FORCED STERILIZATION OF INDIGENOUS WOMEN

EXPERT MEETING: MARCH 25TH, 2019

SUMMARY PREPARED BY:
DR. JENNIFER LEASON & CHANEESA RYAN

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I. HISTORY & IMPACT OF FORCED-COERCED STERILIZATION

Dr. Karen Stote

a. Alberta Sexual Sterilization Act 1928-1972

i. Indigenous peoples represented 3% of the total population, and approximately 6-8% of those sterilized.
ii. From 1969-1972, 25% of sterilizations were Indigenous peoples.

Jana Grekul, Harvey Krahn and Dave Odynak[1] conclude:

> *"Aboriginals were the most prominent victims of the Board's attention. They were over- represented among presented cases and among those diagnosed as "mentally defective." Thus, they seldom had a chance to say "no" to being sterilized. As a result, 74% of all Aboriginals presented to the Board were eventually sterilized (compared to 60% of all patients presented)."*

b. British Columbia Sterilization Act 1933-1973

i. Few Records have been located.

Supervisor of Social Services at Essondale[2], 1961:

> *"Patient is a mentally defective Indian girl who has always been incorrigible, wild, undisciplined and promiscuous…Sterilization is, therefore, strongly recommended to prevent patient from having illegitimate children which the community would have to care for and for whom it would be very difficult to find foster home."*

Correspondence from T.R.L. Mac Innes, Secretary at the Indian Affairs Branch in Ottawa, to Major D.M. Mackay, Indian Commissioner, Vancouver, 1939: Dr. J. Cecil Dunn of Masset. B.C., has forwarded the following recommendation to the Department. [Name withheld] is mentally deficient. He recommends:

> *"That as she has had 4 children all of whom are imbeciles, she beset to Prince Rupert General Hospitals for operation to render herself sterile, as soon as leave is granted- if delayed there may be another child".*

c. Sterilizations in the North 1966-1976

i. 1970: NDP MP David Lewis alleges a program of sterilizing Aboriginal Women exists in the North.
ii. 1973: CBC alleges an intensification of this sterilization program to reduce birth rate.
iii. 1976: Rev. Robert Lechat names six Northern communities where women were sterilized without their consent.
iv. 1976: Federal government conducts internal inquiry.

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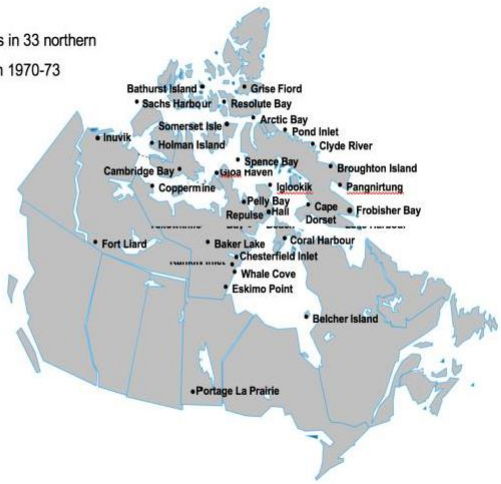
[1] Jana Grekul, Harvey Krahn and Dave Odynak, "Sterilizing the 'Feeble-Minded': Eugenics in Alberta, Canada, 1929–1972," *Journal of Historical Sociology* 17,4 (2004), 375.

[2] *D.E. (Guardian ad litem) v. British Columbia* 2003 BCSC 1013: 132-134.

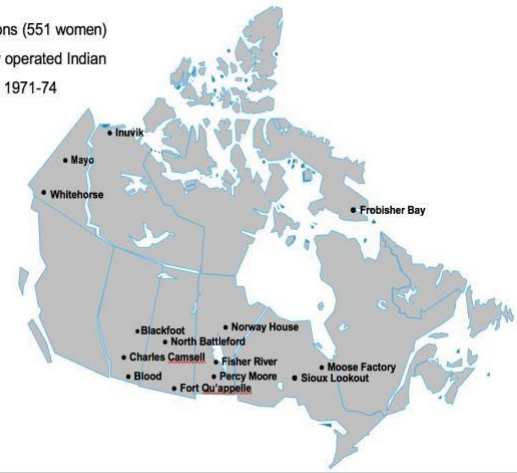
Parliamentary inquiry acknowledged
70 sterilizations in six settlements
from 1966-76

