Neocoloniality of Canada's Birth Evacuation

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Abstract

This thesis examines in detail anti-Indigenous racism within the Canadian healthcare system. Because of Canada's history as a settler colonial state, there are still practices and policies in use which negatively affect Indigenous peoples. In this thesis I focus on a practice which disproportionately affects Indigenous women in rural areas, birth evacuation. Birthing people must often travel more than 200km to give birth and relocate for months pre- and post-partum, away from their community and support systems. I use semi-structured interviews with birth workers based in rural areas of British Columbia, Canada as well as policy analysis to investigate the problem. Drawing from Reproductive Justice and Indigenous feminist scholarship, I find that Indigenous birth workers fight against systemic racism in the healthcare system by advocating for their clients in situations of vulnerability, which is leading to a growth of First Nations birth workers in British Columbia. I argue that birth evacuation is a legacy of colonial governance aimed at continuing the assimilation of First Nations communities into the westernized health system.

Declaration

I hereby declare that this thesis is the result of original research; it contains no materials accepted for any other degree in any other institution and no materials previously written and/or published by another person, except where appropriate acknowledgment is made in the form of bibliographical reference.

I further declare that the following word count for this thesis are accurate:
Body of thesis (all chapters excluding notes, references, appendices, etc.): 21,089 words
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Signed: Georgia Huggan

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List of abbreviations

2SLGBTQQIA- Two-spirit, Lesbian, Gay, Bisexual, Trans, Queer, Questioning, Intersex, Asexual
BC- British Columbia
BCCNM- British Columbia College of Nurses and Midwives
BIPOC- Black and Indigenous People of Colour
DAFGP- Doulas for Aboriginal Families Grant Program
DONA- Doulas of North America
ER- Emergency room
FNHA- First Nations Health Authority
GP- General Practitioner
IRSS- Indian Residential School System
Medivac- Medical Evacuation
NACM- National Aboriginal Council of Midwives
NICU- Newborn intensive care unit
OBGYN- Obstetrician Gynaecologist
OR- Operating room
RCMP- Royal Canadian Mounted Police
SOGC- Society of Obstetrics and Gynaecology Canada
TAP- Travel Assistance Program
TRC- Truth and Reconciliation Commission

Chapter 1: Introduction

Canada's healthcare system is often revered internationally as one of the most successful examples of universal, publicly funded healthcare on the basis of need rather than financial ability (H. Canada 2011). In this thesis I will demonstrate that the healthcare system disadvantages Indigenous people, and rural and remote healthcare functions with a lesser quality of care than urban centres. A report on racism within British Columbia's healthcare system reported "this system failure for Indigenous peoples contributes to reduced life expectancy, increased rates of significant early-life health challenges and mortality, increased rates and earlier onset of chronic disease, and increased likelihood of having multiple diverse health conditions" (Turpel-Lafond 2020, 25). Hence, Indigenous people are treated poorly, ignored when in need, and stereotyped as people who use alcohol or drugs (Turpel-Lafond 2020). Health Canada's Special Advisor on Rural Health proclaimed in 2002 "If there is two-tiered medicine in Canada it's not rich and poor, its urban versus rural" (Laurent 2002). This inequality of access to healthcare in rural communities is exacerbated by the racism deeply engrained in Canada's society and history. According to the Government of Canada, "over half of the people living within municipalities identified as Indigenous communities live in the most remote or more remote areas of Canada, compared with less than 5% for Canadians living in municipalities that are not Indigenous communities" (Government of Canada 2022). Canada's immense land mass and northern climate have created a conglomeration of population (88%) along the southern border, focusing resources and attention on urban areas and neglecting the rural and remote communities which are home to many First Nations reserves. In Canada Indigenous people are more likely to live in rural areas, because of the reserve system as well as traditional pre-contact territories. Indigenous women in particular receive an inferior standard of care. In a survey on women's health in British Columbia (BC), 83% of young Indigenous women (16-24) reported challenges accessing the medical care they needed. One in 3 Indigenous women rate their emotional health as "poor" ("In Her Words" 2019). People living in rural and remote areas experience worse care, women experience worse care, and Indigenous people experience worse care (Yeates 2016; "In Her Words" 2019; Turpel-Lafond 2020). Therefore, Indigenous women living in rural and remote areas are particularly vulnerable within the healthcare system.

It has been argued that women's experiences are improved when they receive culturally appropriate care (Birch et al. 2009). By training more Indigenous practitioners and birth workers, Indigenous birthing people and mothers can feel safer in settings where before they may have had traumatic encounters, thus improving overall health of the population and form new traditions that meld together traditional and modern biomedical healthcare. The colonization of birth occurred for over one hundred years, and it is just recently that there has been a push for the return to community-based births for Indigenous mothers and birthing people. One of the groups spearheading the movement back to traditional birthing practices are doulas. Doulas are non-medical specialists who work alongside a mother or birthing person through the entire perinatal process. Full spectrum doula work includes pregnancy, birth, post-partum, abortion, and miscarriage. The term doula is not Indigenous; however, doula has come to mean the same as a traditional birth helper in Indigenous culture. A doula provides emotional, physical, spiritual, and mental support for the mother or birthing person (Doenmez et al. 2022). The role of a midwife is often misidentified with doula work, however a midwife is medically trained to support and assist with the birth, whereas a doula is not. Doulas and midwives have begun working within their communities to provide safer and culturally appropriate births. The support of a doula provides better birth outcomes; reduced pain, shorter labour, less interventions performed, eases anxieties and helps women with complex emotions that come up during childbirth (Doenmez et al. 2022).

A disproportionately high number of Indigenous birthing people must travel large distances to give birth (Smylie et al. 2021). Statistics show that 23.2% of Indigenous women in rural areas travelled 200km or more, whereas only 2.1% of non-Indigenous birthing people travelled 200km or more (Smylie et al. 2021; Renouf and Steacy 2021). This practice, which I will refer to throughout this thesis as birth evacuation, disproportionately affects Indigenous mothers and birthing people, who are already marginalized. Initially, the practice of birth evacuation was to provide safer birth experiences for mothers living in rural and remote locations, as there is scarce access to hospitals and emergency services in many areas. Instead of helping, it has created a neocolonial practice which projects a complete disregard for Indigenous culture and tradition. Neocolonial here refers to the continuing colonial systems which oppress and subjugate Indigenous peoples (Young 2019; Lacchin 2015).

I argue that through birth evacuation, the government is controlling Indigenous bodies, and imposing western medicine while restricting traditional Indigenous practices. This is an act of neocolonialism, as it controls Indigenous populations by restricting their right to healthcare. In this thesis, I will investigate the effect of birth evacuation on Indigenous birthing people in British Columbia, through the experiences of birth workers in rural and remote communities.

1.1 Historical Context

Before I present my original research, it is important to give a brief overview of colonization in Canada. Firstly, I will explain the onset of colonization and the reserve system. Then I will explain the residential school system, the Sixties Scoop, the missing and murdered Indigenous women and girls crisis, and finally the situation in British Columbia.

The colonial government began parceling off small allocations of land to Indigenous people as early as the 17th century. In 1850, the government began officially creating the reserve system in British Columbia (Hanson 2009a). The reserves were created away from urban centres, and the reserves in BC are in fact smaller than reserves elsewhere in Canada. Reserves historically provided little resources or opportunities. When the government created the reserve system, traditional territory was often overlooked and entirely ignored. Traditional territory refers to the land that has been used by a nation for generations. At the beginning of the 20th century, the capitalist methods of the colonial government began to industrialize the workforce, and many First Nations people struggled with poverty (Hanson 2009a). Reserves held very little opportunities, and opportunities in urban centres were difficult to come by because of racism and discrimination. Reserves today are still often impoverished communities with a multitude of systemic issues. A well-known statistic and contentious point is the long-term boil water advisory which have been in place for decades in many reserves. As of April 25th, 2022 there are still 33 boil water advisories in 28 Indigenous communities in Canada (G. of C. I. and N. A. Canada 2017). The reserve system has directly impoverished and isolated First Nations communities, stealing the land that for hundreds and thousands of years was their territory. The aim of the system was to alienate and eventually assimilate all Indigenous peoples, however reserves have become strong and powerful sites of tradition, healing, and community (Hanson 2009a).

The goal of the schools was to assimilate Indigenous children and eliminate their culture. The first school was opened in 1831, and by 1920 attendance was made mandatory by the Indian Act[1] (Hanson 2009b). There were 139 schools that were officially recognized by the government; however, this does not include schools that were run solely by the church (National Centre for Truth and Reconciliation n.d.). For generations, parents had their children taken away from them and when (or if) they returned, they were changed forever. The trauma that the children suffered in the residential schools was reportedly horrific (National Centre for Truth and Reconciliation n.d.). Many children died at the residential schools. Despite official logs showing a certain number of deaths at the schools, testimonies described a much more sordid story, and it was well known within Indigenous communities that the death count was in reality much higher. Official logs from the residential schools showed that approximately 3,200 students had died at the schools (National Centre for Truth and Reconciliation n.d.). Estimates are now much higher, as 1,300 unmarked graves have been recently discovered and only a fraction of schools have been searched (Voce et al. 2021). Deaths were caused by disease and malnourishment mainly, as well as drowning, fires, and suicide (Voce et al. 2021; National Centre for Truth and Reconciliation n.d.). In 2015, the Truth and Reconciliation committee (TRC) released 94 calls to action to the Canadian government. These calls to action were made after 6 years of hearing testimonies from survivors of the residential schools. The TRC concluded that the government engaged in cultural genocide against Indigenous peoples (Truth and Reconciliation Commission of Canada 2015; Barrera, Beaudette, and Bellrichard 2018). The ongoing, intergenerational trauma from the residential school system perpetuates inequalities and the health of Indigenous peoples.

As the residential school system subsided, the government intervened with a new assimilatory practice. The Sixties Scoop was a period of forcibly removing Indigenous children from their families and placing them into white Anglo European families. This has created a child welfare system which routinely targets Indigenous families to this day ("Sixties Scoop" n.d.). Systems such as birth alerts (social workers pre-deciding mothers as unfit and immediately taking the child away) have created a norm of forced removal of newborn babies and children from their

[1] The Indian Act is legislation in place by the parliament. The Indian Act was enacted in 1876 to regulate the Indigenous population. It forced Indigenous peoples to live on small parcels of land henceforth known as reserves. It has changed throughout the years however today many of the original clauses remain (Hanson 2009b).

families without warning, which causes detrimental effects on mothers, birthing people, and children (this practice was only just criminalized in most provinces as of 2021) (Favaro, St. Phillip, and Jones 2021). Child removal is used as a technique to halt Indigenous reproduction and has fostered a warranted fear of apprehension from Indigenous mothers and birthing people.

The residential school system enforced patriarchal, homophobic, and misogynistic values. Women were affected by these values, the Sixties Scoop, *and* forced sterilization, which is still occurring illegally to this day (Rao 2019). Forced sterilization was legal in Canada, and estimates say that up to 42% of Indigenous women were sterilized between 1968 and 1982 (Ross and Solinger 2017). The crisis of violence against Indigenous women has been created from the onset of colonization, from assimilationist and racist policies targeted at women, girls, and 2SLGBTQQIA people (Two-Spirit, lesbian, gay, bisexual, transgender, queer, questioning, intersex and asexual) and their families. Estimates say around 1,200 Indigenous women and girls are missing or murdered since the 1960s, however Indigenous groups say the real number is much higher (Al Jazeera Staff 2022). Many of these cases were ignored by RCMP (Royal Canadian Mounted Police, the federal police) and are unsolved. The National Inquiry into Missing and Murdered Indigenous Women and Girls state that the MMIWG crisis amounts to "race-based genocide of Indigenous peoples" (2019, 1).

In British Columbia there is a stretch of highway of 724 km between Prince George and Prince Rupert known as the highway of tears. It is estimated that over 30 Indigenous women and girls have gone missing or were murdered along this highway (Carrier Sekani Family Services 2022). The danger that faces women and girls is not lessened in rural areas, in fact it is exacerbated by poverty, drug and alcohol use. Hitchhiking is a common practice along the highway to get from community to community, and many of the women and girls go missing after trying to go home. An RCMP task force was created to solve the cases and make the highway safer, however they have been faced with intense criticism as a colonial governmental organization well known for racist officers. The RCMP oversaw controlling the Indigenous population and forcing them onto reserves, into residential schools, and deciding when they were able to leave the reserves (Morin 2020). Indigenous women are in danger from the entity tasked to protect them.

1.2 Research Question, Contribution, and Motivation

The previous section provided an overview of the issue, as well as the colonial and neocolonial regulatory measures in Canada's past and present. This thesis will evaluate birth evacuation and answer the research question: how are birth workers subverting the neocolonial elements of birth evacuation in British Columbia? I will draw from the theoretical frameworks of Reproductive Justice and Indigenous feminism. "Reproductive Justice", defined by SisterSong is "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (Sister Song n.d.). The theory outlines how racism interacts with reproductive rights, and how black and Indigenous women of colour are specifically targeted by reproductive constraints against their bodies (Ross and Solinger 2017). Indigenous feminism is the school of thought which emphasizes the oppression and abuse from colonization and racism that Indigenous women face. It is different but not completely separate from intersectionality; which argues that each person is identified through multiple oppressions, because of the unique experiences of Indigeneity, restriction on Indigenous women's bodies, and colonization (Green 2007; Crenshaw 1989). I plan on filling the gap in the research by arguing that Indigenous birth workers and allies are challenging the biomedical model of birth evacuation, and safe births are possible in community with their support and advocacy. I argue that the Canadian government is failing at their goal of reconciliation through the continued use of birth evacuation, negatively affecting Indigenous women and their health care experiences. Indigenous birth workers, such as doulas, are reclaiming tradition and creating safer experiences for Indigenous mothers.

