Prenatal Evacuation: Addressing the Birth Customs and Perinatal Care Needs of Indigenous Women in Northern Canada

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Abstract

Expectant Indigenous women in northern and remote communities across Canada are often subject to forced prenatal evacuation to give birth in urban health centers. The historical background of Health Canada's prenatal evacuation policy is lined with elements of colonial practices as traditional birth practices and customs diminished under its implementation. Using the medicine wheel as a framework to review the physical, mental, emotional, and spiritual health impacts of prenatal evacuation on childbearing Indigenous women, it is evident they suffer from adverse birth outcomes, mental health issues, emotional distress, and cultural degeneration in part due to Health Canada's prenatal evacuation policy. Federal reports, including the *Mental Health Strategy of Canada, 2012* from the Mental Health Commission of Canada, and the *Truth and Reconciliation Commission of Canada (TRC),* 2015's *Calls to Action* neglect to address health issues experienced by Indigenous childbearing women, leaving healthcare providers ill-equipped to address concerns specific to this population. By expanding on the *Calls to Action* from the TRC with current research, the healthcare provider's role in providing culturally safe care to Northern childbearing women is in advocating for change within the Health Canada policy to allow for culturally safe care through the integration of education, social support systems, and Indigenous advanced practice healthcare professionals.

Keywords: prenatal evacuation, Indigenous health, birth customs, cultural competence, cultural humility, and cultural safety.

Giving birth is a life-changing event. In Indigenous communities in Canada, intergenerational customs and traditions are essential to connecting the new child and its mother to their physical and spiritual community (National Aboriginal Council of Midwives [NACM], 2016). The Society of Obstetricians and Gynecologists of Canada (SOGC) asserts children born into their community are better connected to their cultural identity, heritage, and community (SOGC, 2017). They also emphasize community birth as a means to provide traditional practices to improve perinatal women's health and wellbeing (SOGC, 2017). However, these customs are stripped from Indigenous women and their families through Health Canada's prenatal evacuation policy (Lawford et al., 2018). Current Health Canada policy forces expectant Northern Indigenous women to medically evacuate from their communities and support systems to give birth in urban centers (Currado, 2017; Indigenous Health Canada [IHC], 2019). Prenatal evacuation has physical, mental, emotional, and spiritual repercussions that are infrequently addressed in literature. Using the medicine wheel as a framework, the health consequences of Health Canada's prenatal evacuation policy for Northern Indigenous women will be described, while reflecting upon recent federal government reports including the *Mental Health Strategy of Canada* (Mental Health Commission of Canada [MHCC], 2012), and the *Truth and Reconciliation Commission of Canada's* (TRC, 2015) *Calls to Action.* Adherence to cultural competence, humility, and safety, will help clarify the health provider's role in bringing cultural practices back to Indigenous birth.

Definitions and Key Concepts

Prenatal evacuation, Indigenous women, and traditional and biomedical ways of knowing, are central terms and concepts within this paper. For the purpose of this paper, governmental and scholarly publications will be used to define and clarify these concepts.

Indigenous Women

Although the legal term from Canada's Constitution Act in 1982 is 'Aboriginal', the term 'Indigenous' is increasingly finding social and legal acceptance in Canada. The federal government has now moved to embrace Indigenous and all of its legal ramifications, since endorsing the *United Nations Declaration of the Rights of Indigenous Peoples* in 2010 (Indigenous Corporate Training [ICT], 2014; 2016).

Section 35 (2) of the Constitution Act, in 1982 states: *"Aboriginal peoples of Canada" includes the Indian, Inuit and Métis peoples of Canada* (ICT, 2016; Indigenous Services Canada [ISC], 2020). Indigenous women make up four percent of the Canadian population with 718,500 people and have the highest birth rate in the country (Arriagada, 2016; Richmond & Cook, 2016). Approximately half of Indigenous women live in remote communities (Organization for Economic Cooperation and Development [OECD], 2020). Indigenous mothers are younger than non-Indigenous women and are less likely to be educated or to be married (Sheppard et al., 2017). Despite their high birth rate, the SOGC (2017) admits access to appropriate care is a significant determinant of health that poorly impacts the well-being of Indigenous women and their children in comparison to the non-Indigenous population.

