Understanding the Experiences and Processes of Health Canada's Evacuation Policy for Pregnant First Nations Women in Manitoba

by

Karen Lawford, R.M., A.M.
Masters of Arts, University of Ottawa, 2011
Bachelor of Health Science (with distinction), Midwifery, McMaster University, 2005
Bachelor of Science (Honours), Chemistry and Environmental Resource Science,
Trent University, 1999

Supervisors: Dr. Ivy L. Bourgeault, Ph.D. and Dr. Audrey R. Giles, Ph.D. Committee Elder: Paul Chartrand, B.A., LL.B. (Hons), LL.M Committee Member: Dr. Cecilia Benoit, Ph.D. Committee Member: Martha Jackman, B.A., LL. B., LL.M. Committee Member: Dr. Denise Spitzer, Ph.D. Internal Committee Member: Dr. Wendy Peterson, R.N., Ph.D. External Committee Member: Dr. Colleen Varcoe, Ph.D.

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Abstract

First Nations women who live on reserves receive maternity care from a variety of government health care systems: Federal, provincial, and municipal. At first glance, this seems like an abundant amount of health care; however, the lack of coordination has led to poorer outcomes as demonstrated for example by the twofold IMR for First Nations on reserves compared to that of non-Aboriginal populations. To inform discussions and changes to health care policy and programming for maternity care for First Nations on reserves, my dissertation focuses on Health Canada's evacuation policy within the province of Manitoba. It describes how First Nations women journey among these three health care systems in the provision of that care. This federal policy instructs federally employed nurses to arrange for the transfer of pregnant First Nations women who live on rural and remote reserves to an urban – and usually southern – location so that the women can receive labour and birthing services. Women are evacuated out of their home communities between 36 and 38 weeks gestational age and wait in the city, often alone, for labour to start. While there is a general understanding of how different elements of this federal policy work, there is no literature that describes its execution in detail nor in full. To address this critical knowledge gap, my dissertation consists of three stand-alone papers. For the first paper, "This Policy Sucks and It's Stupid: Mapping Maternity Care for First Nations Women on Reserves in Manitoba," I used intersectionality, institutional ethnography, and semi-structured interviews to produce a descriptive and visual map of the evacuation policy. Using intersectionality and a case study approach, the second paper, "Health Canada's Evacuation Policy for Pregnant First Nations Women in Manitoba: Resignation, Resilience, and Resistance," semi-structured interview data are analyzed

through a thematic analysis to understand the experiences and perspectives of First Nations women, family, and community members. I argue for the development of a specific theoretical framework that makes explicit the specific legal and policy influences particular to First Nations women who live on reserves in the third paper, "The Legal Categorization of First Nations Women in Health: The Need for a First Nations Feminist Theory." Taken as a whole, these three papers address some of the knowledge gaps related to maternity care services for First Nations women once they are evacuated. They also situate these gaps within the legal context of health care for First Nations women so that tangible improvements can be made.

Dedication

I dedicate this dissertation and every publication that comes out of this research to the First Nations women, family, and community members who shared their experiences of the Health Canada's evacuation policy with me. First Nations women are fierce, determined, and courageous souls. I dedicate my life and my heart to them. Kiitchi meegwetch with all my heart.

Impetus

After I had finished my Master's of Arts, I asked my mom and Elijah for direction. Should I find a job in public service or get a Ph.D.? My mom said to ask Elijah, who gave me very clear direction. He asked me to get a Ph.D. so that I can have the recognized credentials to offer expert advice for the improvement of maternity care services for those who live on reserves. Elijah was very aware that such credentials would also position my testimony as legitimate within in a court of law. I took this direction seriously and offer this dissertation as a demonstration of my commitment to Elijah's request.

Giving Thanks

To put into words my gratitude to the many people and organizations that have been with me during my doctoral degree is impossible. I know I will forget to acknowledge a kindness, a word of encouragement, and so many simple acts of support that kept me going during the many times I thought I needed to leave my program due to the financial challenges and feelings of inadequacy that are rife within academia. As such, the list of people and organizations that are mentioned below does not fully capture all of those who were with me along my doctoral journey.

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Staff with the Government of Manitoba and the Government of Canada: Various staff with

both provincial and federal governments spoke with me in person and on the phone to provide information and context related to Health Canada's evacuation policy. Thank you for your trust and confidence that my research project was an important contribution towards the improvement of maternity care services for First Nations on reserves.

Anna-Lise and Kieran: You are the most wonderful people to me and I am so very thankful you chose me to be your mother. You are my heart forever and ever.

Scholarships and Awards

Every scholarship and award that I received during my doctoral studies was most appreciated. Without these, I would not have been able to afford the most basic of necessities: food, utilities, and a home. Even feeding my children was sometimes a financial challenge. Scholarships and awards are what allowed me to stay school and complete this degree. Meegwetch.

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First Place

Dawn Walker Grant, Canadian Foundation for Women's Health

Personal Reflection

Kiitchi meegwetch for the academic opportunity to research and write about Health Canada's evacuation policy for pregnant First Nations women living on reserves in rural and remote regions of Manitoba. The extent to which this federal health policy has affected the roles and meanings of women, pregnancy, and birth within First Nations communities continues to shock me. After many conversations, I have found that we are at a point in time that some cannot even remember the truly important, powerful, and foundational roles of family, community, and nation. The ceremonies, rituals, and customs related to pregnancy, labour, and birth are not being practiced and embraced as a normal, routine, and celebrated part of health and wellness. Instead, there is an energy of survival and of conformity. This is understandable. It takes courage and support to actively live life in a way that reflects ways of being that are similar to our ancestors, particularly in the face of state sanctioned child apprehension under the guise of child welfare and policies of forced and coercive sterilization that are framed as reproductive choice. While there is courage in abundance, support is still being built. Meanwhile, federal and provincial government systems continue to create and recreate conditions of day-to-day living and purposefully remove health care services incrementally. It is no wonder health outcome measures for First Nations who live on reserves remain substantially different compared to that of white settler populations.

When I was reaching out for interview participants, people were helpful to the extent that they were able. The timing of my research coincided with a federal election, which pitted the Conservatives against the Liberals and NDP, and a provincial election that was largely between the NDP and the Conservatives. As a result, federal and provincial

public servants were very hesitant to speak with me and did so with anonymity. It seems that my research did not go unnoticed during these politically charged times, as I was contacted by a federal public servant within the NIHB Manitoba region who told me that I was wrong: there was no such thing as a federal evacuation policy. She recommended I change my research project so that I didn't embarrass myself and harm my academic reputation. While this woman's call was quietly but pointedly threatening my future employment and questioning my intellectual choices, I am certain she was pressured into making the call by those above her. Little did she know that her words only convinced me to be more meticulous and careful with my descriptions of Health Canada's evacuation policy so that others who thought like her might be swayed to consider another perspective. In fact, during the final stages of my dissertation, I published a paper that is not part of this dissertation, but which contributes a policy tool that can be used to identify invisible polices, the first of its kind within the literature: Lawford, K. (2016). Locating invisible policies: Health Canada's evacuation policy as a case study. Atlantis: Critical Studies in Gender, Culture & Social Justice, 37, 2(2), 147-160. I provide this reference not to flaunt what I believe to be true, but rather to generate discussions about the transparency – and the notable lack of transparency - of policy making that affects First Nations who live on reserves.

Personal Introduction

I introduce myself to situate my scholarship, responsibilities, and obligations within all my relations (Kovach, 2009; Lavallée, 2009; McCaslin & Breton, 2008; Monture-Angus, 1995; Steinhauer, 2002; Wilson, 2008, 2001; Wright Cardinal, 2016). I am the grand-daughter of Dedibaayaanimanook Sarah Keesick Olsen. Namegosibiingonjii Dedibaayaanimanook. Gaaminitgwashkiigaanig gii' izhinitaawigi. Odeden, omishoomenzha'gayeomishoomisan, Giizhiggaagiiizhinikaazonij, gakinagii' onjiiwaa' Namegosibiing. Gaye odaanikoobidaaganan, Jiiyaangaagii' izhinikaazonij, Namegosibiinggewiingii' onjiiwan. Apiimewinzhagakinaigiweniwaggii' izhidazhiikewag Namegosibiing. Wiingegii' onizhishinNamegosibmewinzha. Wiingeogii'zaagitoonaawa o-Namegosibiimiwaa. Wewenigayeogii' ganawendaanaawaa. Dedibaayaanimanookomishoomisan,Giizhig,gii' ikidooniijaanisa' iidibendamowaajNamegosib.

I am an Aboriginal midwife from Namegosibiing (Trout Lake, Lac Seul First Nation, Treaty 3) and a registered midwife (Ontario). I follow this course of self-location and self-identification as a public acknowledgement of my health care training, which was largely focused on the Euro-Canadian biomedical model. My self-location also demonstrates an accountability for my work, since my research will create knowledge and situate that knowledge within a First Nations perspective and introduces and makes legitimate First Nations' viewpoints (Kovach, 2009; Monture-Angus, 1995) concerning the evacuation policy, one that names maternal health care for First Nations women as a component of Canada's ongoing colonial agenda.

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List of Acronyms

Acronyms

FNFT – First Nations feminist theory

FNIHB – First Nations and Inuit Health Branch

WRHA – Winnipeg Regional Health Authority

Chapter 1: Introduction

Purpose of the Research

There is a serious and significant information gap in the most every day and regular of occurrences of life in Canada: giving birth. This is particularly notable for First Nations women giving birth and the processes associated with Health Canada's evacuation policy for First Nations women who live on reserves. Every day, First Nations women are evacuated from their rural and remote reserve communities between 36 and 38 weeks gestational age and travel to urban centres to wait for labour to start so they can give birth in a hospital. This is a regular occurrence because it happens to First Nations women who live in rural and remote areas all across Canada. The lack of details that explain how this federal policy actually works is shocking and perhaps even negligent. How is any health care system able to plan for the necessary maternity care resources - especially in the midst of a national maternity care crisis (de Leeuw, 2016; Grzybowski, Stoll, & Kornelsen, 2011; Kornelsen, Kotaskan, Waterfall, Willie, & Wilson, 2011; Lisonkova, Sheps, Janssen, Lee, Dahlgren, & MacNab, 2010; Ontario Maternity Care Expert Panel, 2006; Smith, Brown, Stewart, Trim, Freeman, Beckhoff, & Kasperski, 2009; Society of Obstetricians and Gynaecologists, 2008; Sutherns & Bourgeault, 2008) - when there is little to no information about the processes related to the longstanding and routine evacuation of pregnant First Nations women? Indeed, that Canada has such a crisis indicates there is little in the way of planning or foresight that considers the maternity care needs for any group of women. Instead, these services are reactionary and strained, which in turn contributes to burnout, an unstable workforce, and costly overtime (Kornelsen, 2003; Kornelsen, Anhorn, & Grzybowski, 2005; Kornelsen & McCartney, 2015). My doctoral dissertation, which takes the format of publishable papers, is offered as a small, but significant, contribution to

filling this knowledge gap. Through the production of three independent but interwoven papers, research addressed two research questions: How does Health Canada's evacuation policy work in Manitoba?; and How is the evacuation policy experienced by First Nations' women, their families, their communities? As a result, I mapped Health Canada's evacuation policy in Manitoba, I described the experiences of First Nations women and community members, and, finally, I argued for the articulation of a First Nations feminist theory.

Overview of the Evacuation Policy for First Nations on Reserves

In 1892, the Government of Canada decided that two physicians should start providing obstetrical care on a reserve in Ontario (Lawford & Giles, 2012a). This was not a benevolent decision; rather, it was a way to introduce "state sanctioned medical authority over First Nations women with the intention to end long-standing First Nations pregnancy and birthing practices in favour of a Euro-Canadian biomedical model of care" (Lawford & Giles, 2012a, p. 332). The Government of Canada expanded obstetrical care to reserve communities all across Canada and also introduced other Euro-Canadian bio-medically trained providers such as midwives and nurse-midwives to those who lived on reserves. Over the decades and in conjunction with national efforts to get rid of Canada's "Indian problem" (Campbell Scott, 1920, para. 1) through assimilatory techniques such as mandatory attendance at a Indian Residential School (Truth and Reconciliation Commission of Canada, 2015), federal government bureaucrats and health care providers purposefully and methodically pressured First Nations to change their maternity care practices (Lawford & Giles, 2012a). At first, labour and birth were moved from the outdoors and within communities into nursing stations and then into federally run hospitals. When federal hospitals closed, labour and birthing services were shifted into provincially run hospitals, which were often at a great physical distance from reserve communities.

The historical context of the shifting the location of birthing on the land and in the community described above has culminated in what is contemporarily known as the evacuation policy (Baskett, 1978; Bellrichard, 2014; Gallagher, 1997; Jasen, 1997; Kaufert, Koolage, Kaufert, & O'Neil, 1984; Lalonde, Butt, & Bucio, 2009, Lawford, 2016; Lawford & Giles, 2012a; 2012b; Phillips-Beck, 2010; Wiebe, Barson, Auger, Pijl-Zieber, & Foster-Boucher, 2015). This federal policy instructs nurses to "arrange for transfer to hospital for delivery at 36–38 weeks' gestational age according to regional policy" (Health Canada, 2011, p. 12-6). As a result, all First Nations women who live on rural and remote reserves are relocated to urban cities, most of which are located in southern Canada, and wait for labour to start so they can be admitted to hospital for birthing services. Surprisingly, very few details about the evacuation policy have been documented. In response to this substantial information gap, I undertook this doctoral research project to provide details of the evacuation policy with a focus on the province of Manitoba. As I detail more fully below, I chose Manitoba primarily because most women are evacuated to Winnipeg and there is large on reserve population in the province's North.

To understand the focus of my doctoral project, an overview of the health services provided to First Nations on reserves within the provinces¹ in Canada is first required, as these are uniquely constructed. The Government of Canada, through the First Nations and Inuit Health Branch (FNIHB) of Health Canada, provides primary health care services to First Nations who live on rural and remote reserves. Community health nurses employed by the federal government use Health Canada's Clinical Practice Guidelines for Nurses in

Primary Care to provide primary care services for on reserve populations, of which prenatal and post partum care is a component. Labour and birthing services, however, are not components of these primary care services, so First Nations women are evacuated out of their communities between 36 and 38 weeks gestational age. When any First Nations person leaves her/his reserve community to receive care, the care is provided by provincially employed caregivers; thus, First Nations engage with the provincial health care system. While in the city, a First Nations person may receive municipal health services, such as vaccinations, which are provided by municipally employed public health nurses. Unfortunately, the provision of health care services across these three health care systems – federal, provincial, and municipal – is neither seamless nor coordinated. In fact, the lack of coordination of these services has received a great deal of attention from the Commission on the Future of Health Care in Canada & Romanow (2002) and the Office of the Auditor General of Canada (2015). Uncoordinated services, fragmented funding, incomplete mandatory training of federally employed nurses, health workforce shortage, socioeconomic inequalities, and geographic isolation (Commission on the Future of Health Care in Canada & Romonow, 2002; Maar et al., 2013; Office of the Auditor General of Canada, 2015) all contribute to less than optimal health outcomes for First Nations.

The health of First Nations is not just affected by health care systems but also by purposeful and coordinated efforts led by the Government of Canada to civilize and assimilate Indigenous peoples into the generic Canada body. Through the substantial power of the law of the constitution, the *Indian Act* was introduced in 1876, a piece of legislation that controlled every aspect of those that lived on reserves. For example, in 1920, the *Indian Act* was amended to make attendance at residential schools mandatory. It is through

the Royal Commission on Aboriginal Peoples (1996) and the Truth and Reconciliation Commission of Canada (2015) that we are just beginning to learn the depths to which the Government of Canada and many Christian organizations aggressively worked together towards the destruction of Indigenous peoples – their identities, cultures, practices, traditions, and knowledges.

Maternity Care on Reserves

Chapter 12 of Health Canada's (2011) Clinical Practice Guidelines for Nurses in Primary Care provides detailed information about the obstetrical care that First Nations women are to receive from federally employed nurses. After women are evacuated out of their reserve communities between 36 and 38 weeks gestational age to receive care in urban centres for labour and birth services, these details stop being provided. This glaring absence of information near the end of a pregnancy does not make sense, since this is a time when prenatal care increases in frequency to weekly and even twice weekly appointments. The Manitoba Minister of Health acknowledged there were gaps in information, so it dedicated resources to improve health experiences of

expectant women who relocate from First Nations, Inuit and Métis communities and rural/remote communities for extended periods of time to give birth [in Winnipeg so they] have access to a coordinated system of prenatal and social support coordinated system of prenatal and social support. (Maternal and Child Healthcare Services [MACHS] Taskforce, 2008, p. 2)

The MACHS Taskforce recognized that without clear policies, procedures, and communication between the three health care systems, the maternal and child healthcare services offered in Manitoba were less than optimal. Unfortunately, when the Minister of

Health, Theresa Oswald, resigned from her position in 2014, the momentum of MACHS to effect change disintegrated. Indeed, unclear or unavailable policies, models of care, and guidelines used to support the evacuation of First Nations women makes it challenging, if not impossible, to know where maternity care services can be improved. My goal with my doctoral research was to contribute important information to the maternity care knowledge gap for First Nations who live on reserves in Manitoba.

Theoretical Framework

To make sense of the maternity care services received by First Nations women who live on rural and remote reserves, I chose intersectionality to underpin the research and analysis presented in my doctoral dissertation. This theoretical approach was first described by Crenshaw (1989) to make evident the synergistic interactions among race, gender, and political positioning, which result in the systemic subordination and marginalization of Black women in the United States. The particular context of its development was in response from "a scholarly movement born in the legal academy committed to problematizing law's purported colour-blindness, neutrality, and objectivity" (Nash, 2008, p. 2). Crenshaw's important and pivotal contribution to critical anti-racist feminist theorizing "provided a name to a pre-existing theoretical and political commitment" (Nash, 2008, p. 3), a legacy upon which social science research flourishes.

Since its initial articulation, this theoretical framework has been used to reveal the ways that multiple systems interact with each other to position specific groups of people as inferior to a dominant ruling class, which helps to contextualize the poor health experiences and outcomes of specific populations, including Aboriginal women (de Leeuw & Greenwood, 2011; Dhamoon & Hankivsky, 2011; Hankivsky, Reid, Cormier, Varcoe,

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Clark, Benoit & Brotman, 2010; Hole et al. 2015; Van Herk, Smith, & Andrew, 2011). de Leeuw and Greenwood (2011), for example, used intersectionality to explicitly name the construction of Indians as "an act of colonial conceit predicated on assumptions that any person who was not a Eurocolonial settler was a member of a homogeneous and static 'Other' group" (p. 58). This homogenization facilitated government-led efforts to deploy national efforts to civilize this constructed Other, which had significant and negative intergenerational health effects on First Nations. I felt at the onset that it was through the employment of an intersectional lens that the poor health outcomes and measures associated with First Nations women could be therefore be understood as multiple, nuanced, and synergistic.

The primary legislative tool that the Government of Canada used to gain control over the lives of First Nations was the *Indian Act*. Using the power of the law of the constitution, the federal government leveraged this piece of federal legislation to ensure it would have complete control over the lives of Indian peoples (Hart & Rowe, 2014; Palmater, 2011). The *Indian Act* was also used to purposefully undermine the rights and roles of Indian women and as a result, only men were recognized as independent holders of rights and identity (Boyer, 2006). This inequality between women and men was a direct reflection of British common law, which positioned "women as having no social or legal status, but as chattels and dependent first on their fathers and then their husbands" (Boyer, 2006, p. 11). Consequently, societies that were matrilineal and/or matriarchal were not legally recognized by the Government of Canada. Through the *Indian Act*, a variety of interwoven assaults on Indian peoples have culminated in substantial inequalities between those who fall under this *Act* and those who do not.

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In addition to experiencing this legal discrimination, First Nations women are positioned within the literature as the embodiment of a risky maternal body – one that has resulted in a two-fold infant mortality rate (IMR) for First Nations in comparison to the non-Aboriginal population. Indeed, First Nations women are frequently described as epitome of risk and danger because of high rates of disease entities like gestational diabetes (Dyck, Klomp, Tan, Turnell, & Boctor, 2002) and cervical cancer (Browne & Fiske, 2001). Adelson (2005) has reminded people to be mindful that observed "health disparities are related to economic, political and social disparities – not to any inherent Aboriginal trait" (p. S45). It is no wonder these influences effect the health and wellbeing of First Nations women to converge in health outcomes that are less than optimal. It is because of these various influences that I chose intersectionality as my theoretical approach since these influences cannot be understood in isolation from each other.

For example, the federal government used its substantial power and authority over Indian peoples to infiltrate "First Nations' ways of knowing and wellbeing and replaced them with a knowledge base grounded in the Euro-Canadian biomedical model, thus promoting colonial goals of civilization and assimilation for First Nations people" (Lawford & Giles, 2012a, p. 335). By forcibly inserting the Euro-Canadian biomedical model of care during pregnancy and childbirth, First Nations women's bodies became one of the sites upon which Canada's colonial goals of civilization and assimilation could be realized. This colonial project has culminated in the routine and blanket application of Health Canada's evacuation policy for pregnant First Nations late in their pregnancy. Women living on rural and remote reserves are physically removed from their family and community supports into urban centres where they wait, alone, for their labour to start so

they can be admitted to hospital to receive birthing services.

The multiple points of marginalization that First Nations women experience during their pregnancy has been examined by others using intersectionality. Van Herk, Smith, and Andrew (2011), for example, chose

an intersectionality paradigm [as it was] particularly important for understanding and explicating Aboriginal women's [healthcare] experiences, whose stories have been shaped by the intersecting forces of colonization, confiscation of traditional land bases, forced assimilation, residential schools, patriarchy, and the ongoing removal of Aboriginal children from their homes. (p. 33)

Through the course of my research, I found that the legal underpinnings of health care for First Nations on reserves becomes underplayed when intersectionality is used as the theoretical approach. As such, I argued that the legal aspects are the most influential and as such, require a First Nations feminist theory that foregrounds the *Indian Act* to explain the circumstances that led to the Government of Canada delivering health care for First Nations women living on reserves and the significance of such decision-making.

Methodology

Institutional Ethnography

In the first publishable paper in this dissertation, I used institutional ethnography (IE) to develop the descriptive and visual maps of the evacuation policy in Manitoba, as it has been used to understand a variety of health care systems (Bisaillon, 2012; Nichols, Fridman, Ramadan, Jones, & Mistry, 2015; Rankin, 2015). For example, Nichols and colleagues (2015) employed IE to map "all of the things parents do to support the health and well-being of their children" (p. 3) to better inform and improve the health care

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systems related to children. Rankin (2015) used IE to map the care experiences of an elderly woman with cancer while she was in the hospital. Through the process of developing the map, Rankin (2015) found that rather than accentuating patient-nurse interactions, the growing inclusion of computerized systems to chart and communicate among various health care providers overshadowed and sometimes replaced these vital components of nursing care. Bisaillon (2012) also used IE to map the complicated administrative and health care systems that HIV positive immigrants navigate as part of their refugee applications in Canada. Her research found "medical testing is evidently among the highest of government priorities" (p. xl), which introduced "systems of surveillance, tracking, and recording of immigrants with HIV" (p. 271), findings that challenged and are in contradiction with Canada's image of humanitarianism and benevolence. These three examples show that as a methodological tool, IE can be employed to make sense of macro and micro health care systems, and it is therefore a useful tool to make sense of the evacuation policy for First Nations women who live on reserves in Manitoba.

