The transformation of the Prairie West, during the late nineteenth century, from an economy based on the fur and buffalo robe trades to a white settler society grounded in agriculture and respectability created new social arrangements that marginalized Aboriginal women. European Canadians denigrated the skills and knowledge of Aboriginal women; their presence in cities and towns was seen as a problem by the white community, and they were increasingly subjected to state surveillance as part of the government’s effort to transform Indigenous society. However, Aboriginal women’s skills and knowledge, specifically women’s obstetrical expertise and experience, remained important resources in their communities, especially during this period of profound social and economic dislocation.

European Canadians, particularly women arriving in growing numbers after the 1890s, took advantage of the obstetrical expertise of Aboriginal women. Far from traditional networks of familial support, European-Canadian women relied on local Aboriginal women to aid them as midwives, caregivers, and healers. Even the wives of Indian Agents, the North West Mounted Police (NWMP), and missionaries drew upon the therapeutic skills of Aboriginal women. Settlers’ diaries, correspondence, and later reminiscences are rife with harrowing tales of Aboriginal women arriving at the last minute to save the day. Although individual stories of these women have not endured in great detail, if examined as a group, the accounts show a pattern that provides a glimpse into the lives of the Aboriginal midwives who worked in the Prairie West. Creating a composite picture of Aboriginal midwives illustrates that these women drew upon a formidable reservoir of obstetrical knowledge passed down
from generation to generation, that European-Canadian women knew how and where to find Aboriginal healers and midwives, and that Aboriginal women’s therapeutic knowledge was a resource that both Indigenous and non-Indigenous communities relied upon. For too long has western history overlooked the place of Aboriginal women; Indigenous women were active in the new society that was being formed in western Canada and their skills were central to the reproduction of both Indigenous and non-Indigenous communities. This article seeks to redress this neglected chapter in the narrative of western settlement.

One of the most damaging legacies of the colonial project in western Canada has been the discursive erasure of Aboriginal women from the landscape after the 1870s. Obscuring Indigenous women from the history of the West, and in particular western settlement, helped legitimize European-Canadian settlement and made the presence of Indigenous women seem out of place or unnatural. This effacement of Aboriginal women during the late nineteenth and early twentieth centuries was central to the construction of an imagined white settler society premised solely upon European-Canadian values and beliefs. As Susan Armitage eloquently notes in her article “Making Connections: Gender, Race, and Place in Oregon Country” settlers brought their cultural baggage with them and as much as possible tried to “replicate old ways rather than invent new ones.” And in this emerging social framework, there was very little room for Indigenous people, especially Indigenous women.

Postcolonial and feminist scholarship has begun to redress this epistemological violence by tracing how the colonial project constructed difference and designated who belonged and did not belong in the Prairie West. In excavating the lives of Aboriginal women, we must look to often neglected or unseen practices: the intimate and the domestic. Postcolonial scholar Linda Gordon urges us to turn our “attention to relations not always visible,” and thus, render intelligible those systems obscured by the processes of colonialism. Unearthing the domestic shows us that Aboriginal women, instead of fading into the background as traditional narratives of western settlement suggest, remained at the forefront of their communities’ survival and persistence. Moreover, repositioning the intimate makes visible the gendered encounters that took place between Aboriginal and non-Aboriginal women premised upon shared experiences of childbirth. Accounts of Aboriginal midwives placing hands on white bodies during what was a very frightening and vulnerable time in women’s lives require a reimagining of the colonial project and breaking
the “code of silence around intimate matters.”

That European-Canadian settlers required the help of Aboriginal women in order to reproduce their communities and societies suggests a more complicated history of western settlement. In order to uncover the obstetrical work of Aboriginal midwives we must consult a diverse resource base and measure the silences and gaps in the records. Oral histories, field notes of anthropologists, and accounts of settlers, government officials, and missionaries reveal that Aboriginal women provided obstetrical services to their own and newcomer communities well into the twentieth century.

European Settlement and the Creation of Reserves, Post-1870s

The 1870s and '80s were decades of dramatic transformation for the Indigenous peoples of the Prairie West. The 1870s witnessed the negotiation of numbered treaties, Aboriginal settlement on reserves, and the decline of the buffalo, nearly wiped out by 1883. Additional pressure was placed on local resources by the growing numbers of European-Canadian settlers who began to put up fences, build cities and towns, and demarcate white space from Indigenous space. The Northwest Rebellion in 1885 produced disproportionate concern for the vulnerability of white women, and unfounded fears of another uprising led the European-Canadian community to impose restrictions on the social and economic freedom of Indigenous people and further entrenched white domination of the West with impunity. These restrictions included the pass system and local bylaws prohibiting Indigenous women from entering or living in urban areas without the consent of the local police or magistrate.

