Primary Research

Forced or Coerced Sterilization in Canada: An Overview of Recommendations for Moving Forward

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ABSTRACT

Between 2015 and 2019, over 100 Indigenous women from six provinces and two territories have come forward to say that they were forced or coerced to undergo a sterilization procedure in Canada. Despite this, government action is lacking. Through this paper, the research team aims to collect and synthesize the recommendations that have been made in response to the recent cases of forced or coerced sterilization of Indigenous women in Canada. Through a secondary analysis of data, we outline the findings of a thematic analysis of 162 recommendations from four selected sources: (a) Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women, an external review by Senator Yvonne Boyer and Dr. Judith Bartlett, July 22, 2017; (b) a meeting of the Senate Committee on Human Rights, April 3, 2019; (c) meetings of the House of Commons Standing Committee on Health, June 13 and 18, 2019; and (d) a letter from Bill Casey, Member of Parliament and Chair of the House of Commons Standing Committee on Health, to three federal ministers, August 2, 2019. Seven themes emerged following the thematic analysis of the 162 recommendations: (a) Services and Supports, (b) Accountability, (c) Training and Education, (d) Legislation and Policy, (e) Criminalization, (f) Data Collection, and (g) Investigation. These themes represent seven areas where immediate government action is required to meaningfully and appropriately respond to the recent cases of forced or coerced sterilization of First Nations, Inuit, and Metis women in Canada.

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Introduction

The forced or coerced sterilization of Indigenous women is not only an extremely serious violation of human rights, medical ethics, and reproductive rights but also an assault on the cultural integrity of Indigenous populations. Sterilizing Indigenous women against their will violates their rights to equality, nondiscrimination, physical integrity, health, and security, and constitutes an act of genocide, violence, and torture against women (OHCHR et al., 2014; United Nations Committee against Torture [UNCAT], 2018). The act of forced or coerced sterilization is a reprehensible act and we must call for its immediate and abrupt end. We must implement policies and practices that recognize and protect Indigenous women and girls in a way that centres, respects, and appropriately addresses their experiences and voices while working collaboratively to support their health and wellbeing. Indigenous people are holders of Aboriginal and treaty rights, with the inherent right to self-government and self-determination, and of human rights including gender-based rights and the right to health.

This article outlines findings from a thematic analysis of 162 recommendations from four selected sources:

- a. *Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women*, an external review by Senator Yvonne Boyer and Dr. Judith Bartlett, July 22, 2017
- b. a meeting of the Senate Committee on Human Rights, April 3, 2019 (Canada, 2019c)
- c. meetings of the House of Commons Standing Committee on Health, June 13 and 18, 2019 (Canada, 2019a, 2019b)
- d. a letter from Bill Casey, Member of Parliament and Chair of the House of Commons Standing Committee on Health, to three federal ministers, August 2, 2019 (Casey, 2019)

We also offer insights on the recommendations made which outline actions for moving forward. This approach is in alignment with the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) Article 29(3), which requires states to take measures to ensure that programs for monitoring, maintaining, and restoring the health of Indigenous Peoples are developed and

implemented by the Peoples the programs are intended to impact (United Nations, 2007). Additionally, the final report from the National Inquiry into Missing and Murdered Indigenous Women and Girls (National Inquiry into MMIWG, 2019) states that Indigenous women must be actively involved in developing and providing services for other Indigenous women. Immediate national action guided by expert recommendations, including responding to incidents of forced or coerced sterilization and addressing the reasons for genocide and systemic racism, is required in a way that is both culturally safe and trauma informed.