Despite the utility of IE, it is a challenging methodology as it produces inherently complex and contradictory information due to the many relationships among interview participants, textual information, and influencing systems outside of the immediate focus of inquiry (Bisaillon, 2012). Such complexity is managed by placing the descriptions and experiences of the users of the health care system as front and centre. This approach is informed from the users of a system, which "is a distinctive feature of institutional ethnography" (Campbell & Gregor, 2002, p. 86). By untangling the complexities of the

health care systems that provide maternity care to First Nations women with the use of IE, improvements can be made to these systems as the shortfalls become apparent.

I was also drawn to the use of IE within my own scholarship as this methodology can also be used to recognize that those conducting the research bring their own knowledge to the project and have life histories that affects the research itself (Campbell, 1998). Indeed, I am a registered midwife (Ontario) and an Aboriginal midwife (Namegosibiing -Lac Seul First Nation, Treaty 3). Although I have not lived on my reserve community or indeed on any reserve, I am compelled to dedicate my life to improving the health care services that First Nations women receive in pregnancy. I made this decision after I realized that it was difficult - or rather impossible - to provide midwifery services on reserves despite the profession being recognized as a regulated and publicly funded primary health care profession. The purposeful decision to be actively engaged with my research aligns with Wilson's (2008) descriptions of Indigenous research methods, which are premised on the idea of relationality, that is "relationships do not merely shape reality, they are reality" (p. 7). IE is thus compatible with Indigenous research methodologies as well as offering a methodological tool to generate a map of Health Canada's evacuation policy.

Manitoba as the Qualitative Case Study

In the second publishable paper in this dissertation, I employed a qualitative case study approach and used the approach described by Stake (2005), which uses many sources of data to understand "real life situations" (Boblin, Ireland, Kirkpatrick, & Robertson, 2013, p. 1270) and to determine how these situations function (Boblin et al., 2013).

The provision of maternity care to First Nations women on reserves during a particular period of time within the province of Manitoba comprised the case study. Like any other methodology, a case study approach has strengths and weaknesses. One strength of a case study approach is that the results are contextual, thus allowing "for a holistic understanding of a phenomenon within real-life contexts from the perspective of those involved" (Boblin, Ireland, Kirkpatrick, & Robertson, 2013, p. 1268).

The research that I conducted for the second paper was bounded by the physical and political borders of Manitoba, so that the ensuing results were specific to one location. This approach allowed me to reflect on the complexities and nuances specific to evacuation within one Canadian province. For example, initial information suggested First Nations women living in Manitoba were all evacuated to Winnipeg. Interviews with women and community members, however, revealed that women are also evacuated to The Pas and Thompson. Pimicikamak Cree Nation members and everyone living north of this community are evacuated to Thompson. Members of Norway House, Churchill, the Island Lake Tribal Council, and those living south of these areas are evacuated to Winnipeg. The Pas provides care to women from Chemawawin, Grand Rapids, Moose Lake, and Pukatawagan. All women with a high-risk pregnancy, however, were evacuated to Winnipeg, as it is home to the province's only tertiary level maternity care unit.

Another benefit of a case study is that when information is found but is outside the research questions, it can still be incorporated into the case findings (Boblin et al., 2013). By using the case study, I left myself open to finding something unexpected or different than anticipated. For example, I gave room for women or families to report that evacuation

is a process this is positive to their maternity care experience; however, that did not happen.

A weakness of a case study is the inability to extrapolate the research findings beyond the boundaries of the research project, and as such, the findings within my second paper may or may not be applicable to other provinces or territories.

Data Collection, Coding, Analysis, and Mapping

I gathered information from semi-structured participant interviews and documents within the public domain that described maternity care services for First Nations on reserves.

Participant Recruitment

I contacted three categories of informants for interviews: First Nations women and members of their communities; politicians, policy makers, and government officials at the federal, provincial and municipal levels; and health care providers working on reserve and in urban referral centres. My rationale for choosing these three categories of informants was based on a research goal to clarify the evacuation policy in Manitoba from a variety of perspectives but to also maintain the experiences of the First Nations women and members of their communities as central to the process. This approach is aligned with institutional ethnography, a methodology that is used to describe the actual ways that a policy is experienced, compared to the textbook descriptions of the policy (Bisaillon, 2012; Campbell, 1998; Smith, 2006; Walby, 2013).

To connect with First Nations women and community members who have experienced the evacuation policy, I emailed a letter of introduction and participant recruitment letter to every First Nations organization in Winnipeg that had a health

department. I also emailed recruitment letters to First Nations communities throughout Manitoba and First Nations leadership (n=42). I directly emailed a request for an interview to politicians, policy makers, physicians, obstetricians, midwives, nurses working on and off reserves, and government officials (n=103). I searched federal, provincial, and municipal staff databases for names and positions related to health care on reserves. I also searched the following websites to identify potential participants: University of Manitoba, College of Physicians and Surgeons of Manitoba, the Manitoba College of Family Physicians, College of Registered Nurses of Manitoba, and College of Midwives of Manitoba. On occasion, snowball sampling (Emmel, 2013) occurred, which resulted in additional participants who were referred by others who knew of my research project. I conducted a semi-structured interview with every person who wanted to participate.

Semi-structured Interviews

I conducted semi-structured interview with each participant using a series of open-ended questions that I provided in the letter of introduction (Appendices B & C). This interview approach was chosen as the semi-structured interview's "protocol is designed to be cumulative and iterative. It creates the space for a continuum of structure. What the participant narrates and how that narrative unfolds inform the remaining segments of the interview" (Galetta, 2012, p. 72). I asked open-ended questions "to create space for participants to narrate their experiences; however, the focus of the questions is very deliberate and carefully tied to [my] research topic" (Galletta, 2012, p. 47).

Each interview began with an explanation of the research, the purpose of the interview, a review of the consent form, and a description of the transcription verification process. Every participant was told that if she/he wished or if she/he changed their

inclusion decision, the interview would be excluded from the project. The only point at which the interview data could not be excluded was after public dissemination, such as through an article or presentation. I encouraged participants to ask me any question, however personal, as a way to develop trust. Since I am an Aboriginal midwife but not from a community in Manitoba (my family is from Lac Seul First Nation, Treaty 3 in Ontario), I did this to develop both rapport and relationality, an important component of Indigenous research (Wilson, 2008). By explicitly creating an opening for discovering me through personal questions, I was "put into relationship through mutual friends or even through knowledge of certain landmarks, places or events [as] shared relationships allow for a strengthening of the new relationship" (Wilson, 2008, p. 84). Before the interview started, I provided each person with a \$25 honourarium. If the honourarium was declined, the money was donated to Got Bannock, an organization that distributes bannock and other food to homeless people in Winnipeg.

After I obtained consent by signature or by verbal agreement, the interviews began and I digitally recorded them. In total, I interviewed 32 participants in person (Winnipeg 7 female/4 male and Ottawa 1 female), on the phone (17 female/2 male), or through written correspondence (northwestern Manitoba 1 female). One male participant that spoke with me was a child of an evacuee and he wanted me to hear the story of his experience of being apprehended at birth, placed into a white family, and then taken out of the country. I draw attention to the experience of this one man to highlight the fact that I did try to recruit men to talk about evacuation as well as to underline the paucity of responses from men. The number of male participants is noteworthy because it points to a possibility that men are

not involved in their partner's or family member's pregnancy. Could it be that men did not want to talk about an issue that was perceived to be within the realm of a woman's issue?

Interviews took between 30 minutes to 120 minutes, and I interviewed each participant once. All interviews were transcribed verbatim, except for the one written response. I emailed interview transcripts to each participant via password-protected documents or mailed by Canada Post for review. I gave each participant two weeks to review the transcript with the caveat that extra time would be provided should it be needed. No one requested additional time to review her/his/their transcript. I applied every requested change to the final transcripts, which I then entered into NVivo for coding and analysis. Requested changes were mainly requests for omission of personal or community-specific information. All informants are referred to by their first name unless they requested to be anonymous, which is indicated as such.

Document Collection

I included in my data collection all documents within the public domain that described any aspect of processes related to the evacuation policy for First Nations women in Manitoba and in Canada. I reviewed peer reviewed literature, grey literature, conference proceedings, and materials from government and non-government organizations that described the evacuation policy in Canada to inform the construction of the visual representation of the policy and the descriptive map for the paper focused on IE. Databases, such as CINAHL, MEDLINE, Scholars Portal, and Scopus were searched for literature using the following search terms: Aboriginal, birth, evacuation, Canada, First Nations, Indian, Indigenous, labour, Manitoba, policy, pregnancy, provincial, and travel. Each document was assessed against the research goals: to map Health Canada's evacuation

policy in Manitoba. Those relevant to the topic were included in the generation of the map.

I <u>excluded</u> any material from other provinces and territories, and information related to evacuation for reasons outside of maternity care, such as flooding, forest fires, or dialysis.

Data Management and Coding

I entered all the interview data into NVivo for coding and analysis. This qualitative data analysis software is commonly used in health science research (Woods, Paulus, Atkins, & Macklin, 2016). Instead of manually colour coding the interview data and then entering the information into a spreadsheet, which is the process described and utilized by Bisaillon (2012) in her IE analysis, NVivo permits the coding of each transcript directly within the software, where they can then be sorted accordingly. Notable quotes can also be captured, thus facilitating an amalgamation of analytical steps.

Data Mapping

For the first paper, I produced a descriptive and a visual map of Health Canada's evacuation policy as experienced by First Nations women in Manitoba. This was entitled: "This Policy Sucks and It's Stupid:' Mapping Maternity Care for First Nations Women on Reserves in Manitoba." I followed a mapping process that was described by Bisaillon (2012). The descriptive map linked the details of the processes that were provided by First Nations women and community members with the literature available in the public realm that is related to evacuation for birth. The visual map provided a one-page summary of the evacuation policy in Manitoba, which facilitated an at-a-glance understanding of the gaps in the maternity care services that are provided to First Nations women once they are evacuated.

Thematic Analysis

I used thematic analysis for the second paper: "Health Canada's Evacuation Policy for Pregnant First Nations Women in Manitoba: Resignation, Resilience, and Resistance" to analyze the interview data within NVivo. I used the six steps to thematic analysis that were described by Braun and Clarke (2006). Transcribing the digital interviews and reading the transcript several times was the first step. During this first step, I wrote down my initial coding ideas. In the second step, initial codes were formally developed by systematically reviewing the initial codes alongside the entire set of interview data.

Looking for themes amongst the codes was the third step, which were reviewed again in the fourth step. In the fifth step, the themes were labeled. The sixth and final step provided citations found within the interview transcripts that were related to the research questions; these were included in the final report.

As an analytical tool for organizing interview data, thematic analysis is well suited for my research because it is focused on understanding a health policy. In fact, Braun and Clarke (2014) position thematic analysis as "a really useful qualitative approach for those doing ... research that steps outside of academia, such as into the policy or practice arenas" (p. 2). Another strength is that thematic analysis is "not wedded to any pre-existing theoretical framework, and therefore it can be used within different theoretical frameworks" (Braun & Clarke, 2006, p. 81). A weakness is that when a data set is organized through a thematic analysis, "some depth and complexity is necessarily lost" (Braun & Clarke, 2006, p. 83). Overall, however, it is a functional and effective way of organizing interview data.

Ethics

My doctoral research project received ethics approval from the University of Ottawa – File number 05-15-26. I also met regularly by phone and in person with Paul Chartrand, a Commissioner with the Royal Commission on Aboriginal Peoples (RCAP, 1996), who is my doctoral committee Elder. It was through these lengthy conversations that I ensured my research project adhered to the Ethical Guidelines for Research that were described in RCAP (RCAP, 1996, vol 5).

Dissertation Format

My dissertation has been prepared in a publishable paper format with three standalone papers: 1. "'This Policy Sucks and It's Stupid:' Mapping Maternity Care for First Nations Women on Reserves in Manitoba"; 2. "Health Canada's Evacuation Policy for Pregnant First Nations Women in Manitoba: Resignation, Resilience, and Resistance;" and 3. "The Legal Categorization of First Nations Women in Health: The Need for a First Nations Feminist Theory." The first paper provides a descriptive map and a visual representation of the evacuation policy as practiced in Manitoba. Interview data from semistructured interviews informed this paper, as was information from peer reviewed literature, grey literature, and materials from government and non-government organizations that described the processes related to the evacuation policy. The second paper describes the First Nations women's and community member's experiences of the evacuation policy in Manitoba. From thematic analysis of these interviews, it is very evident the maternity care services that are provided to First Nations women after they leave their communities is woefully inadequate. The final paper argues for the need to develop a First Nations feminist theory to account for the specific legal context of First

Nations women, which substantially influences the health care that they receive and is a consequence of the *Indian Act* and power of the law of Canada's constitution.

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¹Health services for those living in the territories of Canada are not described here, as they are constitutionally different than the provinces.

Chapter 2

"This Policy Sucks and it's Stupid:"

Mapping Maternity Care for First Nations Women on Reserves in Manitoba, Canada

Abstract

Background: First Nations women who live on rural and remote reserves in Canada leave their communities between 36 and 38 weeks gestation age to receive labour and birthing services in large urban centres, which is in accordance with Health Canada's evacuation policy. Unfortunately, the process and administrative details of this policy are not documented, despite decades of relocation as a routine component of maternity care. Study design and data collection methods: Data were collected using a total of 32 semi-structured interviews with First Nations women and members of their communities; politicians, policy makers, and government officials at the federal, provincial and municipal levels; and health care providers both on reserve and in urban referral centres. Peer reviewed literature, grey literature, and materials from government and non-government organizations that described the processes related to the evacuation policy were reviewed to further construct a descriptive map and the visual representation of the policy.

Results: By mapping the evacuation policy in Manitoba descriptively and visually, four gaps that need to be addressed were found: information for First Nations women, coordination of services, written policies and guidelines related to the evacuation policy, and publicly available standards of maternity care services.

Conclusion: This paper contributes new and detailed information about the evacuation policy and associated administrative processes through the production of a descriptive and a visual map. Oriented by intersectionality theory, and using institutional ethnography to make sense of the interview data, gaps in care are made evident. Recommendations to address these gaps are presented.

Keywords

First Nations, pregnancy, evacuation policy, mapping, institutional ethnography

First Nations women who live on rural and remote reserves in Canada receive labour and birthing services usually at a great distance from their home communities. In accordance with Health Canada's evacuation policy for pregnancy, First Nations women leave their communities between 36 and 38 weeks gestational age to access these maternity care services (Lawford, 2016). The evacuation policy is often premised as an intervention to improve the lives of First Nations maternal and child health; however, First Nations women's perspectives are not incorporated into the policy (Lawford & Giles, 2012a). According to Lawford and Giles (2012a), the evacuation policy undermines important aspects of their health as described in the literature by First Nations peoples themselves: decolonization, self-determination, ties to land, and community. To affect change that could incorporate these aspects, it is important to first describe the actual processes and procedures of Health Canada's evacuation policy as such a description has yet to be published despite the longstanding practice of routine evacuation for First Nations on reserves (Couchie & Sanderson, 2007; Lawford & Giles, 2012b).

This paper begins to address this knowledge gap in the literature by presenting a descriptive map and a visual representation of the policy for a First Nations woman with a healthy pregnancy, using the case of the Canadian province of Manitoba, where women are evacuated to Winnipeg, Thompson, or The Pas. There are 63 First Nations communities in Manitoba, 23 of which are not accessible by an all-weather road. It has 140, 975 First Nations peoples, the second highest population of First Nations in Canadian provinces, and 60.2% live on reserves (Indigenous and Northern Affairs Canada, 2016; 2014). Just more than half, 54%, of First Nations in this province are under the age of 25 (Government of Manitoba, 2014-2015), and the birth rate is twice that of the Canadian non-First Nations

population (Health Canada, 2014a). Notably, the infant mortality rate (IMR) for First Nations in Manitoba is twice that of the general Canadian population (Health Canada, 2011a).

The key questions guiding the development of the descriptive and visual maps included the following: How does the evacuation policy work in Manitoba? When and how are women evacuated from their communities? Where do women stay once they are evacuated? Who provides maternity care services to women before, during, and after evacuation? And, when and how do women and their babies return to their communities after giving birth? Through the mapping of the evacuation policy, the inequities and gaps in maternity care services for women who live on reserves are identified, which demonstrate how the evacuation policy continues to isolate and marginalize First Nations peoples.

Situating the Researcher

I am an Anishinaabe midwife from northwestern Ontario and academic researcher and am all too familiar with the ways in which past and current approaches to maternity care have harmed First Nations women and their communities. The loss of birthing services in a community results in a loss in ceremonies, cultural practices, and knowledge transmission between community members and among generations. As such, two tenets underpin my research: First Nations women are experts in their health care, and health care based solely on the Euro-Canadian bio-medical model and that excludes Aboriginal ways of health and wellness can only result in health outcomes that are less than optimal (Adelson, 2005; Browne & Fiske, 2001; Dyck, Klomp, Tan, Turnell, & Boctor, 2002). My criticism of the Euro-Canadian bio-medical model is well deserved: It is a model that has been used to purposefully and systemically harm Aboriginal peoples and discredit

Aboriginal knowledges (Lawford & Giles, 2012b). My approach to this research is informed by Beaulieu's (2016) encouragement of care providers "to never lose your curiosity, consider your patients as partners, trust their intelligence and capabilities, and work as a team player" (p. 968). Engaging with my research in this way enables me to leverage my academic privilege so that the experiences and perspectives of First Nations women and community members are made apparent and are positioned as foundational to health policy and practice development. It also enables me to contribute scholarship that inserts the knowledges, voices, and experiences of First Nations women and community members into academic literature. It is upon these foundations that this manuscript has been produced and is offered as witness to the experiences that were shared with me by First Nations women and community members.

Maternity Care for Women Living in Rural and Remote Communities in Canada

Canada is the second largest country in the world in terms of land mass and has one of the lowest population densities, with 90% of the population residing within 160 km of its border with the United States (Canadian Broadcast Corporation [CBC], 2009; Natural Resources Canada, 2009). As a result of this southern concentration, and exacerbated by budgetary constraints, health care services have become centralized in more populous locales (Grzybowski, et al., 2015; Klein, Christilaw, & Johnston, 2002; Miller, Couchie, Ehman, Graves, Grzybowski, & Medves, 2012; Rechel et al., 2016). Consequently, the accessibility of health services for rural and remote populations is challenging, regardless of First Nations status. The provision of maternity care services has been particularly problematic for women living in rural and remote communities across Canada, as the number of maternity care services in rural and remote regions is decreasing precipitously

across Canada (Grzybowski et al., 2015; Klein, Christilaw, & Johnston, 2002; Rechel et al., 2016; Society of Obstetricians and Gynaecologists [SOGC], 2008).

Women living outside of urban centres must travel outside of their communities to access labour and birthing services, which has fuelled a growing body of literature that is drawing attention to what has become known as Canada's maternity care crisis (de Leeuw, 2016; Kornelsen, Kotaskan, Waterfall, Willie, & Wilson, 2010; Lisonkova, Sheps, Janssen, Lee, Dahlgren, & MacNab, 2010; Ontario Maternity Care Expert Panel, 2006; Smith, Brown, Stewart, Trim, Freeman, Beckhoff, & Kasperski, 2009; SOGC, 2008; Sutherns & Bourgeault, 2008). Closures of rural and remote birthing units, decreasing numbers of family physicians who provide obstetrical services, and the concentration of obstetricians working in urban areas contribute to this health care crisis (Grzybowski et al., 2011; Kornelsen et al. 2010; Peterson, Medves, Davies, & Graham, 2007; Smith et al., 2009). To advocate for maternity services in rural and remote settings, an SOGC Joint Position Paper was authored by physicians, midwives, and nurses, which stressed the importance of including the "social and emotional needs of rural women" (Miller et al., 2012, p. 984) in service planning. There does not, however, appear to be any resolution to this crisis despite rural women wanting "access to care that is local, appropriate, continuous, relational, and empowering" (Sutherns & Bourgeault, 2008, p. 865).

Scholarship that described the experiences of non-First Nations women indicated that traveling for birth has many negative effects. Women in rural settings reported receiving maternity care that was compromised, inaccessible, rushed, inflexible, unfamiliar, inconsistent, unpredictable, uncoordinated, uncertain, and stressful (Sutherns & Bourgeault, 2008). In fact, Kornelsen, Stoll, and Grzybowski (2011) found that traveling

more than one hour to access maternity care services increases women's stress seven fold, which was assessed using the Rural Pregnancy Experience Scale. En route deliveries and increased rates of induction of labour are also associated with traveling for birth (Bourgeault & Sutherns, 2010; Grzybowski et al., 2011). Unfortunately, far less is known about the experiences of First Nations women who travel for birthing services in Manitoba.

Maternity Care for First Nations Women Living On Reserves

First Nations women who live on rural and remote reserves receive maternity care services in two locations: within and outside of their reserve communities. For most of the pregnancy, First Nations people receive primary health care services by community health nurses employed by Health Canada (Health Canada, 2015a; Olson & Couchie, 2013). Between 36 and 38 weeks gestational age, First Nations women are evacuated to urban centres to await labour and deliver. As a result, women can spend almost a month – or more - outside of their communities so as to avail themselves of maternity care services. This set of practices constitutes Health Canada's de facto evacuation policy (Baskett, 1978; Bellrichard, 2014; Gallagher, 1997; Jasen, 1997; Kaufert, Koolage, Kaufert, & O'Neil, 1984; Lalonde, Butt, & Bucio, 2009, Lawford, 2016; Lawford & Giles, 2012a; 2012b; Phillips-Beck, 2010; Wiebe, Barton, Auger, Pijl-Zieber, & Foster-Boucher, 2015). Physicians, health administrators in both sending and receiving communities, and nurses working with First Nations on reserves are very familiar with the evacuation policy; however, the details of Health Canada's evacuation policy remain elusive and undocumented (Couchie & Sanderson, 2007).

First Nations women's experiences of being evacuated are less than optimal. They experience high levels of stress, lack of choice and support, loss of appetite, weight loss,

embodied physical suffering, depression, financial stress, and racism from care providers (Olson, 2013; Phillips-Beck, 2010; Varcoe, Brown, Calam, Harvey, & Tallio, 2013). Feelings of anger, loneliness, fear, guilt, and incessant worry are further exacerbated by the lack of a partner or family support person (Olson, 2013; Phillips-Beck, 2010). Unfortunately, being alone during labour and birth was a common experience, since travel escorts are not funded for First Nations, even for women giving birth. Although it could be argued that evacuation for birth is an intervention that improves pregnancy outcomes by increasing access, the two-fold Infant Mortality Rate (IMR) of First Nations in Manitoba compared to non-First Nations indicates the care received requires improvement. As such, the purpose of this paper is to provide a descriptive map and a visual representation of the evacuation policy for First Nations women in Manitoba with goals to influence and inform improved health policy.

Theoretical Framework

The maternity care services provided to First Nations women separates them from family and community support, removes them from their land, advances a colonial agenda, and hinders their self-determination (Lawford & Giles, 2012a). To make sense of these intrusions and also privileging the experiences of First Nations women requires a theoretical framework that takes into account the synergistic effects of the structural oppressions described above. Intersectionality is one such theoretical lens through which to understand the research project and analysis presented here.

