

The Return of Traditional Indigenous Midwifery Practices in Quebec

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Article abstract

Indigenous mothers face unique challenges and violence when they seek assistance from the healthcare system for themselves and their unborn children. From the mid-20th century on, when Canada's Indigenous communities were sedentarized, women were compelled to give birth in hospitals. By taking control of Indigenous women's bodies, the hospital-based healthcare system altered the fundamental structure of Indigenous societies. Even when efforts were made to expand accessibility by creating community health facilities, Indigenous women were still forced to give birth in hospitals. By centering on Innu and Atikamekw women's voices, we examine how Quebec's medical colonialism has affected Indigenous women giving birth in medical facilities. We demonstrate how the healthcare system disrupts Indigenous practices and knowledge regarding pregnancy, childbirth and postnatal recovery, thus altering an entire communal support system. We also examine the growing movement among Quebec's Indigenous communities to reclaim control over childbirth as a means of opposing medical colonialism, notably through the return of traditional midwifery practices.

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The Return of Traditional Indigenous Midwifery Practices in Quebec

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Abstract

Indigenous mothers face unique challenges and violence when they seek assistance from the healthcare system for themselves and their unborn children. From the mid-20th century on, when Canada's Indigenous communities were sedentarized, women were compelled to give birth in hospitals. By taking control of Indigenous women's bodies, the hospital-based healthcare system altered the fundamental structure of Indigenous societies. Even when efforts were made to expand accessibility by creating community health facilities, Indigenous women were still forced to give birth in hospitals. By centering on Innu and Atikamekw women's voices, we examine how Quebec's medical colonialism has affected Indigenous women giving birth in medical facilities. We demonstrate how the healthcare system disrupts Indigenous practices and knowledge regarding pregnancy, childbirth and postnatal recovery, thus altering an entire communal support system. We also examine the growing movement among Quebec's Indigenous communities to reclaim control over childbirth as a means of opposing medical colonialism, notably through the return of traditional midwifery practices.

Keywords

Indigenous, women, midwifery, childbirth, medical colonialism, self-determination

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The Return of Traditional Indigenous Midwifery Practices in Quebec

Joyce Echaquan—an Atikamekw woman from the Manawan community in Quebec—died in a hospital “as a result of pulmonary edema caused by cardiogenic shock in the context of a diseased heart [...] associated with possibly deleterious effect manoeuvres [...] without adequate supervision” (Kamel, 2021, p. 20). The untimely death of Mrs. Echaquan at the age of 37 caused deep distress within her family and community. It shocked Quebec as a whole, raising concerns about the blatant lack of cultural safety regarding the services she received. Coroner Géhane Kamel concluded in her report on the incident that “[t]he racism and prejudice that Mrs. Echaquan faced was [*sic*] certainly a contributing factor to her death” (Kamel, 2021, p. 20).

Sadly, the death of Joyce Echaquan was not an isolated incident. It is a reminder of the institutional violence faced by Indigenous people—more specifically Indigenous women—in Canada due to systemic racism, misogyny, and colonialism (NIMMIWG, 2019; Shaheen-Hussain et al., 2023). Because public organizations follow regulations and are generally well-regarded in society, institutional violence has long been overlooked, to the point of becoming ingrained in the Canadian society (NIMMIWG, 2019; SSCHR, 2022).

Despite the vital role they play within their communities, Indigenous mothers face unique barriers when accessing the healthcare system during their pregnancy and the delivery of their babies, including “healthcare providers’ [wrongful] perceptions [...] and fear of accessing healthcare when child apprehension by government officials is being threatened” (Leason and Sutherland, 2022, p. 61). According to Leason and Sutherland (2022), “Indigenous women’s birth outcomes are inextricably connected with the extent to which they have power, choice, and control over their maternal health and maternity experiences” (p. 61), yet many Indigenous women continue to be denied these rights.

