Free and informed consent and imposed sterilizations among First Nations and Inuit women in Quebec

Research report

September 2022

UQAT
ÉCOLE D'ÉTUDES AUTOCHTONES
SCHOOL OF INDIGENOUS STUDIES

CANADA RESEARCH CHAIRS
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FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

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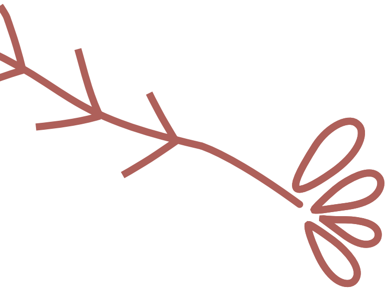
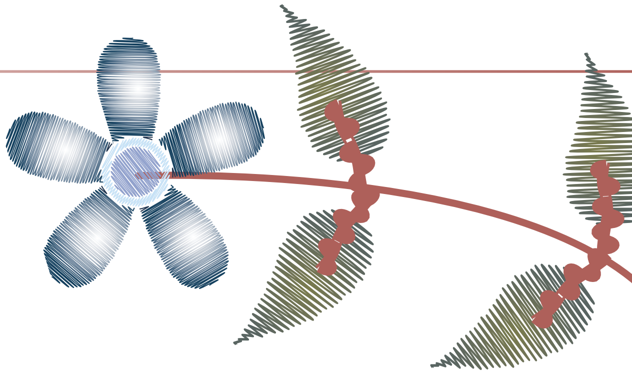
AFNQL	Assembly of First Nations Quebec-Labrador
AI	Amnesty International
BQ	Barreau du Québec
CBHSSJB	Cree Board of Health and Social Services of James Bay
PLRP	Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec: listening, reconciliation and progress
CER-UQAT	Comité d'éthique de la recherche avec des êtres humains de l'Université du Québec en Abitibi-Témiscamingue [Université du Québec en Abitibi-Témiscamingue Ethics Committee for Research Involving Humans]
CMQ	Collège des médecins du Québec
CSDEPJ	Special Commission on the Rights of the Child and Youth Protection
CWEIA	Cree Women of Eeyou Istchee Association
FNQLHSSC	First Nations of Quebec and Labrador Health and Social Services Commission
FQPN	Fédération du Québec pour le planning des naissances
NCCIH	National Collaborating Centre for Indigenous Health
NIMMIWG	National Inquiry into Missing and Murdered Indigenous Women and Girls
NRBHSS	Nunavik Regional Board of Health and Social Services
QNW	Quebec Native Women
RCAAQ	Regroupement des centres d'amitié autochtone du Québec
RNR	Regroupement Naissance-Renaissance
SSCHR	Senate Standing Committee on Human Rights
UNDRIP	United Nations Declaration on the Rights of Indigenous Peoples
UQAT	Université du Québec en Abitibi-Témiscamingue





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To all the participants, without whom this project could not have been undertaken, to those who have shown incredible courage in speaking their truth, to those who have honoured us with their trust—we thank you from the depths of our hearts. This simple message cannot convey our gratitude and the deep appreciation that we feel toward each of you. Your sincerity, your voice and your deep humanity are most essential to the process, and it is very important to acknowledge this. You are the reason behind every step of this process, and we hope that this research report will measure up to the trust you have placed in us.

Note to readers

Many people are uninformed about imposed sterilization and are perplexed by this practice and the degree of violence it entails. However, to this day, Indigenous women continue to see their rights severely violated in the context of gynecology and obstetrics care. The extremely sensitive and upsetting testimonies collected in this research affirm the need to address this issue head on. We had to use a number of complex medical terms in this report. For ease of understanding, a glossary is included at the end (Appendix A). For example, the term "imposed sterilization" was a topic of discussion with the Regional Committee that oversaw the research. One of the participants mentioned that many of the women underwent a sterilization procedure without their knowledge (they did not know that they had been sterilized; sterilization was thus imposed on them). The expression "forced sterilization," which is more commonly used in the literature, is less accurate in conveying the circumstances surrounding these non-consensual actions according to testimonies gathered during this research carried out in Quebec.

Highlights

In Quebec, the practice of imposed sterilization has received little attention and has been poorly documented. Moreover, some First Nations and Inuit women may have been reluctant to talk about their experiences due to the complexity, shame and emotional burden associated with imposed sterilizations and due to the formal and potentially intimidating context of a public inquiry commission. Furthermore, based on the pattern that emerged from the various testimonies received during the public inquiry commissions, it is plausible to think that few or no complaints about imposed sterilizations were reported to medical authorities.

The absence of data is not, however, a reliable indicator that this practice does not occur in the province, and thus legitimize the Quebec government's refusal to participate in the working group on cultural competency in health care established by the federal government.

The purpose of this research is to make up for the lack of data on the imposed sterilization of First Nations and Inuit women and to provide a portrait of this reality in Quebec. Data collection took place between May 2021 and January 2022 and involved 35 testimonies from people from five different Nations or peoples.

Several participants did not realize that they had been sterilized until years after the procedure, when they saw a medical professional for fertility issues.

Of the testimonies collected, nine involved imposed sterilization, 13 involved imposed sterilization and other obstetric violence, six involved obstetric violence without imposed sterilization, three involved forced abortion and four involved such acts being done on a family member or in a work context and being witnessed by the participant.

Several participants reported that they did not sign consent forms. In cases where consent forms were signed, participants explained that the information provided by the medical staff (in a second or third language for some of them) did not allow them to understand how the procedure would affect their ability to have children. Some participants were given incorrect information about the reversibility of the procedure.

For 22 of the total 35 participants (63%), a tubal ligation was the only method of contraception proposed to them, regardless of how old they were or how many children they had had.

The sterilizations were carried out in a hurry, often after childbirth; the participants had never spoken with their doctor about contraception during their prenatal care, and there was no medical reason for carrying out an emergency procedure.

The majority of research participants were between the ages of 17 and 33 when they were sterilized; from a biological standpoint, the optimal time to bear children is between the ages of 20 and 35. The last case of imposed sterilization reported in Quebec was in 2019.

In addition to having their bodies and rights violated, some participants reported side effects or trauma as a result of the procedure, such as untreated biological disorders following a hysterectomy; some began to mistrust health services and refused to return for medical care.

Several testimonies mention the differential treatment, negative attitudes and degrading remarks that medical staff directed at First Nations and Inuit women.

At least 20 other women in Quebec who underwent imposed sterilization, or another form of obstetric violence were not able to participate in this research project for a variety of reasons. The number of cases documented in this report is therefore an underestimate of the reality.

After analyzing the testimonies gathered for this research project and comparing them with the conclusions of recent research on the issues faced by First Nations and Inuit in public services in Quebec, it is clear that all this research converges on the same finding: the presence of systemic racism.

1. Introduction

> *Coerced sterilization is only one of many forms of violence experienced by Indigenous women, but it is such an intimate form of violence—a violation of bodily integrity and theft of humanity—the humanness of bearing children. There is no getting over this. Most especially when the reasons for this violence continue.* (Stote, 2021: 117)

This quote from the researcher Karen Stote reminds us that Indigenous peoples, and specifically Indigenous women, have been the target of numerous attempts at eradication and have experienced many forms of dispossession, including dispossession of land (Stote, 2021, 2022). Attempts by colonial states across the world to sever Indigenous peoples' connection to their land and thus interrupt the transmission of knowledge about pregnancy and childbirth, together with deliberate attempts to reduce the number of Indigenous people through various means, are part of an explicit plan of genocide (Stote, 2015). Although there are several international instruments that stipulate that forced sterilizations (1) are an act of violence against women (*Beijing Declaration and Platform for Action*, 1995), (2) constitute the crime of genocide and crimes against humanity (*Rome Statute of the International Criminal Court*, 2002) and (3) must be eliminated and condemned (*Eliminating forced, coercive and otherwise involuntary sterilization: an interagency testimony*, 2014), it has been shown that population control policies in certain countries have deliberately targeted Indigenous women and have resulted in thousands of them being sterilized without consent (AI, 2019; WHO, 2014).

In Canada, imposed sterilization fits into a continuum of colonial violence that continues to this day. It has been shown that federal government policies from the 1960s to 1970s, such as decriminalization of contraception and the introduction of family planning programs, were in part intended to reduce the birth rate among Indigenous peoples (Stote, 2022). This control over fertility is rooted in persistent and harmful stereotypes, including the "welfare queen" (a woman who is said to repeatedly become pregnant to receive financial support from the state) and the stereotype of the careless, negligent woman who is unable to care for a child (Sullivan, 2001). These stereotypes are frequently applied to Indigenous women and serve to legitimize state control over them, their bodies and their families (Smith, 2003). Furthermore, the work of Jana Grekul has shown that Indigenous women were over-represented compared to other groups in the application of *The Sexual Sterilization Act* (legislation allowing for the sterilization of those deemed unfit to reproduce), which was in effect in Alberta from 1928 to 1972 (Grekul, 2002). It has also been shown that "temporary forms of sterilization," such as subdermal implants, Depo-Provera injections and the insertion of contraceptive spirals,[1] are more often prescribed to Indigenous women, who are considered too "lazy" to use self-administered birth control products such as the pill (Clarke, 2021; Dyck and Lux, 2016). These methods of contraception were prescribed to Indigenous women even before they were approved for use by all Canadian women.

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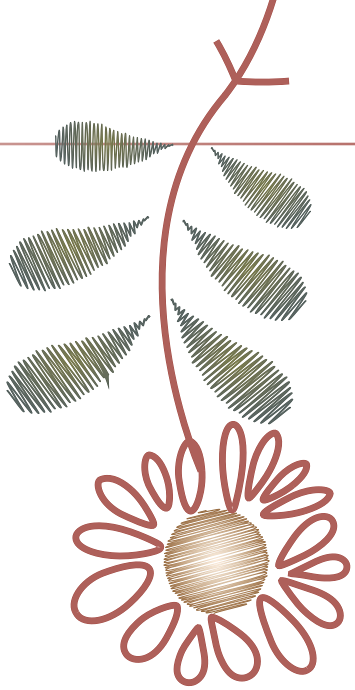
[1] At the time of writing, the Danish Minister of Health has announced an investigation into the "spiral scandal" in Greenland. In the 1960s and 1970s, intrauterine devices known as contraceptive spirals were inserted into many Greenlandic women and girls without their consent or their parents' consent. This birth control campaign is estimated to have reduced the population of Greenland by 50% (Haahr Pedersen, 2022).

In the collective imagination, the representation of the “squaw”—portrayed as an “easy,” promiscuous woman—has often coloured the political and social discourse surrounding Indigenous women (Smith, 2003). First Nations and Inuit women in Quebec are not spared this treatment. The inquest report by coroner Géhane Kamel on the death of Joyce Échaquan—a young Atikamekw woman and mother of seven children from the community of Manawan who died on September 28, 2020—detailed the abusive, sexist and racist remarks directed at her by the medical staff at the Joliette hospital before her death (Kamel, 2021). In this case, as in others, colonization and the upheaval it created have greatly affected the health of Indigenous women, their connection to the land, the intergenerational transmission of knowledge and many other spheres of their life (Basile, 2017; Labra and al. (in press)). Still today, many of them must fight to have the wrongs they suffered recognized and to obtain reparations (Ryan and al., 2021).



2. The context of consent in Canada

In Canada, the imposed sterilization of Indigenous women is an issue that causes controversy, dismay and incomprehension. In 2013, Indigenous women in Saskatchewan spoke out for the first time in the media about how they were treated when they gave birth at the Royal University Hospital in Saskatoon (NCCIH, 2020; Crozier, 2017). They reported being pressured and threatened by medical staff to consent to a tubal ligation[2]. When they were about to give birth, the medical team kept insisting that they agree to undergo this procedure. Tubal ligation consists of tying, cauterizing or cutting the tissue of the fallopian tubes to prevent fertilization. It is a permanent procedure that is practically impossible to reverse, which means that the woman is no longer able to bear children afterward. Surgery can be attempted to restore the tissue of the Fallopian tubes, but it is a "[…] complicated, expensive procedure that does not always work" [Translation] (FQPN, 2022).

These patients report having accepted the tubal ligation under coercion and out of fear. No consideration was given to their physical, mental, emotional and spiritual state; they were not provided with information they required to give free and informed consent; and their repeated refusals were ignored. They were in a vulnerable state; they felt nervous about childbirth and about their health and the health of their baby. The lack of consideration, the insistence and even the harassment on the part of the medical staff caused them to feel deeply fearful (Boyer and Bartlett, 2017).

These first denunciations in Saskatchewan created a groundswell, and many Indigenous women from across the country ended up coming forward to report that they too had undergone an imposed sterilization. The common denominator of their accounts is the undermining or outright absence of free and informed consent. For example, some patients consented to a tubal ligation based on false information, such as the assurance that the procedure was reversible. Others underwent a tubal ligation without their knowledge, most often during a caesarean section. When their attempts to conceive a child were unsuccessful, they sought medical help months or years later, and this is when they learned that they had undergone a tubal ligation (Crozier, 2017).

Before the Standing Senate Committee on Human Rights (SSCHR), which was tasked with studying forced and coerced sterilization in Canada, lawyer Alisa Lombard stated that free and informed consent rests on four pillars: capacity; full disclosure of risks, consequences and other birth control options; the patient being afforded the proper time, in the appropriate environment and atmosphere, to consider the information that has been imparted to them; and no coercion (SSCHR, 2021). In the testimonies of Indigenous women who have undergone imposed sterilization, it can be observed that these four pillars were undermined if not ignored by the medical staff (Crozier, 2017; Fournier, 2021). Let us not forget that, in Canada, women's rights are enshrined in several important pieces of legislation, including the *Canadian Charter of Rights and Freedoms*. The right to bodily integrity, dignity, autonomy, life and security are at the heart of the *Charter*.

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[2] From now on, we will use the term "tubes" to refer to the fallopian tubes.

3. The context of consent in Quebec

Like the *Canadian Charter*, Quebec's *Charter of Human Rights and Freedoms* recognizes the right to bodily integrity (or inviolability), which means that individuals shall not be given medical care without their consent. A cornerstone of patient rights, free and informed consent is a concept that governs the relationship, interactions and decision-making process between doctors and their patients (CMQ and BQ, 2018). As stipulated by the Collège des médecins du Québec (CMQ), the objective of consent is: "[…] that the care provided respects the wishes of the patient and, in accordance with what has been deemed medically necessary, is the most appropriate care for him or her" [Translation] (CMQ, 2021). Specifically, patients are free to express their wishes, and their consent must be obtained without threats, pressure or coercion (CMQ, 2021). For consent to be considered informed, the facts about a medical intervention (e.g., diagnosis, risks, alternatives, etc.) must be conveyed to the patient in a way that is objective and understandable. The self-determination of the individual, as well as the notions of inviolability and the right to bodily integrity, is intrinsically linked to consent (CMQ and BQ, 2018). More specifically, "[…] the patient's decision-making autonomy in medical settings is essentially exercised in his or her right to accept or refuse the care proposed by the doctor—that is to say, the care that the doctor has deemed medically relevant" [Translation] (CMQ and BQ, 2018: 14).

The *Code of ethics of physicians* contains several articles that specifically address the issue of free and informed consent and the need to obtain it prior to any medical intervention (including sections 4, 28, 29, 30). In addition, the *Civil Code of Québec* contains provisions that reaffirm the rights of patients, such as the right to inviolability of the person and the notion of free and informed consent (sections 10 and 11) (RNR, 2019). Despite the mechanisms in place, we must examine the law in action, particularly in a hospital setting (Cadorette, 2006). It is possible to examine in this light the *Code of ethics of physicians* and the *Act respecting health services and social services*, which set out the obligations of health professionals in providing information to patients in Quebec (sections 23 to 29).

Concretely, several factors can disrupt or even restrict a patient's full agency[3]: comprehension, the quality of the information conveyed, the context in which the patient is presented with different choices, etc. In the cases involving imposed sterilization, there is a direct correlation between a patient's agency and her ability to consent to care, assess the information provided by the medical team and communicate this information herself. It is also important to consider the vulnerability and stress of a woman giving birth and the fact that the parturient[4] is "captive" of her condition (Cadorette, 2006).

Despite the legal framework and the many protections surrounding free and informed consent of patients in Canada and Quebec, this notion can be undermined in different care contexts. It is important to examine the divergences between the guidelines prescribed by law and their actual application in a therapeutic relationship.

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[3] Agency refers to a person's ability to act vis-à-vis others and the world.
[4] This term refers to a woman who is in labor.