Settlement on reserves introduced a completely new set of limitations on Indigenous people and, accordingly, they employed innovative strategies to circumvent the state and its agents. For example, although the Department of Indian Affairs (DIA) expected, and at times demanded, that Aboriginal women subscribe to European-Canadian practices and modes of domesticity, the adoption of such measures often reflected local needs rather than the wishes of the Department. Indeed, Plains women often combined Indigenous knowledge with new techniques and skills. This was the case with knitting, for instance, which was used to supplement, and in some instances replace Indigenous methods of making clothes when animal skin and buffalo hides became scarce. To some extent, this strategy of adaptation was also apparent in the obstetrical work of Aboriginal women. Ellen Smallboy, a Cree woman, born in 1853 near James
Bay, remembered that the Indian Agent, a doctor, had taught one of the midwives on the reserve techniques that enabled her to better deal with difficult childbirths. In other instances, physicians asked well-known Indigenous midwives to attend the obstetrical cases they could not. Thus, prescription and practice differed dramatically as local circumstances demanded. In the harsh and isolated environment of the Prairie West, many people did not have access to physicians, and even when one was available, it was quite likely many women preferred to consult an Aboriginal midwife. Nor was obstetrics held in high esteem by the medical profession generally, and training—or the lack thereof—reflected this, thus ignoring the reality that most general practices comprised a significant number of childbirths.

Midwifery in Western Canada

Until recently, the history of midwifery in Canada during the late nineteenth and early twentieth centuries has been characterized as a struggle between male European-Canadian medical professionals and female European-Canadian midwives. This story has largely ignored the obstetrical work and expertise of women who were not white, not European-Canadian, or lived outside of Ontario. Indeed, the choices women could and did make about childbirth often corresponded to the nature of region. In isolated and underpopulated areas, such as the Prairie West, female European-Canadian settlers drew upon a variety of resources to meet their obstetrical needs. For example, women who lived in rural locales often called upon female neighbours, even if they possessed no training, when they had to. Other women relied on husbands and family members and, in some cases, women reached across boundaries of race and culture and made use of the knowledge and expertise of Indigenous women healers and midwives.

Unlike their Aboriginal counterparts, many European-Canadian women did not receive formal training and frequently knowledge was “informally transmitted; that is, it formed part of a popular birth culture, which women learned by participating at births or by giving birth themselves.” Usually, the involvement of European-Canadian women in such popular birth cultures took place on an emergency basis. In contrast, Indigenous women who were recognized as experienced and effective midwives in their communities underwent significant apprenticeship and training, which usually began at a young age. Understanding the patterns and rhythms of childbirth and where, when, and how to use medicinal plants required a great deal of preparation and knowledge. In the Prairie
West, Indigenous women continued to perform as healers and midwives in their communities well into the twentieth century.

The decline of midwifery was an uneven process in the West, reflecting a range of historical circumstances. For instance, while the state and certain members of the medical profession sought to restrict the work of midwives, larger developments, such as the growth of modern hospitals and advancements in medical technology and asepsis techniques, had a greater effect on the choices people made about childbirth. In the 1930s and ‘40s, other options arose in the Prairie West. European-Canadian women who had the financial resources and could afford to spend extended periods of time away from home turned to maternity homes. However, in spite of such developments, for settlers trying to survive in the uncertain economy of the Prairie West, geography and financial resources remained the strongest forces determining the options available to European-Canadian women.

In western Canada, the obstetrical practices of Indigenous women were largely overlooked in their communities until after the First World War. Indeed, the war served as a watershed in popular perceptions of public health, particularly the well-being of children, and the role of the state in guaranteeing that health. Recruitment during the war had confirmed the fears of health officials regarding the unhealthy nature of the Canadian population. This revelation, combined with a study performed by Dr. Helen MacMurchy, Chief of the Child Welfare Division for the Department of Health, revealed that maternal mortality was the leading cause of death among women; the Prairie Provinces suffered from the highest maternity mortality rates in Canada. The weight of medical experts and the persistent lobbying of women’s groups across the West forced the state to address the health and well-being of mothers, and thus children, the future of the nation.

