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VOICES FROM THE FIELD

Welcome to Voices from the Field, a podcast produced by the National Collaborating Centre for Indigenous Health (NCCIH). NCCIH focuses on innovative research and community-based initiatives promoting the health and well-being of First Nation, Inuit and Métis peoples in Canada.

EPISODE 9

"Uncovering the Forced and/or Coerced Sterilization of Indigenous Women"

This episode is based on a keynote address, *"Uncovering the Forced and/or Coerced Sterilization of Indigenous Women,"* delivered by Senator Yvonne Boyer and Dr. Judith Bartlett on January 28, 2020 it was part of the national gathering on *Culturally Informed Choice and Consent in Indigenous Health Services*. The NCCIH was honoured to have these esteemed Métis women, scholars and health professionals present the findings from their seminal paper, *External Review on Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women*. A member of the Métis Nation of Ontario with her ancestral roots in the Métis Nation-Saskatchewan and the Red River, Senator Boyer has a background in nursing, a Doctor of Laws from the University of Ottawa, and was named to the Senate of Canada in 2018. Raised in northern Manitoba, Dr. Judith Bartlett is a retired Métis physician with decades of experience in the health, research and community health development sectors.

BIO

Senator Yvonne Boyer is a member of the Métis Nation of Ontario with her ancestral roots in the Métis Nation-Saskatchewan and the Red River. With a background in nursing, including in the operating room, she has over 21 years of experience practicing law and publishing extensively on the topics of Indigenous health and how Aboriginal rights and treaty law intersects on the health of First Nations, Metis and Inuit people. She is a member of the Law Society of Ontario and the Law Society of Saskatchewan and received her Bachelor of Laws from the University of Saskatchewan, and her Master of Laws and Doctor of Laws from the University of Ottawa. In 2013, she completed a Post-Doctoral Fellowship with the Indigenous Peoples' Health Research Centre at the University of Regina. She is a former Canada Research Chair in Aboriginal Health and Wellness at Brandon University.

In addition to running her own law practice, she came to the Senate of Canada from the University of Ottawa, where she was the Associate Director for the Centre for Health Law, Policy and Ethics and a part time professor in the Faculty of Law. She worked previously as counsel to the Native Women's Association of Canada, legal advisor to the Canadian Nurses Protective Society, and an executive with the Aboriginal Healing Foundation and the National Aboriginal Health Organization.

Among many others, Senator Boyer has served on the boards of the Champlain Local Integrated Health Network and Save the Children Canada. She is a former Canadian Human Rights Commissioner and an appointed Member of the Federation of Sovereign Indigenous Nations, First Nations Appeal Tribunal. Senator Boyer is one of eight people from across Canada chosen to be a holographic narrator in the Turning Points for Humanity Gallery at the Canadian Museum for Human Rights in Winnipeg. Her ongoing work has

been recognized with numerous awards including a 2018 Honorary Doctorate in Education from Nipissing University.

Senator Boyer resides near the beautiful village of Merrickville, Ontario. She is married to Marv Fletcher and is the mother of four children and has four grandchildren.

BIO

Dr. Judith Bartlett, a retired Métis physician raised in northern Manitoba, has decades of experience in the health, research and community health development sectors. She began as a 'flying doctor' for northern First Nation communities followed by six years as Director of Health Programs (federal government) for Manitoba First Nation communities. She then completed a MSc. (Community Health) and did Métis research as an Associate Professor (Faculty of Medicine, University of Manitoba 2003-2015) and Director of Health & Wellness Department, Manitoba Métis Federation (2005-2012).

She has done extensive Indigenous health research and health planning (Canada, New Zealand, Australia, United States, and South and Central American). She has multiple publications in First Nations, Métis, and international Indigenous population's health. Her last research project was the external review of tubal ligation in Aboriginal women in Saskatoon hospitals in 2017. She continued part-time clinical practice (Aboriginal Health and Wellness Centre of Winnipeg and Addictions Medicine at Winnipeg's Health Science Centre).

