Locating Invisible Policies: Health Canada's Evacuation Policy as a Case Study

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Abstract
I describe an initial tool for revealing invisible policies. Invisible policies are made apparent by three criteria: allocation of resources, material impacts, and reactions. Allocation of resources can be economic, human, or otherwise. Material impacts are those that are tangible and can be described as having a physical impact in some manner. Finally, the reactions of those impacted by the policy, like agencies and scholars, provide a third lens through which these policies can be understood and identified. Using the three criteria, I reveal the long-standing "evacuation policy" as a genuine and authentic policy, which is currently applied to those First Nations populations falling under federal jurisdiction. My contribution to policy analysis is to provide another tool to close a gap in the literature with respect to the analysis of invisible policies.

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Résumé
Je décris un outil initial pour révéler les politiques invisibles. Les politiques invisibles sont mises en évidence par trois critères : allocation des ressources, impacts matériels et réactions. L'allocation des ressources peut concerner les ressources économiques, humaines ou autres. Les impacts matériels sont ceux qui sont tangibles et peuvent être décrits comme ayant un impact physique quelconque. Enfin, les réactions de ceux qui sont touchés par la politique, comme les organismes et les chercheurs, fournissent une troisième perspective selon laquelle ces politiques peuvent être comprises et cernées. À l'aide de ces trois critères, je révèle la « politique d'évacuation » de longue date comme une politique véritable et authentique, qui est actuellement appliquée aux populations des Premières Nations relevant de la compétence fédérale. Ma contribution à l'analyse des politiques est de fournir un autre outil pour combler une lacune dans la littérature en ce qui concerne l'analyse des politiques invisibles.

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This paper describes "invisible" policies that lie in the grey zone between federal and provincial jurisdiction. By drawing on Canada's evacuation policy for pregnant First Nations women living on reserves as a case study, I suggest that, as a result of the invisibility of these policies, the delivery of maternity care services for First Nations women living on reserves is negatively impacted by poor communication between the federal and provincial health care systems. This impedes the delivery of maternity care services to the detriment of First Nations women and children. The lack of alignment between federal and provincial governments demonstrates inadequate attention to respective jurisdictions when attempting to facilitate access to provincial health care resources for First Nations living on reserves (Canadian Health Services Research Foundation, 2011). As an added challenge, jurisdictional incongruencies related to health services between federal and provincial governments are not well explored in the literature, particularly with regards to maternity care services. This gap signals a need for those involved in the realm of policy making to consider all populations that reside within the geopolitical boundaries of Canada with particular attention to policies that are invisible due in part to the challenges of inter-jurisdictional health care services.

My paper will use Health Canada's evacuation policy as an example of an "invisible" federal policy that creates a reliance on provincial maternity resources to ensure First Nations women living on reserve have access to intrapartum care. I do not consider the federal/territorial jurisdictions or health policies as they pertain to Métis and Inuit peoples. An examination of this "invisible" federal policy reveals a gap between between federal and provincial health care systems related to maternity care services for First Nations women. The absence of a clearly articulated policy means that provincial policies are not linked to the federal evacuation policy, resulting in dependence on individual practitioners for the success, or failure, of maternity care services for this particular group of women. Jurisdictional incongruencies between federal and provincial health care systems further confound efforts to mitigate the impacts of the evacuation policy, in part, because the policy largely remains invisible. Further, invisible maternity care policies contribute to fragmented health care systems for First Nations women and, as such, deserve attention and analysis.

What is Policy?

Before presenting a policy analysis of the Canadian government's evacuation policy for pregnant First Nations women living on reserves, it is important to articulate how policy is defined and described. Thomas Dye (1978) describes policy as "whatever governments choose to do or not to do" (3). This definition complements Harold D. Lasswell's (1936) definition of politics as "who gets what, when, how" (1) because it introduces the issue of government resource allocation. Daphne A. Dukelow (2006) further describes policy as "a government commitment to the public to follow an action or course of action in pursuit of approved objectives" (360) because policies have "power to influence and change" (Robinson 2008, 244). Governments, therefore, use policy as a way of communicating to its constituents and garnering support for a specific course of action. This is demonstrated by "the passage of a law, the spending of money, an official speech or gesture or some other observable act" (Miljan 2008, 3). It is the federal government's course of action as it pertains to pregnancy and childbirth among First Nations women that will be analyzed here.

Why is Policy Analysis Useful and What are Invisible Policies?

