Taking Medicine

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Women's Healing Work and Colonial Contact in Southern Alberta, 1880-1930

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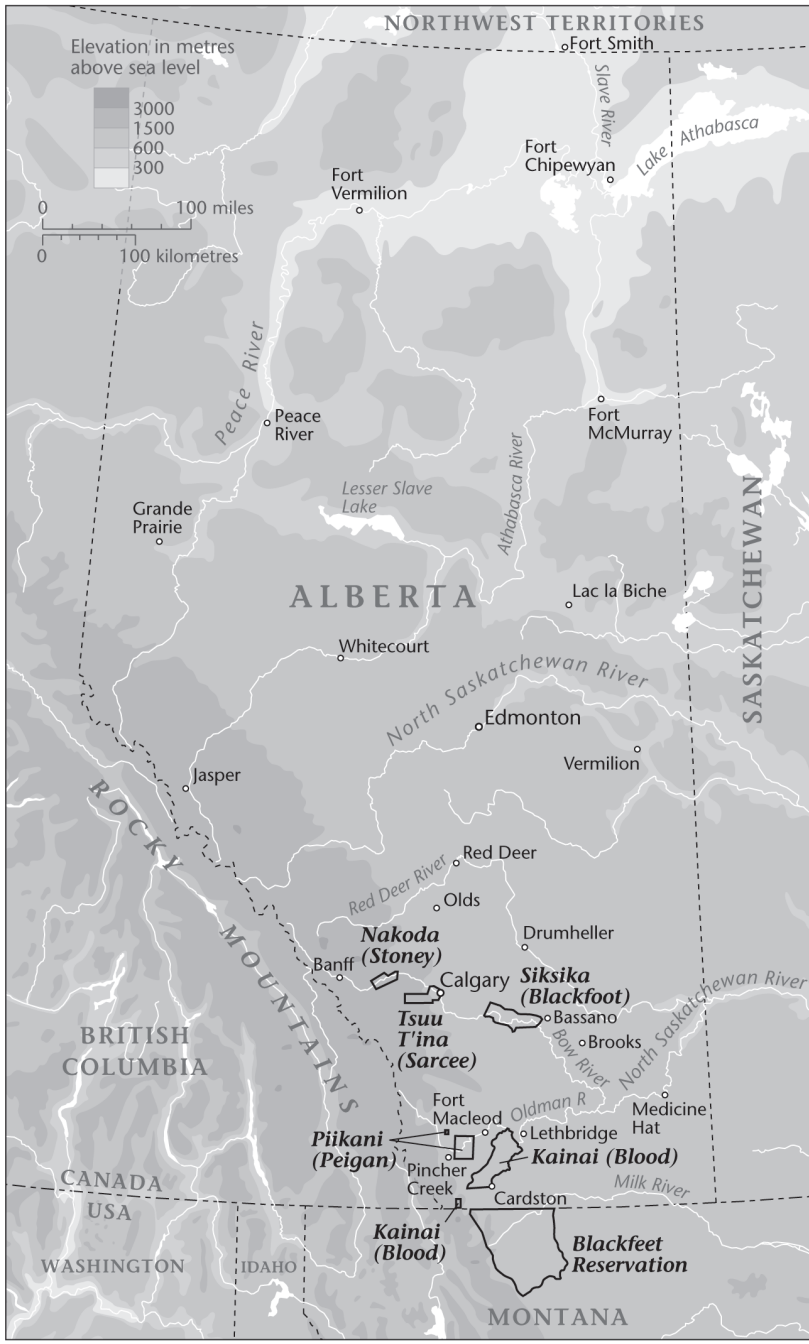

Map of southern Alberta and Treaty 7 communities | Cartographer: Eric Leinberger

Introduction

Aboriginal and Euro-Canadian women in western Canada were responsible for a diverse range of health care activities in Aboriginal and non-Aboriginal communities during the late nineteenth and early twentieth centuries. Aboriginal women who lived in what is now called the Prairie West (present-day Alberta, Saskatchewan, and Manitoba) possessed a great deal of expertise in midwifery and medicinal plants. This knowledge was essential to the well-being of both their own people and the newcomers who were settling in western Canada in increasing numbers. The Euro-Canadian women who came to live and work in the West after the 1870s, both as settlers and as missionaries, also brought with them varying degrees of expertise in Western healing and nursing practices. Both groups had formal therapeutic systems that were codified around precise treatments for specific illnesses, and this knowledge was transmitted from generation to generation in an orderly and circumscribed manner. Thus, when Aboriginal and non-Aboriginal women encountered each other, they, for a brief time, participated together in an informal system of healing and nursing care that drew on both traditions and centred on shared domestic concerns relating to childbirth and general childhood and family illnesses.[1] Over time, as the number of white settlers grew, the formal structures of Western medicine and nursing care increasingly dominated these more informal arrangements.

This study traces patterns of women's curative and caregiving work in a specific treaty area – that of Treaty 7 – across three generations, from the 1880s to the 1930s. In doing so it addresses important ques-

tions about gender, culture, and colonialism. First, an examination of Aboriginal women's curative and caregiving work in both Aboriginal and settler communities shows patterns of persistence, resistance, and change throughout these decades. Aboriginal culture was not a fragile entity, and though what constituted effective, necessary, and appropriate healing and medical care changed and was reimagined throughout this period, it was always understood within an existing cultural framework.[2] In other words, although the everyday practices of healing might have been modified, the underlying cultural values, meaning, and goals that characterized how Treaty 7 people and practitioners dealt with and understood health and well-being remained the same. Indeed, exposure to new diseases required Aboriginal peoples to develop new therapies, to use existing botanical medicines and treatments in different ways, and to incorporate elements of Western biomedicine that proved effective against particular illnesses. The adoption of certain elements of Western medicine by Aboriginal women did not signify cultural disintegration; rather, it was a pragmatic response to changing social, economic, and political conditions. Within this framework of survival and adaptation, Aboriginal women performed important health care functions in their communities – and to a lesser extent among non-Aboriginal people – well into the 1930s.

Second, Euro-Canadian women did much to establish Western-style medical systems on reserves and in the Prairie West more generally. The emergence of colonial health care regimes in Treaty 7 communities during the final decades of the nineteenth century coincided with the gradual transformation of nursing in Canada into a respectable profession carried out predominantly by trained middle-class white women.[3] Important developments in the professionalization of nursing through education and regulation occurred in the late nineteenth and early twentieth century. Health care undertaken by untrained or partially trained women with varying degrees of skill, experience, and respectability was gradually taken over by a cadre of educated women licensed by the Province of Alberta. On Treaty 7 reserves, this so-called professionalization process took place more gradually and was shaped by the broader assimilative goals of both the churches and the state.

Examining a specific treaty area brings the activities of non-Aboriginal female health workers into sharper focus. Euro-Canadian women, both as untrained attendants and as graduate nurses, did much to help establish the federally funded Indian Health Services (IHS) in 1928. The IHS was a key element in the colonization of Aboriginal peoples. After Treaty 7 was negotiated in 1877, the federal government and its employees solidified their

control over Aboriginal peoples in southern Alberta, and Euro-Canadian women were caught up in this process, especially through their health care work, first as mission workers and later as government employees.

In some ways the medical facilities established on Treaty 7 reserves operated under the same patriarchal and hierarchical regimes that characterized hospitals and staffs in white communities. However, social and physical isolation combined with the absence of male medical professionals and the influence of the church ensured that female health workers on reserves, trained and untrained, carried out their work under different conditions than their urban counterparts. Reserve health workers sometimes made treatment decisions far beyond their level of training; at other times, Euro-Canadian nurses were required to navigate multiple and often conflicting levels of authority to achieve not only the best treatments for their patients but also workplace autonomy.

