

# MARGINALIZATION AND COERCION; CANADA'S EVACUATION POLICY FOR PREGNANT FIRST NATIONS WOMEN WHO LIVE ON RESERVES IN RURAL AND REMOTE REGIONS

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## ABSTRACT

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

Keywords: evacuation policy, First Nations, archives, maternity care

The federal government hires nurses to deliver primary health care for First Nations peoples who live on rural and remote reserves. Pregnant First Nations' women on these reserves are routinely evacuated to urban Canadian cities, often hundreds of kilometres away. According to Health Canada's<sup>2</sup> *Clinical Practice Guidelines*, federally employed nurses are to "arrange for transfer to hospital for delivery at 36–38 weeks' gestational age according to regional policy (sooner if a high-risk pregnancy)" (Health Canada, 2012, p. 12-6). This is known as Health Canada's evacuation policy (for a detailed history of the policy, see Lawford and Giles, 2012). Evacuated pregnant women stay in hotels, boarding homes, or with family or friends, "killing time" (Welch, 2010), waiting to go into labour, at which point they are admitted to a hospital to give birth. After hospital discharge, the women return to their families and communities with their newly arrived baby or babies. This routine, long-standing, nation-wide practice is currently articulated as originating between the 1960s and 1980s due to the Government of Canada's desire to reduce maternal and infant mortality rates amongst First Nations populations (Baskett, 1978; Couchie and Sanderson, 2007; Douglas, 2006). Our

1 First Nations are those individuals and communities that fall under the legislated authority of the *Indian Act* (1876). We use the term "First Nations" to counter and resist the historical context of the word "Indian"; this is a common practice among First Nations scholars.

2 Health Canada is Canada's federal department that is mandated to oversee the various health systems within Canada.

research shows, however, that this ignores the evacuation policy's true beginnings and the ways in which it has been used to marginalize First Nations' birthing practices and coerce First Nations into accepting the Euro-Canadian biomedical model. Current understandings of the evacuation policy fail to account for the ways in which it was, and continues to be, part of the Government of Canada's efforts to civilize and assimilate First Nations. In this paper, we refute the notion that it was or is based solely on an interest in the promotion of infant and maternal health amongst First Nations.

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## LITERATURE REVIEW

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

tives of the British Crown, and then, from 1867, the Canadian federal government.

Health care delivery to First Nations began to be formalized when Canada was formed in 1867 through the *British North America Act* (Graves, 1954). It was through this legislation that First Nations became wards, and thus the responsibility, of the Crown (Bryce, 1922). Section 91(24) of the *British North America Act 1867* granted the federal government authority over "Indians and lands reserved for Indians." Nine years later, the *Indian Act* (1876) unilaterally bestowed the colonizing forces with authority over Indians (First Nations from here on, unless cited authors use different terminology). The *Indian Act* (1876) also prescribed the location and living conditions for First Nations through the development of the reserve system (Dickason, 2009). Reserves were portions of land that were policed by federal Indian Agents to limit the exchange of goods and services between First Nations and Euro-Canadians (Dickason, 2009). Indian Agents were also given the task of ensuring First Nations people became "civilized" enough to "assimilate" into the broader Euro-Canadian society (Carter, 1996; Dickason, 1992). Until this was achieved, First Nations were to be kept separate from non-First Nations.

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

<sup>3</sup> Treaty making between First Nations and Britain began after the American War of Independence in 1759 with the Royal Proclamation of 1763. It became the means by which the two groups agreed to share First Nations territories.

<sup>4</sup> The federal government also assumes health care responsibilities for federal inmates, military personnel, and federal police (Canadian Health Services Research Foundation, 2011).

who lived on reserves (MacIntosh, 2008; McPherson, 2003; Waldram et al., 2006; Woolford, 2009).

