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Canada's forced birth travel: towards feminist indigenous reproductive mobilities

Jaime Cidro^a, Rachel Bach^b and Susan Frohlick^c 

^aAnthropology, University of Winnipeg, Winnipeg, MB, Canada; ^bMidwifery Education Program, Ryerson University, Toronto, ON, Canada; ^cAnthropology and Gender Studies, University of British Columbia Okanagan, Kelowna, BC, Canada

ABSTRACT

The mandatory travel for birth experienced by Indigenous women living in rural and remote areas of Canada is examined using an emergent lens of Indigenous reproductive mobilities. Current evacuation practices are contextualized within the historic and ongoing systems of oppression experienced by Indigenous people in Canada. Indigenous feminist and decolonial theoretical approaches are used to outline one way in which Indigenous women counter settler colonialism to assert sovereignty over their birth experiences – through the resurgence of culturally-based doulas or birth workers. A further contribution of these analyses is the inclusion and centering of the voices and experiences of those previously neglected within this particular body of scholarship, shifting the power relations underpinning reproductive mobilities.

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Introduction

Many pregnant women are unrestricted in their mobility to access the type of childbirth care they desire and can afford, yet this is not so for others. Pregnant Indigenous women living in rural and remote reserve communities throughout Canada have little say about the mobilities required of them to be placed under medical care not chosen by them.¹ Known as Health Canada's 'birth evacuation policy,' a complex intersection of federal and provincial jurisdictional policies mandates the evacuation of women from rural and remote communities to give birth in hospitals located in Southern metropolises (Olson and Couchie 2013). While all women living in rural or remote communities who are isolated from health services infrastructures may be required to travel for birth, Indigenous women have been particularly affected (Kornelsen and Gryzbowski 2004) as travelling away from their traditional and ancestral homelands to birth is contrary to traditional birthing practices and ontologies (Lawford and Giles 2012a, 2012b). The regulation and pathologizing of Indigenous women's bodies and reproductive capacities along with the subjugation of traditional midwifery knowledge is a troubling part of the Canadian legal apparatus surrounding childbirth and maternal care policies – one that has critical implications for Indigenousizing reproductive mobilities.

Unlicensed midwifery, including traditional Indigenous midwifery, was outlawed across Canada in the late 1800s. The speed at which birth came under the domain of licensed medical doctors was uneven as certain communities were able to protect midwifery. However, as birth became increasingly medicalized, women were forced to have hospital deliveries by the 1970s, which resulted in the absence of legal birth attendants out-of-hospital. The effect for rural and remote Indigenous women

meant forced travel weeks before their due date, often to cities hundreds of kilometres away from their home communities.

This article examines mandatory birth travel in Canada through an emergent lens of Indigenous reproductive mobilities. Our main contribution is the articulation of a decolonizing and Indigenizing theoretical approach to considering reproductive mobilities in the context of historical colonization, ongoing settler colonialism, white dominance, and national-patriarchy. Broadly, an Indigenous feminist approach to issues related to gender, sexuality, and reproduction aims to re-center women's agency and to critique heteropatriarchal settler colonialism (Simpson 2017, 2014; Tallbear 2016). Indigenous scholar Hunt (2016) states that when talking about decolonization, violence is not our starting point: the starting point is what existed before violent relationships were imposed. Simpson (2011) talks about picking up the things we were forced to leave behind—songs, dance, values, and philosophies—and bringing them back into existence. She clarifies that she is not talking about literally returning to the past, 'but rather re-creating the cultural and political flourishing of the past to support the well-being of contemporary citizens' (Simpson 2011, 50–51). In this sense, decolonization refers to embracing the fluidity around our teachings, rather than sticking to the rigidity of colonialism. Our analysis of the birth evacuation policy and its im/mobilizing effects on Indigenous women in Canada shows both the damaging outcomes of forced travel for medicalized birthing care and the recuperative decolonizing practices by which women counter evacuation as one form of displacement generated by heteropatriarchal settler colonialism. We focus on the deleterious dimension of waiting that inheres in the reproductive travel mandated from home communities to hotels and other 'stranger' spaces in urban centres, as well as the ways in which Indigenous women are asserting sovereignty over their bodies and birthing practices through a resurgence of cultural-based birth workers, commonly known as doulas.

A secondary contribution is a shift in thinking about power relations underpinning reproductive mobilities to render visible the experiences of Indigenous women within a body of scholarship that has largely ignored them. To date, assisted reproductive technologies (ARTs) have tended to be examined within medical mobilities and cross-border care scholarship, which has privileged travel across internationally recognized borders rather than those cultural and/or national borders that exist within settler states (although see Speier this issue). Furthermore, when women of colour or marginalized women have been the focus of such analyses, they appear in the scholarship as providers of reproductive services through the use of their bodies such as surrogate mothers or egg donors, not birth tourists (also see Lozanski this issue). In this respect, Indigenous reproductive mobilities challenge the racialized geographies of reproductive mobilities scholarship.

Jointly written by two Indigenous scholars (Cidro, Bach) along with a settler scholar (Frohlick), we put an Indigenous feminist perspective into dialogue with the critical mobilities scholarship that has begun to engage with decolonizing and Indigenizing interventions. Jaime Cidro, an anthropology professor, and Rachel Bach, a midwife in training and former graduate student of Jaime's, carried out the research. They presented their research at a workshop on reproductive mobilities held in August 2018 at UBC Okanagan, where the three of us met. As a collaborative means to place previously disparate bodies of knowledge in a dialogue with one another, this article brings together Cidro and Bach's expertise in the policies, practices, and politics of birth evacuation and birth worker mobilization and Frohlick's interest in the mobilities framework.