Background

Permanent contraception for women is most often carried out through a surgical procedure called tubal ligation. Tubal ligation eliminates a woman's ability to reproduce naturally, by closing the tubes where fertilization occurs (Patil & Jensen, 2015). Other options for permanent contraception include hysterectomies, total salpingectomy, and induced abortions (Patil & Jensen, 2015). Regardless of the form of contraception—permanent or otherwise—free, prior, and informed consent¹ must be obtained by the healthcare provider. Such consent should never be obtained by coercing exhausted, emotional, and often overwhelmed women during or shortly after childbirth. When an individual's ability to reproduce is tampered with through tubal ligation, without free, prior, and informed consent, it constitutes involuntary, forced, or coerced sterilization.

Historically, within the North American context, forced or coerced sterilization resulted from colonization, forced assimilation, and the eugenics movement. The eugenics movement allowed government to control which women were able to reproduce. Typically, women in the upper and middle classes were encouraged to reproduce, while women who were poor or marginalized were targeted (Stote, 2012). For example, in 1928, Alberta enacted the Sexual Sterilization Act that disproportionately, if not exclusively, targeted Indigenous women (Grekul et al., 2004). The vast majority of Indigenous women (77%) who were sterilized in Alberta during this time were viewed as sexually promiscuous or diagnosed as mentally defective through systemically biased IQ tests that were ill equipped to accurately establish mental competency (Stote, 2015). While the support of policies that promoted sterilization stopped in 1972–1973, they were not outlawed. Data indicate that between 1970 and 1975, 1,200 Indigenous women were sterilized in Canada and the Indigenous birth rate fell from 47 per 1,000 people in the 1960s to 28 per 1,000 people in 1980 (Collier, 2017; Stote, 2015). Sterilizations were conducted under the guise of being in the best interest of Indigenous populations, as a means of protecting “unfit” Indigenous women and families from the burdens of larger families (Stote, 2015). In reality, however, they were a means of population control, and a way to reduce

¹ Free, prior, and informed consent (FPIC) is an ethical and legal obligation of healthcare providers and stems from an individual's right to direct what happens to their body (Gossman et al., 2020). FPIC is the process through which a healthcare provider explains the details, risks, benefits, alternatives, and expected outcomes of a procedure, treatment, or intervention **prior** to administering it. The patient is then entitled to consent voluntarily without undue pressure or coercion (Evans, 2016; Gossman et al., 2020). The provider must ensure that the consenting individual understands what has been explained to them and that they are aware that they are the main voice in the decision-making process, ultimately determining their own medical course of action (Evans, 2016).

costs associated with the implementation of necessary public health measures (Stote, 2012). After all, it is far more economical to sterilize Indigenous women than to invest in the improvement of social determinants of health within Indigenous communities (Stote, 2012). These poorer social determinants of health were directly linked to colonialism and expropriation of Indigenous lands.

Although forced sterilization is often viewed as something that occurred in the past, contemporary cases also exist. Between 2015 and 2019, over 100 Indigenous women from Alberta, British Columbia, Manitoba, Northwest Territories, Nova Scotia, Nunavut, Ontario, and Quebec have come forward to say that they were forced or coerced to undergo a sterilization procedure in Canada (Canada, 2019a, 2019b). Following allegations of sterilization in Saskatchewan, the Saskatoon Health Authority commissioned Senator Yvonne Boyer and Dr. Judith Bartlett to conduct an independent review. During the review they interviewed healthcare providers as well as women who were forced or coerced into sterilization (Boyer & Bartlett, 2017). They found that Indigenous women were often pressured, if not threatened, by healthcare providers to consent to sterilization while in labour or shortly after. Women were often offered inadequate information about the procedure and other options for birth control were rarely provided (Boyer & Bartlett, 2017). This led to women consenting to sterilization without fully understanding its risks or permanency. In some cases, sterilization procedures were conducted despite the women expressly refusing to provide consent and/or sign consent forms (Boyer & Bartlett, 2017).

