Obstetric and Gynecological Violence and Imposed Sterilizations

Among First Nations Women in Quebec

Research report

Phase II – May 2026

UQAT
ÉCOLE D'ÉTUDES AUTOCHTONES
SCHOOL OF INDIGENOUS STUDIES

CANADA RESEARCH CHAIRS
CHAIRES DE RECHERCHE DU CANADA

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

Author

Suzy Basile, Professor, Canada Research Chair in Indigenous Women's Issues, Director of the Research Laboratory in Indigenous Women's Issues – Mikwatisiw, Université du Québec en Abitibi-Témiscamingue (UQAT)

Research team

Suzy Basile, Professor, School of Indigenous Studies, UQAT

Patricia Bouchard, custom doctoral student, School of Indigenous Studies, UQAT

Sébastien Brodeur-Girard, Professor, School of Indigenous Studies, UQAT

Caroline Fiset, Research Agent, First Nations of Quebec and Labrador Health and Social Services Commission, (FNQLHSSC)

Nancy Gros-Louis McHugh, Research Sector Manager, FNQLHSSC

Patricia Montambault, Research Agent, FNQLHSSC

Contributors

Ioana Comat, Consultant

Eric Duchesneau, Communications Manager, FNQLHSSC

Marie-Christine Dugal, Consultant

Laurie Paquin, PhD candidate in Indigenous Studies, School of Indigenous Studies, UQAT

Anne-Frédérique Perron, custom master's student, School of Indigenous Studies, UQAT

Emmanuelle Piedboeuf, custom doctoral candidate, School of Indigenous Studies, UQAT

Marjolaine Siouï, Executive Director, FNQLHSSC

Linguistic revision

Geneviève Blais

Translation

Kathryn Casault

Graphic design

Corsaire Design | Communication | Web

The use of purple in this report is dedicated to Joyce Echaquan. We have feminized the narrative to do justice to and give visibility to the many First Nations women whose voices are heard in the following pages. The design of this report is inspired by a work created by Étiennette Benjamin, offered to Suzy Basile by Puakuteu, the Women's Committee of Mashteuiatsh. The work titled "*Mikuniss – Baby Feather*" is a contribution by Xan Choquet, a Pekuakamiulnu (Ilnu) from Mashteuiatsh and a student at the UQAT School of Indigenous Studies.

We would like to thank everyone who contributed in any way to this research project.

This report was written without the use of generative artificial intelligence (AI) tools.

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All requests must be sent to the FNQLHSSC by mail or by email, at the following addresses:

First Nations of Quebec and Labrador Health and Social Services Commission
250 Place Chef-Michel-Laveau, Suite 102
Wendake, Quebec G0A 4V0 Canada
info@cssspnql.com

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We would also like to thank the interpreters and everyone else who assisted the research team during the interviews with the participants. Your work was crucial in ensuring that the voices of the women who shared their stories were heard.

Available support

If you feel the need to talk to someone about this sensitive topic, we invite you to contact the Survivors' Circle for Reproductive Justice helpline, which is available 24 hours a day, 7 days a week.

You can reach the helpline by phone at 1-877-386-0750 ext. 100 (ext. 113 for service in French) or chat online at https://www.reproductivejusticesurvivors.ca/.

The Survivors' Circle for Reproductive Justice is working to establish a national registry of people who have undergone imposed/coerced sterilization and also offers a Healing Support Fund.

Note to readers

We invite you to consult the Phase I report of this research, published in 2022, to hear from the women whose contributions have made it possible to document the sensitive issue of imposed sterilizations (IS) in Quebec.

The testimonies gathered during Phase II of this research may be difficult to read due to the degree of violence of the incidents reported by the participants. It is important to note that we did not attempt to corroborate their testimonies with the contents of their medical records, nor did we seek the perspective of health professionals on the situations that were recounted. The primary objective of this research is, on the other hand, to give a voice to First Nations women and, on the other hand, to collect their testimonies in order to illustrate their journeys within the health and social services system of Quebec.

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[1] First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC). (2022). *Free and informed consent and imposed sterilizations among First Nations and Inuit women in Quebec* (Research report), FNQLHSSC, Wendake, 76 pages. https://files.cssspnql.com/s/CG-KiiNtINdTYkGF?_gl=1*1e9kuz8*_up*MQ..*_ga*MTQ1NTgwMzgwNi4xNzczODQ2NTM0*_ga_906VEPXQGV*czE3NzM4NDY1MzQkbzEkZzAkdDE3NzM4NDY1MzQkajYwJGwwJGgw

Table of contents

List of boxes

List of figures

List of tables

Highlights

The research report *Free and informed consent and imposed sterilizations among First Nations and Inuit women in Quebec*, published in November 2022, created a shockwave. The 35 testimonies collected during this Phase I of the research demonstrated that imposed sterilizations (IS) and other forms of obstetric and gynecological violence (OGV) took place in healthcare facilities across Quebec.

The testimonies from Phase I cover the period from 1980 to 2019 and highlighted the systemic nature of acts of violence through the similarity, recurrence, and temporal and geographic scope of the reported events, set against the diverse profiles of the research participants. Those from Phase II occurred between 1956 and 2023 and report more than three times as many incidents as in Phase I.

The primary objective of Phase II of the research was to continue documenting the realities of First Nations women who have experienced OGVs, including IS and to ensure that those who were unable to participate in Phase I had their voices heard. This follow-up research is based on the *Declaration of Commitment to Ensure Free, Prior, and Culturally Informed Consent in Health Services for First Nations Girls and Women in Quebec* by the Assembly of First Nations Quebec-Labrador, adopted in 2022.

Phase II of the research allowed to gather 97 additional testimonies, including 55 cases of IS. Combined with those from Phase I, a total of 132 testimonies were recorded, of which 77 were cases of IS. It is estimated that 17 additional testimonies could have been collected.

Several categories of OGV have been identified based on the testimonies, many of which are marked by racism and deep-seated prejudice against First Nations women. The types of OGV identified fall into four categories: 1) verbal, emotional, and psychological OGV; 2) physical and sexual OGV; 3) ethnic-based discriminatory OGV and 4) imposed sterilizations (IS).

An analysis of ethnic-based discriminatory OGV testimonies reported by First Nations women in Quebec (36% of the testimonies heard) has revealed new forms of violence within a colonial context, distinct from those experienced by other marginalized groups in the population. They can be summarized as follows: birth alerts, misidentification of Mongolian spots, blood tests performed on newborns without prior parental consent, and imposed abortions.

The most frequently cited category of OGV in the research corpus involves IS (59% of testimonies). These testimonies describe incidents spanning nearly 50 years, from 1974 to 2022, and originate from five First Nations in Quebec. The two age groups most represented among the 55 documented cases of IS are women aged 19 to 29 (37 testimonies) and women aged 30 to 39 (15 testimonies) at the time of the procedure.

Of the 55 cases of sterilization discussed during Phase II, 21 participants said they did not sign a consent form, while 16 were unsure if they had. The remaining 18 participants recalled signing a consent form under worrisome circumstances, such as being pressured, during active labor, or having their hand physically guided by nursing staff.

The reported cases of imposed sterilization occurred under the following circumstances: insufficient communication, inadequate medical escort and interpretation services, sterilization procedure performed without prior consent, confusion about clipping and "unclipping", sterilizations during C-section, and tubal ligation used as a contraceptive method. Several of the women interviewed discovered they had been sterilized much later, only after subsequent consultations related to other health issues.

The 77 testimonies about imposed sterilizations from Phases I and II capture only a portion of the reality, as many First Nations women were unable to participate in the data collection process, and others may have passed away before their voices could be heard. As a result, it is impossible to determine with certainty the number of First Nations women sterilized without their consent in Quebec. However, it is reasonable to assume that many of them were unknowingly sterilized.

An imbalance of power occurs when research participants face obstacles in accessing their medical files, during medical consultations marked by the stereotype about First Nations women having "too many" children and allusions to "quotas" by health care providers, all of which further erode trust in the health care system.

The repercussions of OGV on psychological, physical, and sexual health, on femininity and spirituality, as well as on interpersonal relationships and the immediate family, leave an indelible mark on the lives of First Nations women. These are part of a continuum of violence inflicted upon Indigenous peoples. It should be noted that more than half of the participants were 57 years of age or older at the time of the interviews. The majority of them (31 out of 47) are residential schools survivors.

Women and their families have developed a range of protective strategies, including forgoing prenatal checkups altogether or coordinating family support networks to ensure that women are not alone when giving birth. In response to OGV-related incidents, some women have either filed complaints or contemplated taking such actions.

As actions for reparation, in addition to practicing certain rituals associated with pregnancy and childbirth, some participants reported taking on the role of foster parents for children within their community or Nation, thereby strengthening the network of mutual support central to the social organization of Indigenous peoples.

The analogous nature of the experiences shared by the women involved in this research indicates, without any doubt, that Indigenous and non-Indigenous women were subject to differential treatment; however, patterns of treatment were consistent across First Nations, and across regions. In other words, the research findings demonstrate the existence of systemic racism.

Obstetric and gynecological violence (OGV), including imposed sterilization (IS), should now be included in the list of recognized traumas experienced by First Nations women and Indigenous peoples in Quebec and Canada.

Mikuniss – Baby Feather

While listening to Senator Yvonne Boyer's conference on the sterilization of Indigenous women in Canada as part of the course *SOC2401E Selected Topics in Indigenous Studies* at the Université du Québec en Abitibi-Témiscamingue (UQAT), I felt compelled to move forward with my eagle feather penholder project which I have been working on for the past few weeks. Hearing Senator Boyer speak of the lost generations that will never be born because of these mutilations moved me to tears.

I seized the moment and spent the hour after the lecture crafting a small pouch for "Mikuniss – Baby Feather." As I sewed, I prayed for these women, hoping that the medicine of this young eagle would find its way to them.

Xan Choquet, Mashteuiatsh, February 18, 2026

Master's student in Indigenous Studies, UQAT

Introduction

On November 24, 2022, the research report entitled *Free and informed consent and imposed sterilizations among First Nations and Inuit women in Quebec* (FNQLHSSC, 2022) was submitted and presented at a meeting of the Chiefs of the Assembly of First Nations Quebec-Labrador (AFNQL). The primary objective of this research was to make up for the lack of data about cases of imposed sterilization and document related experiences of First Nations and Inuit women in Quebec. The publication of this report stems from a collaboration between the First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC) and the Université du Québec en Abitibi-Témiscamingue (UQAT). Both organizations firmly believed in the necessity and relevance of conducting research on this topic. Discussions to this effect began in February 2019. The report (FNQLHSSC, 2022), designated as "Phase I" of the research, outlines the national Canadian and provincial Quebec contexts within which this initiative is being implemented.

During this initial phase, 35 testimonies were collected from First Nations and Inuit women who described experiencing obstetric and gynecological violence (OGV), as well as imposed sterilizations (IS), between 1980 and 2019 in contemporary times. The gathering of data also brought to light the systemic nature and distinct geographic distribution of these acts of violence denounced by members of five Indigenous Nations (four First Nations and one Inuit nation) occupying a large part of the province's territory. The reported incidents took place in hospitals and clinics throughout multiple administrative regions of Quebec, all situated along the north shore of the St. Lawrence River, extending from east to west across the province. Several significant commonalities can be observed in the testimonies, despite considerable variation in participant profiles, particularly in terms of age and region of origin[2]. However, a thorough analysis of the similarities, recurrences, temporal and geographical distribution of the reported events did not yield a definitive explanation for these set of circumstances. While no overarching intent should be inferred, there is evidence of a specific *modus operandi* in the methods employed to address "reproductive issues" faced by pregnant women and new mothers. When combined with deep-seated prejudices against First Nations and Inuit women, this *modus operandi* may account for the systemic nature of these actions. Quebec now joins the list of other Canadian provinces and territories where numerous instances of **obstetric and gynecological violence (OGV)**, including **imposed sterilizations (IS)**, have been reported and documented over the past few decades. See **Appendix A** for a summary of documents published in the 1970s and 1980s on this subject.