Third and finally, during the decades this book examines, the healing expertise of Aboriginal women served as a means of cultural exchange between Aboriginal people and Euro-Canadians, especially the women of both groups. The need for health care and nursing in the Prairie West helped develop a space where women came into contact with one another through shared domestic health concerns. These moments were not typically sustained but ended as soon as the crisis or illness passed. But sometimes these exchanges were repeated over long periods – for example, when a local Aboriginal woman came to be relied on by white settler communities for her healing powers or when two individuals came to rely on each other over many decades. However great the geographical and social distance between Aboriginal and non-Aboriginal women during this period, these women sought one another out in times of need and illness at locations that ranged from camps and farmhouses to dispensaries and hospitals. Colonialism and its internal (read "intimate" or "domestic") applications were still very much in effect in these locations, but to see this clearly we must, as historian Linda Gordon urges, turn our "attention to relations not always visible."[4]

In the early decades of white settlement in the West, the healing expertise of Aboriginal women produced brief moments of connection between Aboriginal and non-Aboriginal people. The expansion of white settlement and of Western health care eventually, and in fundamental ways, transformed relations between Aboriginal and Euro-Canadian people, especially women. Euro-Canadian women played significant roles in the founding of Western health care regimes on Treaty 7 reserves, both as front-line workers and as agents of social change. After 1900 the important therapeutic work

performed by Aboriginal women became less and less visible. Indeed, the health of Aboriginal communities and the use of biomedicine became standards by which the progress of Aboriginal people was measured and contested. As front-line health care, social service, and educational workers, Euro-Canadian women mediated, administered, and adjudicated many of the experiences Aboriginal peoples had with the colonial state. Yet the healing and midwifery skills of southern Alberta's Aboriginal women continued to be viewed as important resources, despite the growth of Western medical services. Perhaps this was because of continued demand in impoverished communities. By focusing on the health work of women in the Treaty 7 area and among specific Aboriginal groups – the Blackfoot Nation, consisting of the Kainai (Blood), the Siksika (Blackfoot), and the Piikani (Peigan), as well as the Tsuu T'ina (Sarcee) and Nakoda (Stoney) – this book provides a more complicated picture of the state's impact on areas such as health and of the different ways women responded to and were affected by colonialism.

Western medical institutions and the health care work of Euro-Canadian women were at the heart of the colonial project in southern Alberta. As in so many other colonial locales, the Catholic and Protestant churches and their various missions built hospitals, school infirmaries, and dispensaries during the 1890s, the purpose of which was, as they saw it, to civilize Aboriginal peoples. These missions relied on Euro-Canadian women to operate the medical facilities and to provide domestic instruction to Aboriginal women. To fund these facilities and programs, the churches approached Ottawa, which found itself drawn reluctantly into financing a growing patchwork of medical institutions and services. After 1915 the Department of Indian Affairs (DIA) began to take direct control of mission facilities and programs. Euro-Canadian women remained the primary workers for both the churches and the state because they were an affordable and dedicated labour force; in addition, their gender allowed them entry into domestic sites believed to be in desperate need of improvement.

In western Canada, as elsewhere, the colonization of Aboriginal peoples and cultures resulted in close links between church and state. Missionaries were at the forefront of producing what Jean and John Comaroff refer to as a "state of colonialism."[5] The cultural interventions of missionaries – transforming people's perceptions, changing material habits, and reforming rituals – paved the way for later state interventions. Female missionaries in southern Alberta worked as trained and untrained health workers and ran instructional programs for Aboriginal women. After 1915 this work was increasingly taken over and managed by female government employees and

public health nurses. The relationships that missionary women formed with Aboriginal women were different from those formed by female DIA employees. Missionaries spent years – indeed, often decades – living and working on reserves. Lay health workers did not. Female missionaries opened their homes to Aboriginal women and children. They regularly cared for them during times of illness and taught them to cook or knit in their own kitchens. In contrast, government employees were often stationed for only short periods, and there were fewer of them. In some ways, the intimacy that missionary women developed with Aboriginal women made their activities all the more insidious because the intentions of female Euro-Canadian mission workers were more opaque than those of their counterparts in the civil service.

Although the government was willing to fund this patchwork of mission-run health facilities and workers, these programs had little impact on the overall health and well-being of Aboriginal communities. The presence of Western health care facilities and female workers did not address real problems, which were rooted in poverty and colonialism. Historians Mary-Ellen Kelm and Maureen Lux – whose research focuses on British Columbia and the Prairie West, respectively – have explored the relationship between rates of morbidity and mortality and poor rations, insufficient clothing, and inadequate housing.[6] Both scholars describe the impact of economic and social dislocation that took place in Aboriginal communities during the late nineteenth century. Confined to reserves, cut off from hunting and gathering activities, and subjected to the harsh governance of federal authorities, Aboriginal people were less able to combat and rebound from ill health. Material deprivation led to a rise in diseases associated with poverty, malnutrition, and poor living conditions, such as tuberculosis.

This study builds on the work of Lux and Kelm by focusing specifically on the healing work of Aboriginal women, female medical missionaries, and white graduate lay nurses, in the early and informal network of healing and caregiving in western Canada and in the colonial medical regimes that developed after the 1890s. I seek to foreground women's therapeutic work not only as part of cultural persistence, resistance, and change in Aboriginal communities but also as an integral part of western settlement and the creation of colonial regimes.

Since the late 1980s, scholars have increasingly recognized women's place as both colonizers and colonized in the colonial project. They have identified gender as a central component in the operation of colonialism. It is now clear that understandings of femininity and masculinity were essential to the creation of sites of difference and meaning. The bodies of

women and the works they performed in both public and private space were always at centre stage and did much to inform how opposing cultures viewed and reacted to one another. In the Treaty 7 area, racial differences were embodied first in domestic, medical, and healing practices and beliefs. Later, after the DIA health regime was created, those same differences were embodied in the strictures of Western medicine and in what the colonizers viewed as appropriate domestic and personal hygiene.[7] In this way, women's bodies and their domestic skills came to be the focus of state efforts to transform Aboriginal society. For female missionaries and DIA employees, "ideas of cleanliness, sanitation and middle-class white material culture were conflated as the indicators of Christian belief and 'civilized' behaviour."[8]

Examining the range of medical, healing, and nursing care interactions that took place between Aboriginal and Euro-Canadian people, especially women, also opens a path to consider a more complex network of social relations in the West. White settler societies did not suddenly appear fully formed. Rather, these societies developed in ways that reveal how gendered and racial categories are constantly reworked when encounters take place between different cultures and peoples. In western Canada, women's bodies might have served as boundary markers in an official and discursive capacity between Aboriginal and non-Aboriginal people. But at the same time, the experience of living in the West required that boundaries be transgressed in very personal and intimate ways, especially with regard to childbirth and family illnesses. As anthropologist and historian Ann Laura Stoler correctly points out, it was in the domestic intimacies of daily life that "colonial regimes of truth were imposed, worked around ... worked out," and often bound in "codes of silence."[9] The work that Aboriginal women did in the homes of white settlers remains largely unacknowledged in the narrative of settlement.

A broad range of interactions took place between the peoples of western Canada over a century of contact, as elsewhere in the colonial world. As colonizers, the arriving Europeans set out to establish a white settler society with white women as mothers of the race.[10] But given the remoteness of the Prairie West, how were white women supposed to give birth to a white society when they were far from traditional support networks, including midwifery care? To help answer this question, we should consider Stoler, who rejects the "fixity of racial categories" and instead explores how identities were set and then reconfigured in the colonial context. A Blackfoot woman could well find herself welcome in the home of a white rancher

as a healer but prohibited from walking the streets of Medicine Hat or Lethbridge without a pass. Colonial categories were social concepts – that is, they were "provisional rather than placeholders and subject to review and revision," depending on the circumstances.[11] This was especially true in colonial settings, where gender complicated categories of race. As historian Anne McClintock aptly observes, because colonial women were "barred from the corridors of formal power, they experienced the privileges and social contradictions of imperialism very differently from colonial men."[12] The danger of giving birth in the harsh environment of the West required white women to seek help from the very people they were trying to dispossess. This paradox reveals, first, the contradictions of the colonial project and, second, that women's bodies were "often bound up in creating and perpetuating an often hidden complex, contradictory, and fraught history."[13]

Re-examining the spaces where women from different cultures met is extremely important because these encounters challenged Euro-Canadians' preconceived assumptions and stereotypes about Aboriginal women.[14] In her work on female missionaries in the North, historian Myra Rutherdale found that the very nature of the mission field – that is, the social isolation and the physically harsh environment – created ambiguity in the relationships between the missionaries and Aboriginal people.[15] This study reveals that a similar situation existed in western Canada: women who lived in isolated and remote regions looked for other women to assist them during childbirth, regardless of their cultural background or practices.