4. Timeline of events

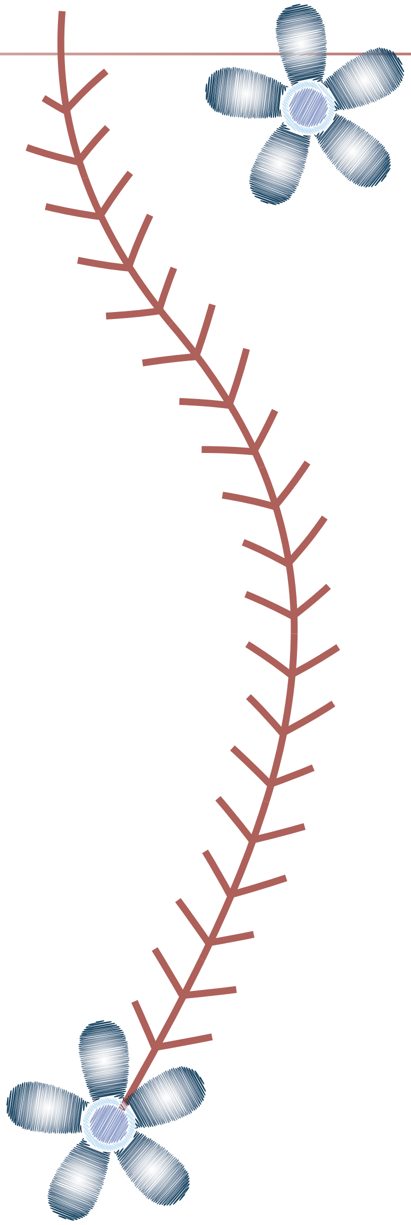
In recent years, much has been written about the issue of imposed sterilization in Canada. The various events presented below allow for a better understanding of the political and social context that gave rise to this research project. It is important to acknowledge the courage and determination of the Indigenous women in Saskatchewan who chose to break the silence and share their experiences with the world. Their voices and their activism paved the way for initiatives such as this research project.

The accounts that came out of Saskatchewan set off a wave of outrage across the country and have helped to open up a discussion on this issue (Barrera, 2019; Kirkup, 2018a; CP, 2019; Shield, 2017). In the wake of this, many Indigenous women reported being involuntarily sterilized in different circumstances, in various Canadian provinces. Their stories have had an impact in the media and in the political realm. First, an investigation was conducted at the Royal University Hospital in Saskatoon to shed light on sterilization practices. This work was led by the Métis senator Yvonne Boyer and physician Dr. Judith Bartlett. Their report, entitled *External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experience of Aboriginal Women*, was published in 2017. A total of seven women recounted their experiences; they reported that health professionals disregarded their capacity to make a choice and exercise their rights, that the procedures were not sufficiently explained and that their repeated refusals were knowingly ignored. As for the signing of a consent form for the procedure, two scenarios occurred: some of the women have no recollection of signing the document and others report having signed it during or just after childbirth because they were too overwhelmed or exhausted to continue to refuse (Boyer and Bartlett, 2017). In their testimonies, these patients talked about the various repercussions they have experienced: the sense of having lost their femininity, emotional and mental repression following the event and the end of a marital relationship, etc. In addition, all the women interviewed report that they now avoid health services at all costs, as the very idea of seeing a health professional is a source of fear and anxiety for them. Their lack of trust in medical staff makes them reluctant to seek help even for acute health problems (Boyer and Bartlett, 2017).

In 2017, lawyer Alisa Lombard filed a class action lawsuit in Saskatchewan and, at the time of writing, about 100 Indigenous women from across the country have joined the lawsuit (Fournier, 2021; Personal communication, 2021). According to the most recent information available, the class action lawsuit is awaiting court authorization, a judicial step that ensures that the conditions prescribed by law are met. In 2018, the United Nations Committee Against Torture conveyed its concern over the cases documented in Saskatchewan and wrote that “the State party [Canada] should […] take legislative and policy measures to prevent and criminalize the forced or coerced involuntary sterilization of women” (Kirkup, 2018a). The committee also raised serious concerns relating to human rights and requested that Canada submit an interim report on the progress it has made on this matter rather than waiting for the next five-year review. Subsequently, in 2019, the SSCHR began conducting hearings on this matter and met with several experts as part of its mandate.

Also in 2019, the federal government created a working group on cultural competency in health care. The issue of forced sterilizations was at the heart of the efforts of this working group (Kirkup, 2018b). According to the most recent information available, no actions or commitments have been formally announced.

On the legal front, Atikamekw women from the community of Manawan in Quebec have decided to file a class action lawsuit (Josselin, 2021). Based on the information available, two women acting "as representatives for all women of Atikamekw origin who, since December 1971, have undergone a surgical procedure at the CISSS de Lanaudière that compromised their fertility without their free and informed consent" [Translation] (Josselin, 2021; Dionne Schulze, 2022). Filed in October 2021, the class action has not yet been authorized by the Court, and other women can still join it (Dionne Schulze, 2022).



5. The need for research in Quebec

In 2019, the Quebec government declined to participate in the federal government's working group on cultural competency in health care. Representatives of the Health Minister said that they were already "aware" of the issue (Shaheen-Hussain, 2021). They also mentioned that there have been no cases of imposed sterilization reported in Quebec and that jurisdiction over health care is exclusively provincial (CP, 2019). It should be noted that provincial and federal governments share jurisdiction over health care for First Nations in Canada, as reiterated in the report of the Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec: listening, reconciliation and progress (PLRP, 2019). This position has been strongly criticized by the Canadian political class (Indigenous and non-Indigenous politicians and senators) as well as by several Indigenous researchers and organizations in Quebec. Even though many First Nations and Inuit women in Quebec have revealed (in interviews with certain media outlets, notably) that they have been victims of imposed sterilization, the Quebec government has remained firm in its position and has stood by its refusal to participate in the working group[5] (Basile and al., 2019; Fournier, 2021; Lombard and Shaheen-Hussain, 2021; Nadeau and Sioui, 2021b).

The subject of imposed sterilizations among First Nations and Inuit women is little known and poorly documented in Quebec. No scientific data was available to assess the extent of the practice and to better understand the circumstances in which the free and informed consent of Indigenous patients was not respected. In the summer of 2019, a literature review on the subject of sterilizations of Indigenous women around the world was conducted by the Research Laboratory in Indigenous Women's Issues – Mikwatisiw of Université du Québec en Abitibi-Témiscamingue (UQAT). The quantity of information available on the situation in the different provinces in Canada varies considerably. While there are numerous scientific articles and dissertations that focus on the western provinces of Canada, there was very little data and testimonies from the eastern provinces, including Quebec.

In line with the objectives of this research project, we wanted to document the situation in the province of Quebec and record cases of imposed sterilizations of First Nations and Inuit women. We believe that the absence of data was not a reliable indicator that this practice did not occur in Quebec. It is only recently that First Nations women have begun speaking out in the media and revealing that they were victims of this practice in Quebec (Fournier, 2021; Nadeau and Sioui, 2021b). In addition, some of the participants told the research team that they were very hesitant to talk about their painful experiences but resolved to do so in order to put an end to this practice.

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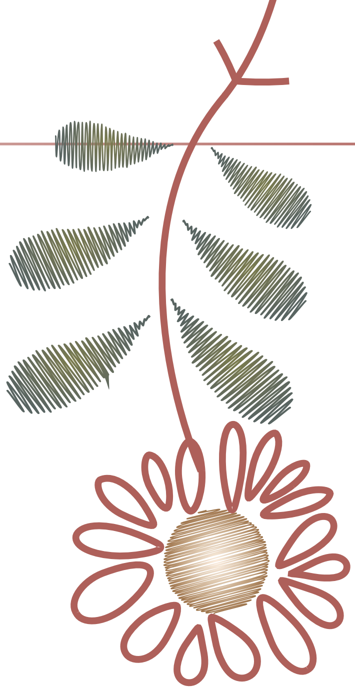
[5] On May 21, 2021, Premier Legault made a public statement regarding the series of articles in Le Devoir concerning the mistreatment of Indigenous people in the health care system: "Quebec Premier François Legault found it 'disconcerting' and 'sad' to see that numerous Indigenous people are mistreated when they seek care in Quebec health care institutions […] 'Now, there is zero tolerance,' he responded at the press conference" [Translation] (Nadeau and Siouï, 2021a). On September 29 of the same year, a motion adopted unanimously by the National Assembly of Quebec calls for an immediate end to imposed sterilization as well as all other forms of obstetrical violence perpetrated on First Nations and Inuit girls and women in Quebec (ANQ, 2021).

We hypothesize that medical authorities (e.g., CISSS/CIUSSS, CMQ, etc.) have not received complaints about imposed sterilizations. This is a trend that we observed in a number of the testimonies collected in the work of the Viens Commission (PLRP). If we look at all the public services as a whole, it is apparent that "[t]he existing systems and procedures also do not tell us exactly how many Indigenous people have filed complaints about services obtained" (PLRP, 2019: 224). Commissioner Viens also points out that there is a lack of knowledge and information as well as mistrust on the part of Indigenous people regarding the various complaint processes. That said, no cases of imposed sterilization were presented during the Commission hearings. We believe that some women did not give testimonies due to the complexity of the subject, the shame and the emotional burden they carry, not to mention the official and potentially intimidating context of a public inquiry commission.



6. Objectives of the research project

The purpose of this research is to make up for the lack of data on the imposed sterilization of First Nations and Inuit women in Quebec. This is a unique opportunity for First Nations and Inuit women in Quebec to share their stories and give testimonies in a context that respects the principles of research involving Indigenous peoples (Asselin and Basile, 2012). To our knowledge, no study has yet been done on this subject in Quebec, so the research project is novel in this sense and meets a real need to perform further research on the issue. Research on the imposed sterilization of First Nations and Inuit women also sheds light on the issues underlying this problem. Accordingly, the notion of free and informed consent is at the heart of this research project, as is the study of the systemic racism and discrimination experienced by Indigenous women in the health care system.

This research project has also allowed us to learn more about the circumstances, the quality of information given to patients and the perspectives First Nations and Inuit women have on the sterilization procedure they underwent. Their personal experiences highlighted various issues related to communication, adequate understanding of medical terms and the cognitive, emotional and physical factors that affected their ability to consent. In addition to documenting experiences of imposed sterilization among First Nations and Inuit women, this research aims to shed light on the medical practices that impact the health care they receive and their decision-making autonomy as patients.

7. Implementation of the research project

Professor Suzy Basile of UQAT and Marjolaine Siouï, Executive Director at First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC), decided to join forces and lay the groundwork for a research project on imposed sterilization after becoming aware of the findings outlined above and participating together in a national forum on choice and informed consent held by NCCIH in January 2020. The two parties signed a cooperation agreement to define the parameters and responsibilities of the organizations and individuals involved in the research project.

One of the first steps in the implementation of the research project was the creation of a Regional Committee for the Quebec region, composed of several Indigenous organizations. The first meeting of the committee was held on November 6, 2020. The committee was comprised of representatives from the following organizations:

- Université du Québec en Abitibi-Témiscamingue (UQAT)
- First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC)
- Assembly of First Nations Quebec-Labrador (AFNQL) Council of Elected Women
- Quebec Native Women (QNW)
- Cree Women of Eeyou Istchee Association (CWEIA)
- Regroupement des centres d'amitié autochtones du Québec (RCAAQ)
- Nunavik Regional Board of Health and Social Services (NRBHSS)
- Cree Board of Health and Social Services of James Bay (CBHSSJB)
- Office of Senator Yvonne Boyer
- Dionne Schulze law firm

Terms of reference were drafted to set out the roles and responsibilities of each person as well as the procedures and ethical rules that would guide the committee's work. The Regional Committee received assistance from an Elder in the Kahnawake community as well as a retired Indigenous nurse who had spent many years doing Indigenous-focused research.

8. Ethical approach

Special attention was given to developing an ethical approach that respects the protocols and guidelines governing research involving Indigenous people. These include the *First Nations of Quebec and Labrador Research Protocol* (AFNQL, 2014), *Guidelines for Research with Aboriginal Women* (QNW, 2012) and *Tri-Council Policy Statement: Ethical Conduct for Research Involving Humans – TCPS 2* (CIHR and al., 2018). All the research instruments developed (call-out, interview guide, consent form, etc.) were written in French, translated into English and validated by members of the Regional Committee. The ethics review request was accompanied by a list of resources available for psychological support in an Indigenous context, a document outlining the steps to be taken to access one's own medical records, a document explaining the legal steps to be taken to obtain such access, if necessary, and a confidentiality agreement form.

The Comité d'éthique de la recherche avec des êtres humains de l'UQAT [UQAT Ethics Committee on Research Involving Human Subjects] (CER-UQAT) approved the research on March 3, 2021. The approach was presented to the Quebec First Nations Communities Health Directors Network. The health departments were asked to keep an eye on the members of their community to see if anyone needed support or help from the caseworkers at their health centre. This approach was, alongside the list of available resources, part of a safety net put in place for the research participants.

9. Communication strategy

The research project was launched with a press release on May 17, 2021. A communication strategy was developed to publicize the research project throughout Quebec. Various bilingual promotional materials were created, including a call-out, an internet page, an email address, a toll-free line (with secure voicemail), a poster and video clips (in French, English and Eeyou). Additionally, a postcard was sent out to each First Nations community and Inuit village in Quebec. Moreover, each member of the Regional Committee was responsible for relaying information and sharing these different tools in their respective communication channels. Quebec Native Women (QNW) devoted time to disseminating information on this research project at each of their Nation Councils (among 10 First Nations and the urban area) held in the fall of 2021. Community radio stations in several First Nations communities broadcast the content of the call-out and some stations invited the research director in studio for an interview. Professor Suzy Basile and Marjolaine Siouï took part in other media interviews. These interviews were used to publicize the research so that potential participants would be encouraged to share their experiences with the research team. They were featured, for example, on the podcast *Ça s'explique*, the Radio-Canada show *Enquête* in a report entitled "On m'a volé ma fertilité," an APTN news bulletin and a report broadcast on CTV (Ambroise, 2021; De Lancer, 2021; Dunham, 2021; Fournier, 2021).

10. Methodology

Data collection was carried out between May 2021 and January 2022. The people who participated in this research project came forward on their own. Many had been encouraged to do so by those around them or had heard a call-out in the media or a presentation on the subject. They were asked to talk about their experiences, specify when and where the incidents had occurred and discuss the circumstances. Next, they were asked about their understanding of the procedure they underwent as well as the quality of the information they received about the risks and consequences and alternative birth control options. They were also asked how they had felt during the whole process and whether they had been given a consent form.

10.1 Context and limits

First of all, the full deployment of the communication strategy took longer than expected. As a result, the official launch of the research project took place on May 15, 2021. The situation surrounding the COVID-19 pandemic brought uncertainties and the need for adjustments. Several communities had to close off access to non-residents and many of the planned trips were postponed or cancelled. Moreover, on June 3, 2021, *An Act to authorize the communication of personal information to the families of Indigenous children who went missing or died after being admitted to an institution* was passed. This legislation came into force on September 1, 2021, and finally allowed families to search for information on their children who disappeared or died in the Quebec health system. It is possible that numerous individuals and families who might have spoken about their experiences for this research project decided instead to focus their energy on the issue of their missing children. Furthermore, the discovery of unmarked graves at former residential school sites across Canada in the summer of 2021 and up until recently has brought back painful and difficult memories for many First Nations and Inuit people. Potential participants who were shaken by the news about the residential schools may have felt disinclined to participate due to the sensitive nature of the subject of our research. Finally, we cannot forget the first anniversary of the death of Joyce Échaquan on September 28, 2021. This tragic event was a reminder that Indigenous people—and Indigenous women in this case—have experienced a great deal of violence in health care facilities in Canada. This event probably influenced some people's decision as to whether or not to participate in this research project. Data collection officially ended on January 31, 2022.

10.2 Data collection

Data collection was conducted in two distinct phases.

10.2.1 Phase I

In Phase I, the participants called the secure, bilingual toll-free phone line set up for the research project. The resource person responsible for taking these calls also had a personal email address at which the participants could reach her in complete confidentiality.

- Initial contact with participants: participants' questions were answered and an interview was scheduled (over telephone or a video conferencing platform)
- Interview: first the consent form was read, then the interview guide, which focused on the circumstances in which the women were sterilized or experienced a form of obstetric or gynecological violence (year, type of procedure undergone, reasons for hospitalization, whether or not consent was obtained, information they received regarding the repercussions and risks of the procedure and alternative contraception methods, etc.)
- One week after the interview: a call was made to see how the participant was doing and to clarify certain information if necessary. This was part of the safety net put in place for this research project.

10.2.2 Phase II

Phase II consisted of a more in-depth interview that was conducted by a doctoral student assigned to this research project. The same steps were followed as in Phase I. It should be noted that participants were at liberty to choose whether or not to participate in Phase II. This phase had a different objective—namely, to give more voice to women who had undergone an imposed sterilization or experienced another form of obstetric violence and to examine the repercussions of this procedure on various facets of their lives.