First articulated by Crenshaw (1989), intersectionality draws attention to race, gender, and political oppression and was originally described in the context of understanding the oppression of Black American women. Instead of assuming a simple

additive approach, it was used to position subordination and marginalization as synergistic and purposeful processes that magnified the individual effects of racial, gendered, and political oppression. The use and application of intersectionality has broadened since Crenshaw's original articulation. It is now used to make visible nuanced and tangled webs of oppression and the complexity of multiple lived realities outside of Black women's lives in the United States. As a result, intersectionality is being used with increasing frequency to examine the health of marginalized populations (Dhamoon & Hankivsky, 2011; Hankivsky, Reid, Cormier, Varcoe, Clark, Benoit, & Brotman, 2010; Hole et al., 2015) including Aboriginal women (Van Herk, Smith, & Andrew, 2011).

The use of intersectionality by de Leeuw and Greenwood (2011) highlighted its applicability to help contextualize "the way that health services are delivered (or not delivered) to" First Nations women in birth (p. 56). In my opinion, the use of intersectionality inadvertently underplays the unique legal situation experienced by First Nations women as a direct result of the *Indian Act* (1876), something that non-First Nations women do not experience. In fact, it is through this *Act* that the Government of Canada dictated every aspect of life for those who lived on reserves (Hart & Rowe, 2014; Palmater, 2011) and with particular attention to First Nations women. It destroyed the roles and rights of women as "caregivers, nurturers and equal members of the community" (Boyer, 2006, p. 7), which resulted in women becoming subservient to men. The previous matrilineal and matriarchal functioning of some societies was forced underground as the visible social and political leadership of women was destroyed. It was not just the *Indian Act* but the collective power of the law of the constitution that was used to undermine and eradicate "Indigenous systems of knowledge, including First Nations' medical knowledge" (de

Leeuw, Maurice, Holyk, Greenwood, & Adam, 2012, p. 908). Concurrently, the knowledges and responsibilities of First Nations midwives was purposefully destroyed as a strategy to drive labour and birth practices into hospitals where the Euro-Canadian biomedical model could be enforced (Lawford & Giles, 2012b), thus imposing a colonial agenda upon First Nations women and their babies. It is precisely this constitutional leveraging and the ensuing changes to women's roles and stature within their families and communities that have contributed to the substantial health care gaps between First Nations and non-First Nations peoples. These legislative issues have not been situated as front and centre within conventional applications of intersectional theory; nevertheless, they need to be acknowledged.

Nevertheless, intersectionality can be an effective theoretical framework for constructing a coherent picture of complex and ambiguous systems of oppression. It helps, for example, in drawing attention to gaps in care that result from the absence of clear communication and coordination among various levels of government for those who reside on reserves (Jackman, 2000). Intersectionality is also structured to contextualize and improve comprehension of the Government of Canada's assertion that it provides health care on reserves as a consequence of a "policy for federal programs for [First Nations] people, (of which the health policy is an aspect), [which] flows from constitutional and statutory provisions, treaties and customary practice" (Health Canada, 2014a, para. 2). Further, this theory can be used to draw attention to the lack of clarity, organization, and coordination of health care services on reserves that is profound (Commission on the Future of Health Care in Canada, & Romanow, 2002) and greatly and adversely affects the health of First Nations who reside on reserves (de Leeuw & Greenwood, 2011).

Methodology

To bring to light these confusing systems of care, I engaged with institutional ethnography (IE) as it is congruent with the theoretical underpinnings of intersectionality. Both are used to draw attention to the ruling relations that create systems of oppressions for specific populations and can be used to understand health care services. IE, first articulated by Dorothy Smith, is grounded in people's experiences to discover "how things are actually put together" (Smith, 2006, p. 1) and "to examine the way that the social organization is put together such that people experience it as they do" (Campbell, 1998, p. 60). Although seemingly simple in its goal, the use of IE facilitates an understanding of the interactions among the textual representations of an institution, policy, or process and the lived experiences of those who interact with the institution, policy, or process (Bisaillon, 2012; Walby, 2013). The production of a map to visualize these interactions produces an inquiry that "scrutinizes unexamined, assumed, and accepted practices and activities (Bisaillon, 2012, p. 102). By bringing to light these relationships, "organizational disjunctures" (Smith, Mykhalovskiy, & Weatherbee, 2006, p. 169) can be made apparent so that the institution and its processes can be improved upon, should there be a will to do so. Campbell and Gregor (2002) further describe IE as a methodology that can be used to make clear the "things being put together systematically, but more or less mysteriously and outside a person's knowledge, and for purposes that may not be theirs" (p. 18). Certainly, the absence of literature that describes the processes associated with the evacuation policy for First Nations on reserves indicates a shrouding of information, whether or not this shrouding is, as it could be claimed, unintentional.

Bisaillon (2012) provided an example of using IE to produce a map to reveal the details of a health care process. The goal of her doctoral research was to "uncover features of the social organization of refugee and immigrant experience and knowledge and ruling relations associated with mandatory immigration HIV testing" (p. 96). Developing categories based on colour-coded excerpts from interview transcripts facilitated the creation of a map to visual the testing processes that were experienced (Bisaillon, 2013). This mapping permitted the investigation and empirical tracing of federal and provincial government systems, which immigrants and refugees navigate as part of their arrival into Canada. The embedded hierarchies in these systems were also made apparent through the mapping process.

In addition to the practicalities of providing an analytic tool to map the evacuation policy, I am drawn to IE because it is explicitly feminist and recognizes the experiences of women as legitimate sources of knowledge (Campbell, 1998). By revealing the texts that are used to "process people and manage aspects of their lives" (Campbell & Gregor, 2002, p. 22), the experiences of anyone subject to ruling relations form an important source of knowledge and influence. The ruling relations become discoverable when knowledge and power intersect to generate prescribed processes that must be followed (Campbell, 2001). Accordingly, it is through the employment of an IE methodology that a mapping of the evacuation policy can be used to illustrate how First Nations women are made subject to the ruling relations that positions a federal policy as foundational to their maternity care services.

Methods and Data Sources

Data were gathered through semi-structured interviews and a review of the existing literature that described the evacuation policy and the provision of maternity care services for First Nations in Manitoba and Canada. The decision to employ a semi-structured interview process was based on the versatility of this method, which can "yield considerable and often multi-dimensional streams of data" (Galletta, 2012, p. 24). Also, it is a method that engages participants in a manner that is reciprocal and "creates space for the researcher to probe a participant's responses for clarification, meaning making, and critical reflection" (Galletta, 2012, p. 24). Peer reviewed literature, grey literature, and materials from government and non-government organizations that described the processes related to the evacuation policy for First Nations women in Manitoba and Canada were reviewed to construct a visual representation of the policy and a descriptive map. I also reviewed government and non-government reports, guidelines published by health care professional groups, media reports, websites, blogs, and public Facebook pages. I excluded any material from other provinces and territories as well as information related to evacuation for reasons outside of maternity care, such as flooding, forest fires, or dialysis.

The information provided by First Nations women and community members, however, was privileged when the final map was developed, which is in keeping with the tenets of IE (Walby, 2013). Such privileging recognizes the experiences of the users of a policy as fundamental to its understanding since they are the ones actively engaged with the policy and the systems that support the actualizing of evacuation.

I contacted three categories of informants for interviews: First Nations women and members of their communities; politicians, policy makers, and government officials at the federal, provincial and municipal levels; and health care providers both on reserve and in urban referral centres. To gain contact with First Nations women who had been evacuated and community members who had experience with evacuation, I emailed recruitment letters to First Nations organizations in Winnipeg, First Nations communities throughout Manitoba, and First Nations leaders (n=42). I directly emailed a request for an interview to politicians, policy makers, physicians, obstetricians, midwives, nurses working on and off reserves, and government officials (n=103). I searched federal, provincial, and municipal staff databases for names and positions related to health care on reserves. I also searched the following websites to identify participants: University of Manitoba, College of Physicians and Surgeons of Manitoba, the Manitoba College of Family Physicians, College of Registered Nurses of Manitoba, and College of Midwives of Manitoba. On occasion, snowball sampling (Emmel, 2013) occurred, when an informant referred others to join the study. I conducted a semi-structured interview with every person who wanted to participate.

I provided a letter of introduction, the list of potential semi-structured interview questions, and consent forms to the informants via email. Interviews were conducted in person in Winnipeg (11 – 7 female/4 male) and Ottawa (1 – female), or on the phone (19 – 17 female/2 male), for a total of 32 participants. Interviews ranged in length from 30 minutes to 120 minutes. One participant chose to write her responses to my interview questions and submitted these to me by email. Each participant was interviewed once. Participant consent was obtained by signature or by verbal agreement. All informants, save the one written respondent, agreed to have their interviews digitally recorded. I transcribed the interviews verbatim and then mailed them by Canada Post or emailed them to the

informant as a password-protected document for review. Informants had at least two weeks to review the document to request changes. All requested changes were applied to the final transcript, which was then entered into NVivo for coding and analysis. Unless specified, all informants are referred to by their first name. Those who requested to be anonymous are indicated as such.

I also met regularly by phone and in person with Paul Chartrand, a Commissioner with the Royal Commission on Aboriginal Peoples (RCAP, 1996) who is my doctoral committee Elder. It was through these lengthy conversations that I ensured my research project adhered to the Ethical Guidelines for Research as described in RCAP (RCAP, 1996, vol 5) Research ethics approval was granted by the University of Ottawa (File number 05-15-26).

Analysis

I initially reviewed the interview data from First Nations women and community members and based on these narratives, drafted an outline of a process map of the evacuation policy in Manitoba. Their descriptions covered the full map and therefore, were the most logical preliminary source of information. After the map was generated, I added details from the perspectives care providers interviews. I then added information from the interviews of politicians, policy makers, and government officials, which was layered onto the map. The final addition of information to the process map came from my review of peer reviewed literature, grey literature, and materials from government and nongovernment organizations that described the processes related to the evacuation policy for First Nations women in Manitoba. My review of clinical practice guidelines, media reports, websites, blogs, and public Facebook pages also comprised this final step. The initial draft

outline of the process map that was described by First Nations women and community members, however, remained the essential core framework.

Mapping the Evacuation Policy

The results of this research project are presented in two parts: the first is a descriptive map, which details the policy from participant interviews; and the second is a visual representation of the evacuation policy, which is found in Figure 1.

Detailing the Evacuation Policy

The details of the policy are derived from participant interviews and are integrated with documents that describes the policy and as well as standards of maternity care in Manitoba. If Manitoba specific standards are unavailable, other provincial or federal standards are described. To structure the results, the details of the evacuation policy are separated into five sections: pregnancy until evacuation; travel to the city; care while in city; labour and birthing services in hospital; and discharge scenarios These sections reflect the distinction between federal and provincial health care systems that First Nations women encounter throughout their pregnancy and the postpartum period and also permit the identification of health care gaps.

Pregnancy until evacuation. In Manitoba, pregnant First Nations women who live on reserves in rural and remote regions receive prenatal care services from federally employed community health nurses who work at one of the 22 nursing stations and 42 health centres (Anonymous First Nations registered nurse). Registered midwives do not work on reserves as the "First Nations Inuit Health Branch....do not support the practice of midwifery in....their government funded facilities" (Anonymous First Nations registered nurse). Registered nurses (RN) and licensed practical nurses (LPN) provide primary care

services, which are supported and managed by Health Canada's Office of Nursing Services (Health Canada, 2015b). This office also develops standards, policies, and guidelines for these federally employed nurses who work on reserves. The prenatal care services, for example, follow Health Canada's Clinical Practice Guidelines for Nurses in Primary Care; the Obstetrics guidelines, Chapter 12, are found within the Adult Care section (Health Canada, 2011b).

Federally employed nurses working on reserves use the antenatal forms from the province in which the reserve is located to document each visit (Anonymous federal registered nurse A). The scheduling of the prenatal visits is not specified in Health Canada's Guidelines nor are they found on the Manitoba Prenatal Record (Government of Manitoba, 2000). The Manitoba Physician's Manual, however, states that obstetrical fees cover "prenatal care includes a comprehensive pre-natal assessment, follow-up pre-natal visits, which would generally occur at four (4) week intervals to twenty-eight (28) weeks, followed by visits every second week to thirty-six (36) weeks, then weekly until delivery" (Government of Manitoba, 2016b, p. N-9). This visit schedule aligns with the Society of Obstetricians and Gynaecologists of Canada's (1998) *Guidelines for care during pregnancy and childbirth*, but exceeds the eight minimum appointments recommended by the World Health Organization (2016).

Women who live in fly-in communities rarely, if ever, see a physician in their first or second trimester; the community health nurse conducts all the prenatal care visits (Anonymous federal nurse B). Some reserves, however, have access to a physician who regularly flies in for a few days every three or four weeks to review charts and provide clinical care. In this instance, the physician arrives in the morning to conduct chart reviews

and spends the afternoon seeing patients (Anonymous federal registered nurse B). One First Nations woman, Ingrid, described having a physician fly into the community every week and who stayed Monday to Friday. Since the Government of Canada no longer directly hires physicians to provide care on reserves (Anonymous federal registered nurse B), physician services on reserves are purchased by the federal government from the Government of Manitoba on a contractual basis from the Northern Medical Unit at the University of Manitoba and from Amdocs (Anonymous federal registered nurse A & Anonymous federal registered nurse B), a private physician workforce agency that "provides primary physician services in remote and northern Canadian communities" (Amdocs, 2009, para. 1).

Travel to a city. First Nations women who have a routine and uncomplicated pregnancy leave their community between 36 and 38 weeks of pregnancy and travel to a city. The timing of evacuation is based on Health Canada's *Clinical practice guidelines for nurses in primary care* (2011). The costs associated with the woman's travel are covered by the Non-Insured Health Benefits (NIHB) Program (Anonymous federal registered nurse A & Anonymous physician). A transportation clerk working at NIHB or the community health nurse makes travel arrangements (Rachel). Women travel alone as they "don't get an escort" (Anonymous federal nurse A). Niki Ashton, the NDP Member of Parliament for the Churchill-Keewatinook Aski riding in northeastern Manitoba, noted, "women are basically given no choice but to leave their community a number of weeks before they are due and taken away from most of their support network." While the NIHB program does "cover eligible travel costs for medical or non-medical escorts in certain circumstances" (Health Canada, 2016, para. 8), each request is reviewed on a case-by-case. Physicians, for

example, can request an escort for the woman, but they do not have any decision-making authority (Dr. Menticoglou). If the woman is under 18, she can receive a non-medical escort (Dr. Menticoglou); however, First Nations women residing in Manitoba generally do not get an escort (Anonymous policy maker).

Some reserves have their own community van that provides transportation to, from, and within the city for their community members. Pregnant First Nations women may use the community van to get to appointments in the city, however, these transportation services are not available throughout the duration of a woman's pregnancy. According to one participant, there is a policy that does not allow women over five months of pregnancy to ride in the van, the origins of which were unknown (Anonymous First Nations woman). The rationale provided was that the women become "high risk" after five months of pregnancy. Instead, women may be given money for travel. One woman received each \$96 for a return trip to Winnipeg (Anonymous First Nations woman), the source of which was unknown, while another received \$80 for a one-way trip from her reserve to Winnipeg. Not having access to the community van services makes it more challenging for women living on reserve to access prenatal care at a time when prenatal visits increase in frequency; that is, the visits become weekly according to provincial and national standards of care (Government of Manitoba, 2016b; SOGC, 1998).

Depending on the resources available and the season, women may also travel by personal vehicle, bus, taxi, plane, boat, helicopter, and/or snow machine. During freeze up and break up of lakes, for example, women might use a helicopter to get across the unsafe water and then use another form of less expensive travel. In other areas, roads may only exist in the summer or winter. Winter ice roads require long periods of cold weather before

they are safe enough for vehicles use. As a result of warming global temperatures, these roads take longer into the winter season to be safe enough for travel. Flying to Winnipeg is not an uncommon form of travel in Manitoba, especially for those without road access. Policies regarding travel in pregnancy are made by each airline. For example, Air Canada will allow women who are 36 weeks gestational age and less to travel on any of their flights (Air Canada, 2014). This policy is closely aligned with recommendations from the Government of Canada, which states that "pregnant women can safely fly up to 36 weeks gestation" (Government of Canada, 2016, para. 5). Smaller air carriers providing services to northern Manitoba, such as Bearskin Airlines (2016), Calm Air (2016), and Perimeter Aviation (2006), require a physician's note stating that the woman is acceptable for travel. Obtaining such a note when some women may never receive care from a physician presents an administrative challenge. Perimeter Aviation (2016) does not have travel restriction for pregnant women; however, it does explicitly state that it is not liable for damages for women who are pregnant or for the unborn child. Calm Air (2006) will not provide services to a woman after 40 weeks gestational age. For women who travel by bus into Winnipeg from the north, Elder Mary Wilson described the preparation that some pregnant women make: they fast for 24 hours before traveling so they don't have to use the bathroom en route because they cannot fit into the bathroom since it is too small for them to access.

Care within Winnipeg¹. When women arrive in Winnipeg, their accommodations can be at a boarding home, a hotel, or they can stay with family or friends. There are six boarding homes in Winnipeg that provide lodging for First Nations community members who travel to the city for medical services: Ekota Lodge, Lennox Bell Lodge, Nakiska Group, Swampy Cree Medical Receiving Home, an Island Lake boarding home, and a

Norway House boarding home (Winnipeg Regional Health Authority [WRHA], n.d.). These "First Nation and Inuit Health contracted boarding homes" (WRHA, n.d., p. 7) are federally funded by Public Works and Government Services Canada, information that was obtained by calling a boarding home. A request for additional information to learn more about who is permitted to stay in these homes, the services offered therein, and the specific funding arrangements was declined by a boarding home staff member, who was concerned that providing such information would negatively effect their funding from the Government of Canada.

First Nations who receive Non-Insured Health Benefits can stay at the boarding homes at no personal cost. The boarding homes provide lodging for all First Nations who travel to Winnipeg for medical appointments (Melissa) and meals are provided (Ingrid). As a result, pregnant women staying at boarding homes "are housed with sick people" (Melissa) as there is no boarding home in Winnipeg that is specifically for pregnant women. Although staying at a hotel could offer less exposure to a variety of illnesses, Ingrid said that "women actually don't feel safe" at the hotels due to some guests drinking a lot and the presence of violence. For those who do stay in one of the NIHB- approved hotels, a food voucher is provided (Ingrid). For women who stay with family or friends, no money was provided to the woman (Ingrid). Another respondent, however, said she received \$50 for meals when staying with family while in Winnipeg (Anonymous First Nations woman). According to the Peguis First Nation website, it offers a daily allowance of \$25 including meals for its membership who stay in a private residence (2015). In comparison, the daily meal allowance for federal public servants is \$79.80, an incidental allowance of \$17.30, plus \$50 per night of stay in private accommodations for a total of

\$147.10 (National Joint Council, 2016). It is difficult to make sense of the funding available to First Nations women who stay outside of boarding homes and hotels, as the funding allocation is inconsistent and substantially different than amounts available to federal public servants, including in the FNIHB.

First Nations women who travel to Winnipeg may have prearranged prenatal appointments with an obstetrician, which take place in a hospital setting and are scheduled by the community health nurse (Rachel). For those who stay at a boarding home, a nurse may also help schedule doctor appointments. One anonymous First Nations woman was connected with an Aboriginal social worker who worked at the Women's Hospital to help coordinate appointments. This woman, however, was the only one who mentioned such assistance. Melissa, an Aboriginal registered midwife working in Winnipeg, stated she does not receive referrals from those who provide prenatal care in the North, which was reiterated by Jaime, an academic who also researches maternity care for First Nations. This lack of referral is unwarranted, because the model of midwifery care practiced in Manitoba has been shown to positively affect maternal and neonatal outcomes as well as being cost effective (Thiessen, Nickel, Prior, Banerjee, Morris, & Robinson, 2016). In addition, "midwifery was legislated in the province of Manitoba with the explicit intent of serving the Aboriginal population and the policy of evacuation" (Olson & Couchie, 2013, p. 984).

On occasion, First Nations women present in labour at the hospital without receiving any prenatal care once they have arrived in Winnipeg, a rare but not uncommon occurrence. A few women even presented themselves in labour with no history of receiving any prenatal care at all. Women who live in poverty, use substances, are scared of child welfare involvement, or are "accessing traditional Indigenous cultural practices in

healthcare practices" may not seek prenatal care (Holly), all of which influence a woman's decision to purposefully avoid interactions within western health systems. Additionally, none of the women reported receiving prenatal education² while they stayed in Winnipeg, because this is not offered to First Nations women who travel from reserves (Melissa; Jaime; Struthers & Girard, 2014). The lack of prenatal education for First Nations women who were evacuated to Winnipeg was noted in the Maternal and Child Health Care Services (MACHS) task force in 2008, a Manitoba Health project that has since lost considerable momentum. Without prenatal education classes, there is very little for the women to do in Winnipeg other than waiting to go into labour.

As described by Jaime, an academic and health researcher, the conditions that First Nations women are subjected to are harsh: "it's inhumane that we should expect women to be sitting for three weeks by themselves waiting to go into labour with nothing to do and no support and maybe, you know, seeing the doctor when they are only required to." For example, when one First Nations woman (Anonymous) was evacuated to Winnipeg, she watched TV, read books, and went on her phone. It seems, however, that not everyone has such a mundane or safe experience. Two health researchers, who were interviewed independently from each other, described the recruitment of evacuated pregnant women by gangs operating in Winnipeg for the purposes of selling sex. One of the researchers, a male, was approached to buy sex from a pregnant Aboriginal woman. When recounting this experience with his work colleagues, he learned that "lots of folks had said that they had been approached." Indeed, pregnancy is not a deterrent to gang involvement. Instead, the recruitment of pregnant women by gangs is largely unnoticed and invisible within "the

gang world [that] is highly patriarchal – a 'macho' environment characterized by male domination of power' (Nimmo, 2001, p. 2).

The MACHS taskforce in Manitoba did not mention sex work gang involvement or exposure to other forms of violence in relation to First Nations women who are evacuated; however, women who were evacuated to Winnipeg reported feeling "lonely, bored, isolated, overwhelmed and fearful for their health and safety" (Struthers & Girard, 2014, slide 3). The MACHS taskforce was brought together to "develop a regional maternal newborn service strategy" (MACHS, 2008, p. 2) and included First Nations, Inuit, and Métis peoples. Specifically, one goal of the taskforce was to "ensure that expectant women who relocate from First Nations, Inuit and Métis communities and rural/remote communities for extended periods of time to give birth have access to a coordinated system of prenatal and social support" (MACHS, 2008, p. 2). At the time, MACHS was led by the provincial Minister of Health, Theresa Oswald. When Minister Oswald resigned her cabinet position with the governing Manitoba NDP party in 2014, the momentum of the taskforce dwindled because it had lost its political champion. Indeed, one anonymous participant described the loss of Minister Oswald as significant to the taskforce: MACHS used to be "a priority in the province [but] I think it's fallen off the page" (Anonymous policy maker). Despite the initial enthusiastic support of MACHS from a variety of partners, including the Assembly of Manitoba Chiefs, federal nursing stations, and the Manitoba FNIHB office (MACHS, 2011), very little seems to have changed. As a result, First Nations women who are evacuated to Winnipeg are placed at risk when they engage with a policy that was purportedly created to improve the outcomes of their pregnancies.

