

***External Review:
Tubal Ligation in the Saskatoon Health
Region: The Lived Experience of Aboriginal
Women***

***Dr. Yvonne Boyer & Dr. Judith Bartlett
July 11, 2017***

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*To the Courageous First Nations, Métis and Inuit Women Who Came Forward
– For Our Children’s Children*

and

*To the Concerned Saskatoon Health Providers Who Came Forward – For
Honesty, Insights and Ideas on Improvement Opportunities*

Highlights of Report on Aboriginal Women and Tubal Ligation in the Saskatoon Health Region

This report examines the issue of Aboriginal¹ women from Saskatoon and surrounding catchment area who have reported being coerced into having a tubal ligation in Saskatoon hospitals. The overall aim of this review is to examine the issues and provide recommendations or ‘Calls to Action’ to the Saskatoon Health Region to prevent the coercion of Aboriginal women into tubal ligation. The report provides an historical colonization-impacted context Aboriginal of women’s lives, as well as the history of forced sterilization in Canada. A community-engaged methodology was used to design the review, and to analyze anonymized interview data for Aboriginal women affected and for health providers who provide services in Saskatoon Health Region hospital maternal and child services. Examination of maternal and child and the Child and Family Services (CFS) Ministry involvement with Aboriginal women in hospital after childbirth was completed. Interviews were done with Aboriginal women, health providers and CFS staff.

The themes that arose from the interviews with the Aboriginal women revealed that all clearly felt stressed and under much duress from being coerced to have a tubal ligation while in labour, which added more stress to the usual stress of childbirth. The overarching themes arising from Aboriginal Women’s interviews include: ‘Feeling Invisible, Profiled and Powerless,’ ‘Experiencing Coercion,’ ‘Impacts on Self-Image,’ ‘Relationships’ and ‘Healthcare’ and ‘Calls to Action.’ The review outlines the depth of Aboriginal women’s experience with being coerced into tubal ligation. Themes arising reveal that many of the Aboriginal women interviewed were living often overwhelming and complex lives when they were coerced, their lives were intricately bound within an overriding negative historical context of colonialism. Most of the women did not understand that tubal ligation was permanent, thinking it was a form of birth control that could be reversed in the future. Essentially all of the women interviewed felt that the health system had not served their needs, and they had felt powerless to do anything about it. A complete lack of trust and avoidance of health care is a consequence of being coerced into having a tubal ligation immediately after birth. Aboriginal women who have had such an experience that prevents them from accessing health care are aware that they are higher risk for negative consequences of health problems that are preventable or treatable if diagnosed early; they still cannot get past their distrust. Despite this lack of trust, the Aboriginal women overcame their significant anxiety to tell their story to the reviewers of being coerced into tubal ligation for the benefit of other Aboriginal women. Based on their own personal and difficult experiences, the woman provided concrete suggestions on how the health system must respond to their needs related to tubal ligation.

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The themes that arose from the health providers showed that they were very concerned on hearing that Aboriginal women experienced coercion to tubal ligation in the Saskatoon Health Region. Overarching themes arising from health provider's interviews include: 'Policy and Team Challenges,' 'Attitudes Toward Aboriginal Women,' 'Internal and External Impacts on Care,' and 'Calls to Action'. Data analysis revealed that health providers work within a large, complex and ever-changing hospital systems and environments. Most felt that, in recent years, positive policy and practice change in maternal and child care that was implemented with the aim to improve the experience of mother and infant had been successful. Some health providers recognized that Aboriginal women attending labour and delivery may still fall through the cracks thus not having their needs met appropriately. Some health providers revealed that there are negative perceptions and attitudes about Aboriginal woman by other health providers. All health providers felt that a significant negative and traumatic experience arose for Aboriginal women when the Ministry of Child & Family Services apprehended infants in hospital shortly after childbirth. Health providers related that Aboriginal women who are vulnerable of being coerced into having tubal ligations are women who are most in need of services that support complex lives. All health providers were committed to ensuring that Aboriginal women had a positive experience in labour and delivery in SHR hospitals. Suggestions were presented on how Aboriginal women could be supported in accessing health care to meet their needs, and in particular support for Aboriginal women who are at high risk of not being able to access health services during pregnancy.

The Calls to Action rather than Recommendations are provided based on the advice and direction utilized through the community engagement process. The ten Calls to Action are formed from the Themes created based on what was heard from the voices of the Aboriginal women and the Health Care Providers. This External Review has been written with a commitment to see positive change. It is believed that this can be started through the implementation of the Calls to Action which will form the base for an Action Plan to address root causes and inequities that have made the Aboriginal women vulnerable to coerced sterilization in the first place.

1. Background

In the fall of 2015, there were media reports indicating several Aboriginal women stated they had been coerced into having a tubal ligation immediately after childbirth in a Saskatoon Health Region hospital. In 2016, the Saskatoon Health Region (SHR) responded by doing an internal review of the issue resulting in a change to their post-partum tubal ligation policy. The SHR Aboriginal Health Council, an entity under SHR, in consultation with the SHR First Nations and Métis Health Service suggested that a more intensive process in keeping with First Nation and Métis values was necessary. The SHR subsequently realized that to be effective and credible, the review must be more than a standard approach of reviewing a medical issue.

The SHR contacted Dr. Yvonne Boyer and Dr. Judith Bartlett in October 2016 to determine their availability and interest in conducting an external review of the Saskatoon Health Region on the issue of tubal ligation of Aboriginal women immediately post-delivery.

Dr. Yvonne Boyer holds a Doctorate in Law (U of Ottawa) and is the Canada Research Chair in Aboriginal Health and Wellness at Brandon University. She is a member of the Métis Nation of Ontario and a member of the Law Society of Upper Canada and Law Society of Saskatchewan. With a background in nursing, she has over 20 years of experience practicing

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law and publishing extensively on the topics of Aboriginal health and how Aboriginal and treaty rights intersects on the health of First Nations, Métis and Inuit.

Dr. Judith Bartlett, a Métis physician raised in northern Manitoba, has 30 years of experience working with Aboriginal people, in Canada and Internationally. She retired from an Associate Professor appointment from the University of Manitoba's College of Medicine in 2015 and the Manitoba Métis Federation in April 2012. In both workplaces, she held large grants from a variety of research funding bodies. Her expertise includes health services research, community-based research, health administration; and she maintained a part-time clinical practice. On Canada's Tri Council Panel on Research Ethics (2010-15), she also volunteered in more than 50 community organizations over the decades.

Dr. Boyer and Dr. Bartlett agreed that to ensure clear, careful analysis throughout the review process, there must be engagement with the community, a respect for privacy of health information, a high level of credibility and most critically, having direct engagement with impacted Aboriginal women. Accordingly, the ensuing report will be made public with all identifying characteristics of the interviewees removed.

The Saskatoon Health Region area serves nearly 256,000 people in the City of Saskatoon and over 93,000 in the rural areas.² The External Review began on January 15, 2017 and will conclude on July 30, 2017. A local Elder who is well respected and experienced with women was offered tobacco in protocol and agreed to work with the reviewers from the beginning to the end of the process. Every morning, prayers were held and a smudge was performed if it was possible. The Elder was with the external reviewers each day and attended the face to face interview if the Aboriginal women wanted her to attend. The Elder's role was critical to begin this process and to ground it in the protocol of the local area in prayer and ceremony. The Elder's services were offered to the women who came for an interview and to others where appropriate. In any case, time was always made daily to respectfully observe local protocols of prayers and ceremony. Recognizing that the topic of the external review is sensitive and traumatic, the Elder was available for the women previous to the interview, during the interview and following the interview. Confidential counselling sessions were also offered to the women following the interview and an offer was made for ongoing supports. All accommodations and considerations were made available for the women and their own support groups and individuals as much as possible for the women knowing that this process and topic may produce a certain amount of re-traumatization.

A First Nations woman was hired as the Review Assistant who lives in Saskatoon and is well known and respected in the Aboriginal community. She is fluent in the Cree language which helped facilitate the meetings that she organized.

An initial community engagement occurred in January 2017 whereby appointments were made and meetings were held in Saskatoon with a variety of Indigenous representatives, groups and local Indigenous experts in the area of maternal and child health. These groups and individuals were chosen based on the advice of the Review Assistant who had a broad historical understanding of local Aboriginal protocols and communities, the network of the external reviewers, and the working relationships of the Saskatoon Health Region. The principle focus for inclusion of groups and individuals with which to engage was their closeness to the grassroots Aboriginal community of Saskatoon; the place where the women who reported being coerced into tubal ligation had been when the procedure was done. The reviewers strove to contact local leaders and knowledge keepers and subject matter experts in the area of reproduction and Indigenous maternal and child health whenever possible. The reviewers also

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attended at the Royal University Hospital and engaged in a detailed tour of the obstetrical units of the hospital.

With input from the community engagement groups and individuals, a poster encouraging affected Aboriginal women to be interviewed developed. Thirty-six posters were placed within areas of Saskatoon where it was expected that Aboriginal women might see them or hear someone talking about them. The poster was also sent to the media who had initially carried stories on the women being coerced into having a tubal ligation. The media was asked to distribute the posters to the women they had interviewed for their articles. The posters were also circulated through social media networks, and contacts within the Indigenous Health Law Research Centre and the Indigenous People's Health Research Centre. A major distribution method to encourage women to be interviewed was through two newspapers that serve the many Aboriginal and Northern communities. The Eagle Feather News states it is the most widely circulated Aboriginal newspaper in Saskatchewan with 12 issues per year and 10,000 copies per issue that averages 20,000 hits per month. The Eagle Feather News ad ran in the March 2017 issue. The First Nations Drum distributes to bands, friendship centres, tribal councils, schools, colleges and universities, libraries and various Aboriginal businesses and organizations throughout Canada. The ad ran in the First Nations Drum in the March 2017 Western Edition. Each organization was telephoned by the Review Assistant to determine if they required more posters or if they thought the information reaching the people they were intended to reach. Considering the time, it took to adequately reach the women who had reported being coerced, an extension was requested of the Saskatoon Health Region from a deadline of April 30 to June 30 to ensure as many women as possible were able to engage in the process.

Sixteen (16) women called and spoke to the Review Assistant. It is unknown how many Aboriginal women called but did not leave a message. Six (6) women were interviewed in face to face interviews, and one was interviewed by telephone. An additional seven (7) women made appointments but did not attend an interview. Eight (8) interviews were completed with Saskatoon Health Region health care providers. Two additional individuals from the Ministry of Child & Family Services were interviewed together. See Appendix "A" for a Chart of Contacts and Poster Placements.

Following the interviews, a workshop occurred where individuals from the community organizations initially engaged and the Senior Managers of the Saskatoon Health Region attended. This was to facilitate the continuation of the community engagement process that is explained in section 1.4.4 Methodology.

The external review is as independent from the Saskatoon Health Region as possible. The Saskatoon Health Region contracted with the reviewers and provided travel expenses and the review assistant expenses and the costs associated with the review. The Saskatoon Health Region did not impair the independence of the External Review in any way.

This report is divided into four sections. The first section provides the critical contextual historical information on First Nations, Métis and Inuit women that is necessary to understanding how Aboriginal women became a specific category of impacted women.

A description of the study then follows and the process the reviewers took to write the report is presented. The participatory methodology is explained as well as the underlying ethical principles follows with limitations of the review. The second section presents the voices of the Aboriginal women interviewed as well as the health care providers of the Saskatoon Health Region. It includes the outcomes from the collective analysis of the interview data. The third section discusses what was heard during the interviews in the context of the health records,

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policy documents, legislation and results from the environmental scan. The review concludes with the fourth and final section of ‘Calls to Action’ that provides opportunities for change based on the information gathered in the review.

1.1 Aboriginal Women in a Historical Context³

Aboriginal women, historically, held the highest degree of respect within their communities as the givers of life and family anchors. They kept the traditions, practices and customs of their Nations. They were revered for their ability to create new life and their ability to facilitate these new relationships with the Creator.⁴

Métis scholar Dr. Brenda Macdougall writes of the Ile a la Crosse, Saskatchewan family kinship birthing network being much like the “strawberry plant runner,” Dr. Macdougall explains that when the Métis were birthed it was near water and they “took root on the shores of Sakitawak, and as the demands of the economy were exerted, these families began to radiate outward from the lake, establishing themselves throughout the region in new communities.”⁵

Elders and scholars agree that Aboriginal traditions were marked by egalitarian relations between men and women⁶ based on division of labour for community function.”⁷ While men’s roles included the hunt and keeping the community safe, women’s roles ranged from “household chores and livelihood provided by snaring and gathering”⁸ to “childbirth, infant care and raising and educating children in a society where practical and spiritual matters rarely seem far apart” to “the prominent role in exercising social control.”⁹ Eventually, as the fur trade began to flounder, Aboriginal populations were under the influence of forced acculturation.¹⁰ Modern patterns of patriarchy and male-dominance were introduced only through European missionary work and the new forms of trade relations and Western institutions of governance and the state.¹¹ After European arrival and effective imperial control, particularly the mass arrival of European women,¹² the position of Aboriginal women changed dramatically and negatively.

With colonization, patriarchal laws, policies, legislation and regulations instituted attacks on Aboriginal women in their role as family anchors.¹³ The social fabric of the core of the family unit was attacked through the imposition of tools of assimilation. The loss of identity through colonizing actions such as the *Indian Act*, residential school policies, mental health laws, forced removal of children and the Sixties Scoop¹⁴ are some of the determinants that have contributed to erosion of women’s role in Aboriginal cultures. Eroding the position of Aboriginal woman as caregivers, nurturers and equal members of the community inflamed the false colonial perception that Aboriginal women were somehow worthless and free to be exploited.¹⁵ Male-created and dominated values have shaped institutions, laws, legislations and policies that have implemented a long-lasting negative effect on the physical, mental and social health of Aboriginal women. Unfortunately, far too many institutions today claim to be value free but continue to reflect a colonial male dominated comprehension of reality.¹⁶ Along with a guardian and ward model, these realities continue to underpin the health policies in our medical institutions today and have real and harmful effects on the health of Aboriginal women.¹⁷

The socio-economic marginalization that affects Aboriginal women and their families is deeply alarming. Research shows that Aboriginal women are negatively affected by racism, poverty, lower educational attainment, higher unemployment, poorer physical and mental health and lack of housing.¹⁸ Researchers Smylie and Allen describe the importance of viewing racism as a determinant of health:

Racism and colonization are intertwined and together deeply impact the health of Indigenous peoples in Canada. Both in Canada and internationally, colonization

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has been recognized as having a fundamental impact on the health of Indigenous peoples.¹⁹

Experts, who have lived the experiences and were canvassed for the 2014 Public Safety Canada report, "Trafficking of Aboriginal Women and Girls," were clear that racist experiences were a strong element, if not the overarching theme, in the experiences of vulnerable women when accessing health care. Stories told and retold were experiences of racism, including routinely asked questions by hospital staff such as: "How much have you had to drink?" "What drugs have you done?" and "You are a prostitute, are you not?" These vulnerable women told of the horrors of being trafficked and raped and having to endure the smack of racism from cold responses, racial questioning and refusal of care. Some of the women were fortunate to find and rely upon a trusted advocate to ensure the violence they endured would be taken seriously by the health-care system. There was a clear and common perception that the nursing staff hoped the woman would just go away. Indeed, far too many women did get tired of waiting, and went back to the street or a shelter and did not return to the hospital, thus the rape went unreported.²⁰

With exception of one, all of the Aboriginal women who were interviewed for the Saskatoon Health Region Report stressed experiencing the same level of degradation. There clearly is a lack of trust between the health care system and the women. Most had not been back to the doctor or had very little health care since they had felt coerced into sterilization. They also said they would find it very difficult to go back to a doctor, and refuse to go. These findings are further discussed in section 3 Discussion.

1.2 Canada's History of Forced Sterilization²¹

Coercion into having a tubal ligation is not the first attempt at controlling the reproductive ability of Aboriginal women in Canada. Carol Strange (1996 with Tina Loo), in *Making Good: Law and Moral Regulation in Canada, 1867–1939*, "highlights the management of Canada's marginal populations (in particular, Aboriginal people, non-Anglo-Saxon immigrants, and the poor) in the project of nation building."²² Historically Canada's sterilization policies have had great detrimental effects on Indigenous women. Large numbers of Aboriginal women and men were sterilized for being "mentally unfit" – when in reality, for various cultural and historical reasons they did not fit in with the Eurocentric dominant society's definition of "fit." Not only has this caused the destruction of ancestral lineage but has brought many lives to a brutal violent end. In Canada, both Alberta (1928) and British Columbia (1933) enacted eugenics legislation. It is estimated that between 1929 and 1972, 2,800 people were sterilized under Alberta's *Sexual Sterilization Act*.²³ Although many provinces considered the idea of eugenics, British Columbia and Alberta were the only provinces that legislated in favor of eugenics. Alberta sterilized far more people than did British Columbia, which sterilized 400 people under the BC law.²⁴ Karen Stote raises some important questions about coercion and sterilization of Aboriginal women, indicating that sterilization has occurred in both legislated (Alberta and BC) and non-legislated (NWT) form. At the same time, Stote cautions that "one cannot paint all sterilizations performed on Aboriginal women as coercive: to do so would be to deny the agency of Aboriginal women to make choices about their own reproduction and continue the paternalism so rampant in past Indian policy."²⁵

Even though the Alberta nor the BC Sterilization Acts does not, on the face of it, overtly discriminated against Indigenous women, the implementation of the laws had devastating effects, since both provinces have always had high populations of Indigenous peoples. Because of their

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social strata, a disproportionately high number of women²⁶ were referred and sterilized,²⁷ thus logic would hold that high numbers of Aboriginal women also fell within these strata.

