



# THE SCARS THAT WE CARRY:

FORCED AND COERCED

STERILIZATION OF PERSONS

IN CANADA - PART II



SENATE | SENAT  
CANADA

Report of the Standing Senate Committee on Human Rights

The Honourable Salma Ataullahjan, *Chair*

The Honourable Wanda Thomas Bernard, *Deputy Chair*

JULY 2022

## The Scars that We Carry: Forced and Coerced Sterilization of Persons in Canada - Part II



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## **ACKNOWLEDGEMENT**

The Standing Senate Committee on Human Rights (the Committee) wishes to extend its gratitude to the witnesses who appeared during this second part of its study on forced and coerced sterilization of persons in Canada.

While expert witnesses provided the Committee with greater understanding of the context surrounding forced and coerced sterilization and its repercussions, survivors of the practice shared difficult and courageous testimony that communicated an unvarnished portrait of the barbarity of the practice, and of the suffering and self-doubt that has resulted from actions taken against them at moments of utmost vulnerability.

The Committee was moved by their stories and inspired by their resilience and strength.

## THE COMMITTEE MEMBERSHIP

The Honourable Senator Salma Ataullahjan, *Chair*

The Honourable Senator Wanda Thomas Bernard, *Deputy Chair*

The Honourable Senator Michèle Audette (until June 2022)

The Honourable Senator Yvonne Boyer

The Honourable Senator Amina Gerba

The Honourable Senator Nancy J. Hartling

The Honourable Senator Yonah Martin

The Honourable Senator Ratna Omidvar

### ***Ex-officio members of the committee:***

The Honourable Senator Marc Gold, P.C., or Raymonde Gagné

The Honourable Senator Donald Plett or Yonah Martin

### ***Other Senators who have participated in the study:***

The Honourable David Arnot

The Honourable Brian Francis

The Honourable Peter Harder, P.C.

The Honourable Frances Lankin, P.C.

The Honourable Kim Pate

The Honourable David Wells

### ***Parliamentary Information, Education and Research Services, Library of Parliament:***

Robert Mason, Analyst

Brendan Naef, Analyst

### ***Senate Committees Directorate:***

Sébastien Payet, Committee Clerk

Barbara Reynolds, Procedural Clerk

Marc-André Lanthier, Administrative Assistant

Adam Thompson, Committee Clerk (April 25, 2022)

Martine Willox, Administrative Assistant (April - May 2022)

### ***Senate Communications Directorate:***

Ben Silverman, Communications Officer, Committees

## ORDER OF REFERENCE

Extract from the *Journals of the Senate* of Thursday, March 3, 2022:

The Honourable Senator Atallahjan moved, seconded by the Honourable Senator Wells:

That the Standing Senate Committee on Human Rights, in accordance with rule 12-7(14), be authorized to examine and report on such issues as may arise from time to time relating to human rights generally; and

That the committee submit its final report to the Senate no later than June 12, 2025.

The question being put on the motion, it was adopted.

Gérald Lafrenière

*Interim Clerk of the Senate*

## EXECUTIVE SUMMARY

Sterilization is a surgical procedure to prevent conception. Forced or coerced sterilization occurs when sterilization is performed without the patient's free, prior and informed consent.

Canada has a long history of forced and coerced sterilization. For much of the 20th century, laws and government policies explicitly sought to reduce births in First Nations, Métis and Inuit communities, Black communities, and among people with intersecting vulnerabilities relating to poverty, race and disability. Though these explicit eugenic laws and policies have been repealed, the racist and discriminatory attitudes that gave rise to them are still present in Canadian society, and forced and coerced sterilization still occurs.

Beginning in 2019, the Standing Senate Committee on Human Rights (the Committee) undertook a study on the extent and scope of forced and coerced sterilization of persons in Canada, hearing from experts and civil society groups. In 2022, the Committee heard additional testimony on this issue, including from several survivors who courageously shared their stories.

The practice of forced and coerced sterilization is not confined to our distant past, and law and policy changes are needed to prevent this horrific practice from being inflicted on others. This report highlights the experiences and perspectives of survivors and outlines solutions that the Committee believes are urgently needed to bring an end to this unacceptable practice.

## Introduction

Forced and coerced sterilization is a horrific and ongoing practice in Canada. It is contrary to Canadian and international law, and it must end.

There is growing recognition of the severity and scope of the problem in Canada. In 2015, media reports of forced and coerced sterilization prompted the Saskatoon Regional Health Authority to commission an external review, which was completed in 2017 and included calls to action relating to support and reparations, cultural training and education, and law and policy reform.<sup>1</sup>

Subsequent media reports and ongoing class action lawsuits have identified additional cases. Internationally, the United Nations (UN) Committee against Torture, the Inter-American Commission on Human Rights, and two UN Special Rapporteurs have called on Canada to take concrete action on this issue.

In 2019, the Standing Senate Committee on Human Rights (the Committee) undertook a study on the extent and scope of forced and coerced sterilization of persons in Canada. The Committee heard from several experts and civil society groups with the aim of gaining a preliminary understanding of the issue, to be followed by a more comprehensive study in a future parliamentary session.

In June 2021, the Committee released its initial report, which found that the practice of forced and coerced sterilization is clearly continuing in Canada today, and is both underreported and underestimated. The Committee also expressed concern about the disproportionate impact of this practice on vulnerable and marginalized groups in Canada, including Indigenous women, Black and racialized women, persons with disabilities, intersex children and institutionalized persons.

The Committee recommended further study on the issue, including to hear from survivors in a culturally appropriate and trauma-informed manner, and ultimately to provide recommendations on how to end forced and coerced sterilizations in Canada.

In 2022, the Committee continued its examination of this topic under its order of reference “to examine and report on such issues as may arise from time to time relating to human rights generally.”<sup>2</sup>

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<sup>1</sup> Yvonne Boyer and Judith Bartlett, *External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women*, 22 July 2017.

<sup>2</sup> Senate of Canada, *Journals of the Senate*, 3 March 2022.



## The Scars that We Carry: Forced and Coerced Sterilization of Persons in Canada - Part II

The Committee held four meetings, hearing from 19 witnesses, including nine who identified as survivors.

This report provides an overview of the Committee's findings and outlines recommendations that the Committee believes are necessary to bring an end to this appalling practice in Canada. It is divided into three main sections. The first section of the report provides a brief history of forced and coerced sterilization in Canada, followed by a summary of survivor testimony. The second section outlines the legal framework and federal responses to this issue. The third section discusses the key policy areas in which solutions are needed, including ensuring accountability and compensation for survivors, reforming consent processes and education, supporting Indigenous, Black and racialized medical professionals, and improving data collection to better inform future legislative and policy responses. The report concludes with a full list of the Committee's recommendations.

## The Situation in Canada

### Historical context

Forced and coerced sterilization has a long history in Canada, including as a strategy to subjugate and eliminate First Nations, Métis and Inuit peoples. The National Inquiry into Missing and Murdered Indigenous Women and Girls highlighted that official policies of sterilization emerged in the 1920s as part of the eugenics movement and formed part of a genocidal policy against Indigenous peoples.<sup>3</sup> In testimony to the Committee, Alisa Lombard (lawyer, Lombard Law) and several survivors agreed with this characterization of the history of forced and coerced sterilization in Canada.<sup>4</sup>

Dr. Evan Adams (Deputy Chief Medical Officer of Public Health, Indigenous Services Canada) stated that “[f]or Indigenous women in particular, forced and coerced sterilization is an act of sexism, racism and cultural genocide, rooted in colonization and paternalism.”<sup>5</sup> Dr. Karen Stote (author and Assistant Professor, Women and Gender Studies Program, Wilfrid Laurier University), pointed to historical documents that show approximately 1,150 sterilizations of women from the North of Canada and women being treated in federally operated Indian hospitals.<sup>6</sup>

Madeleine Redfern (President, Amautiit Nunavut Inuit Women’s Association) spoke further about this research and what it reveals about the experiences of Inuit women in particular:

*In an inquiry that was done in the 1970s, it was determined that hundreds of Indigenous women from 52 Northern communities were sterilized. Through her research, Dr. Karen Stote, a professor at Wilfrid Laurier University, was able to determine, through looking at the historical records, that at least 70 Inuit women were sterilized. In Igloodik, 26% of women between the ages of 30 and 50 were sterilized. In Naujaat, formerly known as Repulse Bay, almost 50% of women in the 30 to 50 age group were sterilized. In Gjoa Haven, 31% of women had been sterilized. More than 25% of women in Chesterfield*

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<sup>3</sup> National Inquiry into Missing and Murdered Indigenous Women and Girls, *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*, Volume 1a, 2019, pp. 53, 266 and 267; National Inquiry into Missing and Murdered Indigenous Women and Girls, *Supplementary Report – Genocide*, 2019.

<sup>4</sup> Standing Senate Committee on Human Rights (RIDR), *Evidence*, 25 April 2022 (Alisa Lombard, Lawyer, Lombard Law, as an individual).

<sup>5</sup> RIDR, *Evidence*, 25 April 2022 (Dr. Evan Adams, Deputy Chief Medical Officer of Public Health, Indigenous Services Canada).

<sup>6</sup> RIDR, *Evidence*, 3 April 2019 (Dr. Karen Stote, Author and Assistant Professor, Women and Gender Studies Program, Wilfrid Laurier University, as an individual).

*Inlet and Kugaaruk had been sterilized. Those are the only ones that were well documented, but we know that there were a lot more.*

*Other data from the Minister of National Health and Welfare indicates that at least 470 Inuit and Aboriginal women were sterilized in 1972 alone. In addition, it would be remiss if we didn't acknowledge that some men were also given vasectomies and sterilized without their knowledge or consent.<sup>7</sup>*

While the available record indicates that First Nations, Métis and Inuit women have disproportionately been the target of policies of forced and coerced sterilization, the Committee heard that other vulnerable groups have also been disproportionately subjected to these procedures, including Black and racialized women, persons with disabilities, intersex children and institutionalized persons. For example, in a submission to the Committee, the Canadian Association of Community Living and People First of Canada observed that until the 1970s, Alberta and British Columbia legislated the sterilization of persons with intellectual disabilities without their consent, particularly targeting those living in institutions and those with racial, sexual, cultural or socioeconomic differences that were deemed to be deviant or unfit.<sup>8</sup>

As discussed in the Committee's previous report, forced and coerced sterilization did not end with the repeal of these explicit laws and policies.<sup>9</sup> During her appearance before the Committee in 2019, Dr. Josephine Etowa (Professor, University of Ottawa) spoke of her participation in a 2002 project that investigated health care delivery in rural Nova Scotia for Black women. Professor Etowa explained that, upon reviewing data from the study, team members noticed "the issue of hysterectomy continually coming up in the qualitative interviews involving 237 women."<sup>10</sup>

The findings prompted a follow-up study by one of Professor Etowa's graduate students, which focused on the experiences of seven Black women who had hysterectomies for non-life-threatening reasons in the Halifax Regional Municipality. The study found that the women who had undergone hysterectomies did not fully understand why they were subject to the procedure and that the "sociocultural context" of Black women had a significant impact on how they experienced a hysterectomy.<sup>11</sup>

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<sup>7</sup> RIDR, *Evidence*, 9 May 2022 (Madeleine Redfern, President, Amautiit Nunavut Inuit Women's Association).

