

First Nations Women's Evacuation during Pregnancy from
Rural and Remote Reserves

By

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Abstract

Pregnant First Nations women who live on reserves in rural and remote regions of Canada are routinely evacuated to urban cities to await labour and birth; this is commonly referred to as Health Canada's evacuation policy. I produced two stand alone papers to investigate this policy. In the first, I investigated the development and implementation of the Canadian government's evacuation policy. Archival research showed that the evacuation policy began to take shape in 1892 and was founded on Canada's goals to assimilate and civilize First Nations. My second paper employed First Nations feminist theory to understand why the evacuation policy does not result in good health, especially for First Nations women. Because the evacuation policy is incongruent with First Nations' epistemologies, it compromises First Nations' health. I offer policy recommendations to promote First Nations health in a way that is consistent with First Nations' epistemologies and goals towards self-determination and self-governance.

Personal Introduction

I introduce myself to build trust and to articulate my responsibilities and obligations to all my relations (Kovach, 2009; Lavallée, 2009; McCaslin & Breton, 2008; Monture-Angus, 1995; Steinhauer, 2002; Wilson, 2008, 2001). I am the grand-daughter of Dedibaayaanimanook Sarah Keesick Olsen. Namegosibiingonjii Dedibaayaanimanook. Gaaminitgwashkiigaanig gii' izhinitaawigi. Odeden, omishoomenzha' gayeomishoomisan, Giizhiggaagiiizhinikaazonij, gakinagii' onjiiwaa' Namegosibiing. Gaye oidaanikoobidaaganan, Jiyaangaagii' izhinikaazonij, Namegosibiinggewiingii' onjiiwan. Apiimewinzhagakinaigiweniwaggii' izhidazhiikewag Namegosibiing. Wiingegii' onizhishin Namegosibmewinzha. Wiingegii' zaagitoonaawa o-Namegosibiimiwaa. Wewenigayeogii' ganawendaanaawaa. Dedibaayaanimanookomishoomisan, Giizhig, gii' ikidooniijaanisa' jidibendamowaaj Namegosib.

I self-identify as an Aboriginal midwife from Namegosibiing (Lac Seul First Nation, Treaty 3) and, as such, accept the responsibility and obligation to work towards improving health for women and children from all Nations, both Aboriginal and non-Aboriginal. I follow this course of self-location within my research to accept accountability for my work, since my research will create knowledge and situate that knowledge within a First Nations perspective. My objective is to introduce and make 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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Thanksgiving Address

Kiitchi meegwetch for the opportunity to research and write about Canada's evacuation policy for pregnant First Nations women living on reserves in rural and remote regions of Canada. The evacuation policy is a substantive federal policy that has significant and long reaching impacts on First Nations women, families and communities. To those women, families, communities, care providers, policy makers and researchers that strive to remove or decrease the negative impacts of evacuation in pregnancy, kiitchi meegwetch!

Kiitchi meegwetch to the many, many supportive people who have encouraged and helped me along this very personal academic journey. My family and friends have been an enormous source of inspiration and laughter throughout my lengthy university career. Ian is a wonderful partner, thank you for your kindness and support! Kieran (XO♥XO♥) and Anna-Lise (XO♥XO♥) remind me what is important in life and keep me grounded in the here and now. Where I would be without the teachings of children, I do not know. My mom, Anita Olsen Harper, Ph.D., has reviewed and corrected my numerous attempts at communicating through written English — kiitchi meegwetch! Elijah Harper, my step-father, has patiently listened to years of ranting about societal injustice; in his own quiet way, he has taught me to listen — kiitchi meegwetch!

Kiitchi meegwetch to Audrey Giles, my thesis supervisor. The silencing and colonial aspects of university have been painful and demoralizing on a very deep personal level. I am very thankful that Audrey has encouraged me counter the silence and contribute my voice as a First Nations woman through the production of my thesis project. With her support, I have articulated a First Nations feminist theory and First Nations feminist methodology to analyze a topic very close to my heart: the evacuation policy for pregnant First Nations women. I am privileged and honoured to be a member of "Team Giles." Kiitchi meegwetch Audrey!

Kiitchi meegwetch to Dawn Smith, Ivy Bourgeault, and Wendy Peterson, my thesis committee members. Your expertise and encouragement have been invaluable.

Canadian Born

We first saw light in Canada, the land beloved of God;
 We are the pulse of Canada, its marrow and its blood:
 And we, the men of Canada, can face the world and brag
 That we were born in Canada beneath the British flag.

Few of us have the blood of kings, few are of courtly birth,
 But few are vagabonds or rogues of doubtful name and worth;
 And all have one credential that entitles us to brag-
 That we were born in Canada beneath the British flag.

We've yet to make our money, we've yet to make our fame,
 But we have gold and glory in our clean colonial name;
 And every man's a millionaire if only he can brag
 That he was born in Canada beneath the British flag.

No title and no coronet is half so proudly worn
 As that which we inherited as men Canadian born,
 We count no man so noble as the one who makes the brag
 That he was born in Canada beneath the British flag.

The Dutch may have their Holland, the Spaniard have his Spain,
 The Yankee to the south of us must south of us remain;
 For not a man dare lift a hand against the men who brag
 That they were born in Canada beneath the British flag.

Tekahionwake (Johnson, E.P.) (1917). *Flint and feather: The complete poems of E.*

Pauline Johnson. Toronto, ON: The Musson Book Company.

In Canada, pregnant First Nations women living on reserves in rural and remote regions of Canada are evacuated to urban cities to complete their pregnancy and await labour and birth. Due to a Government of Canada policy known as the evacuation policy, these women leave their homes between 36 and 38 weeks of pregnancy (Health Canada, 2005) and wait in boarding homes, hotels, or with family or friends for labour to begin. My thesis is comprised of two stand alone papers that address the evacuation policy's origins and impacts. In the first paper I use archival research to construct an understanding of the Canadian government's strategies to develop the evacuation policy. In the second paper, I offer a First Nations feminist analysis of why the evacuation policy does not result in good health for First Nations women, infants, and their communities.

Situating the Research

An in-depth understanding of the research I conducted requires a cursory overview of the role colonialism played in the formation of Canada. For over thirty thousand years, Indigenous peoples lived and flourished on what is now known as the North American continent (Dickason, 1992, 2009; Royal Commission on Aboriginal Peoples, 1996). French and British colonizing forces sought to expand each of their empires by invading and destroying pre-existing Indigenous societies around the world, including those in North America (Anderson, 1993; Young, 2001). The nation-state now geo-politically identified as Canada was founded through colonial efforts by first the French and then the English (Anderson, 1993; Boyer, 2009; Flores, 2006; Haworth-Brockman, Bent, & Havelock, 2009; Jiménez & Jansen, 2006; Lapore, 2000; LaRocque, 1996; McCaslin & Breton, 2008; Schevill, 1951; Varcoe, Hankivsky, & Morrow, 2007). In 1867, Canada was formed as a British colony through the *British North America Act* (Dickason, 2009); Section 91(24) of

the *British North America Act*, the *Indian Act* (1876), gave the colonizing forces authority over First Nations, naming them as wards of the Crown.

Using the legislative strength of the *Indian Act* (1876), the federal government introduced the reserve system to civilize and assimilate “primitive” First Nations (Burnett, 2008; Robertson, 1991; Wissler, 1936). First Nations were forced to live on discrete pieces of land that had their borders policed by Canadian Indian Agents to limit interactions between “Indians” and Euro-Canadians and to regulate the exchange of goods and services (Carter, 1996; Dickason, 1992). If First Nations chose to live off reserves, the federal government no longer recognized them as *Indian* within the meanings of the *Act*.

The *Indian Act* (1876) had particularly significant repercussions for First Nations women (Armstrong, 1996; Emberley, 2001; MacIntosh, 2008; Wesley-Esquimaux, 2009). Through the *Act*, the Canadian government destroyed the legal right of First Nations women to be classified as *Indian*; that designation applied only to “male persons.” First Nations women could, however, obtain *Indian* status if her father was First Nations, or through marriage. If First Nations women married a non-First Nations individual, these women were removed from the federal government’s formal Indian registry and no longer qualified to live on reserves with their families. Ironically and illogically, the federal government extended Indian status to women with no First Nations heritage if they married First Nations men (Brant Castellano, 2009; Fitznor, 2006; MacIntosh, 2008). First Nations women and men challenged the *Indian Act* (1876) at the Supreme Court level to contest the patrilineal aspects of the *Indian Act* (1876) in an effort to re-instate First Nations women as independent holders of rights, irrespective of heterosexual marriage and paternity. *Lovelace v. Canada*, 1981 (Jones, 1985) and *McIvor v. Canada*, 2009 (Lavoie, Forget, & Browne, 2010) are two

Supreme Court decisions that have attempted to reconcile the patrilineal *Indian Act* (1876) with women's pre-contact positions within First Nations societies. The breadth of impact of these Supreme Court decisions, however, has been critiqued as inadequate for First Nations women.

The *Indian Act* (1876) undermined the honoured and respected roles First Nations women had prior to colonial contact (Anderson, 2009; Brant Castellano, 2009; Fiske, 1996; Hungry Wolf, 1996; Lapore, 2000; Monture-Angus, 1995; Olsen Harper, 2009; Peacock & Wisuri, 2002). According to Armstrong (1996),

The role of Aboriginal women in the health of family systems from one generation to the next was one of immense power. The immensity of the responsibility of bearer of life and nourisher of all generations is just becoming clear in its relationship to all societal functioning. (p. ix)

The Royal Commission on Aboriginal Peoples (1996) supported the assertion that First Nations women held pivotal roles that supported the health and wellbeing of their families and communities — that they were crucial members of their families and communities (Turpel, 1993). The *Indian Act* (1876) introduced a male-dominated and female subjugated hierarchal structure of family and rights, which damaged the positions and roles First Nations women played in their communities. The colonial agenda effectively interfered with individual and community health (Emberley, 2001) and thereby ensured that First Nations were emotionally, spiritually, mentally, and physically destabilized.

When Canada was formed in 1867 through the *British North America Act*, the federal government formalized its delivery of health care to First Nations (Graves, 1954, June 14) through the *Indian Act* (1876). At that point in time, First Nations' lives were subjected to

federal policies through the substantive legislative powers of the *Indian Act* (1876) without evidence of meaningful input from or consultation with First Nations. The evacuation policy is an example of one such federal policy that is based on the *Indian Act* (1876). The *Indian Act* (1876) has not resulted in good health, as demonstrated by the disproportionately high rates of disease and illness among First Nations who live on reserves (Altamirano-Jiménez, 2009; Browne, Smye, & Varcoe, 2007; Dickason, 2009; Frohlich, Ross, & Richmond, 2005; Grescoe, 1987; MacIntosh, 2008; MacMillan, MacMillan, Offord, & Dingle, 1996; Richmond & Ross, 2008; Varcoe, Hankivsky, & Morrow, 2007; Young, 2003; Zhong-Cheng et al., 2010). First Nations women bear the brunt of health discrepancies as evidenced by their higher disease burden even in comparison to First Nations men (Browne & Fiske, 2001; Browne, Smye, & Varcoe, 2007; Dion Stout, 2009). My thesis research thus analyzes the evacuation policy for pregnant First Nations women living in rural and remote reserves as an active health policy that is grounded in the *Indian Act's* (1876) colonial goals of civilization and assimilation.

Research Questions

I used First Nations feminist theories and methodologies to construct the questions that guided my thesis research:

1. How did the Government of Canada develop and implement an evacuation policy for pregnant First Nations women who live on rural and remote reserves?
2. Why does the evacuation policy not result in good health for First Nations women, infants, and their communities?

Objectives

My first research objective was to determine the strategies that were employed by the

Canadian government to develop and implement the evacuation policy. To achieve this objective, I reviewed and analyzed archived textual materials held at the Library and Archives Canada in Ottawa, Canada related to the development of the evacuation policy for First Nations women living on reserves in rural and remote communities. The existing body of literature that refers to the evacuation policy discusses the policy in relation to health care services (Browne & Fiske, 2001; Kaufert & O'Neil, 1990) and its impacts on First Nations (Benoit, Carroll, & Millar, 2002; Couchie & Sanderson, 2007; Grzybowski & Kornelsen, 2009). There is no literature, however, that presents the historical context of the federal government's strategies to develop and implement the evacuation policy. The research I present in this master's thesis helps to close this information gap.

