

Canadian Maternal Healthcare Policies and Indigenous Women

The Systemic, Symbolic, and Individual Oppression of Indigenous Women in Canada

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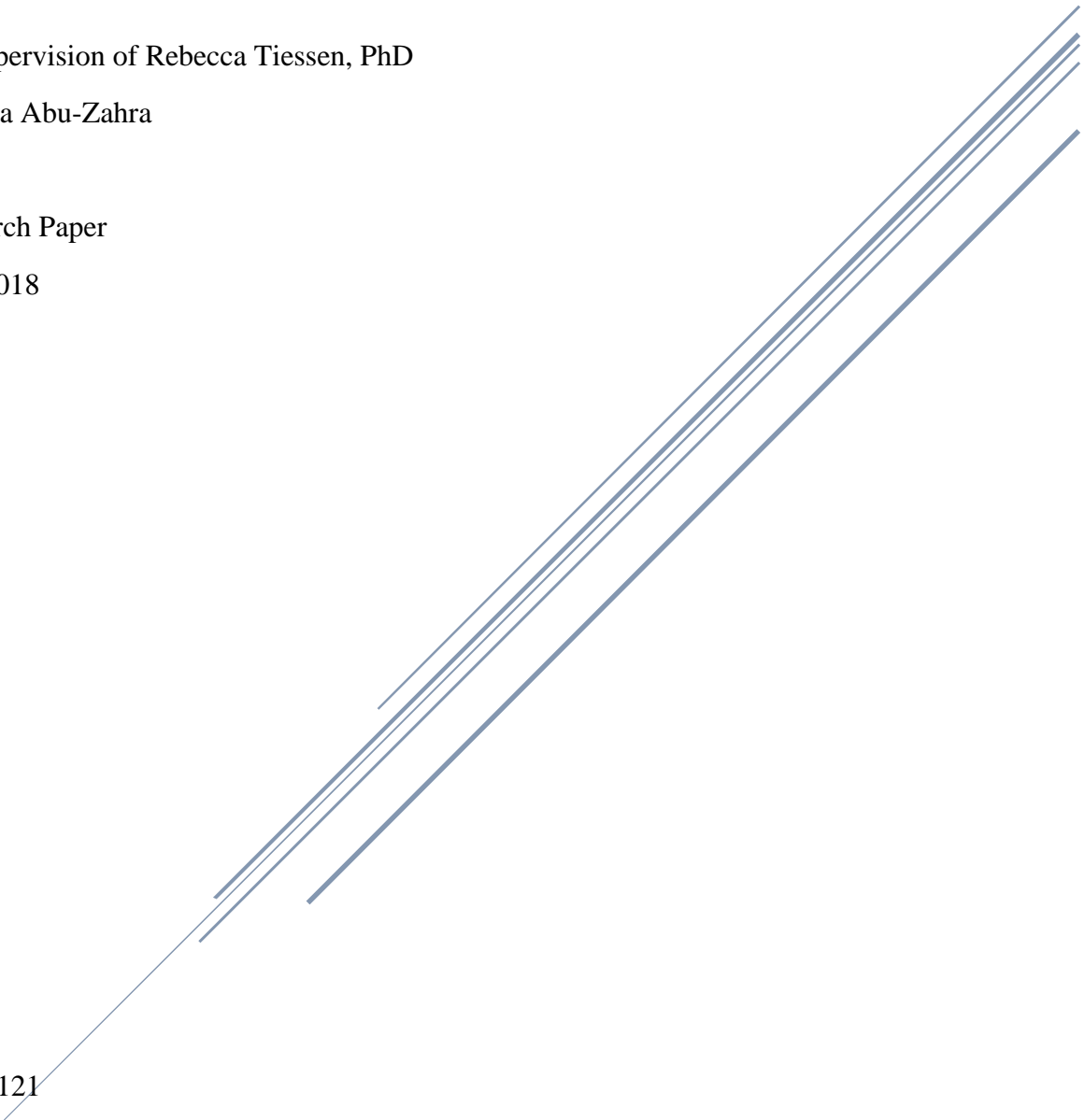


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Abstract

Indigenous women in Canada experience disproportionate maternal health problems compared to non-Indigenous women. The health problems they experience are in large part due to colonial policies which have oppressed them systemically through policies like the *Indian Act*, the removal of personal agency in pregnancy, and their forced assimilation and destruction of traditional birthing practices. The Canadian federal government and some provinces and territories are in the process of decolonizing healthcare policies to promote culturally safe practices, improve health outcomes, and reconcile historic inequities. The following environmental scan of Canadian maternal and Indigenous healthcare scans illustrates our problematic history, and the positive changes that are being made.

Key Terms

Indigenous, Canada, maternal health, maternal healthcare, healthcare, cultural safety, agency, healthcare policies

1. Introduction

The Canadian healthcare system has entrenched Indigenous peoples in a cycle of negative health outcomes for centuries. Particularly, Indigenous women living in Canada experience unequal outcomes in maternal healthcare, which leads to health problems for the mothers and babies (Lavoie et al., 2010). The government of Canada, as a colonizer, is responsible for decades and centuries of death, hurt, and pain, for the Indigenous peoples of these lands. Wiebe et al. (2015) write that the “systematic suppression of traditional beliefs,” (p. 59) and other colonial practices, contributed to the erosion of health and culture of Indigenous peoples. The systemic oppression of traditional practices, including birthing practices, is due to institutional barriers, policy gaps, and cultural differences in approaches to healthcare, and a lack of continuity of care (Sokoloski, 1995), as well as personal choice on the part of the mothers. In comparison to non-Indigenous Canadians, Indigenous babies in Canada have shown a higher rate

of macrosomia¹, diabetes (Oster, Mayan, & Toth, 2014), stillbirths (Kornelson, 2010; Riddell, 2016), and fetal alcohol spectrum disorder (National Collaborating Centre for Aboriginal Health, 2012). Indigenous mothers have shown higher rates of post-partum depression, gestational diabetes, and other health complications related to pregnancy (Daoud, Smylie, Urquia, Allan, & O'Campo, 2013; Liu, Shah, Naqshbandi, Tran, & Harris, 2012; Oster et al., 2014).

These discrepancies point to systemic issues within Canadian healthcare and the governmental system and demonstrate the opportunity for the government to work on reconciliation. Institutionally, there are gaps in patient intake, care processes, service standards, and language barriers between federal, provincial/territorial, and municipal governments. These gaps lead to Indigenous women and their babies being lost within the Canadian healthcare systems (Lavoie, 2013) and puts them at risk from preventable health problems. There are limited culturally appropriate policies in Canada to address the gaps in Indigenous healthcare because there are provincial/territorial and federal disagreements over jurisdiction. However, some governments, like the provinces of British Columbia and Ontario, have created positive change for Indigenous and maternal health.

Nonetheless, Canada's current Indigenous health care policies reflect the historical relationships between Canada and Indigenous peoples. The government-to-government relationships do not adequately provide for the needs of the Indigenous mothers and babies, and reflects institutional racism and a lack of political will (Richmond & Cook, 2016). As an essential part of life and cultural practice, childbirth represents an opportunity to integrate culturally-safe approaches (Lalonde, Butt, & Bucio, 2009). Smith et al. (2006) write that

¹ Macrosomia is a birth weight over 4,000g, above the 90th percentile for gestational age, which can cause challenging labour, and leads to negative health problems later in life, including diabetes (Mohammadbeigi et al., 2013).

pregnancy can be an opportunity for Indigenous people to heal from and resist the impacts of colonialism, by reclaiming traditional practices. As will be shown in the environmental scan of Canadian policies, some provinces and territories, as well as the federal government, are making efforts to change the system and promote Indigenous traditional knowledge and culturally-safe maternal health practices, although there is room to improve these policies for better health outcomes.

Canada's 2016 Census includes 1.67 million Indigenous people in Canada, accounting for 4.9% of the population (Government of Canada, 2017). 145,645 Indigenous children were aged 0-4 in 2016 (The Canadian Press, 2017). This is an increase from 3.8% in 2006. According to the 2006 Census, the fertility rate for Indigenous women is twice that of non-Indigenous (2.6 versus 1.5, respectively) (Statistics Canada, 2006), and these rates have remained steady (Statistics Canada, 2016). The rate was highest for Inuit (3.3) and lowest in Metis women (2.2) (Statistics Canada, 2006). An increased life expectancy has also been shown in the new statistics (Kirkup, 2017). Significantly, governments have been unreliable in counting Indigenous health statistics, because children may not have been registered *yet* with their Indian status, and some are ineligible (Elias, Busby, & Martens, 2015, p. 180).

This paper offers a critical analysis of the health care system – a system that perpetuates health inequalities. The objective of this study is to better understand why Indigenous women in Canada experience systemic, unequal participation in, and access to, maternal healthcare, through a post-colonial narrative. This paper includes a literature review of colonialism, feminism and women's agency, discrepancies in health outcomes, self-determination, cultural safety, and Indigenous maternity. The second part of this paper is an environmental scan of what healthcare policies there are federally and provincially/territorially in relation to Indigenous

peoples. These policies and initiatives demonstrate the immense cultural harm for Indigenous women's birthing practices, as well as physical and emotional harm for the women. The environmental scan is not exhaustive, due to time and space constraints, but demonstrate gaps in healthcare policy. This scoping of Canadian maternal healthcare policies and their impacts on Indigenous women in Canada provides insight into the kinds of healthcare practices that must be developed, and how changes are being structured, to be more culturally relevant and effective by integrating Indigenous women's voices and increasing their agency in their healthcare. By addressing the healthcare processes that need to be addressed, this paper highlights the importance of Indigenous women's agency in culturally safe maternal healthcare practices.