Inuit women were also sterilized in record numbers in the 1970s.²⁸ In fact, 26% of all Inuit women in Igloolik between the ages of 30 and 50 were sterilized.²⁹

The simple fact that Saskatchewan did not complete its enactment of its sterilization legislation (along with Ontario and Manitoba) but only drafted the laws which were defeated in 1930s,³⁰ the sterilization legislation legacy remains intact through imprints in not only Saskatchewan but all of Canada's health care system.

It is also well documented that "mental" institutions were breeding grounds for experiments in sterilization. Sterilization was used as a method for controlling an institutionalized population from reproduction and also as methods of control and mental health management. Yet, without consent or with being coerced into consent, sterilization is an act of violence. Forced sterilization has also become part of residential school claims.³¹

Aboriginal women moved from highly respected placement in their communities as family anchors to enduring multi-levels of trauma in Canadian society. Laws, legislation policies and regulations and religions were implemented that reflected a non-Aboriginal male-centered version of reality. These underlying values have shaped the institutions and as a result have also had a negative effect on the emotional, spiritual, physical, intellectual/mental³² and social health of Aboriginal women. Multigenerational chronic stress no doubt plays a decisive role in the complex lives of Aboriginal populations, particularly women who tend to carry a majority of family responsibilities. Along with a guardian and ward model, these gender based realities underpin the health policies in our medical institutions today and continue to have a harmful effect on the health of Aboriginal women. Many Aboriginal women generally suffer from poverty, poor housing, and poor physical and mental health. The issues are compounded by the negative effects of racism and systemic discrimination that is grounded in false notions that somehow they are in some way responsible for their own plight. Racism is a determinant of health. Some governments imposed policies and laws geared toward sterilizing Aboriginal women who, by virtue of the placement on the Canadian social strata, appeared to be prime candidates for sterilization. In addition to gender bias,³³ it is well documented that systemic discrimination and racism in health care exists.³⁴ Decades and generations of Aboriginal people affected are accordingly distrustful of this system.

1.3 History of the Saskatoon Health Region

Saskatchewan Health is currently comprised of 12 health regions. The fall of 2017 is set to see all 12 consolidate into one provincial authority. The Saskatoon Health Region (SHR) is the largest in the province with a geographical area of 34,120 square kilometers. They serve approximately 350,000 people in more than 100 cities, towns, villages, and First Nations.³⁵ Saskatoon Health Region states that their Mission is to "improve health through excellence and innovation in service, education and research, building on the strengths of our people and partnerships." Their Values are "Healthiest People, Healthiest Communities, Exceptional Service." Their stated Promise is "[e]very moment is an opportunity to create a positive experience in the way we treat and care for people, in how we work and interact with each other, and in how we deliver quality service. We promise to seize every opportunity."³⁶ Moreover, the Saskatoon Health Region First Nations and Métis Health Service provides "an integrated and culturally respectful approach to care for First Nations and Métis people coming into Saskatoon

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Health Region for treatment and other services.³⁷ The restructuring of Saskatchewan Health provides a prime opportunity for positive change for First Nations, Métis and Inuit people within the province.

The genesis of the external review began with the Aboriginal women and the SHR took up the challenge to move it forward. Jackie Mann, Vice President for Integrated Health Service at the Saskatoon Health Region noted that in 2010, 94 tubal ligation procedures had been completed after vaginal delivery and in 2015; the number had lowered to 20. Ms. Mann suggested the new 2015/16 policy on post-delivery tubal ligation ensured that women “had that conversation with her physician prior to coming to the hospital” about tubal ligation.³⁸ The statistics provided by the Saskatoon Health Region show that between 2010 and 2016 there was a total of 1152 post partum c- section tubal ligations performed, with a total of 1468 tubal ligations. These C-section statistics remained unchanged from 2014 to 2016. See Appendix “J.”

The Saskatoon Health Region First Nation and Métis Health Services is offered to “provide an integrated and culturally respectful approach to care for First Nations and Métis people coming into Saskatoon Health Region for treatment and other services” and “[t]o better serve First Nations and Métis people in the care of Saskatoon Health Region.”³⁹ The staff includes three cultural navigators that may provide links to other services, translation services; and provide support through advocacy. These services were implemented and developed through a partnership with Central Urban Métis Federation Inc. and the Kinistin Saulteaux Nation and is detailed in their final report “Strengthening Circle—Partnering to Improve Health for Aboriginal People.”⁴⁰ It is reasonable to expect that Inuit who live in Saskatoon would be including within their services.⁴¹

In the mid 1990s, labour and birth services were amalgamated from the 3 Saskatoon Hospitals to the Royal University Hospital. With the exception of a small number of low risk deliveries that occur at the Humboldt Hospital all other hospital births within the Saskatoon Health Region are at the Royal University Hospital. In 2016/2017 there were 5,650 births at RUH. The Saskatoon Health Region also has 6 midwives employed that support birth both at the client’s home and in hospital. Royal University Hospital is the complex obstetrical referral centre that serves the north half of Saskatchewan.

1.4 The Review

1.4.1 Purpose of the External Review

The purpose of this external review is to augment what is currently known about Aboriginal women’s experience with tubal ligation in SHR by engaging with relevant subject matter experts, stakeholders, health care personnel and relevant service providers, including the women who reported being coerced. This review focussed on the extent and situation in which Indigenous women state they experienced pressure to submit to a tubal ligation immediately after the birth of their child while under the care of the Saskatoon Health Region. See Appendix “A” for a detailed list of anonymized contacts and interviews completed.

1.4.2 Objectives of the External Review

- Broadly seek input of clients who have had negative experiences in SHR related to tubal ligations;
- Support Aboriginal women to participate in the review with a goal toward telling their stories (including having counselling services available during the interview process);

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- Document the experiences with tubal ligation in the SHR of the Aboriginal women participating in the review;
- Document the tubal ligation processes and environment within SHR at the time;
- Examine points where the tubal ligation processes and environment may have contributed to the clients' experiences; and,
- Examine current SHR practices and provide recommendations for addressing the issues documented in the external review.

1.4.3 Ethics

Community Engagement Approach

In line with the ethical policy of the three main research funders in Canada (*Tri Council Policy Statement 2 on Ethical Conduct for Research Involving Humans- Chapter 9, Research with First Nations, Inuit and Métis Peoples of Canada*), the reviewers used an ethical community engagement approach to guide the review. This engagement process included two trips to meet with First Nations, Métis and Inuit individuals and community organizations and the health sector / hospital community to request guidance on the review, as well as requesting their participation in anonymized data analysis of the interviews once completed.

All community individuals and organizations engaged were asked to provide feedback on methodology, methods, and review questions, and to suggest other entities or individuals that may have valuable information about this issue. Important guidance was provided that resulted in amendments to the research questions, along with direction to focus outcomes on “Calls to Action” rather than ‘Recommendations’.

Risks and Discomforts

There was no direct physical health risk associated for an individual being interviewed but talking about this issue can raise extreme emotional distress. Health Providers had access to counselling support from their workplace. Aboriginal women had access to an onsite Aboriginal Elder and/or a Counsellor during and/or after the interview. Aboriginal women were anonymously provided with three hours of counselling services which included supporting the women to seek emotional support resources in the community, if needed, on an ongoing basis following the interview.

Benefits and Costs

There was no direct benefit or cost to individuals or community members for participating in this external review. Information learned may benefit Aboriginal women and their families, as well as health practitioners, in Saskatoon. It is hoped that there will be long term benefits gleaned from this research which will positively impact some systemic barriers faced by Aboriginal women and their families. An honorarium only was offered to Aboriginal women to cover their minor expenses, such as cab fare for participating in the external review. A community-based approach to the review and a unique collaborative collective data analysis process involving community and health organizations increased the chance of the Aboriginal community and the health sector moving forward together to address the issues of coercion in tubal ligation.

Confidentiality

Information gathered in this review is intended to be a public report; however, names and other identifying information was not used or revealed unless an individual participant wished to be identified and their express informed, prior and free given consent was obtained and documented as such. Verbatim transcripts were provided to the participants for review and amendment if required.

1.4.4 Methodology and Methods⁴²

Methodology or the ‘way of knowing’ is the overall philosophy or approach that underpins a study, while *methods* or ‘the ways of doing’ are the activities and tools used to carry out the research. The methodology and methods of this external review are, respectively, a ‘qualitative community-based participatory approach’ and a collective data analysis. Thus, methodology (community engagement) and method (collective analysis) are logically and securely linked. Community individuals (not interviewees) with whom the reviewers engaged prior to data collection were involved in data analysis.

Methodology

The methodology used in this review is community engaged examination of the ‘lived experience’ of the Aboriginal women and the health providers interviewed. The review is steeped ‘within Aboriginal cultural orientations’ that are collective in nature and depend upon trust, relationships, respect and reciprocity among participants, communities and reviewers. The reviewers strived to imbue a level playing field and sense of fairness across participants; while at the same time pursuing an independent (from SHR) external review. Combining the expertise of researchers as a Métis lawyer with a previous health profession career and a Métis physician (the reviewers), along with the informative and interpretive power of the Aboriginal and health sector through their involvement, communities greatly supported the integrity of the review results.

Methods

Preparation and Implementation of Tools and Processes

A highly experienced First Nation Review Assistant (RA) in Saskatoon who was fully connected to and knowledgeable of the Aboriginal communities in Saskatoon was hired.⁴³ Based on direction and content information from the reviewers, the RA was responsible for distribution of community engagement letters of introduction (Appendix “B”), administrative and coordination of the community engagement meetings and data analysis session, design and distribution of recruitment poster for Aboriginal Women (Appendix “C”), along with organizing all travel and interview schedules. She was the initial contact that any Aboriginal women made with the reviewers. She is also fluent in the Cree language and her ease and acceptance in the Aboriginal community in Saskatoon facilitated this process. The distribution of the Health Provider poster (Appendix “D”) was facilitated through Saskatoon Health Region (SHR) staff webpage, along with other informal personal network contacts by the reviewers. SHR senior managers encouraged their staff to participate in the review.

Interested and relevant Aboriginal community organizations provided invaluable insight into the issue as well as sound advice on content and placement of recruitment posters to reach affected Aboriginal women. The Saskatoon Health Region (SHR) senior managers were engaged

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at various points during the review to access health policy information required and to assist in providing information to the health care providers that would allow them to anonymously access the reviewers. The reviewers engaged with several members of the SHR's Aboriginal Health Council⁴⁴ during the second visit in order to obtain their views on the methodology proposed. Two teleconference engagement calls were completed with physicians.

In preparation for the interviews, interview questions for Aboriginal women and for health practitioners were shared with community individuals and groups to determine appropriateness and relevancy. Feedback was implemented to amend the questions (Appendix "E" and "F"). Preliminary agreement to participate in a collective analysis of the anonymized interview data was sought at the community engagement meetings and teleconference. The intent of this collective analysis was to ensure the themes arising from the data are identified by more than two external reviewers, and are grounded within the cultural context of Aboriginal people in Saskatoon, the environmental context of SHR health providers and the Saskatoon community in general. A collective analysis approach prevented inadvertent development of a preconceived notion about what themes will arise prior to group analysis.

Data Collection

This review focused on a narrow inclusion criterion. Only identified Aboriginal women who had experienced feeling coerced into having a tubal ligation immediately after the birth of a child in a Saskatoon Health Region hospital were included in the study, as per the SHR/Reviewer contractual requirements. Any Aboriginal woman who felt that she was coerced into having a tubal ligation at any other time in the Saskatoon Health Region was offered counselling and/or a referral to the SHR for assistance but excluded for the purposes of this external review. Inclusion for health service providers included any staff person that has knowledge or information about the issue of tubal ligation in Aboriginal women from their work on the obstetrics wards in the Saskatoon Health Region.

Data was collected for seven women who had a negative experience with tubal ligation immediately following the birth of their infant, and nine health service providers who were related to labour and delivery in SHR hospitals. The reviewers completed a one to two-hour face to face interview with Aboriginal women who had their baby in a Saskatoon hospital (even if they did not live in Saskatoon) and felt pressured to have their tubes tied right after their baby was born. The reviewers also included completed telephone and written questionnaires in lieu of face to face interviews. Several women contacted the reviewers and several more made appointments to be interviewed but were unable to be interviewed for the reasons described.

The reviewers also completed an approximate 50 minute confidential interview with health and social services providers who were involved with the care of Aboriginal women who had their baby in a Saskatoon hospital, including nurses, medical social workers, child welfare social workers, and physicians.

For both Aboriginal women and health service providers, in almost all instances, an introduction telephone call was made or received by the Review Assistant to go over the process and objectives of the review and send them, either by email or mail or in person, a copy of the review questions and consent forms for their review before the interview. Prior to beginning the interview, the reviewers provided interviewees with another overview of the review as well as a further detailed explanation of the interview consent form. Interviewees were advised that their data would be anonymous unless they wished to be identified. The process of de-identification was clearly explained. Questions were encouraged and any questions from the interviewees

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were answered by the reviewers and the consent form was signed by the interviewee and witnessed by both reviewers after it was determined that there was free, prior and informed consent. Following the interview, Aboriginal women were asked if they would provide consent for the reviewers to access their medical records which might help to inform the medical factors around the tubal ligation. Initially, the reviewers intended to request only access to the childbirth/tubal ligation hospital record but during some interviews it became apparent that relevant information was related to an additional admission. Given the task to ascertain coerced tubal ligation, other admissions sometimes provided further clarity to the eventual fact of the tubal ligation. Interviews were transcribed and hard copies were couriered to interviewees for their ongoing consent, review and feedback. Questionnaires were offered to women to fill out if they were more comfortable with that process, or a telephone call was offered with one of the reviewers.

Data Preparation

Interview data and medical chart data (when available) were reviewed to examine factors related to Aboriginal women feeling coerced into having a tubal ligation. Interviews were processed to produce sections of text (or codes) from each interview transcription. Essentially all interview text was included in key text statements. The statements were then paraphrased, while strictly adhering to the intent of the statement. Each text statement was placed on a 3 x 5 inch card; on the flip side was the paraphrased statement in lettering large enough for a group to read at a distance of four to five feet. Keeping the paraphrased cards connected to their full statement helped to ensure that the paraphrase text has not been misunderstood or misinterpreted by the reviewer; and could be reviewed during the group analysis if required. All data was processed in this manner to prepare for the Collective Consensual Data Analytic Procedure.

Data Analysis

Collective Consensual Data Analytic Procedure⁴⁵ (CCDAP)

Data analysis, using the *CCDAP* procedure, was completed for the Aboriginal women's interviews and for the health provider interviews. Within the collective analysis approach, it is not possible to have a preconceived notion about what themes will subsequently arise from the data.

The *CCDAP* is essentially a clustering process that results in approximately 10-12 columns of cards that contain interviewee's experience. The final step for each group analysis is to consider all of the cards in each column, and then collectively assign a label that reflects the overall theme of the cards (i.e. what are the cards, as a group, about).

Of importance to note is that the *CCDAP* was completed twice; once for the interviews with Aboriginal women, and once for the interviews with the health providers. The volunteer Aboriginal community individuals and the voluntary health service providers are involved in both *CCDAP* analyses. After the *CCDAP*, the cards within the overall themes are further grouped by the reviewers to describe the underlying sub-themes.

The outcomes of the *CCDAP* themes and the reviewer categorized sub-themes are used, along with the policy document review as well as any other materials reviewed, to write a draft report with 'Calls to Action. Draft 1 of the review was submitted to SHR for feedback as per the reviewers' agreement to contract. None of the interviewees were in attendance at this session.

1.4.5 Limitations of the Review

The reviewers initially thought that this review would be completed in a four-month period. However, after embarking on the review it was clear from feedback from initial groups met with that a number of factors were important. There was a need to build in additional time for more community engagement in order to have any possibility of building a trust level that might help Aboriginal women to come forward to tell their story. Extra time was taken to consult with the community to ensure the wording in the poster was what would resonate best with Aboriginal women in Saskatoon and the catchment area for Saskatoon hospitals. At the point of trying to ensure that the posters reached the people they were intended to reach, it became obvious that the time period to reach out to the women had been underestimated. The reviewers requested that the SHR extend the end date to June 30 and then to July 30 to accommodate these concerns as much as possible. Even though the reviewers are confident that the ‘key and common experiences’ of Aboriginal women were clearly delineated in the completed interviews, it is still important to outline any limitations of the review that may have existed.

Anxiety in Potential Aboriginal Women Interviewees

The anxiety that any woman would feel in discussing such an intimate experience with complete strangers was very likely a limitation to recruitment. One woman, who eventually did come to an interview, said she tried to come up with many reasons why she should not attend. Her anxiety would rise every time the interview came to her mind. Eventually she did attend, and brought a support person with her. Some Aboriginal women may very well have decided to ‘let things lie’ in order to just get on with regular living and coping with life. For such a woman, doing an interview would not undo what happened; it would only require her to relive the experience. Fortunately, however, most Aboriginal women related a feeling that a weight had been somewhat lifted at the end of the interview.

Anxiety in Potential Health Provider Interviewees

Health providers may have felt anxiety in considering whether to be interviewed, which may have stopped some from being interviewed. It required a bit of internal SHR engagement to confidentially encourage providers to interview. No health provider had to worry about any repercussions from the review because all interviews were confidential and data can not be connected to individuals. Providers that did attend an interview spoke with honest candor, and indicated their comfort in the interview.

Narrow Inclusion Criteria for Women

The relatively small number of Aboriginal women interviewed may be seen as a limitation of this review. Unfortunately, nearly half of the Aboriginal women who contacted the Review Assistant were unable to move beyond the call to be interviewed; some tried on more than one occasion to attend an interview. However, it is important to state here that for reasons and factors related to colonial residue negatively impacting Aboriginal women, this inability of women to be interviewed was expected. It can only be imagined the courage it took to make the appointments; there was probably even more angst and guilt feelings when a woman could not follow through. As stated in the introduction to this section, the Aboriginal women who were interviewed did express the key factors related to being coerced into having a tubal ligation.

