entendais les "When I was young, I remember hearing the kukum (grandmothers) when they were helping a woman give birth in a tent. The kukum would say: "No. You can't see that, you mustn't stay around, you can't see that, you're not allowed to see that." That's what they told us. It was a disservice to those who followed because I could have carried on the tradition and known what to do when a pregnant woman is having contractions" (N1).

"I was scared in those days; I didn't want those three kukum (grandmothers) to deliver my baby. I would have preferred to have a doctor. We had a doctor, but he was miles away. I was waiting for the doctor to come. I didn't want these midwives delivering the baby in the tent, because I was afraid it wouldn't go well. Or that the baby would be, I don't know... I didn't trust them, and I didn't know how to give birth. I didn't even know where the baby was going to come out. I wondered if I was going to have an incision. I knew nothing about childbirth. That's why I was afraid of the midwives. I had no idea how they were going to get the baby out" (N4).

"In 1962, I became pregnant, I had just gotten married. The following spring, in June, I was about to give birth, and then I was a little worried because my mother hadn't told me much about what was going to happen. Any information she gave me was very limited. She only gave me the essentials" (E1).

"With the last baby in our family, my mother gave birth at home. I wanted to be there, but I wasn't allowed. I already had two children and even then, she didn't want me to attend her delivery. But at the hospital, I was present at my daughters' deliveries" (N2).

The medical control exercised by nurses and doctors contributed to women's skepticism about their community's midwives and, for some, to their preference for a hospital birth. One participant recalls her experience:

"Because back then nurse started telling us to go to hospital to give birth. They probably didn't trust midwives. Even two or three years later, they insisted that we go to hospital. That's why" (E1).

"They stopped giving birth in the community in the 60s or the 70s. Hospital births started in the 1970s. […] it was mostly the nurses coming into the communities who didn't recognize birthing with midwives. […] they said that home births were quite unsanitary. Yet, we never noticed any infections. My sister gave births I don't know how many times. Probably close to 16 times in the community or on the land" (E1).

"I felt safer going to the hospital, since it was about forty kilometers from Mingan. There was a boat that came by once a week" (E1).

"It definitely had an impact [the transition of childbirth to hospital], it wasn't something we were used to [seeing]. Like, for example, being in a hospital with someone from another Nation. What's more, the women didn't speak French, so communication was also a problem. As I said [...] I thought it would be safer for me to give birth in hospital, but it wasn't what I felt [...]. I regretted not having given birth with my sister's help" (E1).

The perpetuation of taboos surrounding childbirth by elders with the younger generations, and specifically with children, seems to have created fertile ground for the imposition of a medicalized vision of this stage of life. At the same time, the nurses working in the Ekuanitshit and Nutashkuan community dispensaries probably played a key role in this dynamic, specifically because they discredited the traditional methods whose knowledge was held by the midwives and spread a rhetoric of risk associated with childbirth among the younger generations. This factor needs to be understood in the context of the medical policy at the time, which forced the evacuation of women at the 32nd week of pregnancy to the Jean-Eudes hospital in Havre-Saint-Pierre to prevent possible complications. Thus, the cohabitation of taboos surrounding the younger generation's relationship to the body and their exposure to the rhetoric of risk promoted by their community's dispensary nurses contributed to the younger generation's growing skepticism towards the knowledge traditionally held by midwives and associated with childbirth.

Atikamekw women's connection to the land

As in the case of their Innu sisters, the six Atikamekw women interviewed for this study also expressed a strong sense of pride in their experience of life on the land.

The pride of growing up "in the woods"

The Atikamekw women we met had lived for many years on the land with their extended families or surrogate parents. That's where they inherited these traditional skills. Two of them explain:

"I was born at Opitciwan, I'm 54. I say that I come from Opitciwan, but I was brought up in the woods…" (O1).

"When I was young, we lived in the woods. We always stayed there. We left in the spring, in March. I remember that they pulled us in a sled. […] we were travelling to our father's territory […] or where […] lives, on the other side. Sometimes, on the land of […]. How I'd love to go back" (O2).

She adds:

"In summer also, we got in canoes. They brought us and we were tented near the lake. All summer long! All summer in the woods. We only ate bannock, fish... Then in spring, it was hare, partridges, fish too. We ate so well" (O2).

Two other women share the same experiences:

"When I was about 7, I was with another family, and they took me into the woods" (O3).

"Nobody lived here [in the community] before. In summer, fall and spring, they all left here" (O4).

During the interviews, women who had experienced both land and community lifestyles expressed melancholy for the ancestral way of life and emphasized its benefits:

"I remembered my parents bringing us. I cried when I thought of it. They weren't tears of sadness, but of joy. I remembered the joy I felt. It was fun. Sometimes

I get lonely thinking about it. That's why I always go in the woods. I always have to be in the woods" (02).

"When I'm in the woods, if I sleep in a cabin for too long, I feel like I'm missing something. A longing to be in a tent with the trees. To sleep there. In the evening, when it's cold, to build a fire. It's such a good place to sleep. The smell of spruce boughs is strong. It's a good place to sleep. That's something I notice today. With the smell of spruce trees, you fall asleep faster. Here (in the cabin), it takes me longer" (01).

She adds the following about an annual two-week walk on the land:

"I miss it... I miss the Moteskano walk. I wanted to walk in the woods. To walk between the trees. It used to be fun to walk in the forest" (01).

Another woman makes a connection between access to the land and her family's health:

"It's true that they [her parents] were in good health... When they were walking with their children...raising their children. I don't remember being sick very often. We were always outside playing with my brothers and sisters. I don't remember being very sick. We were told to drink medicinal plants (bear plant). We always drank them. That's what they used. Then it all stopped (they stopped). [Her brother] said it was the government's fault... The government was against us having our own medicine. That's what he said, and that it (the government) decided that we should stay here (in the relocated community)" (06).

So, because the women we met clearly expressed their territorial preference for the experience of living "in the woods" compared to sedentary life in a community, this life experience plays a fundamental identity role in the construction of their connection to the land.

The land, a learning place

This prolonged experience of life on the land involved flexibility in the ways of learning traditional knowledge. In other words, the participants described this experience as a daily opportunity to learn knowledge handed down by their elders.

"I was in the tikinakan (baby carrier with a wooden board) and I could see my mother cutting wood with a saw. I remember thinking that one day I'd do like my mother. That's why it's important to bring the young one into the woods" (01).

Figure 5. Tikinakan. Photo by Conseil de la Nation Atikamekw, 2013

She explains how flora and fauna resources were used:

"I remember times in the woods with my parents, I would bring plants to my mother, and she would tell me what they were and what they were for." (01).

"There were many grandmothers who prepared the moosehide, Matihiketcik (fleshing the hide), aseketcik (tanning the hide) with their husbands" (01)..

Another participant adds:

"That's what my grandmother taught me, my parents... To make cipahikan (boiled game and bannock), doughnuts, homemade bread, crafts, that's all from my grandmother" (03).

Learning not only involved acquiring tangible knowledge on how to use available resources such as plants and animals, but also a spiritual understanding intimately linked to the use of the land. As their spirituality is tied to the land, some families have perpetuated these practices over the years, but have not necessarily passed them on to the next generation, as living in a community is less conducive to the transfer of spiritual knowledge. One participant recalls her experience:

"We used to do the old ceremonies in the woods, and they (the elders in his family) still do. I remember when I was a child, we were in the woods, and I woke up in the middle of the night. I heard things and maybe that's what they were doing, the kosapaktcikan (shaking tent) ceremony. When I came out (of the tent), I could see light above (the other tent)" (01).

She adds:

> *"When I had my first child, my father had never told me about the ceremonies. When I told my father I'd had my baby baptized, he said, "Why didn't you tell me?" And I said, "Why?" He replied: "Because I would have shown you what we used to do" (O1).*

Know-how and support system

For the Atikamekw, childbirth was probably not taboo, and young girls were initiated into midwife practices (ka odapanaso "the one who welcomes the child" or ka otapinawoso "the one who catches the child". One participant describes how the midwives applied their know-how by actions and words:

> *"On one occasion, the baby hadn't turned over and the mother was increasingly in pain. The midwife spoke to the baby and asked him to turn around. She asked the baby to turn around so that he could be born, because the mother was very tired" (O1).*

However, not all girls were interested in midwifery, as explained by one of the participants.

> *"Tell us the story of when you ran away. When they wanted to initiate you. Oh yes, when I ran away [laughs]. I could already see the child coming. I told the grandmother I had to go out first. Shortly afterwards, she called out: 'Where did she go? She's the one who's supposed to catch the child?' She was angry. I told my mother and she got mad at me too. She told me I shouldn't behave like that when someone was trying to teach me something. I answered that I was afraid to see the child being born" (O5).*

Disposal of the placenta (*otirawoson*) after delivery was done with the utmost respect. One participant explains:

> *"Women took the time to take good care of the placenta. Because when you look at the placenta, it looks like a tree. That's what I was taught. They (the midwives) wrapped the placenta before burying it, because it's the placenta that will take care of the earth afterwards. In the past, the placenta was burned in winter. I really liked what my mother told me, she taught me a lot of things. The placenta will grow, and beautiful things will grow" (O1).*

Pregnancy and childbirth practices go well beyond the knowledge acquired and passed down from generation to generation: they also involve a whole system of ties and mutual support between women. One of the participants recounts:

> *"In the old days, when the kokom (grandmother) gave birth, there were no nurses. When one of them was pregnant, another woman would help her, and the latter would wait a few months before becoming pregnant, and so on" (O1).*

> *"I've often heard it said that women helped each other out during pregnancy" (O1).*

This mutual assistance manifested itself through the mobilization of several women around the mother who was about to give birth.

