ISSUE: Royal University Hospital Employees coercing and forcing Indigenous women to have tubal ligations.

SUBMITTED TO: Dan Florizone, President and Chief Executive Officer (Saskatoon Health Region), Jackie Mann, Vice President of Integrated Health Services (Saskatoon Health Region), Leanne Smith, Director of Maternal Services (Saskatoon Health Region), Gabe Lafond, Director of First Nations and Métis Health Services and Representative Workforce (Saskatoon Health Region), Honourable Jim Reiter, Minister of Health (Government of Saskatchewan), Honourable Jane Philpott, Minister of Health (Government of Canada), Honourable Donna Harpauer, Minister of Government Relations and Minister Responsible for First Nations, Métis and Northern Affairs (Government of Saskatchewan), Honourable Carolyn Bennett, Minister of Indigenous and Northern Affairs (Government of Canada), Honourable Tina Beaudry-Mellor, Minister of Social Services and Minister responsible for the Status of Women (Government of Saskatchewan), and Honourable Patty Hajdu, Minister of Status of Women (Government of Canada), Honourable Gordon Wyant, Minister of Justice and Attorney General (Government of Saskatchewan), Honourable Jody Wilson-Raybould (Government of Canada).

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KEY MESSAGES:

- Since mid-November 2015, five Indigenous women have spoken with journalists about Royal University Hospital (RUH) employees pressuring them to have tubal ligations and other unethical practices.
- RUH policies regarding tubal ligation are not publically available.
- News stories report that RUH has changed their policy in response to public outcry. According to a hospital spokesperson Leanne Smith, the revised policy specifies that a) women who have vaginal births cannot have tubal ligations while in the hospital for delivery, and b) women who have caesarean births and discuss and consent to tubal ligations prior to coming to RUH for childbirth can have tubal ligations while in the operating room for delivery.
- While possibly intended to reduce coercion, the revised RUH policy unnecessarily diminishes the reproductive choices of women who have vaginal births.
- Reproductive justice necessarily includes respecting women's autonomy and choice to make decisions to have or not to have tubal ligations. RUH policies and practices currently constrain Indigenous women's rights to reproductive justice in numerous ways.

- There is no evidence that the revised policies address systemic racism, heterosexism, and classism, which are the root of coercive and forced sterilization. Without addressing these systemic issues, Saskatoon Health Region (SHR) and RUH will continue to put Indigenous women at risk of other coercive and harmful practices, such as being pressured to use long-term contraceptives or being flagged for child protection concerns without due cause.
- **Several recommendations are offered to foster culturally safe, trauma- and violence-informed care that respects and supports Indigenous women's rights to reproductive autonomy.**

BACKGROUND:

On November 18, 2015 the *Saskatoon Star Phoenix* first published two Indigenous women's stories of RUH employees pressuring them to have tubal ligations and other unethical practices (1). In the months following at least three other Indigenous women spoke with reporters about similar experiences. The coercive sterilization of Indigenous women at RUH is tied to Canada's history of denying Indigenous peoples' reproductive futures, along with other people who have been deemed unfit to parent, such as people who identify beyond the gender binary of male/female, people who have sexual relations outside of heterosexual monogamy, people who are differently-abled, and people living in poverty, particularly women (2-6). Whether performed through legislation or through coercive practices, sterilization without informed consent violates Indigenous women's rights to reproductive justice and the rights of Indigenous peoples. Reproductive justice is often defined as the rights of women to decide and control a) whether or not to have a child or children, b) how and where women give birth, c) and being able to raise their children in safe and healthy environments, free from violence (7). RUH policies and practices currently constrain Indigenous women's rights to reproductive justice in numerous ways.

Coercive and forced sterilization has a long history in Canada. British Columbia and Alberta had sexual sterilization legislation in the 20th century. BC's legislation was in effect from 1933 until 1979 and Alberta's legislation was in effect from 1928 until 1972. Among the cases presented to the Alberta Eugenics Board, both Indigenous people and women were overrepresented (2). While Alberta's legislation framed the acceptable conditions for sterilization in medical terms, Park and Radford's (1998) analysis of case files makes clear that the board's decisions were made based on racist, heterosexist, and classist assumptions about who is fit/unfit to parent and sterilizations were justified using social Darwinism (3). In her recent book, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women* (2015), Karen Stote demonstrated that Indigenous women were coerced into sterilization in other provinces and territories without official legislation (4, 5). There is ample evidence that stereotypes and colonial, racist, and heterosexist views continue to influence healthcare providers' treatment of Indigenous people with deleterious results (8-14).

It is disappointing that the RUH tubal ligation polices in place when Indigenous women were coercively sterilized are not available to the public despite requests for this

information (15). In personal communication, Leanne Smith (Director of Maternal Services) stated the only policy in place during this timeframe was that all women who came to RUH for delivery until 2012 were asked at intake whether they wanted to have a tubal ligation (16). In a media interview, Smith reported that their revised policies are: a) women who have vaginal births cannot have tubal ligations while in the hospital for delivery, and b) women who have caesarean births and discuss and consent to having tubal ligations prior to coming to RUH for childbirth can have tubal ligations while in the operating room for delivery. However, a written policy document to this effect is not available to the public (15). Further, if Smith's report is accurate, this revised policy unnecessarily diminishes the accessibility of tubal ligations for those who have vaginal births. There is also no indication that there is policy attention to the systematic colonialism, racism, and heterosexism underlying discriminatory health care practices including coercive and forced *sterilization* and limiting access to other reproductive health care. These revised policies continue to put Indigenous women at risk of other coercive practices, such as being pressured to use long-acting reversible contraceptives or being flagged by child welfare without due cause. The SHR is proceeding with an external review of these women's experiences at RUH. Additional policy changes are required to ensure Indigenous women's rights to reproductive autonomy and culturally safe care.