Through settler colonial policies, Indigenous populations in Canada have been targeted by various assimilation policies and practices including, among others, the Indian Act, residential schools, and the Sixties Scoop. Forced or coerced sterilization continues the history of colonization and is designed to control and/or eliminate a population (Patel, 2017; Stote, 2015). By eliminating Indigenous women's ability to procreate, forced sterilization severs the connection between Indigenous women and future generations (Stote, 2012). It effectively reduces the number of those who can claim Indigenous identity, and, consequently, Indigenous rights, title to land, and in turn, the federal government's obligations to them (Stote, 2015). Therefore, forced or coerced sterilization is not only an assault on the individual rights of Indigenous people but affects Indigenous families, communities, and populations as well.

Forced sterilization undermines Indigenous women's bodily autonomy and their ability to make decisions about their own lives. Additionally, women who have been impacted by forced or coerced sterilization have experienced various physical and emotional symptoms, including pain, tissue scarring, hormonal imbalances, depression, anxiety, feelings of inadequacy, social isolation, loss of identity and self-worth, distrust in the healthcare system, and fear of authority (Boyer & Bartlett, 2017; Lombard, 2017). This in turn leads to a hesitancy to seek medical care, increasing women's vulnerability to preventable and treatable medical conditions (Boyer & Bartlett, 2017; Lombard, 2017).

Although clearly violating medical ethics, the forced or coerced sterilization of Indigenous women is not explicitly illegal in Canada. In addition to the absence of legislation

prohibiting it, the continuation of forced or coerced sterilization of Indigenous women in Canada can be attributed in part to the deeply rooted systemic racism and patriarchal policies that exist in Canadian systems, including, but not limited to, healthcare (Boyer & Bartlett, 2017). The limited understanding and knowledge that many Canadians, including healthcare providers, have about Indigenous people proliferates negative stereotypes, which heightens racism, marginalization, and stigma (Wylie & McConkey, 2019). Indigenous women are often stereotyped as promiscuous, lazy, poor, and unfit as mothers (Stote, 2015). Ideologies that rationalize the continued systematic sterilization of Indigenous women and girls are the same ideologies that justified policies like the Indian residential school system and the Sixties Scoop, whose ultimate goal was to reduce or eliminate the Indigenous population and subsequently abolish the federal government's obligations to this population.

Methods

The research question guiding this study was as follows: What recommendations have been made in response to the recent cases of forced or coerced sterilization of Indigenous women in Canada? To answer this question, a secondary data analysis was conducted on five documents from four sources (Boyer and Bartlett, 2017; Canada, 2019a, 2019b, 2019c; Casey, 2019), all of which are publicly available online.

The documents were selected through purposive sampling. Purposive sampling is a widely used technique in qualitative research for the identification and selection of information-rich cases in order to most effectively utilize limited research resources (Patton, 2002). These documents were selected due to their relevance and potential sociopolitical impacts on the national discourse on forced or coerced sterilization of Indigenous women in Canada. Furthermore, documents were selected due to shared characteristics: Each document included recommendations from various stakeholders on how to respond to the issue of forced or coerced sterilization. Key stakeholders included Indigenous women with lived experience; Indigenous women's organizations; and experts from the criminal justice, legal, policy, and medical health professions. Two of the documents (Boyer & Bartlett, 2017; Casey, 2019) contained enumerated recommendations, to which we applied a comprehensive thematic analysis. The other documents (Canada, 2019a, 2019b, 2019c) provided transcripts that the research team analyzed, pulling out what we interpreted as explicit recommendations.

The analysis involved three stages. The first stage, open coding, categorized themes of the data into codes. The second stage, axial coding, grouped related codes together into new categories. The third stage, selective coding, identified themes that emerged from the previous two steps. Codes were collaboratively developed by the authors at each stage. Although coding processes are inherently subjective (Joffe & Yardley, 2004), any coding that was ambiguous or difficult to determine was discussed by the entire research team until a consensus was reached. These discussions, in tandem with constant interaction with the data, ensured analytical rigour (Seale & Silverman, 1997). The iterative process of thematic analysis (Braun & Clarke, 2006) allowed for a collaborative approach to selecting codes, looking for commonalities and

validating those commonalities to further refine and develop larger themes (Glaser & Strauss, 2009). It is through this process that we were able to categorize and synthesize 162 recommendations into seven themes.