180 sterilizations in 33 northern
settlements from 1970-73



344 sterilizations performed on
women from 52 northern
settlements from 1970-75

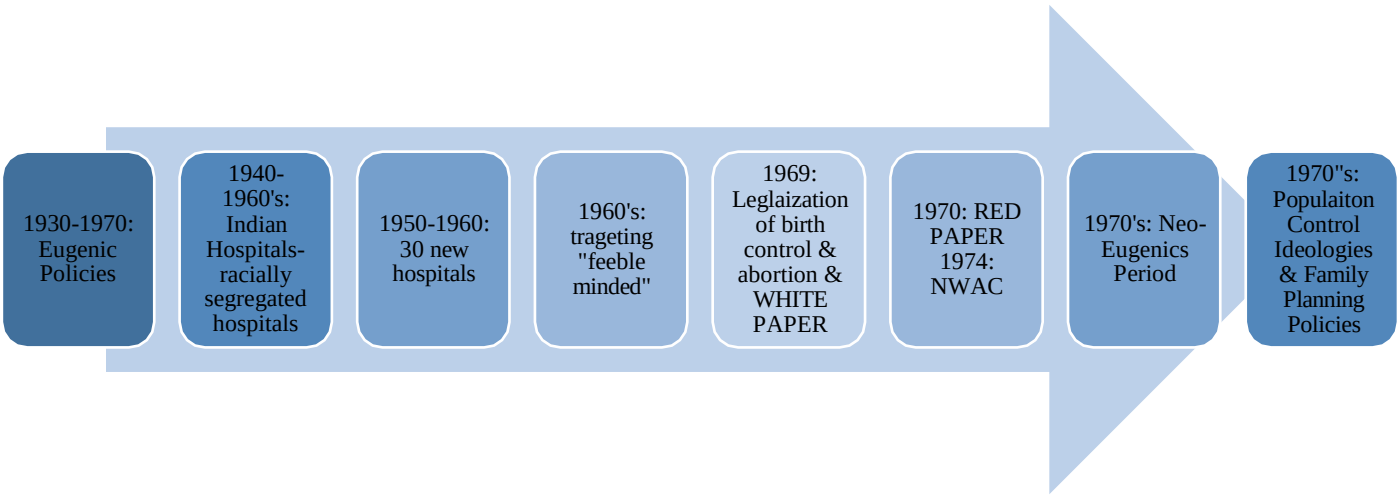
580 sterilizations (551 women)
at 14 federally operated Indian
hospitals from 1971-74



Potentially more than 1145
sterilizations from 1966-76

Stote, Karen (March 25, 2019).

Dr. Maureen Lux & Dr. Erika Dyck



1930-1970: Eugenic period

1960's: Explicit language- shifting sterilizations away from "feeble minded" towards Indigenous women, specifically women without status (including Métis) and have children in the welfare system.

1969: Amendments to criminal code: decriminalize birth control & abortion: birth control was used in Indigenous communities.

1970's: Family Planning Policies and "white strategies": targeting marginalized populations. Population control ideologies: Fear of over-population, poverty, maternal/infant mortality- justify interventions. Birth rates need to decline- globe cannot support population growth.

1977: Introduction of pre-requisite to accessing abortion. Federal changes to law- changed the context to allow medical practitioners and social workers to act. CONSENT FORMS were not to inform patients; but aimed to protect physicians.

State policies target Indigenous populations, women in poverty, and aim to assimilate Indigenous women, children and families.

1977: Evacuate to southern Indian hospitals. **Physicians to press views on women who have "excessive pregnancy" to be sterilized.**

1979: Preventative policies target teen pregnancy; intervening intensively with high risk youth. Targeting the "Indian Problem" who are identified as young, single Indigenous mothers.

1950-1960's: Racially segregated healthcare through "Diseased threat" of Indian tuberculosis. Indian hospitals received 50% less funding and created isolated and degraded care.