Traditional and Biomedical Ways of Knowing

Traditional Indigenous ways of knowing provides a holistic approach to understanding health and illness. Intergenerational teachings on traditional and spiritual health knowledge and beliefs focus on achieving balance between one's physical, emotional, mental, and spiritual self (George et al., 2018). The medicine wheel is an example of a traditional holistic view of health which demonstrates the need for balance between all aspects of self: physical, mental, emotional, and spiritual (Morcom & Freeman, 2018). Health can only be understood by examining all parts of the medicine wheel as no part can be understood without the other (Gesink et al., 2019). The aspects of self are further impacted by an individual's interconnection with his or her community and environment (Morcom & Freeman, 2018). Lessons from the medicine wheel can cross many populations, cultures, and belief systems. The medicine wheel's ability to be adapted to suit the world view of the user or community while also being relatable to people of different cultures, ages, genders, and life experiences makes it an exceptional tool to symbolize health and healing.

Contemporary medicine relies on biomedical ways of knowing primarily focusing on physical health and quantitative scientific data to address health and illness (Douglas, 2013). Although contemporary medical models are founded in principles of biomedical ways of knowing, newer medical models are emerging to include holistic approaches to health and healing (Agarwal, 2018; Wrona-Polanska, 2016). However, Katz and colleagues (2017) express the biomedical model used in Canadian healthcare excludes Indigenous ways of knowing and is insufficient to care for the holistic needs of Indigenous women. Contemporary approaches in the care of Indigenous peoples need to be grounded in Indigenous culture and values to address the holistic needs of their population (Katz et al., 2017).

Prenatal Evacuation

Prenatal evacuation is a form of medical evacuation in which Indigenous women from northern or remote communities are transported to urban centers to give birth (SOGC, 2017). Evacuation occurs when the pregnancy reaches 37-38 weeks gestation, or sooner if the expectant women has a high-risk pregnancy (SOGC, 2017). The expectant mother is often transported without a support person and is placed in temporary accommodations until labor ensues or medical induction is warranted (Lawford et al., 2018). Escorts are only federally funded if the expectant mother is a juvenile or if there is a medical complication requiring the transport (IHC, 2019; O'Driscoll et al., 2011).

Prevalence Rates

There is little documentation of the frequency of prenatal evacuation in Canada from federal or provincial governmental sources. The Non-Insured Health Benefits program (NIHB), which funds the prenatal evacuation of Northern Indigenous women, does not differentiate between prenatal and non-prenatal transportation (ISC, 2017). However, they report one third of their budget, roughly $417.0 million, is used for medical transportation and living expenses following transportation (ISC, 2017).

History of Prenatal Evacuation Policy

Historically, the holistic needs of Indigenous childbearing women were provided by traditional Indigenous midwives in their communities (Currado, 2017). The midwives learned the art of birthing through experience and intergenerational teaching, and were instrumental in

performing traditional birth ceremonies (Bowen & Pratt, 2018; Currado, 2017). Following colonization, in the 1890s the biomedical model of care emerged as the primary source of obstetrical knowledge and Indigenous birth practices were deemed as superstitious and useless (Douglas, 2013; Lawford et al., 2018). As a result, the role of Indigenous midwifery and traditional birth practices were eradicated and "women's bodies thus became a site upon which colonial goals of civilization and assimilation could be realized" (Lawford & Giles, 2012, p. 332).

In the 1970s in an attempt to lower the maternal mortality rate attributed to inaccessibility to healthcare providers, Health Canada deemed births in remote communities unsafe (SOGC, 2017). Due to this ruling and the centralization of obstetrical care, the creation of Health Canada's prenatal evacuation policy formalized the practice of forcing Indigenous women to deny their cultural birth traditions and give birth outside of their communities (Lawford et al., 2018; SOGC, 2017). Some scholars describe prenatal evacuation as a colonial practice used to assimilate Indigenous women and their children through the removal of traditional birth practices in Indigenous communities (Lawford & Giles, 2012; O'Driscoll et al., 2011). Prenatal evacuation is now integrated and accepted into the routine perinatal care of Northern Indigenous women while the physical, mental, emotional, and spiritual toll on their health remain concealed within the biomedical model of care (Lawford et al., 2018).

Current Literature

Literature on prenatal evacuation can be viewed through a holistic lens using the medicine wheel. When used as a framework to review current literature, the medicine wheel reveals the mostly negative extensive impacts of prenatal evacuation on Indigenous women's health and well-being.