My second research objective was to explore why the evacuation policy does not result in good health for First Nations women, infants, and their families. This objective is important as it provides information that is necessary to generate policy changes that directly impact First Nations. Since Canada is facing human health resource deficiencies, particularly for maternity services (O'Brien & Young, 2009) and most profoundly in rural and remote First Nations communities (Hearns et al., 2010), my research will contribute meaningful information to better inform health care policy and planning.

Methodology/Approach

Theoretical Framework

Feminism is the effort to remove or decrease the harms and disadvantages faced by women (Ramazanoglu, 2008), and is comprised of multiple theories (Hesse-Biber, Leavy, & Yaiser, 2004; Lengermann & Niebrugge-Brantley, 1988; Ritzer, 1988; St. Denis, 2007; Weedon, 1987). The diversity of feminist theories facilitates the exploration of the multiple

ways in which women are made subordinate and disadvantaged. For example, postcolonial (Brah & Pheonix, 2004; Rosser, 2005; Suleri, 1992), Indigenous (Anderson, 2009; Monture-Angus, 1995; Moreton-Robinson, 2009; Smith, 2007), and queer (Alexander, 2008) feminist scholars construct unique articulations of feminist theories to influence and legitimize experiences beyond the assumed universal oppression of white, middle-class, able-bodied, heterosexual women (Young, 1994). In Canada, for example, sexism and racism do not operate in isolation to oppress First Nations women; both forms of subjugation impinge on these women in multiple and synergistic ways. As a result, analyses of race and gender cannot be separated (Altamirano-Jiménez, 2009; Emberley, 1996; Monture-Angus, 1995).

First Nations feminist theories can be situated among broader global Indigenous feminist theories. Indigenous theorists use feminist and other theories to understand the oppression of Indigenous peoples and the suppression of their ways-of-knowing. Altamirano-Jiménez (2009), Emberley (1990-1991, 1996, 2001), Monture-Angus (1995), Moreton-Robinson (2009), Smith (2007), and Turpel (1993) are a few of the Indigenous scholars that have shaped my articulation of a First Nations feminist theory. Because Indigenous groups differ greatly (TallBear, 2002), individual articulations of First Nations feminist theory also vary. In North America, Abbott Mihesuah (2003), Chiste (1994), Emberley (1990-1991, 1996, 2001), Monture-Angus (1995), Smith (2005, 2007), and Turpel (1993) are prominent Indigenous feminist scholars whose work resonates with First Nations' ways-of-knowing. Each of these scholars contributed to my understanding and articulation of a First Nations feminist theory that is useful for my research needs.

The foremost activity of First Nations feminist scholars is to expose the *Indian Act's* (1876) negative influence on the First Nations women, families, and communities

(Emberley, 1996; Monture-Angus, 1995; Turpel, 1993). Through an investigation of the *Indian Act's* (1876) legal authority under Canadian law, I began to formulate an understanding of the gendered and racialized health systems that negatively influence the daily lives of First Nations women, which in turn directly impacts their families and communities. First Nations feminist theory served to reveal the extent to which the Canadian government has introduced and reinforced colonial ideals through the health systems that First Nations accessed and continue to access. The utilization of First Nations feminist theory makes it possible to develop and present a nuanced understanding of the intricacies of colonial ideologies as components of Canada's evacuation policy, an understanding that I hope will strengthen decolonizing efforts concerning this policy.

Methodology

I used a combination of First Nations and feminist methodologies for my thesis research. First Nations methodologies challenge Euro-Canadian history with a goal to reclaim First Nations' ways of knowing, to regain and reclaim ancestral wisdom, and as a way to de-colonize ourselves (McCaslin & Breton, 2008, Wilson, 2001). The use of a First Nations methodology substantiates a First Nations perspective, one that is omitted, obscured, and overlooked in contemporary accounts of Canada's history. By choosing to use a First Nations methodology, I am tasked to enrich, not appropriate or degrade, those involved in my research effort (Wilson, 2001). The use of a First Nations methodology further expressed my obligation to the "greater good" (Steinhauer, 2002, p. 79) and required a careful and thoughtful consideration of First Nations epistemology, axiology and ontology, as a researcher's worldview must be congruent with the chosen methodology (Wilson, 2008).

Feminist methodologies have been described as those that centralize women's experiences in a research project (Jordan, 1996; Pini, 2003; Ramazanoglu, 2008). Using women's voices, experiences, and perspectives as the focus to build a knowledge base that was previously absent or relegated to the margins serves to assert women's knowledge as valid and worthy of sustained attention. Feminist methodologies facilitate the generation of understandings of social and cultural conditions (Jordan, 1996; Buss, 2001) through an academically sound process. Women's contributions can be uncovered and re-discovered through feminist methodologies.

By using First Nations and feminist methodologies in concert, I have produce scholarship that both decolonizes the academy and resists imperial ideologies that harm First Nations women, families, and communities – and, I would add, the academy. First Nations and feminist methodologies also incorporate relationality (Wilson, 2008; Kovach, 2009), a concept that reminds me, the reader, and the multiple communities to which I belong that this research is part of who I am; I am not separate from the research topic or the research results. The use of these methodologies further positions my research as accountable to First Nations women, families, and communities.

Sources

To achieve my first objective, I used archival documents to construct the historical context and strategies used to develop and implement Canada's evacuation policy. Dukelow (2006) defined archives as "the body of documents of all kinds, regardless of date, created or received by a person or body in meeting requirements or carrying on activities, preserved for their general information value" (p. 30). I used the *Access to Information Act* (1985) to access archived textual materials held at the Library and Archives Canada (Ottawa, Ontario).

Health-related archived materials are catalogued in the National Health and Welfare Record Group 29. To aid in the identification of individual documents, the Library and Archives Canada has produced Finding Aids, which are brief descriptions of an archival collection's contents. I read all of the Finding Aids for Record Group 29, after which I submitted viewing requests for documents I suspected were relevant to my research topic. Each publicly accessible document was then read and assessed to map out the federal government's policy intentions with respect to First Nations pregnancy and birthing practices to formulate an understanding of the development of the evacuation policy for pregnant First Nations women living on reserves in rural and remote communities in Canada. Not all requested documents were available, which resulted in the construction of historical circumstances through government documents held at the Health Canada Library (Ottawa, Ontario).

I also accessed the archives held at the Health Canada Library (Ottawa, Ontario) and reviewed all available annual federal Medical Service Branch and Health Canada reports, annual regional Medical Service Branch and Health Canada reports, federal policies and mandates, articles, reports, newsletters, and position statements related to health policy for pregnant First Nations women living on reserves. Published and "grey" literature, for example government reports, provided additional information to elucidate the context of and rationale for Canada's evacuation policy.

Analyzing archived documents to "memorialize and rememorialize" (Sebastian, 2003, p. 10) the context of events that shaped the current positions of health and wellbeing for First Nations women, families and communities is a valuable tool for my research. Archival research helps illuminate the ways in which colonial efforts were employed to

assimilate and civilize First Nations; this contributes to the remembering and regaining of knowledge that was previously hidden from First Nations (Peers & Brown, 1999). Through archival research, I have “engaged in archival exegesis as a way of rememorializing the narratives and voices which have been subjected to institutional and exegetical forgetting” (Sugirtharajah, 1999, p. 22). I further utilized archival research to understand the historical context of the development of the evacuation policy for pregnant First Nations women living on reserves—a substantive achievement for my first thesis objective.

For my second objective, to determine why the evacuation policy does not result in good health for First Nations women, I sought to identify data sources relevant to First Nations’ understanding of health and how they articulate with the evacuation policy. I searched scholarly health and social science literature through the employment of several strategies. First, I undertook a search of relevant computer databases: Women's Studies International, Gender Watch, CINAHL, MEDLINE, and Scholars Portal. Search terms included the following singly and in combination: First Nations; Indigenous; Indian; Aboriginal; birth; pregnancy; evacuation, antenatal; perinatal; health; and Canada. I then further identified literature through a review of each article’s references section. I performed a thematic analysis of the existing body of literature and used First Nations feminist theory to guide the process. More detailed information concerning my identification of relevant literature and archives can be found in the two papers that comprise this thesis.

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My research “engaged in archival exegesis as a way of memorializing the narratives and voices which have been subjected to institutional and exegetical forgetting.” (p. 22)

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Marginalization and Coercion:
Canada's Evacuation Policy for Pregnant First Nations Women
who Live on Reserves in Rural and Remote Regions

Abstract

Canada's evacuation policy for First Nations women living on reserves in rural and remote regions is contemporarily understood to have been founded on concerns of First Nations' health and wellbeing. Archived documents held at Library and Archives Canada (Ottawa, ON), however, provide evidence of a very different beginning for the evacuation policy, one founded in goals related not to good health, but on attempts to assimilate and civilize First Nations. My research uncovered that the evacuation policy began to take root 1892, significantly earlier than currently thought. Further, I identified two strategies the federal government employed to propel the evacuation policy forward: the marginalization of First Nations pregnancy and birthing practices and the use of coercive pressures on First Nations' to adopt the Euro-Canadian bio-medical model. With this knowledge, the evacuation policy can be evaluated to determine if policy alternatives should be generated as First Nations work towards self-governance and self-determination in health care.

Pregnant First Nations¹ women who live on reserves in rural and remote regions of Canada are routinely evacuated to urban Canadian cities, often hundreds of kilometres away, when their pregnancies are between 36 and 38 weeks gestational age (Health Canada, 2005); this is commonly referred to as Health Canada's² "evacuation policy." Evacuated pregnant women stay in hotels, boarding homes or with family or friends, "killing time" (Welch, 2010) — waiting to go into labour, at which point they are admitted to a hospital to give birth. After hospital discharge, the women return to their families and communities with their newly arrived baby or babies. This routine, long-standing, nation-wide practice is currently articulated as having started between the 1960s and 1980s due to the government of Canada's desire to reduce maternal and infant mortality rates amongst First Nations populations (Baskett, 1978; Couchie & Sanderson, 2007; Douglas, 2006). My research shows, however, that such an assertion ignores the evacuation policy's beginnings and the ways in which it has been used to marginalize First Nations' birthing practices and coerce First Nations into accepting the Euro-Canadian bio-medical model. As a result, current understandings of the evacuation policy fail to account for the ways in which it was, and continues to be, part of the Government of Canada's efforts to civilize and assimilate First Nations. In this paper I thus refute the notion that the evacuation policy was and is based solely on an interest in the promotion of infant and maternal health amongst First Nations.

I am motivated to elucidate the evacuation policy's origins as a First Nations woman, an Aboriginal midwife, a registered midwife, and as a policy researcher. Without understanding why the evacuation policy came into effect, it is impossible to know if it is serving its intended purposes today. As such, this paper makes an important contribution to not only understanding the rationale for the evacuation policy, but also to understanding it as

a product of very specific socio-historical circumstances. With this knowledge, the evacuation policy can be evaluated to determine if policy alternatives should be generated as First Nations work towards self-governance and self-determination in health care.

Literature Review

To understand the context of health care services for First Nations in Canada, such as maternity services, it is necessary to begin with a cursory explanation of the unique relationship between First Nations and the federal government. Prior to colonial contact, First Nations in Canada had treaties or confederacies between each other to facilitate positive relationship-building and regulate the resources for those living in close proximity (Royal Commission on Aboriginal Peoples, 1996).³ When Canada was formed in 1867, First Nations and the various European colonizing forces also used the treaty process to outline the terms of their relationships (Royal Commission on Aboriginal Peoples, 1996); these treaties were negotiated on a nation-to-nation basis. Based on treaty negotiations between First Nations and the colonizers, health care services to First Nations were delivered by representatives of the British Crown, which since 1867 has been the Canadian federal government.

Health care delivery to First Nations began to be formalized when Canada was formed in 1867 through the *British North America Act* (Graves, 1954, June 14). It was through this legislation that First Nations became wards, and thus the responsibility, of the Crown (Bryce, 1922). Section 91(24) of the *British North America Act* was referred to as the *Indian Act* (1876); it unilaterally granted the Crown ultimate authority over First Nations. The *Indian Act* (1876) also prescribed the location and living conditions for First Nations through the development of the reserve system (Dickason, 2009). Reserves were portions of

land that were policed by federal Indian Agents to limit the exchange of goods and services between First Nations and Euro-Canadians (Dickason, 2009). Indian Agents were also tasked with ensuring First Nations became “civilized” enough to “assimilate” into the broader Euro-Canadian society (Carter, 1996; Dickason, 1992). Until such a time, First Nations were to be kept separate from non-First Nations.