The government created administrative divisions to facilitate the delivery of First Nations' health care: headquarters, regional, and zone offices. Health care for First Nations living on reserves was organized hierarchically with *headquarters* in Canada's capital city, Ottawa, Ontario. Canada was divided into *regions*, which contained smaller units called *zones*. Each zone had a medical superintendent, who was also the Indian Agent for the reserve(s) located in that zone. Federally employed staff members, like doctors and nurses within these divisions, were charged with providing First Nations with "medical attendance in consistency with the policy of the Department of Indian Affairs" (Superintendent General of Indian Affairs, 1925, p. 1). Nurses and physicians were hired in the late 19th century to provide medical services to First Nations (Conroy, 1917; Bell, 1911; Deputy Superintendent General of Indian Affairs, 1893; Inspector, 1912; McLean, 1919).

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

## FIRST NATIONS BIRTHING

The ways in which a First Nations woman experienced pregnancy and birth was substantively changed by the federal government's provision of health services. Prior to European contact, a First Nations woman laboured and gave birth in her

home or special locations and structures (Couchie and Sanderson, 2007; Mitchinson, 2002) with the assistance of community members such as her partner, midwives, friends, neighbours, Elders, or older children. After each birth, ceremonies were conducted to establish familial relationships between families and strengthen communities (Kornelsen et al., 2010). The birth of a baby was more than an addition to the community's population; it symbolized a growth between individuals and the future of communities. It also reinforced the essential role a First Nations woman held as the "bearer of life and nourisher of all generations" (Armstrong, 1996, p. ix) as an honoured and respected member of her First Nation (Anderson, 2009; Brant Castellano, 2009; Fiske, 1996; Hungry Wolf, 1996; Lapore, 2000; Monture-Angus, 1995; Olsen Harper, 2009; Peacock and Wisuri, 2002).

Federally operated hospitals and nursing stations were established in the early 20th century and staffed by physicians and nurses. These "White Fortresses" (Canada's Health and Welfare, 1950), portrayed as the pinnacle achievement in Canada's medical progress, were to complement public health care provided on reserves by federally employed nurses, nurse-midwives, and nurse practitioners (Stone, 1935). These same nurses also conducted most of the deliveries for those living on reserves in rural and remote locations (Baskett, 1978; Benoit et al., 2002; Grzybowski and Kornelsen, 2009). Such arrangements enabled pregnant First Nations women to remain in their home communities for the full duration of their pregnancies and for childbirth, unless the woman required an in-hospital surgical intervention, like a cesarean section (Zelmanovits, 2003).

The mechanisms that repositioned First Nations women's labour and birth to hospital and the ensuing evacuation policy are currently understood as attempts to curb First Nations' child and maternal mortality rates (see, for example, Baskett, 1978; Couchie and Sanderson, 2007; Grzybowski and Kornelsen, 2009). This is predicated on the assumption that Euro-Canadian biomedical models of health and healthcare are superior to the birthing practices that First Nations used for millennia prior to the colonizers' arrival and their subsequent inter-

vention into labour and birthing. While, certainly, Euro-Canadian health interventions have made some important contributions to First Nations peoples' health, the ways in which the government displaced and dismissed First Nations birth practices, how it achieved its goals, and how these factors contributed to the larger colonial project requires further inquiry.

## METHODS

Our study is informed by archival research. Archives are defined as

the body of documents of all kinds, regardless of date, created, or received by a person or body in meeting requirements or carrying on activities, preserved for their general information value. (Dukelow, 2006, p. 30)

Conducting archival research to understand the past is challenging, as archived materials, however complete, can never tell the entire story (Smith and pui san lok, 2006). Archived materials are filtered and categorized by institutional authorities who did not and/or do not have the capacity to store and catalogue all materials related to a topic; further, it may also be in the authorities' interest to destroy or restrict access to certain materials. This results in archives that are incomplete, which leaves the researcher to engage "less with the archives content than with the omissions and anomalies" (Smith and pui san lok, 2006, p. 24). To assemble a plausible account of history, archival findings can be complemented with materials outside of the archives, such as published and "grey" literature, like government reports.

First Nations have turned to archival research to regain knowledge that was lost when their ways of life were interrupted by colonial efforts to "civilize" and "assimilate" them into semblances of Euro-Canadians (Peers and Brown, 1999). Conducting archival research is "an act of both memorializing and rememorializing" (Sebastian, 2003, p. 10) events and people that shaped a particular outcome. Archival research

engages in archival exegesis as a way of rememorializing the narratives and voices which have been subjected to institutional and exegetical forgetting. (Sugirtharajah, 1999, p. 22).