White women, as missionaries or settlers, did not compel Aboriginal women to adopt their own cultural preferences; instead, the West demanded a great deal of accommodation and collaboration between cultures. In her examination of Euro-Canadian women in the North, Barbara Kelcy contends that geographical isolation and a sparse white settler population limited the influence that white women had on Aboriginal peoples.[16] In the late 1800s, white settlement in southern Alberta and southwestern Saskatchewan was sparse, and white settlers were outnumbered by the local Aboriginal population until the 1890s. As a result, Euro-Canadian women were forced to accept the help of Aboriginal women. The Canadian west offers a wealth of examples that show how Aboriginal women assisted female colonists, sharing information with them regarding the environment and its resources.[17] These interactions reveal the inherent contradictions present in white settler communities. Boundaries between Aboriginal and non-Aboriginal people were fluid, and this mutability was

especially evident in the encounters women had that involved health and healing.

This is not to suggest that these encounters were free of anxiety or that they ameliorated unequal power relations. Anxieties about race were often reactions to the complex relationships that had developed in western Canada – relationships that seemed to produce porous rather than fixed social categories. The diversity of mixed-race relationships in colonial locales, and their sheer number, provoked a great deal of unease regarding white men's claims to morality, manliness, and racial superiority.[18] In British Columbia, missionaries and civic leaders tried to temper interactions between Aboriginal and Euro-Canadian people through legislation and social censure. Likewise, in Calgary, municipal authorities tried to prevent Aboriginal women from traversing city streets, in the belief that they threatened social order and morality.[19] An examination of local newspapers revealed that similar concerns were never raised about Aboriginal women placing their hands on white women during childbirth or working as domestic servants in settlers' homes. Department of Indian Affairs annual reports applaud the domestic work of Aboriginal women in the homes of ranchers as they entirely overlook their midwifery work. Economic geographer Linda McDowell notes that "domestic space is the material representation of the social order"; consequently, because the "domestic help" of Aboriginal women took place in the home rather than in public space, the presence of Aboriginal women was not viewed as threatening or subversive. It instead reproduced Euro-Canadian visions of a white settler society and Aboriginal women's place within it.[20]

This book examines the healing work of the Siksika, Kainai, Piikani, Tsuu T'ina, and Nakoda women of southern Alberta from the 1880s to the 1930s. Focusing on a particular treaty area and its five reserves shows how the colonial experience was gendered, how it operated differently for different groups, and how even within the administrative limits delineated by the treaties, disparities continued to exist between reserves in terms of policy, personnel, and access to services. Although Treaty 7 remains the primary geographical focus of this work, there are times, particularly in the first and second chapters, when this study's geographical boundaries expand and contract. I adopted this practice for a number of reasons. First, the provinces of Alberta and Saskatchewan were created in 1905 and, thus, are relatively recent constructs. Second, before the treaties were negotiated and the reserves were settled, present-day boundaries meant little to the people of the Prairie West. Third, the fragmented and Eurocentric nature

of the source materials required me to draw from a larger geographical area to discern a pattern. And fourth and finally, there are enough similarities relating to the progress and nature of settlement among different regions in prairie Canada over time that comparisons can be drawn.

There is no universal term for Aboriginal people in North America.[21] In Canada, the term *Aboriginal people* collectively refers to the original people of North America and their descendants "without regard to their separate origins and identities." I have chosen to use the term *Aboriginal people(s)* – which comprises Indian, Métis, and Inuit – because it is a more inclusive term (the Prairie West contained many different cultures and groups that do not fit under the rubric *First Nations*).[22] Moreover, because the documentary records (settlers' narratives, travellers' accounts, and so on) that describe the curative and caregiving aid offered by Aboriginal women do not identify whether individuals or groups belong to specific nations – the term *Aboriginal people* is appropriate. When sources (both written and oral) allow, I refer to specific nations and bands.

To understand the roles that Aboriginal and Euro-Canadian women played in this era of state building, colonization, and Aboriginal survival and resistance, this study draws from a wide range of primary sources. Each type demanded careful reading because of the ways in which gender and race combined to produce the record. This is especially true for primary materials pertaining to Aboriginal women. The Aboriginal peoples of the northwestern Plains, especially the Blackfoot, were among the most closely studied Aboriginal groups in twentieth-century North America. Much of the interest was propelled by the imagery of the buffalo hunter, whose masculine traits came to represent the classic Indian in the imagination of North American people.[23] Within this source base, Aboriginal women rarely appear. Anthropological accounts, memoirs, oral histories, local histories, and government and church records must therefore be read carefully for the glimpses of Aboriginal women's lives they contain. Except for certain oral history materials, these sources were produced almost entirely by Europeans, with marginal Aboriginal participation.

In contrast to their Aboriginal counterparts, white women had more opportunities to pen their own histories, be these first-person accounts or entries in institutional and organizational records. Still, government records are surprisingly silent on many aspects of white women's work and often foreground the roles of professional men such as doctors or government officials such as Indian agents. Because of the challenges posed by the primary resources, this study draws from a wide range of materials and

seeks to use each type carefully by situating them in the context of the political and social world in which they were produced.

Interviews were not conducted for this study. In the current political and social climate of southern Alberta, many members of Treaty 7 are reluctant to talk because treaty litigation is ongoing. In addition, they are largely tired of the constant scrutiny of researchers, and few people are alive who are old enough to remember the period prior to 1940. I instead rely on oral history collections that have been completed by other researchers over the past thirty years. This oral history material is especially useful for allowing us to hear the voices of Aboriginal people in a historical record dominated by Europeans.

Published and unpublished sources serve as important complements to the oral history material. Over the past twenty years, a number of memoirs of individuals associated with Treaty 7 have been published, in part to address the lack of Aboriginal voices in the historical record and in part to document the memories of elders before their cultural knowledge is lost. These works, like the oral history materials, speak to contemporary political and economic struggles in Aboriginal communities, especially those issues dealing with land claims and treaty rights. There are also a substantial number of published and unpublished memoirs of settlers and retired government officials. These accounts reflect Euro-Canadian experiences within the broader story of the West's settlement. They are structured around a broader narrative of development, progress, the advance of civilization, and the marginalization of Aboriginal cultures. Yet they also contain candid reflections of daily life.

Anthropological texts and field notes pose a similar challenge. In the late nineteenth and early twentieth centuries, ethnographers and anthropologists – many of them amateur – spent a great deal of time living and working among the Aboriginal peoples they studied. These observers were in many ways participants in Aboriginal culture. They relied on interviews with Aboriginal people to secure information about cultural practices, and some of them, such as Clark Wissler, used Aboriginal men to perform fieldwork.

Franz Boas, often considered the father of American anthropology, initiated profound changes in North American anthropology.[24] As a professor at Columbia University, he accelerated a shift from anthropology as a part-time hobby to anthropology as a discipline practised by academically trained natural scientists concerned with the collection of hard data.[25] Of course, Boas was not alone in encouraging the professionalization of anthropology: academics in England, Germany, and even New Zealand were

developing their own anthropological traditions. In Canada, the work of New Zealand–educated Diamond Jenness has been especially important. Jenness received a degree in anthropology in 1910 under the supervision of R.R. Marett. During his first five years in Canada (from 1913 to 1918), he collected and organized anthropological data for the southern party of the first Canadian Arctic Expedition, organized by Vilhjalmur Stefansson. Although Jenness is best known for his work among Inuit, during the summer of 1922 he spent two months doing field research among the Tsuu T'ina.[26]

Whether written by amateurs or professionals, published anthropological reports often include only limited discussions of women's work. Yet many anthropologists' unpublished field notes document a range of practices and activities that are not included in the published texts. Those anthropologists who performed fieldwork during the 1930s left behind unedited field notes, and discussions of childbirth and birth control figure quite prominently in them. The original copies of these notes are housed in a range of North American repositories, and the Glenbow Archives in Calgary has copies of them. The acquisition reflects Glenbow Archive's resolve, in co-operation with Treaty 7 communities, to locate and house these materials. Unfortunately, the field notes from Jenness' two-month stay among the Tsuu T'ina have not survived.