One of the main characteristics of the Canadian healthcare model is hospitalocentrism (Gaumer & Desrosiers, 2004; Shaheen-Hussain et al., 2023). Starting with the sedentarization of Indigenous communities in the mid-20th century, women were forced to give birth in hospitals (Basile et al., 2023a). This concentration of care in hospitals transformed the fabric of Indigenous societies by taking control over Indigenous women’s bodies (Basile et al. 2023a; Sinclair, 2024). Even after the development of community health services, Indigenous women were still being forced to give birth in hospitals (Dagenais, 1982; Routhier, 1984). The rationale was to ensure proximity between obstetrics and other specialized medical units, with the objective of reducing infant and maternal mortality rates (Lawford, 2011; Routhier, 1984). While the intention was laudable, the dire consequences on Indigenous cultures and lifeways have not been given proper consideration.

Medical colonialism refers to how “colonial governments appropriated medical power by encouraging the production of knowledge about Indigenous bodies that justified racial hierarchies. The same medicine reified those hierarchies by providing segregated and inequitable services on the basis of race” (Kelm 2004, p. 335). Indigenous women forced to give birth in hospitals feel emotional pain as they are separated from their social and intergenerational safety net (families and midwives) (Corcoran et al., 2017). Hospitalocentrism not only prevented Indigenous women from becoming midwives, it also

disconnected pregnant women from their land, where childbirth used to be practiced before sedentarization (Basile et al., 2017; Basile et al., 2025).

“Medical and health agencies have been instrumental in shaping colonial ‘biopower’ [...] to ensure that First Nations lives are managed in accordance with the colonial settler state project.” (Anthony & Blagg, 2021, p. 71-72). This led to abuses on Indigenous women in the healthcare system, such as forced contraception and forced sterilization (Sinclair, 2024; SSCHR, 2022). According to Carol Dubé, Joyce Echaquan’s husband, his wife had been pressured to undergo abortions on several occasions, as well as a tubal ligation after the birth of their last child (Shaheen-Hussain et al., 2023). Similar testimonies have been reported by Basile and Bouchard (2022) as well as during the National Inquiry on Missing and Murdered Indigenous Women and Girls, which described “how these acts of cultural, institutional, and interpersonal violence [cause] widespread trauma, suffering, and pain, which can, in turn, lead to further violence” (NIMMIWG, 2019, p. 421).

In this article, we explore the effects of medical colonialism on Indigenous women in Quebec. After providing a concise historical overview of the medicalization of Indigenous childbirth in Quebec, we give voice to Atikamekw and Innu women, showing how they dealt with the changes that were forced upon them with regards to pregnancy, childbirth and postnatal recovery. Lastly, we look at the emerging movement to retake control over childbirth in an effort to resist medical colonialism, notably through the return of traditional midwifery practices.

Hospitalocentrism: The Medicalization of Childbirth in Quebec

For Indigenous women in Canada, the medicalization of birth occurred in two phases: first, the federal government marginalized Indigenous midwives, and then it applied coercive pressure to force Indigenous women to accept the Euro-Canadian biomedical paradigm (Lawford, 2011). Through these regulations, the federal government intended to control pregnancies and births as part of a larger plan to assimilate and “civilize” Indigenous peoples (Lawford, 2011).

In the early 1980s, the Conseil Atikamekw Montagnais (CAM) commissioned a report on health services which described how, in those days, there were no resident physicians in the communities (Dagenais, 1982). This was partially compensated for with traveling medical staff, but several people had to go to the nearest hospital to access services. Although each community had a nurse-run dispensary, pregnant women who were in their seventh month of pregnancy were urged to evacuate to hospitals. For example, Atikamekw women from the Opitciwan community who were about to give birth were “offered” a plane trip to Saint-Michel-des-Saints and then had to drive to Joliette or take a train to La Tuque (almost 6 hours away) or Senneterre (almost 4 hours away) (Basile et al., 2023a, p. 38). According to Dagenais (1982), such transfers after only seven months of pregnancy were too early. Nowadays, patients are driven to the Roberval hospital four weeks before the scheduled date or, in case of emergency, they are either airlifted by helicopter or driven by ambulance.

In the mid-1990s, the Collège des Médecins du Québec (College of Physicians) actively advocated to obtain “monopoly over most diagnostic and therapeutic activities” (Goulet, 2004, p. 43), *de facto* causing a decline in midwifery practices. Midwives and nurses were demoted to the rank of “auxiliaries”

(Goulet, 2004; Routhier, 1984). Although Indigenous and rural midwives have been exempted from medical supervision for some time (Goulet, 2004), medicalized childbirth became more prevalent in the 1940s to 1960s and “natural” childbirth came to an end (Routhier, 1984).