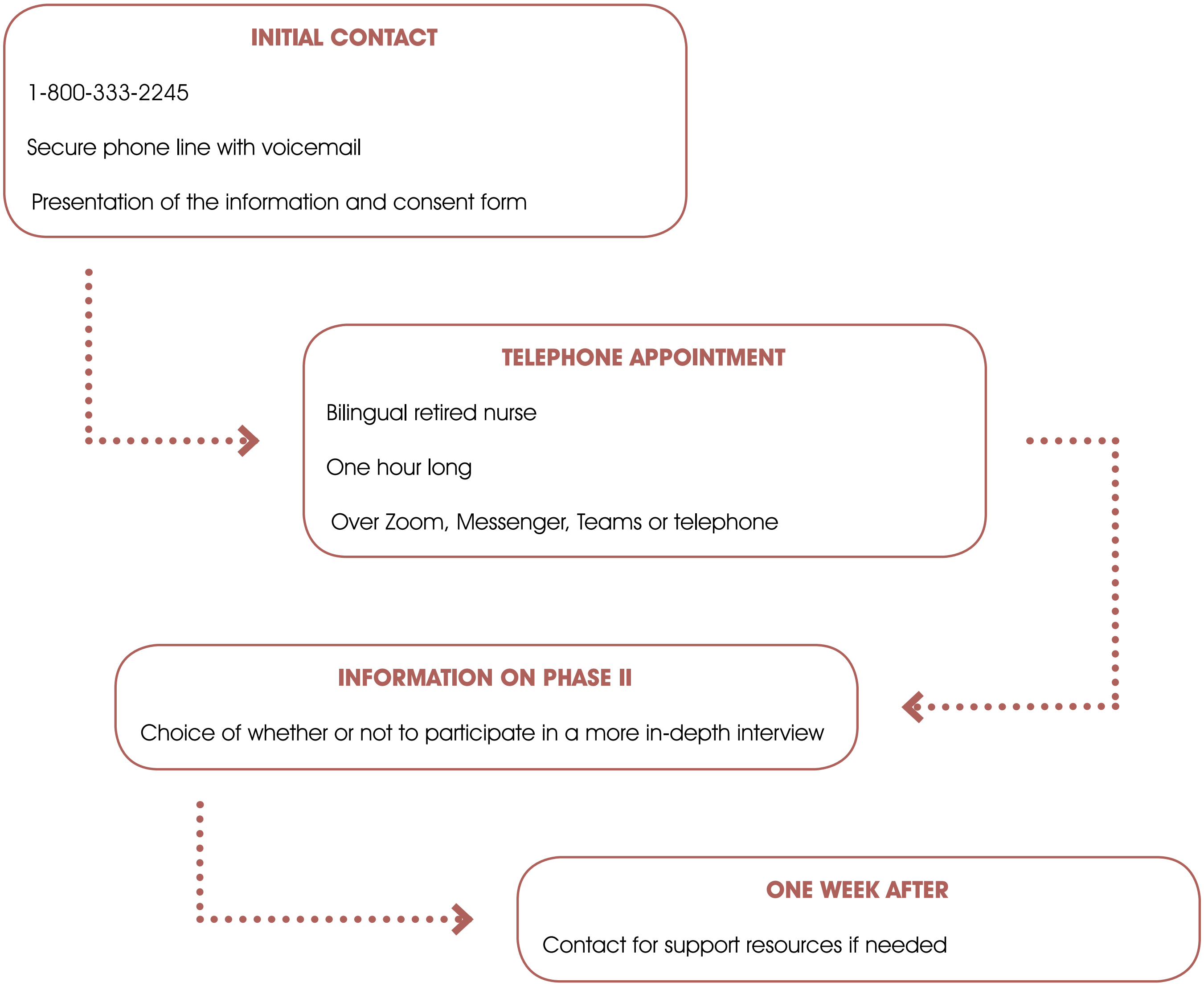
Although a semi-structured interview guide was created, it was not used in a rigid and predictable fashion. Based on the participants' accounts, some clarifying questions were asked, and other lines of discussion were pursued. The subject of obstetric violence of various kinds was explored in great depth through discussions on women's experiences of childbirth and on what they were feeling at this important moment in their lives.

With respect to the technical parameters of data collection for both phases:

- All interviews were recorded (audio or video), and handwritten notes were taken at the same time. The data was stored in a secure database and was only accessible to a very limited number of people on the research team.
- An interview tracking table with coding that anonymized participant data was developed at the beginning of the collection of testimonies.
- A safety net was put in place; as part of this safety net, participants were provided with a comprehensive list of support resources available in each community. This list included contact information for health centres, Indigenous organizations, phone lines, community organizations and other types of resources.
- A secure folder was created on the FNQLHSSC server, and another folder (research data manager) was created on the UQAT server for storing the information collected. Data transfer was done through mutual access to SharePoint, a secure document sharing platform. Each participant was assigned a code to anonymize the data the moment it was collected. The raw data will eventually be destroyed according to the protocol that was developed for this research project.

Figures 1 and 2 illustrate the two research phases:

Figure 1. Steps of Phase I



INITIAL CONTACT

1-800-333-2245

Secure phone line with voicemail

Presentation of the information and consent form

TELEPHONE APPOINTMENT

Bilingual retired nurse

One hour long

Over Zoom, Messenger, Teams or telephone

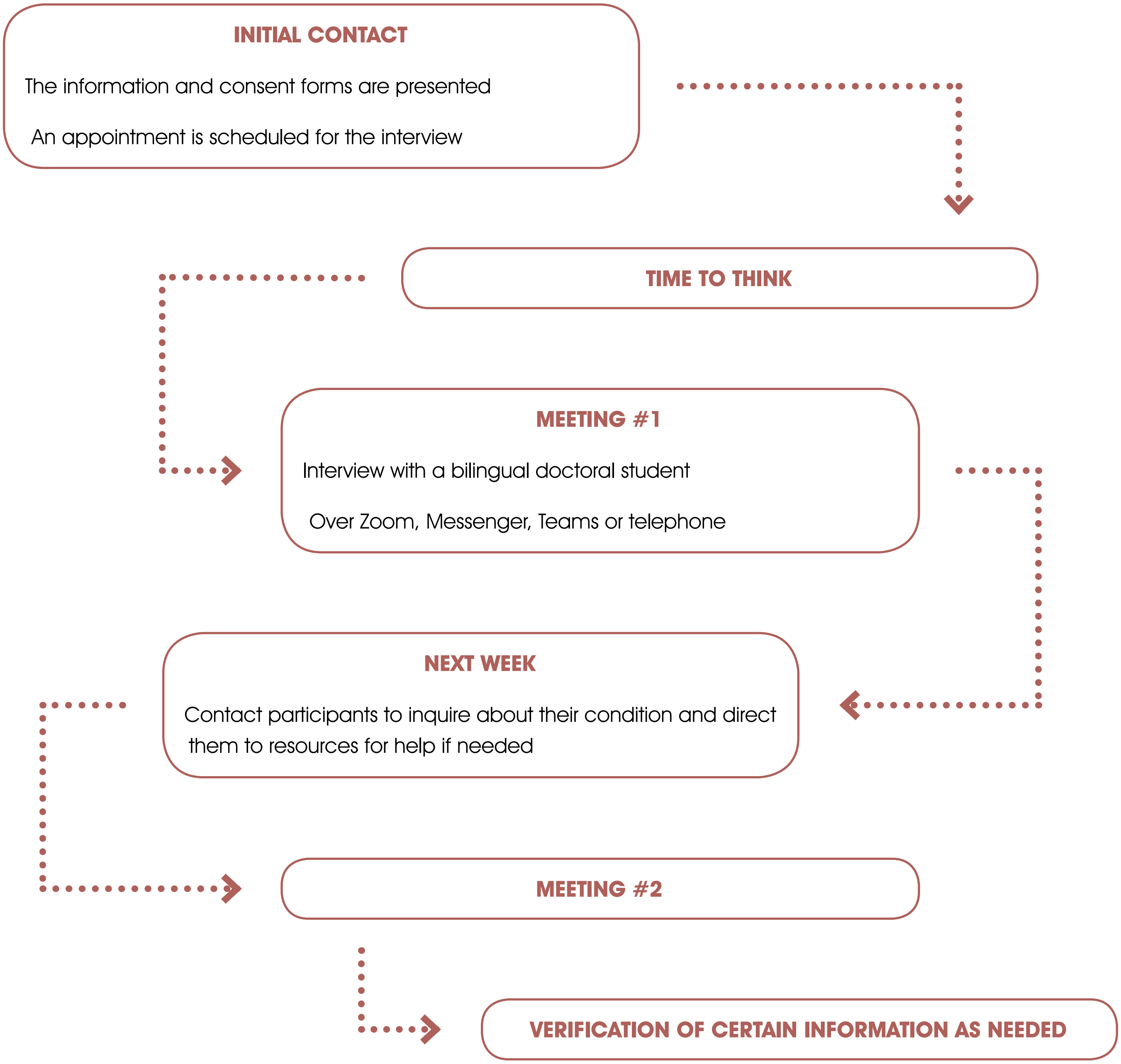
INFORMATION ON PHASE II

Choice of whether or not to participate in a more in-depth interview

ONE WEEK AFTER

Contact for support resources if needed

Figure 2. Steps of Phase II



INITIAL CONTACT

The information and consent forms are presented

An appointment is scheduled for the interview

TIME TO THINK

MEETING #1

Interview with a bilingual doctoral student

Over Zoom, Messenger, Teams or telephone

NEXT WEEK

Contact participants to inquire about their condition and direct them to resources for help if needed

MEETING #2

VERIFICATION OF CERTAIN INFORMATION AS NEEDED

11. Analysis of the findings

The content of the Phase I interviews was transcribed into the interview guide, which included space for this text. The content of the Phase II interviews was fully transcribed verbatim. The information collected during both phases was transcribed in French or English, depending on the language spoken during the interview. The research team validated transcripts when requested by participants.

An analysis strategy was developed in order to organize the transcripts by theme. The themes presented in the interview guides were used as a basis for the coding system, which in turn was revised as the analysis progressed to account for new themes that emerged from the testimonies.

To make it easier to analyze the testimonies, we used the NVivo qualitative data analysis software (QSR International) to process all the data collected during Phases I and II. The resulting coding system went through several rounds of verifications and discussions by the research team to ensure that it was relevant and valid. This made it possible to identify several key themes from the participants' testimonies. In parallel to this, an analysis table was created based on three pivotal moments that emerged from the participants' stories: "before," "during" and "after" the sterilization procedures and/or episodes of obstetric violence. These temporal markers are related to free and informed consent and how it plays out in the relationship between the Indigenous patient and the health care provider. There was a particular focus on the circumstances and on the patient's feelings and perceptions. This analytical method was validated by the FNQLHSSC's research sector.

12. Findings

A total of 35 testimonies were collected. Of the 35 participants, 26 participated only in Phase I and nine participated only in Phase II. A total of 19 people agreed to participate in both phases.

Aside from the 35 participants, six people withdrew (they either changed their mind or did not respond to further communications), and 14 potential testimonies could not be collected as the research team was unable to travel to four communities that had wanted to host them during the fall of 2021 and winter of 2022. Although those involved wanted these interviews to be conducted in person, the research team was unable to travel to collect testimonies due to the situation surrounding the COVID-19 pandemic. If not for this, about 20 additional testimonies could have been added, which allows us to posit that, according to our present knowledge, over 55 First Nations and Inuit people in Quebec have experienced imposed sterilization or obstetric violence.

12.1 Testimonies collected per Nation or people

The participants were mainly First Nations and Inuit people living in Quebec. Two men provided testimonies on behalf of a woman in their immediate family. One non-Indigenous person participated as a witness (WI) to events that occurred in an Indigenous context.[6] The number of testimonies per Nation or people is as follows (Table 1):

Table 1. Testimonies received per Nation or people

Indigenous Nation or people	Number of testimonies received
Atikamekw	14
Innu	10
Anishnabe	5
Eeyou	4
Inuit	2
TOTAL	**35**

The individuals that were met with were between the ages of 15 and 46 at the time of the medical interventions, and their experience of imposed sterilization and/or obstetric violence occurred between 1980 and 2019. The youngest woman to have undergone an imposed sterilization was 17 years old at the time (Table 2). In contrast, the oldest woman to have undergone a hysterectomy[7] (referred to as the "grande operation" in French) without consent was 46 years old at the time. The youngest woman to have experienced obstetric violence was 15 years old at the time. Based on the testimonies, the most recent case of imposed sterilization (age aside) occurred in 2019.

Table 2. Age at the time of the medical intervention

Age at the time of the medical intervention	Time of the medical intervention
Youngest age: 17 years old	Furthest in the past: 1980
Oldest age: 46 years old	Most recent: 2019

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[6] In this study, as in recent work carried out in public inquiry committees (National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG)) and commissions (Truth and Reconciliation Commission of Canada (TRC, PLRP)), we allowed people to provide testimony on behalf of someone in their family or someone who asked them to provide testimony on their behalf. As this is such sensitive subject matter and as some participants required an interpreter to express themselves adequately, we wanted to give participants as much latitude as possible so that they could share their experiences in a respectful environment.

[7] A hysterectomy involves removing the uterus and sometimes the ovaries and fallopian tubes as well. This makes the patient sterile and may cause major hormonal changes. In other words, it has major effects on a woman's health and irrevocably alters her reproductive capacity.

12.2 Coding system for the types of medical intervention

The following coding system was used to analyze the 35 testimonies collected:

- Imposed sterilizations (IS) and a sequential number
- Imposed sterilizations and obstetric violence (IS-OV) and a sequential number
- Imposed abortions (IA) and a sequential number
- Obstetric violence (OV) and a sequential number
- Witnesses to various acts (WI) and a sequential number

12.2.1 Imposed sterilizations (IS)

Nine participants reported having undergone an imposed sterilization (IS)—either a tubal ligation or a hysterectomy.

12.2.2 Imposed sterilizations (IS) and obstetric violence (OV)

An additional 13 participants reported having undergone an imposed sterilization (tubal ligation or hysterectomy) while also experiencing other forms of obstetric violence (OV). Both sterilization procedures (tubal ligation and hysterectomy) figure in the experiences of the Indigenous women who provided testimonies for this study.

Among the 22 participants of these two categories who experienced imposed sterilization, 13 underwent a tubal ligation following childbirth; eight underwent a hysterectomy; for one of the participants, it is not known which procedure she underwent.

12.2.3 Imposed abortions (IA)

The unexpected theme of imposed abortion (IA) emerged from the testimonies collected. In the sample, imposed abortion was mentioned in three testimonies. One woman reported having undergone an imposed abortion following a procedure performed at a health centre, and another recounted the pressure put on her before she accepted to undergo an abortion that she came to regret. A third testimony, provided by the spouse of a deceased Indigenous women, recounted how the latter had been victim of several forms of obstetric violence. Lastly, another participant narrowly escaped an imposed abortion. The letter P for “potential” was added to her code, but she was not counted in the imposed abortions category.

12.2.4 Obstetric violence (OV)

In our sample, a total of six testimonies relate to obstetric violence (OV) without sterilization. These women report having been victims of discriminatory acts, attitudes and remarks from health care staff in clinics or hospitals in Quebec. Their stories highlight the differential treatment many Indigenous patients experience and the fear these patients feel when they need to seek medical care.

12.2.5 Witnesses to various acts (WI)

This category comprises four testimonies of individuals who witnessed discriminatory actions or who, in practising their profession, were informed of discriminatory practices toward First Nations or Inuit women. Two of these participants had previously worked in the health care field and two served as witnesses for immediate family members who had undergone imposed sterilization.

Table 3 presents the number of testimonies received for each type of medical intervention:

Table 3. Types of medical intervention and number of testimonies

Types of medical intervention	Number of testimonies	Additional information
Imposed sterilizations (IS)	9	Tubal ligation or hysterectomy
Imposed sterilizations and obstetric violence (IS-OV)	13	Tubal ligation or hysterectomy and obstetric violence
Imposed abortions (IA)	3	Three separate cases (plus one unrecorded case with the letter P for "potential")
Obstetric violence (OV)	6	Actions, attitudes, remarks, differential treatment
Witnesses (WI)	4	Individuals who witnessed various acts in the context of either their profession or family
Total	**35**	**31** testimonies from women **4** testimonies from witnesses

The cities mentioned in the testimonies correspond to points of service near several of the First Nations communities (Table 4). Several other cities in Quebec were mentioned during the interviews; however, the ones listed here figure most often in the reported cases.

Table 4. Number of cases per city where the incidents occurred

Roberval	4 testimonies concerning imposed sterilization 1 testimony concerning obstetric violence 1 witness of various acts related to lack of consent and imposed sterilization
La Tuque	4 testimonies concerning imposed sterilization
Val-d'Or	1 testimony concerning imposed sterilization 2 testimonies concerning imposed sterilization and obstetric violence 1 testimony concerning obstetric violence
Joliette	4 testimonies concerning imposed sterilization and obstetric violence 3 cases of imposed abortion 1 case of obstetric violence
Sept-Îles	1 testimony concerning imposed sterilization and obstetric violence 3 cases of obstetric violence

13. Timeline of events

To shed light on the circumstances surrounding the imposed sterilizations (IS), obstetric violence (OV) and imposed abortions (IA), the timeline of the events reported by the participants is presented based on the following categorization: (1) "before," (2) "during" and (3) "after" the medical intervention. These categories allow us to better understand the sequence of the events, determine the pivotal moments and examine the trajectory of patients in clinics and hospitals in Quebec.

