

Bringing Birth Home: An Analysis of Inuit Birthing Practices and Policies

Inuit birthing practices changed dramatically following first contact with European colonialists in the 16th century. Since then, the Canadian government has played a large role in determining what birthing practices are or are not appropriate and available to Inuit communities. In turn, Inuit women and their families have shown great resistance to the imposition of strictly biomedical models that remove childbirth from the community. This essay briefly traces the evolution of governmental policies regarding Inuit childbirth from the 19th century until present, focusing specifically on the practice of relocating Inuit women from their homes to give birth in southern hospitals in the 1980's. While there is great degree of diversity in cultural practices and regional infrastructure throughout the North, this essay aims to be as broad as possible. I employ a case study of an Inuit-led birthing center to explore how Inuit resistance to government policy led to a resurgence of traditional Inuit midwifery practices that incorporate biomedical technology. Inuit women and their communities have demonstrated throughout the past 30 years that it is politically, culturally and medically detrimental to relocate Inuit women to the South to give birth. The choices Inuit women have in childbirth are still highly constrained by political, geographic and economic factors, yet the case study reveals that resistance from Inuit communities produced a viable model for community births that utilizes both biomedical and Inuit midwifery practices. The history of childbirth in Northern Canada reveals that it is imperative to bring births home to Inuit communities.

There is no singular model of Inuit traditional birth practices, but according to Inuit oral history, prior to European contact, Inuit childbirth “embodied an ethic of self-sufficiency or a belief in the mother’s active role in achieving a good outcome,” (Jansen 1997, p. 385). Inuit women often gave birth in the company of other women and a midwife or in some circumstances, such as during a hunting trip, women gave birth alone or with the help of their husbands (Jansen 1997, p. 384). The midwife played, and to some extent still plays, a significant role in Inuit childbirths. In Inuktitut, midwives are called Sanaji, which means “she who makes,” (O’Neil 1995, p. 61). This name refers to the Sanaji’s role to establish the sex of the child during birth as biological sex is traditionally viewed as being determined just before birth, not at conception (ibid). The Sanaji also presides over the various rites and rituals of birth (ibid). In other areas of the north, midwives are called Ikajuri which means “the helper,” which reflects the duty of the midwife to coach women through their births (Puaktuutit 1990). The role of the traditional Inuit midwife extends beyond delivery of the child; the midwife is also responsible for pre-term rituals and surveillance as well as playing a role in the rites of passage of children as they grow up (O’Neil 1995, p. 61).

In the 19th century, Jesuits and missionaries provided any and all health services available to Inuit communities because the British government did not provide any medical services in the North at this time (Jansen 1997, p. 390). In 1880, the British government gave dominion title and the responsibility to

govern the North to the Canadian government. Beginning in the 20th century, the Canadian government began to provide some health services to Inuit communities. The Department of Indian Affairs appointed its first Chief Medical Officer, Dr. Peter Bryce in 1904 (Jansen 1997, p. 393). Bryce believed that the high rates of tuberculosis and other infectious diseases in Inuit settlements needed to be addressed so as to protect other Canadians from ill health (*ibid.*). He argued that the high rates of infection from childbirth in Inuit communities could be attributed to “how frequently ‘native customs’ prevail at childbirth,” (*ibid.*).

In conjunction with the professionalization of medicine in the 1920’s and the rise of the public health movement following WWI, Inuit health became a greater source of interest to the federal government (Jansen 1997, p. 394). Bryce introduced mobile nurse visitors to the North in 1922 and established the first nursing station on Man Reserve in the 1930’s (*ibid.*). The professionalization of medicine led to a marginalization of alternate forms of health services, such as midwives throughout Canada (Tester 2006, p. 93). The diaries of Dr. J.A. Bildfell, a physician stationed at Panniqtuuq, Baffin Island between 1933 and 1934 reveal the sentiment that Western medicine is equated with rationality and progress while other forms of medicine are inferior. In speaking about the Inuit community being hesitant and even adverse to the idea of Western medicine, Bildfell wrote in 1933: “The difficulty becomes interesting only when some effort is made to understand this peculiarity... this sacrilege (For surely such an attitude toward Medicine can be called a sacrilege)... Unless one secures an insight into this strange mental condition, the practice of Medicine among them not only is less interesting, but less efficient and less tolerable,” (Tester 2006, p. 94). The reason the Inuit were so unwilling to accept Bildfell’s medical advice was, according to him, due to their primitive condition and inability to reason (*ibid.*, p. 102).