Labour and birthing services in hospital. When a woman thinks she is in labour, she can use a taxi, city bus, personal vehicle, or call an ambulance to get to the hospital. According to a municipal staff member, the costs associated with an ambulance ride are payable to the City of Winnipeg. If the woman cannot afford to pay the price of an ambulance, which is approximately \$500, the city absorbs the costs (Anonymous municipal employee). There are three sites that offer labour and birthing services in Winnipeg: St. Boniface, Health Sciences Centre's Women's Hospital, and the Birth Centre. Only midwives work at the Birth Centre and none of the women interviewed had midwives attend their labour and birth, which left the two hospital sites. Once the woman arrives at either one of these hospitals, she is triaged and assessed for active labour. If she is not in labour, she goes back to her lodging and waits alone for the contractions to increase, unless she is staying with family or friends. When the woman is in active labour, she is admitted to the hospital for labour and birth services by provincially employed obstetricians and nurses. Most, if not all, First Nations women who are evacuated receive care from an obstetrician and the residents on call, as the maternity units are located within teaching hospitals. Jessica, for example, did not know the doctor on call who was at her birth and also was not aware of that an on-call rotation was a component of her obstetrical care while in Winnipeg. So in addition to her seeing an obstetrician, Jessica may have seen an obstetrical resident, a number of other specialty residents, medical students, and nursing students.

After the baby is born, the woman is moved to the postpartum unit. One First Nations woman described seeing the lack of breastfeeding support in this unit and how First Nations women from the North were particularly guided towards formula feeding:

There we found so many northern girls are having their babies and cases of milk at the foot of the hospital bed, so they weren't being encouraged to nurse...there's no prenatal kind of support that would talk about the benefits of nursing.

This same participant linked formula feeding with the challenges – and even dangers - associated with the need to wash and sterilize bottle-feeding equipment, which requires clean water, a resource that is not available in all First Nations communities. The absence of teachings and support related to breastfeeding combined with the promotion and free supply of formula feeding while in hospital creates a cycle of reliance on nutrition that is less than optimal and even unsafe due to the preparations required.

Discharge scenarios. After the baby is born, there are three discharge scenarios. If the woman and the baby are both well, they are discharged together. The discharge policy for the Women's Hospital was not located, however, the St. Boniface Hospital's (2016) discharge policy is:

24 to 48 hours or sooner after vaginal birth, with no complications for mom or baby; 48 to 72 hours or sooner after a cesarean birth, with no complications for mom and baby; night births are discharged right after breakfast following 48 hours or 72 hours. (para. 1)

If the woman is well but the baby needs extra care and remains in hospital, the woman is discharged and she returns to her lodging. Participants who have experienced this second scenario stayed with family members and traveled back and forth between the hospital to spend time with the baby as well as provide breastmilk. Some women have access to their community's medical van in Winnipeg, which provides transportation back and forth from their lodging to the hospital (Ingrid). The third possibility is that the baby is well but the

woman remains in hospital. This situation is highly uncommon and as such, would be resolved on a case-by-case basis to take into consideration immediate and extended family support. If family was not available to care for the healthy newborn, she/he would be placed into temporary foster care.

When the woman and baby are discharged together, the return travel arrangements can be uncoordinated, which results in a delay, increased costs for lodging and meals, and poses additional risks to their health. It also increases the length of time the woman and her baby are isolated from family and community support. The lack of coordination also has an effect on postpartum care because this is when breastfeeding often ends, in part because they receive no postpartum care while they are waiting to return home (Anonymous). One First Nations woman (Anonymous) who was evacuated from Norway House, for example, did not have any postpartum appointments scheduled after she was discharged but stayed in Winnipeg for a few days. Instead, she was given a list of numbers to call if she needed to talk to someone; explanations of what these numbers were for or when she was to call were not provided to this woman. Public health nurses employed by the Winnipeg Regional try to see First Nations women before they return home, however, "it is challenging because women want to get out of here, like on the next available opportunity, so they don't always connect" (Anonymous health policy maker). This lack of information and postpartum care is not uncommon, as First Nations women who are evacuated to Winnipeg find themselves within a "service void" (Anonymous).

For women who reside in a "strictly fly in [community], they would fly back to their communities. The ones where there is road access, they would take a bus to Thompson and then they would fly from there back to their home community"

(Anonymous federal registered nurse A). Participants described vehicle travel that can take upwards of 14 hours with the newborn in a car seat (Jaime & Rachel & Anonymous policy maker). The duration and mode of transport for the baby is concerning. Health Canada's (2012b) recommendations for safe sleep make it clear that babies should not sleep in a car seat for "long periods of time" (p. 2) because "when sleeping, a baby's head can fall forward because their muscles are under-developed, and their airway can become constricted" (p. 13). The recommendation, unfortunately, does not define what constitutes a long period of time. Care providers can – and do - mitigate these risks by modifying the care that they provide to women. An example of such modification was provided by Olson (2013), who interviewed a midwife who recounted the birth story of a woman who sustained a small perineal tear that did not require surgical repair. The family of the woman, however, asked for the midwife to repair the tear with a stitch because such a procedure would be documented on her chart. This medical intervention permitted the woman and her baby to return home by flight, instead of a 14-hour bus ride. In this example, the care provider, family, and the woman understood the flight approval requirements enough to request and consent to a procedure that was not medically necessary.

The timing of postpartum care for the woman and baby once they returned to their community was inconsistent. First Nations women who were interviewed in this study knew they received postpartum care within days after returning home from the federal nurse or a provincially employed physician; however, the exact timing of the visits was not easily recalled. One participant remembered having an appointment with the community health nurse one week after last seeing a care provider in Winnipeg. Another participant

was told to see her doctor two weeks after her baby was born for a check-up. Such medical advice means that the woman and her baby received no postpartum assessments for two weeks and is in contradiction to Health Canada's Clinical Practice Guidelines. These Guidelines advise community health nurses to see the newborn at 1, 2, 4, and 8 weeks of age, with subsequent visits clearly listed. St. Boniface Hospital (2016) advises women to see "a care provider by one to two weeks of age" (para. 6). One participant, an anonymous federally employed nurse, described how she meets the woman and the baby at the airport and helps them get home. If she is unable to meet them at the airport, the nurse goes directly to the woman's home to provide postpartum care.

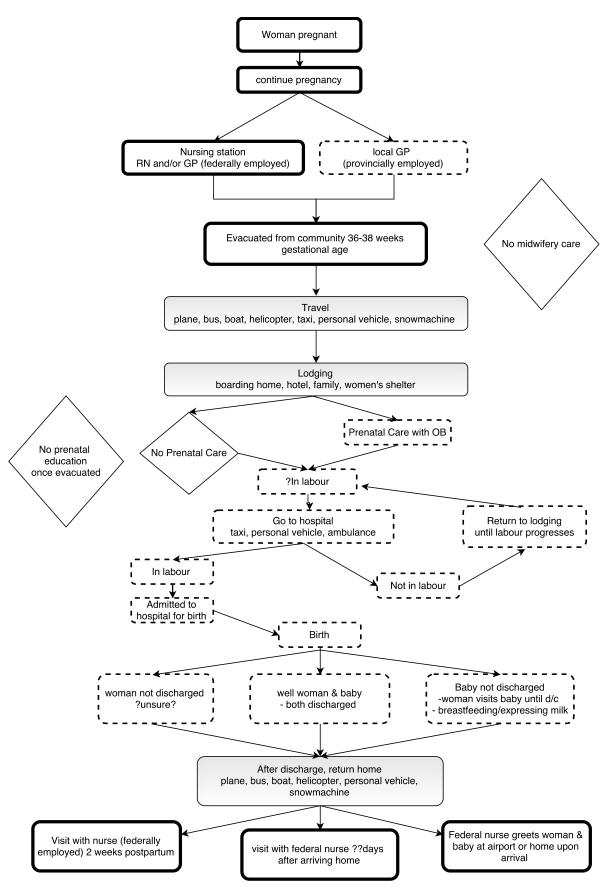


Figure 1: Map of the evacuation policy for a First Nations woman living on reserves in Manitoba Legend: Diamond: no public services; Heavy outline: federal services; Dotted outline: provincial health services; Thin solid line: travel

Gaps and Recommendations

Mapping Health Canada's evacuation policy provides a simplified picture of the complex processes, people, and policies that underpin the evacuation of pregnant First Nations women from their homes on reserves in Manitoba for birth. From the comparison of services provided in the map with accepted standards of maternity care, the gaps in care are made obvious. Rachel, a First Nations woman who is also an academic researcher, succinctly sums up the effects of the evacuation policy: "People love their babies and having babies is a really nice thing[,] [but] this policy sucks and it's stupid." As discussed below, the culmination of these gaps reveals a system of health services that urgently requires attention and commitments from multiple levels of government to improve maternity care for First Nations women.

Information for Women

The absence of information isolates and marginalizes women because they may not know what they should be expecting or anticipating when they travel for maternity care services. While women were able to piece together enough information to travel to and from their communities to Winnipeg, Thompson, or The Pas and make their way to the hospital for birth, this was largely accomplished through information from family and friends. For example, there is no printed or online material that describes maternity care services and processes for First Nations women in Manitoba. This information would benefit women, families, and community members as well as the care providers and administrators. Examples of such information are names and contact information (phone, fax, and email) of the people or agencies that arrange travel to and from the reserve community; explanations of travel within the city, which may include taxi chits, busses, or

access to the community's van; birthing options, including midwifery care and a birth at the birth centre; signs and symptoms of active labour; how to get to the hospital; numbers to call for information and connections in the receiving city, such as public health; and hospital/birth centre discharge routines for the woman and baby/babies. Contact information should be available in English as well as prominent Aboriginal languages and dialects in Manitoba like Cree, Oji-Cree, and Ojibwe.

Communication

Poor or absent communication on the part of health care providers with women and other care providers results in maternity care services that are uncoordinated and, as a result, far less than optimal. In some cases, the absence of communication results in care that does not seem to be provided at all. The lack of communication between various levels of government bureaucracy, health care providers, and women is glaring and must be addressed so that women and their babies can receive the best maternity care possible. First Nations women, family, and community members should know which government, agency, or health care provider is involved with the provision of maternity care services. Direct contact information, including phone numbers and email addresses, should be available along the entire care pathway, including those in Winnipeg, Thompson, and The Pas. It is vital that efforts should be focused on having the best communication possible so maternity care services and outcomes are the best possible.

Coordination

Greater coordination along the entire pathway of care is required so that undue burden is not placed on women, families, community members, health care providers, and other individuals who are involved in the provision of maternity care. For example, prearranged prenatal and postpartum appointments with an obstetrician, family doctor, or midwife for women before they are evacuated and once they return home would assist with early identification of health issues before they become an emergency. Attention to prenatal scheduling would also permit provincial and national standards of care to be met, which recommend weekly visits after 36 weeks gestational age. Inclusion of municipal public health nurses could assist with appointment coordination and also provide prenatal education classes. If the woman or the baby requires any immunizations, the public health nurse could administer these vaccinations. These municipal staff members could also share information of the local activities available for women who are pregnant so there is something to do other than stay in their lodging to read books and watch television when they are evacuated.

Written Policies and Guidelines

The practices surrounding evacuation are only perfunctorily described by Health Canada's direction, which reads: "arrange for transfer to hospital for delivery at 36-38 weeks' gestational age according to regional policy (sooner if a high-risk pregnancy)" (Health Canada 2011b, 12-16). This direction, which stands as policy because it results in the allocation of resources, has material impacts on women, and causes reactions within of health care systems and from providers (Lawford, 2016), is inconsistent in its application, due in large part to the lack of details within the policy itself. As a result, most of the processes associated with this policy are inferred from historic or current practices. For example, the uncovering of inconsistent and varying funding arrangements with respect to travel, accommodations, and meal stipends points to a need for clarity and consistency. Policies and guidelines related to travel to and from Winnipeg are urgently needed because

access, funding, and information is fragmented and inconsistent. The escort policy also requires attention, because the decision-making criteria regarding funding for an escort in all circumstances are unavailable, so decisions appear to be haphazard. Everyone involved in evacuation, especially women, families, and community members requires written and detailed policies and guidelines that comprise the maternity care services that are received by First Nations women on reserves. The production of these materials would promote a transparent and consistent evacuation policy for all First Nations in Manitoba.

Publicly Available Standards of Care

Every standard of care along the entire maternity care pathway for First Nations women resulting from the evacuation policy needs to be made publicly available and easily accessible as print and online material. While Health Canada's (2011b) Clinical Practice Guidelines for Nurses in Primary Care are available, they are not specific to Manitoba standards of care and, as a result, may be inappropriate or unattainable within the province. Poor or less than optimal practices contribute to poor outcomes and measures, like the twofold IMR for First Nations. As such, the development of publicly available standards of care is necessary. The development of publicly available standards of care would facilitate the scheduling of prenatal visits when evacuated, encourage information sharing, and promote a culture of quality and equality in health care services for First Nations women. Standards of care related to breastfeeding, for example, would promote, support, and protect breastfeeding, a goal of the Government of Manitoba. Standards of care related to primary care visits and support during the postpartum period are other necessary standards that need to be developed to ensure early care interventions are received before emergent issues arise.

Conclusion

Interviews with three categories of participants - First Nations women and members of their communities; politicians, policy makers, and government officials at the various levels; and health care providers both on reserve and in urban referral centres – facilitated the identification of maternity care gaps for women who are evacuated. First Nations women are isolated, marginalized, and made more vulnerable when they are evacuated to Winnipeg for maternity care because of they lack community support and information. Poor or absent communication among government employees, care providers, and women prevents the provision of optimal maternity care services. As a result, First Nations women are largely responsible for ensuring maternity care is provided to themselves and other First Nation women when they are evacuated due to the lack of coordination among federal, provincial, and municipal services.

The actual processes and procedures associated with Health Canada's evacuation policy for pregnant First Nations women who live on reserves in Manitoba were made apparent through the generation of a descriptive map that is also visually presented, a mapping that has been thus far absent within the literature. The most significant and fundamental maternity care gaps identified and described herein are a result of the distinct and problematic legal and constitutional positioning of First Nations women and their babies within legal, political, and health care systems that purport to care for their wellbeing.

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¹The focus of this section is travel to Winnipeg since the majority of women are evacuated to Winnipeg and all women with a high-risk pregnancy are evacuated to Winnipeg.

²Prenatal education can be provided privately or by public health nurses to prepare prospective parents for labour and birth, as well share information about infant care, breastfeeding, and community supports.

Chapter 3:

Health Canada's Evacuation Policy for Pregnant First Nations Women in Manitoba:

Resignation, Resilience, and Resistance

Abstract

Health Canada's evacuation policy requires all First Nations women living on rural and remote reserves to leave their communities between 36 and 38 weeks gestational age and travel to urban centres to await labour and birth. In Manitoba, some First Nations women are evacuated to The Pas or Thompson, but most – including all women with high-risk pregnancies - go to Winnipeg. Despite the frequency of this practice, the literature that describes First Nations women's and community members' experiences and perspectives of the evacuation policy is sparse. Applying intersectional theory to data collected through semi-structured interviews with women and community members in Manitoba who had experienced the evacuation policy revealed three themes: resignation, resilience, and resistance. These findings demonstrate there is a pressing need to improve the maternity care services that First Nations women receive when they are evacuated out of their communities, particularly when understood from the specific legal and constitutional position of First Nations women in Manitoba.

Keywords

First Nations, birth, evacuation policy, women, maternity care

Despite millennia of birthing on the land, First Nations women who live on rural and remote reserves across Canada are required to leave their communities late in their pregnancy to access labour and birthing services (Couchie & Sanderson, 2007; Lawford & Giles, 2012a). This relocation is fuelled by Health Canada's evacuation policy, which instructs federally employed nurses to "arrange for transfer to hospital for delivery at 36-38 weeks' gestational age according to regional policy (sooner if a high-risk pregnancy)" (Health Canada, 2011, p. 12-6). This has become a routine component of maternity care for First Nations women (Lawford, 2016). Even though there are calls to return birthing to First Nations communities, women's experiences and perspectives of the evacuation policy and practices are noticeably absent in the literature (Olson & Couchie, 2013; Society of Obstetricians and Gynaecologists of Canada [SOGC], 2010). It is vital that they are made evident to inform and influence policy and program development, and to affect change for the improvement of maternity care services for those who reside on reserves. To address this gap, I conducted a case study in the province of Manitoba. Through semi-structured interviews with First Nations women and members of their communities, I addressed two questions: 1) What are the experiences of First Nations who are evacuated from their communities for birth?; and 2) What are the perspectives of community members regarding the evacuation policy? Drawing on intersectional theory and analyzing the interview data using thematic analysis, three overarching themes were revealed: Resignation, resilience, and resistance. These themes illustrate how the evacuation policy results in maternity care that is inadequate and continues to adversely affect First Nations women's health. I conclude by suggesting avenues for future research and policy change to improve maternity care services for First Nations women.

Situating the Researcher

I am an Anishinaabe midwife from northwestern Ontario and academic researcher and am all too familiar with the ways in which past and current approaches to maternity care have harmed First Nations women and their communities. The loss of birthing services in a community results in a loss in ceremonies, cultural practices, and knowledge transmission between community members and among generations. As such, two tenets underpin my research: First Nations women are experts in their health care, and health care based solely on the Euro-Canadian bio-medical model and that excludes Aboriginal ways of health and wellness can only result in health outcomes that are less than optimal (Adelson, 2005; Browne & Fiske, 2001; Dyck, Klomp, Tan, Turnell, & Boctor, 2002). My criticism of the Euro-Canadian bio-medical model is well deserved: It is a model that has been used to purposefully and systemically harm Aboriginal peoples and discredit Aboriginal knowledges (Lawford & Giles, 2012b). My approach to this research is informed by Beaulieu's (2016) encouragement of care providers "to never lose your curiosity, consider your patients as partners, trust their intelligence and capabilities, and work as a team player" (p. 968). Engaging with my research in this way enables me to leverage my academic privilege so that the experiences and perspectives of First Nations women and community members are made apparent and are positioned as foundational to health policy and practice development. It also enables me to contribute scholarship that inserts the knowledges, voices, and experiences of First Nations women and community members into academic literature. It is upon these foundations that this manuscript has been produced and is offered as witness to the experiences that were shared with me by First Nations women and community members in Manitoba.

Experiencing Evacuation for Birth: A Review

First Nations women who live on rural and remote reserves are evacuated out of their communities at between 36 and 38 weeks of pregnancy to receive maternity care in urban centres, which is a result of Health Canada's evacuation policy (Lawford, 2016). Archival research has identified that this federal policy stemmed from the introduction of an obstetrician into a reserve community in 1892, which signalled a beginning of concerted efforts to abolish pre-contact maternity care practices, midwives, medicines, ceremonies, and to shift labour and birthing into a hospital setting (Lawford & Giles, 2012b). Subsequently, in the early twentieth century, a wave of Euro-Canadian health care providers was established within reserve communities. They positioned First Nations midwives, their medicines, and ceremonies as superstition and senseless (Lawford & Giles, 2012b). A united attack led by federal public servants and federally employed physicians, nurses, and nurse midwives effectively marginalized the practice of First Nations midwifery. By spreading falsehoods and referring to fictitious laws, federal public servants coerced First Nations into accepting Euro-Canadian bio-medical ideals, which pressured First Nations women into giving birth in hospital (Lawford & Giles, 2012b).

There is, however, a growing interest in the restoration of community and home birthing (Olson & Couchie, 2013; SOGC, 2010). Unfortunately, the experiences of First Nations women who are evacuated for birth have been given scant attention in the literature. What does exist associates evacuation with post-partum depression, experiences of racism, and disconnection from family and community (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2011; O'Driscoll, Kelly, Payne, Pierre-Hansen, Cromarty, Minty, & Linkewich, 2011; Varcoe, Brown, Calam, Harvey, & Tallio, 2013). For example, First

Nations women from the Haida Nation living in Old Masset and Skidegate, 'Namgis First Nation in Alert Bay, and Nuxalk First Nation in Bella Coola, all located in British Columbia, Canada, linked evacuation for birthing services with postpartum depression due to isolation from family and community support (Varcoe et al., 2013). These women additionally reported experiencing racism and a lack of choice of birthplace. Kornelsen et al. (2011) reported similar findings from interviews with First Nations women from Bella Bella, British Columbia, who emphasized the connection between evacuation and postpartum depression and further reported that children felt distress and sadness when their mothers were evacuated out of the community without them, which is standard practice (Kornelsen et al., 2011). The process of evacuation also contributed to feelings of disconnection between family and community members and the woman and her new baby or babies (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010). In northwestern Ontario, First Nations women who were evacuated to Sioux Lookout from their northern reserve communities described similar feelings: loneliness, disruption, and separation from their children and family support (O'Driscoll et al., 2011). Indeed, independent of the province in which they were located, First Nations women have reported experiencing loneliness and disconnection when they are evacuated for birth.

Evacuation to regional and urban centres for labour and birthing services has also resulted in a loss of knowledge concerning traditional birthing practices. Varcoe et al. (2013) identified the "almost total destruction of traditional birthing practices in all four communities [in western B.C.]" (p. 4). They found that "only a few surviving Elders could recall customs, and this knowledge was being continually lost as Elders died" (p. 4). First Nations women who were evacuated to Sioux Lookout, Ontario, also identified the absence

of traditional pregnancy and birth teachings (O'Driscoll et al., 2011). Women from Cree and Stoney Nations in Alberta have similarly described the substantial and negative repercussions of removing birthing from their communities on their ability to transmit knowledge (Wiebe, Barton, Auger, Pijl-Zieber, & Foster, 2015). With the loss of birthing, the communities lost knowledge transmission from Elders, Aboriginal midwives, traditional knowledges and practices, collective caring, reproductive health and sexuality teachings, positive perspectives of sexuality, and ceremonies. The loss of birth ceremonies was also equated with the loss of celebrations in communities (Kornelsen et al., 2011), which has left a significant cultural gap. According to Ellen Blais, former co-chair of the National Aboriginal Council of Midwives, "when birth leaves a community, you take away something that brings joy and happiness" (Robinson, 2017, para. 52).

The routine evacuation of First Nations women who live on reserves has affected more than women's experiences and their knowledge. The unpredictable and varied birthing services for First Nations in B.C., for example, were found to detrimentally affect neonatal outcome measures due to current standards of maternity care services not being provided or accessible to First Nations women (Riddell, Hutcheon, & Dahlgren, 2016).

These gaps in services, which are exacerbated by distance to a maternity care unit, likely contributed to the two-fold infant mortality rate for First Nations compared to non-Aboriginal people (Smylie, Fell, Ohlsson, & the Joint Working Group on First Nations, Indian, Inuit, and Métis Infant Mortality of the Canadian Perinatal Surveillance System, 2010). Indeed, quantitative research conducted by Grzybowski, Stoll, and Kornelsen (2011) that examined all singleton pregnancies in B.C. concluded that women who travel for birth have increased rates of induction and unplanned out of hospital births along with

significantly increased perinatal mortality and morbidity. To improve the pregnancy outcomes for First Nations women and their babies, the evacuation policy needs to be changed; however, the details of this federal policy, the processes that facilitate the travel of women, and the transfer of care and responsibility among various governments are opaque. Most importantly, First Nations women's experiences of this policy are largely absent in the literature. It is through this manuscript that this information gap begins to be addressed.