As part of Phase I, the research team identified approximately 20 persons who, for various reasons, were unable to participate in the data collection process (COVID-19 pandemic, cancellations, lack of access to technology or mobility issues, etc.). Consequently, the number of testimonies in Quebec could potentially have been higher. It is against this backdrop that, in November 2022, the AFNQL Assembly of Chiefs[3] expressed the importance of continued research on the topic, which subsequently resulted in the initiation of a second phase. The main objective of this second phase is to further document the realities of First Nations women affected by OGV, including IS, and to ensure that those not heard in Phase I are also given the opportunity to share their stories (see Section 1.6 on methodology). Following

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[2] The participants did not know each other and had no connection to one another. Several of them mistakenly believed they were the only ones who had experienced an IS and stated that they had never discussed their experience with anyone, including their family members.

[3] In November 2022, the AFNQL unanimously adopted the *Declaration of Commitment to Ensure Free, Prior and Culturally Informed Consent in Health Services for First Nations Girls and Women in Quebec*. This declaration specifically reiterates the sexual and reproductive health rights of First Nations girls and women (AFNQL, 2022), see **Appendix B** to read the full text. Online access at: https://cssspnql.com/en/produit/declaration-of-commitment-to-ensure-free-prior-and-culturally-informed-consent-in-health-servicesin-health-servicesfor-first-nations-girls-and-women-in-quebec/

the release of the Phase I report, several **significant outcomes** emerged, such as actions initiated by the *Collège des médecins du Québec* (CMQ) (see **Appendix C**). Since then, a series of **ancillary events** related to Indigenous women's reproductive health of occurred, sometimes concurrently with the development of Phase II. These include a class-action lawsuit on behalf of Atikamekw Nehirowisiw women who were allegedly sterilized without their consent at Joliette Hospital (see **Appendix D**), a bill (S-228) introduced in the Canadian Parliament that seeks to amend the *Criminal Code* by adding a provision stipulating that forced (without consent) sterilization[4] is a criminal act (see **Appendix E**), and finally, a national inquiry into a campaign of anticonception (derived from the Danish term *antikonception*, which refers to the prevention of fertilization) that took place in Greenland (see **Appendix F**).

Tribute

Following the tragic death of Joyce Echaquan on September 28, 2020, a public coroner's inquest shed light on the circumstances of her passing and on a darker side of her life as a woman and a mother.

Box 1. Tribute to Joyce Echaquan

Joyce Echaquan was also a survivor of obstetric violence. Here is an excerpt from a text written by those involved in this research. It highlights the extent of the violence and the deep-rooted prejudices that Indigenous women may face:

> The circumstances surrounding the death of Ms. Joyce Echaquan at Joliette Hospital in September 2020 serve as a stark reminder of the violence and virulence of prejudice against Indigenous women. While alone, in critical condition, and strapped to her hospital bed, she was subjected to racist insults, particularly regarding her fertility and the number of children she had (Kamel, 2021). Despite her distress, she managed to record her final moments and post them on social media (Radio-Canada, 2020). The content of this video sent shockwaves through Quebec and beyond. The repercussions of her death are far-reaching and are still being felt today (CAM and CNA, 2020; CMQ, 2023). Furthermore, during the coroner's public inquiry, it was revealed that Ms. Echaquan had previously experienced involuntary abortions as well as an imposed sterilization a few months before her death (Shaheen-Hussain *et al.*, 2023) (Translation) (Bouchard *et al.*, 2026, p. 138).

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[4] See explanations regarding the use of the terms "forced" and/or "imposed" on page 9.

Part 1. Definitions, ethical and methodological considerations

1.1 Obstetric and gynecological violences (OGV)

> OGV refers to systemic and gender-based violence related to reproductive and sexual health occurring in the context of gynecological or obstetric care. They can be experienced during childbirth, a miscarriage, or an abortion, as well as during a routine gynecological appointment, an ultrasound, or a mammogram (Translation) (Regroupement naissances respectées (RNR), 2019, p. 1).

Research on obstetric and gynecological violence (OGV) and imposed sterilizations (IS) has been on the rise in Canada over the past 10 years (Stote, 2015, 2022, 2025; Dyck and Lux, 2016, 2020). Indigenous women (from First Nations, Métis, and Inuit) have been the focus of particular attention from researchers, notably due to the large number of women who have spoken out about the treatment they received in Canadian hospitals, as well as the attention given to legal actions taken and research conducted on the subject (Boyer and Bartlett, 2017; Mercredi and Fire Keepers, 2024; Shaheen-Hussain *et al.*, 2023).

The concept of "obstetric violence", which emerged in South America in 2007 (Pérez D'Gregorio, 2010), refers to the dehumanisation, mistreatment, diminished autonomy, and restrictions on women's ability to make independent decisions for themselves within the scope of obstetric care – specifically in the context of childbirth – to which women are normally entitled (Pickles, 2024). This violence is exercised in a context of "taking control" over women's bodies and includes deliberately keeping women in the dark about their right to consent to medical care or procedures that occur during childbirth. Researcher Sylvie Lévesque and her colleagues suggest a definition that also includes the dimension of cultural diversity, which is particularly relevant to the Quebec context and that of First Nations in this study:

> Obstetric violence experienced in health care facilities encompasses actions taken or professional practices carried out – or omitted – during childbirth without women's approval and informed consent, thereby denying their reproductive agency. This systemic violence creates and reinforces power imbalances that exist at the time of childbirth and causes suffering and distress among women. The manifestations, recognition, impact, and extent of this violence vary from person to person, from context to context, and from culture to culture (Translation) (Lévesque *et al.*, 2018, p. 230).

"Gynecological violence", however, encompasses a range of practices conducted by health care professionals within the context of gynecological consultations, excluding obstetric care. This type of violence can be manifested through acts of negligence as well as verbal, physical, or sexual mistreatment, all of which are part of an inherent relationship of subordination between the medical personnel and the women seeking care (Cárdenas-Castro and Salinero-Rates, 2023). Gynecological violence can be perpetrated in many ways: by withholding information, making disparaging comments, infantilizing patients, or performing pelvic exams or examinations without consent or without justification (Cárdenas-Castro and Salinero-Rates, 2023).

These acts of violence can occur quite suddenly, in the context of rushed, and therefore expedited, consultations, against the backdrop of the power and authority dynamic that inevitably develops between health care providers and patients. Activist Sonia Bisch notes that:

> The doctor-patient relationship is one of inequality, since a health professional holds a position of authority, while a patient awaiting a diagnosis, prescription, or treatment is in a vulnerable position. Some professionals abuse the power conferred by their position (Translation) (Bisch, 2025, p. 16).

Ultimately, the common thread linking obstetric and gynecological violence is the disproportionate balance of power between health care providers and patients, resulting in the latter's voices being silenced in favor of the former.

1.2 Types of OGV

For the purposes of this research, OGV has been classified into three categories: 1) verbal, emotional, and psychological OGV; 2) physical and sexual OGV; and 3) ethnic-based discriminatory OGV. This last category, which applies specifically to First Nations women, is further divided into four subcategories. These include **birth alerts** (notifications to child protective services about a child deemed to be at risk of harm; see **Appendix G** for additional information), reports due to the presence of **Mongolian spots** (suspicion of abuse because of on a bluish mark on the child's body), and **blood tests**[5] (a blood sample taken from a newborn without the parents' prior consent to test for substance use by the mother) and cases of **imposed abortion** (termination of pregnancy without consent or accepted under pressure)[6].

1.3 Imposed sterilization (IS)

Sterilization is a permanent surgical procedure that irreversibly prevents childbearing. This research highlights cases of sterilizations performed without consent or without informing the woman, classifying the procedure as an integral part of OGV. Given the highly symbolic nature of this form of violence, imposed sterilizations (IS) are the subject of a distinct section in this report. The definition proposed by the World Health Organization (WHO) is as follows:

> 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).

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[5] The Guthrie test (neonatal screening, also known as the Phenyl or Heel-prick tests), which involves a heel prick blood sample, is performed on all babies born in Canada to screen for rare genetic disorders. A larger blood sample may be taken, or the test may be repeated to conduct additional screening.

[6] See section 1.6.10 of this report for their coding.

As in the Phase I report, the term "imposed sterilization" had been preferred over "forced sterilization" – a term more commonly used in the literature – to describe sterilization procedures performed without the women's knowledge. This choice is explained as follows:

> Several terms are used in the literature to refer to non-consensual sterilization: forced, involuntary, coerced, compulsory, etc. We have chosen the term "imposed sterilization" based on a recommendation from the Regional Committee guiding 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 was imposed on women without informing them, so they had no say over what was done to their body and their reproductive capacities. (FNQLHSSC, 2022, p. 74).

1.4 Non-permanent contraceptive alternatives

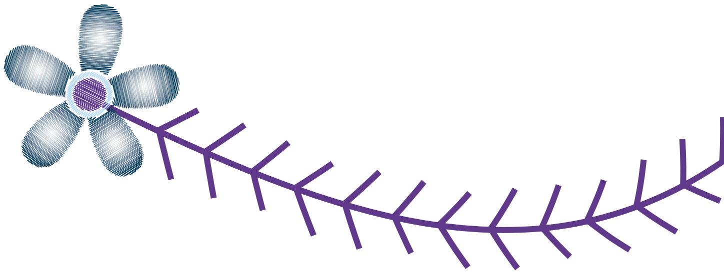
The testimonies provide insight into cases where women's agency was not respected when temporary forms of contraception – such as Depo-Provera, the IUD, the pill, the contraceptive patch and the contraceptive implant – were either imposed upon or withheld from them. The enforced use of contraception on First Nations women is part of a longstanding and ongoing history of discrimination. Initially promoted by officials of Indian Health Services Canada to reduce maternal and infant mortality rates, contraception has also served as a cover for efforts to reduce government spending on "its" Indigenous people by mechanically controlling their fertility rates through contraception (Dyck and Lux, 2016). The analysis of testimonies on this subject suggests that this practice is still ongoing today.

1.5 Intersectional approach

The analysis of the testimonies collected, presented below, draws on the intersectional approach which recognizes that various systems of oppression – such as colonialism, patriarchy, and capitalism – interact with one another and influence the (re)production of inequalities based on gender, race, social status, and age (Crenshaw, 1989). This approach, in the context of OGV is illustrated by authors Ferron-Parayre *et al.*, (2024).

> Beyond the medical domain, OGV stems from gender-based violence as well as biases and stereotypes about **women** (biological or gendered) and mothers. More particularly, OGV can encompass the expression of medical **racism** and **colonialism** that places racialized and Indigenous individuals at greater risk to experience it (Translation) (Ferron-Parayre *et al.*, 2024, p. 1, bold text added by the author of this report).

The analysis of the testimonies heard for this research also required the application of an intersectional approach owing to the intertwining forms of OGV experienced by the participants. As mentioned earlier, categorizing experiences that encompass both psychological and discrimination-based OGV, such as those associated with ethnic origin, can present significant challenges. The journey of Joyce Echaquan, an Atikamekw Nehirowisiw woman who died amid a barrage of racist and sexist insults at Joliette Hospital on September 28, 2020, perfectly illustrates this phenomenon. The circumstances surrounding her passing highlight the violence and differential treatment she received from health authorities, as a result of her intersecting social status.



1.6 Methodology

1.6.1 Issues

Since 2015, many Indigenous women across Canada have reported that they were sterilized while they were unable to give their free and informed consent for the procedure. Research conducted across all Canadian provinces and territories has shown that many Indigenous women were sterilized under similar circumstances, often through tubal ligation conducted without their knowledge during childbirth. The lack of available data for Quebec prompted the launch of Phase I of the research in 2020, as well as the current Phase II.