Despite efforts to enforce containment within reserves, First Nations and non-First Nations did interact, which resulted in the spread of communicable diseases (Waldram, Herring, & Young, 2006). Reserves were often overcrowded, had poor living conditions, sanitation, and housing, which contributed directly to the spread of disease throughout First Nations communities (Royal Commission on Aboriginal Peoples, 1996). Because of the jurisdictional boundaries legislated through the *Indian Act* (1876), health care for First Nations did not fall under provincial or territorial health care regimes, as it did for most other non-First Nations individuals.⁴ Pressured to protect the Euro-Canadian population from health problems like tuberculosis and venereal diseases, the federal government thus assumed responsibility for delivering public health services to First Nations individuals who lived on reserves (MacIntosh, 2008; McPherson, 2003; Waldram et al., 2006; Woolford, 2009).

The government created administrative divisions to facilitate the delivery of First Nations’ health care: headquarters, regional, and zone offices. Health care for First Nations living on reserves was organized in a hierarchical order with *headquarters* located in Canada’s capital city, Ottawa, Ontario. Canada was divided into *regions*, which contained smaller units called *zones*. Each zone had a medical superintendent and often this physician was also the Indian Agent for the reserve(s) located in that zone. Federally employed staff

members, like doctors and nurses, within these divisions were charged with providing First Nations with “medical attendance in consistency with the policy of the Department of Indian Affairs” (Superintendent General of Indian Affairs, 1925, January 24, p. 1). Nurses (Conroy, 1917) and physicians (Bell, 1911, July 1; Deputy Superintendent General of Indian Affairs, 1893, January 16; Inspector, 1912, January 12; McLean, 1919, April 25) were hired in the late nineteenth century to provide medical services to First Nations.

Despite sporadic changes to the 1876 *Indian Act*, the “1876 framework has been preserved fundamentally intact” (Government of Canada, 1999, para. 1) and remains an active piece of legislation. As such, the federal government continues to assume responsibility for health care delivery, including the provision of pre- and post-natal care, for First Nations individuals who live on reserves (Health Canada, 2005; Smith, Edwards, Varcoe, Martens, & Davies, 2006; Waldram et al., 2006). The current iteration of the government agency responsible for First Nations health on reserves is the First Nations and Inuit Health Branch (FNIHB) of Health Canada. FNIHB does not provide a rationale for today’s evacuation policy for pregnant First Nations women who live on rural and remote reserves, but simply instructs federally-funded nursing personnel to “arrange for transfer to hospital for delivery at 36– 38 weeks gestational age” (Health Canada, 2005, p. 275).

First Nations Birthing

The ways in which a First Nations woman experienced pregnancy and birth was substantively changed by the federal government’s provision of health services. Prior to European contact, a First Nations woman laboured and gave birth within her home or special locations and structures (Couchie & Sanderson, 2007; Mitchinson, 2002) with the assistance of community members such as her partner, midwives, friends, neighbours, Elders, or older

children. After each birth, ceremonies were conducted to establish familial relationships between families and strengthen communities (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010). The birth of a baby was more than an addition to the community's population; it symbolized a growth between individuals and the future of communities. It also reinforced the essential role a First Nations woman held as the "bearer of life and nourisher of all generations" (Armstrong, 1996, p. ix) as an honoured and respected member of her First Nation (Anderson, 2009; Brant Castellano, 2009; Fiske, 1996; Hungry Wolf, 1996; Lapore, 2000; Monture-Angus, 1995; Olsen Harper, 2009; Peacock & Wisuri, 2002).

Federally-operated hospitals and nursing stations were established in the early twentieth century and were staffed by physicians and nurses. These "White Fortresses" (Canada's Health & Welfare, 1950, May) were portrayed as the pinnacle achievement in Canada's medical progress and were to complement public health care that was provided on reserves by federally-employed nurses, nurse-midwives, and nurse practitioners (Stone, 1935). These same nurses also conducted most of the deliveries for those living on reserves in rural and remote locations (Baskett, 1978; Benoit, Carroll, & Millar, 2002; Grzybowski & Kornelsen, 2009). Such arrangements enabled pregnant First Nations women to remain in their home communities for the full duration of their pregnancies and for childbirth, unless the woman required an in-hospital surgical intervention, like a cesarean section (Zelmanovits, 2003).

The mechanisms that repositioned First Nations women's labour and birth to hospital and the ensuing evacuation policy are currently understood as attempts to curb First Nations' child and maternal mortality rates. Such an understanding is predicated on the assumption that Euro-Canadian bio-medical models of health and healthcare are superior to the birthing

practices that First Nations used for millennia prior to colonizers' arrival and subsequent intervention into labour and birthing. While, certainly, Euro-Canadian health interventions have made some important contributions, the ways in which the government displaced and dismissed First Nations birth practices, how it achieved its goals, and how these factors contributed to the larger colonial project requires further inquiry – such is my purpose in this paper.

Methods

My study is informed by archival research. Archives are defined as “the body of documents of all kinds, regardless of date, created, or received by a person or body in meeting requirements or carrying on activities, preserved for their general information value” (Dukelow, 2006, p. 30). Conducting archival research to understand the past can be challenging, as archived materials, however complete, can never tell the entire story (Smith & pui san lok, 2006). Archived materials are filtered and categorized by institutional authorities who did not and/or do not have the capacity to store and catalogue all materials related to a topic; further, it may also be in the authorities' interest to destroy or restrict access to certain materials. This process results in archives that are incomplete, which leaves the researcher to engage “less with the archives content than with the omissions and anomalies” (Smith & pui san lok, 2006, p. 24). To assemble a plausible account of history, archival findings can be complemented with materials outside of the archives, such as published and “grey” literature, like government reports.

First Nations have turned to archival research as an approach to regain knowledge that was lost when their ways of life were interrupted by colonial efforts to “civilize” and “assimilate” them into semblances of Euro-Canadians (Peers & Brown, 1999). Conducting

archival research is “an act of both memorializing and rememorializing” (Sebastian, 2003, p. 10) events and people that shaped a particular outcome. Archival research “engages in archival exegesis as a way of rememorializing the narratives and voices which have been subjected to institutional and exegetical forgetting” (Sugirtharajah, 1999, p. 22). Such research can be used, for example, to provide historical insight into assimilation and civilization policies directed at First Nations.

For this research, I reviewed archived documents held at the Health Canada Library and the Library and Archives Canada, both located in Ottawa, Ontario. At the Health Canada Library, I accessed all available annual federal Medical Service Branch and Health Canada reports, annual regional Medical Service Branch and Health Canada reports, federal policies, and mandates, articles, reports, newsletters, and position statements related to health policy for pregnant First Nations women who live/d on reserves.

At the Library and Archives Canada, I accessed Record Group (RG) 29, which holds the Finding Aids related to Canada’s National Health and Welfare. Finding Aids are brief descriptions of an archival collection’s contents. After I reviewed all the Finding Aids for RG 29, I submitted viewing requests to the Library and Archives Canada by using the provisions of Canada’s *Access to Information Act* (1985) to gain access to archived federal government records. Archived textual materials that were publicly accessible were made available to me by the Library and Archives Canada and I reviewed them on site. The documents I accessed were comprised of correspondence, including reports, between federal and provincial government workers, doctors, nurses, Indian Agents, and Christian missionaries, and newspaper clippings. As I outline below, I read each document and then used accepted understandings of policy to determine which documents informed the creation

and sustained use of the evacuation policy for pregnant First Nations women living on reserves in rural and remote communities of Canada.

Understanding Policy

Because the evacuation policy was not always labelled as such, I required a definition of policy to facilitate its identification in the archived documents. There are numerous ways in which a policy can be defined. A law is the most concrete form of a policy (Brooks, 1998). The articulation of policy through law allows a policy to gain substantive regulatory power. A policy can also be labelled as “policy,” which greatly aids in its identification. A widely known federal policy related to First Nations, for example, is the evacuation policy for pregnant women who live on reserves in rural and remote regions of Canada. Policy is most commonly understood as a government’s intentions – or “whatever governments choose to do or not to do” (Dye, 1978, p. 3). A government uses policy to rule, exercise a specific will and intent, and influence and control the decisions people make (Cohen & Chehimi, 2007; Goodin, Rein, & Moran, 2006; Pencheon, Guest, Melzer, & Muir Gray, 2006; Ritzer, 1988; Wilson, 2006). Policy can also be used to demonstrate a government’s commitment to a course of action to achieve objectives (Dukelow, 2006) and can be thought of as a general rule that is used to achieve those objectives (Goodin et al., 2006).

When I examined the archived documents, I initially read each piece to determine if its content was related to First Nations, First Nations women, or First Nations’ pregnancy and childbirth practices or locations. Next, I examined each document again to determine if it was related to national policy decisions, First Nations’ health and wellbeing, and First

Nations' pregnancy and childbirth practices. Finally, I grouped the findings into the two most prominent thematic categories that emerged: marginalization and coercion.

Results

In what follows, I provide archival evidence that the federal government intentionally marginalized First Nations' pregnancy and birthing practices and that this marginalization was leveraged to coerce First Nations to adopt Euro-Canadian bio-medical standards of care. These results point to the ways in which the evacuation policy was not just about good health, but rather also about furthering the colonial project of First Nations' assimilation and civilization. I do not assert that these were the only driving forces that informed the evacuation policy, as archives are always incomplete (Smith & pui san lok, 2006) and history always contested (Bizzell, 2000); I do, however, suggest that existing archives reveal them to be the most prominent.

The Marginalization of First Nations Birthing Practices

The role women and children played in the production and sustainment of First Nations populations was brought to the attention of Indian Affairs in 1892 (Wilson, 1892, June 29). Recognizing women's and children's importance to population growth, Dr. Wilson, the Superintendent General of Indian Affairs, advocated for "systemic, honest and persistent" regular medical care for First Nations by a salaried federal physician, lest they become "exterminated" (Wilson, 1892, June 29, p. 3). The federal government thus employed physicians to provide medical services (Deputy Superintendent General of Indian Affairs, 1893, January 16) and medicine (Clerk of the Privy Council, 1893, February 6) to First Nations on reserves beginning in 1893.

Four years later, a husband and wife team of physicians, Drs. Mitchell and Mitchell, were hired by the federal government to provide medical services to the Chippewas and Muncey First Nations (Ontario) (Reed, 1896, July 30). One of the physicians, the wife, was specifically hired to provide midwifery services to these First Nations communities. Indian Affairs' hiring strategy reveals the federal government's intentions to introduce a Euro-Canadian bio-medical model of care related to pregnancy and birthing practices to First Nations in the nineteenth century; importantly, this is the earliest evidence in the archives that related directly to the provision of perinatal care for First Nations.

Within the first quarter of the twentieth century, the archives provide documentation of how First Nations women living in the Northwest Territories were pressured by federally-employed nurses to shift their birthing location from "outside, in the woods" to inside their cabins, an objective that was brought forward to counter "old superstition" (Bourget, [ca. 1922-1927], p. 1). Simultaneously, federally employed physicians were asked by the federal government to provide "any advice which you may give to Indian women regarding the proper care of their children, or with respect to sanitary conditions in their homes" (MacKenzie, 1926, December 12, p. 1), care which began with the baby's birth. Nurses and physicians exerted state sanctioned medical authority over First Nations women with the intention to end long-standing First Nations pregnancy and birthing practices to cultivate a Euro-Canadian bio-medical model of care amongst First Nations.

In the early twentieth century, maternal mortality gained national attention, particularly among First Nations. In 1935, Canada's Dominion Council of Health outlined the general policy of location of birth for all Canadian women (Canadian Welfare Council, 1935) in attempts to curb the mortality rate. The policy recommended that all births be

conducted by a physician with a qualified nurse in attendance. The Council did not limit the possibility of homebirth, but rather listed exclusionary criteria: if a physician or a physician-approved obstetrically trained attendant was not available for a homebirth, the birth was to take place in hospital. First Nations care providers, such as midwives and Elders that a community relied upon during labour and birth, were excluded from policy goals of improved health for First Nations. With the Dominion Council of Health's policy recommendations, First Nations' pregnancy, birthing, and early infant care locations and practices were made irrelevant and invisible to the achievement of the federal goals of improved maternal health. Hospital births with Euro-Canadian bio-medically trained personnel thus formed Canada's strategy to improve First Nations' health.

The federal government viewed birthing, whether at home or in the hospital, as an influential means through which to assimilate and civilize First Nations into the colonial world. The archives provided an illustrative newspaper clipping from the *United Church Observer*. In 1939, the newspaper proudly reported the efforts of the Bella Coola hospital to advance the "savage" through Christianity and touted the hospital's contribution of a "stork" to deliver babies, which referred to Dr. Galbraith, a federally-employed physician who provided maternity services in homes and hospital (*United Church Observer*, 1939, August 15, p. 17). By trivializing the skills and knowledges required to ensure the safety of the woman and the baby during labour and birth, the stork caricature relegated First Nations birthing practices and practitioners to a position that was not only marginal, but also beneath that of fantastical cartoons.