Challenges:

- ➢Archival research: there are no patient files and there is a "records management problem"
- ➢National archivists- files of national health and welfare/ Health Canada have never been given to the archive of Canada
- ➢May have been given to provinces or collected after the fact. Hospital records are not an accurate measure of identity "ABORIGINAL"

II. NATIVE WOMEN'S ASSOCIATION OF CANADA

Chaneesa Ryan, Director of Health

a. NEEDS:
   - ➢Research on forced sterilization – need to understand the full scope of the problem to make informed policy and program recommendations
   - ➢Disaggregated data – First Nations (status and non-status, on and off reserve, Inuit and Metis)
   - ➢Research Capacity - proposal development to data collection and analysis (Indigenous data sovereignty)
   - ➢Communities directing health research agenda
   - ➢Evidence to make informed decisions and recommendations

b. OPPORTUNITIES:
   - ➢Member of FNIHB's Advisory Committee on Indigenous Women's Well-Being
   - ➢FNIHB funding for capacity on forced sterilization
   - ➢CIHR institutional eligibility (NWAC can hold research funds)
   - ➢Community and academic partnerships. "This project can model something good in terms of academic and indigenous organization partnering" (Smylie, 2019)

Virginia Lomax, NWAC Legal Counsel

"Litigation does not always lead to long lasting social change- litigation is just one tool" (Lomax, 2019).

c. LEGAL IMPLICATIONS OF RESEARCH
   - ➢GOAL: Centering victim's voices through the betterment of people who have been subjected to this practice
   - ➢Reduce harm to those who may be involved in litigation by encouraging them to speak to legal representative first
   - ➢Use trauma informed research processes including a wraparound process to put health and well-being at the FRONT and CENTRE of mind
   - ➢AFTERCARE from research/litigation is vital because it can cause people to withdraw and lose people in litigation
   - ➢There are close to 100 women who have come forward

III. DISCUSSION THEMES

a. Range of COMPLEX Issues

- Women and girl's health
- Reproductive health: family planning and birth control
- Maternal-child health: labour, birth, delivery
- Medical Evacuations for birth
- Rights and Informed Decision Making (control over our bodies)
- Intergenerational Resiliency and Indigeneity

b. Indigeneity

- Work with community - desperate for traditional birthing, teachings and traditional ways of knowing. Re-Matriating Indigenous Traditional Laws
  - *"90% of it was annihilated. Give back what was taken. It's time to REDREAM our existence back!"* (Carol Couchie, 2019)
- Indigenous doulas, midwives, ceremonialists.
  - Need to build alternatives outside the institutions through local plants and Traditional Knowledge Systems.

c. Colonialism

- Ongoing colonialism (residential schools, 60's scoop, forced sterilization).
- Terminates legal obligations of the state by terminating lineage = land theft.
- Human rights violation and act of genocide.
- Jurisdictional divide (Jordan's Principle): Era of health services being downloaded to provincial government. Provinces didn't want to pay for federally responsible "status" Indians.

d. Racism and Sexism

- Historical Racism: Climate of Racism, Paternalism: language used.
- Systemic Racism: Target groups of family planning- target young, unmarried Indian school girls.
- Attitudes are created, maintained and embedded in medical/university education. There is a need for critical evaluation of western institutions.

e. Trauma-Informed

- Support women, families and communities who have experience(d) complex ongoing colonialism and violence.
- Enhance trauma-informed and trauma-engaged research through story medicine.

f. Access

- Prenatal care access is limited.
- Trips to have babies: we do not have access to MATERNITY care.
  "Northern communities take 2 trips in for care. It's dangerous to be pregnant in that community" (Carol Couchie, 2019).

g. Free, Prior & Informed Consent

- Defining free, prior and informed consent

- Empowering young Indigenous women and men to make decisions (and not rely on health care personnel to make decisions for them).
- Consent must be looked at on a continuum, we need to unpack what was coerced and what was a choice?

h. Reproductive Health

- Birth Control
- Abortion
- Informed consent and decision making: taking control over our bodies.
- Materials to support women

i. Support

- What supports are currently available?
- 1-800 numbers, i.e. Hope for Wellness line, for women to access for questions/supports in regard to coerced and/or forced sterilization.

j. Reproductive Justice

- Addressing Male and paternalistic discourse of women controlling their own fertility and reproduction.
- According to the United Nations Population Fund (2014), having the right to decide on the number, spacing, and timing of children as well as a right of access to safe and dignified health services defines reproductive rights which is a significant component of human rights.

k. Evaluation and Training for Professional Associations

- What is the current role and response of professional associations (College of Physicians and Surgeons, College of Nurses, Midwifery, College of Social Workers, etc.)?
- Physicians and healthcare providers have breached the "do no harm" section of the Hippocratic Oath as they are/were instrumental in forced/coerced sterilization. While many healthcare providers believe that they were doing the right thing for their patients and the community, training is required to ensure that healthcare providers return to the fundamentals of medical integrity and the Hippocratic Oath, provide prudent and diligent care and ensure ethical conduct of healthcare providers.