Changing the current health care structure is a process of decolonization. Gomes et al. (2013) write that decolonizing Canada's health care processes involves addressing the effects of colonialism and creating transformative change. Healthy public policy would recognize investment in holistic health, which addresses economic, social, environmental, and colonial factors (Richmond & Cook, 2016). In the context of Indigenous maternal health, it must address the colonial structural violence and destruction of cultural practices to heal generational trauma and give agency to those perspectives (Kroeker, 2017). Until recently, there were few Canadian policies that were specific to Indigenous people and healthcare, or maternal health, as demonstrated in the environmental scan. The scan begins with historic documents like the *Indian Act*, to show the systemic racism embedded in Indigenous life. The earlier healthcare policies perpetuated discrepancies and were not culturally safe. For example, the federal government evacuates Indigenous women living on reserves to urban areas at 36-38 weeks of pregnancy to have their babies outside of their communities, which disrupts community and individual identities (Lawford & Giles, 2012). Although there are no statistics available for how many

women have been evacuated, the policy is applied in situations where hospitals or birthing centres are unavailable. Women who have gestational diabetes or other risks and are unable to go to a hospital are evacuated by the federal government (Health Canada, 2012).

In 1989, the *Health Transfer Policy* framework gave Aboriginal communities south of the 60th parallel control of the resources in their communities. Now many communities control their own medical resources, although they lack continuity for resource distribution, or necessary medical training (Lavoie, Toner, Bergeron, & Thomas, 2011). The healthcare system is fragmented between federal, provincial/territorial, municipal governments, the private sector, and Indigenous authorities (Lavoie, 2013). Healthcare has been relegated to the provinces and territories, yet the *Constitution Act of 1867* established that “Indians” (or First Nations) were a federal jurisdiction (Lavoie, 2013), and included no provision for Inuit or Metis. The scoping of these policies illuminates the holes, where culturally relevant and safe practices could be harmonized into the Canadian system. It will also highlight the positive changes any of the federal, provincial, and territorial governments may be making.

2. Research design, methodology, and ethics

This environmental scan and post-colonial feminist analysis traces Canadian maternal healthcare policies, and those related to Indigenous peoples, to illustrate the significant gaps in services in comparison to culturally relevant and safe practices. This literature and environmental scan does not involve primary research involving human subjects and therefore did not require approval of the Research Ethics Board. However, there are ethical considerations involved in this research. Specifically, I acknowledge that I am a non-Indigenous settler woman, and therefore must continually reflect on my privilege and positionality within Canadian society. This question of privilege and positionality is an ethical consideration because I do not wish to perpetuate

colonial ideologies, yet I am an outsider to Indigenous beliefs. I do not have training or an official education in Indigenous issues, so I cannot profess to have all the knowledge required to understand the situation. However, I believe that my background in gender studies and peace and conflict studies has allowed me to reduce “othering” in this paper. Recognizing this gap in my knowledge, I decided that I could address the health inequalities in Canada for Indigenous women through an environmental scan of Canadian settler policies, to deconstruct and critically evaluate the healthcare system.

Articles for the literature review were selected through research databases focusing on terms like “Indigenous,” “maternal health,” “social determinants of health,” “Canadian Indigenous policies,” “self-determination,” “women’s agency,” and “Aboriginal health” in Canada. Most of the articles have been published since 2000, with most of the data collected from studies in British Columbia and Alberta. An effort was made to include research from self-identified Indigenous people, as well as, Indigenous health organizations. The environmental scan of policies was sourced through federal websites, like GCJustice, while other policies were available with Google searches. Each policy was searched for using specific words: “women,” “gender,” “mothers,” “maternal,” “health,” “Indigenous,” “Aboriginal,” “First Nations,” “Inuit,” “Metis,” “pregnancy,” and “babies” to determine their use.

In this research paper, I employ a framework of postcolonial feminism to understand how historical systems have, and may continue to, impact Indigenous women’s healthcare. Using the search terms listed above in the methodology, specific words were filtered through a lens of post-colonial feminism. Post-colonial feminism develops a structural analysis of policies that promote ongoing colonial practices through policies like the *Indian Act*, which perpetuates inequalities

and inequities for Indigenous women. This lens also highlights the absence of indigenous women's voices, agency, and participation in their own healthcare needs.

There are two components of the framework: a postcolonial feminist lens is necessary for the analysis of policies to facilitate an examination of the power structures in the current Canadian healthcare system to see how Indigenous women are able to access or participate in maternal healthcare (Darroch & Giles, 2016; Mohanty, 2003). "Post colonial" has been used by many scholars as an attempt to disrupt Western/European values, and question how colonial messages are propagated in current policy. The post-colonial lens allows theorists to challenge colonial structures, and recognize historical inequities and inequalities, to decolonize the hierarchy of power, therefore it is necessary in this project.

A feminist analysis is also important for this paper because it enables us to discuss the oppression of various groups, not just patriarchal oppression of women. In fact, contemporary feminism dismantles oppression for women of colour, different ethnic groups, and queer women, etc., and is extremely political (hooks, 2012). Although the beginnings of feminist movements were inherently racist and classist, and worked for the suffrage of white, upper class women, since then, many types of feminism have emerged, including various Indigenous feminisms. As will be shown in the environmental scan, Canadian policies around the time of the third wave of feminism (1990-2000) demonstrate the beginning of challenging structural inequalities (Elliot & Mandell, 2001). Women need to navigate a complex intersectionality of identities, which is exponential for Indigenous women in Canada, who face institutionalized oppression (Shaw & Lee, 2011). Gender and race are a social construct, and are reinforced by the systems which created them—in this case, colonialism. Indigenous women are at the lowest stratification system of gender and race (Lorber, 2012). The Canadian healthcare system facilitates the privilege of

non-Indigenous women over Indigenous women, which has led to the disparities in maternal health. Formative to my arguments for this paper is Harding's (1986) contention that that gender oppression is structured along three main dimensions—the institutional, the symbolic, and the individual. I have informed the structure of my arguments around this: First, systemic gender inequalities have been imposed on Indigenous people through specific practices which reinforce colonialism. Colonization is built into the health practices in Canada, and a post-colonial analysis of the structures shows what is required for decolonization. Second, Indigenous women are symbolically oppressed through the cultural assimilation of birthing practices, so when Indigenous communities oversee their own healthcare, it is culturally appropriate and safe, and is responsive to the women's contexts, as long as they have continuity of health care. Finally, when women are active participants in their healthcare, they re-gain their agency. In sum, I employ post-colonial feminist theory in this paper to challenge historical structures of Canadian healthcare, the symbolic assimilation of birthing practices and their harm, and the removal of Indigenous women's agency in healthcare.

3. Literature Review

The literature reviewed for this research paper begins with the examination of core terms and concepts relevant to a study of Indigenous women's agency in maternal health programs. The literature demonstrates the power imbalances in Canadian policies, symbolic cultural discrepancies, and the individual lack of agency for Indigenous women in their health care. This includes working definitions for: colonialism, post-colonialism, Indigeneity, maternal health, health transformation, self-determination, reconciliation, cultural safety, and harmonization. An analysis of key terms for the research paper is provided below, followed by an introduction to the feminist and health policy scholarship on this subject.

3.1 Colonialism, Post-Colonialism, and Decolonization

When North America was colonized by Europeans, relationships with the Indigenous groups were primarily based on trading but turned sour. Many Indigenous people were killed in battles, by new diseases and viruses; others were tricked into giving ownership of their land over to these new inhabitants. Years of strife followed, including residential schools which were introduced to assimilate and destroy “Indian” culture, sterilization, and the reservation system. Colonialism is an ongoing process in Canada, which can be observed throughout the policies and practices that perpetuate inequality through ongoing governance structures. Czyewski (2011) writes that colonialism is defined as the control and governance of a nation on another nation, and the system by which the nation inflicts its power. Colonialism is a determinant of health (Czyzewski, 2011, p. 12), because it determines access to resources, and rejects traditional knowledge, which leads to the maternal health disparities for Indigenous women. Neocolonial policies perpetuate discrimination and social exclusion today (Richardson, Driedger, Pizzi, Wu, & Moghadas, 2012).

3.2 Indigeneity

“Indigenous” is used as a blanket term for the people who were the original inhabitants of land. It is not used by all but is useful to convey messages more simply. The United Nations functions with the understanding that “indigenous” refers to the people who are the descendants “of those who inhabited a country or a geographical region at the time when people of different cultures or ethnic origins arrived. The new arrivals later became dominant through conquest, occupation, settlement, or other means” (United Nations & Chakrabarti, 2017). Indigeneity is relational, and inclusive of all first peoples and common in their experience of colonialism (S. Wilson, 2008). Hamilton (2005) writes “the process of racialization rationalizes the creation and sustaining of social and economic inequalities” (p. 112) within Canadian institutions and power

structures, including the health care system. Drawing from these definitions, I will be using “indigenous” to refer to First Nations, Inuit, and Metis in Canada, as it was the term used most frequently in more recent research, rather than “Aboriginal” or any other term, although I use “Indian” while describing the *Indian Act*.