By the middle of the twentieth century, the federal government specifically cited "grey headed old ladies" (Wood, 1950, p. 2) and "old crones" (Wilson, A. Report Merritt,

B.C., September, 1952, p. 1), or First Nations midwives, as unsuitable care providers for First Nations women. For example, Miss Wilson, a federally employed nurse, proudly reported to her superiors how she “snatched a primipara in labor, from the none-too-gentle hands of an Indian Mid-wife and took her to the hospital” (Wilson, A. Report Merritt, B.C., September, 1952, p. 1). Through the marginalization and elimination of First Nations’ birthing practices and care providers, federally-employed practitioners introduced the Euro-Canadian bio-medical model of care during pregnancy and childbirth. First Nations women’s bodies thus became a site upon which colonial goals of civilization and assimilation could be realized.

Coercing First Nations to Accept the Euro-Canadian Bio-medical Model

The federal government has a long-standing history of attempting to control First Nations’ bodies through the use of authority and threats. For instance, in 1928 the Deputy Superintendent General of Indian Affairs sought to enforce the authority of physician’s advice by writing to a First Nations’ Chief:

The Government wants all the children in the Band to grow up to be strong men and women, but they have not much chance if you do not follow the advice of the doctor and the rules which have been given you. The Government holds the Chief and Councillors of the Band responsible for seeing that these laws are carried out.

(Deputy Superintendent General, 1928, October 9, pp. 1-2)

The “laws” to which the Deputy Superintendent referred were entirely fictional. Through such perjurious communication, the government introduced Euro-Canadian standards of maternal and child health practices as the norm within First Nations’ communities. The above quote captures the extent to which the Canadian government attempted to enforce the

Euro-Canadian bio-medical model by directly interfering with and making illegitimate First Nations' practices related to pregnancy, birthing, and childcare through coercion, threats, and fictitious legislation under the guise of care and protection.

Another strategy the federal government used to coerce First Nations into adopting the Euro-Canadian bio-medical model, which included prescriptive birthing practices and locations, was through the offering of free maternity services in hospital. With the marginalization of First Nations' pregnancy and birthing practices and locations, women were faced with two options: have no care provider or go to the hospital. Indian Affairs reinforced the Department's position regarding hospital admission for pregnant women in labour: "the Department is always willing to provide hospital care if there is fear of complications or special difficulties" (Director of Indian Affairs, 1937, March 17, p. 1). Further, "the Department would be very pleased to be able to provide such accommodation in a large number of cases as it is aware that many Indians are under poor circumstances at home" (p. 1). These statements revealed the federal government's priorities: perinatal services in hospital were to be fully funded, but improvements to the homes of First Nations women, often the cause of the "complications or special difficulties," were not even considered an option, an option that could have resulted in the sustainment of home and community birthing.

When in 1942 Indian Affairs expressed preference of home birthing as a means to reduce the department's financial expenditures during WWII, as hospital births increased federal expenditures, Dr. St. John, a federally-employed physician, referred to this direction as a "reversal of...[a] policy...which was pursued for many years, namely that of educating Indian women to avail themselves to the advantages offered by a hospital" (St. John, 1942,

February 16, p. 1). He disputed the suggested policy reversal by explaining the incompatibility of public health and personal safety with home birthing in the “unsanitary” (p. 2) living conditions and isolated locations where First Nations women lived. First Nations women’s containment in hospital for four to five days following the birth was believed to provide them with “a rare opportunity of acquiring notions of hygiene affecting herself and her offspring” (p. 2). Hospital births thus facilitated the federal government’s sustained and intentional efforts to inculcate standards of Euro-Canadian bio-medical standards of health in First Nations women. A return to home birthing never occurred.

My research found that the trajectory of the federal government’s coercive policy of physician-attended hospital birthing had an immediate and profound impact on the location of First Nations births. For example, all the reported births from an Alberta Agency (Blackfoot Indian Agency) took place in hospital from 1941-1942 (Gooderham, 1942, February 11; Gooderham, 1941, July 8; Gooderham, 1941, June 4; Gooderham, 1941, September 8; Gooderham, 1941, October 6; Gooderham, 1941, November 7; Gooderham, 1941, December 8). It was further reported that a “steady stream of expectant mothers” came to the hospital to give birth (Gooderham, 1942, February 11, p. 1), which indicated the acceptance and even the expectation of hospital birth by First Nations’ members. A similar acceptance of hospital birthing by the First Nations who lived in the Alert Bay region of British Columbia was described by Dr. St. John (1942, February 16), who wrote that “the Indian women from Alert Bay and the surrounding districts today accept it as a matter of course that they should be admitted to hospital for confinement, and that is the situation which I found here when I took over six months ago” (St. John, 1942, February 16, p. 1).

The federal government's coercive endeavours with respect to hospital birthing became so ingrained they were even accepted by First Nations' children. Miss Wilson, a federally employed nurse, provided an account in a First Nations community in Saskatchewan mid twentieth-century. Upon finding a woman in labour in the community, a girl ran to get the nurse, saying that the woman "should have gone to the hospital to have her baby, but had no car" (Rath, O.H., 1958, Newsletter Saskatchewan region Indian Health Services, Report 4, p. [?]). Miss Wilson's report demonstrates that hospital birthing was viewed as *the* location of birth by the mid-twentieth century and that even children were aware of this policy standard. The federal government's policy goals to inextricably alter First Nations pre-contact pregnancy and birthing practices and locations were thus instilled in future generations. These examples demonstrate the effectiveness of federal government's use of coercion to achieve its policy goal of physician-attended hospital birth.

Concerns of the production of "potentially useful citizens" (Rath, 1958, p. 1) provided Canada with added rationale to coerce First Nations women to birth in hospital, as First Nations had disproportionately high rates of maternal and infant mortality compared to non-First Nations. For example, the infant mortality rate was reported to be 100% on one Alberta reserve in 1926 (Stone, 1951) as well as in Churchill, Manitoba in 1943 (Fierst, 1943, August 5). These astonishing rates, combined with the growing medicalization of birth, drew attention to maternity services, or rather the lack thereof, available on reserves (Boyd, 2007; Douglas, 2006; Jasen, 1997; Kaufert & O'Neil, 1990; Morrow, 2007; Varcoe, Hankivsky, & Morrow, 2007). Public health concerns thus added further pressure for the relocation of First Nations' births to the hospital and the use of Euro-Canadian bio-medically trained personnel.

Under the umbrella of public health, federally employed nurses were tasked to teach maternal and child health education, which included parenting classes, to First Nations women and families in the mid-1950s (Anonymous, ? [ca. 1955]; Willie, ? [ca. 1955]). To teach First Nations women how to care for their infants and children in ways that reflected Euro-Canadian notions of public health, nurses were advised they “must use persuasive teaching methods” (Raynor, ? [ca. 1955], p. 3) in the home and in hospital. The close interactions between nurses and First Nations through home visits was highlighted as a technique through which to “establish a personal basis of trust and friendship with many individuals which is impossible for other health workers” (Willie, ? [ca. 1955], p. 2). The goal of such relationship-building was to ingrain Euro-Canadian notions of health and health care into the lives of First Nations, to ensure individual and community “cooperation is forthcoming” (Willie, ? [ca. 1955], p. 2), and “to debunk old wives’ tales” (p. 3). The federal government thus not only sought to influence First Nations’ birthing practices and locations, but it intentionally undermined First Nations’ unique knowledge base through coercive tactics.

In the late 1960s, the Canadian government cited maternal and child health as the “top priority” for those providing care to First Nations communities, a shift from previous efforts, which had focused primarily on the eradication of tuberculosis (Rath, 1967, September 1, p. 5). First Nations women’s bodies consequently became the site upon which sustained attention could be focussed using public health as a pretext for interference and surveillance. Through public health education campaigns, federal nurse midwives sought to persuade First Nations women to give birth using their services. Most First Nations women, however, were not able to give birth in the nursing stations with federally-employed nurse

midwives, as the federal government's restrictive policy stated that "all primiparas [first pregnancy], all gravida IV [fourth pregnancy] and over and those with suspected complications" (Rath, 1967, p. 5) were to have maternity care delivered by a physician in hospital; this resulted in 85-90% of First Nations women giving birth in hospital (Rath, 1967). The post-war interest in maternal and infant health, combined with the obstetrical community's push to assert its authority in maternity services, thus resulted in the evacuation of most First Nations women from rural and remote locations to give birth in urban cities.

A few years later, the Canadian government was tasked to assist First Nations' access to "hospitals, nursing stations and health care facilities" (Black 1972, May 2, p. 4) and this was to be accomplished, in part, by ensuring that all pregnant women were "delivered in hospital or nursing station" (Black 1972, May 2, p. 6). Increased access to hospitals and nursing stations meant a departure from First Nations' practices, locations, and practitioners. As a result, First Nations women were again made subject to the Euro-Canadian bio-medical model through coercive strategies, such as hospital birthing and public health education, delivered by federally-employed nurses, nurse midwives, and physicians under the guise of "access".

The archival findings demonstrate the ways in which hospital birthing, physician attended births, and public health campaigns were used to coerce First Nations women to relinquish knowledges, practices, and practitioners during pregnancy and birth. Federal officials threatened First Nations with fictitious laws that placed physician advice in the category of legislation. The evacuation policy, as a federal policy, was very successful in influencing and controlling the decisions of First Nations, a policy's ideal outcome (Cohen

& Chehimi, 2007; Goodin, Rein, & Moran, 2006; Pencheon, Guest, Melzer, & Muir Gray, 2006; Ritzer, 1988; Wilson, 2006).

Discussion

The introduction of the Euro-Canadian bio-medical model approach, often through coercion, to First Nations' pregnancy and childbirth undermined, marginalized, and made irrelevant the First Nations' knowledges, practices, and practitioners that sustained their existence for thousands of millennia. Canada's current evacuation policy for pregnant First Nations women living in rural and remote locations is testament to the realization of the federal government's intentions to alter First Nations practices' in pregnancy and labour. The appropriation and relocation of First Nations' pregnancy and birthing practices served as a conduit through which the Canadian government infiltrated First Nations' ways of knowing and wellbeing to intentionally replace them with a knowledge base grounded in the Euro-Canadian bio-medical model and thus to promote colonial goals. With the provision of maternity services by Euro-Canadian bio-medically trained personnel alongside the active exclusion of First Nations health care providers, the evacuation policy served, and continues to help realize, Canada's goals to civilize and assimilate First Nations.

Archival documents point to the federal government's intentional involvement in and interference with First Nations pregnancy and birthing practices as beginning in 1892. The hiring of Dr. Mitchell in 1896 is the earliest archival evidence of direct provision of care when she was hired to provide obstetrical services to the Chippewas and Muncey First Nations. Existing literature cites the late 1960s (Douglas, 2006) as the time during which the federal government introduced the evacuation policy. My research, however, has documented the beginnings of federal policy development related to First Nations'

pregnancy, labour, and birth practices as being almost seventy years earlier. This timeline coincides with a period of overtly aggressive and violent colonial acts aimed at First Nations to forcibly impose Euro-Canadian ideals. Canada's evacuation policy thus does not stem from seemingly benevolent public health policies, but instead from much earlier times and from colonial efforts that were propelled by marginalization and coercion.

The strategic use of Euro-Canadian public health also disrupted the knowledge transfer between First Nations women, Elders, and midwives by relegating their knowledge to the diminutive category of "old wives' tales." Through a hospital birth, First Nations women were isolated from their families and communities, which allowed nurses and physicians to further instruct First Nations women on the tenets of the Euro-Canadian biomedical model. These coercive tactics marginalized knowledge bases and relationships that had previously ensured community members' health and wellbeing. Public health, while celebrated for improving the lives of many, relegated First Nations' knowledges, especially women's, to the periphery.

The Canadian government's policy strategy to impose the Euro-Canadian biomedical model through pregnancy and birthing demonstrates the attention that First Nations women's bodies were given to advance the colonial goals of civilization and assimilation. Archived examples of Canada's attempts to coerce First Nations women to give birth in hospital with the use of physician services suggest the government was well aware of the enormous role women played within their communities. Not only were First Nations women the "bearers of life and nourisher of all generations" (Armstrong, 1996, p. ix), but they held unique knowledge bases that directly contributed to their communities' health and

wellbeing. The government's deliberate disruption of First Nations women's roles and responsibilities is testament to its aggressive tactics and colonial goals.