The colonization of birth and mandatory birth travel for indigenous women

Across Canada, settler colonial interference began in the 1800s, negatively affecting Indigenous women's traditional reproductive practices (Jasen 1997; Theobald 2017). Evolutionism influenced racial hierarchies within the realm of reproduction, where 'women of superior breeding' (i.e. settler women) were believed to suffer pain and be less fit for reproduction than 'primitive' women (i.e. Indigenous women), who 'like animals' were believed to 'give birth "without ceremony" or assistance, and resume normal tasks again within hours' (Jasen 1997, 387). By the twentieth century, the

threat of a 'degenerate immigrant, labouring, and aboriginal population' overwhelming settler civilization resulted in new attention placed on the childbearing practices of 'the nation's under-classes' (Jasen 1997, 389–393).

Understanding the systems that influence and control Indigenous women's health requires grounding those systems in the larger historical mandate of the Indian Act, established in 1876. This legislation granted federal government authority over 'Indians and lands reserved for Indians'. The Indian Act bestowed powers to create the reserve system (known today as First Nations communities), an important tool in assimilating First Nations people into Canadian society. Negotiations resulted in the development of numbered treaties. In Treaty Six, a 'medicine chest' clause was incorporated, creating the rationale for the provision of health care services to First Nations people living on reserve (MacIntosh 2008). Early efforts at addressing health disparities in the communities primarily focused on eradicating disease such as tuberculosis and sexually transmitted infections (Lawford and Giles 2012a). Public health interventions and service provision slowly continued and now, unlike non-First Nations populations in Canada who receive health care services through their provincial government, the federal government is responsible for the provision of the majority of health care services to First Nations people living on reserve including health promotion and some services for mental health and chronic disease (Palmer, Tepper, and Nolan 2017). However, this responsibility for provision does not manifest as on-reserve access to medical services. At this point in time, the services provided by provincial governments and the federal government to First Nations communities is best described as a patchwork (Palmer, Tepper, and Nolan 2017). Moreover, many First Nations people have to leave their reserve in order to access secondary or tertiary health care (Lavoie, Forget, and Browne 2010). Indeed, Boyer (2009) argues that health care delivery to First Nations people has long been problematic because of jurisdictional disputes between the federal and provincial governments and the ways in which the corresponding physical, emotional, cultural and financial costs are often born by First Nations governments and people.

Indigenous women's reproduction was subjected to medicalization throughout the mid-twentieth century, wherein a main assimilationist goal was to transform the culture of childbirth. Settler colonialism began to characterize Indigenous peoples as 'a sickly and misguided race' (Jasen 1997). As the overall health of First Nations people declined in relation to newly created reserves at the time, an assimilationist policy tried to regulate childbirth through direct government control of women's bodies. As Jasen (1997, 400) argues, 'Subjected, simultaneously, to ideologies of both gender and race, Aboriginal people underwent a particularly stark transformation in their reproductive lives.' By the 1970s, efforts to decrease maternal mortality and morbidity in the general population led to a move towards hospital deliveries for all women designated as 'high-risk.' In the 1980s the government pushed for all deliveries to occur in tertiary care centres, which were not always within the geographic area of the woman (Kaufert and O'Neil 1990). This practice was not developed with First Nations people and communities, but instead through the 'marginalization of First Nations pregnancy and birthing practices and use of coercive pressures on First Nations to adopt the Euro-Canadian biomedical model' (Lawford and Giles 2012b, 327).

Birth evacuation as 'invisible' policy

This policy of forced birth travel is still in effect and is referred to as 'maternal evacuation' or 'birth evacuation.' Health Canada policy obliges all remote rural or remote reserve-living pregnant women between 36- and 38-weeks gestational age to use labour and birthing services in urban centres, such as Thompson or Winnipeg in the province of Manitoba (Health Canada 2015). As a result, pregnant women must leave their communities and travel to a boarding home or motel in a tertiary care centre to wait for labour to commence so that the birth takes place in medical facilities. For Indigenous women living in rural and remote communities without hospitals, birth evacuation results in their being transferred out of their home community to unfamiliar places weeks before their due date (Society of Obstetricians and Gynecologists of Canada 2010; Chamberlain and Barclay

2000). As Lawford and Giles observe, women 'await labour and delivery and recover during the immediate postpartum period, typically in isolation from their families and communities' (Lawford and Giles 2012b, 330).

The policy prioritizes western biomedicine in obstetrical management of pregnant bodies, often necessitating long-distance travel and lengthy waiting times for the women who constitute the targeted demographic: Indigenous women (Lawford, Giles, and Bourgeault 2018). Located primarily in the Health Canada Clinical Practice Guide, the details of this policy are elusive and undocumented (Couchie and Sanderson 2007). Lawford, Bourgeault, and Giles (2019) describe directives to nurses to arrange for hospital transfers at a certain gestational period as inconsistent in its application because the policy itself is nebulous and lacking in details. How these directives are operationalized is based on historic or current practices rather than detailed clinical guidelines.

Lawford (2016) refers to birth evacuation as an 'invisible' federal policy because it meets three criteria: (1) it has material impacts, (2) there are allocations of resources, and (3) there is a reaction to this policy (Lawford 2016). The material impacts of this policy perpetuate the loss of traditional social and cultural practices related to pregnancy, labour, childbirth, and post-partum recovery and the forced assimilation of First Nations people (Lawford 2016). In discussing resource allocation, Lawford (2016) argues that the lack of job classification at the federal level for midwives, an occupation that would mitigate the impacts of birth evacuation or even make birth evacuation unnecessary, is an active decision that allocates resources to the process of removing women from their communities to birth in tertiary care centres instead of developing in-community alternatives: in 'the absence of midwifery,' Lawford argues, 'the evacuation policy remains necessary' (Lawford 2016, 154). The range of reactions to the evacuation policy includes widespread reactions from academics (Couchie and Sanderson 2007; Women and Health Care Reform 2007) and professional societies including The Native Women's Association of Canada who have prepared a guidebook for women traveling for birth that attempts to minimize the damaging effects of the evacuation policy. Ultimately, this invisible policy serves to create 'a reliance on provincial [i.e. off reserve] maternity resources to ensure First Nations women living on reserve have access to intrapartum care' (Lawford 2016, 148) while devaluing traditional birthing practices and midwifery.