<sup>8</sup> RIDR, Briefs, *Submission to the Senate Standing Committee on Human Rights*, submitted by the Canadian Association for Community Living and People First of Canada, 17 May 2019.

<sup>9</sup> RIDR, *Forced and Coerced Sterilization of Persons in Canada*, June 2021.

<sup>10</sup> RIDR, *Evidence*, 15 May 2019 (Dr. Josephine Etowa, Professor, Faculty of Health Sciences, University of Ottawa).

<sup>11</sup> Ibid.

While the historical record relating to forced and coerced sterilization is incomplete for various reasons,<sup>12</sup> it is nevertheless deeply troubling, and indicates that forced and coerced sterilization has disproportionately targeted First Nations, Métis and Inuit women, Black women, and women with intersecting vulnerabilities relating to poverty, race and disability.

### What the Committee Heard from Survivors

In sharing their stories with the Committee, witnesses who identified as survivors of forced and coerced sterilization spoke of the significant impact the procedures have had on their physical and mental health, their relationships, their families, and their communities. The following provides graphic descriptions of forced and coerced sterilization; its contents could be disturbing or upsetting, especially for individuals with past traumas.

#### Power imbalances and vulnerability during non-consensual procedures

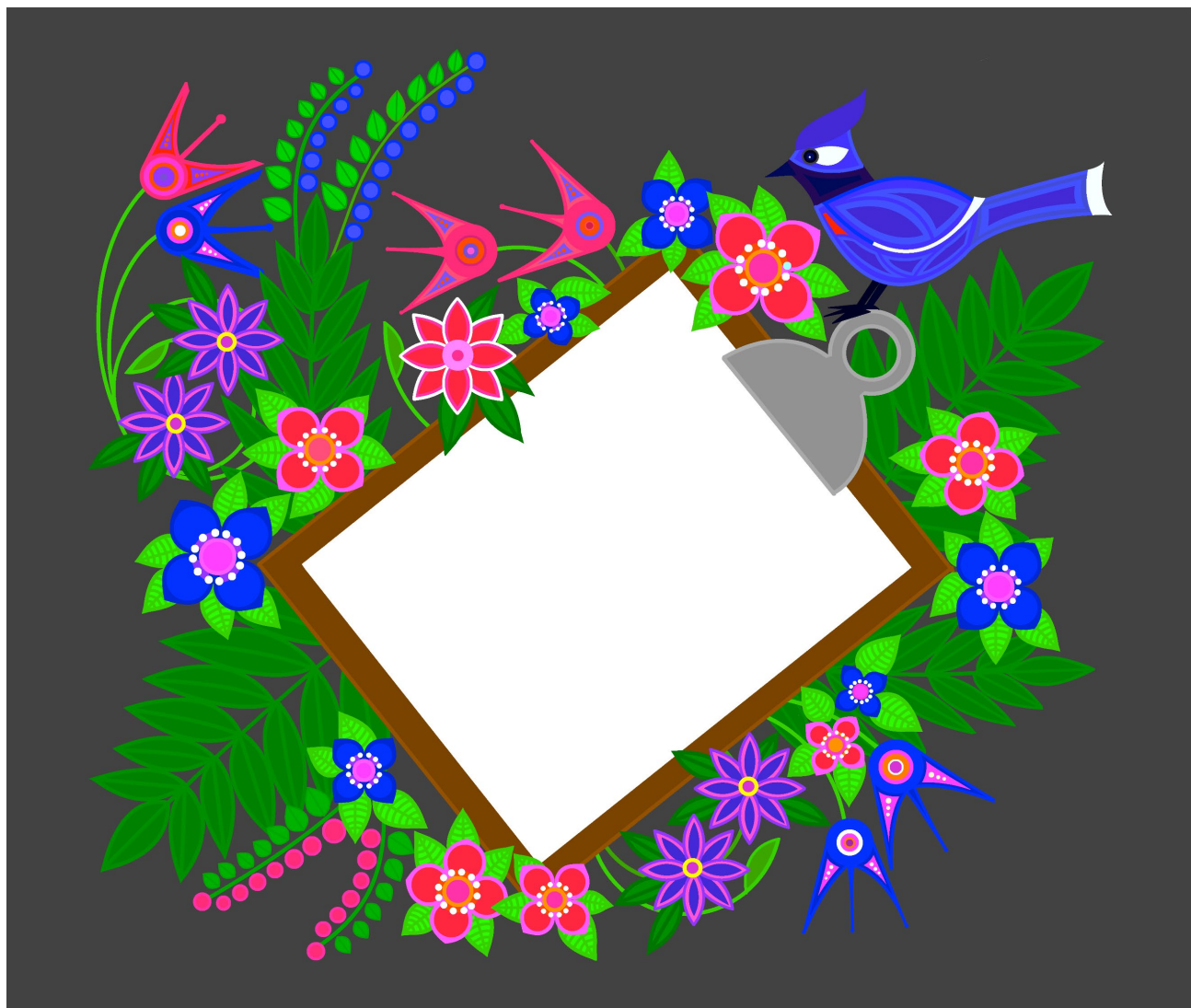
All the survivors who testified before the Committee described scenarios in which their sterilizations lacked free, prior and informed consent. These included medical staff seeking consent for the procedure at inappropriate times; threatening patients; misinforming patients about the necessity, or the effects, of sterilization; and, in some cases, not requesting consent at all.

On 11 September 2001, Nicole Rabbit was scheduled to undergo a caesarean delivery at the Royal University Hospital in Saskatoon, Saskatchewan. She was administered an epidural and nitrous oxide for the procedure and her hands were restrained to her sides. She recounted that “[t]he delivery was normal and we welcomed our daughter baby Ali. My partner and I were so happy.”<sup>13</sup> Their happiness, however, was replaced with concern when – while she remained immobilized – her newborn baby was taken away and the doctors and nurses left the room.

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<sup>12</sup> Witnesses indicated that some of these reasons include survivors not coming forward due to trauma, shame, not knowing what happened to them or not knowing what their rights are. See for example RIDR, *Evidence*, 10 April 2019 (Melanie Omeniho, President, Women of the Métis Nation).

<sup>13</sup> RIDR, *Evidence*, 2 May 2022 (Nicole Rabbit, as an individual).



**Figure 1: *The Most Sacred Ceremony*, March 2020**

by Lisa Boivin

"The clipboard represents the process of informed consent. Informed consent is the most sacred ceremony between clinician and patient. This is a ceremony where both parties come together equally and participate in clinical plan that benefits the patient. As such, I have added a Blue Jay because they are careful and clear in their communication. Committed to truthfulness and justice, they sing the sweetest songs, encouraging us to move forward in a good way. Clinicians must develop equal relationships with their patients that are free from coercion, with a solid process of informed consent."

*Some nurses and doctors returned. I could hear them talking. My partner, who was sitting on my left side by my head told me that the delivery team were huddled at my feet. A nurse then approached me on my right-hand side and said really loud that I couldn't hold another baby, and it was best that they tie my tubes. I was confused and I looked towards my partner. The nurse then turned to my partner, and she said, "She can't hold another child. It's in her best interest to have this procedure done." My partner reiterated what the nurse had said, so I asked if it was reversible. She said yes.*

*I had no time to think, and I couldn't think clearly. The nurse informed me that I needed to decide. I was coerced into deciding, still being fully exposed, my abdomen still open from the C-section, my arms still tied down and numb. I felt pressured to say yes.*

*Moments later I could smell something burning and thought, "Did they just burn my tubes?" Then the doctor proceeded to close me up.*

*I trusted the medical team but knew something wasn't right when I smelt the burning flesh. These were strangers who I had no previous encounters with who insisted I tie my tubes. The medical team took advantage of me in a vulnerable state.*

...

*No one asked me what I wanted. No one explained to me why I apparently needed this done, and I didn't sign any forms. I still have no real idea what the options were and why they said it was best for them to sterilize me. I know now that the sterilization can't be reversed.*

*Nicole Rabbit*

Another survivor, who wished to remain anonymous, shared the story of the birth of her son in 2018, when she was 24 years old. She described both her vulnerability and confusion when doctors raised the possibility of tubal ligation while she waited for a caesarean delivery for her distressed baby and risked going into septic shock. The witness explained that, given her state of mind at the time, she was willing to provide consent for the sterilization if it meant the caesarean section would proceed and her baby would be saved.<sup>14</sup>

*Before they brought me the papers to sign [for the caesarean delivery], they brought up a tubal ligation. Since they would already be operating on me, they said that this would be a quick process. Prior to hearing this, I never had any thoughts about a tubal ligation and, honestly, I had no clue about what a tubal ligation was. I remember asking what that meant, and the answer I got seemed very vague and cruel. The doctor told me that the person performing the surgery had a very good reputation and that it was a safe surgery. They explained to me that they cut my Fallopian tubes and sear them closed, and made a joke about how nothing would be getting through them. At that point, I didn't second-guess my decision, because the only thing that was on my mind was surviving and the survival of my unborn child.*

*I felt like the life of my unborn child was in my hands if I didn't sign the documents fast enough. After I agreed, I remember the doctor, and the nurse entering the room. They asked my partner, who was also clearly Indigenous, to leave the room and give us a*

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<sup>14</sup> RIDR, [Evidence](#), 9 May 2022 (Witness A, as an individual).

