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RESEARCH

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Indigenous Peoples' responses to evacuation for birth in Ontario: conceptualizing risk through an Indigenous midwifery-led approach

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Abstract

Background Currently, pregnant Indigenous Peoples living in remote, rural, and northern Indigenous communities in Canada are subjected to evacuation birth policy, whereby they are evacuated out of their community to large, urban hospitals to give birth. Evacuation for birth is assumed to decrease biomedical risk because people are birthing in hospitals. In Canadian health systems, evaluating and mitigating biomedical risk has become a standard in health decision-making but this framework disregards Indigenous ontologies and epistemologies that guide Indigenous people in their evaluation of health risk. In this study, we sought to understand how pregnant Indigenous people in Ontario conceptualise health and risk.

Methods We collected data through semi-structured interviews with 43 participants who have been evacuated for birth or are kin of an evacuee who live in Ontario, Canada.

Results Risks associated with evacuation for birth were conceptualised by participants in a wholistic manner based on principles of self-determination. Participants identified multiple risks that shaped their overall assessment of health risk when facing evacuation for birth including the risk of being separated from kin, confronting a lack of health services, and experiencing discrimination. As participants spoke about risk, they reimagined perinatal care to mitigate these risks, which requires bringing birth back to Indigenous communities through Indigenous midwifery.

Conclusions We outline actions to limit the practice of evacuation for birth, support the return of birth to Indigenous communities, and expand understandings of risk within policy and clinical practice.

Keywords Self-determination of Risk, Wholistic Risk, Evacuation for Birth, Bringing Birth Home, Indigenous Midwifery, Indigenous Health, Ontario, Canada

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Introduction

In response to the Association of Ontario Midwives [AOM] Indigenous Midwifery Team's final report, *Bring Birth Home! Voices from the Indigenous Midwifery Summit: A Reclamation of Community Birth Through a Northern Indigenous Vision* [1], we explored one of the summit's themes: risk. Summit delegates determined that Indigenous Peoples' understandings and processes of identifying risk related to birth were not the same as what was described by the Euro-Canadian biomedical model [1]. As such, the forced evacuation for birth of pregnant Indigenous Peoples to urban, usually southern hospitals outside of Indigenous communities relied on a Eurocentric assessment of risk. Our research was also driven by the Call for Justice 3.2 from *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls* [2], which requires all governments to fund the return of health services to communities to prevent the relocation of Indigenous women, girls, and 2SLGBTQQIA + peoples out of their communities when accessing healthcare. To bring birth home cultural understandings of birthing and risk in Indigenous communities must be considered in the provision of perinatal care and formation of policy. To better understand the present context of birthing for Indigenous Peoples, specifically within the Province of Ontario and how they understand risk, our study explored the question: How do pregnant Indigenous Peoples in Ontario conceptualize health and risk?

Background

Evacuation for birth and risk

Efforts to bring birth home is a reaction to the Government of Canada's long standing and harmful practice of evacuating pregnant Indigenous Peoples in northern, rural, and remote communities to southern, tertiary hospitals to give birth. In the 1890s, the Government of Canada began to interfere with Indigenous midwifery and Indigenous Peoples' maternity care by employing two strategies: "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" ([3] pp. 327). Coordinated efforts among the federal employees, physicians, nurse-midwives, and nurses to eradicate Indigenous Peoples' maternity care practices and Indigenous midwives were directly linked with national efforts of civilization and assimilation. Federal government officials even cited fictional laws to coerce and threaten Indigenous Peoples into using Canadian, non-Indigenous physicians for all their health care, not just for maternity care. Presently, federally employed nurses working for the First Nations Inuit Health Branch are directed by the Government of Canada's clinical practice guidelines to arrange for transport of pregnant clients at 36–38 weeks of gestation or sooner, a wide-spread blanket policy that has national impacts [4, 5].

It is important to note that the medicalization of childbirth occurred at the same time as substantive nationwide resources were directed into "killing the Indian in the child" [6]. Pregnant Indigenous Peoples were forced to leave their community to access reproductive health services provided by physicians in urban centres to erase customary birthing practices and introduce the Euro-Canadian biomedical model. Evacuation for birth was developed as a policy and practice rooted in colonization and ethnic cleansing because health services provided by the nation-state centre Eurocentric understandings of health at the expense of Indigenous health knowledges [5]. Birthing outside of Indigenous communities stems from an intentional desire to assimilate Indigenous Peoples by *civilizing* them and by forcing them to spend time in Euro-Canadian healthcare spaces [5].

Today, Indigenous midwifery is in a resurgence across Turtle Island (a term used by some Indigenous Peoples to define what we now colonially refer to as North America); however, colonial policies like evacuation for birth prevent Indigenous midwives from working in many northern, rural, and remote Indigenous communities by limiting them from caring for Indigenous pregnant people and their newborns. Evacuation for birth is not just about the care provider, because it also has negative consequences on the pregnant person and their kin. Studies have reported that pregnant Indigenous Peoples who are evacuated for birth and their families experience physical, emotional, and economic stressors due to the enforced separation from community and culture [7–13]. For instance, stress is caused by the additional costs incurred in their absence from home, such as childcare and loss of wage, as well as a lack of wholistic postpartum care like breastfeeding support, social support, and pain relief [7–13]. The return of birth to home and community, including social and emotional support that is available throughout the perinatal period, improves health outcomes for Indigenous Peoples including shortened labour, improved chest feeding rates, greater satisfaction with the birth experience, and a decreased use of analgesics, oxytocin, forceps, and caesarean Sects. [14, 15].

Returning birth home requires a greater understanding of how Indigenous Peoples conceptualize risk. Risk continues to be weaponized as a tool of coercion by the settler-colonial health workforce to remove Indigenous Peoples from their communities for birth because birth, especially birth in community, is deemed as risky by Euro-Canadian biomedical frameworks. Indigenous Peoples, however, have expressed that it is risky to leave

their community for birth for reasons including, but not limited to, being separated from their children who remain at home in someone else's care and experiencing institutional racism in healthcare settings like hospitals [16]. Human trafficking and forced sex work during a person's evacuation for birth via gang activity has also been reported in the literature [16], which certainly constitutes risk. As authors, we recognize the need to travel for healthcare when Indigenous communities are not equipped with the proper resources to address health needs, whether it be for sexual and reproductive care or otherwise, but the blanket application of forced evacuation for birth demonstrates the continued strength and dominance of the Euro-Canadian biomedical model over Indigenous health practices and over Indigenous Peoples. We draw attention to the reality that there is more than one perspective of what constitutes risk. Indigenous Peoples' concepts of risk have not been taken into consideration in the evacuation policy or really any other state sanctioned policy, legislation, or action.

Context of canadian health systems and indigenous health

In Canada, healthcare is funded and delivered provincially and territorial for most citizens, however for status First Nations peoples and Inuit healthcare is funded via Non-Insured Health Benefits (NIHB) by the federal government through Indigenous Services Canada (ISC). The FNIHB oversees primary care delivered in First Nations reserve communities and some Inuit communities. Care outside of FNIHB for status First Nations and Inuit are accessed through provincially/ territorially funding health services and providers. For Métis, funding and access to care looks the same as settler citizens to Canada, whereby healthcare is funded provincially/ territorial. In the province of Ontario, most people who are evacuated for birth are First Nations. Ontario has the largest First Nations population—236,685 peoples—compared to other provinces and territories in Canada [17]. In Ontario, 23 percent of First Nations peoples live on reserves, 78 percent live in northern Ontario, and 1 in 4 of all First Nations communities in Ontario are in remote regions accessible only by air or ice roads in the winter [17].