Her life passion has been creation and use of the 'Aboriginal Life Promotion Framework© (1993)' and the 'ALPF Wellness Areas© (1996)'. This holistic framework is the base for all her work including: MSc thesis; health services research and planning; knowledge translation research; development and implementation of a policy research department in a community-based Métis organization; and, finally, for the development and implementation of the Aboriginal Health & Wellness Centre of Winnipeg.
Dr. Bartlett has volunteered in 50+ local, national and international organizations over the years, including five years on Canada's Tri Council Panel on Research Ethics. This is her way of 'giving back' for the tremendous education and career opportunities she has had.

TRANSCRIPT

Yvonne Boyer - In 2015, I was at Brandon University and I was busy doing my thing and I got a call from Betty Ann Adam from the Star Phoenix. She said, "Hey Yvonne, there are two women who have come forward to me who have been sterilized in a Saskatoon Hospital and they're Indigenous. They were sterilized against their will." And I said, "What!? What is going on there?" And she said, "Well what do you think about this?" I said, well I flew into a rant and I said "well what about an assault? What about Indigenous rights? What about UNDRIP? What about consent? What about malpractice? What about, what about, what about?" These two women, the first women to come forward and this is Tracy Bannab and Brenda Pelletier and I mention their names because they are the most courageous, brave women on earth. What they underwent after they came forward was brutal, with social media and racist and derogatory remarks about who they were. So that was the beginning, and then more women came forward, and more women came forward, and more and more. Then pretty soon I am thinking, 'what is going on?' I am getting interview requests from various media outlets and I am saying the exactly the same thing, "this is unheard of, this is terrible. This can't be happening. Why are they sterilizing these women?" So I had probably given 4 or 5 interviews across the country and then I got a call from the Saskatoon Health Authority. They said to me, "Would you do an external review on our practices on tubal ligation?" I said, "Are you sure you know who are talking to? I've

been bad-mouthing you all over the country". They said, "Yes, we are sure. The Elders have asked for you". So I said, "Yes, I'll do it."

I realized I couldn't do it… this isn't something I could do it by myself. Judy and I had worked together at NAHO many years before and we were very compatible working together. She had the background as a Métis physician and I was an old operating nurse and I knew the culture. We both knew the culture and what goes on in the OR and the cultures of the hospitals. So we were a good pair. The first reaction – that when the women came forward before the actual review was started – was that Saskatoon Health Authority did a knee jerk reaction and changed the tubal ligation policy to prevent any tubal ligations from going forward unless there had been previous discussion with the obstetrician and the woman who was giving birth. But that caused a lot of problems for Indigenous women because many of the women that were going to the hospital were from the north and they had also not had prenatal care. They had gone into a walk-in clinic. It immediately removed the agency of these women to be able to choose to have a tubal ligation if they had wanted to. Or maybe they had used a traditional midwife.

Judy and I both had kinship relations and research relations in Saskatchewan. I was born and raised there. I had finished some of my studies in Saskatchewan. I had already developed a fairly wide network in Saskatoon and we were sitting pretty well, reaching out into the Aboriginal community. What we did first of all, we engaged Mary Lee, who is a Cree Elder, and we wanted to make sure that we were using proper protocols and processes when we were doing this. Willna Masuskapoe, who was also a Cree speaker. I had worked with both of these lovely women in the past and Willna became our ground… our ears and eyes to the ground. She was the first person that any of the women we would be interviewing would speak with. Our catchment area of Saskatoon includes much of the north where there are many, many Cree speakers. Mary was always available. She was our skeleton. She kept us up. She was always available when we were doing the interviews and would become part of the interview process if the woman wished or if they wanted to speak to her or provide counselling to her after the interview. She stayed close to us but she didn't come in unless she was invited. She was in the room next to us and generally was beading and she was always available to us. It was really important that we all stayed together very close. Every morning we prayed. We knew that we had a very difficult job to do. Mary was the one who grounded us.