In the mid-20th century, countries across the globe increasingly utilized the national infant mortality rate (IMR) as a gauge for measuring the advancement of civilization and humanism since the figure could be easily compared (Jansen 1996, p. 395), Dougals 2006, p. 122). To reduce IMR in Northern Canada would be a “metaphor for the success and moral virtue of Canadian colonial penetration,” (Jansen 1997, p. 397). Infant mortality became a metric for Canada’s success in “civilizing” and assimilating its Aboriginal populations. On June 17, 1946, Brooke Clazton, the former Minister of National Health in Welfare, raised the question of IMR in the House of Commons by describing, “infant mortality among the native peoples in the North in 1942, 1943 and 1944 was roughly three times higher than among white Canadians outside of the NWT,” (Duffy 1988, p. 75). The situation did not improve in the next ten years and by 1958, the Inuit population’s IMR was the highest of any Canadian ethnic group (Jansen 1996, p. 395).

The Medical Service Branch conducted a statistical survey in 1962 to monitor the health of all Inuit infants born that year (Jansen 1996, 396). They identified the major health risks infants faced in Northern communities and attributed the problem to births being attended by “native midwives untrained in the usual meaning of the word,” (*ibid.*). One estimate suggests that in 1966, two thirds of births in the Canadian Arctic took place outside of hospitals and nursing stations and were not attended by any medical professional (Mitchinson 2002, p. 72). The government responded to the elevated level of risk for Inuit children by encouraging, sometimes forcibly, Inuit communities into permanent settlements where they could be provided with medical services (Douglas 2006, p. 122). In the larger communities of over 100 individuals, the government provided community health centers run by nurse-midwives and visiting physicians (Jansen 1996, 296). Nurse-midwives were brought in from Britain because the Canadian government did not legally per-

mit midwife training or certification in Canada until the mid-1990's (ibid) throughout the 1970's, the vast majority of Inuit births took place at community nursing stations (ibid). Baskett reports that between 1971-1975 in the Northwest Territories, of the 622 infants born in these years, 556 births took place in the community nursing stations or base hospitals if the community possessed one (1978, 1002). While at this time the Canadian government and British nurse-midwives undervalued Inuit midwives' knowledge, many Inuit midwives still attended Inuit births, if only to perform ceremonial rites (Douglas 2006, p. 122).

The introduction of health centers to Inuit permanent settlements reflects the Canadian government's paternalistic approach to Aboriginal issues. It is certainly important that Northern settlements have access to medical services, but the government never consulted Inuit communities about what services they needed or desired since they were deemed unfit to make such decisions. As explained in the Department of National Health and Welfare Annual Report of 1961, "A large part of the original races native to Canada still live under rather primitive conditions in relatively underdeveloped areas often remote from normal medical services and, in the main, lack both the knowledge and means to arrange for such services themselves. The federal government, through this department, assumes a moral obligation to assist these people to meet their medical needs," (p. 19, italics added). The view that Aboriginal people were incapable of "[arranging] for such services themselves," and therefore required government intervention was solidified by the establishment of epidemiology as a scholarly field (O'Neil 1995, p. 64). The development of technologies to measure obstetric risk in the 1970's produced a growing rhetoric based upon risk levels, morbidity, and mortality (Kaufert and O'Neil 1990: p. 434). The Canadian government justified their "moral obligation" to provide Western biomedicine to Inuit communities with the weight of risk percentiles

and the statistics of epidemiology (O'Neil 1995, p. 64). The government believed that births performed in nursing stations or hospitals lowered the risk for complications from childbirth, thereby validating the government's intervention into Inuit births (ibid).

As a result of changing immigration policies that limited the numbers of immigrants into Canada as well as the growing inability to recruit medical workers to the North, the number of nurse-midwives drastically declined in the late 1970's, compromising the viability of the community nursing centers (Douglas 2006, p. 124). The nurse-midwives who did continue to work in the North lacked the training, resources and technology to deliver children in the isolation of Inuit communities (O'Neil 1995, p. 67). Some nurse-midwives were responsive to the idea of delivering Inuit infants in the settlements, but they "receive[d] no support from the government bureaucracy to do so," (Davis 1997, p. 449). By 1980, up to 98% of pregnant women in the North were transferred to Iqaluit or Montreal despite the fact that the official government policy at the time that favored nursing station births (Douglas 2006, p. 124). The government made the policy to relocate all pregnant Inuit women to southern hospitals official in 1982. The reasoning behind this decision was a combination of the government's fear of lawsuits if a birth went wrong in northern settlements, the new epidemiological rhetoric of clinical risk and the decline of nurse-midwives in Canada (Davis 1996, p. 449). The birthing policy of 1982 became a de facto medical policy because of reduced numbers of nurse-midwives and the government's unwillingness to provide further resources to community nursing stations.