Before: This section presents the reasons for a patient's visit and explains the condition for which she required medical attention and care (e.g., childbirth, surgery). It also details the information that she received about her health status, the feelings she had at the time and the broader context of her hospitalization, if applicable.

During: This section outlines the circumstances surrounding the imposed sterilization, imposed abortion or obstetric violence. Through the participants' stories, it is possible to examine the infringements on patients' agency and right to free and informed consent.

After: This section presents the repercussions of imposed sterilization, imposed abortion or obstetric violence on a patient's care trajectory. The psychological, physical, spiritual and relational consequences of such events are examined.

The following analysis is based on the words and stories of the women who underwent these medical interventions, as well as their individual perspectives on what they experienced. Accordingly, this section features numerous quotes taken verbatim from the testimonies.

13.1 Before

13.1.1 Reasons and location of the consultation

Most of the participants were at the hospital to give birth. However, some were there for consultations for operations unrelated to fertility or their reproductive organs (e.g., bladder prolapse, bowel surgery, etc.). For example, one participant spoke about the circumstances in which her late sister had undergone a tubal ligation without her consent. She had initially been hospitalized for tonsil surgery.

> *I know my sister went through it; she died of uterine cancer in 2014. We were told she was going down for a tonsillectomy and when she came back, we found out she had a tubal ligation. She never spoke about it. We did talk right after she came back, and I was trying to cheer her up or make her laugh. I said, "Well, you must have had a lousy doctor. Your tonsils are in here and your fallopian tubes are down there."* (11-IS-OV-2).

Some participants reported having consulted a doctor for severe, recurring menstrual pain. One patient said she had been diagnosed with endometriosis. Another participant had gone to a hospital following a miscarriage. Some patients had sought medical care at a medical clinic or health centre.

> *I was having a lot of problems with heavy periods, and they sent me down to Montreal to see a doctor. I had fibroids and while the doctor was examining me, he asked me if I had problems with incontinence. And he said, "When you sneeze, are you leaking urine?" And I said no. And he said: "Your bladder muscles are very weak, and you are going to get problems when you get older, so I recommend fixing it now." Made an appointment, I went down again later* (11-IS-OV-2).

13.1.2 Risks and repercussions of a tubal ligation

It was confirmed in several testimonies that the doctor did not provide the patients with basic information about the risks and repercussions of a tubal ligation. "No, he didn't tell me anything. He just said, 'It would be better if you had a tubal ligation. You wouldn't have any more children. You've had two and that's enough.' That's what he told me" [Translation] (26-OV-1).

Another woman recounted:

> *Then, for my last child, when I gave birth to [name], the doctor told me, "We're going to perform a tubal ligation."*
>
> *– "What's a tubal ligation?"*
>
> *– "We're just going to tie your tubes, and you won't have any more children after."*
>
> *– "No more children after? No, no, no, no, you can't do that to me." So he left, I didn't receive a tubal ligation. Then they kept calling me [over the phone], saying, "We'll make an appointment for you for your tubal ligation"* [Translation] (13-IS-OV-4).

13.1.3 Absence of information or inaccurate information about the permanent nature of a tubal ligation

Participants reported that, in their previous consultations, particularly during their prenatal visits, the subject of tubal ligation was never raised with their doctor. The participants all said the same thing: that the possibility of getting a tubal ligation or hysterectomy was not discussed at any point in the consultations related to their pregnancy or their preparation for childbirth. They did not, as a result, receive any information, documentation or medical advice about these procedures.

Moreover, the testimonies reveal that the patients were generally unaware that the procedure is permanent. Lacking information concerning the risks and repercussions of a tubal ligation and alternatives to this procedure, the participants believed that it was a reversible contraceptive method and that it was possible to "untie" their tubes or "reverse" the tubal ligation when they wish to have a child again. In short, it appears that the women were left in the dark during this process, not having received all the relevant information about the true nature of this procedure. One participant told us what her doctor said on this subject:

> *Before he did the tubal ligation, he swore to me that if I want to have more children, it was possible to reverse the tubal ligation [referring to a doctor who was performing her bowel surgery and wanted her to have a tubal ligation at the same time]. So that's when I said "OK"* [Translation] (13-IS-OV-4).

Another participant (7-IS-7) was frightened by her doctor's prognosis as to the risks of a future pregnancy and agreed to undergo a tubal ligation after she had been assured that her tubes could be "reconnected."

In addition, four participants consented to the tubal ligation on the basis of erroneous and inaccurate information given by their doctors regarding the reversibility of the procedure, among other things. It is troubling, to say the least, that participants who had said that they wanted to have children again were proposed a tubal ligation, a procedure that permanently compromises fertility.[8] The following are some excerpts from testimonies that illustrate the lack of information patients received about the procedures they underwent. From an excerpted discussion with one participant: "Were you informed about the risks and the impacts of a hysterectomy on your hormonal health and physical health?" – "Never, never, never" [Translation] (2-IS-2). From an excerpted discussion with another participant: "Concerning the tubal ligation, did you think that it was just a method of birth control? Is that what you were told?" – "Well yes" (2-IS-2). A third participant confirmed that she had not received any explanation about the procedure and believed it would not be permanent (22-IS-OV-13). She believes that the decision was made for her because she already had five children and had had a miscarriage.

13.1.4 Pressure to accept a tubal ligation

Pressure from the medical staff to accept a tubal ligation was mentioned in several of the testimonies. The following excerpt, taken from a testimony collected with the help of an interpreter, shows how one participant's repeated refusals to undergo a tubal ligation seemed to have no bearing on the way her doctor acted:

> *During her one-month stay in [name of city], she was seeing a doctor to prepare for childbirth; she was asked at each visit if she wanted her tubes tied. This became a weekly question at each visit. She said she was not interested. As the due date got closer, she was seeing the doctor two or three times a week, and she was always asked the same question* (19-IS-OV-10).

When this participant gave birth by caesarean section and was hemorrhaging, the medical staff once again suggested that she undergo a tubal ligation. Additionally, the doctor told her husband that, if she became pregnant again, their children may no longer have a mother. As a result of the pressure and fear triggered by the doctor's remarks, she consented to the procedure.

Another woman recounted that, after living in fear of going to the doctor since her third pregnancy, which the doctor had deemed risky, she had a fourth caesarean section eight months into her pregnancy, and a tubal ligation was once again recommended. She has no recollection of providing written consent for a tubal ligation, a procedure she believed was reversible. She was told that she would not have another child, that it was "over" (18-IS-OV-9).

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[8] Tying, cauterizing or cutting the tissue of the fallopian tubes can result in their permanent obstruction: it is no longer possible for eggs to reach the uterus, so fertilization cannot take place. The medical literature on this subject is unambiguous: a tubal ligation is difficult to reverse, and although certain operations can be attempted to restore fertility, these are risky and very rarely successful (FQPN, 2022). A tubal ligation invariably impairs the function of the fallopian tubes; the tissue is damaged so extensively that it is no longer possible for a woman to become pregnant.

One of the participants was a father who wanted to provide a testimony on behalf of his daughter, who had undergone a tubal ligation without her consent (35-WI-4). He said that it was a shock for him to hear what had happened and that he had since been told about similar situations by several people around him. He is now speaking out against the way medical teams pressure women from his Nation to undergo tubal ligations.

13.1.5 Absence of information on alternatives to a tubal ligation

For 22 of the total 35 participants (63%), a tubal ligation was the only method of contraception proposed to them, regardless of how old they were or how many children they had had. Non-permanent alternatives, such as hormonal contraception (birth control pill, vaginal ring, etc.) and intrauterine devices, were not proposed or explained to them. It is also important to point out that many of the participants made it clear to their doctors that they wanted to have more children. Despite this, the only method of contraception proposed to them was a tubal ligation.

> *I was taking the pill, and he told me, "Take the pill, but not for too long because it isn't good for you." He said, "The best thing would be the tubal ligation." He said, "It won't cost you much." Because pills are expensive* [Translation] (13-IS-OV-4).

In the following excerpt, a participant is asked to confirm that her doctor did not propose any methods of contraception apart from the tubal ligation:

> – *During your second childbirth, no doctor or person in the medical team proposed any methods of contraception apart from a tubal ligation? They just proposed the tubal ligation as though it was the only option?*
>
> – *"Yes, that's exactly what he told me. He didn't ask me if I wanted to go on the pill"* [Translation] (26-OV-1).

In the following excerpt, a participant recounts, with the help of an interpreter, that she received a prescription for a birth control pill even though she had undergone a tubal ligation without her knowledge. "They performed a tubal ligation and then offered you the pill anyway?" – "Yes. As though they were concealing from her that she had undergone a tubal ligation." (21-IS-OV-12).

With regard to other methods of contraception, Depo-Provera was mentioned a few times in the testimonies. This contraceptive is injected in the arm and prevents pregnancy for a period of two to three months. It is problematic that the participants were not provided with any information on the risks (with regard to bone density, in particular) and benefits of this method of contraception. This is mentioned in this participant's comments:

> *There are studies showing that if Depo-Provera is given before the age of 23, […] it can have a detrimental effect on a woman's bone density, and as such it is not considered as a good option for women under 23. However, prescribing Depo-Provera is the norm in Nunavik. Doctors prescribe Depo-Provera to young women under 23, starting as soon as they turn 15 or 14 years old. I had already raised this point with a doctor to find out why this was being done, given what the studies say, and the doctors told me, "Yes, we know about this. We understand, but it is a lesser evil compared with unplanned teen pregnancies […]"* [Translation] (32-WI-1).

13.1.6 Absence of information or inaccurate information on hysterectomy

In a testimony about a hysterectomy, a participant stated that she did not receive sufficient information about the procedure and its potential repercussions on her fertility. While seeing a gynecologist for menstrual pains, the gynecologist described the hysterectomy as follows:

> *He said to me, "I'm going to fix your problem once and for all. You already have three kids, I'm going to operate on you again, I'm going to clean things up in your belly." I didn't understand what he meant, he never said the word "hysterectomy," and I didn't know what it was. It was only later that I understood what was meant by "hysterectomy." He never told me that I would never have children again, that he had removed my uterus and I would never have children again* [Translation] (14-IS-OV-5).

In another case of imposed sterilization, the term "hysterectomy" was not used by the medical staff; instead, they used the term "permanent healing." The patient's understanding was that the purpose of the operation was to relieve severe menstrual pain. There was no mention of the impact on her fertility:

> – *"Did they clearly explain that this surgery would render you unable to have any more children?"*
>
> – *"I do not recall that. [...] they just told me that the bleeding will stop permanently. This will help permanently. You won't have any periods and all that"* (15-IS-OV-6).

13.1.7 Absence of information on alternatives to a hysterectomy

The age of the patients and the circumstances in which they underwent a hysterectomy are of particular concern. On this point, the remarks made to one of the participants, who was diagnosed with precancerous cervical cells and endometriosis, are worrying. According to her doctor, further samples could not be taken because her uterus was too "swollen" and the only treatment option available to her was a hysterectomy. She described this in her testimony: "[…] the only option was to have a hysterectomy to prevent future diseases. […] I never had an ultrasound, a scan or anything else to check if there was something wrong" [Translation] (20-IS-OV-11).

She added that she did not feel that her doctor gave her other options:

> *Because I had so many precancerous cells and she was scaring me. She said…, it was like she was scaring me to get me to accept. Because she was talking about cancerous cells, precancerous cells, it seemed like she wasn't giving me a choice* [Translation] (20-IS-OV-11).

Later in the interview, she added:

> *She didn't help me any more than that. Because you know, at my age, at the age I was when I had the hysterectomy, I considered myself young. I considered myself too young to be given only this one option* (20-IS-OV-11).

In addition, her doctor often mentioned the participant's husband, who had a serious illness at the time:

> *Then it's as though she said, "Mrs. [last name], your husband has a terminal illness, you don't have to have any more children." […] Then it was as though I had to do it because my husband had a terminal illness. […] She even told me how long it would take to heal, that later my husband would need me to care for him* [Translation] (20-IS-OV-11).

After her doctor argued that there were no other treatment options for her situation, she agreed to undergo a hysterectomy:

> *I ended up having a hysterectomy on [date] 2019 […]. Then it was like I said, she didn't give me a choice, and she didn't want to treat me. She didn't want to help me anymore because, as for me, deep down I didn't want it… I didn't want to have this procedure. And that's it, I've never seen her again since then. She didn't give me any appointments afterward. For follow-up. I thought to myself, it was like she was saying, "We're going to do this operation, then it's over and done with." After that, I never saw this doctor again* [Translation] (20-IS-OV-11).

A participant reported that she had learned from a discussion with her doctor that other women in her community had undergone a hysterectomy in troubling circumstances:

> *He said, "We found out that all the women we sent down there for whatever reason ended up with a hysterectomy." And I said, "Now I'm angry because I feel like he used us to perfect his surgical skills." And he said, "We don't send the women there to that doctor anymore." The doctor was in Montreal. I can't remember if it was at the [name of the hospital] that I had this done, but I'm not certain. […] And this was in the 1980s* (11-IS-OV-2).

13.1.8 Language barrier

In addition, for some of the participants, the language barrier is a real and important issue they face during medical consultations.[9] The terminology used by the medical team and the language of the forms they receive are barriers to their understanding. One participant suggested:

> *They should be clear about what they're talking about. They need to make sure that [the women] understand the words they're using. Because personally I had no idea what a "hysterectomy" was. And I didn't know these words. I never received any explanation about what [the doctor] was going to do to me. […] There needs to be an effort to ensure that the women fully understand what the doctor is saying. Then [the women] need to ask questions. Because I didn't ask any. I trusted them. I thought I could trust them* [Translation] (14-IS-OV-5).

After examining all the testimonies, it can be asserted that no participant received interpretation services. Most of them speak an Indigenous language in their daily lives, so they are forced to use their second language during medical consultations. This was confirmed by one of the participants: "You were telling me earlier that it isn't always easy for you to understand French. Did this doctor ever suggest that you be assisted by an interpreter?" – "No, never" [Translator] (14-IS-OV-5).

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[9] For First Nations and Inuit in Quebec, French and English are sometimes a second or third language after their Indigenous language.

Another participant highlighted the challenges Indigenous patients face related to the language barrier and comprehension:

> *[…] There's a language barrier because some women don't understand. There are women who won't understand and won't dare to ask questions. Because there are doctors who can do what they want and who don't provide the patient with an explanation, as they should, or [who don't try to] help them get a second opinion* [Translation] (20-IS-OV-11).

A retired health care professional recalled the way some Innu patients were treated in the 1960s and 1970s and the circumstances in which they received health care (33-WI-2). The language barrier and the absence of interpreters undermined the free and informed consent of these patients. This person also spoke about how tubal ligations were performed without the patients knowing and the doctor in charge had a lot of power to make decisions and could not be challenged. She explained, "You might sign even though you didn't want to. Everyone was very scared. It was like we were… in the military. It was, This, this, this and nothing else" [Translation]. She added:

> *But I know that he did it [referring to the tubal ligation] because he was the only surgeon. The nurses would talk about it. They thought that it was good to bring it up. But because we were all scared, we didn't have anyone to report this to or, I don't know, to defend ourselves to. You couldn't actually accuse the surgeon like that* [Translation] (33-WI-2).

13.1.9 Absence of a consent form

In 16 of the 35 testimonies (46%), we find that the patients were not provided with or did not sign a consent form. In some of the situations presented below, the circumstances in which the tubal ligation was performed raises several ethical questions. One participant who had undergone a bladder surgery learned three days later that an hysterectomy was performed on her. There had been no diagnosis and no prior discussion with her doctor. The participant described how she was informed:

> *I developed an infection, and the surgeon went to see me only about three days after the surgery and he said, "Well, while I was in there, I decided to take your uterus out," and that was the first I heard about it because the nurses wouldn't tell [me] what was going on, only that I had an infection of some sort* (11-IS-OV-2).

Other participants underwent a tubal ligation without their knowledge while they were undergoing a caesarean section. Months or even years went by before they sought fertility treatment and learned to their dismay that they had undergone a tubal ligation when delivering their last child. Here are some of the answers received when the participants were asked about this subject:

> *– Were you given a consent form to sign?*
>
> *– I don't think so. I didn't sign a form. No.*
>
> *– Were you given any documentation beforehand, at the hospital?*
>
> *– No, never. They didn't give me anything [Translation]* (2-IS-2).
>
> *– When you had the procedure three days after you gave birth, were you given a consent form to sign?*
>
> *– No, I never signed one.*

> *– You don't remember anything like that?*
>
> *– No* [Translation] (3-IS-3).
>
> *I didn't sign anything agreeing to a tubal ligation. I was still doing fine. […] They decided to do it without my consent. Without my signature. They did it during my C-section* [Translation] (9-IS-9).

In another testimony, a participant stated that her doctor convinced her that she was too young to have children, that it was too dangerous for her health to have more children and that her children might have health problems (7-IS-7). She did not sign a consent form.