Furthermore, according to the preliminary results of the Quebec and Labrador First Nations Regional Health Survey (RHS4)[7] (FNQLHSSC, forthcoming), it is estimated that one in 5 women (19.5%)[8] has experienced violence during her pregnancy(ies) or childbirth(s). The age groups most affected are those aged 25 – 44 (22.5%) and 45 – 64 (19.4%). This data aligns with the findings detailed in subsequent sections and demonstrates that First Nations women continue to encounter violence within a health care system whose mission is to heal and protect them.

1.6.2 Research objectives

The two main objectives of Phase II are as follows:

1) Continue documenting cases of OGV, including IS among First Nations women in Quebec[9].

2) Ensure that women affected by this issue have the opportunity to share their experiences in an environment that is ethical, respectful, and culturally sensitive.

In fact, due to the substantial number of individuals who reached out to the research team after the release of the Phase I report, as well as those unable to participate initially, it was necessary to continue data collection efforts.

1.6.3 Ethical considerations

As for Phase I, the principles guiding research in Indigenous context[10] were applied to carry out Phase II. In the spring of 2023, a new cooperation agreement between the FNQLHSSC and UQAT has been signed. The research team reviewed the research design, data collection tools, communication strategy, and ethical certification application submitted to UQAT's Human Research Ethics Committee. The ethical certification was granted in July 2023 (N° 2020-08 – Basile, S. – Renewed).

1.6.4 Methods and tools for collecting testimonies

The interview guide used in Phase I was updated to include themes that emerged from the data analysis. As a result, questions regarding abortion (consensual or imposed), blood tests performed on newborns, birth alerts filed with Youth Protection (DYP), and couple or family relationships post OGV incident were added to the Phase II interview guide. The consent form was tailored to the context of Phase II, and two documents were prepared to support any steps participants might take: a "guide for accessing medical records" and a list of "legal tools" available in Quebec. A copy of the Phase I report, in French or English, was also provided to each person participating in Phase II of the research.

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[7] This survey is conducted by the FNQLHSSC every five years, and the fourth edition (2025) included questions on obstetric violence for the first time, thereby addressing one of the recommendations from Phase I report of this research.

[8] Weighted estimate from 826 respondents; confidence interval: 16.7%–22.6%.

[9] For Phase II, the research team decided to focus recruitment of participants specifically in First Nations communities in Quebec, as the unique and particular circumstances of Inuit women in Nunavik may warrant a separate study.

[10] The *First Nations in Quebec and Labrador's Research Protocol* (AFNQL, 2014) and the *Guidelines for Research with Indigenous Women* (Basile, 2012) served as guides in the development of this research.

1.6.5 Recruitment of participants

The communication tools used to invite participants to Phase I (posters, messages and banners for social media and email campaigns) were updated, repurposed, and translated into English for Phase II. The visual design, already widely circulated between 2022 and 2023, helped people recognize the topic being addressed. See Figure 1.

The research project's web page[11] was also updated. Interviews with various media outlets (Facebook pages, First Nation community radio stations, *APTN* TV, newspapers and magazines, etc.) were conducted to encourage women concerned to reach out to the research team. The invitation was also forwarded to the Health Directors in Quebec First Nations communities, as well as to organizations involved in Phase I. Word of mouth also helped spread the invitation, especially among previous Phase I participants and those who had not been able to share their experiences.

Figure 1. Visual design for recruitment of participants

1.6.6 Collection of testimonies

The collection of testimonies began on July 17, 2023, and ended on May 31, 2024. Only two members of the research team – the authors of the Phase I report – conducted all of the interviews. In response to the invitations received, they traveled to 18 First Nations communities, 3 Native Friendship Centres, and several cities and villages to meet with the individuals who had reached out to them. Typically, an oral presentation of the Phase I research report served to introduce the subject matter and encourage an open dialogue with those present. Afterwards, individual interviews were conducted, sometimes with the assistance of an interpreter or a support person as needed, at a location chosen by the community, the host organization, or as preferred by the participants. While some participants opted to meet the researchers in the privacy of their own homes, others delayed their interviews and chose to conduct them online through platforms such as Zoom or Messenger. The research team adapted its approach in order to ensure the participants' comfort and safeguard their anonymity.

At the start of the interviews, those present were introduced and the participants' questions were answered. This was followed by the reading of the consent form, with enough time provided or the interpreter to translate it before proceeding with the signing. One copy of the signed form was given to the participant, and the second was retained by the research team. Verbal consent and recorded via audio, was also an option for those who preferred this method. Interviews conducted virtually followed the same procedure; the form and a copy of the Phase I report were sent by email or regular

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[11] The Web page created for the research is available at the following address: https://sterilisationsimposees.cssspnql.com/.

mail. The interview guide provided a framework for the discussion and clarification of certain aspects of the women's stories, in order to fully understand the context in which the OGV and/or IS occurred (year, location, age, type of procedure, reasons for hospitalization, whether or not consent was obtained, information they received regarding risks of the procedure, and alternative contraception methods, etc.). Members of the research team and the interpreters present during the interviews signed a confidentiality agreement.

1.6.7 Documentation and validation

An ongoing literature review was undertaken to systematically identify all new publications relevant to OGV and IS. National inquiries (in Greenland and the state of Vermont, USA), scientific research (in Peru and Chile), class-action lawsuits (in Quebec and elsewhere in Canada) are currently underway, and are generating valuable information that has been taken into account in this research. The appendices to the report summarize some of these works. Upon completing the initial draft of the report, a validation exercise was conducted with six Indigenous women whose professional or personal expertise informed the data analysis. Doctors, nurses, and lawyers were also asked for their input to confirm the accuracy of the terminology and assess the relevance, congruence or perhaps incongruity of certain procedures reported by participants.

1.6.8 Safety net

As with Phase I, a safety net was put in place to support those who felt they needed support following the interview. As a thank you, a bundle of sweetgrass was given to participants after each interview – a gesture they greatly appreciated, and which was intended to contribute to their healing. A list of support and counseling resources for First Nations people was made available to the research team. The participants were contacted again one week after the interview and were directed toward resources, if needed. Team members could also reach out to an Elder for support or simply for a listening ear, if necessary.

1.6.9 Data processing

Each file – recording, consent form, and interview guide – was digitized and coded with a sequential number and acronyms reflecting type of procedure undergone by the participant. An interview tracking table (Excel) was created. All data collected was uploaded to the research data management system (RDM), a secure platform provided to the research team by UQAT. All interviews were transcribed, in French or English, producing verbatim transcripts that constitute the foundation materials of the research corpus.

1.6.10 Coding of reported events

In the interview tracking table, the following categories were created based on the nature of the reported events, along with their corresponding acronyms:

- OGV: Obstetric and gynecological violence
    - Verbal, emotional and psychological OGV
    - Physical and sexual OGV
    - Ethnic-based discriminatory OGV
        - BA: Birth alert
        - MS: Mongolian spots
        - BT: Blood test
        - IA: Imposed abortion
- IS: Imposed sterilization

Please note that the testimony of one interview may fall into one or more of these categories. A single participant might recall several incidents that occurred at different times in her life and involve various forms of OGV (whether or not they included an IS) or a single event might refer to several types of OGV. The IS category of is considered an integral part of OGV. However, for the purposes of this analysis, it was deemed preferable to address them separately in order to provide distinct emphasis.

1.6.11 Data analysis and interpretation

The interview guide served as the basis for the preliminary thematic analysis. The initial coding was then adjusted during the analysis process as new themes emerged. The NVivo 10 qualitative data analysis software (Lumivero, Denver, CO) was used to process all the data collected. This software, along with the interview tracking table, was also used to construct a statistical profile to support the qualitative analysis of the testimonies. Given the large number of significant interview excerpts, an initial selection was made to exclude difficult to interpret or incomplete passages, allowing for a better understanding of the content. A second selection of interview excerpts was conducted, based on an initial categorization according to the types of events and the themes identified. Ultimately a final selection had to be made due to the large number of similar statements, indicative of the repeated nature of distressing experiences. For the purposes of this report, selected statements were translated into either French or English, according to the language employed during the interview.

1.6.12 Profile of participants

Phase II of this research allowed to gather 97 testimonies, citing **94 separate OGV incidents** of various types, including **55 cases of IS**. Two health care professionals provided testimonies about incidents they had witnessed during their careers. These accounts were excluded from the dataset for quantitative analysis, as they did not provide sufficiently detailed information regarding the events described. Two other testimonies referred to the same event and were therefore treated as a single event for the quantitative analysis. However, the content of each testimony (97) was included in the qualitative analysis (see Table 1).

Table 1. Source of testimonies

Testimonies collected	Number
Testimonies from First Nations women	94
Testimonies from health care professionals	2
Testimonies from two people about the same case	1
Total	**97**

As in previous investigations conducted by commissions of inquiry in Indigenous contexts and in Phase I of this research, nine people were able to testify about OGV they had not personally experienced. They spoke on behalf of a family member, either deceased or unable to testify, or as a health care professional with specific knowledge of the events. The letters "WI" for "witness" are listed in the coding ascribed to these interviews.

One testimony lacked details about the time period of the event and was consequently omitted from the **temporal analyses**. However, it was retained for analyses concerning the nature of the violence experienced and the location where the events occurred. Taking into account the 35 testimonials collected during Phase I along with those from the current phase, a total of **132 people** participated in the research. However, only the testimonies collected during Phase II were used for this report.

Nations

The participants in this second phase are from five First Nations in Quebec. The following table presents the distribution of testimonies according to each woman's First Nations affiliation (see Table 2).

Table 2. Number of testimonies from OGV victims per Nation

Nation	Number of testimonies
Innu/Naskapi	50
Atikamekw Nehirowisiw	36
Anishnabe (Algonquin)	5
Eeyou (Cree)	3
Total	**94**

Naskapi women are members of a distinct community in Quebec. To maintain participant anonymity and ensure confidentiality, their stories have been integrated to those of Innu women. The women agreed to this approach, considering it suitable due to the strong cultural and linguistic ties between the two Nations. The geographical location of both Nations also means that Naskapi and Innu women follow the same trajectory of gynecological and perinatal care. Furthermore, the report does not identify or associate any Indigenous community with the testimonies collected.

Age of participants

The persons interviewed were between the ages of 15 and 40 at the time of the events, and their OGV experiences occurred between 1956 and 2023 (see Table 3).

Table 3. Age and date of events

Age at the time of events	Date of events
Youngest: 15 years old	Furthest in the past: 1956
Oldest: 40 years old	Most recent: 2023

At the time of the interview, in 2023-2024, the youngest participant was 19 years old and the oldest was 90 years old. It should be noted that over half (n=47) of participants were 57 years of age or older at the time of their interviews. The majority of them (31 of 47) are residential school survivors. Several said they had decided to break their silence about their OGV experiences because they were now less afraid of the judgment their testimony might provoke, particularly from people close to them.

Languages spoken

The research team adapted to the linguistic context and to the needs of the participants. The majority of the interviews (n=74) were carried out in French, 13 in a First Nations language with the assistance of an interpreter, five in English, and two were conducted in both French and English (see Table 4).

Table 4. Languages spoken during the interviews

Language	Number of people
French	74
First Nations language	13
English	5
French and English	2
Total	**94**

Additional testimonies

Some participants withdrew for personal reasons, either because they found it too difficult to revisit such painful memories or were unavailable when the researchers visited. Many of these women balance jobs, care for their children or grandchildren, and are sometimes foster parents to children in the community. It is estimated that 17 more testimonies could have been collected.

Part 2: Data analysis and results

Consistent with the findings from Phase I of the research, the analysis of Phase II testimonies identifies multiple forms of OGV experienced by First Nations women in Quebec, as well as Innu/Naskapi respondents from the island of Newfoundland (see Table 5)[12]. For any given participant, this violence may have occurred as a single incident, or multiple times. In certain cases, the violence extended over several years. As indicated, the reported incidents took place between 1956 and 2023, involving women between 15 and 40 years of age at the time of the events. Of the 94 testimonies retained for the quantitative analysis, 55 cases of IS have been identified. The remaining 39 testimonies were classified as OGV. Compared to Phase I, Phase II included a greater proportion of older women, which may account for the presence of certain practices that are no longer in use today and seem to belong to a bygone era. In fact, these practices have proved to be highly traumatic for those who experienced them and were still alive at the time of the interviews.