Birth evacuation in practice

The requirement of confinement in temporary accommodations that is inherent in this policy leads to a wide range of social, emotional, and financial repercussions suffered by Indigenous women. In these temporary accommodations, women await the start of labour from motel rooms or boarding homes, often enduring long separation from emotional ties and support of family and community, as well as high costs of travel and subsistence for temporary residence in urban centres. To provide a sense of the scale of these mobilities, in the community of Cross Lake, Manitoba (7,600 people), approximately 150 women leave the community annually to travel by air primarily to Thompson (120 kilometres) and sometimes to Winnipeg (520 kilometers) to wait to deliver their babies. Only recently, after significant pressure from groups like the Society of Obstetricians and Gynecologists of Canada did the federal government begin providing funding for one 'travel escort,' to travel and stay with the expectant woman (Robinson 2017).

The physical health of Indigenous women and their families has also been negatively impacted by the birth evacuation policy. By replacing traditional birthing practices with biomedicine and so-called 'modern' medically-based maternity technologies, deleterious impacts on preterm births, birth weights, and infant and neonatal mortality have occurred, intimately connected to the larger politicization of Indigenous women's bodies and their reproductive health. The infant mortality rate among First Nations remains twice as high as the Canadian average (McShane, Smylie, and Adomako 2009). In Manitoba, it was found that the infant mortality rate for First Nations (Status Indians on reserve) and off-reserve was 10.2 deaths per 1,000 live births from 1991 to 2000, which

was 1.9 times higher than the 'non-First Nations' infant mortality rate of 5.4 per 1,000 (Smylie and Fell 2010, 146).

Prior to the formation of Canada as a colonial nation, a traditional midwife attended home births or, during periods of travel, a family member aided pregnant women (Lalonde, Butt, and Bucio 2009). Knowledge around birthing was transmitted inter-generationally and included not only physical logistics of birthing but also traditional medicines to aid delivery and postpartum recovery (Lalonde, Butt, and Bucio 2009). Due to interruptions resulting from the imposition of colonial policies and practices, maternity care for First Nations women was transferred from home births to births in nursing stations with federally-employed nurses who had midwifery training during the 1950s (Plummer 2000). Furthermore, this transfer of responsibility from traditional roles within the community to external service providers undermined Indigenous birth practices and eventually led to a diminished role for traditional midwives and birth workers.

As a birth-related role, doula has its roots in the tradition of women supporting other women during pregnancy, labour, birth and postpartum, a role often provided by family members or experienced local women (Campbell-Voytal et al. 2011). The more formalized doula care provider that we know today is the result of women living away from their families and, in the case of Indigenous women, being forced to birth away from their home community and thus from family members. Birth workers emerged as a formal birth companion role to address the need for more support for women during delivery. A birth worker provides continuous physical, emotional, and advocacy support during labour and birth, but does not provide medical, midwifery, or nursing care (Campbell-Voytal et al. 2011). We primarily use the terms 'birth helper' or 'birth worker' to describe a doula, although there are many ways to describe birth helpers in different Indigenous languages.

As Varcoe et al. (2013) stated, the role and dominance of biomedicine has resulted in the imposition of medically-based maternity technologies. Indigenous women are now being told 'their time-honoured midwifery and birthing practices were unsafe and that they must turn to the advances of western medical practice for "modern" maternity care' (Varcoe et al. 2013, 7). The impact of this message, and how it is operationalized, are significant to the physical and mental health of First Nations women and their families.

Beyond the physical and mental impacts on individual mothers, the requirement to give birth in tertiary care facilities outside of communities perpetuates assimilation and reinforces the colonial notion that we cannot birth our own babies, but must instead rely on the state to facilitate the delivery of Indigenous children. The lack of midwives in First Nations communities signals the government's continued colonization of Indigenous women's bodies, perpetuates dependence on Western-based models of medicine, and negates the possibilities of incorporating cultural models of reproductive care. Together, colonialism and isolation effectively undermine the cultural health knowledge that exists in community.

Despite this policy that medicalizes childbirth, some communities have resisted the model of temporary relocation of women. In Puvurnituq, Quebec a birth centre staffed by Inuit and non-Inuit midwives opened in 1986 (Plummer 2000). This birthing centre continues to respond to the needs of its communities and has established a training program for Inuit midwives (Centre de Santé Inuulitisivik 2009).

Manitoba, Canada: reasserting sovereignty through birth workers care

In Manitoba, birth workers are also resisting the birth evacuation policy and medicalization of birthing. Along with efforts to return birthing to Indigenous communities, knowledge about Indigenous birthing is integral for improved overall health and wellness. The Indigenous birth worker research project responds to the gap of Indigenous representation in literature on medical reproductive health, and emerged out of relationships between community organizations, community researchers, and university scholars, all Indigenous women and mothers. Wijiiji' idiwag Ikwewag ('Women helping each other') is a pilot training model for Indigenous women to become birth

workers to support pregnant Indigenous women who have families in Winnipeg. Research collaboration between the university researchers, Wijiiji' idiwag Ikwewag, and the First Nations Health and Social Secretariat of Manitoba (FNHSSM) was developed to determine whether or not Indigenous birth workers would have a positive impact for Indigenous women who travelled for birth. This project is still underway with three communities involved: Pimicikamak Cree Nation (Cross Lake); Nisichawayasihk Cree Nation (Nelson House); and Misipawistik Cree Nation (Grand Rapids).