*few moments alone. He left without incident. However, my mother stayed in the room with me. They started asking me if this was what I really wanted and how I could change my mind, because I might regret my decision later on. They also said I couldn't change my mind if I happened to find a new partner and wanted a child with them. This was kind of said in a worst-case scenario type of way, like "if your partner leaves you, and you decide later on that you want a child with a new partner . . ." That's the kind of tone that they had. I was completely caught off guard, and I felt like they were trying to safeguard themselves by making me almost fight for my tubal ligation. At that moment, I felt like I had to prove myself to them and prove how serious and committed I was to my partner.*

*Witness A*

Sylvia Tuckanow informed the Committee that, shortly after she gave birth, medical staff waited for her husband to leave her bedside before forcibly moving her to an operating room, administering an epidural, and sterilizing her, all while she protested and cried uncontrollably.<sup>15</sup>

*I was sterilized against my will when I was 29 years old. On July 9, 2001, I went to Royal University Hospital in Saskatoon in active labour. I gave birth to a healthy baby boy with my late husband by my side. Shortly after the birth, I heard my husband in the hall saying loudly to nurses, "I'm not signing that." No one asked me anything or explained anything to me about what he had been asked, and I'm absolutely sure that I didn't sign anything.*

*As soon as my husband left the hospital, I was taken into an elevator in a wheelchair to another room. I can't recall if I went up or down as I was still disoriented from giving birth and the effects of pain medications. I was placed outside this room by the door. I managed to see into the room, which was unfamiliar to me. I automatically felt fear, so I started trying to wheel myself back to the direction of where the elevator was, but I didn't make it because a man came up behind me and wheeled me back towards that room.*

*I told him I didn't want to do this, but he didn't listen. I didn't know exactly what I was objecting to at the time, but I had a terrible feeling because no one had talked to me about what was going on.*

*I felt terror and fear as I was taken into that room. A few nurses surrounded me — I don't know exactly how many nurses — to prepare me for an epidural. I already had an epidural sticking out of my back from giving birth, so I wondered why they needed to do another one. I kept asking if the one already there can be used. I was trying to*

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<sup>15</sup> RIDR, *Evidence*, 2 May 2022 (Sylvia Tuckanow, as an individual).

*stall them, I believe, because I was coming up with excuses. During this I kept saying "No, I don't want to do this," and crying uncontrollably, but nobody listened to me. I was completely ignored by everyone in that room.*

*I was so vulnerable because my legs weren't working properly because of giving birth and having the first epidural. I was put in that bed in total fear. I kept crying and I was terrified. I was hyperventilating because of the position I was in on that bed. My head was positioned lower than my body, and they tied me down to the bed.*

*I could also smell something burning, which reminds me of the smell of singed chickens to this day. I asked the man doing the surgery if he was done a few times. He didn't reply until the procedure was done. When he was finished, he said: "There, tied, cut and burnt. Nothing will get through that."*

*I felt relief that I was getting out of that room. I was taken back to the maternity ward, and it was then that I got to hold my son. I can't recall if I held my baby before they brought me to the operating room to sterilize me, but I don't think that I did hold him.*

*Sylvia Tuckanow*

Louise Delisle recounted to the Committee that, while giving birth at 15 years old, her mother was barred from the delivery room. She explained that the doctor delivering her daughter took it upon himself to perform a partial hysterectomy, something she would only discover years later when attempting to bear children with her husband.<sup>16</sup>

*I was very young when I had my daughter. I was 15 years old. My parents were not parents whom I could come to and tell them that I was pregnant, so this was a traumatic time for me in my life, and I told no one. I had to leave school because I began to show, and actually my principal was the one who informed my mother that I was with child.*

*Because I was so young, I had no idea what this all meant and how to handle this. Of course my daughter was taken away because I was so young, and I was the eldest of seven children living in a very poor home.*

*I remember her birth. I remember the pain during her birth. I also remember a Black woman being in the room with me as a nursing assistant. I remember, through all the pain, that she got into an argument with the doctor who was delivering my daughter. I remember her voice to this day and the sternness in her voice when she said, "You can't do that. You need permission to do that." The doctor said, "Too late. I don't want to see this girl back here again having kid after kid and going through this and maybe*

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<sup>16</sup> RIDR, [Evidence](#), 16 May 2022 (Louise Delisle, as an individual).



*worse. We won't be in this position again," he said. I had no idea what he was talking about. I was in labour and I was 15 years old, but what I found out was he had done something that would prevent me from having any more children. This was never discussed with me or my mother, who was my guardian while I was in hospital. It was never discussed.*

*My mother was not allowed in the room with me when I was giving birth, which was also something traumatic. The hardest thing for me was to come home without my daughter. Because I was 15 years old, like I said, I had to give her away. I couldn't provide for her.*

*Whatever the doctor did to me, I was not able to have children again in my life, like I said. So when I became 29 I married, and my husband and I wanted to have children. I was not aware what had happened until I was seeing a doctor in a fertility clinic to find out why I wasn't getting pregnant, why my husband and I weren't getting pregnant. That's when I was told I had had a partial hysterectomy.*

*Louise Delisle*

Other witnesses explained how lack of information, or wrong information, affected their consent. A witness who wished to remain anonymous and who is now a registered nurse told the Committee that immediately following the delivery of her baby in August 2004, she was asked if she wanted a tubal ligation "due to a cancellation in the surgeon's schedule."<sup>17</sup> The request followed two days of labour and sleep deprivation. In her own words:

*Paired with blood loss, pain, exhaustion and a lack of family presence, I find it unethical that I was asked to make a choice about a procedure I did not know was permanent. Yet, within two hours of giving birth, I was in the operating theatre getting sterilized.*

*Witness B, Registered Nurse*

Melika Pop was equally misinformed that her sterilization would be reversible. She spoke of being "interrogated, shamed and subjected to systemic racial profiling and harassment" by medical staff prior to and during her caesarean delivery.<sup>18</sup> Ms. Pop also noted the absence of appropriate steps to ensure that free, prior and informed consent had been obtained, explaining that in her case, as in the case of many others, consent was sought "in a time of severe pain, while in the throes of labour."<sup>19</sup>

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<sup>17</sup> RIDR, *Evidence*, 2 May 2022 (Witness B, Registered Nurse, as an individual).

<sup>18</sup> RIDR, *Evidence*, 2 May 2022 (Melika Pop, as an individual).

<sup>19</sup> Ibid.

Elizabeth Esquega informed the Committee that, as a childbearing teenager, she was coerced into having an abortion, during which she was also sterilized. Recounting that a child protection worker told her they would “take the baby one way or another” and characterizing the pressure from a social worker and doctor as “immense,” Ms. Esquega described how she was kept uninformed about the sterilization procedure:<sup>20</sup>

*In my case, I can't think of where I had an opportunity to speak with an actual counsellor or a social worker about the long-term effects of what I was going into here. That wasn't offered. All I recall is being in a small room with a doctor in a white coat and the social worker standing in the corner, and both of them taking their shot at me, so to speak.*

*Elizabeth Esquega*

Lucy Nickerson said she encountered similarly manipulative treatment. She explained that when she went to the hospital for a minor medical procedure when she was 29 or 30 years old, her doctor suggested “[w]hile we’re in there, we might as well give you a hysterectomy.”<sup>21</sup> Ms. Nickerson stated:

*He never explained to me what was going to happen to me, and when I [came] out after the operation, I didn't feel good. I felt alone, racing with myself. It was an awful experience to go through. I wanted to go home. I kept asking them to let me go home, but they wouldn't let me go home... I didn't know what to do with myself. I was racing with myself. I never want to go through that again. That was my experience of it all. I wish they would have told me what I was going to go through.*

*Lucy Nickerson*

Morningstar Mercredi was sterilized without her consent at the age of 14. She told the committee she had been unable to talk about her sterilization until she was in her 50s and chose not to address the details of the event before the committee to avoid re-traumatizing herself.<sup>22</sup> Ms. Mercredi explained:

*As to myself and what happened to me when I was a 14-year-old girl and pregnant, I'm choosing not to disclose the details because I can confidently say that you can read the*

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<sup>20</sup> RIDR, *Evidence*, 2 May 2022 (Elizabeth Esquega, as an individual).

<sup>21</sup> RIDR, *Evidence*, 16 May 2022 (Lucy Nickerson, as an individual).

<sup>22</sup> RIDR, *Evidence*, 2 May 2022 (Morningstar Mercredi, as an individual).

*book, and the book is Sacred Bundles Unborn. Should anybody require any of the horrific details of the inhumane, brutal torture and incident that I only speak of to myself, you can read the details in the book.*

*Morningstar Mercredi*

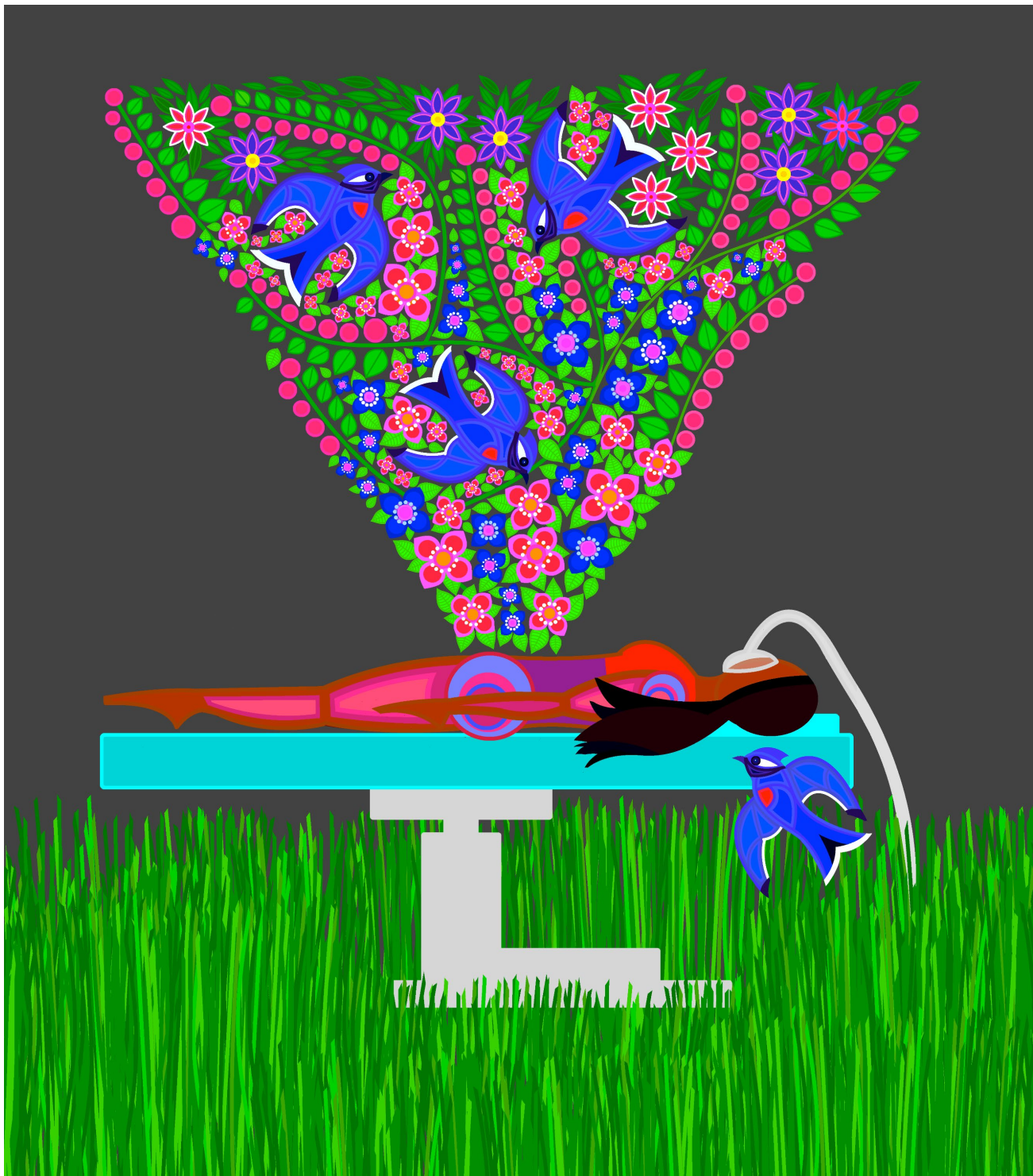
## **Racism and discrimination**

The Committee's June 2021 report on forced and coerced sterilization highlighted the link between racism and the practice of forced and coerced sterilization in Canada.<sup>23</sup> During the current study, witnesses once again underlined the role racism has played with respect to obstetric violence in Canada and the continuing problem of racism within Canada's healthcare system.<sup>24</sup> Survivors confirmed this, and further explained how racism and discrimination have hampered efforts to raise awareness about the issue of forced and coerced sterilization. They also provided suggestions on how to address the issue.