Table 5. Number of IS and OGV testimonies in each phase of collection

Phase of collection	Total of participants	IS experiences		OGV experiences (without IS)	
	n	n	%	n	%
Phase I	35	22	63%	13[13]	37%
Phase II	94 (+3)[14]	55	59%	39	41%
Total	**132**	**77**	**58%**	**52**	**39%**

The following subsections draw upon an analysis of the narrative discourse and experiences shared by interview participants. First, they outline cases of OGV based on the established categories, then describe more detailed instances of IS, and lastly provide an overview of the repercussions associated with the forms of violence previously described.

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[12] Five Innu women remembered the days when they were evacuated to St. Anthony on the island of Newfoundland. Because of its proximity, they were sent there to give birth or for other health reasons. According to the testimonies heard, they were hospitalized at the Charles S. Curtis Memorial Hospital as late as the 1990s. This hospital was the birthplace of the International Grenfell Association (IGA), which performed more than twenty sterilizations on women deemed mentally feebleminded between 1928 and 1934 (Connor, 2019). According to this author, it is possible that there were more cases of sterilization than the available records indicate, and that Indigenous women were among those who were sterilized.

[13] Cases of OV, IA and WI, as documented in the Phase I report, have been grouped together here for a total of 13.

[14] As previously mentioned, three testimonies have been excluded from the quantitative data analysis.

2.1 Verbal, emotional and psychological OGV

Verbal forms of OGV translate into brutal language, lacking any respect or kindness on the part of health care staff toward the women who seek medical care before, during, or after childbirth, or for any other gynecological reason. In an article published in 2015 in *PLOS Medicine*, Bohren *et al.* also classify verbal OGVs as threats, judgmental or accusatory comments, threats of withholding treatment, and statements that ridicule, blame, or admonish women. According to the WHO (2015) verbal abuse during obstetric and gynecological care is a widespread issue experienced by women across the globe and that such instances of disrespectful treatment have the potential to contribute to negative outcomes for both mothers and their infants. At a time when quality care is essential, women giving birth are particularly at risk of experiencing various types of violence.

The emotional and psychological repercussions of this type of OGV are considerable; they include symptoms of anxiety, depression, or post-traumatic stress disorder, as well as a sense of having been mistreated, invisibilized or completely ignored (Lévesque *et al.*, 2018; Standing Senate Committee on Human Rights (SSCHR), 2022). These women struggle with feelings of fear, shame, inferiority, or inadequacy (Bohren *et al.*, 2015). In fact, these experiences affect not only women but can also lead to the breakdown of the family unit (SSCHR, 2022). Typically, this type of OGV occurs in a context where structural factors – such as the existence of hierarchies and asymmetries of power – shape the doctor/patient relationship (Cárdenas-Castro and Salinero-Rates, 2023).

In this research, verbal, emotional, and psychological OGV were the most frequently reported among the three types of OGV identified (see Table 6). Among all of the testimonies (n=94), **62%** of the participants (n=58) reported having experienced this type of OGV, along with other types of OGV, and **17%** (n=16) of participants have only experienced this type of OGV. While some of the testimonies refer solely to verbal forms of OGV, in most cases these are compounded by additional types of OGV. The cumulative effect of the overlapping of violence inevitably leaves indelible marks on the women involved.

Table 6. Number of participant testimonies referring to verbal, emotional and psychological OGV per Nation

Nation	Total of participants	Total of verbal, emotional and psychological OGV listed		Verbal, emotional, and psychological OGV only (without any other forms of OGV or IS)	
	n	n	%	n	%
Anishnabe	5	4	80%	2	40%
Atikamekw Nehirowisiw	36	21	58%	5	14%
Eeyou	3	3	100%	0	0%
Innu/Naskapi	50	30	60%	9	18%
Total	**94**	**58**	**62%**	**16**	**17%**

In their testimonies, several of the participants report that health care personnel made disparaging remarks and treated them with contempt. The following excerpts illustrate this scorn, along with other examples of verbal, emotional, and psychological violence against women.

2.1.1 Verbal violence

One participant remembers a racist incident that occurred after she had an abortion in 1992:

> There was no support (…) I opened my eyes and looked around for some *Kleenex* when a nurse came in and said: "Stop bawling." She treated me like I was *sh*… (…) (She said:) "You shouldn't have screwed around." Another nurse who heard her said: "Well, no big deal – she's an Indian; she'll just lean against a tree and make another one." I was already crying, and I kept crying. She said that out loud, and one of the girls (there) started laughing. I heard: "Yeah, you know, those people!" (116-OGV).

Another participant shares that, in 1983, while accompanying her mother to a medical appointment, the doctor clearly expressed his disapproval of her pregnancy and even went so far as to claim that Indigenous people were a burden on society:

> I was accompanying my mother to her doctor's appointment at the hospital in (name of city). We went into an office, and the doctor, Dr. (name), asked me how old I was. I was 21 and about seven months pregnant. He asked me how many children I had, and I replied, quite proudly: "This is my third." He snapped at me and said, "By the way, you (do) know that we're the ones who support you? We pay taxes, and it's for that." I remember him saying, " When are you going to stop having kids?" (106-OGV).

In another statement, the doctor assumes that a woman is incapable of caring for her children:

> In 1981, it was my fifth pregnancy (…) At a follow-up appointment, I told her I wanted a tubal ligation after this pregnancy. She replied, "Anyway, even if you hadn't asked me, I would've had it done" (…) I didn't like that. That's not something you say to someone. She also told me, "Because right now, you don't have a husband, you don't have a partner to take care of you, you already have five children…" I was able to take care of my children; I didn't need a man for that (102-OGV).

Participants report that health care staff frequently communicate in a highly directive manner. The words and tone used tend to dictate a course of action, creating an imbalance of power, where a patient is expected to simply follow instructions. The statement below illustrates the longstanding practice of making decisions for Indigenous women. The case involves a hysterectomy ("*grande opération*" in French) in 1978:

> The doctor was the one who did that. He said, "You're going to have to do this." He said (that) I had no choice (048-IS-OGV).

Without even mentioning the absence of patient consent, this style of communication implies that interventions and treatments are imposed rather than offered. Some women are thereby deprived of their free will:

> So, when I had my daughter in 1999, I wasn't even given the choice to breastfeed or not. They said: "We encourage you not to breastfeed because you'll probably go back to school and it's just going to complicate things." I was thinking about (breastfeeding) but when the nurse told me that, in French, I just thought that (breastfeeding) would be impossible. That was hard, it was hard to go through that because I had no say (077-OGV).

This testimony suggests a lack of support from health care staff, and their disregard for the patient's needs, thoughts, and perspectives about the care she intends to provide to her own child. This lack of consideration and attentiveness is also at the heart of OGV cases involving the withholding or denial of care.

2.1.2 OGV involving withholding or denial of care – Between verbal and psychological violence

The existence of OGV resulting from the withholding or denial of care to Indigenous women has been demonstrated in the Phase I report of this research (FNQLHSSC, 2022). This type of OGV has also been documented globally, as evidenced by literature reviews across multiple countries (Bohren *et al.*, 2015, 2022) as well as other research studies and inquiry commission reports, thereby confirming cases in Quebec (PLRP, 2019; Shaheen-Hussain *et al.*, 2023).

It has been mentioned that health care providers are sometimes seen as wielding excessive authority over patients, creating an environment conducive to the emergence of OGV. One woman describes how, in 1994, she decided to leave a hospital located in a remote area with her baby, because she felt the nurse was being rude to them. The consequences were significant. She tells her story through an interpreter:

> After that, the doctor wouldn't let her bring her children to the hospital anymore – that's what was written (in her medical file). They told (the woman's name) before she left the hospital not to come back here if her child got sick (125-IS).

This situation will lead, for instance, to being silenced and making drastic decisions that will be difficult, if not impossible, to challenge. After an ultrasound, one woman had questions for the doctor, who replied:

> "*Shush*, I need to concentrate. I'll answer your questions at the end." But then, no. I wasn't able to ask my questions. She stood up, took off her gloves, whispered a few words to the nurse, and then left (037-OGV-BA-BT).

Other participants felt like they were extremely low on the medical staff's list of priorities. Some mentioned being ignored by both doctors and nurses. One woman, who was 15 years old in 1980, described her childbirth experience as follows:

> I went through all of that – without any sense of security, without any comfort, without a nurse. To them, my suffering didn't matter. It all happened in silence, without any compassion (089-OGV).

A second event occurred in 2012:

> Again... it was rough... awful care from the nurses in the delivery room in (name of city). I had no intention of going back there to give birth, never again (042-OGV-BT).

And finally, some women experience feelings of isolation and neglect during their stay in a health care facility, and some may even attempt to leave their ward and reach the emergency room on the ground floor to have their concerns heard.

2.1.3 Emotional violence

Emotional violence can be expressed through a climate of fear created by healthcare personnel attempting to impose decisions made without regard for the women's feelings. The following testimonies denounce instances of imposed contraception: one involving a permanent method in 1997, and one involving a non-permanent method in 2001:

> Then, I was in labor, so I kind of felt pressured to sign that paper (...) When they found out my baby was sick, they pressured me by saying, "All your other children are going to get sick. They're all going to die like that." So, whether I wanted to or not, that played on my mind. So, I signed the paper. I'm aware that I signed it, but it was because of all the pressure they put on me (047-IS-OGV).

> I was scared. The doctor had told me: "If you ever get pregnant, either you or your baby – or both of you – are going to die." He scared me, and that's when I agreed (to have an IUD inserted) (117- OGV).

Another woman talks about her delivery in 1984:

> I was really scared when I delivered, nobody took care of me (056-IS-OGV).

Box 2. Traumatic experiences of Kanienkehà:ka women from the Kahnawà:ke community

In the summer of 2023, *The Eastern Door* newspaper reported on the harrowing experiences of three Kanienkehà:ka from Kahnawà:ke. These ordeals fall within the spectrum of psychological and emotional violence. Two of the reported cases involved childbirth at the Anna-Laberge Hospital in Châteauguay, while the third occurred during a mental health consultation at the same hospital. To varying degrees, all three women reported problematic situations related to the fact that they were speaking English in a French-speaking hospital. One of them felt as though people were pretending not to understand her. Two of the three women felt they were being mocked. After being treated dismissively by a doctor who had agreed to fill in for a colleague who spoke poor English, one of the women said she was inconsolable for two days, wondering if she was to blame for such treatment. The two women who gave birth at Anna-Laberge felt that the medical staff ignored them. The first woman said a nurse barely listened to her (despite her comments being based on advice from her own physician, who was not there at the time). This woman also felt patronized by the health care staff – who insisted on the fact that she needed two infant car seats (and not just one) since she had just given birth to twins. A social worker also questioned her repeatedly about her partner's participation in family life, implying that his involvement might be insufficient. The second woman's distress is palpable as she tells *The Eastern Door* how she was treated while desperately trying to retrieve her placenta after leaving it at the hospital. She explains: "The nurse pretended not to know English, she pretended to not know what I was saying, and she kept hanging up on me. I called, again and again, but she started to transfer my calls to random departments, to x-ray, for instance. I was crying, I wanted my placenta so bad" (Cable, 2023a, b).

Incorrect diagnoses

Testimonies reveal that 11 women received incorrect diagnoses, such as being told they were pregnant or had miscarried, when neither was true. In another case, a woman was encouraged to undergo an abortion because of a mistakenly reported fetal abnormality. Finally, other women experienced communication or dosage errors, or were given incorrect information about the stage of their pregnancy. These diagnostic or procedural mistakes were subsequently confirmed by medical staff members. This type of emotional OGV has serious consequences for parents who were mistakenly told that their child would be born with a birth defect or disability. These women – the first was 14 years old in 2005 and the second was 23 years old in 1995 – share the following experiences:

> I went back to see her, and she did another vaginal exam, just like she always did, and then she said, "Oh, you're pregnant." She was touching my stomach while doing the vaginal exam. (…) But I'd never had sex. I was traumatized. I was like, "Wait, what's going on? Was I raped without realizing it?" All sorts of thoughts went through my head. She told me, "You're about eight weeks pregnant." (…) Then she sent me to the family planning clinic; she sent me there. They ran some blood tests (and they told me:) "No, you're not pregnant" (042-OGV-BT).