To outline the history of Western health care regimes in Aboriginal communities, this study utilizes the records of the DIA and of the churches and their affiliated missionary organizations. Department of Indian Affairs records tend to foreground the work of male medical professionals. The nursing care provided by female workers – which was often the bulk of day-to-day medical care – is not described directly and can only be inferred. Still, the sheer volume of correspondence and reports generated by the DIA reveals the shape that Western medical services took, the federal government's objectives, and what the DIA regarded as necessary and appropriate medical treatment for Aboriginal people.

The records of the churches and their affiliated missionaries are invaluable because they help make visible the work of female health care providers. In some ways the reports and letters of church and mission employees were more self-promotional than those produced by DIA employees because missionaries needed the financial support of congregations in eastern Canada. This meant that missionaries – especially female ones – had to show there was a real need for their work. Since Euro-Canadian women could not perform the rite of conversion, their importance in the mission field lay in the social services they provided – in particular, nursing care. The

records of missionary organizations contain some of the few descriptions and letters produced by Euro-Canadian women on reserves. Descriptions of day-to-day nursing labour are embedded in the letters these women wrote to missionary societies.

Access to church records for this book presented a particular challenge. The Anglican Church is facing litigation because of its administration of residential schools and has been very cautious about opening its records to researchers. The records for the Anglican Church, Calgary Diocese, are stored in a number of places. A few decades ago, several churches within the Calgary Diocese donated their records to the Glenbow Archives. This record group contains almost five years of reports from the nurses stationed at the Tsuu T'ina Reserve – an unusual find. Subsequently, in 2002, before the remainder of the Calgary Diocese records were deposited at the University of Calgary, a careful culling of the materials was undertaken. As a result, parish records documenting births and deaths and materials pertaining to health conditions in residential schools are incomplete, making it impossible to chart precisely the health status of Aboriginal people who lived in Anglican parishes.

I faced similar restrictions researching Catholic parishes. The Sisters of Charity, who hold baptismal and death records for the southern Alberta region, refused to provide access to those records. The order did, however, grant access to the institutional records and correspondence produced by the sisters at the Blood Hospital, especially those materials written by the sister superior and the reverend general at Nicolet. In return for being allowed access to this source base, I promised I would not publish personal information about any of the sisters or use their real names.

At the end of the day, despite the broad and diverse record base I relied on, it is difficult to "know" Aboriginal women. Most of the records used for this study are ethnocentric and patriarchal in tone, and they really only tell part of Aboriginal women's stories. But I hope this is not simply another history of colonizing whites gazing at the Other. These types of interpretations imply that Aboriginal women did not have volition. I suggest that we can catch glimpses of the curative work performed by Aboriginal women – not the mindset or the intention, but the work. The curative and caregiving work of both Aboriginal and white women was vital to Aboriginal and newcomer communities in the late nineteenth and early twentieth centuries. But as white settlement expanded along with Euro-Canadian institutions, the work of Aboriginal women was displaced. Within the health care framework that developed in western Canada after the 1890s, Euro-Canadian women were important. They helped establish

colonial medical regimes on Treaty 7 reserves. The healing work of Aboriginal women did not disappear, but it struggled to survive the challenges it faced under the weight of the colonial state.

Chapter 1 outlines the history of the Siksika, Kainai, Piikani, Tsuu T'ina, and Nakoda peoples. Chapter 2 examines the healing skills and knowledge that were the domain of Aboriginal women in the late nineteenth and early twentieth centuries. Chapter 3 extends the examination of Aboriginal women's healing work to the curative skills that Aboriginal women made available to newcomers – in particular, to the white women who participated in the founding of white settler colonies in western Canada. Chapter 4 looks at the growing presence of missions and missionaries in southern Alberta. In this period the mission house and the healing and nursing care provided by mission women became part of the therapeutic strategies followed by Aboriginal people. Chapter 5 shifts the focus to the evolving institutional structures of Western medicine in Aboriginal communities. Euro-Canadian women played a key role in these institutions because they were a cheap source of labour dedicated to working among Aboriginal people. The work of missionary nurses laid the foundations for the state-run apparatus that emerged in the years surrounding the First World War. Chapter 6 examines the federal government's gradual takeover of health services in southern Alberta and emphasizes the role of nurses in DIA hospitals, clinics, and public health programs. By the 1930s the shape that IHS would take for the next several decades was in place.

The final chapter comes full circle to look at the persistence of Aboriginal women's healing work, especially midwifery, in their communities in the twentieth century. Throughout the 1920s growing numbers of Aboriginal women made use of DIA institutions for confinement and childbirth, but they did not entirely abandon Aboriginal curative, caregiving, midwifery, and reproductive practices. Rather, the women of southern Alberta's Aboriginal communities drew from a range of Aboriginal and Western health care strategies as they struggled to sustain their families and culture.

1
Niitsitapi
The Northwestern Plains

This study is framed by the geographic, political, economic, and social boundaries created by Treaty 7 after 1877. But to understand the gender-specific nature of northwestern Plains peoples' healing practices and the interactions of those practices with European ones, it is necessary to understand the place of curative regimes in the broader region's history and economy.

The First Peoples

The five tribes that currently reside in the Treaty 7 area – Tsuu T'ina and Nakoda and the three tribes of the Blackfoot Nation (Siksika, Kainai, and Piikani) – contain further divisions. The Piikani are divided geographically into North and South Piikani, and the South Piikani live in Montana and are referred to as the Blackfeet. These current divisions reflect the drawing of national boundaries in the nineteenth century and the efforts of Aboriginal people to negotiate dramatic social, political, and economic changes.[1]

The Blackfoot language belongs to the Algonquian family. According to archaeologists, the Blackfoot were originally an Eastern Woodlands people.[2] They were probably the first group to arrive on the northwestern Plains, and there is physical evidence that they were present in southern Alberta as early as the 1550s.[3] By the late eighteenth and early nineteenth centuries, the Blackfoot Nation encompassed an enormous area, bounded on the west by the Rocky Mountains, on the north by the North Saskatchewan

River, and on the east by the present-day Alberta-Saskatchewan border. The nation extended as far south as the Missouri River.[4]

The Tsuu T'ina, an Athapaskan-speaking people, originated in the Canadian subarctic. An offshoot of the Tsattine (Beaver) of present-day northern Alberta (near Lesser Slave Lake), the Tsuu T'ina split from the Tsattine sometime between 1700 and 1750 as a result of the fur trade's westward expansion.[5] Incursions into the region north of the North Saskatchewan River by groups of Cree hunters armed with guns drove the Tsuu T'ina farther and farther south onto the parklands and foothills of present-day southern Alberta.[6] The animosity the Tsuu T'ina and the Blackfoot shared toward the Cree helped solidify an alliance between the two groups. When the Tsuu T'ina moved out onto the plains of southern Alberta, they adopted a lifestyle similar to that of the Blackfoot. They copied their social organization, military societies, and religious practices.[7] Yet they also held on to their language and their separate tribal identity.

The Nakoda (Assiniboine) were originally part of the Yaktonai Dakota (who in turn were part of the Sioux-Nakoda Nation). Internal conflict led to a split between the Assiniboine and the Yaktonai Dakota. The Assiniboine moved north into the territory around the Lake of the Woods and Lake Winnipeg, where they became allies of the Cree. The Assiniboine were highly active as go-betweens in the fur trade and, as that trade shifted farther west, the Assiniboine followed it, spreading west across the Plains into Saskatchewan and Alberta as well as south into Montana.[8] As certain kinds of fur-bearing animals became scarce, the Assiniboine modified their role within the fur trade. Instead of trapping and trading furs, they began supplying trading posts with dried meat and pemmican.