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<sup>23</sup> RIDR, *Forced and Coerced Sterilization of Persons in Canada*, June 2021.

<sup>24</sup> RIDR, *Evidence*, 9 May 2022 (Gerri Sharpe, President, Pauktuutit Inuit Women of Canada); RIDR, *Evidence*, 25 April 2022 (Dr. Evan Adams, Deputy Chief Medical Officer of Public Health, Indigenous Services Canada); RIDR, *Evidence*, 25 April 2022 (Suzy Basile, Professor and Canada Research Chair in Indigenous Women Issues holder, Université du Québec en Abitibi-Témiscamingue, as an individual); RIDR, *Evidence*, 25 April 2022 (Dr. Unjali Malhotra, Medical Director, First Nations Health Authority).



**Figure 2: *The Warning*, March 2020**

by Lisa Boivin

“This is an image of a woman’s surgical sterilization. Blue Jays are protectors. They swarm around her anesthetized body singing a song of warning. They are telling her she will soon be separated from her biological fertility. However, even this violent act will not sever her from the beauty and resilience living in her body, which is represented by the flowers and berries growing from her powerful womb.”

### ***Racism within healthcare settings***

The survivors who shared their stories with the Committee were unequivocal: they believed that racism was the driving factor behind their forced or coerced sterilizations.<sup>25</sup> For example, Ms. Mercredi stated that “racism is undoubtedly a key factor in forced coerced sterilization, in the demise and the inhumane treatment of Indigenous, Métis, Inuit women, and women of colour, but specifically as we refer to Indigenous women, absolutely.”<sup>26</sup>

Similarly, Ms. Delisle attributed her sterilization to the fact that she is Black and comes from a large, Black family, stating: “I feel, that, truly, if I had been somebody else, a different culture, a different colour, it would not have happened.”<sup>27</sup>

Despite their respective traumas, the survivors communicated their hopes that new and better education for healthcare practitioners could counter racism within healthcare settings. Suggestions included yearly classes on accountability for doctors and nurses,<sup>28</sup> and educational programs that provide an understanding of institutional racism.<sup>29</sup> Ms. Esquega noted the importance of training in cultural competency, as well as the history of racism towards Indigenous people.<sup>30</sup>

### ***Racism while raising awareness***

Several survivors of forced and coerced sterilization spoke of the difficult process of coming to terms with events of their past, while gathering the courage to speak out. They informed the Committee of discriminatory comments they received when attempting to raise awareness of the issue. Ms. Mercredi explained that interviews she participated in on the topic of forced and coerced sterilization have incited violent and racist comments: “It is not safe for me on any venue via multimedia to discuss sterilization. The response is violent. It is beyond racist; it is violent. I feel even more intensely targeted.”<sup>31</sup>

One witness recounted being denigrated on social media, despite her knowledge of the consent process gained from her work as a health care professional.<sup>32</sup> Ms. Pop explained the degree to which public ignorance surrounding forced and coerced sterilization is painful for survivors.<sup>33</sup> More

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<sup>25</sup> RIDR, [Evidence](#), 2 May 2022 (Melika Pop, as an individual); RIDR, [Evidence](#), 2 May 2022 (Elizabeth Esquega, as an individual); RIDR, [Evidence](#), 2 May 2022 (Witness B, as an individual); RIDR, [Evidence](#), 2 May 2022 (Nicole Rabbit, as an individual).

<sup>26</sup> RIDR, [Evidence](#), 2 May 2022 (Morningstar Mercredi, as an individual).

<sup>27</sup> RIDR, [Evidence](#), 16 May 2022 (Louise Delisle, as an individual).

<sup>28</sup> RIDR, [Evidence](#), 2 May 2022 (Melika Pop, as an individual).

<sup>29</sup> RIDR, [Evidence](#), 2 May 2022 (Elizabeth Esquega, as an individual).

<sup>30</sup> Ibid.

<sup>31</sup> RIDR, [Evidence](#), 2 May 2022 (Morningstar Mercredi, as an individual).

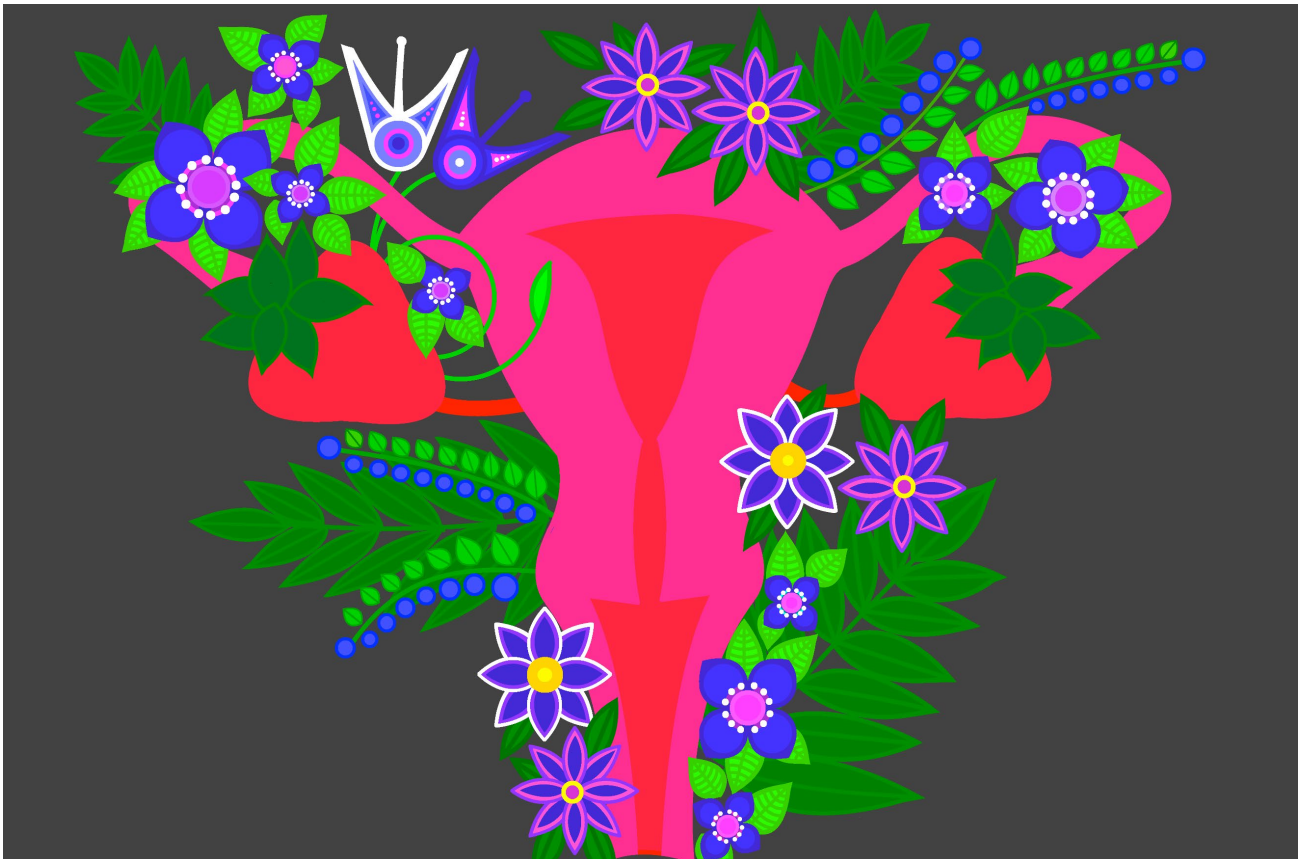
<sup>32</sup> RIDR, [Evidence](#), 2 May 2022 (Witness B, Registered Nurse, as an individual).

<sup>33</sup> RIDR, [Evidence](#), 2 May 2022 (Melika Pop, as an individual).

than one survivor highlighted the retraumatizing character of the public comments, with several noting they avoid all forms of social media.<sup>34</sup>

Survivors suggested that, similar to health care practitioners, society in general could benefit from education on forced and coerced sterilization. Ms. Pop highlighted the importance of public education to communicate the extent of harm suffered by survivors of forced and coerced sterilization, as well as the intergenerational trauma that accompanies the practice.<sup>35</sup> Ms. Esquega urged “more awareness to the public that this isn’t just a figment of some people’s imagination, but these are actual truths and stories from women who have experienced these horrendous acts.”<sup>36</sup>

### Repercussions of sterilization



**Figure 3: *What Will Always Be*, March 2020**

by Lisa Boivin

“Indigenous women are extremely powerful. The ovaries are replaced with strawberries. Strawberry is a woman’s medicine. She is the only berry brave enough to wear her seeds on the outside.”

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<sup>34</sup> Ibid.; RIDR, *Evidence*, 2 May 2022 (Morningstar Mercredi, as an individual).

<sup>35</sup> RIDR, *Evidence*, 2 May 2022 (Melika Pop, as an individual).

<sup>36</sup> RIDR, *Evidence*, 2 May 2022 (Elizabeth Esquega, as an individual).

In addition to the trauma experienced by survivors detailed earlier, witnesses spoke of long-term psychological consequences, including depression, anxiety and loss of trust, as well as the collapse of their families and communities.