> My second pregnancy went really well. (…) The guy doing the ultrasound told me, "Your son is going to be missing an arm." (…) I was 22 weeks along, I think. I was dumbfounded. And he wasn't even supposed to give me any results (047-IS-OGV).

In 2021, during her first pregnancy at the age of 26, a woman was told by a staff member that her baby had died. She was then offered medication to help expel the fetus. However, she remained convinced that her baby was still alive. She asked to be transferred to the hospital in the nearest city, as she lived in an isolated community:

> That's when I left (...) I arrived there during the weekend, so it took a while to see Dr. (name). They did another ultrasound – I didn't want to look at the screen – and the nurse said, "Are you sure they said you had a miscarriage?" (I said) "Yes!" I didn't want to look, I was crying, tears running down my face. My boyfriend wasn't even allowed to be inside the room with me. I was scared; I didn't know what to do. Then, the nurse told me: "Do you want to see the baby moving? The baby's moving a lot!" "What!" I cried but this time I was very happy. The nurse went to get my boyfriend, and he came in and asked me what was wrong. "The baby is still alive!" "I knew that she was still there!" He was very shocked (100-OGV).

Mistakes can also occur when administering specific medications:

> Because I have a friend who worked there, she was a nurse, and she told me, "You should go see a lawyer; what happened in the operating room isn't right." She came back to see me later; she'd looked at my file and they'd given me medication – a nurse had given me medication for end-of-life care. Palliative care (061-IS-OGV-BA-BT).

2.1.4 Psychological violence

The denial of a patient's autonomy and capacity to make informed decisions about her own health, along with actions that manipulate or violate her personal identity are considered as forms of psychological violence. One participant reported that after the birth of her fourth child in 1993, healthcare staff implied that the government was imposing a kind of quota on the number of children Indigenous people could have. They then tried to convince her to undergo a tubal ligation. This is how she remembers her conversation with the health care personnel:

> Because we think your children were born too close together, and that it's going to be hard for you to raise all four of them." That's what they told me. But I was really adamant and said, "No, that's out of the question, I don't want (a tubal ligation)." But they forced me because they told me: "It's the government that wants this; they think some Indigenous people have too many children and that some Indigenous people have family problems, social problems (068-IS).

Peripheral to obstetric and gynecological care, participants reported receiving derogatory comments about their weight (5 testimonies), their alleged lack of hygiene (2 testimonies)[15] and their origins (34 testimonies). Such remarks undermine the dignity and self-esteem of those on the receiving end, while prejudices, sometimes racist, may influence the manner in which health care staff interact with patients. This is illustrated by the following example from 2023:

> Recently (…) I asked for an appointment with a psychologist, but they sent me to a psychiatrist instead. Then the psychiatrist started telling me, "Oh, you Indigenous people, you're all the same. You're all suicidal." I said, "What? That's not what I came here for. I'm not suicidal. I want to get rid of my pain." I got up and left. (…) Then another time, on another occasion (…) I had pain in my chest. I thought it was my heart. They sent me for a (stress) test. I got there, and right away, he made the same comment. He said: "Oh, you Indigenous people, you're all the same." I said, "What?" (He said:) "You're all suicidal. You all have suicidal ideations. I can't understand that." I said, "Well, I don't have suicidal thoughts." (He replied:) "Oh no, no. You're in pain, so you kill yourself." That's what he told me (038-OGV).

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[15] Because of limited space, these two topics could not be analyzed in greater depth, and excerpts from the testimonies had to be excluded from this report.

Frustrated by the lack of attention and racially charged generalizations, this participant was unable to obtain the personalized support she needed.

Misconception about substance abuse

Based on a myth deeply rooted in several countries, including Canada, suggesting that Indigenous people possess a biological predisposition to alcoholism and other forms of addiction (Institut national de santé publique du Québec (INSPQ), 2022), the women interviewed reported having experienced discriminatory situations. This phenomenon is also well documented in the Viens Commission report, which noted the deterioration of relations between Indigenous peoples and certain public services in Quebec, including the health care system (PLRP, 2019). The persistent prejudice about substance abuse among Indigenous people is reflected in the remarks made to pregnant women in 1998 and 2011:

> I've often heard that all Indigenous women use substances during their pregnancies. They (health care workers) say it's normal for them to use (substances) during their pregnancies (110-IS-OGV).

> That's when I told them, "No, it's not ok, I'm in pain from this hour to that hour, from 9 p.m. to 2 a.m." The nurses replied, "You're just in withdrawal; you're faking it; you just want drugs." So, they wouldn't give me anything. (...) They never intended to give me anything. Until I told them: "I'm going downstairs to the emergency room." That's when the nurse gave me something (061-IS-OGV-BA-BT).

This preconceived notion about drug use may for instance, distort a nurse's assessment of a patient. The following testimony relates a conversation that took place in 2019:

> A nurse or a nursing assistant asked me, "Are you going through withdrawal?" The nurse also said to my partner, who was taking care of the baby, "In my opinion, your girlfriend is in withdrawal." He asked, "Withdrawing from what?" She replied, "Drugs." My boyfriend said no, that was impossible, that I didn't do drugs (104-OGV-BA).

See the section on ethnic-based discriminatory OGV which further explores the consequences of perpetuating such prejudices (about alcohol or drug use), ranging from a loss of self-esteem among women to covert blood tests and birth alerts.

Box 3. First Nations maternity

As in most cultures, First Nations maternity is a socially valued and culturally celebrated event. It gives a prominent place to the family, the spouse, the pregnant woman and the child, called awacak or "little being of light" in many Algonquian languages. While all the stages of childbearing are essential to the construction of Indigenous identity, which is intrinsically linked to the place of origin, the territory, childbirth holds particular significance for women, for:

> Coming into the world is the first rite of passage, it is a pivotal, spiritual and sacred moment (Anderson, 201; CWEIA, 2018; Simpson, 2006). A woman's first birthing is a fundamental ceremony since this event ensures her passage to adulthood (Anderson, 2011). Similarly, "by giving birth to a new person, the woman is spiritually joined to both the past and the future", therefore, childbirth is a fundamental moment of cultural identification and spiritual connection (Begay, 2004, p. 556) (Basile *et al.*, p. 22).

Government policies of evacuating pregnant women to cities, and the erosion of the role of midwives, have significantly limited the ability of First Nations women to choose how they give birth and receive perinatal care adapted to their needs:

> In addition to depriving Indigenous women of their right to choose with whom, where and how they wish to give birth, the control and the institutionalization of births have contributed to alienating Indigenous women from their spirituality: "Overall, birth was a time for women to honour and celebrate 'the prodigious power' they held as life givers (Corea 303)" (Finestone and Stirbys, 2017, p. 179) (Basile *et al.*, 2023, p. 23).

Today, numerous healing initiatives have been implemented, such as the return of land-based births and the practice of ceremonies and rituals related to the birth of a child, all of which are contributing to the revitalization of the vital link between First Nations and the territory. The strength, resilience, and knowledge demonstrated by First Nations women and families are enduring characteristics of their maternity (Neufeld and Cidro, 2017).

Number of children

In light of this brief overview on the significance of maternity for First Nations women, the fact that they have a higher fertility rate (number of children per woman), even double that of the non-Indigenous Canadian population (Statistics Canada and the Assembly of First Nations (SC and AFN), 2021), sparks derogatory remarks. The rhetoric that Indigenous women have "too many babies" is a recurring theme in the testimonies heard. Here are a few examples.

With the help of an interpreter, a woman recalls that in 1974:

> She heard a lot of things like that. Especially from the nurses. At the hospital, they said that women from (name of the Nation) didn't know how to raise children, that they had too many children, and that it was better to sterilized them. They were made to feel worthless so that they would agree to the surgeries (090-IS-OGV).

In the 1980s, a woman withstood pressure from medical staff who urged her to undergo sterilization. She says she did not let herself be intimidated by the doctor's insulting and hurtful comments:

> When I gave birth, they offered to perform a tubal ligation on me. The doctor who delivered my baby asked me, "How many kids do you have now?" I said that this was my fifth. (The doctor said:) "Don't you think you've had enough?" I told him that I was the one who would decide when enough was enough (085-WI-IS).

The following statements contain comments heard in 1988 and 2015, respectively, suggesting how prejudice endures and continues to shape conversations:

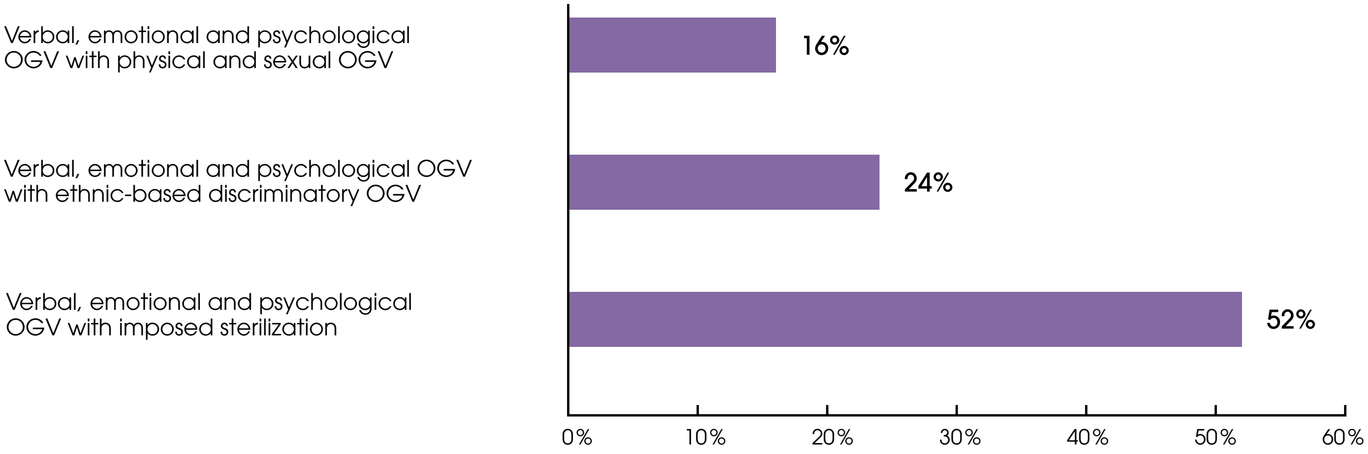
> Except for what Dr. (name) said when I started the process. He told me, "I think that's ok now; you have enough children. You already have three. Your family is complete" (105-IS-OGV).

> It really upset me when she told me I was having too many babies at my age. I felt insulted (063-IS-OGV-IA-BT).

In numbers

The following numbers indicate that verbal, emotional, and psychological OGV may occur independently; however, they are often accompanied by other forms of OGV, such as IS (see Table 7). Of the 58 testimonies reporting verbal, emotional, and psychological OGV, 9 (16%) also cited physical and sexual OGV, 14 (24%) also experienced ethnic-based discriminatory OGV, and 30 (52%) also underwent imposed sterilization. The cumulative effect of these various forms of OGV may result in significant repercussions, which are addressed in a subsequent section.

Table 7. Percentage of women who reported experiencing verbal, emotional, or psychological OGV combined with another form of OGV (n=58)



Role of nursing staff

In contrast to Phase I of this research, testimonies collected in Phase II place greater emphasis on the role of nursing staff on the health care experience. Several women describe difficult interactions with nurses, typically the first people they encounter within the health care system during hospital stays. Here are three instances of experiences that occurred in 1978, 1984, and 1999, respectively:

> But when we went to the hospital, after I gave birth, some of the nurses were *rough* with us. (…) They kept telling us we were savages (048-IS-OGV).