In Chapter 4 I will analyse in detail birth evacuation and Indigenous health care policies in Canada. I pose the question of whether birth evacuation is a policy or an institutional practice using policy analysis and qualitative methods. In Chapter 5 I will present shortcomings of the medical system which have reinforced systematic racism which prohibits Indigenous mothers and birthing people from experiencing safe care, specifically referring back to birth evacuation. In Chapter 6 I will present my findings on the subversive and disruptive methods adopted by birth workers in order to navigate the neocolonial system of birth enforced by the government.

Chapter 2: Theoretical Framework

Reproductive Justice emerged in the 1990s from the organization SisterSong in the United States (Sister Song n.d.). It is an intersectional framework that focuses on the rights of all people to have a child, not have a child, to parent children in safe and healthy environments, and to maintain bodily autonomy (Ross and Solinger 2017; Sister Song n.d.). This discourse came out of the large sterilization campaign that targeted poor women of colour in the USA in the 20th century. While many feminist discourses surrounding reproductive rights were pushing for birth control and abortion rights, many women of colour were faced with unauthorized sterilization and refusal for them to have children. As discussed in the historical context, forced sterilization of Indigenous women was and continues to be an issue in the Canadian context. A combination of the terms "reproductive rights" and "social justice", Reproductive Justice centers around BIPOC rights. Ross and Solinger point out in *Reproductive Justice: An Introduction*, that achieving Reproductive Justice relies on access to community-based resources, namely a healthy environment to raise children, good health care, a living wage, and access to education (2017).

Coen-Sanchez et al. explain that the colonial practices and racial oppression include health policies that perpetuate racism experienced by Black and Indigenous People of Colour (BIPOC). Because of the systemic racism engrained in Canada's history and healthcare system, Indigenous people are faced with barriers not only receiving care, but also entering into the healthcare profession (Coen-Sanchez et al. 2022). The racism and oppression has perpetuated Reproductive Injustice, which added to capitalism, globalization, medicalization and neoliberalism, has formed a system under which racialized people experience poorer health outcomes (Coen-Sanchez et al. 2022). In *Reproductive Justice: The Politics of Health Care or Native American Women*, Gurr states "[Reproductive Justice] simultaneously works from an expanded conceptualization of health, justice, economic security, and self-determination that includes community needs and institutional structures and rejects narrow formulations of reproductive health as an individual experience" (2015, 32). The state has clearly failed to protect Indigenous children and mothers, and it purposefully dismantles families from birth. Both Coen-Sanchez et al. and Gurr explain the importance that lies in specific policy making and Reproductive Justice. Indigenous bodies are policed more heavily and frequently by systemic racism, and health campaigns confirm this in both Canada and the United States

(Coen-Sanchez et al. 2022; Gurr 2015). Indigenous people in North America have faced different legislation and assimilation (or elimination) tactics from the colonial governments. Reproductive Justice as a theoretical framework is working to dispel these systems of oppression.

Therefore, I argue that Reproductive Justice is crucial to advocate for Indigenous mothers and birthing people's rights within the healthcare system in Canada. The literature on rural and remote maternity care, the birth evacuation policy, and Indigenous healthcare, while including the main tenets of Reproductive Justice, do not frame their arguments around this concept. Coen-Sanchez et al. in fact mention the birth evacuation policy as an issue of Reproductive Justice, however they do not go into detail as their paper is on the framework, not the topic. By writing this paper from the standpoint of Reproductive Justice and referring back to the main points[2], I will contribute to the scholarship on this issue.

My secondary, but no less important theoretical framework is Indigenous Feminism. Indigenous feminism is a subsect of feminism that highlights the distinct lived experiences and intergenerational trauma that Indigenous women and 2SLGBTQQIA people endure. Indigenous feminism is a counteractive measure to the gendered colonization Indigenous women experience. Joyce Green writes in *Making Space for Indigenous Feminism* "the emerging Aboriginal feminist literature and politic, while the terrain of a minority of activists and scholars, must be taken seriously as a critique of colonialism, decolonization and gendered and raced power relations in both settler and Indigenous communities" (Green 2007). Indigenous feminism works directly with decoloniality and anti-racism. Decoloniality is the effort to create new systems where systems of power previously subordinated a specific race, in this case Indigenous people (Quijano 2000). More than simply creating equality where for so long there was an intense racial hierarchy, it is the promotion of systems which reverse the power imbalance, actions which create change. Decoloniality comes from Latin American scholars (Quijano 2000, Lugones 2008), and from this I theorize birth evacuation is an example of neocoloniality, the continuation of coloniality of power, as defined by Quijano. Indigenous feminism connects directly with this and specifies the systematic dehumanization of Indigenous women.

[2] "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities" (Sister Song n.d.)

I draw mainly from Joyce Green's book *Making Space for Indigenous Feminism* (2007). I also draw from Native American poet Paula Gunn Allen's book *The Sacred Hoop* (1986) wherein Gunn Allen effectively introduced the concept to western academia and literature that Indigenous women subverted patriarchal values that colonizers assumed. Her work brought attention to the "gynocentric" (matriarchal) governing systems that many Indigenous communities had. Indigenous feminism is recognizing the unique struggles that Indigenous women face in neocolonial society, and the trauma that has affected generations. It is acknowledging racism, micro-aggressions, and oppressive systems that continue to govern Indigenous women and 2SLGBTQQIA bodies.

In this research I refer back to tradition often, as one of the calls is for the return to community-based birth, and Indigenous birthing traditions which have been stripped and erased by colonization. Green explains the nuance of the term tradition in regard to Indigenous feminism. Tradition, in Indigenous circles, often refers to pre-colonial times, when Indigenous people had agency and self- determination (2007). Green argues that tradition is not a monolith, not a concept to be essentialized into one meaning. Tradition can change and grow and transform. Power relations must be addressed and gendered or sexist traditions re-imagined. Critique, and feminist critique in particular, is essential for transformation. Through this theoretical framework I will analyse the work that doulas and Indigenous birth workers are doing in Canada, and the biases that Indigenous people face in the healthcare system, keeping in the forefront of this undertaking my position as a settler.

Reproductive Justice and Indigenous feminism work together as they both advocate for the rights of marginalized women of colour. By connecting the two concepts, I present the argument that birth evacuation is taking away the bodily rights of Indigenous women. Neocolonial tactics of the state continue to govern Indigenous people in Canada. The two theories are essential together for the purpose of this argument. I suggest that the right to healthcare is inadequate as the issue of birth evacuation is deeply engrained with feminist reproductive mobility rights as well as issues of racism and oppression. The state is essentially deciding who has the right to have children and who does not have the right to have children. Indigenous children are born into a system of neocolonial oppression under which

reconciliatory efforts have fallen flat. I argue that Indigenous birth workers are subverting this system, allowing for decolonial actions, and supporting the rights of mothers outside of a system that has been deemed over and over again as racist and unsafe.

Chapter 3: Methodology

I chose to use qualitative research methods, in the format of semi-structured interviews. I selected this research method to hear from practitioners working on the ground what their experiences were and how they themselves viewed the issues that are so thoughtfully presented in literature. Sem-structured interviews allowed me to tailor the questions to each participants knowledge and hear their expertise and personal experiences. There is limited scholarship which centres the experiences of birth workers and birth evacuation, how it affects them, and how they see it affecting their clients. Interview subjects were located all throughout British Columbia, and often in very difficult to access communities. To travel throughout the province taking interviews would have been very costly and time consuming, thus interviews were held online. I drew from Hannah Deakin and Kelly Wakefield's research on Skype interviewing, to help with online interviewing skills (Deakin and Wakefield 2014). Some things that I focused on were things such as the lack of non-verbal cues, technological competency, and access to internet. It was important to analyze the interviews paying attention to these differences, and to be aware of outside issues that may affect the participants answers. There was an instance in my research where an interview subject did not show up for our interview, and the reason was that the internet had completely shut off in her area for hours. I specifically chose to interview birth workers instead of mothers because of a lack of time and resources. If I were interviewing mothers, I would have preferred to provide honorariums for their time and provide follow up availability because of the intensity of emotional labour of discussing experiences of racism in birth and labour.

The theory of decoloniality guided the creation of my questions, and how I conducted the interviews (Quijano 2000; Lugones 2008). In this research, I argue that Indigenous birth practices must be not just honored, but promoted, to ensure the proliferation of Indigenous knowledge and traditions. In my research, though the participants are Indigenous and settlers, I have prioritized Indigenous voices both from the data I collected and from previous scholarship. I was open and honest with all participants about my personal background as a settler, and how that also affects my work and privilege to be able to conduct this research.

I began researching this topic in 2017 during my bachelor's degree at McGill University. Indigenous rights is a topic that is important to me, especially because I was born on stolen unceded land in what is now known as Vancouver, British Columbia. When considering possible thesis topics, I continued to come back to themes of medicine, gender, and race. This topic is the intersection of these issues. Indigenous people have faced years of oppression and malpractice, and the struggles experienced deserve to be heard. Racism is a considerable problem in the healthcare system and by researching this topic I aim to highlight the inequalities Indigenous people face.

I am a white settler with European roots, born on the unceded territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and Sel̓íl̓witulh (Tsleil-Waututh) Nations. I am writing this thesis and conducting this research from a European University based in Vienna, Austria. My academic background comes from colonial institutions. Decolonizing the academy is a large point of contention, especially within Canada, and I recognize here that by working within a system that has oppressed Indigenous people for hundreds of years, this research is further complicated. I acknowledge the immense privilege that I hold to be able to conduct this research, and I am grateful for the opportunity to contribute this research to the field.

What I refer to as "Canada", "British Columbia", "Vancouver", "Victoria" and other settler colonial named places are unceded lands stolen from Indigenous peoples on Turtle Island (North America). I use the term Indigenous throughout this paper, which includes First Nations, Métis, and Inuit peoples. First Nations refers to most, but not all, reserve-based communities in Canada. Technically this term only refers to people who have Indian Status. Métis and Inuit are not First Nations. Many older papers and articles use terminology such as Aboriginal or Native. The term Indian is only used in discussion with governmental laws and policies, such as the Indian Act, Status-Indian and Non-Status Indians. Indian is an offensive and derogatory term, and although it has been reclaimed by many Indigenous people, it must not be used by settler and non-Indigenous peoples.

I have chosen to work with the terms "mother" and "birthing person" to describe the people who give birth and seek the support of birth workers, and who are affected by maternity health care and perinatal services. I recognize that people who give birth hold many gender and sexual identities, including people who identify as women, trans men, non-binary, intersex, and two-

spirited. Two-spirited is a uniquely Indigenous gender identity, and the exact meaning differs from group to group (them 2018). It is thought of in many nations as holding both masculine and feminine spirits within yourself. I also recognize that many people who give birth may not identify themselves as "mothers". I chose to use both terms, however, as a recognition of those who *do* identify as mothers and wish to be known as such, as well as allowing for diverse identities and emotions around childbirth and pregnancy. Drawing from Reproductive Justice as my theoretical framework, I see it as important to give recognition to mothers who have fought injustices to claim this identity (Sister Song n.d.). I also recognize that terminology is an ever-changing flow of knowledge, and what may be thought of as appropriate today may change in the future.

My data comes from interviews conducted over the period of two months, April – May 2022. I found the participants through research of birth workers in BC. My common search terms were "Indigenous" "First Nations" "doula" "midwife" "rural" "BC" "British Columbia" "northern" "remote" "collective" "Aboriginal" "Birth worker". I located some birth workers from this, and then I went more specifically through the official midwife registry of BC ("Find a Midwife - Midwives Association of British Columbia" n.d.), and the Doulas for Aboriginal Families doula finder ("Doulas for Aboriginal Families Grant Program" 2022). When contacting settler doulas, I checked that they were certified to work with the Doulas for Aboriginal Families Grant Program (DAFGP). This was my method of guessing that they would have knowledge on the subject and were engaged with working with Indigenous clientele. The doula registry proved difficult to work with (it relies on searches by specific postal code instead of community name). I then searched for "Doula + rural community" for example "Doula Port Hardy", and then cross referenced with the DAFGP. I also searched for Indigenous birth workers in urban centers, such as Vancouver, Victoria, and Prince George. I contacted a variety of Indigenous health collectives and community centres via email and some birth workers via Facebook when there was no email available. My initial email included a summary of the research project, so they would know what kind of questions to expect. I sent numerous follow up emails, however a number of people declined, and some never answered. Once I began interviewing, I received a number of recommendations for further interview subjects. Out of the 24 groups and individuals contacted, I conducted 5 interviews.

All interviews were held over Zoom and lasted from 30-60 minutes. I had guiding questions (attached in annex 1), however depending on the direction the interview headed I would alter or add questions when I deemed it was necessary. Having flexibility in the interviews was important to me, as each subject has different and unique knowledge and experiences. The interview subjects have a range of experience in birth work from 2- 20 years in rural and remote communities. They are Indigenous and white settlers. Each interviewee signed a consent form before-hand, and I requested live consent over zoom that I could record the meeting.