### ***Health effects***

Several witnesses described suffering from post-sterilization depression and anxiety. For Ms. Delisle, the sterilization led to a variety of health issues: “It caused me to have anxiety. It caused me to go through early menopause. It caused many episodes of depression and not knowing why.”<sup>37</sup> At 15 years old, and eight months after she was sterilized, Ms. Mercredi attempted to take her own life. Noting that it took time for her to come to terms with the severity of her trauma, Ms. Mercredi told the Committee that her struggles with post traumatic stress disorder and suicidal depression are ongoing. In her own words: “The impacts that it has had on me and my well-being are profound and indescribable. The impact it has had on me as a woman is indescribable.”<sup>38</sup>

Another witness spoke of the waves of grief she experiences from what she characterized as the loss of her identity as a woman.<sup>39</sup> Ms. Esquega described feeling “empty with my maternal instinct and God-given ability to bear life cut and ripped from me.”<sup>40</sup> Part of this emptiness, she explained, came from feeling that she was an accomplice. Comparing her coerced sterilization to sexual assault, she stated that she “internalized deep-seated fear, shame and guilt. This led to a greater loss of my own being as shame overtook my sense of self.”<sup>41</sup> She also explained how the sterilization left her unprepared to cope with the loss of her mother, which occurred shortly after she was sterilized. She stated, “I did not know what to do or where to turn as another life trauma was intensified and triggered.”<sup>42</sup>

The Committee heard that avoiding health care services is a common result of the anxiety and fear related to forced and coerced sterilization for survivors, as well as for their families and communities. Speaking about her distrust of doctors and hospitals, one witness explained that she delayed seeking medical help for her mental health and was afraid to bring her child to the doctor for medical assessments.<sup>43</sup> Other witnesses stated that when they did go to the doctor, they were distrustful of the treatment. Ms. Delisle explained, “I had no confidence that they really wanted to help me. That was my problem with the health care system.”<sup>44</sup> Ms. Tuckanow noted that she now has anxiety that, should the issue of forced and coerced sterilization not be addressed, her daughter could suffer the same fate.<sup>45</sup>

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<sup>37</sup> RIDR, *Evidence*, 16 May 2022 (Louise Delisle, as an individual).

<sup>38</sup> RIDR, *Evidence*, 2 May 2022 (Morningstar Mercredi, as an individual).

<sup>39</sup> RIDR, *Evidence*, 9 May 2022 (Witness A, as an individual).

<sup>40</sup> RIDR, *Evidence*, 2 May 2022 (Elizabeth Esquega, as an individual).

<sup>41</sup> Ibid.

<sup>42</sup> Ibid.

<sup>43</sup> RIDR, *Evidence*, 9 May 2022 (Witness A, as an individual).

<sup>44</sup> RIDR, *Evidence*, 16 May 2022 (Louise Delisle, as an individual).

<sup>45</sup> RIDR, *Evidence*, 2 May 2022 (Sylvia Tuckanow, as an Individual).

### ***Impact on generations and communities***

Beyond the personal suffering of survivors, forced and coerced sterilization affects their families, their communities, and their nations. Several survivors explained that their inability to conceive contributed to the end of their marriages and hampered future intimate relationships.<sup>46</sup> One witness described her struggles to form a bond with her newborn son, explaining that milestones during his development became a reminder that she could no longer conceive.<sup>47</sup>

While speaking about the impact of forced and coerced sterilization on Indigenous communities, Ms. Mercredi highlighted that “[t]he foundation of who we are is based on matriarchal societies” and that “community is everything.”<sup>48</sup> Using the example of her family, Ms. Rabbit explained that forced and coerced sterilization compounded the dispersion of Indigenous communities that occurred under residential schools. She noted that it has “limited our supports,” especially with respect to community elders.<sup>49</sup>

Ms. Pop drew a clear line between forced and coerced sterilization and the erasure of Indigenous lineages. She explained that “[w]here the violated have Indian status, such as myself, the repercussions reflect an inability to pass that status on to future generations and decreases the numbers of our people.”<sup>50</sup> For these reasons, several survivors and expert witnesses described this practice as amounting to genocide.<sup>51</sup>

Ms. Mercredi stated that she believes:

*We will never adequately be able to determine the number of women, men, girls and boys that were sterilized in residential schools and in Indian hospitals. I say that to acknowledge the fact that this has been ongoing for as long as those institutes of genocide have been in place in Canada and is currently ongoing now in 2022. We will never be able to adequately determine the number of women that are being tortured and subjected to forced coerced sterilization.<sup>52</sup>*

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<sup>46</sup> RIDR, [Evidence](#), 16 May 2022 (Louise Delisle, as an individual); RIDR, [Evidence](#), 2 May 2022 (Sylvia Tuckanow, as an individual); RIDR, [Evidence](#), 2 May 2022 (Witness B, Registered Nurse, as an individual); RIDR, [Evidence](#), 2 May 2022 (Morningstar Mercredi, as an individual); RIDR, [Evidence](#), 2 May 2022 (Nicole Rabbit, as an individual).

<sup>47</sup> RIDR, [Evidence](#), 9 May 2022 (Witness A, as an individual).

<sup>48</sup> RIDR, [Evidence](#), 2 May 2022 (Morningstar Mercredi, as an individual).

<sup>49</sup> RIDR, [Evidence](#), 2 May 2022 (Nicole Rabbit, as an individual).

<sup>50</sup> RIDR, [Evidence](#), 2 May 2022 (Melika Pop, as an individual).

<sup>51</sup> Ibid; RIDR, [Evidence](#), 2 May 2022 (Morningstar Mercredi, as an individual); RIDR, [Evidence](#), 2 May 2022 (Sylvia Tuckanow, as an individual); RIDR, [Evidence](#), 9 May 2022 (Gerri Sharpe, President, Pauktuutit Inuit Women of Canada).

<sup>52</sup> RIDR, [Evidence](#), 2 May 2022 (Morningstar Mercredi, as an individual).



## The Legal Framework and Federal Response

### International Law and Calls for Canadian Action

As discussed in the Committee's previous report, freedom from unwanted interference with one's body and reproductive rights are protected under Canadian and international human rights frameworks, including section 7 of the *Canadian Charter of Rights and Freedoms* and the UN *Convention Against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment* – which Canada has ratified – as well as by policies regulating medical professionals in all Canadian provinces and territories.

In December 2018, the UN Committee against Torture adopted concluding observations in response to Canada's seventh periodic report under the *Convention against Torture and Other Cruel, Inhuman or Degrading Treatment or Punishment*. The observations expressed concern about reports of extensive forced or coerced sterilization of Indigenous women and girls, including recent cases in Saskatchewan.<sup>53</sup>

The Committee against Torture made the following recommendations to Canada regarding forced and coerced sterilization:

- Ensure that all allegations of forced or coerced sterilization are impartially investigated, that the persons responsible are held accountable and that adequate redress is provided to the victims;
- Adopt legislative and policy measures to prevent and criminalize the forced or coerced sterilization of women, particularly by clearly defining the requirement for free, prior and informed consent with regard to sterilization and by raising awareness among [I]ndigenous women and medical personnel of that requirement.

...

- [P]rovide, by 7 December 2019, information on follow-up to the Committee's recommendations [including] on ... involuntary sterilization of [I]ndigenous women.<sup>54</sup>

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<sup>53</sup> United Nations (UN) Committee against Torture, *Concluding observations on the seventh periodic report of Canada*, 21 December 2018.

<sup>54</sup> Ibid.

In 2019, these concerns and recommendations were echoed by the Inter-American Commission on Human Rights (IACHR) and by two UN Special Rapporteurs following visits to Canada that included meetings with various stakeholders and government officials.<sup>55</sup>

The IACHR's statement urged Canada "to guarantee effective access to justice for survivors and their families, to conduct impartial and immediate investigations, to hold those responsible to account and to take all of the necessary measures to put an end to the practice of sterilizing women against their will."<sup>56</sup> The IACHR noted that it had received many reports from Indigenous women and girls alleging that they had been subjected to sterilizations without their free and informed consent. The IACHR expressed concern about these allegations and highlighted that surgical sterilizations must be subject to particularly rigorous controls to ensure that consent is provided in a free, informed and voluntary manner.

### Criminal Offences in Canada

Canada provided follow-up information in response to the UN Committee against Torture's observations and recommendations. Canada's response noted that forced or coerced sterilization is a crime in Canada, constituting an offence under one or more sections of the *Criminal Code*, such as sections 265 (assault), 267 (assault causing bodily harm) and 268 (aggravated assault), and that in addition, all provinces and territories have legislation requiring consent for medical care and treatment. Canada's response further noted that the federal government, through the Royal Canadian Mounted Police, is committed to investigating reported allegations and treating those who report such crimes in a respectful manner.<sup>57</sup>

Despite the existence of these offences, Alisa Lombard noted that there have been no reports of doctors facing consequences for acts of forced or coerced sterilization. Ms. Lombard and several other witnesses advocated for the inclusion of a specific offence in the *Criminal Code* relating to forced and coerced sterilization.<sup>58</sup>

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<sup>55</sup> Inter-American Commission on Human Rights (IACHR), *IACHR expresses its deep concern over the claims of forced sterilizations against [I]ndigenous women in Canada*, News Release, 18 January 2019; UN Human Rights Council, *Visit to Canada: Report of the Special Rapporteur on violence against women, its causes and consequences*, UN Doc no. A/HRC/41/42/Add.1, 3 June 2019; UN Human Rights Council, *Visit to Canada: Report of the Special Rapporteur on the right of everyone to the enjoyment of the highest attainable standard of physical and mental health*, UN Doc. no. A/HRC/41/34/Add.2, 19 June 2019.

<sup>56</sup> Inter-American Commission on Human Rights (IACHR), *IACHR expresses its deep concern over the claims of forced sterilizations against [I]ndigenous women in Canada*, News Release, 18 January 2019. Note that Canada is a member of the Organization of American States (OAS) but has not ratified the *American Convention on Human Rights*. The Inter-American Commission on Human Rights has a mandate under the OAS Charter and the Convention to promote and defend human rights in the region.

<sup>57</sup> UN Committee against Torture, *Information received from Canada on follow-up to the concluding observations on its seventh periodic report*, 16 April 2020.

<sup>58</sup> RIDR, *Evidence*, 25 April 2022 (Alisa Lombard, Lawyer, Lombard Law, as an individual).

In addition to criminal offences, healthcare practitioners can face disciplinary measures from their professional governing or licensing body. Abby Hoffman, (Assistant Deputy Minister, Strategic Policy Branch, Health Canada) explained that:

*Each province and territory has laid out through statute its own framework for oversight of health-care professionals by self-regulating bodies. These bodies are responsible, in turn, for setting standards of practice, credentialing providers, for reviewing and responding to complaints made against health care professionals under their authority, for education and for disciplinary action when warranted.<sup>59</sup>*

## Federal Actions to Address Forced and Coerced Sterilization

In recent years, the federal government has taken several steps to specifically address reports of forced and coerced sterilization.