Theoretical Framework

My research employed intersectionality since it is a theoretical approach that can be used to understand and contextualize health care issues (de Leeuw, Maurice, Holyk, Greenwood, and Adam, 2012; Hankivsky & Christoffersen, 2008; Hankivsky, Reid, Cormier, Varcoe, Clark, Benoit, & Brotman, 2010; Huber et al., 2011; Van Herk, Smith, & Andrew, 2011). First articulated by Crenshaw (1989), intersectionality has been used to respond to and critique the absence of theoretical approaches that explicitly examine the ways in which race and gender are leveraged in concert to politically marginalize and discriminate against Black women and other marginalized women. Rather than describing the social construction of race and gender as having an additive effect, intersectionality was generated to draw attention to the synergisms between various forms of oppression and marginalization, which accentuate the experiences of discrimination (Veenstra, 2013). Such an approach counters an additive approach, which isolates each form and structure of discrimination from one another, something that has been referred to as double jeopardy or triple jeopardy. These types of jeopardies occur when "people with multiple subordinate group identities predominantly experience the distinctive forms of oppression associated

with each subordinated identity as separate phenomena" (Veenstra, 2013, p. 647). Intersectionality, thus, is used to purposefully connect different forms of marginalizations and oppressions together with each other.

The strength of intersectionality is, then, that it helps to make explicit the complexities of structuralized systems of marginalization and oppression that women encounter, enabling feminist scholars to activate discussions and draw attention to systems, such as legal and political systems (Hancock, 2007). For this paper, I deliberately identify the legal and constitutional contexts that inform the evacuation policy, because they are crucial to understanding the complex webs of oppression that inform and influence First Nations women's maternity care.

First Nations On Reserves

First Nations peoples who live on reserves within the provinces of Canada receive health care services from three government systems: federal, provincial, and municipal (Commission on the Future of Health Care in Canada & Romanow, 2002; Jackman, 2000). On reserves, health care services are provided by federally employed community health nurses and physicians, which align with Health Canada's Clinical Practice Guidelines for Nurses in Primary Care (Health Canada, 2015a). Unfortunately, the coordination and communication among these three health care systems is less than sufficient (Jackman, 2000), and the funding mechanisms have been described as "confusing and unsatisfactory" (Commission on the Future of Health Care in Canada & Romanow, 2002, p. 217). For example, when First Nations peoples in Manitoba leave their reserve and go to a hospital or to see a specialist, they engage with the provincial health care system. Public health

services that are received in a city, like vaccinations, are provided by a municipal health care system.

The maternity care services provided to First Nations women who live on reserves are likewise provided by three government systems. Federally, community health nurses on reserves provide prenatal care that adheres to federal standards of obstetrical care (Health Canada, 2011). Between 36 and 38 weeks gestational age, First Nations women are evacuated out of their communities to receive care in hospital within urban centres (Lawford, 2016), like Winnipeg. Women with high-risk pregnancies are evacuated out earlier, with the timing largely depending on their specific medical needs. After they are evacuated, women engage with the provincial health care system and those employed by the province. Should any vaccinations be administered while in the city, women could receive these from municipally employed public health nurses. Engagement with three health care systems, however, is uncoordinated and fragmented (Commission on the Future of Health Care in Canada & Romanow, 2002), which results in health services that are less than optimal. With the application of intersectionality, the complexity of health care services can be understood, because it draws attention to and makes explicit the layers of health care experiences.

Methods

I used a case study approach to understand how First Nations women living on reserves in Manitoba experience the evacuation policy (Stake, 2005). This methodology was chosen because it incorporates the use of "multiple sources of data, [which are] rich in real-life situations" (Boblin, Ireland, Kirkpatrick, & Robertson, 2013, p. 1270). A case

study is also well suited to research that is focused on a policy (Exworthy & Powell, 2011), particularly one that is geopolitically bound (Yazan, 2015).

I initially selected the province of Manitoba as the case because most First Nations women in the province are evacuated to one site, Winnipeg, which would have enabled streamlined data collection. During the interviews, however, it became apparent that women are also evacuated to other areas. Women who are part of Pimicikamak Cree Nation as well those living north of this community are evacuated to Thompson. Women from Norway House, Churchill, the Island Lake Tribal Council, and those living south of these areas are evacuated to Winnipeg. Women living in Chemawawin, Grand Rapids, Moose Lake, and Pukatawagan go to The Pas. All women with a high-risk pregnancy are evacuated to Winnipeg, because it is home to the province's only tertiary level maternity care unit.

Manitoba also provided a strong case because there are 140, 975 First Nations people living in the province, the second highest population of First Nations on reserves and in total in Canada (Indigenous and Northern Affairs Canada, 2016, 2014). As well, more than half (54%) of First Nations in this province are under the age of 25 (Government of Manitoba, 2014-2015) and the First Nations birth rate in Manitoba is twice that of non-First Nations (Health Canada, 2014a). Unfortunately, the First Nations infant mortality rate is also twice that of non-First Nations in Manitoba, a rate that is similarly found in First Nations communities across Canada (Health Canada, 2011b).

To recruit First Nations women and community members who have experienced the evacuation policy, I used purposive and snowball sampling (Emmel, 2013). I first emailed all First Nations organizations that had a health department and were located in Winnipeg.

I provided them with detailed information to share with community members regarding the research project, including a recruitment letter, consent form, and the interview guide that would be used in the semi-structured interviews. I also emailed all tribal councils and First Nations communities outside of Winnipeg, if their contact information was available online. Unfortunately, not all communities have a website and many do not provide email contact information. In total, I contacted 42 organizations and communities, all of which were involved in the provision or administration of health care services for First Nations on reserves. As a result, I expanded the outreach of interview requests by directly calling the health directors associated with various tribal councils. Study participants occasionally referred others to the research project. Every person who contacted me was interviewed. In total, there were 12 participants: seven First Nations women and five community members (four female, one male). These 12 participants were a subset of the 32 individuals who were interviewed for my doctoral research project.

All of the women that were interviewed had either been evacuated for birth or had a close family member who had experienced evacuation. Aside from the one male participant who contacted me because his mother was evacuated for birth, no other males expressed interest in participating in the research. Research participants ranged in life stage from early adulthood to Elder. The experiences of evacuation was described from many communities: Bloodvein First Nation, Fisher River First Nation, Island Lake Tribal Council, Long Plain First Nation, Norway House Cree Nation, Peguis First Nation, Pimicikamak Cree Nation, Pinaymootang First Nation, and Wabaseemong First Nation. Interviews took place between July 2015 and June 2016 either in person (two) or on the phone (nine). One participant chose to submit her responses in writing. Data saturation was

determined once descriptions of women's experiences with the evacuation policy were repeated and additional codes were not generated from analysis (Bowen, 2008; Fusch & Ness, 2015). At this point, data collection ceased.

Each participant was asked a series of open-ended questions that did not impose a value judgment on the positive or negative aspects of evacuation, some of which included the following: Do women like being evacuated for labour and birthing services? What are some good things and not so good things about being evacuated for labour and delivery services? When women are evacuated, can they bring anyone with them? Do women have family or friends to help out when they are evacuated? Is there anything else you would like to tell me so I can understand how the evacuation policy works? If you could change anything about your care, what would it be? How could the evacuation policy be improved?

All interviews were digitally recorded and transcribed verbatim, except that of the one participant who chose to write her responses to the interview questions and submitted them by email. After transcription, each participant was mailed a hard copy or emailed a password-protected copy of her/his interview transcript for review. All requested corrections, edits, and amendments were incorporated into the final transcript, which was then entered into NVivo v. 11.3.2 for coding and analysis. Some participants requested anonymity, while others elected to have their names used. As such, names appear with permission while the other participants are indicated as anonymous.

Thematic Analysis

I used thematic analysis to organize the interview data, because it is a "flexible and useful research tool, which can potentially provide a rich and detailed, yet complex account

of data" (Braun & Clarke, 2006, p. 78). This analytical tool can be used to capture important elements that were previously unidentified or thought to be irrelevant to the research question (Braun & Clarke, 2006). In this way, I employed thematic analysis to develop themes to increase my understandings of the evacuation policy from the perspectives of those most affected: First Nations women and community members.

I used the analysis process described by Braun and Clarke (2006) to identify, analyze, and report themes. The first step was to transcribe the interviews, which was followed by several readings of the transcripts. Coding each transcript was the second step, which was accomplished using the software NVivo v.11.3.2. Examples of the codes are included birth place, ceremony, choice, culture, family support, lack of support, midwife, resource requirements, solutions, and travel. In the third step, a purposeful attempt was made to generate broad coding themes based on the initial coded data. A review of the themes was the fourth step, which was accomplished by assessing the themes against all of the interview transcripts. The fifth step entailed a process of refining and labelling the themes to ensure they reflected the account of the experiences that First Nations women and community members shared. The final and sixth step was to choose text from the transcripts for inclusion in this manuscript to address the research questions.

Results

Three overarching themes emerged after a thematic analysis of the interview data from First Nations women and community members: resignation, resilience, and resistance. This order of themes represents their prominence within the research findings. I defined resignation akin to the concept of learned helplessness, which is "a type of passive resignation that occurs following prolonged exposure to uncontrollable negative events"

(Krejtz & Nezlek, 2016, p. 664). I defined resilience as "the process of adapting well in the face of adversity, trauma, tragedy, threats or significant sources of <u>stress</u>" (American Psychological Association, 2017, para. 2). Finally, I defined resistance as an intentional action that opposes the usual course of action (Merriam-Webster Online, 2017).

Resignation

A profound sense of resignation with respect to either the location of care or the type of reproductive care provided was described by participants, which was epitomized by a quote from an anonymous First Nations woman: "Nobody has a choice." This statement was reiterated by Chief Merrick from the Pimicikamak Cree Nation (Cross Lake First Nation). She spoke of the absence of birthing services in her community and the routine evacuation of all women to Thompson, MB, to give birth: "It's not by choice," she stated. In fact, all women in the 28 First Nations located in northern Manitoba are evacuated to give birth in Thompson. When asked if the women could go to Winnipeg for birthing services, Chief Merrick responded, "They don't have that choice. Cross Lake goes to Thompson to give birth. Norway House goes to Winnipeg to give birth, right?" The absence of choice was also described by another anonymous First Nations woman as being related to an absence of knowledge, which instilled a further sense of resignation:

I think it's because people don't know that they can ask for stuff or demand stuff or be like, "you know what? I have every right to have my baby in the community. I want services and I want help." And I think to some people, like myself included, the thought to think outside that box of you have to go to Winnipeg, you have to have your baby in Winnipeg, you have to have all your medical services in Winnipeg, like that doesn't even occur to a lot of people, I think.

Without information, knowledge, and choice, the women did question the reproductive services they were receiving. Irene, a First Nations woman from Bloodvein First Nation, gave an example of how resignation infuses compliance related to the timing of evacuation: "I know a lot of the women that are sent out too early...They don't like that. But the doctor sends them out." This cursory description of the relationship between the doctor and the woman hints at an unchallenged hierarchy of decision-making, one that does not permit choice and positions health care providers as ensuring the evacuation policy is followed. Irene added,

And then they ship them out to the city [alone] for...2 weeks or 3 weeks before they're actually supposed to give birth. And then they're away from...their family for that long....to come and wait in the city to have a baby. Why can't they wait at home?

Questioning the timing of evacuation suggests there may be interest in amending the procedures women experience to ensure they are not alone for long periods of time and to improve the support systems available. The necessity of the evacuation policy, however, remains unchallenged, thus highlighting the sense of resignation that First Nations women may feel.

Closely related to the absence of choice were descriptions of the normalcy of the evacuation policy. When asked if they had envisioned anything other than being evacuated to give birth, participants described the process as, "just the way it is." One First Nations woman (Anonymous) noted, "I think everyone out here just accepts that's the way it is." Jessica echoed her remarks: "Like yeah, that's just how it is." She further characterized the pervasiveness of the evacuation policy and the processes associated with it:

Nobody really told me to go. I just kind of knew I had to go. And I knew I had to go because, well, my sisters both have kids, and it's what they had to do. Like they both had to leave. So I knew I was going to have to leave.

The routineness of the evacuation policy should not be surprising, however, since, "now, everybody goes out, right" (Chief Merrick, Pimicikamak Cree Nation)? One participant had no memory of community and home birthing. When asked if all women from her community are evacuated to Winnipeg to give birth, a respondent answered: "Yeah, everybody basically goes... I've never heard of anybody having a baby in the community" (Jessica). When asked if everyone in her community is evacuated, Ingrid replied: "Probably everybody...Like they just go because they know this is the only way we've been having our babies." All of the participants spoke of traveling for birth as an event that was not out of the ordinary. Indeed, Irene noted that when a one woman returned home from Winnipeg still pregnant after being evacuated, community members called her "crazy," adding that "she should have just stayed in the city" and that "she should have just waited to have her baby in the city." When asked to contextualize these sentiments, Irene explained that community members were concerned with the costs associated with the medevac to Winnipeg for the woman should she go into labour within the community.

The lack of maternity care choices for First Nations was discussed by Doris, who positioned the lack of choices within the provision of maternity care alongside broader efforts to eradicate First Nations knowledges and practices by Euro-Canadian bio-medical practitioners:

When the College of Physicians and Surgeons started their journey across Canada putting laws into place for themselves on what they were in charge of and what they

were in control of... birthing babies was one of them. And so they outlawed our midwives by saying, "You cannot deliver babies anymore because you don't have the credentials. We didn't give you those credentials. We have them. You don't."....[Midwives] would not give up that practice because they knew what they were doing. They cared about mothers and children and babies being born at home. They knew how to do that. So then our midwives' [practice] became an illegal area because of that.

Another anonymous participant drew attention to an Elder midwife in the Island Lake

Tribal Council area who delivered close to 100 babies before the nursing station was in

place and when "people were still just living off the land." In the Pimicikamak Cree Nation

not one of the community's midwives is still alive (Chief Merrick). These descriptions give

insight into the purposeful efforts that took place so that labour and birthing services had to

be located off reserves. As a result, on reserve birthing services are no longer available and

a sense of resignation has been cultivated.

Resilience

The ability of First Nations women to withstand and endure the isolation caused by Health Canada's evacuation policy is testament to their resilience. Respondents consistently drew attention to being evacuated alone and the lack of support during their labour and birth as issues that negatively affected their birthing experience. Ingrid was evacuated alone during the winter holidays and spent many weeks in hospital prior to the birth of her child. When asked how she felt being in the hospital alone, she replied:

Well, actually I was just crying most of the time....It was really hard....Like it was supposed to be a happy time in my life, like having my first baby. But it

didn't seem that way because I was so lonely. Like, I didn't have anybody with me....Yeah, it was really hard.

Ingrid knew that being isolated from family and friends for birth was not something only she experienced: "Yeah, it is hard...I know women that go have their baby, like they leave here and they leave their kids, their family, and they're alone over there." Another respondent echoed the Ingrid's description of being women being alone when she was evacuated for birth:

They are not allowed to bring anybody with them, especially if they are in crisis from a pregnancy. If you have to fly out for ...on an urgent matter, you're not allowed to bring anybody, so you're literally left by yourself on your own in such an important time in your life. (Anonymous)

Irene, however, suggested that sometimes a support person is able to accompany the woman: "sometimes maybe their sister or husband go with them." When Siobhan was medevaced by plane from Thompson to Winnipeg, for example, her partner was unable to travel with her. Though he did join her in Winnipeg, they did not receive any financial support to offset the \$2,000 out of pocket expenses related his travel and accommodations. Siobhan noted,

When I finally went to Winnipeg, I did not having any friends/family living there at the time. I felt isolated and scared of being away from family. My common-law [partner, who paid for his own travel] ended up having to leave Winnipeg to go back to work.

This experience shows that despite public funding of evacuation and of maternity care, families bear the financial burden of providing an in-person support system to the

labouring and birthing women. This adds financial stress to an already emotionally difficult time.

The importance of having a support person with the woman during labour and birth was a perspective shared by other participants. Chief Merrick, for example, asserted, "the father-to-be, you know, the father needs to be there to see their children born. To have that one-on-one." When recounting her sister's experience of being evacuated alone to give birth in Winnipeg, an anonymous participant shared:

I think not having my mom there, not having my sisters, not having any like female relations there for her was really hard... I think that's really shitty because I think it's such a special time in your life [and] that there should be support there. You should have support and love and encouragement, especially from other women.

The same participant noted that the pain of being alone for birth was rationalized – and even minimized - by family members because everyone had experienced the same thing: "It was kind of like, well, you're having a baby... everyone has a baby. You know what I mean? ...Like that thing of, 'I've done it, you can do it'" (Anonymous). The loneliness and the pain of birthing alone were viewed as acceptable as First Nations women are viewed as being resilient.

The theme of resilience also emerged from the interviews that highlighted the lack of information regarding the evacuation policy. An anonymous participant stated: "They didn't tell me anything...We don't get information, enough information about the traveling." Siobhan shared her experience of being medevaced to Winnipeg after being routinely evacuated to Thompson. She described the lack of information for her travel to Winnipeg as negatively affecting her care:

I felt the experience was terrifying and scary, but also in the back of my head that being in Winnipeg, [it] would be the best care for myself and the baby. Because it was very rushed I felt I did not have all the information or what was happening until I got to Winnipeg.

While the medevac was understandably necessary, written information during her prenatal care that described the process should an emergency transfer be required was wanted, because it would have eased the transition between care in the North to a Winnipeg hospital: "I think having the most information given to you is beneficial. Having contact sheets information and numbers [for the women and their families] really would have been helpful." Even without necessary medical and travel information, First Nations women courageously navigated their health care needs.

Resistance

The lack of information provided to those being evacuated and their families perpetuated the viewpoint that First Nations women, families, and communities should not ask questions about their maternity care services. To counter this idea, one participant linked the ability to ask questions with the empowerment and self-determination of First Nation's maternity care services:

There's nothing wrong with asking those questions. Why can't I have my baby in [the community] or, you know, at the local hospital? Why can't I get support?....

Because it's like once someone starts making waves, like okay, I want to have my baby here, I want to be in the community and I want a midwife and I want a doula, and I expect a space within this hospital. And I don't know about any of that stuff.

But this is what I want, and this is what needs to happen for me. I think maybe people are either going to be like, "you know, you're right?" (Anonymous)

Having information was thus viewed by participants as being connected with choice and a

way to resist the evacuation of all First Nations women from rural and remote reserves.

Interest in giving birth in the community and even at home was another way that resistance was observed from participant interviews. Jessica, for example, was asked to imagine alternatives to being evacuated for birth and to imagine an ideal birthing situation. She replied:

J: To give birth at home.

Interviewer (I): [Your dream] is to give birth at home?

J: Yeah.

I: What do you mean by home?

J: Like our home, like where we live in, like that home.

I: Oh, like your literal home, not like in your community but in your home.

J: Yeah, in our home home. I think it would be more meaningful.

I: Who would attend you? Like would you have any caregivers involved?

J: Yeah.

I: And who would you like to have there?

J: Family.

I: Family, okay. What would your family be doing while you're in labour?

J: Just supporting - a support system.

Irene also described a shift from routine evacuation to community birthing as desirable: "I think [women] would prefer to have their babies in the community. [They would] rather

stay home and have their babies at home in their own community. A lot of the people...don't like staying in the city." Chief Merrick noted:

There are 28 First Nations in our area. And all of them have to take their women out to go give birth. All of them. Not one of them have a birthing centre in their community....I would love to have a birthing centre in my community!

Ingrid also added that midwifery would be important for community birthing: "If I could wish, I wish I could have...a midwife here so women don't have to leave the community to have their baby." Community birthing and even home birth were thus ideas that some of the participants identified as alternatives to the evacuation policy. The ability for First Nations women to decide where to give birth reinforced the theme of resistance by visioning a future of labour and birthing services that is different from the evacuation policy.

One participant defied the evacuation policy in an extraordinary manner: she chose to have a home birth in her community. In order for her to have a home birth with two registered First Nations midwives, however,

We had to get permission from Chief and Council to deliver [on the reserve].... So my mom had to go and find the Chief and the council member to sign this letter for me to...in order for me to have permission to have my baby in my mom's house.

(Anonymous)

This woman's resistance to the normalization and resignation of evacuation for birth was also noticed by community members, who were "pointing and whispering" at her when she was out in public. Being in her community to give birth gave her great comfort:

I found like just being on the land really helped calm me down for the birth. And I felt... I just felt really cocooned there, and I felt that all those worries that I had suddenly were being washed away by just me being on the land walking.

This experience points to the remarkable efforts that one woman, her family, and her caregivers had to exert to resist the evacuation policy.

The same participant described experiencing support, love, and encouragement during her labour and birth, which was attended by two registered Aboriginal midwives.

It was a really hard delivery, like of course all of them are. But I just stuck it out.

My aunts were there. My mom had two of her sisters living in the house at the time.

So like it was familiar...You know, they were going to sleep, they were having coffee and tea. It was just sort of like a normal day but I was giving birth in my mom's bedroom....I felt really loved and cared for, that's for sure. (Anonymous)

This woman's labour and birthing experience with the support and presence of her family was framed as positively affecting the woman, her family, and her community, a stark contrast to other women's descriptions of evacuation for birth.

Discussion

The experiences shared by First Nations women and community members show that the processes associated with Health Canada's evacuation policy are far less than optimal. Women are shuffled among health care systems and are offered very little or no choice in the location of their birth or in who attends their birth, which perpetuates a sense of resignation. There is, however, an individual and collective remembering of maternity care practices and providers before evacuation became a widespread and routine practice: when midwives, doulas, ceremony, and cultural events were the norm. Despite the

resignation of some women, there is a strong sense of resilience and in some cases resistance that underlies decisions to defy the evacuation policy and birth in a manner that is local, relational, and community oriented.

The resilience and resistance of women in response to evacuation for birth highlights the critical role played by colonialism – through the *Constitution Act*, 1867 and the *Indian Act* – as a force that uniquely shapes the oppressions experienced by First Nations women during the duration of their maternity care. This identification opens a discussion about the importance of a theoretical framework that draws attention to the specific lived experiences of First Nations women living on reserves in Canada. Indeed, the resignation, resilience, and resistance of First Nations women and community members expressed as a result of evacuation enables maternity care to be framed within the specific legal and constitutional context of Canada. As described above, the federal, provincial, and municipal health care systems that are involved with First Nations who live on reserves are historically positioned and are also actively practiced as components of Canada's colonial identity.

Resignation

A lack of information, isolation, and uncoordinated maternity care services for First Nations women has given rise to an endemic sense of resignation among First Nations women and community members. Since all women on rural and remote reserves are evacuated and may be unaware "that they can ask for stuff or demand stuff" (Anonymous First Nations woman), there is little they can do but comply with routine evacuation for birth. As a consequence, the effects of Health Canada's evacuation policy are perceived as something that happens to their loved ones, rather than providing a component of maternity

care services in which they can be involved as active and influential participants. One participant's sense of profound resignation is compelling and provides an example of the effects of the lack of information regarding the timing and process of her evacuation to Winnipeg: She just knew when she should leave her community. Such a finding is remarkable and worthy of consideration because it points to the extent that the evacuation policy has become established as such an indispensible component of maternity care for those residing on reserves that instructions about evacuation may be not necessary.