The Government of Canada has used coercion, threats, and fictitious legislation to control First Nations, and to marginalize First Nations' knowledges and practices. Through the development of the evacuation policy, women became a vessel through which the federal government could pursue its goals of making First Nations civilized and assimilated by advancing the "savage" through federal health policy. The federal government's evacuation policy remains a core component to the obstetrical services offered by federally-funded nursing staff, a testament to the ongoing colonial project directed towards First Nations.

Conclusions

When the federal government assigned attention and resources to pregnancy and birthing practices in 1892, the groundwork was laid for the development of a national evacuation policy for pregnant First Nations women living on reserves in rural and remote regions of Canada. Though Euro-Canadian bio-medical services have undoubtedly improved the lives of some First Nations in specific situations, the evacuation policy is premised on more than the improvement of First Nations' lives; it is predicated on the marginalization and medical subjugation of First Nations and the ongoing federal goals of assimilation and civilization.

With the identification of marginalization and coercion as propelling the evacuation policy, First Nations women, families, and communities can evaluate this health policy in a new light. Evacuating some women in pregnancy to give birth in urban locations will no doubt continue in some instances. Nevertheless, as First Nations continue to fight for self-governance and self-determination, some may choose to determine if policy alternatives, like

home and community birthing and First Nations midwifery, should be used in place of the evacuation policy. Self-governance and self-determination play important roles in improving First Nations' health outcomes (Lavoie, Forget, Prakash, Dahl, Martens, & O'Neil, 2010); given that First Nations women, children, and communities continue to experience poor health, re-examining the evacuation policy might play a crucial role in improving First Nations' health.

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Footnotes

1. First Nations are those individuals and communities that fall under the legislated authority of the *Indian Act* (1876). I use the term “First Nations” to counter and resist the historical context of the word “Indian”; this is a common practice among First Nations scholars.
2. Health Canada is Canada’s federal department that is mandated to oversee the various health systems within Canada.
3. Treaty making between First Nations and Britain began after the American War of Independence in 1759 with the Royal Proclamation of 1763. It became the means by which the two groups agreed to share First Nations territories.
4. The federal government also assumes health care responsibilities for federal inmates, military personnel and federal police (Canadian Health Services Research Foundation, 2011).

How much do you want us to change? Indians asking now!

Is it completely wrong to be born an Indian? Is everything that we have inherited from our ancestors totally opposed to the Canadian way of life that you want us to share?

Isn't there something in our own history as well as in our way of thinking, feeling and behaving which is worth while preserving for the whole nation and of which our children can be justly proud?

Can you train children for life in your competitive society without acknowledging and cultivation their self-respect, their pride in being what they are?

Renaude, A. (? [ca. 1950s]). *How much do you want us to change? Indians asking now!*

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The Routine Evacuation of Pregnant First Nations Women Living on Reserves in
Rural and Remote Canada: A First Nations Feminist Analysis

Abstract

A Canadian policy requires the routine evacuation of pregnant First Nations women who live on reserves in rural and remote regions to larger centres to gain access to perinatal services. Despite this access, First Nations women's health remains poor and the First Nations infant mortality rate remains high. In this paper, I employ First Nations feminist theory to understand why the evacuation policy does not result in good health, especially for First Nations women. Four themes emerge: decolonization, self-determination, land, and community. Based on these results, I argue that First Nations' concepts of health are largely incongruent with the Euro-Canadian bio-medical model, a model that is foundational to the evacuation policy. Until health policies incorporate and are congruent with First Nations' epistemologies and related health practices, their health will continue to suffer. Policy recommendations are offered to promote First Nations health in a way that is consistent with First Nations' epistemologies.

Pregnant First Nations women who live on reserves in rural and remote regions of Canada are routinely evacuated to urban Canadian cities, often hundreds of kilometres away, when their pregnancies are between 36 and 38 weeks gestational age (Health Canada, 2005). It is in Canada's large urban centres that these women await labour and delivery and recover during the immediate postpartum period, typically in isolation from their families and communities. In this paper, I employ First Nations feminist theory to analyse the Canadian government's evacuation policy for pregnant First Nations women who live on reserves in rural and remote areas to understand why it does not result in good health for First Nations, especially women. Four main themes were identified as being crucial to First Nations' health: decolonization, self-determination, land, and community. These results illustrate that First Nations' concepts of health are largely incongruent with the Euro-Canadian bio-medical model, a model that is foundational to the evacuation policy (Baskett, 1978). My research demonstrates that First Nations health policies must be based on First Nations' epistemologies, which are not typically included in health care, if they are to truly be beneficial for First Nations peoples' health. As such, I offer policy recommendations for First Nations health managers and federal government policy makers for the incorporation of First Nations epistemologies into health care regimes.

Review of Literature

First Nations lived autonomously in what is presently known as North America for over thirty thousand years (Dickason, 1992; Waldram, Herring, & Young, 2006). In contrast, Canada, as a country, was founded less than one hundred and fifty years ago as an English colony through the *British North America Act 1867* (Dickason, 2009). Section 91(24) of the *British North America Act 1867*, referred to as the *Indian Act* (1876), unilaterally bestowed

the colonizing forces with authority over Indians,¹ who became wards of the Crown. The *Indian Act* (1867) also included the creation of a reserve system, which still jurisdictionally defines services for status Indians from the federal government (Royal Commission on Aboriginal Peoples, 1996). Reserves are piece-meal plots of land that were policed by federal Indian Agents to limit the exchange of goods and services between “Indians” and Euro-Canadians and to keep First Nations people confined and away from Euro-Canadians. It was within reserves that First Nations people were to become “civilized” and “assimilated” into semblances of Euro-Canadians (Carter, 1996; Dickason, 1992).

Negotiations between the British Crown and First Nations are based on the 1763 Royal Proclamation from King George III (Woolford, 2009); they resulted in the formation of numbered treaties in the late 1800s, which described the terms and conditions of the relationship. Reference to a “medicine chest” in Treaty Six formed, in part, the rationale for the federal government policy to provide health care services to First Nations living on reserves (MacIntosh, 2008; Waldram et al., 2006). In addition, the Canadian government faced international pressure in the early twentieth century to protect non-First Nations populations from communicable diseases like tuberculosis and venereal diseases. Although confined within reserves, interactions between First Nations and non-First Nations resulted in the spread of these diseases, which put the larger Canadian population’s health at risk. Because health care in Canada was delivered by the provinces and territories but First Nations received health care from the federal government, a gap in health care services for First Nations resulted (McPherson, 2003). This gap propelled the delivery of public health on reserves by the federal government based on the jurisdiction over First Nations as described in the *Indian Act* (1876). Since the debut of health services for Indians offered by

the federal government and its representatives, however, such services have incorporated almost exclusively European notions of health and neglected First Nations health practices (Royal Commission on Aboriginal Peoples, 1996). In fact, some practices that served to maintain and improve First Nations individual, family and community health, such as the Sundance and the potlatch, were made illegal through the *Indian Act* (1876) (Waldram et al., 2006).

Today, the *Indian Act* (1876) continues to impact the health and wellbeing of First Nations through the federal government's direct delivery of health care services and programs to First Nations. This arrangement is largely unique to First Nations in Canada in that the federal government delivers health care services to those who live on reserves (Smith, Edwards, Varcoe, Martens, & Davies, 2006; Waldram et al., 2006), while all other Canadians typically receive health care from provincial or territorial governments.² Critiques of federal health care provision to First Nations peoples frequently point to the fact that the resulting services are truncated, sporadic, or even absent (Clarke, 2007; First Call BC Child and Youth Advocacy Coalition, n.d.; Lett, 2008; MacDonald, 2009; MacIntosh, 2008; Wekerle, Bennet, & Fuchs, 2009). Further, health care delivery for First Nations is often rife with jurisdictional disputes, often at a significant cost — physical, emotional, cultural and financial, to First Nations governments and people (Boyer, 2009; Browne, Smye, & Varcoe, 2007; Dickason, 1992; MacIntosh, 2008). First Nations women, in particular, bear the brunt of inequitable health care services as indicated by alarmingly high rates of diseases among this population, even in comparison to First Nations men (Browne & Fiske, 2001; Browne et al., 2007; Dion Stout, 2009). The evacuation policy and the associated diminished health of

First Nations women is indicative of the negative influence that the *Indian Act* (1876) preserves and demonstrates the federal government's continued colonial efforts.

The origins of the concept of First Nations birthing outside the home and the community were based on a goal of civilizing the “women in savage life” (Jasen, 2000, p. 393). This goal was reinforced by the concurrent medicalization and male appropriation of pregnancy, labour and birth organized by male doctors who sought to legitimize their profession (Cahill, 2000). First Nations women were encouraged to deliver at nursing stations, as opposed to their homes, using federal nurses with midwifery training as birth attendants (Plummer, 2000). By the early 1980s, almost all First Nations women living on rural and remote reserves were evacuated out of their communities near the end of their pregnancy to deliver in a hospital setting and to be attended by a physician (Plummer, 2000), as these services were not available on reserves. Today, First Nations women living on reserves in rural and remote communities still leave their homes and families to access perinatal health services when their pregnancies are between 36 and 38 weeks gestational age (Health Canada, 2005). Yet, despite the access to medical services that result from evacuation, the infant mortality rate among First Nations remains twice as high as the national average (McShayne, Smylie, & Adomako, 2009). Below, I use a First Nations feminist lens to understand why the evacuation policy leads to poor health for First Nations, and to suggest ways in which the policy might be changed to promote First Nations health in a way that is consistent with First Nations' epistemologies.

Theoretical Framework

First Nations feminist theories are gaining prominence and acceptance within academia. The diversity of First Nations in Canada is reflected in the unique productions of

First Nations theories, some of which I utilized for this paper. These theories are advanced by scholars who use their own research and lived experiences to provide a context and foundation for their understandings of First Nations women's, their families', their communities', and their Nations' position relative to broader Canadian society. The research contained herein is thus a contribution to my community, Namegosibiing (Lac Seul First Nation, Treaty 3), and towards the improvement of health for all women, families, and communities.

To understand First Nations feminist theories, it is important first to situate them within the group of theories to which feminism refers. The overall intention of feminist efforts is to remove or decrease the harms and disadvantages women face (Ramazanoglu, 2008). Postcolonial (Brah & Pheonix, 2004; Rosser, 2005; Suleri, 1992), Indigenous (Anderson, 2009; Monture-Angus, 1995; Moreton-Robinson, 2009; Smith, 2007), and queer (Alexander, 2008) feminist scholars have nevertheless challenged articulations of feminism that privilege only the voices of white, middle-class, heterosexual women whose experiences of gender-based discrimination are incorrectly assumed to be universal (Young, 1994). First Nations women, for example, cannot simply choose to address sexism or racism, as both intersect and influence their daily lives in multiple ways. Like many women in Canada, they do not have the luxury of separating race from gender (Altamirano-Jiménez, 2009; Emberley, 1996; Monture-Angus, 1995). Emerging articulations of feminist theories reflect these intersections to illuminate the multiple oppressions women encounter.

First Nations feminist theories must also be situated within Indigenous feminist theories. Indigenous theorists continue to build on aspects of feminist theories to address issues pertaining to oppression and Indigenous ways-of-knowing. Such theories have been

articulated by a number of scholars: Altamirano-Jiménez (2009); Emberley (1990-1991, 1996, 2001); Monture-Angus (1995); Moreton-Robinson (2009); Smith (2007); and Turpel (1993). Just as Indigenous groups differ greatly (TallBear, 2002), so too do the ways in which Indigenous feminists articulate their theories. There are several prominent North American Indigenous feminist scholars whose work resonates with First Nations' ways-of-knowing: Devon Abbott Mihesuah, Katherine Beaty Chiste, Julia V. Emberley, Patricia Monture-Angus, Andrea Smith, and Mary Ellen Turpel. While not all these authors have experienced the systemic oppressions embedded in the *Indian Act* (1876) (Abbot Mihesuah and Smith live outside of Canada), they all offer theoretical tools that have shaped my understanding and articulation of a First Nations feminist theory that is useful for my research. It is from these scholars that my understanding and use of a First Nations feminist theory is constructed.

First Nations feminist scholars' foremost activities involve recognizing and critiquing the *Indian Act* (1876) and its subsequent amendments to illustrate the specific ways in which women are oppressed (Emberley, 1996; Monture-Angus, 1995; Turpel, 1993). Understanding the gendered, cultural, and legal aspects of the *Indian Act* (1876) is vital to my use of First Nations feminism, as this theoretical lens situates the Canadian legal machinery within the numerous systems that influence the daily lives of First Nations women, families and communities. Identifying these restrictions to a specific segment of society, which includes women, is a reminder of the extent to which the Canadian government continues to embed colonial ideals into multiple systems that deliberately – and often deleteriously, impact First Nations.