Such research can, for example, provide historical insight into assimilation and civilization policies directed at First Nations.

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

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

## UNDERSTANDING POLICY

Because the evacuation policy was not always labelled as such, we required a definition of policy to facilitate its identification in the archived documents. There are numerous ways in which a policy can be defined. A law is the most concrete form of a policy (Brooks, 1998). The articulation of policy through law gives it substantive regulatory power. A policy can also be labelled as "policy," which great-

ly aids in its identification. A widely known federal policy related to First Nations, for example, is the evacuation policy for pregnant women who live on reserves in rural and remote regions of Canada. Policy is most commonly understood as a government's intentions — or “whatever governments choose to do or not to do” (Dye, 1978, p. 3). A government uses policy to rule, exercise a specific will and intent, and influence and control the decisions people make (Cohen and Chehimi, 2007; Goodin et al., 2006; Pencheon et al., 2006; Ritzer, 1988; Wilson, 2006). Policy can also demonstrate a government's commitment to a course of action to achieve objectives (Dukelow, 2006) and can be thought of as a general rule that is used to achieve those objectives (Goodin et al., 2006).

When we examined the archived documents, we initially read each piece to determine if its content was related to First Nations, First Nations women, or First Nations' pregnancy and childbirth practices or locations. Next, we examined each document again to determine if it was related to national policy decisions, First Nations' health and wellbeing, and First Nations' pregnancy and childbirth practices. Finally, we grouped the findings into the two most prominent thematic categories that emerged: marginalization and coercion.

## RESULTS

In what follows, we provide archival evidence that the federal government intentionally marginalized First Nations' pregnancy and birthing practices and that this marginalization was leveraged to coerce First Nations to adopt Euro-Canadian biomedical standards of care. Because complete archived materials were not available, as archives are always incomplete (Smith & pui san lok, 2006), our results draw on archived reports submitted from a variety of locations across Canada. Numerous examples are provided to demonstrate the systematic and methodical deployment of a national policy to advance the entrenchment of Euro-Canadian biomedical practices. Our research results point to the ways in which the evacuation policy was not just about good health, but rather also about furthering the colonial project of First Nations' assimilation and civiliza-

tion. We do not assert that these were the only driving forces that informed the evacuation policy, as history is always contested (Bizzell, 2000); we do, however, suggest that existing archives reveal their prominence in evacuation policy's genesis.

### THE MARGINALIZATION OF FIRST NATIONS BIRTHING PRACTICES

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

Four years later, a husband and wife team of physicians, Drs. Mitchell and Mitchell, were hired by the federal government to provide medical services to the Chippewas and Muncey First Nations in Ontario (Reed, 1896). The wife was specifically hired to provide midwifery services to these First Nations communities. Indian Affairs' hiring strategy reveals the federal government's intentions to introduce a Euro-Canadian biomedical model of care related to pregnancy and birthing practices to First Nations in the 19th century; importantly, this is the earliest evidence in the archives that relates directly to the provision of perinatal care for First Nations.

Within the first quarter of the 20th century, the archives provide documentation of how First Nations women living in the Northwest Territories were pressured by federally employed nurses to shift their birthing location from “outside, in the woods” to inside their cabins, an objective that was brought forward to counter “old superstition” (Bourget, c. 1922–1927, p. 1). Simultaneously, federally employed physicians were asked by the federal government to provide “any advice which you may give to Indian women regarding the proper care of their children, or with respect to sanitary conditions in their

homes" (MacKenzie, 1929, p. 1), care which began with the baby's birth. Nurses and physicians exerted state sanctioned medical authority over First Nations women with the intention to end long-standing First Nations pregnancy and birthing practices in favour of a Euro-Canadian biomedical model of care.