I transcribed the interviews using a transcription service, and then went through again to correct any mistakes, and listen to the interview in full again. Once fully transcribed, I coded the transcripts through thematic analysis, searching for thematic patterns.

Because of the importance of the birth evacuation policy in my research, I conducted policy analysis. To conduct policy analysis on an "invisible policy" was quite difficult. In this manner, it consisted of coding government and health services websites, Indigenous activist group websites, and previous scholarship on the topic or surrounding topics to gain a clear image of birth evacuation and what it is. As I will discuss in Chapter 3, my aim was to determine whether the birth evacuation policy is a policy or more of an institutional practice. The coding was also used to determine the neocolonial impacts of birth evacuation. In the long run, policy or not, birth evacuation is a fact of life for rural and remote birthing people and mothers. My intention through policy analysis is to discover the reasoning for the practice, the impact of it, and the future ramifications that it may have. In researching policy analysis, I also have included governmental and health policies, and detailed information on how these systems act and interact with Indigenous and settler constituents.

Chapter 4: Policy Analysis of Birth Evacuation

4.1 Literature Review

The birth evacuation policy has been coined largely by Dr. Karen M. Lawford, an Indigenous midwife and academic who currently teaches at Queens University in Kingston, Ontario. Lawford has done extensive research into maternity care for First Nations peoples on reserves. She has written and co-authored a plethora of articles related to the topic of mandatory birth travel (e.g. K. M. Lawford 2016; K. Lawford and Giles 2012; K. M. Lawford, Giles, and Bourgeault 2018).

In existing literature, the term "evacuation policy" is inconsistent. Some literature, for example Colleen Varcoe et al. do not mention the terms evacuation, forced, or mandatory. Instead, they use a softer "birth travel" (Varcoe et al. 2013). The Government of Canada has now added a point under "Chapter 4: Birth and Labour Guidelines", recognizing that many Indigenous mothers have to travel long distances to give birth. Evacuation is not mentioned. Other papers choose to use "evacuation": Cidro, Bach, and Frohlick (2020) use the term "evacuation" freely. "Evacuation" is written in the Transformative Change Accord, a set of recommendations to the British Columbian government written by the First Nations Leadership Council (2006). The National Aboriginal Council of Midwives has also released a statement on the birth evacuation policy, calling for its demise (2020). The semantics of evacuation infer an emergency situation, that is most likely negative. Evacuation calls to mind natural disasters. Birth travel, however, is a much lighter term that may not connote a negative experience. The change of terminology throughout the literature demonstrates inconsistent opinions on the gravity of the practice.

The majority of scholars on the topic are First Nations or Métis. The literature focused on in this research is specific to British Columbia and Canada. I chose not to include articles focused on other provinces to keep the scope of the research small and specific. The literature dates from early 2000s to the present. Themes in the literature are racism, and problems within Indigenous healthcare. Where Lawford focuses on policy, other contributors to the topic focus on reclaiming and creating new spaces for Indigenous practices (Varcoe et al. 2013; Cidro, Bach, and Frohlick 2020).

Within the thesis I refer back to the 94 calls to action from the Truth and Reconciliation Commission of Canada (2015). The progress or lack thereof on the calls to action demonstrate the government's efforts of reconciliation and working together with Indigenous communities to improve quality of life and eliminate oppressive tactics (Barrera, Beaudette, and Bellrichard 2018). I also refer to the First Nations Health Authority as experts on Indigenous health in British Columbia, and the British Columbia College for Nurses and Midwives for expertise on birth work within the province (BCCNM 2016).

The First Nations Leadership Council published a report in 2006 that included calls to action and goals to be finished by 2015 to improve First Nations health throughout British Columbia. One of three main goals listed is to return births to rural and remote communities, signaling that this is a major issue within Indigenous healthcare (First Nations Leadership Council 2006). Since this report, there has been a tripartite agreement implemented in British Columbia, and there is now the First Nations Health Authority (FNHA) which oversees grants and funding for First Nations health care. The FNHA is First Nations run and organized and works in partnership with health authorities in British Columbia.

Although Coen-Sanchez et al. do refer to Reproductive Justice within the Canadian healthcare system, sterilization of Indigenous women, and the birth evacuation policy, they do not elaborate on it any further. My research is adding to the field of Reproductive Justice by arguing that birth evacuation enforces neocoloniality within birth care.

4.2 Chapter Introduction

Birth evacuation is the process of leaving your community either in advance or under emergency procedures to access maternity care. Birth evacuation has been labeled by Karen Lawford as an "invisible policy" (K. M. Lawford 2016; K. Lawford and Giles 2012). According to Lawford, despite there being proof from first-hand accounts that the policy is being enforced in rural and remote communities and reserves, the written and formal policy is nowhere to be found. The policy is supposedly affecting all women who live in remote and rural areas, regardless of status, and to all Indigenous women living on reserves in rural and remote areas (Smylie et al. 2021; K. M. Lawford 2016). Because of the history of cultural genocide, and the

removal of traditional birth practices for many years, birth evacuation is highly criticized as constraining Indigenous reproductive mobilities (Voce et al. 2021; National Centre for Truth and Reconciliation n.d.; Cidro, Bach, and Frohlick 2020). Cidro, Bach, and Frohlick describe the problematic nature of the practice, and its futility:

> Mandatory birth travel practices stem from the western idealization of a built obstetrical care environment that is hygienically- and technologically advanced, with biomedical emphasis on the intrapartum moment. Despite the decades of following a policy that is predicated on the medical subjugation of Indigenous knowledge and traditional birth practices, these idealized obstetrical environments, shaped by settler colonialism, have not resulted in better outcomes for Indigenous women (2020, 184).

The history of colonialism, trauma, violence, and racism have left the Indigenous population in dire need of better healthcare. The intergenerational trauma from the Residential school system, the Sixties Scoop, the missing and murdered Indigenous women and girls crisis, and many more instances of racism and trauma have left the Indigenous population sicker and with worse health outcomes that non-Indigenous Canadians (First Nations Leadership Council 2006). Outcomes are 2 to 5 times worse for Indigenous pregnancy and infancy for every indicator, and preterm birth rates are worsening (Varcoe et al. 2013). In a community-based study in British Columbia, there was nearly no knowledge left of traditional birthing practices due to assimilation tactics by the Canadian government, and it depletes more and more as elders pass away (Varcoe et al. 2013). In this chapter I will explain the system of Indigenous healthcare regulation in Canada for contextual information. I will then analyze the birth evacuation policy, and compare this investigation with findings from my interviews, posing the question of whether or not birth evacuation is an "invisible policy", or rather a problematic institutional practice. Finally, I will examine the problems and potential solutions for the issue of evacuation from rural and remote communities. In this chapter I argue that birth evacuation is a remnant of Canada's colonial past and is adding to the challenges of accessing safe care for First Nations people.

4.3 Indigenous Health Care Regulation and Policy in Canada

Lawford names the birth evacuation policy "invisible". This is because of the unwritten nature of the policy, the fact that there is no official guidelines which enact the policy on First Nations birthing people's bodies. The practice itself is evident. The National Council of Aboriginal Midwives have a policy statement condemning the birth evacuation policy. So why, if Indigenous scholars, midwives, doulas, and birthing families are aware of the practice, is it not

clearly published as an official policy where all stakeholders affected are able to inform themselves on rights and guidelines? Having this "under the table" type policy means it is unregulated, without clear instructions for birth workers and birthing families, and therefore birthing people may be taken advantage of and not know their full rights. According to Lawford, the birth evacuation policy comes from a combination of federal and provincial policies. Canada's policymaking overall comes from an amalgamation of horizontally and vertically divided power. Canada's government is divided into legislative, judiciary, and executive powers, which work together to form the government. Canada's federal government works alongside the provincial and territorial governments, meaning that it is vertically separated geographically (Knill and Tosun 2012). This separation of power, and the complication that comes with the Indigenous health care system, means that policies related to Indigenous healthcare are often difficult to locate and hard to follow, furthermore, they may change province to province despite being federally regulated. The federal government is officially in charge of all First Nations health care, however, because of the organization of the system, provinces and territories often administer the care, with federal funding stepping in afterwards to reimburse provincial costs (G. of C. I. S. Canada 2021). Although the Government of Canada recognizes birth evacuation as a problem in their childbirth and labour guidelines; the practice is still in place and change is not occurring at a sustainable pace:

> Colonization has led to a loss of traditional values, beliefs, and practices, including those surrounding birth. Currently, women are often transferred out of rural and remote communities to give birth, often remaining there after the birth—often alone. This can result in loneliness, insecurity, culture shock and anxiety. The SOGC guideline Returning Birth to Aboriginal, Rural, and Remote Communities encourages training programs and policies that facilitate the return of birth to rural and remote communities for woman at low risk of complications. (P. H. A. of Canada 2018)

The careful and cautious wording of the statement (using terms such as "often" "can result" "encourages") suggests that birth evacuation is not systematic, instead it is an unfortunate occurrence which may affect Indigenous women. The statement is too vague and unspecific, and furthermore does not acknowledge the full Society of Obstetrics and Gynaecology of Canada's statement. There is no room for action within this statement, as there is no promise of change or enforcement.

Provincial and federal governments have been found to end up arguing about who is supposed to pay for First Nation individuals healthcare, leaving the patient at risk[3]. Lawford has described this intricate web of politics as resulting in a lack of accountability, communication, and too high of a reliance on individual practitioners, when the government should be taking responsibility for the situations (K. M. Lawford 2016). If the government put conscious efforts into the need for more trained health practitioners in perinatal care and placed them in remote and rural communities, or on reserves, travel for birth would be unnecessary. There has been a call to change the system and create an Indigenous specific health policy (First Nations Leadership Council 2006), and the First Nations Health Authority in BC is an example of the federal government working alongside First Nations policy makers. The FNHA is not separate from the Canadian Government, rather they work in tandem to support First Nations constituents. An example is the Doulas for Aboriginal Families Grant Program, which is funding available through FNHA, and not through the government. The midwife or doctor must sign forms for the grant to be accessed, therefore showing the interconnectedness of the two systems ("Doulas for Aboriginal Families Grant Program" 2022).

The separation of powers into federal and provincial level governments is inadequate, critiques say (Lavoie 2013). Lavoie argues that "The fragmented nature of the healthcare system, to which jurisdictional issues add complexity and confusion, creates a patchwork of policies and programs for First Nations, Inuit and Métis" (2013, 1). As discussed previously, the First Nations Leadership Council is an example of a formalized organization. In British Columbia, the First Nations Leadership Council published "The Transformative Change Accord: First Nations Health Plan" in 2006, which outlined goals for the province to implement by 2015. One of these goals was to return birth to First Nations rural and remote communities. The province then adapted the Tripartite agreement, which works to improve health outcomes for First Nations in BC (G. of C. I. S. Canada 2021). Creating a new level of governing, as

[3] Jordan was a boy from Northern Cree House Nation, in Northern Manitoba, who was born with complex medical needs. He was placed in foster care because the government provides so little support to families with children who have special needs who live on reserve. He spent his entire life in the hospital while the provincial and federal government argued over who should pay for his care. He died at age 5 without returning home (Assembly of First Nations 2019). The new policy "Jordan's Principal" was created after this, which states that the government or ministry/department of first contact must pay for the services in the case of a dispute without delay or disruption. Then, after the payment has been completed the paying party may refer the matter to jurisdictional dispute mechanisms. There remain issues with this policy, however, as the Government has chosen to enact it solely in extreme cases exactly like Jordan's, leaving many children still struggling within the system (K. M. Lawford 2016).

advocated by the First Nations Leadership Council, is all the more complicated by a western conception of government and power that Indigenous people traditionally do not subscribe to. As Matthew Tomm wrote, "Aboriginal people must constrain themselves to the moral lexicon and justificatory practices of the dominant culture in order to successfully assert their rights and interests" (Tomm 2013, 294). The government has forced Indigenous groups for hundreds of years into western notions of state, policy, and governance, without recognition of cultural differences. A system must be created under which Indigenous mothers and birthing people can access safe (in all aspects) care. Lavoie posits that changes to legislation (for example Jordan's principal or the birth evacuation policy) are more focused on clarification of jurisdiction, instead of improving quality of care (Lavoie 2013).

Similarly, one of the critiques formulated by Indigenous feminism is the use of white and colonial modes of discourse such as Tomm discussed. Protections promised by the constitution often do not protect Indigenous women, and simply enforce capitalist structures of colonialism (Green 2007). The benefits are often theoretical, with Indigenous women suffering continuously from oppression. Thus, the Constitution and other policies bearing legacy from colonialism prove inadequate advocacy tools for Indigenous women. Practical change is likelier to happen through actions initiated by Indigenous activist groups.