In Alberta developments in health care were slow to materialize, and left the more remote and isolated areas of the province largely unaffected. In 1919, Alberta District Nursing Services was created to meet the needs for midwifery and emergency services in rural communities. The first Child Welfare Clinics were established in Edmonton, Calgary, Medicine Hat, Drumheller, and Vegerville in 1922. In the summer of 1924, provincial travelling clinics were introduced in rural districts to service those communities without access to medical and dental care. However, the recession of the early 1920s forced the provincial government to cut funding to health services and thus, for the majority of the rural European-Canadian
population, biomedical health care remained beyond their financial and physical grasp.23

On reserves, similar concerns regarding maternal and infant mortality were expressed by the DIA and their medical workers. The DIA ignored poor nutrition and poverty as part of the problem. Rather they believed that Indigenous people, and women in particular, were negligent parents and indifferent to the health of their children. The failure of Indigenous women’s homes to conform to middle-class Euro-Canadian standards and the choices they made about medical treatment were evidence of this indifference. In the 1920s, Duncan Campbell Scott, the deputy Superintendent General of Indian Affairs, made intervention in the childbirth cultures of Treaty 7 women a priority. Greater efforts were made to track expectant mothers and ensure childbirth took place either in a hospital or was attended by a physician or nurse trained in obstetrics. Nevertheless, in spite of the DIA’s efforts and the interruption in the transmission of intergenerational knowledge that residential schools were having, Indigenous midwifery persisted.24

Oral History Accounts
Oral histories can provide a window onto the midwifery work that Aboriginal women performed in their communities. One useful set of interviews was conducted in the early 1990s with Treaty 7 Elders born between 1905 and 1934. These interviews were designed to capture Elders’ memories before they passed away.25 The interviews concentrate on treaty and land rights and the abuse of individuals by the colonial state. In some instances, however, the interviewees discussed their births, including whether they were born in a DIA hospital or in a tent or house attended by a midwife and surrounded by female family members. In an effort to establish ownership and right of residence to the land by providing details about their births, the Elders opened a window onto more intimate matters.

Of the 200 Elders interviewed, 142 offered some details surrounding the circumstances of their birth. These interviews reveal that until 1920 the vast majority of births took place in the home in the presence of female family members.26 Between 1905 and 1934, eighty-five people were born at home while fifty-seven were born at a hospital. Only six people interviewed were born at a hospital before 1920. Out of the ninety-four Treaty 7 Elders who were born between 1920 and 1934, forty-three people were born at home while forty-five who were born at a hospital under the supervision of doctor or a nurse with obstetrical training.27 It is clear that
the number of non-hospital births declined after the 1920s as a result of several factors, such as disrupting the intergenerational transmission of knowledge, the efforts of the state to persuade women to give birth in hospitals, and the fact that improvements in biomedicine dramatically increased a woman’s chance of surviving childbirth in a hospital setting. There is still evidence to suggest that midwives were not entirely displaced. Indigenous women seem to have used departmental and white hospitals strategically. For instance, oral history and admission records at the Kainai (Blood) Hospital indicate that Indigenous women were more likely to use the facility during the winter than the summer.

In partnership with the Methodist, Anglican, and Roman Catholic churches and their mission organizations, the DIA beginning in the late 1890s, established small cottage hospitals, school infirmaries, and dispensaries in Treaty 7 communities. The DIA supplied the initial land and building materials and later provided nominal annual maintenance grants. The churches were responsible for maintaining and staffing these poorly funded and attended facilities. The institutions were staffed primarily by European-Canadian women, some of whom possessed formal medical or nursing training. After 1915, the DIA increasingly took over management of these small hospitals, school infirmaries, and dispensaries. Rundown buildings and outdated equipment made these intuitions unpopular for much of the early twentieth century.

Some of the Treaty 7 interviewees offer personal descriptions of who was present when they were born. Such information is important given that birth attendants often formed long-lasting and intimate relationships with the family. Midwives were considered members of the family and thus received titles that reflected this closeness. Agnes Red Crow, for instance, recalled that she was born at home in a tent surrounded by her grandmothers, who were there to assist her mother. Frank Eagle Tail Feathers related that he was born at home on 3 March 1918 and that his mother had been attended by “some elderly women who were midwives.” Allan Shade’s mother had a similar experience: she was cared for by Allan’s great-grandmothers, who were also midwives.

