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Separating Birth from Community: Colonialism and Historical Institutionalism in Indigenous Pregnancy Evacuation Policies

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Abstract

Evacuating pregnant Indigenous individuals who live in remote communities to urban centres for birthing is not a formal or written policy in Canada, but has been the norm for several decades. Canada is a geographically large country with remote communities, often inhabited by Indigenous peoples, which provides universal health care to communities spanning from the Pacific to Atlantic oceans. The evacuation of pregnant Indigenous peoples has resulted in a disconnection between birth and community, land, ceremony, and Traditional Healing. This policy displacing pregnant Indigenous women has been reported to bring them emotional, financial, and physical harm. Historical institutionalism may be precluding significant change to the norm of maternal evacuation. Euro-Canadian epistemologies and colonial mindsets have prevented biomedical institutions from seeing the detachment from land and community as a problem, as the transfer to tertiary hospitals may have been considered beneficial for Indigenous women. Indigenous self-determination in reforming Indigenous maternity care policies is crucial in addressing this health systems issue.

L'évacuation des personnes enceintes autochtones vivant en communautés isolées vers des centres urbains pour y accoucher n'est pas une politique officielle, ni écrite, au Canada, mais la norme existe depuis plusieurs dizaines d'années. Le Canada est un pays géographiquement vaste comptant de nombreuses communautés isolées, souvent habitées par des personnes autochtones, et fournissant des soins de santé universels aux communautés qui s'étendent de l'océan Pacifique à l'océan Atlantique. L'évacuation des personnes enceintes autochtones a entraîné une déconnexion entre la naissance et la communauté, la terre, les cérémonies et la guérison traditionnelle. Cette politique de déplacement des femmes enceintes autochtones leur causent des effets néfastes émotionnels, financiers et physiques. L'institutionnalisme historique peut empêcher un changement significatif de la norme d'évacuation des mères. Les épistémologies euro-canadiennes et les mentalités coloniales ont empêché les institutions biomédicales de considérer le détachement de la terre et de la communauté comme un problème, car le transfert vers des hôpitaux tertiaires a pu être considéré comme bénéfique pour les femmes autochtones. L'autodétermination autochtone par rapport à la réforme des politiques de soins obstétricaux chez les personnes autochtones est cruciale pour résoudre ce problème de systèmes de santé.

Key Messages

- Indigenous self-determination in maternity health reform and supporting Indigenous midwives will improve experiences of pregnancy in Indigenous women and two-spirited people.
- Inequities in obstetrical and neonatal outcomes experienced by Indigenous women and two-spirited people are related to maternal evacuation policies.
- Historical institutionalism and colonial mindsets may be precluding policy change in maternal evacuation policies despite broad consensus from biomedical and Indigenous organizations.

Messages-clés

- *L'autodétermination autochtone dans la réforme des soins obstétricaux et le soutien aux sages-femmes autochtones amélioreront l'expérience de grossesse chez les femmes autochtones et les personnes bispirituelles.*
- *Les inéquités en matière de résultats obstétricaux et néonataux dont souffrent les femmes autochtones et les personnes bispirituelles sont liées aux politiques d'évacuation des mères.*
- *L'institutionnalisme historique et les mentalités coloniales peuvent empêcher de modifier les politiques d'évacuation maternelle malgré le consensus soutenu des organisations biomédicales et autochtones.*

1 BACKGROUND

For decades, pregnant people in Canada living in remote communities have been made to experience childbirth away from their homes in dedicated urban centres. According to Health Canada's *First Nations and Inuit Health Branch (FNIHB) Clinical Practice Guidelines for Nurses in Primary Care*, nurses are instructed to "arrange for transfer to hospital for delivery at 36–38 weeks' gestational age according to regional policy (sooner if a high-risk pregnancy)" (First Nations and Inuit Health Branch 2011, 6). These transfers to urban settings come at financial, emotional, spiritual, and physical costs of the affected Indigenous (and non-Indigenous) pregnant people affected (Chamberlain and Barclay 2000; Kornelsen et al. 2010; Lawford et al. 2019).