Wijiiji' idiwag Ikwewag provides training for Indigenous birth workers to support mothers and families as they guide new life from the spiritual to the physical realm. Training includes personal healing and reflection as well as knowledge about pregnancy, birth, and parenting from both Indigenous and Western knowledge systems. In this program, women from each reserve community and from urban centres are recruited for birth worker training, to ensure that each pregnant participant has a two-person birth worker team. Once the pregnant women leave the community for the urban centre, they are supported by the Indigenous birth worker in the city. In conjunction with the birth worker training and provision of care for birth evacuees, the research project also considers mothers' experiences of prenatal care, interpersonal processes of care, stress and anxiety, postnatal depression, and breastfeeding uptake. Qualitative interviews invite Indigenous women to discuss the role of culture and spirituality in their birthing experience.²

The training is unique in that it teaches the traditional knowledge around birth from within and from outside the Nation. In each training component, the curriculum is reviewed by the community advisory circle and it is infused with local Indigenous knowledge by asking the local Knowledge Keepers to provide local teachings on pregnancy, birth and parenting. This training supports efforts to de-colonize our practices. As Simpson (2017) says, we are picking up the things we were forced to leave behind – such as songs, ceremonies, values, practices, teachings, and philosophies – in an effort to re-create the the cultural and political flourishing of the past to support the well-being of contemporary citizens. The resurgence work of Wijiiji'idiwag Ikweg directly challenges the rigidity of colonization and it centers on dismantling systems of cis-heteronormativity, patriarchy, and white supremacy that challenge Indigenous sovereignty over land and body. As our research focuses on the training pilot and its implications for Manitoban First Nations communities, we turn to other scholars' work on birth evacuation to illuminate the inequity that comes about from 'waiting' for the onset of labour.

Waiting for labour: inequitable mobilities and immobilities

That was rough 'cause it was my first kid and staying in a hotel, I didn't like that. You had to stay in a hotel the whole time and you go there for a whole month before you have your baby (Kornelsen and Grzybowski 2004, 75).

This quote from an Indigenous woman in northern Alberta emerged from research that examined the lived experiences of women directly affected by the birth evacuation policy and practices (Kornelsen and Grzybowski 2004). In this research, perils associated with the physical journey to the state-legitimized childbirth care facilities in urban destinations were not identified as an issue as much as the disconnectedness experienced by evacuees resulting from the time and distance away from home. The term 'evacuees' (rather than 'birth travellers') focuses on the ways in which women are forced to spend an inordinate time away from their homes and relatives, including infants and young children. The time period from the due date until post-delivery is the cause of considerable anxiety and distress for many Indigenous women (Kornelsen and Grzybowski 2004). The 'loneliness, disconnection from community, isolation from family and culture, and discrimination' alongside stress and anxiety related to the management of family life while they are away, exacerbate existing poor pregnancy and infant health conditions (Varcoe et al. 2013, 4).

In its implementation, the evacuation policy emphasizes the 'intrapartum period' of maternal care, that is, the labour and delivery of the baby. Its main objective, from governmental and biomedical perspectives, is to ensure women are physically located in hospitals or medical facilities

with 'appropriate' medical staff at the onset of labour so that the entire birth is managed obstetrically. The emphasis on the intrapartum period takes away from resources that could be spent on prenatal and postnatal support, much needed back in the home communities for mothers as well as family members (Kornelsen and Grzybowski 2004). The timing of evacuee women's labour is a key aspect to what the state and the western medical establishment see as 'successful' birth evacuation. From an Indigenous feminist perspective, however, the fixation on the intrapartum period has subjugated Indigenous women by placing them in modes of waiting – reproductive immobilities – that are inequitable across race, class, and nation and that have harmful effects on their bodies, as well as on their families. The medical approval required for the discharge of the maternal patient from the hospital adds to the length of immobility that is essentially mandated by the state.

The waiting-in-place for the onset of labour (and hospital discharge) entails being made to wait in places that are foreign and inhospitable, despite well-intentioned hospitality extended to the rural and remote visitors. These waiting practices involve occupying 'invisible and indivisible spaces' (Adey 2017, 12). Adey (2017) views waiting as an inequitable form of immobility constituted and patterned through the world's mobilities, such as international travel or transit. His examples are asylum seekers and migrants waiting as they are held at detention and reception centers – a list to which we add women subjected to Canada's birth evacuation policy held to wait in hotels and motels before their transfer to medical facilities when labour begins. Such forms and spaces of waiting are not only invisible to others but occur in spaces under surveillance in ways that other transit spaces, such as hotels and airport lounges, are not (Adey 2017). Zones of waiting are zones of immobility, inseparable from the mobilities that constitute them (Adey 2017). Waiting zones in urban centres for Indigenous birth evacuees constitute inequitable immobilities situated within a global politics of reproduction and regulated by Canada's federal birth evacuation policy. Not all women are subjected to forced birth travel; not all women are subjected to intrapartum waiting that must take place outside of their communities in urban centres.

Which pregnant bodies wait, where do they wait, and why? The intrapartum period is a temporality that derives from the western professionalization and medicalized expertise of childbirth (Eri et al. 2010). 'Precise knowledge of the foetus age is deemed imperative for the ideal management of labor,' suggests Eri et al. (2010). This imperative of knowing the foetus age has led to the hegemony within local and global processes and practices of contemporary reproductive healthcare, of 'the waiting mode,' conceptualized as 'a state of active waiting' organized around the estimated date of delivery (Eri et al. 2010). Intrapartum waiting generates acute states of bodily attention that have been found to be 'all consuming' for pregnant persons and, moreover, are oriented around technologies of intervention in the birth process, including ultrasound (Eri et al. 2010, 172).