> *"[…] and one of the midwives I knew. There was also the late [...], but she never delivered me. [...] and [...] (Tcipireto, my grandmother), they were the ones who always helped me. There was another one, I don't remember. The grandmother of the deceased [...] was also a midwife. She delivered me once, with Tcitwe (deceased), accompanied by [...] (deceased). All three of them were there" (O4).*

This system of intergenerational mutual support included the transfer of knowledge and the development of childcare skills. The Atikamekw women we interviewed perpetuated the ways of their mothers and grandmothers with their own children and did not embrace so-called modern methods. For example, despite pressure from medical staff, they continued to use swings (*wepison* 'hammock') and baby carriers (*tikinakan* 'cradleboard'). Women continued to use them, even with their grandchildren.

> *"We didn't have to buy a little bed… We used hammocks and tikinakan" (O4).*

> *"No, I never bought a baby crib. I made a hammock" (O5).*

> *"What have you heard about baby carriers and tikinakan?? I was told why they were wrapped up. Not to tie them too tight. It's to keep them strong. That's what I was told. [...] [My children] I wrapped them up (swaddled)" (O1).*

> *"Yes, that's what I've always done too (put the baby in a tikinakan). Even today, with my granddaughter" (O1).*

The present-day survival of these practices is precisely one of the major differences between the paths of the Innu and Atikamekw women we met during this project.

Conclusion: Similarities and differences in the legacy of land-related maternity

The paths of the Innu and Atikamekw women we met reveal a number of commonalities, starting with a pride in identifying with the land, both as a place of birth and as a place of daily life. The use of the land is also associated with the learning of knowledge, whether for basic survival (e.g., hunting for food and clothing) or specifically for pregnancy and childbirth through available natural resources such as medicinal plants and animals.

Where childbirth is concerned, older women are obviously the main holders of this knowledge. They may be midwives, whose role is clearly defined within social groups, or more generally, female members of the extended family, such as aunts, mothers-in-law, mothers, sisters and so on. In all cases, mutual help and support - from which men are not excluded, as they may participate indirectly by gathering certain resources, for example, play a major role in the monitoring women's pregnancies and childbirth.

On the other hand, if the transmission of this 'traditional

knowledge' took place in a similar way, i.e., through use of the land, this dynamic seems to have been historically modified in differentiated ways, whether in the case of the two Innu communities or the Atikamekw community. In the case of Opitciwan women, we note a continuity in the transmission of maternity-related knowledge that translates into its survival, whereas in the case of Innu women, the imposition of a biomedical vision seems to have had more far-reaching effects. Taboos surrounding pregnancy and the arrival of a baby seem to have persisted until recently, leaving many women in the dark about the birth process. Atikamekw women also mentioned, but to a lesser extent, the existence of birth myths designed to shield children from extensive and factual knowledge about this stage of life.

Because the experience of childbirth is intimately connected to life on the land, it has contributed in both cases, Innu and Atikamekw, to forging the identity of the people we met. This is why the relocation of the practice of childbirth from the land to hospitals has had a major impact on culture and identity.

SECTION 4

The impacts of sedentarization on the transformation of pregnancy and childbirth-related practices

The impacts of sedentarization on the transformation of pregnancy and childbirth-related practices

The life stories shared by the participants helped us to understand what consequences the forced relocation of the birthing site had in the reshaping of their relationship to the land, starting with their sedentarization within communities. From the land to the hospital to the community, there was far more than a mere displacement of the birthing site. Not only have the identity-building processes of mothers and the unborn been transformed, but their living conditions have undeniably deteriorated whether in Ekuanitshit, at Nutashkuan or at Opitciwan.

The transformation of Innu women's connection to the land

The Innu women we interviewed experienced the transition from semi-nomadic life to partial, then complete, sedentarization in communities from the 1950s onwards, especially with the obligation for Indigenous children to attend residential school. It was from this point on that the relationship with the land underwent a profound transformation, particularly as childbirth ceased to be practiced there. On the other hand, the practice of *tshukuminant* ("midwife") continued for some years in the community until the women who held this know-how were too old to practice anymore. At the same time, women were forced to go to hospital to give birth.

The persistence of midwife know-how in the community

The practice of Indigenous midwives was different from that of nurses and doctors. In the early days of community settlement, when Indigenous midwives were still present, they continued to practice the traditional methods used for land births. One of the participants recalls her experience:

> *"We were still living in tents when I went into labour. When I started giving birth to my children, it was in a tiny wooden house, a cabin, it was no bigger than, I don't know, maybe 12 by 12 (feet), no bigger than that [laughs]" (E1).*

> *"I went back to see my mother. I told her, 'It's started, I'm going to give birth soon.' I was a little apprehensive. But she reassured me: 'It's going to be fine, you're not going to have a big baby, you're tiny. And it should be fine. Your sister [...] is going to help you bring your child into the world. She's very experienced, and she'll help you. She's delivered almost all the children in the community. I'm very confident, all you have to do is go home. Send someone when you feel you're really about to give birth'" (E1).*

She describes her second birth under similar circumstances:

> *"I gave birth at home. It was very quick. It was the same thing. It was the same person who delivered me. My mother was there too. And this time, my spouse was there too. It went very well. It was the same thing: my sister delivered me. They massaged me, as I said about the first one, from top to bottom. And it felt good. That's the way it is. It was the second time I'd given birth at home, and it wasn't that painful" (E1).*

Another participant talks about the transition of the birthing place for women in the Nutashkuan community:

> *"There were several women who helped each other to deliver babies in the community at that time. That's what they did. It was these ladies who helped deliver... I used to give birth in the community. In those days, there was no specialist doctor, but there were women who gave birth, women who were called tshukuminant. Kanani was my aunt [...], and one of the first midwives in the community. They were the ones [...] who started delivering babies in the community. […] That stopped when the women were transferred to a hospital in Havre-Saint-Pierre, 200 km from here. That's when these women stopped delivering babies in the communities. Some women chose to give birth either in the community or in hospital" (N2).*

These accounts testify to the trust originally placed in Innu midwives, while at the same time highlighting the mutual support system characteristic of childbirth practice in which accompanying the pregnant woman guides the midwives' practice. This system of support and accompaniment was built around a number of specific methods in which, in contrast to the immobile and supine position advocated in hospital, movement, such as walking and massages, is encouraged. One participant describes her experience:

> *"I said to my mother, "I think labour has started and I'd like you to tell me how it's going to go." What she said was, "When labour starts, you have to keep moving. Especially walking. It's going to push the labour forward; it's going to push the baby down. That's what you have to do for the next few hours. It could last until tomorrow, and maybe you'll give birth at this time tomorrow. I said, "Is it going to take that long?" She said, "Yes" (E1).*

She adds that the midwife, her sister, explained how to position herself:

> *"Then she said to me: "Get down on your knees, then put your elbows on the bed, then you can even rest your forehead on the bed if you find it hard. This is the position in which we can help you". She put the bedspread with the pillows at the end of the bed so I could grasp them*

when I was in pain. She explained how it would work. When I wasn't in pain, she'd say, "Walk around the room." I had to move. My mother was there too. Every time I went near her, she'd come up to me and she'd do these massages on my back. She'd go up and down, and every time she did that, it seemed to stimulate my baby to come down. And for me, it was a relief, it reassured me to feel that every time she did that, she was pushing the child down, and that the child was also pushing" (E1).

Another woman mentions that:

"Yes, they squatted, they massaged the uterus at the same time as they sat (on their heels)" (N3).

These midwives held the medicinal knowledge essential to their practice, and continued to use it when they settled in the community. Some participants shared their experiences:

"After they gave birth, a kind of spruce gum was applied to the belly to clean everything inside the uterus so that everything would go well and probably also so that the placenta would come out. That's what I saw done and that's what was done to me also" (N4).

"My placenta really didn't want to detach itself. It took an hour; the midwife was going back and forth to see the placenta. And she gave me... You're not going to believe this! She put salt in the palm of my hand and in the other hand too. And at that moment, the doctor from Natashquan, Dr. [...] arrived and [...] told me: "Your placenta will come out any minute now." She asked me to blow into my right hand. Then to blow into my left hand. There was salt in my hands, and it was gone after I blew in my hands. Immediately afterwards, the placenta came out. The salt was gone, there was nothing left. [...] The old woman (name of the midwife) asked me to clench my fists tightly and blow hard. I wondered what would happen to me after that. I thought the salt would come out of my hands when I blew, but no, at some point the placenta came out. I didn't have any tearing, nothing" (N2).

"She says they used beaver glands. They boiled them in water and drank them. It helped induce labour in the woman. Sometimes it worked, sometimes it was the nurse who came. There was a nurse who came from Lac-Saint-Jean, she assisted in the delivery. It was the same nurse twice, for my brother and sister. She came to help the midwives, the elders" (E5).

"There was a kukum (grandmother) who kept a close eye on the woman for a year. Then, the mother's belly would be wrapped in cloth to tighten her belly a little and monitor her blood loss and all that, her menstruation. Then for a month, she'd keep an eye on the mothers who'd just given birth to monitor the pain. Even in those days, when there were no washers and dryers, she'd keep an eye on the women, and for a month they couldn't do their washing. As you know, there was no tap water, no washing machine. You had to fetch water, collect wood and build a fire, and the women had to be on all fours to wring out their clothes. These women were watched from afar for a month. They couldn't do their own washing" (N1).

On the subject of breastfeeding, this same participant adds:

"There was no commercial milk. It was all breast milk. For one or two nights after birth, the baby was [placed] close to its mother's nipples to feed it and to have direct contact with the breast. The breasts and nipples had to be cleaned. There was a cloth like a kind of white absorbent cotton that they put under the breasts so that it was clean where the child was breastfed. To ease the discharge from the breasts, you had to eat meat and a herbal tea made with spruce gum" (N1).

The accounts gathered show that the transition from life on the land to life in the community has disrupted practices and knowledge concerning pregnancy, childbirth and postnatal recovery. From handling the placenta to breastfeeding newborns, and including practices for accompanying women during childbirth, it's an entire system that has been transformed.

The consequences of sedentarization on the management of pregnancies and childbirth

The example of how to dispose of the placenta is a perfect illustration of all the changes happening because of sedentarization within communities. According to one participant, the placenta was burned instead of being buried:

"When they were on the land, they buried the placenta. The midwives buried them in front of a tree. It's in the communities that they started burning the placentas because of all the dogs. If not, the dogs would dig them up" (N2).

