CHILD, YOUTH, AND FAMILY HEALTH

FORCED AND COERCED STERILIZATION OF INDIGENOUS WOMEN AND GIRLS IN CANADA: *Understanding the practice and how to end it*

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Forced and coerced sterilization is a horrific and ongoing practice in Canada. It is contrary to Canadian and international law, and it must end (Senate of Canada, 2022, p. 8).

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Sterilization [1] is a permanent procedure to prevent pregnancy. Common methods of sterilization include tubal ligation (i.e., to have a woman's "tubes tied") and male vasectomy procedures (World Health Organization, 2014). Within this fact sheet, sterilization refers to all surgical methods intended to prevent a women's pregnancy.

For decades, Indigenous [2] women and girls from all across Canada have been subject to sterilization procedures that were performed either forcibly or out of coercion (House of Commons [HOC] Standing Committee on Health, 2019a).[3] When forced, sterilization often takes place during or following childbirth and without the mother's free, prior, and informed consent.

Coerced sterilization occurs when consent is obtained either voluntarily or involuntarily and on the basis of false, misleading, or inadequate information, generally coupled with the use of threats, harassment, intimidation, or other forms of physical or psychological pressure to influence sterilization (Boyer & Bartlett, 2017; Senate of Canada, 2022). In some

[1] Content warning: This paper may be triggering or cause distress for some readers. It discusses colonial violence, human right violations, and obstetrical violence and harms toward Indigenous women, girls, and gender diverse peoples. For support, please reach out to the *Hope for Wellness Helpline* at https://www.hopeforwellness.ca or call 1-855-242-3310. Please take care while reading.

[2] The term "Indigenous" is used throughout this fact sheet to refer collectively to First Nations Peoples, Inuit, and Métis Peoples, as defined under Section 35 of the Canadian *Constitution Act* of 1982. When referring to a specific Indigenous group, the terms "First Nations", "Inuit", and "Métis" are used where relevant.

[3] Forced and coerced sterilization procedures affect the lives of Indigenous women, girls, and men (Stote, 2012). To maintain focus and scope, this fact sheet focuses on the experiences of Indigenous women and girls. Further work is thus recommended to explore this issue as it pertains specifically to the experiences of Indigenous men.

National Collaborating Centre for Indigenous Health
Centre de collaboration nationale de la santé autochtone

sharing knowledge · making a difference
partager les connaissances · faire une différence
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The urgency of this issue has recently caught national and international attention, prompting collaborative efforts between human rights activists, politicians, and allies to document truths and advocate for legislative and policy change.

cases, sterilization is medically necessary or personally desired by the patient. However, when sterilization is forced or coerced, it can leave damaging impacts on the physical and mental health and well-being of patients, their families, and communities; tarnish trust with healthcare systems; and significantly impair patients' perceptions of self-image, confidence, and sense of womanhood (Boyer & Bartlett, 2017). Indigenous women specifically have had a long history of forced and coerced sterilization and continue to disproportionately experience these practices. While the exact number of Indigenous women in Canada who have experienced this violation is underreported and underestimated (House of Commons, 2019d; Senate of Canada, 2021), as of 2018 more than 100 Indigenous women and girls from multiple provinces and the territories have come forward to talk about and disclose traumatizing experiences of sterilization that was either forced or coerced in a hospital setting (HOC Standing Committee on Health, 2019a). The practice of forced and coerced sterilization is internationally recognized as an act of torture and genocide (Senate of Canada, 2022; United Nations [UN] General Assembly, 2016), is considered a "clear violation of human rights and medical ethics" (HOC Standing Committee on Health, 2019d, p. 5), and must be stopped.

The urgency of this issue has recently caught national and international attention, prompting collaborative efforts between human rights activists, politicians, and allies to document truths and advocate for legislative and policy change. Much of this work provides recommendations tailored towards healthcare systems, educational institutions, professional associations, and all levels of government. This fact sheet consolidates and summarizes these efforts and serves as a starting point to learn about the issue from both national and global perspectives. The information provided in this fact sheet is intended to facilitate productive and informed discussions at community, systems, and structural levels, as well as increase knowledge and awareness of evidence-based strategies that aim to end the heinous practice of forced and coerced sterilization among Indigenous women and girls. To this end, the following sections provide background information on the practice pertinent to Canada and describe how Canada has approached the issue; how the issue is addressed at the global level; and what needs to be done moving forward.

Background: What we know about the practice

One of most pervasive effects of forced and coerced sterilization is its direct violation of patients' rights to all elements of free, prior, and informed consent to any medical procedure (Senate of Canada, 2021). Within this context, free, prior, and informed consent encompasses the "capacity to consent", unaffected by the stressors of pregnancy or childbirth; a full and accurate disclosure of the risks, consequences, and other alternatives to contraception; "proper time in the appropriate environment and atmosphere" to consider the information, weigh options, and make informed choices; and a delivery of information that is without any form of coercion or bias (Lombard, 2019, as cited in Senate of Canada, 2021, p. 15). The duty of healthcare professionals to obtain free, prior, and informed consent from patients is regulated in Canada by policies under medical professional regulatory bodies. What's more, Section 7 of the *Canadian Charter of Rights and Freedoms* (*Constitution Act*, 1982) constitutionally protects reproductive rights and security over one's body. Case law describes this right, explaining:

> the right to determine what shall, or shall not, be done with one's own body, and to be free from non-consensual medical treatment, is a right deeply rooted in [Canadian] common law. This right underlies the doctrine of informed consent […] every competent adult has the right to be free from unwanted medical treatment (*Fleming v. Reid*, 1991).

Yet, testimonies of Indigenous women who have experienced forced or coerced sterilization and investigative reports point to a historical pattern of medical professionals in Canada failing to obtain free, prior, and informed consent, without coercion, often at the expense of the rights and security of Indigenous women and girls in vulnerable states. This practice is influenced by a long history of discriminatory policies and paternalistic ideologies (Billinger, 2014; Stote, 2012).