An emphasis on timing – determining the due date – is of considerable significance for women who are forced to leave their communities in order to utilize a particular form of childbirth obstetrical management in that it presses them into a particular temporality. Gasparini (1995) has conceptualized such intrapartum waiting modes as a means by which pregnant women are forced to be oriented to the future. To travel away for the purpose of giving birth, in what is considered by biomedicine as the 'proper' healthcare setting, means the displacement of women's bodies from home through air or road travel to a hospital elsewhere and interpolates racialized bodies into 'spaces, zones, and practices of waiting' (Adey 2017, 12).

Research on transnational commercial surrogacy in India underscores the uneven mobilities between racialized Indian women who work as gestational surrogates and the transnational clientele (commissioning parents) who travel from the U.S. and Europe to access the reproductive services available in India (Deomampo 2013; Vora 2015). Many of the Indian women involved in reproductive labour, as they carry and give birth to children for other couples, are required to live in 'maternity homes' for the duration of the pregnancy. Ostensibly by keeping the surrogates under restricted movement and within reach of biomedical care and technologies of childbirth, fertility clinics and commissioning agencies ensure the safety of the foetus (Deomampo 2013). This safety is enacted through control and surveillance of the body of the surrogate, not only because this body carries the

foetus, but because the surrogate herself is understood as a source of risk for the foetus (Lozanski and Shankar 2019). The period of confinement in the maternity homes during gestation to delivery also serves to manage anonymity and the shame, stigma, self-doubt, and even mourning, experienced by surrogates, related to the ambiguity women experience about supplying 'a source of biological reproduction for consumers in the Global North' (Vora 2015, 116).

Low income Indian and migrant women undertaking reproductive labour in India for mostly middle-class and elite, normatively white, commissioning parents lived in maternity homes for several months, away from their families and in unfamiliar neighbourhoods, sometimes expected to remain indoors at all times – a kind of 'spatial imprisonment' (Deomampo 2013, 519). Deomampo compares the ways in which the waiting mode in maternity homes, paid for by the commissioning parents and supplied by the fertility agencies, was enforced upon racialized surrogate women. Low-income Indian women surrogates and the wealthy commissioning parents wait differently for babies to be born. As Deomampo notes, 'in contrast to surrogates' experiences of spatial imprisonment and restricted mobility ... intended parents [from the U.S. or U.K. mostly] moved with relative comfort throughout their travels' (Deomampo 2013, 528).

A critical mobilities analysis underscores how the emphasis on the intrapartum period in the management of women's reproduction creates zones of waiting that are lived forms of 'inequitable immobilities' (Adey 2017). Unlike commercial surrogates in India who participate in commoditized reproductive labour by 'choice,' albeit a choice determined by economic exploitation and marginalization, pregnant Indigenous women from remote and rural areas of Canada do not have a choice about the required birth travel. Yet both groups of women and their reproductive immobilities are subjected to forms of colonialism that continue to control the bodies of racialized women (Deomampo 2013), and in which the inequities of waiting are a pernicious aspect of reproductive mobilities.

Indigenous women's political bodies: doulas' presence in alter-native mobilities

'Killing time,' as Lawford and Gilles describe being 'sent out' for birth and waiting for labour onset (2012b) has resulted in numerous emotional, physical, and economic stressors including 'enforced separation from family, culture and the community as a result of being sent out for birth', a lack of help with breastfeeding resulting in pain, rapid birth with no pain inhibitors, along with the costs associated with phone calls, babysitters, and airfare for partners (Chamberlain and Barclay 2000, 118). Such stressors lead to negative health impacts and must be situated within a wider Canadian context in which pregnancy and infancy indicators (teen pregnancy, preterm birth, low and high birth weight, infant and neonatal mortality) are two to five times worse for Indigenous people (Varcoe et al. 2013). Studies show that women who were able to give birth with support from families during delivery 'connected those experiences to better outcomes' (Varcoe et al. 2013, 4), making support a critical factor in healthy pregnancies. Continuous support is associated with shorter labours, a decreased need for the use of analgesics, oxytocin, forceps, caesarean sections and higher levels of satisfaction with the birth experience (Bohren et al. 2017). Continuous support has the greatest benefits when the support begins early in labour and when the provider is not an employee (Hodnett et al. 2005).

The National Aboriginal Health Organization (NAHO) found that continuous emotional and social support to women during childbirth has positive impacts for labour and delivery, as well as for breastfeeding rates and attachment (National Aboriginal Health Organization 2008). The basis of childbirth support for First Nations women is a positive relationship. Research with First Nations communities in BC has shown that importance of 'respect, understanding of cultural context and connection with communities' (Varcoe et al. 2013, 4). Birth experiences of Inuit women indicate that Inuit maternity workers provided additional psychosocial support in the birthing centre, including personnel counselling with abused women (Chamberlain and Barclay 2000, 121). To work successfully in First Nation communities, health care providers must be culturally safe, be able to apply their knowledge, have self-awareness, and have personal attributes and attitudes that facilitate respectful partnerships with communities (Wiebe et al. 2015).

Culturally-based doula practices or birth workers are emerging in communities across Canada as counter to hegemonic colonial approaches to reproductive healthcare and the mandatory im/mobility of Indigenous women's pregnant and reproducing bodies. Indigenous women are increasingly returning to culturally-based birthing practices to assert their sovereignty over their bodies and their birthing experience. The impact of colonization on birthing experiences for First Nations women in Canada has been profound and extends across generations. Traditional birthing includes many traditions such as placenta burying and belly button ceremonies (Lawford and Giles 2012a). These traditions and this circle of care and support resulted in resiliency, strength, and a connection to the land and family.