Other reminiscences of childbirth experiences were recorded and later published by Beverly Hungry Wolf, a Kainai woman, who interviewed her grandmother, AnadaAki, during the late 1970s. AnadaAki’s first childbirth experience shows the integral roles Indigenous midwives played and the critical importance of both their wealth of obstetrical knowledge and the support they provided:
I went into labour at night. I kept on with it all the next day, that night, and on through the morning. It must have been near noon when the baby was born we had our Indian doctors around, and they made brews for us…. I started to feel good and cheerful. Right after the baby was born and taken care of, my mother started to clean me. After I was cleaned she started massaging my bones back into place. I was given some broth to drink and then she laid me down to rest…. During this period of confinement the new mother was bathed and given a cleansing ceremony every four days. Her mother would wash her and then cover her up with a blanket…. To bring the mother’s body back to shape in addition to massages, she was made to wear a “belt” or girdle of rawhide.35

The oral history accounts, although limited, suggest several elements about Indigenous women’s obstetrical practices in their communities. First, in spite of the best efforts of the state, the presence of medical facilities, and the disruptive influence of residential schools in the transmission of vital cultural knowledge, Indigenous midwives continued to provide important services to their people. Second, such detailed memories suggest not only the importance of these women, but also that they were part of a network of family relationships, whether they were biological relatives or trusted friends and advisors. Finally, the account from AnadaAki reveals a skill set designed to ensure a safe labour, to alleviate some of the pain during childbirth, and to care for the physical and emotional well-being of the mother following the birth. Furthermore, the existence of a support network within their communities indicates that Aboriginal women had a foundation of knowledge to deal with the childbirth experience.

Anthropology
Substantial descriptions of Indigenous obstetrical practices can also be found in the field notes of Lucien and Jane Richardson Hanks, as well as Esther Goldfrank. The Hanks and Goldfrank studied the Blackfoot in 1938 and 1939 in a field school run by the well-known anthropologist Ruth Benedict. They had several informants who related the importance of Aboriginal midwives in their communities. The field notes offer several key insights into the culture of childbirth among the Plains people: the existence of a tradition of obstetrical knowledge practised by medicine women or midwives, the presence at births of female family members who shared obstetrical skills,
and the practice of an experienced woman caring for mother and child for several days following the birth and helping mothers become accustomed to new responsibilities. The story of the Hanks’ informant, Mary White, revealed several of these features: “At birth mother of mother, mother in law and any near female relatives of the expectant mother are supposed to be present. A medicine woman may be called in to ease the labour. One woman holds the arms, another kneads the abdomen gently, and the third delivers the child. The mother used to be kept awake for four days, turned constantly to prevent the ‘blood from clotting.’” Jessie, Esther Goldfrank’s informant, recalled the central role that Mrs. Scraping Wolf, a medicine woman, played during her first pregnancy. Mrs. Scraping Wolf was the first person to examine Jessie and inform her that she was pregnant, she attended Jessie during the birth, and she remained with Jessie following the delivery until Jessie was comfortable nursing her son Sam. Such examples reveal that there were mechanisms within Aboriginal communities intended to help women during and after childbirth.

Goldfrank’s and the Hanks’ field notes also remarked on the work of Indigenous midwives and their use of medicinal plants to facilitate deliveries, although which plants were used was never recorded. According to anthropologist Diamond Jenness, medicine-women gave expectant mothers “a decoction of boiled herbs” to ease the delivery. Likewise, Esther Goldfrank wrote that during the birth of Jessie’s first child, Mrs. Scraping Wolf had rubbed a painkiller on Jessie’s belly to ease her labour. Goldfrank’s field notes did not indicate what the painkiller was, in part because anthropologists were concerned with chronicling the social and cultural aspect of Plains culture and not the medicinal qualities of local plant life.