A policy analysis is relevant because it provides an opportunity to assess a government's chosen course of action and permits a constituent to interrogate and influence government direction. Governments construct policies to respond to public concerns (Miljan 2008) based on present or foreseeable issues or problems based on current knowledge. As such, a policy seeks to address an issue that has been problematized. It makes an issue relevant and assigns to it a certain priority, it provides a framework for understanding, and it describes particular solutions that are amenable to the implementation of a policy (Miljan 2008). Government values and priorities are reflected in what issues are problematized and in the policies and courses of action chosen to address these problematized issues. A policy analysis thus reveals government standards, directions, and priorities.

A policy analysis also exposes a government to scrutiny because governments have a "vested interest

in maintaining a problem-free public image, particularly when the problems have the potential to seriously undermine the credibility of their regime or establishment" (Bessant 2008, 298). It is, therefore, to a government's benefit to make invisible "the confusion and malevolence that characterize state policy-making, [while it] ignores the possibility that some policy-makers operate in a delusional state about what is happening" (297). While it could be argued that policy makers are not necessarily delusional, Judith Bessant's (2008) perspective does point to a frustration in the policy world where state-made policies do not align with the lived realities or needs of its citizens. Therefore, a policy analysis is an important, and even responsible, activity that brings to light the decisions and direction of government as well as the processes that lead to those decisions and direction.

One challenge associated with conceptualizing policy, however, is that absent the label policy, government intentions can be difficult to locate, prompting a need to create a set of criteria upon which a policy can be identified. Unlabelled government policies are invisible because they reside outside of distinct policy language, but remain true to the defining parameters of policy, which include the allocation of resources, material impacts, and reactions to it; these are discussed in detail below. Invisible policies are also labelled as "silent" (Murray 2011, 54) or as residing in a "vacuum" (Abele et al. 2011, 87; Brennan and Willis 2008, 300). Additionally, invisible policies might not be "passed by legislatures or formally adopted" (Seiter and Kadela 2003, 368), resulting in little to no public accountability for the impact of the actions that underpin those policies. Suzanne Mettler (2011) highlights this lack of accountability by describing invisible policies as those that "represent a fundamentally undemocratic development" (14). Archival research by Karen Lawford and Audrey R. Giles (2012a) demonstrates that Canada's evacuation policy was not developed in consultation with First Nations, but rather via "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" (327). Regardless of their invisibility, these policies do have material impacts because of the guidance and instruction they infer and the resources they impart.

Because they have material impacts (Brennan and Willis 2008; Giri 2011; Seiter and Kadela 2003; Theimer 2012), invisible policies need to be interrogated to ensure policy goals are being met and that government is responsive and accountable to its constituents. This is particularly important, however, when governments use non-engagement as a technique to ensure policies remain outside of critique (Lea et al. 2011). Non-engagement is described as a process that governments use to exclude "key issues from policy consideration while appearing to be inclusive" (Lea et al. 2011, 322); that is, when key issues in government policies are absent, citizens do not engage because their priorities are not addressed in the policy in question. Further, Lea et al. (2011) describe engagement as having "an inarguable moral rationale, [but] at the same time…[is] deeply implicated in the practical maintenance of social inequality" (322). Paradoxically, the rhetoric of engagement can be employed to argue that those affected by a policy had meaningful input into its development, so that any resulting inequalities are the responsibility of those who were engaged and not that of government.

Ram A. Giri (2011) discusses the concept of invisible policies at length. He draws attention to policies in Nepal that are largely unnoticed, yet have real impacts on the Indigenous peoples there. As a strategy to limit critique, for example, national policies are issued in "a language [that] has been given power, recognition and prestige while, as a corollary, the remaining minority languages are impoverished and marginalised" (Yadava 2007, 2). Giri (2011) further explains how ruling politicians manoeuvre and employ dominant language to render national policies invisible:

> Invisible language politics [are] deliberate bureaucratic and political attempts to avoid, delay and ignore language-related issues, or impose hidden agendas disguised as nationalism, to create and promote language hegemony for the elite language, namely Nepali. By hegemony of language, I mean limiting knowledge and learning of other languages except the elite languages. (198)

Giri's policy analysis highlights how Nepal's language policy is employed as a tool to make policies "invisible" to some segments of the population, namely the Indigenous population, so that the dominant class can rule without critique. Invisible policies thus serve to silence those affected by and/or in opposition to those policies.