Health Canada's evacuation policy removes choice in birthing from women and isolates them from sources of support and their community (Kornelson et al. 2011; Lawford, 2011; Lawford & Giles, 2012a, 2012b; Robinson, 2017 Jan 1; Varcoe et al., 2013). First Nations women do not have any say in the location to which they are evacuated and the timing of evacuation is not negotiable nor is it explained. Irene, a First Nations women who was evacuated twice, was aware of the absence of choice and situates such decisions as stemming from medical practitioners: "the doctor sends them out," she stated, despite women not liking evacuation. As a result, the provision of labour and birthing services outside of First Nations communities is prescriptive and dogmatic. A lack of choice also reinforces the idea that Euro-Canadian trained maternity caregivers are experts in each individual First Nations women's maternity care and positions them as the sole decision makers for women, including knowing the best place for birth and kind of care they are to receive. As a result, resignation towards the evacuation policy is not accidental; rather, it represents the culmination of the Government of Canada's longstanding efforts to realize the evacuation policy's original goal: "the marginalization of First Nations pregnancy and birthing practices and ... the [adoption of] the Euro-Canadian biomedical model" (Lawford & Giles, 2012b, p. 327).

Resilience

Some participants connected the absence of labour and birthing services on reserves with Canada's goals to assimilate First Nations into a generic Canadian identity were realized through a strategic approach: remove labour and birth from communities (Lawford 2011; Lawford & Giles, 2012b). For example, Doris, a First Nations woman and community leader, remembered how the College of Physicians and Surgeons "outlawed our midwives," which resulted in the loss of home and community birthing. Asserting the power of the *Indian Act* to ensure physicians had complete authority over the health services that were received on reserves was a tactic used by various authorities, including those who worked for the Government of Canada; they even went as far as to fabricate fictional laws if communities were non-compliant (Lawford & Giles, 2012b). It is thus unsurprising that Health Canada's evacuation policy was leveraged to target the removal of labour and birthing services as a means to deliberately outlaw, remove, and destroy health care practitioners, practices, medicines, and ceremonies that First Nations had used for millennia (Lawford & Giles, 2012b). Despite these substantive efforts to erase the roles of women and midwifery services, some participants longed for community and home birthing and spoke of doula and midwifery services. Their capacity to envision a future that included a choice of birthplace and of caregivers even in the midst of multiple systems of oppression and marginalization over multiple decades demonstrates the tenacity and resilience of women and community members. This finding acknowledges First Nations women's remembering and visioning of community and home birthing, which could act as

a catalyst for transformative changes to the maternity care services provided to women on reserves.

My findings, along with those from Kornelsen et al. (2011) and Varcoe et al. (2013), do indicate that to withstand the substantially negative effects of the evacuation policy, First Nations women must possess extraordinary resilience in the face of systemic pressures to submit to Euro-Canadian bio-medical policies that are founded on assimilation and coercion. As described above, the current provision of services is far less than optimal. Ingrid and other anonymous participants described the loneliness and isolation of birthing alone as less than optimal and as "shitty." These findings reflect those reported by Kornelsen et al. (2011), who drew attention to the "sense of isolation [that] was felt through estrangement from larger cultural norms surrounding birth" (p. 61) when birth does not involve family and community.

Varcoe et al. (2013) documented similar findings: "loneliness, disconnection from community, isolation from family and culture, and discrimination" (p. 5), which were found to contribute to "post-partum depression and affected their capacities to bond with and nurture their infants" (p. 6). The First Nations women and community members who were interviewed as part of this current study, however, did not report racism during their evacuation or postpartum depression as a result of leaving their community. This is not wholly unexpected, as women have "divergent experiences of childbirth outside of their community" (Kornelsen et al., 2011, p. 61). As well, the focus of this research was on the evacuation policy, not the care that was received once evacuated or the outcomes after returning home. Certainly, this is important information related to the provision of health care services and should be considered for future investigations so that the full physical,

mental, spiritual, and emotional health effects of Health Canada's evacuation policy are made apparent.

Resistance

Without caregivers who support this change and because of the evacuation policy, women have few alternatives to evacuation for birth. Nevertheless, numerous participants described reimagining and visioning birthing in the community, at home, and on the land. One anonymous participant who gave birth at her mother's home on reserve is an example of how re-thinking and disrupting routine evacuation can affect change. With the involvement of family and community members, this woman's pregnancy, labour, and birth facilitated a return of practices related to pregnancy, labour, and birth. Her active resistance to Health Canada's evacuation policy, however, was not simple to achieve. Permission from Chief and Council had to be granted before a home birth was allowed. This necessity speaks to the extent that the evacuation policy has become ingrained as a normal, routine, and acceptable component of maternity care – even by First Nations governments themselves. It is all the more extraordinary that she had to go through this permission process considering she was receiving care from registered Aboriginal midwives, who are licenced, regulated, and insured to provide labour and birthing services in homebirth settings all across the province of Manitoba.

Other participants also spoke about resistance to the evacuation policy through words of strength and hope. To counter the removal of labour and birthing services within communities and homes due to the evacuation policy, the need for maternity care and birthing services on reserves, home birthing, and midwifery services was voiced. These findings mirror those documented by O'Driscoll et al. (2011), Kornelsen et al. (2011), and

Varcoe et al. (2013) and are aligned with recommendations from the SOGC (2010). The relationship among ceremonies, sacred knowledges, and community and home birth was spoken about as wistful visioning as well as with fierce determination to affect change for future generations. Hope for change is nascent, but evident in discussions with women about birth. While there are efforts to search for traditional maternity care information from Elders to "inform the development of hospital-based cross-cultural care" (O'Driscoll et al., 2011, p. 25), this information does not address the absence of choice with respect to mandatory evacuation in late pregnancy, as all who are receiving care in a hospital have already been evacuated.

Resistance to evacuation is also evident in the Manitoba Indigenous Doula Initiative (Brown, 2016). Members of this initiative, "encourage traditional approaches to healthy pregnancies, healthy sexuality, culturally-appropriate childbirth education, and breastfeeding and parenting support through community-based programming" (para. 7). Women caring for women in their own communities, offering choice of birth place and caregiver, and bringing birth back home - these are parts of the future for First Nations in Manitoba.

Conclusion

Often the only point of continuity in their own care, pregnant First Nations women in Manitoba transit multiple systems of care and, as a result, are often resigned to experience the structures, processes, and failings of Health Canada's evacuation policy. Documenting the voices of First Nations women and family members who experience evacuation exposes the effects of the evacuation policy, which underscores this sense of resignation. It also makes evident the resilience and resistance of women who are at the

behest of the care, and lack of care, of Euro-Canadian bio-medical systems of healthcare in Manitoba. Insights of the workings of the evacuation policy from First Nations women and family members also clearly show a lack of information along the entire pathway of maternity care, which contributes to the perpetuation of poor or even absent federal, provincial, and municipal health care services. This article contributes important perspectives from First Nations women and family members, individuals whose voices are often absent within the literature related to maternal and child health. It also acknowledges the importance of restoring choice to women and honouring the roles they have to bring about changes to improve their own health and for generations to come. My research also points to a pressing need for change that will foster and support the provision of maternity care that First Nations women and community members want. Instead of surviving Health Canada's evacuation policy, First Nations women and their babies should be thriving. To reach this aspiration, those involved in policy, health research, and health workforce planning must prioritize the involvement of First Nations women and families in discussions related to the provision of maternity care in Manitoba and all across Canada.

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Chapter 4:

The Need for a First Nations Feminist Theory: Considering the Case of the Legal Categorization of First Nations Women's Health and Healthcare Services.

Abstract

Health care for First Nations women who reside on reserves is complicated because of the many health care systems involved, both on and off reserve: federal, provincial, and municipal. The lack of cohesion, cooperation, and communication among these organizations results in services and access to these services that are less than optimal. It is through the power of the law – and the *Indian Act* in particular - that First Nations women have immense legal and policy attention focused on their bodies, and particularly their reproduction. There is a need to account for this unique legal positioning of First Nations women within the Canadian constitutional context. The purpose of this paper is to argue for just that: through a specific First Nations feminist theory (FNFT) which can provide a framework upon which an analysis of women's health and health care on reserves, and other research, can be conducted. In this paper, I will first present a review of the literature to describe the power of the *Indian Act* and how it has affected and continues to affect the legal status of First Nations women. I then discuss how pan-Aboriginal/pan-Indigenous theories are being used with increasing frequency to counter the fragmentation of Aboriginal peoples that is a direct result of Section 35(2) of the Constitution Act, 1982, which describes Aboriginal peoples in Canada as Indian, Inuit, and Métis. While pan-Aboriginal theoretical approaches work towards a goal of decolonization and the reframing of identity within emerging ideas of self-determination and autonomy, I argue that they may not capture the specific consequences, particularly for women and their access to healthcare as a result of the legal categorization of First Nations in Canada. I conclude by arguing that the depth of analysis offered by a First Nations Feminist Theory, gaps in the health and reproductive care needs of First Nations women on reserves and gaps in our

understanding of these needs can be better understood. With the use of a FNFT, academics, policymakers, and healthcare practitioners can better appreciate the contextual influences on the health care experiences of First Nations women within a framework that takes into consideration the legal and policy conditions that have profound consequences for First Nations women's care.

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A broad (a.k.a. Canadian) overview of any subject in Native Studies requires considerable sensitivity and rigour to avoid falling prey to overgeneralization and misrepresentation. The reality is that no one general study can fairly represent the lives and experiences of all Aboriginal women in Canada because not all Aboriginal Peoples are alike.

Stevenson, 1999, p. 75

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Colonial policies and practices continue to have a disproportionately negative effect on First Nations women in Canada. Theoretical approaches that consider the specific legal and constitutional positioning of First Nations women within feminist and health scholarships are sometimes incomplete or lack the specific cultural articulations that give voice to the foundational and authoritative position of these women and their experiences. This paper is intended to start the process of addressing this gap in the theoretical literature that is commonly used in the social sciences by taking the first step to make evident the need for a First Nations feminist theory (FNFT). I argue that it is through this theoretical framework that research specific to First Nations women can be used to understand and improve the health care services, policies, and processes for First Nations women who reside on reserves.

While there is an increasing use of pan-Aboriginal theoretical approaches as tools to work towards goals of decolonization and reframing of identity within emerging ideas of self-determination and autonomy, I¹ strongly assert that in some contexts, these broad theoretical approaches neglect the very real consequences of the unique legal categorization of First Nations in Canada, including for women and their access to health care services. Similarly, while the use of intersectionality as a theory within health research is often used to make sense of health care systems and resulting poor outcomes for First Nations women (de Leeuw & Greenwood, 2011; Dhamoon & Hankivsky, 2011; Hankivsky, Reid, Cormier, Varcoe, Clark, Benoit & Brotman, 2010; Hole et al. 2015; Van Herk, Smith, & Andrew, 2011), the significant legal and constitutional positioning of these women remains obscured in these analyses. A specific focus within intersectionality theory considering Indigenous women, articulated recently as "Red Intersectionality" aims

to "centre the historic and ongoing resistance of Indigenous girls to violence through colonial policies and practices" (Clark, 2016, p. 46) by challenging "conventional intersectionality scholarship by foregrounding anti-colonialism and Indigenous sovereignty/nationhood" (Clark, 2016, p. 46). But this literature too underplays the form of colonialism that is specifically experienced by First Nations women and girls grounded within a specific legal and constitutional positioning in Canada.

The *Indian Act* of 1876, a leveraging of the power of Canada's constitution, was used to dictate who was federally recognized as an 'Indian' person, where they lived, the types of health services that they were eligible to receive, and enforced attendance at Indian Residential Schools. Those who fall within the legislative framework of the *Indian Act* have these and other critical elements of their lives controlled by the Government of Canada. Indeed, the *Indian Act* remains a substantial piece of federal legislation that is largely unchanged from its original form, and thus forms part of the analysis presented herein.

This paper is inspired by the stories and voices of resilience and resistance of First Nations women whom I interviewed for my doctoral research. It is born out of my frustration and anger at the disparities in maternity services offered to women who reside on rural and remote reserves – services that fall short of those recommended in national professional guidelines and pale in comparison to those for women who reside in urban settings. I practiced as a registered midwife in Hamilton, Ontario for three years. The work I did as a midwife and as part of a larger practice was founded on the importance of informed choice and culturally safe care. The women whose babies I helped deliver had choices. Their families had choices. They had the opportunities to make decisions about the

kind of care they would receive, where they would receive this care, and who would be present during the care, except in cases of emergency.

By stark contrast, women who reside on remote and rural reserve communities are offered very little choice about the way in which they give birth to their children (Canadian Research Institute for the Advancement of Women, n.d; Lawford & Giles, 2012a; Varcoe, Brown, Calam, Harvey, & Tallio, 2013; Wiebe, Barton, Auger, Pijl-Zieber, & Foster-Boucher, 2015). The geopolitical boundaries of their reserve communities further restricts women's access to maternity care choices, which are physical conditions that are dictated through the power of the *Indian Act*. Unless they hide on the land, they are not given the choice to have their birthing experience at home or even within their communities (C. Couchie, personal communication, July 29, 2015). Instead, they are removed (sometimes forcibly) from their lands, from their communities, and their families and flown south to give birth among strangers with little familial connection and support (Lawford & Giles, 2012a). They leave the familiarity and comfort of their families, homes, and communities for strange cities where their connection to their lands and culture are broken, and are subjected to often-foreign stressors, racism, violence, and threats of their security such as through gang recruitment. For example, interviews with First Nations women found that "women described having 'no power, no choice, and no control' in their birth experiences and [face] considerable racism in their health care encounters" (Varcoe, Brown, Calam, Harvey, & Tallio, 2013, p. 5).

In my own research, I have found that women are resigned to the processes surrounding Health Canada's evacuation policy, and the resulting lack of informed choice with respect to their maternity care. The continued and sustained lack of national attention

to the disparate and disjointed maternity care services First Nations on reserves suggests the various health care systems involved regard the status quo as acceptable. It is this acceptance that I aim to disrupt.

I construct this case for a FNFT first with a description of pan-Aboriginal theories increasingly used to counter the fragmentation of Aboriginal peoples; this is a direct result of Section 35(2) of the Constitution Act, 1982, which describes Aboriginal peoples as Indian, Inuit, and Métis. While pan-Aboriginal theoretical approaches contribute towards a goal of decolonization and the reframing of identity within emerging ideas of selfdetermination and autonomy, I argue that they neglect the specific consequences of the Constitution Act, 1982 and the Indian Act in the way that these legally determine and colonize the bodies and experiences of First Nations women in Canada. To substantiate this critique, I proceed to a description of the power of the *Indian Act* and how it has affected and continues to affect - the legal status of First Nations women, in particular, and subsequently the choices they can and seemingly cannot make around their maternity care. This critique points to a pressing need for a theory with which to understand and articulate the health care and maternity care needs specific to First Nations women on reserves. After reflecting on the tenets of intersectionality and its use in my own research, I conclude by arguing that absent the depth of analysis offered by a First Nations feminist theory (FNFT), gaps in the health and maternity care needs of First Nations women on reserves will be perpetuated, as will the gaps in our understanding of these needs. This work provides the impetus for future work to elaborate the details of a FNFT and to examine its implications for acknowledging, understanding, and addressing the resignation, resilience, and resistance of First Nations women in the face of persistent colonialism.

Pan-Aboriginal Theoretical Frameworks

Pan-Aboriginal theoretical approaches are increasingly being used by social scientists as a way of drawing attention to the commonalities of colonial influences and circumstances of Aboriginal peoples' lives (Moore, Walker, & Skelton, 2011; Ouellette, 2010; Scheim, Jackson, James, Dopler, Pyne, & Bauer, 2013). These theories can be effectively used as an antidote to the fragmentation of Aboriginal peoples (Allan, 2013), who are regulated according to the legislative needs of the Government of Canada. Theories that rely on homogeneity or premised on pan-Aboriginality can, however, reinforce generic and essentialist notions of Aboriginal peoples, which erases the cultural specificity of each Aboriginal group. Distinct elements of autonomy, self-determination, and self-governance may be lost in discussions that employ a pan-Aboriginal theory. In fact, activist Sacheen Seitcham (2012, November 8) strongly asserted that pan-Aboriginal approaches can be linked with continued assimilation:

pan indianism + homogenization + assimilation = NO THANK YOU! I love being a Kuus Xulmux woman! the west coast is my home, and where my ancestors are from. While I can claim all of turtle island for my home, I am concious [sic] aware and respectful of the fact that turtle island encompasses many Nations.

Tallbear (2001) also described a pan-Aboriginal approach as problematic when used by distinct tribal groups to achieve tangible and meaningful input into activities that directly affect them. She argued that "*specific* tribal cultural practices, histories, and community needs...that specifically promote tribal sovereignty and political authorities are nearly non-existent" (p. 3) when negotiations are premised on an idea of pan-Aboriginality.

Consequently, a pan-Aboriginal approach has the potential to obscure the specific disadvantages that are faced by on a particular group of Aboriginal people.

A pan-Aboriginal approach could also erase the unique and relational knowledges that are site specific by glossing over the "geographic, language, and cultural divides" (Indigenous Peoples' Health Research Centre, 2005, p. 1), thus amalgamating Aboriginal peoples into a meaningless residual category of 'other'. In response to such generalizations, some Aboriginal scholars are critiquing pan-Aboriginal theories and creating contextualized theories by embedding place within descriptions of Aboriginal peoples. Hunt and Holmes (2015), for example, described the geographies of private and intimate spaces, such as home and families, within Coast Salish territories to resist colonization. By focusing on these non-public spaces of resistance, Hunt and Holmes reassess the ways in which colonization affects their lives, resulting in an approach that is relational and unique.

As a group of theories, pan-Aboriginal theories are not used to call attention to the uniqueness of specific Aboriginal groups nor do they take an explicit gender focus. While useful in some contexts, the application of a pan-Aboriginal theory to understand the specific needs of First Nations women on reserves obscures, for example, the significant legislative and regulatory roles of the *Indian Act* and the law of the constitution. These very real conditions affect the lives of First Nations women, their children, and their families, all of which are premised upon the *Indian Act* and must form the basis of a FNFT.

The Power of the *Indian Act*

Who is Indian? Implications for Women

The Crown's perceived need to regulate Indian populations predates the formation of Canada as a country. In 1850, the British wrote *An Act for the Better Protection for the*

Lands and Property of the Indians in Lower Canada, which defined the membership code for Indians as

First – All persons of Indian blood, reputed to belong to a particular Body or Tribe of Indians interested in such lands, and their descendants.

Secondly – All persons intermarried with any such Indians and residing amongst them, and the descendants of all such persons

Thirdly – All persons residing among such Indians, whose parents on either side were or are Indians of such Body or Tribe, or entitled to be so considered as such:

And

Fourthly – All persons adopted in infancy by any such Indians, and residing in the Village or upon the lands of such Tribe or Body of Indians, and their descendants. (Act for the Better Protection of the Lands and Property of the Indians in Lower Canada, 1850 (U.K.), 13 & 14 Vict., Cap. 42., p. 1248)

A year later, the *Act* (1850) was amended to "exclude those adopted in infancy and non-Indian men married to Indian women" (Peach, 2012, p. 105). This wholly gendered decision ignored "matrilineal descent and matrifocal family and kinship structures, [which] were a feature of many Indigenous nations" (Eberts, 2013, p. 154). For simplicity, further discussion of this is excluded here. While likely created to limit the benefits of treaties to only those defined in the *Act*, this code did signal the intent of the colonial legislatures to use their power to define and control who was and would become "Indian." This power is echoed in subsequent legislation, laying the groundwork for specific measures to control First Nations women.

Indeed, the formation of Canada in 1867 through the Constitution Act (1867) gave the newly formed federal government the legislative authority to constitutionally define Indian peoples, which was accomplished nine years later. The *Indian Act*, enacted in 1876 under the guidance of Canada's first Minister of Indian Affairs – John A. Macdonald continues to be used today as a piece of "recognition legislation through which the Canadian state determines which Aboriginal individuals it will acknowledge as 'Indians' and which Aboriginal groups it will acknowledge as Indian 'bands'" (Giokas & Groves, 2002, p. 47). The *Indian Act* (1876) is significant in that it explicitly linked Indian status with men only: "First. Any male person of Indian blood reputed to belong to a particular band; Secondly. Any child of such person; Thirdly. Any woman who is or was lawfully married to such person" (s. 3.3). This membership code imposed the values and ideology of the legislators at the time, that is, a family was nuclear in formation with a man as the head of the family (P.L. Chartrand, personal communication, October 27, 2105; Emberley, 2001). This was in stark contrast to the matrilineal and matrilocal practices of some aboriginal peoples. This is an example of one of the Government of Canada's earliest intrusion on and regulation of Indian populations' identity and membership, which had a disproportionate impact on women.

The federal government's power and authority to legally define and regulate Indian identity is derived through the power of the law of the constitution, which is "often considered a country's highest form of law" (Borrows, 2012, p. 351). With respect to the membership code within the *Indian Act*, Cannon (2005) pointed out the obvious:

It [is] important to establish that Aboriginal women who 'married out' have never voluntarily consented to a loss of Indian status. Even if women made so-called

'choices' when they 'married out,' the consequences were different from that of men's 'choices,' and they did not justify the sex discriminatory sections of the Indian Act. Even when women were separated from their husbands or widowed, they could not... return to the community. (p. 380)

Decisions to have children with or marry men who did not fall under the *Indian Act*, thus affected women's kinship and familial relationships. This "highly discriminatory treatment of women under the *Indian Act*" (Eberts, 2013, p. 155) was one of utmost controversy (Binnema, 2014), used to make women invisible and control their belonging through marriage and birth.

A critical element of the *Indian Act* is the Government of Canada's enforced Indian Residential School system (Truth and Reconciliation Commission of Canada, 2012). To ensure Indian children attended an IRS, the *Indian Act* was amended in 1920 to make school attendance mandatory for children between the ages of 7 and 15. Through attendance at IRS, the Government of Canada aimed to "remove and isolate children from the influence of their homes, families, traditions and cultures, and to assimilate them into the dominant [Western] culture" (Harper, 2008, p. 1).

In addition to using the police to enforce attendance at a residential school, the school's principal had authority from the power of the *Indian Act* to have any Indian student - female and male - sterilized using provincial legislation as the legal basis for such decisions (Pegoraro, 2015). The *Sexual Sterilization Act* was enacted from 1929-1972 in Alberta; in British Columbia, the *Sexual Sterilization Act* was enacted from 1933 to 1979 (Grekul, Krahn, & Odynak, 2004; McLaren, 1986; Stote, 2015). Federal physicians who provided obstetrical and gynecological care to female Indian students and Indian women on

reserves also determined who should be sterilized. Indian women and girls "who proved hostile to conversion and assimilation, those who refused to go to church, or those who married a non-Christian Indian man" (Pegoraro, 2015, p. 163) were prime targets for forced sterilization. The Government of Canada supported such procedures and funded Indian Affairs to provide financial incentives to any physician who sterilized Indians, "especially if they [Indian women] weren't church-goers" (p. 162). While the exact numbers of Indian women and men sterilized are unknown due to record destruction, the remaining files show that women were overrepresented (Boyer, 2006; Pegoraro, 2015). The Government of Canada, thus, employed various pieces of legislation to ensure the "Indian problem" (Campbell Scott, 1920, para. 1) identified by Duncan Campbell Scott was eradicated. This "problem" – the very existence of "Indian" peoples in Canada – would be eliminated through legislative and educational actions, with unique consequences for "Indian" women.