Evacuations take place due to colonial policies that have upended Indigenous midwifery within First Nations communities in rural, remote, and norther areas, and so, people in these communities must travel for birth because they do not have access to midwives and physicians in their communities, nor infrastructure to support birth. Most reserves have a nursing station funded by the FNIHB; however, the station is not equipped with personnel to support births, and therefore employees of the nursing stations – namely registered nursed and nurse practitioners are directed in their clinical guidelines to evacuation pregnant people for birth at 36–38 weeks' gestation [4]. For non-status First Nations and Métis healthcare is covered through provincial health insurance plans, meaning that this population is unlikely to be evacuated because of FNIHB policy, but if they are living in remote, rural, or northern communities, they will need to travel to a hospital for birth, because of the colonial disruption to Indigenous midwifery and birthing in community.

Objectives

We aimed to: 1) investigate how Indigenous Peoples in Ontario, Canada who are pregnant and were evacuated for birth conceptualize risk and how this informs their navigation of pregnancy, birth, and postpartum period; 2) document the responses and strategies employed by Indigenous Peoples to maintain their spiritual, emotional, physical, and mental health and wellness when evacuated out of their community to give birth; and 3) explore the effects of evacuation for birth and its risks on children, families, and communities during pregnancy and the postpartum period.

Methods

Participants

Our study cohort was drawn from current and former Ontario residents who self-identified as Indigenous (First Nations, Métis, and Inuit) with a focus on those who lived in northern, rural, and remote reserves and communities, and have been evacuated for birth or will be evacuated. Additionally, we included people who have experienced evacuation for birth during the COVID-19 pandemic. We also sought participants who had a partner or a family member who was or will be evacuated for birth prior to and during the pandemic. We encouraged participants of all genders and sexualities to join the cohort to ensure our research reflects Indigenous philosophies of inclusion, kinship, and relationality. Anyone under the age of 15 or those who did not have the capacity to consent were excluded. In total, 43 Indigenous participants were interviewed using a semi-structured interview guide. Participants were interviewed and recorded online via Zoom as well as in person when public health protocols for COVID-19 permitted in person gatherings. Participant enrolment began in March 2022 and ended in November 2022. No participants declined to participate or withdrew from the study.

Participants were recruited through social media, emails, in-person events like Powwows, and snowball sampling. Twitter, Facebook, and Instagram were used as social media platforms to circulate recruitment posters and information. Recruitment posters were also

circulated via email by the Association of Ontario Midwives (AOM), which is an established network of registered midwives (n = 1012) and Indigenous midwives (n = 65) in the province of Ontario. Midwives were asked to inform clients about the study. Community Health Representatives (CHRs), who are federally employed community members funded by First Nations and Inuit Health Branch, a branch of Indigenous Services Canada, in rural and remote reserves to do community health outreach, were asked to share recruitment information within the community and supported with interviews and translation. Lastly, research team members attended a Powwow in northern Ontario in the Fall of 2022 and circulated recruitment information attendees. Some participants were recruited through referrals by other participants. In total, 43 participants were included who identified as First Nation or Métis. Of the participants, 33 were interviewed who had been evacuated for birth, and 10 were interviewed who were Elders (a respected member of the community, recognized for their knowledge and importance to the community), grandparents, parents, and partners of evacuees as well as Indigenous midwives.

Ethics

Our study was approved by Health Sciences and Affiliated Teaching Hospitals Research Ethics Board (HSREB) at Queen's University. We adhered to the *Tri-council Policy Statement: Ethical Conduct for Research Involving Humans (TCPS) 2, Chapter 9 – Research Involving the First Nations, Inuit and Métis Peoples of Canada* and *The First Nations Principles of OCAP* established by the First Nations Information Governance Centre. In consultation with Indigenous bioethicist, Dr. Lisa Boivin, PhD, it was established that the Indigenous Midwifery Team at the AOM would steward the data throughout the study and five years after the study's completion. By taking this approach, our data storage meets the OCAP requirements for storing data from Indigenous Peoples in community. Following Indigenous sovereignty protocols to ensure each participant owns, controls, and has access to their data, interview transcripts were returned to interviewees for review and to ensure they possessed their own data and controlled which aspects of the data were used in the study. All materials intended for public use were reviewed by study participants prior to dissemination and were revised based on feedback by participants.

Informed consent was obtained through a signed consent form that was accompanied with a letter of information about the project, its funding source, researchers' identities, and data management information. Consent was also obtained verbally at the start of each interview, and participants were reminded they could withdraw at any point without question or a requirement to return honoraria and gifts. Participants were compensated for their time. Evacuees and their kin received $50.00 CAD and a gift. Elders received $500 CAD and a gift. Gifts were prepared by Dr. Karen Lawford, PhD and contained tobacco, beads, fabric, and more. The gift aligns with cultural protocols and was offered to participants to recognize their time and knowledge shared with researchers while providing items to support ceremony and healing, as we know evacuation for birth is often a difficult experience.

Study design

Our research theory is based on *Determinants of Indigenous Peoples' Health* as articulated in the chaptered book edited by Greenwood, de Leeuw, and Lindsay [18]. Our theoretical lens is mirrored in the experience of Indigenous Peoples because of the structured oppression and marginalization embedded in colonial projects, such as healthcare in Canada. Determinants of Indigenous Peoples' health is a multifaceted understanding of social, political, economic, environmental, and cultural notions that shapes the health of Indigenous Peoples and communities. This theory explores the historical and contemporary implications of the ongoing process of colonization on not only the health of Indigenous Peoples, but also the land and water. We approach our research with a wholistic lens, meaning we considered relationality between all relations, such as people, community, land, animals, water, knowledge, and the cosmos [19, 20]. These relations are interdependent, such that the health of one depends on the health of all its relations, therefore these relations cannot be separated [20].

We employ an Indigenous Feminist methodology and as such, do not strive to find definitive or static answers to our research questions. Rather, Indigenous feminist research methodologies are concerned with power relations and provide a research structure to analyse imperialism, colonization, and injustice in health research within a given context [21]. Indigenous feminist methodology centres relationality and kinship, thus recognizing Indigenous ontologies (ways of being) and epistemologies (ways of knowing) [22]. This methodology aligns with our research aims because we intend to uplift the knowledge and experiences of those who have been evacuated for birth as well as knowledge from their kin in order to advocate for policy changes that respect relationality and the kinship of pregnant people with their families, communities, cultures, and land. In addition, Indigenous feminist methodology aligns with the ways data was managed and how informed consent was sought. The research team does not own the data, participants own their own data and have control over the

stories they shared, their desired changes to perinatal care, and how their knowledge is represented to the public. Indigenous feminist methodology also informs how the research team operates. By bringing together Indigenous midwives, an Indigenous bioethicist, and Elders, as well as Indigenous, settler, and arrivant researchers, care providers, students, and health policy makers, we created an Indigenous-led team that prioritised mentorship and relationship building.