13.1.10 Intersecting issues surrounding sterilization

Another participant recounted the experiences of her five aunts who had sought help for menstrual problems. They all underwent a tubal ligation between the ages of 14 and 18. She underscored several key issues in her aunts' situation: they were dealing with a language barrier, were unfamiliar with medical terminology and had not given their consent. She also believes that her parents and her aunts were not aware of what was happening and did not necessarily question the decisions of the medical team. When she was asked why her aunts had been sterilized, she said she believed that these procedures were performed in order to reduce the number of Indigenous people by preventing them from having children (34-WI-3).

The context surrounding gynecological consultations in Nunavik was described in the testimony of one of the participants (32-WI-1). She explained that once a year, gynecologists come to the villages to perform procedures, including tubal ligations. Patients are referred to them by the general practitioner, and the gynecologists they consult with are responsible for explaining the procedure in detail. However, this participant had doubts and questions about how well-informed Inuit patients are before making decisions. She identified several issues influencing these patients' ability to fully exercise their consent: the language barrier, the value judgements made by some health professionals concerning Inuit women and the young age of the patients. She reported three cases in particular that made an impression on her; these involved Inuit women aged 22, 25 and 28 who had undergone a tubal ligation.

In her testimony, she compared the situation of young women in Nunavik and young women in Southern Quebec as it relates to tubal ligations:

> *Because it's also a double standard, if we look at what is said in the south. What stood out to me when I saw that women under 30 were on this list is that, in the south, if you want to undergo a tubal ligation and you're under the age of 30, you need to have the opinion of two gynecologists […] and you really need to have a special medical reason to be allowed to undergo the procedure. Whereas in Nunavik, the general practitioner may have discussed it with you and decided with you, and that's it, you're on the list. Then the gynecologist goes ahead with the procedure. You just undergo it, and then that's it* [Translation] (32-WI-1).

13.1.11 Presence of a consent form

In six testimonies, participants reported having signed a consent form. However, two participants point out that the procedure that they ended up undergoing was not explicitly mentioned or explained:

> *As consent to have your surgery right away. So I signed it [referring to the consent form]. I guess somewhere it was written, but I do not remember seeing it. So, I do not know. I do not recall seeing hysterectomy on anything when I signed. Maybe it was written, but I don't know. They told me I had hysterectomy and they removed ovaries and everything* (15-IS-OV-6).

> *But there was nothing written on it [referring to the consent form for her procedures]. The hospital staff said, "You have to sign a consent paper for the procedure," but it didn't specify which procedure I was going [to have]. It was just a paper. I signed the paper. It said nothing about me undergoing a hysterectomy* [Translation] (14-IS-OV-5).

One participant mentioned that she signed the form after receiving a very brief explanation of what it said:

> *Yes, but [as for] the actual document, [they told us to just] sign the bottom and that's it. They didn't even have us read these documents. She explained very briefly what the form said without reading it to us properly* [Translation] (20-IS-OV-11).

Another participant recounted that she had asked for a tubal ligation after giving birth and that she had not received all the relevant and necessary information to give fully informed consent.

> *I was the one who asked for it after giving birth. I wanted a tubal ligation. They said, "We'll do it right away, while we're here." They cut into me at the navel.*
>
> *– Still without talking to me about the consequences, repercussions, recovery, things like that?*
>
> *– No. He [the doctor] told me, "You won't have any more children." He said it like that. I said, "Oh really?" I didn't think that it was anything more than that. I thought that [I was going to] have more children at some point in the future.*
>
> *– So he didn't take the time to explain what he had done?*
>
> *– No.*
>
> *– And he also didn't explain the permanent consequences that that would have?*
>
> *– No* [Translation] (3-IS-3).

13.1.12 Perceptions and feelings about the hospital environment and medical staff

Numerous participants told us about their perceptions and feelings regarding the hospital environment and medical staff. Three themes emerged from their remarks: the hostility of the medical staff, the fear they felt and the differential treatment they received.

With regard to the hostility of the medical staff, we are talking about attitudes, looks and actions that reveal a discomfort with or even exasperation toward First Nations and Inuit women seeking health care. One participant described her doctor's approach and attitude toward her as follows:

> *But when I came to give birth there, he was there, Dr. [last name]. And that was it, he was, ah the look! The look he gave me, the way he looked at me, you know, it was crazy… It was like, ah, I don't know how to describe that look. It was like he could care less* [Translation] (13-IS-OV-4).

Moreover, participants reported that the fear they felt was fueled by the accounts of family members and community members who had had negative experiences in hospitals. So when they walk through the doors of a hospital, they are already filled with apprehension and fear. Sometimes they are recalling their own past experiences. One participant mentioned that she accompanied her daughter to each of her prenatal visits and childbirths because she was fearful that her daughter would undergo an imposed sterilization or experience obstetric violence, like she had.

> *Every time she gave birth, she had a C-section. I had to go. She didn't know why I wanted to be there […] I had to be there. You know, I was worried, I don't know what they're going to do [to her]. Even though things have changed today, it's still worrying* [Translation] (5-IS-5).

The differential treatment experienced by the women was a subject that was raised repeatedly in the interviews. Participants noticed that they were treated with less care and consideration because of their background. For example, they reported being given very quick consultations in which they did not receive answers to their questions. Furthermore, they sensed that their ailments and pain were not taken seriously. Here is an excerpt from a testimony that illustrates this situation:

> *Let's say I was asking questions about an ailment or something like that, you know, she wouldn't answer my questions clearly. Then I would think, "What's the point? I just want her to deliver my baby and that's it." As for the rest, I'm going to stop… Because I sensed that I was really bothering her. Then even when I tried to make appointments with her before the procedure, she told me that I didn't need to call, that when it was time she would call me. It was like I was bothering her when I tried to get more information* [Translation] (20-IS-OV-11).

Several participants stated that they had been anxious to leave the hospital in order to get away from an environment they considered harmful. In addition, they observed that they were not treated the same as other patients in several ways:

- Some participants noticed that First Nations and Inuit patients were given markedly shorter consultation times compared with other patients (10-IS-OV-1, 14-IS-OV-5, 29-OV-4).
- One participant saw the patient next to her being offered an epidural for pain, whereas she had never been offered this by the medical staff (15-IS-OV-6).
- One participant noticed that gifts are given to new mothers, but not to First Nations and Inuit mothers (17-IS-OV-8).
- Some participants heard remarks about new mothers when they were in the hospital, such as "her again," "she should have her tubes tied," "all her children should be taken away from her," etc. (13-IS-OV-4, 15-IS-OV-6, 26-OV-1).

One participant shared her perception of racism and differential treatment toward First Nations and Inuit patients:

> *I would have liked to have been treated the same as non-Indigenous patients because I could already see when I was in the waiting room, I could already see the racism. They were talking about Indigenous people and then when my family doctor retired, I went to see him […] to thank him for all the years he had been my doctor. I said, "Even though you didn't… Even though I was never diagnosed with anything, I still want to thank you for taking the time to see me." Then he said, "I did my best. I took on all the Indigenous women from [name of community] as patients because no other doctor in [name of city] wanted to have these Indigenous women as patients. I'm the one who took them all, I'm the one who looked after them, I delivered babies for many Indigenous women in [name of community]." I said, "Could you tell me why the doctors didn't accept Indigenous women?" He said, "Oh, that I couldn't tell you. What I did for my part is accept all the women"* [Translation] (14-IS-OV-5).

Another participant stated, "If you believe a white woman, you should […] believe a Native woman who has the same problems. A woman should not be judged by the colour of her skin or the language […] she speaks" [Translation] (10-IS-OV-1).

13.2 During

This section details the immediate circumstances surrounding the imposed sterilization, obstetric violence and imposed abortion. The participants' words help us to understand their psychological, physical, emotional and spiritual state at the time of the incident. It will then be possible to examine the participants' care trajectory and determine how it was impacted by the actions, remarks, attitudes and procedures they experienced.

13.2.1 Imposed sterilizations

There are nine testimonies that relate specifically and only to imposed sterilizations (Table 5). At the time of the procedure, all of these women were under 35 years old—that is to say, within the ideal age range for childbearing.

Table 5. Information on the participants who underwent an imposed sterilization

Code	Purpose of hospitalization	Age at the time of the incident	Procedure the patient underwent	Signed consent form
1-SI-1	Abdominoplasty and tubal clips	About 30 years old	Hysterectomy	Yes
2-SI-2	Heavy menstruation, a situation for which she was proposed a hysterectomy to prevent cancer	25 years old	Hysterectomy	No
3-SI-3	Childbirth	28 years old	Tubal ligation	No
4-SI-4	Childbirth	22 years old	Tubal ligation	No
5-SI-5	Childbirth	33 years old	Suspected tubal ligation	Information is not known
6-SI-6	Childbirth	28 years old	Tubal ligation	Yes, but she thought she was consenting to the insertion of an intrauterine device
7-SI-7	Childbirth	17 years old	Tubal ligation	No
8-SI-8	Tubal ligation (tubal clips)	25 years old	Tubal ligation	No
9-SI-9	Childbirth	26 years old	Tubal ligation	No

To supplement the information presented in the above table, here are some passages from testimonies that reflect the context in which these procedures were performed.

In an interview, one participant reported that she had undergone a tubal ligation and a hysterectomy. She was particularly concerned about the hysterectomy because she claims that it was performed without her consent. Moreover, when she was asked about the tubal ligation, it turned out that she did not know that the procedure had affected her fertility. She learned this during this interview:

> – *I didn't know it was final, permanent. I had no idea.*
>
> – *They just proposed it without giving you any further information?*
>
> – *No. Not at all. I didn't know. They didn't tell me anything, they didn't tell me anything. I just found out right now that it's final, permanent* [Translation] (2-IS-2).

A tubal ligation was proposed to one participant when she was about to give birth, even though this procedure had never been discussed during her prenatal care:

> – *I remember signing it [the consent form] when I was on my bed.*
>
> – *On your bed, about to give birth?*
>
> – *Mmm [yes]. I was able to sit up.*
>
> – *But I mean, you were in labour?*
>
> – *Yes* [Translation] (6-IS-6).

In the case of another participant (1-IS-1), she learned that her uterus was "diseased" while she was hospitalized for a bowel problem. Her doctor described her uterus as being "rotten" and recommended that she undergo a hysterectomy. Several years later, when she reviewed her medical records with another doctor, he told her that her uterus had been in good condition and there had been no need to remove it.

Other recurring themes in the testimonies about imposed sterilization are insistence and pressure on the part of the medical staff. Here is an excerpt concerning an exchange between a participant and her doctor: "Then he asked me if I wanted to remove my uterus. I said, 'No.' I wanted to have more babies. Then for maybe 45 minutes or an hour, he wouldn't drop the subject. Then I said, 'No' [Translation] (6-IS-6).

Another participant went to see a gynecologist two years after a miscarriage. At this point, her periods were extremely painful, and she wondered if this might be because she did not undergo a dilation and curettage (D&C) after her miscarriage. After her doctor performed some tests, she learned that her fertility was compromised:

> *"You have a 10% chance of getting pregnant. Five per cent will be tubular and 5% will kill you." He said, "Don't get pregnant." My tubes were so full of cancer, I did not know it was full of cancer until about a year ago. […] they just said, "your uterus is full because something was left inside you, so it just formed cancer"* (10-IS-OV-1).

13.2.2 Imposed sterilizations and obstetric violence

A total of 13 participants (37%) experienced obstetric violence in addition to an imposed sterilization. Two patterns emerge from the testimonies. For some of the women, the obstetric violence was part of a continuum of violence that they experienced over several childbirths, culminating in an imposed sterilization. For others, they were victims of obstetric violence and sterilization during their first pregnancy or childbirth.

The testimonies collected mention different forms of obstetric violence (Table 6) committed by medical staff. These can be grouped into five categories:

- Pain not being taken seriously
- Violence through non-action: not providing assistance, not investigating a health problem, not believing the person when she reports symptoms, not answering her questions
- Physical violence: performing harsh actions, closing the patient's legs when she is about to give birth, manually removing the placenta without warning or explanation, inappropriate touching during a vaginal examination
- Psychological violence: giving an exasperated look, having an attitude of disdain or indifference, negative facial expressions (anger, condescension, annoyance), putting pressure on a patient to consent, scaring her with alarming prognoses ("your child is going to be deformed, severely disabled")
- Verbal violence: making judgemental and contemptuous remarks; making inappropriate remarks regarding patients' bodies, their parenting skills, the number of children they have, their lifestyle, their Indigenous background, etc.

Here is some key information concerning the testimonies about imposed sterilizations and obstetric violence:

Table 6. Information on the participants who underwent an imposed sterilization and obstetric violence

Code	Purpose of hospitalization	Procedure the patient underwent	Age at the time of the procedure	Signed consent form	Types of obstetric violence the patient experienced
10-SI-VO-1	Severe menstrual pain due to a miscarriage	Hysterectomy	26 years old	No	Pain not taken seriously Violence through non-action Verbal and psychological violence
11-SI-VO-2	Bladder surgery	Hysterectomy	In her thirties	No	Physical violence
12-SI-VO-AI-3	Abortion	Suspected tubal ligation following an imposed abortion	31 years old	No	Verbal violence
13-SI-VO-4	Bowel surgery	Tubal ligation	In her thirties	No	Physical, sexual, psychological and verbal violence
14-SI-VO-5	Menstrual pain	Hysterectomy	33 years old	Yes	Verbal violence
15-SI-VO-6	Painful and heavy periods	Hystérectomie	17 years old	No	Pain not taken seriously Verbal and psychological violence

Code	Purpose of hospitalization	Procedure the patient underwent	Age at the time of the procedure	Signed consent form	Types of obstetric violence the patient experienced
16-SI-VO-7	Emergency procedure following an ectopic pregnancy	Damage to the fallopian tubes	33 years old	No	Violence through non-action Verbal and psychological violence
17-SI-VO-8	Childbirth and hemorrhaging following removal of the placenta	Hysterectomy	23 years old	No	Psychological violence
18-SI-VO-9	Childbirth	Tubal ligation	28 years old	Does not remember	Psychological violence
19-SI-VO-10	Childbirth	Tubal ligation	28 years old	Yes	Psychological violence
20-SI-VO-11	Pain related to endometriosis	Hysterectomy	46 years old	Yes	Pain not taken seriously Psychological violence
21-SI-VO-12	Childbirth and hemorrhaging	Tubal ligation	27 years old	Yes	Physical violence
22-SI-VO-13	Bowel surgery and a "rotten" uterus	Tubal ligation	32 years old	Yes	Verbal violence

Here are some excerpts from testimonies that illustrate the different forms of obstetric violence experienced by the participants:

> *You aren't treated like a person, a human being. You're treated like a savage, you know, a "dirty Indian" who is going to make a mess. Ah! Those are the sorts of remarks I heard [when giving birth]. It wasn't easy* [Translation] (13-IS-OV-4).

One of the participants added that one of the times she gave birth, the doctor said the following to her:

> *He told me, "We're going to perform a tubal ligation." I said, "No, I don't want that! I don't want to have a tubal ligation. I want to have more children later!" – "Don't you think that you've already had enough? It's enough, you need to stop there. All the children that you bring into the world will live in poverty." My God…* [Translation] (13-IS-OV-4).

These violent remarks, which imply that she will be a neglectful mother, that her children will experience difficulties later in life, that she is too young and that she has too many children, cover a broad spectrum of prejudice. The participant plainly states in her testimony that she has experienced racism on multiple occasions and that these negative experiences have impacted her self-esteem as a mother.

> *I got off to a bad start with my first one [referring to all the incidents of verbal violence that she experienced before, during and after giving birth]. [They put it] in my head that I wouldn't be a good mother and that I would abandon my child. That's what I went away with! Yes, I was young, I was 17 when I had my first, but that's no reason to talk to me like that* [Translation] (13-IS-OV-4).

Here are some examples of remarks that were said to her or that she overhead at the hospital. These things were said about her by different members of the medical teams.

She received remarks about her body: "You stink, you aren't clean." She was discriminated against because of her age: "You shouldn't be having children at your age. It isn't the time to have children. You're too young." And: "What are you going to do with this child? With this baby? You're going to give it to your mother then run off?" [Translation] (13-IS-OV-4). Derogatory remarks were made toward her concerning how many children she had had: "Aren't you tired of it? Aren't you tired of having babies? Next time, cross your legs!" [Translation] (13-IS-OV-4). On another occasion, she heard similar remarks, but directed at other Indigenous women:

> *I heard nurses, and I heard young Indigenous women, Indigenous girls coming to give birth there [when one of her granddaughters was in the hospital]: "Well! Her again! When is she going to understand?" I was there, and heard that then I looked… My God, what year is it and I'm still hearing things like that! "She needs to get her tubes tied, she needs to. They need to take away all the children she's had." And that's what ended up happening. My God, what is that all about? And I saw non-Indigenous women too. Remarks like that were never made about them!"* [Translation] (13- IS-OV-4).

She also heard many discriminatory remarks concerning the future of her newborn daughter:

> *"She's going to get beaten, she's going to get raped, […] poor girl, she's going to have a very hard, very difficult life, she's going to get abused." Ah! I said, "Really?" Then I went into my bed, and I cried* [Translation] (13-IS-OV-4).