By the 1700s several small Nakoda bands had separated from the Assiniboine and migrated as far west as the Rocky Mountains. Some of these bands lived in the woodlands and foothills; others moved out onto the Plains and hunted buffalo.[9] During the 1860s and 1870s, the Nakoda divided into three bands: Bearspaw, Chiniki, and Goodstoney. The Bearspaw band hunted the southern portion of Nakoda territory, travelling south into Montana to hunt buffalo. To the north, the Chiniki band hunted the area around present-day Banff National Park. The Goodstoney band lived in the woodlands near the headwaters of the North Saskatchewan.[10] The Goodstoney and Chiniki bands continued to hunt buffalo, but elk, moose, and deer were their primary source of animal protein. Today, these three groups reflect contemporary band membership and residence among the Nakoda in southern Alberta.

Despite important historical, cultural, and linguistic differences among the peoples of the northwestern Plains, by the nineteenth century they shared a common economic structure that was heavily influenced by local environment. The northwestern Plains are largely flat, treeless, and arid and are subject to extreme and fluctuating temperatures.[11] The seasonal availability of plants and the migration of the buffalo determined Plains peoples' annual cycle of journeys. In the winter they gathered in small bands along wooded river bottoms near the foothills. In the spring they moved out onto the prairies.[12] Recent work by archaeologists Mary Malainey and Barbara Sheriff offers evidence that buffalo herds wintered on the open prairie, and so too did the people who hunted them.[13]

The buffalo were extremely important to the economy of the Blackfoot, Tsuu T'ina, and Nakoda. Buffalo were more than just a food source: they supplied the northwestern Plains peoples with shelter, fuel, clothing, bedding, containers, and tools.[14] Nevertheless, given the "unpredictable alternation of abundance and scarcity" that was characteristic of a reliance on buffalo, survival and prosperity in this region meant locating and drawing from a wide variety of animal and plant resources. Women's knowledge of the local environment was therefore vital.[15] Aboriginal women gathered and preserved a range of plants, roots, and berries throughout the year. These harvesting activities ensured that Plains people had a mixed diet. They also cushioned communities against times of scarcity.[16] Women's harvesting activities would remain an important part of the household economy in the West. Throughout the late nineteenth and early twentieth centuries, newcomer women who helped their husbands establish farms on the northwestern Plains found it necessary to rely on local plants and roots to feed their families.[17] And these women acquired their botanical knowledge from Aboriginal women.

Bands organized themselves in ways that ensured the community's survival. The band was the smallest political unit of the tribe and consisted of many unrelated nuclear families who formed groups on the basis of friendship and co-operation rather than kinship. The size of a band was flexible and could number anywhere from one hundred to three hundred. Generally, though, a band was small enough to find food for all its members but large enough to ensure safety from enemy attacks.[18] Bands split up and reconstituted themselves for a variety of economic, political, and social reasons. For example, the availability of food and other resources often determined band size. A successful bison drive required at least one hundred people.[19] During the nineteenth century, other factors, such as

epidemics, also affected the number of bands, their membership, and their size.[20]

Religious and spiritual activities also influenced band movements and group composition. Early summer saw individual bands gathering in large camps that usually included the entire tribe.[21] The tribe came together once a year during the spring and summer to hold a large, community-based ceremony called the *okan* or Sun Dance. Bands would gather at an annual meeting place and, after the week-long ceremony was finished, the tribe would disperse back into bands to gather food and to hunt. Before reserves were created, the okan was traditionally the only time of year that all the tribes came together.

The social life of northwestern Plains people was structured further by societies.[22] Each tribe had a set of age-graded societies. Membership was based not on kinship but rather on age. An individual would therefore belong to several societies throughout his or her lifetime. Societies were essential to the survival of the entire tribe. They helped forge relationships and obligations with people beyond the immediate family and the band. Most important, societies were essential to the religious and physical well-being of communities.[23]

Within a given tribe, each society had roles and responsibilities that were both secular and religious.[24] Societies helped ensure the band's physical well-being by protecting it from temporal threats and by performing rituals intended to bring about good hunting and clear weather. Some societies had fixed rules, songs, and dances to perform; others owned medicine bundles and their associated rituals and powers; still others performed civil functions. For example, military societies or sodalities were responsible for fighting enemies but were also expected to perform internal policing tasks.[25] Other societies, such as the Horn Society, offered help, support, and spiritual guidance to members of the band.[26] The Horn Society was also in charge of deciding when the okan was to be held.

Most societies were strictly for men but, according to Siksika ceremonialist Reg Crowshoe, all members needed to have a female partner, usually a relative, in order to belong to a society. Some tribes had exclusively female societies – for example, the Old Women's Society, also known as the Motoki Society. The Motoki was a companion society to the Horn Society. The Motoki Society was responsible for acknowledging the importance of the buffalo and ensuring good luck in future hunts.[27] Aboriginal women also played important roles in other rituals and ceremonies, such as the okan, and many of them owned sacred bundles. Although information on women's ceremonial activities at the turn of the century is limited, what

is available tells us that after the horse was introduced, male participation in ceremonial activities tended to be emphasized.[28]

Individuals received the power to heal and the rights to certain rituals and ceremonies through visions or dreams. Some dreams resulted in the creation of sacred objects called medicine bundles. A medicine bundle is a "generic term for any objects wrapped together and used for ritualistic purposes."[29] Individuals and societies could own medicine bundles, and bundles could be passed down, purchased, or sold. Other dreams or visions provided people with information on how to heal a particular illness through a spiritual helper. No two healers used the same medicine bundle, ritual, or ceremony, and these items thus remained the recipient's sole property unless sold.[30]

In Blackfoot, Nakoda, and Tsuu T'ina communities, healing rituals and ceremonies could either be conducted by individuals or they could involve entire groups or societies or even the entire tribe. One well-known community-based ceremony was the okan. This took place in the summer over seven days, was attended by all tribes, and was a composite of rituals and functions performed by individual ceremonialists.[31] During the year, an older woman made a vow to hold the okan, typically to aid in the recovery of a loved one. The Holy Woman's vow and the okan ensured the well-being of the tribe by fulfilling important social, religious, and political functions. The okan brought people together to restore and repair tribal unity. It also functioned as a means to re-establish balance with the environment when there were no buffalo or when there was ill health.[32]

The okan was the most important ceremony held by Plains people, one in which the Holy Woman played a central role. In preparation for it, the Holy Woman, with help from her husband, purchased a *natoas* (Sun Dance bundle),[33] performed the prescribed rituals, and acquired and dried the buffalo tongues used in the ceremony.[34] On the first day of the okan, the Holy Woman and her partner began a fast, which lasted for four days. On the fifth day, after the natoas was brought out and important rituals were performed, there was a procession to the Medicine Lodge, where the Centre Pole was raised. Inside the lodge the buffalo tongues were distributed. The first people to receive pieces of the dried tongues were the other virtuous women – those who had made vows to help loved ones. Afterwards, offerings were brought forward to be blessed by the sun to ensure future good luck. On the final day – after harmony was re-established and friendships and alliances were confirmed and renewed – the various bands left for their fall hunting grounds.

On balance, then, current scholarship agrees that the spiritual and religious practices of the northwestern Plains people were gendered, with women playing important and complementary roles to the more public and performative activities of men. The spiritual and communal well-being of communities has been well studied, but less attention has been paid to how Aboriginal peoples in southern Alberta addressed more mundane, day-to-day health concerns. The scholarly literature focuses on individual or collective responses to illness and ill health and says little about injuries, accidents, daily health and illness, and even life events such as childbirth and aging. When we turn our attention to the full range of healing work, we find possibilities for understanding how these societies responded to a wide array of health problems. For example, botanical cures were sometimes received in dreams, but more often than not plant knowledge was the result of an apprenticeship with an older woman in the community. Healers who used plants needed to know their seasonal availability and how to harvest, prepare, and administer them as medicine. Considerable expertise was required to properly use plant remedies. As a result, apprenticeships were long and often expensive, but they brought prestige. In the decades following the Second World War, ethnobotanist Joan Scott-Brown found that Nakoda women who wanted to learn about plants from their female elders had to purchase the knowledge. One woman interviewed by Scott-Brown expressed concern that because the learning process took a number of years and was expensive, her grandmother might pass away before she could afford to complete her education.[35] Turning our attention to these kinds of healing alternatives brings women's work to the fore.