To generate data, we used an open-ended, semi-structured interview guide, which included ten questions. Indigenous bioethicist, Lisa Boivin reviewed the interview guide to ensure questions were open-ended and framed in a way that centred Indigenous epistemologies. Questions were created to encourage an in-depth response by participants and to help the interviews to flow conversation-like [23]. Interviewers, Elder Carol Couchie, Carmel Meekis, Charitie Rae, and Julie Kenequanash and Dr. Karen Lawford, PhD, asked additional questions to further the depth of the participants' responses. Interviews flowed like conversations. Participants shared their own or their kin's birth stories and experiences of pregnancy and postpartum and were prompted by interviewers to share their desire for perinatal care within their community.

All audio from interviews were recorded and transcribed using Otter.ai with team members reviewing the transcript and editing the transcript to ensure accuracy. Prior to data analysis, all transcripts were securely sent via email through a password protected document to participants for review. All participants participated in this review process. Participants reviewed the transcript and were able to make changes to the transcript by deleting sections they did not want shared or the anonymisation of the transcripts, like removing their name, names of children, community names, dates, hospital names, etc. Once participants gave us permission to use the transcript, it was securely moved to Dedoose, an encrypted data management software system that has the capacity for data coding. To analyse data, we employed reflexive thematic analysis as defined by Braun and Clarke [24] to centre the researcher's subjectivity and to facilitate deep reflection when engaging with the data. During the open coding process, 420 codes were applied to excerpts from interviews. These codes were then brought together to form overarching themes presented in the results section. Data analysis was led by Sarah Durant, a Mohawk graduate student and researcher from Akwesasne Mohawk Territory as well as Erika Campbell and Melanie Murdock, both white settler researchers. To ensure the generated themes captured the experiences and needs of Indigenous participants, as well as to be transparent throughout the research process, we used member checking throughout the analysis by engaging participants in reviewing our findings. Themes were reviewed by members of the research team and participants to ensure the research team framed results through determinants of Indigenous Peoples' health theory and Indigenous feminist methodology.

Governance Structure

The research project was initiated by Dr. Karen Lawford, an Anishinaabeg midwife from Lac Seul First Nation and Associate Professor at McMaster University, in response to requests from Indigenous midwives for research that examined concepts of risk from the perspective of Indigenous Peoples themselves. Dr. Lawford's research collective, comprised of Indigenous and allied researchers and community members who are dedicated to systemic health reform for Indigenous Peoples, *Returning Care and Health Home (RCHH): An Indigenous Health Commitment*, acted on this request. Using a consensus-based approach to decision making and through iterative discussions, RCHH developed the research project, interview guides, recruitment strategy, and community research engagement.

Specifically, Dr. Lisa Boivin (Deninu Kue First Nation) ensured ethical oversight by reviewing study materials alongside Indigenous ethical standards, such as OCAP®. Interviews were conducted by Dr. Lawford, Elder Couchie, and three Community Health Representatives: Carmel Meekis, Charitie Rae, and Julie Kenequanash. Review of interview transcripts was completed by RCHH student researchers and were then verified by research participants. RCHH team members completed the thematic analysis which was then sent back to research participants for member checking. Dr. Campbell, as the first author, developed the manuscript that was then again shared with all research participants for review and feedback prior to journal submission. At each stage of the research project, RCHH enacted reciprocal, transparent, and engaged research governance with research participants to ensure the research findings and resulting manuscript correctly represented the words and intentions of the research participants.

Results

Indigenous Peoples are diverse and therefore experience pregnancy, labour, postpartum and healthcare differently. While people's experiences of evacuation for birth differs, there are three concepts of risk that were universally shared by the research participants: 1) Self-determination of Risk; 2) Risk of Separation from Kin, 3) Risk due to a Lack of Health Services and 4) Risk of Discrimination. As well participants reimagined the provision of perinatal care, whereby participants remembered birth in

the community, dreamt of kindness and support in care, as well as bringing birth home. Many Indigenous families across Turtle Island experience evacuation for birth. The findings of this study do not account the diversity of experiences with birth evacuation, but rather account for a small group of Indigenous Peoples, comprising of First Nations and Métis, from remote, northern, and rural areas in the Province of Ontario, Canada.

Self-determination of Risk

Conceptualizations of risk are influenced by many factors, meaning risk is subjective and unique to each person. By defining the risk of birthing on reserve or in remote communities through the Euro-biomedical model, conceptualizations of risk fail to recognize other elements Indigenous Peoples consider when making decisions about perinatal care. Risk must be recognized by health systems, policy makers, and care providers as a concept that is self-determined, rather than a concept that is imposed onto patients through the Euro-biomedical model. Participant 22, a mother and Indigenous midwife, explained:

> *In terms of like, free birthing, and things like that, you know, like, there is, like, I feel like you really can't attach, I guess your idea, like, your perception of like, is that safe or unsafe. You know? And for that family who is deciding to do that, or, you know, refuse ultrasounds, you know, all those things, or whatever. They're making an informed choice, and they're making it based on, you know, usually research, it's not just, they're making these decisions blindly, you know, so they're very well researched. And so that, in itself is very, you know, beautiful and empowering that somebody is doing that, and kind of taking on that responsibility, of whatever, you know, risks and, you know, benefits and things that come with that. So I do feel like to say, 'that it's more risky.' You know, it's very, it's very hard in that sense to say, because they may feel that it's more risky, in a non-Indigenous hospital, you know, that they feel more, you know, and I agree with that, like, I think that if they feel more safe, like, among family and community, you know, that's very important, you know, for them to feel, to feel that level of safety. You know? So I don't know that I can dig into all those pieces and things. But you know, I do, I do think that when somebody is making that decision, that they've weighed the pros and cons out for themselves.*

Participant 22 articulated that pregnant Indigenous Peoples and their families determined what is risky for themselves by considering a multitude of factors including safety in Indigenous spaces compared to non-Indigenous spaces like hospitals, research about birth, considerations of their health, and proximity to family and communities during birth. Risk was thoughtfully evaluated through the deliberation of different factors, and then an informed choice was made. Participant 22 also highlighted that informed choice was beautiful and empowering. Since contact, colonizers and the settler colonial government have sought to limit and remove Indigenous Peoples' self-determination, so reclaiming self-determination of risk to make an informed choice about birth and perinatal care is an act of resistance against colonialism for pregnant Indigenous Peoples.

While Participant 22 articulated the importance of self-determination of risk for pregnant people, in practice that does not happen for all pregnant Indigenous Peoples. Other participants were forced to ascribe to the Euro-biomedical model's conceptualization of risk. Participant 14, an Elder and grandmother, explained:

> *Interviewer: If you... What would you think if they were ...if people were deciding to stay here? Some of them like the ones that were low risk or had no problems delivering their baby their first baby. Do you think that that would be too dangerous?*
> *Participant 14: That's probably what the nurses think, why they're sending them out right after the baby's born.*

Participant 14 highlighted how clinical practice guidelines set by FNIHB require nurses to arrange for evacuation prior to birth and immediately after birth if one occurs within the community. Participant 14 demonstrated that Euro-biomedical concepts of risk are dominant in governmental policies and health practices in many communities, and they influence how decisions are made for the location of birth and evacuation for birth. Similarly, Participant 12, who was initially evacuated to Sioux Lookout, and requested to be transferred to Thunder Bay, explained:

> *I felt the doctor was quite upset with my request to go have my baby in Thunder Bay, it was more like mother's instinct, about the baby, at the time of delivery, baby's heart stopped during contraction, seeing the nurses rushed over the bed and grabbing the blanket- rolling me over to other side and back and forth, until heart beat started again, she was born with heart murmur, I was in Thunder Bay for 3 months, I lost a lot of blood, which I had transfusion.*

Participants demonstrated their ability to make assessments of their health and care needs to determine the best option for healthcare.