The goal of our work generally is to expose colonial healthcare structures and address systemic racism against Indigenous women. As such, this study design was informed by critical Indigenous qualitative research methodologies, which centre and value Indigenous knowledge over Eurocentric knowledge (Denzin & Lincoln, 2008), as well as by critical feminist research methodologies, which centre and value experiential knowledge over disembodied, “objective” knowledge (Collins, 2002). Further, our coding was guided by a Human Rights in Patient Care (HRPC) framework (Patel, 2017). We analyzed our selected documents within these broader frameworks, using guiding concepts including, but not limited to, cultural safety (Smye & Browne, 2002), trauma-informed care (Bath, 2008), systemic discrimination (Kendall et al., 2020), and Indigenous intersectionality (Levac et al., 2018).

Results

Seven themes emerged following our thematic analysis of the 162 recommendations: (a) Services and Supports (b) Accountability, (c) Training and Education, (d) Legislation and Policy (e) Criminalization (f) Data Collection, and (g) Investigation.

Services and Supports

With 36 recommendations, another prominent theme that emerged was the need for services and supports for Indigenous women who have experienced forced or coerced sterilization. Ten recommendations stressed the need to provide reparations in the form of financial, physical, cultural, and emotional support. It was further stated that this needs to include a formal apology and acknowledgement of the issue. Four recommendations went on to explain that reparations, financial or otherwise, can help women heal and assist with reconciliation. These supports need to be determined by survivors and must be trauma informed. One recommendation called on the Government of Canada to establish a community-based Indigenous healing program that supports women by providing counselling.

Another suggested the development of reproductive centres that provide wraparound services for women with complicated pregnancies. The need to increase access to culturally safe, trauma-informed birthing supports, such as Indigenous midwives and doulas, was specified by five recommendations. One indicated that such supports would not only support women but also build community capacity and support families. The importance of adequately timing birth control discussions for Indigenous women by healthcare providers was underscored by one recommendation, and another stressed the importance of ensuring the availability of all contraceptive options to all Canadians without barriers including cost. Another recommendation highlighted the importance of allowing Indigenous women to freely choose between Western medical approaches and traditional Indigenous options when it comes to healthcare. Regardless of the services Indigenous women access, one recommendation stressed the importance of

ensuring the availability of trained Indigenous language interpreters at all healthcare facilities across the country, to ensure unilingual Indigenous patients fully understand the services they are provided and to ensure informed consent.

Eight recommendations highlighted the importance of including an Indigenous navigation, ethics, or advocacy office in every hospital. This would help ensure not only that Indigenous healing practices (including midwives and doulas) and culturally safe services are provided but also that Indigenous patients are protected from racism, sexism, and discrimination. Such an office can also help Indigenous patients navigate a Western medical system and empower them with decision-making processes. Two recommendations suggested the development of an advisory council with authority to help women who have experienced forced or coerced sterilization and support them on their healing journey. This council should partner with Indigenous healthcare providers and can comprise Elders, grandmothers, Indigenous women, and community members. Finally, one recommendation suggested the inclusion of an Indigenous ombudsperson and an Indigenous human rights tribunal at healthcare facilities to provide support to Indigenous candidates and conduct arm's-length investigations following allegations of professional misconduct, racism, or discrimination.