First Nations feminist theories illuminate the ways in which the *Indian Act* (1876) “touches the Aboriginal person’s experience in multiple ways” (Monture-Angus, 1995, p. 60). A First Nations feminist critique of the *Indian Act* (1876) facilitates an understanding of the intricacies of colonial ideologies in, for example, the evacuation policy. Decolonizing efforts can then emerge and be used to address problems and formulate potential solutions and policy recommendations that are congruent with First Nations’ epistemologies (Wilson, 2008). First Nations feminist theories are key to my analysis of the evacuation policy, as they foreground women’s experiences and incorporate the legislative components that directly and uniquely impact First Nations women. While the evacuation policy is focussed on the health of the woman and the infant, the utilization of First Nations feminist theories allows the analysis to be expanded to include other components, such as the themes identified below, that are crucial for a wholistic and nuanced understanding of First Nations health.

Data Sources

In order to identify data sources relevant to First Nations’ understanding of health and how they articulate with the evacuation policy, I searched scholarly health and social science literature through the employment of several strategies. First, I undertook a search of relevant computer databases: Women's Studies International, Gender Watch, CINAHL, MEDLINE and Scholars Portal. Search terms included the following singly and in combination: First Nations; Indigenous; Indian; Aboriginal; birth; pregnancy; evacuation, antenatal; perinatal; health; and Canada. I then further identified literature through a review of each article’s references section.

Literature was then reviewed for relevance to First Nations, women, community, family, health and pregnancy and then sorted based on recurrent themes. Only literature that focused on First Nations was included in the thematic analysis, which resulted in the exclusion of literature related to Inuit, Métis, and non-First Nations women.

Thematic First Nations Feminist Analysis

Thematic analysis is an approach used to analyze data to identify themes or patterns (Arson, 1994). For the research presented herein, First Nations feminist theory was used to ground the analysis in such a way as to appreciate the unique and complex ways in which women are targeted by the *Indian Act* (1876). Together, thematic analysis and First Nations feminist theory were used to guide the identification of the themes that emerged from the existing body of literature.

Thematic analyses have been used “to understand the health issue in question from the experiences and point of view of the groups of people targeted by [health promotion and public health] interventions” (Thomas & Harden, 2008, p. 46). Rather than testing an intervention, thematic analysis seeks to determine which interventions are congruent and meaningful from a population’s viewpoint. Thematic analysis uses qualitative data to “explain differences in the effectiveness of different interventions” (p. 46), which for First Nations women, families and communities can explain why some health interventions do not achieve the anticipated health improvements that are realized in non-First Nations populations.

Thematic analysis requires “conceptual saturation” (Thomas & Harden, 2008, p. 47) to determine the range of concepts related to the subject; this is different to quantitative data analysis, which incorporates all available literature related to the topic using an exhaustive

search. To conduct a thematic First Nations feminist analysis, literature was reviewed to identify themes related First Nations women, families, communities, pregnancy, and health. The benefit of using this specific analytical approach is that the emergent themes are germane to a specific population – in this case, First Nations peoples; the disadvantage is that the results may or may not be applicable to another population. Four themes emerged as being crucial to First Nations' health with respect to the evacuation policy: decolonization, self-determination, land, and community.

Analysis and Discussion

The four themes that emerged from the thematic First Nations feminist analysis do not reflect Euro-Canadian bio-medical notions of health, such as rates of morbidity and mortality. This absence may seem surprising; however, First Nations' resistance to national efforts to eradicate First Nations epistemologies, ways of knowing and First Nations themselves, advanced through the *Indian Act* (1876), is reflected in the emergent themes as unique articulations of resiliency as the original inhabitants in what is now known as Canada. Below, I examine the themes and illustrate the ways in which each is crucial to understanding why the evacuation policy does not results in good health for First Nations.

Decolonization

To understand First Nations' health, Euro-Canadian health care needs to be examined and understood as a colonial endeavour (Kelm, 2004). Measurements of First Nations health are typically based on quantitative epidemiological evidence that is gathered by public health researchers and then used to assign First Nations peoples, particularly First Nations women, into categories of abnormal, diseased, and sick (O'Neil, Reading, & Leader, 1998; Wilson & Rosenberg, 2002). Through a First Nations feminist lens, such epidemiological evidence can

be understood to be a colonial production aimed at coercively enforcing Euro-Canadian health practices and definitions of health (Smith et al., 2006) on First Nations populations—and especially women. Decolonization offers a restorative response to illuminating and countering health care that does not recognize First Nations' values, meanings, and processes of health.

Decolonization is a process that foregrounds First Nations' values, knowledge, voices and epistemologies (Denzin, Lincoln, & Smith, 2008). It is an active form of resistance that is used to illustrate that the supposed “norms” related to health and wellbeing do not belong to First Nations, but rather belong to the (typically male) colonizer (McCaslin & Breton, 2008). Decolonization facilitates the recognition that colonialism is embedded in Canadian health legislation and policy to influence deliberately and negatively First Nations individuals, families and communities. It reminds First Nations that the activities that fall under the auspices of the *Indian Act* (1876) were, and continue to be, the “complete code for the management of Indian affairs” (Armitage, 1995, p. 78), which served to and continues to promote the assimilation of First Nations.

In health care, assimilatory policies, programs, and operations are promoted using Euro-Canadian bio-medically-based evidence to force First Nations to abandon their axiologies and epistemologies, which enabled them to live and flourish for over thirty thousand years in what is now known as Canada. The absence of First Nations epistemologies in health care in Canada has been critiqued (Browne & Varcoe, 2006; Smylie & Anderson, 2006; Wilson & Rosenberg, 2002) and, as such, a trend is emerging among scholars and health care providers to recommend the incorporation of First Nations epistemologies into health care to ameliorate these omissions. While the inclusion of these

epistemologies is an important step, it does not necessarily lead to the decolonization of health care for First Nations.

The decolonization of a federal health care policy, such as the evacuation policy, requires First Nations to decolonize themselves in order to “assert the reality — shocking and ungrateful as it may seem to many colonizers — that the colonial system is not the savior [sic] of Indigenous people but our oppressor, the systemic cause of our suffering” (McCaslin & Breton, 2008, p. 529). Individuals, families and communities can employ the process of decolonization to reflect on the impact that colonialism systems have had on pregnancy and childbirth. By decolonizing the evacuation policy, First Nations women, families, and communities can counter the colonial narrative based on “civilizing,” which has driven the creation and maintenance of the evacuation policy, to help restore the strengths and knowledges that produced good health prior to European contact, including those specific to women (McGuire Adams, 2009). Knowing the perinatal practices prior to European contact can, over time, tailor and transform health care to expand the repertoire of services offered to each First Nations.

First Nations women who are evacuated to urban cities in their pregnancy to await labour and delivery directly experience health care that is grounded in colonialism (Moffitt & Vollman, 2006; Whitty-Rogers, 2006). Evidence-based medical practice points to the necessity of perinatal medical care by a licensed health care professional (Enkin, Keirse, Neilson, Crowther, Duley, Hodnett, & Hofmey, 2000) and in Canada it is against the law to practice medicine without a licence;⁴ this denies the accessibility of First Nations midwives, “traditional” healers, and medicine people. Evacuation further removes and isolates the woman from family, friends and potential sources of support during the immediate

postpartum period. Together, evidence and legislation serve to undermine First Nations' health knowledges, and even make illegal the knowledge and practices of First Nations women, First Nations midwives and medicine men that ensured the continuity of life since time immemorial (Dawson, 1993; Whitty-Rogers, 2006). Through the process of decolonizing the federal evacuation policy, the extent to which health services serve to propel colonialism will be exposed. Decolonization will allow First Nations individuals, families, and communities to prioritize and contextualize health care decisions related to pregnancy and birth within Canada's broader colonial agenda. With this process, the very foundations of the Euro-Canadian bio-medical model can be challenged at the beginning of the life cycle.

Self-determination

Decision-making opportunities in health resources allocation improve First Nations' health (Lavoie, Forget, Prakash, Dahl, Martens, & O'Neil, 2010; MacIntosh, 2008). The federal government, however, dictates the allocation of health care funding, so decision-making opportunities are extremely limited for First Nations. Defining health care resources and establishing the means of controlling them is central to First Nations' self-determination and self-governance (Fiske & Browne, 2006; Grzybowski & Kornelsen, 2009; Parlee, O'Neil, & Lutsel K'e Dene First Nation, 2007). The overwhelming majority of First Nations in Canada, however, have not achieved self-determination and self-governance (Waldram et al., 2006), which I argue is reflected in First Nations' health, especially the evacuation policy.

First Nations' self-determination was practiced and expressed in multiple ways prior to European contact. In 1876, however, Canada's *Indian Act* (1876) forcibly restricted First

Nations' political, economic, social, and cultural development (Burnett, 2008; Dickason, 2009), all of which legally define self-determination (Dukelow, 2006). The health care services imposed by the federal government, beginning in the early twentieth century, played an active role in eroding First Nations women's self-determination (McPherson, 2003).

Federal nursing services were powerful in undermining First Nations' health epistemologies and practices by advancing the tenets of colonialism through health care. For example, nurses who worked on reserves had a duty to teach First Nations women individual, family, and household cleanliness (Kelm, 2004; McPherson, 2003). Such practices reified the notion of "the dirty savage" who lacked the prerequisites of knowing cleanliness as a pinnacle of civilization, as defined by Euro-Canadian standards. Colonial-inspired Christian notions of hygiene also determined whether or not a home was adequate; this became a means by which children were apprehended and placed into residential school or adopted out to non-First Nations families (McPherson, 2003). While these undertakings eroded First Nations women's autonomy as individuals and introduced colonialism into their "bodily experience" (Rutherford, 2008, p. 58), bio-medical perinatal care has also served to undermine expressions of self-determination.

After World War II, infant mortality rates in Canada garnered international attention because they were so high, particularly among First Nations populations. The federal government's response to these rates fuelled efforts to hire midwifery-trained nurses to work in remote nursing stations to teach prenatal care, deliver babies, provide postpartum services, and arrange medical evacuations (Zelmanovits, 2003). Nurses' instructions, decisions, and services were based on the Euro-Canadian bio-medical model; there is no evidence that suggests First Nations were involved or consulted in the nursing practices they received.

Rather, Euro-Canadian medical authorities prescribed the criteria that necessitated labour and birth in distant cities (Baskett, 1978; Kornelsen & Grzybowski, 2005). These practices reveal the extent of the colonial and patriarchal manner in which Canada, in cooperation with the medical establishment, developed policies that had directly negative impacts on First Nations women, their families and communities. Euro-Canadian medical professionals' authority over First Nations health epistemologies persists today (Greenblatt, 2009), which further confounds First Nations' efforts to gain control over their health care and improve their health, particularly during and after pregnancy.

Pregnancy and childbirth are not simply physiological effects on a body; they are important experiences in a woman's life (Bryanton, Gagnon, Johnston, & Hatem, 2008). Positive experiences with childbirth have been linked to increased competence and maternal attachment, whereas negative experiences can result in guilt, disappointment, feelings of failure, postpartum depression, and even posttraumatic stress disorder (Bryanton et al., 2008). Research findings point to why evacuation in pregnancy is so detrimental to First Nations women: they report "severe psychosocial consequences, including the loss of birth as a community event to birth becoming an isolating experience resulting in feelings of loss of control for women" (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010, p. 638). Evacuated women are confronted by a lack of choice, not only in the decision to leave the community, but during labour and birth (Chamberlain & Barclay, 2000). Evacuation impedes a woman's ability to make a decision that could incorporate her family and community into the pregnancy, labour, and birth; it also impacts the way in which a First Nation expresses itself through community events and ceremonies. For example, some First Nations have deeply-entrenched birthing and welcoming ceremonies for a woman and her

newborn. When birth occurs outside the community, these ceremonies can be forgotten as their timing is functionally tied to the birth itself (Kornelsen et al., 2010).

An essential aspect of self-determination is decision-making — a denial of decision-making is a denial of self-determination. Among First Nations, this association was eroded by the Canadian government; it has extended to inhibiting self-determination at an individual level. Reconstructing self-determination, an important step towards decolonization, leads to improved health (Alfred & Corntassel, 2005). Once the evacuation policy is recognized as a deterrent to self-determination, its harmful outcomes can be contextualized within First Nations epistemologies to restore women's health in pregnancy and birth.