Through the *Indian Act*, Indian Status determines who is considered Indian, and therefore can receive services from the government. Originally, “Indian” was used to refer to the original inhabitants of North America by European colonizers. It is generally a derogatory term now, although some Indigenous people still refer to themselves as Indian. Under the *Indian Act* (1876), people with Status could live on a reserve, share money, and inherit property, but were prevented from voting. “Status” was handed down along patrilineal family lines, despite cultural traditions of matrilineal inheritance (Haworth-Brockman, Bent, & Havelock, 2009, p. 17). If a woman married a non-Indigenous person, she lost her Status and therefore lost her rights afforded by the *Act*, including financial or community support, healthcare, education, and other resources. For First Nations women who maintain their Status, they are often unaware of their entitlements or programs available to them. For Metis and non-Status women, Haworth-Brockman et al. (2009) wrote that most significant is the women’s lack of entitlement beyond provincial and territorial programs (p.18), unlike First Nations and Inuit women, because they have few supports federally.

3.3 Health Disparities

One significant factor in health problems for mothers and babies is the disruption of lifestyles and diets due to colonization, poverty, and food insecurity, which has been linked to obesity and other health problems in Indigenous peoples (Smylie, 2014). On average, there are poorer health and social outcomes for Indigenous peoples than non-Indigenous peoples due to colonial and post-colonial policies, which have undermined Indigenous cultures and promoted

Westernized medical approaches to healthcare and birthing (Anderson et al., 2016; Health Canada & First Nations and Inuit Health Branch Canada, 2009; Lavoie et al., 2010; Riddell, Hutcheon, & Dahlgren, 2016; Kathleen Wilson & Rosenberg, 2002). Kant (2013) calls the colonial system an “endless circle of disadvantage” which is challenging to overcome (2013, p. 463). In general, cultural and racial minorities experience less access to services, including education, housing, and mobility (Olson & Couchie, 2013), which “contributes to a cycle of oppression and social injustice” (Darroch & Giles, 2016, p. 6) and leads to poor conditions for mothers. Additionally, Indigenous people living in urban areas are often subject to worse health problems than those in rural areas, because they may not be able to afford health care, or they may experience racism within the system (Lalonde et al., 2009).

There are many instances where researchers have demonstrated the disparities between Indigenous and non-Indigenous mothers and their babies. Some of the studies in healthcare show that First Nations people experience higher levels of morbidity than those who are not Indigenous (Kornelsen, Kotaska, Waterfall, Willie, & Wilson, 2010; Kathleen Wilson & Rosenberg, 2002). Indigenous populations in Canada deal with macrosomia, excessive fetal growth, at a significantly higher rate than non-Indigenous Canadians (Auger et al., 2013). Pregnant Indigenous women often surpass weight-gain recommendations (Darroch & Giles, 2016, p. 6), and a study by Vallianatos et al. (2006) showed that many women thought that weight gain during pregnancy would increase milk production, rather than cause diabetes. Liu et al. (2012) found that gestational diabetes was more prevalent in First Nations women (10.3 versus 6.0%), and they received less care than non-First Nations women with diabetes. Many women also experience food insecurity, which acts as a barrier to eating well during pregnancy, and therefore influences weight gain (Smylie, 2014).

National infant mortality rates for Indigenous babies remain unavailable, but some studies in specific regions do show a disparity between Indigenous and non-Indigenous babies. In British Columbia, the infant mortality rate for Indigenous versus non-Indigenous babies in rural areas was 13.8 versus 6.1 deaths per 1000 live births, and 12.7 versus 6.1 deaths per 1000 births in urban areas (Richmond & Cook, 2016, p. 4). In Manitoba, the rate is also twice the average, 9.8 versus 5.0 deaths per 1000 live births (Richmond & Cook, 2016, p. 4). Indigenous babies in Canada have shown a higher rate of macrosomia, diabetes (Oster et al., 2014), higher rates of stillbirths (Kornelson, 2010; Riddell, 2016), fetal alcohol spectrum disorder, (National Collaborating Centre for Aboriginal Health, 2012) and other complications for mothers, than non-Indigenous Canadians. For babies, specific birth outcomes, like preterm birth and low birth weight (LBW) demonstrate problems with health (Ichikawa, Fujiwara, & Nakayama, 2015, p. 1).

There is a large body of research showing that adequate prenatal care leads to improved outcomes, but many Indigenous women do not attend pre-natal checkups regularly (Sokoloski, 1995, p. 89) because of accessibility issues like remoteness, inability to take time off work, or spiritual beliefs which prevent participation in Western medical healthcare. In addition to cultural differences of healthcare, access to service is also an issue. For example, most rural Indigenous communities in Canada do not have access to health services through public transit, do not have cars, cannot take time off work, or because there are no doctors, midwives, doulas, or nurses in the community (Lavoie et al., 2010).

A final reason for the disparities in maternal health is that the majority of theoretical models for health care are developed from the perspective of the health care provider, rather than focusing on the patient's needs which can lead to misunderstandings or avoidance (A. Wiebe & Young, 2011). For example, reasons for medical testing are often not explained effectively to the

Indigenous women, like testing for Down Syndrome, Trisomy 18, neural tube defects, and other health problems. Improved testing practices could help Indigenous women make more informed decisions about possible terminations to pregnancy, as well as preparing for possible health outcomes. Rates of testing are lower in Indigenous and rural populations, likely due to a combination of access, training, and spiritual understandings (Riddell et al., 2016; Winqvist et al., 2016). Many healthcare professionals do not have the adequate tools to communicate their concerns about possible health problems effectively to the pregnant Indigenous women, which prevents effective interactions (A. Wiebe & Young, 2011). Continuity of care is also very important. Sokoloski (1995) also found that many healthcare practitioners had an “authoritarian approach,” would have “attitudes of prejudice,” and often women experienced long waits for appointments and rushed visits. Recommendations for improved healthcare practices are provided in section 6, to demonstrate how Indigenous women may experience improved maternal health outcomes.

3.4 Cultural Identity and Birthing Practices

Cultural and social identities play a large part in the social determinants of health for Indigenous peoples in Canada and how meaning is defined. I will not summarize all the Indigenous beliefs around childbirth in this paper, although it demonstrates the complexity involved in addressing multiplicity in policies. The medicalization of health has changed the way women experience pregnancy and childbirth, including standards of care and locality in all cultures. Policies have been harmful for Indigenous communities with strong connections to the land, each other, individual women, and their babies. Residential schools, community relocation, and cultural suppression have disrupted Indigenous birthing practices, and have been partially replaced by “mainstream maternity” and practices which focus on physical checkups and immunizations (Smylie, 2014, p. 1). For many Indigenous communities, health involves a more

holistic paradigm than medicalized Western perspectives: it focuses on physical, mental, emotional, and spiritual well-being (Health Canada & First Nations and Inuit Health Branch Canada, 2009), and therefore is considered more culturally appropriate forms of healthcare for Indigenous mothers and babies. In fact, Indigenous health is an approach that could be modelled in all maternal healthcare practices. Birth still involves sacred traditions and ceremonies (Lalonde et al., 2009). It is celebrated as a web of relationships between families and the environment (National Aboriginal Health Organization, 2008; Smylie, 2014, p. 1). Many Indigenous peoples conceptualize pregnancy as a spiritual process—babies are gifts from the creator and should not be interfered with (Sokoloski, 1995). Technical interventions in pregnancy are frightening for some Indigenous women (Sokoloski, 1995). This creates tension between spiritual beliefs and Canadian healthcare paradigms. However, not all women feel this way, and welcome medical aid—the primary factors for their maternal health are not spiritual, but rather a result of the health system which is gendered and serves a hierarchy of race identities.

There is a historic, institutional racism in education and health. Indigenous women experience intersectional disparities in health, both through their Indigenous identities, and their gender. As will be discussed later, changes in policies and health care funding have required women to leave remote communities to give birth in urban centres, often far from their families, which is extremely challenging to their holistic health (Kornelsen et al., 2010). Childbirth has moved out of the community into urban centres. This is a shift in geography and cultural practices, since previously childbirth was celebrated by the community (A. D. Wiebe et al., 2015). The suppression of traditional beliefs and assimilation into Canadian culture by the Government of Canada and other institutions, has perpetuated the significant health gaps (A. D.

Wiebe et al., 2015). Local birth contributes to an individual's identity, including kinship ties and the relationship to the land (Kornelsen et al., 2010, p. 638). The cultural identity for the mother, child, and family, are challenged when confronted with culturally unsafe health practices.

Finally, a large part of Indigenous maternal health focuses on the traditional role of a midwife or doula. Until the development of obstetrics in the mid 1800s, midwifery was common for all women's birthing practices. However, with the medicalization of birth, came the belief that midwife births were unsafe, and affected Indigenous maternal health policies (Lalonde et al., 2009). Presently, midwifery is becoming more prevalent in mainstream Canada, which is a demonstration that governments in Canada have the capability to understand different approaches to childbirth. Support for Indigenous midwifery has increased, and includes Indigenous training models (National Collaborating Centre for Aboriginal Health, 2012). Couchie & Sanderson (2007) demonstrated limited improvements in prenatal care and birth experiences for Indigenous women. Indigenous midwifery is expanding, like regulations on non-Indigenous midwifery around Canada. For example, although the Government of Manitoba has ruled that some non-*Canada Health Act* services are not their fiscal responsibility, there is a strong midwifery education program (Allec, 2005). Indigenous midwifery integrates Indigenous "traditional knowledge," and has been successful for lobbying for community-based health care (The Vanier Institute of the Family, 2017). The challenge for health policymakers is to adapt policy to fit Indigenous practises, despite the colonial system.