The policy of maternal evacuation was never enacted as a formal law at a governmental level, yet the practice became ubiquitous across all provincial and territorial health care systems (Lawford 2016). Thought to have started between the 1960s and 1980s, maternal evacuation policies were framed as stemming from "the Government of Canada's desire to reduce maternal and infant mortality rates amongst First Nations populations" (Lawford and Giles 2012b, 327). However, archival research of Library and Archives Canada revealed the overt effort to assimilate birthing practises in First Nations communities as early as the 1890s (Lawford and Giles 2012b). In 1935, a governmental policy to address maternal mortality recommending the presence of physicians during childbirth coupled with the assimilationist tactics used to discredit Traditional Knowledge led to the eventual widespread implementation of maternal evacuation policies across the country (Lawford and Giles 2012b).

Maternal health, infant mortality, and birth rates are among the key health indicators on which progress in closing the gap between Indigenous and non-Indigenous communities is a critical Call to Action (Truth and Reconciliation Commission of Canada 2015). Indigenous women [1] in Canada have worse health outcomes compared to the analogous non-Indigenous population (Carrie et al. 2004). This applies to many health issues outside of the scope of pregnancy; however, people with self-reported Indigenous identity are more likely to deliver preterm babies, babies large for gestational age, or stillborn babies (Sheppard et al. 2017). Furthermore, Indigenous infants have double the risk of requiring hospital admission compared to non-Indigenous infants (Guèvremont et al. 2017; He et al. 2017). Due to the harms of colonialism resulting in inequitable access to healthy foods, Indigenous women are more likely to have diabetes before becoming pregnant or develop gestational diabetes while pregnant (Chan et al. 2019; Dyck et al. 2020a, 2020b; Hummelen et al. 2020; Poirier et al. 2020). This risk compounds across generations as the risk of developing diabetes in the offspring is higher and the diabetic process starts earlier in life when born to a mother

[1] The term "women" is used broadly throughout this text as cisgender women represent most of the discourse and literature on the topic of maternity care. The authors would like to acknowledge that this term should also include anyone at risk of pregnancy who identifies as two-spirited, non-binary, transgender, or gender diverse.

with diabetes during pregnancy (Morriseau et al. 2020). Despite these higher rates, First Nations women were found to be less likely to see an endocrinologist (a medical specialist who manages diabetes) during their pregnancy if diagnosed with diabetes in pregnancy (Velez et al. 2020). Breastfeeding, which is less common amongst First Nations mothers, has been found to be protective against the development of diabetes later in life (Martens et al. 2016). This finding demonstrates the deep and ongoing harms of settler colonialism as previous governmental policies enforced the use of milk powder on reserve, thus separating mothers from their traditional practise of breastfeeding (Schroeder et al. 2019).

Many factors can be investigated to better understand, and eventually improve inequitable maternal outcomes in Indigenous women and two-spirited people. Low levels of trust in the Euro-Canadian biomedical system and increased hesitancy to seek care have negatively impacted Indigenous Peoples' experiences with health care, ultimately affecting their health (Phillips-Beck et al. 2020). Intersectional socioeconomic factors have placed Indigenous women at increased risk of poverty, inadequate housing, and substance use, which affect perinatal outcomes negatively (National Collaborating Centre for Infectious Diseases 2019a, 2019b). On a health systems level, the organization of care delivery may play a role in current health disparities. In British Columbia, adverse perinatal outcomes are associated with higher travel times to access maternity services, with an adjusted odds ratios of perinatal mortality 3.17 times higher if needing to travel more than 4 hours to receive care (Grzybowski et al. 2011). According to Statistics Canada, 35.9% and 20.9% of the Indigenous population live in rural or small population centres, respectively (Statistics Canada 2021).

Maternal evacuation policy and the displacement of birthing away from communities and into centralized biomedical hospitals may contribute to the poor perinatal outcomes observed in Indigenous women and two-spirited people. Although most remote or rural First Nations communities operate under the evacuation policy, Indigenous midwives have led practices that integrate Traditional Healing and biomedicine, offering birthing services that are becoming available across Canada (Lawford et al. 2018; National Aboriginal Council of Midwives 2020). In this heath reform analysis, we examine maternal evacuation policy through the policy triangle and multiple streams frameworks (Kingdon 1984; Walt and Gilson 1994). We intend this publication as exploratory and hope to continue the discussion on returning Indigenous births to community, land, and tradition through Indigenous self-determination in health system reform. Lee acknowledges her position as a non-Indigenous author who cannot speak on behalf of the diverse Indigenous voices that are too often excluded from academic discourse (Smylie and Phillips-Beck 2019).