Then, at the start of hospital births, burning or burying the placenta was impossible for the women wanting to continue the practice, like generations before them:

"That's what missing for many women when they give birth. It doesn't happen anymore, we don't know what happens [to the placenta] after, do they destroy it? Do they throw it out? Where does it go? We never get to see the placenta. That's when the rupture with the past happened. Before, we gave birth with the help of kukum (grandmothers), we could see what they did with the placenta. […] That's how it should be done (burning or burying). The placenta was sacred" (N1).

Another participant explains, though her interpreter, the transition of births from home to hospitals:

"Havre-Saint-Pierre [is] close by, about twenty minutes from here. Deliveries took place at the hospital there. As soon as houses were built here in the community, hospital deliveries started. I can't remember in what year. I [interpreter] was born in 1974, and from that year on, she always went to Havre-Saint-Pierre hospital" (E4).

The shift to hospital births brought many other changes for Innu women, including the end of breastfeeding, which in the 1970s was not encouraged by the medical profession.

Participants share these stories:

> *"No, I didn't breastfeed any of the children I delivered at the hospital. I gave them the bottle. Before, in the beginning, we breastfed them. Some children were getting older, but we still breastfed them" (N1).*

> *"Yes, in those days, we started to feed babies with formula milk because we were entering into a sedentary lifestyle. It was the beginning of sedentarization, and then people went into the woods less around 1963, which is what I'm talking about. Women breastfed less once they settled in the community? Yes, all men went hunting in those days because children were starting school. There was a school here, a grade school, and since children had to go there, women had to stay here, and the men went hunting" (N3).*

She adds:

> *"That's also where it started with the doctor here. For those who couldn't breastfeed, he prescribed (formula) milk, then most of the people who stayed here because of school went to Havre-Saint-Pierre. They went to give birth in Havre-Saint-Pierre. Sometimes, they stayed there for a month before giving birth because there were very few travel possibilities. There was just the boat once a week in the summer, the occasional plane and when there were difficulties for pregnant women, they sent them to Havre-Saint-Pierre, in the days when the nuns were there" (N3).*

The myth that Indigenous women don't feel pain during childbirth was also taking root and persists to this day. In fact, Indigenous women were encouraged to avoid expressing their pain. Verbalizing pain is all the more complex in a context where women are embarrassed to find themselves in a foreign environment, cut off from the support of their families, and where the medical profession does not speak the same language as they do. At the time, only the women's travel was supervised by the medical staff, while fathers and other family members were responsible for their own travel. With the help of her interpreter, one participant recounts her experience with pain control:

> *"She says that you [young generation], you're quite afraid of pain! Her mother told them not to cry, not to scream, to endure the pain. That's what they asked women to do when they gave birth. But that's what my mother also told me when I went into labour. That's what she told her daughters and granddaughters. Because I have two nieces who already have babies. She told them not to scream or swear. Because some women also swear when they're in labour. I didn't realize that's what they were telling us every time. And the hospital staff also say that when white women give birth, it's so dramatic. But when an Indigenous woman gives birth, no one hears her. There's a doctor in Havre Saint-Pierre who said she'd rather deliver an Indigenous woman because you don't hear her compared to a white woman" (E4).*

The participant expresses frustration that the medical profession doesn't seem to take into account how Innu women feel:

> *"Sometimes, they don't offer us sedatives, as if we didn't feel any pain. Sometimes I ask myself: "Are they going to give us sedatives?" We aren't made of wood!" (E4).*

One participant talks about the language barrier and another, helped by her interpreter, of the fact that she was alone at the delivery:

> *"I already spoke French, but for the women who didn't, it was really… They didn't speak at all. They couldn't understand anything. […] I can tell you that communication was a big problem, a barrier" (E1).*

> *"She says that she was alone to give birth. She stayed for one week. She says it went well, nurses and nuns were in the hospitals in those days" (E5).*

This is how the loss of decision-making capacity surrounding births slowly took hold. As well as losing the social recognition that comes with midwifery, mothers and fathers also lost a form of power, sometimes even down to choosing the baby's name. Participants report how decisions were made by others. One participant explains:

> "And you, have you helped other women give birth? *No. Maybe if I hadn't been (almost) forced to give birth in hospital. Maybe I would have learned later. Because my sister, she had a lot of experience" (E1).*

Another woman states, through her interpreter, that only the doctor made decisions for pregnant women:

> *"She was never able to attend [a birth]. It was the doctor who sent the women to the hospital to give birth. The doctor was the only one to see a woman give birth. And a nun. The nuns were at the hospital when they gave birth" (E2).*

One participant shares how the choice of her daughter's name was imposed on them:

> *"Like my daughter (name 2), I absolutely wanted to name her (name 1) in honour of a friend. Then I started to hemorrhage, just a bit, not a lot of blood, I just needed some rest. That's what my sister recommended: 'Just rest a bit.' That's what I did. I couldn't even go to my daughter's baptism. My spouse went, with the godmother and godfather. When he brought my baby back, I asked him: "(name 1) is baptized?" He said: "No, the priest decided to change the name and call her (name 2), she couldn't be christened (name 1)." I was very disappointed; I was in a really bad mood" (E1).*

So far, the narratives we have gathered suggest that the gradual loss of influence by midwives goes beyond the simple fact that there has been no successor to ensure the transmission of their knowledge and practices. The imposed biomedical vision of pregnancy, embodied by the relocation of childbirth to hospitals, has in fact supplanted the weight of these know-hows and, concomitantly, hastened the gradual loss of control that pregnant women could exercise over their childbirth. The testimonies of the Atikamekw women we consulted have provided an in-depth look at the geographical conditions that precipitated this loss of power.

The transformation of Atikamekw women's connection to the land

Based on an analysis of their life stories, for the majority of Atikamekw women who had lived part of their lives in the ancestral way, the transition to community life in the second half of the twentieth century had little impact initially on their strategies for accompanying pregnant women. Rather, it was the gradual transfer of births from the land to the community, and even more significantly when women had to leave their communities to give birth in hospital, that altered the system of mutual support between women and, indirectly, their territorial anchoring.

The gradual shift of land births to community births, then to hospital births

While almost all women interviewed were born on the land, "(…) the island over there. I was told that I was born there. They call that place *Kosapatcikan nimictikw* ("Island of the shaking tent")" (O4). One of the women interviewed gave birth to three of her children in the community. It was in the 1970s, when pregnant Atikamekw women were told by nurses to stop going to the land but give birth in the community. This is the first step towards the systematic introduction of transfers to hospitals. One of the Atikamekw women recalls:

> *"Three times in Opitciwan. I don't know why, they told us to stop going [in the woods]. I don't know why. I accepted and delivered in Opitciwan. […] In those days, they started telling people to go to the hospital to give birth" (O6).*

For some, the era of sedentary communities also brought about a transformation in family and community solidarity. The same woman remembers a woman who had raised her children alone and who died after multiple pregnancies:

> *"I would see this woman; her child wasn't even a year old when she got pregnant again. She was really overwhelmed. We didn't support her very well. She looked after her children alone. She died in Joliette. When she arrived at the hospital, she was told there was nothing more they could do for her. Her child was a year old. I really felt sorry for her" (O6).*

She goes on:

> *"They called a meeting for us, all of the women... after the death of this woman. To tell us about it. She didn't use contraception to avoid getting pregnant. It's true, it's useful. We were brought together [...] so that we could take the thing that prevents us from getting pregnant. I took it for two years. This woman was really unlucky. Kitimakisiw ("she had such a hard time "). Nobody took care of her" (O6).*

Some women speak about the transition of birthing to the hospital:

> "Had you ever been at a delivery? *Only once. When my mother gave birth, but it was in Opitciwan. […]* When you had your own children, did you go to the hospital? *Yes" (O2).*

> *"Because we were fourteen children. Over time, she [her mother] started to go to the hospital.* Were you the first-born? *[The] fifth.* And were you born in the woods? *Yes, that's it" (O2).*

> *"I didn't give birth in the woods; I went to town. The last time I saw a woman deliver at Opitciwan was when my grandmother helped my sister give birth. My mother also helped at the delivery (of my sister)" (O1).*

> *"I gave birth in the city, and I waited a long time (one month) before delivering. I was fed up because I felt really bad. I didn't speak French very well and waited for a long time before having my first child. I was in pain constantly, all night, because they didn't tell me what to do" (O1).*

In the early days of hospital births, there was no organized medical transport to take women about to give birth. Over time, they were offered transportation by train to La Tuque or Senneterre, but only after a journey by canoe, as well as a seaplane to Joliette (Dagenais, 1982), but this proved to be a difficult organization to plan for childbirth. So, instead of giving birth in hospital, these women sometimes gave birth in the community or on the land, before having reached the hospital. In those days, experienced midwives were still alive and providing assistance.

> *"I gave birth to my first son (name). They brought me from Opitciwan to take the train for the hospital of La Tuque. Except that I didn't make it in time. We left too late. Halfway there, we stopped on the headland to sleep a bit and that's where I gave birth. […]. A grandmother […], she was travelling with us, probably knew I was about to give birth. She could recognize when women were about to give birth. She was a midwife. So, that's where we stayed. A short while after arriving by canoe, my labour started. He was born that morning. My late mother caught him and […] was there also. I got to see this midwife […], while she was still alive" (O4).*

At that time, women still had a measure of control over their bodies and childbirth, and some doctors recognized their expertise.