In 2019, Indigenous Services Canada (ISC) established an Advisory Committee on Indigenous Women’s Wellbeing, which provides ongoing gender- and distinctions-based advice to ISC on issues relating to the social determinants of health, with a particular focus on sexual and reproductive health.<sup>60</sup> It includes representatives from several Indigenous organizations as well as the Society of Obstetricians and Gynaecologists of Canada.<sup>61</sup> Based on its recommendations, Budget 2021 provided \$33.3 million to expand support for Indigenous midwifery and doula initiatives in Canada.<sup>62</sup>

The federal government has also provided funding to Indigenous women’s organizations for the development of information products on reproductive rights. In testimony to the Committee, Dr. Adams noted that this initiative stemmed from a recommendation of the Inter-American Commission on Human Rights.<sup>63</sup>

Further, in January 2020, ISC worked with the National Collaborating Centre for Indigenous Health to facilitate a Forum on Culturally Informed Choice and Consent in Indigenous Women’s Health.<sup>64</sup> Dr. Adams informed the Committee that themes from this forum included “promotion of Indigenous-led midwifery and Indigenous patient advocates, accountability, improved data

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<sup>59</sup> RIDR, *Evidence*, 15 May 2019 (Abby Hoffman, Assistant Deputy Minister, Strategic Policy Branch, Health Canada).

<sup>60</sup> Indigenous Services Canada (ISC), *2022–23 Departmental Plan: Gender-Based Analysis Plus*.

<sup>61</sup> Global Affairs Canada, *Crown-Indigenous Relations and Northern Affairs Canada and Indigenous Services Canada implementation of Canada’s National Action Plan on Women, Peace and Security*.

<sup>62</sup> RIDR, *Evidence*, 25 April 2022 (Dr. Evan Adams, Deputy Chief Medical Officer of Public Health, ISC).

<sup>63</sup> Ibid.

<sup>64</sup> National Collaborating Centre for Indigenous Health, *Summary Report: Informed Choice and Consent in First Nations, Inuit and Métis Women’s Health Services*, 2021.

collection, the role of child welfare, changes to the Criminal Code and mandatory anti-racism training for health care providers.”<sup>65</sup>

Finally, Dr. Adams highlighted that the “racist mistreatment and tragic death” of Joyce Echaquan in September 2020 prompted the Government of Canada to convene three national dialogues in October 2020, January 2021 and June 2021 to address anti-Indigenous racism in Canada’s health systems.<sup>66</sup> At the third national dialogue, ISC and Health Canada announced an initial federal response to address anti-Indigenous racism in health systems. The response includes increased funding for several initiatives, including Indigenous health systems navigators and patient advocates, the development of cultural safety and anti-racism tools and resources, targeted data collection, increased Indigenous representation in health professions, and ongoing national dialogues and roundtables.<sup>67</sup>

## Key Issues and Solutions

### Accountability

Forced and coerced sterilization is an ongoing injustice that must end. Witnesses identified several avenues for deterrence, denunciation, and restitution, including amending the *Criminal Code* to specifically criminalize forced and coerced sterilization, and compensating survivors for the harm and suffering that this practice has inflicted.

Several survivors told the Committee that they want to see greater accountability through the creation of a specific offence that would “ensure that these kinds of human rights violations end.”<sup>68</sup> Ms. Lombard stated that – in addition to being the approach that many survivors want – the creation of a specific criminal offence would serve as a deterrent. She noted that:

*So far, there have been no reports of doctors facing consequences... there have been none. However, the risk of criminal sanctions could have an impact. At least we know that it would be better than what we have at the moment, which is nothing at all. I think that this is a measure that would be immediate. It must be understood that, in order to denounce a practice that is absolutely unacceptable, the measure must equal*

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<sup>65</sup> RIDR, [Evidence](#), 25 April 2022 (Dr. Evan Adams, Deputy Chief Medical Officer of Public Health, ISC).

<sup>66</sup> Ibid.

<sup>67</sup> ISC, [Addressing anti-Indigenous racism in health systems: Federal response](#).

<sup>68</sup> RIDR, [Evidence](#), 2 May 2022, (Melika Pop, as an individual).

*the harm caused. If doctors know that they could potentially be subject to criminal sanctions, this could change behaviour quite quickly.*<sup>69</sup>

Sandeep Prasad (Executive Director, Action Canada for Sexual Health and Rights) also stated that the addition of a specific criminal offence should be considered, along with changes to existing accountability mechanisms such as professional disciplinary procedures. However, he also warned the Committee that any accountability mechanisms should be designed in a way that avoids chilling effects:

*[O]n the availability and accessibility of high-quality sexual and reproductive health services based on free and informed consent, particularly for those people often stigmatized and discriminated against by the health sector. Those who are Indigenous or otherwise marginalized are often disproportionately targeted by law enforcement and so are among the least likely to seek police protection. The problem will not be solved without comprehensive changes within the health system.*<sup>70</sup>

Nevertheless, other witnesses expressed scepticism about using criminal law to pursue accountability in this context. For example, Virginia Lomax (Legal Counsel, Native Women's Association of Canada) explained that a specific offence may not solve the problem since its effect would depend on police enforcement. She noted:

*[M]urder is a crime and that has not solved the problem of missing and murdered Indigenous women in this country. It's clear to me that this is a much larger systemic issue. Criminalization will only be a small piece of the puzzle. Every moving part of the system that creates these injustices must be informed in a way that will prevent, not simply react.*<sup>71</sup>

For similar reasons, Melanie Omeniho (President, Women of the Métis Nation) argued that the focus should be on crafting legislation and policies that change practices in health care institutions.<sup>72</sup> Dr. Adams noted the need to ensure that there be repercussions for violence, racism, and sexism in the health care system, but suggested that this approach need not be punitive.<sup>73</sup>

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<sup>69</sup> RIDR, *Evidence*, 25 April 2022 (Alisa Lombard, Lawyer, Lombard Law, as an individual).

<sup>70</sup> RIDR, *Evidence*, 3 April 2019 (Sandeep Prasad, Executive Director, Action Canada for Sexual Health and Rights).

<sup>71</sup> RIDR, *Evidence*, 10 April 2019 (Virginia Lomax, Legal Counsel, Native Women's Association of Canada).

<sup>72</sup> RIDR, *Evidence*, 10 April 2019 (Melanie Omeniho, President, Women of the Métis Nation).

<sup>73</sup> RIDR, *Evidence*, 25 April 2022 (Dr. Evan Adams, Deputy Chief Medical Officer of Public Health, Indigenous Services Canada).

Dr. Unjali Malhotra (Medical Director, First Nations Health Authority), underlined the role the governing bodies of midwifery, nursing and medicine could play in changing how forced and coerced sterilization is discussed and treated, and in “what ramifications are in place for providers who are embarking upon any coercion regarding reproductive health.”<sup>74</sup> Similarly, Ms. Lomax stated that while criminalization should be one piece of the puzzle “[a]nother piece will be getting the involvement of the medical regulatory authorities who have oversight over doctors.”<sup>75</sup>

### Recommendation 1

**That legislation be introduced to add a specific offence to the *Criminal Code* prohibiting forced and coerced sterilization.**

### Recommendation 2

**That the Government of Canada work with provincial/territorial governments in adopting a non-adversarial dual jurisdictional approach;**

- **to study, publish a report on, and include in training the clinical psychological and physical impacts of sterilization generally, and forced and coerced sterilization specifically;**
- **to mandate medical associations and professional governing and licensing bodies to denounce forced and coerced sterilization and provide a clear consent framework consistent with governing legal principles;**
- **to ensure that all healthcare practitioners are required to undergo intensive training in the physician/patient fiduciary relationship, bodily autonomy, and medical self-determination and mandate that health practitioners are required to pass such training as a condition of their license; and,**
- **to support and augment the rigor of College disciplinary processes to achieve the above pressing objectives.**

## Acknowledgement and Compensation

Witnesses discussed the possibility of providing compensation for survivors as another avenue to promote accountability and deter future instances of forced and coerced sterilization. In developing a framework for compensation, witnesses noted the importance of accounting for the direct and indirect costs that this practice imposes on individuals, families, and communities.

The direct costs associated with attempting to reverse some of the harms of unwanted sterilization procedures can be significant. A 28-year-old survivor who wished to remain anonymous stated that she and her partner are trying to save between \$10,000 and \$15,000 for a procedure that could

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<sup>74</sup> RIDR, *Evidence*, 25 April 2022 (Dr. Unjali Malhotra, Medical Director, First Nations Health Authority).

<sup>75</sup> RIDR, *Evidence*, 10 April 2019 (Virginia Lomax, Legal Counsel, Native Women’s Association of Canada).

enable her to have another child. She stated that “[In vitro fertilization] and those kinds of things are expensive, but I would love to be able to experience them eventually.”<sup>76</sup>

Ms. Lombard described these direct costs in greater detail, noting that:

*[A]ny technology designed to reverse the procedure — to which she did not consent and did not want — costs at least \$5,000 and holds little to no chance of success, based on, I admit, my very rudimentary medical understanding. Reproductive technologies cost upward of \$50,000, and the losses they experience while not being able to try some of these alternative methods cost them unknown quantities of human dignity on a daily basis. However, they wait, increasingly impatiently. They know that legal remedies can only go so far to restore what they have lost. They know that no judicial pronouncement, class action or otherwise, like so many in the past, can replace what they have lost, and most importantly, make future generations of Indigenous women and girls safe from the devastating violations of forced sterilization.*<sup>77</sup>

Moreover, the harm of forced and coerced sterilization goes well beyond the direct costs of medical procedures. Dr. Malhotra explained that the trauma of a single instance of forced or coerced sterilization can ripple through families and communities, and that this needs to be taken into consideration when developing a framework for compensation.<sup>78</sup>

Ms. Omeniho called for acknowledgement of this trauma, potentially including financial compensation, stating that:

*There is no real compensation, but at least there should be an acknowledgment of the trauma they have experienced as a result of forced sterilization. I don't necessarily say that it has to be money, but at some point there should be some engagement or acknowledgment of what has happened to these women and how it has affected and changed their lives.*<sup>79</sup>

Gerri Sharpe, (President, Pauktuutit Inuit Women of Canada) also emphasized the importance of acknowledging the harm that forced and coerced sterilization has inflicted, stating that:

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<sup>76</sup> RIDR, *Evidence*, 9 May 2022 (Witness A, as an individual).

<sup>77</sup> RIDR, *Evidence*, 25 April 2022 (Alisa Lombard, Lawyer, Lombard Law, as an individual).