The Siksika, Kainai, Piikani, Tsuu T'ina, and Nakoda, like many contemporary North American societies, practised a sexual division of labour that shaped women's use of space.[36] Women carried out most of their work in the camp, where they were responsible for setting up and looking after the lodge (which the women owned), raising children, tanning hides, making clothes and teepee covers, collecting roots and herbs, and preparing food.[37] Outside the camp, women's responsibilities included gathering edible and medicinal plants. In the early spring, women and children gathered wild plant foods, and in the late spring they dug bitterroot.[38] In July they dug wild prairie turnips and camass bulbs near the mountains. Midsummer saw women and children collecting savis berries, and they gathered chokecherries in October.[39] Besides their numerous gathering activities, women hunted and snared small game, fished, and helped their male counterparts with the buffalo hunt.[40] The men of the northwestern Plains often cut a striking image as they traversed the prairie on horseback.

Women's use of the terrain was less dramatic. Aboriginal women were more likely to be found picking berries in a patch or gathering herbs and roots in a grove of trees.[41] But because effective subsistence strategies were not always consistent with a strict sexual division of labour, there was some flexibility. Women's and men's activities were often determined by need and practicality. Gathering activities were often performed communally – in other words, men and children joined in.[42] As well, general knowledge about edible and medicinal plants was shared for the benefit of everyone. Plant gathering, much like a successful buffalo hunt, required the participation of the entire band.

There is considerable scholarly debate regarding the value placed on the labour of women and men in northwestern Plains communities, especially after European contact. Some have speculated that the introduction of horses, the robe trade, and European technology devalued women's work. The sources that support this argument are problematic because they were written mainly by non-Aboriginal men and coloured by the cultural values that Europeans placed on different types of work. As a result, the stereotype of the overworked Indian drudge has remained surprisingly resilient in white culture.

Nor was the performance of particular roles determined entirely by biological sex. Two-spirited – that is, cross-gendered – people were not unheard of in Plains societies. These people claimed an identity based on the performance of a social role rather than their physiology. Cross-gender women participated in activities typically relegated to men, such as raiding, and they sometimes took wives and had children. Other Aboriginal women were not cross-gender but played significant leadership roles and headed successful raiding parties.[43] The manly-hearted woman among the Blackfoot is yet another example of the complex ways in which gender operated among Aboriginal peoples. The manly-hearted woman was married, but she was also aggressive, independent, and ambitious and possessed sexual confidence.[44] To be manly-hearted was not necessarily to be cross-gendered; rather, it was a quality that allowed individual women to transgress certain gender norms and behaviours as they continued to be perceived as female.

There is evidence that these sorts of gender behaviours and social institutions persisted beyond the 1880s.[45] The degree to which Aboriginal women's status changed as a result of contact is difficult to determine. It is conceivable that the robe trade diminished the importance of certain aspects of women's work. Other possible causes are the decline of the fur trade, the establishment of reserves, and a decline in local resources. When

examining so-called women's work, it is not the nature of that work that should be adjudicated but rather the cultural assumptions made about it. Feminist scholar Evelyn Blackwood contends that the performance of gender roles in Aboriginal communities should be regarded as the carrying out of a specific set of duties that were not inferior to but rather part of a "system of reciprocity that ensured the interdependence of the sexes."[46] The healing and caring work of Aboriginal women after the 1880s is an important window through which to trace not only cultural persistence but also important transformations in the meanings of women's work and knowledge.

Economic and Social Changes of the Nineteenth Century

The gendered organization of northwestern Plains peoples' social, cultural, and economic lives crystallized during the tremendous changes of the eighteenth and nineteenth centuries.[47] Between 1700 and 1730, the appearance of the horse and the gun set off a series of social and geopolitical shifts in Plains culture. In combination, the horse and the fur trade sparked what Bruce Trigger called in a different context a cultural florescence.[48] Because horses could travel longer distances and carry more material goods, they stimulated trade and communication.[49] Age-graded societies, medicine bundles, and the art of bead making all flourished. As mentioned earlier, however, there is still considerable scholarly debate about the impact of the horse and the expanding robe trade on the status and well-being of Plains women. Historian Andrew Isenberg argues that the horse created irreconcilable contradictions for Plains people because, as a symbol of wealth and success, it threatened communalism. Trade further complicated the situation by pushing Plains people toward commerce and individualism.[50] The introduction of the gun and the horse also shifted the balance of power on the northwestern Plains and brought about a long period of territorial conflict.[51] Indeed, the Blackfoot were almost constantly at war throughout these decades. They fought the Apsálooke (Crow), Shoshone, and Nez Perce to the south and southwest for horses and the Cree and Assiniboine to the north over hunting grounds.[52]

In the 1790s, contact between the Blackfoot and the Europeans increased with the establishment of trading posts – including Fort Edmonton and Rocky Mountain House – along the northern edges of Blackfoot territory. But the Blackfoot and Tsuu T'ina did not participate directly in the fur or robe trade until after the 1830s, when the American Fur Trade Company

gained quick access to western trade routes along the Missouri River.[53] By the mid-nineteenth century, the Aboriginal peoples of the northwestern Plains were under a great deal of pressure from overhunting, European immigration, and the whisky trade. Shortages of buffalo developed as early as the 1830s. In some areas the scarcity of buffalo became a real concern by 1848.[54] A combination of overhunting and encroaching European settlement restricted seasonal subsistence activities. By the early 1880s, the buffalo had all but disappeared.

In addition to economic and territorial pressures, the people of the northwestern Plains faced a series of epidemics during the late eighteenth and nineteenth centuries. Using winter counts, Linea Sundstrom estimates that northern Plains groups suffered through thirty-six epidemics between 1714 and 1919.[55] The last pre-reserve smallpox epidemic endured by northwestern Plains groups was in 1869. An estimated 1,200 people of the Blackfoot Nation perished from it that year. Exposure to epidemics transformed Plains peoples' understanding of disease and contagion.[56] Human geographer Jody Decker maintains that, by 1869, Aboriginal people's awareness of contagion had "clearly changed and grown to include the concept of spreading an infectious disease through its victims and its discharges."[57] For example, when disease struck a mobile hunting and gathering band, its members practised their own form of quarantine by dispersing into small groups.

Women's knowledge of medicinal plants seems to have been a particularly important part of Aboriginal peoples' response to new health problems. Aboriginal healers adapted traditional remedies to treat the symptoms of new afflictions. When poor rations (including white bread and bad meat) caused digestive problems, Blackfoot women brewed a variety of herbal drinks to alleviate abdominal distress. Likewise, people with a tubercular cough were given infusions of yellow berries or tea made from willow. Willow bark, which contains salicin, the active ingredient in aspirin, helped soothe the patient.[58] The social and economic conditions that developed during the final decades of the nineteenth century, outlined in the following section, only increased the importance of healing and caregiving work performed by Siksika, Kainai, Piikani, Tsuu T'ina, and Nakoda women.

The Creation of Reserves

When Treaty 7 was negotiated in 1877, the inclusion of the Siksika, Kainai, Piikani, Tsuu T'ina, and Nakoda in one treaty had less to do with internal

alliances and more to do with geographic proximity. At first, Treaty 7 was administered as a single agency under one Indian agent. By the late 1880s, however, the five tribes had been assigned their own communities and were managed separately. As an exception to this, the Tsuu T'ina and the Nakoda would remain part of the same agency until 1918. The treaty established an inequitable relationship between the federal government and Aboriginal peoples in southern Alberta. Perhaps even more significant, Treaty 7 reorganized the physical landscape of southern Alberta by separating Aboriginal space from white space. After the 1880s the movement of Aboriginal women between reserves and nearby settlements was restricted by authorities. It is therefore noteworthy that encounters between Aboriginal and white women persisted. Many of those encounters were premised on healing.