The evacuation policy was predicated on the idea that modern technology was essential to lowering rates of infant mortality and improving maternal health and that these technologies were only available in a hospital setting (Jansen 1996, 397). Initially Inuit women were

relocated to regional hospitals in Yellowknife, Iqaluit or Churchill but soon after women were increasingly sent to southern urban centers such as Montreal, Edmonton or Winnipeg where the government believed that the most sophisticated equipment would lead to lower IMR (Douglas 2006, p. 124). The growing ease and availability of air travel at this time enabled such a policy to operate (Puaktuutit 1990). However, because airlines were unwilling to fly women who were close to full term in their pregnancy, the government removed women from their communities weeks or months prior to their due date (Puaktuutit 1990). Either local families billeted the expectant mothers or they stayed in government-operated hostels (Davis 1988, p. 446). The policy's exorbitant financial costs meant that the government would fly the expectant mother alone to the southern hospital where she gave birth surrounded by strangers (Jansen 1997, p. 397). Despite this, the increased hospitalization of childbirth did correlate with reduced IMR. Infant mortality among the Inuit population dropped from 95 per 1,000 births in 1971 to 38 per 1,000 births in 1982, but it is unclear if the increase in hospitalization alone caused this decline (Plummer 2000, p. 172). Although the decline in IMR was important for the vitality of Inuit communities and families, it came at a high cultural and social price.

Medical interventions are often well intended to reduce illness or promote health but in practice, the medicalization and hospitalization of Inuit births led to many negative consequences. The priority of this policy is to decrease the clinical risk for the mother and infant in terms of mortality and morbidity and lessen the legal risks of allowing births in ill-equipped nursing stations (Davis 1996, p. 444). What is ignored by this perspective however, are the cultural, social and personal risks incurred by this policy. Culturally, the removal of Inuit women from their communities risks erasing traditional birthing practices. When traditions are not afforded opportunities to be utilized,

new generations cannot learn the techniques and valuable knowledge becomes lost. Rhoda Karetak, a midwife and past president of the Inuit Cultural Institute, lamented that she learned birthing rituals and techniques though watching elders but now that women give birth in hospitals, the ability to learn through observation is greatly diminished (Puaktuutit 1990). While there is a high degree of cultural and linguistic diversity in Northern Canada, women who were removed to southern urban hospitals may not have been able to sufficiently converse in the same language of the medical staff (Davis 1996, p. 444). Other important cultural practices and rituals surrounding birth cannot be performed when the mother is in a distant hospital. For example, in hospital, women are required to name their infants on a birth certificate but traditionally in some communities it is the grandparents who bestow the names of newborns (Plummer 2000, p. 172).

Financially, evacuated women reported spending a great deal of money on babysitters and phone calls to their families and also noted a potential loss of income for partners who took time off to care for the children (Chamberlain and Barclay 1999, p. 120). One father estimated that the total cost of his wife's births of their four children outside of their community was \$10 000 (ibid). The financial burden of this policy is not felt exclusively at the family level. The evacuation of one pregnant woman can cost the government \$8,000 per birth (Globe and Mail November 10, 1986). The cost of airfare, accommodation, food and medical fees is an expensive endeavor for the government and these funds could be used for improving birthing facilities within larger Inuit communities.

Beginning in the mid-1980's, Inuit women mobilized against the evacuation policy. The Inuit political movement grew rapidly along two main avenues throughout the 1980's: the right to self-determination and the development of interregional solidarity among

Inuit people in Canada (O'Neil 1995, p. 68). The Inuit women's movement incorporated these values in advocating for self-governance over medical needs, including birth, and interregional cooperation to advance these goals (ibid). In 1970, Pauktuutit, the Inuit Women's Association, was established as a forum for women's issues. According to its mission statement, "Pauktuutit fosters greater awareness of the needs of Inuit women, advocates for equity and social improvements, and encourages their participation in the community, regional and national life of Canada," (Pauktuutit 2011). The mission is broad and inclusive of all Inuit women in the North. Initially the group focused on family violence but by the mid-1980's, childbirth became a major concern (ibid). In 1990, they released a video entitled *Ikajurti the helper: Midwifery in the Canadian Arctic* examining the role of the traditional Inuit midwife, the evacuation policy and a successful birthing centre in Povungnituk. The video clearly conveys that the evacuation policy is unacceptable and other avenues need to be explored to allow Inuit women to give birth within their own community.