Sarah Theimer (2012) is another scholar who has drawn attention to "invisible policy" (280) and the substantive impacts this type of policy strategy has on her field of research, which examines the death of languages. To help identify an invisible policy, Theimer offers the following:

> Policy is communicated through official documents, but can be inferred from people's language practices, ideologies, and beliefs. There are implicit and covert ways of regulating a language. This may be as simple as avoiding, delaying, and ignoring certain language issues or deliberately limiting the knowledge and learning of other languages. Such a strategy has been called the 'invisible policy' (Giri, 2011). Visible or invisible, languages plans are often used to maintain current power structure, influence public opinion, and allocate resources for the education and promotion of the chosen language. These policies often lead to benefits for some and loss of privilege status and rights for others. (280)

Another technique to make a policy invisible is to introduce it in obscure locations such as in a meeting or in a publication that is not widely read (Brennan and Willis 2008; Theimer 2012). This policy implementation approach limits critique, while positioning the policy as legitimate and authentic.

Identifying Invisible Policies

Based on the overview of the literature related to policy and invisible policy above, I propose three criteria as a means to identify an invisible policy. The first is through the allocation of resources, economic (Giri 2011, 199) or otherwise (Theimer 2012), as this reveals government intentions (Dye 1978). The second way to find an invisible policy is through the material impacts or consequences that it has on its constituents (Brennan and Willis 2008; Giri 2011; Seiter and Kadela 2003; Theimer 2012). The third way to locate a policy is by showing that practitioners act in such a way that they are responding to something or implementing a process (Robinson 2008). The development of guidelines and/or protocols demonstrates a reaction to policy and thus the presence of a policy whether or not it is explicit or invisible. The combination of three criteria to identify an invisible policy can be graphically represented:

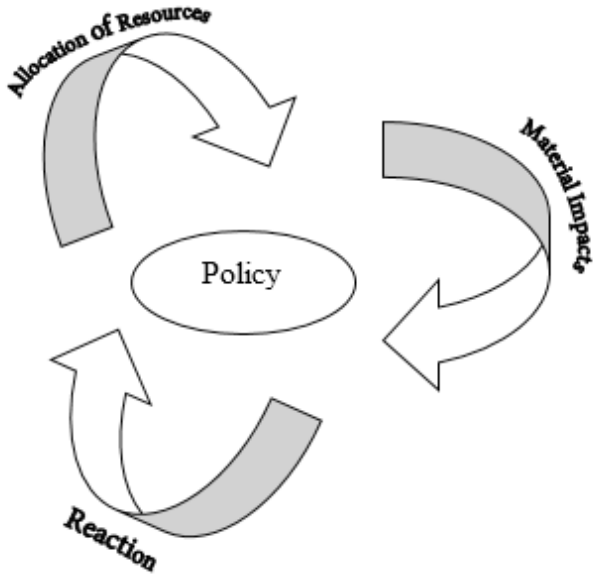

Figure 1: Three criteria used to identify a policy.

Health Care Systems in Canada

Before examining Canada's evacuation policy, certain aspects of its political system need to be explained. Canada's governance systems are based on federalism with a division of powers between federal and provincial levels of government provided for in sections 91 and 92 of the *Constitution Act, 1982* (Lewis et al. 2001). Section 91 provides a list of powers that fall within the jurisdiction of the federal government, while Section 92 provides a list of the powers that fall within the jurisdiction of provincial governments. Canada's Senate and House of Commons, that is, the federal government, has authority over "Indians, and lands reserved for the Indians" based on Section 91(24). Section 92(7) states that provinces have exclusive powers overs the "establishment, maintenance, and management of hospitals, asylums, charities, and eleemosynary institutions in and for the province, other than marine hospitals" (*Constitution Act, 1982*). It is noteworthy that the word health is absent in the first iteration of the *Constitution Act, 1867*. At the time of Canada's formation, health was thought be a personal matter and the responsibility of households and churches. Governments were only exceptionally involved in health care at the time of Confederation in 1867 (Braën 2002; Gibson 1996; Lux 2010). Indeed, court decisions have determined that,

> 'health' is not a matter which is subject to specific constitutional assignment but instead is an amorphous topic which can be addressed by valid federal or provincial legislation, depending in the circumstances of each case

> on the nature or scope of the health problem in question. (*Schneider v. The Queen* 1982, 142)

Further drawing attention to the jurisdictional flexibility of health care, the Government of Canada is adamant that the provision of "health programs and services including Non-Insured Health Benefits are provided to First Nations and Inuit on the basis of national policy and not due to any constitutional or other legal obligations" (Canada. Health Canada 2014, 1). Thus, it is federalism and components of the *Constitution Act, 1982*, particularly the incongruencies between Sections 91 and 92, that create jurisdictional gaps in health care for First Nations living on reserves.