Accountability

With 33 recommendations, accountability was a recurring theme in our analysis. Seven recommendations explicitly called for the development of accountability mechanisms or frameworks within healthcare facilities to hold practitioners, at all levels, accountable by leveraging licensing. Two recommended accountability mechanisms for obtaining consent and stipulated that the development of these mechanisms needs to be led by Indigenous women with full cooperation of medical authorities. To monitor trends, identify the number of Indigenous women sterilized, and understand practices, one recommendation advocated for the generation of annual reporting procedures from medical regulatory authorities. Another called on the Government of Canada to collaborate with provinces and territories as well as Indigenous organizations to establish culturally safe accountability mechanisms for Indigenous patients to report complaints against healthcare providers. Similarly, to ensure disciplinary measures for professional misconduct are applied when necessary, one recommendation suggested that the Government of Canada must collaborate with medical regulatory authorities, provinces, and territories. Finally, one recommendation advocated for the development of a framework that encompasses the Truth and Reconciliation Commission of Canada (TRC, 2015) Call to Action Number 18,¹ UNDRIP (United Nations, 2007), and the constitutional rights of Indigenous Peoples in Canada. This framework should be underpinned by Indigenous laws and legal

¹ 18: "We call upon the federal, provincial, territorial, and Aboriginal governments to acknowledge that the current state of Aboriginal health in Canada is a direct result of previous Canadian government policies, including residential schools, and to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties" (TRC, 2015, p. 322).

traditions with an emphasis on traditional medicine and Indigenous knowledge approaches to reproduction.

Three recommendations pointed out that the Government of Canada has already committed to recommendations from several reports and called for their implementation. More specifically, one recommendation called for the implementation of the 231 Calls for Justice from the final report of the National Inquiry into MMIWG (2019); another explicitly called for the execution of Call for Justice 1.7;¹ and a third called for follow-through on TRC Calls to Action 19.² Three recommendations asked for a governmental response to the UNCAT's (2018) recommendations on forced or coerced sterilization. UNCAT called on the Government of Canada to implement measures that prevent forced or coerced sterilization, punish perpetrators, and provide reparations to victims of the practice. Finally, one recommendation highlighted the importance of implementing and monitoring Saskatoon Health Region's (n.d.) report, *Awaken the Power of Change: Representative Workforce Strategic Plan Renewal 2014-2018*,³ and another suggested the implementation of the recommendations included in the National Aboriginal Council of Midwives (NACM, n.d.) position statement.⁴

Three recommendations called for the immediate and abrupt end of forced or coerced sterilization. To create adequate solutions to stop the practice and mitigate harms, five recommendations suggested collaborative work with Indigenous women, organizations, and survivors to ensure that Indigenous voices and experiences are centred in the discussions.

Another large topic within the theme was the need for systemic change to fundamentally change Indigenous women's interactions with a system that consistently marginalizes them. Nine recommendations stressed that unless systemic change is implemented, and unless Indigenous women are allowed the opportunity to achieve the same quality of life as other women in Canada, incidents like forced or coerced sterilization will continue to happen. One recommendation went on to explain that this parity can be achieved by ending conditions of

¹ 1.7: "We call upon the federal, provincial, and territorial governments, in partnership with Indigenous Peoples, to establish a National Indigenous and Human Rights Ombudsperson, with authority in all jurisdictions, and to establish a National Indigenous and Human Rights Tribunal. The ombudsperson and tribunal must be independent of governments and have the authority to receive complaints from Indigenous individuals as well as Indigenous communities in relation to Indigenous and human rights violations, and to conduct thorough and independent evaluations of government services for First Nations, Inuit, and Métis people and communities to determine compliance with human and Indigenous rights laws. The ombudsperson and the tribunal must be given sufficient resources to fulfill their mandates and must be permanent" (National Inquiry into MMIWG, 2019, "Calls for Justice," p. 7).

² 19: "We call upon the federal government, in consultation with Aboriginal peoples, to establish measurable goals to identify and close the gaps in health outcomes between Aboriginal and non-Aboriginal communities, and to publish annual progress reports and assess long-term trends. Such efforts would focus on indicators such as: infant mortality, maternal health, suicide, mental health, addictions, life expectancy, birth rates, infant and child health issues, chronic diseases, illness and injury incidence, and the availability of appropriate health services" (TRC, 2015, p. 322).