Until the 1970s, Alberta (1928) and British Columbia (1933) had sexual sterilization Acts in place to legalize the forced sterilization of women and girls who were deemed "mentally defective" (*Sexual Sterilization Act*, R.S.A. 1928, c. 37, s.1) – meaning to have varying intellectual abilities or mental illness. Consent for the procedure was only required by women who were deemed by

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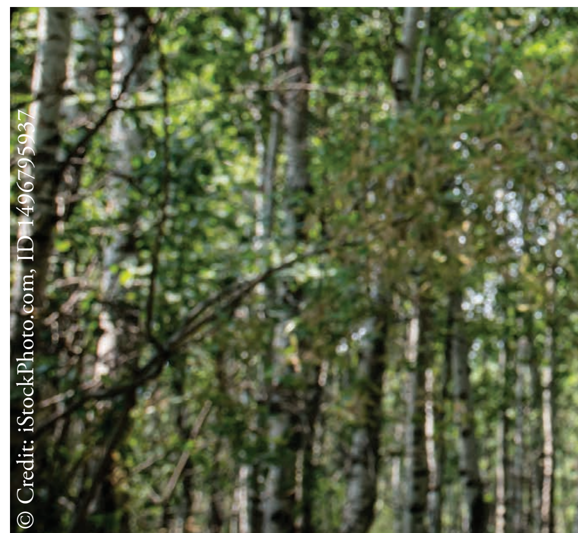
the province (led by a "Board of Eugenics" in British Columbia) to be mentally fit and capable of providing consent (described as "valid" consent in Alberta) (*Sexual Sterilization Act*, R.S.A. 1928, c. 37, s.1; *Sexual Sterilization Act*, R.S.B.C. 1933, c. 59). Similar legislation was proposed in Saskatchewan, Manitoba, and Ontario but had not proceeded to become law (Senate of Canada, 2021). Despite the absence of legislation, forced sterilization procedures continued to take place at high numbers across the country (Stote, 2012). The practice was oftentimes performed out of the "goodwill" of healthcare providers who perceived sterilization as a public health measure capable of improving society (Stote, 2012, p. 124). Within this mindset, healthcare providers sought sterilization as a means to alleviate or prevent poverty, by way of reducing the number of people – often with prejudicial bias toward Indigenous and other marginalized women – who were born into impoverished conditions and reliant on government-sponsored social programs (Billinger, 2014; Stote, 2012).

Although sterilization policies mainly targeted women in correctional facilities and mental health institutions (as well as girls residing in Industrial Homes for Girls in British Columbia), literature shows that hundreds of First Nations, Inuit, and Métis women were forcibly sterilized under these policies (Billinger, 2014; Boyer & Bartlett, 2017; Senate of Canada, 2022; Stote, 2012). Paternalistic assumptions and racist attitudes caused many Indigenous women and girls to be deemed "mentally defective" or "unfit", thereby excusing any requirement to obtain consent for sterilization procedures (Billinger, 2014; Stote, 2012). Forced and coerced sterilization of Indigenous women and girls was also a common practice in federally-run "Indian hospitals"[4] (Senate of Canada, 2021, p. 17). These policies were all overturned in the 1970s, but the practice continues in all corners of the country today (Boyer, 2020; Boyer & Bartlett, 2017; Senate of Canada, 2022; Zingel, 2022). As recent evidence explains, the history of the procedure in Canada places forced sterilization of Indigenous women as "consistent with how other medical services have sometimes been offered to Indigenous Peoples as attempts to control their bodies while criminalizing Indigenous health and reproductive practices" (Senate of Canada, 2021, p. 22).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What's happening in Canada?

Many studies and reports in Canada focus on health and human rights issues related to the forced and coerced sterilization of Indigenous women and girls (Boyer & Bartlett, 2017; HOC Standing Committee on Health, 2019d; Senate of Canada, 2021, 2022; Stote, 2012). Such reports aim to understand both the historic and contemporary complexities of the issue, as well as the traumatic realities of the procedure from the perspectives of both patients and witnesses. This fact sheet showcases select reports stemming from provincial health authorities, the Government of Canada, and national Indigenous health organizations.

[4] Racially segregated "Indian hospitals" and "Indian wards" or "Indian annexes" (generally located in the basement of general hospitals for settler populations) were established in the late 1800s by the federal government for the medical treatment of First Nations people and Inuit. By 1981, every "Indian" hospital was either closed or converted to a desegrated institution (Lux, 2018).

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(Boyer & Bartlett, 2017).

Provincial level

In 2015, two Indigenous women from Saskatchewan publicly disclosed and talked about their experiences of coerced sterilization, without their free, prior, and informed consent (Adam, 2015). Their truths have since prompted both internal and external reviews of the Saskatoon Health Region (SHR) and its practices surrounding sterilization procedures, specifically tubal ligation (Boyer & Bartlett, 2017).

Following the internal review, the SHR (now centralized under the Saskatchewan Health Authority [SHA]) revised their post-partum tubal ligation policy to address free, prior, and informed consent (Royal University Hospital, 2016). The new policy forbid sterilization following birth and prohibited any healthcare staff from discussing the procedure, unless an initial discussion between the patient and healthcare provider had already taken place prior to hospitalization and was documented in the patient's prenatal records (Royal University Hospital, 2016). The new policy was criticized by healthcare providers, based on its abrupt development, which saw little consultation with women who underwent the procedure, as well as the lack of education and training for healthcare staff that accompanied the policy's implementation (Boyer & Bartlett, 2017). The new policy also contained distinct gaps which disadvantaged people without a regular family physician, since the potential need for a tubal ligation could only be discussed with a regular family doctor, prior to hospitalization (Boyer & Bartlett, 2017). As a result of the new policy's limitations, the SHR arranged for a more thorough and meaningful external review to approach the issue. In 2017, Senator Yvonne Boyer and Dr. Judith Bartlett conducted the external review and explored the realities of coerced sterilization in the SHR, based on the perspectives of healthcare providers and Indigenous women who had experienced feeling coerced into having a tubal ligation immediately after childbirth (Boyer & Bartlett, 2017).