With respect to health care, there are three broad health systems in Canada: provincial, territorial, and federal. As mentioned above, Section 92(7) of the *Constitution Act, 1867* bestows on provinces jurisdiction for the health care of its citizens (Canada. Health Canada 2012a). Territorial jurisdiction for health care is not assigned under the *Constitution Act, 1867*; rather, its authority to administer health care is delegated by the federal government (Canada. Privy Council Office 2010). Health care for "First Nations people living on reserves, Inuit, serving members of the Canadian Forces, eligible veterans, inmates in federal penitentiaries, and some groups of refugee claimants" (Canada. Health Canada 2012a, par. 18) is a responsibility accepted by the f*ederal government (Romanow 2002). Roy J. Romanow (2002) draws attention to the growing production of distinct and heterogenous health care systems, which if left unchecked, "*will inevitably produce 13 clearly separate health care systems, each with differing methods of payment, delivery and outcomes, coupled by an ever increasing volatile and debilitating debate surrounding our nation, its values and principles" (xviii). The presence of public and private prescription drug plans, each different in each jurisdiction, further confounds the direction and responsibility of health care systems in Canada.

The provincial, territorial, and federal health care systems in Canada are not flawlessly connected, but rather are complicated by jurisdictional incongruencies that are made apparent when the systems do not interact in a manner that supports those who need health care. A well-known case that demonstrates an appalling outcome of these jurisdictional incongruencies in health care systems occurred when the Manitoba health care system clashed with the federal system during the care of Jordan River Anderson.

Jordan was a member of the Norway House Cree Nation who died at the age of five in a Manitoba hospital in 2005 (Blackstock 2008). Cindy Blackstock (2008), a well-respected national advocate for Aboriginal children's health, explains:

> Jordan was born with complex medical needs, and because the federal and provincial governments provide so few services to support families with special needs children on reserves, Jordan had to be placed in foster care. In a government policy that baffles common sense, the federal government will pay foster parents to look after First Nations children with special needs, but will not provide support for the child's own family to care for them at home, even when there is no abuse or neglect. Jordan spent the first two years of his life in hospital while his medical condition stabilized…Just after Jordan's second birthday doctors said Jordan was well enough to go home, but as Drs Noni MacDonald and Amir Attaran noted in their 2007 editorial, 'bureaucrats ruined it.' Provincial and federal government officials decided that Jordan should stay in hospital while they argued over expenses related to his at-home care. Days turned into weeks, weeks turned into months and months turned into years…Jordan passed away in hospital at five years of age, never having spent a day in a family home. (589)

National attention to the horrendous treatment of Jordan resulted in the formation of Jordan's Principle in December 2007, a policy that seeks to address the "confusing jurisdictional debates" (Clarke 2007, 79) that impact First Nations living on reserves. The First Nations Child and Family Caring Society of Canada (2011) describes Jordan's Principle as follows:

> Where a jurisdictional dispute arises between two government parties (provincial/territorial or federal) or between two departments or ministries of the same government, regarding payment for services for a Status Indian child which are otherwise available to other Canadian children, the government or ministry/department of first contact must pay for the services without delay or disruption. The paying government party can then refer the matter to jurisdictional dispute mechanisms. In this way, the needs of the child get met first while still allowing for the jurisdictional dispute to be resolved. (1)

This Principle recognizes and seeks to address the administrative and financial challenges of providing health care to those who access care cross-jurisdictionally.

Jordan's Principle, however, "remains in limbo" because "federal and provincial governments remain stuck in the same bureaucratic and jurisdictional quagmire that hampers service provision to [First Nations] children" (Lett 2008, 1256). When called to testify under oath regarding the terms of implementing Jordan's Principle, an official from Aboriginal Affairs and Northern Development of Canada stated that "the federal government would only provide funds for Jordan's Principle cases involving children with complex medical needs and multiple service providers" (Blackstock 2012, 367). By shifting the intention of Jordan's Principle to only extreme needs situations, the Government of Canada further signalled an unwillingness to address the cross-jurisdictional challenges experienced by all First Nations living on reserves. While Jordan's case demonstrates an appallingly horrific outcome when health systems do not have policies that ensure seamless health care delivery between jurisdictions, it also speaks to the invisibility and lack of accountability of health care systems that provide care to First Nations on reserves.

The events that led to the formation of Jordan's Principle bring to light the overwhelming challenges that First Nations living on reserves face with respect to equitable health care. It is obvious the uncertainty of who pays for health care services negatively and materially affects First Nations lives. As such, it is vital that seemingly invisible policies are made unequivocally visible and that the government responsible for that policy is held accountable. It is with this intention that I seek to make visible a federal health policy that focuses on perinatal care.