In 1990, Martha Greig, the former vice-president of Pauktuutit, commented to the media that when it comes to birth, Pauktuutit's stance is that "we just want Inuit women to be given a choice," (Kitchener Waterloo Record, December 3, 1990). Greig went further in 1993 to assert that evacuating pregnant women is intolerable to Pauktuutit: "To us, healthy children are born into their family and their community; they are not born thousands of miles from home to an unhappy, frightened mother," (National Aboriginal Health Organization 2008, p. 19). Pauktuutit continues to advocate for restoring Inuit births to their communities (O'Neil 1995, p. 68). Their claim is based on a combination of political, cultural, and medical rationale. Politically, they argue that the growing dependence of Inuit communities on the federal government is problematic and that Inuit communities should not passively accept "medical paternalism," (ibid). They

worry that being born outside of the North will compromise Inuit children's right to services available to them in accordance with the Indian Act (ibid). Culturally, the organization believes that returning births to Inuit communities will help foster a revival of cultural practices, which can lead to healthier pregnancies and strengthened communities (ibid). Medically, evacuating pregnant women can be traumatic for the mother as well as for the child and every effort should be made to avoid such a practice (ibid). They object to the medical perception that birth is an illness that needs to be treated and they advocate that traditional birthing practices promote positive understandings of pregnancy and the value of women and their bodies (ibid). The organization also discounts the argument that birthing in hospitals reduces clinical risk. They argue that a study of Inuit groups shows that organic risk is viewed by the general perception as a "necessary part of everyday life," and some risks are worth taking (National Aboriginal Health Organization 2008, p. 20).

Povungnituk (POV or Puvirnituk) was the first Inuit community to successfully establish an in-community birthing centre in 1986 as part of the Inuulitsivik Health Centre in Nunavik (O'Neil 1995, p. 70). The birthing unit, called The Maternity, is still currently operational. The women of POV and cultural activists in the community lobbied for a birthing centre, reporting that their community "has a reputation for not always saying yes to the white man," (Davis 1988, p. 452). The women of Povungnituk mobilized and petitioned the board of Inuulitsivik who quickly teamed up with the women to design a birthing centre (Van Wagner et al. 2007, p. 384). Together, they first conducted a survey to establish what women's ideal birthing situation would be (Davis 1988, p. 453). This led to the formation of a midwifery model that "values the integrity of the natural processes of birth, nurturant emotional and physical support of the laboring woman, mutual connection and respect between patient and practitioner and non-hierarchical rela-

tionships among the practitioners themselves,” (ibid). The midwives in this model combine traditional techniques such as a squatting birthing position, pre-term diets rich in game meat and customary rituals while also incorporating biomedical technologies such as ultrasounds (Puaktuutit 1990). The midwife is responsible for her patient’s prenatal, birth and post-natal care so that a relationship is formed between the midwife and mother over time (ibid).

Additionally, only those pregnancies deemed high risk by the perinatal committee (comprised of community midwives, nurses and physicians) are sent to hospitals in regional centers or in more extreme cases, to Montreal (Puaktuutit 1990; Van Wagner 2007, 387). The risk assessment model used to determine if woman needs to be flown to a hospital involves more than just clinical risks; the evaluation incorporates social and financial risks to the mother and her family (Van Wagner 2007, p. 387). Only women who require tertiary care and are pregnant with twins, breech presentation, who want to have a vaginal birth after a cesarean, have hypertension or preterm labor before 35 weeks are transferred to a Montreal health facility (ibid).

At The Maternity birthing centre, non-Aboriginal midwives and Inuit elders from the settlement train the Inuit women selected by the community to become midwives (Davis 1988, p. 453). The training program at Inuulitslvik is highly unique as midwives are trained in traditional practices, pharmaceuticals and emergency scenarios involving technological interventions (Van Wagner et al. 2007, p. 389). Canadian or European midwives teach the community midwives but the explicit basis of this program is that the non-Inuit instructors are there to “teach but not lead,” (ibid). The teaching style relies on traditional Inuit practices that value “being shown rather than told,” (Van Wagner 2007, p. 288). In 1988, there were 3 non-Aboriginal midwives training Inuit midwives, two of which were fully trained, two that were soon to be given status and

two more just beginning their training (ibid). By 2007, there were nine graduate midwives from the program and seven students were in training (Van Wagner et al. 2007, p. 388).