The inclusion criteria of ‘post-delivery’ is a limitation since there was at least one person who contacted the reviewers because she felt that her doctor is currently coercing her into having

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a tubal ligation during her pregnancy. If an Aboriginal woman called because she felt she was being coerced to having a tubal ligation at any time other than immediately after childbirth, the reviewers connected that woman with the counselling service to access supports to explore the issue and/or the phone number of the correct person to speak with at the SHR to discuss the issue.

Inaccessibility of Medical Charts

Medical charts, which show formally legally documented experiences, were only available for Aboriginal women who had a delivery in the past ten years. The reviewers were advised by the Health Records Personnel that hospital records were not stored beyond this period of time. It was stated that all charts over ten years old are destroyed.

Narrow timing, short duration

The short duration of the review timeline may have impacted recruitment. The sensitivity of this review required a sound community engagement process, which also requires more time to achieve as discussed previously. The time-frame was also short for engaging with, receiving interview question feedback and recruiting health practitioners. The SHR was asked to place the review recruitment poster in prominent places in the health services environment. It was also placed on the SHR staff webpage immediately upon receipt from the reviewers.

Recruitment

The poster for Aboriginal women recruitment could have been extended to radio ads in the Northern part of the Province. As it was, the timing was too short of a period to prepare an ad in English and/or Cree, Michif or Dene and have it effectively broadcast. The study could have reached more women over time. The simple fact of reading a recruitment poster may have triggered significant anxiety among women who were unable to defeat their fears about the topic of the interviews. Again, there could have been more women interviewed with a longer timeline. For healthcare providers, recruitment could also have benefited from a longer review period. Despite the recruitment poster being loaded onto the SHR staff webpage, it is expected that health practitioners may not have reviewed the webpage on a daily basis.

Distrust

Considering the history of legislated (BC and Alberta) and non-legislated (NWT) sterilization policies in Aboriginal populations, particularly women, the general systemic discrimination in the health care system, and that the SHR first attempt at an external review was unsuccessful, trust issues are deep within the Aboriginal community. In initial engagement meetings with the Aboriginal community, they were well aware of the issue. If an issue is broadcast in the mainstream media, Aboriginal women who heard about and could relate to the experience certainly did but they might not want to be interviewed for fear of lack of confidentiality. One woman interviewed stated that she did not even trust the multiple free health and social programs available in Saskatoon because her confidentiality had previously been breached. The issue of coercion for tubal ligation is complex. The combination of all of these factors very likely prevented some Aboriginal women from initially coming forward.

It was also obvious that some healthcare providers felt mistrust in interviewing as well. This lack of trust though is much different than the deep underpinning trust issues that exist in the daily lives of many Aboriginal women.

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Narrow Geographic Scope

Because of the inherent racism experienced by Aboriginal people in many health care settings, comments were made that suggested there should be an expansion of the review beyond the boundaries of the SHR; to include all hospitals and health care providers in Saskatchewan (and indeed in Canada). These suggestions arose from the initial pre-review Aboriginal community engagement process, as well as from the Aboriginal women interviewed.

The ten-year rule of destruction of medical files is a very large limitation and a barrier to some peoples' closure or healing processes when they believe they were forced or coerced into sterilization. This also creates another level of distrust.

Part-time Review Assistant

Both reviewers were from out of province, which had the advantage of being able to take a fully independent review with as little bias as possible. At the same time, the review still required an 'on the ground' person to organize the engagement processes and interviews, as well as administrative duties. With the intense community engagement needed to achieve recruitment, the reviewers concluded that the review would have benefited from a full-time review assistant spending much more time working with local organizations and agencies on an ongoing manner. For the review, it was possible only to have the review assistant doing mainly administrative tasks.

As stated, for any review, it is important to list all potential limitation of the review. Although constrained within the described limitation, the reviewers are confident that the depth of women's and health providers' voices provides an accurate account of Aboriginal women's experiences of coercion. This depth is used in crafting the Calls to Action for the Saskatoon Health Region to move forward with the Aboriginal communit(ies) to ensure that Aboriginal women's maternal and child health needs are met

1.5 Legislation, Regulations and Policy

The reviewers examined Saskatchewan health related legislation and corporate policies as well as the Saskatchewan *Child and Family Services Act* to determine its interaction with Aboriginal women's' experiences on the Obstetrics labour and delivery wards. See Appendix "G" for the table outlining the health documents reviewed, and Appendix "H" for a list of the web addresses for access to the major legislation and corporate policy documents reviewed.

Generally, the reviewers found that the regulations and legislation matched the SHR policies, although the policies were neither cognizant of nor reflective of an Aboriginal worldview, reality or thought. There are several areas of note that warrant an in-depth discussion in section 3 and other policies that should be mentioned. For instance, the *Ethics Consultation Service* and the *Bioethics Brochure* as well as the *Post Partum Tubal Ligation Policy* Number 1300 October 2016 (previous date of April 2010) and the *Consent Policies*.

2. The Voices are Heard

2.1 Outcomes for Data Analysis

On June 9, 2017 the Aboriginal community members, Saskatoon Health Region senior managers, and the reviewers had a day-long data analysis workshop using the *CCDAP* process. The collective analysis was used in the workshop to sort data cards into major themes. Nine major themes arose in the Aboriginal women’s interview data and nine major themes arose in the health provider’s interview data. Interviews for Aboriginal women and health providers both contained the theme of Solutions/Actions. This section below provides summative statements of the data analysis supported by quotes from Aboriginal women or health providers. For writing purposes, the themes that arose in the analysis workshop, for both groups, were organized within larger overarching themes. (see Appendix “I”). To ensure the integrity of the workshop participant’s interpretation, no data cards were moved from their original theme location by the reviewers during the writing process. The themes used are the verbatim themes resulting from the Workshop.

2.1.1 Aboriginal Women Interview Outcomes

Themes produced in the *CCDAP* workshop analysis of Aboriginal women’s interviews were grouped into four overarching thematic areas. Overarching thematic areas were labeled with a title to reflect the theme within. For example, the four themes of: ‘*Abuse of Power*’; ‘*Impacts of Agencies & Powerlessness*’; ‘*Profiling, Racism, Discrimination*’; and ‘*Woman is Invisible*’ were grouped as an Overarching Theme of ‘FEELING INVISIBLE, PROFILED AND POWERLESS’.

Data analysis revealed that many of the Aboriginal women interviewed were living often stressed and complex lives, and these effects were greatly exacerbated through their experience of labour and delivery due to feeling coerced into having a tubal ligation immediately after birth. Most of the women did not understand that tubal ligation was permanent, thinking it was a form of birth control that could be reversed in the future. Essentially all of the women interviewed stated through their interview that the health system had not served their needs and they felt powerless to do anything about it. Themes that arose from the women revealed that most felt stressed and under much duress in childbirth, in addition to the usual stress of childbirth on its own. Overarching themes arising from Aboriginal Women’s interviews include:

- ‘*Feeling Invisible, Profiled and Powerless*’;
- ‘*Experiencing Coercion*’;
- ‘*Impacts on Self-Image, Relationships’ and Healthcare*’; and
- ‘*Calls for Action*’.

a) Feeling Invisible, Profiled and Powerless

The overarching theme, ‘Feeling Invisible, Profiled and Powerless’, contains four themes including: *Abuse of Power*; *Impact of Agencies & Powerlessness*; *Profiling, Racism, Discrimination*; and *Woman is Invisible*.

Abuse of Power – women expressed that there was either no explanation, or a misrepresentation of the permanency of tubal ligation. “It was just, like, we’re going to do this” and after, “I wasn’t

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told anything, no explanation that it was permanent.” The power differential between an Aboriginal woman in labour and a health provider is obvious. One woman stated, “When [I was] in for C-section, nurse came to [get] me to sign the paper for tubal ligation...Even though I didn’t want to, I signed it.” Women also felt harassed by labour and delivery staff into signing the consent form for a tubal ligation. Another woman said, “I refused the tubal so many times that they had the doctor and another person come in and say, ‘it just clamps and we can remove them.’” Women felt the harassment not only from nurses and doctors, but also for other individuals. One woman stated, “The hospital family worker is the one who started [it], say[ing], ‘Well, we want you to have a tubal.’” Another said the staff sent a social worker in to say “We don’t want you to leave until the tubal ligation is done.” Some women experienced what can only be seen as scare tactics from a healthcare provider about what might happen if a tubal ligation was not done. “I said, no, no, and the doctor would tell me stories, about women. ‘A woman had her first C-section and passed away with her firstborn; and the tubal ligation came up again.’” One woman and her husband made a decision to have a tubal ligation because they were being told that because one of her children had a health problem, that all future children would suffer the same fate. The woman said “because my daughter had cerebral palsy, the doctor told my husband that all future kids are going to be sick; have some kind of health problem.” Women (and everyone) do not always understand what a doctor is saying, especially when using medical terms, and this may be interpreted as intimidation or trying to scare them into signing consent for a tubal ligation. “[Dr. X] came into the room to do a check-up after son birth by C-section’ said tubal ligation is the right thing; my amniotic sac was see-through and there was a risk of complications if pregnant again.”

Aboriginal women experienced what might be interpreted as both physical and psychological pressure to have a tubal ligation immediately after childbirth. One woman said, “I tried to leave [the place where the tubal ligation was to be done]. A man said, ‘where are you going’; he turned me [in the wheelchair] around. I said to a nurse, ‘I don’t want to do this’” and another related, “they [nurses] hover, they can make you do stuff you don’t want to, just from the pressure alone; if there are enough of them in the hallways saying, ‘why is she so stubborn, why won’t she sign.’” Another felt crushed and helpless to stop the tubal ligation from happening. This woman attempted to state that she did not want the procedure. “And I just said, ‘I don’t want to do this; and he [the doctor] just didn’t hear me.’ I was being ignored.” Another woman’s experience in the operating room showed that her clear statement that she did not want to proceed was blatantly ignored. “I told the anesthesiologist that I don’t want this. The doctor was talking to the nurses and said, ‘did she sign consent?’ The nurse said ‘yes’. But the doctor clearly heard me say, ‘I don’t want this.’”

Aboriginal women felt powerless to stop the tubal ligation or discuss what happened with the physician. One woman stated, “I’ve never talked to Dr. X [about it] after because I just; she just; I just feel like I was, I had to do something I didn’t want.” This statement in particular shows that this woman ‘still feels and relives the incident’ as can be seen in the present tense of her language used in describing what happened, “I just ‘feel’ like I was...”. The women tended to push the experience of tubal ligation deep inside, and some felt they had developed coping mechanisms that were self-destructive; while at the same time not realizing how impacted they felt. One woman who had buried the issue for years, and eventually felt devastated after having initially just accepting it because she felt powerless to say no. “I didn’t realize it was going to affect me so much. At the time, it was just...just his decision for me...just because he was a doctor, I listened.” Another woman was quite upset at the glibness of the physician in describing

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what she felt was a devastating experience. “What really appalled me – the doctor said, ‘well, you’re tied, cut and burnt; nothing will get through that.’” Powerlessness was reinforced by health providers telling a woman that the decision to have a tubal ligation was in the woman’s best interest; that she, in essence, did not know what was good for her own life. One woman said, “Then the doctors and nurses say ‘it’s for your benefit. You have all these children. Enjoy her while you have her.’” Some women were very angry after about feeling coerced into being sterilized. One woman said, “I want everybody to know what Dr. Y did. I don’t think Dr. Y should be allowed to practice medicine. I want proof of what Dr. Y did to me.” Another woman wanted to know “Who is going to be held accountable? Why is nobody being held accountable?” for the losses that women coerced into tubal ligation felt.

Impact of Agencies & Powerlessness – women felt extremely impacted by Child and Family Services (CFS), something that led to additional significant stress. Many women interviewed felt they were profiled by CFS even when they had not had contact with them for years. It was expressed that if one had contact with CFS at some point in life, it would follow them for the rest of their lives. One woman related that “any woman with a history of children in care, there’s a birth alert [on her chart]”. In some cases, past history was used against a woman as an excuse for coercing her into having a tubal ligation. Women felt powerless in both accessing and standing up for themselves in the healthcare environment. They feel judged as irresponsible for not having a family doctor; something that is clearly a system issue far beyond their control. One woman said that she felt they looked at her as if she was not being responsible. “I didn’t know how to get a family doctor. I just went to a walk-in clinic.” This woman also stated ‘I saw the same female doctor at the walk-on for my whole pregnancy, but when I got to the hospital, a male doctor did the delivery. She was very disappointed and again felt powerless to do anything about that situation. Even when the woman did recognize that something terrible just happened, she still had difficulty with addressing the issue, “I knew something was wrong and I ordered my health record, but it was too painful to explore.” One woman described her perception of what happened. “It feels like, if you go to the doctor to have a broken finger fixed and they cut off your hand to fix the finger problem. I went to have a baby, not a tubal ligation.”

Profiling, Racism, Discrimination – Aboriginal women talked about feeling profiled in labour and delivery. One woman felt that she was profiled because she was new to the city and had few supports. She stated, “I’m thinking I was an easy target. I was alone, new to city; no supports; nothing. I was out here by myself.” Any woman who has had contact with CFS is potentially at risk of the agency investigating this pregnancy. One woman said, “My records were flagged by the Ministry of Social Services.” Another woman said, “so I just think they, with the birth alert, that they just basically targeted.” Most women felt judged by healthcare providers as represented in the following statement by one woman. “I went to have a baby, not to be judged; told I can’t think for myself.” One woman felt that racism occurred. “At the time, I still think now, it’s because I’m native.”

Woman is Invisible – Aboriginal women also felt invisible in the healthcare environment, and at times even in their personal relationship when it comes to deciding what should or should not happen to their bodies. One woman felt abused and invisible in her relationship with her partner of many years. “He was abusive to me. It [our relationship] was on and off. I just had babies with him. I was a teen mom and had three kids by the age of twenty.” Healthcare providers ought to

know that some Aboriginal women occupy these powerless places, thus the healthcare system should take extra means to not put her into an even more compromising position. Another woman felt invisible in interaction with healthcare staff and a partner, “Yeah, I felt alienated; I’m pregnant; and the nurse is supposed to be talking to me but she’s talking to my husband like I’m not even in the room.”

b) Experiencing Coercion

The theme ‘Experiencing Coercion’ contained much complexity on its own and did not break down to subthemes. A range of factors were present that most Aboriginal women simply did not know how to address. Coercion was long-term and unrelenting in one woman’s experience as she dreaded seeing her obstetrician. She said, “Yeah, [for] three years I felt coerced” to have a tubal ligation. Another explained that “...all through my fifth pregnancy she kept bringing up [tubal ligation]; and I was dreading to see her.” Some women that were feeling coerced, had certainly made attempts to put a stop to it. One woman related that “I was getting so tired of saying no. I just didn’t feel right going to see the doctor so I brought my husband. Unfortunately, this was not enough to counteract the eventual tubal ligation since the physician then moved to scare tactics that were described above. One woman who had not considered tubal ligation indicated that, “The day before [the C-section] I think, I just went in to see the nurse and she did her ultrasound and her check-ups...and she asked me if I wanted a tubal ligation; and I told her no.” It is difficult to fathom this type of conversation, yet this woman had a tubal ligation after her C-section.

Common to all Aboriginal women was their clear understanding that there was a lack of options for contraception other than tubal ligation; and they thought that the tubal ligation procedure was a form of birth control. One woman indicated, “I didn’t want to do it. I just, I wanted to maybe, birth control.” Another woman said, “And the doctor explained to me in medical terms; however, I understood that it was a form of birth control.” One woman related that, “I was naïve. I had no one to talk to about what the doctor said. He was an authority figure that I just went along with it.” And another said, “Like, I thought that [tubal ligation] was, like, birth control; not permanent.” A woman who had been considering some type of birth control, but not tubal ligation said, “I have never been on birth control. I had two older children and then three more [in a row] later. I was considering birth control.”

Aboriginal women felt that the tubal ligation procedure was either not explained at all, or if explained, it was done in medical terms that were not understandable, “This was my fourth baby; no one explained the procedure.” One woman suggested that there need for balanced choices to be available to women. She said, “So you know, it’s very important to balance needs; [the need for] access to birth control and [the need for] not being coerced.” All women interviewed either do not recall signing consent, or signed because of being too tired and overwhelmed to fight any longer. One woman said, “the consent form for tubal ligation was just given to me; not explained.” Another stated, “I don’t recall signing anything, but I did think of it when I was pregnant, but...I knew at time [of delivery] that I didn’t want it done.”

Finally, all women expressed that they felt extremely upset that tubal ligations are done without women really understanding what is happening or are refusing but the procedure still occurred. One woman related, “I was sterilized when I was in my mid-twenties.” Another said, “I refused right up to the very end. Like, in the morning, ‘You need to sign.’ I didn’t want to, even on the table. Some women had belief systems that forbade sterilization. One woman who had protested throughout her experience related, “A tubal ligation is against religion... and I just felt,

no. I can't do this; I just can't do it." One woman said, "Nurses were trying to reassure me about [epidural] needle. And yet, I was saying no. I said no to the nurse." This statement was followed by a heartbreaking statement; "...after they put the needle in my back [I thought], oh, there's nothing I can do."

Most women were angry at the time in their interview because she had said 'No' to tubal ligation on more than one occasion. One woman's words echo the sentiment of all women interviewed, "No means no, it was no in the beginning and should have been left alone"; and another said, "...in my heart...and when I said no, and no, he [the doctor] wasn't right."

c) Impacts on Self-Image, Relationships and Healthcare

The overarching theme, 'Impacts on Self-Image, Relationships and Healthcare', contains three themes including: *Ongoing Personal Impacts*; *Impacts on Relationships and Disengagement from Healthcare*.