In the early 20th century, maternal mortality gained national attention, particularly among First Nations. In 1935, Canada's Dominion Council of Health outlined the general policy of location of birth for all Canadian women (Canadian Welfare Council, 1935) in attempts to curb the mortality rate. The policy recommended that all births be conducted by a physician with a qualified nurse in attendance. The Council did not remove the possibility of home birth, but rather listed exclusionary criteria: if a physician or a physician-approved obstetrically trained attendant were not available for a home birth, the birth was to take place in hospital. First Nations care providers, such as midwives and Elders that a community relied upon during labour and birth, were excluded from policy goals of improved health for First Nations. With the Dominion Council of Health's policy recommendations, First Nations' pregnancy, birthing, and early infant care locations and practices were made irrelevant and invisible to the achievement of the federal goals of improved maternal health. Hospital births with Euro-Canadian biomedically trained personnel thus formed Canada's strategy to improve First Nations' health.

The federal government viewed birthing, whether at home or in the hospital, as an influential way to assimilate and civilize First Nations into the colonial world. The archives provided an illustrative newspaper clipping from the *United Church Observer*. In 1939, the newspaper proudly reported the efforts of the Bella Coola hospital to advance the "savage" through Christianity and touted the hospital's contribution of a "stork" to deliver babies, which referred to Dr. Galbraith, a federally employed physician who provided maternity services in homes and hospital (*United Church Observer*, 1939, p. 17). By trivializing the traditional skills and knowledges required to ensure the safety of the woman and the baby during labour and birth, the stork caricature relegated First Nations birthing practices and practi-

tioners to a position that was not only marginal, but also beneath that of fantastical cartoons.

By the middle of the 20th century, the federal government specifically cited "grey headed old ladies" (Wood, 1950, p. 2) and "old crones" (Wilson, 1952, p. 1), or First Nations midwives, as unsuitable care providers for First Nations women. For example, Miss Wilson, a federally employed nurse, proudly reported to her superiors how she "snatched a primipara in labor, from the none-too-gentle hands of an Indian Mid-wife and took her to the hospital" (Wilson, 1952, p. 1). Through the marginalization and elimination of First Nations' birthing practices and care providers, federally employed practitioners introduced the Euro-Canadian biomedical model of care during pregnancy and childbirth. First Nations women's bodies thus became a site upon which colonial goals of civilization and assimilation could be realized.

#### COERCING FIRST NATIONS TO ACCEPT THE EURO-CANADIAN BIOMEDICAL MODEL

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

The Government wants all the children in the Band to grow up to be strong men and women, but they have not much chance if you do not follow the advice of the doctor and the rules which have been given you. The Government holds the Chief and Councillors of the Band responsible for seeing that these laws are carried out. (Deputy Superintendent General, 1928, pp. 1-2)

The "laws" to which the Deputy Superintendent referred were entirely fictional. Through such perjurious communication, the government introduced Euro-Canadian standards of maternal and child health practices as the norm within First Nations' communities. The above quote captures the extent to which the Canadian government enforced the Euro-Canadian biomedical model by resorting to coercion, threats, and fictitious legislation (under the guise of care and protection) to interfere with

and make illegitimate First Nations' practices related to pregnancy, birthing, and childcare.

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

In 1942 Indian Affairs expressed preference of home birthing as a means to reduce the department's financial expenditures during WWII, as hospital births increased federal expenditures. Dr. St. John, a federally employed physician, referred to this direction as a "reversal of ... [a] policy ... which was pursued for many years, namely that of educating Indian women to avail themselves to the advantages offered by a hospital" (St. John, 1942, p. 1). He disputed the suggested policy reversal by explaining the incompatibility of public health and personal safety with home birthing in the "unsanitary" (p. 2) living conditions and isolated locations where First Nations women lived. First Nations women's containment in hospital for four to five days following the birth was believed to provide them with "a rare opportunity of acquiring notions of hygiene affecting herself and her offspring" (p. 2). Hospital births thus facilitated the federal government's sustained and intentional efforts to inculcate standards of Euro-Canadian bio-

medical standards of health in First Nations women. A return to home birthing never occurred.