Boyer and Bartlett's (2017) report identified common experiences among Indigenous women who underwent coerced sterilization, as the women shared experiences of feeling invisible, profiled, and powerless. They spoke about the abuse of power stemming from healthcare providers who used misinformation, scare tactics, intimidation, or even the women's medical history as tools to influence tubal ligation (Boyer & Bartlett, 2017). Healthcare providers, on the other hand, spoke of policy challenges and lack of systemic coordination as key contributors to the

issue (Boyer & Bartlett, 2017). Healthcare providers explained that there was a lack of education surrounding tubal ligation policies and its underlying values, as well as a disconnect and minimal communication between healthcare providers and Child and Family Services (CFS) social workers. In fact, the role and presence of CFS social workers during childbirth was repeatedly noted as problematic by both the women and healthcare providers. As explained by healthcare providers, CFS social workers often deal with child apprehensions and their role in specific pregnancies is not often communicated to healthcare providers. The method by which CFS social workers obtain patient information is also unclear. The presence of CFS social workers in hospital is thus met with increased stress by both women and healthcare providers and perceived as a mediating factor for coerced tubal ligation (Boyer & Bartlett, 2017). Lastly, the report found the hospital environment, particularly racist attitudes toward Indigenous women, as well as discrimination, bias, and cultural ignorance often led to "subtle coercion" (p. 30); that is, explanations of tubal ligation that were either inaccessible (e.g., not in plain language) or insufficient (e.g., missing discussion on alternative forms of contraception) (Boyer & Bartlett, 2017).

The SHR's external review raised awareness of the issue of coerced sterilization and sparked a ripple effect in policy changes. Since the completion of the review, over 100 Indigenous women have joined a class action lawsuit against the SHR and several other class action lawsuits continue to surface, with many cases involving women in Alberta, Saskatchewan, Manitoba, Quebec, and Nova Scotia (Boyer, 2020; Narine, 2022). In terms of policy changes, the SHA has since implemented an Indigenous Birth Support Worker Program, which provides Indigenous women with "respectful, culturally safe, and trauma-informed care throughout labor, delivery and postpartum" (Pantey et al., 2022, p. 1). It also promptly revised its tubal ligation policy to improve clarity on the importance and procedure of obtaining free, prior, and informed consent and reiterate its commitment to create an "inclusive culture grounded in […] safety, accountability, respect, collaboration and compassion" in honour of First Nations and Métis peoples (SHA, 2021, p.1).

In following suit, in November 2022 the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and the Université du Québec en Abitibi-Témiscamingue released their investigative study into acts of imposed sterilization procedures[5] among First Nations and Inuit women in Quebec (Basile & Bouchard, 2022). The study was borne out of the need for data collection and widespread understanding on the realities and severities of this issue in the province. Researchers explained the need to understand the quality of information provided to patients regarding sterilization procedures and the associated environmental factors which may influence how or why consent is given for the procedure (e.g., communication between healthcare providers and patients, visible attributes of cultural safety, decision-making space allotted to patients). Researchers heard from 35 testimonies,[6] although an additional 20 testimonies could have been collected if not for the logistical challenges surrounding the COVID-19 pandemic (Basile & Bouchard, 2022).

[5] Imposed sterilization refers to undergoing a sterilization procedure without one's own knowledge. This description differs from forced or coerced sterilization and is used by the FNQLHSSC and Université du Québec en Abitibi-Témiscamingue in their report to illustrate an accurate depiction of First Nations and Inuit woman's experiences.

[6] The number of First Nations and Inuit women who have experienced imposed sterilization is considered to be underestimated (Basile & Bouchard, 2022).

Of these collected testimonies, nine women experienced imposed sterilization, 13 experienced imposed sterilizations and obstetric violence[7], three experienced imposed abortions, six experienced obstetric violence in an attempt to impose sterilization, and four witnessed acts of imposed sterilization and obstetric violence (Basile & Bouchard, 2022). In most cases, the women spoke about the blatant absence of or misinformation on consent forms and the pressure they experienced to consent to sterilization procedures. Many of the women (22 of 35) also noted having limited access to information on hysterectomies and tubal ligations, particularly on the permanency of these procedures and impacts on fertility, or on alternative forms of contraception beyond tubal ligation to assist them in making informed decisions. One woman recounted her experience in reviewing a consent form prior to her caesarian section only to find plans for "tubal ligation" embedded in the forms 'by mistake'. Another woman underwent a hysterectomy during her bladder surgery, without any prior discussion or consent. Across all testimonies, researchers found commonalities, specifically in the fear and mistrust First Nations and Inuit women have with the mainstream healthcare system and their experiences of differential treatment, and anti-Indigenous racism and discrimination in these settings, as well as a complete disregard for their right to free, prior, and informed consent (Basile & Bouchard, 2022).

In the weeks following the release of the FNQLHSSC and Université du Québec en Abitibi-Témiscamingue's report, calls for a second phase of the inquiry have been made to hear further testimonies of people who have undergone or witnessed imposed sterilization (Narine, 2022). Up to 12 Atikamekw women have also begun the groundwork to pursue a class action lawsuit against the Lanaudière Integrated Health and Social Services Centre in Quebec and three healthcare physicians for their experience of sterilization without their consent (Narine, 2022).

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[7] Obstetric violence is a form of systemic violence experienced in healthcare settings when healthcare professionals perform or do not perform certain acts without the knowledge and consent of the patient during childbirth.