The federal government assigned the Siksika land east of Calgary, just south of the village of Cluny. Most of the reserve was open prairie with rolling hills and deep coulees. The region was subject to climate extremes – bitter cold and heavy snow in the winter, followed by severe drought with strong, dry winds and nightly frosts in the summer. The area was less than ideal for crops but quite suitable for grazing. Year after year, in his annual reports, the Blackfoot agent described his reserve's lack of agricultural success, except for potatoes. He blamed the failure on the poor climate. Limited water resources exacerbated the region's drought conditions. Small sloughs dotted the reserve landscape, but these dried up in the spring. Only two creeks contained water throughout the year: Arrowwood Creek in the reserve's southwest corner and Crowfoot Creek to the northeast.[59] In addition, the reserve lacked any significant timber: only cottonwood and poplar were found along the river.[60] The ability of the Siksika to build and maintain European-style houses was restricted by the shortage of water and timber, but rarely was this recognized.

The Kainai were at first offered land adjacent to the Siksika, but this tract of land was only four miles wide and located in one of the driest parts of Alberta. In 1883 the Kainai renegotiated the treaty and took land between the Belly and St. Mary rivers south of Fort Macleod. The negotiation made their reserve the largest in Canada.[61] Despite the reserve's size, it lacked timber, with the exception of clumps of berry shrubs at the north end and a few straggling cottonwoods in the valley. The Kainai faced much the same environmental challenges as the Siksika: their reserve's interior was dry, open, undulating plain without lakes or even ponds; the coulees were usually dry by early summer; and the temperature swings all but crippled the land for agriculture.[62]

The Piikani took land west of Fort Macleod. As with other parcels carved out for the Blackfoot Nation, the Piikani's land was most suitable for livestock grazing, even though the Department of Indian Affair's (DIA) intended to turn Aboriginal people into farmers. However, the Piikani were luckier that most groups with regard to the availability of timber. In the Porcupine Hills, they owned eleven-and-a-half acres of wood suitable for frame houses.[63] Thus, unlike the Siksika and the Kainai, the Piikani could build homes and barns without bankrupting themselves. Water for domestic purposes was obtained from the Oldman River, Beaver Creek, and Scott's Creek. These sources were, however, closed during the winter.[64]

Three Nakoda bands took land in the foothills west of Calgary near what had been the Morleyville mission. The Bow River ran through this reserve, fed by numerous streams and springs. Except for a small piece of land in the southeast, nearly all the reserve was gravelly and hilly and thus unsuitable for agriculture. This problem was exacerbated by high winds, drought, and early frosts.[65] The Nakoda pursued seasonal rounds of hunting in the mountains and worked as labourers for local ranchers because there was no opportunity for large-scale farming on their reserve.

After the signing of Treaty 7, the Tsuu T'ina settled on the Blackfoot Reserve. Then, after further negotiation, they acquired about seventy thousand acres of land located ten miles southwest of Fort Calgary in 1882.[66] As a result, the Tsuu T'ina Reserve today lies on the western outskirts of the expanding city of Calgary. Unlike the three tribes of the Blackfoot Nation, the Tsuu T'ina had greater access to water: a number of small streams that fed Fish Creek and the Elbow River crossed their land.[67] According to Indian agents at the Sarcee Reserve, a fairly large portion of the land on the eastern section of the reserve was suitable for cultivation, and the western section contained ample timber and firewood.[68] However, like the other reserves, the Sarcee Reserve faced environmental constraints on farming: drought, high winds, and frosts.[69] All three were typical of southern Alberta.

Treaty 7 did not immediately restrict the Aboriginal peoples of southern Alberta to their reserves. They continued to search for food and trading opportunities outside their reserve boundaries, and they would continue to do so until the 1880s.[70] During that decade the effects of the pass system and the growing presence of white settlers strained the capacity of Plains Aboriginal people to sustain their communities. By 1880 the bison had all but disappeared from western Canada – the last hunt in the northwestern United States was held in 1883.[71] The completion of the railway across the western prairies, the growth of ranching, and the Euro-Canadian settlement

of southern Alberta further limited the ability of Aboriginal peoples to follow their old subsistence patterns. As a result, the residents of the Treaty 7 area increasingly turned to agriculture and ranching to try to support themselves.

Unfortunately, there would be very little successful agriculture in southern Alberta until extensive irrigation systems were built and dry-farming practices were perfected. During the early twentieth century, the Siksika, Kainai, Piikani, and Tsuu T'ina made strong efforts to dig irrigation ditches to make the land more fertile. The lack of water, however, continued to be a serious impediment. Even the Euro-Canadian settlers, who arrived in southern Alberta with a great deal of farming experience, found the lack of water a major obstacle and agriculture an expensive and high-risk venture.[72] Indeed, 40 percent of the non-Aboriginal homesteaders who tried to establish farms in southern Alberta between 1905 and 1930 failed to meet the government's conditions under the Dominion Lands Act.[73] It is noteworthy that while Indian agents often blamed crop failures on the unfavourable environment – that is, on the lack of timber or water – the same excuses were never offered for the inability of Aboriginal women to live up to the domestic standards set by Europeans. The shortage of water and building materials was rarely offered as an excuse for poor housekeeping.

Nation Building in Western Canada

After it purchased Rupert's Land from the Hudson's Bay Company in 1869, the newly founded Dominion of Canada took a series of steps to consolidate its control over the West and to open up lands for settlement. Key to all this was the Dominion Lands Act of 1872, which organized western settlement and determined how lands would be distributed. During the 1870s the seven western treaties were negotiated and signed with the region's Aboriginal peoples. In 1873 the North West Mounted Police (NWMP) was founded as a means to ensure peaceful and orderly Euro-Canadian settlement. Twelve years later, in 1885, the Canadian Pacific Railway was completed to carry settlers and manufactured products to western Canada and wheat back to the east.

These nation-building activities were accompanied by further measures designed to do more than restrict the original inhabitants to their reserves. New federal laws extended other forms of control over Aboriginal people. In 1876, as a first step, Ottawa consolidated all existing laws pertaining

to Aboriginal peoples into one piece of legislation called the Indian Act. All future legislation affecting Aboriginal people would be based on this Act.[74] Later amendments to the Act were part of an attempt to control and transform land use, marriage and family structure, cultural beliefs and practices, and political participation among Aboriginal peoples.[75] One of the more coercive federal measures from that time was the pass system, a DIA policy introduced immediately after the 1885 Rebellion and never formally rescinded, which was designed to limit the mobility of Aboriginal peoples living on the Prairies.

This expansion of restrictive measures was accompanied by the development of the DIA bureaucracy. The department was created in 1880, and the minister of the Interior was placed in charge as the superintendent general. The department had two arms: the Land Sales Branch and the Accountant's Branch. Four new branches were created in 1885: the Statistics and School Branch (counting and education), the Correspondence Branch (communication), the Registry Branch (membership), and the Technical Branch (preparing surveys, drawings, and instructions). In 1889 a Land and Timber Branch was added to the department. These branches reflected the government's dual agenda, which was to manage Aboriginal people through services such as schools as it acquired their land and resources. As historians such as Douglas Leighton have shown, the DIA did not attract the best prospects for the civil service; as a result, most positions were filled by candidates who knew very little about Aboriginal people.[76]

The Health of the Siksika, Kainai, Piikani, Nakoda, and Tsuu T'ina, 1880-1930

Aboriginal people responded as well as they could to the new challenges they faced from Euro-Canadian settlement. Poverty and severe malnutrition during the 1880s exacerbated the impact of European diseases. Historian John Ewers estimates that in Montana between 1882 and 1885, of 7,000 Piikani, somewhere between 250 and 550 starved to death.[77] Ethnographer George Bird Grinnell, who lived among the Piikani during the 1880s, placed this number much higher. He calculated that 2,500 people (about one-third of the population) had starved to death.[78] The situation in southern Alberta was not much better. After spending the winter of 1880-81 hunting in Montana, hundreds of starving Blackfoot crossed the border into Canada. Norman Thomas Macleod, the brother of Colonel James Macleod and newly appointed Indian agent for all of Treaty 7, made efforts to feed

the seven thousand hungry Aboriginal people who then occupied southern Alberta. The federal government responded by ordering Macleod to reduce rations. Macleod resigned in disgust in 1882.[79] The reports of starvation were not addressed seriously by the federal government, despite the pleas of individual Indian agents and other government employees.[80]