Our research found that the federal government's coercive policy of physician-attended hospital birthing had an immediate and profound impact on the location of First Nations births. For example, all the reported births from an Alberta Agency (Blackfoot Indian Agency) took place in hospital from 1941–1942 (Gooderham, 1942, 1941b, 1941a, 1941c, 1941d, 1941e, 1941f). It was further reported that a "steady stream of expectant mothers" came to the hospital to give birth (Gooderham, 1942, p. 1), which indicated the acceptance and even the expectation of hospital birth by these First Nations' members. A similar acceptance of hospital birthing by the First Nations who lived in the Alert Bay region of British Columbia was described by Dr. St. John (1942), who wrote that

the Indian women from Alert Bay and the surrounding districts today accept it as a matter of course that they should be admitted to hospital for confinement, and that is the situation which we found here when we took over six months ago. (St. John, 1942, p. 1)

While these archival documents do not demonstrate a Canada-wide acceptance of hospital birthing by all First Nations, a substantive transformation of pregnancy and birthing practices is illustrated.

Miss Wilson, a federally employed nurse, provided an account of a mid 20th century First Nations community in Saskatchewan. Upon finding a woman in labour in the community, a girl ran to get the nurse, saying that the woman "should have gone to the hospital to have her baby, but had no car" (Rath, 1958). Miss Wilson's report demonstrates that hospital birthing was viewed as *the* location of birth by the mid 20th century and that even children were aware of this policy standard. The federal government's policy goals to inextricably alter First Nations precontact pregnancy and birthing practices and locations were thus instilled in future generations. These examples demonstrate the effectiveness of coercion to achieve the policy goal of physician-attended hospital birth.

Concerns for the production of "potentially useful citizens" (Rath, 1958, p. 1) provided Canada with

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

Under the umbrella of public health, federally employed nurses were expected to teach maternal and child health education, which included parenting classes, to First Nations women and families in the mid-1950s (Anonymous, c. 1955; Willie, c. 1955). To teach First Nations women how to care for their infants and children in ways that reflected Euro-Canadian notions of public health, nurses were advised they "must use persuasive teaching methods" (Raynor, c. 1955, p. 3) in the home and in hospital. The close interaction between nurses and First Nations through home visits was highlighted as a technique through which to "establish a personal basis of trust and friendship with many individuals which is impossible for other health workers" (Willie, c. 1955, p. 2). The goal of such relationship-building was to ingrain Euro-Canadian notions of health and health care into the lives of First Nations, to ensure individual and community "cooperation is forthcoming" (Willie, c. 1955, p. 2), and "to debunk old wives' tales" (Willie, c. 1955, p. 3).

In the late 1960s, the Canadian government cited maternal and child health as the "top priority" for those providing care to First Nations communities, a shift from previous efforts, which had focused primarily on the eradication of tuberculosis (Rath, 1967, p. 5). Through public health education campaigns, federal nurse midwives sought to persuade First Nations women to give birth using their services. However, the federal government's restric-

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

A few years later, the Canadian government was charged with assisting First Nations' access to "hospitals, nursing stations and health care facilities" (Black 1972, p. 4). This was to be accomplished, in part, by ensuring that all pregnant women were "delivered in hospital or nursing station" (Black 1972, p. 6). Increased access to hospitals and nursing stations meant a further departure from First Nations' birthing practices, locations, and practitioners, and increased exposure to the Euro-Canadian biomedical model of hospital birthing and public health education, delivered by federally employed nurses, nurse midwives, and physicians.

The archival findings demonstrate the ways in which hospital birthing, physician attended births, and public health campaigns were used to coerce First Nations women to relinquish knowledges, practices, and practitioners during pregnancy and birth. Federal officials threatened First Nations with fictitious laws that placed physician advice in the category of legislation. Evacuation, as a federal policy, successfully influenced and controlled the decisions of First Nations, a policy's ideal outcome (Cohen and Chehimi, 2007; Goodin et al., 2006; Pencheon et al., 2006; Ritzer, 1988; Wilson, 2006).