> *"I gave birth to my son (name) here in Opitciwan. My placenta almost didn't come out. My stomach was very swollen. I couldn't bend over. [The doctor's name was [...]. I told him, "Let me try!" He didn't want to, because he was afraid the cord that was connected to the placenta would detach itself. He said that if that happened, it was all over. He raised my bed (so I was in a sitting position). I slowly started to pull myself. I started to feel something coming down. I did it slowly and then suddenly, my placenta came out! I'd done it! [...] The grandmothers there began to dance. [...] They cried out: "At last!" My aunt [...] (deceased) was there too. The doctor was very happy too. The women rushed up to hug me. They said to me: "Oh, you were right to try!" (O5).*

It was this apparent accommodation between the know-how of midwives and that of the medical profession embodied

by the figure of the doctor that gradually disappeared as evacuations to the hospitals of La Tuque, Senneterre or Joliette, and later Roberval, became systematized. Extracted from their original environment and thus isolated from their traditional support and accompaniment system, pregnant women were left at the mercy of a medical staff whose objective was to treat their bodies in a total disconnection from the rest of the elements - notably personal, spiritual, emotional and cultural - that underpin the identity of Indigenous mothers.

The arrival of biomedical medicine: between loss of power and medical abuse

Over the years, the total takeover of hospital births by the medical profession meant that women no longer had any control over where, how and with whom they gave birth. For example, when Atikamekw women were forced to give birth in hospital, the choice of hospital was imposed on them:

> "Do you know why you were sent to Joliette and not in another hospital? *No, but I'd like to know" (O3).*

Furthermore, historical practices such as breastfeeding were discredited by the medical profession:

> *"They never told me about breastfeeding" (O1).*

Despite the lack of support, many have perpetuated the practice of breastfeeding:

> *"Right after birth, I breastfed all of my children. I didn't give them a bottle like young girls do today. They give them a bottle right away. I breastfed for a long time" (O4).*

The same is true of the placenta ritual. Not only were women no longer able to dispose of their placenta, were not informed of how it was being handled and were excluded from this important process. One woman recounts:

> *"My mother asked me how I felt about not being able to bring my placentas home. I can say that I was upset. It's part of me, this placenta. My mother asked me what they (doctors) did with it, and I said I didn't know. I wonder where they took it and what they did with it" (O1).*

Another woman adds:

> *"Our placentas are the last thing to come out. They never gave them back so we could bring them with us. […] they probably threw them away. I wonder what the doctors and nurses thought about that, the placentas" (O4).*

Avant même l'évacuation précoce des femmes enceintes Even before the early evacuation of pregnant women to the nearest hospitals, the biomedical discourse was promoted within the very communities where these women were progressively sedentarized. And with good reason. While many Atikamekw families continued to make their traditional medicine, the presence of nurses at summer gathering sites, and the easy access to the medicines they distributed, led some to abandon their know-how and use biomedical medicine.

> *"Up to the arrival of nurses [in the community]. That's when I think they had it easy. I personally think that they [people] accepted the medication. I remember being sent to get something that you had to rub on yourself, in your chest area. My mother would tell me to go and get some. They'd give me a bowl and the nurses would poured some in there. Syrup too. I had to go and get some. I think they were starting to make good use of these syrups, and I think that's why they started to abandon traditional medicine" (O6).*

The authority granted to the medical profession had not only stripped Atikamekw women of all power over their own births and those of their loved ones. The medical profession indulged in unacceptable liberties, such as forced sterilization, obstetrical violence by inducing delivery of several women at the same time, and involvement in the disappearance of children from the Quebec healthcare system, which to this day continues to fuel Indigenous mistrust of public health services. The following four accounts illustrate this mistreatment:

> *"The visiting doctor's name was Dr. […]. He was my family doctor. My husband and I went to see him, he told us we couldn't have any more children. Ligatured for life! I was disappointed, frustrated. My husband also. They only told us six months after I gave birth […]. I didn't even know that my tubes were tied. For the longest time, we didn't speak about it, my husband and me. We didn't care for each other anymore. No more love" (O3).*

> *"We were several pregnant women from Manawan and Opitciwan to leave. In January. There were several of us. We all gave birth on the same evening. I was deeply disturbed by that. I was the first to be induced because I was there the night before. I was the first to give birth. They were all labour inductions. [...] They treated us badly when we went there to give birth. [...] We've been mistreated for a long time. [...] That's the most awful experience I had in a hospital. To have been induced. I think it's because our stay was so expensive perhaps" (O6).*

> *"I remember when my brother brought back the little body. He was crying. I remember when my brother brought back his little brother. […] opened the coffin. We wanted to see what was inside because we hadn't seen him yet. When […] opened it, there was only plastic inside, like balloons. […] I asked my mother his date of birth, I could maybe ask somebody to look into it. But she didn't remember. She never received the birth certificate. […] I believe that they sold him. […]. I don't believe that he died. I can feel him, somewhere. […] They only told my mother that my little brother had died. But when […] opened it… The coffin was white… wrapped up, covered up, screwed shut... … They didn't want us to open the coffin. My father told my uncle to open it. I looked inside because I wanted to see my little brother. I hadn't seen him yet. […] My mother asked someone, I don't know who… They told her they had done an autopsy on the baby and that they didn't know why he died. Today, I understand. It's impossible, doing an autopsy and then cutting him up in little pieces… We believed them… At that time, we thought that an autopsy was done like that. Today, we understand" (O3).*

"When I hear the women, the grandmothers talk… There were many. When women went to give birth… When they gave them an injection, then hid the baby telling the mothers, your baby is sick. I remembered that when stories [about finding unmarked graves of Indigenous children] started to come out. Memories, of [name] with her twins. I wonder where her children went to. She said that she had heard the babies crying… She said: 'He's crying… where is he?' They did terrible things to her" (O6).

In addition to the issue of differential treatment to the disadvantage of Indigenous mothers, the Atikamekw women we met mentioned the surgical procedures carried out without their consent, such as tubal ligation to sterilize them, again here, in violation of fundamental human rights, notably the right to consent. Women's loss of power is not only about their own bodies, but also about their responsibility as mothers to their children. In this respect, the disappearance of newborn babies[11] seems to have been a common practice throughout the second half of the twentieth century. This pattern, as well as the early evacuation of mothers to regional hospitals, testifies to the control exercised by medical authorities over Atikamekw women's bodies, and therefore indicates a loss of decision-making power exercised by the latter. This form of objectification of mothers' bodies corresponds chronologically to the imposition of a biomedical vision of pregnancy in the wake of the forced sedentarization of these populations.

Conclusion: Convergence of Innu and Atikamekw experiences in the forced relocation of birthplaces

The early evacuation of pregnant women to hospital, their social isolation within this institution, the control exercised by medical staff over their pregnancy experience, the differentiated treatment of these women in breach of the most fundamental human rights and leading to a systemic fear of medical institutions, are all elements that will gradually characterize the life trajectory of the research participants.

While the imposition of a biomedical vision of health care altered the trajectory of Innu women just as much as that of Atikamekw women, this process seems to have been more gradual in the case of the latter, since, based on the testimonies received, the practice of midwifery initially persisted when childbirth took place in the community, at the beginning of sedentarization. However, beyond this slight distinction, the journeys of Innu and Atikamekw women converge in such a way that their loss of decision-making power also corresponds to a loss of influence of the midwives who, traditionally, were at the heart of the mutual support system designed to accompany pregnancies in tandem with the pregnant woman's extended family.

Accordingly, there is a strong correlation between this double delocalization of childbirth - from the land to the community, and from the community to the hospital - and women's loss of power over their own destiny. On the other hand, while the sedentarization of these populations has facilitated the imposition of a biomedical vision of childbirth centered around hospitalization, it has not completely eroded the relationship of filiation traditionally maintained by these women towards their land of origin. This is precisely the focus of the strategies to revitalize leadership and governance practices envisioned by the participants in this research, with a view to consolidating the connection to the land for children now being born in the city.

11 Calls for Justice 20 and 21 in the Supplementary Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls – Kepek - Quebec (MMIWG, 2019b) refer to the circumstances surrounding the disappearance or death of their children following admission to a health and social services institution between 1950 and 1980, in Quebec. Bill 79, in force since September 2021, authorizes the communication of personal information to the families of these Indigenous children. The Act allows to access medical documents and church archives. In July 2023, over 156 requests for information about Indigenous children have been processed.

SECTION 5

Ensuring women's leadership in the consolidation of their connection to the land

Ensuring women's leadership in the consolidation of their connection to the land

The following section examines the areas in which participants considered that Innu and Atikamekw women could regain power. Despite attempts to limit their capacity for health-related actions, this project has demonstrated the present-day relevance of their skills in this area, which we will examine below. By initiating a discussion on these subjects, the women were then able to suggest practices aimed at ensuring their leadership with a view to consolidating children's and, more generally, urban-born people's connection to the land.

The present-day relevance of women's role

Whether having worked in a hospital setting or coped with such a major event as the worldwide pandemic of COVID-19, the participants demonstrated the relevance of the knowledge they still possess today.

With Innu participants

Innu women oversaw all aspects of pregnancy and childbirth before the takeover by religious and medical authorities. Although knowledge was shared with the men, as everyone had to be prepared to deal with any situation, it was the women who took the lead in the birthing process. Today, everything revolving around pregnancy and childbirth is undoubtedly an area where Indigenous women can reclaim their power. Two participants talk about their respective contributions to the medical field:

> *"I worked at the hospital for 20 years. Starting in 1991, I did two years in standby because the hospital didn't have any interpreters. Then, I applied for the job. I worked there from 1993 to 2009" (E1).*

> *"I would serve as an interpreter when there were patients from Natashkuan, la Romaine, Mingan, and I worked with a nun. The doctor would come fetch me and the nun was not happy [she said] "Hey! I need her, you're always taking her downstairs". I would make the patient's case history in Innu. Doctors made case histories at their admissions. [They asked]: "What's wrong with her? Why did she come to the hospital? Any complications?" Everything… I was the one to write the admission document, put it on the nun's desk, then she met the patient, I was interpreting, the one to tell the lady what had been said to the doctor. I worked a lot in the beginning. I was the only one to have studied that. I worked for four years, then, that's what I did most of the time, be an interpreter, be there when people were admitted, assist when elderly people died" (N3).*

The same applies to knowledge and practices in traditional medicine related to childbirth and, more generally, to the health of the population in general. Some of the participants, one with the help of an interpreter, spoke of their family and friends' health-related know-how:

> *"My sister, she was a woman doctor, a bona fide gynecologist, tons of experience. She treated men, children, babies, she actually was the woman doctor in the community. She took care of everyone in the community. […] My mother also, she made medicinal plants. In fact, she healed me twice with the help of medicinal herbs, and animal part. She was good with that" (E1).*

> *"She says that they used to go into the woods to heal themselves when they were sick. They didn't have any medicine before. They never took any medicine with them. They found what they needed to heal themselves out there. Medication, traditional medicine. [...] She wanted to mention that. When someone was sick, she searched for plants to heal the person" (E3).*

The survival of traditional medicine knowledge is another area where the expertise of the Atikamekw women we met stood out.