³ The action plan aims "to build a workforce that is representative of the community we serve, to provide quality, client centered experiences to patients, residents and families within the Saskatoon Health Region" (Saskatoon Health Region, n.d., p. 3).

⁴ The NACM position statement makes three broad recommendations to healthcare providers, government, and medical regulatory authorities.

colonialism, allowing Indigenous people to return to their lands and resources and freely address their needs how they see fit. Another explained that solving the issue of forced or coerced sterilization cannot happen without first addressing the lack of infrastructure in Indigenous communities; the prevalence of racism, stigma, and discrimination; and the need to ensure cultural competency. Finally, one recommendation suggested changing the system to assure proactive measures to injustices as opposed to reactive ones.

Training and Education

With 32 recommendations, another theme that emerged from the analysis was the need for training and education. This theme can be divided into three categories: (a) training for healthcare providers, (b) training for Indigenous people and communities, and (c) training within Canadian primary and secondary schools.

With 19 recommendations, training for healthcare providers dominated this theme. Fourteen recommendations stressed the importance of including mandatory cultural training, human rights training, and Indigenous rights training that incorporates women's health issues for healthcare providers at all levels. This training needs to be skills based, require self-reflection, and encompass issues of privilege and power. Given the ever-changing environment and cultural nuances, three of these recommendations stressed that training should be an ongoing requirement that leverages licensing. Two of them called upon the Government of Canada to provide support and funding for this training. Further, four recommendations underscored the importance of training healthcare providers on the historical and ongoing issues impacting Indigenous populations in Canada. These include colonialism and its detrimental impacts, addressing systemic racism and harmful stereotypes, and how these issues continue to impact patient-provider interactions. One of these recommendations explained that understanding Indigenous experiences can not only ensure the generation of effective solutions but also prevent these horrific incidents from happening again. Finally, two recommendations highlighted the importance of training healthcare providers on the meaning of free, prior, and informed consent (FPIC) and what that means in practice.

Ten recommendations suggested the need to provide training for Indigenous women. Training around human rights and patient rights, specifically around FPIC, was emphasized by six recommendations. Further, two recommendations supported TRC (2015) Calls to Action 23 and 24¹, as well as Calls for Justice 7.6, 7.7, and 7.8 regarding training and education issued by

¹ 23: We call upon all levels of government to:

Increase the number of Aboriginal professionals working in the health-care field.

Ensure the retention of Aboriginal health-care providers in Aboriginal communities.

Provide cultural competency training for all healthcare professionals.

24: "We call upon medical and nursing schools in Canada to require all students to take a course dealing with Aboriginal health issues, including the history and legacy of residential schools, the *United Nations Declaration on the Rights of Indigenous Peoples*, Treaties and Aboriginal rights, and Indigenous teachings and practices. This will require skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism" (TRC, 2015, p. 323).

the National Inquiry into MMIWG (2019) and advocated for an increase in the number of Indigenous healthcare providers. One recommendation encouraged the provision of sexual health and healthy relationships education targeting Indigenous women in all Indigenous languages. Finally, one recommendation explained that ideologies that supported forced or coerced sterilization were grounded in ableism as well as racism and discrimination. This recommendation indicated the importance of promoting self-advocacy to ensure Indigenous women with disabilities were partners in their own care. The recommendation went on to advocate for education about ableism, sexism, and disabilities for healthcare providers.

Two recommendations stressed the importance of education on human rights and UNDRIP (including what to do when those rights are violated) as part of primary and secondary school curriculums. They explained that early awareness of these rights can not only help an individual understand and stand up for their rights but also prevent them from violating someone else's rights later in life.