2 POLICY ANALYSIS

Intersectional frameworks aim to recognize that lived experiences cannot be whittled down to individual identities (Hankivsky and Christoffersen 2008). In fact, they recognize that

our experiences and the effect of systemic oppression exists at the intersection of all the social positions interacting at once in any given setting. This type of analysis recognizes the deeply social determinants of health and how socioeconomic position influences one's health on every level (Siddiqi et al. 2018) and, in particular, the harms of colonialism, systemic racism, and gender discrimination that Indigenous women experience. These harms place them at higher risk of suffering from stigma and barriers related to mental health, poverty, and remote living. Using de-colonial and intersectional lenses, together with the policy triangle and multiple streams frameworks to explore specific elements of this health systems issue that can lead to an Indigenous-led solution.

2.1 Policy triangle

The policy triangle proposed by Walt and Gilson (1994) explicates policies by examining four components: content (what the policy entails), context (why the policy is needed), actors (who participates in and influences formulation and implementation of the policy), and process (how the policy was brought forward and implemented). This framework provides a comprehensive overview of a policy, enabling deeper analysis of factors contributing to policy inertia or facilitating reform.

2.1.1 Content

The Government of Canada defines remote communities as having fewer than 10,000 inhabitants with "no residents that commute to an urban location for work or are located in the Yukon, Northwest Territories, Nunavut, Nunavik or Nunatsiavut" (Vodden and Cunsolo 2021, 109). Health Canada recommendations on maternal evacuation result in the vast majority of pregnant people living in remote communities getting flown to larger centres for childbirth regardless of risk profile (First Nations and Inuit Health Branch 2011; Lawford et al. 2018). Without providing any rationale, Health Canada 'asks' all remote and rural pregnant Indigenous and non-Indigenous peoples to travel between 36 and 38 weeks gestational age to an urban centre, although the ramifications of declining transfer remain unclear (Cidro et al. 2020). For example, in Manitoba, Indigenous women with low-risk pregnancies are transferred to either Winnipeg, Thompson, or The Pas (Lawford et al. 2019). Few Indigenous women refuse the evacuation as they worry about consequences of not leaving (Dreaddy 2019). Although they are transported for childbirth, many Indigenous women receive their prenatal care in clinics closer to home, provided either by nurses or visiting doctors (Lawford et al. 2019).

Most transfers occur between 36 and 38 weeks gestational age, but anyone with a past experience of preterm delivery or experiencing obstetrical complications will be transferred to the city even earlier (Lawford and Giles 2012a). According to experts in Indigenous midwifery, current policies do not appear to serve Indigenous women well, and may be tied to the observed inequities in obstetrical and neonatal outcomes (Lawford and Giles 2012a).

The practise of restricting childbirth to hospital settings began in the mid-twentieth century as childbirth became increasingly medicalized and pathologized in the setting of high maternal mortality (Olson and Couchie 2013). According to Cidro et al. (2020), traditional midwifery was outlawed and devalued by biomedical professionals. This phenomenon was not specific to Indigenous communities, as the marginalization of midwifery resulted in non-Indigenous women living remotely also getting transferred to large centres for their obstetrical care. By the 1970s, the practise of flying women to cities for childbirth was widespread and included all pregnant people regardless of Indigenous ancestry.