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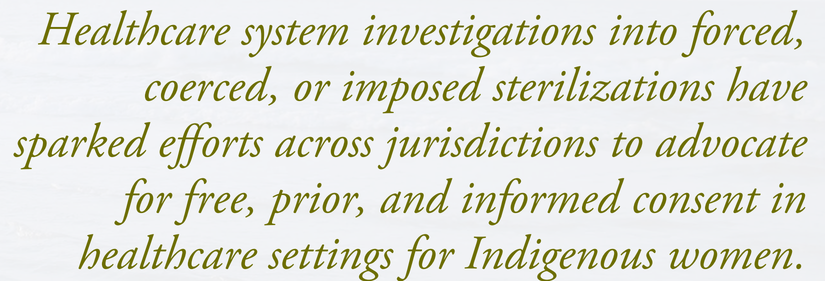
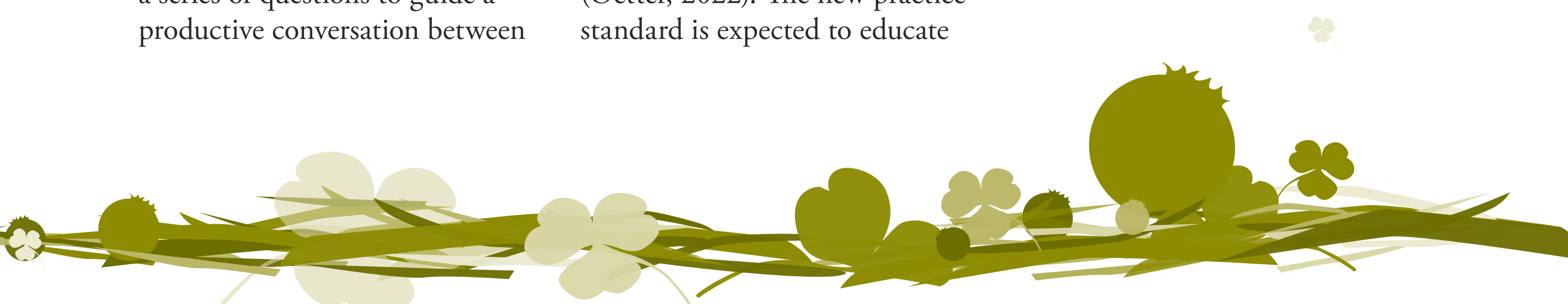
Policy changes are anticipated in Quebec's healthcare system, as the Indigenous Affairs minister reaffirmed the government's commitment to enshrine cultural safety into the province's health care legislation (Stevenson, 2022). This work is proposed under Bill 32, *An Act to establish the cultural safety approach within the health and social services network*, and sits under consideration by the National Assembly of Quebec.

By 2024, the Collège des Médecins du Québec released a seven-step action plan in response to the 2022 FNQLHSSC and Université du Québec en Abitibi-Témiscamingue report and its recommendations (Basile & Bouchard, 2022). The plan aims to regain First Nations and Inuit women's trust in Quebec's healthcare system and "ensure that no woman ever again undergoes sterilization without her knowledge or against her will" (Collège des Médecins du Québec, 2024, p. 2). The action plan involves revising Codes of Ethics for physicians to forbid any discrimination based on culture and identity; instituting mandatory basic cultural safety training for all physicians, as created by the Collège des Médecins du Québec; improving physicians' training on informed consent; and creating reproductive health awareness tools with First Nations and Inuit partners (Collège des Médecins du Québec, 2024). Experts on the issue assert the plan may be a promising policy action, from which other provincial medical governing bodies may learn, in efforts to end obstetrical violence across jurisdictions (Rukavina, 2024).

Healthcare system investigations into forced, coerced, or imposed sterilizations have sparked efforts across jurisdictions to advocate for free, prior, and informed consent in healthcare settings for Indigenous women. For example, the First Nations



Health Authority (FNHA) in British Columbia, Métis Nation of Ontario, Perinatal Services BC, and Senator Yvonne Boyer developed the *Shared Decision-Making Guide and Form: Informed Consent for Contraception*, which aims to "prevent decisions about contraception being made in an acute setting (that is, just before, during or after giving birth) and to ensure the patient's voice is heard and understood" (FNHA & Perinatal Services BC, n.d., p.1). The resource identifies the greater need for consent for First Nations people, Inuit, and Métis people and provides a series of questions to guide a productive conversation between the healthcare provider and patient about consent, ensuring that if consent is provided, it is informed, free from any stressors, and granted in an appropriate setting (FNHA & Perinatal Services BC, n.d.). Moreover, professional bodies, such as the College of Physicians and Surgeons of British Columbia (CPSBC), have also come together with registrants, the public, and patient advocacy groups to inform the development of a new practice standard regarding the importance of obtaining informed consent, in alignment with principles of cultural humility (Oetter, 2022). The new practice standard is expected to educate healthcare professionals on the consent process as it pertains to the needs of differing cultural contexts, including the needs of Indigenous Peoples. This measure aims to ensure that the consent process is both culturally safe and appropriate (Oetter, 2022). The development of this standard comes in response to the growing awareness of forced and coerced sterilization among Indigenous women, as documented in both provincial and federal reports (Oetter, 2022).



The issue of underreporting and underestimating incidences of forced and coerced sterilization due to the lack of a culturally safe environment was also brought forward, with racism and colonial attitudes toward Indigenous Peoples within the healthcare system cited as some of the fundamental causes (HOC Standing Committee on Health, 2019d).

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Federal level

The federal response to forced and coerced sterilization of Indigenous women and girls also stems from the SHR external review and is largely led by the Senate of Canada's Standing Senate Committee on Human Rights and the House of Commons (HOC) Standing Committee on Health. Both committees have recently studied and reported on the issue, finding similar outcomes and mirroring their recommendations for change.

In 2019, the HOC Standing Committee on Health explored the issue through two meetings involving witnesses of forced and coerced sterilization and other knowledge holders on the issue. The findings from these meetings are summarized in a final report presented to the House of Commons along with 18 recommendations for effectively addressing and ending forced and coerced sterilization of Indigenous women in Canada (HOC Standing Committee on Health, 2019d; HOC Standing Committee on Health, 2019b). These discussions provided ample evidence of the gaps in standard health care practice to obtain free, prior, and informed consent, prior to sterilization, rendering healthcare providers in breach of their "therapeutic alliance between the patient and the healthcare provider… [and] ethical responsibilities with respect to preserving the autonomy of the patient" – both key components to care in which physicians are made fully aware and responsible (Blake, 2019, as cited in HOC Standing Committee on Health, 2019d, p. 5). Moreover, the HOC Standing Committee on Health found little to no measures to hold healthcare providers and organizations accountable by health or justice systems (HOC Standing Committee on Health, 2019d). The issue of underreporting and underestimating incidences of forced and coerced sterilization due to the lack of a culturally safe environment was also brought forward, with racism and colonial attitudes toward Indigenous Peoples within the healthcare system cited as some of the fundamental causes (HOC Standing Committee on Health, 2019d). Implementation of accountability structures and improvements in data collection and reporting methods are prominent recommendations proposed by the HOC Standing Committee on Health (HOC Standing Committee on Health, 2019d).