3.5 Women's Oppression and Agency

Gendered and sexualized oppression has been harmful for people for centuries, and has removed agency from women everywhere. Feminist analysis gives us the opportunity to disrupt and understand this oppression. For bell hooks, feminism is a commitment to eradicating race,

class, and sexual domination, and to the reorganization of society (hooks, 2000). However, not all forms of feminist thought are sufficient for tackling societal injustices. For example, liberal feminism fails to analyze dominant institutions and the systemic barriers to gender equality, and offers little in the way of intersectional analysis, often treating women as a homogenous group. Third wave feminism (1990-2000) recognizes the limitations of liberal feminism, highlighting gender inequality as well as systemic racism in state policies, including racism affecting Indigenous peoples on and off-reserve (Elliot & Mandell, 2001).

To challenge the structures that oppress Indigenous women, their voices need to be integrated into the policies and programs that dictate their health outcomes. Women's voices need to be integrated into policy through effective and culturally safe consultation. Eckermann (1997) writes that women have the potential to rewrite ideologies rather than subverting dominant discourse, in order to create positive action and social change (Day, Johnson, Milnes, & Rickett, 2010). "Bringing birth home" - both physically and spiritually - for those whom who choose locally-based birth options, transforms the dominant narrative of childbirth to a positive holistic experience, or as Sen (1982) would say, a "positive freedom."

3.6 Self-Determination

Self-determination, the process by which a group determines its own statehood and own governance process, is one of the main solutions to colonialism (UNPO, 2017). The self-determination of health programs is one of the main solutions for problems in health care for Indigenous peoples in Canada. Self-determination and revitalization are the ways "through which individuals and communities become responsible for, and in control of, all aspects of their lives and futures" (Ranford, 1998). Although not a perfect transition for all communities involved with health transfers because of lower capacity and capital, the transfers enable Indigenous

communities to direct their own programs and promote their own agency. Lemchuck-Favel and Jock (2004) list six markers of cultural continuity for self-empowerment and determination, which includes band-controlled health services shared between communities with permanent health care workers, those with fly-in providers, and those with temporary clinics. Self-determination is incredibly important for Indigenous groups to overcome the continual impacts of colonialism. For two centuries, the Indigenous peoples of these lands have been unable to direct their own outcomes, and deserve the human right to self-determination (UNPO, 2017).

3.7 Cultural Safety

Cultural safety is an approach to integrate and recognize the impact diversity can have on our lives: it is based on the consideration of historic and social contexts, as well as “structural and interpersonal power imbalances,” and how those shape health experiences (Ward, Branch, & Fridkin, 2016). Culturally based community support and health perspectives are necessary to ensure that the needs of the clients are properly addressed (A. D. Wiebe et al., 2015, p. 47). Like equity-based analysis, cultural safety looks at how the needs of individuals and communities are addressed on factors such as age, gender and sex, sexuality, socioeconomic status, ethnicity, religion, ability, and geographic location. In healthcare, cultural safety is also used to study the power dynamics between the client and the healthcare practitioner and their healthcare paradigm (De & Richardson, 2008). Cultural safety differs from cultural sensitivity, which simply recognizes the differences between the cultures (Ward et al., 2016).

Cultural safety, or harmonization, offers an important new model for healthcare. Unlike cultural sensitivity, which can lead to cultural stereotyping and the continuation of colonial attitudes (Baker & Giles, 2012), cultural safety can ensure effective health care does not diminish, demean, or disempower cultural identities (Baker & Giles, 2012; A. Wiebe & Young, 2011). Harmonization “aims to enable each system to maintain its integrity as a holistic model

while working in coordination with the other to meet the needs of those requiring healthcare services” (A. D. Wiebe et al., 2015, p. 50). To illustrate needs for cultural safety, old-order Mennonite families, for example, have rejected clinical birth practices in favour of home births (Kathi Wilson & Kryzanasuskas, 2010). One of the arguments arising from the feminist scholarship to support the changing practices around maternal health care stem from changing views of birth as a culturally-significant experience, one in which women are not treated as vestibules for growing humans and objects for health care interventions (Tiessen, 2015).

The concept of cultural safety is integral to improving Indigenous maternal health outcomes in Canada because it harmonizes traditional practices that have been negatively impacted by colonization, and requires healthcare practitioners to reflect on the patients’ worldviews. As will be demonstrated later in the paper, cultural safety is one of the ways Canadian healthcare can be decolonized, and supports community-based healthcare systems. It can also help women regain their agency in their own pregnancies by giving them more options in aspects of their experiences. In terms of the larger picture of the paper, this literature gives the reader the tools to: understand the disparities in healthcare for Indigenous women in Canada; and situate the maternal and Indigenous health policies in colonialism and concepts of Indigeneity, and the right to self-determination. The literature review illustrated some of the differences in cultural identity and birthing practices for the Indigenous women and provided an overview of Indigenous women’s oppression and agency through institutional racism and sexism.

4. Environmental Scan of Canadian Healthcare Policies, Rulings, Frameworks, and Actions

The second part of this paper includes an environmental scan and analysis of the Canadian healthcare policies, rulings, frameworks, and actions, which have shaped both

Indigenous-Crown relationships, Indigenous patient-healthcare professional relationships, and the health outcomes of mothers and babies. This environmental scan reinforces the historical relationship between policy context and health outcomes for Indigenous women. It is necessary to include the historical context here because it demonstrates the systemic and institutional racism within the government policies and the Canadian healthcare systems, which have led to the previously mentioned health disparities. A postcolonial feminist lens is applied to assess what gaps are presented by the policies, how Indigenous women have been oppressed, and what positive changes appear for First Nations, Metis, and Inuit women. These policies which were available for study cover a large range of time within Canadian constitutional history, including provincial and territorial policies. It is not an exhaustive list, because of the limited scope and timeframe for this project. Policies were selected based on historical significance (e.g. the *Constitution Act of 1876* and self-governance legislation). Some initiatives or government projects have also been chosen to demonstrate the funding architecture because they demonstrate political will. This project demonstrates that the Canadian healthcare system is a mess of federal, provincial, territorial, municipal, Indigenous governments, and private sector. These ambiguities in responsibility result in gaps (Lavoie, 2013, p. 1). One major gap in Indigenous healthcare policies is that until recently, Inuit women were not included in Indigenous health policies, and Metis are still excluded (Lavoie et al., 2011, p. 3; Kathi Wilson, Rosenberg, & Abonyi, 2011). Until recently, the federal government did not acknowledge their responsibility for Metis people's health (Haworth-Brockman et al., 2009, p. 3). In fact, the Northwest Territories are the only provincial/territorial government with a Metis Health Policy. The policies have been divided into sections: older history (the *British North American Act of 1867* until 1968) to contextualize the systemic and institutional racism against Indigenous peoples in Canada, the

modern period (*The White Paper* of 1969-1983) which demonstrates a shift in government-to-government relations, and the post-colonial policies (1984-present) which include positive changes for Indigenous maternal health. The environmental scan of Canadian federal and provincial/territorial Indigenous and maternal health policies illustrates the necessity for the decolonization of the health care system. Earlier colonial policies reinforced the systemic, symbolic, cultural, and individual oppression for Indigenous women. More recent policies support community-based birthing centers, funding for Indigenous midwifery programs, and acknowledge the right to self-governance.

My analysis of the policies for the last 100+ years highlights the immense cultural harm for Indigenous women's birthing practices. The policy review and analysis also marks a positive change in some areas for the women's ability to enact agency and community-driven health programs. The purpose of analyzing historical policies is to demonstrate structural inequities, which reinforce colonialism within Canada, and to gain an understanding of how and why Indigenous women face such large maternal health disparities in comparison to the rest of the Canadian population. My three key arguments in this paper are that 1) gender inequalities have been imposed on Indigenous women through specific practices; 2) the process of colonization is built into health processes in Canada, and a post-colonial analysis of the structures shows that Canadian healthcare requires a process of decolonization, 3) when Indigenous communities oversee their own healthcare, it is culturally appropriate and safe, and is responsive to the women's contexts.

4.1 Historic Canadian Healthcare Policies (1867-1968)

In 1867, the provinces of Ontario, Nova Scotia, and New Brunswick signed the *British North American Act*, to be united as one dominion under the United Kingdom (United Kingdom,

1867), disregarding the rights of the Indigenous peoples, their cultures, and traditions (United Kingdom, 1867). Healthcare was designated within provincial government control, and Indigenous affairs fell under the federal government's responsibility. As the first ruling on Indigenous people, the act left implementation gaps for Indigenous people's health (Lavoie et al., 2011, p. 2) and removed any Indigenous agency. Soon after, the *Constitution Act of 1876* created the Dominion of Canada, and reaffirmed Indians as a Federal jurisdiction (United Kingdom, 1876).