Similar to Wijiidiwag Ikwewag in Manitoba, a similar group has formed in Alberta to support women who travel for birth or in urban settings.³ Vancouver also has a doula collective called *ekw'i7tl*, a group of Indigenous doulas that provides full-circle support to mothers and families during pregnancy, labour, birth and postpartum care.⁴ Indigenous birth workers provide an important role not only in re-igniting traditional practices around pregnancy, birthing and parenting. They also work to promote the returning birthing practices to communities and to support the profession of midwifery as a politicized alternative to the long-standing policy of mandatory birth evacuations and medicalized birthing.

For Indigenous women, the move from births in home communities to births in tertiary care centres has meant the loss of traditional teachings, elders and a birthing mentor. The role of an older woman relative is documented as an important component of pregnancy and childbirth and critical cultural practices that are respected as essential to establishing and revitalizing the strong cultural connection and spiritual path for First Nations children. As Wiebe et al. (2015) describe, 'the attention from older people in the community enhanced the mother's self-confidence and sense of empowerment, because these relationships constituted a powerful and enduring connection which extended to her unborn child' (54). In an Alberta First Nation, the role of birth workers was identified as a central recommendation to addressing childbirth and infant health. The researchers noted that First Nations women should be trained and should accompany the pregnant women through the entire birthing process. Beyond pregnancy, birth, and delivery, birth workers should provide prenatal teaching, connections, support, and a liaison role with health care professionals in the mainstream system as needed (Wiebe et al. 2015). Knowledge already exists in these First Nations communities and women 'just need the confidence and certification to get into the classroom. Often the elders are tired, but maybe the younger grandmothers could accompany the pregnant women' (Wiebe et al. 2015, 64).

Culturally-based birth workers are not solely about providing improved birth experiences for women and families, but also about rejecting the dominant medicalized reproductive health practices. Indigenous birth workers provide a pathway back to retrieving women centered knowledge around women's bodies, infant care and parenting that promote resiliency in Indigenous families. Birth worker practices can be regarded as 'alter-native mobilities' (Adey 2017), as responses and counter-actions to the mandatory birth travel that characterizes the oppressive birth evacuation policy and its attendant subjugations of Indigenous knowledges, practices, and culture around women's reproductive healthcare and childbirth. Alter-native mobilities signals a postcolonial politics whereby obfuscated mobilities of subalterns are revealed and also critiques an overly celebratory, imperialist view of physical and geographical mobilities often seen in mobilities theory (Adey 2017). Alter-native mobilities reveal how 'mobilities are highly classed, racialized and easily express the imperial ambitions of Europe' (Adey 2017, 48). We take Adey's alter-native framework further.

Critiques of the colonization of Indigenous women's bodies articulated by Indigenous feminists including Michi Saagiig Nishnaabeg scholar Leanne Betasamosake Simpson (2017) and Kahnawake Mohawk scholar Audra Simpson (2014) lend crucial insights to an Indigenous feminist analysis of mandatory birth travel. Such an analysis is critical of the imposition of mobility (travel outside for birth) and immobility (waiting for labour) as a practice rooted in heteropatriarchal settler colonialism while re-centering Indigenous women's agency. Indigenous feminist alter-native mobilities recognizes Indigenous women's bodies as political bodies in their (forced) crossing of borders within the

nation and their insertion of culturally-competent support persons (birth workers) in the waiting zones. Culturally-based birth workers play a central role in the re-centering of Indigenous women's own knowledge and boundary-making during the birth process, which opposes the colonial approach to reproductive health with its over-emphasis on the intrapartum period and its biomedical surveillance and management.

The historical context of birthing and the removal of local midwifery care from Indigenous communities to tertiary care facilities in urban centres some distance away is intimately connected to the larger politicization and, we argue, mobility and immobility of Indigenous women's bodies and their reproductive health. The dominance of biomedicine cannot be separated from the politicization of Indigenous bodies in a colonial context (A. Simpson 2014; L.2017). Audra Simpson (2014) describes how the settler state has a 'death drive to eliminate, to contain, to hide and in other ways disappear what fundamentally challenges its legitimacy: Indigenous political orders' and that Indigenous women represent these alternative political orders and thus are targets for destruction.' Simpson (2014) also asserts that Indigenous women were, in fact, a threat to the colonial project and the destruction of their bodies, whether physically or metaphorically, is intended to diminish political systems often led by women and instead favour systems more politically aligned with colonial ways of ruling. Leanne Simpson, too, describes the impact of colonization; looking directly at Canada's Indian Act, she notes, 'a large part of the colonial project has been to control the political power of Indigenous women and queer people through the control of our sexual agency because this agency is a threat to heteropatriarchy ... Indigenous body sovereignty and sexuality sovereignty threaten colonial power' (Simpson 2017, 96). Anderson (2010) draws attention to Indigenous motherhood and family as a key target of colonialism. She writes, 'empowered motherhood was not only a practice but also an ideology that allowed women to assert their authority at various political levels' (Anderson 2010, 83–84). These Indigenous feminist scholars make the link between the undermining of Indigenous women's bodily autonomies and the undermining of Indigenous political power through generations of colonial interference (Simpson 2014, 2017; Anderson 2010).