4.4 "Invisible Policy" Continuing Neocoloniality

In this section, I wish to shed light on the Impact that Policies have on Indigenous peoples' lives when they are not properly regulated and controlled. Through policy analysis complemented with the analysis of my interview data, I show that the birth evacuation policy in British Columbia follows neocolonial patterns affecting First Nations birthing people. Neocoloniality is the perpetuation of control over a population or group, using methods such as economic imperialism and globalization to assert power. Although the government of Canada has issued formal apologies and makes efforts towards reconciliation, coloniality persists in the opinions of many residents and politicians. Reconciliation is not the same as decoloniality, as Freeman argues:

> Resistance is more important than relationship-building with non-Indigenous peoples, which can be seen as a dangerous letting down of the guard that may subvert or short circuit true decolonization. Indigenous peoples must work on building strength and self-

> sufficiency within their own communities and nations, these scholars argue, and on asserting self-determination without waiting for recognition by settler polities (Freeman 2014)

The former Prime Minister of Canada, Stephen Harper brazenly announced at a G20 Summit in 2009 that "We also have no history of colonialism" (Ljunggren 2009). This complete disregard for Indigenous oppression shows the divide within Canada, anti-Indigenous racism is a present and active force. Thus, it is imperative to draw attention to the neocoloniality of Canada's healthcare system and the racism that Indigenous people face when attending routine activities. Indigenous scholars and activists advocate for more education and admittance of Canada's past settler colonialism.

Lawford provides three points under which to categorize "invisible policies" (K. M. Lawford 2016). The first is allocation of resources, economic or otherwise. While Lawford's explanation of this allocation is based mainly on the lack of regulation of midwives through the federal government, midwives are now regulated and paid for through the Medicare system, in the same way as doctors (2016; BCCNM 2016). She explains that some academics see birth evacuation as a norm rather than a policy and claims that this further erases the birthing people affected by the policy. The government has vested interest in evacuating the residents of rural and remote communities and pays for a person to accompany them. Medical evacuations can be highly expensive, as they can involve last minute flights. I would argue that these are more tangible allocations of resources, as the government is paying and investing money into removing birthing people from their communities.

The second criterion listed by Lawford (2016) is material impacts or consequences that the policy has on its constituents. Birthing people are isolated from support systems and go through and emotional and intense experience on their own. Although there is funding for one partner or support person to join in an emergency evacuation, many times a partner cannot afford to spend weeks in a different location, away from work and potential other children or family members in need. The assimilation techniques used by the Canadian Government through residential schools and colonization erased many Indigenous traditions, including those surrounding pregnancy and childbirth (Varcoe et al. 2013; Cidro, Bach, and Frohlick 2020; K. M. Lawford 2016). Through continued exclusion from community connections, traditions remain difficult to revive. Removing Indigenous people from their land is reminiscent of the

reserve system in Canada, as discussed in the historical context. This constant battle between the state and the land shows the state's refusal for decoloniality. Reconciliation has been criticized as a top-down, governmentally controlled plan which in no way creates actual decoloniality of the state (Freeman 2014). Although a good first step in theory, in the biggest reconciliatory statement in Canada's history, the Truth and Reconciliation Commission's calls to action, have gone mainly unfulfilled, proving once again the governments empty promises towards Indigenous peoples.

Lawford's third and final criterion (2016) is actors responding to something or implementing a process. There is no admittance on government platforms or official midwifery sites of a policy of evacuation for rural and remote mothers and birthing people. What is clear, however, is the rules regarding access to hospitals and medical professionals. The BCCNM stated this in their place of birth handbook under home birth guidelines: "Emergency transportation with trained personnel access to medical services are available" , and in the Policy for Home Birth Transport Plan it is stated that there must be a hospital plan in place before providing home birth services (BCCNM 2016). This policy ensures that no home births can take place far away from a hospital, therefore essentially removing that possibility for birthing people on rural reserves. Through the literature review I have already illustrated that birth evacuation is discussed by scholars and organizations alike. Birth evacuation takes place, and Lawford argues that it is a policy, not just a practice. I now turn to the data collected through my interviews to delve further into the topic.

4.5 Interview Analysis in Contrast to Existing Literature

Each interviewed birth worker shared an experience with birth evacuation. There is no doubt that traveling for service is the norm for rural and remote populations. It is not only for birth, but for any medical service necessary- dentists, doctors, surgeries. If there is no hospital, people must travel to get the care they need. Birth is unique because of the necessity to evacuate weeks before the due date and function in a new environment often times without support systems. Interviewees did not agree on the normal time frame for evacuation, which suggests that it varies from place to place, or birth worker to birth worker. Interviewee 5 (a First Nations doula in a very rural area) had the longest evacuation timeline, with mothers and birthing people "being shipped out*"* six weeks in advance of giving birth. That does not include the time post-

natal when the mothers and birthing people are supposed to stay for after care and rest. Interviewee 4 (a white settler doula located in a bigger service area where people are evacuated to) said about four weeks total (two prenatal and two postpartum). Interviewee 3 (a First Nations doula in a rural area) spoke more in detail about emergency evacuations, where the mother did not plan on being medically evacuated. In this case the mother was away from a few weeks pre-birth and just a few days post.

Land is strongly connected with health and wellness of First Nations peoples, and instrumental to positive birth outcomes. The National Aboriginal Council of Midwives (NACM) position statement affirms: "Giving birth in community is safe; communities under the care of a community midwifery program with careful risk screening can have better health outcomes than communities which have a blanket evacuation policy" (2020). The forced removal of mothers from their homes can be argued as maintaining colonial practices. *In Her Words*, a report on women's healthcare in British Columbia agrees, "a lack of local access to maternity care has been linked to increases in complications and infant mortality" (2019, 7). The cultural importance of giving birth in community is paramount, and these statistics illustrate the gravity of the situation. Although midwifery is regulated in BC, the stability of birth workers in the province is precarious, and there are not enough birth workers to sustain each rural First Nations community. Haida Gwaii (a remote island off the west coast of BC) is one of the few locations where there is midwifery located on reserve. An interviewee working there praised the maternity care on island and expressed a wish that more reserves could use their system in BC (interviewee number omitted for sake of anonymity). Seabird Island (located on the lower mainland in BC) and Haida Gwaii are the only two reserves in BC with registered midwifes on site. Besides those two locations, everyone who lives on reserve must travel off reserve for birth (MABC 2017).

When it is necessary to evacuate to a hospital, however, in the case of emergencies or higher risk births, birth workers explain that they cannot travel too far from the service area. Interviewee 1 stated that she is unable to go further than 30 minutes driving from the town she lives in, leaving the majority of rural and remote clients forced to travel for care. Interviewee 5, however, stated that she travelled to wherever her clients needed, often driving for multiple hours to reach her destination. Interviewee 2 discussed the choice of leaving the island for care and said that she did not note a difference between her First Nations and non-First Nations

clients in their decision making of whether to stay or leave. Interviewee 3 stressed the importance of electing appropriate birth workers for birth experiences, and that was the reason for a lot of travel within her client base. Because of a lack of practitioners in her area, many of her clients choose to birth in bigger towns nearby to ensure their needs were met. Despite the fact that providing home births is part of the midwifery mandate, many practitioners are unable to provide the service because of hospitals being out of range.

When asked about funding available for First Nations clients, each birth worker pointed towards the FNHA (First Nations Health Authority) doula grant. This grant allows any First Nation family to have access to a doula, free of charge. On the FNHA website it also outlines the travel expenses covered by the Health Benefits. Travel, gas, and meals are covered up to a certain extent (First Nations Health Authority 2021). Interviewee 5 explained how the birthing families have no say in the accommodation. It is all done for them through the health benefits plan. The FNHA states in the guidelines that the person applying for coverage does not have control of the accommodation (First Nations Health Authority 2021).

The loneliness that accompanies birthing people who must evacuate to give birth is documented through the literature and emphasized through interviews. The government has only recently begun providing funding for the mothers to be accompanied by a loved one for emergency evacuation (National Aboriginal Council of Midwives 2020). Before, they would have had to pay themselves, which could have had a very high cost, depending on the evacuation location. Interviewee 3 (an Indigenous doula) explained the hardship she felt when her Indigenous client was evacuated to Prince George to give birth, separated from her birth plan and community. In this case, the mother reached out to her community for financial support during the evacuation:

> She went to be medically induced, and then she went to a hotel for a few days before returning home. I do not know if she received any… no, she did not receive any accommodation support from the hospital. She actually went online and called out to her community and said, ‘we're in need of support’ and her community, they raised funds for her. So, they didn't have as much financial strain from that sudden trip.

This community support stresses the cost of the process. From this story I hypothesise that some First Nations mothers do not know about coverage available, or the coverage is not enough to sustain a last-minute or lengthy evacuation. An emergency evacuation for this mother lasted perhaps a few days, however as previously stated, in many cases mothers and birthing families

are asked to relocate for over a month. In regard to support systems in her community, Interviewee 4 (whose town serves as a service area for many rural and remote areas that are difficult to reach) elaborates:

> The majority of [birthing people] don't want to have to uproot and move from their communities to give birth, a really important part in your last four to six weeks of being pregnant is finding your safe place to birth. That sort of transition from "I'm nesting at home" and "now I have to uproot", I think that's really hard. Not only that, is a lot of stillness and downtime, that is hard for a lot of people, especially if they don't know anybody in the community. No one says they love it. Like, no one's ever said, "this is amazing". It's pretty much, 'when can I go home?'.

The desire to return home, or stay home, from the hospital in some situations, can lead to adverse effects on the birthing person and child. Kornelson and Grzybowski (2006) found that when the birth occurs outside of their community, often times mothers or birthing people will ask for an earlier discharge, leading to exhaustion, trouble breastfeeding, and possible postpartum depression once returning to their home communities. Another tactic recorded by birthing people and mothers to avoid the hospital is to wait until they are already far into labour before alerting their birth worker(s). In doing so, the mother or birth person ensures that the child will be born where she desires, and she avoids the possible trauma and racism found in the biomedical healthcare system. This, however, is a dangerous tactic and is not common because of the extreme risk that it presents to the baby and mother/ birthing person. While some mothers choose to stay home, some choose to go further and further distances in order to find hospitals without history of racist mistreatment ("In Her Circle: The Influence of the COVID-19 Pandemic on Indigenous Women's Health in BC" 2021). Systemic racism is hindering birth workers ability to provide safe care to their clients, and though there may be more Indigenous birth workers being trained, the system is still reliant on biomedical and colonial limitations that constrain Indigenous traditions.

4.6 Chapter Conclusion: Policy or Practice?

The interviewees expressed diverse explanations of birth evacuation. In fact, most subjects stressed that birth evacuation is *not* mandatory. Nevertheless, is it a choice if they have no other options? Interviewee 2 stated "nothing is mandatory", Interviewee 4 stated "you can go home whenever, this is *your* body" (emphasis added), however her recommendation is to stay until lactation begins. Interviewee 3 suggested a certain degree of mandate, "They highly

recommend. They didn't really give her a choice". While Interviewee 1 did not give a firm answer on the degree of force, however she explained that because of the hospital access, community birth is next to impossible. Interviewee 5 claimed that birthing in community was not an option depending on where mothers and birthing families live. All interviewees have suggested the same line of thinking: although it is not officially mandated, there is really no other option if the birthing family desires a medically safe birth experience. Thus, whereas Lawford considers birth evacuation a policy, I rather argue that it is an institutional practice. For it to be a policy, all First Nations on all reserves would have to evacuate, while there have been births in community of late, as I will further analyse in Chapter 6, because of the extensiveness of British Columbia's rural areas, and diverse needs of birthing people, it is unlikely that birth evacuation will stop in the near future. However, through the advent of more Indigenous birth workers and population rise in rural areas, bringing birth back to communities may grow instead of shrink.

To conclude, birth evacuation, though it may be invisible, is causing not only cultural harm to First Nations women, but physical and emotional harm as well. The health care system for Indigenous people in Canada is not functioning as it should, and culturally appropriate birth practices are lost in the conflict. The literature about this policy shows that evacuation for birth is often times necessary to save the mother or the baby. They are not advocating against the biomedical system, but rather they advocate for an overhaul and a streamlining of the process so that the policy is not invisible anymore, and women may get the help they desire in culturally appropriate manners. Another important step that the government should take is granting more funding to women who must evacuate. Birth evacuation, as it is today, is controlling Indigenous women's bodies, reproductive rights, endangering their mental and physical well-being, and is a multifaceted web of provincial and federal policies, lacking coherency. Birth evacuation should have clearly outlined guidelines for health practitioners to follow, and they should be easily accessible by mothers and birthing people. The Canadian government must work harder to end neocolonial practices that are suppressing the Indigenous population.

Chapter 5: Systemic Racism in Rural Maternity Care

5.1 Literature Review

There is a wide range of literature on rural maternity care in British Columbia, literature on racism within the healthcare system, and research on the unique struggles of Indigenous women in healthcare. However, data on First Nations women's experiences of racism in rural maternity care is still missing. I aim to fill the gap by connecting all of these topics and I argue that due to systemic racism and oppression First Nations women in British Columbia experience worse birth care when living in rural and remote areas.

The main scholars writing on rural maternity care in BC are Stefan Grzybowski and Jude Kornelson (Kornelsen and Grzybowski 2006; Grzybowski and Kornelsen 2005; Grzybowski, Kornelsen, and Cooper 2007; Kornelsen et al. 2010). They are both white settlers, and although the literature does explain in detail First Nations women's unique challenges, their research is on rural maternity care in general. They argue for a return to community-based births, and for more infrastructure within rural maternity care.

One of the major issues in rural healthcare is the lack of skilled healthcare professionals (First Nations Leadership Council 2006; Varcoe et al. 2013; Yeates 2016). This means that not only birth work is affected by shortages, but all healthcare is precarious when living in a rural and remote area. The literature documents strained relationships with existing health care providers and experiences of racism.