> And sure enough, at the hospital in (name of city), they laughed at us. Even during childbirth, they told me, "Oh, your baby has black hair, he's going to have lice." That's what they said when I had my first baby. It was the nurse who said that: "He's going to have lice" (086-IS-OGV).

> The nurses were very rough. (She said): "Let's go, move, come on!" (077-OGV).

Box 4. Role of nursing staff

Historically, First Nations women have consistently experienced issues in relationships of power with the nursing staff at their community dispensaries. Due to this imbalance of power between them and the nursing staff, it was generally determined from the second half of the 20th century, onward, that women would be evacuated to urban facilities to give birth, therefore, cutting them off from their support network and the knowledge of midwives:

> By refusing to monitor pregnancies and by actively spreading a rhetoric of risks associated with birthing within the community, dispensary nurses have played a prominent role in the generalization of this type of medical practice, which can be described as hospitalocentrism (Desrosiers, 1999; Gaumer and Desrosiers, 2004) (Basile *et al.*, 2023, p. 52).

In 2021, the *Ordre des infirmières et infirmiers du Québec* (OIIQ) published a position statement noting that: "All forms of discrimination and racism, including systemic racism against First Nations and Inuit, have been denounced and condemned for several years now (National Collaborating Centre for Indigenous Health (NCCIH), 2013)" (Translation) (OIIQ, 2021, p.1). In addition, the Order acknowledges that the history of the nursing profession and its relationship with First Nations people is tainted by medical colonialization, thereby contributing to undermine the trust that is supposed to form the cornerstone of the care provided. It (OIIQ) suggests the implementation of concrete actions for instituting a culturally safe approach and encourages its members to "denounce all situations that could contribute to the perpetuation of racism and discrimination" (Translation) (OIIQ, 2021, p. 16) against First Nations people.

2.2 Physical and sexual OGV

Recognized as a global scourge by international organizations, violence against women and girls is now better documented than ever before. An estimated 736 million women, almost one in three, have been subjected to physical and/or sexual violence at least once in their life (UN Women, 2025). Among all forms of violence, OGV is certainly the least visible and most stigmatized worldwide, even though these cases are far from isolated in women's experiences within different health care systems. Bisch (2025) adds that "they are at the heart of sexist gender-based and sexual violence (SSV) and involve practices and acts carried out without respect for personal privacy, free and informed consent, or in an inappropriate manner" (Translation) (p. 15) in addition to manifesting itself in "the same patterns of denial, shifting of blame, disregard for victims' voices, rape culture, and impunity" (Translation) (p. 18). The WHO is equally clear on this matter:

> Many women experience disrespectful and abusive treatment during childbirth in facilities worldwide. Such treatment not only violates the rights of women to respectful care, but can also threaten their rights to life, health, bodily integrity, and freedom from discrimination (WHO, 2015, p. 1).

In Canada, Indigenous women are not exempt from this phenomenon. According to a recent Statistics Canada report on violence against Indigenous women, the legacy of colonization continues "to impact Indigenous families and communities" (Heidinger, 2022, p.3). For instance, the proportion of Indigenous women who are victims of physical violence (56%) and sexual violence (46%) far exceeds the proportion of non-Indigenous women who are victims of the same types of violence, with rates of 34% and 33%, respectively. Furthermore, many stereotypes about Indigenous women are prevalent within the health and social services system. They are often viewed as hypersexualized, immoral, and more tolerant of violence and pain; they are also assigned a lower status compared to other women in the general population (Amnesty International (AI), 2015; Native Women's Association of Canada (NWAC), 2022).

In numbers

In Phase II of this research, it was not uncommon for the same respondent to report having been a victim of more than one type of OGV during her lifetime. In fact, 21 women (22%) out of 94 reportedly experienced physical and sexual OGV, independently or in conjunction with other types of OGV, with or without sterilization. The following table (Table 8) indicates the number of testimonies mentioning this type of violence, per the respondents' Nation. For example, 17% of Atikamekw Nehirowisiw women who participated in the research reported having experienced physical and sexual OGV, including other forms of OGV and an imposed sterilization. Among the Innu women who participated in the research, the rate was 24%.

Table 8. Number of participant testimonies referring to physical and sexual OGV per Nation

Nation	Total of participants	Physical and sexual OGV (combined with other forms of OGV and IS)		Physical and sexual OGV only (no other form of OGV of IS)	
	n	n	%	n	%
Anishnabe	5	0	0%	0	0%
Atikamekw Nehirowisiw	36	6	17%	0	0%
Eeyou	3	1	33%	0	0%
Innu/Naskapi	50	12	24%	2	4%
Total	**94**	**19**	**20%**	**2**	**2%**

2.2.1 Tolerance to pain

As early as 2022, the Phase I report of this research was already condemning one persistent bias against Indigenous women and identified as a root cause for certain forms of OGV. There seems to be a popular belief that First Nations people have a higher tolerance for physical pain. Therefore, they are less likely to be given pain medication when the medical staff believes this assumption (Heino, 2018). This misconception, combined with similar belief about substance abuse, reinforces this type of violence, physical in nature, against First Nations women, with the result that "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 CAO cited in FNQLHSSC, 2022, p. 59).

Among the testimonies from Phase II, at least four women describe physical OGV that could possibly be linked to the assumption that Indigenous people have a higher threshold for pain. For example, one woman described the intense pain she felt while in childbirth, in 1985, when the doctor performed a manual uterine examination (retrieving the placenta by hand):

> But the doctor, back then, told her that the piece of placenta that was still there – because there was a part he tried to pull out. He had pushed his hand, his arm, all the way in to try – It hurt! Then he kept pulling – Until it tore. I tried to poke him to tell him to stop, but he kept going. He was hurting me (064-IS-OGV).

In 1986, while in labor with her second child, one participant asked for water and another painkiller:

> When I started having strong contractions, I asked for help. But the nurse was in too much of a hurry to help me; she was rushing through everything. (…) I tried to calm myself down because I knew she wouldn't pay attention to me when I asked for something to relieve my pain. That's my experience (097-OGV).

Another woman recalls that, in the early 2000s, undergoing a cervical check was expected to be painful because the doctor performing it was notorious among women for being rough:

> I'd already heard things like, "Watch out for Dr. (name) – he's got long fingers. He'll hurt you." Things like that. It's true that he was rough. At one point, he came to *check* my cervix. I remember saying: "Oh no. Not again? You're hurting me." Then he told me: "It has to hurt" That's what he said (041-IS-OGV).

Sometimes, nursing staff step in to address a colleague's violent actions against a woman, as in this 2014 case:

> They inserted a balloon to dilate me, to get me dilated.
>
> Q: "In the cervix?"
>
> A.: "Yes, my cervix." It didn't work. They tell me my baby is stuck. (…) Dr. (name), I feel like he's… It feels like he's shoving his whole hand into my vagina; something's going on there. The nurse who was watching said, "No, that's enough!" He said, "We need to get her ready and bring her down." He (the doctor) was so desperate to get my baby out of my vagina right then. I could tell that what he was doing to me wasn't normal (078-IS-OGV).

One particular testimony illustrates how this woman has taken a step back since the 1980s, as she concludes that:

> I've often been in hospital. I never felt any respect. I didn't know if that was normal or not. I've been thinking about that for a while now, and I feel like I was never treated like a patient should, respectfully and gently... I've always been shoved around (101-IS).

Finally, one participant shared comments she heard during her time working in a hospital in early 2010:

> Another thing I've heard in my medical practice is that many Indigenous women complain less while in labor, so (nursing staff) assume they're more tolerant to pain. So, it's as if there might be a positive or negative stereotype, like, "Indigenous women are strong. They tolerate pain really well" (046-WI-OGV).

2.3 Ethnic-based discriminatory OGV

While OGV may also shape the health care trajectory of non-Indigenous women, Indigenous women experience them in a context where racism, whether direct or systemic[16], influences interactions, thereby leading to differential treatment. For First Nations women, this violence is embedded in a system where racial prejudice is layered on top of their experience of abuse, making it more severe. In Quebec, discrimination is prohibited by the Charter of Human Rights and Freedoms, which also applies to health care and social services establishments. And yet, although discrimination and systemic racism have been repeatedly condemned in the public

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[16] The *Commission des droits de la personne et des droits de la jeunesse* adopts the following definition of systemic racism: "Systemic racism refers to an unequal social relationship characterized by dynamics of inferiorization, subordination, and exclusion arising from social structures, which impose a cumulative set of disadvantages on racialized groups - particularly Black communities and Indigenous peoples – across various aspects of their lives: education, employment, housing, health, public safety, the justice system, and so on" (Translation) (CDPDJ, 2021, p. 123).

sphere over the past few decades, in practice, these issues have received little focus in public policies in Quebec (CDPDJ, 2021).

The examples of OGV collected during this phase indicate that, for First Nations women, this form of violence occurs within a colonial context distinct from that experienced by other marginalized groups. Implicit in these practices is a blatant lack of trust on the part of health care staff towards the women and their families, further contributing to the feeling that their parenting skills are devalued because of their ethnic background.

An analysis of the testimonies reveals four types of ethnic-based discriminatory OG, which can be summarized as follows: birth alert (BA) = 7 testimonies; misidentification of Mongolian spots (MS)[17] = 3 testimonies; blood test without prior consent (BT) = 12 testimonies; and imposed abortions (IA) = 12 testimonies. In total, more than one-third of the testimonies, 34 (36%) out of a total of 94, mention at least one of these types of OGV. Seven testimonies mention two of them.

These four manifestations are considered here to be OGV, as they fall within the purview of obstetric care. Indeed, some birth alerts were filed before or immediately after delivery, sometimes due to suspected abuse based on the presence of Mongolian spots, and blood samples were taken from the newborn immediately after birth. As for abortions (terminations of pregnancy), they are considered part of obstetric care by Quebec health services; however, the "imposed" nature of the procedure, as described in some testimonies, raises concerns. Within the scope of this research, it has been determined that the four types of OGV are rooted in the ethnic background, particularly the Indigenous heritage, of the individuals concerned. As for the Mongolian spot, it caught the attention of physicians and anthropologists as early as the beginning of the 19th century. A number of publications document its existence and emphasize that it is a genetic trait common to many indigenous babies around the world. With respect to blood tests conducted without prior consent, the Viens Commission report acknowledges that this issue was raised with the commissioner; however, there is no available data concerning blood samples taken from Indigenous individuals (PLRP, 2019). Lastly, cases of imposed abortion have been documented in the Phase I report of this research, as well as in several additional publications. Specific questions on this issue were therefore added during Phase II of the research.

2.3.1 Birth alerts

The first form of ethnic-based discriminatory OGV is the birth report, better known as the "birth alert". This practice has been experienced by seven participants or their family members. A report is filed by health care staff (or others) with the DYP when there is a risk of neglect or abuse toward the newborn. Social service workers are then called in to assess the situation. Though presented as a protective measure, this practice can just as easily become a stigma that weighs heavily on Indigenous families who fear losing their children. For many, these alerts represent yet another attempt at assimilation, following in the footsteps of Indian residential schools, the Sixties Scoop – the widespread removal and placement of Indigenous children by social services, and the removal and disappearance of Indigenous children from healthcare facilities and other public institutions, as well as another form of reproductive violence (Durant *et al.*, 2024). Ultimately, this type of OGV affects everyone, even parents who have done nothing wrong. The hard-hitting report by Boyer and Bartlett (2017), which examines cases of forced sterilization in Saskatchewan, also documents the difficulties new Indigenous mothers encounter when social services contact them even before their child is born.

Based on the testimonies presented, multiple biases are interrelated, resulting in threats, attempts to remove children, or actual removals. One participant remembers an incident that occurred in 1999, and the fear she felt after a nurse's veiled threats. The nurse's comments implied that First Nations mothers regularly abandoned their children:

> The nurse told me that if I wasn't back in 45 minutes, they'd call social services. (I said:) "I'm just going down to the cafeteria, and my boyfriend is going outside for a smoke, that's all. I'll be right back." The fear! I never wanted to leave my baby alone at the hospital because the DPJ would be involved.