With Atikamekw participants

Information gathered from the Atikamekw women show that their connection to the land is still very well anchored. They have retained a wide range of knowledge related to natural resources. If they can't make it to the land themselves, they ask that younger people (women and men) bring back the resources they need to prepare, for example, traditional medicines. Their medicinal knowledge is still very much alive and relevant today. One woman explained that she prepared treatments to prevent infections during the COVID-19 pandemic:

> *"This is cedar. I mix it with maskominanatikw (bear plant). They prepared a lot of it during COVID" (O3).*

> *"If we use this one and maskominanatikw/wakanakanic. It's green. It was used during COVID. […] I went to see my aunt […] in the woods and I noticed that there were other colours [laughing]. My aunt is also my teacher. The cedar, I keep it for myself. It's hard to find it around here" (O3).*

> *"My daughter had just found out that a work colleague had tested positive (for COVID), and that she was at risk. She was told to isolate. She had just arrived in Alma, and I was at home. I panicked because we had seen each other. I asked for plants. Within 24 hours, I took 3 kinds. […] My sisters brought me medicine and told me to mix it with the others. I know had three plants" (O3).*

The context of the COVID-19 pandemic is the example of a situation where trust in traditional medicine surfaced[12], with all generations:

> *"During COVID, my son was starting to make medicine. He came to me and asked me to put $50 worth of gas in the truck. He said: 'Come along. We'll be going with my father, grandfather and grandmother.' We drove close to Chibougamau. That's where you can find it [cedar]. Here, there isn't any. Maybe by canoe, near the lake. But this one I guard carefully" (O3).*

The mastery of traditional-related knowledge may be sporadic, as demonstrated by the mobilization during the pandemic, but it is not limited to this type of event. On the contrary, this knowledge seems to be part of women's daily lives in their relationship with the land.

> *"That's what I also experienced. I love all of that, the forest. Even the bark, I gather it. When it starts to peel of (from the tree), that's when I know it's ready, when it's really thick (talking about the bark)" (O4).*

Beyond the modern relevance of this type of knowledge, the elders we met also spoke of the losses that recent generations have incurred in their mastery of traditional health-related knowledge, and the concomitant weakening of their connection to the land. Based on this observation, it was possible to initiate a reflection on the practices needed to revitalize Innu and Atikamekw women's leadership and governance, with a view to consolidating their connection to the land.

The consolidation of the connection to the land: a few practices

The next two subsections provide some answers to the third research question: what are the practices and measures taken to consolidate children's ties to the territory since childbirth has moved to the city? This question has revealed several major themes that could potentially enable generations of all ages to consolidate their connection with their land.

The revitalization of Innu women's practices in leadership and governance

The testimonies gathered show that the connection to the land has not been lost in recent decades, but rather transformed. Many Innu women and their families have always continued to go to *Nitassinan* for hunting, fishing, gathering and other traditional activities. Time spent on the land is now shorter, and the traditional tent has been exchanged for the cottage, but the connection to the land as a source of Indigenous identity has never been completely severed. According to the women elders interviewed for this study, there are a number of ways in which women and girls can strengthen their connection to the land, such as continuing to visit significant places, passing down knowledge about traditional medicine, promoting pregnancy and childbirth-related know-how, and fostering the return of midwifery to the community.

1. Introducing significant sites to the younger generations

Young people should all have the opportunity to visit the places associated with significant events in the lives of their ancestors and contemporary relatives. These journeys on the land[13] should be undertaken with the extended family, including elders when their health permits. It would also be an opportunity to introduce the traditional names associated with these places, to transmit medicinal knowledge and to tell stories connected to these sites, as well as myths surrounding births. Participants, the first with the help of her interpreter, share memories of their native land:

> *"It's a land where she [the participant] likes to go. It's called Nukuashkanit (where there's a burial ground). A lot has happened there. [...] It's her family's territory; when she goes there, it's with the children, her family, her brothers" (E3).*

> *"Pitapeu (name of a birthplace) was the medicine used by my grandmother, who would put it on her hands when she had blisters. It's the wooden poles that caused blisters on my grandmother's hands. The current is quite strong, and you had to row very hard to reach your destination. That's what my grandmother told me. It's a glimpse into the harsh reality of our ancestors' lives. Even when the rain was pouring down, we had to get to our destination if a woman was about to give birth" (N1).*

Another participant, with the help of her interpreter, sadly reports the lack of recognition of traditional family territory:

> *"Earlier, you mentioned an area of the land that will soon be flooded. […] It's La Romaine River. About 200 km further on. At km 130 and beyond, the land is there. Your family territory? Yes, on my mother's and father's side. The water is rising because of the dam? Yes. […] It hasn't been officially announced, but someone posted it on Facebook. I don't know why there wasn't a ceremony to say a final goodbye. That's what I would have wanted us to do. To do a tobacco offering maybe or... some other kind of ceremony. […] Because for our young people, they're going to say, 'You gave permission to destroy all the land on the Romaine River?' But no, that's not it. Even if we'd said no, the dam would still be there" (E4).*

Despite this, many other places are still frequented, respected and highly significant. For example, a place near Nutashkuan is called *Kukum nassiu assi*, which means "land of the *kukum*". People go there to honour the memory of those who lived and died there. Since these places have a spiritual, even religious significance, some people

12 For a more in-depth look at the subject, see: Asselin (2020). Les savoirs autochtones pourraient-ils nous aider à affronter les prochaines pandémies? The Conversation (April 6). https://theconversation.com/les-savoirs-autochtones-pourraient-ils-nous-aider-a-affronter-les-prochaines-pandemies-135022

13 For a better understanding of the benefits of organized walks in traditional lands, see Labra *et al.* (2023).

make a point of maintaining them from a commemorative perspective. Some participants speak eloquently of these places:

> *"We obviously have a great deal of respect for our land, which is why we've now set up a place to gather, a sacred place, the 'blue mountain'. That's why we hold gatherings to commemorate the days when our ancestors passed through here on their way up and down the land. You can see the sea, the land and take in the beauty of nature. How do you pronounce the blue mountain in Innu? Pemetatauaka, translating as 'from where you can see the hillsides'" (N2).*

> *"Even this year, there are others who have left, they've gone to pray. There are two places. There's where the children are buried, to the east, and the grandmother is further west. They're two different places, but they're still places where people go to pray. The children were hungry, that's what happened to them. The grandmother was sick. But these are not places that are far apart. They're places known to members of the community. Even this winter, there are men who went to pray, who went to see if it was respectful or not. Last year, for instance, they changed the cross. It's well maintained, they take good care of it" (E2).*

> *"Yes, she was born in the woods, but my mother comes from Mingan. My father is from La Romaine's Bellefleur family. The Innu used to gather every summer in Musquaro[14]. That's where marriages between families took place. Families from Mingan would meet there, and then they'd get married, and that's when my mother came to live in Nutashkuan" (N3).*

In addition to the symbolic and memory significance of the places characteristic of the Innu presence on the land, the revitalization of women's governance practices also involves a reappraisal of their role in terms of accompanying pregnancy and childbirth.

2. Valuing midwife practices

Many of the elders we met put forward the idea of reintroducing midwifery into their communities. Revaluing the role of midwives would help to restore their support role within the community, and thereby emancipate them from the formal structure inherent to a hospital setting. A first woman mentions, with the help of her interpreter:

> *"She says it would be nice if women could give birth at home. But today, we no longer have women who deliver pregnant women. [...] she says it would be nice, but you'd need competent people for that, midwives" (E3).*

Other participants add:

> *"It would be great if we could re-establish our traditions, if we could show women what it was like in the past, the challenges; it wasn't difficult for women to give birth, except during the winter. That there be a program to educate, to give training to our Innu women or from any other nation, so that they can become midwives and revive the traditions" (N1).*

> *"Yes, yes. If you know you're going to give birth naturally, prepare in advance, yes, that would be something very [good]. Because if you give birth in an operating room, it's not the same as giving birth to the sound of good music and at home." (E4).*

> *"Personally, I think that midwives are coming, I'm starting to hear about them. Personally, I would have liked to give birth at home, maybe at a community clinic, to have been closer to my children." (N2).*

While talking about her community's health centre, called *Tshukuminu Kanani* meaning "Our Grandmother Caroline" (she was a midwife) in the Innu language, one participant adds:

> *"A new health centre was built in Nutashkuan. In the new centre, I was told there was going to be a program for midwives. But there wasn't any; I was thinking of joining, and I was very excited to get this training. Two kukum (grandmothers) […] were named to teach the program, but I never saw it materialize. I would have loved to get that training. Later, the two kukum died and the training didn't happen. Today, there's nobody left to train midwives. What will become of us if there are no midwives in our communities?" (N1).*

The revitalization of this practice would necessarily be accompanied by a component on medicinal plants and other treatments. An entire body of knowledge could be updated, taking as an example the "Innu pharmacy" that already exists in one of the communities taking part in the research. Two participants express their thoughts on the use of plants by the Innu:

> *"It would be nice if we could preserve this, the way we lived there. How women were treated after giving birth, and how the baby was cared for. I'd like to keep that. It wasn't easy when people lived in the woods. It's really hard when I think about it. [...]) They took measures to [...] properly clean the mother, properly clean the baby. The white people, [they] disinfected everything. They [the Innu] used to boil water and wash with the boiled water, then with the fir tree, all the Innu medicines they took. I find that very remarkable" (N3).*

> *"The three ladies sitting around me said, "The placenta so it doesn't stick." That's why we make the lady stand up. At the same time, we push here on the back, on the belly, to loosen the placenta. [...] That's where they put the wet towels with the medicine [...]. That's when they told me: "It's to loosen the placenta". But what kind of medicine? I can't remember. I didn't even ask around. I was like the others, I was young, I thought: "Now, we're in the modern world, we don't need this anymore." It's only now that I realize it. We definitely should have kept it" (N3).*

In addition to the practice of traditional medicine to support pregnant women, certain key moments in the life cycle were cited by several women as opportunities to celebrate their connection to the land.