Some Elder participants remember a time when people birthed in community or on trap lines during the hunting

season with Indigenous midwives, and want to bring birth back in the community:

> *"Interviewer: Would you like it if there was more midwives here to start delivering babies in [community]?*
> *Participant 13, Grandfather): Yeah, I kind of want that. I think, I think they should, they should try to have babies here, see how, how that's gonna be, because they were allowed to deliver babies here before…"*

Language used by Participant 13 demonstrated that pregnant Indigenous Peoples living in remote communities determine risk for themselves, however, because of the federal evacuation for birth policy, they are not *allowed* to birth in the community. This Elder participant remembers a time when pregnant people were allowed to birth in their community. However, various colonial policies were employed to relocate birth away from community, land, and culture through the criminalization of Indigenous midwives and the purposeful assimilation of Indigenous Peoples to Euro-Canadian, Christian ways of life during hospital stays while evacuated for birth [3, 4]. These colonial policies, including the current evacuation for birth policy, positioned pregnancy and birth as a health condition that was highly medicalized, as opposed to an experience rooted in socio-cultural connections. Instead of using epistemologies of the Euro-biomedical model, pregnant Indigenous Peoples and their communities conceptualize risk in a wholistic manner. In other words, risk is evaluated based on a multitude of factors that are not considered within current systems of care provided by the Government of Canada.

The next three themes: Risk of Separation from Kin, Risk due to a Lack of Health Services and Risk of Discrimination explore additional facets of risk related to evacuation for birth that include and go beyond biomedical risk.

Risk of Separation from Kin

Participants identified that evacuation for birth could be risky because often they were separated from their kin. Kin refers to the respectful relations between humans, and between humans and more than humans, like water, land, animals, and the cosmos [20]. Kinship is the relationality between kin. Participants spoke about broad networks of kin who support them and their wellbeing. Participants who had been evacuated for birth identified partners, children, Aunties, siblings, grandparents, Elders, community members, and land as their relations, that is, their kin. Their kin created support networks for them when pregnant, and during birth and the postpartum period.

However, when evacuated for birth, many pregnant people were not physically surrounded by their support networks. NIHB through ISC, participants explained that evacuees can bring one escort, and in some cases under Jordan's Principle or other funding streams, young children and other family members might be able to come to the birth in addition to the escort. Anyone else would need to pay their own way and arrange flights and accommodations to be present for the birth. Multiple participants who were evacuated for birth wished they had more of their support network around them, and family members of people who were evacuated and who were unable to escort them, expressed a desire to be present for the birth. Participant 39, a mother and evacuee, shared their emotions of being away from their sister when evacuated for birth.

> *Participant 39: Me and her cried to each other when I called to come and she said, 'I was so worried about you and the baby.'*
>
> *Interviewer: Yeah.*
> *Participant 39: She's like, 'it's okay. We're okay now.' She video called and I was so happy to see her.*
>
> *Interviewer: Yeah, it's tough in a big town with nobody.*
>
> *Participant 39: It still brings tears to my eyes sometimes.*

Participant 39 was one of many participants that described the emotions of being away from kin. Participant 15, who was evacuated to Sioux Lookout Meno Ya Win Health Centre for birth explained, "that was kind of heartbreaking going to Sioux Lookout because I didn't have no one over there and, and Winnipeg there, I have family over there." For this participant, there was also no choice as to where they were evacuated.

Participants expressed that evacuation for birth was particularly challenging for the birthing person because of isolation and the stress of leaving family, specifically other children behind to give birth. Participant 2, who was evacuated for birth, explained, "It's just leaving my kids is… it was stressful, because I had to leave one of them home. And I was only able to take one of my kids because they go to school now." Some participants who were evacuated for birth reported advocating to FNIHB nurses to be transported to health centres closer to where they have support networks. Or in some cases, like Participant 12, a mother and pregnant person evacuated for birth, they found their own way from where they were transported to another health centre that was closer to their family.

Participant 12: In Sioux Lookout, I wasn't too comfortable there. And then when I explained that to my sister, who happened to live in Thunder Bay at the time, and I told her I said, 'I don't feel comfortable here.' She said 'why' and I said 'I don't know. Something... I'm not quite or I just wasn't so comfortable with the doctor too.' And when I got, I got a ride from Sioux Lookout to Thunder Bay and my sister got me there, they got a ride and to make sure I would go out and walk around, stretch my leg, to get me all my prenatal paperwork and stuff like that. And she set up an appointment I can go to and with the doctor she set up, I can go see. So I had to do all that before I left Sioux Lookout and I was there, I can't remember how long I was out, but I was there two weeks before delivery.

Being close to support networks was a priority for many participants to feel comfortable, supported, and safe giving birth, especially when they had children they had to leave behind. Separation from kin through evacuation for birth was conceptualized as a risk as demonstrated by the actions evacuees and their kin take such as advocating to FNIHB and NIHB to be sent to specific locations, and with their children, or taking direct action to ensure the birthing person was not alone.

In addition, pregnant people were separated from more than human kin. Participants specifically spoke to concerns about being separated from the land and knowledge. Indigenous Peoples have knowledge about medicines, pregnancy, birth, and postpartum. Medicines come from the land and participants commonly referred to them as bush medicine. When people were separated from their communities, they were separated from the land that holds medicine and from the people who knew about the medicine. Participant 29, a mother, and evacuee, explained this connection between people, land, and medicine.

Participant 29: What I usually do is I... I think… to ask the Elders, like for example, my mother-in-law or my husband's dad. They provide always good... provide good answers, what to do. Like, for example, when I had high blood pressure, to tell me what I needed to eat, what to take. Stuff like that...

Interviewer: Do they know medicines?

Participant 29: Yeah, they do.

Interviewer: Like bush medicine?

Participant 29: Yeah, they know it.

Being in community and on land is not only important to have medicines and to be around people who have knowledge about medicines, but provides a connection that makes people stronger and improves people's health.

"Participant 29: I was born on…

Interviewer: Yeah, you were born on the land, right?

Participant 29: Yeah.
Interviewer: Yeah.

Participant 29: It's very unique. How… it's not here, on the reserve.

Interviewer: Yeah.

Participant 29: I was only shown where I was born.

Interviewer: Yeah.

Participant 29: In… in a…

Interviewer: In a tent, right?

Participant 29: In a tent in September.

Interviewer: And I mean, I just asked this of this other lady... but do you feel it made you stronger?

Participant 29: Yeah.
Interviewer: To be... to have that experience? Even though you don't remember it,
Participant 29: Probably. Because um... what um... my aunt told me. It was my aunt that told me.

Interviewer: The story of your birth?

Participant 29: Yeah.

Interviewer: Yeah?
Participant 29: She had told me when... she told me before: 'You're gonna be a strong person, you'll be an outdoors person.' Yeah, told me that... outdoors person.

Interviewer: Yeah.

Participant 29: And I know, I'm always outside.

Interviewer: Well, yeah, you're going hunting tomorrow. It's like…

Participant 29: I know… I'm always um… outside. I'm always working.

Participants also described the importance of being on land for strength beyond pregnancy and birth, but throughout one's life.