<sup>78</sup> RIDR, *Evidence*, 25 April 2022 (Dr. Unjali Malhotra, Medical Director, First Nations Health Authority).

<sup>79</sup> RIDR, *Evidence*, 10 April 2019 (Melanie Omeniho, President, Women of the Métis Nation).

*Reconciliation and moving forward have to start with recognizing what has happened and acknowledging it so that other people can be aware of what has happened, and maybe they can realize that it has happened to them as well.<sup>80</sup>*

### Recommendation 3

**That the Government of Canada, led by survivors, develop a compensation framework that reflects both the direct and indirect harms that forced and coerced sterilization has inflicted.**

### Recommendation 4

**That the Government of Canada issue a formal apology on behalf of all Canadians to all persons who have been subjected to forced and coerced sterilization in Canada.**

## Consent Processes and Education

The Committee heard that all provinces and territories have legislation requiring the informed consent of patients. While the wording of these laws varies, each requires that patients receive information about the nature of any proposed treatment, the benefits and risks, and the possible alternatives. Moreover, for consent to be valid it must be voluntary, and the patient must have the capacity to understand what is being conveyed. These principles are further reflected in the policies and ethics codes of professional regulatory bodies.<sup>81</sup>

Nevertheless, forced and coerced sterilization is clearly continuing in Canada. To address the gap between the current consent framework and the reality experienced by survivors, several witnesses expressed the importance of changing the way that health care professionals seek and obtain consent, including through revised regulations from governing bodies in midwifery, nursing and medicine, and through ongoing education about patients' rights for both health care practitioners and the broader public.

For example, Native Women's Association of Canada recommended that medical regulatory authorities work with governments to develop sterilization policies and procedures, including consent processes, anti-racism training, and reporting obligations to monitor regional and national trends.<sup>82</sup>

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<sup>80</sup> RIDR, *Evidence*, 9 May 2022 (Gerri Sharpe, President, Pauktuutit Inuit Women of Canada).

<sup>81</sup> RIDR, *Evidence*, 15 May 2019 (Abby Hoffman, Assistant Deputy Minister, Strategic Policy Branch, Health Canada).

<sup>82</sup> RIDR, *Evidence*, 10 April 2019 (Francyne Joe, President, Native Women's Association of Canada).



Dr. Malhotra emphasized that the requirement to ensure free, prior and informed consent extends to the entire continuum of medical decisions “from someone accessing birth-control pills, right up to accessing sterilization.”<sup>83</sup> Dr. Malhotra outlined several principles to be incorporated into the consent process, including:

*[C]onversation-based consent; empowerment versus extraction in history taking; consent over time versus in acute settings; frame-of-mind and confounding-impact considerations; acknowledgment of a care directive being initiated by patient or provider – asking who is bringing the conversation up; accountability outside of subjective chart notes; and a consideration of someone’s entire life journey versus one moment.*<sup>84</sup>

Dr. Malhotra noted that these approaches informed the development of a shared decision-making guide to informed consent, as well as a storytelling project through the University of British Columbia that aims to create a safe space for Indigenous women to share their experiences in reproductive health care access.<sup>85</sup> In contrast, Suzy Basile (Professor and Canada Research Chair in Indigenous Women Issues holder, Université du Québec en Abitibi-Témiscamingue) expressed concern that Quebec does not recognize the concept of cultural safety as part of its public health policy.<sup>86</sup>

While the policy framework for the consent process is critical, education for both medical practitioners and patients is also necessary to ensure that policies are followed.

In testimony to the Committee, Dr. Adams spoke about his experiences during medical school and residency, where he encountered “paternalistic and racist approaches to clinical care for women,” including “being asked by obstetricians many times: ‘What are you going to do about Indigenous birth rates and teen pregnancies?’”<sup>87</sup>

Witnesses suggested that the best time to change racist and paternalistic attitudes in healthcare professions is in schools, and highlighted the importance of anti-racism and intercultural competency training as recommended by the Truth and Reconciliation Commission of Canada’s Call to Action 24:

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<sup>83</sup> RIDR, [Evidence](#), 25 April 2022 (Dr. Unjali Malhotra, Medical Director, First Nations Health Authority).

<sup>84</sup> Ibid.

<sup>85</sup> Ibid. This guide was created by the First Nations Health Authority in collaboration with Senator Yvonne Boyer and Perinatal Services British Columbia First Nations Health Authority, see First Nations Health Authority, [Informed Consent for Contraception](#).

<sup>86</sup> RIDR, [Evidence](#), 25 April 2022 (Suzy Basile, Professor and Canada Research Chair in Indigenous Women Issues holder, Université du Québec en Abitibi-Témiscamingue, as an individual).

<sup>87</sup> RIDR, [Evidence](#), 25 April 2022 (Dr. Evan Adams, Deputy Chief Medical Officer of Public Health, Indigenous Services Canada).

*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.<sup>88</sup>*

Dr. Malhotra further emphasized the importance of education for health care professionals, stating that “having these discussions being top-of-mind and in our curriculum is important. I know that no one wants to hear that they could potentially be the surgeon on the other end of this, but they need to hear it.”<sup>89</sup>

In addition to educating healthcare workers, several witnesses spoke about the importance of empowering patients and communities by educating them about their rights. For example, Ms. Omeniho stated that:

*We need to find a way to educate our young women in our communities that they have a right to say no to this. Regardless of their decision, people can't go around and threaten to take away their children. They can't threaten to throw them off social assistance because they don't have the financial means to care for themselves. They can't threaten them to be involved in any other process that will make them vulnerable. That's not acceptable anymore.<sup>90</sup>*

### Recommendation 5

**That the Government of Canada encourage provincial/territorial governments to implement measures to ensure that professional standards of governing and licensing bodies are adhered to, that mechanisms are in place to investigate and respond to complaints, and that consent policies and practices adequately protect all patients, particularly in moments of vulnerability.**

### Recommendation 6

**That the Government of Canada take all steps necessary to support the implementation of the Truth and Reconciliation Commission's Call to Action 24 and ensure that all medical**

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<sup>88</sup> RIDR, *Evidence*, 10 April 2019, (Francyne Joe, President, Native Women's Association of Canada). See *Truth and Reconciliation Commission of Canada: Calls to Action*, 2015.

<sup>89</sup> RIDR, *Evidence*, 25 April 2022 (Dr. Unjali Malhotra, Medical Director, First Nations Health Authority).

<sup>90</sup> RIDR, *Evidence*, 10 April 2019 (Melanie Omeniho, President, Women of the Métis Nation).

and nursing schools in Canada require all students to take a course dealing with Indigenous health issues, including skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.

### Recommendation 7

That Health Canada work with applicable partners to launch a public education campaign about patient's rights and consent procedures, and that the campaign be tailored to the specific needs of Indigenous, Black, racialized, remote and marginalized communities, as well as to those of people with disabilities.

## Indigenous, Black and Racialized Medical Professionals

While cultural competence, respect for rights, and applying the principles of free, prior and informed consent are the responsibility of all medical professionals, the Committee heard that many people do not feel safe within existing healthcare systems, and that support for Indigenous, Black and racialized medical professionals – particularly midwives and doulas – can improve healthcare outcomes for survivors and for remote and marginalized communities.

In her testimony to the Committee, Ms. Delisle spoke about a Black nursing assistant who objected to the doctor performing a partial hysterectomy without her consent when she was just 15 years old. She stated that decades later she finally feels safe accessing the healthcare system:

*[B]ecause I have a doctor of colour, a doctor that looks like me. But I didn't. When I went to a doctor, I didn't believe what they were telling me, partly because of what happened to me, and because I felt they didn't understand me or how to treat me. I had no confidence that they really wanted to help me.<sup>91</sup>*

Likewise, as discussed in section one of this report, many First Nations, Métis and Inuit women do not feel safe in the healthcare system. Ms. Lombard noted that some women who have experienced forced and coerced sterilization never see a doctor again, with serious consequences to their overall health, because they do not feel safe returning to the health institutions that perpetrated these harms.<sup>92</sup> Dr. Stote emphasized the importance of Indigenous health systems, stating that:

*We need to be interacting with Indigenous peoples as nations. Indigenous peoples have a right to reconstitute their ways of health and healing, as well. It's not just about*

<sup>91</sup> RIDR, *Evidence*, 16 May 2022 (Louise Delisle, as an individual).

<sup>92</sup> RIDR, *Evidence*, 3 April 2019 (Alisa Lombard, Lawyer and Partner, Semaganis Worme Lombard, as an individual).

*having more culturally competent care within Western institutions, in my opinion, though that is important. It's also about providing Indigenous peoples with opportunities to reconstitute their own ways of health and healing.<sup>93</sup>*

As noted in section two of this report, participants in the 2020 Forum on Culturally Informed Choice and Consent in Indigenous Women's Health emphasized the importance of Indigenous midwives in the health care system, including to facilitate access to services in Indigenous languages and promote culturally safe, trauma-informed care practices.<sup>94</sup>

These priorities echoed concerns raised by witnesses in testimony to the Committee. For example, Anne Curley, Vice President, Pauktuutit Inuit Women of Canada, explained that:

*The imposition of the western medical model has displaced and undermined our traditional culture of midwifery and childbirth. For example, in my community of Hall Beach, all women are sent to distant hospitals for childbirth for a lengthy period of time. It feels like having your baby at home would be breaking the law. This policy has had serious social and cultural consequences. We want to bridge the best of our traditional cultural ways and western medicine.<sup>95</sup>*

Ms. Curley further highlighted the fact that investments in community-based midwifery in northern and remote communities is particularly beneficial, given the costs associated with sending women and support persons to distant hospitals to give birth.<sup>96</sup>

Professor Basile explained that the return of midwifery practices and of certain Indigenous rituals related to birth are contributing to a revitalization of knowledge in the area and are important components to the reclaiming of women's health by Indigenous women.<sup>97</sup>

Professor Basile warned the Committee that the contribution of knowledge of Indigenous women to maternal health is too often ignored. She noted that the Truth and Reconciliation Commission of Canada and the National Inquiry into Missing and Murdered Aboriginal Women and Girls recommended that Indigenous knowledge and practices be integrated into health and that these

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<sup>93</sup> RIDR, *Evidence*, 3 April 2019 (Dr. Karen Stote, Author and Assistant Professor, Women and Gender Studies Program, Wilfrid Laurier University, as an individual).

<sup>94</sup> The national forum took place in January 2020. See National Collaborating Centre for Indigenous Health, *Summary Report: Informed Choice and Consent in First Nations, Inuit and Métis Women's Health Services*, 2021.

<sup>95</sup> RIDR, *Evidence*, 10 April 2019 (Anne Curley, Vice President, Pauktuutit Inuit Women of Canada).