The *Indian Act* was created in 1876, to determine how the Government of Canada should interact with the bands, how the bands are expected to behave, and who is considered an "Indian" (Government of Canada, 1985). This piece of policy is the most significant historically for Indigenous people in Canada. The *Indian Act* of 1876 has generated the most "debate, anger, and sorrow" of any Canadian document (Coates, 2008, p. 2), but still is the main element in managing Indigenous affairs. People who live off-reserve are not guaranteed health coverage through the *Indian Act* (Lavoie, 2013), and may not have the resources to access health services in rural or urban areas. The *Act* gave the Department of Indian Affairs the authority to define who is "Indian," (Kathi Wilson et al., 2011) and abolished traditional systems of governance and inheritance. The *Act* gave the federal government the authority over band affairs, Indigenous lands, and trust funds, and for directing family lives. The *Indian Act* strove to assimilate the "inferior, unequal, and uncivilized" Indigenous population (Richmond & Cook, 2016, p. 2). The policies opposed "pre-existing principles of governance, and moral, and social order" prior to colonization (Richmond & Cook, 2016, p. 3), which is damaging to individuals and Indigenous cultures. These structural changes to traditional power structures are still prevalent today. For example, until the 1950s, women were not able to run for positions on band councils, although

they did gain the right to vote at the same time as Indian men (Leslie, 2016). The *Indian Act* is patriarchal: it elevates men at the expense of women and disenfranchises women if they married non-status men (Halseth, 2013). People with Status can live on a reserve, share money, and inherit property, and Status is handed down through the male line, dismissing matrilineal inheritance (Haworth-Brockman et al., 2009)

Some groups (like the Chiefs of the Indian Association of Alberta) have argued against repealing the *Indian Act* because it would remove the government's legal fiduciary responsibilities to First Nations. Elias (2015) writes that Indigenous peoples in Canada are marginalized "to a life of statistical health inequality" and are prevented from removing themselves from their oppressed state (p. 185). Richmond & Cook (2016) write that "the persistent support of the *Indian Act* reinforces the assumption that the Indigenous Peoples of Canada are not worthy of respect, recognition, or equity, in access to quality services in all public service systems" (p. 11).

Until 1939, federal rulings for Indigenous groups only applied to First Nations peoples; Inuit and Metis groups were not involved. In 1939, the Supreme Court of Canada determined that Inuit were "Indians" under the *British North America Act*, therefore also a federal responsibility, although the Inuit in Quebec remain excluded (Supreme Court of Canada, 1939)—which shows discrimination for Indigenous peoples based on their geographic location. Only one program applies to all First Nations and Inuit, regardless of where they live: The *Non-Insured Health Benefits* (NIHB) program. The ruling confirmed the federal government's responsibility of the Inuit, but did not address their health (Lavoie et al., 2011, p. 2). Although the 1939 ruling demonstrated the federal government taking responsibility for First Nations and

Inuit (not including in Quebec), it still disregarded the responsibility to provide health care for Metis peoples.

By the middle of the 20th century, there was a push to medicalize and standardize childbirth around Canada. The standardization was done by encouraging or mandating births take into hospitals, under the increased authority of clinicians over midwives (Olson & Couchie, 2013). The standardization of childbirth through mainstream medicalization efforts was in response to high infant mortality for Indigenous babies, although as we have seen, disparities still exist, and the cultural harm has been extreme.

4.2 A Change Begins (1969-1983)

Status Indians received the right to vote in the 1950s, which ushered in a new period of Indigenous civil rights. The *White Paper*, or “Statement of the Government of Canada on Indian Policy, 1969,” attempted to overrule previous legal documents, including the *Indian Act* and treaties, assimilating all “Indian” peoples under the State (Sinclair & Lagace, 2017). The *White Paper* highlighted the “right of Indian people to full and equal participation in the cultural, social, economic, and political life of Canada,” and said that “to argue against this right is to argue for discrimination, isolation, and separation” (Government of Canada; Indigenous and Northern Affairs Canada; Communications Branch, 2008). The introduction acknowledges the systemic problems and says that Indians lack the power and agency to change their situations. To remedy colonial disparities, the Government of Canada determined it would be best to remove the “special status” of Status Indians and assimilate into one culture where all peoples are equal and all humans are guaranteed rights.

The White Paper was met with opposition from Indigenous leaders, despite the government’s intention to achieve equality among all Canadians (First Nations and Indigenous

Studies, 2009). In fact, the *White Paper* even says that policy to remove barriers for Indigenous people “must spring from the Indian community itself—but government can create a framework within which all persons and groups can seek their own goals” (2008, pp. 6–7). One issue with the *White Paper*’s proposal is that it is not to achieve equality, because Indigenous peoples do not generally have the same tools and advantages that other Canadians have access to because of historic oppression. Indigenous socioeconomic disadvantages are the fault of the Canadian colonial government, and there are no promises to return natural resources, lands, clean water, or other self-determination rights to Indigenous communities. It is therefore Canada’s responsibility to work towards reconciliation and acknowledge that the government has not met its duty to provide for its citizens.

The language in the *White Paper* places the blame on Indigenous peoples for not “doing better,” rather than admitting the failure of the Government of Canada for creating the system, which forced them into a new way of living. For example, it blames reserves for not developing their own services since they were exempt from federal and provincial tax systems, which included health services (2008, p. 10). However, this tax exemption only applies to approximately 272,000 First Nations status on-reserve, and excludes children 0-14—the tax exemptions are also very rare (âpihtawikosisân, 2011). Coates (2008) underscores that the *White Paper* advocates for replacing the collective rights of status Indians with the integration into Canadian culture. He also argues that the *Indian Act* is maintained in Canada because it reinforces the federal government’s legal and fiduciary responsibility to Indigenous people in Canada (2008, p. 9). Indigenous peoples were upset because despite a consultation process for the *White Paper*, it failed to address their concerns, including addressing historical grievances

(First Nations and Indigenous Studies, 2009). It also does not address land and resource theft, or the necessity of cultural safety.

The *White Paper* marked a change in government-to-government relationships and their potential for reconciliation (Bear, 2015) because there was a recognition of a change, and the entrenchment of Indigenous health and socioeconomic status. In 1970, The Chiefs of the Indian Association of Alberta (IAA) responded to the *White Paper* with “Citizens Plus: the Red Paper,” which was an act of resistance, and emphasised the treaty connection between First Nations people and the federal government, and self-governance (Bear, 2015). This policy response has been included because it is necessary to demonstrate the problems with the *White Paper*. The *Red Paper* rejects the removal of Indian Status, because at least Status holds the government to judicial responsibility.

The *White Paper* intended to overturn the *Indian Act* and make Canadian society more equitable. However, Indigenous groups were upset with the lack of consultation, and the suggestion that the government remove Indian status, explaining that it would challenge their current rights, limit services given to them in an oppressive system, and ignore the need for reconciliation without the return of land, water, and resources, little can change. Because of the *Red Paper*, the Government of Canada, as well as the territories and provinces, started to make changes to health care approaches for Indigenous people. Federal changes for Indigenous health care have been primarily health transfer options for communities that are deemed to have the capacity to administer funding and programs. Request B.3. Channels of Services (b) in the *Red Paper* asks for “the provision of health services to the Indian people on the reserve or off the reserve at the expense of the Federal government anywhere in Canada” (1970, p. 194). They write, “Indians have the right to receive, without payment, all healthcare services without

exception and paid by the Government of Canada” (1970, p. 196), and for Community development corporations that look at economic development and health services (1970, p. 205), as well as addressing the wiping out of tribal medicine men “as part of a deliberate campaign to wipe out the folkways of persons held to be pagan” (1970, p. 220).

In 1974, the Government of Canada produced a policy *Concerning Indian Health Services*, which said that there were no treaty obligations to provide health services to Indians, although they might give financial assistance to “indigent Indians” (Health Canada, 2005c). However, in the next year, the *Indian Relationships Paper* served to define a policy framework for strengthening Indian control of programs and services, including 75% of the Bands gaining responsibility for some health programs, including the Community Health Representative Program (Health Canada, 2005a), which is a departure from the 1974 policy which stated the federal government was not responsible for Indigenous health services. The distinction is that these programs are Indigenous-led, not determined by the federal, provincial, or territorial governments.

The 1979 *Indian Health Policy* acknowledges that “Indian” communities have been disadvantaged in comparison to other Canadians. The goal was “to achieve an increasing level of health in Indian communities, generated and maintained by the Indian communities themselves” (Health Canada, 2007). Finally, the federal government admitted fiduciary and legal responsibility to make changes for health outcomes for Indigenous peoples. However, this does not include reparation for stolen lands and resources, which would greatly increase community’s abilities to improve their own capacity, promote healing and self-determination.

The *Constitution Act of 1982* gave Canada its independence from the United Kingdom (Azzi, n.d.). The *Charter* confirms the rights of Indigenous peoples. Section 25 says that the *Charter* “shall not be construed so as to abrogate or derogate from any aboriginal, treaty or other rights or freedoms that pertain to the aboriginal peoples of Canada” (Legislative Services Branch, 1982), and affirmed the right to self-governance.

4.3 Post-Colonial Hope (1984-present)

I termed the final section a “post-colonial hope,” because while Canada is no longer a British colony, its devastating impacts remain, despite a strong effort to de-stabilize and deconstruct the colonial structures of the federal government. The period of 1984 to the present witnesses self-governance decisions, and agency for Indigenous communities surrounding their healthcare. Changing policies has been a learning process for federal, provincial/territorial governments, and has not always effectively involved consultation with Indigenous peoples. However, in the past few decades, more alternatives to medicalized healthcare have been accepted in the mainstream. Communities have been able to participate in traditional healing ceremonies (Lalonde et al., 2009). This part of the paper includes the *Canada Health Act*, self-governances, and local health models.