In June 2021 and July 2022, the Standing Senate Committee on Human Rights released its preliminary and final reports on the troubling and horrific realities of forced and coerced sterilization among women in Canada generally, although much discussion focused on the specific experiences of Indigenous women (Senate of Canada, 2021, 2022). Each report outlines the direct links between racism and forced sterilization, as well as the colonizing and genocidal agendas that underpin the practice (Senate of Canada, 2021, 2022). The final report recounts testimony of Indigenous women who experienced forced and coerced sterilization and draws connections between their shared experiences of overt racism and discrimination and the long-lasting impacts they felt alongside their families and communities (Senate of Canada, 2022). Many women said they experienced depression and post-traumatic stress disorder following involuntary sterilization procedures, as well as anxiety and fear that cultivated distrust in the healthcare system (Senate of Canada, 2022). The report also identifies links between the practice and "erasure of Indigenous lineages", explaining how "several survivors and expert witnesses described [forced and coerced sterilization] as amounting to genocide" (Senate of Canada, 2022 p. 24). Recommendations to move forward centre around accountability, reparations for women subjected to forced or coerced sterilization, improved education, and other key factors (discussed in later sections) (Senate of Canada, 2022).

The federal government has since implemented measures to address forced and coerced sterilization, such as establishing an Advisory Committee on Indigenous Women's Wellbeing to advise Indigenous Services Canada (ISC) on issues pertaining to Indigenous women's health, including their reproductive health (HOC Standing Committee on Health, 2019d). ISC also allocates funding to support operations of the *Hope for Wellness Helpline* – a telephone and online counselling service, available to all Indigenous

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(Senate of Canada, 2022).

people across Canada, in English, French, Cree, Ojibway (Anishinaabemowin), and Inuktitut, 24 hours a day, seven days a week (Hope for Wellness, 2022). In line with its mandate, the *Hope for Wellness Helpline* has been cited as a supportive resource for people affected in any way by coerced or forced sterilization (Leason & Ryan, 2019). ISC also funds initiatives designed to address anti-Indigenous racism within healthcare systems (ISC, 2021), as well as Health Canada's *Addressing Racism and Discrimination in Canada's Health Systems Program* and the National Collaborating Centre for Indigenous Health's (NCCIH) *Cultural Safety Collection*. Health Canada's *Addressing Racism and Discrimination in Canada's Health Systems Program* funds communities and health organizations in their pursuit of projects and engagement activities, aimed at eliminating systemic racism and discrimination across healthcare systems. Projects funded under this initiative are intended to be informed by "lived experiences of Indigenous, racialized and marginalized communities" (Health Canada, 2022, p. 1). The NCCIH's *Cultural Safety Collection* is an online library of Indigenous-specific cultural safety and anti-racism tools and resources, such as videos, podcasts, research articles, and training materials. This cultural safety repository is the first of its kind in Canada (NCCIH, 2021a).

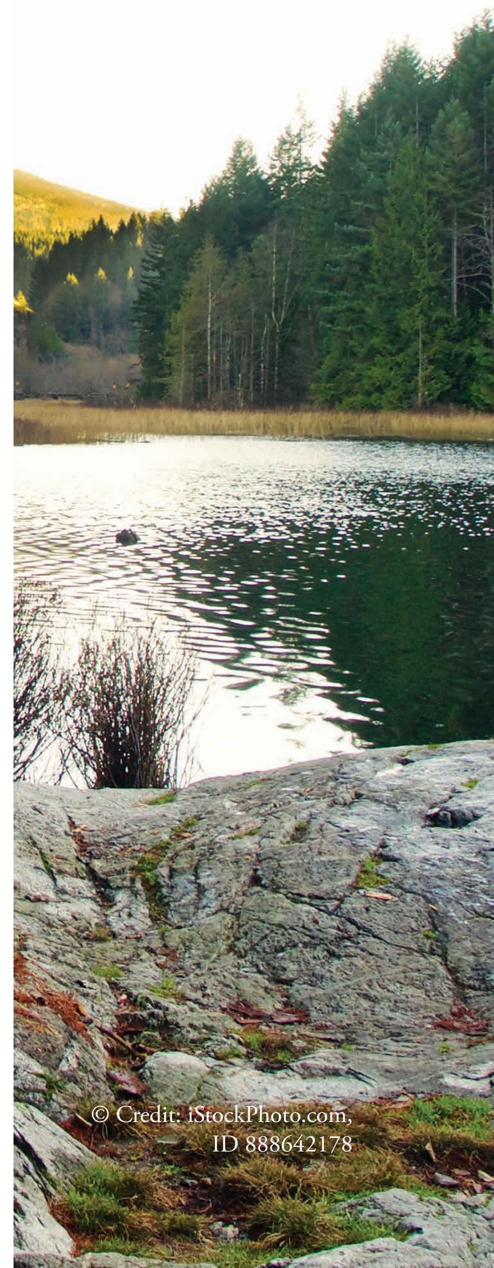
ISC also funds programs that support Indigenous midwifery practices (ISC, 2022). However, despite funding efforts, both the HOC and Senate Committees emphasize the need for additional federal support to improve the accessibility and capacity of community-based midwifery practices in order to sustainably and effectively address the needs of Indigenous communities (discussed in detail below) (HOC Standing Committee on Health, 2019d; Senate of Canada, 2022).

National Indigenous health organizations

Several national Indigenous health organizations are advocating and working on behalf of Indigenous women and girls and gender diverse people to stop unwanted sterilization, with many of these efforts financially supported by the ISC Advisory Committee on Indigenous Women's Wellbeing, as mentioned above (Global Affairs Canada, 2022). The Native Women's Association of Canada (NWAC) has been actively involved in this issue, from developing toolkits to enhance women's knowledge of their rights, to holding national conventions and participating in international dialogue to inform policy actions (NWAC, 2022). Les Femmes Michif Otipemisiwak (Women of the Métis Nation) and Pauktuutit Inuit Women of Canada have also

investigated forced and coerced sterilization using distinctions-based approaches to identify key issues and formulate calls for government action. Les Femmes Michif Otipemisiwak hosted a national forum to discuss the issue from the perspective of Métis women's experiences and summarized what was heard into the organization's policy statement on forced and coerced sterilization and related recommendations for the Government of Canada (Les Femmes Michif Otipemisiwak, 2021). Similarly, Pauktuutit Inuit Women of Canada examined the issue from the perspective of Inuit women living in Inuit Nunangat (Pauktuutit Inuit Women of Canada, 2019). The year-long study identified issues pertinent to Inuit women's access to high quality and trauma-informed reproductive health care and explored the meaning of free, prior, and informed consent specific to the needs of Inuit women (Pauktuutit Inuit Women of Canada, 2019). The National Aboriginal Council of Midwives (NACM) has also released its position statement and recommendations for change regarding forced and coerced sterilization of Indigenous Peoples, explaining how the practice is directly tied to historical and contemporary colonial agendas of colonization and assimilation (NACM, 2019).