During the late 1870s and early 1880s, the total population of the Siksika, Kainai, Piikani, Nakoda, and Tsuu T'ina who lived in Alberta was around seven thousand. On Treaty 7 reserves, morbidity and mortality rates remained high throughout the late nineteenth and early twentieth centuries.[81] At the Sarcee Reserve, in 1887, for example, Inspector Alex McGibbon reported six births and seventeen deaths – one family alone had lost three children to tuberculosis.[82] These high death rates did not continue throughout the period of this study; even so, by 1918 the Aboriginal population of Treaty 7 had declined by more than half, to just under three thousand people.[83]

Recurrences of contagious diseases such as smallpox, whooping cough, and measles decreased but did not disappear entirely. For instance, a major smallpox epidemic struck every Aboriginal community in southern Alberta in 1904. That year, the death rate at the Blackfoot Reserve was 100 per 1,000, while at the Blood Reserve it was 110 per 1,000.[84] Epidemics were not the only serious concern. By the 1890s, diseases of poverty such as tuberculosis had become a source of misery for Treaty 7 people. By the turn of the century, TB rates for prairie Aboriginal peoples were 42.6 per 1000 – nearly twenty times the rate for non-Aboriginal Canadians.[85] Economic disruption and inadequate rations had left Aboriginal people ill-equipped to deal with chronic and often fatal infections.

Historians have thoroughly documented that the federal government was unwilling to make the necessary commitments to deal with the social and economic dislocations experienced by Aboriginal peoples at the end of the nineteenth century and the beginning of the twentieth.[86] Maureen Lux, in *Medicine That Walks,* describes the impact of substandard rations, hunger, ragged clothing, and torn lodges on the health of Aboriginal communities. In the Treaty 7 area, inadequate housing was an especially severe problem because of the scarcity of building timber. The Siksika in particular faced an acute housing shortage throughout most of the period discussed in this book.[87] Similarly, Hugh Shewell, in *Enough to Keep Them Alive,* describes Ottawa's parsimony in response to requests for social assistance. Aboriginal people were primary targets of the federal government's persistent efforts to practise fiscal constraint.[88]

Poor living conditions remained the greatest challenge in attempts to address the ill health of Aboriginal people. Throughout the twentieth century, the health of Aboriginal peoples in southern Alberta was negatively affected by terrible living conditions and social and economic confusion. These circumstances exacerbated illnesses of poverty, including tuberculosis. Between 1891 and 1900, 199 deaths were recorded among the Tsuu T'ina; 46 percent of them were TB related.[89] A study conducted by the Canadian Tuberculosis Association in 1924 revealed that although Aboriginal peoples constituted only 4.5 percent of Canada's population, they accounted for 25 percent of all deaths from TB – a staggering proportion.[90]

Little would be done to improve this situation until after the Second World War. During the Great Depression of the 1930s, federal spending on Aboriginal peoples dwindled, especially with respect to medical services. The DIA's annual report for 1933 indicated that the federal government had provided 20 percent less money for medical services than the preceding year. With regard to TB, the report stated that "no progress can now be made toward the solution of the tuberculosis problem. On the contrary the department has been forced to refuse the admission to sanatorium of many cases which the attending physician indicated would improve under proper care."[91]

Medical historians maintain that improvements in living conditions and diet during the early twentieth century had a greater impact on the health of North Americans than the advent of scientific medicine. They point, for example, to Herbert Ames's 1897 study of Montreal, which documented how death rates fluctuated dramatically among neighbourhoods.[92] For example, the death rate for Montreal as a whole in 1895 was 24.81 per 1,000, yet the death rates (from 32.32 to 35.51 per 1000) were much higher in working-class wards that were predominantly French Canadian.[93] This historiographical emphasis on the effects of living standards has influenced Lux's examination of material conditions in Aboriginal communities in western Canada. She has shown that the standard of living for Aboriginal people remained well below that of the average Euro-Canadian into the 1930s and 1940s.[94]

Faced with this demographic and economic crisis, the federal government had little choice but to offer health services to Aboriginal people. When the DIA was first created, it took no formal steps to provide medical services to those in its charge. The BNA Act stated that medical services were a provincial jurisdiction and that federal authority over medical matters was limited to immigrant health and quarantine practices. As a

result, any medical services made available by the DIA were piecemeal. They were often initiated only in response to requests from concerned Indian agents, missionaries, and settlers. For instance, the DIA hired the NWMP surgeon after 1877 to enforce vaccination and quarantine.[95] In 1883 physicians from settlements adjacent to Treaty 7 reserves replaced the NWMP surgeon. These medical officers were expected to attend Aboriginal people in their homes and camps and to oversee residential and day schools. The doctors visited the reserves once a month and were on call for emergencies. These part-time physicians were the extent of medical services provided to Aboriginal people by the DIA. Although Aboriginal peoples were considered the federal government's responsibility (in other words, ineligible for municipal or provincial services), the DIA continued to drag its feet when it came to providing them with health care.

In the 1890s the churches and their missionary organizations began to develop a broader system of medical services for Aboriginal people. Anglican, Methodist, and Roman Catholic groups established hospitals, school infirmaries, and dispensaries to address ill health among their Aboriginal congregations. By this time, missions and missionaries had been informally providing Aboriginal people with basic medical aid and nursing care for several decades. These developments mirrored those in Euro-Canadian communities in southern Alberta that were large enough to support a medical doctor. On reserves where the local mission was unable to erect a hospital, Euro-Canadian women served as both matrons and nurses in the residential schools. The churches and their missions tried to provide some medical and nursing care for the reserves in their charge. Department of Indian Affairs medical officers continued to make monthly visits, and they included the church-run hospitals as part of their rounds. The DIA contributed little funding for these institutions. It was not until 1904, when the position of medical inspector was created, that the DIA began to take a more active role in Aboriginal health care.[96] Between 1900 and 1920, the DIA provided public health nurses for schools and temporary nursing stations, but only when it decided that conditions required them. During the 1920s and 1930s, the DIA took over management of the Blackfoot and Blood hospitals and built medical facilities at the Stoney, Sarcee, and Peigan reserves. Besides taking a more direct role in hospital management, the DIA created public health programs to deal with what the department believed were the underlying causes of ill health on reserves. A public health service was finally created in 1904, and a travelling nurse program was instituted in 1922. This system was formalized as the DIA's Indian Health Services in 1927.

Conclusion

The enormous social, political, and economic transformations taking place in the late nineteenth and early twentieth centuries altered the landscape of southern Alberta, and it was during these decades that reserves took on real physical and social meanings. Nevertheless, Aboriginal and newcomer women continued to encounter one another. They first met in the houses and sod huts of Euro-Canadian women and later in the tents, camps, and houses of Aboriginal women. As the West underwent more Euro-Canadian settlement, fewer newcomers drew from the therapeutic knowledge of Aboriginal women. Simultaneously, the healing encounters between Aboriginal and Euro-Canadian women became more formal, more often than not taking place in institutional space. In some situations, depending on the type of illness and the quality of service, Aboriginal women drew from the medical services of Euro-Canadian women; in other situations, they continued to rely on traditional knowledge acquired over generations. Although less visible, Aboriginal women possessed significant knowledge about the medicinal nature of local plants and applied them on a daily basis for the good of the community. The decline in missionary women's use of Aboriginal women's healing expertise fundamentally altered relations between them. Aboriginal women were not unaware that the help of Euro-Canadian women came attached with conditions; therefore, they were constantly negotiating when and how to use Western medicine. The following chapters outline this slow and uneven process.