14 Its name in Innu language is *Mashkuanu-sipu*, meaning "river of the bear tail". It is a highly productive salmon river of the Côte-Nord region.

3. Celebrating births and burials on the land

Some women mentioned that they would like to be buried on the land where they were born, like other women before them. Three women express their wishes regarding the burial site, as well as the story of a well-known woman:

> *"I spoke to my husband about it when he was alive. I'd like to be buried on the land where I was born. That's where I'd like to be reborn" (N1).*

> *"The lady, the one who died, was buried there by her family. The grandmother, she said she didn't want her body brought back to Mingan. She wanted to be buried there because she said that the Creator is there in nutshimit (the forest). That's why she's not buried in Mingan. They made her a cross. Her rosaries are still there, with holy water" (E2).*

> *"It's an old lady who died in the woods. She didn't want to be brought back. She wanted to stay in on the land over there. That was her request." (E4).*

These statements show just how deep the bond to the land runs for people born there. In this respect, the question of giving an Indigenous name at birth seems to indicate a much-needed connection to the territory. An increasing number of parents are choosing an Indigenous name for their child, rather than an English or French one. In the days of land births, this name was often connected to the birthplace. Assigning a name associated with the family's territory is another practice that helps consolidate the connection to the land for younger generations. One participant explains the origin of her first name, *Nata*, and her surname, *Nuna*, which means "earth" in Inuktitut.

> *"I also have an Innu name. My mother never called me by my French name. [...] My mother always called me Nata. The first four letters of Natashkuan because I'm a native of Natashkuan. And my father's family name was Nuna, because he was from Nunavut. So that's why" (E1).*

Another participant describes how the name could be given while waiting for the religious baptism ceremony.

> *"According to her, the name was chosen by the person, an elderly male who was conducting a kind of baptism. Then he would name the baby. In her brother's case, it was the older man who named the mother's baby. He was the one who performed the baptism ritual, because afterwards it was the priest who christened the child. As for the naming, it was the man who did it, who sprinkled water on the child and gave the name" (E3).*

In any event, bringing births back to the land would undoubtedly be one of the most significant ways of consolidating the relationship between the younger generations and the land.

4. Reintroducing spiritual ceremonies

The question of births and burials on the land calls for thoughtful consideration about spiritual ceremonies that could revitalize Innu women's leadership and consolidate their connection to the land. However, the ceremonial significance of this type of practice is a sensitive and complex issue. Today, a growing number of Indigenous spiritual ceremonies are being reintroduced. In the case of the Innu of the Côte-Nord region, the interviews we conducted do not allow us to assert that families practiced ceremonies in the spiritual sense prior to settlement in communities. The only land-based ceremony mentioned was the baptism practiced by a family member, similar to the Catholic christening (a religion adopted by several elders). As for the placenta, it was either burnt or buried, but only one participant raised the sacred connotation attached to this act. Several women were unsure of what the midwife had done with their placenta. Four women shared their experiences, and the last woman, with the help of her interpreter, said she couldn't remember the practices of the time:

> "Did you ever see any rituals performed when the baby arrived, or was there some kind of ceremony that took place? *No, we just relied on prayer, there was no special ritual. Only Christian, Catholic prayer. The only ritual was perhaps the baptism, when the priest came to christen the child. Or when the priest was away or not readily available, one of the kukum (grandmothers) would take the water and baptize the child" (N4).*

> *"When the child was born, the midwife would lay the placenta on a surface to take a good look at it. Even the doctor looked at the placenta. Then, the midwife assisted by another kukum, would examine the placenta for any abnormalities. After that, when the placenta had been checked by both people, she would wrap it in a cloth and burn it in the wood stove" (N1).*

> *"It was her brother who was born. His name was (first name). The grandmother had the holy water. Before she baptized him, she put holy water on his forehead to announce what the child would be called. Then they said a prayer. The grandmother who blessed her little brother decided to call him (first name) because that was the name of her son who had just died" (E2).*

> *"On the land, my father's role was to pour water to baptize the baby and give it a name" (N2).*

> *"No, she's never seen a ritual for children, as they do today.* And the placenta? *No.* Did they burn it? *No, she doesn't remember" (E5).*

The ceremonies currently being revitalized are, as shown in the literature, often inspired by the cultures of other Indigenous peoples. Once again, these are living practices that are transformed and updated over time. Even if this research does not allow to demonstrate the presence of birth-related spiritual ceremonies, the holding of "new" ceremonies on the land could certainly become a way of consolidating the connection to the land for younger generations.

The revitalization of Atikamekw women's practices in leadership and governance

As previously mentioned, Atikamekw women have continued to maintain a close relationship with the land. Occupation of the territory seems intimately connected to the widespread use of the Atikamekw language, the continuity of traditional medicine-making and newborn objects, and the recent revitalization of traditional ceremonies taking place on the land. These knowledges and practices, with midwives playing a central role, are therefore aspects that help to consolidate the connection with the land for the younger generations.

1. Fostering the return of midwives

Most of the Atikamekw women interviewed expressed an interest in midwifery. The dynamic of mutual aid surrounding this practice is still highly valued by the women. They also see it as a way of ensuring the safety of mothers who don't have the time to travel and who give birth in the community. Three participants tell us:

> *"I often hear that women helped one another during their pregnancies" (01).*

> *"Sometimes I mind her baby for 15 days to help her out. The other […], she gave birth not too long ago. Her baby is one year old. I attended the birth also. […] seeing them being born makes me so happy! I comfort them a lot during their labour because they're in pain. Even though they're getting epidurals, they suffer just as much. I tell them, 'It won't be long now! We're almost there!'" (03).*

> "What do you think if women were re-educated to be midwives? *Yes, that would be good. Some women don't always come to the hospital. When the delivery comes suddenly. So they could go and help them. Helping the baby to be born" (04).*

Access to midwives from the community would certainly help re-establish a system of mutual support among women. The midwives of yesteryear were women recognized for their skills. Although the elders we interviewed were in favour of the return of midwives, some wondered whether the younger generation could be as competent as the midwives they knew, or women as strong in giving birth at home. Three women express their wishes about midwifery:

> *"How would you envision the return of midwifery... Bringing back their role of catching, delivering (taking the baby leaving mother's womb) the babies that are born. I'd like that. I'd like to do that. I'd like someone to teach me, to tell me how to do it" (02).*

> *"I also think that women aren't as strong as they used to be when it comes to giving birth. In the past, they were very strong and that's why they were able to give birth (helping each other)" (01).*

> *"I've seen many births. I have 15 grandchildren. My daughters, my daughter-in-law, and my other daughter-in-law. I attended their births. [...] I found it up lifting to see them give birth. I think I could practice childbirth as a midwife. Because I've already seen several deliveries" (03).*

2. Using traditional knowledge to make objects and medicine

The crafting of traditional objects for young children, such as the *tikinakan* (baby carrier), requires knowledge of the species of tree needed, where to find it on the land, the time of year to collect it, and so on. As with traditional medicine, these gestures involve a wealth of knowledge connected to the land's resources. One participant refers to the *tikinakan* as follows:

> *"The tikinakan helps the baby grow stronger. The (wooden) board is there for a reason. That's why we put the child upright, so he'll get stronger. When you take him into the woods with you, your child sees you and sees what you're doing" (01).*

These objects also reflect a whole new approach to childcare, as in the case of the *wepison* (hammock), which enables parents to stay in contact with their child throughout the night

> *"At night, I made sure that the rope (a piece of rope attached to the hammock) reached my bed. If I heard my baby crying during the night, I'd pull on the rope (to rock the infant)" (05).*

> *"When I was young, that's what I always used to see. Babies in their baby carriers misaspison (without wooden boards) in a hammock, a wepison to put them to sleep" (02).*

Figure 6. Misaspison. Photo by Josiane Awashish, 2023

At the same time, much of the medicinal knowledge surrounding childbirth is still retained and would benefit the younger generation through its transmission from grandmothers to daughters and granddaughters. One participant talks about plants for pregnant women:

> *"The bear plant, maskominanatikw, helps fortify the*

metabolism. You could drink it, even before giving birth. Another plant helps women who lose a lot of blood. I don't know how to say it in French, but it looks like a tree with long roots. [...] My father went to look for a plant in the woods called mictekw. [...] It helped me heal. Today, no one knows about it" (O1).

She adds:

"When it comes to plants, you can remove the bark and use only the green part. In the old days, women used to cover their bellies with it to keep them strong. I once took a plant to my mother, and she told me it cured liver stones. There's another plant, atocipi, that helps children with sores. [...] Personally, these teachings were never passed on to me" (O1).

Whether for pregnancy care or any other type of treatment, the ability to make your own medicines from local resources is a source of pride. Two participants share their experiences:

"I learned a lot from my grandmother. She showed me a lot of things. I'm still learning today. I was with [...] and I learn from her... Medicines, in the woods. I believe in that. I'm a big believer in Atikamekw medicines. It's my tradition" (O3).

"It's true that it was good to use things to heal yourself. For a woman. Taking plant medicines after childbirth" (O6).

Another participant talks about the correct dosages to have the energy needed for childbirth:

"I say that a woman who's seven months along should (drink it). When I take maskominanatikw, I drink it for a week... I stop for two weeks... half a cup in the morning, half a cup in the evening. Then I stop. You mustn't take too much. Personally, I think that's what they should do so they don't get sick when they give birth. Today, they take the epidural. They don't feel any pain" (O3).