In 2020, the NCCIH, in partnership with the First Nations Inuit Health Branch of ISC, hosted a national forum on *Informed Choice and Consent in First Nations, Inuit and Métis Women's Health Services*. The forum discussed the realities of coerced and forced sterilization, concepts of informed choice and consent, and culturally safe practices in health care from a distinctions-based lens, finding that, in most instances, "consultation does not equal consent" (NCCIH, 2021b, p. 8). The forum also identified concrete actions to address injustices, support those affected, and stop unwanted sterilization. These included the need to empower women, support healing initiatives, acknowledge anti-Indigenous racism in health care, and improve both the accountability and education of healthcare providers (NCCIH, 2021b). Recommendations were developed for all levels of government, institutions, and organizations for health care education, regulatory bodies and professional associations, Indigenous and other organizations, and communities (NCCIH, 2021b). While the forum brought to light the many tragic truths of coerced and forced sterilization, it also emphasized the ongoing nature of the issue and the need for systemic and institutional cultural change, noting "coerced and forced sterilization continues to happen and it is not just because of a lack of cultural competence, it is because of systemic anti-Indigenous racism" (Lombard, as cited in NCCIH, 2021b, p. 7).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What's happening globally?

The ways in which this issue have been prioritized by the global human rights community speaks loudly to the urgency of ending forced and coerced sterilization and the need for Canada to implement immediate policy action. As it happens, much of the national reports previously discussed are outcomes of international calls on Canada to investigate and address the issue. The urgency and influence stemming from the global community makes it imperative to learn about how the issue is perceived at the global level and gather a more well-rounded sense of the measures being called on governments and what may lie ahead for Canada in its efforts.

The United Nations (UN) is one such international organization that has long investigated forced and coerced sterilization. In 2014, the UN, in partnership with the World Health Organization (WHO), produced an interagency statement to address coerced sterilization and provide guiding principles for its prevention and elimination in practice (WHO, 2014). The interagency statement presents coerced sterilization as a global issue – one that discriminates against and violates the basic human rights of Indigenous women, as well as those living with HIV and disabilities, and transgender and intersex persons (WHO, 2014).

In 2016, the UN Special Rapporteur on *Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* affirmed forced and coerced sterilization as a form of torture (UN General Assembly, 2016), thereby aligning the practice with the definition of torture as per Article 1 of the UN *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*, established in 1984 and ratified by Canada in 1987 (UN, 1984, n.d.). The UN Special Rapporteur's 2016 report explained how forced and coerced sterilization is "an act of violence and a form of social control [that] violates a person's right to be free from torture and ill-treatment" (UN General Assembly, 2016, p. 12).

As the truths of coerced sterilization among Indigenous women came to light in Saskatchewan, the issue captured

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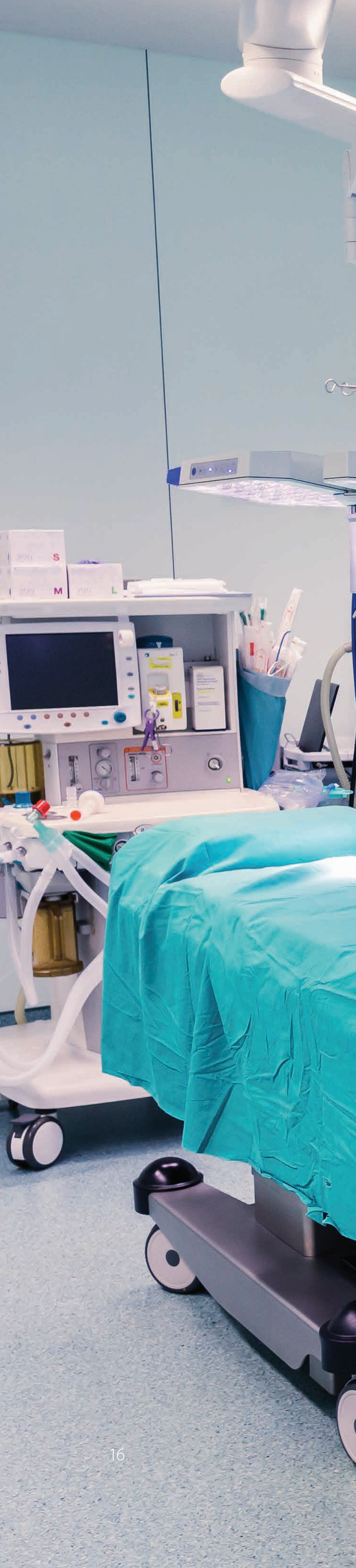
the interest of international headlines and prompted the UN Committee against Torture to classify 'involuntary sterilization of Indigenous women' as a 'principal subject of concern' in its periodic report to Canada in 2018 (UN Committee against Torture, 2018). The UN Committee against Torture raised concerns regarding the lack of action taken by Canada to address the SHR report (Boyer & Bartlett, 2017) and its many calls to action, particularly calls to address reparations for women who had been affected by unwanted sterilization (UN Committee against Torture, 2018). The UN Committee against Torture (2018) therefore recommended that Canada impartially investigate all allegations of forced and coerced sterilization to ensure accountability of all those responsible and that afflicted women receive proper redress. The committee further recommended that the Government of Canada:

> adopt legislative and policy measures to prevent and criminalize the forced or coerced involuntary sterilization of women, particularly by clearly defining the requirements of free, prior and informed consent with regard to sterilization and by raising awareness among Indigenous women and medical personnel of that requirement (UN Committee against Torture, 2018, p. 12).

Other international human rights organizations have since echoed these recommendations, including the Inter-American Commission on Human Rights (IACHR) and Amnesty International (IACHR, 2019; Amnesty International, 2019).