l. Identify Additional Partnerships & Opportunities

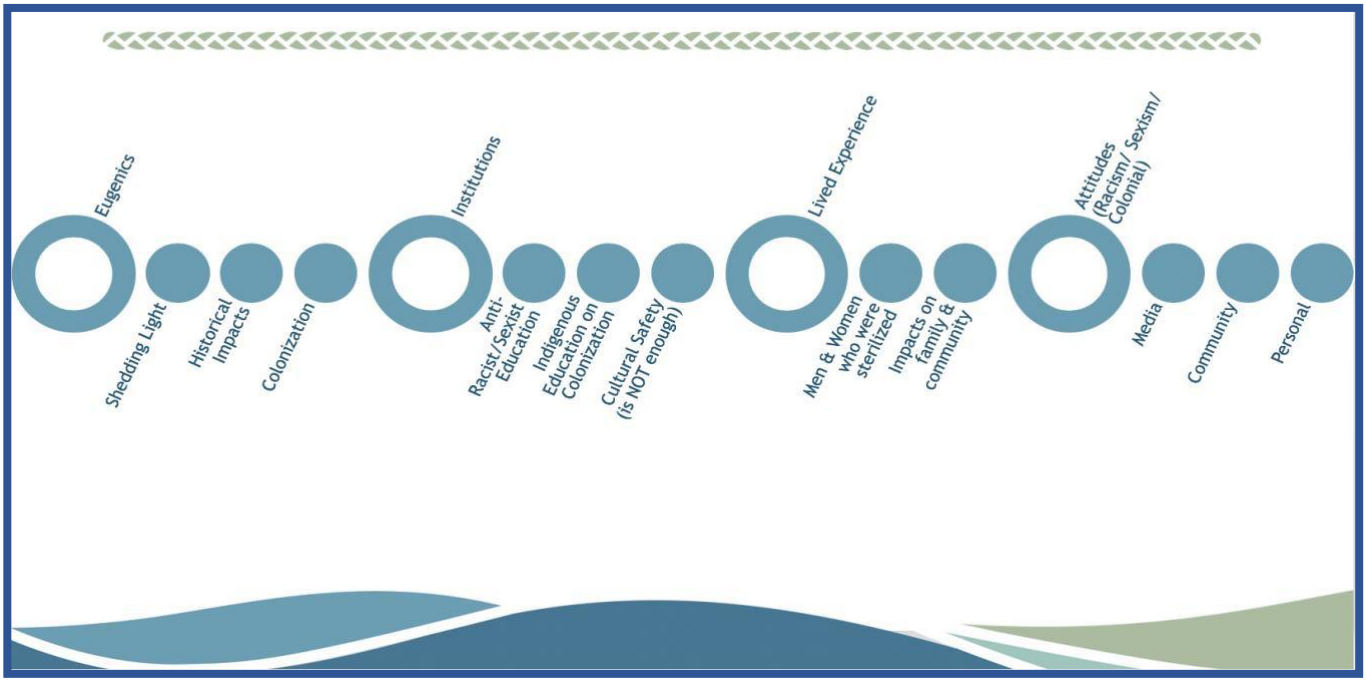
- Indigenous scholars
    i. Dr. Sarah Carter (Métis)
    ii. Dr. Mary Ann Kelm: Colonizing Bodies
- Funding Opportunities
    iii. CIHR IIPH
    iv. SSHRC
    v. FNIHB

m. Data Challenges

- Disaggregated data: Tracking data: by First Nations, Métis, Inuit: Misleading- we may not know. Métis- there is no data. Distinction based model: FN/M/Inuit- and disaggregate by region (rural, remote, urban) "Our data systems are completely broken for indigenous people but the problem with existing data is that indigenous people are not well identified" (Smylie, 2019)"

- Differing experiences: we don’t know if Métis women were targeted the same way
- Records were destroyed: Eugenic records: Archival Research: 551/580 were women.
- Contextual unspecific: which communities/identities were referred to in the data?
- “not all were coercive” what is in the documents- failed to provide documentation, consent forms were difficult, problems with interpreters
- Data systems are broken won’t be well identified in them
- Data has been collected but we don’t know about it/have access to

IV. RESEARCH



Research is needed to examine the historical and contemporary understanding of why has and is this still occurring? By including the lived experiences and examining Canadian attitudes and institutions, we can then shed light on the forced and coerced sterilization of Indigenous Women.

a. ACTION

- Quit talking about it and do something about it!
  - *"We need Real solutions that will make a difference for our young people."* (Couchie, 2019).
- The research already exists- pull together existing research and work towards action planning.
  - *"There's a lot of data out there- we need to pull it together. We don't need any more junk to fuel the garbage fire."* (Couchie, 2019).

b. **VOICE** of the survivors, women, youth, family, communities and Elders (primary data collection) must be centered in research. "We have a chance to contextualize a critical interconnected story and the only way to do this is to give voice to women to tell their stories themselves" (Martin-Hill, 2019).