According to the *Canada Health Act* of 1984, provinces and territories are required to provide insured services to all insured persons, including First Nations on and off reserve all governments signed, except for Manitoba, who determined that the federal government is responsible for non-*CHA* health services to First Nations people who are Status Indian. This decision by the Manitoba government means that services normally provided to First Nations under the *Act* are being neglected (Allec, 2005). Policies such as Manitoba’s response to the *CHA*, demonstrate continued lack of support in certain areas for Indigenous rights to health care.

It is significant that Manitoba has the highest population of Indigenous people in Canada, which means that for the province, the change in health care funding would be significant to taxpayers. There are also no other policies from Manitoba relating to Indigenous health—in fact, only municipal groups are attempting to find solutions to the health disparities. However, we cannot say that Indigenous maternal health is simply an issue of taxed funding, because that negates the context of historical racial oppression and resource theft (Abu-Zahra, 2018).

The *Sechelt Band Self-Government Act of 1986* gave the First Nations community of Sechelt Band in British Columbia self-governance of their health services and lands (Health Canada, 2005b). The *Act* set a precedence for other Indigenous groups to be able to do so. Between 1986-2016, 22 Indigenous governments in Canada groups have gained self-governance. In statement 14 (1), the *Act* says: that the Band Council can create its own laws in relation to health services (Legislative Services Branch, 1986, pp. 5–6). Following the *Sechelt Act*, in 1988, the federal government released a *Cabinet Approval for Health Transfer South of the 60th Parallel*, which recognizes that First Nations and Inuit can assume responsibility for administering their own health care systems below the 60th Parallel at their own pace (Health Canada, 2005b). It presented mandatory health programs and supported the finances to overcome the programming and delivery barriers. To complement the *Cabinet Approval*, the government produced the *Health Transfer Policy*, which was rolled out by First Nations and Inuit Health Branch (FNIHB) of Health Canada in 1989, (now administered by Indigenous Services Canada—ISC) to give opportunities for communities to plan and deliver their own community-based health services (First Nations and Inuit Health Branch Canada, 2004, p. 5). What is special about these two pieces of government legislature, is that Community-based control of health care was accepted by the federal government as beneficial and desirable for Indigenous groups.

However, the federal government realised quickly that not all communities were ready to move into that level of control, and required more capacity-building, whether from political will, lack of capital or education, or because of every other systemic colonial oppression. More work needs to be done in these communities so they have the capacity to control their own health care.

After the release of the *Health Transfer* Policy, provincial and territorial governments began to produce policies on Indigenous healthcare. Some governments, like Manitoba, New Brunswick, Nova Scotia, Prince Edward Island, Quebec, and Saskatchewan continue to have lackluster policy, for whatever reasons. British Columbia, Ontario, and Northwest Territories are the most progressive, and unfortunately Ontario's newest policy on Indigenous health is still under development, so it cannot be included here. Alberta also has many resources listed on their website for Indigenous health, as well as maternal health, although their "strategy" is under construction. Lavoie (2013) wrote that the Yukon is the "only jurisdiction where health legislation recognizes the need to respect traditional healing practices, and the importance of establishing partnerships with Aboriginal peoples" (p. 4).

Ontario's 1994 *Aboriginal Health Policy* was created to help the Ministry of Health address inequities in First Nations/Aboriginal health (Ministry of Health, 1990). It was described as the most holistic and comprehensive policy in place in Canada, and the first of its kind (Lavoie, 2013), seeking to create new health relationships. Self-determination in health would be supported through financial and human resources (p. 3). Principle 4 recognizes, respects, and protects "Traditional Aboriginal approaches to wellness" (p. 4). Principle 6 writes, "First Nation/Aboriginal people must have control of health planning and resource management processes pertaining to Aboriginal policies, programs, and services" (p.4). It is intended to "act as a governing policy and assist the Ministry of Health in addressing inequities," and was the

most comprehensive policy at the time in Canada (Hall, 2012, p. 6). The Aboriginal Health Access Centres (AHACs) were created out of the Health Policy, although the Anishnawbe Health in Toronto and Misiway Milopemahteswin in Timmins, had been established since the 1980s. Because AHACs are Indigenous-led, they eliminate cultural risk (Hall, 2012). Midwifery Acts in provinces and territories began regulating midwifery in the 1990s. All provinces and territories have regulations for Indigenous midwifery, except for Prince Edward Island and the Yukon. Public funding is also available in exclusion to New Brunswick. However, many families do not have access to midwifery (National Aboriginal Council of Midwives, 2016). Midwifery can play a role in reconciliation (National Aboriginal Council of Midwives, 2016) and has implications for returning birth to communities (Olson & Couchie, 2013).

The province of British Columbia signed a *Tripartite Framework Agreement on First Nation Health Governance* in 2011 with the Government of Canada and the First Nations Health Society. It was to build on previous plans to “help improve the health and well-being of First Nations people in British Columbia,” and develop a partnership (First Nations Health Authority, 2011, p. 4). The *Agreement* gives legal expression to a Framework Agreement the parties drafted in 2010. The *Agreement* is guided by the *Canada Health Act* (p. 5), and gives BC First Nations the agency to be involved in decision-making, planning of programs, and delivery. The Office of Indigenous Health has a particular focus on maternal health (Ministry of Health, n.d.). This *Agreement* is a strong example of governments and health practitioners working together for the benefit of communities.

The most recent government information is from the Public Health Agency of Canada (PHAC), released in December 2017. These guidelines are for health care providers, other Canadians involved with maternal and newborn health, and those who plan health programs

(Public Health Agency of Canada, 2017). Principle 6 says that maternal and newborn care requires a holistic approach, principle 8 calls for culturally-appropriate care, and principle 9 says that Indigenous peoples “have distinctive needs during pregnancy and birth” (Public Health Agency of Canada, 2017). The new guidelines acknowledge historical experiences, remote locations, as well as cultural differences. These guidelines challenge healthcare providers to consider the social determinants of health for the women, including experiences of sexism, racism, unemployment, and inaccessible health services, in order to “prioritize information sharing, partnership, and collaboration” (Public Health Agency of Canada, 2017).

Many Indigenous women who live in remote areas without access to hospital or community birthing centres have experienced the federal evacuation policy. The women who live in rural or remote areas are flown into larger cities to give birth in hospitals even up to 500 kilometers away from their home, and often spend up to four weeks alone before labour (National Aboriginal Council of Midwives, 2016). Medical transportation is paid for by the federal government, as is an escort only if the mother is under 16 (Olson & Couchie, 2013). The evacuation policy causes a disconnect between the community, mother, and her baby (Douglas, 2006). In the Northwest Territories, 40% of women have had to evacuate for birth, as well as 23% in the Yukon, and 38% in Nunavut (Public Health Agency of Canada, 2009). Despite the evacuation, the women’s health remains poor, and infant mortality rates remain high (Lawford & Giles, 2012). Lawford & Giles (2012) argue that Indigenous concepts of health are “incongruent with the Euro-Canadian bio-medical model” (p. 329). Health services are also limited in remote locations which causes many women to travel away to urban centres. Research has shown that when maternity care is located closer to the home, better outcomes happen for the women and their families (O’Neil, 1995).

The Northwest Territories have a policy on the *Standards of Practice for Midwives* (2005), created by the Midwives Association of the NWT and Nunavut, in collaboration with the Department of Health and Social Services. This *Standard* supports the NWT *Midwifery Profession Act*, and are the only policies relating to maternal health that were found in NWT in the process of the environmental scan (National Aboriginal Council of Midwives, 2016). However, the provinces offer no other documentation for Indigenous or maternal health.

Nunavut only has one policy related to Indigenous or maternal health listed on the website. The *Maternal and Newborn Health Care Strategy 2009-2014* (2009) sought to improve community-based births and services, including strengthening maternal care and midwifery services (Department of Health and Social Services, 2009). The department acknowledges the high standards of maternal care available when evacuation is performed, but emphasizes the agency and choice Nunavummiut women would get by giving birth in their own communities. Nunavut needed a unique solution for the highest teenage pregnancy rate in the country, with 24% live births to mothers under 19 years old, compared to the national average of 5% in 2004 (Department of Health and Social Services, 2009).

The *Integrated Health Model* developed by the Government of Canada in 1994 includes three approaches for increased control of health services: health services transfer, integrated community-based health services, and self government (First Nations and Inuit Health Branch Canada, 2004). For some communities who require more capacity-building or may have had more pressing matters to deal with, health transfers have not worked. “Integrated healthcare” is a more organized health delivery system, which focuses on the community’s needs, shares information, and challenges the status quo (Leatt & Guerriere, 2000), although there are many different interpretations, which has led to different integrative policies around the world.

A report submitted by Health Canada in November 2002 lists the three major barriers to integrated health programming in Canada as: the misunderstanding of the terms and approaches, overlapping initiatives, and resistance to change in bureaucracies (Health Canada, 2002). Communities with Self-Government had the greatest control over their health care, and had more flexibility in management structure, and decision-making (First Nations and Inuit Health Branch Canada, 2004). The *Integrated Health Model* broadened opportunities for community control. In 2003, 176 communities had signed the agreement (Lavoie et al., 2011, p. 3).

In 2006, the Government of Ontario created the *Local Health System Integration Act*, whose purpose was to enable Ontarians to have higher quality healthcare more readily available. The *Act* recognizes the role of “First Nations and Aboriginal peoples in the planning and delivery of health services in their communities,” and confirms the challenges of geographic locations for health integration (Ontario Ministry of Health, 2006, pp. 1–2).