Ongoing Personal Impacts – Aboriginal women expressed that a strong value in their lives was an innate sense of cherishing motherhood, "I'm a good mother. I would have liked to have more kids – a very good mother. I kept all my kids, I worked," said one woman. Having a child was a strong incentive to get clean and sober for some women, "I'm now drug and alcohol free for many years." At the same time some women related how a health provider used her love of motherhood as a tool in coercing her to have a tubal ligation. "It was just scary thinking, you know, my child's going to be sick." This was what the doctor said would happen if she got pregnant again. A sense of womanhood is a complex aspect of most women's life. Most women interviewed felt they had lost their sense of womanhood as represented in the following quotes, "It's, like, nobody's ever going to want me anymore. I didn't feel like a woman." Women related that a core part of their being had been removed along with the tubal ligation. One woman said, "Something's been taken away from me, and this is a gift. The doctor took away my gift." One woman echoed the deep pain she felt while the tubal ligation was being done. "I cried right through the whole tubal ligation surgery. I was so scared, and they did not listen to me, they just ignored me" and "I had – it was just like something left me – I just cried... and I knew I couldn't do anything."

Most women subconsciously blocked the devastating emotions about the tubal ligation, sometime for many years. One woman said, "For all those years it was just blocked – the feeling of it was blocked." Another woman stated, "I, kind of, just shoved it, shoved it down, like [it was] nothing, but it was...still bothered me." Women that were blocking the feelings of being coerced into tubal ligation were in fact coping from feelings of powerlessness. One woman said, "I was young, like I thought, you know, what's the use? I didn't think I could do anything anyways – who would believe me?" Another said, "Then I just – I guess accepted it and forgot about it. It was just horrible." Pushing these feelings down and unconsciously attempting to keep them repressed was obvious in one woman's interview. I had to keep making up excuses to not call. He [my husband] said it might help me heal. I had not told anyone but him what happened to me." One woman only allowed the depth of her anger to rise within the interview, stating, "I feel anger. I feel, now, like I'm actually being heard. I didn't know - I didn't know it affect me this way."

For some women these blocked emotions came out in self-destructive behaviours that affected their ability to live a healthy positive life, "...it just wasn't right; after that. I started school but rebelled against teachers. I wouldn't let them tell me what to do or how to think. I

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went into depression again.” Additionally, one woman said “The pharmacist said I could get addicted to the antidepressant so I was afraid to take it. I turned to alcohol and marijuana; I coped this way for many years.” Along with bouts of depression most of the women suffered from anxiety, and one even had a hint of PTSD with olfactory flashbacks of the very moment her sense of womanhood was gone, “What I remember most, is the smell, the burning.” The woman said, “I had a lot of anxiety when I agreed to do this interview. I wasn’t sure I was going to go through with it.”

Women who spoke out about what happened to them were left feeling broken and isolated, “I know it’s bad to isolate myself, but I stay home because it’s where I feel safe. No one is judging me and telling me to kill myself.” For one woman who tried to cope with her feeling of helplessness through self-destructive means had her children taken. This added to the insult from the initial pain of tubal ligation. She said, “It broke me again to lose my kids.” Women said that they needed some way to get through the feeling of having been coerced into having a tubal ligation. One woman stated, “I think, I probably do [need counselling],... there’s other stuff added on to it. I just don’t know how to deal with that [tubal ligation] – I just don’t know.”

Impacts on Relationships – Aboriginal women also experienced significant impacts on their partner relationships due to having undergone a tubal ligation. One woman felt that the tubal ligation was the direct cause of her relationship failing. She said, “After [the] tubal ligation, then my relationship went down because I was sterile. I got depressed. The doctor tried to put me on antidepressants and I didn’t know what this was.” Another woman indicated, “And it [tubal ligation] did affect my marriage after – we divorced.” One woman said, “We swept in [tubal ligation] under the rug. Like I was no good to him anymore; or something... it’s like my womanhood was gone.”

Women felt that the tubal ligation not only negatively affected their current marriage, but also affected any potential for a future new marriage. “Yeah, but it [tubal ligation] was one of the factors why our relationship ended.” Another woman said “no to marriage cause he wanted to have kids. I couldn’t have no more.” Another felt immense relief when the man in their new relationship did not want children. “I started going to church. I met my husband there. He didn’t want kids so that was a relief.” Despite being in a stable marriage with someone who was okay with the woman not being able to have children, there was still an undercurrent of regret that caused unspoken emotional distress for the woman, “I got remarried. I’ve told him...and he says, if your tubes weren’t tied, we’d have a baby,... it kind of breaks [me] when he says stuff like that, he means it in a good way.” Another relationship that had a significant effect on one woman was her mother’s traditional beliefs that kept her in an abusive relationship for years, “We were common law the whole time. And my mom was traditional; no matter what, you stay with him, so I stayed.” This no doubt had an impact on this woman not being able to advocate for herself when she did not want and tubal ligation but the procedure was done anyway.

Disengagement from Healthcare – Aboriginal women who have felt coerced into having a tubal ligation, some more than ten years ago have a higher risk for health problems because they are not getting preventive care. In particular, lack of preventive care will result in higher mortality from cervical cancer, which can easily be addressed with a regular Pap Test. A serious issue revealed in this review is that all women interviewed avoid healthcare. These women who have had a tubal ligation immediately after childbirth, particularly under circumstances in which they did not want to have the procedure done, or they were unable to make a clear thought out

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decision before the procedure went ahead, now go to great lengths to avoid doctors; to avoid the fear of being re-traumatized, “I don’t go to the doctor, especially a gynecologist...the fear is so – I don’t know if I can overcome it.” Another woman who avoided doctors said, “Well I hardly go to the doctor now. I think I went this year, once, wow, since my last child...yeah.” Her last child had been born some years before.

One woman felt that she was up against huge and racist system; something she felt powerless to affect. She said, “I don’t like talking about it. I don’t trust anybody. It’s doctors who are white and educated against native woman.” One woman felt that the tubal ligation caused her health problems but did not have enough trust to get these attended to. She stated, “I have so many problems since it [tubal ligation] was done. I never got a check-up after that [tubal ligation] got done.”

Even in situations that may be serious or even life threatening, women resist having to see a health care provider, “I was in so much pain but I didn’t want to go to emergency even when I couldn’t move, “[Someone] forced me to go.” One woman said, “I won’t go for PAP tests. It’s too scary. I won’t go to a doctor.” Women clearly know there is a risk for not seeing a doctor so try to live in a healthy way so they don’t require it. One woman expressed that, “I’m at risk for diabetes because both my parents passed from it. I try to look after myself so I don’t have to see a doctor for anything.” Likewise, some women have trust issue with the city’s free health services. “You know, like they have free supports around the city. I don’t trust those people. I’ve already had problems with them with confidentiality.” One woman felt confused and vulnerable on the labour and delivery ward. “...you’re getting a C-section, you don’t know, it is a happy moment, a scary moment, you just don’t know.” And after feeling this, she was confronted by coercion to have a tubal ligation. Given the well documented high incidence cervical cancer and prevalence of diabetes in the Aboriginal population, anxiety and fear related to low health services access will contribute to those high rates.

d) Calls for Action

These women were insightful and practical in their suggestions. Despite the fact that any future management of tubal ligation would not benefit them personally, all were engaging in their concern for other women. The voices of the Aboriginal women, in relation to how the Saskatoon Health Region could address the review issues, are reiterated in section 4 Calls to Action.

The next section presents the outcomes for the collectively analyzed health provider data. The nine themes arising for health provider data were also grouped into four overarching themes. For example, the two themes entitled ‘Policy Challenges’ and ‘Lack of Team Approach/Integration (to support families)’ were grouped under the overarching theme of POLICY AND TEAM CHALLENGES. As before, the workshop participant’s interpretation was respected and data cards were not moved from their original theme location.

2.2 Health Providers Interview Outcomes

Data analysis revealed that health providers work within a large, complex and ever-changing hospital systems and environments. Previous positive policy and practice changed in maternal and child care that was implemented with the aim to improve the experience of mother and infant have been largely successful. Nevertheless, some Aboriginal women attending labour and delivery do ‘fall through the cracks.’ This is not to say that these previously implemented new policies for improving the mother-child experience do not benefit Aboriginal women, but rather

that many Aboriginal women experience additional unique stresses and challenges. Some healthcare providers interviewed felt that some of their colleague's negative perception and attitudes about Aboriginal woman was an issue. All health providers felt that very negative experience arose for Aboriginal women when the Ministry of Child & Family Services became involved. Although descriptions provided by medical social workers and CFS social workers were clear, such clarity would not be available to an Aboriginal woman in labour or shortly after delivery. Some external health providers attempted to intervene with CFS at the time, but admission and discharge turnaround is so fast that the external provider often does not know the end result. Overarching themes arising from health provider's interviews include:

- *'Policy and Team Challenges'*;
- *'Attitudes Toward Aboriginal Women'*;
- *'Internal and External Impacts on Care'*; and
- *'Calls to Action'*.

a) Policy and Team Challenges

The two themes that were grouped under this overarching theme include: *'Policy Challenges'* and *'Lack of Team Approach/Integration (to support family members).'*

Policy Challenges – Health providers related that the new tubal ligation policy was a 'top down' approach and change put in place without discussion internally with staff or externally with Aboriginal communities. One health provider reported how she heard about the policy on post-partum tubal ligation. "I heard, in department, that it [tubal ligation] was an issue, and a new policy was 'put down' to stop doing them till further notice." Another health provider said, "No", when asked, given it was Aboriginal women complaining, if there was any consultation with the Aboriginal community. One health provider talked about the difficulty ensuing from maternal and child care physically being spread out with "ante-partum and labour are on different floors" although it was agreed that the physicality issue will soon be resolved with the completion and transfer to the new Children's Hospital. Healthcare providers also indicated that there are educational challenges. One said, "There is no education about policies and underlying values in the health region," while another was concerned that there was "no training for medical social workers on the new tubal ligation policy." Several health providers were concerned that a 'one size fits all' tubal ligation policy may very well solve one problem but it creates more problems. One health provider indicated, "It's easy for middle class women, but that [marginalized] woman would have less choice." Another said that the "new tubal ligation policy solves a problem but creates another for women; women who are marginalized; women do not have a family doctor or obstetrician." Another health provider thought that the hospital should "get nurses [who see woman more] involved, with two physicians in tubal ligation discussions ... nurses spend more time; can call us if the patient has changed her mind." There was concern as to how the Ministry of Child & Family services seemed to have access to certain information about patients. One external provider asked, "I've always wondered about that [if CFS has a mandate to access personal health information]." Another wondered about how CFS social workers know if a woman has been using drugs. The healthcare provider stated, "I have not been asked to release them [toxin screen] ... so then how are they ... Who's letting your tox[ins] screen information go to CFS?" Finally, a major issue that is surely affecting how Aboriginal women perceive the

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services they get on labour and delivery is the confusion about the different roles of hospital social workers and CFS social workers. One health provider was quite upset when the news article implied that a hospital social worker coerced a woman to have a tubal ligation. The health provider stated, “I’ve never had a patient sign a consent; never have I brought a consent paper in [for signature].” Another health provider was concerned with the lack of communication from CFS, saying, “The [CFS] like to do things in secrecy. They don’t tell us when they’re coming; or who they are coming for.” Another stated concern that apprehensions were not well documented, indicating, “After hours, CFS comes in the evening and nothing is documented on our medical charts. They [CFS Social Workers] can’t document, and nurses don’t document what took place.”

Lack of Team Approach/Integration (to support family members) – In this review some of women interviewed who felt coerced into having a tubal ligation also had current or past involvement with the Ministry of Child & Family Services (CFS). For some, such involvement may have been many years in the past. Many Aboriginal populations are afraid of CFS (as noted in section 3 – Distrust). The reviewers wanted to understand interactions and intersectionality between CFS and SHR healthcare and social worker providers in obstetric services. Healthcare providers, medical social workers and the CFS social workers may all be involved at various points in apprehensions by CFS. It was clear that each type of Social Worker (SHR and CFS) fully understood and carried out their individual mandates. It appears that these roles have not been adequately communicated as there is confusion with other staff members, the public and particularly Aboriginal women.

SHR’s Royal University Hospital has 15 full time social workers (Mon-Fri) that cover 22 departments or units in the hospital. It has 2.2 staff coverage (10am to 10pm) for all obstetrics related units including ante-natal, labour & delivery, post-partum and neonatal intensive care, plus casual staff for after hours on-call to make various small administrative arrangements. On-call SWs do not attend the hospital. A SHR-SW indicated, “Yes, we get a referral and we have to prioritize. It’s a heavy caseload with all the different units and we kind of make a decision on who needs to be seen first.”

SHR-SWs reported that “consults are requested by computer. Nurses enter the consult.” or “the physician will consult me or call me.” Sometimes patients say they have a social worker in the community or an addictions counsellor. Other times “...we get referrals if there is ...drug use/violence in pregnancy; but it’s not just that. We’re there to support families and patients.” One SHR-SW stated, “I am always transparent. If I am obliged to report to child protection, I tell the patient why; I report only if risk of harm or violence.” SHR-SWs were clear that they have no involvement with tubal ligation, with one SW indicating, “there has been no change in Social Worker tubal ligation policy because we don’t do that. It’s the physician role [to get consent for tubal ligation]. SHR-SWs were quite concerned that “people often just think we’re involved when there’s child protection concerns.”

CFS-SWs reported that “intake will screen and decide if there is enough information to warrant an investigation.” Referrals were from a wide variety of individuals, family and groups; “[Referral] can be from family, police, medical personnel, neighbours, school, and anonymous website, email, fax, drop-ins, etc.” CFS-SWs indicate that they have “lots of discussion with the women during pregnancy to see what has changed before we apprehend.” They also indicate that their usual contact in the health system is the hospital Social Worker. “We’re usually working with the [hospital] social worker who calls on behalf of the nurse or doctor, providing

information to us.” Some hospital SWs solve this by “giving out our Medical Social Worker pamphlet.”

There is certainly confusion between SHR and CFS Social Workers. One SHR-SW stated, “people get mixed up between SHR hospital Social Workers and other Social Workers.” Even though they have clear and different mandates, to a patient they are all social workers. “If you say ‘social worker; they think you’re a child protection worker.” Yet, there are critical reasons for making a referral to child and family service. Firstly, it is “hospital policy is that ‘suspected child abuse’ must be reported.” One SHR-SW indicated that, “it’s not straight forward. Maybe [the woman is] not flagged but the woman has a CFS worker in community. Sometime [she’s] using crystal meth during pregnancy, so we’re reporting that information and CFS is opening a file.” If an obstetric SHR healthcare provider is uncertain if a particular behaviour in a woman warrants reporting “a SHR Social Workers can have their supervisor enquire with child welfare without giving the patient name – 90% of the time we would not call.” What is perhaps not known to the SHR healthcare provider, as reported is that “if the hospital calls and we don’t investigate, we file the call for future; historical. . . ., if three other reports, those altogether, may end up being an investigation. All calls from hospital are kept in our system.” Communication is a problem between SHR hospitals and the Ministry of Child & Family Services. One individual stated, “the only way these two big Ministries [Health & CFS] connect is through a Social Worker.” One CFS-SW indicated, “We want more information but the [medical] Social Worker doesn’t have it because she’s getting that third-hand [from nurses or physicians].” One CFS-SW indicated, “I don’t know if there is a lack of communication between the Ministry and the hospital. [T]he hospital’s pretty good about phoning us right after the baby is born.” One wonders if every woman having a child is subjected to having her whereabouts reported to an external agency. Healthcare providers report that the Aboriginal Health Services in hospital are very good for patients, “Now we have First Nations and Métis Health in hospital, which is a positive experience for our patients.” Some healthcare providers advocate for women who were expressing a need, and felt that the action of nursing was unnecessary – “one girl was crying while getting an epidural. She wanted her mom, and the nurse were, like, she can’t come in the room. We weren’t in the OR, we were in a birthing suite. There was no reason for that.” Some felt that if notified, they might have intervened in an apprehension; “I asked the nurse, “Who was with her when CFS came?” The nurse said, “Well, nobody. We try to be there.” I said, “Well, I was in house. Nobody called me.”

b) Attitudes Toward Aboriginal Women

Provider Perceptions of Women’s Challenges and Experience – Health providers suggested that significant challenges exist for Aboriginal women in hospital due to the effect of having a newborn apprehended by Child & Family Services (CFS). Providers feel that “[the women] are the ‘most’ traumatized,” and that the “potential for apprehension is high if a woman says she does not want to meet with [the] CFS worker.” One health provider related that, “the [Aboriginal] community, I think is very traumatized by that [apprehensions].” Another related that there are significant effects on the ability of mom and baby to bond. Most providers felt that apprehensions on Labour and Delivery interfere with access to healthcare for themselves and their family, “Apprehensions from CFS scare women into not coming to the hospital; this is a barrier to healthcare” and “[a woman] not accessing healthcare] also affects the family, [since the woman coordinates access for her family].” Health providers also shared their perceptions on factors that influence and Aboriginal woman’s understanding of and access to reliable

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contraception as can be seen in the following quotes: “Much information [is now available], but some women still think tubes can be untied or the clips [taken] off” and the “only opportunity for women who may have controlling partners to have reliable contraception is post-delivery.” There is a concern that tubal ligation can no longer be done immediately post-partum unless a prior discussion and agreement was made with a family doctor or obstetrician. One reflected that “I see in our [obstetrics practice] that many people don’t have family physicians, and it’s a huge problem.” Another stated, “some women may not have the capacity within a chaotic life, to plan for follow through.” Most health practitioners were extremely concerned that Aboriginal women felt coerced into having a tubal ligation. One said “it’s a basic human right that’s been taken away from them if they felt pressure to do that; it’s not something that you can reverse.” Another related that it is likely that it is “high-risk women who may be more easily coerced.” Despite concerns for the women, one health provider was not completely sure that if when a woman changes her mind that the procedure is stopped. The health provider stated “...the tubal ligation, you’ve thought about this, the consent’s already been signed; as we were kind of taking you over to L&D, and you changed her mind; would they [nurses] kind of say anything?”