The field notes of these anthropologists seem to confirm the evidence of oral testimonies. In both we see the presence of supportive and experienced women throughout the labour, the use of medicinal plants to control or minimize pain, and the important role midwives played in helping new mothers adjust to their childcare responsibilities. The sources suggest, therefore, that Indigenous midwives were key members of the community, well known and respected, and formed long-lasting relationships with the women and families they served and treated. The field notes also show that Aboriginal midwives used medicinal plants in their work, and undertook a period of apprenticeship and training in order to learn about these medicines. Women were trained by Elders in the proper procurement and application of medicinal plants, a set of skills proven effective over time and use.
The anthropologists whose field notes included these accounts of Indigenous women’s obstetrical work failed to publish any of this material. Instead, their published works focused on tracing what they regarded as cultural change among Aboriginal communities. They were especially interested in the pace of assimilation among the tribes of southern Alberta, and wanted to know to what degree government policy was facilitating this transformation. Evidence of midwifery work may have been ignored in the anthropologists’ published findings because such practices ran contrary to the narrative of assimilationist progress they were trying to produce.

Local History

The final set of evidence comes from settlers’ narratives and the personal papers and unofficial correspondence of government employees and missionaries. White women drew upon the obstetrical services of Aboriginal women for several reasons. In a sparsely settled region where most farmers were separated from their closest neighbours by miles and lived far from traditional European-Canadian support networks, Aboriginal women possessed skills and knowledge that European-Canadian women desperately needed. Given the boom and bust nature of agricultural production in the dry arid environment of the West, paying for the services of a doctor or for prolonged stays in faraway hospitals was not a viable option for most settlers. As a result, Indigenous midwives fulfilled a necessary role in the lives of women arriving and settling in western Canada at the turn of the century. Childbirth was one medical situation that a married woman was almost guaranteed to experience during her lifetime. Indeed, in a pioneer questionnaire distributed by the Saskatchewan Archives Board during the 1950s, respondents identified childbirth as the most common reason for family members being bedridden and needing the attention of a doctor during the late nineteenth and early twentieth centuries.41

One of the earliest recorded accounts of a white woman drawing upon the services of an Aboriginal midwife was in 1808 and involved Marie-Ann, the French-Canadian wife of Jean-Baptiste Lagimodière, a voyageur. Grant MacEwan’s 1975 popular history ... And Mighty Women Too, written as an addendum to his earlier work Fifty Mighty Men, chronicles Marie-Ann’s tale as part of a larger collection of stories written about white women during the settlement of the Prairie West. Following their marriage in 1807, Marie-Ann, unwilling to be left behind by Jean-Baptiste when he rejoined the North West Company’s spring brigade, decided to accompany him on his trip to present-day Manitoba. The “brave and mighty” Marie-Ann gave
birth to their first child the following year at Pembina, Northwest Territories. Jean-Baptiste prepared for the birth by arranging for a local Cree woman to remain near his cabin so that she could assist his wife during labour. The midwife was the wife of an Aboriginal man with whom Jean-Baptiste trapped. During the labour, the Cree woman used herbal tea to ease Marie-Ann's pain and following the birth advised her to use a moss bag. The moss bag was attached to a cradleboard and made of leather or fabric. Moss was placed inside the bag to serve as a diaper. The story of Marie-Ann is included in MacEwan's collection of stories about trail-blazing women because she gave birth to the first “legitimate” white baby in western Canada.

Details regarding the Cree midwife are included only as they relate to Marie-Ann and no consideration is paid to the fact that this woman provided a set of skills and expertise during and after the birth that were essential to the survival and comfort of both mother and child. The Cree midwife’s erasure is symbolized by her namelessness.

Western Canada remained predominantly rural and sparsely settled until after World War II. As a result, when European-Canadian women realized they were pregnant they prepared for the birth ahead of time. Whenever possible, European-Canadian women planned to be with female relatives or friends close to their due date. However, even the best-laid plans often went awry. Following her marriage in 1864, Susan Allison lived with her husband, John, on his ranch in the Similkameen Valley, British Columbia. Susan Allison gave birth to two of her children during the late 1860s and early 1870s with the help of Indigenous midwives. Before the birth of her first child, she had planned to travel to Hope, British Columbia, to be with her mother, but was caught by surprise when the baby was born two months early. Fortunately for Susan Allison, John was able to acquire the services of Suzanne, the sister of one of the Indigenous workers on a nearby ranch. As soon as Suzanne arrived, she calmed Susan by giving her whiskey to dull the pain.

Susan Allison described her experience with Suzanne: “[she] was good to me in her way—though I thought her rather unfeeling at the time. She thought that I ought to be as strong as an Indian woman but I was not.” By characterizing Suzanne as taciturn and unsympathetic, Susan Allison highlighted Suzanne’s dissimilarities in feeling and expression from European-Canadian women. In doing so, Susan maintained her racial and social distance in spite of the intimate nature of the services Suzanne provided. Susan’s second birth was also attended by an Indigenous midwife.