Davis reports it is difficult to assess the success rate of The Maternity because the small number of births in the community makes statistical analysis impossible (1988, p. 455). However, Davis does report that, “keeping the births in POV results in fewer interventions... and happier mothers, apparently without compromise to overall safety,” (1988, p. 456). By 2007, Van Wagner et al. used longitudinal statistical information taken from The Maternity in 1987-1988, 1990-1991 and 1995-1996 to compare the outcomes with women who were relocated from smaller communities to Tuulavik Hospital in Kuujuaq. The study shows that at Inuulitslvik there were “improved outcomes and lower rates of intervention,” which refers to the number of emergency C-sections performed (Van Wagner et al. 2007, p. 387). Jusapie Padlayat, a Saluit elder, expressed the belief that even though births may be more risky in the community centre that lacks the same level of resources, technology and expertise as a southern hospital, it is well worth the risk: “I can understand that some of you may think that birth in remote areas is dangerous. And we have made it clear what it means for our women to birth in our communities. And you must know that a life without meaning is much more dangerous,” (Van Wagner et al. 2007, p. 386).

The Inuulitslvik midwife-training program and Maternity Centre have been recognized internationally as a model to follow. The World Health Organization wrote to the government of Quebec that the centre is a “very important innovative project... If ever there was an example of community health promotion... this is it,” (ibid). The Society of Obstetricians and Gynecologists of Canada, the Royal Commission on Aboriginal Peoples, and the World Bank also applauded the pro-

gram for meeting Millennium Development Goals for Safe Motherhood (Kitchener Waterloo Record, December 3, 1990).

Many Inuit midwifery organizations have been established since Inuulitslvik, such as Irnisuksiiniq (Inuit Midwifery Network), kanaci otinawawasowin Baccalaureate Program, and the Ranklin Inlet birthing centre (National Aboriginal Health Organization, 2008). The proliferation of these organizations is partially due to the 1988 parliamentary decision to transfer responsibility for Inuit health services from the federal government to provincial jurisdiction (Kaufert and O'Neil 1990, p. 428). Today there are a diversity of policies and programs regarding Inuit birth in the provinces and territories but many do have regional birthing centers (Carroll and Benoit 2004 p.263). The Canadian government has “come full circle, recognizing the vital role that Aboriginal midwifery [has]” (Carroll and Benoit 2004:263). Widespread recognition of the value of Aboriginal midwifery however has not translated into fully effective programming in the North. As of 2004, Carroll and Benoit note that the number of midwives practicing in Inuit communities has not been able to keep up with the growing demand for their services (2004:280). As a result, many Inuit women continue to be sent to regional or southern hospitals.

Reinstating birth to the community of Pauktuutit means Inuit mothers and active community members have resisted the hegemonic control of governmental policies in several ways. Firstly, the Inuulitslvik case study indicates that Inuit communities rejected the government's claim in 1961 that Inuit communities “lack both the knowledge and means to arrange for [medical] services themselves,” (Ministry of Health and Welfare 1961, p. 19). The community of POV successfully established The Maternity and while non-Inuit individuals are involved in the operation of the program, for the most part the community determines

how The Maternity operates. Secondly, the maintenance of traditional midwifery practices challenged the conception that only advanced technologies can lead to successful births. As Van Wagner et al. reports, the combination of traditional midwifery practices with biomedical technologies at Inuulitslvik shows, “improved outcomes and lower rates of intervention,” when compared with a community where women must be flown to a regional hospital (2007, 387). The inclusion of cultural practices goes beyond responding to clinical needs; it gives value to both social and cultural needs and desires when it comes to birthing decisions.

The Inuulitslvik case study exemplifies that for Inuit women, it is of the utmost importance to have the ability to give birth within their own community or at least their own region. The 1982 evacuation policy was detrimental culturally, psychologically and financially. The government's goal of reducing IMR was well intentioned but ignoring the voices and opinions of Inuit communities in decisions pertaining to their own health was highly problematic. Inuit mothers and active community members were successful in ending this policy and suggesting alternative approaches to childbirth in the North that incorporate both traditional practices and biomedical technologies. The Inuulitslvik model utilizes biomedical technologies to reduce medical risks during childbirth while also including traditional practices to promote the vitality and strength of contemporary Inuit culture. This case study is by no means representative of all Inuit women's experiences as each community faces unique constraints and opportunities in terms of childbirth. Furthermore, many Inuit women still face many significant challenges to making autonomous decisions when it comes to their births due to the lack of available options in their geographic region. However, the Povungnituk Maternity model exemplifies that there are safe, financially viable, culturally appropriate ways to maintain the ability for Inuit women to give birth in

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