- Survivors
  i. Critical story of genocide and infanticide
  ii. Connect to larger context of colonialism
- Women
  i. Women to make INFOMRED choices
  ii. CHOICE versus COERCION: do women know their rights?
  iii. Need for pregnant, addicted and/or street involved women (perception and treatment from healthcare providers differ)
- Youth
  i. Digital Story-telling or Photovoice- youth VOICE: impact on self-esteem, value,

worth, suicide

- Intergenerational
    i. Elder teachings and TKS (Indigenous knowledges are science).
    ii. Intergenerational experiences of colonialism, racism and sexism.

c. CONTEXTUALIZE: Community Based Research

- Women's experiences:
    i. Women's strength & resiliency: celebrating the positives
    ii. Birthing stories
    iii. Experiences with reproductive health care
- Stress, complicated life environments, history of violence and maltreatment.
- Healthcare experiences: Margaret Lock: pragmatic women = negotiating in a context of healthcare providers = engrained in what they think is right and wrong.

d. IMPACTS

- Women themselves who have experienced this (depression, anxiety, addiction, trauma, parenting, relationships, mental health, well-being, premature death)
- Family members, community, Nation: we all feel it.
- What supports are available to survivors? What supports are needed?

e. Critical and Decolonized Research on Systems and Cultural Safety

"Cultural safety is a misnomer as we are talking about colonial systems, in terms of health care, it's not just geographical access; do you feel safe enough to go to the hospital?" (Bourassa, 2019).

- Evaluation on current cultural safety delivery and training (clicking boxes is NOT ENOUGH).
- Need to understand service provider's perceptions. "Service providers think they are engaging in a moral and ethically sound practice. We need to talk about that? Why do service providers feel that way? (Tait, 2019)
    - They see themselves protecting (not eliminating) the next generation.
- Court & legal systems: interface of legal and healthcare systems: Indigenous women are falling through the divide.
- Examine professional training, licensure, and accreditation.

f. Historical Analyses & Longitudinal Research

- Look at the last 20 year period- what's changed throughout the RCAP era and TRC? What recommendations have been provided and what's been implemented?
- What has been improved? What has NOT been improved?

g. Knowledge Translation and Policy

- Shifting from "reactive" policy making to "informed" decision-making.
- Need research on forced sterilization to make evidence based/informed policy and practice recommendations.

V. RECOMMENDATIONS

a. Returning Birth & Supporting Women

- Mobilizing and training existing community support systems (aunties, birth partners, doulas, traditional midwives) - *"this would not be happening if everyone had an Indigenous*

midwife [or doula] by her side." (Carol Couchie, 2019).

- Returning birth closer to home: evacuations for birth have become normalized – this needs to be undone.
- Support for traditional jobs, healers, supports, land-based healing, traditional knowledge.

b. Research (see above)

- There is a need to redirect the "research gaze" away from Indigenous peoples towards systemic deficiencies.

> As Maori Elder Marita Mita says in Smith (2009) Decolonizing Methodologies: "we have a history of putting Indigenous peoples under a microscope much like an insect, whereby the ones doing the looking are giving themselves the power to define." By redirecting the research gaze towards systemic barriers, racism and structures, we put the issues of power, colonialism and control under the microscope.

c. Environmental Scan for Maternal-Child & Reproductive Health

- Traditional and non-traditional supports for women to identify supports, gaps, needs and coverage/access.
- Identify needs, identities, barriers, etc.
- Access to prenatal, labour and postpartum care.
- Look at intersections of justice, child welfare and health.

d. Community Engagement

- Host a community engagement to ask community about their perceptions
  - Dr. Dawn Martin Hill (McMaster University) offered to host an event in Six Nations
  - Dr. Caroline Tait (University of Saskatchewan) offered to host with a focus on Saskatchewan/Saskatoon Health Region context.
- Engage youth on reproductive health and rights.

e. Resources and Supports

- Lobby FNIHB and Tri-council: CIHR & SSHRC for Indigenous women's health research and action.
  - Indigenous women and mothering, traditional practices and ceremonies
  - Returning birth
  - Maternal-child health
  - Reproductive health and rights
  - Forced Sterilization

f. Gender Based Research Centre

- CR-GBA+ research strategy that supports community needs, priorities and directions. "Gender has been overlooked for too long" (Martin-Hill, 2019).
- Strength-Based/ Resiliency focused; housed within the Resiliency Centre at NWAC in partnership with supporting institutions and universities.