<sup>96</sup> Ibid.

<sup>97</sup> RIDR, *Evidence*, 25 April 2022 (Suzy Basile, Professor and Canada Research Chair in Indigenous Women Issues holder, Université du Québec en Abitibi-Témiscamingue, as an individual).

recommendations are consistent with Article 24 of the *United Nations Declaration on the Rights of Indigenous Peoples*.<sup>98</sup>

As noted in section two of this report, officials from ISC highlighted federal investments to expand support for Indigenous midwifery and doula initiatives, including \$33.3 million committed in Budget 2021.<sup>99</sup> This includes support for programs in which Indigenous women are being trained in Indigenous communities by other Indigenous midwives.

Officials also noted that some Indigenous midwifery projects are coming to fruition, highlighting, for example, a birth in February 2022 in Sturgeon Lake First Nation, Saskatchewan, which was the first birth in the community in 50 years. However, the same officials noted the existence of ongoing challenges and barriers in terms of access to such programs, and conceded that existing funding was likely not sufficient to ensure that every person has access to the care that they should have locally.<sup>100</sup>

### **Recommendation 8**

**That Indigenous Services Canada increase its investments in community-based midwifery in northern and remote communities, and ensure that the funding is sustainable and adequate to serve the needs of Indigenous and remote communities across Canada.**

### **Recommendation 9**

**That the Government of Canada take all steps necessary to support the implementation of the Truth and Reconciliation Commission's Call to Action 23, with a view to increasing the number of Indigenous healthcare professionals, ensuring that Indigenous healthcare providers are retained in Indigenous communities, and providing cultural competency training for healthcare professionals of all backgrounds.**

### **Recommendation 10**

**That Indigenous Services Canada and other relevant departments expand programs such as the Post-Secondary Student Support Program to increase representation of Indigenous, Black and racialized students in healthcare fields.**

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<sup>98</sup> Ibid.

<sup>99</sup> RIDR, *Evidence*, 25 April 2022 (Dr. Evan Adams, Deputy Chief Medical Officer of Public Health, Indigenous Services Canada); and RIDR, *Evidence*, 25 April 2022 (Aimie Hillier, Acting Director, Healthy Children, Youth and Families Division, First Nations and Inuit Health Branch, Indigenous Services Canada).

<sup>100</sup> RIDR, *Evidence*, 25 April 2022 (Aimie Hillier, Acting Director, Healthy Children, Youth and Families Division, First Nations and Inuit Health Branch, Indigenous Services Canada).

## Data Collection

The Committee's 2019 report noted that gaps in data related to forced and coerced sterilization are related to both the method in which data has been recorded and factors that discourage survivors from coming forward.

In 2019, representatives of Health Canada and ISC informed the Committee that information on sterilization procedures does not include data on the ethnicity of the patients who receive them.<sup>101</sup> In explaining why information on forced and coerced sterilization in Canada is limited, Ms. Hoffman stated that “[w]e do not, at Health Canada as a department, collect or track data on how often or under what conditions sterilization is occurring.”<sup>102</sup>

In testimony to the Committee in 2022, Professor Basile explained that although several studies have been launched on the subject of forced and coerced sterilization in Western provinces, there is a distinct lack of data and research in Quebec, which contributes to a lack of awareness and recognition of the seriousness of this issue for First Nations and Inuit women in Quebec.<sup>103</sup>

Ms. Omeniho explained that the intensely personal nature of the harms leads to reluctance among survivors to be identified, which contributes to the scarcity of data. In testimony to the Committee in 2019, she stated that for these reasons, “we don’t have a lot of data to assist us, and we never will.”<sup>104</sup> Despite these challenges, Ms. Omeniho called for “further research and data collection on forced or coerced sterilization procedures in Canada, with a focus on disaggregated data collection and dissemination.”<sup>105</sup>

Other witnesses echoed the importance of improved data collection to better understand the scope of the problem, ensure accountability and promote healing. For example, Dr. Adams stated that having some data on when policies are transgressed is important to ensure that there are appropriate repercussions.<sup>106</sup>

### Recommendation 11

**That the Government of Canada develop a national plan to collect and publish anonymized data on forced and coerced sterilization to help authorities fully understand the scale of the issue and develop adequate responses.**

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<sup>101</sup> RIDR, *Forced and Coerced Sterilization of Persons in Canada*, June 2021.

<sup>102</sup> RIDR, *Evidence*, 15 May 2019 (Abby Hoffman, Assistant Deputy Minister, Strategic Policy Branch, Health Canada).

<sup>103</sup> RIDR, *Evidence*, 25 April 2022 (Suzy Basile, Professor and Canada Research Chair in Indigenous Women Issues holder, Université du Québec en Abitibi-Témiscamingue, as an individual).

<sup>104</sup> RIDR, *Evidence*, 10 April 2019 (Melanie Omeniho, President, Women of the Métis Nation).

<sup>105</sup> Ibid.

<sup>106</sup> RIDR, *Evidence*, 25 April 2022 (Dr. Evan Adams, Deputy Chief Medical Officer of Public Health, Indigenous Services Canada).

**Recommendation 12**

**That Parliament remain apprised of Canadian and international developments relating to the issue of forced and coerced sterilization.**

**Recommendation 13**

**That a parliamentary committee conduct further study as needed on the issue of forced and coerced sterilization, including to monitor government efforts to address this issue and to develop further recommendations.**

## Full List of Recommendations

### Recommendation 1

That legislation be introduced to add a specific offence to the Criminal Code prohibiting forced and coerced sterilization.

### Recommendation 2

That the Government of Canada work with provincial/territorial governments in adopting a non-adversarial dual jurisdictional approach;

- to study, publish a report on, and include in training the clinical psychological and physical impacts of sterilization generally, and forced and coerced sterilization specifically;
- to mandate medical associations and professional governing and licensing bodies to denounce forced and coerced sterilization and provide a clear consent framework consistent with governing legal principles;
- to ensure that all healthcare practitioners are required to undergo intensive training in the physician/patient fiduciary relationship, bodily autonomy, and medical self-determination and mandate that health practitioners are required to pass such training as a condition of their license; and,
- to support and augment the rigor of College disciplinary processes to achieve the above pressing objectives.

### Recommendation 3

That the Government of Canada, led by survivors, develop a compensation framework that reflects both the direct and indirect harms that forced and coerced sterilization has inflicted.

### Recommendation 4

That the Government of Canada issue a formal apology on behalf of all Canadians to all persons who have been subjected to forced and coerced sterilization in Canada.

### Recommendation 5

That the Government of Canada encourage provincial/territorial governments to implement measures to ensure that professional standards of governing and licensing bodies are adhered to, that mechanisms are in place to investigate and respond to complaints, and that consent policies and practices adequately protect all patients, particularly in moments of vulnerability.



### **Recommendation 6**

**That the Government of Canada take all steps necessary to support the implementation of the Truth and Reconciliation Commission's Call to Action 24 and ensure that all medical and nursing schools in Canada require all students to take a course dealing with Indigenous health issues, including skills-based training in intercultural competency, conflict resolution, human rights, and anti-racism.**

### **Recommendation 7**

**That Health Canada work with applicable partners to launch a public education campaign about patient's rights and consent procedures, and that the campaign be tailored to the specific needs of Indigenous, Black, racialized, remote and marginalized communities, as well as to those of people with disabilities.**

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**Recommendation 13**

**That a parliamentary committee conduct further study as needed on the issue of forced and coerced sterilization, including to monitor government efforts to address this issue and to develop further recommendations.**

## Conclusion

Witness testimony confirmed the ongoing practice of forced and coerced sterilization in Canada. The forms of coercion described by witnesses ranged from confinement to manipulation, exploiting vulnerability, or omitting to consult patients before forever removing their ability to conceive. Most survivors attributed their sterilizations to racism. Some further highlighted that forced and coerced sterilization is part of a greater system that targets Indigenous communities and nations.

Witnesses discussed the need for greater accountability for those who commit forced and coerced sterilization. They also explained why compensation for victims is needed. While noting the importance of improving consent processes and educating current healthcare professionals, witnesses also informed the Committee of the benefits of representation of minority groups within the healthcare professions.

When the Committee set out to build upon its 2021 report, the senators were aware that data on forced and coerced sterilization in Canada is elusive. This absence of data placed a heavy burden on survivors of forced and coerced sterilization to come forward to share their stories, a task that this Committee understood would be extremely difficult. Their testimony, along with the testimony of those who shared their valuable expertise, has deepened this Committee's understanding of the long-term effects of forced and coerced sterilization on survivors, their families, and their communities. It has also been instrumental in guiding the Committee's consideration of recommendations to stop this practice.

The Committee is grateful to all witnesses who shared their valuable expertise and lived experiences throughout the course of this study, particularly the many survivors who courageously shared details of traumatic experiences that should never have occurred. The Committee hopes that this report sheds light on their important perspectives and leads to changes that will finally close this horrific chapter in our history.

## **APPENDIX A – Witnesses**

### **Monday, April 25, 2022**

- Dr. Evan Adams, Deputy Chief Medical, Officer of Public Health Indigenous, Services Canada
- Suzy Basile, Professor and Canada Research, Chair in Indigenous Women Issues holder, Université du Québec en Abitibi-Témiscamingue
- Aimie Hillier, Acting Director, Healthy Children, Youth and Families Division, First Nations and Inuit Health Branch Indigenous, Services Canada
- Alisa Lombard, Lawyer, Lombard Law
- Dr. Unjali Malhotra, Medical Director, Women's Health, First Nations Health Authority
- Tasha Stefanis, Associate Vice President, Public Health Agency of Canada

### **Monday, May 2, 2022**

- Elizabeth Esquega, Survivor
- Alisa Lombard, Lawyer, Lombard Law
- Morningstar Mercredi, Survivor
- Nicole Rabbit, Survivor
- Sylvia Tuckanow, Survivor
- Melika Pop, Survivor
- Witness B, Registered Nurse, Survivor

### **Monday, May 9, 2022**

- Madeleine Redfern, President, Amautiit Nunavut Inuit Women's Association
- Gerri Sharpe, President, Pauktuutit Inuit Women of Canada
- Witness A, Survivor
- Shauna-Marie Young, Director of Programs, Pauktuutit Inuit Women of Canada

### **Monday, May 16, 2022**

- Louise Delisle, Survivor
- Lucy Nickerson, Survivor

## **APPENDIX B – About the artist**

*The beautiful artwork you see on these pages is by Lisa Boivin, a member of the Deninu Kue First Nation. She is an interdisciplinary artist and a doctoral student at the Rehabilitation Sciences Institute at University of Toronto, Faculty of Medicine.*



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