The relocation of birthing from Indigenous communities to hospitals forces pregnant Indigenous women to rely on the western medicine and, in so doing, limits control over and access to the various ways Indigenous communities have long supported birthing women. A hospital setting is a major obstacle to the use of traditional medicines and approaches to birthing and to supporting Indigenous women. An Indigenous woman's choice to utilize traditional medicine and birthing practices are not only limited in a hospital setting, but are undermined by the political and institutional structures guided by western medicine. The assertion of power and sovereignty that a birthing woman obtains becomes diminished when the Indigenous woman is forced to birth outside of ancestral territories. This power allows for the development of kinship building that reaffirms a woman's responsibilities as a life-giver and a carrier and transmitter of culture (Anderson 2010). We bring this critique of mandatory birth evacuation and highlight efforts to resist the practice through decolonizing birth for Indigenous women into conversation with the critical mobilities framework for two main reasons. First, we seek to interrogate the ways in which 'the place of mobility and immobility' was and is at the center of settler-colonialism processes (Adey 2017, 53; Clarsen 2015). The birth evacuation policy imposed on Indigenous women that circumscribes and controls their mobilities at vulnerable points in their reproductive lives is one of many policies in a settler colonial nation where settlers were free to roam 'while immobilizing the former sovereign owners of those territories' (Clarsen 2015, 42). Second, we want to emphasize an 'alter-native mobilities' (Adey 2017) approach to reproductive mobilities that recognizes the recuperation of Indigenous women's agency in their reproductive decision-making through the mobilization of birth workers into birth practices that continue to be circumscribed to waiting zones in the southern metropolises of Canada.

Towards indigenous reproductive mobilities

Indigenous women are missing from the growing body of reproductive cross-care and medical mobilities scholarship (e.g. Gürtin and Inhorn 2011; Kasper, Walton-Roberts and Bochaton 2019). Literature tends to focus on middle-class and elite women and gay men from the global North traveling mostly to countries in the global South and Eastern Europe to access ARTs and the reproductive labour of racialized low income women who provide eggs or gestational surrogacy (e.g. Deomampo 2013; Inhorn 2015; Nahman 2013; Whittaker 2015; Speier 2016). An Indigenous reproductive mobilities framework is a step toward rectifying the missing bodies, voices, experiences, and knowledge of Indigenous women, young people, men, two-spirited, and others whose reproductive practices have been excluded. The inclusion of Indigenous people's experiences and practices is critical in this historical moment of reconciliation within Canada and globally. Also, in Adey's (2017) call for greater attention to alter-native mobilities, Indigenous scholarship, knowledge, and ways of knowing have been missing in mobilities scholarship more broadly.

As we begin to think through an Indigenous reproductive mobilities framework, we draw on Norman et al.'s (2015) work on rural Indigenous mobilities, in which pathologies of obesity and related disease are constructed around settler mythologies of sedentary Aboriginals. They specifically examine how obesity as a healthcare crisis in Manitoban First Nations (Swampy Cree) communities has been constructed through false notions about how the built environment of the Swampy Cree communities is not conducive to health. The health care policymakers and experts who direct blame towards 'obesogenic environments' for obesity in local populations, assume urban landscapes (characterized by green spaces, bike paths, and affordable healthy food) to be the singular referent (Norman et al. 2015, 167). By assuming that the addition of bike paths and green space will alter health outcomes, policymakers and experts overlook how 'Indigenous people's connections to the land is constitutive of a distinct spatial ontology,' where their 'identities are deeply rooted in the land over which they move' (Wilson and Peters 2005, 396, in Norman et al. 2015, 167). Imagined geographies of rurality in Canada that imagine Indigenous peoples to be fixed in place simultaneously imagine Indigenous people to be pathological for seemingly inherent sedentary immobile lifestyles (Norman et al. 2015, 168). An analysis of obesity that sees the environment as both the blame and the solution, Norman et al. (2015) argue, erases histories of Indigenous migratory and other mobility practices.

These ostensible immobilities are imaginable only through the active forgetting of the historical mobility of Indigenous peoples and colonial dispossession, alongside other forms of 'Indigenous spatiality,' such as residential schools, which divided the country along racial lines (Norman et al. 2015, 169). The causation of obesity that gets overlooked in the Canadian healthcare policies is the dispossession of territorial lands: through an Indigenous mobilities framework, the repossession of these stolen territories, rather than more 'green spaces' and 'bike paths', provide viable solutions to health issues.

As a counternarrative and corrective to notions of disease and place-bound Indigenous sedentariness and pathological mobility that does not conform to normative Euro-Canadian ideals of a 'settled productive lifestyle' (174), Norman et al. (2015) articulate an Indigenous mobilities framework in which movement is not neutral but is actively embedded in power relations. Critiquing mobilities studies for the race-blind celebration of largely urban white modernity that ignores rural and racialized movement, they reclaim the historical grounds on which the current cultural mobilities of Indigenous people are an outcome of Indigenous-settler relations, and call attention to the longstanding anxiety in Canada over Indigenous movements (Norman et al. 2015, 167). An Indigenous mobilities framework pushes back against the settler mythologies that fix in place Indigenous peoples and that obscure historical practices of Indigenous movement within rural areas and between rural towns and urban centres, calling for 'a more nuanced perspective of complex, interwoven spatialities that underlie place-specific mobile cultures' (Norman et al. 2015, 174). This framework, in conversation with Indigenous feminism, can be applied to Canada's birth evacuation travel. We see three key themes in the development of a decolonizing and feminist Indigenous reproductive mobilities framework.

First, Indigenous reproductive mobilities underscores the power relations in which birth travel practices are embedded; childbirth (and obstetrical) mobilities, enforced by the Canadian federal government, are hardly neutral or apolitical, despite being framed as such within maternal and infant population health discourses. Since the late twentieth century, birth evacuations have been circumscribed by settler-colonialism in Canada and reiterates the historical displacement of Indigenous peoples from their territorial lands, simultaneously impounding them on reserves – ‘piecemeal plots of land that were policed by federal Indian agents to limit the exchange of goods and services between ‘Indians’ and Euro-Canadians and to keep First Nations people confined and away from Euro-Canadians’ (Lawford and Giles 2012a, 330). Canadian nation building has relied upon managing Indigenous spatiality. The reserve system, dictated in the Indian Act, RSC 1985, c15, which affirms the authority of the federal government over First Nations, resulted in healthcare delivery falling to federal rather than provincial or regional authorities, which in turn resulted in continuing jurisdictional disputes that lead to gaps and absences of care (Lawford and Giles 2012a, 331). While mandatory birth evacuation may appear neutral as ‘policy,’ the ensuing travel practices that force pregnant women out of their community at a time when culturally- and place-based support is fundamental to maternal and infant health, came about, paradoxically, as an outcome of colonial incarceration of First Nation populations.