I remain hopeful that, like other policies, health policies can be instruments of change and can be used to consolidate resources across jurisdictions to address an issue (Bierman 2009). Whether health policies are broad or specific, they also signal an intention of governments to achieve specific goals and work within or across jurisdictions. As such, health policies are amenable to analysis using the three criteria that I set out above: allocation of resources, material impacts, and reactions.

Origins of the Evacuation Policy in Canada

Archival research conducted by Lawford and Giles (2012a) uncovered the Government of Canada's interference with the labour and birthing practices of First Nations living on reserves. Using the substantive authority granted through the *Indian Act* (1876), the federal government placed physicians on reserves to provide medical services in the 1890s. In 1896, Dr. Mitchell was hired to provide midwifery services to Chippewas and Muncey First Nations in Ontario. The introduction of federal physicians, specifically those that provided labour and birth services, was fuelled by national efforts to civilize and assimilate First Nations. The Government of Canada "enforced the Euro-Canadian biomedical model by resorting to coercion, threats, and fictitious legislation (under the guise of care and protection) to interfere with and make illegitimate First Nations' practices related to pregnancy, birthing, and childcare" (332). Throughout the twentieth century, increasing pressures from federal physicians and nurses resulted in the shift from home and community birthing to nursing stations and then to hospitals.

The Public Health Agency of Canada refers to the evacuation of pregnant women beginning in the 1970s as a matter of fact reality associated with living in northern Canada (Canada. Public Health Agency of Canada, 2009). One obstetrician working in the Northern Medical Unit and Department of Obstetrics and Gynaecology at the University of Manitoba, Dr. Thomas F. Baskett (1978), described the evacuation policy as "very simple: all primigravidae, grand multiparae, and any patient with a significant obstetric history or antenatal complication are electively evacuated for delivery in hospital" (1003). It appears that Dr. Baskett practiced the evacuation policy in a manner unlike other care providers in rural and remote communities in that criteria were developed for evacuation. Currently, the evacuation policy is applied to all First Nations women living on reserves in remote and rural Canada, regardless of obstetrical history. The blanket evacuation of all pregnant First Nations women is in accordance with a federal government policy decision as relayed through Health Canada Clinical Practice Guidelines that instruct federally employed nurses to "arrange for transfer to hospital for delivery at 36-38 weeks' gestational age according to regional policy (sooner if a high-risk pregnancy)" (Canada. Health Canada 2012b, 12-16).

Canada's Evacuation Policy for Pregnant First Nations Women Living on Reserves

The First Nations and Inuit Health Branch of Health Canada is responsible for the delivery of primary health care for First Nations who live on reserve (Canada. Health Canada 2012a). Primary health care services are predominantly delivered by nurses who provide prenatal care and only address emergency postpartum care issues, such as postpartum hemorrhage and severe hypertension, when required (Canada. Health Canada 2012b). To assist, Health Canada has developed *Clinical Practice Guidelines* "for use by community health nurses employed by Health Canada providing primary care in isolated, semi-isolated, and remote First Nations communities" (Canada. Health Canada 2013, par. 1). Health Canada's *Guidelines* "contain information to assist in the identification, diagnosis, and treatment of illness and other health issues in a primary care setting and may be used for reference and education purposes" (Canada. Health Canada 2012c). The *Guidelines* are separated into two broad categories: Adult Care; and Pediatric and Adolescent Care. Chapter 12 in the Adult Care category contains Health Canada's *Guidelines* related to obstetrics. Only one sentence in the *Guidelines* makes reference to the evacuation policy, which reads as follows: "arrange for transfer to hospital for delivery at 36–38 weeks' gestational age according to regional policy (sooner if a high-risk pregnancy)" (Canada. Health Canada 2012b, 12-16). Although the *Guidelines* do not explicitly make reference to the evacuation policy, I will use the three criteria of a policy discussed above to argue that this federal direction to nurses is, in fact, a policy.

Identifying the "Invisible" Evacuation Policy

Before examining the evacuation policy using the three criteria that are used to identify an invisible policy, I want to briefly re-introduce the quotation from Theimer (2012). By replacing her reference to language with concepts related to health and maternity care services for First Nations women living on reserves, the quotation reads as follows:

> Policy is communicated through official documents, but can be inferred from people's language practices, ideologies, and beliefs. There are implicit and covert ways of regulating [maternity care services for First Nations women]. This may be as simple as avoiding, delaying, and ignoring certain [maternity care] issues or deliberately limiting the knowledge and learning of other [maternity care systems]. Such a strategy has been called the 'invisible policy' (Giri, 2011). Visible or invisible, [maternity care] plans are often used to maintain current power structure, influence public opinion, and allocate resources for the education and promotion of the chosen [maternity care plan for First Nations women]. These policies often lead to benefits for some and loss of privilege status and rights for [First Nations people]. (280)

With this re-framing of Theimer's quotation, I will now examine the evacuation policy using the perspective of "invisible policies" discussed above.