Physical Health

To attain physical perinatal health, many studies identify accessibility to healthcare as a determinant of health. With greater disparity in rural locations, Indigenous populations have double the infant mortality rate than that of non-Indigenous populations (Gilbert et al., 2015; Luo et al., 2010). This is in part linked to the travel required for women to give birth (Grzybowski et al., 2011; Riddell et al., 2016). Riddell and colleagues (2016) identified two contributing factors to the elevated rate of adverse birth outcomes of First Nation's mothers when compared to non-First Nations women in British Columbia. First, the lack of access to prenatal care in First Nations women's home communities, and second, the travel required to attain prenatal care both contributed to First Nations women's increased rate of adverse birth outcomes (Riddell et al., 2016). Unaddressed health conditions impacting elevated adverse birth outcomes rate, such as preeclampsia, intrauterine growth restriction, and congenital anomalies, are missed due to the infrequency of prenatal care assessments and early ultrasounds (Riddell et al., 2016). Reeve et al's (2016) research complements this assertion as they found when midwives provided prenatal care in Indigenous communities, there was a significant increase in the number of prenatal visits, ultrasound screenings, and cigarette smoking screenings than by those who were required to travel to receive care.

Emotional Health

Prenatal evacuation elicits stress and anxiety in pregnant Indigenous mothers. Indigenous women identify the forced separation from family and social support during birth as the most significant stressor associated with prenatal evacuation (Chamberlain & Barclay, 2000; Currado, 2018; Lawford et al., 2018). Pregnant mothers describe substantial feelings of worry and distress when their children are left in their home community with caregivers for an unknown amount of time (O'Driscoll et al., 2011). Indigenous women also describe loneliness and disconnection from their family and community as dominant emotions felt during the evacuation, birth, and postpartum periods (Lawford et al., 2018; O'Driscoll et al., 2011). Although healthcare providers attempt to fill the void of absent social support, Gruber and colleagues (2013) report due to the extensive breadth of duties required of obstetrical nursing staff, their time spent providing direct labor support is minimal at best. Continuous labor support from support people improves APGAR scores, shortens labors, and improves birth outcomes (Bohren et al., 2017; Heslehurst et al., 2018; NACM, 2016). Therefore, the inability for Indigenous women to give birth in their home communities, along with the lack of funding for the transportation of support persons in Health Canada's prenatal evacuation policy, may directly impact the mental health of Indigenous women and indirectly contribute to poor birth outcomes.

Mental Health

Alongside the emotional distress, research shows a link between maternal mental health concerns and prenatal evacuation. The NACM (2016) states mood disorders and postpartum depression can occur as a result of lack of social support and culturally safe care in pregnancy and birth. Several studies reveal the feeling of isolation due to lack of social support during the evacuation and birth process as a contributing factor to postpartum depression in Indigenous mothers (Kornelsen et al., 2010; Lawford et al., 2018; Varcoe et al., 2013).

Another consequence of forced evacuation is the loss of agency. For several decades, Indigenous women were forced to assimilate and adhere to prenatal evacuation as a result of the Health Canada evacuation policy (Currado, 2017; Lawford et al., 2018). The loss of choice of where to give birth has given way to a culture of normality and resignation where forced evacuation is the expectation for pregnant Northern mothers. Those who resist the evacuation policy and wish to give birth in their community must overcome several barriers to gain permission from their chief and council (Lawford et al., 2018). This again contributes to the loss of agency as Indigenous women in Canada continuously require permission from local or federal governments to choose their birth location. Further research is needed to fully understand the extent and cause of loss of agency experienced by Indigenous peoples and communities.

Spiritual Health

The removal of birth from Indigenous communities contributes to the demise of cultural and spiritual birth traditions and customs (Lawford et al., 2018; NACM, 2016; O'Driscoll et al., 2011). Varcoe and colleagues (2013) found there are few remaining Elders who can recollect traditional birthing customs in several First Nations communities in British Columbia. The loss of intergenerational teaching directly impacts the transmission of spiritual and cultural knowledge to younger Indigenous generations (Varcoe et al., 2013; Wiebe et al., 2015). Indigenous women in Shahram (2017) and team's research linked their lack of cultural

connections early in life to their substance abuse, feelings of lack of belonging, and absence of cultural identity. These women mourn as cultural traditions and customs were not part of their lives as children and young adults (Shahram et al., 2017). With cultural practices removed at birth via prenatal evacuations, the resulting spiritual and cultural loss may create a cultural gap for all future generations of Indigenous peoples.

Governmental Reports and the Role of the Healthcare Provider

While many physical, emotional, mental, and spiritual consequences of prenatal evacuation exist for Indigenous women, healthcare providers should be provided with federal reports and resources which focus on the health concerns specific to Indigenous childbearing women. However, few of these reports exist today. The *Mental Health Strategy of Canada* (MHCC, 2012), and the TRC's (2015) *Calls to Action* are two examples of influential federal reports which do not include explicit key components of Indigenous childbearing women's health in Canada.