In Plain Sight is a landmark report that investigated claims of racism within the BC healthcare system (Turpel-Lafond 2020). The report was called for after accusations that hospital employees were playing "The Price is Right" when intoxicated Indigenous people came in, betting on the blood alcohol levels of the patients. Though the report did not uncover proof of the alleged game, it concluded that there is widespread racism, discrimination, and stereotyping of Indigenous people in the healthcare system. Racism limits access to medical treatment for Indigenous people and Indigenous women and girls are disproportionately impacted by Indigenous specific racism in the healthcare system. The report found that current public health

emergencies magnify racism and vulnerabilities (COVID-19, overdose crisis[4]) and Indigenous healthcare workers face racism and discrimination in their work environments (Turpel-Lafond 2020). *In Plain Sight* is referenced by newer literature, however older literature still argues that the healthcare system is racially biased against First Nations people.

All of these papers tie together Indigenous experiences of living in rural areas and a reliance on the biomedical system which has proven prejudiced, racist, and harmful. As I will argue in this chapter, the challenges that birth workers face are varied and racism is deeply engrained in the system. Here I will provide an overview of the intersecting and diverse challenges, which existing literature does not provide. The literature on First Nations birth care in rural and remote areas tends to focus on one issue specifically instead of looking holistically at the systematic and historical oppression that has led to the broken system.

5.2 Chapter Introduction

According to the 2016 census, 40% of registered Indians[5] live on reserve (reserves are located all throughout the province, in rural and urban areas alike), 14% live in rural areas (off-reserve), and 42% live in urban areas. These statistics show that First Nations peoples make up a significant amount of people living in rural areas. One in four Indigenous women travel more than 200km for birth. The number for non-Indigenous mothers and birthing people is one in every 200 (Renouf and Steacy 2021). This stark difference calls attention to the discrepancy of care between Indigenous and settler people in rural British Columbia.

As illustrated in the previous chapter, birth evacuation is a fact of life for many rural residents. In this chapter I will continue to illustrate that First Nations residents of rural and remote

[4] The opioid overdose crisis in British Columbia is a massive health crisis that is overwhelmingly overrepresented in the First Nations population, and particularly First Nations women. It is a public health emergency. During 2020 and 2021 the numbers of overdoses skyrocketed and overtook the number of COVID-19 deaths, due to numerous reasons such as supply shortage, isolation while using, and reduction of safe injection sites (Baines 2020; First Nations Health Authority 2020).

[5] Indigenous people are registered under the Indian Act. The gendered history of enfranchisement meant that any woman who married someone who wasn't a registered Indian would lose her status. Any woman who was not registered and married a man who was, would gain status. For a while any person who gained a university education was also enfranchised. Enfranchisement meant being removed from the reserve and losing one's status. Registration today allows for specific benefits as well as the right to live on reserve. The history of registration is complicated and intertwined with colonial methods of control (Crey 2009; G. of C. C.-I. R. and N. A. Canada 2018).

communities are more severely affected by the gaps and failings of the system. I argue that although birth workers such as midwives and doulas are imperative for healing the broken system, their efforts are hindered due to the many blockades of rural maternity care, their efforts are hindered. I analyse interviews I conducted with birth workers working in rural and remote areas and describe the barriers they face in their work. First, I discuss the lack of practitioners and healthcare workers generally in rural and remote areas, and the retention issues because of racism and prejudice. I then elaborate on a potential lack of cultural safety training, despite the Truth and Reconciliation Commission's Call to Action #24: "require all medical and nursing students to take a course dealing with Aboriginal health issues". I next argue that due to the economic agenda of the federal and provincial state, there are financial barriers that birth workers must comprehend when working with First Nations communities. Finally, I look at the example of COVID-19, and how an emergency such as the pandemic crippled rural and remote First Nations communities birthing experiences disproportionately compared to the rest of the population. I posit that maternity services in rural and remote areas of British Columbia are incumbered by slow moving policy changes, systemic racism, and neglect, which consummates in fostering the neocolonial system under which birth workers and birthing people struggle.

5.3 Retention Difficulties of Indigenous Birth Workers in Rural and Remote Areas

There is a high demand and desire for more Indigenous health care workers, especially in perinatal care (Varcoe et al. 2013; First Nations Leadership Council 2006; Turpel-Lafond 2020). Systemic racism in Canada is impeding Indigenous people from moving forward in their careers and stunting the number of practitioners graduating from programs. With more birth workers available in smaller communities and reserves, birth evacuation would be lowered, and with more Indigenous birth workers in community, birth outcomes would improve and negative experiences due to racism within the healthcare system may be lessened.

In a white paper commissioned by Perinatal Services BC, Lee Yeates demands change in rural maternity care and states "without *urgent* improvements in rural maternity and surgical service delivery, rural populations will continue to be affected by ever increasing barriers to accessible care and worsening social determinants of health" (sic) (2016, 1). Since 2000, many rural health centres have been shut down (Kornelsen et al. 2010). This is echoed by the interview participants, citing a lack of service centres as a barrier to adequate healthcare (Interviewees

1,3,4,5). Though some rural and remote communities may have a doctor, a midwife, or nurse, if there is no specialist in obstetrics and gynaecology (OBGYN), or Operating Room (OR), people with medium to high-risk pregnancies are transferred to a bigger service location with more resources. However, as is the case for nearly all reserves, there are no midwives and few doctors, thus every patient must travel for care, even if they are low risk (Renouf and Steacy 2021). This then involves transportation that could be hours of driving, plane rides, and/or ferries. There is additionally a documented shortage of doctors in the province, especially in rural areas. A recent article from the CBC cites that nearly 1 million residents of BC have no family doctor (Watson 2022).

Indigenous doctors are extremely underrepresented, leading to a lack of culturally safe care (Ohler 2018). This affects First Nations people who have experienced trauma within the healthcare system caused by colonization and the residential school system. Interviewee 2 (a white settler midwife) explains that though there is not a shortage of doctors in her area, there are still retention problems with other healthcare practitioners. Interviewee 4 (a First Nations doula) had issues herself when wanting to give birth, as her community did not have the care available that she desired. She explained that the doctor in her community did not have the training necessary to support her in a water birth. However, she further suggested that a lack of training was in fact unwillingness to support her birth choices. In rural and remote areas, the lack of practitioners directly renders a lack of options. Interviewee 4 explained that the obstetrician in her community had a negative reputation and many First Nations birthing people were uncomfortable around him, however because he is the only OBGYN in the service area, they are left without a choice. This forces a confrontation with racism knowingly, something that is extremely traumatic and can have dire effects on a person's mental or physical well-being. Interviewee 5, a First Nations doula, shared that birth used to be an option in her community, however, after a bad outcome, birth has completely stopped, despite there being qualified doctors at hand. From listening to the interviewee's stories and histories, I found that health practitioners often feel a great deal of fear when working in these unique environments, if something is to go awry, and instead of training more, they shut down and refuse to give care that they are able to give.

Some rural communities have better reputations in the province than others. Some remote areas are heralded as gems of the country, gorgeous rural spaces that have a booming tourism

industry- marked by expensive lodges and nature expeditions. Other rural communities are classified as industrial bases in forestry or mining and characterized as undesirable by the rest of the province. These differences in class and financial state are important in analysing maternity care in BC. Even if there are more birth workers being trained and who are willing to work, there may or may not even be enough clients depending on where they decide to settle and work. A reason for the difficulty of retention highlighted by participants, and agreed upon by existing literature, is the importance of a support network for practitioners. If new practitioners do not connect with the community, then there is a higher risk of quitting or moving away from their post. Interviewee 1 stated: "You might even have success in recruiting somebody, but if they're not well suited to or, are not prepared to work with the skill set that's required to work out here recruitment might be short-lived for example, or if they're not competent in cultural interaction with the community". Interviewees 1, 2, and 4 expressed instabilities in the birth work sector. Especially with doula work, the interviewees explained that though many doulas may be trained, not many take on the role full time because of the volatility of the job.

5.4 Lack of Cultural Safety in Birth Work

The Truth and Reconciliation Commission's Call to Action #24 is: require all medical and nursing students to take a course dealing with Aboriginal health issues (2015). The First Nations Health Authority's transformative change accord has also called for a curriculum for cultural competency (First Nations Leadership Council 2006). In an excerpt from *Naskapi Women: Words, Narrative and Knowledge*, Lèvesque, Geoffrey and Polèse (2016) emphasize the importance of Indigenous knowledge production and sharing as a vital part of reconciliation: "Excluded from the places of knowledge production for too long, Indigenous peoples have gradually advanced their own intellectual traditions, epistemologies, knowledge systems, and "regimes of nature" all of which express both the complexity of their relations with the various worlds-natural, social, spiritual-with which they interact" (Lèvesque, Geoffroy, and Polèse 2016, 80). I argue in this section that cultural safety training is imperative for all birth workers in British Columbia and is an important step in reconciliation. As many reserves are in rural and remote areas in BC, cultural safety is crucial for improving the care of First Nations birthing people.

San'yas Indigenous cultural safety training is a program developed by the BC provincial health service's Indigenous health program in 2008; however, participation remains voluntary for most organizations (medical schools, practices, healthcare workers) ("About-- San'yas" 2022; Turpel-Lafond 2020). This extensive training course lasts 8 weeks and is completed with a group, not individually, with discussion boards and activities. The Doulas for Aboriginal Families Grant Program (DAFGP) also offers a cultural safety training, which is online and takes 2-3 hours. Both trainings are developed by Indigenous individuals and companies.

One interview subject, when asked about whether she had completed cultural safety training, responded that she did an 8-hour course (I hypothesise it was San'yas), but would not describe herself as proficient in the area, and had forgotten the name of the course. This comment points to the privilege a white settler has when taking a cultural safety course. For them, it may be easier to forget the name of a course as, First Nations people, they have not experienced the trauma firsthand. Interviewee 1,2 and 4, who are settlers, expressed the importance of humility, constant learning, and reflection. Despite this, Interviewee 2 is the only settler birth worker who has stated clearly in her biography about the effort to support Indigenous families in healthcare, as well as a link to the San'yas course. This demonstrates an active effort to engage with culturally safe as well as a commitment to anti-racist work. The others had written their certification with the DAFGP but did not share any other information publicly about culturally safe care or specific First Nations care. Interviewee 3 (a First Nations doula) recently took part in an Indigenous doula training, to supplement her other trainings and learn more about culture and traditions, as she described that her own traditions have been lost to colonization. Through trainings, which I will elaborate on further in the next chapter, birth workers are reclaiming practices and disrupting the neocolonialism in the health care system. Interviewee 5, also a First Nations doula, was working closely with FNHA for some years, and she works with her tribal council, making her substantially involved in her community.

Joyce Green writes that Indigenous feminism provides a politicized and critical conceptualization of First Nations history and oppression (2007). By studying and learning about the oppression that First Nations people experience, settler birth workers can provide improved care, and First Nations birthing people can feel safer within a system that has often harmed them. It was surprising to me, although they were eager to be interviewed on the topic of anti-Indigenous racism within the healthcare system, some of the settler birth workers did

not advertise culturally safe birth practices or emphasize support for their Indigenous clients on their webpages. Each person interviewed was competent and aware of the problems, so why, as settlers, would they not make more effort to promote allyship or support for their Indigenous colleagues? Interviewee 4 explained that though she used to have a lot more First Nations clients, now that there are First Nations birth workers in her community, the birthing families prefer working with them instead of her as a settler. She expressed excitement for this change, since her beginning as a doula in her community the profession has grown exponentially. Interviewee 4 did not see it as a loss but a transfer of services, to practitioners who were able to provide more holistic and culturally appropriate care, instead of her as an ally.

The literature surrounding Indigenous birth practices emphasizes the lack of Indigenous practitioners, and it is consistent with my findings. The FNHA's transformative change accord from 2006 called for a maternity access project to be implemented so that birth may be brought "back into the hands of women", reducing the need for birth travel. An agreement was signed with the British Columbian government and federal government to enact a tripartite agreement for healthcare in 2013, however "maternity" "midwife" "doula" and "rural" are not mentioned in the agreement. Why has this important part of the original agreement been sidelined in the official document? Having mandatory training for all medical professionals on cultural competency, safety, and protocols would potentially save lives (Turpel-Lafond 2020).

Racism in the healthcare system affects both practitioners and patients. In some instances, mothers and birthing people have chosen to stay home and avoid the hospital because of previous instances of maltreatment and racism, directed at either them or their family members. Each of the interviewees indicated experiences with racism. Interviewee 3 (an Indigenous doula) discussed that she personally had not experienced racism within the healthcare system and credited it to being white passing. She described a friend's experience: "she has felt discrimination from more of the social services community and feeling like living in fear of making a parenting decision that might change their perception of whether her children are safe or not in her care." Social services has played a large role in many mothers and family's lives, from residential schools to the Sixties Scoop, to today's child welfare crisis. This apprehension restricts reproductive rights and the ability to parent freely. Interviewee 5 explained that just recently a client had been pressured into having an unnecessary procedure and was at a loss as to what the reason could have been, except for experimental: "This young mum, who's just 21

was kind of pushed and coerced into doing this procedure that she said, no, I don't want to, and I wasn't sure, but the doctor kept pursuing for it". The history of residential schools is still deeply engrained in Indigenous lives-- Interviewee 5 explained that many of her First Nations clients will just believe whatever doctors say without advocating for themselves: “we're also still where a lot of families, intergenerationally still believe doctors know best. Because for some of them, we only have one generation from residential school where it's the people in authority know what's best for us”. Patient advocacy is an important skill, and doula work is based on advocating for mother and birthing people. I will discuss advocacy, as a central tenet to my argument, more in the following chapter. Through cultural safety programs, institutional racism may be cut off at the root, with all incoming birth workers aware of the oppression and barriers that First Nations people experience.