While the domination of the modern healthcare system by the medical profession generally improved health outcomes for the population—as shown by increased life expectancy (Goulet, 2004)—, it also imposed a man’s vision of reproductive health. Beginning in the early 1980s, in Quebec and other Western countries, “the male physician, particularly the OB/GYN [obstetrics and gynaecology] male specialist, 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” (Laurendeau, 1987, p. 174).

The introduction of new notions such as “high-risk pregnancy” caused great confusion among Atikamekw women, who had to consider 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 culture (Routhier, 1984). Despite some resistance at first, the religious and medical discourse succeeded in making Indigenous women feel guilty, helpless, and “clueless about their needs” (Lévesque et al., 2018, p. 13). They finally resigned themselves to trusting the medical and nursing teams during pregnancy and childbirth. Over time, Indigenous practices were judged unnecessary (Lawford, 2017), midwives were mistrusted, and their knowledge disqualified (Sinclair, 2024).

Jurisdiction disputes between the federal and provincial governments are among the causes of healthcare differences between the Indigenous and non-Indigenous populations in Canada (Corcoran et al. 2017; Lévesque et al., 2018). According to the Indian Health Policy, which was adopted in 1979, on-reserve health services are federally funded but self-governed (through band-councils), whereas city-located hospitals and CLSCs (Centres locaux de services communautaires—Local community service centres) fall under provincial jurisdiction (Gaumer & Desrosiers, 2004). However, the healthcare funding given to band councils is insufficient because it is not based on actual requirements, but rather on past expenditures that change based on the number of registered members (Lévesque et al., 2018).

Indigenous women have long raised complaints about the treatment they receive in hospitals, but most grievances are disregarded (PLRP, 2019). Medical professionals perform certain procedures without ascertaining that patients 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.

The situation described above, exacerbated by the transmission of intergenerational trauma stemming from the colonial past, results in Indigenous women being at greater risk of mental health issues than non-Indigenous women during pregnancy and childbirth (Roy, 2014). Indigenous women often feel unprepared at the time of giving birth not only due to the lack of information about the physical process of giving birth, but also about parenthood and motherhood, causing stress, fear and anxiety (Whitty-Rogers *et al.*, 2006). Moreover, there is limited help available for the relatives of these women because

Health Canada does not pay for their travel or lodging (except for the father during childbirth only) (Dagenais, 1982; Lawford, 2011; Routhier, 1984).

The many hurdles faced by Indigenous women within the medical system has prompted a movement calling for the return of traditional midwifery practices in recent years (Basile et al., 2023b; Basile et al., 2025). Across Canada, Indigenous women and organizations are asking for improved perinatal services and revitalization of traditional practices related to pregnancy and childbirth (Alex, 2017; Baker, 2022; Wheeler, 2017; Williams, 2021).

Methods

We draw on two separate research projects led by one of us. In the first project (Basile et al., 2023a), semi-structured interviews were conducted with 15 women from three communities—Ekuanitshit (formerly called Mingan), Nutashkuan, and Opitciwan. These women were recruited based on the knowledge they had about pregnancy and childbirth as midwives and childbirth assistants. In the second project (Basile et al. 2023b), 27 semi-structured interviews were conducted with representatives from 19 communities, six Indigenous organizations, and two persons having participated in their own name. Both projects were informed by Indigenous research methodologies and were centered on Indigenous women's voices (Kovach, 2021; Smith, 2021; Wilson, 2008). The projects followed the Guidelines for Research with Aboriginal Women (QNW, 2012) and good practices in terms of ethics of research with Indigenous peoples (AFNQL, 2014; Asselin & Basile, 2012; SSHRC et al., 2022). Approval was granted, and letters of support were provided by the band councils of each participating community as well as Indigenous organizations. Both projects were also approved by the Ethics Review Board of the Université du Québec en Abitibi-Témiscamingue.

As holders of expertise, the participants were fully involved in the co-construction of these studies, including designing interview guides (Basile et al., 2018). Following the interviews, transcriptions were sent to the participants so they could validate their accuracy.