During the COVID-19 pandemic, land was very important to Participant 1, a mother and grandmother. They explained:

So yeah, that's what I need to risk, because it's just me following the rules, and not anybody else in the household and I could get sick, you know? And I need to be on the land. I have to do this, yeah. Because I'm [older] now and I can... I need to get out to the bush. I'm Aboriginal and I was raised out there, so that's why I need to do this now.

The *rules* that Participant 1 spoke about are the public health guidelines and restrictions set by the Government of Ontario during the pandemic. Participant 1 explained that she followed the rules, but for her it was still risky being in a populated area, so being on land lessened risks associated with COVID-19. She explained that it was healthy for her to get out to the bush. Being on land and having a connection to kin was important and was seen to promote health and lessen risk. However, for participants who experienced complications that impacted birth, they understood that being on land was risky because of the limited resources and health workforce at FNIHB nursing stations. The impact of lacking health services in Indigenous communities on evaluating health risk will be explored next.

Risk due to a lack of health services

FNIHB nursing stations do not have the capacity to support birth. For example, nursing stations do not have a labour and delivery room nor a surgical suite but have basic equipment and medication used during birth in case of an emergency. FNIHB nursing stations do not staff proper personnel, like midwives, general practitioners, or obstetricians, who within their scopes of practice, can deliver babies. The lack of resources to support labour and birth at FNIHB nursing stations within many First Nations communities in Northern Ontario was conceptualized by some participants to be risky. However, many participants recognized that if there were midwives, birthing in their community would be less risky and was a preferred option for those who were assessed as being low risk.

The current lack of full-spectrum perinatal care within most Indigenous communities in Northern Ontario was conceptualized by participants as a contributing factor to risk. Pregnant people are not just being evacuated for birth, they must travel throughout pregnancy for advanced care, like ultrasounds, or care that is beyond the scope of practice of nurses in Ontario and beyond the care FNIHB nursing stations are equipped to provide. Leaving their communities for healthcare was a common and normalized experience for most participants. Participant 33, mother, and evacuee for birth, explained, "I'm just really used to having to fly out for every little thing that needs something important taken care of, I guess."

Participants recognized that the lack of resources and personnel at FNIHB nursing stations, as well as other health services in their community, makes birthing in the community risky. If there were resources and personnel to support and care for the needs of birthing people, participant preference is to birth in their community.

Interviewer: And if... if there was the opportunity for people not to travel, for those that were low risk, would you think that was a smart idea? Or a crazy idea?

Participant 6: I don't know.

Interviewer: Like, would you worry a lot?

Participant 6: Well…

Interviewer: If they were trained, like your Kookum, or more because they would know modern things.

Participant 6: Yeah. I think I would be comfortable with that. Like, I think that would be really cool and really new. A little bit scary, but yeah. I think that would be more practical because you get more support, and you can have whoever you want.

Participant 6, an evacuee and mother, along with other participants who were evacuated for birth or who had kin evacuated for birth, supported birthing in communities if there were appropriate personnel available, like midwives. Participant 6 had a Kookum (grandmother) who was a midwife in the community. Similarly other participants recalled stories of their Kookums, Aunties, and other community members who were midwives. Indigenous midwives have a long history of providing perinatal care and other forms of care in their community, and based on their training and scope of practice, are well positioned to continue this work. As well, being able to give birth in community was recognized by Participant 6 and others as more supportive because it allowed for more involvement of their kin. However, for younger generations, Participant 6 explained that birthing in the community is a new concept because of colonial interventions that

interfered and then halted the contributions of Indigenous midwives. Participant 6 was not alone in voicing apprehension to birthing in their community. Some concerns were raised about wanting access to full spectrum perinatal care to make birthing safe in the community including personnel with expertise in perinatal care, medications, and equipment, especially if complications arose and if there were concerns with the newborn's health.

Participants, whose births were determined to be high risk by biomedical models of risk, had concerns about giving birth in their community because they may need a caesarean section. FNIHB nursing stations do not have capacity for caesarean sections, which require a surgical suite, a complement of medications and equipment, the ability for blood transfusions and oxygen supply, an obstetrician or a physician trained to perform a Caesarean section, an anaesthesiologist, a surgical nursing team, and post-operative care. The idea that a surgical delivery was an anticipated outcome, instead of a rare event, shows the extent to which pregnancy, labour, and birth have become medicalized. These concerns were highlighted by Participant 34, a mother and evacuee:

> *Participant 34: I would probably worry about [my children]. Like they don't have good, like equipment here and stuff.*
>
> *Interviewer: Like Caesarean section, or something like that?*
>
> *Participant 34: Yeah, because that's how I had all my kids.*

Such normalization of medicalized and surgical birth is noteworthy.

While Western biomedicine aims to decrease Caesarean section rates, this goal is not translated into promoting physiological birth within Indigenous communities for those who are low-risk candidates. In the above exchange, Participant 34 understood that if someone had more than one Caesarean section, the standard of care is to have a repeated operative birth. As expressed by this participant, it was reasonable for her to anticipate another operative birth. Thus, wholistic concepts of risk influenced participants' perceptions of what was risky for them. For participant 34 and others who delivered via Caesarean section, birthing in community was conceptualized as risky compared to participants who delivered through a physiological birth. Thus, the variation in concepts of risk illustrates participants' ability to make decisions about where they want to receive perinatal care and that their understanding of risk is based on a multitude of factors.

An additional factor participants discussed in their conceptualization of risk was environmental factors. For example, Participant 42, a mother and evacuee, explained:

> *The other stuff that we don't control is the weather, right? Yeah, when the baby wants to be here so we gotta wait for the weather. Or else just wait for the baby to be born here. But I'm glad sometimes a doctor is here. So we're okay.*

In Northern Ontario, participants explained that extreme winter storms as well as the environmental consequences of climate change such as forest fires, flooding, and warmer temperatures affecting ice thickness for fly-in communities, made medical evacuation for health emergencies challenging, including for perinatal and newborn complications. Participants shared that the impacts of climate change were increasingly becoming a factor in conceptualizing the risk of evacuation for birth or birthing in communities because they imposed barriers to transportation. Also, the impacts of climate change on transportation can prevent someone from returning to community after they give birth, especially in fly-in communities where planes or helicopters may not be able to land safely, meaning they are away from their kin longer. Weather and climate change collectively influenced concepts of risk because environmental phenomena can limit access to healthcare resources and personnel for pregnant people.

Participants relied on many factors in their conceptualization of risk, especially access to perinatal health services. The current lack of comprehensive, full-spectrum perinatal care in many Northern Indigenous communities was conceptualized by participants as a risk for birthing in community or on reserve. Participants felt that birthing in community would be less risky with access to healthcare providers who can deliver babies and who are accompanied by the necessary resources for low-risk pregnancies. Birthing in the community was a preferred option because pregnant people could remain closer to kin and have more supports throughout pregnancy, delivery, and the postpartum period.

Risk of discrimination

It is deeply upsetting that pregnant Indigenous Peoples evacuated for birth face anti-Indigenous discrimination and racism, and as a result of colonial approaches to birth, they do not receive the care they desire. Multiple participants who were evacuated for birth, and their kin, characterized the behaviour of healthcare providers as harsh, rude, and aggressive, and expressed that they had concerns about birthing at these health centres. Participant 37, a mother and grandmother, explained:

Interviewer: Did you feel like it was more risky for your daughter to go down to Sioux Lookout during the pandemic than it would be if she had maybe stayed here?
Participant 37: Probably yeah, because I don't know. Some of them are rude. And some of them don't really care, let's say for our people.