Nor did the plans of Elizabeth Matheson—the wife of the Anglican
missionary at Onion Lake, a Cree community fifty kilometres north of present-day Lloydminster—go smoothly when she went into labour for the first time in the early 1890s. As the birth of her first child approached, Elizabeth prepared for its arrival by asking the only other white woman in the area to attend her. Unfortunately for Elizabeth, on the day she went into labour the woman was drunk and incapable of supervising the birth. Elizabeth grudgingly relied on a Cree woman from the reserve.

Annie Greer, a recent immigrant from Ontario, shared a similar experience. During her first winter (1893–94) in Dauphin, Manitoba, Greer, living in a log and sod hut, was by herself when she went into labour. She gave birth to her first child with the assistance of the local midwife, Caroline, who was the wife of the chief on the neighbouring reserve. Caroline came prepared with a satchel full of herbs, roots, bark, and leaves; she saved the mother’s life and refused payment for doing so. How Caroline knew when to come remains a mystery, but her timely arrival suggests that Caroline was well known in the community and that arrangements were made prior to the departure of Greer’s husband. A decade later Mary Lawrence of northern Alberta made the same choice when securing help to deliver her first child. She evidently preferred the presence of an Indigenous midwife to the only available alternative: her father-in-law.

In some cases European-Canadian women expressed their preference for Indigenous midwives and obstetrical practices. When Mary Lawrence gave birth to her third child at Fort Vermillion at the turn of the nineteenth century, her midwife, Julie Nookum, encouraged her to give birth “as an Indian woman would have done, kneeling.” In her memoirs, Mary noted that this “had been the easiest of any childbirth so far. And I was convinced of the logic of this natural method over that to which white women are usually enforced that I abided by it henceforth.” Changes to birthing positions that required women to lie flat on their backs reflected doctors’ preferences and actually slowed down delivery.

Indigenous midwives living on nearby reserves made their expertise available to local settlers. Frank Lucas remembers that when his wife went into labour he called upon the services of a midwife from Hobbema to attend his wife. Another woman living in the St. Albert district was attended by an Indigenous midwife for all seven of her children. Eliza Schwerdt, a recent immigrant from Germany during the late 1920s, recounted her experience with Granny Whitford, an Indigenous healer and midwife who attended the birth of all of her children. “I remember [Granny Whitford] trying to save my seven month old baby. We kept it alive.
for a week, and then my little boy passed away.”55 Such heroic stories are emblematic of the work Indigenous women undertook in order to help European-Canadian women and their children survive.

In other instances, Aboriginal women were called upon because of the close ties they had developed with a community over time. A European-Canadian woman living in the Rocanville district of Saskatchewan during the late 1880s fondly remembered a Cree woman who was called whenever there was a birth in the family and acted as a general nurse for the district.56 Another European-Canadian female settler warmly remembered relying on a “nice old Cree lady, Mrs. Fisher, from across the lake, who acted as both doctor and nurse for the neighbourhood.”57 Although Mrs. Fisher could not speak English, the nearest doctor was at Qu’Appelle, Saskatchewan, and so whenever there was a birth, Mrs. Fisher was called. Ethel Hopps recalled that she was “brought into the world by a wonderful Cree midwife named Mrs. Plante of George Lake.”58 Sometimes Indigenous midwives maintained long-term relationships with the children they helped bring into the world, much as they did in their communities. For instance, Raymond Aylesworth was born in December 1907 under the care of Mrs. Jim Bangs. For the next fifteen years, Mrs. Bangs made Raymond a new pair of moccasins every year.59 These examples suggest there was an informal system of health care taking place across the West where women came together around shared concerns. Even the wives of government employees and missionaries relied on the services of Aboriginal midwives. For instance, Effie Storer, the wife of a North West Mounted Police (NWMP) officer, used the obstetrical services of an Indigenous woman when her husband was stationed at Whitefish Lake, Northwest Territories (in present-day Alberta). Storer’s daughter Irene was born on 30 March 1894 and since the closest doctor lived in Edmonton, she was forced to rely on the services of an “old medicine woman.”60 The following year when her husband was transferred to Battleford, Northwest Territories (in present-day Saskatchewan), her daughter, Muriel, was born prematurely and, once again, an Indigenous midwife was called in to oversee the labour.61 Although Storer’s tone clearly indicates that she would have preferred a doctor, in the absence of one she drew upon the most viable alternative: an Indigenous midwife. Perhaps Storer’s declarations were self-aggrandizing. Early settlers’ stories always seemed to draw upon several tropes: the presence of unnamed, and potentially threatening, Aboriginal people; the absence of “modern” conveniences, such as Western medicine; and the poor lonely white woman who was without the comfort of other white “women.”62
The wives of missionaries who worked to convert Indigenous people to Christianity also required the services of Indigenous midwives. For example, Mary Cecil, a Cree midwife, attended Eliza Boyd, the wife of the well-known Methodist missionary, John McDougall, and her sister-in-law Annie McDougall when they gave birth to each of their children at the Stoney reserve in the late nineteenth century. Cecil worked for the McDougalls as midwife, nurse, and servant for many years. In a newspaper interview conducted in the late 1920s, Annie McDougall remembered Mary Cecil affectionately, saying that although she had initially feared her, “she had soon become very fond of [her] because of her kindness and faithfulness. For twenty eight years I had no better servant or friend, and the children loved her as well as any white woman.” Nevertheless, in spite of this affection, Annie never mentioned Cecil in any other forum. Were it not for the newspaper interview and the questions posed by interviewer Elizabeth Bailey Price in the late 1920s, Mary Cecil would be lost to the “condescension of posterity.”