The Mental Health Strategy of Canada (MHCC, 2012)

The *Mental Health Strategy of Canada* (MHCC, 2012) lists strategic directions in which to address mental health concerns in Canada. Two of these strategies include to:

> 4. Reduce disparities in risk factors and access to mental health services, and strengthen the response to the needs of diverse communities and Northerners.
> 5. Work with First Nations, Inuit, and Métis to address their mental health needs, acknowledging their distinct circumstances, rights and cultures (MHCC, 2012, p. 11).

While these strategies appear to broadly focus on improving the accessibility of mental healthcare resources to Indigenous peoples living in northern and remote communities, there is little mention of maternal mental health (MHCC, 2012). When nearly a quarter of women in Canada report experiencing postpartum depression, with a significantly higher prevalence in Indigenous women than non-Indigenous women, the MHCC fails to explicitly address a significant aspect of Indigenous women's health concerns (Nelson et al., 2018; Statistics Canada, 2019). If the MHCC does not prioritize, or even recognize maternal mental health as a growing problem amongst Northern Indigenous women, then healthcare providers will be ill-equipped to care for this vulnerable population.

The Truth and Reconciliation Commission of Canada (2015) Calls to Action

The TRC's (2015) *Calls to Action* is yet another federal report which does not address issues specific to Indigenous childbearing women in Canada. Following the damaging impact of the residential school system on Indigenous peoples in Canada, the TRC (2015) outlined 94 key calls to action to bridge the socioeconomic and health inequities between Indigenous and non-Indigenous populations and to promote the healing and well-being of Indigenous peoples. The role of healthcare providers is an integral part of the mission to support the healing and reconciliation process between Indigenous and non-Indigenous peoples. In disregarding Indigenous women's issues in this prominent federal report, healthcare providers are required to navigate the TRC's (2015) recommendations in conjunction with multiple other resources and research to gain a greater depth of understanding of the current and historical factors impacting

Indigenous women's health and to recognize the relationship between past oppressive events with today's prenatal evacuation policy.

Recommendations

While this document does not address specific recommendations to address Indigenous women's health concerns, healthcare providers can look to three of the TRC's (2015) recommended calls to action to begin navigating the negative impacts of the prenatal evacuation policy:

> 19. We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services (p. 2).
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> 22. We call upon those who can effect change within the Canadian health-care system to recognize the value of Aboriginal healing practices and use them in the treatment of Aboriginal patients in collaboration with Aboriginal healers and Elders where requested by Aboriginal patients (p. 3).
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> 23 (iii). We call upon all levels of government to increase the number of Aboriginal professionals working in the health-care field…and provide cultural competency training for all healthcare professionals (p. 3).

The three *Calls to Action* from the TRC (2015) call for greater accessibility to healthcare services, the incorporation of Indigenous healing practices and practitioners in modern medical models of care, and for a greater number of Indigenous health workers. Earlier major government reports, such as the *Royal Commission of Aboriginal Peoples, 1996* and the *Romanow Report, 2002,* made similar calls to increase Indigenous representation in health professions to build a representative workforce and to address barriers to healthcare service accessibility (Government of Canada, 2011; Health Canada, 2009). While there are some improvements in workplace representation and healthcare accessibility, as evidenced by the inclusion of designated seats in professional healthcare colleges and opportunities for advanced education specializing in rural and remote healthcare provision, there remains consistent gaps in care for expectant Indigenous women (Government of Saskatchewan, 2019; University of Saskatchewan, n.d.). To address the TRC's actions in relation to prenatal evacuation, each individual Indigenous northern community should be assessed as to the needs and outcomes of that community as to whether the government policy of prenatal evacuation should be implemented. For example, infant mortality needs to be weighed against maternal mental health. For some women, the stress of giving birth away from home may not be in the best interest of the mother in terms of their emotional health. Healthcare providers must incorporate cultural safety into their daily practice, and advocate for funding for social support persons to be transported with expectant Indigenous mothers. Finally, health care providers should call on the federal government to allow Indigenous midwives, trained in both modern obstetrical practices and

traditional cultural birth customs, to be present with Indigenous mothers before, during, and after childbirth in rural, remote, and urban communities in which they give birth.

Cultural Competence, Humility, and Safety. The TRC's (2015) calls to action can be demonstrated through the integration of cultural birth practices in urban, rural, and remote healthcare settings. Roy (2014) suggests the knowledge and integration of traditional healing practices with the current medical best practice guidelines allows for patients to connect with their Indigenous identity and to promote healing through holistic practices. To accomplish this, healthcare providers must demonstrate cultural humility by reflecting on and critiquing their own cultural biases, seeking education on the provision of culturally competent care, and working alongside those who are knowledgeable in Indigenous birth practices and customs (Bowen & Pratt, 2018; Greene-Moton & Minkler, 2020). Whether the expectant mother receives prenatal care in her community or evacuates to an urban center to give birth, healthcare providers must seek to provide culturally safe care. Culturally safe care occurs when healthcare providers acknowledge the power discrepancy between the provider and the patient while also addressing the sociocultural factors that impact the patient's health outcomes (Roy, 2014). Bowen and Pratt (2018) state when the healthcare provider understands the traditional birthing practices and ceremonies of the mother, they are promoting culturally safe birth.