Maternal evacuation policies exemplify how Euro-Canadian biomedical systems paternalistically assume they can determine what is best for Indigenous women and two-spirited people. A review of the Inuit maternal health literature by Brubacher et al. (2020) found almost two out of every five articles (n=28) related to obstetrical evacuation or location of birth. Considering this review included any study relating to clinical management of any obstetrical condition in Inuit people, maternal displacement occupies an important focus in the biomedical discourse. Paradoxically, the biomedical knowledge production has predominantly misaligned with established maternal evacuation policies. Although the validation of biomedical research methodology centres non-Indigenous epistemologies, the biomedical literature has supported low-risk deliveries as being safe and feasible in communities for decades (Baskett 1978; Chatwood-Affleck et al. 1998; England 1998). The Society of Obstetricians and Gynaecologists of Canada released an article in 2013 stating that all health care providers should recognize the necessary role of Indigenous midwives in the provision of obstetrical care to Indigenous women and two-spirited individuals who can become pregnant (Wilson et al. 2013). The Indigenous Physicians Association of Canada, the Aboriginal Council of Midwives, the Canadian Association of Midwives, and the Society of Obstetricians and Gynaecologists of Canada united their voices to overtly support the return of birthing to First Nations and Inuit communities in low-risk deliveries (Society of Obstetricians and Gynaecologists of Canada 2017). The Public Health Agency of Canada released national guidelines on maternity care which echoed the calls in this guideline and reinforced the importance of cultural safety in maternity and newborn care (Public Health Agency of Canada 2018). Despite these unified calls, disheartening examples of unsuccessful attempts to repatriate birthing to communities continue to surface. For example, two Inuuk midwives in Rankin Inlet were pushed to step away from their roles due to persistent discrimination and undermining of their skills, leading Rankin Inlet to lose their only Indigenous midwifery services (Tranter 2021). The contrast between the maternal evacuation policy content and the positions of prominent Indigenous and non-Indigenous voices raises questions as to the barriers to policy change.

2.1.2 Context

Lawford and Giles (2012b) suggest that the policy of maternal evacuation served as one of the many tools used by Canadian government in the assimilation of Indigenous Peoples. By

removing pregnant Indigenous women from their communities, Indigenous Peoples were coerced into accepting Euro-Canadian biomedical models of care and lost Traditional Knowledge that informed their birthing practises before colonial contact. Although the use of Euro-Canadian biomedical medicine has certainly saved Indigenous lives, broad imposition of this model of care perpetuates colonial harm by ignoring the importance of community and land in the experiences of Indigenous childbirth (Lawford and Giles 2012a).

Furthermore, this policy aligns with the prioritization of hospitals in the delivery of health care in Canada. Hospitals have been the central unit of provincial health care systems, with universal coverage and reimbursement designed primarily around inpatient and diagnostic services (Government of Canada 2019). Although not directly tied to colonialism, the decision to build our health care system around tertiary care hospitals in settler colonial cities inherently disadvantages anyone living in remote Indigenous communities.

2.1.3 Actors

The actors with the greatest to gain or lose are Indigenous women and Indigenous midwives. Prior to settler colonial contact, Indigenous women delivered babies surrounded by community members such as their family, midwives, Elders, and neighbours (Lawford and Giles 2012b). Today, however, they must deliver in city hospitals with doctors and nurses present, sometimes accompanied by an escort (partner or family member) or community members who are in the city awaiting their respective confinement for delivery. The absence of choice in being able to deliver elsewhere was notable across the literature on this topic (Lawford and Giles 2012a). This lack of options rang particularly strong given the ongoing popularization of midwifery and doula services among non-Indigenous women living in the city. Does the lack of institutional support for Indigenous midwifery and birthing in community relate to issues of racism, sexism, both, or neither? Despite broad consensus from established (mainly biomedical) organizations, organizational barriers in the delivery of health services to remote communities appear to persist in supporting Indigenous-led birthing services. This could be an area for further investigation.

Several qualitative studies describe the physical, emotional, and financial stresses contributed to the negative experiences of Indigenous birthing persons (Chamberlain and Barclay 2000; Kornelsen et al. 2010). Having to leave their other children behind was often cited as the cause of significant emotional distress and logistical hardships (Chamberlain and Barclay 2000; Kornelsen et al. 2010). Boredom and disconnection were described as affecting their time in the city. The financial cost of staying in the city or bringing support people with them were routinely reported in these first-person accounts (Chamberlain and Barclay 2000; Kornelsen et al. 2010). In worst-case scenarios, some Indigenous women needed to turn to gang recruitment and sex work to survive while awaiting the onset of labour away from their homes (Lawford et al. 2019). More broadly, experiences of anti-Indigenous racism when receiving care outside of their communities were reported as negatively impacting their birthing process (Vang et al. 2018).