Spectrum and Continuum of Ignorance, Bias, Racism & Discrimination – Health providers indicated that they did see coercion conversation amongst staff at times. One health provider indicated, “I think it’s more people talking amongst themselves saying, ‘this person had so many children. She’s not taking care of them; shouldn’t we tell her stop?’” One health provider “complained to the charge nurses [about] bias [toward Aboriginal women] in some staff that may have been there [employed at the hospital] for a while.” Another health provider related, “It’s a constant struggle for Social Work. Nurses ask ‘Aren’t you apprehending that baby?’ and ‘That baby should not go home [with mom].’” Health provider comments reflect that there is systemic discrimination towards Aboriginal populations. One provider stated, “what has been happening with apprehensions is similar to residential schools.” A health provider indicated, “It’s a fight to convince people that this stuff [tubal ligation] is wrong, yet we have to conduct our ways in a manner where we try not to make the white people feel uncomfortable.” Interviews reveal both covert and overt racism in the hospital environment. The lack of understanding of what systemic racism actually means is apparent. A health care provider stated, “If you’re part of the dominant society, you don’t think twice about going to the doctor or the emergency room. I’ve had tons of community and family member who will say. ‘I will never go back there [to hospital].’” One provider’s clear lack of understanding systemic racism is apparent in understanding. This health provider stated, “...the nurses in our hospital are all races, and I don’t think that there is racism involved.” Another health care provider felt severe racism first hand, “One resident on labour and delivery said, I f...g hate you people more than any other race on this entire earth.” There is an unrecognized power differential that is not perceived by some health providers. One provider indicated that, “I don’t see us as a paternalistic department. ...it’s not something I’ve perceived to be an issue.” Another provider, in attempting to understand why some Aboriginal women might not hear the whole explanation of tubal ligation, indicated, “And so when you talk to them [about tubal ligation], bring those long discussions to them, I’m sure they’re not attentive and you know, patients they are quite stressed and this is a stressful time for them, childbirth and like especially if they are coming away from home, they have other family there and kids” Another healthcare provider knowingly stated, “If a person has always had power, they don’t know what it is like to be powerless.”

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Implicit Bias – Health providers clearly related that the media was reporting did not have the full story, “I felt it [the media report] was a misrepresentation of the larger scope, the way that we practice.” As well, some providers also felt that the media did not fully check facts before printing the story, “[the] reporter never came to us – telling experiences without investigation does not make journalism.” It is clear that many health providers were upset, shocked, and saddened when they were confronted with the media reports. Some health providers questioned the truthfulness of Aboriginal women’s in the media reports. One provider said, “[the] reporter never came to us. Telling experience without investigation does not make journalism.” SHR management had to address the complexities of such a report, specifically notifying staff and deciding what response was required. Health providers felt that there was minimal internal discussion about the media report, “Next day or a couple days later, senior manager talked to our group. I think the decision had already been made to do an external review.” One provider indicated that they “were told not to complain” and [in any case] “we would never discuss patient information.” It was a time of some confusion since “they [senior staff] could not find the people that complained.” Besides implicit bias from media, some health providers felt that there could be subtle bias toward Aboriginal women relative to tubal ligation. One provider state, “I do think there may be coercion but I don’t think it’s in your face type of, ‘have a tubal ligation or else.’” Another stated that “staff – and it may well be that the physicians involved as well – sit around the desk and talk about women having five children, and four have been apprehended – ‘it’s time to stop.’” All health practitioners interviewed made observations and had concerns about what may be happening to Aboriginal women in their care. One provider stated, “I want them to have the opportunities they need to manage their lives the way they feel it should [be] without being coerced.” Another reflected that “if I heard they felt pressured, I’d have acted as a mediator.” One health provider was concerned that “apprehensions - it’s another state sanctioned We think we’re doing it for the right reasons, but it’s entirely wrong.” There were also comments on the ‘social worker conundrum’; that media reported it was a social worker that coerced a woman to sign consent for tubal ligation. Some health providers stated that this information was totally incorrect because requesting consent is outside of their scope of practice in the hospital. “It [news report] said Social Workers had them sign consent; when, it is outside our work.” Great angst was expressed in that “if people don’t trust social worker to start with, then what?”- given that social workers role in hospital is emotional and family support for patients. One health provider felt that it was a problem that “CFS will not engage prior to [birth] and so they have to make a decision with poor information or no information [in short hospital stay].” At the same time, a provider from CFS indicated that they cannot intervene until the baby is born, and often they have had contact with the women in the community prior to admission for delivery. There is clearly a lack of coordination and understanding about the roles of the health sector and the child protection sector. One health provider indicated that there is “no solution to confusion [between SHR social workers and CFS family workers] that has not already been tried.”

c) Internal and External Impacts on Care

Informed Choice Perceptions – Health providers interviewed felt that they provide contraception options to women in their obstetrics or family doctor office. They generally had difficulty understanding why a woman would be coerced into having a tubal ligation. One health provider stated, “[There are] all kinds of alternatives to tubal ligation.” Another said, “I show it to them, and I say, this [is] what an IUD failure rate [is], and this is the lowest one...].”

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To suggest that a woman have a tubal ligation would occur only under certain circumstances, one healthcare provider stated that, “[I] might advise tubal ligation if I had a C-section and we find the lower segment of the uterus is very tense.” All health providers interviewed who do tubal ligations indicated they carry out a detailed consent discussion, including the fact of permanency, “I tell them specifically that it’s permanent regardless of the type of tubal ligation.” Health providers indicated that tubal ligation is part of standard obstetrics practice, particularly with a planned C-section, and most do not think that coercion could happen. One healthcare provider stated, “[there is] no reason to coerce anyone. It [tubal ligation] makes our day more difficult to arrange for doctors, nurses and anesthetists.” While another expressed; “in 2010, could it have happened on my watch? Yeah. I didn’t see every mom.”

Health providers who carry out tubal ligation stated that they are very clear with women that the procedure is permanent, “And [I] always tell my patients, ‘I want you to be 200, 300 percent sure that you want this tubal ligation done.’” At the same time, some think that the permanency factor may not always register with a woman, “Like I say, okay, this is permanent; maybe that part does not get registered.” One healthcare provider indicated that despite a woman having signed consent, there is always another check before proceeding, “Even if it’s documented, I prefer that we check again after she’s had a baby – whether she really want it done.” Clarity was provided by healthcare providers that hospital Social Workers are not involved in garnering consent for tubal ligation from a woman but they can and do “assist on the pros and cons of a decision they [the women] are considering. We never say ‘you should.’”

Health providers generally supported the policy to not have a woman making the decision for tubal ligation during pregnancy. Most health providers indicated that physicians have adapted to the new policy, but stated that “tubal ligation has decreased a lot.” Some felt that the new policy would also have a potential negative impact for some women. “I was concerned that not offering tubal ligation [was a problem]; what if a woman really wants one and has no family doctor, and so many social barriers. [This is] another barrier.” One health provider indicated that “every woman can certainly talk to her healthcare provider, and arrange a tubal ligation.” Others felt that “because of our unique and rural population, as well as high needs inner city women, it [tubal ligation] actually served our population well.” One provider was advocating for access to postnatal tubal ligation for women who have to travel a far distance and may not have access to a family doctor or obstetrician. “I believe women should have opportunity for a tubal ligation. For north, a good opportunity after birth, if your choice.”

Perceptions of Care –Healthcare providers spoke of the ward environment as a factor in the care of Aboriginal women. One provider indicated, “It comes down to the personality of the day; some nurses roll with things, and others want to stop all business to do other things. It’s not the same every day.” The general mood of the obstetrics ward “depends on the day; on the charge nurse; the morale of the particular group of nurses; and somewhat on the staff person of the day. It’s very, very, very busy.” A factor that seems to be quite confusing is the mandate and presence of Child and Family Services in hospital. One health provider stated, “We [CFS social workers] work with them [hospital social workers] only if there is a possible protection issue before birth; or they call us after birth.” These external CFS staff feel that “a [communication] disconnect is [that] nurses and doctors are not giving information to their hospital social worker to relay to us.” One hospital social services provider felt caught in the middle between healthcare providers and CFS. “... We [hospital social workers] are the communications between mom and social services [some of the time].” “I’m sometimes the middle person between the medical team and the patient

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and the [child protection] social worker.” Most providers saw a problem in communication from CFS when a child was to be apprehended. One healthcare provider stated, “Sometimes I see that baby is apprehended only by a notice on the chart front. I have no clue what took place.” Generally, the overall sense was that “There are many support programs in the community, and much confusion about what services come and go in hospital.”

Another health provider mentioned that there is often subtle coercion about tubal ligation with Aboriginal women. Also existing is an ongoing level of ‘desk talk’ related to potential coercion to influence an Aboriginal woman to have a tubal ligation. One provider felt that coercion by some nurses would not be restricted to Aboriginal women. This provider stated, “I think that [desk talk about patients] does occur; probably in any unit.”

As with any organization, change is a long and sometimes difficult process. All health providers indicated that there was a positive and progressive strength-based management system in place in the last several years. One provider indicated, “Out of an external review, our new maternal manager has been a godsend. [We] accomplished more in a short time.” All hospital health and social service providers indicated how much they loved their work in labour and delivery. One healthcare provider indicated, “I absolutely love obstetrics. Yes, I enjoy it. I just...I don’t know.” Another stated, “...this is my area so I feel very passionate...and very strong and I wanted my experience to be heard.” Health providers, particularly social workers who were the focus of the media report, indicated they received excellent management support. One stated, “[we had] complete support shown by senior social work managers.”

Health providers indicated that progressive changes have occurred in the past five to seven years. For example, one provider stated, “a lot of change [has occurred] in the last 5 to 7 years. Apprehension is the very last resort; even if drug use during pregnancy. Supports are put in place instead.” Another example is the institution of a patient advocate. Managers have developed creative ways to stay on top of issues that may arise. One provider indicated, “so there were things that I could see, if I was out there [on the ward, and if I heard there might be a problem arose] I asked the nurses to give the patient my card.” Most health providers stated their appreciation of the health regions’ Aboriginal services, and that increasing numbers of staff had access to cultural education, “Our SHR Social Work education was ‘cultural education’ last year.” At the same time, one health provider was unsure if senior nurses had yet had an opportunity to attend cultural training. Cultural education is not mandated, and usually younger people are sent.

Impact of External Social Services (provincial), Policies & Practice – One health provider suggested that the “biggest trauma is CFS in hospital. I understand that children need to be protected, but I don’t believe the hospital is the place for that [apprehensions].” Health provider’s comments reveal a ‘prenatal engagement gap between healthcare and child protection. One social services provider stated, “our [child protection] involvement would not happen until after the baby is born. We are not present at labour and delivery.” One health worker felt that “[CFS] have ongoing maintenance of the family file and the child care files.” A health provided stated, “We only see a snapshot of [the woman for] 48 hours. Social services have knowledge of [the woman’s] background.” One healthcare provider stated, “[we are] working with ‘X’ clinic. We have high risk rounds and are trying to connect between CFS and medical community, but it’s not [CFS] mandate.”

d) Calls to Action

Please see section 4 for a complete discussion of this section. It is similar to that in the analysis of Aboriginal women's experiences, is a record of all suggestions made for solutions and/or actions that need to be taken to improved Aboriginal women's experience with labour and delivery.

3. Discussion - Aboriginal Women's Reality in the Context of the Saskatoon Health Region

*The discrimination visited daily on Indigenous people so robs them of their dignity and self-respect, that some begin to believe they deserve no better.*⁴⁶

3.1 The Disconnect

This section has been named "The Disconnect" because pervasive structural discrimination and racism in the health care system in general (despite attempts to remedy these) remains unmistakable. There is a gap between what the women experienced and what the health care providers experienced. From the reviewer's perspective, a cultural disconnect is evident. It is impossible for a mainstream health provider to interpret what is going on with an Aboriginal woman without significant and appropriate cultural competency training. The health care structure and the policies of the Saskatoon Health Region (and generally all policies) are geared to the mainstream, non-Aboriginal populations and as such do not serve the health needs of the Aboriginal population.

Some of the health care providers, on initial immediate reflection could not appreciate that any type of coercion or racism existed in on the labour and delivery service in Saskatoon hospitals. For instance, one comment received by a health care provider stated, "...the nurses in our hospital are all races, and I don't think that there is racism involved." This is a clear indication that this healthcare provider does not understand that racism in an Aboriginal context is about power relations.⁴⁷

There are Intergenerational impacts of colonization steeped in racism that reach to every institution in Canada. It is then not surprising that racism exists in health care and that it reaches into the Saskatoon Health Region. One healthcare provider expressed,

'If it had been a non-indigenous woman coming forward, someone might have lost their job. Racism needs harsh consequences.'

Communication is disconnected between the Aboriginal women and the health care providers. For instance, when an Aboriginal woman was being sterilized she described the conversation with the nurse who said, "the burning was from hernia repair. I said I didn't have a hernia." The communication was, at times, inappropriate, "... Nursing staff made negative comments on my lifestyle." It was stressed by all of the women interviewed that when they said no – they meant no but were sterilized anyway. One woman related, "I told the anesthesiologist that I don't want

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this. The doctor was talking to the nurses and said, ‘did she sign consent?’ The nurse said ‘yes’. But the doctor clearly heard me say, ‘I don’t want this.’”

Communication between the departments of the Saskatoon Health Region can also be improved. For instance, a top down policy implementation was felt, “I heard, in department, that it [tubal ligation] was an issue, and a new policy was put down to stop doing them till further notice.” The reviewers were also told that the policies were more of a “one size fits all approach” and this should be taken into consideration, [This change in policy], It’s easy for middle class women, but that [marginalized] woman would have less choice.”

There were also grave concerns about the interaction between CFS and the Obstetrics in the SHR ranging from confusion about the different roles and mandates within the system to the harsh consequences of being in the CFS system. Communication is an issue, “The only way these two big Ministries [Health & CFS] connect is through a Social Worker.” “we want more information but the [medical] Social Worker doesn’t have it because she’s getting that third-hand [from nurses or physicians].”

The women interviewed (see Appendix “I” and Voices section) were clear that they either were coerced, or felt coerced, or felt an attempt to be coerced into sterilization. While the policies seem to follow the Saskatchewan legislation, they are missing a critical link of the reality of an Aboriginal worldview and are culturally incompetent and thus flawed. There are policies in place; however, these could be revised and utilized to implement a culturally competent framework which will be discussed in Section 4 – Conclusions, Directions and Calls to Action.

3.2 The Policies

The Post Partum Tubal Ligation Policy Number PP 7-3.6 was in place during the time period that many of the women stated they were coerced into Tubal Ligation (2005 to 2010). The policy describes the procedure for a woman to access a tubal ligation. It states that all consents must be obtained before the patient enters the Operating Theatre (1.8). The procedure that is followed is that the nurse identifies a patient requesting a tubal ligation within 72 hours of delivery and the postpartum “unit” is responsible for obtaining consent from the surgeon or designate (3.6). The patient is required to stay in “holding” until the consent is obtained. There is no definition of who a designate may be and considering there is limited space and time in the operating rooms, the likelihood of pressure to move a patient out of holding will occur thereby creating undue pressure to sign a consent form. Indeed, complaints were made by the Aboriginal women about who was obtaining consent.

In 2015 there was a public response to the media outcry of several Aboriginal women who believe they were coerced into sterilization. As a result, the Post Partum Tubal Ligation Policy Number 1300 October 2016 (previous date of April 2010) was drafted, passed and implemented. This policy garnered much attention during the interviews by both the Aboriginal women and the health care providers. Several people expressed concerns regarding the availability of tubal ligation for some Aboriginal women. An Aboriginal woman did not have a family doctor or obstetrician prenatally but did wish to have a tubal ligation after childbirth would be excluded by this policy. It also likely excludes women who live in the north but have to deliver their baby in the city. They may have difficulties in returning to the city to have a tubal ligation later. It was also questioned whether or not the Aboriginal women who would be affected by this policy were consulted.⁴⁸ The new policy seems to be a quick response by the

Saskatoon Health Region without consultation with the women who would be affected by this policy.

The ability to reproduce is an established Aboriginal right (and possibly a treaty right) that is protected by the highest law in Canada, the Constitution.⁴⁹ There is a legal requirement to consult and accommodate the holders of section 35 Aboriginal and treaty rights that are constitutionally protected. It also does not address the systemic issues which are at the core of why the women feel they were coerced in the first place.

The progression of the consent forms was also reviewed, 1995, 2007 and 2015. Some of the omissions from the earlier policies were addressed in the 2015 such as a definition section and an “overview” or preamble. Although consent is defined, it does not include the principles of free, prior and informed consent. Without the inclusion of understanding what these words mean and ensuring that the words free prior and informed are understood by all before implementing it is possible that a true consent may not be achieved. It would further be beneficial to review the *UNDRIP*; TRC Calls to Action; an Aboriginal and treaty rights analysis; a cultural review (applicable culture for the Saskatoon Health Region meaning Cree, Sauteaux, Dene, Dakota, Métis and Inuit) and a solid set of definitions that include the Aboriginal worldview, linguistics and thinking on consents and tubal ligation.

3.4 Hospital Admission Record Notes

In some instances, the reviewers were able to garner health care records of the women who provided free, prior and informed consent to do so. The following section is a summary.