Judith Bartlett - I'm going to spend a little bit of time talking about community based research. It was a really important underpinning approach to what we did in that you know, for instance, I would not have taken this project on if the community had not asked me to do it. The idea, the issues have to come from the community, not only the Aboriginal community but the health community. They have to have a willingness to make changes. We met a lot of Aboriginal people. We took two trips to Saskatoon to do engagement meetings with the Aboriginal communities – there is a broad scope of Aboriginal people there – and also with the health sector. With both of them, we actually reviewed our draft questions and got their feedback on exactly what it was that needed to be asked.

Yvonne Boyer - As far as the actual interview process, we had many, many people call us and hang up, and many of them said nothing. We expected that because we soon realized that the women that we had interviewed and were interviewing were very traumatized and definitely were in PTSD. I'd never seen anything like the damage that had been done to these women. We had 18 women call that we actually connected with. We interviewed six in person, one by phone. Others had appointments but they were unable to keep it for the simple reason that they were too traumatized. We had 9 health care providers, and we interviewed those nine health care providers.

Judith Bartlett - Just a quote from one woman we did interview, she said, "I had a lot of anxiety when I agreed to do the interview. I wasn't sure if I was going to go through with it. My daughter came with me". This woman, her and her daughter sat downstairs and the whole time it was really difficult for her not to get up and walk out before we came to meet with her. It was really difficult for them.

Yvonne Boyer - I just want to mention too, again, on how important it was that we had Mary Lee with us. It was traumatic for Judy and I as well, and when we had asked Mary to come into the room when somebody had fallen apart, Mary would come in and say, "I will hug you back together' and she would hold her until she could speak again. The women were completely devastated and untrusting of any healthcare. Probably many had not sought healthcare after the sterilization.

Judith Bartlett - I am going to talk about what women said and what was going on with them. One of the major areas, they were feeling invisible, profiled and powerless. They felt there was an abuse of power. There was no information given and when it was, it was misrepresented. One woman said, "I was sterilized when I was in my 20s". Another said, "It was just like we are going to do this, and after I wasn't told anything, no explanation that it was permanent". Something that came up over and over and over again, from the women as well as from the healthcare providers, was the impact of external agencies, in particular, child and family services. One woman said, "Any woman with a history of children in care, there is a birth alert that goes on her chart and her baby is almost automatically apprehended".

They were feeling like they were being profiled, that there was racism and discrimination. For example one woman went to a walk in clinic throughout her whole pregnancy and ended up feeling like she was being judged as not responsible simply because there was no access for her… the walk in clinic was the best for her. She said, "I saw the same doctor all the time". So it was difficult for her. One woman talked about how invisible she felt. She said, "It was as though I was not even in the room". She had been coerced for a long time, years, to have a tubal ligation. Then she says, "I'm pregnant and the nurse is supposed to be talking to me and she's talking to my husband like I'm not even in the room." Worse for her was the fact that the doctor eventually convinced the husband that it was too dangerous for her to have any more children. Women, in terms of the actual experience of coercion, some were coerced immediately after they had their baby, and as I said, some were under pressure for years. One woman said, "Yeah for 3 years I felt coerced". Another said "The doctor explained to me in medical terms; however, I understood it was a form of birth control." Others stated that they did not sign consent. One said, "No consent form for tubal ligation was given to me, not explained." Some said, "No" before going into the operating room. One woman said, "I refused up to the very end. Like in the morning you need to sign and I didn't want to. Even on the table I didn't want to." All women felt that no should mean no.