Participant 37 along with other participants explained that evacuation for birth was risky because of the harmful ways healthcare providers care for evacuees and their kin. Participant 37 went on to explain that:

You have to watch out for some people that…they're kinda of rude 'cause, they don't... like say when they're giving out or when they're taking out your bed and giving you the IVs sometimes they are rough and they don't know it. We had this one, my oldest when she was out [at a hospital to give birth]. She would be really rough on getting the IV and she would stick it in and then if it wouldn't go in she would take it out and stick it in again. It's like holy crap…that I was just crying to them. (...) [The nurse] was so rough. And my daughter had bruises the next day. (...) And then [the nurse] tried coming back in that same, the same nurse. I talked to another nurse in the hallway and I said can we get another nurse... you should see my kid's arm right now. (...) So rough, so rude...to the patients

Participant 37 along with other participants spoke about the advocacy role they took to intervene and to stop rude and rough behaviour from hospital staff. Participants believed that not all non-Indigenous healthcare providers truly care about Indigenous Peoples and their wellbeing.

Due to the mistreatment, they experience in health settings, participants wondered if they receive this kind of treatment because they are Indigenous. Participant 22, a mother and Indigenous midwife, explained:

But I just feel like there's always this question like, and it's not just for me, it's for like, lots of other community members that feel this way. There is this, I guess, this sense of like, if there was an emergency, like, would we be cared for by an ambulance that was like a local or sorry, like an external ambulance that was coming to care for us. So I feel like there's and I've heard it from so many people and myself included, there's always that, like, do I drive my child myself, you know, if there was an emergency, like, even from my own births, you know, like, they've had home births and things, and there's always that question of like, and I've said, you know, like, while in labour, things like that, but I've said, like, don't let me go, don't let them take me in an ambulance, you know, because I just can't, I can't verify and be certain that I would be cared for, you know, and not, not compromise, I guess you could say, like, along the process. And then the same pertains to, like, once at the hospital, like, I've had one too many experiences.

Participant 22 and others experienced a fear of mistreatment on the basis of anti-Indigenous racism and explained how this makes accessing healthcare in non-Indigenous spaces risky.

Discrimination also manifests as a risk in the form of stereotyping, specifically about Indigenous women and mothers, which relies on white supremacist and colonial tropes used to apprehend children by claiming Indigenous mothers were *unfit parents* [25]. Instead of being met with care and compassion, some participants reported being stereotyped for misusing substances during pregnancy or being judged for using substances during pregnancy. Participant 36, a mother and evacuee, explained her experience with pain management during pregnancy, stereotyping, and threatened child apprehension:

I was smoking, but not lots, just to subside the morning sickness, so I can eat. And that's what I did with my first pregnancy. Then, I almost did that with my second one. But then I... but I was already long gone from quitting already. So, I didn't smoke anymore. But my second one was really hard for me because I had ovarian cysts, and I was always in pain all the time. And I think half my pregnancy with that when I was on morphine. And also the morning sickness too with the Gravol. Then, when I had my [child] at [hospital name], that's where they almost apprehended [them] because [my child] was like having the shakes and everything - saying [my child] is withdrawing and because it said in my chart that I was taking morphine for pain. But when they like extracted or something...used the needle and got rid of [the ovarian cysts]. And probably when I was about six months, or could have been five [months gestation], then that's when I didn't take [morphine] anymore. And they still had it in my chart that I was still taking morphine. And I told them I never took it after they took out my cysts as they use the really big needle and ultrasound too.

All too often, pregnant Indigenous Peoples must overcome harmful stereotypes and judgements around Indigeneity, parenthood, and substance use. These stereotypes and judgements make accessing care risky, especially for pregnant Indigenous Peoples who are using substances, like morphine or other opioids. Oftentimes,

care providers did not respect or believe people who use substances during pregnancy and are more likely to contact social services to apprehend their newborns. Risk was increased when pregnant people did not have their full support network to advocate on their behalf or to champion alternatives to apprehension by the colonial child welfare system. Understandably, participants were fearful of the risk of having their children taken away from them even when they followed the rules imposed by healthcare providers.

Reimaging perinatal care

Participants were asked how perinatal care could be reimagined in their community. Many participants dreamed of comprehensive care closer to home, with births taking place in the community led by kinder care providers and more support throughout pregnancy. When participants dreamed about birth in the community, many remembered a time when their Aunties, Kookums, and people who are now Elders in their community delivered babies. This memory of community care directly shaped how participants reimagined perinatal services. By reimagining maternity care in their communities, participants provided recommendations to lessen the risk of evacuation through kind and supportive care, and by bringing birth back to communities.

Remembering birthing in community

There was a collective memory of birth taking place in community, which did not position birth as risky, but as a part of ceremony and kinship. Prior to the enforcement of evacuation for birth, community midwives were trained by their mothers, Aunties, Kookums, and Elders to deliver babies. Participant 28, a mother, Elder, and midwife, delivered babies in her community. She began attending births as a young adolescent and learned how to catch babies from her mother who was a midwife and her father who was a healer. In more recent years, participants shared that if a community member went into labour prior to evacuation, Elder midwives would attend births at nursing stations and deliver the baby. Participant 4, a mother and evacuee, described this process:

> *Participant 4: Sometimes they [Elder midwives] would...if it's [the baby] was born early, yeah. They had their babies here. But the Elders... the Elders used to step up and run to the nursing station and they would help deliver the baby. A lot of the times, the Elders that's how... and it would be. News would spread really fast, and everybody would go and sit around and wait.*
>
> *Interviewer: And they were happy?*
>
> *Participant 4: Yeah. But after that, they were... they... they, most of the times, they're [the mother and baby] always sent out after the birth.*

Indigenous midwives have always existed, however policies like FNIHB's evacuation for birth policy repressed their roles in communities by forcing pregnant people to be transported and give birth with a physician in a hospital. These policies also prevented midwives from passing knowledge from one generation to the next because community members were evacuated for birth, meaning there were no training opportunities in the community.

Indigenous midwives were described by participant 13, a grandfather and Elder, as a profession and a trusted role in the community. Participant 13 drew on his memory of Indigenous midwives from long ago to dream of having births at home and within his community:

> *I also think that it would be nice to have babies in your own home delivered as long as we know that the baby's safe. If we know that there's something that's going to happen there in that delivery, I think [pregnant people] should be looked after by the professionals. But I think…I always think that all the ladies [Indigenous midwives] are professionals and that they have their own ways that they know what to do. I would trust the ladies, even my Aunties or anybody that's old, older to look after that, but I never heard of anybody, anyone had delivered babies right inside their homes. Not lately anyway. Only a long time ago they used to have that. Right?*

Elders remember when birth took place in communities with midwives. Participants who were Elders play an important role in remembering home births and Indigenous midwives as well as dreaming of returning birth back to communities.