Because this knowledge is still largely held by women, they are its custodians, most often taking on the role of caretakers for the health and well-being of their family members. In so doing, this sphere enables Atikamekw women to exercise family and community leadership that enshrines the trust generated by traditional medicine.

3. Participating in ceremonies

Traditional ceremonies related to childbirth and the newborn are also intimately connected to the use of the land. Their perpetuation enables people to experience interconnection with the surrounding elements and to live out their identity, an experience treasured by Indigenous peoples, particularly Atikamekw women. A participant speaks of the revival of certain ceremonies:

"In the past, they planted [buried] the placenta, and trees have certainly grown over it" (O1).

"Today, ceremonies are making a comeback. First steps, newborns, baptisms (giving a traditional name)" (O1).

"When it was a boy, he was placed over the teweikan (drum) and told what he could do (later). He'd be placed in an easterly direction (wabanok), then a southerly one (cawonok). Next, he was moved in the other direction, west (nakapehonirowew) and then north (kiwetin). When it's finished, he's picked up and lifted (the "godfather" does this). He tells the baby that he's going to help him. We go around in all directions" (O1).

Another participant shared her enthusiasm that the practice of properly disposing of the afterbirth was revived in her family:

"I was happy to see her [her daughter] bring back her placenta. She had swaddled it well. That's what I was saying earlier, I wondered where mine was. I wonder what my children think. The placenta. Today, I'm hearing more and more about it. People who want to bring them back" (O2).

Several excerpts in this section demonstrate the importance of speaking the Atikamekw language, which, like all Indigenous languages, is intimately connected to the land. In fact, the Atikamekw women we met spoke predominantly in their own language during the interviews. This language is still widely used and is an expression of the ongoing bond of Atikamekw people with the land. Although none of the participants directly identified language as a means for consolidating the connection to the land among the younger generations, a theme not included in the list of interview questions, this cultural aspect raises a powerful issue in terms of its transmission, not least because its scope is not purely linguistic, but needs to be considered in relation to the use of the land.

Conclusion: Revitalization strategies adapted to each context

Despite the tools implemented to deprive them of the control they have been able to exert over their destiny, and specifically over their bodies - as exemplified by imposed hospitalization following the sedentarization of their community or, more generally, the imposition of the biomedical model of health - women have contributed to safeguarding traditional knowledge geared towards their well-being. Far from being passive, they have become the guardians of this knowledge, which is directly connected to their use of the land. That's why strengthening the new generation's connection to the land is necessarily a matter of valuing their leadership throughout the life cycle, from birth to death, by way of childbirth.

Given that the historical trajectories of Innu and Atikamekw women differ somewhat, as we have seen, strategies for revitalizing their leadership must be articulated around their specific characteristics. In other words, each strategy must serve to increase the prominence of these women in the governance of their communities, based on their own specific heritage. Among Innu women, the burden of religion seems to be greater than among Atikamekw women, as evidenced by the delicate issue of Catholic-inspired

ceremonies. As much is indicated by the Innu women's references to certain on-the-land life stage celebrations, such as baptism, whereas Atikamekw women are more comfortable with the reintroduction of ancient ceremonies, including those related to the handling of the placenta after childbirth, or the first steps ceremony. In either case, the symbolic significance of using the land will be different, but very real.

In parallel, the narratives of these women unanimously converge on two types of strategies that are interrelated, as they form two faces of the same reality. First, both Innu and Atikamekw women cited the return of midwives to the community as an essential prerequisite for revitalizing their leadership. Second, fostering the transmission of knowledge specific to traditional medicine, as well as the crafting of objects such as the *tikinakan*, would help structure their practice. In this way, the reintroduction of midwives and the valorization of their traditional knowledge would make it possible to celebrate the land while making use of its resources. In this association lies the key to strengthening Innu and Atikamekw women's sense of identity with the land, and that of their families and communities down to the urban-born children.

Conclusion

A transversal analysis of the testimonies

General conclusion, a transversal analysis of the testimonies

Beyond the situational differences characterizing the journeys of the Innu and Atikamekw women we met, these women's stories converge around several historical elements. Because this research was attempting to understand the consolidation of the connection to the land through the themes of pregnancy and childbirth, this cross-sectional analysis focuses on the different places that mark out the shift in the practices of accompanying pregnant women, from the land to the community, from the community to the hospital.

On the land

The question of the connection to the land as understood through pregnancy and childbirth is expressed in numerous ways. This project initially demonstrated that **the land is perceived as a space of identification**, i.e., that life experienced on the land, starting with birth, is viewed as a deep source of pride that sustainably anchors and strengthens the lifelong identity of those consulted, their families and close ones.

The land is also experienced as a space for the transmission of knowledge. The experience of living "in the woods" is described by the participants as an opportunity to learn traditional knowledge intended to ensure physical and mental well-being through familiarization with natural resources, whether wildlife or vegetation. This use of resources allows to take advantage of knowledge destined to, in the context of this research, support pregnant women throughout their pregnancy, delivery and post-partum recovery, but also to control births. In this regard, Basile (2017) points out that the works of historian Claude Gélinas have put forward the following hypothesis: "(he) mentions that Atikamekw women could have planned births in keeping with the nomadic lifestyle of the period between 1851 and 1865. In fact, births were higher in the months of April and October, two key moments in the year: one preceding travel to hunting grounds and the other, the return to summer camps. Some plants may have been used for planning births" (Basile, 2017: 186, Translation). This last point, regarding contraception, cannot be thought of outside the scope of pregnancy, with which it forms a set of practices dedicated to the control of fertility. Mentioned by some participants in the project, the issue of contraception is echoed in the work of researcher Kim Anderson, for whom:

> Native women history demonstrates that family planning was women's business that incorporated knowledge about sexual and reproductive health systems. 'Traditional' family planning took into consideration community economics, social and health concerns and harmony with the environment (Anderson, 2003, p. 178).

The transmission of traditional teachings on reproductive health as experienced 'in the woods' therefore suggests an understanding that integrates the economic (a dimension not included in this report), social, cultural, spiritual and environmental dimensions that characterize one's nation. In short, traditional knowledge dedicated to fertility reflects a holistic vision of the relationship with the world.

The Innu and Atikamekw experiences described in this research also indicate that **the land is a space of mutual support**. In other words, survival on the land rests on a system of reciprocal support structured around the extended family. Multi-generational cooperation around major events such as births is one prime example. In this system of mutual support, Innu and Atikamekw women position **the expertise of midwives on the land** at the center of the support and guidance strategies regarding pregnancy. In essence, the role of midwives is fundamental to the transmission of pregnancy-related know-hows. It also bears witness to the sovereignty exercised by women within traditional societies, at least until colonization:

> Pre-contact Indigenous women in North America enjoyed considerable power, social status, respect, and influence. They were treated with reverence, as the givers of life. They were seen as the keepers of tradition, practices, and customs, and the decision makers in realms of family, property rights, and education (Shahram, 2017, p. 14).

The power held by Indigenous women, while expressed through their responsibilities over multiple aspects of their group's day-to-day life (Charest, 2021), is emblematically translated within everything that has to do with the relationship to the body (Anderson, 2003). The role of female elders in education not only involves assisting with pregnancies, but also managing natural contraceptives and even abortions when the life of the mother or child is in danger (Anderson, 2003). However, their expertise and role as decision-makers, in short, their leadership is intimately connected to the experience of the land, which is more than a space for cultural identification. Because the land is the site for learning and passing down traditional knowledge, living on it plays a central role in the exercise of Indigenous women's leadership. This is precisely where the process of colonization has interfered by setting of a decrease in the power held by women through a double geographical delocalization.

On the one hand, women's sedentarization on reserves and school attendance by their children have gradually limited their movements on the land, therefore creating a disruption in the transmission of traditional knowledge. In the case of Atikamekw women, the responsibilities of mothers towards their children explain the following phenomenon:

> Establishing schools in Atikamekw communities has also contributed to preventing women from going into the woods as often as before since they must stay in the community with the children (Atikamekw History Society - Nehirowisiw Kitci Atisokan, 2014). In addition, the fact that children attend school leaves them with less time to go into the woods, which has changed their connection to the land (Landry *et al.*, 2020) (Basile *et al.*, 2022, p. 11, Translation).

Secondly, this initial forced relocation opened the way to imposing the biomedical model in the management of pregnancies and from which ensues a control by the medical personnel (nurses and doctors) and of the Church (priests and nuns) over the bodies of the pregnant women as well as a breakdown, through the forced evacuation to hospitals, of their mutual support and guidance networks which structured the leadership of the women, and especially midwives, up to then. These two stages, the sedentarization in the community, then the systemic evacuation towards hospitals, constitute another similarity in the experiences shared by the Innu and Atikamekw women interviewed.