POLICY RECOMMENDATIONS:

1) Proceed with a thorough external independent review of the coercive sterilizations of Indigenous women, which includes a) using mainstream and social media sources to publicize the external review and invite women who experienced coercion around tubal ligations at RUH to participate; b) privileging Indigenous candidates when choosing an external reviewer; c) ensuring the external reviewer has extensive knowledge of colonial relations and Indigenous perspectives in Canada; d) ensuring the review thoroughly addresses RUH's previous policies and practices with respect to informed consent around tubal ligations; and d) sharing the findings of the external review with the public, including information about RUH's previous policies and practices of informed consent and tubal ligations in order to rebuild relationships between Indigenous and non-Indigenous communities. Women who share their personal testimony in the external review must be given the opportunity to decide whether and how their stories are shared with the public. Particularly, women must be given the choice to a) share their personal testimony in a public record; or b) keep their testimony anonymous and confidential (17).

2) Formally apologize to Indigenous women who have experienced coercion related to tubal ligations and provide financial compensation including funds for a) counselling and support services; b) loss in quality of life; c) loss in worktime hours; and d) tubal ligation restoration, and/or in-vitro-fertilization and/or private adoption depending on the options pursued (17).

3) Increase cultural safety training in SHR. Ensure cultural safety training in SHR thoroughly addresses: a) racism, colonialism, and heterosexism within healthcare institutions and broader society; b) processes by which healthcare providers and

social workers can recognize individual and institutional bias; and c) fostering and growth of culturally safe care (18-25).

4) Ensure that the Representative Workforce Strategy evaluations collect and analyze information about patients' experiences of discrimination and bias in SHR (17, 25).

5) Train healthcare providers and social workers to provide trauma- and violence-informed care including women-centered care for all women (25-27). Given the evidence of the particularly problematic care received by pregnant and parenting women who use substances (28-31), special attention should be paid to training providers in care for pregnant and parenting women who use substances and harm-reduction models.

6) Continue working towards a representative workforce by increasing Indigenous employees, women, employees of all genders and sexualities, and differently-abled employees within SHR at all levels.

7) Change SHR's tubal ligation policies and long-acting reversible contraceptives policies so that:

    a) ***If*** women discuss the benefits, risks, and alternatives to long-acting reversible (LARC) and/or permanent contraceptives (including Depo-Provera, Intrauterine device, and tubal ligations) with their care providers ***before going into labour*** and consent to using a LARC or permanent contraceptive postpartum, *ensure women's timely access to LARCs or permanent contraceptives while in hospital. If women rescind their consent before or during the procedure, the procedure must be ceased.*

    b) ***If women are in a situation where they are likely to feel pressured*** to agree to use any type of long-acting reversible or permanent contraceptives (including Depo-Provera, Intrauterine device, and tubal ligations), *do not seek consent for long-acting reversible or permanent contraceptives at this time.* These situations include i) while receiving a termination; ii) during labour; or iii) directly following delivery. If women express interest in these contraceptives in these situations, ensure timely follow-up appointments are scheduled and document the conversation (17).

8) Fund a full-time reproductive and maternal health advocate/liason position housed in RUH's Birthing Unit to provide information and connect women to services and supports in their community. The advocate/liaison should work with any woman who is interested in information, services, and supports. The work should include, but not be limited to: a) one-to-one education and counselling about contraceptive options; b) scheduling follow-up appointments with women who are interested in long-acting and permanent contraceptives and did not consent to using these contraceptives before coming to the hospital for childbirth; c) breastfeeding support referrals; d) respite

childcare referrals; e) housing support referrals; and f) foodbank and food security supports referrals.

9) Fund a full-time education consultant housed in Sexual Health Centre Saskatoon to provide:

    a) Mandatory workshops to healthcare providers and social workers in SHR about contraceptive options and the principles of voluntary and informed consent, with an emphasis on the meanings of free, fully-informed consent and informed consent best practices. The benefits, risks, and alternatives of contraceptive options should be discussed and patient-centred written informative materials should be distributed to attendees. It is vital that such materials be appropriate for those with low-literacy and consent procedures include verbal and written consent (17, 32-34), and;

    b) Support to healthcare providers, social workers and patients' education by compiling, creating, and sharing useful and relevant resources.

10) To evaluate the effectiveness of recommendation #3 through #9, SHR should support research with women who are seeking or receive long-acting reversible or permanent contraceptive care in SHR. In particular, a) gather demographic and health information of women who are seeking or receiving long-acting reversible or permanent contraception; b) support external researchers to conduct quantitative and qualitative interviews with women about their experiences seeking or receiving contraceptive care in SHR, researchers must use unobtrusive recruitment strategies and ensure women's free, fully-informed consent; and c) support external researchers to explore trends of long-acting reversible or permanent contraception use through qualitative and quantitative research, particularly trends that suggest women's rights to free, fully-informed consent and reproductive autonomy are being compromised.

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