Social Support Systems. Healthcare providers should also consider the participation of the childbearing women's social support system as an essential part of integrating traditional and medical healing practices. Social support significantly impacts birth outcomes as well as the mental, emotional, and spiritual health of the childbearing mother (Gruber et al., 2013; Heslehurst et al., 2018; O'Driscoll et al., 2011). As the current healthcare system does not allow time or resources for healthcare providers to provide the necessary birth support required for expectant women, social support systems are vital to the birth process and the transmission of cultural birth practices (Gruber et al., 2013). It is imperative that healthcare providers advocate for policy change which would see funding for social support persons to be present during prenatal evacuation and in local birthing venues.

Indigenous Midwifery. Bringing birth back to Indigenous communities through medically-trained Indigenous midwives knowledgeable in traditional birth customs can drastically address the cultural and health gap elicited by forced prenatal evacuation while also approaching concerns of accessibility to healthcare services (NACM, 2016; World Health Organization, 2020). Indigenous midwifery in remote and northern communities can provide better continuity of care, improve access to antenatal assessments, and promote traditional birth customs and traditions (NACM, 2016). As the continuity of care improves through a culturally competent healthcare provider in remote communities, urban healthcare teams can access their knowledge and expertise when prenatal evacuation is warranted.

Success stories are evident across Canada. Le Centre de Sante Inuukitsivik (2019) has been providing Indigenous midwifery care to the Inuit population of Nunavut since 1986. Onkwehonwe Midwives in northern Ontario participate in upwards of 75% of births in Indigenous communities which drastically reduces the number of women requiring prenatal evacuation (NACM, 2016). Looking to the west, the Seabird Island Band in British Columbia

fund an Indigenous midwife to provide not only birthing support, but also perinatal education, prenatal and postnatal assessments, and drug and alcohol treatment programs (NACM, 2016). The NACM (2016) list the lack of federal funding as the greatest barrier to the use of Indigenous midwifery in remote communities in Canada. They urge healthcare providers and their professional associations to rally with Indigenous communities to advocate for the training of Indigenous women to become midwives and for Indigenous midwifery and traditional birth practices to return to Indigenous communities (NACM, 2016).

Future Considerations

Further research is essential to fully understand the health impacts and cultural consequences of prenatal evacuation on childbearing Indigenous women and to affect positive policy change. Research should focus on Indigenous communities providing perinatal care through midwifery and advanced practice healthcare providers to comprehend how this approach addresses the health inequities experienced by Indigenous peoples. Quantitative data will reveal how an integrated and culturally safe approach impacts prenatal evacuation rates and adverse birth outcomes. Qualitative studies are needed to fully elucidate and address the mental, emotional, and spiritual impact of prenatal evacuation on Indigenous childbearing women. Finally, further studies are required to understand Indigenous women's perspectives on prenatal evacuation and its integration into the norm of healthcare provision in northern and remote communities in Canada.

Conclusion

While healthcare providers reflect upon and respond to federal reports, like the TRC's (2015) *Call to Action* and the MHCC's (2012) *Mental Health Strategic of Canada*, there remains a need to highlight and address the cultural and health repercussions of Health Canada's prenatal evacuation policy on Northern Indigenous childbearing women. The TRC calls for healing, but Ellen Blais, an Indigenous midwife policy analyst, testifies "when birth leaves a community, you take away something that brings joy and happiness. When babies are not taken away, the healing begins" (Robinson, 2017). Health Canada's prenatal evacuation policy does not align with the TRC's call to integrate cultural practices and healers back into the care of expectant Northern Indigenous women, nor does it advocate for birth practices to return to Indigenous communities through the use of culturally competent Indigenous healthcare workers. Meanwhile, Indigenous birth practices and customs are being oppressed and lost, damaging the holistic health of Indigenous women and their communities for generations to come. Through the lens of the medicine wheel, it is evident Indigenous women's physical, emotional, mental, and spiritual aspects of self are off-balanced and disrupted because of forced prenatal evacuation. Healthcare providers have a responsibility to work with Indigenous persons to address the perinatal health discrepancies that exist today in Canada.

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