The NVivo 10 software (Lumivero, Denver, CO) was used in both studies to conduct a thematic analysis of the data. An inductive approach allowed us to embrace the complexity of the participants' experiences (d'Arripe et al., 2014). Initial analyses of the data were validated by the participants, and the final reports were presented to the participants and to community research coordinators. To protect the anonymity of the collected testimonies, a coding system will be used when reporting women's sayings in the following sections (first letter of community name, or first three letters of organization name, followed by a sequential number).

Results and Discussion

Innu and Atikamekw Views on the Medicalization of Birthing

Among the Innu and Atikamekw, as in other Indigenous peoples, births traditionally occurred with the assistance of a midwife, or a family member when no midwife was available (Anderson, 2011; Carroll and Benoit, 2004; Cidro et al., 2017; Dawson, 2017; Dion Fletcher, 2017; Finestone and Stirbys, 2017;

Olson et al., 2019; Pambrun et al., 2019; Tabobondung, 2017; Basile et al., 2025). Knowledge about pregnancy and childbirth was transmitted among Indigenous women:

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

In Atikamekw and Innu communities, midwives who first practiced birthing on the land held on to the medicinal knowledge essential to their practice and continued to use it when people settled in said communities. An Innu participant shared 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] [...] I told [my mother], ‘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 [...] 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’” (E1).

Another participant explained that she gave birth in her community (Nutashkuan), but that soon after women were forced to give birth in hospitals:

“several women [...] helped each other to deliver babies in the community [...] In those days, there was no specialist doctor, but there were women who gave birth, women who were called *tshukuminant*. [...] That stopped when the women were transferred to a hospital in Havre-Saint-Pierre, 200 km from here” (N2).

Innu participants recalled the trust they had in the midwives and their knowledge of medicinal plants: “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” (N4). They also highlighted the support that elders (often midwives) provided to pregnant women: “There was a *kukum* (grandmother) who kept a close eye on” (N1). At the time of birth, walks and massages were encouraged, which contrasts with the immobile and supine position advocated in hospitals. One participant described her experience with her sister acting as a midwife:

“[She told 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” (E1).

Over the years, the takeover of childbirth by the medical profession meant that women no longer had any control over where, how and with whom they gave birth. Even the hospital where they would deliver was imposed on them, some situated far from their communities. The knowledge that midwives had of birthing practices was gradually disqualified by the medical profession (Basile et al., 2025). In rare cases, however, midwives and nurses worked together: “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. [...] She came to help the midwives, the elders” (E5). While many Atikamekw families continued to use traditional medicine, the presence of nurses at summer gathering sites and the easy access to the medicines they distributed led some to gradually abandon their knowledge: “[Upon the arrival of nurses in the community] I personally think that they [community members] accepted the medication” (O6).

The authority granted to the medical profession led in some cases to obstetrical violence. Innu and Atikamekw participants mentioned surgical procedures carried out without their consent, such as tubal ligation to sterilize them, in violation of fundamental human rights, notably the right to consent. According to a participant:

“My husband and I went to see [our] family doctor, [and] he told us we couldn’t have any more children. Ligatured for life! I was disappointed, frustrated. My husband also. [...] 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).

Apart from forced sterilization, the participants also mentioned unwanted medical intervention such as the induced delivery of several women at the same time:

“We were several pregnant women from Manawan and Opitciwan to leave [at the same time for the hospital]. [...] We all gave birth on the same evening. I was deeply disturbed by that. [...] They were all labour inductions. [...] They treated us badly when we went there to give birth. [...] 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).

Participants also mentioned screening drug tests administered to newborns without parental consent: “I don’t dare look in my own file to see if they’ve done it. They never came to ask for consent to do drug testing during my deliveries. I’m sure they do it without the parents’ consent (COM09)”. Similar testimonies were brought to the attention of the Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec, which reported “unethical practices targeting women,” that were “based on addiction-related prejudices, such as drug testing carried out without consent on Indigenous women who have come to give birth” (PLRP, 2019, p. 367). One participant explained how traumatising it can be for women to learn that drug tests were carried out on their baby without their consent:

“It was the same thing with another woman [...]. She went to every appointment, ate well. She did everything we told her to do. After giving birth, she breastfed her baby. She was told by the doctor, the physician, ‘We did the drug test on your baby, it’s negative.’ This hurt her so much.