As Elders and Elder midwives who remember community birthing age and pass away, the collective memory midwives and community birthing diminishes. Participant 23, an evacuee, and mother, shared that a person in her community is currently training to become an Indigenous midwife and explained the importance of young people pursuing midwifery:

> *Interviewer: Are you happy about [the student midwife] getting her education here?*
> *Participant 23: Yeah. I mean, she'll be the first, the youngest midwife. And plus, we're losing our Elders and nobody could continue on the education tools that we need around.*

Remembering when birth was led by midwives in community was important to participants because it reminded them that birth can be brought home by

passing along the knowledge held by midwives onto the next generation. While several generations have not been born in community due to the Government of Canada's evacuation for birth policy, the resurgence of Indigenous midwifery and community birth is possible through the formation of Indigenous midwifery education programs and the passing down of knowledge by Elders about midwives.

Dreaming of Kindness and Support in Care

Participants wanted comprehensive perinatal care in their communities where providers are kind and supportive of pregnant people. Also, they wanted more frequent check-ups and the possibility for ultrasounds and blood work to take place in the community. Participants felt these services should be in the community so families can attend appointments with the pregnant person. Participant 4, a mother, and evacuee explained the importance for the fathers to be able to attend appointments and explained, "The father is to be involved. The father's to be there. For them to be able to go for the ultrasound and see what their baby looks like, things like that." Comprehensive maternity care must be delivered in communities to reduce the number of pregnant people having to leave the community for appointments throughout pregnancy and for birth.

When accessing perinatal care, participants wanted kindness from their care providers so they could build trusting relationships. Participant 37, a mother, and evacuee, dreamed of:

> *Probably more friendly, more caring [nurses]. Asking the mothers more questions. 'How they feel? Like their body?' Because when you're young and pregnant, they don't really... our parents never really taught us how to talk. To ask questions. They just go, 'oh you, okay, you're pregnant,' then that's like, 'okay, go to the nursing station.'*

In addition to friendly and caring health providers, participants explained that care providers should also provide pregnant people with information, education, and support. Participant 6, a mother, and evacuee, explained:

> *Like people that know how to help during that time and people that... just basically more help, more clarity, more information, more people to trust. Because some people, even though they're like our own people, they're mean and they're just like, yell at people or they don't.... they're not sensitive to teenagers, or they're not sensitive to people, or even like the nurses are not sensitive too...they get offended because the parents, the young teenager... teenage pregnant woman get offended because of the treatment that the nurses are giving. You know? I mean like the stigma of having... but it's not only young people, like it's not only. But yeah, like more help, more information, more sensitive people. Nice nurses, yeah.*

Participants dreamed of care providers who are sensitive, friendly, kind, caring, and trustful and expected care providers to support pregnant people by providing information that is clear and culturally appropriate.

For participants living on reserves equipped with Community Health Representatives (CHRs), they credited these community members with fulfilling many of their dreams. Participant 36 explained the role CHRs play not only in maternity care but healthcare in general:

> *And like I would feel comfortable with [the CHRs] because sometimes, at the nursing station it's... how can I describe it? Sometimes frustrating and [nurses] don't seem like they have enough patience with you. And with [the CHRs], like [they] have a lot of patience and, you know, [they'll] wait until you're comfortable and to open up, or something. And like [they are] very welcoming too. So...and I would feel...feel that getting more service with someone that you know, very... like someone that you know and was usually there for you and your kid would be much better than all these nurses we get. Because sometimes it changes, you get a different nurse. It just gets pretty overwhelming sometimes you have to tell them the same thing from before.*

While CHRs provide support, education, and advocate on behalf of community members, they are not regulated healthcare professionals and cannot deliver healthcare.

Healthcare providers need to actively demonstrate care, kindness, patience, friendliness, and trustworthiness toward their patients when delivering care. Multiple participants echoed concerns raised by Participant 36 about the frequent turnover of FNIHB nursing personnel. Participant 4 explained:

> *It would be nicer if you know, their care is given by somebody from the community who knows them. I would say that instead of having to go through the history. I can't imagine how blindsided the nurse must feel when she comes here. And she's trying to do prenatals and she doesn't know the mother. She doesn't know the history of the family. She doesn't know everything and yet at the same time, can you honestly say that they're being honest with you? So that's one area that would...will be great if it was ever to come here.*

Participants recommended that health services be delivered by trained community members and to end the high turnover of FNIHB nurses in order to promote continuity of carer, continuity of care, and relationship building between providers and community members.

Dreaming of bringing birth home

Participants conceptualized the risk of evacuation for birth wholistically and by considering multiple risk factors, they made informed choices about their healthcare. However, FNHIB's mandatory evacuation birth policy for birth removes choice from where pregnant Indigenous Peoples from northern, rural, remote communities can birth. For participants who had high-risk births, they felt that being evacuated to birth in a hospital was appropriate for them. Contrary, participants who had low-risk births expressed a desire to give birth in their communities with midwives, because the risks of being away from kin could be remedied. As participant 33, a mother and evacuee, explained:

> *Participant 33: That'd be cool to have my family and my kids around when the baby is born. Instead of waiting, like a month or I dunno.*
> *Interviewer: Well, three weeks, yeah?*
> *Participant 33: Sometimes they keep you locked in, like as long as they can, seems like it.*

In the quote above, the use of the words "locked in" and "for as long as [healthcare providers] can" are examples of Canada's aim to assimilate and civilize Indigenous Peoples through Western healthcare services and demonstrates the underlying goal of maintaining Canada's evacuation for birth policy. In fact, evacuation for birth remains a type of traumatic confinement because it forces Indigenous Peoples to be demobilized in a clinical setting and removes them from their community and kin. To return perinatal care to communities, participants identified midwives as key care providers and dream of midwifery being offered at nursing stations or in community birth centres. As participant 42 explained:

> *I would…I would like to have a midwife…a midwife at the nursing station to teach us, our... teach our girls, what they want to be expecting. You know, at the clinic. We had a midwife here before. She was here, maybe about three years on, on and off.*

Bringing birth home to northern, remote, and rural communities through midwifery was a dream shared by many participants, but so was a desire to have access to expanded services throughout pregnancy, like ultrasounds. As participant 35, a mother and evacuee, explained:

> *So if you were able to go... if you were able to go to one place... and there was someone like [CHRs and midwives] that looked after everything for you. Like they were able to order your bloodwork, get your ultrasound, check you out, do your blood pressure.*

Currently, pregnant people must leave their communities for ultrasounds and are evacuated to clinics and hospitals that offer these services. Additionally, some communities require pregnant people to leave for routine blood work and other diagnostic testing, meaning that pregnant people do not just leave their community for birth but also throughout pregnancy. Participants dream of accessing perinatal services in their communities through midwifery. Participants dream of bringing birth home.

Discussion: actions to bring birth home

Indigenous Peoples interviewed in our project have clearly articulated that risk was not only biomedical but was self-determined and wholistic. Risk was conceptualized by pregnant Indigenous Peoples and their kin to include risks associated with being separated from kin to a lack of health services, and to experiencing discrimination and anti-Indigenous racism. These risks are interconnected to colonial process in Canada. The Euro-biomedical model, and more broadly the Canadian settler-colonial state, has denied Indigenous Peoples the right to self-determination [3, 4, 6, 26]. Based on a series of policies introduced in the 1890s and onwards, health systems denied the rights of Indigenous Peoples to determine where, with whom, and how people birth by upholding the evacuation policy [3, 4]. Dismissing and removing Indigenous Peoples' self-determination is a central aspect of colonialism. Countless colonial projects, including but not limited to the Indian Residential School system, the reserve system, Indian Hospitals, and the Sixties Scoop have removed Indigenous Peoples right to self-determination over education, healthcare, language, kinship, land, and governance [3, 4, 6, 25, 26]. Even with systems in place to remove self-determination in healthcare, participants explained that they determine risk for themselves based on their ontologies and epistemologies in relation to the health system and care needs.