Land

Being “born of the land” (Cardinal, 2001) is a component of identity for First Nations and invokes a responsibility and relationship to that land. First Nations people's lives are influenced culturally, spiritually, emotionally, physically and socially by the land (Adelson, 1998; Parlee et al., 2007; Wilson, 2003). This does not mean that First Nations across Canada have land-use practices and meanings that are identical, but rather that the interruption of being born of the land through the federal government's evacuation policy disrupts unique self-expressions of identity at the very beginning of one's life.

The evacuation policy results in women completing their pregnancies and birthing their babies outside of their communities. While the location of birth may seem to be of trivial detail from a Euro-Canadian bio-medical viewpoint, the land upon which babies are born is significant to First Nations (Kornelsen et al., 2010; Parlee et al., 2007). Research has shown that land is directly tied to First Nations' meanings of health and wellness (Parlee et al., 2007; Richmond, 2007; Struthers, 2000). The formidable significance of land can be

appreciated when one notes that First Nations have equated land appropriation with genocide (Graveline, 2002; Woolford, 2009) and cultural devastation (TallBear, 2002).

Land has been identified as the most important component of identity for First Nations (Kendall, 2004), as well a critical component of First Nations' health (Cardinal, 2001). The relationship between land and health is not included in Euro-Canadian bio-medical health care models. For Euro-Canadians, land is typically associated with natural resources and development projects (Parlee et al., 2007). The social determinants of health as developed by the Public Health Agency of Canada, for example, do not include land (Public Health Agency of Canada, 2010). In contrast, the Cree Nation of Eeyou Istchee and the Gitksan First Nation have identified the relationship between health and land as essential to their wellbeing (Johnson, 2000; Papillon, 2008). The land forms the basis for water, soil, plants and animals, so without land, there cannot be human life (Adelson, 1998; Steinhauer, 2002). When the land becomes contaminated or toxic, the water, plants, and animals are also affected, which directly impacts humans' lives. This viewpoint shifts the responsibility from the land to produce for the benefit of humans onto humans to ensure ongoing and sustained stewardship of land and its many contributions to our health and indeed our very survival (Turpel, 1993).

For a baby born outside of her/his community – off of her/his land, her/his first encounters with health care services are ones based on colonialism and assimilationist intentions. Birth certificates document the place of birth, not the place of belonging. Reading the name of an urban Canadian city where one was born can lead individuals and community members to question where one is from, which impacts one's self-identification (Kornelsen et al., 2010) and sense of belonging as a First Nations citizen (Greenwood, 2005). Further,

community events and ceremonies, such as “uplifting” ceremonies, are postponed or do not occur for some of these babies (Kornelsen et al., 2010). The evacuation policy is thus more than physically transporting a woman with an occupied uterus. It represents the continued efforts to assimilate First Nations into “acceptable” semblances of a Euro-Canadian citizen, beginning with their first breath, which is taken on land that is not – or at least no longer, their own.

Community

Pregnant women who are evacuated typically leave their communities alone; this is necessitated by the financial and employment responsibilities of partners and family members, as well as the practical care needs of their other children who are left behind (Jasen, 1997). Further, Health Canada does not fund travel escorts (Health Canada, 2011). The isolation of evacuation, however, is not without consequence. Research has demonstrated that evacuation leads to psychosocial consequences that can be classified as severe (Kornelsen et al., 2010). Evacuation extinguishes the considerable contributions that community birthing offers, such as emotional, physical, psychological and spiritual supports throughout the perinatal period (Grzybowski & Kornelsen, 2009; Kornelsen et al., 2010; Kornelsen & Grzybowski, 2009; Paulette, 1990; Tedford Gold, O’Neil, & Van Wagner, 2007). Women are not the only ones affected by evacuation. The children and family left behind experience increased rates of illness and anxiety that is expressed in the home as well as the school environments (Kornelsen & Grzybowski, 2005).

Historically, First Nations communities and families played vital roles in the health of the individual (Graveline, 2002; Peers & Brown, 2000; Richmond & Ross, 2008; Royal Commission on Aboriginal Peoples, 1996). The inverse is also true: the individual also

contributed to family and community health. For First Nations, a child's birth connected family and community members together in ways which were as unique as the child (Kornelsen & Grzybowski, 2005; Paulette, 1990). Aboriginal midwives, Elders, men, helpers, family members and extended family members were involved in some way during the labour and birth. Helping and supporting women during labour and birth was "an honour and privilege to perform" (Paulette, 1990, p. 76). These relationships served to strengthen what has been labelled as "social embeddedness" (Richmond & Ross, 2008, p. 1425) or "interconnectedness" (Steinhauer, 2002, p. 77), which served to reinforce health promoting behaviours and activities in the community, family, and the individual (Greenwood, 2005).

Birthing in the community contributes to the strengthening of relationships between individuals and families, which results in increased feelings of community, belonging, support, and caring (Grzybowski & Kornelsen, 2009; Kornelsen et al., 2010), and ensured knowledge transmission among community members (Paulette, 1990). Because First Nations' concepts of health are linked beyond the individual and extend to the family and the community (Parlee et al., 2007), interruptions in these relationships directly and negatively impact an individual's health. For example, ceremonies to mark a birth involve the community, not just the woman, her partner, and the infant. As discussed above, the timing of ceremonies, however, can be interrupted or the ceremonies even foregone when women are evacuated. Without these events, First Nations' epistemologies that reinforce the strength of women, their unique and meaningful contributions to the community, and the meanings of birth can become lost over time (Grzybowski & Kornelsen, 2009).

The employment of a thematic First Nations feminist analysis illustrates that the evacuation policy for pregnant First Nations women living on reserves does not reflect First

Nations' epistemologies and contributes to poor health amongst First Nations. While it would be presumptuous (and preposterous) to suggest that all bio-medical measurements of maternal and infant health are not relevant to First Nations, this thematic First Nations feminist analysis has demonstrated that the evacuation policy is indeed problematic and must undergo reform.

Policy Recommendations

In Canada and other British colonized countries, imperial ideology laid the foundations for dominant policy narratives, which were reinforced by pungent and forceful Christian influences (Anderson, 1993; Bennett & Jaenen, 1986; Smith, 2005) that ignored First Nations' epistemologies; such is the case in health care policy. Although policy language might lend to a public perception that policy is neutral, it is not. Rather, policy language in Canada contains codes and meanings that exert authority and support a "dominant vision of truth" (Iannantuono & Eyles, 1997, p. 1611), enforce a normative (i.e., Euro-Canadian) thought process (Goodin, Rein & Moran, 2006), and/or change accepted norms (Cohen & Chehimi, 2007); in short, the federal government's policies advance Canada's assimilatory goals. The evacuation policy for pregnant First Nations women who live on remote and rural reserves provides a strong example of the ways in which the systematic marginalization of First Nations' epistemologies has resulted in and continues to result in poor health for First Nations individuals and communities. I assert that the colonial underpinnings of the federal evacuation policy need to be recognized and ameliorated by all stakeholders to ensure First Nations achieve optimal health, as defined by First Nations themselves. Using the themes described above, I offer policy recommendations related to the federal evacuation policy for pregnant First Nations women.

Decolonization

First Nations women, families, communities, and health managers need to review existing policies related to pregnancy and childbirth. To begin a decolonizing process, the evacuation policy needs to be considered as an instrument that perpetuates colonialism. By critically assessing this policy, First Nations women, families and communities, health care providers and policy makers can fashion a perinatal health policy that considers and incorporates First Nations' epistemologies and meanings of health; this may include medicine and healing practices that are labeled as "traditional," such as First Nations midwifery, doula services and/or the use of First Nations medicines. The re-introduction of midwifery services, for example, can contribute to a process of decolonizing birth by remembering and employing strengths and knowledges specific to First Nations women and childbirth.

A First Nations community may seek the return of community birthing as a step towards decolonizing the evacuation policy. Such an outcome would require a non-hierarchical team approach (Wrede, Benoit, & Einarsdottir, 2008) that includes women, family, community members, and health care professionals. Barriers that prevent or restrict health care teams that consist of a mixture of health care professionals should be addressed; this may include barriers such as remuneration between providers, restrictive scopes of practices defined by legislation, and limited understanding and appreciation of the skill sets held by various health care professions involved in maternity services. By removing these barriers, a complete complement of maternal and infant/child health services could be provided on reserves or at least closer to a reserve, which would enable more or even most women to remain closer to home to give birth. Prior to the implementation of such a model,

however, it is imperative that First Nations investigate their health care needs, something that should be fully supported, financially and legislatively, by federal and provincial/territorial governments.

Self-determination

First Nations women, families, and communities need to be offered maternity care options and have the ability to influence those options so they can exercise self-determination. When women are not aware of or offered choices, the evacuation policy become prescriptive and routine and treated as if it is a law, which it is not (Dukelow, 2006; Page, 2006).³ The absence of choice in the evacuation policy needs to be recognized as a conscious and deliberate effort by the federal government to forcibly “assimilate” and “civilize” First Nations and their health practices. The ongoing health discrepancies between First Nations and non-First Nations are testament to the colonial strategy of federal policies; as such, the motivations that underpin health policies that restrict self-determination should be interrogated by First Nations women, families, and communities.

To promote self-determination, it is imperative that First Nations have control over their health services, including funding allocations (Lavoie et al., 2005). Health agreements with provincial/territorial and federal governments, including tripartite agreements, need to incorporate a flexible and responsive process to ensure future articulations of self-determination can be integrated without revisiting time-consuming, and costly, legislative procedures. Access to health care providers that accept and promote First Nations’ efforts to determine their own health care needs should also be recognized by federal and provincial/territorial governments and program and policy makers as critical components to individual, family, and community self-determination.

Land

To bring birthing back to the community and onto the land, First Nations require access to all primary maternity services, including family doctors, nurse practitioners, midwives and obstetricians. While it may not be feasible to have continuous access to some maternity providers, regular and routine on reserves visits would benefit the community as well as build the knowledge and expertise for those care providers within the immediate vicinity. For those women who require a higher level of care, perhaps because of a multiple pregnancy, evacuation will still be required. The relationships built through regular and routine community visits would likely reduce some anxiety and stress of the evacuated women. The number of primary maternity providers, however, is on the decline in Canada (Canadian Institute of Health Information, 2004), which limits the number of First Nations communities that can access maternity services.

Despite the plummeting numbers of primary health care professionals who offer obstetrical services (Wrede et al., 2008), the federal government has yet to acknowledge the expertise and quality of care of midwifery services (Treasury Board of Canada Secretariat, 2005) — this restricts the health services available to First Nations, which is in contrast to every province and territory, each of which has regulated and publicly funded midwifery or is in the process of doing so (Canadian Midwifery Regulators Consortium, 2010). To address this gap, the federal government should immediately add midwifery to the Health Services Group Definition and establish a Midwifery Qualification Standard (Treasury Board of Canada Secretariat, 2007). Such a process could be facilitated by an Essential Service Agreement, which includes services, facilities, or activities “of the Government of Canada that is or will be, at any time, necessary for the safety or security of the public or a segment

of the public” (Treasury Board of Canada Secretariat, 2005, sect. 4.1). The World Health Organization, of which Canada has been a member since its inception, recognizes that “midwives are essential to the delivery of quality services before, during, and after childbirth for women and newborns” (World Health Organization, 2011, para. 2). Only with a full spectrum of health care providers can First Nations women, families, and communities return birthing to the land. The use of Aboriginal midwives as services providers for First Nations women who are routinely evacuated also requires further investigation, with particular attention to those communities who have successfully implemented this provision of care. Until these changes are made, First Nations women who live on reserves will continue to bear the brunt of health care inequities due to health care services that do not incorporate First Nations’ epistemologies.

Community

The inclusion of community in the perinatal period is essential for First Nations’ health. The evacuation policy provides health care services that isolate the pregnant woman from her support system in a potentially unfamiliar urban Canadian city (Couchie & Sanderson, 2007). Compounding the isolation, women typically leave their communities alone, as the federal government does not provide travel companion assistance during the evacuation period (Couchie & Sanderson, 2007). Perinatal health policies need the explicit inclusion of community to recognize the relationships between First Nations members, as individuals and as groups.

Immediate measures to decrease the harms of family and community exclusion can be addressed by funding a travel companion for each evacuated woman and for the coverage of expenses related to childcare needs for the children the evacuated woman leaves behind.

For women with young families, their children may need to be evacuated as well. To facilitate the inclusion of additional family or community members will require the return of community birthing services. Birthing services could be re-established on reserves or in close proximity to the reserve using a team approach that would rely on the involvement of a variety of health care providers, including Aboriginal and registered midwives, family doctors, nurse practitioners, nurses, and doulas.