The third larger area was that women were experiencing really severe impacts on their self-image, their relationships and their ability to access health care. In terms of on-going personal impacts, one woman said, "I'm a good mother. I would have liked to have had more kids. A very good mother. I kept all my kids. I worked." Another said, "It's like nobody is ever going to want me anymore. I don't feel like a woman." A woman said, "It's like something left me. I just cried. I knew I couldn't do anything." Another woman said, "For all those years it was blocked, the feeling was just blocked." Relationships were impacted for these women and from the incident on, their life changed. A woman said, "Yeah, but it was one of the factors why our relationship ended." Another said, "I said no to a marriage because I knew he wanted kids and I couldn't have no more." Another woman said, "I got remarried. I told him what happened. He says 'If your tubes weren't tied, we'd have a baby'. It kind of breaks me", she said, "when he says stuff like that." Women were disengaged from healthcare as a result of this. One woman said, "I don't go to the doctor anymore, especially a gynecologist. The fear is so I don't know if I could overcome it." Another woman said, "I won't go for pap tests, it's too scary. I won't go to a doctor," even when they know they are at risk for diseases. One woman said, "I'm at risk for diabetes. My parents both died of it. I try to look after myself so that I don't have to go to the doctor."

Yvonne Boyer - We also found that they were very unwilling to take their children to the doctor as well.

Judith Bartlett - Health providers were really quite forthcoming and honest. I think this, you know, is something that was really required for this to go to the next place. Policy and team challenges came up as an overriding theme, a lack of team support. The policy challenges included the whole ward structure. Things

have changed because now they have moved into the children's hospital, but there was a lot of difficulties because the ward was structured on different floors and things like that. One provider said, "The new tubal ligation policy solves the problem but creates another one for women who are marginalized - women who do not have a family doctor." Most providers felt that the environment was changing but there was a sense of the old guard had to transition out.

A theme that came up was the team approach, the lack of team approach and integration between the Saskatoon Health Region and Child and Family Services.

Judith Bartlett - Aboriginal women don't know who is seeing them in the hospital. They don't know that the physician is supposed to get the consent signed. They don't know who is interacting with them. It is very confusing for them. In busy ORs, often times it is a nurse who hands you the consent form and says, "Sign it." They are quite busy, so they just keep doing that. One provider said that one of the biggest things that she was concerned about was the apprehension of newborns. She said, "The only way these two big ministries, Health and Child and Family Services (CFS), connect is through a social worker". Certainly, I found that in the policy. There really wasn't much in the policy to say who was supposed to be doing what. There were some who attempted advocacy. One provider said, "One girl was crying while she was getting an epidural. She wanted her mom. The nurses were like 'she can't come into the room'. We weren't in the OR, we were in a birthing suite. There was no reason for that." One physician said, "I asked the nurse who was with her when CFS came. The nurse said 'Well, nobody. We try to be there'." The physician said, "Well I was in house and nobody called me."

The next big section was on an attitude towards Aboriginal women. Again, the providers looked at their perceptions of the women's challenges and experiences and again newborn apprehensions arose. One person said, "They scare women into not coming to the hospital. It's a barrier to healthcare and it also affects the family." The new policy was that high risk mothers are probably the ones that are more easily coerced. These are the moms who were getting their babies apprehended. There was a spectrum and continuance of ignorance, bias, racism and discrimination that was observed in the hospital environment. Some do not understand racism. A provider said, "The nurses in our hospitals are all races. I don't think there is racism involved." That kind of took me back a little bit. Providers related that there is a differential in power between Aboriginal women and the health providers. A nurse will ask a social worker, "Aren't you apprehending that baby? That baby should not be going home with mom." Some say, "It's more like people talking amongst themselves, you know, desk talk." This person may say, "This person had so many children, shouldn't we stop her?" Yet others do understand stating, "If a person has always had power, they don't know what it's like to be powerless." Another issue that came up from health providers was what was termed 'implicit bias' in the media and this was, in particular, that some were quite upset and shocked that social workers were pointed out as the people who did this by the media. They were upset that the media didn't do some fact checking. The other thing was that some people were upset and they questioned the truthfulness of the women who reported in the media. But our study actually showed that this was the typical experience; it wasn't just these two women who reported it. Finally the internal and external impacts on care Informed choice perception [was another theme]. Providers felt that they give good contraception options and cannot understand why women would be coerced. Perceptions of care – the ward environment [came up]. There was a general sense on ward on any given day, it comes down to the personality of the day. Some of the nurses will roll with things and others will want to stop everything and solve that one problem. And then one person related that there were a particular group of nurses that they felt might be actually coercing. Overall, they all said that there had been a lot of change in terms of a positive change, but definitely they were willing to have more change. Again, the impact of external social services came up. One provider said, "The biggest trauma is CFS in the hospital. I understand that children need to be protected but I don't believe the hospital is the place for that to happen, the apprehensions of newborns." There is a prenatal gap with healthcare and child and family services. The woman is only in the hospital for a couple of days max and CFS cannot get involved until they actually have the baby. Yet health doesn't know what is going on out in the community, so they found that was difficult to handle. There were attempts to make changes. There was a particular clinic that