5.5 Economic Agenda of the State: Cycle of Poverty

One in 4 Indigenous peoples are living in poverty, and 40% of Indigenous children are living in poverty (“Poverty in Canada” n.d.). As discussed, a variety of causes has led to the impoverishment of Indigenous people in Canada, from the onslaught of colonization to the reserve system, the residential school system, and racist prejudices. Living below the poverty line means that actions such as buying extra gas for more doctors’ appointments, booking accommodation in a bigger city for pre- and post-natal care, or supporting a family on a single income can be out of reach. The costs associated with birth and birth travel can become exponential, despite grants and funding available. In this section, I argue that the economic agenda of the state affects Indigenous birthing families negatively.

Interviewee 1 explained that because rising gas prices due to the war in Ukraine, her First Nations client coming in from a rural reserve was unable to afford a trip for a checkup. The distance needed to travel by some birthing people to get regular care is so long that these become notable barriers. As previously mentioned, 1 in 4 Indigenous birthing people must travel 200km or more to give birth (Renouf and Steacy 2021). This also suggests that regular checkups and doctor’s appointments may also require long travel times and expenses. Interviewee 4 discussed the lack of affordable accommodation in the town she lives in for her clients. Often times, she described, her clients were unable to find suitable accommodation and had to shorten the schedule instead of staying the recommended period of time after birth.

Interviewee 3, who travelled for her own birth, estimated that it cost her $2000-3000. Interviewee 4 explained that birthing families often do not budget these extra costs into their birth plan, especially if something changes or goes awry, leaving the family in a precarious financial situation and unable to choose the desired care. Interviewee 5 explained that the grants available in theory cover all costs, however the vast differences within the province leave many families with leftover bills.

Part of the First Nations Health Authority plan of action was funding for more doula training, to support culturally sustainable birth practices, and bring birth back into the hands of Indigenous women and communities. Though many people go through doula training, some people may not continue on with the career. When the services are not covered by medical, and only some families are eligible for funding and grants available, this can mean unstable income. Interviewee 5 explained that there were Indigenous women and aunties (Indigenous female Elders) in her community who identified as birth workers for their community before doing official doula training. In Ontario, another Canadian province, there is a separation between Aboriginal midwives and registered midwives ("Indigenous Midwifery" n.d.). The exemption means that these Indigenous midwives are able to work more freely in their own communities, however, only recently were they able to access funding as registered midwives do. In an interview with the Midwives Association of BC, Evelyn George, the Indigenous lead of MABC, suggests that this model would not work in BC because of how spread out Indigenous communities are compared to Ontario (MABC 2017). This will be discussed in more detail in Chapter 6.

5.6 Rigid Understandings of Risk

Jude Kornelson et al. organized a study based in Bella Bella in 2010 to research birthing at home for First Nations women. Their study found that the importance of familial and community support was emphasized over concerns about access to biomedical emergent care. This aspect of differing understandings of risk is echoed throughout the literature on Indigenous birthing families, specifically coming from rural areas ("Returning Birth to Aboriginal, Rural, and Remote Communities" 2010; Varcoe et al. 2013). What is understood is not a lesser risk, but a different hierarchy of importance. For many mothers and birthing people, the social consequences they foresee from leaving their community to give birth outweigh the risk of

staying. Kornelson and Grzybowski explain that the social construction of risk from the western perspective must be analysed and critiqued (Kornelsen and Grzybowski 2006). The SOGC further this notion by suggesting that because people who live in rural areas deal with differing life circumstances and different environments than those living in bigger urban centres, activities classified as "risks" may be seen differently. Interviewee 2 (a white settler midwife) explained that people have diverse opinions and images of what birthing in their community truly looks like. She explained that part of her job as a midwife is ensuring that her clients understand exactly what the situation will look like in each risk scenario. Interviewee 2 suggests that those who have lived in the community the longest have the best perception of the risk of staying or leaving. Both options come with complications. Interviewee 1 stated her clients will also choose what she deems as a "riskier" birth plan in order to stay closer to their community. Birth workers interviewed focused seriously on their efforts to explain risk levels to their clientele, and hope that they make what *they* deem as the safest choice. Interviewees 1, 2 and 3 emphasized the importance of the birthing person being well informed and armed with the right tools. Interviewee 5 emphasized the futility of birthing in a hospital when the patient is low risk: "if you're at high risk, then yeah, it's totally understandable. But if you're at low risk and if you're willing to be at home, I don't think we should have to be mandated or forced to have that, but sadly enough, we don't have midwives … which makes hard for families. It's kind of not an option depending on where you live". Through this discussion of land, community, and risk, the interviewees and literature agree that evacuation is often unnecessary and a relic of the past, and birth work needs to be more open and accessible without as much government intervention when the setting is low risk and deemed safe by the parties involved. If there were more birth workers available, birthing in community would not be deemed as risk taking behaviour. However, because of the current lack of facilitation in rural communities, birth workers are torn about what is the best decision for their clients.

5.7 Birth Work During COVID-19

A pertinent example of the complete reliance rural and remote populations have on external factors is from April 2022. Over one weekend, the crew members of the ferries that normally transport people from Haida Gwaii to the mainland caught COVID-19, leaving BC Ferries without enough crew members to safely transport people off the island. Without the regularly scheduled ferries, the population was essentially stranded until BC Ferries chartered flights off

the island, prioritizing those who were leaving for medical attention (Kerr 2022). These types of situations are not uncommon in rural and remote areas, and the coronavirus has added to the stress of birth in rural and remote areas. Interviewees discussed the fears that they had in the beginning of the pandemic, being primary birth workers in their regions. If they fell ill and had to quarantine, their clients were left without alternatives (Interviewee 1, 2).

Indigenous people have been criticized during the pandemic for resisting vaccinating (Mosby and Swidrovich 2021). Indigenous communities have been subject to many horrendous medical experiments and surgeries without consent, which fosters distrust in the system (Rao 2019; Voce et al. 2021; Mosby and Swidrovich 2021; Zingel 2022). Because First Nations people are already more vulnerable to illness, with worse health than the other populations in Canada, more impoverished, and living in worse conditions (often overcrowded houses or apartments), there was an intense effort to vaccinate Indigenous peoples (Mosby and Swidrovich 2021). One interviewee explained that her mother warned her as a young child to never write on her vaccination card that she was Indigenous, in case they gave her an experimental drug. Interviewee 1 described some of her clients being "alternative", and against the biomedical system. These assumptions and judgements passed by people working in healthcare can have negative effects on patients and clients. Whether or not she was speaking about First Nations clients changes the narrative. I regrettably did not ask for clarification. Interviewee 3, who is First Nations, professed hesitation for the vaccine, explaining she felt forced into getting vaccinated because of her work in healthcare (there is a vaccine mandate for all healthcare workers) and was extremely upset by it. Bodily autonomy is a key factor of Reproductive Justice, and because of the COVID-19 pandemic, complications have arisen. Attitudes and microaggressions may negatively affect standards of care, increasing hesitancy towards the healthcare system.

A report released in 2021, *In Her Circle*, notes that accessing care is already challenging for Indigenous women and during the pandemic these difficulties are exacerbated (2021). Not all responses were negative, however. Interviewee 3 suggested that some mothers and birthing people felt relieved at the regulations on people in the birthing room, as it allowed them to have smaller and more intimate births without offending extended family members and friends. Some women cited found online or telephone options for healthcare a positive change, especially for women located in rural areas, where often wait times and travel times mean a

large gap between noticing a problem and receiving care. They explained that what used to be multiple in person visits could happen over the phone, such as prescription refills and prenatal check-ups ("In Her Circle: The Influence of the COVID-19 Pandemic on Indigenous Women's Health in BC" 2021). This was echoed by Interviewee 5, "With doctor's appointments it's hit and miss, some are more accessible now. I use our First Nations Health Authority 'doctor of the day' phone in and have an appointment within a day or two…instead of waiting a month to see our doctor downtown…I've actually had pretty good diagnoses over virtual health". Despite the challenges that the pandemic imparted on the healthcare system, there were positive aspects to come out of changing technology and allowed many rural areas to be more connected with healthcare practitioners.

5.8 Chapter Conclusion

To conclude, the historical oppression and intergenerational trauma of Indigenous peoples has contributed heavily to a broken system under which it is extremely difficult to succeed as a birth worker or birthing person. Although the government has promised funding over and over again to provide improved health outcomes for Indigenous communities, there hasn't been enough changes made (H. Canada 2017). There is a gap between policy recommendations, and on the ground changes. First Nations activism is at the root of the resurgence of culturally safe care, and they need policies put into place to solidify and allow more flexibility within birth work. This could allow for more in-community births, and education for birth work. While colonization and loss of knowledge cannot be undone, efforts can be made to ensure what traditional knowledge is left prospers. The complex issues facing First Nations healthcare necessitates a multifaceted action plan. Stakeholders must work together to ensure success and continuation of goals. Solutions needed are more resources and funding put into rural and remote areas, opening instead of closing health centres, more cultural safety programs for existing practitioners, and a more clear and coherent set of guidelines for birthing people to follow. Birth workers are the key to changing experiences for Indigenous women in rural and remote areas, and in the following chapter I will provide some of the disruptive techniques that birth workers employ to counteract the neocolonialism within birth work.

Chapter 6: Disruptive Techniques of Doulas and Midwives

6.1 Literature Review

The scholarship on Indigenous midwifery and doula work in BC has varied literature. This topic has somewhat limited literature, however as of late there has been an increase in publications. The SOGC's recommendation to return Aboriginal birth to rural and remote areas is referred to throughout other literature as a landmark recommendation ("Returning Birth to Aboriginal, Rural, and Remote Communities" 2010). The call came from a large organization, which caters to all birthing people and mothers. The Society of Obstetrics and Gynaecology of Canada is referred to in the Government of Canada's call for return to community based births, as well as the First Nation Health Authority's recommendation for community based births (P. H. A. of Canada 2018; "Returning Birth to Aboriginal, Rural, and Remote Communities" 2010; First Nations Leadership Council 2006).

The literature agrees on most points. The statistics shared within the articles point to better health outcomes for mothers and birthing people who choose to birth in their community, with culturally appropriate traditions (Birch et al. 2009; Butt and Lalonde 2009; Cidro 2018). The more recent papers direct the reader's attention to the scarcity of acknowledgement of racism within the healthcare system (Doenmez et al. 2022). These papers point out the colonial history related to birth work. I draw from historical data on the medicalization of birth (Ehrenreich and English 1973), and from Native American scholar Paula Gunn Allen to frame this chapter, along with Reproductive Justice and Indigenous feminism. Gunn Allen's criteria for the changing systems due to colonization offer a decolonial perspective for the history of birth work seen in Canada (Gunn Allen 1986).

The literature on community-based births does not go into as much detail on the role of tradition and the theory behind it. For this reason, I focus on the loss of traditional knowledge and the theorization of tradition in this chapter. Decolonizing birth work is intertwined with decolonizing the medical system, and healthcare. While newspaper articles such as Auger 2020 and Doenmez et al. describe the emotional labour that comes along with Indigenous midwifery care and doula work, the other articles do not. None of the articles mention advocacy, nor

activism. In this chapter I aim to fill the gap in the research by explaining the emotional labour that Indigenous birth workers endure, and the positive and joyous aspects of their work. I will also discuss the loss and reclamation of Indigenous birth work knowledge and tradition, to argue that through these reclamations and acts of advocacy, Indigenous birth workers disrupt the neocolonial system of birth in British Columbia.

6.2 Chapter Introduction

Indigenous women particularly face a multitude of barriers when accessing healthcare. Because of the legacy of colonization and assimilationist policies, Indigenous women have had the tradition of birth taken away from them. Since the 1970s most Indigenous women who live in rural and remote areas are forced to leave their community and travel to a hospital to give birth, away from their family and cultural traditions. Midwifery was made illegal in the late 1800s, and only regulated again starting in the late 1990s (Plummer 2000). The push of medicalization caused Indigenous tradition to be lost, and perinatal care to be put into the hands of the western biomedical system. As discussed in the introduction, First Nations midwives and doulas are reclaiming traditional knowledge and birth practices and working to bring birth back into rural and remote Indigenous communities.

In this chapter I argue that Indigenous birth workers, such as doulas, are forces of feminist advocacy and knowledge counteracting the colonial history of birth. Relying on qualitative methods, I analyse interviews with Indigenous and white settler doulas and midwives working in rural British Columbia. I show that reclamation of Indigenous knowledge production and growing factions of Indigenous birth workers are methods of resistance. I then elaborate on how bringing birth back into the communities is key for moving towards safer Indigenous healthcare. I finally share the disruptive of stories of birth workers as advocates in their communities.