The Changing Legal Status of Indian Women

My personal bloodlines boil when I think of the power that the *Indian Act* has to determine which women are inside and which are outside of the Government of Canada's imposed definitions of "Indian-ness" (Eberts, 2013, p. 149). How many women and their families and offspring are now outsiders, forcibly removed from their heritage because of the *Indian Act*? How many women have been forced from their families and communities by these archaic rules – rules that were meant to colonize, assimilate, and eliminate Indian women, and by extension, Indian peoples? Without their consent, these women and their families were ejected from their lands, affecting a form of *terra nullius in utero*². My anger persists, particularly in the face of changes to membership – described next - that only

address recent historical discriminations and not the overarching colonialism and patrilineality of the *Indian Act* and its imposed membership rules.

The *Indian Act* bestows the Government of Canada a constitutionally legislated "comprehensive mechanism of social control" over Indians (Gibbons, 1997, p. 21), which is deliberately detrimental to Indian women's identities and has substantially changed the pre-contact roles of women. The reproductivity of Indian women, that is their ability to bear children (Stote, 2015) and actively contribute as woman leaders, was particularly targeted though this piece of federal legislation as a strategic move by the Government of Canada. By interfering with the generational transmission of rights through women, kinship and familial relationships were severed.

The *Indian Act* only recognized Indian men, such as fathers or husbands, as having the ability to pass along Indian status (Eberts, 2013). As noted above, such recognition completely disregards the matrilineal and matriarchal governance structures of some Aboriginal peoples. Mi'kmaq peoples, for example, "had always been matrilineal" (Simon & Clark, 2013, p. 105), so lineage was passed from mother to daughter. To address the overt patrilinearity of the *Indian Act*, the Government of Canada has tried to address the "woman follows man" mentality embedded in the text of the *Act*. The woman follows man approach mimics that of the membership code in the *Indian Act*, which links registration with maleness and a male head of family and reflects the Victorian values of British colonizers (Fitznor, 2006; Giokas & Groves, 2002). The two meagre constitutional amendments that attempted to affect the patrilineal membership code for Indians in Canada are Bill C-31 (1985) and Bill C-3 (2010). Preceding both Bills was the patriation of the *Constitution Act*, 1982, which provided the impetus for change when the *Canadian Charter*

of Rights and Freedoms was added (Hurley & Simeone, 2014). Section 15(1) of the Charter states:

Every individual is equal before and under the law and has the right to the equal protection and equal benefit of the law without discrimination and, in particular, without discrimination based on race, national or ethnic origin, colour, religion, sex, age or mental or physical disability.

The inclusion of the word "sex" within 15(1) pushed the federal government to align the *Indian Act* with the *Charter*, which the Government of Canada addressed by introducing Bill C-31, *An Act to amend the Indian Act* (Canadian Bar Association, 2010; P.L. Chartrand, personal communication, October 27, 2105; Hurley & Simeone, 2010).

Sections 6(1) and 6(2) of Bill C-31 focus on the inclusion of Indian women within the membership code of the *Indian Act*; however, the *Act's* "gender discrimination was not fully amended by Bill C-31" (Canadian Bar Association, 2010, p. 1). In fact, these amendments simply added additional categories and also limited the number of generations that are entitled to Indian registration (Furi & Wherrett, 2003). After two generations of an Indian person marrying a non-Indian person, the third generation is no longer eligible for Indian status. The amendment to the *Indian Act* by Bill C-31, thus, did not address the foundational exclusion of women; it merely postponed the exclusion of some Indian women from community membership.

It is noteworthy that not all Indian bands have accepted these constitutional changes to the *Indian Act. Sawridge Band* v. *Canada* (2009) is an example of a court case in which an Indian band attempted to use a "woman follows man" approach to exclude some women from band membership; this case has now been dismissed (Gover, 2016). Borrows (2012)

describes the woman follows man approach as problematic: "whether used by distinguished members of the Supreme Court of Canada, or by respected elders within Indigenous communities, adverse discrimination should be rejected as contrary to other constitutional approaches within each tradition" (p. 391). Despite constitutional direction to eliminate inequality in the *Indian Act*, it remains a difficult task to include women as independent holders of constitutionally recognized Indian status.

Bill C-3: *Gender Equity in Indian Registration Act* was a second attempt by the Federal Government to further amend, or at least ameliorate, the inequality embedded within the *Indian Act*. Section 6(1)(c.1) was added to the *Indian Act* and extended the membership code to include those:

- whose mother lost Indian status upon marrying a non-Indian man,
- whose father is a non-Indian,
- who was born after the mother lost Indian status but before April 17, 1985,
 unless the individual's parents married each other prior to that date, and
- who had a child with a non-Indian on or after September 4, 1951. (Canadian Bar Association, 2010, p. 4)

Rather than removing the original exclusion of women within the membership code, Bill C-3 modified the existing membership code to increase the number of Indian people eligible for registration with the Government of Canada in a limited manner³. The decision to preserve the discriminatory legislation that affected Indian women was "vehemently defended" by the Government of Canada (Palmater, 2014, p. 37). As a result, the inequality that was originally embedded within the first iteration of the *Indian Act* remains essentially unchanged.

A substantial critique of this *Indian Act* amendment is that Bill C-3 acts as a surrogate for the continuation of defining Indian peoples by the concentration of Indian blood in a particular body, a concept that is otherwise known as blood quantum (Palmater, 2011). Blood quantum is critiqued as perpetuating notions of racial purity, which undermines self-determination and self- governance by individuals and by communities (Giokas & Groves, 2002; Palmater, 2011). The idea of Indian blood being an essential component of the registration for Indians is found in the first version of the *Indian Act* (1876), which lists the first criterion as "any male person of Indian blood" (s. 3.3). While Bills C-31 and C-3 are the Government of Canada's attempts to amend the sex-based membership code outlined in its original iteration of the *Indian Act* (1876) in order to align it with the *Charter* federal registration for Indians remains largely biased against women and can continue to be used to control women and their bodies. As Palmater (2014) astutely observed,

Canada's view of Indigenous peoples remains frozen in time at the period of contact, and every subsequent generation of Indigenous peoples becomes more and more remote from the original group of Indigenous peoples at contact. While Canada is not the only state to have ever used blood quantum, it is has the dishonor of being the last. (p. 37)

It remains clear, then, that the colonialism that pre-dates the creation of Canada continues to persist in spite of its devastating effects, particularly on First Nations women. First Nations womens' lives, their fertility, and their maternity care continue to be controlled by the fact that the *Constitution Act*, 1982 and the *Indian Act* establish and manage the very basis of their existence in the eyes of the Canadian state. Theoretical approaches to

understanding the experiences of colonialism by First Nations women must reflect the fundamental importance of this legal and constitutional reality.

Reflections on Intersectionality Theory

Is a theoretical approach that provides space for voices of First Nations women who experience the realities described above sufficient for the purposes of dismantling the structures that shape their experiences? In my research, which is discussed elsewhere, I chose to apply intersectional theory because it is an approach that has been used effectively to understand and contextualize health care issues (de Leeuw, Maurice, Holyk, Greenwood, and Adam, 2012; Hankivsky & Christoffersen, 2008; Hankivsky, Reid, Cormier, Varcoe, Clark, Benoit, & Brotman, 2010; Huber et al., 2011; Van Herk, Smith, & Andrew, 2011). First developed by Crenshaw (1989), intersectionality has been used to respond to and critique the absence of theoretical approaches that explicitly examine the ways in which race and gender are leveraged in concert to marginalize and discriminate against Black women in the unique social and political context of the U.S.A.. With the application of intersectionality to make explicit the complexities of structuralized systems of marginalization and oppression that women encounter, I have been able to make visible the specific systems and conditions that inform First Nations women's maternity care, specifically Health Canada's evacuation policy.

Health Canada's evacuation policy exemplifies the Government of Canada's purposeful attention to the reproduction of Indian women. Beginning in the late 19th century, the Government of Canada began to provide maternity services on reserves, which was delivered by a female physician (Lawford & Giles, 2012b). As the federal government became more involved in the provision of all medical services on reserves, there was

increasing pressure placed on Indian women to birth in federal nursing stations. Using the authority of the *Indian Act* to dictate where birth occurred, nurses and physicians pressured Indian women to further relocate birthing into federal hospitals. This shift from community and even outdoor birthing practices was fuelled by Canada's efforts to "assimilate and civilize First Nations into the colonial world" (Lawford & Giles, 2012b, p. 332), a world that only practiced a Euro-Canadian bio-medical model. The loss of community birthing also led to a loss of the medical and cultural knowledges that sustained Indian peoples for millennia. Today, Health Canada's evacuation policy dictates that Indian women living on reserves in rural and remote regions are routinely evacuated - without their partners or children - between 36 and 38 weeks gestation age to urban areas to await labour and delivery, which isolates women, removes all family support, and is emotionally cruel (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010). While there are calls to return birthing to home and community (Couchie & Sanderson, 2007; Lawford & Giles, 2012a; Society of Obstetricians and Gynaecologists of Canada, 2010; Van Wagner, Epoo, Nastapoka, & Harney, 2007; Wright, 2015), the Government of Canada has yet to indicate an interest in ameliorating or amending its longstanding evacuation policy.

The application of intersectionality in the case of framing an understanding of Health Canada's evacuation policy revealed its usefulness in making room for the voices of women, their families and communities, and their experiences of the processes surrounding evacuation for birth. It is through intersectionality that the stories of resignation, resilience, and resistance of First Nations women in Manitoba with respect to Health Canada's evacuation policy were revealed for greater understanding and analysis. The use of intersectionality to understand health care for First Nations is well established in the

literature (de Leeuw & Greenwood, 2011; Dhamoon & Hankivsky, 2011; Hankivsky & Christoffersen, 2008; Hankivsky, Reid, Cormier, Varcoe, Clark, Benoit & Brotman, 2010; Hole et al. 2015; Van Herk, Smith, & Andrew, 2011).

The use of intersectionality in my research also revealed challenges in its application. When I considered the unique legal and constitutional positioning of First Nations women Canada, and I further reflected on how the use of intersectionality has expanded since its original articulation, I reflected on a particularly troubling question: have I co-opted intersectionality to the point that the original intention described by Crenshaw (1989) has been lost? I asked this, recalling that the original intent of intersectionality was to draw attention to and provoke conversations about the oppression of black American women in the United States.

As a First Nations woman and social scientist, I became more and more uncomfortable and unwilling to participate in academic projects – theoretical or otherwise – where privilege and whiteness over-write the needs of Black women. Bilge (2013), for example, has analyzed the use of this theory and found that it risks being reframed ...

...to neutralize the political potential of intersectionality, such as confining intersectionality to an academic exercise of metatheoretical contemplation, as well as "whitening intersectionality" through claims that intersectionality is "the brainchild of feminism," and that it requires a reformulated "broader genealogy of intersectionality." (p. 405)

For example, Clark (2016), who makes a case for "Red Intersectionality", asserts that it is nothing new because "Indigenous ontology is inherently intersectional and complex in its challenging of the notions of time, age, space, and relationship" (p. 49).

While Clark recognizes that Crenshaw did "coin the term intersectionality in 1989" (p. 49), she claims that violence experienced by Indigenous women and girls has always been intersectional. The rebranding of intersectionality as Red Intersectionality by Clark (2016) and dismissal of Black woman's significant contributions to theorizing positions Indigenous women's systemic marginalizations and oppressions from colonization as more authentic and long lived compared to Black women. This positioning can serves to deauthenticate the scholarship of Crenshaw (1989)in a similar way to the "whitening of intersectionality" (Bilge, 2013, p. 412). The specific legal and racial contexts in which Crenshaw first articulated intersectionality do not mirror the same specific legal and constitutional realities of First Nations women in Canada. While further reflection is required on the translatability and transportability of theoretical approaches from their original into new contexts, I strongly assert that a clear and thorough understanding of issues that are important to First Nations women in Canada must be theoretically informed by the legal categorization of First Nations as Indians and as women in Canada.

Making the Case for A First Nations Feminist Theory

While it is beyond the scope of this paper to fully develop and articulate a FNFT, I argue that a FNFT that recognizes and takes into consideration the power of Canada's constitution and the *Indian Act* has many benefits, particularly for examining complicated health care services for First Nations, especially women, who reside on reserves. Maternity care for First Nations women on reserves is an excellent example of an area of health care where an FNFT can be of great use, particularly as the federal government provides very few details about Health Canada's evacuation policy, which is broadly described above. Indeed, the use of a FNFT to frame a discussion of the evacuation policy, and other federal

health policies pertinent to First Nations women on reserves, should correctly reflect the foundational roles of constitutional law and the *Indian Act* in controlling, regulating, and restricting the health care services available to these women. A FNFT that leverages the foundation roles of constitutional law and the *Indian Act* would also place into consideration the involvement of provincial and municipal governments as they currently provide health care services to First Nations women when they are evacuated to cities. The production and use of such a FNFT could, therefore, be used to assist health planners and health policy analysts to contextualize the legal positioning the health care services for those First Nations residing on reserves within a comprehensive legislative framework reflective of the reality in which these services are offered.

The use of a FNFT can also be used to foreground the experiences, voices, and perspectives of First Nations women and those important to them. For instance, instead of focusing solely on individuals, a FNFT approach could include partners, children, and extended family members. The inclusion of these community members may also offer an opportunity for the restoration of pre-contact family and kinship relationships. Another possible application of a FNFT is within research projects that examine and refute the imposed gender binaries that are a result of the legislated dichotomy found within the *Indian Act*. For example, the meanings of terms such as gender diverse and gender fluid can be explored within and outside of academia with the assistance of a FNFT, reflecting the increasing importance of identity as an integral component of Aboriginal self-determination and self-identification. The application of a FNFT to draw attention to constitutionally embedded gender binaries could provide a theoretical conduit through which identities can be re-examined, also a much needed area within feminist scholarship.

Conclusion

There is a need for a FNFT to account for the legal positioning of First Nations women within the Canadian constitutional context. With the use of a FNFT, the involvement of federal, provincial, and municipal governments in the lives of First Nations who live on reserves can be made clear. Further, the use of First Nations feminist theory enables the understanding the legal and constitutional contexts of their health care services. Finally, the use of a FNFT also positions women as authentic and legitimate knowledge holders so that their voices legitimately influence policy and planning. A FNFT will allow us to move beyond the limitations of pan-Aboriginal and intersectional theoretical approaches, and provide us with a theoretical approach that reflects the realities of First Nations women in Canada. Indeed, an FNFT presents researchers with rich and fertile grounds to re-imagine many issues facing First Nations women, replacing resignation to colonialism with the voices of resilience and resistance.

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¹Although this paper is co-authored, it is written in the voice of the first author. Academia marginalizes the voices of First Nations authors; here, we resist this practice by privileging the voice of the first author, a First Nations woman.

²Terra nullius is the Latin term used by the French and English to "substantiate their right to assert sovereignty over regions belonging to non-Europeans" (Reid, 2010, p. 340) and means nobody's land. *In utero* is also a Latin term, which means in the womb. I use these words together to link land with Indian identity.

³Out of the 617 First Nations in Canada, approximately 230 First Nations define their own membership codes (Hurley & Simeone, 2014).

Chapter 5:

Conclusions

My doctoral research was guided by two research questions:

- 1. How does Health Canada's evacuation policy work in Manitoba? and
- 2. How is the evacuation policy experienced by First Nations' women, their families, and community members?

These questions were answered within the first two papers and are summarized below.

Based on the realizations that emerged from the process of preparing these two substantive papers, I wrote a third paper to argue for the development of a new theoretical framework, First Nations feminist theory, to foreground the significant constitutionally-based positioning of First Nations women. Together, these papers represent important contributions to our knowledge of the processes and outcomes of the evacuation policy as well as a theoretical contribution to feminist theory more broadly.

In this conclusion, I provide an overview of these papers, the contributions that they make to begin to address the gaps in our knowledge identified at the outset, and I also discuss the limitations of my research, including my experiences of applying for ethics approval and how this affected my research. Finally, I propose immediate and long-term recommendations based on my research findings and provide suggestions for future avenues of research to encourage the continuation of this important line of inquiry.

Overview of Thesis Manuscripts and Key Contributions Paper One: "This Policy Sucks and It's Stupid"

In this first paper, I applied intersectionality as the theoretical framework and institutional ethnography as the methodology to understand how Health Canada's evacuation policy for pregnant First Nations women who live on reserves works in the province of Manitoba. The processes and administrative details of this federal health policy

were mapped two ways - descriptively and visually - using information from semistructured interviews with First Nations women and community members, politicians, policy makers and government officials at the federal, provincial, and municipal levels, and health care providers both on reserve and in urban referral centres. Peer reviewed literature, grey literature, and materials from government and non-government organizations also informed the development of the maps.

Through the mapping process, I found that First Nations women and their family members were largely responsible for coordinating their own evacuation and prenatal care appointments once they were evacuated out of their communities. The lack of coordination and communication among staff working in the federal, provincial, and municipal health care systems resulted in the complete absence of prenatal education by public health nurses employed by the Winnipeg Regional Health Authority. Further, First Nations women are not referred to midwifery services once they are evacuated, even though "midwifery was legislated in the province of Manitoba with the explicit intent of serving the Aboriginal population and the policy of evacuation" (Olson & Couchie, 2013, p. 984). The lack of public documents in Manitoba that describe the content and timing of routine prenatal and postpartum visits is a gaping information void that must be addressed immediately. My research found that some First Nations women are not receiving care once they are evacuated and some – including their babies - are not receiving postpartum care until two weeks after giving birth, a health care practice that is contrary to Health Canada's Clinical Practice Guidelines for Nurses in Primary Care (2009, p. 1-1), and as such, is completely unacceptable.

Paper Two: Health Canada's Evacuation Policy for Pregnant First Nations Women in Manitoba

To understand the experiences of First Nations women and community members' experiences of Health Canada's evacuation policy in Manitoba, I interviewed First Nations women and community members using a semi-structured interview format to answer two questions: What are the experiences of First Nations who are evacuated from their communities for birth?; and, What are the perspectives of community members regarding the evacuation policy? I used thematic analysis (Braun & Clarke, 2006) to identify three themes that emerged from the interview data, which I designated as: resignation, resilience, and resistance.

The lack of choice, reinforced by the absence of information and coordination of maternity care services provided to First Nations women and community members in Manitoba identified in the first paper, has resulted in a sense of resignation by First Nations women and community members to the ways in which maternity care is provided.

Traveling and staying alone as routine components of evacuation further isolated First Nations women from family and community support; this perpetuated feelings of resignation. The tenacity of First Nations to persevere even when they were removed from their family and communities during an important life event speaks to the individual and group resilience in the face of considerable pressures exerted upon them to conform to Euro-Canadian bio-medical practices. Identifying this response as resilience helps to address the more typical 'victim' motif. One participant's description of a planned home birth on reserve demonstrated resistance to the routine and blanket application of Health Canada's evacuation policy in Manitoba.

Paper Three: The Legal Categorization of First Nations Women in Health

In the third paper, I made the case for the development of a First Nations feminist theory (FNFT), an insight that emerged from the limitations of the application of theoretical tools in the first and second manuscripts. I began making this case by providing an overview of pan-Aboriginal feminist theoretical frameworks and examples of such frameworks to demonstrate their utility within certain contexts, notably to draw attention to colonial influences and its broad and significant effects on the lives Aboriginal peoples. Using the example of the provision of maternity care to First Nations women who live on reserves, I drew attention to the Government of Canada's use of the power of the law of the constitution and the *Indian Act* to gain absolute control over First Nations peoples and especially First Nations women and their reproduction. I argued that pan-Aboriginal feminist frameworks and intersectionality theory are insufficiently able to attend to such legal issues. As a result, I concluded that a theoretical orientation informed by these realities – a FNFT - is necessary in order to comprehensively situate First Nations women's lives within the limits constructed by the law of the constitution, which includes the provision of health care services and specifically, maternity care services.

Main Contribution and Implications of Findings

My research makes novel contributions to the body of existing literature on maternity care in Canada, feminist theory, and a stronger understanding of the *Indian Act's* implications on health service provision. I documented Health Canada's evacuation policy that First Nations women and family members navigate. This is a critical component of a largely invisible system of maternity care that was founded on nationalistic goals of assimilation to increase the generic Canadian population and eliminate all populations of

distinct First Nations peoples (Lawford & Giles, 2012a). I found that First Nations women and community members continue to support each other even in the face of systemic and colonial efforts to govern their bodies, their families, and community knowledges, which speaks to their resilience, even if this resilience reflects a core need for survival.

I documented a tension between the resignation to and acceptance of the evacuation policy alongside the desire for maternity care services that reflect the cultural practices of First Nations in Manitoba. This tension gives rise to an energy that fuels First Nation's women and family members' resistance to evacuation. Irene, a First Nations woman who experienced evacuation twice, recalled a woman who came home from Winnipeg before giving birth despite having been evacuated. This woman was labeled as "crazy" by fellow community members, despite showing a personal resistance to the evacuation policy even in the face of community disapproval. Asking questions and "making waves" (Anonymous First Nations woman) were also forms of resistance that were observed from participant interviews. One First Nations woman's experience of choosing a homebirth on her reserve with two registered Aboriginal midwives as the care providers demonstrated personal resistance to birthing outside the community; her experience also highlighted the substantial efforts that were required to resist the chief and council's internalized normalization of evacuation for birth. These findings are new to the literature, and to academia. It was not the intent of my analysis to make a spectacle of First Nations women and family member's experiences of evacuation for the "intellectual masturbation" (Rodriquez, 2017, para. 15) of reveling in the resilience and resistance of an oppressed and marginalized group. Rather, I am trying to contextualize the reasoning for First Nations

women's resilience alongside the very systems that seek to eradicate them: "there is no choice but to be resilient" (Ghoulette, 2017).

To foreground the voices and experiences of First Nations women and make them central to my doctoral research, I employed intersectional theory, first articulated by Crenshaw (1989). My application of intersectionality, however, was not without some frustration and sense of inadequacy. This is simply because the focus of my research – First Nations women's experiences of Health Canada's evacuation policy - is structured by the unique legal and constitutional positioning of First Nations women. Consequently, my third paper described the limits of the use of intersectionality in health research that involves First Nations women, where it is stripped of its original cultural and racial contexts. A further challenge arises due to the inherent privilege and whiteness embedded within some of the applications of intersectionality in the academe. This underlines the importance of the positioning of First Nations women – one that requires a theoretical orientation that is not pan-Aboriginal, but is specific to First Nations women and the pieces of federal legislation that substantially influence and limit their health and wellbeing. It is for this reason that the development of a new theoretical framework, a First Nations feminist theory, is warranted, something that has yet to be more fully articulated in future research.