Allocation of Resources

Resources can be economic (Giri 2011, 199), human, or otherwise (Theimer 2012). Canada's contribution to human health resources to support the evacuation policy is shown by their employment of nurses to deliver primary health care services to First Nations living on reserves, including prenatal care (Canada. Health Canada 2012b, 2012c, 2013). Health Canada's direction to not provide intrapartum care is evidence that the routine evacuation of all pregnant First Nations women living on reserves is a policy as it demonstrates the government's choice (Dye 1978). The federal government chooses not to hire those who could mitigate the impacts of the evacuation policy, such as midwives (Lawford and Giles 2012b), despite having the legislative authority to do so through the *Canada Health Act* (1985).

The absence of midwifery as a job classification is curious because, nationally, midwifery is regulated and publically funded in almost all provinces and territories—or is in the process of being regulated and funded (Canadian Midwifery Regulators Consortium 2010). The federal system, then, is, exceptional (Canada. Treasury Board Canada Secretariat 2006; Lawford and Giles 2012b). The exclusion of midwives as federal employees limits the maternity health services available to First Nations women on reserves. While there is limited research on the degree of interest in having midwifery services accessible on reserves, Stefan Grzybowski and Jude Kornelsen's (2009) study suggests community interest. The National Aboriginal Health Organization (2006) also draws attention to interest in midwifery services and to national research showing that 59 percent of First Nations surveyed were unable to access

such services. The lack of a midwifery job classification is arguably a policy decision, as the Canadian government has yet to expand their employee classification to include midwives nor is there indication that future inclusion is being planned. The absence of midwifery, in turn, ensures that the evacuation policy remains necessary.

Across the country, resources have been allocated to meet the growing maternity care needs of First Nations women who are routinely evacuated in pregnancy. The Meno-Ya-Win Health Centre in Sioux Lookout, Ontario, for example, has seen a doubling of births (CBC News 2012). In Manitoba, provincial and Winnipeg governments have dedicated resources to develop the *Maternal and Child Health Care Services Provincial Perinatal Referral Process*, a process that is intended to mitigate the negative impacts the evacuation policy has on their provincial health system (Government of Manitoba 2011). According to the Winnipeg Regional Health Authority, women that relocate for birthing services "are not receiving adequate services and support related to a healthy pregnancy once they reach urban locations. They often experience loneliness, boredom and isolation" (4). Unfortunately, a search to determine how this referral process is being developed and implemented was unsuccessful. As a result, it is unclear if and how the Manitoba process is affecting the care that women receive.

Manitoba health researchers are drawing attention to the evacuation policy and its effects. In their analysis, Ashley Struthers et al. (2015) refer to it as "traveling for birth" and advocate for changes to "address the injustices created through the enforced practice of having to evacuate their home community to give birth" (n.p.). It is noteworthy that this analysis does not refer to traveling for birth as a policy, but rather describes it as a norm (n.p.). This normalizing of a policy makes it invisible, particularly as the federal government becomes increasingly reliant on other levels of governments, organizations, and individuals to provide services "through a variety of indirect mechanisms" (Mettler 2011, 13).

Material Impacts

Jennifer M. Dawson (1993) and Lawford and Giles (2012a, 2012b) have examined the material impacts of Canada's evacuation policy. Lawford and Giles (2012b) focus on First Nations women living on reserves and seek to understand why "the evacuation policy does not result in good health" (329). They found that the policy has material effects on First Nations women, families, and communities because it physically removes women from their support systems. The isolation of women also obstructs First Nations' social and cultural practices that are specific to pregnancy, labour, childbirth, and the postpartum period (Dawson 1993; Grzybowski and Kornelsen 2009; Kornelsen and Grzybowski 2005; Kornelsen et al. 2010; Paulette 1990). The loss of these practices results in the assimilation of First Nations, a process that is not accidental. Citing the national colonial project, Patricia Jasen (1997) positions the evacuation policy "as part of its 'civilizing mission,' [which] the Canadian government adopted [as] an interventionist policy which led, in recent decades, to the practice of evacuating pregnant women to distant hospitals" (383). As such, the loss of First Nations pregnancy, labour, and birth practices is not an unintended outcome of evacuation, but rather is a purposeful and intentional policy outcome, as it reinforces other Government of Canada policies of assimilation like the Indian Residential School system. Canada's evacuation policy, therefore, impinges upon First Nations self-determination (Dawson 1993; Lawford and Giles 2012b) because it removes choice and autonomy in the area of health, a process that is legislatively grounded in the *Indian Act* (1876).