6.3 Colonial Conversion to Heteropatriarchal Eurocentrism

In the Middle Ages in Europe, women played a large role in healing, especially related to pregnancy and childbirth (Ehrenreich and English 1973). The great majority of witches were in fact healers, medicine women to the peasant population. Women learned from each other,

taught each other remedies, and searched for herbs and healing antidotes to common ailments. The suppression of witches "marks one of the opening struggles in the history of man's suppression of women as healers" (Ehrenreich and English 1973, 6). This association of witches then was not in the too far distant path when colonization of North America took place, and settlers came across Indigenous midwives and healers. The fear of a woman knowing more than a man plagued the medical profession, and soon enough medicine turned into a completely male sphere, and women were cast to the side (*Ibid.*). Despite this patriarchal history, before medical services were available, settlers would use Indigenous midwives to help with their births, due to the silent and seemingly calm way that Indigenous women gave birth. The birth workers were used for their advantages, and then soon after turned on, and told that their work was dangerous and savage compared to western doctors (Butt and Lalonde 2009). Connecting to Reproductive Justice, the systemic repression of Indigenous bodies manifested in racism becoming a socioeconomic determinant of health (Coen-Sanchez et al. 2022). In the late 1800s midwifery was banned in Canada, except for in rural areas where women had no access to other hospitals (Plummer 2000). Healing and medicine was taken out of Indigenous people's hands, and they were forced to subscribe to western biomedical systems. Since colonization Indigenous people's health has significantly declined, owing massively to the rigorous assimilation attempts by the Canadian government and Catholic Church (Cidro 2018; National Centre for Truth and Reconciliation n.d.). Through the residential school system, children were punished for speaking their own language or acknowledging any part of their indigeneity. Furthermore, chief traditional practices such as the potlatch were banned under colonial rule (National Centre for Truth and Reconciliation n.d.). The continued racism and prejudice against Indigenous tradition is being fought through reclamation by Indigenous allies, activists, and advocates.

Native American scholar and poet Paula Gunn Allen's book *The Sacred Hoop: Recovering the Feminine in American Indian Traditions* (1986) explains how the colonial history of the Americas is largely skewed, and erases the existence of Native American women from historical records. Allen introduces four objectives for the transformation of egalitarian, "gynecentric" systems and societies into hierarchical, patriarchal ones. The first objective is "the primacy of female as creator is displaced and replaced by male gendered creators" (Gunn Allen 1986, 65). I will not elaborate deeply on creation stories; however the most well-known legend is that of Sky Woman falling onto the turtles back, which then becomes Turtle Island

(what is known as North America), and Sky Woman is the first human (Gunn Allen 1986; Wall Kimmerer 2013). Allen argues that the legend becomes tainted and changed with European contact, and Sky Woman suddenly has a smaller role, with all of her ideas coming from her father or grandson, who originally play smaller roles in the story. The second objective, which is pertinent to this research, is "tribal governing institutions and the philosophies that are their foundation are destroyed". Through colonization and assimilation tactics, the Canadian government imposed racist policies onto Indigenous bodies, and I argue here, continues to suppress mothers and birthing people's bodies through neocolonial techniques. Philosophies such as women centred birth and community centred birth have been taken away from First Nations communities. The third objective is "The people are pushed off their lands, deprived of economic livelihood, and forced to curtail or end altogether pursuits on which their ritual system, philosophy, and subsistence depend" (Gunn Allen 1986, 66). This is the root of Reproductive Injustice, and the heart of my argument. First Nations people, who for time immemorial have birthed in community, have had it taken away from them due to colonizing tactics from the Canadian government. As I will elaborate on further in this chapter, birth is slowly returning to communities, due to First Nations birth workers and allies fighting for their rights (Auger 2020). The final objective outlined by Gunn Allen is the transfer from the traditional clan structure to the nuclear family (1986). The control of reproducing bodies due to birth evacuation limits childbirth and constrains mothers and birthing people to abide by the western ideals of medicine and practice. The birthing families are unable to birth in community, and thus the beginning of life is in the westernized system. I conclude that through these four objectives, the western medical system has effectively transformed birth into a heteropatriarchal system of hierarchy and erases the gynocentric systems of birth that are traditional in Indigenous communities. Gunn Allen uses "gynocentric" to refer to women/ female centred practice, politics, and power (1986, 13). Through the reclamation of Indigenous knowledge, and reclamation of birth practices in rural and remote First Nations communities, birth workers are disrupting this heteropatriarchal hierarchy.

6.4 Knowledge Lost and Knowledge Reclaimed

Traditional knowledge is a key aspect in the fight for reclamation. From data gathered, a large amount of traditional birthing knowledge has been destroyed through colonialization. When

asked about whether she included traditions passed down from her family in birth work, Interviewee 3 responded:

> All that knowledge has been completely lost through colonization. There's very little that is truly Indigenous left that we're aware of… At this point it's more or less doing prayer around [the birth] and incorporating what feels appropriate for reclamation and adopting, which is what we're doing… Keeping the stump that falls off from the umbilical cord is a tradition. That is the only one, unfortunately, that I know specifically, and then just keeping it as a very sacred object to then pass on to the child. This is a representation of your connection to your mother and how she gave you life, and the sacredness of that.

Her words were wistful when recounting the lack of traditional knowledge available to her. The same interviewee took part recently in an additional training program for Indigenous doulas, to gain a deeper cultural connection with her work, showing the dedication. Interviewee 5 also explained that the traditions vary from nation to nation, and that she would not impose any traditional knowledge upon them unless they requested it, but she did have clients bringing their own traditions into the birth. The settler midwives and doulas expressed that their First Nations clients would occasionally request traditional practices during the birth, and that they would accommodate them.

Joyce Green explains the nuance of the term tradition in regard to Indigenous feminism. Tradition, in Indigenous circles, often refers to pre-colonial times, when Indigenous people had agency and self- determination (2007). Green argues that tradition is not a monolith, not a concept to be essentialized into one meaning. Tradition can change and grow and transform. Power relations must be addressed and gendered or sexist traditions re-imagined. Critique, and feminist critique in particular, is essential for transformation. Many traditions have been lost, and scientists have learned more about childbirth and pregnancy to ensure safer outcomes, which enables Indigenous birth workers, mothers, and birthing families to create new traditions and include remaining aspects in order to foster a sense of community and recognize the importance of the past. Indigenous health and medicine have adapted to flowing social and cultural differences (Butt and Lalonde 2009).

Bearing this in mind, I argue that Indigenous knowledge must be prioritized in the healthcare system in British Columbia. Allyship plays an important role, and the White midwives and doulas interviewed recognized the humility and respect that must come with supporting and

uplifting Indigenous practitioners, mothers, and birthing families. It was interesting, however, listening to the settler birth workers explain their roles of allyship, as I noted that on the websites of 2 out of 3 participants there was no mention of Indigenous specific care, except to say that they were certified with the Doulas for Aboriginal Families Grant. How is a First Nations family searching for birth care intended to trust a practitioner without explicit information on the quality and safety of care, when there is so much racism embedded in the system? Not all birthing families have the same needs, and if birth workers are intending to work as allies with First Nations families, they must emphasize the importance of difference and recognize the unique struggles that First Nations birthing families face within the health care system. The words in the interviews were sincere, however an outsider's perspective would be that of settler focused care, instead of intersectional decolonial care. Interviewee 2, who had extensive information about First Nations care and safety advertised, stated: "It's a constant process for me to just kind of be always checking in on myself. It's really based in trauma informed care and making space for culture in the care where it seems appropriate. And trying to be really aware of things that I'm saying and just being respectful and humble". Interviewee 2 was also the only settler birth worker who introduced herself as such, stating she was a white setter with European descent.

As I have extensively discussed, the healthcare system in BC is embedded with systemic racism. Traditional Indigenous knowledge has not had a place in the system, until very recently, and the government has started to make changes. The de-centering of the healthcare system is a massive undertaking, and small changes and personal determinations make a difference. Despite the Government's recognition that social determinants influence health, Indigenous activists and scholars have criticized it because of the lack of inclusion of colonization and assimilation in the determinants (Lewis, Williams, and Jones 2020). Interviewee 2 stated: "I think a lot in healthcare is de-centering the White narrative of the Western dominant colonial healthcare view. It's so perpetual in all of healthcare. We are the Western medicine narrative, it's just very dominant. I try and de-center myself and center the family and what works best for them and just really work hard to develop a relationship". To work to dismantle a system from within is a large undertaking, however this quote illustrates that White and settler birth workers can also make efforts against systemic neocolonialism. Birth workers are of course flawed beings, as the rest of us, and it is unfair to generalize as there may well be many examples of birth workers who are not providing culturally safe care for their clients. As

Interviewee 2 has stated, focusing on the birthing family seems to be a disruptive tactic engaged by many of the birth workers. Lewis, Williams, and Jones argue that "Indigenous peoples continue to be viewed through a deficit lens on the basis of their vulnerability. Because of this, Indigenous worldviews and cultural practices are seen as being relevant solely to improving their own health and well-being, rather than as a vital knowledge-base for a shared planetary future" (2020, 898). The recognition of the importance of Indigenous knowledge is imperative for bettering the health of Indigenous peoples, these scholars, and I, argue. Instead of "tokenistic" additions of Indigenous knowledge, there must be a complete overhaul, with Indigenous voices at the forefront, and Indigenous knowledge and knowledge production prioritized as Interviewee 2 suggested. Decentralizing from the western biomedical models does not mean sacrificing safety and standards of care. Instead, it can mean moving towards a more holistic, healthy, and inclusive health care system under which all patients and practitioners' benefit, with racist discourses and practices firmly in the past.

6.5 Indigenous Midwifery and Doula Work Creating Positive Change

The sentiment repeated through the literature and by the research participants is clear: more Indigenous birth workers equals better Indigenous health outcomes, and safer experiences within the healthcare system. Danette Jubinville is one of the founding members of the Ekw'ɨ7tl ("ek-WAIT-ul") collective in Vancouver, BC, who run Indigenous doula trainings throughout the province. She emphasizes the harm that residential schools did on trying to break familial bonds between parents and children (Ducklow and Coelho 2016). Children were taken away from their families at young ages, and placed in the residential schools often so far away that their families had no way of accessing them (National Centre for Truth and Reconciliation n.d.). The children were stripped of their culture and tradition, and mentally, physically, and sexually abused. The Catholic Church ran the majority of the schools, and indoctrinated Indigenous children into the Catholic religion. Thousands of children who were sent to the schools never returned, and only recently mass unmarked graves have begun to be uncovered at the sites of previous residential schools (Gilmore 2021). Reproductive Justice is the fight for families to have the same rights to life, children, and choices (Sister Song n.d.). Through the residential school system, the Canadian government denied Indigenous people the right to family life. Training more Indigenous doulas and having them as a part of the birth is at the heart of Indigenous cultural resurgence. Slowly, tradition is returning to Indigenous communities and

work to undue the hundreds of years of colonial assimilation. If one person's family history is lost due to colonization, an Indigenous doula may share her experiences and traditions with her client, and in the case of the increased Indigenous doula trainings, they may share with an even wider audience of First Nations mothers, women, elders, and birth workers (Ducklow and Coelho 2016).

I argue that doulas work as activists in their communities against the heteropatriarchal power that the western biomedical system has imparted for decades onto Indigenous bodies, through advocating for a return to traditional methods that include spiritual and cultural connections, reclaiming what their ancestors have taught them. By sharing knowledge and wisdom with more and more women, birth may slowly return to Indigenous communities, and shift away from the mandatory evacuation and birth travel. From the interviewees, there is a large increase in Indigenous doulas in British Columbia. When asked whether they had seen an increase in First Nations doulas, all interviewees responded yes. This confirms the main argument of the reviewed literature, which describes doula work as revitalizing Indigenous birthing care (Birch et al. 2009; Cidro, Bach, and Frohlick 2020; Doenmez et al. 2022). Unfortunately, there has not been such an impressive increase in Indigenous midwives.

Jaime Cidro promotes the "role of culturally based doulas because of the focus on re-centering Indigenous women's own knowledge and boundary-making during the birth process which is in direct opposition to the colonial approach to reproductive health that currently dominates health care" (2018, 2). This centring on Indigenous based knowledge and knowledge sharing is a feminist act. Especially in Indigenous doula trainings, the passing of knowledge from elders to a group of younger Indigenous women is a feminist act of knowledge sharing and production (Doenmez et al. 2022). Female Elders historically play a very important role in the traditional birth and are looked up to as a source of wisdom and leadership during the perinatal stages (O'Driscoll et al. 2011). The concept of doula collectives is also a particularly feminist practice, working together with practitioners, clients, community members, and elders in an anti-capitalist manner. Interviewee 4 shared that on occasion if the family needs extra support that she worked with, outside of the doula funding from FNHA, she will accept trades in place of monetary compensation, such as local frozen fish. This attitude towards doula work is Indigenous feminism and an act of decoloniality. Quijano describes decoloniality as changing systems and disallowing the continuation of oppression by the state (2000). By creating new

systems that divest entirely from capitalism, birth workers are agents of decoloniality, finding ways to subvert norms in order to provide care and service beyond the minimum necessity. Doulas act as activists and advocates in the hospital, at home, and after the birth by supporting the new mother or birthing person and advocating for their needs and for their rights. Interviewee 3, a First Nations doula, and mother of three, stated clearly that her second and third births were better experiences for her because of having a doula by her side, as opposed to her first with only a midwife.