The wives of Indian Agents, like the wives of missionaries and the NWMP officers, also drew upon the obstetrical skills of local Aboriginal women. Similar to agricultural families, Indian Agents and their wives lived in isolated and underserviced communities. F.C. Cornish, the Indian Agent for the Tsuu T’ina from 1887 to 1890, in an unpublished collection of reminiscences recalled that his eldest son had been born while he was employed at the Tsuu T’ina reserve. Cornish wrote “in those days it was not an easy matter making provision for such an event. The nearest doctor was in Calgary. Nurses were unattainable.” Mrs. Cornish had been able to obtain the obstetrical services of the interpreter’s wife, a Sarcee woman, who was well known as a good midwife.

It is interesting that during a period when government employees and others were charged with resolving the “Indian problem” by, among other things, replacing Aboriginal culture and practices that the obstetrical skills and expertise of Indigenous women was drawn upon so frequently by European-Canadians. Indeed, it seems that Aboriginal women were able to circumvent the restrictions placed on their movements when their therapeutic services were required by European-Canadians, especially the wives of NWMP officers. The silence surrounding this work that has persisted into the present, and the invisibility of Indigenous women from the history of the region more generally, evokes the consolidation of European-Canadian hegemony over the West. This silence was necessary in order to blame Aboriginal women as the root of their communities’ problems.
and target them for change. In order to pursue the creation of a legitimate white settler society the colonial imagination had to ensure that Indigenous women remained a “present absence.”68 It is not surprising then that evidence of Aboriginal women’s midwifery and healing sits awkwardly amidst broader colonial narratives about the process of settlement and nation-building. Recognizing Aboriginal women had very important domestic and curative skills would have challenged the ideological underpinnings of the colonial project.

Conclusion
Although none of these accounts provides detailed information regarding the work of one particular midwife, together they suggest several patterns. Aboriginal communities continued to rely on the expertise of Indigenous midwives well into the twentieth century. Indigenous midwives possessed a skill set that was premised upon training and experience. These women provided emotional support before, during, and after labour and offered their patients some pain relief. Finally, the obstetrical knowledge of Indigenous women was a resource that European Canadians used; European Canadians knew where to find Aboriginal midwives, and these women played an important role in reproducing European-Canadian communities.

Evidence of Indigenous women working as midwives among newcomers, especially for representatives of the nascent state in the Prairie West, exposes some fundamental inconsistencies of the colonial project and the creation of white settler societies. When women such as Effie Storer, Annie McDougall, and the wife of F.C. Cornish begrudgingly called upon the skills and expertise of Indigenous women, they laid bare both the realities that women faced living in western Canada and the hypocrisy of colonial claims of the fundamental superiority of European medicine and the backwardness of Indigenous culture. They also revealed how their silences had helped make Aboriginal women invisible. It is extremely important to re-examine traditional narratives of western settlement in order to unearth and acknowledge the central roles Indigenous women continued to play in the West after the 1870s.

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