Here is how the doctor of another participant reacted when she mentioned to him several times that she wanted to have more children:

> – *When he told you, "You already have three children," did he ask you if you wanted to have more?*
>
> – *He said, "How many children do you want to have?" I said, "Five, six." He said, "Well you already have three"* [Translation] (14-IS-OV-5).

Another participant recalls the circumstances of her childbirth as follows: "Well, for example, I would like to be treated as a human being. Ah, I was not really treated well when I had my daughter" (15-IS-OV-6).

Obstetric violence can refer to medical interventions that were performed improperly. For example, the doctor of one participant removed her placenta without performing a massage, causing uterine inversion and a major hemorrhage. The medical team told the woman's husband that she had 24 hours to live and that a hysterectomy had to be performed. She was 23 years old at the time of the incident (17-IS-OV-8).

Participants also reported inappropriate sexual touching during examinations or prenatal care. For example, one participant mentioned that her doctor touched her inappropriately during a gynecological examination:

> *I went in for a vaginal examination, the doctor was hurting me, and I complained. He did not have a nurse in the room, and he started rubbing me inappropriately and he said, "Now, does that feel better?" So, it was very uncomfortable, and I never went back to see that doctor. [...] I had never had a vaginal exam before. So, I didn't know he was supposed to have a nurse in the room… It was just an embarrassing thing I went through. Uncomfortable* (11-IS-OV-2).

Another participant mentioned that she completely avoided health services during her pregnancy because she was afraid:

> *I was kind of always scared. Going to the clinic. First time when I had my baby, there was no record. How do you say? My pregnancy was not recorded in any clinic. Because of being afraid, because I had a friend who was older than me who had a baby. But her baby passed away a few months after. I do not know what happened. So, she was the one who spoke to me about the clinic, which is why I was scared to go there. I was scared, so I never went there when I was pregnant* (15-IS-OV-6).

Another participant suffered a miscarriage, hemorrhage and a rupture in the fallopian tubes during an ectopic pregnancy as a result of her symptoms being inadequately treated and not regarded as serious (16-SI-VO-7). Subsequently, despite undergoing a procedure to repair the damage done to her fallopian tubes, she was unable to become pregnant again. In her eyes, the nurse's negligence had irreparable consequences on her fertility. Moreover, she reports that she has not seen a gynecologist since 1997 (16-IS-OV-7).

13.2.3 Obstetric violence (without sterilization)

With regard to obstetric violence without sterilization, six testimonies mention actions, remarks, attitudes and practices that had a negative impact on participants' care trajectory.

The following testimony describes events that occurred in 1980. One of the participants reports that she was hospitalized with several other women from her community in a facility far from where they lived. They were all pregnant, and each of them was induced into labour, one after the other. This episode deeply "disturbed" her, and, to this day, she questions the motives behind this type of "assembly-line" medical care.

> *What they did was really risky. It was dangerous. Inducing women to go into labour. I find that really unpleasant. They brought me a needle. I wondered what they were planning to do to me. There was a woman on the verge of giving birth, I don't remember who. It didn't take long before she did […]. There were several of us who took a flight to give birth. I still can't get over what we went through. I've never talked to anyone about what happened to me. What the other women went through. Nobody talks about it. The women started giving birth. I don't know what they did. I don't know what drug they gave us. I'm guessing it was a drug* [Translation] (29-OV-4).

Another participant had gone to the hospital to fill out documents related to her planned caesarian section. When she examined the information, her doctor had compiled (which was not in her first language), she noticed something surprising:

> *[…] But then I turn the page and I see "Wants a tubal ligation." Then I turn around. I go to see my doctor. I say to her, "What is this all about? I don't want to have my tubes tied. I want to have another baby eventually." She answered, "Ah, no, no, no. It was the other patient who came in earlier." However, I was the only patient there all afternoon. I was at the hospital for almost two hours. I said to her, "I don't want to have my tubes tied." She answered, "OK, that's fine. I'm going to erase everything." I was really surprised. If I hadn't turned the page, and [if I hadn't gone back to see] the surgeon, I wouldn't have known [that they were going to] tie my tubes during my C-section* [Translation] (30-OV-5).

In the case of another participant, obstetric violence took the form of non-consensual touching and thinly veiled references to tubal ligation. In the excerpt below, she describes the circumstances of her prenatal care:

> *You know, [I was] 15 years old, and I show up to my appointments by myself. And he often touched my breasts. At almost every appointment. Then at some point, as things went along, you know, he said, "You're quite young, then, "Have you ever thought about…" He didn't say the word "tubal ligation," but it was like, to not have kids after. He said, "You're young. You need to think of your future." And I said, "What do you mean?" He said, "Because you would have no more children after." But he never said the word "tubal ligation" at the time. But he made it clear that he wanted me to get my tubes tied after* [Translation] (31-OV-6).

Discriminatory remarks about the women's Indigenous identity were reported multiple times in the testimonies. One participant reported that a doctor had insinuated that she was lucky to be able to undergo a tubal ligation.

> *It was my second child, I was young, I was about 20 years old. And sure, I didn't have a stable life exactly, but you know, I kept my children. Then, when I gave birth, the doctor told me, "You know, you should stop having children because they'll end up in foster care. That's what happens with Indians. You need to put an end to it now." Then he said, "Ah, there's an opening in the afternoon. You're lucky!" Lucky eh, lucky to have my tubes tied!* [Translation] (26-OV-1).

Later in her testimony, she talked about the fear she felt while in the hospital after she had given birth. "I was scared, I wanted to leave. I never talked about it because I thought that no one [would] believe me. Who would believe me?" [Translation] (26-OV-1).

Another participant recalled a difficult second pregnancy and spoke about how she was pressured to give up her child for adoption.

> *And there was a social worker assigned to me, and she was more in favour of that [adoption]. She saw that I was having a hard time. She put a bit of pressure on me to… She said that maybe it would be better if I gave her away, that she had already found a good family* [Translation] (27-OV-2).

This participant added that, in addition to being pressured in this way, she was told by a nurse at the beginning of her pregnancy that "it would be better [if she had an] abortion" [Translation] (27-OV-2).

13.2.4 Imposed abortions

Unexpectedly, the subject of imposed abortions came up in several testimonies. A total of three participants described how they underwent abortions without their consent. The common denominator of their testimonies is the medical staff being insistent and pressuring them to undergo this procedure. All of the participants state that they were unsure and fearful about having an abortion. The factor of time was also mentioned: they had little time to make a decision and to really understand the medical reasons provided for why they should agree to have an abortion.

In one of the situations reported, a participant went to her community clinic because she was experiencing stomach pain. She thought she was pregnant, but the medical team did not think so. She met with a nurse and a doctor, and they put her on an examination table. Suddenly, without any explanation, the nurse inserted an instrument into her vagina. This triggered sharp pain and severe blood loss. She returned home afterward, but the pain was so intense that the ambulance came to pick her up and take her back to the clinic. At the clinic she suffered a miscarriage. And while examining her, the nurse said, "You would have done the same anyway." The participant mentioned that this nurse was judgemental about her being a single mother and said that she had too many children and should not have any more (23-IA-1).

In the excerpt below, a participant (acting as an interpreter for another participant) tells the story of a young woman in her community who also underwent an imposed abortion. Note that this woman who underwent an imposed abortion did not participate in the study, but her situation was brought up during the interview.

> *She let it happen. But she didn't want it. There was no one [with her], and she was so afraid she just froze. When she came back, she told her boyfriend. He said, "I'm sure that you knew that, and you went there." Then he told his mother. […] It's as if she was expelled from the family because she had an abortion. She didn't have an abortion: her body was raped. Because how these women, these young girls, I said to my boyfriend, "She described herself as a young woman who was raped." It's the same, same, same thing* [Translation] (24-IA-OV-2).

It is this participant's husband who reported what she said and the pressure she dealt with when she underwent the imposed abortions. In total, two abortions were non-consensual.

> – *Yes, she didn't want it [referring to the imposed abortions].*
>
> – *What were the circumstances in which they occurred?*
>
> – *They usually told her when she was sick, since she was known to have a heart condition. They used that, they used her heart condition [they told her] that she couldn't have a child, that they were going to be handicapped or deformed [referring to what the doctors said to convince her to have abortions]. Birth defects, [like] the brain [not being] there, stuff [like] that. Often, [these incidents occurred] when she was alone. When I was with her, I didn't witness this form of violence* [Translation] (24-IA-OV-2).

He described how the medical staff pressured his wife to have an abortion.

> *They urged her to get an abortion, to not carry [the baby] to term, [on the pretext] that it was deformed. In the videos she made while she was alive, before she went to [name of city], she shared that she was afraid of [name of city], that she was afraid that they would take him [her child] away. She wanted to keep him, and they said that he wasn't going to survive, that he was severely handicapped. She had to choose between herself and him because one of them wasn't going [to survive].*
>
> *[…] They showed us websites with stuff like the kinds of diseases and the missing brain [that could affect] [name of the child], then I was glad to return to the hospital in [name of city] when he was born [referring to their child, who was born healthy, despite the doctors' prognoses—none of which were correct]* [Translation] (24-IA-OV-2).

Moreover, when this woman became pregnant with her seventh child, she learned during a medical consultation that an intrauterine device had been inserted without her knowledge.

The experience of another participant reflects the full spectrum of violence examined in this research project: she experienced obstetric violence and underwent an imposed abortion and imposed sterilization (12-IS-OV-IA). While she was pregnant with her fifth child, she learned that this was a high-risk pregnancy. Rather than focusing on her physical health or physiological risks, the medical staff's interventions with her were related to her marital and family situation:

> *– Did they take the time to explain to you what the issues were? Why was it high-risk?*
>
> *– No, they never explained anything to me. What they did say to me was, "You have children by yourself, you have children who are still young. Let's say that you get pregnant again. Who is going to take care of them? Who is going to help you take care of your child, given that your spouse has a drinking problem, and you have a problem too." They said so so many things to me. About drinking, abuse, all of that. Neglect. […] They focused on the problems. Drinking, all the drug problems. […] I hadn't taken any blood tests or ultrasounds. No medical care. Just them saying these things to me* [Translation] (12-IS-OV-IA-3).

In these circumstances, she and her spouse were very unsure about whether or not to proceed with an abortion. Remarks like this made during her medical appointments factored into her decision: "So I was kind of hesitant, and at one point one of the nurses said to me, 'Either you die or your child does. If you die, who's going to take care of your other children?'" [Translation] (12-IS-OV-IA-3). Later in the interview, she described her mixed feelings and the way that the medical staff was insistent with her:

> *I would say, such a difficult meeting for me and I had to say yes then and there, but I was not capable of saying yes. I said, "Give me more time, I'll think about it." They answered, "No, no, don't think about it too much, you just have to say yes." […] It was like they were insistent; insisting that I have an abortion. […] Then I was very convinced about having this abortion. Sometimes I regret having signed, having said yes. And I wouldn't want that to happen to other people* [Translation] (12-IS-OV-IA-3).

After undergoing this abortion, her attempts to conceive another child were unsuccessful, although she had had no issues with fertility in the past. She wondered if a tubal ligation had been performed on her without her knowledge:

> *I never had a child after that, and I always asked myself that question. Why can't I do it? Why, what did they do to me? Did they cut me? Did they tie me? I don't know. I have no idea what they did to me. Maybe they did something inside me that I don't know. That's all I have to say, that's everything I went through. It was very hard* [Translation] (12-IS-OV-IA-3).

Another participant was able to avoid an imposed abortion by insisting on further testing and refusing to undergo a D&C (25-IA-3-P). When she was pregnant for the fourth time, she went in for a nuchal translucency ultrasound. Her gynecologist told her that her fetus was too small and that she needed to have blood tests. Her professional opinion was that the fetus had died. However, during the ultrasound, a nursing student who was present noticed a heartbeat on the screen. Despite this, the gynecologist insisted that she undergo a D&C in the city she was about to move to. When she went to her appointments at this new hospital, the professionals who reviewed her file reported that the fetus was doing well and that she could carry the baby to term without worrying. In her eyes, she would have undergone a D&C for no good reason if she had followed her gynecologist's advice. As it turned out, her fourth child was born healthy (25-IA-3-P).

13.3 After

Some participants explained the circumstances in which they learned that they had been sterilized. Other spoke about the repercussions on their health and on their personal life. Some of them reported that this subject was rarely brought up in their social circles and that they were convinced that the were the only ones who had been subjected to this type of violence.

13.3.1 The circumstances in which participants learned that they had undergone a sterilization procedure

Depending on the situation, several days or even several years may have passed before participants learned that they had undergone a tubal ligation and were thus no longer able to have children. In most cases, they were informed that they had undergone this procedure when they went to a fertility clinic following unsuccessful attempts at becoming pregnant. They were shocked and completely surprised to learn that they could no longer have children. Here are some excerpts from testimonies that detail these circumstances:

> *I gave birth in 1989. Three days after giving birth, they did it – I had asked for a tubal ligation. At the time, I just understood "tied." I found out later, in 1997-98, what it was… They had cut my fallopian tubes. […] Because I asked about having another baby, and they said, "You can't Ma'am." I said, "Why is that?" – "Because your fallopian tubes are cut." I said, "Oh really?" It was like… I was surprised about that* [Translation] (3-IS-3).

Another participant decided to see a doctor when she was having fertility issues with her new partner:

> *That's when I went back to see the doctor. I'm not getting pregnant, what's the problem here? He said, "We can't reverse the tubal ligation." And at the time I was like… I was no longer there. I don't know if you can say that I was no longer there, but it was like… It shocked me. I was shocked that he said that, and, besides that, I thought to myself, "Oh damn, I'm going to stop all of this, I'm going to stop asking questions, I'm going to stop"* [Translation] (13-IS-OV-4).

It was only when this participant attended the public presentation of this research project that she was able to understand what she had been through: "When you came for the presentation, that's when I understood. That it wasn't… That it was irreversible, that that couldn't be done and that I would never have children again" [Translation] (13-IS-OV-4).

A second participant (4-IS-4) learned that she had been sterilized while she was seeking fertility treatment two years after the birth of her last child. Her doctor told her that her fallopian tubes had been "clipped"—a procedure that had never been explained to her by the gynecologist who treated her during her three pregnancies. Moreover, she had received a prescription for a contraceptive pill after she had had her last child, so she had no reason to think that her fertility had been compromised. She was 22 years old when she underwent a tubal ligation, and, to this day, she has no idea why this procedure was performed without her knowledge.

Another participant learned, to her dismay, that the tissue of her fallopian tubes had been cut when she went to have her intrauterine device removed, four to five years after giving birth to her last child:

> *I wanted to have another baby. […] But I found out that I didn't have fallopian tubes anymore. I went to see a nurse to make sure. I was in shock. The nurse knew me. She knew that I wanted to have other babies and that I love my children very much. Anyways, it was hard for me* [Translation] (6-IS-6).

Another participant was experiencing a loss of sensation in her stomach and sought medical care to get some answers about her condition:

> *I had gone to see a doctor for that, to see what was happening to me. That's when he told me, that's when he explained to me, "It's definitely not cancer because you no longer have a uterus." I froze, I couldn't say a word, I was in shock. I began to understand why I wasn't getting my period. I asked why and he said, "You signed a consent form [for the operation]." I said that I didn't understand that I didn't understand what had happened to me. Then I said, "How can you say that I don't have cancer? Can you see through me?" He hadn't even done an examination yet. He said, "You can't have cancer because there's nothing in your belly that can cause cancer. If you don't have a uterus, you don't have your ovaries either." I was afraid to tell my husband that I could no longer have children. It took me a long time to tell him. That's what I went through* [Translation] (14-IS-OV-5).

Another participant underwent a tubal ligation without her knowledge following a D&C procedure:

> – *But I don't know what they did to me after [I underwent the D&C]. When they did my… In the operating room. Maybe the tubal ligation or I don't know… A hysterectomy.*
>
> – *You didn't have any other children after that?*
>
> – *No, no.*
>
> – *Did you have any other gynecological exams in the years that followed?*
>
> – *Yes, I went to see a gynecologist. He told me that I had had my tubes tied. But I didn't know that… That I had had my tubes tied. I told him that I wanted to have another child* [Translation] (21-IS-OV-12).

Two participants had consented to have their fallopian tubes "clipped" because they believed that it was not a permanent procedure. One of them was in the recovery room when her doctor told her, "I cut you, you were cauterized and you have nothing left" (22-IS-OV-13). The second participant found out the truth when she had a new spouse and was seeking fertility treatment. During a medical consultation, she was informed that her fallopian tubes had not been "clipped," as she had thought, but instead had been cauterized (8-IS-8). Moreover, she does not remember being informed that this was a permanent form of contraception and believes she did not sign a consent form.

Yet another participant was seeking fertility treatment when she learned that she had undergone a tubal ligation without her knowledge and that it would no longer be possible for her to have children:

> *They met with my husband and I to tell us that we could never have children again. Tied for life! I was disappointed. My husband was disappointed too. They didn't tell us until six months after [name] was born. I didn't even know [that I had] had my tubes tied* [Translation] (9-IS-9).