She hadn't been told they were testing the baby. [...] She talked to me about it again, not at the hospital, but afterwards. 'I was crying in the hospital; they did a drug test without telling me. I've never taken drugs in my life. I did everything I was asked to do. [...] They dirtied me'" (COM09).

Blood-testing carried out without the parent's knowledge or consent fall within the broad spectrum of intergenerational trauma inflicted on Indigenous families:

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

Not only did Indigenous women lose power over their own body, but also over their role as mothers. Several Innu and Atikamekw participants mentioned that the disappearance of newborn babies was frequent, which corroborated an observation by the National Inquiry on Missing and Murdered Indigenous Women and Girls that "Hospitals denied parents the opportunity to see their children and to recover their bodies if they were told they had passed away, and some families have never even received a death certificate" (NIMMIWG, 2019, p. 283).

In spite of the measures put in place to rob them of the control they had over their bodies and babies, Innu and Atikamekw participants insisted on the necessity for them and other Indigenous women to reclaim power over their reproductive health.

Revitalization of Ancestral Maternity

In the wake of Joyce Echaquan's tragic death, the Conseil des Atikamekw de Manawan and the Conseil de la Nation Atikamekw developed the Joyce principle in 2020 to "guarantee to all Indigenous people the right of equitable access, without any discrimination, to all social and health services, as well as the right to enjoy the best possible physical, mental, emotional and spiritual health" (CAM and CNA, 2020, p. 10). The principle also calls for "the recognition and respect of Indigenous people's traditional and living knowledge in all aspects of health" (CAM and CNA, 2020, p. 10). The principle is "a call to action and a commitment from governments to end an intolerable and unacceptable situation" (CAM and CNA, 2020, p. 7). Central to this call to action is the concept of cultural safety, coined by Māori nurse Irihapeti Ramsden (2002). Cultural safety is "an outcome based on respectful engagement that recognizes and strives to address power imbalances inherent in the health care system. It results in an environment free of racism and discrimination, where people feel safe when receiving health care" (Kitty, 2020, p. 6). Among the strategies that could be deployed to offer culturally safe responses to Indigenous mothers and mothers-to-be, Indigenous midwifery services are among the most frequently invoked (Alex, 2017; Baker, 2022; Wheeler, 2017; Williams, 2021). For Hartz and McGrath (2017, p. 50), "[a]ccess to culturally appropriate antenatal care, birthing services and maternal and child health services can reduce the risk of poor health outcomes for Indigenous mothers and their babies, children and families".

A recent return of certain traditional birthing practices has been observed in Indigenous communities in Quebec. As one participant noted, “eight years ago, I didn’t see any [midwife]. Now, there are more and more. In the last two years, they’ve started to come back” (COM09). In addition to this much-needed resurgence, participants explained the importance of ancestral Indigenous practices in the life of pregnant women and their communities. These practices build on the importance of nation and family within Indigenous cultures (Basile et al., 2017). Rituals, ceremonies and traditional objects anchor the child’s importance within the community, as “birth is a ceremony” (COM16).

Innu and Atikamekw participants insisted that the crafting and use of traditional objects and the rituals associated with them require an in-depth knowledge of the land on the part of Indigenous women in order to gather the necessary resources and pass on land-use practices. In Atikamekw communities, there is a strong interest in revitalizing ancestral practices such as the use of *mickiki* (traditional medicines), childbirth on the land, bellybutton care, the first steps ceremony, traditional baptism, the baby naming ceremony, the newborn ceremony, the burial of the umbilical cord and placenta, as well as the use of *misaspison* (cloth baby wrap), the baby *wepison* (hammock), and the *tikinakan* (baby carrier). As a participant explained:

“Having our babies born into the hands of Indigenous midwives surrounded by culture, tradition, knowledge, respect and celebration of Indigenous identity is the best start that we can give to our children to remember the strength and pride of being Indigenous” (ORG06).