Next steps: What needs to be done to end it

National and international committees, commissions, and leading advocates involved in reporting on forced and coerced sterilization often point to vastly similar policy recommendations that are critical to ending this horrific, traumatic, and longstanding practice and human rights violation (Boyer, 2022; HOC Standing Committee on Health, 2019d; IACHR, 2019; Lombard, 2018; Senate of Canada, 2022; UN Committee against Torture, 2018). This fact sheet identifies several commonly cited recommendations, each tailored to preventing and ending the practice in Canada and centred on the needs of afflicted Indigenous women and girls.



Criminalization of forced and coerced sterilization

One of the most prominent calls to action is the criminalization of forced and coerced sterilization, by way of amending the *Criminal Code* (1985) of Canada to include explicit prohibition of the practice (Boyer, 2022; HOC Standing Committee on Health, 2019d; Senate of Canada, 2022; UN Committee against Torture, 2018). This recommendation may be coupled with enforcement and implementation of current provisions under the *Criminal Code*. Section 268 may be used to investigate and prosecute instances of forced or coerced sterilization, as depending on the case it may fall under the criteria of aggravated assault (Lucki, 2019, as cited in HOC Standing Committee on Health, 2019c). On June 14, 2022, Senator Yvonne Boyer introduced the Senate Public Bill S-250 *An Act to amend the Criminal Code (sterilization procedures)*. Bill S-250 would amend section 268.1 of the *Criminal Code* to define sterilization procedures and safeguards for obtaining consent. The Bill would make forced or coerced sterilization procedures an indictable offence, punishable by up to 14 years in prison.

At the time of writing, Bill S-250 is under study by the Standing Senate Committee on Legal and Constitutional Affairs, which has heard from legal experts and advocates, federal government officials, healthcare providers, and witnesses and survivors of forced and coerced sterilization. The Bill is expected to deter physicians and promote 'sober second thought' when considering a sterilization procedure, as well as prompt policy making within hospitals, medical associations, and regulatory bodies to ensure medical practices align with the Bill, such as practices in obtaining consent.

However, concerns over the Bill unearth tensions between obtaining consent for sterilization and physicians acting on medical emergencies or other instances that necessitate sterilization. Committee informants caution that in an effort to avoid criminal activity, physicians may be reluctant to perform sterilization procedures when it is required for medical emergencies, for youth under 18 years of age, or when requested by a patient but it is uncertain that the request originated from the patient themselves (i.e., the idea of a sterilization procedure was not voluntarily initiated by the patient and rather came from someone else, such as the healthcare provider). Bill S-250 currently does not fully protect physicians in these instances from later indictment of possible forced or coerced sterilization. These tensions, committee informants caution, pose risks to women and girls' access to care and life-saving procedures, as well as their reproductive health and rights (Standing Senate Committee on Legal and Constitutional Affairs, 2024). The Bill remains under study and will still need to proceed to the House of Commons before it becomes law.

Training for healthcare providers

Increased training and education for healthcare providers is also a primary recommendation. Reports and testimonies call for improved training of healthcare physicians and staff on "the clinical psychological and physical impacts of sterilization generally, and forced and coerced sterilization specifically [and] the physician/patient fiduciary relationship, bodily autonomy, and medical self-determination" (Senate of Canada, 2022, p. 40). Cultural competency, cultural safety, and women's health issues are also of priority to inform care providers' education, as well as all components to informed consent (HOC Standing Committee on Health, 2019d; Lombard, 2018). Adjacent to these recommendations are calls to increase recruitment and retention of Indigenous healthcare providers (such as by the Truth and Reconciliation Commission [TRC] Call to Action #24), as a way to catalyze the recruitment of culturally competent and safe healthcare staff.

It is also recommended that the Government of Canada create an online platform for healthcare providers to access training across the country, as well as mandate such training to be required, as per healthcare practitioner licensing (HOC Standing Committee on Health, 2019d; Lombard, 2018; Senate of Canada, 2022). With this, candidates may be screened for any racial biases and evaluated on cultural competence prior to receiving their license (Lombard, 2018).

Clear consent framework and public education

Federal, provincial, and territorial governments and healthcare institutions are repeatably called upon to develop and implement clearly defined consent frameworks to inform and educate healthcare providers, staff, patients, and their families (HOC Standing Committee on Health, 2019d; IACHR, 2019; Lombard, 2018; Senate of Canada, 2022; UN Committee against Torture, 2018). This framework is suggested to explicitly define requirements for free, prior, and informed consent with respect to sterilization and Indigenous women's health, as well as incorporate protocols for all healthcare providers (HOC Standing Committee on Health, 2019d; IACHR, 2019; Lombard, 2018). Alongside this recommendation is increased public and patient education and awareness on individual rights to informed choice and decision making in health care and on sexual and reproductive rights (HOC Standing Committee on Health, 2019d; IACHR, 2019; Senate of Canada, 2022). Public education campaigns are also suggested to meet the specific cultural and linguistic needs of Indigenous Peoples (NCCIH, 2021b).

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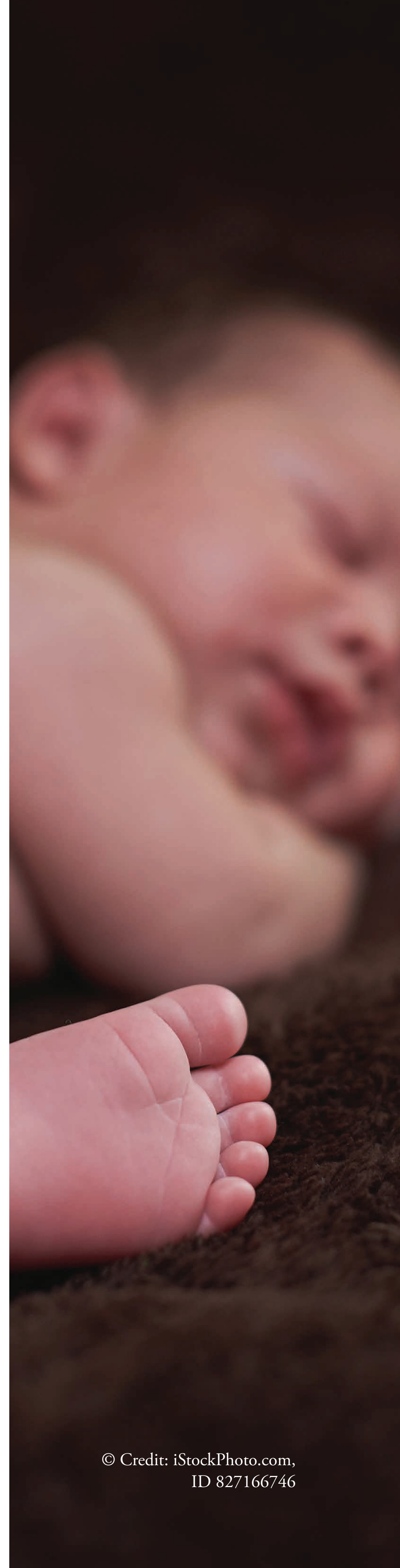
Reparation for Indigenous women and girls affected by unwanted sterilization and their families