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[17] "Located on the buttocks or back, these (mongoloid) birthmarks, which range in color from blue to green or gray, resemble a bruise on the skin. They are the most common birthmarks among newborns of African, Indigenous, North American, Asian, or Hispanic descent" (Translation) (Naître et grandir, 2025).

> That was scary! I know a lot of women experienced that when they wanted to go smoke downstairs, (and they are told:) "You'd better come back, or we'll call the DPJ!" (…) I don't know if they say that to non-Indigenous women. It would be interesting to know. I wouldn't be surprised (if they didn't). I've only heard that kind of story shared by First Nation women. I don't know if it's still like that today, but back in 1999, there was a lot of that (077-OGV).

This stereotype about a disproportionately high rate of child abandonments by Indigenous women is sometimes explicitly expressed overtly by health care professionals. The following statement references an event that took place in the early 1990s:

> Then, they were all staring at me (the students who were with the nurse who was saying) : "How come? You Indigenous people, you have kids and then you just let them go like dogs." Stuff like that. She said that Indigenous people were really good at delivering babies. (She said:) "They give birth like cats, but they abandon their babies… when they give birth, they're high on drugs" (039-IS-OGV).

As a result, health care staff sometimes question Indigenous women's parenting abilities and associate them to another bias: problematic alcohol and drug use. The following testimony describes an incident from 2014:

> She (the health care worker) often talked to me about alcohol. She asked me about how (much) I drank, and then about my parents… It was as if she was trying to get me to tell her that my parents were alcoholics, but that wasn't the case. (…) She had told me, during my previous pregnancy (…) that my child would be monitored (063-IS-OGV-IA-BT).

The following testimonies refer to other cases of birth alerts. These occurred relatively recently, in the 2000s and 2010s:

> Even today. I heard about it from (another woman in the community). She went to give birth in (name of city), and there were people who went to take the baby. It still happens today (092-IS-OGV).

> My older daughter went through this too, a report before her baby was born, during her first pregnancy in 2017. (…) She gave birth to a stillborn baby. Just before we left, the doctor asked, "Do you still want me to contact the DPJ?" (I said:) "What!?" I was surprised. He said: "Oh, you didn't know?" (I replied:) "No, I want to see the form." He went to check the file and then told me the form wasn't there anymore. (…) Maybe it was a common occurrence; my daughter already had a file with the DPJ (…). I had said I would take care of the baby and look after her, but that wasn't enough for the DPJ (115-OGV-BA-BT).

This participant explains that after giving birth, she wanted to use a traditional baby carrier, a tikinakan or misaspison, in which the baby is swaddled (and secured). This comforting cultural practice was strongly discouraged by the nursing personnel. In 2015, she refrained from using the tikinakan to avoid being reported to the DYP:

> Then we tied the baby as we do in First Nations communities. We tie… I don't know how to explain it, but we tie the baby. We were told it was dangerous, that there was a risk of suffocation, and that it wasn't safe because we couldn't untie the baby quickly if something happened. But this is a practice that's been around for thousands of years, you know. (…) So, we stopped doing that at the hospital. I was really afraid of getting a report precisely because they (the nurses) had taken my child during the night without asking me (042-OGV-BT).

Another woman, who says she is doing fine, is surprised when a social worker is assigned to her in 2023, just before her due date. Even though she doesn't think she's in the wrong, the confusion and anxiety this imposition might have caused were unnecessary:

> That's what she (the social worker) told me: "It's just a precaution. All pregnant women are asked these kinds of questions." I looked at the OB-GYN, then I said: "But I've had two previous pregnancies, and I never needed a social worker. No social worker ever came to see me." She didn't say anything and then she left. Then, the social worker told me: "(…) They told me you're giving birth tomorrow morning. So, I'll be there for your delivery. I'll come see you." I said, "OK, you come. There's no problem at my place. Everything's fine" (037-OGV-BA-BT).

To prevent the DYP from taking a child away, female family members support and protect each other:

> That's when my daughter asked the woman, "What do you want with the baby?" Instead of waking me up and speaking to me, she said to my daughter: "Well, we received a report; I'm from the DPJ, and I'm here to take the baby." Then my daughter told her, "No, get out of the room; you don't even have the right to be in here." So, she kind of pushed the woman out of the (hospital) room. After that, my daughter came to me and woke me up. (She told me:) "They would have taken my baby away without even telling me if I hadn't been breastfeeding" (061-IS-OGV-BA-BT).

Another kokom (grandmother) stays with her daughter as a precaution:

> I even stayed with her in the room. There was a bed for her, one for me, and one for the baby. Just to make sure the social worker didn't leave with my grandson (065-IS-OGV).

Some women resist these attempts to remove their children on the grounds that they are deemed too young to be parents. Other women, whose parenting abilities are called into question, ask to be judged on facts rather than on *preconceived notions*. One of them, who refused to let her child be taken away, illustrates this perspective:

> They wanted to take my daughter. They wanted to place her in a foster home. And they wanted to put me in a home for troubled girls. They wanted to place my daughter also. The DPJ asked me what they could do to help me. I answered: "Just let me show you what I can do" (074-IS-OGV-BA).

In numbers

During data collection, seven women reported having been subject to birth reports, and several others mentioned having heard about birth alerts from people they knew, though they were unable to provide specific details (see Table 9).

Table 9. Number of birth alerts per Nation

Nation	Total of participants	Birth alerts	
	n	n	%
Anishnabe	5	1	20%
Atikamekw Nehirowisiw	36	2	6%
Eeyou	3	0	0%
Innu/Naskapi	50	4	8%
Total	**94**	**7**	**7%**

This type of OGV inevitably leaves a lasting impression on the collective and family consciousness of First Nations people, who fear the arrival of the DYP in their lives.

2.3.2 Misidentification of Mongolian spots

The second type of OGV encountered is associated with Mongolian spots, bluish marks found on the skin of 80% of Indigenous newborns in North America (among Native Americans and Inuit people) that normally fade during childhood (Giger and Haddad, 2020). Another scientific publication reports that, according to a doctor, these marks are very common among Indigenous babies in northern Canada (Chambers *et al.*, 2008). The spots can change in size, and at times, resemble large bruises on a newborn's body, which may be mistaken for signs of mistreatment. Based on testimonies, some nurses who suspected abuse, reported cases soon after birth. The three following accounts illustrate how a lack of understanding about this genetic characteristic can seriously affect women and their families.

> The only time we were ever reported was after the birth of my third child (in the early 1980s). (…) At some point, our baby was sick, so we took him to a hospital, and there was (…) an emergency room doctor. He examined him, looked at his back, and asked us, "Is your baby okay?"
>
> A.: He has a fever; that's why we're here. Other than that, yes.
>
> Q.: "Are you feeding him well, treating him well?"
>
> A.: Yes. (The emergency room doctor adds:) "Because that's not what I think. Wait here." Then he left, leaving us in the small room. Next, a pediatrician came in, accompanied by hospital security. The pediatrician took the baby, placed him on the examination table, and said to the doctor: "Ah, you're talking about those bruises? That's normal; some children are born that way, it's in their heritage. They're full-blooded Indigenous, that's why they have that mark" I asked the doctor if he thought our child was being abused, and he told me that given his bruises, yes. (He added:) "It could have happened," pointing at us, "They're Indigenous; they abuse their children sometimes."
>
> Q: Did he apologize?
>
> A: No (064-IS-OGV-MS).

> When my second daughter was little (in the late 1980s), you know, babies have birthmarks, and hers was on her back. People kept asking me all sorts of questions: "Is everything okay at home? Did the child fall?" Then one day, I wondered: "Why are you asking me that?" (They replied:) "Because there's a mark on her back." Well, I told them it was her birthmark. (They insisted:) "It's dark and bluish." (I said:) "Yeah, it's dark!" (050-IS-MS).

> (In 2005), she said she felt intimidated by the doctor. A week after giving birth, she received a birth alert. The doctor who examined the baby believed that the "*mongoloid*" spot (bluish mark) the baby had was the result of abuse. She managed to get her child back after a week (109-BA-MS).

The interviews with the participants did not include targeted questions about the presence of Mongolian spots. This subject should be explored more thoroughly in future research. It would also be relevant to include this topic in the training curriculum of health care professionals in Quebec.

2.3.3 Blood test without prior consent

The third form of OGV identified in this research involves taking a blood sample without prior consent for the purpose of screening for drug and alcohol use. The testimonies indicate that 12 participants (13%) reported experiencing this. Mothers sometimes undergo these blood tests, but they are more often performed on newborns. Their parents are not consulted and learn of the screening only when told the test results. This practice seems to be linked to the assumption that First Nations mothers use drugs and alcohol during pregnancy. This blood test should not be confused with the heel prick test performed on newborns, which screens for rare genetic disorders and is known as the Guthrie or Phenyl test. This latter test, recommended across Canada for all newborns, appears to serve as a pretext for additional screening among Indigenous people. As previously mentioned, the Viens Commission report (2019) in Quebec is the sole source to have briefly addressed this issue.

One participant, who worked in the health care system and witnessed various forms of OGV, states that obtaining parental consent before performing the Guthrie test is not always enforced, even though it is mandatory:

> (The) first test is for genetic disorders. You do the test on the baby's heel; it's called the Phenyl test. You have to fill five circles (on the screening card.) The nurse used to do that. I've done it many times. Poor little heel, so tiny. You have to fill the (capillary tube) and then send it somewhere so they can run genetic tests. They don't ask (the parents) (046-WI-OGV).

Another participant, who was 50 years old at the time of her testimony, distinguishes between the Guthrie test and a "second" test or a larger blood draw, that her five children underwent:

> That's how I found out that a blood test had been performed on my baby without my consent. Oh yes, that happens; my babies all went through that (061-IS-OGV-BA-BT).

Another participant is seemingly well aware that she is suspected of having consumed alcohol or other drugs during her pregnancies. In her testimony, she reports that her two children underwent screening tests at birth. The first time, in 2016, no one asked for her consent. The second time, in 2022, she consented to the screening, but notes that she was only just recovering from surgery:

> After the ligation, they came in; we were in the room, and I was still a little groggy. They asked if they could do a blood test, and I said yes. (…) They asked me that for my baby. I said yes because I had nothing to hide. The weird thing is that they hadn't (asked for consent) during (my first pregnancy). They just did it on their own initiative.
>
> Q: And this time, did they ask for your permission?
>
> A: Yes. That's the difference between the two pregnancies. Plus, I was still out of it when they asked me that. I said yes, go ahead. (…) I knew they wanted to see if I'd used drugs during (my pregnancy) (036-IS-OGV-BT).

In another case, a woman states that in 2012, she denied permission for a drug screening test on her newborn. Despite her refusal, the medical staff conducted the blood draw without her consent, disregarding her rights and showing little concern for her wishes. They questioned both her word and her parenting abilities:

> The doctor came in and held my son as if he were her own baby. She said, "Oh, my little baby, your test is negative!" I was sitting in my bed and looked at her (saying), "I had said no!" She just said, "Oh, I had to do it." I don't know how to put it, it's as if she had just trampled all over my rights. Even though I had said no, I was really angry with her, and I couldn't wait to (go back) home. She did the test anyway, and I was really shocked (115-OGV-BA-BT).

In a similar vein, a grandmother recounts accompanying her daughter during her post-delivery stay at the hospital in 2010, where a blood sample was taken without their knowledge:

> She stayed in hospital for two and a half days. The next day, I think, the doctor came in and told her, "Ma'am, your child's blood test results came back negative." She (my daughter) didn't ask any questions; she didn't even pay attention to it. I was the one who asked him (the doctor): "Why the blood test? What's the test for?" He said it was to check for drug use in the blood. That's what he told us. (I replied:) "I thought we told you there was no drug use during her pregnancy, and you didn't believe us. You still did the blood test?" He just replied, "Well, you don't have to worry" (129-WI-BT).