Legislation and Policy

Seventeen recommendations pertained to the need for the amendment of legislation and policy surrounding sterilization. Eleven recommendations advocated for the amendment of sterilization procedures, including defining FPIC and explaining the proper way to obtain consent to ensure safe practices within healthcare. This needs to be done in partnership with Indigenous women (First Nations, Inuit, and Metis), survivors, Indigenous women's organizations, government, and medical regulatory authorities. One of these recommendations suggested drafting and disseminating a short document that outlines all the new policies pertaining to sexual and reproductive health and requiring all healthcare staff to understand and sign it. Three recommendations advocated for legislation that specifically protects and ensures Indigenous women's rights to FPIC and cultural safety across all healthcare institutions in Canada. Further, two recommendations asked that healthcare services implement informed choice¹ rather than informed consent. Finally, one recommendation suggested amending policies to provide clear instructions to healthcare professionals at all levels about the consequences of violating FPIC to deter the practice.

Criminalization

With 15 recommendations, criminalization of forced or coerced sterilization emerged as another prominent theme. Nine recommendations advocated for the need to amend the Criminal Code to explicitly criminalize forced or coerced sterilization. Another recommendation agreed on the importance of applying criminal sanctions but specifically pointed out that utilizing other accountability processes, such as professional disciplinary measures and civil remedies, may be more impactful. Three recommendations, however, expressed doubt that criminalization alone

¹ Informed choice takes place when an individual is given options for several interventions; educated about the details, risks, benefits, and outcomes of each one; and asked to choose the one that best fits their needs. This model promotes an individual's right to direct what happens to their body, giving control back to the individual in the care setting. This allows them to undergo only interventions that align with their needs, values, and preferences.

would deter the practice. One explained that the justice system itself was plagued with systemic racism; therefore, simply criminalizing the practice without enforcement would not be sufficient. Further, two other recommendations pointed out that the criminalization of murder had not reduced incidents of missing and murdered Indigenous women. These recommendations stressed the importance of combining criminalization, enforcement, and systemic change to make meaningful improvements. Finally, one recommendation specifically noted an urgent need to ensure that the use of criminal sanctions does not have a negative impact on the availability or accessibility of high-quality sexual and reproductive health services in Indigenous communities.

Data Collection

Another theme that emerged from our analysis, with 15 recommendations, was around the requirement for data collection to fully understand the scope and scale of the problem. Seven recommendations called for a better understanding of the scope of forced or coerced sterilization with one specifying the need for a pan-Canadian, comprehensive data collection system that is led by the Government of Canada and developed in partnership with provinces, territories, healthcare providers, and Indigenous organizations. Two recommendations stressed the importance of disaggregating these data by Indigenous identity and providing a broad range of indicators including patient outcomes and geographic location. One recommendation suggested implementing a similar strategy to that of the Public Health Agency of Canada for the opioid crisis, as the strategy is said to be extremely transparent with all the data openly available on their website. One recommendation suggested the generation of annual reports that measure the number of women sterilized. This would ensure that if troubling trends arise, Indigenous advocacy offices within healthcare facilities can conduct investigations. Three recommendations acknowledged that data around the scope of the issue was important but also stressed that exploring healthcare providers' perceptions about why this is happening was equally important. Furthermore, one recommendation stressed that understanding the scope of the issue alone is not enough to fully understand the impact nor would it mitigate the risks. Instead, work to transform the healthcare system must begin.

Investigation

Investigation arose as the final theme following the analysis with 14 recommendations. Eleven recommendations called for a transparent, trauma-informed, pan-Canadian investigation that examines incidents of forced or coerced sterilization. One of these recommendations underscored the importance of developing terms of reference that delineate the scope of the investigation, the rights of the survivors, and the supports that will be made available to them prior to starting the investigation. Another recommendation stressed that this investigation needs to lead to change as opposed to just an understanding of the issue. Further, three stipulated that the Government of Canada be responsible for the investigation by establishing an arm's-length advisory panel that will conduct an impartial investigation, report publicly on the findings, and hold those responsible to account.

Another recommendation advocated for an investigation that explores current consent procedures in the healthcare system and what needs to be done to strengthen and improve them.