As stated previously, this environmental scan did not include every single Canadian maternal or Indigenous health policy. However, I chose the federal policies that guided the colonial narrative, and those that demonstrated a change in practices towards more culturally-safe ideologies. The Canadian federal government created the maternal health disparities by forcing Indigenous peoples onto reservation systems with limited resources, and into residential schools to assimilate and destroy their culture. Therefore, it is the government’s responsibility to make changes, which should include addressing the loss of land and natural resources. As was shown above, after the *White Paper*, the federal government took more care to find health solutions for Indigenous peoples. This involved self-governance acts, transferring health care decision-making to the communities, and funding community birthing centres and midwifery programs. The change in maternal healthcare modeling has been slow and challenging. For

example, many communities do not have the capacity to run their own health systems, do not have adequate funding, including for continued care, or are still forced into participating in the evacuation policy. Many of the provinces and territories are not acknowledging any responsibility, which perpetuates the gaps in healthcare. In the next section, I will discuss the implications of the policies and their structural, symbolic, and individual impact on Indigenous women and their maternal health experiences.

5. Discussion

The federal, provincial, and territorial policies described in the environmental scan demonstrate the structural, symbolic, and individual oppression for Indigenous women and their experiences of maternal health in Canada. The policies mark a positive change in some areas for the women's ability to enact agency and community-driven health programs. The purpose of analyzing historical policies is to demonstrate structural inequities which reinforce colonialism in Canada, and to gain understanding on how and why Indigenous women face large maternal health disparities in comparison to the rest of the Canadian population. Based on my analysis of the policies, I return to my three major findings. First, systemic gender inequalities have been imposed on Indigenous people through specific practices, which reinforce colonialism. Colonization is built into the health practices in Canada, and a post-colonial analysis of the structures shows what is required for decolonization. Second, Indigenous women are symbolically oppressed through the cultural assimilation of birthing practices, so when Indigenous communities oversee their own healthcare, it is culturally appropriate and safe, and is responsive to the women's contexts. Finally, when women are active participants in their healthcare, they re-gain their agency.

For the provinces and territories, there are more policies related to maternal health due to the legal responsibility of provinces and territories to administer health services for Canadians. British Columbia has no policies specific to Indigenous maternal health, although there are some resources on the government website for new-comer women who are pregnant and they have strong general Indigenous health policies. Manitoba does not even have specific Indigenous health policies since Manitoba rejected the *Canada Health Act* because it would require them to provide on- and off-reserve health services for Indigenous peoples. The financial burden of such a health care commitment would be substantial for a province like Manitoba which has the largest Indigenous population and substantial distances between Indigenous communities and health care centres.

As demonstrated earlier, Indigenous women and their babies face statistically disproportionate health problems, many of which are preventable. Perhaps it is in the spirit of reconciliation that there are no federal Indigenous maternal healthcare policies: if communities have self-governance over land, natural resources, and their health programs, what is the necessity of a policy? Can all communities gain self-governance? Simply put, those policies are not enough. For urban Indigenous women who are removed from their communities for maternal health care, how can they get the holistic help with their pregnancies that they need? What ensures they have access to adequate midwives, doctors, and important tests, if provinces like Manitoba will not provide non-insured services as determined by the *Canada Health Act*? What provisions are there for Metis women when most provinces and territories have not acknowledged responsibility to the Metis people? Who provides healthcare to non-Status First Nations and Inuit women if provinces, territories, and federal government are at odds? Until all communities (on-reserve, off-reserve, and urban) have the capacity and funding to provide self-

directed health programming, the government should be held accountable to its promise to improve health for all Canadians.

5.1 The structural oppression of colonialism

Historic health and Indigenous policies have shaped the current health processes in Canada. Structurally, the Canadian healthcare system is a remnant of colonialism, and it requires dismantling to effectively eliminate health disparities. Decolonization is oppositional to colonial ways of thinking, and requires the valuing of Indigenous sovereignty and culture (Sium, Desai, & Ritskes, 2012), as well as the re- or un-learning of healthcare and history (B. Smith & Rogers, 2016). There is structural violence embedded in Canada's frameworks (Kroeker, 2017). Feminist critiques of state policies, combined with intersectional analyses that take into consideration gender inequitable and racist policies and their impacts on Indigenous women on and off-reserve, provide insights into the structural impediments to health care delivery for Indigenous communities (Elliot & Mandell, 2001).

A structural analysis of the healthcare policies in play demonstrates that healthcare is often focused on the practitioner, and protecting the needs of the system, rather than the Indigenous patient's needs. The system is not accessible for Indigenous peoples or newcomers to Canada due to language barriers, different understandings and conceptualizations of health, and a lack of understanding about culturally safe practices. In some studies, Indigenous women admitted experiencing racism in their healthcare (Van Herk, Smith, & Andrew, 2011) and authoritarian approaches (Sokoloski, 1995)

As demonstrated by the environmental scan, there are logistical disagreements between federal, provincial, and territorial governments around responsibility for Indigenous health, which create more disparities for the Indigenous population. These logistical disagreements

challenge governments to reflect on their moral, political and legal obligations to provide for the Indigenous women (Christie, 2014). Policies like the *White Paper* suggest removing the ‘special’ Indian Status, to assimilate approaches to administering Indigenous healthcare. This demonstrates the lack of understanding historically around the federal government’s responsibility to reconcile past damage. Indigenous groups are disadvantaged; therefore, “leveling the playing field” is impossible until there is capacity and funding to do so, which includes self-determination of lands and water.

5.2 Symbolic oppression and cultural appropriateness

The cultural assimilation of Indigenous birth practices (including limiting Indigenous midwifery) has caused immense pain for Indigenous women. When Indigenous communities oversee their own healthcare, it has the opportunity to be culturally appropriate and safe, and is more responsive to the women’s contexts. Concepts like Indigenous midwifery “bring home” Indigenous birth to the communities, and dismantle the symbolic oppression (National Aboriginal Council of Midwives, 2016). Indigenous communities need to have the funding and capacity to control their healthcare programming through the *Health Transfer Policy* of 1989.

Indigenous people should have access to “hybrid” medical training, for a harmonization of traditional beliefs and medicalized techniques. More Indigenous nurses, doctors, and midwives could encourage good health practices within communities. Indigenous midwifery is necessary for improving health outcomes, but policy barriers that inhibit their ability to practice in Indigenous communities must be removed (Olson & Couchie, 2013).

5.3 Individuality, Invisibility, and Agency

Indigenous women in Canada have become invisible through policies. Their needs were silenced through colonialism and further government decisions, and their voices remain

unheeded. Indigenous women have lost their agency, and often cannot make choices about their birth experiences. Governments like Nunavut's are working to increase women's agency and choice around in-community birthing practices. To begin with, gender inequalities have been imposed on Indigenous people through specific practices, as we have seen in the environmental scan. Women lost rights through the *Indian Act* (1876), because of the rules around Indian Status. If women married out of the band, they and their children lost their status and support system. These historic exclusions make it challenging for policies to address women equally for their needs. Many women found that the men in their communities began to misuse their power and resources, and forced evictions from reserves of women and their children (Hamilton, 2005).

Historical policies also challenge traditional power structures through the imposition of male authority and patriarchal relationships. Many Indigenous groups pre-contact were matrilineal and matrilocal. The enforcement of this power structure includes how band councils work (it disrupted traditional leadership decision-making). Band councils are comprised predominantly of men. An amendment to the *Indian Act* in 1951 made things more stringent for women, by denying women who had married out the right to live on-reserve tax-free, to be buried on-reserve, to receive revenues, and to participate in on-reserve services like health and education (Stevenson, 1999). Patriarchal society diminished women's identities, power, agency, and autonomy (Dickson, 2000; Kollahdooz et al., 2016; Medved, Brockmeier, Morach, & Chartier-Courchene, 2013). The implications for this inequality for Indigenous women in Canada are that historically women's health has not been prioritized, they have not been supported sufficiently by the government, who put them in the position of oppression to begin with, and women have not been able to hold positions of power within communities to change their outcomes.

The federal, provincial, and territorial policies analyzed in this paper illustrate a positive change for Indigenous maternal health outcomes. Although certain colonial mechanisms are still built into the system, like the continued employment of the *Indian Act* and Indian Status, the past few decades have brought advancements for government-to-government reconciliation. These advancements include health transfer policies and the self-determination of some Indigenous governments which were deemed to have the capacity to do so. The feminist lens employed in this paper provides insight into the structural oppression of Indigenous women for whom legitimacy, authority, and agency were challenged by the colonizing Europeans. The resultant cultural assimilation harmed traditional birthing practices, and harmed individual Indigenous women.

6. Recommendations

Pregnancy is an important life-changing opportunity for women. For many women, it offers them the chance to make healthier choices for themselves and their children (J. Smith et al., 2006). If Indigenous women could make their own healthy, informed, and holistic decisions about birthing practices, health disparities for mothers and babies could be addressed in culturally appropriate and effective ways. Indigenous communities who have the capacity to self-govern should gain transfer status, and funding and training for healthcare needs to be supported as well as self-determination over resources. The bulk of the recommendations turn on rescinding the evacuation policy, and supporting safe and healthy community births and/or more birthing centres. For women in urban settings, access and support is necessary. Finally, using technology like Skype and webinars can help transfer knowledge between communities and healthcare practitioners (Lalonde et al., 2009). Health practices need to meet these women where they are, and guide them through pregnancy, letting them gain their own voice.