Governments are important actors in this policy. Provincial governments provide the funding and infrastructure for the hospitals and health care professionals who provide the obstetrical care that Indigenous women are flown to. The federal government is involved through the funding of medical transportation for Indigenous women and their support persons, and through the provision of health care in nursing stations situated in remote Indigenous communities. More distal actors include the broader Indigenous communities, the non-Indigenous health care professionals involved, the organizations in charge of housing and feeding Indigenous women while they await labour, civil societies who may be involved in advocating for Indigenous women or provide social services for them, and professional organizations like the Society of Obstetricians and Gynaecologists of Canada or the Aboriginal Council of Midwives.

Indigenous actors should be central and at the forefront of this policy area, supported by current proximal actors such as the involved governments and biomedical health care providers. As shown by the high satisfaction reported after receiving culturally safe birthing services directly in community, Indigenous self-determination in reforming maternity care to Nations-specific needs would improve experiences of pregnancy and childbirth for many Indigenous people (Chamberlain et al. 1998). However, due to fluctuations in allocated resources, programming to support birthing in community has varied over time. Currently, the most notable examples of sustainable self-determined Indigenous obstetrical services exist in Nunavik and the James Bay Cree Nation (Cree Board of Health and Social Services of James Bay 2018; Longchap 2022).

2.1.4 Process

Despite the use of a decentralized model within the federal country that is known as Canada, every participating health care authority adopted their version of expatriating birth away from First Nations and Inuit communities. This was done incrementally, through gradual changes over time which led to the ultimate implementation of clinical guidelines, such as the aforementioned *First Nations and Inuit Health Branch Clinical Practice Guidelines for Nurses in Primary Care* (First Nations and Inuit Health Branch 2011), advising the transfer of every pregnant person to the nearest urban centre to await childbirth.

When interviewing First Nations women in Manitoba, a common theme of feeling resigned emerged, with many interviewees stating there was no other choice or possibility when delivering their babies (Lawford et al. 2018). Nonetheless, participants speaking to Lawford et al. (2018) demonstrated inexorable resilience in withstanding these forced evacuations, and themes of resistance to the policies emerged as they questioned the necessity of the status quo. Yet, reversing this established policy and enacting a completely different approach to obstetrical care for women in remote Indigenous communities represents a formidable task.

Historical institutionalism, or the way decisions in the past influence processes in the present, can create a type of policy inertia that makes it harder to enact policy change when

something has been done a certain way for a long period of time (Browne et al. 2019). The power dynamic between Indigenous communities and the governments that serve them may also contribute to the policy inertia being observed when it comes to maternal evacuation policies. The conflicting responsibilities between provincial and federal governments in providing health care services to Indigenous communities may contribute to impasses when looking to provide support for Indigenous-led initiatives to return birthing to communities for low risk-deliveries and better integrate Indigenous midwifery into the health care system.

2.2 Multiple streams framework

The multiple streams framework (MSF) is a useful tool to elucidate the factors underlying outlined policy change impasses. The MSF states that the convergence of an established problem, a known solution (policy), and the right political context may create a window of opportunity for potential policy-making or policy change (Browne et al. 2019). When all three do not come together at the same time, policy inertia continues. Although prominent biomedical organizations have issued calls to accommodate birthing practices in community, few services exist in alignment with their supportive stances.

2.2.1 Problem

Problems are policy issues deemed to require attention by stakeholders. Loss of Indigenous culture, disconnection from community and land, and inequities in obstetrical outcomes represent significant policy issues recognized by Indigenous scholars (Lawford and Giles 2012a). However, viewing these issues from a settler colonial mindset has resulted in one seeing the transfer of Indigenous women to Euro-Canadian biomedical hospitals as appropriate and desirable. When the practice was implemented and included all women regardless of risk profile, it was framed as offering Indigenous women the same quality of care as non-Indigenous women (Olson and Couchie 2013).