was having high risk rounds that was trying to connect between CFS and the medical community, but the problem was, of doing that, it's not really part of CFS' mandate, so their participation in that is not necessarily sanctioned by their legislation.

Yvonne Boyer - We are going to talk a little bit about the calls to action and some general observations that we've had. I had no idea this was going to explode into the national and international focus that it has taken. Looking back the recommendations and the calls to action were created with the Saskatoon Health Authority in mind. I would have probably, knowing what I know now, would have created them a little bit differently. I also want to commend the Saskatoon Health Authority for actually getting a hold of me. They didn't have to. They sought me out and said they wanted to do something about this. I have to say they were very helpful. They were very good to work with and they allowed us the autonomy to get the job done our way. I think it was very difficult for them but I just want to say that. The first thing for me, as a lawyer, was, "Get me all of your policies, I need to review them." The very first call to action was to revise the policies. They newly implemented tubal ligation and consent policy, we needed to really have a good look at these and to utilize some of the in house people that they had there. They had a very strong First Nation and Métis health service in place that they weren't really using, with Elders on the service. They needed to really implement the use of the people that they had in place. We also asked them to require that all staff understand and comply with the document titled "Our Values in Action," which we reviewed and thought was a pretty good one.

The next call to action was looking at requirements in Canadian law, and because my background is in Indigenous health and the law, I have an understanding of what has gone wrong with Indigenous health in this country and how Indigenous people are the only ones in the country who hold very powerful constitutionally protected rights and rights to health. This is Aboriginal rights and treaty rights that are in Section 35 of the Constitution. These are held by each individual Indigenous person in this country, who also have their inherent laws outside of Western law. This has to form the framework for establishing protections for women who have been forcibly sterilized and for preventing it from happening again. We also need to look at the TRC Call to Action #18 and UNDRIP. Any framework also must include the Inuit, who hold constitutionally protected rights as well, and quite often we see them left out and their rights are just as powerful as First Nations and Métis and they need to be recognized as well.

The other thing that I want to mention at this point, and I hear it every day, it's about the Guardian and Ward theory. It is about health care professionals thinking they know best for Indigenous women or for other people and what happened was in the 1800s, American law was bought into Canada that implemented the Guardian and Ward Theory, where Indigenous people were thought not capable of making decisions on their own and they had to be cared for as "wards." This underpins our health policies that we have today, and it was in 1982, it was replaced with the legally enforceable fiduciary obligation to the Supreme Court Guerin Decision. When I look at some… for the health policies that we have, inherently it's supplementing that imbalance that we see that those Indigenous peoples are not capable of making those decisions, so those decisions have to be made for them. So the forced and coerced sterilization of Indigenous women is a good example of that.

One of the other calls to action was about cultural training. We listed it as a call to action, and I have since heard it over and over and over again as a panacea to fix the problem entirely, but we know that cultural training is good. We know that. I am really pleased to hear that it is working and that it's happening in many educational systems. But it isn't the only solution. For the Saskatoon health Authority this was important and I do believe that they started implementing this as soon as the report was done.

Education was another call to action. We advocated for culturally appropriate education for all health professionals and we needed to see cultural competence training in education, in nursing, medical and all of the health professions. There were some recent approaches in 2017 that were actually pretty good. It was Ontario Indigenous Cultural Safety and Indigenous Healthcare Providers Cultural Safety Training would help

first Nations patients. The First Nations Health Authority in BC has done a lot of good work and there are probably many of you who know what is happening in this area.