Stressed Pregnancy

One chart review found evidence that the woman had an extremely stressed pregnancy. There was no evidence on her prenatal record that she had been provided with supports to manage this stress. It cannot be known whether the woman also had a family doctor who was providing such supports.

Consent Documented

Not surprising, the charts reviewed contained precise documentation of written consent, including detailed documentation of the discussion on risks. A major difficulty in examining whether consent for tubal ligation was documented is that for most of the Aboriginal women interviewed, their medical chart had been destroyed after ten years. In one chart review, the prenatal record showed that the patient had requested that a tubal ligation procedure during pregnancy; and again, at the time of admission. One chart recorded that a woman was put on antidepressants immediately after childbirth. It is thus questionable whether this woman, despite documented consent, was too emotionally vulnerable (or legally capable) to make such a final decision of tubal ligation at that time.

Possible Influences for Recommending Tubal ligation

In one chart review, the operating room noted documented that ‘the fascia was densely adherent to underlying rectus muscle’ which could result in a higher risk of problems if pregnant again. Another chart documented medical conditions that may bring increased risk to the mother or neonate in a future birth. One note stated that the baby had a health problem, which is consistent the fact that in one woman’s interview she indicated that she was told that a tubal ligation was needed because future pregnancies would result in sick children.

Judgmental Staff person

One chart had evidence of a staff person making a judgmental note in chart, indicating that patient was refusing insulin. The next note entry was by the physician who stated that the woman had gestational diabetes and did not required insulin post-delivery.

3.5 The Connect - Reconciliation in the Saskatoon Health Region

The fact that the Saskatoon Health Region has voluntarily undertaken this review is concrete evidence of a desire to make positive changes within the region. This external review was undertaken with the intent to assist the Saskatoon Health Region in making changes that would benefit the future of Aboriginal women who are giving birth in their hospitals. The Saskatoon Health Region is moving toward reconciliation as per the Truth and Reconciliation Commission of Canada⁵⁰ 94 Calls to Action through their Reconciliation Statement that confirms that with the statements that: they foster and maintain respectful relations with all First Nations and Métis people and commit to the adoption of the *United Nations Declaration on the Rights of Indigenous Peoples* as the framework for reconciliation. Saskatoon Health Region also recognizes a holistic view of health and well-being, including traditional medicines and practices. They further recognize the harms done by residential schools and they impact health and must be addressed through constructive action within Saskatoon Health Region. Cultural safety and cultural competency must be addressed as well as the recruitment and retention of First Nations and Métis employees within the Saskatoon Health Region. They also agree to implement the Calls to Action outlined by the Truth and Reconciliation Commission of Canada, that are relevant to health and healthcare.⁵¹

3.5.1 Truth and Reconciliation Commission of Canada Calls to Action.

Aboriginal and treaty rights to health and health care have specifically been identified in the TRC Calls to Action #18,

... to recognize and implement the health-care rights of Aboriginal people as identified in international law, constitutional law, and under the Treaties.

Call to Action #19 and 20 also identify the need for reconciliation:

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

20. In order to address the jurisdictional disputes concerning Aboriginal people who do not reside on reserves, we call upon the federal government to recognize, respect, and address the distinct health needs of the Métis, Inuit, and off-reserve Aboriginal peoples.⁵²

Health and health care is also threaded throughout the remaining TRC Calls to Action that further emphasizes the need for reconciliation. Although international law is not in itself legally binding in the domestic capacity, it is a forceful tool for setting the parameters of a rights based approach that is inclusive of the fiduciary relationship (and ensuing obligations), the honour of the crown and the articulated health principles found in UNDRIP and other international instruments. These solidify a health rights based approach that is anchored in domestic and international law and further advances the goals of an equality based health care approach within the Saskatoon Health Region. It would be beneficial for the Saskatoon Health Region to take this into account when drafting policy that affects the health of Aboriginal peoples in its catchment.

3.5.2 Human Rights, International law and UNDRIP

Health is a basic human right that appears in a variety of United Nations instruments, declarations or conventions that comprise the United Nations framework of rights. The right to health includes the right to health care and encompasses the right to a culturally appropriate health care system. Further, human rights are both interdependent and inextricably linked to the right to a healthy environment,

Health is a fundamental human right indispensable for the exercise of other human rights,” which include, among others, the right to food; the right to adequate housing; the right to education; the right to work and rights at work; the right to life; the right to information; the right to physical integrity; the right to be free from discrimination on any ground, including gender, race, religion, sexual orientation, and disability; and the right to self-determination.⁵³

As with other human rights, the right to health is particularly focused with the disadvantaged and the vulnerable while advancing basic standards of equality and non-discrimination.

The United Nations Declaration on the Rights of Indigenous People remains a forceful and important document in providing its direction on the right to health. Of particular significance is Article 21.1 of the *UNDRIP* states: “Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, health and social security.” In addition, Article 24 states that:

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, to all social and health services.

2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

The *UNDRIP* provides an important framework for a rights-based approach to the health of Aboriginal women under international law as it recognizes the right to health both as a self-standing right and a right that is joined with and interdependent with other rights, including the rights to non-discrimination and to the improvement of economic and social conditions. The usefulness of the *UNDRIP* cannot be understated when drafting principles that affect Indigenous peoples in Canada. It would be useful for the Saskatoon Health Region to take this into account.

Implementing reconciliation takes work, it takes a commitment to make change. The Saskatoon Health Region has shown their commitment to making change. The Aboriginal women and the health care providers who came forward have shown their courage and commitment. Gleaned from the information obtained in the interview, the following are recommendations and Calls to Action to assist the Saskatoon Health Region in making these changes.

4. Conclusions, Directions and Calls to Action

All of the people who have been interviewed for this external review were asked how they thought the Saskatoon Health Region could make improvements that would address the serious issues that initiated the external review. The Aboriginal women and the health care providers were frank as to what they thought may assist in preventing any type of coercion and/or providing some types of reparations for the harms that have occurred. The onus does not fall on the Aboriginal women to understand the complete workings of the Saskatoon Health Region, but when the SHR implements change it is important to ask if the changes reflect and uphold the honor, integrity and cultural understandings of Aboriginal women. This external review is seen as an opportunity for Saskatoon Health Region to become a leader in not only Saskatchewan but nationally as well. The following is a summarization and interpretation of what was heard.

The Aboriginal Women

The data falling within this Call to Action section are a list of non-overlapping ideas that the women responded with when asked the question of what they thought might improve an Aboriginal women's experience so that they would not feel coerced to have a tubal ligation. One woman felt that there should be personal control over one's body stating that, "We should have options, to decide whether or not we want something done to our bodies." Another felt that "you know, maybe another person should be with the doctor to witness." One woman thought that there should be "a specialized nurse social worker, like somebody with both backgrounds, appointed to help women make the decision." Another suggested that, "You know, maybe another person should be with the doctor to witness." Other suggestions included that healthcare should "give information sessions on it [tubal ligation] and give time to think, 'is that what I really want?'" Women suggest "there should be a pamphlet just for tubal ligation, if you're considering it, 'here are the pros and cons in plain and simple language.'" One woman was emphatic that a sterilization discussion "should not be had; ...not before, not during pregnancy, or right after delivery because you're not thinking straight." These women were insightful and

practical in their suggestions. Despite the fact that any future management of tubal ligation would not benefit them personally, all were engaging in their concern for other women.

The Health Care Providers

The health care providers had additional comments and valuable input on how they thought the issue of coerced sterilization could be addressed and solutions and/or actions that need to be taken to improved Aboriginal women's experience with labour and delivery. This section, similar to that in the analysis of Aboriginal women's experiences, is a record of all suggestions made for solutions and/or actions that need to be taken to improved Aboriginal women's experience with labour and delivery.

Administration – This is an area for which most health providers found progression occurring in how the labour and delivery units operated. One provider indicated, “She’s strength-based. We’re headed in the right direction. Tubal ligation was reviewed and a totally different strategy was posted on the website.” Another health provider indicated that it would be “important to see action taken on these types of issues.” Another health provider indicated that the review should take into consideration that “quite a number of the women, we’re hearing, their experience may have been in the past. The hospital may be entirely changed in the way it does business now but that experience has prevented women from receiving healthcare. Hope this review will find a solution [to help women come back].”

One provider indicated that, “with normal delivery, the question of tubal ligation is no longer part of the standard assessment.” It must be stated that previously shown in this report, a number of health providers feel that a ‘one size fits all’ approach to tubal ligation will not serve the needs of Aboriginal women. A healthcare provider indicated that continuing education needs to be revamped so that it is not a burden on staff. When a staff person attends for example, cultural training session, all of their work is still there when they return to the ward. One provider indicated that perhaps “a medical social worker could coordinate with other programs.” One health provider felt it was “important to see action on these types of issues.”

Review Alternative to CFS Apprehension in Hospital – There was much concern that currently “one Ministry’s mandate is to be carried out within another Ministry’s mandate. One health provider indicated that “the new Children’s would be perfect time to get one or two [of our] investigators right on the spot there.” A CFS provider shared what was working with other sectors. This social services provider indicated, “We have two Social Workers working well with police. We should have them in hospital to work with their Social Workers; partner with them.” A healthcare provider “Wonders if it would be reasonable to not allow social services on hospital ground to prevent women from being traumatized.” Another felt it would help if “CFS Social Workers need to be registered. With registration, there is a process for dealing with complaints.” CFS providers felt that communication needed to be more direct to them and not through a third-hand party, “Nurses and doctors should report directly; not via a hospital social worker who doesn’t have the whole picture,” CFS providers clearly understood the “need prenatal preventative work but [this is] not possible with protection mandate.”

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Education and Training – This is another action area that health providers felt would improve healthcare for Aboriginal women. One provider felt it was “important to teach healthcare professionals about institutionalized racism.” Another indicated that some cultural training was occurring, stating that, “Last year, [the social work] education day had cultural competency. But it has to be repeated.” One healthcare provider questioned whether “mandatory training might be the answers’, such as has been done in other provinces. A healthcare provider indicated “a lot of work needs to be done in changing curriculum’ including the “need a way to ensure [Aboriginal] students feel listened to, safe and value, the need for reconciliation within the curriculum in nursing, medicine and social services, and the need for mandated specialty training in Aboriginal women’s health for obstetrics.”

Intensive support for Aboriginal women – All health providers felt there was a need for intensive supports for Aboriginal women who are at risk of feeling coerced into having a tubal ligation. Ideas on models for such care were related. One healthcare provider indicated, “What’s needed is a place like Infinity house, where there could be some supported living for a couple of weeks to observe interaction [between mom and baby].” Another provider state that a “nursing station [in isolated First Nations communities] is an amazing model. It’s way more progressive than what we have in the south.” Another health provider indicated that there is a “need [for] a Sanctum [House] model for antepartum and postpartum supported living for any woman who’s pregnant and high risk.” Others indicated there is a “need more funding for self-care in the community.” One provider felt that the health region would have to work hard to meet the “requirement for a high level of care to Indigenous women [for them to feel safe in hospital].” One might question whether social work services are adequate in obstetrics. One provider indicated, “we get consults for high risk, on antepartum for long time: emotional, psychological, finance, assist family from out of town. We connect them and support them.” Working from a strength-based approach was seen as important. The hospital “needs to work with women in a strength-based perspective.” Another health provider stated the “need more access to midwifery and nurse practitioners; more prenatal care, to improve Aboriginal women’s health.”

Alternatives for Access to Tubal Ligation Information and Consent – Access to alternate means to have a discussion about tubal ligation such that Aboriginal woman can make informed decisions was seen as an important service that needs to be implemented. Ideas were put forward on how this might be accomplished. One health provider said, “...if a woman [with no family doctor] requests a tubal ligation at birth time, have two physicians talk to her, at different times, to make sure she really wants it,” One provider indicated that “Maybe a clinic without doctors; many go to community clinic [which] may be an opportunity; [a] clinic day to learn about tubal ligation’ like PAP day.” Critically important one healthcare provider indicated that a “[tubal ligation] has to be discussed before vulnerability occurs.”

Safe, Private and Convenient Report Method – Some healthcare providers who have witnessed inappropriate apprehensions “took one to health region ethicist and we had it overturned.” Unfortunately, not every healthcare provider has the energy or power to be able to address or counteract abusive or racist situations that Aboriginal women experience. One healthcare provider indicated, there “needs to be a whistle blower policy to ensure family gets good care and the patient will not suffer.”

Calls to Action

The interviewees provided critical advice on how the SHR could improve or revamp its services to implement a system that would prevent future coercion. For such prevention, the SHR must undertake significant change to how it provides services to Aboriginal peoples within the Saskatoon Health Region to address inequities within the health care system itself. Although the Voices Heard influenced the drafting of the following Calls to Action, the overarching themes the Calls originated from is noted within. Already existing within the SHR is the First Nations and Métis Health structure that may be utilized for development, implementation and leadership in many of the following areas:

1. **Requirements** in Canadian Law - Implementation of a framework that is cognizant and reflective of the constitutionally protected and international rights of First Nation, Métis and Inuit, including the legal requirements for consultation and accommodation. (TRC Call to Action #18) and *United Nations Declaration of the Rights of Indigenous People (UNDRIP)*. Require an underpinning of reproduction and traditional health practices as a constitutionally protected right as base starting point; Implement traditional medicine and knowledge approaches to reproduction utilizing the appropriate local Indigenous laws and legal traditions. Any framework must include Inuit and also be culturally appropriate. They too hold constitutionally protected rights.

The themes for Aboriginal women's experience from which this Call is derived include: Aboriginal Women (b) "Experiencing Coercion" and (d) "Calls." The theme for health provider's experience from which this Call is derived is: Health Providers (a) "Policy Challenges."

2. **Cultural Training** - Mandatory culturally appropriate training and human rights and *UNDRIP* workshops implemented immediately (Métis, Cree, Dakota, Sauteaux, Dene).⁵⁴ Address the current false stereotypes that Aboriginal women are not thought capable of "proper" mothering (Guardian and ward theories) and decisions must be made for them.

The themes for Aboriginal women's experience from which this Call is derived include: Aboriginal Women (a) "Feeling Invisible Abuse of Power," "Impact of Agencies and powerlessness" and "Profiling, Racism, Discrimination" and (d) "Calls." The themes for health provider's experience from which this Call is derived include: Health Providers (b) "Attitudes towards Aboriginal Women," "Spectrum and Continuum of Ignorance, Bias, Racism and Discrimination; and Implicit Bias."

3. **Education** – cultural competency education in nursing, medical school and all health professions. It is imperative that the people who chose health care professions have the opportunity to learn and understand the Aboriginal people they serve.

The themes for Aboriginal women's experience from which this Call is derived include: Aboriginal Women (a) "Feeling Invisible - Abuse of Power;" "Impact of Agencies and powerlessness," "Profiling, Racism, Discrimination" and (d) "Calls." The themes for health provider's experience from which this Call is derived include: Health

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Providers (b) “Attitudes towards Aboriginal Women;” “Spectrum and Continuum of Ignorance, Bias, Racism and Discrimination, Implicit Bias”).

4. **Restructuring** - The *Saskatoon Aboriginal Peoples Report* stated that in 2011 there were 16,000 First Nations and 10, 695 Métis individuals (6.2% and 4.2%, respectively) and 290 Inuit living in the City of Saskatoon.⁵⁵ In Saskatoon 1 in 10 people are Aboriginal. Given the commitment to reconciliation, it is imperative that Aboriginal people in Saskatoon become full partners in designing health services that will meet their needs. The new provincial restructuring must include adequate funding and support for this restructuring within the Saskatchewan Ministry of Health and the Saskatoon Health Region, not simply an “indigenization” or an add on but a re-creation that includes First Nations, Métis and Inuit as equal partners in its drafting, planning, implementing and monitoring. For instance, work has already begun by the Saskatchewan Health Authority Transition Team on an Indigenous Health Engagement Strategy. The restructuring must include *extraordinary measures* with culturally-grounded primary health care that Aboriginal women and their families create for themselves, and that will promote comfort and belonging while accessing health care that serves their needs. Examples of an Aboriginal governed and operated comprehensive traditional- contemporary-mixed primary healthcare centres can be found across the country. One example, from a city with very similar Aboriginal population demographics to Saskatoon, is the Aboriginal Health & Wellness Centre (AHWC) of Winnipeg.⁵⁶ The AHWC’s has a community board that provides governance and oversight for twelve major programs; with one program being the clinical services funded by the province through a health authority. The AHWC’s clinical program is connected with and participates in training with the provincial regional health authority’s other ten Winnipeg community health centres.

The theme for Aboriginal women’s experience from which this Call is derived include: Aboriginal Women (a) “Feeling Invisible, Profiled and Powerless; (b) “Experiencing Coercion” (c) “Impacts on Self-image” and (d) “Calls for Action.” The themes for health provider’s experience from which this Call is derived include: Health Providers (a) “Policy and Team Challenges” (b) “Attitudes towards Aboriginal Women” and (c) “Internal and External impacts on Care”) and (d) “Calls to Action.”

5. **Advisory Council with Authority** - Utilize an Advisory Council comprised of Elders, the Grandmothers, community members or their delegates who may have assisted with this review, these members could work with representatives of the women who have been affected by the SHR tubal ligation policies. Utilize a traditional health care blend to assist Aboriginal women to reclaim rightful place in society. Partner with clinical and community cultural content experts such as the Canadian Indigenous Nurses Association and the Indigenous Physician Association of Canada; and utilize the First Nation and Métis Committee and the Saskatchewan Health Authority Transition Team on an Indigenous Health Engagement Strategy. Ensure clinical and community cultural content expert partners, either directly or via negotiations with other governments and bodies, are appropriately resourced appropriately to carry out such expert content advisory role.