The removal of women from their families and communities also removes them, and their babies, from their land base. While this may not be viewed as an important aspect of maternity care services within a Euro-Canadian biomedical model of health care, land is "the most important component of identity for First Nations, as well as a critical component of First Nations' health" (Lawford and Giles 2012b, 335). From a First Nations perspective, the evacuation of pregnant women from their community's land thus materially impacts maternal and child health. Although the Euro-Canadian biomedical model of health and wellbeing may not link land with health, and by extension a loss of land with poor health, it must be remembered that First Nations have health practices and epistemologies that are not necessarily congruent with this dominant model of care (Lawford and Giles 2012b; Waldram, Herring, and Young 2006). The evacuation policy seems, therefore,

to be operating in contradiction with Health Canada's commitment to recognize "that cultural practices and traditions are essential to the health and well-being of First Nations" (Canada. Health Canada 2012d).

Reactions

Various agencies and scholars have critiqued Canada's evacuation policy. The Society of Obstetricians and Gynaecologists of Canada (SOGC), for example, has developed two clinical practice guideline documents that seek to provide direction to maternity care providers to mitigate the impacts of broad evacuation policies on Aboriginal and non-Aboriginal women. The most recent document, "SOGC Policy Statement: Returning Birth to Aboriginal, Rural, and Remote Communities," states that "the SOGC strongly supports and promotes the return of birth to rural and remote communities for women at low risk of complications" (2010, 1187). The SOGC (2010) further recognizes the significant impacts that community/home birthing has on sustaining Aboriginal identity among individuals, families, and communities. In another SOGC document, Carol Couchie and Sheila Sanderson (2007) stress that evacuation has "created hardship for many women, and there is growing evidence that it may contribute to postpartum depression and increased maternal and newborn complications" (251). It is noteworthy that Couchie and Sanderson do not specifically make reference to Health Canada's evacuation policy, even though the document they produced was sponsored by the First Nations and Inuit Health Branch of Health Canada. Rather, their analysis and recommendations are framed around the evacuation of all northern Aboriginal women. To support those who are involved in the provision of maternity care services, Couchie and Sanderson offer six recommendations to draw attention to the evacuation policy:

> 1. Physicians, nurses, hospital administrators, and funding agencies (both government and non-government) should ensure that they are well informed about the health needs of First Nations, Inuit, and Métis people and the broader determinants of health.
> 2. Aboriginal communities and health institutions must work together to change existing maternity programs.
> 3. Plans for maternal and child health care in Aboriginal communities should include a 'healing map' that outlines the determinants of health.
> 4. Midwifery care and midwifery training should be an integral part of changes in maternity care for rural and remote Aboriginal communities.
> 5. Protocols for emergency and non-emergency clinical care in Aboriginal communities should be developed in conjunction with midwifery programs in those communities.
> 6. Midwives working in rural and remote communities should be seen as primary caregivers for all pregnant women in the community. (251-253)

It is apparent that the evacuation policy significantly sustains the loss of rural and remote birthing services, even though the literature demonstrates that it is harmful to women, families, and communities.

Canada's broad evacuation policy for pregnant First Nations women has resulted in the closure of maternity care services in small rural hospitals (Kornelsen et al. 2010); these unit closures also impact non-First Nations women. Nation-wide, "fewer hospitals provide maternity care, forcing many women to leave their families and travel long distances to give birth" (Women and Health Care Reform 2007, 2). Widespread application of the federal evacuation policy to non-First Nations women has, as a consequence, resulted in the closure of health centres that could lessen the impacts of the blanket evacuation policy for all women, families, and communities.

The Native Women's Association of Canada's (2009) public resource, *Journey for Two: A Guidebook for When You're Away From Your Community to Give Birth*, also constitutes a response to Canada's evacuation policy. It was funded by Health Canada—the very federal department that implements the evacuation policy. By funding the development of a resource to minimize the impacts of the evacuation policy, the federal government thus acknowledges that the policy does exist and that it does have negative effects on First Nations women, families, and communities. The various reactions that this policy elicits points to its existence, even if federal documents do not explicitly label it as such.