Discussion

The 162 recommendations, and the themes we have based on them, should help inform a blueprint for an action plan. The action plan would require health system innovation based on meaningful collaboration with Indigenous Peoples at all levels, centring cultural safety and trauma-informed approaches. These themes outline seven areas where immediate government action is required to meaningfully and appropriately respond to the recent cases of forced or coerced sterilization of First Nations, Inuit, and Metis women in Canada.

Throughout our analysis, in addition to the seven themes, we identified a number of cross-cutting priorities. These include collaboration, cultural safety, and action on previous commitments made by the Government of Canada. Collaboration with Indigenous partners could include the creation of Indigenous advisory councils and Indigenous health engagement strategies. Cultural safety, on the other hand, could be applied by embedding it within healthcare, education, and newly developed legislation, policies, and protocols, as well as within accountability mechanisms. Finally, a number of recommendations underscored the importance of implementing recommendations from UNDRIP (United Nations, 2007), TRC (2015), and the National Inquiry into MMIWG (2019). Given the federal government's commitment to reconciliation, it is imperative that appropriate steps be taken to address the harms associated with past, present, and ongoing injustices perpetrated on Indigenous people in Canada.

In the process of forced or coerced sterilization, Indigenous women have been stigmatized, traumatized, and shamed. We cannot risk perpetuating further harm and trauma throughout the very processes that are meant to bring about justice. Therefore, any action in response to forced or coerced sterilization within the identified themes must be informed by cultural safety¹ and trauma-informed care.²

¹ Cultural safety recognizes and respects cultural differences and strives to address power imbalances inherent in various systems, including but not limited to healthcare, the justice system, child welfare, and education. A culturally safe environment is free of racism and discrimination and ensures users of the system feel safe (Smye & Browne, 2002).

² Trauma-informed care (TIC) is a wholistic, strength-based framework based on open-mindedness and compassion that promotes positive health outcomes, empowerment, and healing (SAMHSA's Trauma and Justice Strategic Initiative, 2014). It is grounded in an understanding of the pervasiveness of trauma and the wide-ranging impact trauma has on an individual's physical, mental, emotional, and spiritual health. TIC is understanding, without judgment, where the individual is coming from. It incorporates an awareness that individuals have different pathways to healing and utilize various coping mechanisms to manage their trauma (SAMHSA's Trauma and Justice Strategic Initiative, 2014). It also means understanding that some may never conclude healing or come to a place and space where they find comfort or coping mechanisms. TIC seeks to actively resist re-traumatization and acknowledges the special needs individuals managing trauma require within the care setting. It creates opportunities for survivors to rebuild a sense of control and empowerment in order to live a fulfilling life directed by themselves (SAMHSA's Trauma and Justice Strategic Initiative, 2014).

In response to the recent cases of forced or coerced sterilization of Indigenous women, a number of notable recommendations have been made by expert stakeholders. However, immediate action is lagging. For meaningful and appropriate action, Indigenous women's organizations will require resourcing to lead the response to support survivors and contribute to the end of this egregious act.

Conclusion

The forced or coerced sterilization of Indigenous women is a violation of human rights and constitutes an act of genocide, violence, and torture against women (OHCHR et al., 2014; UNCAT, 2018). Forced or coerced sterilization of Indigenous women in Canada can be attributed, at least in part, to the deeply rooted systemic racism in the Canadian healthcare system. Moving forward, action is required to ensure accountability, provision of services and supports for Indigenous women, training and education for healthcare providers and Indigenous women, investigation of the scope and scale of the issue, and amendments to policies and procedures to bring about the immediate and abrupt end of this heinous act. Principles of cultural safety and trauma-informed practices must underscore this action to ensure no further harm to the survivors. Furthermore, there is an acute need for systemic change at all levels to respond to the underlying causes of forced or coerced sterilization of Indigenous women.

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