The theme for Aboriginal women’s experience from which this Call is based is: Aboriginal Women (d) “Calls” The themes for health provider’s experience from which

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this Call is based include Health Providers (a) “Policy and Team Challenges,” “Attitudes towards Aboriginal Women” and “Internal and External Impacts on Care”).

6. **Ensure full implementation and monitoring** of the “Saskatoon Health Region. Awaken the Power of Change: Representative Workforce Strategic Action Plan, 2010-2014, and 2014-2018.”⁵⁷

The theme for Aboriginal women’s experience from which this Call is based is: Aboriginal Women (d) “Calls” The themes for health provider’s experience from which this Call is based include: Health Providers (a) “Policy and Team Challenges;” “Attitudes towards Aboriginal Women” and “Internal and External impacts on Care”).

7. **Coordination of other supports** in and around Saskatoon. See *Kitaskinaw Report 2013-14*.⁵⁸

The theme for Aboriginal women’s experience from which this Call is based is: Aboriginal Women (d) “Calls” The themes for health provider’s experience from which this Call is based include: Health Providers (a) “Policy and Team Challenges” “Attitudes towards Aboriginal Women” “Internal and External impacts on Care”).

8. **Reparation** - Localized Individualized Reparation; Apology; Support Group; Health Care. Ask and implement what the women tell you they need for their healing journey.

The themes for Aboriginal women’s experience from which this Call is based include: Aboriginal Women - (a) “Feeling Invisible (b) “Experiencing Coercion” (c) “Impacts on Self-image” (d) “Calls for Action”. The themes for health provider’s experience from which this Call is based include: Health Providers “Attitudes towards Aboriginal Women” (c) “Internal and External Impacts on Care” (d) “Calls to Action”).

9. **Reproductive Centre**, and Intensive Support Centre for women with complex life situations and pregnancy must be developed for vulnerable Aboriginal women who are pregnant. One example of an intensive support centre mentioned by health practitioners is Sanctum House⁵⁹ in Saskatoon that provides ‘wrap around care’ hospice with respite and supportive care for people living with and affected by HIV/AIDS. Another suggestion was Infinity House⁶⁰ which provides “a transitional home for mothers and their children providing the opportunity for stabilization, programming, education and employment”. A similar Home may be acceptable and effective to support vulnerable pregnant Aboriginal women to have a safe and supportive environment during and for a period after childbirth. One health provider stated that there were at least 30 high-risk pregnant women in their practice. Such a Home needs ‘wrap around’ services similar to Sanctum House, and stable housing until the infant is of an age where sound parent-child attachment has developed. R Chris Fraley, a Professor at the University of Illinois's Department of Psychology states, "Attachment theory emphasizes the critical role of early experience in shaping the expectations and beliefs a child constructs concerning the responsiveness and trustworthiness of significant others."⁶¹ Thus ensuring such support will benefit the mother, child and community.

The themes for Aboriginal women’s experience that this Call is derived from include: Aboriginal Women (a) “Feeling Invisible, Profiled and Powerless and (c) Calls. The themes for health provider’s experience that this Call is derived from include: Health

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Providers “(d) Calls “Review of Alternative to CFS apprehensions” and “Intensive Supports.”

10. **Policy Revision** - Revisit Tubal Ligation and the Consent Policy and consult those who are affected, utilize the First Nation and Métis Committee and the Saskatchewan Health Authority Transition Team on an Indigenous Health Engagement Strategy. Use ongoing monitoring and implement a short two-page document that requires understanding and signing that states that all staff must understand and comply with policies and the SHR document titled “Our Values in Action.”

The theme for Aboriginal women’s experience from which this Call is based is: Aboriginal Women (d) “Calls for Action.” The theme for health provider’s experience from which this Call is based is: Health Providers (d) “Calls to Action”).

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Appendix “A” Chart of Contacts and Poster Placements

| | Aboriginal Women | | Health Care Providers | | Posters Placed | Newspaper/Social Media Circulation |
|----|-----------------------------|---|------------------------------|---|--|--|
| 16 | Called Hotline | 9 | Called hotline | 1 | Federation of Sovereign Nations | Eagle Feather News |
| 6 | Interviewed in person | 6 | Interviewed in person | 8 | Saskatoon Tribal Council, On Reserve and Urban | First Nations Drum |
| 1 | Interviewed via telephone | 3 | Interviewed via telephone | 1 | University of Saskatchewan | Various posts on social media, facebook, twitter |
| 7 | Appointments made, not kept | 0 | Appointments made, not kept | 1 | Saskatoon FN and Métis Friendship Centre | Indigenous Health Law Research Centre Newsletter |
| | | | | 1 | CUMFI | Indigenous People’s Health Research Centre, Regina |
| | | | | 1 | APTN | |
| | | | | 1 | Saskatoon Star Phoenix | |
| | | | | 1 | CKOM | |
| | | | | 1 | WEST Club Bingo | |
| | | | | 1 | West Side Clinic | |
| | | | | 3 | Mother’s Centre at Station 20 Quint Development Corporation Kid’s First Program | |
| | | | | 2 | Greater Saskatoon Catholic School Board, Oskayak High School White Buffalo Youth Lodge | |
| | | | | 1 | SIMFriendschip Centre | |
| | | | | 1 | Indigenous People’s Health Research Centre in Regina | |
| | | | | 1 | First Nations University of Canada | |
| | | | | 1 | University of Regina | |
| | | | | 1 | Ahtahkakoop Health Centre | |
| | | | | 1 | Cree Nations Treatment Haven (Ahtahkakoop) | |
| | | | | 1 | Planned Parenthood Regina (Sexual Health Centre) | |
| | | | | 1 | All Nations Healing Centre | |
| | | | | 1 | Prince Albert Grand Council | |
| | | | | 1 | Sexual Health Centre in Saskatoon | |
| | | | | 1 | White Bear First Nation | |
| | | | | 1 | Carry the Kettle First Nation | |
| | | | | 1 | Peepeekisis (PPK) First Nation | |

Appendix “B” Letter of Introduction to Community Organizations

January 15, 2017

Greetings

Let us introduce ourselves. Our names are Dr. Yvonne Boyer (a lawyer and researcher) and Dr. Judith Bartlett (a physician and researcher). We are both Métis and were raised in Saskatchewan and northern Manitoba, respectively. We both have many years of research experience with Indigenous Peoples in Canada and internationally. We have been contracted by the Saskatoon Health Region (SHR) to conduct an ‘independent external review’ of the situations in which Aboriginal (First Nations, Métis or Inuit) women have felt pressured into having their tubes tied (a tubal ligation) right after their baby was born in the hospital.

We appreciate that you have taken the time to have a phone conversation with Ms. Wilna Masuskapoe, who is our Research Assistant on the study. Below is a brief introduction to the study below, but the main purpose of this letter is to request a meeting with your organization to get your perspective and knowledge of the issue, and to help us to ensure we are asking the right questions.

We are interviewing women who experienced pressure to have a tubal ligation and health service providers who may have been involved in policies and procedures around post-birth tubal ligation. We will also be reviewing all current and past legislation, policies, procedures and training plans related to tubal ligation procedures occurring during post-labour & delivery services.

This post-birth tubal ligation issue has arisen in the public media and the Saskatoon Health Region has made changes to its policies and procedures to ensure that it does not happen again. It is hopeful that our review will find out why it happened in the first place; what policies, procedures and practices resulted in Aboriginal women feeling pressured in such a manner and what should occur to ensure it does not happen again.

Information you provide will help us to ask the right questions to determine if the policy changes that were made will meet the needs of First Nation, Métis and Inuit women and their communities.

We also hope this independent review may provide the Aboriginal community of Saskatoon with a level of confidence that when they voice a major problem with the health care system that the health system is responsive and appropriate changes are implemented. Our study is also intended to help the Saskatoon Health Region to know if the changes it has made are sufficient to prevent this problem from ever happening again. We will make further recommendations if these are indicated by the study data.

We will be very much appreciative if you are available for a 30-40 minute meeting to review, amend or add to the interview questions we have drafted for the study. After our discussion on the questions, we will also briefly outline our analysis method that is a collective process that ensures that more community and health system experts help us to fully understand the data collected from interviews. If you have a strong interest in this area of examination, we would also be happy if one individual might be involved in the analysis of the data. In terms of time, this analysis would require one day.

In health,

Yvonne Boyer, JD. LL.M. LL.D

Judith G Bartlett MD, MSc, CCFP

Appendix “C” Recruitment Poster for Aboriginal Women

**Are you an Aboriginal Woman who has given birth in a
Saskatoon Hospital and felt pressure to have
your TUBES TIED after delivery?**

SHARE YOUR STORY with us!

- We are Dr. Yvonne Boyer - Metis lawyer and Dr. Judith Bartlett - Metis physician and we have many years of experience working with Aboriginal women.
- We want to understand what happened and how to make sure others don't feel pressure to have their tubes tied.
- Your name and information will be kept confidential (no one will know).
- It will take 50 minutes to be interviewed and will be done in a comfortable hotel in Saskatoon or by phone if you don't live in Saskatoon. (In Saskatoon, your expenses to get there and home will be paid).
- An Elder or counsellor will be available.
- If you have any questions, or want to tell your story, please contact our Review Assistant:

Wilna at 1-306-321-4166

- You do not need to give your name to Wilna. You may give only your first name, last name Initial, and a phone number where you can be reached.



Appendix “D” Recruitment Poster for Health Providers

The ‘External Independent Review’ of Post-Birth Tubal Ligation Experiences in Aboriginal Women in the Saskatoon Health Region

HOW YOU CAN HELP

Reviewers: Dr. Yvonne Boyer- Metis lawyer and Dr. Judith Bartlett- Metis physician. Both live outside of Saskatchewan and have many years of experience working with Aboriginal Peoples and the health sector.

In 2015, several Aboriginal women complained that they felt pressured to have an immediate postnatal tubal ligation in one or more Saskatoon hospitals. The reviewers will make a set of recommendations or ‘calls to action’ to ensure that pressure on Aboriginal women to have a tubal ligation post birth does not occur in future.

We will do 50 minute confidential voluntary interviews with health services practitioners involved in the care for Aboriginal women on the obstetrics wards in Saskatoon hospitals. The interview will be at a downtown Saskatoon location.

We will also examine social services/child welfare’s interaction with Aboriginal women on Obstetrics wards, and review all laws, health strategies, policies, procedures, and staff training documents (old and new) to help us determine if the new policies and training are enough to prevent a future occurrence.

Confidentiality: Your employer will not know you have been interviewed. Information gathered in this review will be published in a Report and presented in public; however, your name and other identifying information will not be used or revealed unless you wish to have your name made public. Preliminary results can be provided to you if you wish.

If you have any questions, or want to share your experiences please contact:

Our Review Assistant, Wilna, who can be reached at 1-306-321-4166

The reviewers will explain the review in detail and help you to decide if you wish to be interviewed.

Appendix “E” Review questions for Women

- 1) Did you have your baby in a hospital in Saskatoon?
 - a) When?
- 2) Before you had your baby, did you have regular checkups with your family doctor or an obstetrician?
- 3) Did you ever talk with your doctor about the idea of having your tubes tied after delivery?
 - a) No
 - b) Yes - Please tell me what you discussed or decided.
- 4) Will you please tell me about your experience (related to the tubal ligation) when you were pregnant (expecting) in a hospital in Saskatoon...
 - a) We are interested in hearing more about the conversations you had with the medical staff (nurses, residents, doctors) before and after your baby was born about having a tubal ligation (your tubes tied)?
 - b) What was that like (these conversations) for you?
- 5) How has this (having a tubal ligation) affected or changed:
 - a) Your life?
 - b) Your relationships?
 - c) Your feelings toward accessing health care (for example, seeing a doctor or going to a clinic or hospital) since the tubal ligation?
 - d) Your feeling safe in a hospital or healthcare facility since the tubal ligation?
- 6) What changes do you think have to be made in the hospital to positively affect the health status of women, their families and their communities?
- 7) Do you have any suggestions on who we can contact to interview or for more information?
- 8) Would you agree to review the transcription of today’s interview for accuracy or to make changes (add or remove information)?
- 9) Where can we send the transcripts of today’s interview, name, and mailing address? Or would you prefer me to call you on the telephone and read you your transcript?

Appendix “F” Review Questions for Health Service Providers

- 1) Please tell us what your experience in SHR is related to tubal ligations in Aboriginal women.
- 2) Is this firsthand experience or is it something you heard from other people?
 - a) If so who and what relationship are they to you? Please give details of when and where this was discussed.
- 3) How did you feel when you heard about the stories of Aboriginal women feeling pressured to have a tubal ligation right after their baby was born?
- 4) Are you aware if policies have been changed as a result of Aboriginal women coming forward with their concerns?
- 5) If so, how did you learn about new policies on tubal ligation in Aboriginal women in the Saskatoon Health Region?
- 6) How do you think the new policies have affected the health of Aboriginal women, their families and their communities?
- 7) What other changes do you think have to be made to improve the health of Aboriginal women, their families and their communities?
- 8) Would you agree to review the transcription of today’s interview for accuracy?
- 9) Do you have any suggestions on who we can contact for further information?
- 10) Where can we send the transcripts of today’s interview, name, and mailing address?

Appendix “G” Policy Documents Reviewed

The table below lists the documents reviewed for the health sector. We also reviewed the Child and Family Services Act for additional context to the issue of coercion to have a tubal ligation.

| SASKATOON HEALTH REGION DOCUMENT REVIEW | | |
|--|--|--------------------------------------|
| Corporate Policy | Relevant Legislation and their associated Regulations | Health Strategy |
| Code of Conduct | Regional Health Services Act | Maternal Services Vision and Values |
| Our Values in Action | Evidence Act | Saskatoon Health Region Strategies |
| Management of Concerns | Mental Health Act | Saskatchewan Health’s Strategic plan |
| Representative Workforce | Public Health Act | SHR’s Respect for People Document |
| Ethics Consultation Service | Health Information & Protection Act | |
| Most Responsible Physician | | |
| Privacy and Confidentiality | | |
| Consent | | |

Appendix “H” Websites for Policy Review

H1 Corporate Policies

Code of Conduct:

<https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-10-001.pdf>

Our Values in Action:

<https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-10-001-Our-Values.pdf>

Management of Concerns:

<https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-20-003.pdf>

Representative Workforce:

<https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-30-012.pdf>

Ethics Consultation Service:

<https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-60-009.pdf>

Most Responsible Physician:

<https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-60-002.pdf>

Privacy and Confidentiality:

<https://www.saskatoonhealthregion.ca/about/RWPolicies/7311-75-003.pdf>

H2 Legislation

Regional Health Services Act:

<http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/R8-2.pdf>

Evidence Act:

<http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/e11-2.pdf>

Mental Health Act:

<http://www.qp.gov.sk.ca/documents/English/Statutes/Statutes/M13-1.pdf>

Public Health Act:

<http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/p37.pdf>

Health Information Protection Act:

<http://www.qp.gov.sk.ca/documents/english/Statutes/Statutes/H0-021.pdf>

Child and Family Services Act:

<http://www.qp.gov.sk.ca/documents/english/statutes/statutes/C7-2.PDF>

Appendix “I” Themes Grouped by Overarching Themes and Themes for Aboriginal Women and for Health Care Providers

ABORIGINAL WOMEN

1.0: Feeling Invisible, Profiled and Powerless

- 1.1 Abuse of Power
- 1.2 Impact of Agencies & Powerlessness
- 1.3 Profiling, Racism, Discrimination
- 1.4 Women is Invisible

2.0: Experiencing Coercion

- 2.1 Coercion

3.0: Impacts on Self-Image, Relationships and Healthcare

- 3.1 Ongoing Personal Impacts
- 3.2 Impact on Relationships
- 3.3 Disengaged from Healthcare

4.0: Calls for Actions

- 4.1 Option and Recommendations to Improve Process & Experience

HEALTH PROVIDERS

1.0: Policy and Team Challenges

- 1.1 Policy Challenges
- 1.2 Lack of Team Approach/Integration (to support family members)
- 1.3 Spectrum and Continuum of Ignorance, Bias, Racism & Discrimination
- 1.4 Implicit Bias

2.0: Attitude Toward Aboriginal Women

- 2.1 Provider Perceptions of Women’s Challenges and Experiences
- 2.2 Spectrum and Continuum of Ignorance, Bias, Racism & Discrimination
- 2.3 Implicit Bias

3.0 Internal and External Impacts on Care

- 3.1 Informed Choice? (Perceptions)
- 3.2 Perceptions of Care
- 3.3 Impact of External Social Services (provincial), Policies & Practice

4.0: Calls to Action

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**Appendix “J” SASKATOON HEALTH REGION - Royal University Hospital
– Inpatient Postpartum Tubal Ligations For Discharges 4/1/2010 to 3/31/2016**



**SASKATOON HEALTH REGION - Royal University Hospital - Inpatient
Postpartum Tubal Ligations
For Discharges 4/1/2010 to 3/31/2016**

Note: Includes all Tubal Ligations done in the Labour and Delivery Operating Room with the Patient Service of 51 - Obstetrics Delivered.

| <u>Fiscal Year</u> | <u>Total Cases</u> | <u>Cases with a C-section</u> |
|---------------------|--------------------|-------------------------------|
| 2010/11 | 264 | 169 |
| 2011/12 | 270 | 185 |
| 2012/13 | 252 | 201 |
| 2013/14 | 234 | 197 |
| 2014/15 | 224 | 200 |
| 2015/16 | 224 | 200 |
| Grand Total: | 1,468 | 1,152 |

Prepared by: Sheree Tesch, CHIM
Health Information Analyst, SHIPS
Quality Improvement
19-Jan-2017

Data Source: Discharge Abstract Database (DAD)
T:\WinRecs Data\Prod\Reporting\Maternal & Child
Health\Obstetrics\L&D stats\Tubal Ligations.rpt

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¹The term Aboriginal is used in this External Review report because it is the term that the women themselves used. It is also used in a legal capacity under section 34 of the *Constitution Act, 1982*. The term Indigenous is used in a global or international sense.