As stated in my methodology section, First Nations midwives were more difficult to locate than First Nations doulas. Because of the added trainings, and medicalized profession, it is more costly and a lengthy process to begin the career. Perhaps it was also a question of First Nations midwives in rural areas that are sparser. In line with existing literature, interviewees agreed that there was a need for more First Nations midwives in rural and remote communities. Except for one interviewee, all noted a lack in their own community. Interviewee 3 added that the doula from her births was now training to be a midwife, "as she wanted to empower more women in a more effective way, she said she wanted to help more and that she felt doula work was somewhat limiting". This sentiment may come from the regulation of midwifery, versus the privatization of doula work. Midwives as a part of the public health system experience more benefits and

According to the interviewees, doula work can be unstable and somewhat precarious. Midwifery, funded through Medicare, is much more stable and financially secure. Further from financial aspects, many more mothers and birthing families choose to use a midwife than a doula, providing care to more than 10,000 families annually. British Columbia in fact has the highest rate of midwifery maternity care in all of Canada, at 27%. This means that although doula work is growing, midwifery is in higher demand.

In 2017, the Government promised $6 million over 5 years to support culturally safe midwifery in Indigenous communities. The minister of health, Jane Philpott stated "I believe it is vital to support midwifery care which will bring traditional birthing practices back to these communities, better support mothers and their babies and build strong families" (H. Canada 2017). Where did this money go? There is only one university which offers midwifery training in British Columbia, which is UBC. There are numerous scholarships and funding available for

First Nations students who choose to study at UBC, however it is an extremely competitive university, ranked in the top 3 universities in the country (Maclean's 2021). There are also two Indigenous midwifery programs in Canada, however they are located in Ontario and Quebec, respectively ("Become a Midwife" n.d.). There is a need for First Nations midwives, to work in rural communities. This will positively affect birth outcomes as well as reduce the need for birth evacuations. The more midwives located in rural and remote communities directly means less travel for births, and more openness towards home births.

Indigenous birth work is intertwined with the community, and bringing birth back into rural and remote areas, specifically reserves. As discussed in Chapter 7, community connection is a vital part of Indigenous birthing practices, and part of a healthy birth outcome. Interviewee 3 was interestingly the only birth worker who discussed supporting the partner as well as the birthing person,

> I'm really there for the partners too. And sometimes that's why they're hiring a doula, is so that their partner has someone to support them as well and reassure them, and also be there as a backup so they can take breaks and take care of themselves and not be the only person there, feeling all that pressure that they're the sole person to provide emotional, physical, and nutritional support to their partner

In this way, the doula is providing support for the birthing team, rather than solely the birthing person. This engages with Gunn Allen's argument of the differing family structures (traditional structure to nuclear family) and gives more influence to the social aspects of birth rather than the medicalization. In this way, the knowledge can be imparted from the doula onto the partner as well, to provide for any future births that they may have. Thus, hospitals are proven to be traumatic and potentially dangerous places for Indigenous people, as previously discussed, and by having a doula by their side, they are able to work towards reclaiming their rights and ensuring better outcomes. First Nations midwives are greatly needed, as midwifery gains in popularity. By reclaiming Indigenous birth practices, and acting as supports for one another, Indigenous birth workers are feminist actors pushing against the colonial history and neocolonial methods that the Canadian government continues to enact on the Indigenous population.

6.6 Activism and Advocacy

Birth workers interviewed stressed their roles as advocates for their clients. On top of health issues, Indigenous children are extremely overrepresented in the child welfare system, so much so that the Indigenous services minister declared a humanitarian crisis in 2017 (Barrera 2017). Birth work through midwives and doulas counteracts this unjust treatment of mothers and birthing families, as the birth worker acts as a boundary between the vulnerable birthing person and the medical/ social services system. When asked whether their work was "activism", Interviewees 2 and 5 immediately said no, they saw their work as advocacy. Interviewee 5 elaborated, advocacy for her meant not directly fighting the system, but instead ensuring the clients are safe and traumatic situations are not repeated. In this way, the birth workers act as a barrier for when systemic racism affects their clients and their work.

My final question to all the birth workers was two-fold. The first part was what were their main values as a birth worker. The second question was whether they saw their work as activism. When arguing that birth workers are disrupting the neocolonial system of birth evacuation, I felt it important to ask exactly how they viewed their work, and what made their work so important to them. Here I would like to take the opportunity to share their answers, which were thoughtful, kind, and compassionate. In "Decolonizing Oral History: A Conversation" Francis et al. discuss the lack of joy in English speaking oral history scholarship from the north. The "fixation" with trauma, as they describe it, of white western scholars hinders scholarship from interacting with this part of resistance (Francis et al. 2021). Therefore, in challenging the trauma informed disruptive techniques used by the birth workers, I will share their positive values and the excitement that they shared when speaking about the future of birth work.

Interviewee 1 described her values as respect, autonomy, family, and relationships. She said she sees midwifery as bridging a gap between the medicalized world of birth and the more holistic world of birth. Interviewee 2 described her values as respect, making it right, everything depends on everything else, and ask first. These values are the four values of the First Nations community that she works with, and it shows true commitment and respect as she works on reserve as a white settler. She explained that when she faces a challenge, she looks to these values for guidance. Interviewee 3 said her values were to provide woman-centred, birther-centred care, and honouring cultural values. Interviewee 4 said her values were to leave judgement and preconceived notions at the door, and to offer constant support. She then said, somewhat bashfully, that her main value was unconditional love. Interviewee 5 expressed her

main values as client-centred, strength-based, and confidentiality. Her values are directly tied to providing the safest and best birth outcome possible. I expected that birth workers would care about their clients and the mothers and birthing people they work with, however, to hear all of their values had quite an impression on me. The joy that came to their faces when discussing their values made the problems previously discussed in the interview seemingly disappear. Many of the interviewees additionally mentioned that they had directly inspired others in their communities to begin careers as birth workers.

As advocates for birthing people, I argue birth workers enable empowering moments and the re-writing of past traumas with a supportive network. They are promoting Reproductive Justice in a system that is failing to support Indigenous mothers and birthing people. Khiara Bridges' theory of the production of unruly bodies by the US medical system is applicable to birth evacuation. Bridges argues that state surveillance of BIPOC women's bodies produces the pregnant body as a medicalized, abnormal, and fragile entity (Bridges 2011). She argues that midwives are able to destabilize this production and de-medicalize pregnancy and birth. Although the Canadian medical system has notable differences with the US's system, midwives and doulas are still working to advocate for mothers and birthing people when they need extra support and strength. As I have emphasized throughout, First Nations women are much more affected by birth evacuation than other people living in British Columbia. It is essential that First Nations women, mothers, and birthing people have access to safe births, and birth workers are making that possible. The historical (and present) control of Indigenous people's bodies through assimilation methods, violence, heteropatriarchal power, and policing has formed a population with warranted fear of state systems. The reproductive injustice of controlling birthing people's bodies under the neocolonial system calls for external advocates, as mothers and birthing people are in an extremely vulnerable position at the time of pregnancy and birth.

6.7 Chapter Conclusion

I wish to conclude this chapter with a quote I found particularly moving, from an Indigenous doula cited from Jaime Cidro's article "Being a Good Relative: Indigenous Doulas Reclaiming Cultural Knowledge to Improve Health and Birth Outcomes in Manitoba":

> You go through another level of love. And not only love for that little human being, and the one who gave birth to it, but love for yourself, love for my mother. All these levels of these women in my family who have created life. The more that I strengthen and am empowered, the more that I reclaim my womanhood-ness, my grand motherliness, my femininity, sovereignty over my body, and reclaiming birth and taking that leadership role in my life, the more that the women that came before me and the women who come after me can do the same on deeper levels. I'm healing what happened and building a future. (2018)

This feeling of reclamation, of power, of femininity, agency and empowerment is echoed by all of the birth workers interviewed. Indigenous women, mothers, children, and birthing people who experience intergenerational trauma are given an opportunity to divest from the neocolonial biomedical system that is imparted onto Indigenous women, the future of Indigenous birth practices may well be in the hands of women from their own community. Through recognition of the issues and collective rising against racist systems and practices, I argue that birth workers create change. Indigenous birth centred on Elders, respect, ceremony, family, and most importantly the mother or birthing person and child is what Indigenous doulas and midwives are hoping to reclaim.

Chapter 7: Conclusion

In this thesis I argue that birth workers are subverting the neocoloniality of birth evacuation and working towards Reproductive Justice within the medical system through advocacy and decolonial actions. I have shown that the medical system, and specifically the perinatal system within Canada is rife with systemic racism. There are few First Nations practitioners, and even though there are positive changes being made, the state's lack of intervention and determination for decoloniality has led to a system under which First Nations people continue to receive worse care than other populations in the province. I introduced the topic of birth evacuation along with historical context of the past and present colonial regime that the state has governed Indigenous bodies under. The government is unwilling to reform systems in order to enact decoloniality. Quijano (2000) states that the coloniality of power has shaped a system under which Indigenous bodies are at the bottom of the hierarchy. I argue this structure of power is visible in Canada today, and birth evacuation is one of many examples under which a system enacted to "help" in fact has neocolonial tendencies and is harmful to First Nations people.

My research findings provide a new perspective to an issue with an already extensive amount of literature. In the past 10 years, since the Truth and Reconciliation Commission's calls to action in 2015, there has been more attention on racism in Canada. There has been increased scrutiny from policy makers, activists, politicians, and academics, leading to a general consensus that there is a problem that needs addressing. Groups such as the National Council for Aboriginal Midwives, the First Nations Health Authority, Midwives of BC, and even the Government of Canada have called for a return to community-based births. This call to bring birth back into the hands of First Nations women is an attempt to alter the path of the current biomedical system, in which traditional medicine and healing rituals have nearly no space. Tradition can be brought back in creative and intersectional ways, using current medical knowledge to ensure the best possible outcomes. Culturally safe birth practices are imperative for better birth outcomes, as I have shown here through interviews and analysis of existing literature.

In Chapter 4, although I disagree with the label of birth evacuation as an "invisible policy" as coined by Karen Lawford, I conclude that birth evacuation is an institutional practice which

enforces neocolonial biomedical norms, and furthermore removes Indigenous birthing people from their community and land which are two important tenants of positive birthing experiences. I argued that because of the separation of governmental power related to Indigenous healthcare, First Nations people receive worse care and regulations are difficult to find and follow, which allows for unpredictable and potentially unsafe scenarios. Without proper guidelines, birth evacuation can be a traumatic event.

In Chapter 5 I presented how systemic racism has created a system under which it is very difficult to succeed as an Indigenous birth worker, which in turn continues the cycle of culturally unsafe care. More Indigenous birth workers are needed to support First Nations clients through a system that has historically and continues to work against them. Many of the other papers on birth evacuation argue that with more First Nations birth workers, and more midwives in general, birth evacuation can cease to exist. I argue however, that because of the intersectional issues and colonial oppression of First Nations people, the challenges to becoming a birth worker are complex and there is not one simple solution. There must be imminent actions to create more opportunities for Indigenous birth workers, cultural safety training for existing practitioners, acceptance of alternative models of medicine and healthcare, and cooperation within stakeholders to ensure success. Increasing birth workers in rural areas is vital to improved health of First Nations birthing people and mothers and must be examined from a must broader perspective than literature has done previously.

Finally, in Chapter 6, I argued that through advocacy and decoloniality for Indigenous clients, birth workers are active agents for positive change. As a summation of the problems outlined and addressed in this research, birth workers are working within small rural communities with First Nations clients in order to provide safer care and ideally aid in reforming past traumas with the healthcare system into positive birth experiences. Birth workers are subverting neocoloniality within the healthcare system by being active support systems, educating mothers and birthing people, and gatekeeping between birthing families and the systems that continue to harm First Nations people.

This topic is overwhelmingly large, and there is still research to be done. Every year medical knowledge grows, and with those transformations come new challenges as well as positive changes. With more time I would have interviewed birthing people and birthing families. I

would have also interviewed more health care workers outside of midwives and doulas, to gain a more well-rounded view of the medical system. The next steps that I would suggest for this research would be to analyse more in depth the different needs of rural reserves in BC. Each location has such diverse populations and necessities, and it is difficult to create overarching recommendations. Birth evacuation and perinatal health in rural and remote areas is a multifaceted issue. Previous recommendations centre around increased First Nations birth workers in rural and remote communities. I think that to achieve this, there must be an overhaul of the system and a large increase in cultural safety awareness. Practices that are disproportionately harming Indigenous populations must be dissolved, funding must go directly into the hands of First Nations authorities to ensure best practices, and there must be at once more flexibility (allowing births in community, and traditional practices) and more guidelines (so that practitioners and clients are well informed and clear on their rights) to provide safe, and practical changes in perinatal services.

I argued that the government is essentially removing the right to have children and parent them in a safe environment for Indigenous mothers and birthing people, and birth workers are tasked with providing safe and positive birth experiences within a system historically intent on harming and restricting Indigenous bodies. There is enough research to prove that community-based births are a standard of care that should be accessible to birthing families who meet safety requirements. Reconciliatory efforts have fallen short, as traditional knowledge has been destroyed through colonization and there has not been enough effort made to return traditional birthing knowledge and practices into the hands of First Nations women and birthing people. In conclusion, I argue that midwives and doulas are subverting systems of control through advocacy and decolonial methods. Birth evacuation is a practice that is outdated and excludes culturally safe births. Medicine is rapidly advancing, however the medical system in Canada is stuck in the past.

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