## DISCUSSION

The introduction of the Euro-Canadian biomedical model approach to First Nations' pregnancy and childbirth undermined, marginalized, and made irrelevant the First Nations' knowledges, practices, and practitioners that sustained their existence for hundreds of years. The federal government successfully shifted from a policy that supported home and



community birthing to the current blanket evacuation of all pregnant First Nations women for birthing in hospital. Canada's existing evacuation policy for pregnant First Nations women living in rural and remote locations is the realization of the federal government's intentions to alter First Nations' practices in pregnancy and labour.

Through the appropriation and relocation of First Nations' pregnancy and birthing practices, the Canadian government infiltrated First Nations' ways of knowing and wellbeing and replaced them with a knowledge base grounded in the Euro-Canadian biomedical model, thus promoting colonial goals of civilization and assimilation for First Nations people. The origins of the evacuation policy demonstrate the devastating effect that a Canadian policy can have on First Nations' knowledges and practices.

Archival documents point to the federal government's intentional involvement in and interference with First Nations pregnancy and birthing practices as early as 1892. The hiring of Dr. Mitchell to provide obstetrical services to the Chippewas and Muncey First Nations in 1896 is the earliest archival evidence of direct provision of care. Existing literature cites the late 1960s (Douglas, 2006) as the time during which the federal government introduced the evacuation policy. Our research, however, documents the beginnings of federal policy development related to First Nations' pregnancy, labour, and birth practices almost seventy years earlier. This timeline coincides with a period of overtly aggressive and violent colonial acts aimed at First Nations to forcibly impose Euro-Canadian ideals. Canada's evacuation policy stems less from seemingly benevolent public health policies, and more from much earlier times and colonial efforts that were propelled by marginalization and coercion.

The strategic use of Euro-Canadian public health also disrupted the knowledge transfer between First Nations women, Elders, and midwives by relegating their knowledge to the derogatory category of "old wives' tales." Hospital birth isolated First Nations women from their families and communities, which allowed nurses and physicians to provide further instruction on the tenets of the Euro-Canadian biomedical model. These coercive tactics marginalized

knowledge bases and relationships that had previously ensured community members' health and wellbeing. Public health, while celebrated for improving the lives of many, relegated First Nations' knowledges, especially women's, to the periphery.

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

The development of the evacuation policy made women a vessel through which the federal government could pursue its goals of making First Nations civilized and assimilated by advancing the "savage" through federal health policy. The federal government's evacuation policy remains a core component to the obstetrical services offered by federally funded nursing staff, a testament to the ongoing colonial project directed towards First Nations.

## CONCLUSIONS

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

texts of the federal government's current blanket evacuation policy for pregnant First Nations women who live on rural and remote reserves is important to understand. It is clear that the evacuation policy must be re-evaluated by First Nations peoples themselves to determine if it supports the goals of First Nations women, families, communities, and governments. If it does not, we argue that political energy should then be directed towards influencing changes to this policy so that it meets its main stakeholders' needs.

We acknowledge that evacuating some women in pregnancy to give birth in urban locations will no doubt continue and be appropriate in some instances. For example, some women may require a higher level of health care services due to pregnancy complications and/or concurrent medical illnesses, or a woman may request evacuation for personal reasons. Evacuating First Nations women to (usually) southern locations to receive perinatal care services, however, has not resulted in First Nations infant health "catching up" to non-Aboriginal infants' health outcomes. For example, the First Nations infant mortality rate is still twice as high as the Canadian average (Health Canada, 2011; Luo et al., 2004; McShane et al., 2009; Smylie et al., 2010) and preterm birth rates for First Nations living in the province of British Columbia are 40–70 % higher than non-First Nations (McShane et al., 2009).

Framing evacuation as a guarantee of improved First Nations maternal and infant health is thus problematic. As First Nations continue to fight for self-governance and self-determination, some may choose to determine if alternatives, like home and community birthing and First Nations midwifery, should be used in place of the evacuation policy. Self-governance and self-determination play important roles in improving First Nations' health outcomes (Lavoie et al., 2010). Since First Nations women, children, and communities continue to experience poor health, re-examining the evacuation policy might play a crucial role in improving First Nations' health.

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