Discussion

There is a scarcity of literature on the concept of an invisible policy and specific research on invisible health policies appears to be nonexistent. Whether explicit or invisible, policies warrant attention and critique because they have tangible consequences on a government's constituents. Moreover, the uncovering of an invisible policy through policy analysis serves to

illuminate the many contexts and implications of a government decision, particularly when the decisions are complicated by incongruencies between government systems. This article has sought to fill a gap in the literature on invisible policy, using Canada's evacuation policy as a case study.

Canada's evacuation policy as it pertains to pregnant First Nations women living on reserves is amenable to being classified as a policy, as demonstrated above. Identifying an invisible health policy is important because it directly impacts people's health. First Nations women, families, and communities are negatively affected by this broad health policy, even if the government's policy goals are to improve access to maternity care services and, by extension, to enhance maternal and child health. Assessing the results of the evacuation policy, however, is difficult because the federal government has yet to articulate its policy goals.

Uncovering the workings and impacts of the evacuation policy as a federal health policy also enables those involved in the provision of maternity care services to better plan for present and future needs so as to attend to identified gaps. These gaps may be human, financial, and/or administrative. Through the clear labelling of the evacuation policy as a Government of Canada policy and a well-defined articulation of the parameters of evacuation, all of those impacted can plan accordingly. Making the evacuation policy visible will further facilitate the identification of gaps in health care systems, especially when those under federal jurisdiction enter provincial health care systems.

Unpacking the evacuation policy through the three criteria I discussed above also makes a contribution to policy analysis. These analytical tools can be used in other contexts to draw attention to the extent to which governments leverage invisible policies to exploit and marginalize certain populations largely without critique. When policies are made explicit, policy analysts can register a need to address gaps in practices and their impacts as well as generate attention within the policy community. Further, the identification of an invisible policy can operationalize extensive resources to tackle significant problems caused by policies that have previously been invisible.

Examining a policy in this manner also permits governments to revise their policies to ensure gaps can be closed. Lawford and Giles (2012b) offer a preliminary consideration of various opportunities in this regard as they relate to the evacuation policy. While some of these appear promising—particularly the promotion of maternity care services that "bridge" the gap between federal and provincial jurisdictions—further analysis and reflection are required.

The legal category of First Nations women residing on reserves as derived from the *Indian Act* (1876) provides a focal point from which to examine the evacuation policy. However, this policy continues to reinforce the gendered discrimination faced by Aboriginal women. My analysis has also created important openings to examine notions of self-determination and the inclusion of reproductive justice movements in relation to federal health policy—not just for those First Nations residing on reserves. Several Aboriginal scholars link these two immense topics by employing pan-Aboriginal/Indigenous perspectives to explore, critique, and position Aboriginal/Indigenous identities, particularly those of women, within policy analysis. The very important work being done by Jessica Danforth and the Native Youth Sexual Health Network focuses on pan-Indigenous sexual and reproductive health, rights, and justice. Sarah Hunt (2014) critiques the process that "requires Indigenous people to identify with profoundly asymmetrical forms of recognition granted to them by the colonial state and society" (29). Bonita Lawrence and Kim Anderson (2005) also draw attention to and refute the legal category of Indian woman:

> Our identities are fragmented from the attack on our cultures and communities, and by legal definitions of 'Indianness' that divide us and encourage us to struggle amongst ourselves for greater access to the state financial support that keeps many of our communities alive. (4)

Leanne Simpson's (2004) scholarship also draws on Indigenous/Aboriginal identities and not on the legal categorization rooted in the *Indian Act* (1876), permitting the contextualization of self-determination and the reclaiming of identity.

My motivation to expose the evacuation policy for First Nations on reserves is to activate ongoing discussions across jurisdictions to improve the health systems that First Nations access, rather than leaving the provision of maternity health services to individual practitioners. Certainly, the identification of Health Canada's evacuation policy as a legitimate and genuine

federal policy will draw attention to the ways in which the Government of Canada chooses to direct, or not, resources to health services for First Nations women and children living on reserves. This will no doubt result in critique; however, efforts to improve maternal and child health are worthy of thoughtful and informed decisions.

Conclusion

Given the lack of literature related to invisible polices, this paper has sought to make apparent policies that are shrouded by governments. I presented an analytical tool to identify invisible policies using three criteria—allocation of resources, material impacts, and reactions. Such identification can assist in policy analysis for the purposes of improving government policy. Broadly, the unveiling of invisible policy has the potential to reveal a multitude of gaps and enable systematic approaches to those impacted by such policies. Specifically, the case study of Canada's evacuation policy for pregnant First Nations women living on reserves reveals it as a government policy and, with this identification, I hope to facilitate an evaluation of the resources necessary to improve the health of First Nations women and children.

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