Many calls to action centre on due compensation for Indigenous women and girls affected by forced or coerced sterilization (Senate of Canada, 2022; UN Committee against Torture, 2018). This initiative must be led and informed by afflicted women; however, it is also recommended that healing programs be established to provide counselling and other supports, as well as healing funds for women to access other alternatives to induce pregnancy such as in-vitro fertilization (HOC Standing Committee on Health, 2019d; Lombard, 2018).

Data collection, reporting, and accountability

Healthcare providers and staff responsible for facilitating or performing forced and coerced sterilization must be held responsible and accountable for their actions. To operationalize this necessity, improved data collection methods must be established. The Senate of Canada and HOC Committees both call for a national plan to safely collect and publish anonymized and disaggregated data related to sterilization, according to a variety of indicators such as "patient lived experiences and outcomes; hospital policies where the procedures occurred; and information on the cultural training and competencies of the healthcare providers" (HOC Standing Committee on Health, 2019d, p. 9). Improved data collection will inevitably advance public and institutional knowledge of the issue and facilitate appropriate health system responses (Senate of Canada, 2022). Adjacent to this recommendation are calls for improved reporting mechanisms for Indigenous people to safely report cases of forced and coerced sterilization without fear of judgement, ridicule, or repercussions (HOC Standing Committee on Health, 2019d; Senate of Canada, 2022). This measure also embodies calls to implement safe reporting procedures such as whistleblowing policies for all healthcare staff (NCCIH, 2021b). Reports must then be treated with respect for those reporting, involve thorough investigation, and follow up with appropriate disciplinary measures (HOC Standing Committee on Health, 2019d; UN Committee against Torture, 2018).

The National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG) Call for Justice #1.7 urges governments to collaborate and establish a National Indigenous and Human Rights Ombudsperson and Tribunal to receive and manage complaints of human rights violations and evaluate



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government services according to their compliance with Indigenous rights (NIMMIWG, 2019). This call is further recommended by the HOC Standing Committee on Health (HOC Standing Committee on Health, 2019d).

Supporting Indigenous midwifery and other community-based maternal health services

Both the Senate of Canada and House of Commons echo persistent calls to increase federal investments in Indigenous midwifery, doulas, and other community-based birth worker and maternal health service initiatives across Indigenous communities in Canada to improve both equitable and local access to these essential services (HOC Standing Committee on Health, 2019d; Senate of Canada, 2022). These calls are made despite recent funding commitments to support Indigenous midwifery practices by ISC (ISC, 2022), as advocates have identified the need for long-term sustainable investments, based on the specific needs of all northern, remote, and rural Indigenous communities (Senate of Canada, 2022). Community-based midwifery practices create healthcare spaces that are more likely to promote culturally safe and trauma-informed care and may offer maternal health services in preferred languages by the community. These elements can dismantle common social, cultural, and linguistic barriers to and harms associated with pre- and -post-natal care in mainstream healthcare systems. Investments in community-based midwifery also prevent the costly practice of necessary or forced travel to receive birthing services (HOC Standing Committee on Health, 2019d). Improved access and choice to receive care from an Indigenous midwife therefore assumes a vital role in ensuring equitable and safe access to sexual and reproductive health care for all Indigenous people, in the safety of their home community (NACM, 2019).

Responding to the Truth and Reconciliation Commission and NIMMIWG

The Truth and Reconciliation Commission (TRC) Calls to Action #23 and #24 and the NIMMIWG Calls for Justice #7.6, #7.7, and #7.8 are often cited as key policy recommendations for all levels of government in Canada to act on forced and coerced sterilization (HOC Standing Committee on Health, 2019d; Senate of Canada, 2022). These calls also touch on increased recruitment and retention of Indigenous Peoples in healthcare provider roles, as well as improved cultural competency training for both working and training healthcare professionals in the areas of "intercultural competency, conflict resolution, human rights, and anti-racism" (TRC, 2015, p. 3) and "the history of colonialism in the oppression and genocide of Inuit, Métis, and First Nations Peoples" (NIMMIWG, 2019, p. 189), among other topics.

Closing remarks

The practice of forced and coerced sterilization disproportionally targeting Indigenous women and girls is a horrific, torturous phenomenon, rooted in anti-Indigenous racism, discrimination, and assimilation. In 2015, the courage, strength, and resilience of Indigenous women was the catalyst to empower other women to come forward with their experiences and build pressure for change. Their courage sparked public and political attention to the issue, with national and international committees, commissions, and leading advocates learning the truths and responding through Indigenous-informed policy recommendations and calls for action. Much more work is needed to continue to spread awareness and lead governments to adopt permanent policy solutions that will abruptly stop and prevent the practice and support all Indigenous women, girls, and their families in their healing journey. The truths are well understood; the time to act is now.

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HOW TO USE THIS FACT SHEET

REFLECT

Talk to others in your community, reflect on the content of this fact sheet, and contemplate how you could make a difference in the health and well-being for yourself, your family or your community.

ENGAGE

Find local friendship centers, community organizations or groups where you can volunteer or participate in healthy positive actions. You too can share knowledge and make a difference in the health and well-being of First Nations, Inuit, and Métis Peoples' of Canada.

sharing knowledge · making a difference
partager les connaissances · faire une différence
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