²Saskatoon Health Region, *Annual Report, 2015-2016*, at 19, online: https://www.saskatoonhealthregion.ca/news/media-centre/Documents/Reports-Publications/shr_annual_report_2015_2016.pdf.

³ Portions of the material in the Historical Context section of this report originated from Y.M. Boyer, M. Kampouris, "Trafficking of Aboriginal Women and Girls," Public Safety Canada, Ottawa, Ontario, April 2014 [Trafficking].

⁴ National Collaborating Centre for Aboriginal Health, "The Sacred Space of Motherhood" online: <http://www.nccah-ccnsa.ca/docs/child%20and%20youth/The%20Sacred%20Space%20of%20Womanhood%20-%20Mothering%20Across%20the%20Generations%20%28EN%20-%20web%29.pdf> at 2.

⁵ Brenda Macdougall, *One of the Family: Métis culture in nineteenth-century northwestern Saskatchewan*. (UBC Press: Vancouver, B.C., 2010) at 88-89.

⁶ Emma D. LaRocque, *Violence in Aboriginal Communities* (Ottawa: National Clearinghouse on Family Violence, Health Canada, 1994) at 73.

⁷ *Ibid.*, see also Ahenakew & H.C. Worfart. (1992). *Kôhkominawak Otâcimowiniwâwa; Our Grandmothers' Lives as Told in Their Own Words*. Edited and Translated by Freda Ahenakew & H.C. Worfart, Fifth House Publishers, Saskatoon, Saskatchewan at 18.

⁸ *Ibid.*

⁹ *Ibid* at 19.

¹⁰ J. Bartlett, Involuntary Cultural Change, Stress Phenomenon and Aboriginal Health Status. *Canadian Journal of Public Health*. May-June 2003. Retrieved July 3, 2017: <http://journal.cpha.ca/index.php/cjph/article/view/449/449>

¹¹ Emma D. LaRocque, *supra* note 6 at 73.

¹² Olive Patricia Dickason, "Review of Many Tender Ties: Women in Fur-Trade Society, 1670-1870 By Sylvia Van Kirk" (1984). *Great Plains Quarterly*. Paper 1777, online: <http://digitalcommons.unl.edu/greatplainsquarterly/1777>.

¹³ Y.M. Boyer (2006), "First Nation, Métis and Inuit Women's Health – A Constitutional Analysis" Discussion Paper Series #4, National Aboriginal Health Organization and the Native Law Centre of Canada (March 2006) at 17.

¹⁴ See Global News, August 23, 2016 "What was the '60s Scoop'? Aboriginal children taken from homes a dark chapter in Canada's history" online: <http://globalnews.ca/news/2898190/what-was-the-60s-scoop-aboriginal-children-taken-from-homes-a-dark-chapter-in-canadas-history/>.

¹⁵ The "Native woman as prostitute" was identified as the new social problem and reported through sensational headlines such as "Indian Girl Sold for 1000 Blankets." See National Archives of Canada, RG 10, Reel 10 193c, Volume 3816, File 57,045 for a collection of newspapers detailing exploitation of Aboriginal women.

¹⁶ See, Ann Scales, "Militarism, Male Dominance and Law: Feminist Jurisprudence as an Oxymoron?" (1989) 12 *Harv. Women's L.J.* 25 in Sherene Razack, "Speaking for Ourselves: Feminist Jurisprudence and Minority Women" (1990-1991) 4 *Canadian Journal of Women and the Law* 440 at 441).

¹⁷ The legal background for the common practice of the government "knowing" what is best for Aboriginal people stems from the basic legal premise of the guardian and ward theory. This is the premise on which health policies were crafted. The guardian and ward theory was the common legal basis for dealing with Aboriginal people prior to the 1984 *Guerin* decision, as the Crown-Aboriginal relationship was understood to be that of 'guardian and ward.' This characterization dates back to a trilogy of American case law, particularly the 1831 case of *Cherokee Nation v. State of Georgia* where the United States Supreme Court stated that the Cherokee Nation's relationship to the United States "resembles that of a ward to his guardian." *Cherokee Nation v. Georgia*, 30 U.S. (5 Pet.) 1, 8 L. Ed. 25 (1831).

¹⁸ Canadian Centre for Policy Alternatives, 2010. *Getting the job done right: Alternative federal budget 2010*. Ottawa: Canadian Centre for Policy Alternatives at 37.

¹⁹ Allan, B. & Smylie, J. (2015). "First Peoples, second class treatment: The role of racism in the health and well-being of Indigenous peoples in Canada" Toronto, ON: the Wellesley Institute at 3 [Smylie].

²⁰ Trafficking, *supra* note 3.

²¹ Y. Boyer, "First Nations, Métis and Inuit Women's Health: A Rights Based Approach", *Alberta Law Review, Health Law Special Edition*, Vol. 54:3, March 2017 [Boyer, Women]

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- ²² Strange, Carolyn & Loo, Tina. *Making Good: Law and Moral Regulation in Canada, 1867–1939*. Toronto: University of Toronto Press, 1997. See also Karen Stote *An Act of Genocide, Colonialism and the Sterilization of Aboriginal Women* (Fernwood Publishing Company, Limited, 2015) [Stote Genocide].
- ²³ *Sexual Sterilization Act* (S.A.) (1928) c.37; *Sexual Sterilization Act* (R.S.A) (1955) c.311 [repealed 1972].
- ²⁴ *Sexual Sterilization Act*, R.S.B.C. 1960, c. 353 repealed by S.B.C. 1973, c. 79.
- ²⁵ Stote, Karen. The Coercive Sterilization of Aboriginal Women in Canada. *American Indian Culture and Research Journal* 36:3 (2012). Retrieved from: http://www.fqpn.qc.ca/main/wp-content/uploads/2016/06/AICRJ_STOTE-STERILIZATION.pdf, June 22, 2017.
- ²⁶ Of patients approved for sterilization [in Alberta] 35.3% were male and 64.7% were female. Thus, not only did the Eugenics Board approve the sterilization of more females, but a disproportionately high number of them were sterilized", See Law Reform Commission of Canada, *Sterilization: Implication for Mentally Retarded and Mentally Ill Persons* (Working Paper 24) (Ottawa: Minister of Supply and Services Canada, 1979) at 42.
- ²⁷ Although Indian and Métis constituted only 3.4% of the Alberta population, they constituted 25.7% of total of all people sterilized. Between 1969 and 1972 more Indian and Métis persons were sterilized than British, which is particularly telling because Indian and Métis had the least population and the British had the highest population.(T. Christian, "The Mentally Ill and Human Rights in Alberta: a Study of the Alberta Sexual Sterilization Act" (1974) [unpublished] cited in K.G. McWirther and J. Weijer, "The Alberta Sterilization Act: A Genetic Critique" (19) 19 *University of Toronto Law Journal* 424 in *Clémentine Sallée*, Reflection on *The Legal Status of Sterilization in Contemporary Canada in Institute of Comparative Law, A thesis* Master of Laws, McGill Montreal 2002). See also, Karen Stote, *supra* note 25 and note 21.
- ²⁸ Annette J. Browne and Jo-Anne Fiske, "First Nations Women's Encounters with Mainstream Health Care Services", *West J Nurs Res* 2001; 23; 126. See also: J. D. O'Neil, (1988) Self-determination, medical ideology and health services in Inuit communities in G. Dack & K. Coates (Eds.), *Northern communities: The prospects for empowerment*. Edmonton, Canada: Boreal Institution for Northern Studies, University of Alberta.
- ²⁹ Robert Lechat "Intensive Sterilization for the Inuit" *Eskimo Fall Winter* 1976-1977 at 5.
- ³⁰ Eugenics Archive, online: <http://eugenicsarchive.ca/discover/connections/5233c9085c2ec5000000093>.
- ³¹ Document 2-81887, Letter from Susan Ayala, Aboriginal Law Services, Department of Justice Canada to Merchant Law Office: Bruce G. Neill discussing the joinder issue.
- ³² Judith Bartlett, "Conceptions and Dimension for Métis Women in Manitoba" *International Journal of Circumpolar Health*. Retrieved June 22, 2017 at: <https://www.ncbi.nlm.nih.gov/pubmed/15736632>.
- ³³ For a discussion on gender bias in health care see, NWAC, "Social Determinants of Health and Canada's Aboriginal Women" July 2007, Submission to the WHO on the social determinants of health.
- ³⁴ It is well documented that a power imbalance, systemic discrimination and racism in health care exists. See, Indigenous Health Working Group of the College of Family Physicians of Canada and Indigenous Physicians Association of Canada, "Health and Health Care Implications of Systemic Racism on Indigenous Peoples in Canada," (Mississauga: The College of Family Physicians and Indigenous Physicians Association of Canada, 2016) online: College of Physicians of Canada, online: <http://www.cfpc.ca/uploadedFiles/Resources/_PDFs/SystemicRacism_ENG.pdf>; Smylie, *supra* note 19; Chinta Puxley, "Brain Sinclair Inquest to look at hospital backlogs; man died after 34-hour ER wait" *CTV News* (5 January 2014) online: < <http://www.ctvnews.ca/canada/brian-sinclair-inquest-to-look-at-hospital-backlogs-man-died-after-34-hour-er-wait-1.1618464>>; Janet Smylie, "Indigenous Child Well-Being in Canada" (2014) Vol: *Dodrecht, Netherlands Encyclopedia of Quality of Life and Well-Being Research* 3220; Blair IV, JF Steiner et al, "Clinicians' implicit ethnic/racial bias and perceptions of care among Black and Latino patients" (2013) 11(1) *Ann Fam Med* 43-52; Samantha Loppie, Charlotte Reading & Sarah de Leeuw, "Aboriginal Experiences with Racism and its Impacts" (2014) *Natl CollabCent Aborig Health*, online: National Collaborating Centre for Aboriginal Health <http://www.nccahccnsa.ca/Publications/Lists/Publications/Attachments/131/2014_07_09_FS_2426_RacismPart2_ExperiencesImpacts_EN_Web.pdf>; Truth and Reconciliation Commission of Canada, *Honouring the Truth, Reconciling for the Future: Summary of the Final Report of the Truth and Reconciliation Commission of Canada* (Winnipeg, Truth and Reconciliation Commission of Canada, 2015) online: Truth and Reconciliation Commission of Canada http://www.trc.ca/websites/trcinstitution/File/2015/Honouring_the_Truth_Reconciling_for_the_Future_July_23_2015.pdf>; Charlotte Reading & Fred Wien, "Health Inequities and Social Determinants of Aboriginal Peoples Health" (2009) *Natl Collab Cent Aborig Health*, online: National Collaborating Centre for Aboriginal Health http://www.nccah-ccnsa.ca/docs/social%20determinates/NCCAH-loppie-Wien_report.pdf; Amy Bombay, Kimberly Matheson & Hymie Anisman, "The intergenerational effects of Indian Residential Schools: Implications

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for the concept of historical trauma”(2014) 51:3 *Transcult Psychiatry* 320; Brian D Smedley, Adrienne Y Smith & Alan R Nelson (Committee on Understanding and Eliminating Racial and Ethnic Disparities in Health Care), “Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care” (Washington, DC: National Academies Press, 2003); Janet Smylie et al, ”Our Health Counts: Urban Aboriginal Health Database Research Project. Community Report: First Nations Adults and Children” (Our Health Counts, 2011) online: <http://www.stmichaelshospital.com/pdf/crich/our-health-counts-report.pdf>; Don McCaskill & Kevin Fitzmaurice, “Urban Aboriginal Task Force, Final Report” (Ontario Federation of Indian Friendship Centres, Métis and Aboriginal Association, and Ontario Native Women’s Association, Ontario, 2007) online: <http://ofifc.org/sites/default/files/docs/UATFOntarioFinalReport.pdf>.

³⁵ Saskatoon Health Region, “About the Region: Vision, Mission and Values”, online: (2016) <<https://www.saskatoonhealthregion.ca/about/Pages/Vision-Mission.aspx>>.

³⁶ *Ibid.*

³⁷ Saskatoon Health Region, “First Nations and Métis Health Service- About us”, online: (2015) <https://www.saskatoonhealthregion.ca/locations_services/Services/fnmh/service/Pages/Home.aspx>.

³⁸ CBC News, November 9, 2015, “I didn't want it done': Saskatoon woman was sterilized against her will” online: <http://www.cbc.ca/news/canada/saskatoon/saskatoon-woman-sterilized-against-will-1.3324980>

³⁹ Saskatoon Health Region, “First Nations and Métis Health Service- About us”, online: (2015) https://www.saskatoonhealthregion.ca/locations_services/Services/fnmh/service/Pages/Home.aspx

⁴⁰ Saskatoon Health Region, “Aboriginal Health Strategy 2010-2015” online: https://www.saskatoonhealthregion.ca/locations_services/Services/fnmh/service/Documents/About-Us%20FNMHS/Aboriginal-Health-Strategy-full.pdf.

⁴¹ See *infra* note 52, there were 290 Inuit living in Saskatoon in 2011. The Inuit are included in section 35 of the *Constitution Act, 1982* as possessing important constitutionally protected rights, along with First Nations and Métis. See, Y.M. Boyer, “Aboriginal Health – A Constitutional Rights Analysis” Discussion Paper Series #1, National Aboriginal Health Organization and the Native Law Centre of Canada (June 2003) and Y. Boyer, *Moving Aboriginal Health Forward: Discarding Canada’s Legal Barriers* (Purich Publishing 2014), 261 pp [Moving].

⁴² This section refers to the approach to data collection from individuals. Legislation and policy review is also included in in 1.5.

⁴³ The RA was accessible to potential interviewees by a private ‘Review’ cell phone, and after initial contact through a protected email address or text depending on the wishes of the Aboriginal woman.

⁴⁴ The Aboriginal Health Council was created from the 2010-15 Aboriginal Health Strategy (AHS) for the SHR. The overall goal of the AHS is “For improved health & well-being for Aboriginal people served by the Saskatoon health region” The AHS has a Secretariat and an Executive Director. Aboriginal Health Services and Aboriginal Human Resources are connected to the AHC.

https://www.saskatoonhealthregion.ca/locations_services/Services/fnmh/representative-workforce/Documents/Aboriginal-Health-Strategy-full.pdf.

⁴⁵ Bartlett, Judith; Iwasaki, Yoshitaka; Gottlieb, Benjamin; Hall, Darlene; Mannell, Roger. ‘Framework for Aboriginal-guided decolonizing research involving Métis and First Nations persons with diabetes’. *Social Science & Medicine*, Volume 65, Issue 11, December 2007, Pages 2371-2382. Retrieved June 14, 2017 from <https://doi.org/10.1016/j.socscimed.2007.06.011>.

⁴⁶ CBC News, “In last appearance as Cree leader, Matthew Coon Come appeals for respect of Indigenous rights” June 14, 2017, online: <http://www.cbc.ca/news/canada/montreal/viens-commission-matthew-coon-come-1.4160361>

⁴⁷ See for instance *supra* note 34.

⁴⁸ This could be seen as a breach of Aboriginal rights. See Y. Boyer, Moving *supra* note 41.

⁴⁹ It is also a basic human right. See Boyer, *Ibid.*

⁵⁰ Truth and Reconciliation Commission of Canada, see <http://www.trc.ca/websites/trcinstitution/index.php?p=905> [TRC]

⁵¹ See, Saskatoon Health Region, “Commits to Reconciliation” online: https://www.saskatoonhealthregion.ca/locations_services/Services/fnmh/Documents/SHR%20Commitment%20to%20Reconciliation.pdf.

⁵² TRC, *supra* note 50.

⁵³ Boyer, Women *supra* note 21.

⁵⁴ See for instance, Ontario Indigenous Cultural Safety Program – online <https://www.aohc.org/Ontario-Indigenous-Cultural-Safety-Training>;

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http://www.capwhn.ca/uploads/documents/CAPWHN_Position_Statement_on_Cultural_Safety_Humility.pdf

⁵⁵ Saskatoon Aboriginal Peoples, 2011 National Household Survey. Retrieved July 3, 2017 from:

<http://www.stats.gov.sk.ca/stats/pop/2011Aboriginal%20People.pdf>.

⁵⁶ The AHWC’s has a community board that provides governance and oversight for twelve major programs; with one program being the clinical services funded by the province through a regional health authority. The AHWC’s clinical program is connected with and participates in training with the provincial regional health authority.

⁵⁷ Saskatoon Health Region. Awaken the Power of Change: Representative Workforce Strategic Action Plan, 2010-2014, 2014-2019.

⁵⁸KITASKINAW, “An Environmental Scan of Programs and Services serving Aboriginal People in Saskatoon, 2013-2014,” online:

https://www.saskatoonhealthregion.ca/locations_services/Services/fnmh/service/Documents/Resources-FNMHS/Aboriginal%20Engagement%20-%20Kitaskinaw.pdf

⁵⁹ More detail on Sanctum House can be accessed at <http://sanctumcaregroup.com/>.

⁶⁰ More detail on Infinity House of Saskatoon can be accessed at <http://shipweb.ca/cumfi-infinity-house/>.

⁶¹ R. Chris Fraley. Attachment Stability from Infancy to Adulthood: Meta-Analysis and Dynamic Modeling of Developmental Mechanisms. Department of Psychology, University of Illinois at Chicago. *Personality and Social Psychology Review*; 2002, Vol. 6, No. 2, 123–151. Copyright © 2002 by Lawrence Erlbaum Associates, Inc. retrieved June 30, 2017 from <http://www.psychology.sunysb.edu/attachment/danfords2002/documents/fraley2.pdf>.