Since Indigenous languages are entwined with cultural practices and facilitate their viability and transmission, issues pertaining to languages prevailed in the interviews. Hearing the Indigenous mother’s tongue at birth not only revitalizes its practice but also enhances the relationship between the child and its homeland (Epoo et al., 2021; Van Wagner et al., 2007). A participant noted that “At [the Hospital], they also respect requests when you want the baby to hear the [Indigenous] language spoken first at birth, those present will not talk before we tell them that it is OK to do so.” (COM08).

Pride in one’s identity was important for the participants, particularly among urban-based Indigenous organizations: “[t]here’s a reconstruction of identity that goes hand in hand with pride in being Indigenous. This pride is less and less concealed. It’s valued. The child’s place in the community is central. So, it’s important for the child to be rooted in the land” (ORG01). To contribute to the revitalization of Indigenous ancestral practices, Native Friendship Centres are actively pursuing a number of initiatives, so much so that “there isn’t a single centre that isn’t currently working on strengthening the provision of more traditional services” (ORG02). At the Val-d’Or Native Friendship Center, for example, Anishnaabe storytelling on birth and pregnancy was introduced on National Indigenous Peoples Day in June 2022 (Déziel, 2022). In short, the revitalization of ancestral practices is a tool for decolonization and to repair traumas. It is essential to the preservation of Indigenous cultures, far too long depreciated by assimilationist policies.

Limitations

Both studies reported here took place during the COVID-19 pandemic. Special measures were taken to ensure that data collection did not put participants at risk, such as hiring local coordinators who set up

the necessary technology to conduct online interviews. Unfortunately, some communities were unable to respond to the invitation due to the level of stress and responsibility they were facing in the context of the pandemic. One of the studies concerned only the so-called non-treaty communities, because of the mandate given to us by the Quebec Ministry of Health and Social Services. Two of the Indigenous peoples under treaty in Northern Quebec (Eeyouch and Inuit) offer midwifery services in some of their communities. The literature on midwifery services in Eeyouch and Inuit communities was nevertheless mobilized to compensate.

Conclusion

Many Indigenous women in Quebec steer clear of health services entirely, in response to their unsatisfactory experiences with hospital care and their problematic relationship with the healthcare system. As noted in the report of the Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec: “this mistrust causes the Indigenous community as a whole to underuse services, which exacerbates and intensifies crises, delays screening, and makes it more difficult to provide care and intervention in cases of domestic violence” (PLRP, 2019, p. 208). Most Indigenous women are still forced to seek perinatal care outside their communities (Basile et al, 2023b). While some women who live in or close to urban centers may find it relatively easy to get these services, women from remote communities nonetheless face significant challenges. Inadequate perinatal care, lack of support and interpreters, extended stays in urban settings plagued by a dearth of accommodation, and feelings of loneliness and stress during forced relocations highlight the need for culturally appropriate and safe health services for Indigenous women. Among the tactics taken into consideration are midwifery services, but funding such services remains a challenge.

The forced medicalization of delivery has damaged the crucial role of Indigenous midwives in their communities. The practice had all but vanished as colonialism undermined the leadership and position of Indigenous midwives, but a resurgence of their knowledge is taking place concurrently with efforts to find harmony and complementarity between Indigenous and Western knowledge systems. Inspiring models in Quebec can be found in Eeyou Istchee (Cree territory), where women can give birth in their own communities with the assistance of Cree midwives, as well as in Nunavik (Inuit territory), where the arrival of Inuit midwifery services has restored childbirth and pre- and postnatal care (Corcoran et al. 2017). At least 86 % of child births in Nunavik now occur in Inuit communities with midwife supervision (Van Wagner et al., 2012). The success of the midwifery programs in Eeyou Istchee and Nunavik stems from the fact that they are run by Eeyou and Inuit midwives trained within their communities (CBHSSJB, 2025; Epoo et al., 2012). Accessibility, flexibility and continuity of services are often cited as benefits of the midwifery services in Eeyou Istchee and Nunavik, contributing to the establishment of positive, supportive, trustful and empowering relationships between women and midwives (Corcoran et al., 2017). Urban Native Friendship Centers are also implementing perinatal care services, so that Indigenous families can socialize and share their parenting experiences with elders in a secure environment. Many Indigenous communities in Quebec hope that similar programs will be implemented so that they have access to the decolonized healthcare practices they so desperately need.

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