Several Elder participants remembered a time when pregnant people were allowed to birth in their community. However, various colonial policies were employed to relocate birth away from community, land, and culture through the criminalization of Indigenous midwives and the purposeful assimilation of Indigenous Peoples to Euro-Canadian, Christian ways of life during hospital stays while evacuated for birth [3–5]. These colonial policies, including the current evacuation for birth policy,

positioned pregnancy and birth as a health condition that was highly medicalized, as opposed to an experience rooted in socio-cultural connections.

In addition, participant shared the racism and discrimination they face when relocated for birth. Other studies examining the experiences of Indigenous Peoples accessing healthcare came to a similar conclusion that Indigenous Peoples strategize around anticipated racism prior to accessing healthcare or avoid care altogether [27–30]. Considering the segregation of healthcare through Indian Hospitals, the forced and coerced sterilization of Indigenous Peoples, and the deaths of Brain Sinclair and Joyce Echaquan resulting from racism in emergency rooms [31, 32], it is unsurprising that racism within the health system impacted participants in this study. While evacuees and their escorts can and have advocated against anti-Indigenous racism, health systems and healthcare professionals must address anti-Indigenous racism to eliminate its risks to the health and wellbeing of Indigenous Peoples, because oppressive systems are embedded in healthcare in Canada.

Instead of strictly using epistemologies of the Euro-biomedical model, pregnant Indigenous Peoples and their communities in this study conceptualized risk in a wholistic manner. In other words, risk is evaluated based on a multitude of factors, including biomedical risk, but also factors, like separation from kin and racism that are not considered within current systems of care. Wholistic risk stems from Wholism, which considers spiritual, emotional, and intellectual processes and experiences [33]. Wholism encompasses an individual and all their relations, which can include relations to family, community, land, cosmos, and knowledge [19, 34–36]. On this basis, wholistic risk considers the spiritual, emotional, intellectual, physical, and relational risks of evacuation for birth. It is critical that pregnant people get to determine for themselves what is risky, because participants demonstrated that risks surrounding of evacuation of birth are far more complex and multifaceted than the biomedical risks that often contribute to medical decision making.

As a result of being separated from kin, facing discrimination, and other risks associated with leaving community for birth, participants reimagined perinatal care by remembering community birth and dreaming of what they want for health and care. Action needs to be taken within federal and provincial health systems to incorporate wholistic and self-determined understandings of risk into policy, programs, and services. Moreover, federal, and provincial systems need to support the return of birth to Indigenous communities through the expansion of Indigenous midwifery. Based on the knowledge shared by participants, the research team developed action items to bring birth home and to prioritize Indigenous concepts of risk in health systems and care.

Firstly, participants emphasized choice in where they birth. Our research points to a needed shift to evacuation for birth policy away from a mandatory practice, as described within FNIHB's *Clinical Practice Guideline for Nurses in Primary Care* to a voluntary, to self-determined, informed choice whereby Indigenous Peoples choose to be transported out of their community for birth. Secondly, in policy guiding healthcare for Indigenous Peoples, it must be considered the multiple elements of risk that shape people's experiences with evacuation for birth; including but not limited to: biomedical risk, risk of separation from kin, risk of discrimination and anti-Indigenous racism, and risk based on the available services. Thirdly, trauma-informed care must be an expectation set in clinical practice guidelines for all care providers with specific attention to supporting pregnant people who have or currently are using substances. Health systems must coordinate care to promote harm reduction for both the pregnant person and newborn by keeping kin together and providing support and services to prevent child apprehension. Additionally, based on participants descriptions that emphasized the importance of Community Health Representatives CHRs, the Government of Canada must continue to support the role of CHRs and build capacity through fiscal support to grow the number of CHRs and their role in the delivery of healthcare and education within the community. Lastly, based on description of anti-Indigenous racism, health systems and organizations must implement processes to prevent anti-Indigenous racism and implement appropriate reporting and response systems to ensure the safety of the pregnant person.

Strengths and limitation of the research

Our research was strengthened by our commitment to community relationships and good data governance. The research team strived to ensure they enacted OCAP principles to respect the knowledge participants shared with the team. Our research took place during the COVID-19 pandemic, which impacted people's experiences with evacuation for birth. The additional risks people evacuated for birth experienced because of the COVID-19 pandemic and public health protocols that limited visitors in hospital settings was explored in-depth in our analysis of interview data and published in an article entitled: *Indigenous Peoples' evaluation of health risks when facing mandatory evacuation for birth during the COVID-19 pandemic: an indigenous feminist analysis* [37]. The knowledge shared by participants was expansive, which unfortunately required that our research be presented in a series of papers as oppose to a singular article.

Conclusion

Risk is a concept that is self-determined and conceptualized wholistically by Indigenous Peoples. Indigenous Peoples emphasized that evacuation for birth is risky because of the risk of being separated from kin including family, community members, land, culture, medicines, and knowledge; risk due to a lack of health services; and the risk of discrimination. These risk factors include and go beyond biomedical conceptualizations of risk. Bringing birth back to all Indigenous communities redresses colonial conceptualizations of risk that are upheld by the Government of Canada's evacuation policy for birth. Indigenous midwives are well positioned to bring birth home and require support across Canadian health systems to carry out their work. We dream with participants in this study that all Indigenous Peoples will have choice over where they birth and have access to comprehensive sexual and reproductive healthcare at home. Thank you to each participant who shared their time, stories, knowledge, and dreams with us. Together we will bring birth home and ensure that Indigenous concepts of risk are centred in healthcare.

Abbreviations

AOM	Association of Ontario Midwives
COVID-19	Coronavirus disease
ISC	Indigenous Services Canada
FNIHB	First Nations and Inuit Health Branch

Acknowledgements

We dedicate this piece in loving remembrance of Carmel Theresa Meekis, White Rock Woman, who was a pillar of strength and kindness for her community, her family, her colleagues, and beyond. Carmel's contributions were indispensable to our work: we share this project to recognize Carmel and continue advancing our shared vision to returning birth home for Indigenous Peoples. We also offer our sincerest thanks to those participated in this study and who shared their knowledges, experiences, and desires with our team.

Authors' contributions

EC: Contributed to project conception, analysis of data, and wrote this article. MM: Contributed to analysis of data and reviewed this article. SD: Contributed to acquisition and analysis of data, and reviewed this article. CC: Contributed to project conception, and acquisition and analysis of data. CM: Contributed acquisition of data. CR: Contributed acquisition of data. JK: Contributed acquisition of data. LB: Contributed to project conception, and acquisition and analysis of data. JB: Contributed to analysis of data and reviewed this article. AEJ: Contributed to analysis of data and reviewed this article. KL: Contributed to project conception, acquisition and analysis of data, and reviewed this article.

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Data availability

No datasets were generated or analysed during the current study.

Declarations

Ethics approval and consent to participate

This study was approved by the General Research Ethics Board at Queen University (Kingston, Ontario, Canada). Project number: 6034362. Informed consent was obtained from all study participants in accordance with the guidelines set be the General Research Ethics Board at Queen University (Kingston, Ontario, Canada) and the Principles of OCAP.

Consent for publication

Not applicable for this publication.

Competing interests

The authors declare no competing interests.

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