Indeed, through the course of writing my papers, I observed that scholarship describing the health care services for First Nations who live on reserves consistently refers back to the power of the law of the constitution and the *Indian Act* to explain the Government of Canada's involvement (Gibbins, 1997; Commission on the Future of Health Care in Canada & Romanow, 2002; Jackman, 2000; Lawford & Giles, 2012a, 2012b; Office of the Auditor General of Canada, 2015; Royal Commission on Aboriginal Peoples,

1996; Varcoe, Brown, Calam, Harvey, & Tallio, 2013). When on reserve, First Nations receive federal health care services. Off reserve, they receive care from provincially employed care providers and may also engage with municipally employed public health care providers. The jurisdictional fragmentation and uncoordinated services among these three health care systems coalesce to negatively affect the health and wellbeing of First Nations. This is a specific and constitutionally grounded set of circumstances that must have an appropriately framed theory to more clearly understand the practical and nuanced effects of this unique positioning in Canada. Moreover, as a result of the embedded patriarchy within the *Indian Act*, First Nations women are legally discriminated against, something that subsequent legislation has attempted to remediate but only inadequately. Because these attempts have been limited, the *Indian Act* remains a substantive piece of federal legislation in the lives of First Nations women. The Constitution Act, 1982 and the *Indian Act* also influence the provision of maternity care that First Nations women who live on reserves receive. Future research that involves First Nations women must recognize and acknowledge the importance of this legal context.

When Health Canada's evacuation policy is analyzed from the multiple perspectives reflective of the various participants who were interviewed, source documents, and the different theoretical lenses applied to their accounts, a richer understanding of its place in Canada's legacy of colonialism becomes clearer. The implications of evacuation, the challenges it poses for women and their families, and its long-term threats to First Nations' cultures and wellbeing are made evident. Despite these serious and negative effects of this federal policy, governments appear to take a disinterested approach in addressing the implications of evacuation and seem unable to make the connection between

the evacuation policy and the persistence of poor maternal and neonatal outcomes including how the First Nations infant mortality rate that is twice that of Canada's (Health Canada, 2011a). Governments do not appear able to assess how the collectivity of its actions – and inactions – contribute to the sustainment of health care systems that continue to control, colonize, and ultimately assimilate First Nations peoples.

While the individual components of evacuation considered in my dissertation are important, it is the place of evacuation in the overall picture of Canada as a colonial construct that remains most significant. Indeed, over the past 150 years, colonial laws, policies, and practices have attempted to erase the connections among First Nation women, reproductive health care, community, and land. This erasure was a substantial component of the Government of Canada's explicit efforts to assimilate First Nations peoples into a generic Canadian body, a strategy that was recognized by interview participants. An example of this control is happening every day: without choice, pregnant First Nations women are evacuated from their communities, and they are transported alone to southern, urban hospitals to give birth in unfamiliar circumstances and attended by strangers.

Evacuation is part of a system – a system of oppression and assimilation that requires deliberate and concerted effort and resources to sustain, particularly in the face of calls to dismantle it. Evacuation is not an incidental outcome of colonialism. Like residential schools and the 60s scoop, it is a fundamental part of that system, which requires a substantial will to sustain and one that can be changed when the will to do so is present.

Recommendations

My dissertation purposefully foregrounds the voices of First Nations women and their families and community members so that their expert knowledge exposes the impacts of a policy that was described by participants as "shitty" (Rachel) and "stupid" (Anonymous First Nations woman). Their knowledge reinforces existing analyses in the literature, which have reported First Nations women's experiences of evacuation as contributing to post-partum depression, increased exposure to racism, and disconnection from family and community support during an important life event (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2011; O'Driscoll, Kelly, Payne, Pierre-Hansen, Cromarty, Minty, & Linkewich, 2011; Varcoe, Brown, Calam, Harvey, & Tallio, 2013). To improve the maternity care services for First Nations women who live on reserve in Manitoba, I offer two immediate recommendations and two longer-term recommendations.

Immediate

Information Guide. The very first item that must be addressed is the lack of written information about the services available in Winnipeg. Health Canada's Clinical Practice Guidelines for Nurses in Primary Care instructs federally employed nurses to "arrange for transfer [of women] to hospital for delivery at 36–38 weeks' gestational age according to regional policy (sooner if a high-risk pregnancy)" (Health Canada, 2011b, 12-16). This is the only text that describes the evacuation policy. No other administrative or process details accompany this federal policy that affects First Nations women who live on rural and remote reserves.

In Manitoba, the absence of publicly available standards of maternity care and the paucity of scheduled prenatal and postpartum visits are glaring examples of the lack of care

provided to women and to the public. As a publicly funded health care service, maternity care standards must be available for review and for scrutiny. Consequently, I recommend that printed and online material related to maternity care services for First Nations women on reserves be produced for First Nations peoples, health care providers, and for administrators who are involved with the numerous aspects of maternity care. Material should be available in English and prominent Aboriginal languages and dialects in Manitoba like Cree, Oji-Cree, and Ojibwe and should visually reflect the Aboriginal peoples in Manitoba. This is a unique recommendation within the literature.

The produced materials must incorporate references to reliable systems of information, which will facilitate coordination of the services and service providers that are part of maternity care services in Manitoba. The publicly available materials will also make evident, accountable, and responsible all those involved in maternity care. Research is a component of compiling appropriate maternity care information for First Nations women who live on reserve and, as such, there is also is a need to include the experiences of First Nations women and community members from other provinces and territories to affect policy and program changes all across this country. I implore researchers, policy makers, health care providers, and politicians to involve First Nations women and community members to re-think the routine and delve into the possibilities of health policy and services that actually improve First Nations women's lives.

Prenatal education. The complete absence of prenatal education and care for First Nations women when they are evacuated to Winnipeg must be addressed. Through a Winnipeg Regional Health Authority pilot project, Nunavummiut women who are evacuated from the Kivalliq region in Nunavut receive prenatal education from WRHA-

employed public health nurses during their stay at the boarding home, the Kivalliq Inuit Centre (Lawford & Giles, 2016). First Nations women from reserves in Manitoba, however, are offered no prenatal education services. Hopefully, the results of the pilot project at the Kivalliq Inuit Centre will facilitate the introduction of these services to the boarding homes for First Nations women in Winnipeg.

Longer-Term

Referral to midwifery and doula services. First Nation women and community members want to receive midwifery and doula services on reserves - these reproductive care services are within our historical and contemporary memories. The complete lack of referrals to existing midwifery services in Winnipeg are easily remedied through the production of an information guide describing all available maternity care services within Winnipeg, The Pas, and Thompson. Such information would not only be for First Nations women, but also for care providers and administrators who are involved with the processes of evacuation. It is my sense that, ideally, these services would be offered by members of their own communities.

The time for a return of reproductive care services provided by First Nations midwives and doulas is long overdue, and communities' impatience and anticipation is growing. Indeed, the National Aboriginal Council of Midwives' [NACM] Vision is predictive of these intentions and goals, which is to have "Aboriginal midwives working in every Aboriginal community" (NACM, 2012, para. 2). As primary health care providers, midwives could work with federally employed nurses and assume the provision of the full spectrum reproductive care; this lies within the scope of midwifery care. There is also a growing call for the services offered by doulas as evidenced by the work of the Manitoba

Indigenous Doula Initiative, which was mentioned by Melissa. The Saskatchewan Indigenous Doula Initiative (n.d.) also indicates a growing interest by Aboriginal communities to learn how to be supportive during pregnancy, childbirth, and the postpartum period. As such, there must be coordinated support from all levels of government to begin the re-introduction of midwifery and doula services into reserve communities.

Systemic changes. Health Canada's evacuation policy must undergo substantial systemic changes that are based on and inclusive of the knowledges and experiences of First Nations women and community members from across Manitoba so that birth can be returned to communities. These changes must be implemented as part of a longer-term commitment to phase out the evacuation policy except for the most critical of cases. Some women may also want to receive labour and birthing services outside of their communities, and this decision should be supported without judgment or criticism. The return of birthing services to First Nations communities will require multi-government support throughout a defined, but flexible, transition period to realize an implementation process that honours First Nations women, families, and communities. Any changes made to maternity care for First Nations women on reserve must take into account their needs and experiences, and must be focused on providing women, their families, and communities with informed choices about care related to their reproductive health.

A very recent example underlines the systemic focus of my policy recommendations. Following the release of the Government of Canada's budget on March 22, 2017, just weeks before submitting my dissertation, a significant component of the evacuation policy was addressed. On April 5, 2017, my friend, who is also an Inuk

midwife, Navalik Helen Tologanak, posted a picture to the Facebook of a new federal policy regarding prenatal escorts (Appendix A). The text reads:

PRE NATAL ESCORTS

NEW FUNDING FOR NIHB

BUDGET 2017

To provide important information regarding new funding for NIHB.

Budget 2017 includes proposals for new funding for NIHB in a number of key areas. This includes expanding the medical transportation benefit to ensure that expecting mothers do not have to travel alone if they require medical transportation outside the community to delivery their babies.

Prenatal Escorts

NIHB will approve request for non-medical escorts for women travelling for child birth, without requesting additional medical or legal reason for the escort.

Please ensure eligible clients are made award so they can take advantage of this benefit enhancement.

I did not believe that the Government of Canada finally agreed to amend the evacuation policy so that First Nations women did not have to be alone when they left their homes and communities. As a result, I phoned NIHB and a staff person as well as a manager in the department confirmed the policy change. The timing of the change was also confirmed: immediately. Years of hard work by many dedicated women, family and community members, health care providers and their respective organizations, researchers, politicians, policy analysts, and many more have resulted in an important change: First Nations women do not have to birth alone any longer. For this, I am grateful. This kind of action, while

sorely overdue, will improve the experience of evacuation for women who are evacuated for birth and their children. Despite this positive step forward, the evacuation policy is still being enforced. Nothing substantial about the provision and place of maternity care for First Nations has been changed by this decision nor does it recognize the spirit of self-governance.

Rather, the Government of Canada's amendment to the evacuation policy, which was implemented immediately upon announcement, demonstrates the power of political will to affect change when that will is present. Indeed, this action reinforces definitions of policy: "whatever governments choose to do or not to do" (Dye, 1978, p. 3) and "a government commitment to the public to follow an action or course of action in pursuit of approved objectives" (Dukelow, 2006, p. 360). This funding decision by the federal government makes it very clear: the continued application of Health Canada's evacuation policy is politically driven and is indicative of the strength and perseverance of Campbell Scott's (1920) goals to somehow eradicate "the Indian problem" (para. 1). The continuation of Health Canada's evacuation policy, albeit now with an escort for the pregnant woman, illustrates the Government of Canada's reluctance and unwillingness to address the assimilatory aspects of this colonial based health policy. Indeed, the evacuation policy becomes more palatable with escort funding; however, First Nations women are still removed from their homes and communities without choice.

As discussed below in the recommendations section, individual elements of the evacuation policy – like the provision of escorts – can be more easily addressed to ameliorate the experience of evacuation for women and their families. However, when considered together, the mapping of the evacuation policy, the experiences of women and

their families of evacuation, and the need for a First Nations Feminist Theory (FNFT), the importance of the broader systems of colonialism and assimilation are made apparent and these require change of a more explicit systemic nature. In their resilience and resistance, women and their families are not just taking action to affect one policy – they are consciously resisting a system of oppression to their cultures, knowledges, and ways of life – and how birth is uniquely situated within those systems of marginalization. The need to draw attention to this system is what prompted my assertion that there is a need for an FNFT. We need a theoretical framework that takes into account the *structural* effects of Canadian law and the power of the law of the constitution on First Nations women. The mapping of evacuation reveals not just a process, but also a system of inter-woven intentions to remove women from their communities and lands. My research situates evacuation squarely within the system of colonialism and reminds us of the importance of research as resistance.

Methodological Limitations and Challenges

All research, no matter the contribution it makes to knowledge and recommended actions, suffers from limitations. My research was not immune to these limitations. During my research, I made efforts to ensure that I recruited and interviewed a sufficient number of individuals involved in or affected by evacuation in Manitoba. Throughout the recruitment of these participants and the design and development of the questions that guided our interviews, I sought the input and advice of organizations responsible for ethical research with Aboriginal peoples. I also designed the questions to be usable by myself or other researchers interested in future research on evacuation in areas other than Manitoba. Despite these efforts, I recognize that there are some practical and methodological

limitations to my work. I also acknowledge the unexpected challenges resulting from institutional requirements for research ethics approval and the trauma-inducing nature of my research work.

Low Number of Male First Nations Participants

I interviewed only one male First Nations community member as part of the research that examined the experiences of the evacuation policy. This participant's mother was evacuated for birth and as a baby, the participant was apprehended as part of the 60s scoop. The relationship between evacuation for birth and child apprehension is worthy of its own analysis, as the Government of Canada could be found complicit with the systemic apprehension of children through the evacuation policy. Regardless of this potential relationship, the experiences of men whose partners and family members are evacuated will be important to include in future research to develop a clearer picture of the effects of routine evacuation in pregnancy.

Institutional Requirements for Research Ethics Approval

There were many ethics processes to navigate throughout my doctoral research. The first ethics process I encountered was the Social Science and Humanities Research Ethics Board at the University of Ottawa. The required application process took much longer, but was much simpler, than what I had imagined. I received the initial ethics approval on June 17, 2015 and the renewal was received on June 17, 2016. The documents are found in Appendix A.

In mid-December of 2015, I was asked by a staff member at the First Nation Health Information Research Governance Committee (HIRGC) to complete and submit a Researcher Application form, since my research involved First Nations persons residing in

Manitoba. This same staff member, who asked to remain anonymous, thought that engaging with the HIRGC would improve my interview reach with First Nations women who had experienced evacuation. The HIRGC is a branch of the First Nations Health & Social Secretariat of Manitoba (FNHSSM), which works with "the 60 AMC [Assembly of Manitoba Chiefs] member First Nations, 7 tribal councils, and PTOs [Provincial and Territorial Organizations] in Manitoba, and it is structured and mandated to pursue tripartite collaboration for a unified health system in Manitoba" (FNHSSM, n.d.a, para. 3). I submitted the completed form by email on January 4, 2016. I received an email confirming my submission on the same day, which also indicated that the first review of my application was set to take place on January 6, 2016. Over the course of several months, I enquired about the status of my applications. On March 7, 2016, I was informed that perhaps it would be reviewed in early April 2016. In early January 2017, I received a letter from the HIRGC, which turned out to be a Christmas card. To date, I have not received a response to my application.

I also applied for ethics with the Winnipeg Regional Health Authority (WRHA), because I was told that this would allow me to interview WRHA staff and allow me to meet with First Nations women while they were in a Winnipeg hospital for birthing services. After submitting the necessary information, my study request was approved by the WRHA Research Access and Approval Committee on April 13, 2016. I also submitted a Health Science Centre Impact Approval Form on April 18, 2016 as per verbal instruction from a Health Science employee.

On May 11, 2016, I received a revised WRHA approval letter from a member of the Health Science Research Impact Committee (HSC RIC) member to amend the initial

document of April 13, 2016. Accompanying the revised document was information that indicated I would also require approval from the HSC RIC

to access potential participants while they are on the maternity ward of the hospital. A request for permission to physically engage potential participants while they are in the hospital requires that you meet the necessary requirements as specified by the HSC RIC. The RAAC has attached a revised letter of conditional approval that more clearly reflects this process. The condition of RAAC full approval is met when the RAAC receives a letter of approval from the HCS RIC.

On May 12, 2016, I received an email that said my research project required that "the Principal Investigator must be either an HSC staff member or affiliated with the University of Manitoba" (K. Shaw-Allan, personal communication, May 12, 2016). Dr. Audrey Giles sent a subsequent email to seek clarity with respect to the affiliation requirements for the Principal Investigator. Ms. Shaw-Allen did not respond to the information request. On May 16, 2016, Dr. Paul Beaudin, Researcher and Chair WRHA RAAC confirmed the affiliation requirements through email. I spoke with Dr. Beaudin on May 18, 2016, who explained the processes related to ethics approvals within the WRHA and the Health Sciences. After many discussions with my supervisors and a WRHA researcher who offered to become the Principal Investigator for my research project, on June 11, 2016, I decided to end the pursuit of an ethics certificate at any of the health facilities in Winnipeg due to the complex and continually evolving application processes along each step of the application process. This was quite a devastating decision for me, as several staff members had voiced support with my project and I was looking forward to meeting First Nations women while they were in hospital.

Applicability and Transferability to Other Provinces or Territories

Health Canada's evacuation policy for First Nations women who live on rural and remote reserves is the same across the Canadian provinces: federally employed nurses are instructed to "arrange for transfer to hospital for delivery at 36–38 weeks' gestational age according to regional policy" (Health Canada, 2011b, p. 12-6). Variability, however, was observed even within the province of Manitoba with respect to the timing of evacuation and the related processes that resulted in women leaving their communities. Manitoba has five regional health authorities, each of which aims to "to be responsible for the delivery and administration of health services in a specific geographical area" (Manitoba Centre for Health Policy, 2013, para. 1). Complicated and undefined relationships between the federal and provincial governments with respect to the provision of maternity care services has resulted in a lack of uniformity. This is rather surprising considering there are only three cities in the province that provide birthing services and all women with a high risk pregnancy receive care in Winnipeg. The Maternal and Child Healthcare Services (MACHS) taskforce (2008) recognized the "many gaps, limitations or inconsistencies in services to First Nations [which] has resulted in services that have been eroded, noncoordinated, highly complicated or non-existent" (p. 20) and developed a plan to address these shortcomings. The MACHS plan, while specific to Manitoba, could serve as a blueprint to fine-tune what is likely a similar situation in other provinces and territories. Such an assertion is based on the findings of the Commission on the Future of Health Care in Canada and Romanow (2002), which stressed that "better results could be achieved by sharing responsibilities rather than jealously guarding jurisdiction" (p. 221).

Engaging with Trauma

I did not expect this research project to be so difficult. I purposefully chose a topic that I thought would be at a distance from research related to missing and murdered Indigenous women, the 60s scoop, and the findings from the Truth and Reconciliation Commission of Canada. These are enormously powerful and emotional topics that are imbued with colonial violence, male violence, white male violence, and multiple systems of legalized oppression and marginalization. The stories shared with me during my interviews were trauma-inducing for me.

Imagine my response when one of the participants disclosed that he was one of the children taken away at birth from his mother after she was evacuated. Or another participant, who shared with me his family's participation in the 60s scoop, when his white parents adopted a First Nations female child who was apprehended from her mother. Learning that some Indigenous women are trafficked into sex work while they are in Winnipeg – and during their final trimester of pregnancy – was heartbreaking. This is a completely different situation than entering sex work as a choice; these women are pressured and coerced into gang activity specifically because they are from the North, are without family and community support, and speak very little English. Imagine learning that hospital staff immediately put crates of formula under the beds of Indigenous women from the North. Who knows if there is clean drinking water to prepare the formula and sterilize the bottles and nipples? On March 21, 2017, the Government of Canada posted 13 water advisories for First Nations reserves in Manitoba: 11 boil water advisories and two do not consume advisories. Newborns cannot be bathed in water that has either of these advisories (Government of Canada, n.d.)

There were so many difficult and traumatic parts of my doctoral research project, for which I was unprepared. I could not have imagined that the stories I would be told would make me sick – physically, emotionally, and spiritually. My bones started aching, my stomach hurt, I experienced migraines, nightmares, and strong urges to be alone lest my rage boil over at the most inappropriate of times. There were also so many good and wonderful people who helped me along the way, a few of whom I acknowledged at the beginning of this dissertation. Through these encounters, I have learned that one should not walk away from kindness, concern, and love. Acknowledge these gifts and accept them the best you can.

Future Research

My research journey has been one of joy and challenge. Along the way, I have learned a great deal. More often, though, I have identified new avenues for research – new research journeys that I will take in the future. Notably, as greater attention is drawn to Health Canada's evacuation policy for birth, further research will be required to address the administrative and financial pathways associated with evacuation. Additionally, work will be needed to facilitate the transfer of existing Elder knowledges to women, midwives, doulas, and other community members with respect to reproductive care that occurs on reserve, but also in hospital settings. While I can continue this work, the work of others will be required to ensure that a broad range of nations, communities, and cultures are reflected back into communities. National attention is also required to attract further focus on the importance of returning birth to all Aboriginal communities – including First Nations, Métis, and Inuit.

I also encourage other scholars to apply a FNFT to related issues in Canada. For example, the ongoing forced and coercive sterilization of First Nations women could be more fully explored by applying this theory. The unquestioned authority of the medical establishment over women's bodies that permits an ending of bloodlines is more than discriminatory, unethical, and immoral; it is a decision to engage with colonial goals to eradicate First Nations people. Work to further the development and refinement of a FNFT is also encouraged.

Concluding Thoughts

It is because "women are the first environment" (Cook, 2003, para. 5) that life is brought into this world. When women give birth, there is an intimate connection between a woman and her family and community relationships. There is a connection with their families, communities, and nations. There was a time when birthing took place on the land, which is the heart of the people whose communities belonged to that land (Lawford & Giles, 2012b) and is within the memory of our Elders, our Kookums, and our stories. We have not forgotten that there was a time of choice that was informed and guided by the knowledge and experiences of midwives and other medicine people.

It is very evident that the evacuation policy and the provision of maternity care services for those living on reserves must be improved significantly for First Nations women and their babies in order to achieve positive and healthy outcomes. Although it may seem, at first glance, that First Nation women are simply resigned to going through the motions with respect to their health services, they are in fact making the best of a less than optimal situation that is immensely sad and lonely. First Nations women and community members who participated in this research are strong, competent, and fiercely determined

to have the best pregnancy outcomes possible. My dissertation is written to honour their determination and to provide an academic foundation upon which other scholars can build for the improvement of the maternity care services provided to First Nations - and indeed all Aboriginal - women in their own communities.

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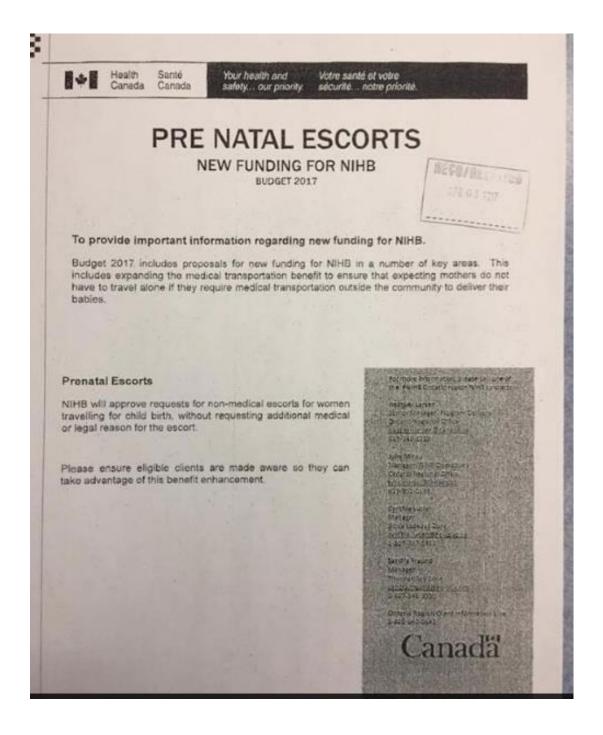
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Appendices

- A. Government of Canada Budget 2017 Prenatal Escort Funding Announcement
- B. Contributions

Appendix A: Government of Canada Budget 2017 Prenatal Escort Funding Announcement



Appendix B: Contributions

Chapters 2, 3, and 4 were written as stand alone publishable papers. Each paper is multi-authored with Karen Lawford as the primary author for all papers and Dr. Audrey Giles and Dr. Ivy Bourgeault as co-authors upon submission to a peer-reviewed journal. Karen Lawford developed the original topic for the doctoral dissertation, completed the ethics preparations, developed and conducted the semi-structured interviews, and wrote each of the three publishable papers. Dr. Giles and Dr. Bourgeault helped in the conceptualization and writing of the papers. Co-authorship recognizes their contributions.