To rectify the exclusion of First Nations' epistemologies and understandings of health in the evacuation policy will likely take time and effort across a broad spectrum of stakeholders. Expertise and administrative support would also be required throughout the process, which, if lacking, could be obtained through a secondment process from other First Nations, federal/provincial/territorial government agencies, non-governmental agencies, and universities. Providing maternity health care services by a variety of health care professionals would require their unique contributions to be recognized. Regulatory, jurisdictional, and liability issues that prevent cooperative practice arrangements need to be identified within each province and territory in order to obtain immediate exemption status, which could be granted by the federal Minister of Health through the legislated authority of the *Canada Health Act* (1985). This exemption would allow multidisciplinary teams to immediately begin providing maternity services to First Nations while, concomitantly, the aforementioned barriers could be addressed through the necessary, and lengthy, legal mechanisms. Investing in amendments to the evacuation policy will require adequate resource allocation that permits meaningful changes for First Nations women, families and communities and should be supported fully by the federal government.

Conclusion

It is unfamiliar territory to critique policies that are purported to improve First Nations' health; nevertheless, First Nations women, families, and communities need to scrutinize the health care systems they access to determine if they are congruent with First Nations' epistemologies, desired goals, and outcomes. Undoubtedly, the evacuation policy is viewed within certain contexts and by some First Nations as improving women's and infants' health. Certainly, Euro-Canadian bio-medical health services have saved the lives of some First Nations women and infants, either through pharmacological or surgical interventions. This First Nations feminist thematic analysis has shown, however, that a blanket evacuation policy that continues without critique and modification perpetuates colonialism and dependence on the federal government, which thus preserves health care inequities, especially for First Nations women. If we are to truly improve First Nations women's health during the peri- and antenatal periods, government policies must be reflective of and congruent with First Nations' epistemologies.

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Footnotes

1. I refer to Indians as First Nations for the remainder of the paper, unless cited authors use different terminology.
2. The federal government also assumes health care responsibilities for federal inmates, military personnel and federal police (Canadian Health Services Research Foundation, 2011).
3. A law is a policy that is explicit embedded within a legal framework (Brooks, 1998); however, not all policies are law. The evacuation policy, for example, is not a Canadian law, but is a federal policy.
4. The Ontario Midwifery Act 1991 provides an exception for Aboriginal Midwives: An aboriginal person who provides traditional midwifery services may,
 - (a) use the title “aboriginal midwife”, a variation or abbreviation or an equivalent in another language; and
 - (b) hold himself or herself out as a person who is qualified to practise in Ontario as an aboriginal midwife. 1991, c. 31, s. 8 (3).

Indian Woman's Lament

Field nurses are my greatest curse, a fever for work they spread
 It's wash the baby, clean the house, make up that dirty bed.
 Now—I don't mind the talking, the drinking tea, or time,
 But it's an awful lot of effort, to get my wash out on the line.

Over my babies they fret and bother, with routines, schedules and such,
 Now—I don't mind the resting, it's the work I dont [sic] like too much.
 The formulas and the bathing, Infantol once a day,
 The moss bag is far less trouble, and I like it better that way.

Oke—so my nose is runny, my bugs are dug in to the root,
 I dont mind the itching, I could'nt [sic] give a hoot.
 My house can be dirty, my baby underfed,
 Live, die, or save me, - enough has been said.

I'll scrub the floor tomorrow, or maybe the day hence,
 But a cup of tea and sitting, makes far more sense.
 Now—I don't have no pleasure, to – why all the woes,
 And please send no more nurses, to keep my on my toes.

I'm cleaning, scouring, scrubbing, until I'm blue in the face,
 ALL this was intended for White Men, NOT for the Indian race.
 But hound and dig and scold me, proding [sic] me on till I drop,
 Just who invented Nurses?
 And when is all going to stop?

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Conclusions

My thesis investigated First Nations women's evacuation during pregnancy in rural and remote regions of Canada. It resulted in two stand alone papers that allowed me to meet two research objectives. The first objective was to understand the way in which the Government of Canada developed and implemented an evacuation policy for pregnant First Nations women. My second objective was to understand why the evacuation policy does not result in good health for First Nations women, infants, and their communities. Taken together, these papers elucidate the ways in which the evacuation policy has altered First Nations' pregnancy and birthing practices and how the policy is incongruent with First Nations' epistemologies. Below, I summarize the key findings from each of the papers that comprise my thesis and situate them within the broader context of women, colonialism, and health in Canada. I then offer some recommendations for the ways in which the evacuation policy can be amended to ameliorate its negative effects on First Nations women, families, and communities. Finally, I outline the contribution that my research makes to feminist scholarship/women's studies.

My first research objective was accomplished through the analysis of textual materials held at the Library and Archives Canada (Ottawa, ON). The archives revealed that the evacuation policy has its roots in the late 1800s – at least seventy years earlier than is suggested in other scholars' work. Efforts to propel the adoption of the Euro-Canadian were part of a larger strategy on the part of the government of Canada to civilize and assimilate First Nations peoples. Through the insistence on the superiority of Euro-Canadian forms of health and healthcare, First Nations' practices concerning pregnancy and birth were marginalized – often through very coercive tactics. First Nations women, families, and communities can now draw upon my research to gain a more nuanced understanding of the

evacuation policy's roots and question the role that it plays in First Nations' decolonization of health and healthcare.

My second research objective was to analyze why the evacuation policy does not result in good health for First Nations women, infants, and their communities. First Nations are contemporarily labelled as the "unhealthiest group in Canada" (Dion Stout, 2009, p. 78); this is at odds with the historical context of First Nations living autonomously and productively in what is presently known as North America for over thirty thousand years (Dickason, 1992; Waldram, Herring, & Young, 2006). Current data highlight First Nations' infant mortality rates as twice that of non-First Nations (McShane, Smylie, & Adomako, 2009) and First Nations women face health challenges at a disproportionately higher rate than non-First Nations women and First Nations men (Van Herk, Smith, & Andrew, 2011). Despite providing access to Euro-Canadian bio-medical services, the evacuation policy has not resulted in comparable outcomes for First Nations.

Through the use of thematic First Nations feminist theory and methodology, I identified four themes as being crucial to First Nations' health and healthcare, including pregnancy and childbirth: decolonization, self-determination, land, and community. I found the evacuation policy is incongruent with First Nations' understandings of each of these themes, and thereby has a detrimental impact on First Nations' health and wellbeing. Health policies that affect First Nations women, families, and communities must therefore incorporate First Nations' epistemologies and related health practices if improved health outcomes are to be realized.

Women, Colonialism, and Health in Canada

My research re-situates the development and implementation of the evacuation policy within a distinct socio-historical time period, one during which aggressive and violent actions were used overtly to civilize and assimilate First Nations into Euro- Canadian society. That the evacuation policy has its beginnings before the twentieth century should challenge the ways in which this policy is contemporarily understood.

Though finances, benevolence, and safety are cited (Baskett, 1978; Couchie & Sanderson, 2007; Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010) as the driving forces behind the evacuation policy, the archives provided evidence that civilization and assimilation were in fact the dominant driving factors behind the policy's development and that marginalization and coercion propelled this policy forward. As a result of my thesis research, the marginalization of First Nations women, health care practices, and health care providers can now be understood as an intentional strategy that was used to unduly pressure First Nations into adopting Euro-Canadian bio-medical ideals. Coercion played a substantive role in shifting the locations and practices of pregnancy and birthing among First Nations. With the location of birth and the provision of services moved into hospitals, the evacuation policy became embedded as a normalized component of perinatal care. The change in locations and care providers eroded the role of First Nations women in particular. Without the sexist colonial relations of power, the evacuation policy's development would not have been possible.

Euro-Canadian understandings of health underestimate the important contributions that First Nations women make to First Nations family and community health. When women's roles and responsibilities are diminished or removed, their stature within their

communities is altered. The separation of pregnant women from their families and communities during the end stages of pregnancy and during birth has resulted in the interruption of the complex socio-cultural contributions that pregnancy and birth play in cultural maintenance, decolonization efforts, self-determination, identity, and community. In short, while the evacuation policy serves to meet Canada's desire to be seen to be attending to First Nations' health issues, it does little to contribute to culturally relevant and thus effective healthcare for First Nations. Indeed, my research has shown that the evacuation policy is not now, nor has it ever been, simply about the promotion of maternal and infant health.

Recommendations

Due to the fact that the evacuation policy has not been shown to result in good health for First Nations women, their families, and their communities, I suggest that several changes need to occur in order better meet First Nations' needs:

1. The evacuation policy should be examined as a federal policy that aims to colonize First Nations. To decolonize this policy, First Nations could consider the re-introduction of pregnancy and birthing services. This approach would require a collaborative model between multiple care providers, such as midwives, nurses, and physicians, and would be dependent on meaningful contributions from Elders and other community members. In particular, any new policy would need to account for First Nations' birthing practices, locations, and care providers.
2. First Nations need to have control of their health services (Lavoie et al., 2005) through flexible and responsive funding agreements to ensure self-determination in health can be exercised. First Nations should have fully funded access to all

health care providers during pregnancy and birth, including midwifery services, which do not currently receive federal funding.

3. Family and community exclusion during the evacuation period could be eliminated by funding a travel companion and enabling women who are evacuated to take their children with them. Further, expenses related to childcare for the children who need remain in their communities (e.g., for schooling) must be covered to reduce stress on evacuated women.

The mechanisms used to coercively pressure First Nations to comply with the evacuation policy should be identified and ameliorated in collaboration with First Nations women, families, and communities.

Contribution to Feminist Scholarship/Women's Studies

My thesis research makes three main contributions to feminist scholarship/women's studies: it further articulates First Nations feminist theory; it provides an example of a way in which the federal government has attempted to use First Nations women's bodies to advance colonialism; and, finally, it provides policy recommendations related to the evacuation policy that call for it to centre on First Nations women's health rather than colonial goals.

My first significant contribution to feminist scholarship/women's studies is through my utilization of First Nations feminist theory. By exploring the historical context of the evacuation policy through a First Nations feminist lens, I have demonstrated the close ties between the *Indian Act* (1876) and the federal government's development of a policy that has a long history – indeed, much longer than previously believed, of impacting First Nations women, families, and communities. I have demonstrated First Nations feminist theory's utility and applicability to explorations of health policies that are framed by colonial

legislation uniquely aimed at First Nations. It is with through this master's thesis that I hope to inspire other feminist scholars to consider using First Nations feminist theory to ground their research endeavours and to contribute to the growing body of First Nations feminist literature. I also hope that this thesis serves as a challenge to those feminist academics that do not yet see the necessity to include First Nations feminist theory in graduate studies courses.

A second contribution that my thesis makes to feminist scholarship is that I have provided an(other) example of the ways in which the Canadian federal government has used and continues to use First Nations women's bodies to advance its colonial agenda. Pregnant First Nations women's bodies were exploited to advance the Euro-Canadian bio-medical model by marginalizing First Nations women's practices and practitioners. As such, my contribution adds to the existing body of literature to demonstrate how First Nations women's bodies have been used as a conduit to advance the colonial agenda.

My third major contribution is that I have provided policy recommendations related to the evacuation policy. Because the evacuation policy's colonial intentions are incongruent with First Nations' meanings of health and wellness, the policy requires amendments. This is a significant contribution as First Nations, and especially First Nations women, tend to be outside of the policy decision making framework. The adoption of First Nations feminist theory and methodology would firmly reposition First Nations women at the centre of re-envisioning a policy that has had and continues to have a large impact on the lives of so many First Nations women, families, and communities.

I would like to close my thesis with the following poem by Tekahionwake (1917):

Lullaby of the Iroquois

Little brown baby-bird, lapped in your nest,
 Wrapped in your nest,
 Strapped in your nest,
 Your straight little cradle-board rocks you to rest;
 Its hands are your nest;
 Its bands are your nest;
 It swings from the down-bending branch of the oak;
 You watch the camp flame, and the curling grey smoke;
 But, oh, for your pretty black eyes sleep is best, -
 Little brown baby of mine, go to rest.

Little brown baby-bird swinging to sleep,
 Winging to sleep,
 Singing to sleep,
 Your wonder-black eyes that so wide open keep,
 Shielding their sleep,
 Unyielding to sleep,
 The heron is homing, the plover is still,
 The night-owl calls from his haunt on the hill,
 Afar the fox barks, afar the stars peep, -
 Little brown baby of mine, go to sleep.

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