The evacuation policy has been shown as harmful, although without sufficient supports for birthing centres, it could be improved. Participants in O’Driscoll et al.’s (2011) study were open to the idea of a culturally appropriate doula program, and in-hospital visits from Elders, and said that this would be more beneficial than a Skype call with their families back home, if the practice had to continue. Mothers need support from their families, and communities, as well as healthcare providers to handle the challenges of giving birth. Ekstrom & Thortensson (2015) found that often the personal attitudes of healthcare professionals affected their quality of care and support (p. 2). Visits from health care workers in remote areas, as well as home visits have been found to improve health outcomes (Olson & Couchie, 2013).

It is key to get a buy-in from the healthcare providers towards a community-based, holistic approach. Education is necessary for non-Indigenous healthcare practitioners to ensure cultural responsiveness and to better understand the colonial contexts, or else they will not understand the necessity of decolonizing health structures (Kolahdooz et al., 2016). A lack of historical knowledge factors into systemic oppression (Vinkle, 2012). Van Herk (2011) wrote about nurses who needed to adjust their paradigm and reaffirm Indigenous women in their roles as mothers to support therapeutic encounters, as well as giving these women the opportunity to define their identity as mothers. Scholars on women and maternal health have long-argued that maternal health must be approached as more than a clinical health practice (Fuller, 2012). Support for local birth through increased medical training, funding, and resources is necessary, as well as encouraging paradigm shifts for doctors who have enforced their racist prejudices on the women (Sokoloski, 1995). Local birth reinforces Indigenous identity through community and kinship ties (Kornelsen et al., 2010). Funding is therefore necessary for rural hospital and birthing centres (O’Driscoll et al., 2011).

Indigenous midwifery care is the best option for maternal health care for Indigenous women (Olson & Couchie, 2013). Further development and support for Indigenous midwifery education is also needed. The National Aboriginal Council of Midwives recognizes that Indigenous midwives are essential for culturally safe and relevant healthcare in any geographic area, they reduce evacuations from remote communities, keep families together during the birthing process, improve health outcomes, and increase agency and self-determination in health care (The Vanier Institute of the Family, 2017). Policies and funding should encourage local delivery and availability of midwives, rather than evacuation with an unknown doctor in a completely different environment (Olson & Couchie, 2013). These practices will incorporate “traditional knowledge” and languages, as well as doulas and other health care professionals who encourage holistic approaches to maternity (National Aboriginal Council of Midwives, 2016).

Within Canada, a growing recognition of the role of midwives and doulas has corresponded with improved satisfaction with the pregnancy, birth and post-birth stages (Ekstrom & Thorstensson, 2015; Okeke et al., 2016). These advances tell us a great deal about shifting perspectives of the role of pregnant women as active agents in their own health and maternal experiences (Canadian Association of Midwives, 2017). Midwives and traditional birth attendants have played important roles in culturally-safe pregnancy and birth experiences within Canada for more than one hundred years (Ichikawa et al., 2015). The National Aboriginal Council of Midwives (2016) suggests that the Treasury Board of Canada must develop an occupational classification for midwives which would enable Health Canada’s First Nations and Inuit Health Branch (FNIHB, although this is now under Indigenous Services Canada’s jurisdiction) to hire midwives in federal jurisdictions, including on-reserve. This is a structural oversight, because it limits the federal government’s ability to deliver.

Indigenous women need to regain their agency within maternal healthcare. Previous healthcare models have been created from the perspective of the practitioner, rather than the requirements and desires of the patient (Baker & Giles, 2012; A. D. Wiebe et al., 2015; A. Wiebe & Young, 2011). Communication of information and physical care needs to be culturally relevant (A. Wiebe & Young, 2011). When Indigenous communities have control of healthcare, it is often more culturally relevant and beneficial for the women and their babies (Lavoie et al., 2010). Under former Prime Minister Stephen Harper, Canada's gender and health policies focused on women exclusively mothers without due consideration for women's agency and human rights and dignity, which affected healthcare policies for women (Tiessen & Carrier, 2015). The experiences of Indigenous women are like women in other post-colonial contexts around the world. Women are treated as "walking wombs," and are not considered active agents in their own decision-making (Tiessen, 2015). Indeed, Harper's Muskoka Initiative was a medicalized, anti-woman approach (Keast, 2017). In that manner, the health policy analysis focuses on holistic approaches to maternal healthcare for Indigenous women in Canada, and how they affect different social determinants of health. Similarly, immigrant and refugee women who also have different health paradigms struggle within the Canadian system to find sufficient healthcare when health professionals do not have the skills to adapt (A. Wiebe & Young, 2011). It stands to reason, then, that these changing practices lay the foundation for improved maternal health care programs and interventions for Indigenous women who attach immense cultural and spiritual significance to pregnancy and birth (Sokoloski, 1995; A. D. Wiebe et al., 2015; Winqvist et al., 2016). Yet, Indigenous women continue to face many obstacles to their full participation in choices and experiences surrounding their maternal health experiences.

Indigenous women experience racism (Ing, 2011) and are treated as objects of medical interventions (Stote, 2012).

Emphasis needs to be placed on healthy traditional practices (Sokoloski, 1995) and how it can be harmonized with a traditional Western approach. Kornelson (2010) suggested emphasizing community involvement in health care decisions, including allocation of resources. Winqvist (2016) writes, “Preferences, values, and priorities of communities must be considered for differences in health practices” (2016, p. 845). Recently, Indigenous peoples world-wide have sought more control over their own health care to improve it, expressing their Treaty rights (Lavoie et al., 2010). This enables “the ability or capacity to benefit from health interventions” in the form of an “improvement, restoration, maintenance, or protection of health status” (Lavoie et al., 2010, p. 717).

Ways to enact cultural safety in health care include interpreters or Indigenous health advocates, as well as understanding the historic context (Smylie, 2000). It is also encouraged in many communities for the Indigenous peoples to take leadership roles in determining appropriate care (Smylie et al., 2016). Relationships with the healthcare providers are necessary to build trust (A. Wiebe & Young, 2011), as well as to improve communication (Sokoloski, 1995). Gomes et al. (2013) write that “health care providers in their position as settlers can actively educate or decolonize themselves as a contribution to building right relationships” as a part of the process to create access for culturally appropriate health care systems (p. 566).

In sum, there are many ways to improve Indigenous maternal health outcomes for mothers and babies. The incorporation of traditional beliefs and an improved understanding of contexts on the part of health care practitioners can facilitate the dismantling of structural, symbolic, and individual oppression. By including women’s voices in the process of developing

new policies, programs, and self-governance of Indigenous communities, we can address the disparities, and create a healthier future for those living in Canada.

7. Conclusion

Canadian policies have historically entrenched Indigenous people in a cycle of structural, symbolic, and individual harm and violence. First Nations, Inuit, and Metis women have had their agency removed through colonization, resource theft and cultural assimilation. Motherhood and birthing practices have been challenged, and have led to disparities in health between Indigenous and non-Indigenous mothers and babies. Over the past few decades, Indigenous health care policies have adapted and been transformed to be more culturally safe, involving self-governance for communities, and the support of midwifery.

Some provinces, like British Columbia, have progressive Indigenous maternal health policies, and the Government of Ontario is working on a new Indigenous health policy including a maternal aspect. To address the systemic oppression, policies made through intensive consultation are necessary to safeguard their health before initiatives like the *Health Transfers* can be implemented across the country. Women's voices are integral to developing new policies and programs. Richmond and Cook (2016) write that national health policy for Indigenous health is necessary to hold Canadian governments accountable to improving health outcomes. Some provincial and territorial governments, like Manitoba, have refrained from creating Indigenous health policies because it would claim fiscal responsibility at a significant cost to taxpayers in the province. However, just like repealing the *Indian Act*, health policies give citizens the opportunity to hold the government accountable to its promises. Rather than abolishing existing policies, federal, provincial, and territorial governments should be challenged to consult with Indigenous women to find viable solutions to the health disparities.

Symbolically, traditional Indigenous birthing practices should be celebrated. Birthing centres, midwifery, doula-ship, and urban resources are all necessary for a positive birthing experience. Health care approaches need to be transformed into harmonized healthcare, with education into historical contexts. Health care professionals should be advocates for First Nations, Inuit, and Metis, which includes being educated on health care barriers, identifying your own assumptions and biases, and recognizing cultural biases (Aboriginal Sexual Health, n.d.). Health and wellbeing of FNIM peoples would improve with the self-determination of health services (Hall, 2012) and proper funding.

Finally, Indigenous women need to be consulted, and need to be empowered decision-makers in their pregnancies. They must be able to have support from their families and community-members, as well as the understanding support of their healthcare practitioners. Pregnancy should be a life-giving experience, rather than a re-affirmation of the cycle of colonialism. In conclusion, Indigenous women in Canada should be able to choose culturally-safe maternal healthcare, which will lead to improved health outcomes for themselves and their babies. By transferring self-governance to the communities who have the capacity, local governments can work to disrupt the institutional and systemic oppression they have been victims of for two centuries. The celebration of local birth and traditions changes the narrative for the symbolism of childbirth. When Indigenous women in Canada have options to control their maternal experiences, we are more likely to see improved health outcomes and enhanced quality of life.

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