Another participant said that she was pressured to have an intrauterine device inserted after the birth of her first child: "[…] But I never really wanted to take it. And then they kept asking me to have an IUD [intrauterine device] so I did. And every time when it hurts, I bled so much, went back, they removed it and put another one" (15-IS-OV-6). An intrauterine device remains effective for several years, so it is difficult to understand why it was removed from this participant and re-inserted multiple times. She noted that, despite the severe pain caused by this method of contraception, the medical staff did not propose any alternatives.

Later, the heavy bleeding associated with her periods led to anemia. It was then recommended to her that she undergo surgery to permanently relieve her pain, and she was also told that she may have uterine cancer. The consent form did not specify that the participant would undergo a hysterectomy (15-IS-OV-6). When she woke up after the operation, she was shocked to learn what had happened:

> *In our room, me and my husband, I started crying and I couldn't breathe. He kept telling me, "Breathe, breathe, breathe," and I cried, and I told my husband, "Does this mean I can't have any children?" And he said... He told me just to comfort me. I'm not sure if he said the right words, but he tried to comfort me, he told me, "Maybe it's better because you're a little older. You will have more complications and maybe it is OK not to have any more children, just one"* (15-IS-OV-6).

After her surgery, tests showed that she did not have cancer, but that there was "something" on her uterine wall that the surgeons were unable to remove. Based on the information she was given, this "something" was neither a tumour nor a cyst, but to this day she has no idea what it was (15-IS-OV-6).

13.3.2 Repercussions on their physical health

Seven participants (20%) mentioned in their testimonies that they experienced complications and uncomfortable symptoms following the procedures they underwent.

There was repeated mention of hormonal complications and repercussions resulting from a hysterectomy, including significant pain lasting several months after the procedure, the onset of premature menopause and the physical symptoms associated with menopause. Participants also reported that they did not receive hormonal therapy and, as a result, experienced bone and dental problems.

One participant in particular experienced major hormonal disruptions due to an overly high estrogen prescription. Years after her hysterectomy, she is still dealing with the consequences of this medication.

> *When he did the hysterectomy, he started me on estrogen. Not the lowest dose of estrogen, he started me on 1.25. You cannot come off that. Since 1994, we have tried seven times to take me off this estrogen to let my body go through normal procedures of life. They cannot, because every time they take me off the estrogen, I go through menopause, and it is 10 times worse than a normal woman going through menopause. Not only did they do that to me, where I have to be on estrogen for the rest of my life* (10-IS-OV-1).

In contrast, another participant was given no information or medication and received no follow-up after her hysterectomy. This procedure triggered premature menopause, accompanied by uncomfortable symptoms.

> *I never had any… How should I put it? It's like they closed my file. Because when I called again at some point to have… Because I was having hormonal problems, as they say. It was like a shock, menopause as they say. They didn't call me back. The secretary just said, "We'll call you back. I'll talk with Dr. [last name]." They never called me back. Because she had said, "Maybe we'll need to prescribe you hormones," or something like that, later if ever. But I never got this kind of medication* [Translation] (20-IS-OV-11).

A second participant reported in her testimony that she was not given adequate information and follow-up after the hysterectomy she underwent to prevent cancer. She was 25 years old at the time of the procedure. Today, she reports that her teeth are "fragile like crystal," and she feels that this health problem is a result of not receiving hormonal therapy. She also stated that she had been "left all alone" and that it had been very difficult for her to recover from this operation [Translation] (2-IS-2). The medical team had told her that her recovery would last no more than three months. Although she was experiencing severe pain that prevented her from walking and performing everyday tasks, she received no information on her ailments or medication to treat them.

One participant reported that she had experienced pain and hemorrhaging, had required a blood transfusion and had gotten an infection following a hysterectomy that was performed without her knowledge while she was undergoing bladder surgery (11-IS-OV-2). Another participant suffered bone problems after she underwent a hysterectomy and was not given hormonal therapy (14-IS-OV-5). Another participant underwent a hysterectomy that triggered premature menopause, a condition that her doctor never explained to her (15-IS-OV-6).

In the case of another participant, the pain she experienced following an abortion had an impact on her health. She mentioned difficulties walking and menstrual periods lasting 15 days. She sought medical care several times to understand and relieve the pain she was experiencing. However, in her appointments with a gynecologist, she received neither explanations nor lasting solutions to treat her pain.

> *When I would have pain, I would go to see the doctor, the gynecologist because I was suffering so badly. I had stomach pain, and they never told me what I had, what this pain was. But I often went to see the gynecologist. For a year, it was often like that, I would go to see the gynecologist. I explained that I had had an abortion and that I had had complications with my second last child. The answer was often, "You have nothing Ms. [name], no scarring from your C-section. I see nothing abnormal." It was so painful that I had trouble walking. So I waited, and I took lots of Tylenol at the time. I only took Tylenol because it was the only thing the nurses gave me. They recommended that I only take Tylenol. I took it almost every day. […] I took Tylenol for almost a year and a half. Then at some point, I got really nauseous. I began to find Tylenol really disgusting* [Translation] (12-IS-OV-IA-3).

Another participant had rushed to the hospital during her last pregnancy because she had gone into labour earlier than expected. She was about to give birth, but a nurse tried to delay the process because there was no doctor on site at the time. This affected the baby's health:

> *The nurse arrived, she closed my legs and said, "we need to wait for the doctor." I said, "No, I can't wait, the baby is going to come out! My baby is going to come out!" She closed my legs again. But when she was born, my baby, [name], didn't have enough air. She was a little blue, bluish. I said, "Why is she blue?" The others were normal colours. "Because your baby didn't have enough air"* [Translation] (13-IS-OV-4).

13.3.3 Repercussions on their mental health

The participants' physical ailments also affected their mental health. The fact that the women were unable to understand their symptoms and had not received any lasting treatment for their pain contributed to the deterioration of their mental and emotional state. One of them suffered from depression following a hysterectomy that she underwent because of complications from giving birth. Later, when her daughters started their own families, she became jealous of their ability to carry life (17-IS-OV-8).

Another participant said that she still feels a desire to have children, that it is still a source of great pain and that the hysterectomy she underwent has had an impact on her femininity, her relationship with her body and her intimate self:

> *You sterilize a dog, you sterilize a cat, you sterilize any animal that you don't want to… You don't do it to a woman, you don't take that from her and expect us to live. […] If I could have a choice, I know they could never give me back my uterus, but I just want my scars gone. I don't want to look at them anymore. I don't want… It's like I tell people, "You might just consider me a trans lady!" They go, "Why, you are female," Like I am female, but I am not female. I don't have my parts. Because the white man decided it wasn't necessary. That's the hard part* (10-IS-OV-1).

She added, "Every child matters, as they say, they got those [orange] shirts out. Every child matters. Yet, if every child matters, who makes children? Women. We matter" (10-IS-OV-1).

One woman recounted being left all alone after her hysterectomy and spoke about the debilitating pain she experienced:

> *I was left completely alone, and I would get up all on my own. Then there were the consequences that followed, because I was left all on my own after this surgery, and it's hard to overcome* [Translation] (2-IS-2).

Another participant spoke about the difficult situation in which many Indigenous people find themselves after being forced to attend residential schools, learning about unmarked graves of Indigenous children at some of these residential schools and dealing with imposed sterilization, to give but a few examples. She said, "Plus, with the residential schools, people don't see how broken my people are and it's hard. They [the whites] don't understand how defeated we feel" [Translation] (26-OV-1).

13.3.4 Repercussions on their personal life

The repercussions on the participants' marital relationships came up several times in the testimonies. Couples who wanted to start a family or have more children found out that it would no longer be possible for them to do so. This impacted the relationships of these couples, as described in the following excerpts from participants' testimonies.

For the spouse of one of the participants, the imposed abortion his wife underwent was a source of regret and blame:

> – *That really affected her, we blamed each other. We both blamed the other. I blamed myself for not being there [referring to the impact of the imposed abortion on their relationship].*
>
> – *Sometimes I would say, "You let this happen."* [Translation] (24-IA-OV-2).

In the case of another participant, when her and her husband found out that a tubal ligation had been performed on her without her knowledge, this sent shock waves through their relationship:

> *For a long time, my husband and I didn't talk to each other. We were no longer interested in each other. In loving each other […]. We were extremely disappointed. We rejected each other for a long time because of that. […] I felt rejected by my husband after. That's when he started leaving all the time. He was always gone. Sometimes for four days, five days. He was disappointed… We were disappointed that we found out six months later. Without my consent, without a signature. […] When they called us to the clinic to tell us. That day, we were disappointed. I don't know how many days there were when we didn't talk to each other. My husband also accused me of signing something or having said something* [Translation] (9-IS-9).

Indigenous women who have been sterilized without their consent may also be judged and stigmatized by the people around them. For example, one participant reported that certain men in her community believed that a woman who has been sterilized can have multiple sexual partners and can thus be regarded as an "easy" woman (7-IS-7). Sometimes, this type of violence originates from family members who think that the life of the woman's spouse has been "destroyed" because he can no longer have a child.

13.3.5 Revelations in the context of the research

Many thoughts and emotions arose for the participants as a result of taking part in this research and sharing what they experienced. Many of them remain convinced that nobody will believe them and that their experiences will not be taken seriously. All these years later, they still have a deep-rooted fear of judgement. These chapters of their life stayed buried for a long time as a result of cultural taboos as well as the silence, denial and loneliness faced by these women. For some of them, this was the first time putting what they had experienced into words. As one participant noted, "Because I just did not think anybody really cared. I hope whatever you are doing, I hope one day sterilizing Native women will stop" (10-IS-OV-1).

Another participant reported that upon learning that she had undergone a tubal ligation, her first reaction was denial.

> *I had suppressed that part of my life so much that I didn't want to go and see, I didn't want to talk about it. For me, the tubal ligation was nothing. But it's also something. A part of me was cut off. Cut off [from the ability to] create life! I couldn't—at least at the time—I couldn't create life anymore [and] have beautiful children* [Translation] (13-IS-OV-4).

The silence around what they experienced is maintained by the fear of being stigmatized and judged. The words of this participant clearly illustrate this fear.

> *I never dared to talk about it openly out of fear of people saying, knowing that I had had an abortion, and judging me, because people can be very mean when they… You know, sometimes, I see things on social media, like someone who had an abortion. It's really… The nasty things people write, it's enough to cause someone to have a mental breakdown. So I never really dared to talk about this subject because it's too hard, it's too hard. At the same time, it's too stressful also. But I know that there are probably some women around me who have experienced such things, but they don't dare to talk about them either because there's too much baggage behind all these stories of women who have experienced this type of violence* [Translation] (28-OV-3).

Another participant spoke about how other women who had had similar experiences have remained silent: "But you know, there are many women who have moved on, so they don't talk about it anymore […] I've been waiting a long time for that. For there to be a path for me to talk about it. I felt alone through all of this" [Translation] (6-IS-6).

Another participant wondered about the repercussions that her testimony could have in the public sphere: "Because if I spoke out, it's not for nothing. I'd like to know what they're going to do with this. They're going to say to you, 'Yes, systemic racism exists.' It isn't just in the west [of the country]" [Translation] (26-OV-1).

Another participant shared how the anger she felt following the death of Joyce Échaquan motivated her to contact the research team and to speak out, so that such an incident does not happen again:

> *I was really shocked by what they did. When I think about what they did to this woman [referring to the death of Joyce Échaquan]. They killed this woman. And what we experienced too. It was really racist there [name of the hospital]. I really wasn't comfortable there* [Translation] (29-OV-4).

One woman put her decision to participate into context as follows:

> *It helps people rebuild their self-esteem and to recognize that when you have rights, you also have the responsibility to know these rights and to call out the things you don't find acceptable* [Translation] (28-OV-3).

One participant stated during her interview that she would be willing to join a class action lawsuit if people started one: "I think that if there is enough of us, I think that I would be willing to testify. Hopefully, at my age, I would be taken seriously" [Translation] (11-IS-OV-2).

14. Main findings

Four themes emerge from the analysis of the testimonies: the undermining of patients' free and informed consent; fear, distrust and avoidance of health services; differential treatment in hospitals; and the age of the patients and the circumstances of their sterilization.

14.1 The undermining of patients' free and informed consent

The testimonies collected during this research project suggest that First Nations and Inuit patients' right to exercise consent was undermined in many ways and, in some cases, completely disregarded. In cases where the language barrier was an obstacle to doctor-patient communication, none of the participants were offered interpretation services. Several participants report never having signed a consent form prior to undergoing a procedure that permanently altered their reproductive capacity (e.g., a tubal ligation or hysterectomy). In cases where participants did sign consent forms, the participants report that they received little information about what the procedure involved and how it would affect their ability to have children. A signed consent form therefore does not in itself constitute free and informed consent. The signature alone is not sufficient and is no substitute for a discussion with a doctor. Moreover, the doctor is responsible for speaking with the patient about the repercussions and risks of the procedure, informing them about alternative medical interventions and ensuring that this information is thoroughly understood.

It is also important to examine the circumstances and patients' general state of mind when their doctor spoke to them about the tubal ligation for the first time. In several cases, the procedure was presented to participants while they were in labour. The physical and psychological effects of going through labour impact a person's analytical, thinking and decision-making abilities. Factors affecting their cognitive state include fatigue, fear, pain and the effects of medications (Cadorette, 2006). The particular circumstances of labour and delivery can have an impact on the exercise of free and informed consent. Additionally, many participants report that the medical staff were insistent and would try to get them to consent over and over, even when these participants had clearly expressed that they refused to undergo this procedure. A tubal ligation is not required for the sake of a women's health and is not considered an emergency procedure, so it is difficult to understand why the medical staff pressured the women to consent to it. Moreover, acting this way with a patient goes against the core principles of free and informed consent, namely that consent "must be obtained without pressure, threats, coercion or promises on the part of the doctor, family or friends" [Translation] (CMQ, 2021). It is equally problematic to obtain consent on the basis of false information, such as the claim that a tubal ligation is reversible. While it is true that a woman can attempt to recover her fertility through various medical interventions, there is no guarantee of success. Participants therefore did not receive all the relevant information about this procedure and its true impact on their fertility.

To sum up, there are several major issues that intersect: the lack of information given to the participants, the pressure they were put under and the inappropriate circumstances in which they were asked to make a decision that would have a major, lasting impact on their fertility. The situations described above are disconcerting to say the least and raise important ethical issues. Note that "consent is based on the ethical principle of personal autonomy and its legal basis lies in the inviolability of human rights" [Translation] (CMQ, 2021:1).

The complete absence of consent detailed in several testimonies leads us to believe that patients' fundamental rights were violated and significantly infringed upon. Before a patient undergoes a surgical procedure that will permanently alter a biological function, the doctor is responsible for informing the patient objectively and comprehensively and presenting the risks and repercussions as well as alternative treatment options (MTESS, 2022). It is difficult to understand why some doctors disregarded the requirement to obtain consent (which can be set aside only in emergency situations) when the situation did not call for an exception to be made.

Time was another factor that impacted participants' ability to consent, as participants were not given enough time to think about what they wanted or to obtain a second opinion. The exercise of consent is a process; it is more than just checking a box on a form after a quick discussion with a patient (Cadorette, 2006).

14.2 Fear, distrust and avoidance of health services

Many of the participants in this research project experienced incidents of violence every time they gave birth, adding to the distress that someone in a vulnerable situation may feel. These negative experiences add up and leave a lasting impression on a person. Discriminatory remarks, actions and attitudes toward First Nations and Inuit women all feed into a climate of insecurity and negatively impact the relationship between patients and the medical team.

It goes without saying that the traumatic experiences the participants went through impacted their overall health and eroded their trust in health services. As mentioned, several participants reported learning that they had been sterilized several years after it happened. The news was a total shock to them and triggered a host of questions concerning the quality of care that they received and the manner in which they were treated. They asked why and how such an important decision could be taken without their consent. They wondered about the intentions and reasoning of the medical staff who treated them in this way. For some of these women, the lasting impact a hysterectomy had on their health acts as a constant reminder of what they went through.

A lack of support and attention from medical staff also came up repeatedly in the testimonies. In the literature, obstetric violence is characterized by non-assistance and a disregard for the pain and other symptoms a patient is exhibiting (Bohren and al., 2015). It is an attitude of deliberate neglect that may be based on a person's prejudices and assumptions about a particular group. For example, there seems to be a popular belief that First Nations and Inuit people have a higher tolerance for pain. They are thus less likely to be given pain medication because the medical staff assumes that they do not feel as much pain (Heino, 2018). At the same time, some health professionals are reluctant to give their Indigenous patients pain medication because they believe that they have a higher likelihood of developing an addiction (WCAH and OAC, 2022).

Some participants reported that they would feel a sense of fear as soon as they walked into a hospital because they knew of other women who had had experiences of this kind (imposed sterilization and obstetric violence). All of these factors contribute to a great deal of apprehension, distrust and fear around seeking medical care, especially obstetric care. As a result of their negative experiences, many of the participants tried to reduce and adjust their interactions with the health care system. To this end, they used strategies such as avoiding prenatal care and/or giving birth in a hospital located in another region of Quebec in the hope of being treated better. Some tried to change their health care arrangement—for example, by changing doctors.