The contrast between the Euro-Canadian biomedical and the Indigenous perspectives highlights the importance of problematization – i.e., defining what is a problem – in policy-making. Without an adequate understanding of Indigenous epistemologies, displacing someone from their community for an important life event that would normally be underlined with Traditional ceremony and community may not seem like a problem. Pushing this idea further, someone with a colonial mindset would consider the loss of Traditional Healing and Knowledge for the Euro-Canadian biomedical model of care as a positive if they believe in the supremacy of the Euro-Canadian biomedical model. Certainly, under the hegemony of Euro-Canadian biomedicine, the centralization of care to cities is necessary to perform specialized skills such as cesarian sections at a rate that maintains provider proficiency in the technique due to higher procedure volumes. However, this way of thinking fails to recognize the rights of Indigenous Peoples to regain and assert their culture in every aspect of their lives. Indigenous midwives and Traditional Healers safely assisted women in their

childbirth since time immemorial. With increasing visibility and awareness of the colonial harms of maternity evacuation policies, the problem of loss of culture, community, land, and ceremony relative to birthing may become increasingly apparent.

2.2.2 Policy

Indigenous scholars and select Indigenous communities have offered solutions to the emotional, financial, spiritual, and physical issues resulting from the maternal evacuation policy. These solutions entail returning birthing to communities (Lawford and Giles 2012b; Lawford et al. 2018). Official consensus between Euro-Canadian biomedical organizations and Indigenous organizations states that supporting communities and training Indigenous midwives should be priorities in the way we move forward in providing care to Indigenous women (Society of Obstetricians and Gynaecologists of Canada 2017).

Successful examples of Indigenous self-determination in reproductive mobility policies have emerged in Nunavik and Manitoba (Cidro et al. 2020). Indeed, Hayward and Cidro (2021) describe how efforts to return birth to community in Manitoba align with the United Nations Declaration on the Rights of Indigenous Peoples and the United Nations Sustainable Development Goals. Modelled on the decades of successful care at the Puvirnituq Maternity Centre in Nunavik, the James Bay Cree Nation have seen their birthing services flourish and expand with the positive response from community members (Cree Board of Health and Social Services of James Bay 2018; Longchap 2022).

Despite these compelling cases, supporting Indigenous midwives has not been central to governmental agendas. Indigenous communities are far from being a monolith and span across the second largest geographical country in the world. Each community will require its own policy distinctions-based or Nations-based solution, thus planning to set up the appropriate human and health resources to support birthing in their communities. Some Indigenous women will likely want to deliver in the cities given the established norm that has persisted through the decades and their choice should be respected and supported.

2.2.3 Politics

Although the problem is becoming more recognized by biomedical organizations and the solution has been laid out by prominent actors in the field, political will within federal and provincial/territorial governments to tangibly address issues with maternal evacuation of Indigenous mothers has not been particularly strong. Perhaps the recent attention garnered by the National Inquiry into Missing and Murdered Indigenous Women and Girls and 2SLGBTQI+ people will bring greater attention to issues affecting the health and well-being of Indigenous women. Strong Indigenous advocacy and agency within this policy area would help to ameliorate the inequities experienced by Indigenous women who are subjected to astounding levels of marginalization through their life course.

The Rt. Hon. Paul Martin explained that the Kelowna Accord stemmed from a clear

understanding that Indigenous Peoples would be best positioned to govern their own issues (Martin 2021). This approach to consensus building when searching for policy solutions has been applauded as an insightful and appropriate process (Alcantara and Spicer 2015). Centring Indigenous voices in the development of de-colonial policies for maternity care will be key to improving the health and wellbeing of Indigenous women and two-spirited people in Canada.

3 CONCLUSION

Indigenous birthing is fraught with challenges that stem from decentralized provincial/territorial governance while the federal government continues to maintain responsibility for First Nations and Inuit peoples. When describing the eras of health care governance, the dispossession and dismissal of Indigenous Traditional Knowledge remains unacknowledged (Berwick 2016). However, the return to Traditional Ways of Knowing and the integration of Indigenous Knowledge and culture have been cited as crucial prerequisites to the improvement of Indigenous Health (Phillips-Beck et al. 2020). Furthermore, narrowing the gaps of inequality have been shown to improve the health of entire populations and societies (Pickett and Wilkinson 2015). As shown in James Bay, Manitoba, and Nunavik, Indigenous self-determination in returning birth to community and supporting Indigenous midwifery practices is the path forward to a more equitable and de-colonial health care system in Canada.

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