Appendix A: Pictures

Appendix B: Agenda

NWAC Expert Forum: Forced Sterilization
March 25, 2019
Lord Elgin Hotel
Ottawa, ON

8:30-9:00	Breakfast (provided)
9:00-9:15	Opening prayer by Elder
9:15-9:30	Welcome and Opening Remarks: NWAC President, Francyne Joe
9:30-9:45	Review of Agenda and Goals: Facilitator, Dr. Jennifer Leason 1. Identify NWAC Research Needs and Gaps 2. Identify Research Directions, Questions, Methodologies 3. Identify Research Partners, Collaborators, Knowledge Users 4. Next Steps- Research proposal to FNIHB
9:45-10:00	Roundtable Introductions
10:00-10:45	History and Impact of Forced/Coerced Sterilization of Indigenous Women • Eugenics Legislation • Colonialism: racism, sexism and cultural genocide
10:45-11:00	Health Break & Elder Support
11:00-11:15	NWAC Health Overview: Director of Health, Chaneesa Ryan • Research Needs and Gaps • Policy Directions (Evidence Informed Decision Making)
11:15-11:30	Legal Implications of Research: NWAC Legal Counsel, Virginia Lomax • Legal implications of research on lived experience
11:30-12:00	Research Overview
12:00-1:00	Lunch (provided)
1:00-1:30	Research Overview continued • What research past or present is the group involved in? • What are the gaps?
1:30-2:30	Group Discussion: Research Directions • How do we respond/support women who have been impacted?

- How do we respond/support families and communities who have been impacted?
- How can research inform prevention, policy and programming?

2:30-3:00 Recommendations: Research & Policy

- What's needed
  - Research
  - Policy and Service provision

3:00-3:15 Health Break & Elder Support

3:00-4:00 Group Discussion

- Research questions
- Research methodologies
- Ethics: engaging women with lived experience
- Data collection and analysis
- Dissemination and Knowledge Translation

4:00-4:30 Next Steps

- Research Team:
  - Identify involvement and expertise
  - Roles & Responsibilities
  - Research needs & supports
- Draft write up of today's meeting and sharing with the group by April 3rd, 2019
- Feedback April 17th
- Draft Research proposal: May 1st, 2019
  - Opportunities FNIHB
  - CIHR/NEIHRS?

4:30-4:45 Forum Summary

4:45-5:00 Closing prayer by Elder Roseann Martin

Appendix C: Participant List

Forced Sterlization Forum Particpants	Affilitation
Francyne Joe, President	President, Native Women's Association of Canada
Elder Roseann Martin	Elder, Native Women's Association of Canada
Chaneesa Ryan	Director, Native Women's Association of Canada
Virgina Lomax	Legal Counsel, Native Women's Association of Canada
Dr. Jennifer Leason (Facilitator)	University of Calgary
Dr. Karen Stote	Wilfred Laurier University
Dr. Carrie Bourassa	Scientific Director, CIHR IIPH
Dr. Dawn Martin Hill	McMaster Universtiy
Dr. Caroline Tait	University of Saskatchewan
Dr. Maureen Lux	Brock University
Carol Couchie	Co-Chair National Aboriginal Council of Midwives (NACM)
Dr. Erica Dyck	University of Saskatchewan
Dr. Janet Smylie	Director, Well Living House, University of Toronto
Claire Dion-Fletcher	Co-Chair National Aboriginal Council of Midwives (NACM)
Alisa Lombard - B. S.Sc., LL.L., JD	Semaganis Worme Lombard
Laura Mitchell	A/Sr. Manager, First Nations and Inuit Health Branch
Dr. Valerie Gideon	Assistant Deputy Minister, First Nations and Inuit Health Branch
Breane Martin	Senate of Canda - Yvonne Boyers office