Other participants stated that it is difficult to establish a dialogue and a relationship of trust with their doctor in such a situation. Looking back, some participants are dubious about the diagnoses they received and the medical examinations they underwent. In their opinion, the symptoms and pain they were experiencing were not properly dealt with. To this day, they feel that their doctor was not sufficiently invested in finding solutions to their health problems and that they were not given access to all the treatment options that could have helped them. Some of the participants had not seen a gynecologist for over 20 years.

14.3 Differential treatment in hospitals

A prominent theme in the collected testimonies, differential treatment relates to the fact that First Nations and Inuit women feel as though they are treated as second-class patients.[10] Such differential treatment is made apparent by certain words, actions, attitudes and practices that seem to be reserved for Indigenous women.[11] For example, the vast majority of participants were proposed a tubal ligation when they were in their twenties, and they were not given an adequate explanation of what this procedure consisted of, nor were they asked clearly whether they wanted to have more children. Insistently questioning whether a new First Nations or Inuit mother wants to have a tubal ligation after the birth of her first child seems to be an existing practice in Quebec.

Differential treatment is also made apparent by the discriminatory, stereotypical and degrading remarks directed at the participants. These inappropriate remarks from medical staff cover a broad spectrum and seem to be based on the stereotype that Indigenous women are problematic patients and neglectful mothers.[12] The medical team made judgemental remarks about some patients' family and marital situation (substance abuse problems, having several children, being young, being a single mother, etc.). All these points were brought up to First Nations and Inuit women as a way of convincing them to undergo a tubal ligation.

Often, their health status seemed to be analyzed through the lens of these prejudices. Notably, some participants clearly stated that they were not treated as human beings when they went to the hospital to give birth. They also stated that, when they went through a difficult recovery, they did not receive the medical support that they were expecting. They would have liked to receive information from their doctors as they dealt with pain, wound infections, hormonal symptoms or other issues; however, their doctor did not provide this follow-up.

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[10] The Viens Commission report illustrates these "walls of mutual incomprehension that separate Indigenous peoples from the main providers of public services in Québec" (PLRP, 2019: 207). More importantly for the mandate of this Commission, the multiplicity of testimonies heard illustrate how this incomprehension can have the effect of limiting access to health care and even put the safety or life of some individuals at risk.

[11] Certain women of colour in Quebec seem to experience similar treatment; the attitude of the medical profession can thus impact other groups in vulnerable situations, as shown in a report on the program *Enquête* (Fournier, 2021).

[12] The Viens Commission report addressed the differential treatment of First Nations and Inuit women: "Unethical addiction-related practices targeting women have also been brought to my attention, such as non-consensual drug tests performed on Indigenous women who have come to give birth" (PLRP, 2019: 367).

It is also important to note the recurrent and persistent nature of these forms of violence. When the testimonies collected in this research project are examined longitudinally, from 1980 to 2019, we see that such incidents of violence reoccur across time. Consistent with the findings of various public inquiry commissions, it would seem that the situation has not improved (PLRP, 2019; NIMMIWG, 2019; CWA and OAC, 2022) and that these trends date further back than the period that has been documented. Indeed, in the recent report on the coming into force of the *Act to authorize the communication of personal information to the families of Indigenous children who went missing or died after being admitted to an institution* (Bill 79), published by the Secrétariat aux affaires autochtones du Gouvernement du Québec (2022), it is observed that children vanished in the health care system in Quebec beginning in the 1950s. This same observation is made in the Final Report of the NIMMIWG (2019): "In the context of its deliberations, several families testified in Québec on children who died or went missing in circumstances unknown to their families after being evacuated from the community for medical reasons or, more broadly, after being admitted to a health and social services institution" (SAA, 2022:1). It should be noted that 70% of the applicants (35 applicants representing 55 children) whose requests were accepted as part of the administration of the Act are women (SAA, 2022).

14.4 Age of the patients and circumstances of their sterilization

Based on the testimonies collected, the ages of Indigenous women who underwent tubal ligations or hysterectomies ranged from early adulthood to mid-thirties. Only four participants had medical conditions that could alter their fertility: lesions on the uterine wall, untreated ectopic pregnancy leading to damage to the fallopian tubes, a tubal ligation performed at the same time as bowel surgery and a hysterectomy with the removal of part of the bowel. In other words, a vast majority of patients did not have health conditions severe enough to require a procedure affecting their reproductive capacity. They were young, healthy and were, by all indications, capable of carrying a baby safely to term. Moreover, none of the participants had a family background of high-risk pregnancy or a diagnosis associated with high-risk pregnancy. Many of these participants explicitly mentioned to their doctor and/or other medical staff that they wished to have more children in the future. Two participants who underwent hysterectomies in their twenties are now suffering from major bone and dental problems. They did not receive any follow-up or hormonal prescriptions following the procedure.

Given all of this information, it is difficult to understand why such young women were constrained to a tubal ligation or hysterectomy despite the availability of less risky and invasive methods of contraception (birth control pills, intrauterine devices, etc.), which were never mentioned to them.

15. Limits of the research project

First of all, this research project is, to our knowledge, the first that focuses on the imposed sterilization of First Nations and Inuit women in Quebec. Given the lack of data, literature and analysis on this subject in the province, it is not possible to draw comparisons or parallels with other empirical work carried out in Quebec. The available literature on this subject generally focuses on the imposed sterilization of Indigenous women in Western Canada, the United States and elsewhere in the world.

Although this research was conducted throughout the province of Quebec and involved a large-scale communication campaign that spanned various forms of media, it is possible that some people did not receive information about its deployment and thus their voices were not included in this work. The language barrier may also have been an obstacle to recruiting participants who cannot easily express themselves in French or English. That said, in some cases the research team was able to conduct the interview in the participant's Indigenous language with the help of an interpreter.

In addition, the situation surrounding the COVID-19 pandemic made the research process much more complicated. For several months, it was only possible to conduct interviews over telephone or a videoconferencing platform. Many Indigenous communities were completely closed off to visitors, so, despite receiving invitations, members of the research team were not able to meet with potential participants.

The sensitivity of the subject matters also needs to be taken into account. In interviews over telephone or videoconference, it is difficult to develop a bond of trust with potential participants so that they can open up about such an intimate, sensitive subject to someone they do not know. The remote format of some of the interviews thus represents an obstacle to collecting this information. Under these circumstances, some people may have chosen not to provide testimonies because they did not feel emotionally capable of doing so.

Some Indigenous Nations or peoples in Quebec are not represented in our sample despite efforts to reach out to them. At this stage, it is difficult to explain this fact and to understand why some Nations are less represented than others or are absent from the sample. There is always the possibility that there simply were no cases of imposed sterilization or obstetric violence among women in these Nations.

16. Conclusion

In light of the testimonies collected and the analysis of these testimonies, we confirm that there have been cases of imposed sterilization, obstetric violence and imposed abortions among First Nations and Inuit women in Quebec. It thus joins the list of Canadian provinces and territories where numerous such cases have been documented and have been the subject of research reports (theses and dissertations) and scientific publications (articles and monographs).

Dividing the events experienced by the women who participated in this research project into three temporal categories (before, during and after) allows us to better understand the sequence of events, identify the pivotal moments and examine the trajectory of patients in clinics and hospitals in Quebec. The analysis of the participants' painful stories showed that their free and informed consent was undermined by the fact that they received little to no information or inaccurate information (in a second or even third language) on their health conditions and on the procedure they were about to undergo; this is highly problematic and has had permanent repercussions on their physical and mental health and their personal lives. It is also problematic that many of the women were pressured to accept permanent sterilization despite their young age, that they were not proposed any alternative contraceptive methods and that the medical staff directed negative attitudes and degrading remarks toward them. The differential treatment experienced by these women, which many of the participants witnessed, perpetuated if not increased their distrust and fear, which in turn contributed to their avoidance of the health services to which they are entitled.

The testimonies collected reveal that, with regard to the various legal texts that set out and protect the rights of patients in Quebec and Canada, there were clearly serious infringements and ethical failures on the part of the medical staff, along with infringements on the integrity of First Nations and Inuit women. These practices, which were kept silent, seems to support the reproduction of discriminatory language and colonial attitudes directed toward women who are forced to use the health system, particularly to give birth. The analysis of the testimonies collected as part of this research project converge on the same finding that emerged in recent research work (Pierre and Bosset, 2020), public inquiry commissions (PLRP, 2019) and surveys (NIMMIWG, 2019; Kamel, 2021) conducted in Quebec—namely, the obvious presence of systemic racism.

17. Recommendations

This section highlights the various actions and recommendations proposed by the participants and the research team. It is important to consider all of them, as they pave the way for immediate changes that are necessary in protecting the fundamental rights of First Nations and Inuit in Quebec.

17.1 Recommendations made by the participants in the research project

For all organizations:

1. Listen to, hear and believe First Nations and Inuit women who speak out about imposed sterilizations, obstetric violence and imposed abortions.

For First Nations and Inuit organizations:

2. Support First Nations and Inuit women who have been victims of imposed sterilization, obstetric violence and forced abortions through health and legal counselling services.

3. Inform First Nations and Inuit patients of their rights.

4. Develop information tools on reproductive health (pamphlet, Facebook page, phone line, radio capsule in several languages) accessible in places such as hospitals, family medicine groups (FMGs), family planning clinics, community health centres and nursing stations.

5. Promote the implementation of a holistic approach to health and wellness intended to help rebuild the self-esteem of First Nations and Inuit women.

For government bodies (Quebec government):

6. Call on the Collège des Médecins to put an end to the practices of imposed sterilization, imposed abortion and pressuring First Nations and Inuit women to accept such procedures.

7. Impose penalties and revoke permits to practice when such acts are perpetrated.

8. Institute mandatory training for health professionals and their professional orders on the realities and rights of First Nations and Inuit in addition to current efforts to promote cultural safety.

For First Nations and Inuit women:

9. To the extent that they wish, share their experiences of imposed sterilization and obstetric violence, speak out about how they were treated and educate their daughters about these issues.

17.2 Recommendations made by the research team

For all organizations:

10. Support efforts to initiate class action lawsuits involving First Nations and Inuit women who have undergone imposed sterilization or experienced obstetric violence.

11. Set up a working group tasked with proposing legislative changes (to the *Civil Code of Québec* and the *Code of ethics of physicians*) to prevent and penalize incidents of imposed sterilization and obstetric violence in Quebec and Canada.

For First Nations and Inuit organizations:

12. Establish a mechanism for monitoring cases of imposed sterilization and obstetric violence, notably by documenting such cases in the First Nations Regional Health Survey published every five years by the FNQLHSSC.
13. Launch an awareness and information campaign on free and informed consent, imposed sterilizations and obstetric violence.
14. Collaborate with the various professional orders in Quebec in the health and social services field to ensure that First Nations and Inuit communities and organizations in Quebec are accessible for students/interns.
15. Adopt a declaration to promote and protect the healthcare rights of First Nations and Inuit women.
16. Continue to generate new knowledge on the subject of consent and imposed sterilization by:
    - Conducting a second phase of research in order to collect the testimonies of First Nations and Inuit women who could not be met with during this research phase
    - Conducting research on imposed sterilization and obstetric violence in collaboration with medical staff
    - Developing research on the experience of First Nations and Inuit people in sanatoriums in Quebec in order to check whether imposed sterilization occurred in these institutions

For professional bodies in the medical profession:

17. Review the training offered to the medical profession on free and informed consent, particularly in the fields of obstetrics and gynecology.
18. Ask the Collège des médecins du Québec to take note of the recommendations in this research project and to adopt a rigorous action plan to tackle this issue, raise awareness among its members and prevent such acts in the future.

For government bodies:

Federal government:

19. Respond immediately to the report by the Standing Senate Committee on Human Rights on forced and coerced sterilization of persons in Canada, the first part of which was published in 2021 and the second part in July 2022.

Quebec government:

20. Call for an immediate end to imposed sterilization, as stipulated in the motion adopted by the National Assembly of Quebec in September 2021, along with all other forms of obstetric violence perpetrated against First Nations and Inuit girls and women in Quebec. By unanimously adopting this motion, the National Assembly has committed to condemning the practice of performing sterilization procedures on First Nations and Inuit girls and women without prior free and informed consent.

21. Convene the Collège des médecins for the purpose of ensuring that all necessary steps are taken to put an end to this practice.
    - It is suggested that an addition be made to section 28 of the *Code of ethics of physicians* concerning the need to pay special attention when obtaining consent from First Nations and Inuit women by taking into account the historical, social and cultural factors that are unique to them.
    - It is suggested that an addition be made to section 11 of the *Civil Code of Québec*, which specifies that no one may be made to undergo care, treatment or any other act without their prior consent, so that the cultural and linguistic particularities of First Nations and Inuit women be taken into account.
22. Examine how the Quebec government's Bill 19 (*Loi sur les renseignements de santé et de services sociaux et modifiant diverses dispositions législatives*) could allow family members to access their mother's medical records to document past cases of imposed sterilization.
23. Implement recommendations 23 and 24 of the TRC, calls to action 3.1 to 3.7 of the NIMMIWG as well as calls for action 74 to 76 of the PLRP, which propose the integration of Indigenous knowledge and practices into health care.
24. Respect article 24 of the UNDRIP, which stipulates that Indigenous people have the right to access health services without experiencing discrimination.
25. Implement the ten calls to action in the report by Yvonne Boyer and Dr. Judith Bartlett (Boyer and Bartlett, 2017), which focus on education, training in cultural competency and cultural safety, the establishment of an advisory council comprised of community members to address the subject of tubal ligation and the review of consent forms for tubal ligation procedures.
26. Adequately fund the deployment of First Nations and Inuit doula training and midwifery services in First Nations and Inuit communities, in addition to funding already existing services in certain regions of Quebec in order to ensure significant, respectful access to these services for First Nations and Inuit women.
27. Adequately fund university midwifery education in French and English, include a cultural component in the curriculum and reserve places for First Nations and Inuit students.
28. Adequately fund interpretation services for Indigenous languages in Quebec hospitals.
29. Support the implementation of the AFNQL's Action Plan Against Racism and Discrimination Against First Nations Peoples – Health Section.
30. Adopt Joyce's Principle.
31. Recognize that there is systemic racism in Quebec.

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Appendix A - Lexicon

Some of the terms used in this research project are from the medical and surgical fields. As such terms can sometimes cause confusion, we have decided to define them clearly. Since this research project focuses specifically on the imposed sterilization of women, terms related to male sterilization will not be discussed.

Tubal ligation

This medical procedure consists of tying, cutting or cauterizing the tissue of the fallopian tubes to prevent the egg from reaching the uterus. Two methods are used: a laparoscopic technique (making small incisions in the lower abdomen to access the reproductive organs) or a transcervical technique (accessing the fallopian tubes through the cervix). It is commonly known as "getting your tubes tied." This surgery is permanent and irreversible: after a woman undergoes a tubal ligation, she is no longer able to have children (FQPN, N/A).

Hysterectomy

This medical procedure involves the removal of the entire uterus. It results in a woman no longer being able to carry a baby (CHUM, 2019).

Oophorectomy

This medical procedure involves removing the ovaries, which results in major hormonal changes that prevent a woman from having children (CHUQ, 2008).

Obstetric violence

This is a term that began appearing in the scientific literature only in the past 20 years, and there is no consensus on a definition. For the purposes of this project, we have used the definition provided by Lévesque and al. (2018):

> "Obstetric violence experienced in health care facilities encompasses acts performed in the exercise of certain professional practices—or the failure to perform certain acts—during childbirth, without the agreement and informed consent of women, resulting in a negation of their reproductive agency. This systemic violence creates and reinforces the imbalance of power that is present during childbirth and causes suffering and distress to women. The manifestations, recognition, impact and extent of this violence vary between people, contexts and cultures" [Translation] (p. 230).

Imposed sterilization

For the purposes of this research project, we have used the definition proposed by the World Health Organization (2014):

> "Sterilization without full, free and informed consent has been variously described by international, regional and national human rights bodies as an involuntary, coercive and/or forced practice, and as a violation of fundamental human rights, including the right to health, the right to information, the right to privacy, the right to decide on the number and spacing of children, the right to found a family and the right to be free from discrimination […]. Human rights bodies have also recognized that forced sterilization is a violation of the right to be free from torture and other cruel, inhuman or degrading treatment or punishment (34; 35, para. 60)" (WHO, 2014, p.1).

Several terms are used in the literature to refer to non-consensual sterilization: forced, involuntary, coerced, compulsory, etc. In this research project, we have used the term "imposed sterilization," following a recommendation from the Regional Committee that guided the research. The sterilizations undergone by First Nations and Inuit women were imposed because they were, in many cases, performed without their knowledge. This surgical procedure is imposed on women without informing them, so they had no say over what was done to their body and their reproductive capacities.

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MISSION

To accompany Quebec First Nations in achieving their health, wellness, culture and self-determination goals.

VISION

First Nations individuals, families and communities are healthy, have equitable access to quality care and services, and are self-determining and culturally empowered.

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