In the community

The settlement process is an attempt to control people's bodies and minds by outside actors ignorant of Indigenous societies' age-old practices. The introduction of 'on-reserve' nurse-run dispensaries to care for the declining health of sedentary populations is based on the idea of managing people's health with no regard for the traditional knowledge that had previously structured health care. The introduction of "on-reserve" nurse-run dispensaries dedicated to the declining health of settled populations is based on the idea that people's health needs must be managed at the expense of the traditional knowledge that had structured health care up to that point. **The takeover of these matters by medical staff was facilitated by the gradual limitation of land use as a historical source for learning and transmission of traditional health-related knowledge.** Consequently, women find themselves cut off from all that previously allowed them to ensure their autonomy, both in terms of resources and of learning traditional knowledge. This leads to the dispossession of their leadership, particularly apparent in the case of pregnant women. Furthermore, families who refuse sedentarization and who continue to go on the land on a regular basis see their children sent to residential schools, for example to the Maliotenam residential school in the case of Innu families (and the St-Marc-de-Figuery residential school and later the Pointe-Bleue residential school in the case of Atikamekw families (Ottawa, 2013; Bousquet & Hele, 2019)), as they do not attend the day schools established in the newly created reserves (Charest, 2021). This type of schooling, because it forcibly removes children from their environment, produces a breakdown in the transmission of traditional knowledge on the land (Basile, 2017), especially of health-related teachings. As a result, **the role of schooling is twofold, as it is connected both to the attendance of day schools in the community and of residential schools outside the community.** Both types of strategies stemming from the colonization process leads to the same outcome, namely a **forced interruption of the transmission of traditional knowledge caused by limiting the movements of families on the land.**

However, this breakpoint does not immediately invisibilize the knowledge mastered by women. In fact, in the early days of sedentarization, pregnant women are not completely isolated from their support network, as evidenced by the presence of midwives in the community. In fact, it is rather through the eroding role of midwives, whose expertise is discredited by community-based medical personnel, that the right circumstances for imposing a biomedical model of health care are created. **As such, if the transmission of women's traditional teachings is in sharp decline, it is not only due to a limited access to the land, and even less to a scarcity of new learners. This lack of transmission is actually attributable to a campaign to overemphasize the role of the medical profession, to the detriment of ancestral knowledge practiced over millennia.**

The transition from a traditional to a biomedical vision of health has been gradual and reflects a shift in responsibility for managing the health of Indigenous people. While are noted the initial coexistence of the two models, several factors precipitated the obsolescence - anticipated by non-Indigenous health care workers - of the traditional model. The rhetoric of the risks associated with childbirth in isolated environments will then justify the early evacuation of mothers for childbirth. At the same time, nursing personnel in communities progressively consolidates their control over the bodies of pregnant women under their perceived responsibility, thereby appropriating leadership in the control over women's bodies. In reality, this type of dominance brought about by the imposition of a monolithic vision of health is characteristic of situations experienced by many Indigenous women around the world, as the Māori experience shows:

> These dominant narratives and knowledge are not neutral or impartial; rather, they are produced in a monocultural framework of maternity care that failed to adequately provide for Māori or Indigenous maternities (Simmonds, 2017, p. 115).

The imposition of a biomedical vision is not the only factor undermining the foundations of the midwives' authority. It is coupled with the insidious spreading of a religion-based discourse, as already mentioned in the early 1980s community health review drawn up by Dr. Dagenais for a report presented to the Conseil Atikamekw Montagnais (Dagenais, 1982). The case of Innu women is a perfect illustration of this situation. Whether it be through medical evacuations to the Jean-Eudes Hospital in Havre-Saint-Pierre where attending nurses were in fact nuns (Dagenais, 1982), or at the Ekuanitshit dispensary managed by a nurse singled out for her "religious indoctrination" (*ibid.*, p. 237, Translation), **the omnipresence of religious discourse has probably contributed to further feed the invisibility of traditional knowledge held by midwives and more generally by Innu women.**

In the face of this invisibilization, the perpetuation of the taboo surrounding births among younger generations, and specifically among children, also seems to have provided fertile ground for imposing a medicalized interpretation of this life stage. The nurses practicing in the Ekuanitshit and Nutashkuan community dispensaries were probably a driving force in this dynamic, specifically by spreading a rhetoric of risk associated with childbirth among the younger generations, while at the same time discrediting the traditional methods of which the midwives are the keepers. **The modesty with which Indigenous women transmit knowledge about pregnancy must therefore be correlated with the spread within the community of a religious discourse in which a relationship with the body is taboo, both factors contributing to a lack of information among younger generations.** The importance of the religious fact is quite apparent in the matter of contraception. Implicitly present in the testimonies received in the course of this research, this issue also seems to be a constant in the journey of Indigenous women in general:

> The church was undoubtedly the greatest obstacle to the practice of traditional birth control […] Christian morals and a Western medical paradigm that gave birth, pregnancy and female sexual and reproductive health matters over to male doctors (Anderson, 2003, p. 181).

The issue of contraception is a broader indicator of the impacts of colonization, in which sedentarization is a key component. For some, sedentarization contributed to the demographic growth of Indigenous populations by improving their general health conditions (Charest, 2021). However, the testimonies collected for this research, which describe women's experiences in their childbearing years, together with the conclusions of the report prepared for the Conseil Atikamekw Montagnais (Dagenais, 1982), show a desire to control or even limit access to contraceptive methods, thereby fueling an increase in birth rates, but without improving the health conditions of the people concerned. This curbing of contraception through the spreading of taboos specific to religious discourse must also be understood in the perspective of the forced placement of children in residential schools, for example in those of Maliotenam and St-Marc-de-Figuery. Case in point:

> Residential schools introduced both sexual repression and sexual abuse to the masses of Aboriginal children who attended them. Christianity condemned traditional understanding of sex as a natural part of life and introduced the dichotomy of virgin and whore as the only options for women's sexuality. Where does all this history leave our youth today? (Anderson, 2003, p. 181).

Therefore, **the coexistence of the religious discourse feeding the taboos around the relationship to the body and the biomedical vision of health**, as favoured by the process of sedentarization, has concomitantly contributed to cutting off the younger generation's access to the traditional teachings of midwives and associated with childbirth, a rupture made all the more blatant with the obligation to give birth in hospital.

In the hospital

In the case of Innu and Atikamekw women, supervising nurses, particularly in the early 1980s (Dagenais, 1982), probably did everything possible to limit the possibilities of giving birth in the community, preferring to evacuate pregnant women to regional hospitals. They were located in Roberval, La Tuque, and even Joliette in the case of Opitciwan, and in Havre-Saint-Pierre for the women from Ekuanitshit and Nutashkuan. This policy of evacuation to hospitals was carried out at a very early stage, in the 32nd week of pregnancy (8th month). **By refusing to monitor pregnancies and by actively spreading a rhetoric of risks associated with birthing within the community, dispensary nurses have played a prominent role in the generalization of this type of medical practice, which can be described as hospitalocentrism** (Desrosiers, 1999; Gaumer & Desrosiers, 2004). Birth experience stories help us understand:

> "...that little room exists for negotiating one's birth experience within the hospital setting. (…) the biomedical risks of childbirth were given precedence over the mitigation of social risks by the healthcare system and policies informing care practices" (Olson, 2017, p. 108).

The policy of mandatory evacuation raises multiple issues, starting with those related to the physical and psychological well-being of pregnant women during transport, as well as in terms of communication barriers with the medical staff at the hospital where they were evacuated. The displacement by plane, train or boat, as testified by the project participants, creates a disconnect in the birthing process, when in fact:

> Giving birth to a baby is an emotional journey. Birthing women require support and love while they are giving birth but also during the time leading

> up to the delivery and the time after delivery. (…) The most common theme emerging from women describing their experiences as expectant mothers was loneliness and isolation (Cidro *et al.*, 2017, p. 82).

The social and cultural isolation of women following evacuation to hospital was deplored by the women we met. First, because they were often on their own, as the husband was unable to accompany his wife, let alone live with her, unless he could pay for his own travel and accommodation in a foster home. The literature on this subject tells us that this type of situation can be generalized to that of Indigenous women who, despite coming from varying cultural backgrounds - not only Innu and Atikamekw, but also Māori, for example - **have been deprived of their freedom of choice in terms of the support they desired.** In fact, "confining birth to the hospital setting contains a powerful political message that can limit how, when, and where women birth, and can define who may be involved in birth" (Simmonds, 2017, pp. 113-114).

At the medical facilities, the treatment of the women themselves left much to be desired. According to the participants. This point is confirmed by the CAM report (1982) which highlights the following complaints:

> It is not uncommon to have two people sleeping in the same bed, even if they don't know each other; the sheets are not always changed, there is a frequent shortage of soap, towels and toilet paper; the meals are often inadequate and the service leaves something to be desired; finally, the management and staff of these homes are non-Indigenous and do not speak Atikamekw or Montagnais (Dagenais, 1982, p. 112, Translation).

In addition to the **differential treatment of Indigenous women compared to non-Indigenous women, the language barrier is a major issue, as it keeps women in a state of confusion due to their lack of information, emblematic of their disempowerment over the control of their bodies and the medical interventions performed on them.** In addition to the disparities in treatment between Indigenous and non-Indigenous women, the language barrier is a major issue, as it keeps women in a state of confusion related to their lack of information, which is emblematic of their disempowerment in terms of control over their bodies and the medical interventions performed on them. The CAM report (Dagenais, 1982) summarizes the oppressive hospital policies in effect during the period witnessed by the women interviewed and concludes as follows:

> The language and cultural barriers only aggravate already tense relations. For lack of time and skills required for the women's arrival, medical escort, translation; off-reserve services are characterized by a lot of incomprehension, e.g., the seriousness and consequences of certain surgical procedures are not understood by the pregnant women, meaning that we are extremely far from informed consent (*underlined by the author*) (Dagenais, 1982, p. 416, Translation).

A recent study on the free and informed consent and the imposed sterilizations of First Nations and Inuit women in Quebec, to which a majority of Atikamekw and Innu women participated (24 out of 35 stories collected), demonstrates that this differential treatment, language barriers, and persistent prejudice against pregnant Indigenous women, viewed as problematic patients (drug and alcohol use, seeking more attention) and neglectful mothers (many children, young, and unwed), are still prevalent: "Often, their health status seems to be analyzed in light of these prejudices. Notably, many of the participants clearly identified that they were not treated as human beings when they went to the hospital to give birth" (Basile & Bouchard, 2022, p. 60, Translation).

This loss of control by Indigenous women over the treatment of their bodies thereby paves the way for disregarding one of the most fundamental human rights. For example, the narratives of Innu and Atikamekw women, as well as the results of the health survey conducted by the CAM (Dagenais, 1982) confirm that the women's wish to breastfeed their newborns was not respected. This denial of women's leadership can also have tragic consequences, as evidenced by the participants' mention of forced sterilization by tubal ligation, or of newborns taken away from mothers who then lost track of them, often forever. Generally speaking, and beyond the issue of Indigenous women's power over their own bodies, "the bond between Indigenous mothers and children has been under attack for over five generations" (Shahram, 2017, p. 22). Consequently, the necessary reclaiming of power by Indigenous women over their reproductive health becomes a priority in the ultimate goal of a return to governance by and for Indigenous peoples.

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