Second, reproductive mobilities scholarship has emphasized the movements of patients, intended parents, donors, surrogates, technologies, and bio-genetic materials (sperm, ovum, oocyte) across national boundaries to ever-changing sites of supply and services within a globalizing healthcare and therapeutic industry and economy. The cross-border travel undertaken by intended parents has been critiqued for the north-south pathways, but the normativity of relatively unfettered international travel as a practice ‘of largely white urban modernity’ (Norman et al. 2015) has remained under-examined (although see Speier, this issue): certain actors’ mobilities have been foregrounded while others’ have been obfuscated. Rural racialized movement remains to be studied within an Indigenous mobilities framework, argue Norman et al. (2015). International borders and transnational networks that have been examined within reproductive cross-care and medical mobilities literatures are not the only geographical movement through which reproductive health and fertility services are mobilized. National birth evacuation attends to the tensions and power relations that inhere in borders within nation-states, for which Indigenous women’s reproductive bodies have become mired in issues of sovereignty. Questions of birth travel in Canada are thus questions of citizenship and sovereignty in a settler colonial context of displacement and dispossession.

Third, the historical legacy of anxiety over Indigenous movement, based on the settler mythology about Indigenous fixed-in-place-ness (Norman et al. 2015), is an idea pertinent to Indigenous reproductive mobilities. Indigenous women’s bodies and sexualities have been seen as a threat to settler sovereignty (Simpson 2017) and the colonial worry over Aboriginal women’s supposedly painless and unceremonious childbirth was, in part, the basis for regulating the relocation of Indigenous women away from home birth practices to normative hospital child-births. Mandatory birth travel practices stem from the western idealization of a built obstetrical care environment that is hygienically- and technologically-advanced, with biomedical emphasis on the intrapartum moment. Despite the decades of following a policy that is predicated on the medical subjugation of Indigenous knowledge and traditional birth practices, these idealized obstetrical environments, shaped by settler colonialism, have not resulted in better outcomes for Indigenous women. Instead, their health remains poor and infant mortality remains high (Lawford and Giles 2012a). The birth worker movement that is taking place in Manitoba and in other parts of Canada is a part of a restoration of Indigenous reproductive health-care that rejects colonial notions of where and how Indigenous women should birth and what their support systems look like. This movement is critical of the hegemonic and colonial bio-medical management of birth that physically displaces not only pregnant women, but also removes them from the proximity of midwives and attendants whose knowledge can contribute to a process of decolonizing birth (Lawford and Giles 2012a, 337). As Lawford and Giles point out, decolonizing the evacuation policy means ‘First Nations women, families and communities, health care providers

and policy makers can fashion a perinatal health policy that considers and incorporates First Nations' epistemologies and meanings of health; this may include medicine and healing practices that are labelled as 'traditional,' such as First Nations midwifery, doula services and/or the use of First Nations medicines' (2012a, 337).

Conclusion

Our analysis of Canada's forced birth travel and its mobilizing effects on Indigenous women in Canada supports an emergent lens of Indigenous reproductive mobilities. Indigenous women are reclaiming sovereignty over their bodies and birth experiences through the mobilization of culturally-based doulas and in so doing, are challenging the settler colonial project in Canada, which underpins mandatory birth evacuation. The work currently undertaken in Manitoba offers a backdrop in which Indigenous feminist and decolonial theoretical frameworks can be used to expand existing reproductive mobilities discourse and scholarship. The main contribution of this work is the articulation of a decolonizing and Indigenizing theoretical approach to considering reproductive mobilities in the context of historical colonization and ongoing settler colonialism, white dominance, and national-patriarchy. A secondary contribution is a shift in thinking about the power relations underpinning reproductive mobilities to render visible the experiences of Indigenous women within a body of scholarship that has largely ignored them. The development of an Indigenous reproductive mobilities framework is a step toward rectifying the missing bodies, voices, experiences, and knowledge of Indigenous women, young people, men, two-spirit, non-binary, gender-non-conforming folks, and others whose reproductive practices have been excluded. The inclusion of Indigenous people's experiences and practices is critical in this historical moment of reconciliation within Canada and globally, calling on others to do the same.

Notes

1. Indigenous is a term widely used in Canada and refers primarily to three distinct groups: First Nations (status and non-status), Metis and Inuit. For the purposes of this paper, the experiences of many Indigenous people, particularly those in rural and remote Canada are similar when it comes to being forced to leave to tertiary care centres for birth. Only First Nations people (who hold Indian status under the Indian Act) and Inuit (who are enrolled as Inuit beneficiaries) are subjected to Health Canada's evacuation policy. Rural Metis people are also required to relocate to tertiary care centres through the provincial health services.
2. The interview guides and other research tools are vetted carefully in each of the communities through a community advisory circle. Each of the three participating communities has also identified other questions that they would like the participants to be asked, which are included in the interview guides. Finally, the birth helpers are supported as they provide care to mothers and families through a coordinator, as well as through continuing education opportunities.
3. <https://edmontonjournal.com/health/family-child/indigenous-doulas-in-alberta-hope-to-provide-more-cultural-birth-support>.
4. <https://ekwi7tdoulacollective.org/>.

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ORCID

Susan Frohlick  <http://orcid.org/0000-0002-4511-826X>

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