We suggested that, well we noticed that no one was asking the people who had been affected, nobody was asking the women who had been sterilized. So given its commitment to reconciliation, we asked that the people in Saskatoon be full partners in designing health services that would meet the needs of Indigenous women and ask the women, ask their opinion and ask them what they would need. We know there have been opportunities that have arisen in the Saskatchewan provincial health care restructuring and it would have been very beneficial to have a real Indigenous focus in that area to advocate on behalf of the Indigenous people in the region. We know that any kind of restructuring requires the inclusion and the direct input of First Nation, Métis and Inuit and requires extraordinary measures with culturally grounded health care that Aboriginal women and families create for themselves. So in this call to actions, it's looking at the advisory council and making sure that they have authority and that we can look at traditional health care to blend in and to assist Indigenous women to reclaim their rightful place in society. They needed to partner with clinical and community cultural content experts such as the Canadian Indigenous Nurses Association and the Indigenous Physicians Association of Canada. Prioritize and use this Saskatoon Aboriginal Health Council that was already in place. They need to use them more effectively and work on an Indigenous health engagement strategy. We asked them to ensure full implementation and monitoring of the Saskatoon Health Region and coordinate with the supports in place around Saskatoon. There are many good structural supports in Saskatoon already. and it would be important to access them and that they not be a sole unit. There is the Federation of Sovereign Indigenous Nations, there is the Métis there and I believe there are Inuit groups as well.

The other thing that is very, very, very important is the reparation aspect. Ask the women what they need, what they want to heal. I have to just tell a little side story here. A couple of months ago, or a month ago, I was booked in late to a hotel and it was just the clerk at the front desk and I at the front desk there. I gave her my credit card and ID and she said, "You are that famous senator." Well I said, "I am not very famous but I am a Senator." She said. "No you are the Senator of Sterilization." I said, "That's an area I work in, yes." She looked at me and the tears started coming out of her eyes and she said, "They sterilized me when I was 21 in Saskatoon. I had 4 children. They told me it was best for me. I am 35 years old now. My children are grown. I have a new man and I want babies. I can't afford IVF. How am I going to have children?" This was not very long ago. So the reparation aspect is really important. Reproductive centres are something that Judy and I had talked about on how important it is to have intensive support for women with really complex life situations and Aboriginal women who are pregnant. One health provider said that there were at least 30 high risk pregnant women in their practice.

Judith Bartlett - What in fact happened by October of 2018, our study finished in July 2017, they did the public apology and they got to work. They actually created something called Sanctum House 1.5. It has been quite successful. They've had 18 babies and moms go through there and only 1 baby was put into care, so that's amazing. The other thing is a birth support worker program that the health region put in place and they've already had nine graduates from that.

Yvonne Boyer - This is how we wrapped up. Mary Lee is a woman of many, many talents. She is a tipi maker as well, so she made a tipi. We raised it at my place just outside of Ottawa. It was a spiritual ceremony that wrapped up what we were doing. The ceremony marked the end of the external review and the beginning of a renaissance in justice in terms of Indigenous women's reproductive rights. Really quickly, where we are at now, we're going to hear about class action lawsuits happening across the country. There have been a lot of media reports. More women have become much more public. I was appointed to the Senate in March and my first speech was about sterilization of Indigenous women. We've have the UN Committee on Torture give a report and give Canada a year to address this. I sit on the Standing Committee on Human Rights in the Senate and we did a short study on it and we are hoping that when our committee is up and running again, that we can continue this with speed. The House of Commons committee studied it and my office has been

very busy. We've been doing more of a clearinghouse in my office and a mapping project. We have lots going on in my office. There's been a lot of media and there's been a lot of international and national attention with some really interesting people. There has been much activity. But I really have to thank Margo Greenwood for indulging me in a Saturday morning coffee and listen to me talk endlessly about these issues and think about it. She made it happen. I want to thank Indigenous Services Canada and Health Canada for putting this conference together because here's where we can come up with a plan and we can make it happen. Meegwich.

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