In 2014, another participant was informed and presented with a *fait accompli*, without the possibility of giving consent:

> They're going to take blood samples to check if I've used alcohol or drugs during my pregnancy.
>
> Q: Did she ask for your consent for the blood tests?
>
> A: No. (…) I was told that everything came back negative, that there were no signs of alcohol or drugs. Then they let me go with my baby (063-IS-OGV-IA-BT).

In 2018, another woman also learned that a test had been performed on her newborn without her consent. After the fact, she was told that even if she had objected (had she been consulted), the blood draw would have taken place anyway. In the event that this hypothetical test had revealed the presence of drugs, she was frightened by the threat of retaliation – imposed sterilization – which would have prevented her from having more children:

> Yes, because the nurse told me they had taken blood samples from my baby to find out if I had taken drugs or alcohol.
>
> Q: Were the blood tests done on your baby without your consent?
>
> A: Yes. They told me afterward. They told me that if I had said no, I wouldn't have had a choice, they would have done a tubal ligation (if they had found) drugs or alcohol in my baby's blood (068-IS).

Some participants do not hesitate to speak openly about the prejudices held against them. The intensity of these biases seems to regularly overshadow the voices of First Nations people:

> When I had my daughter, after she was born, I wanted to breastfeed, I was thinking of that. When I gave birth, she had seizures immediately, so they took her away, they put her in an incubator, and they asked me: "Did you do drugs?" I said: "I don't do drugs. I planned this pregnancy; I quit smoking pot and drinking two or three months before, but I quit." But they didn't believe me, and they took my blood to check, to test. And I was negative. Why would I lie? (…) I agreed because there was nothing to hide. I thought right away that it was because I was a First Nation woman that they did this to me (075-OGV).

Other participants even volunteered to take the test to prove they were telling the truth about being drug-free. One of them shares her experience from 2021:

> I was the one who suggested they take blood samples (…). I told them, "There are no traces of drugs in there. I haven't had a drink in 10 years. You're too late if you want to accuse me of always being wasted." (…) They told me the tests came back negative (067-OGV-BT).

In numbers

The data presented on this subject is the only one available, pursuant to a review of Quebec literature.

Table 10. Number of blood tests performed without prior consent

Nation	Total of participants	Blood test without prior consent	
	n	n	%
Anishnabe	5	2	40%
Atikamekw Nehirowisiw	36	5	14%
Eeyou	3	0	0%
Innu/Naskapi	50	5	10%
Total	**94**	**12**	**13%**

Taking blood samples without prior consent, an action regarded as a form of OGV, can deeply affect First Nations mothers, eroding their trust in health care providers and undermining their right to make choices for themselves and their newborns. Even when asked for their input, their choices are frequently disregarded.

2.3.4 Imposed abortion

Studies indicate that, after abortion was legalized in Canada in 1969, Indigenous women experienced pressure to undergo terminations of pregnancies. At the time, this was largely due to concerns about the size of their families and the associated financial burden on the State (Dyck and Lux, 2020). In Canada, a total of 29 Indian hospitals[18] have been documented. Emma Posca notes that in these hospitals, pregnant Indigenous women "were forced into having abortions and those who were not pregnant were forcibly sterilized" (Posca, 2020, p. 84).

The Phase I research report had already described the practice of imposed abortion (termination of pregnancy) as "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" (FNQLHSSC, 2022, p. 48). Much of this pressure was often exerted in situations when these women had little time to make an informed decision or to fully understand the medical reasons justifying terminating their pregnancy. Not surprisingly, the issue of imposed abortions also surfaced during data collection for Phase II. Twelve testimonies (involving eleven Innu women) report either undergoing abortions or feeling pressured to consent to them. Some participants recall not being given enough time to make an informed decision about agreeing to the procedure. They describe being rushed into it. These experiences occurred in 1980 and 2019, respectively:

> They (the medical staff) didn't say to me, "We're going to wait another two weeks to see how things go." They didn't say, "We're going to wait a little longer. You're going to rest in bed. We're going to keep you here." They could have told me that. Maybe I would have had my baby. But it was right away when I went to the hospital: "You're going to the operating room. That's what's going to happen" (080-OGV-IA).

> All of a sudden, the nurse comes in. She takes out a syringe and injects me right away. (I said:) "Ouch, why? Why?" She told me it was to get the fetus out. I looked at her and said, "But it's still alive! We heard its heartbeat this morning." She replied, "Well, that's it. We told you the baby wouldn't be okay. Or maybe you're the one who's going to die if you keep it." (They told me) it was a complicated pregnancy; there might be bacteria, etc. They gave me all sorts of reasons (to have an abortion) (127-IA).

Two women also refused to have abortions despite warnings of possible genetic disorders or birth defects. Both children, born in 2018 and 2021 respectively, were healthy and had no birth defects:

> That's when they said they saw something abnormal in my blood tests. They told me my son would have Trisomy 18, that he would have facial and hand malformations as well. I was saddened by this news at first. (…) They (also) wanted to perform an amniocentesis on me; they wanted to draw some amniotic fluid. I refused. A specialist told me, "I think you're too young to have a child who's deformed." I was 24. He told me that I was young, that I'd have to spend days, months, even years in the hospital (071-IA-Attempted).

> The doctor told me he was going to send me to Quebec City for a termination of pregnancy: "You have to, you have to have an abortion because your child won't have the best quality of life. He'll be fed through a tube, he'll be in hospital for the rest of his life. He'll be born in the hospital, and he'll die in the hospital" (043-OGV).

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[18] Indian hospitals were segregationist institutions designed to isolate Indigenous patients and protect the general population from infectious illnesses such as tuberculosis. In operation from 1920 to 1980, often located on Indian reserves, these hospitals were under-staffed, under-funded, overcrowded with questionable treatment methods (Lux, 2016).

Other participants advised of having an abortion face the many prejudices against Indigenous women. People assume they have too many children, that their income is insufficient to care for them, that their family environment is problematic, or that they are too young. Two testimonies, recounting events that took place in 1980 and 2015 respectively, reflect these biases:

> The nurse told me to have an abortion because I already had two (children) and that was too many, that it was better for me to have an abortion. (…) I had two abortions because the nurse told me I had to have one. I agreed; I didn't know if it was right for me. I agreed because they kept bringing it up during my prenatal care. (He said): "Do you want to have an abortion?" I answered: "I don't know." (The nurse came up with reasons like:) "Your job, plus your husband drinks…" (096-OGV-AI).

> She (the doctor) knew it was my fourth pregnancy. She suggested I have an abortion, but I really wanted to keep this baby. Second appointment, second follow-up, she suggested again that I have an abortion, and I told her it was a desired child. She said to me: "You don't work plus you're expecting a fourth (child)" (063-IS-OGV-IA-BT).

Another participant describes how her fear of being judged by nursing staff first led her to consider abortion, and subsequently to avoid seeking health care in the early 2000s:

> I remember with my third (child), at first, I wanted to get rid of it because it seemed like I was afraid of being judged. I wanted to get rid of it at one point.
>
> Q: You mean have an abortion?
>
> A: Yes, an abortion. (…) Just because I was afraid of the doctors, I was afraid of prejudice, because I had removed my IUD. Not long after, I got pregnant. Then I didn't go right away for my follow-up appointment. I hadn't gone to tell them I was pregnant precisely because of that (041-IS-OGV).

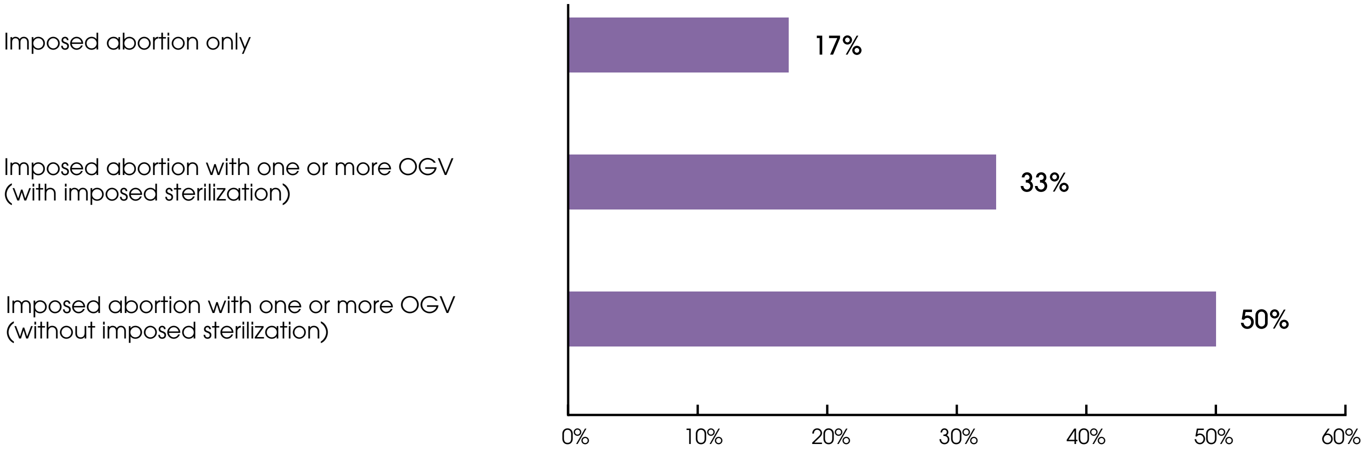
Although some women manage to resist the pressures to have an abortion, they may find themselves caught up in a vicious cycle that leads them from one type of OGV to another. In the early 1990s, a woman was recommended to have an abortion because of her young age. Subsequently, she avoided prenatal care because she feared interventions by social services:

> I was 16 years old. They (the doctors) wanted me to abort (my first baby) because I was young. At five months (of pregnancy), they asked me. They told me I'd have to go to (name of city) to get an abortion, that they did it up to eight months. I thought about it for two more months. And I didn't go to my (pregnancy) appointments. (…) Then, since I'd missed all of my follow-ups, they called the DPJ because I was young. When my daughter was born, they wanted to take her because I didn't go to the follow-ups (074-IS-OGV-BA).

In numbers

The 12 listed cases of imposed abortions were experienced in isolation, alongside other forms of OGV or in combination with an IS (see Table 11).

Table 11. Ratio of imposed abortions combined with another form of OGV (with or without IS) (n=12)



2.4 Sterilization and imposed sterilization (IS)

Sterilization is a surgical procedure that permanently prevents pregnancy. Common methods of sterilization include tubal ligation and hysterectomy for women, and vasectomy for men (WHO, 2014, cited in Webb, 2024).

Tubal ligation is a procedure that involves blocking the fallopian tubes to prevent the egg from reaching the uterus. It can be performed using various techniques (Chapman and Magos, 2008):

- Laparoscopic ligation, most often performed under general anesthesia, involves tying, cutting, and/or cauterizing (burning) the fallopian tubes. This method is effective immediately after the procedure. Other laparoscopic methods of tubal occlusion involve clips or a ring.

- Transcervical sterilization, performed under local anesthesia, does not require an incision, as access to the fallopian tubes occurs through the cervix. It is performed by inserting a device that blocks the fallopian tubes. This technique is not effective immediately after the procedure, and another method of contraception must be used for a period of three months.

The *Institut de la statistique du Québec* (2011) reports that, after it was legalized in 1969, the rate of tubal ligation (for the general population) declined sharply between 1976 and 2010. The steepest decrease was observed among women aged 30 to 34, with rates falling from 48 per 1,000 women in 1977 to just 3.8 per 1,000 women in 2010 (MSSS, 2025).

Sterilization may also be achieved via hysterectomy, which involves removing the uterus (partial hysterectomy) or the entire uterus and cervix (total hysterectomy). In certain medical circumstances, a radical hysterectomy (removal of the uterus, fallopian tubes, ovaries, parts of the vagina, and associated lymph nodes) may be indicated. This procedure is particularly recommended for women who present contraindications to laparoscopic sterilization, such as obesity or a history of pelvic surgery (*ibid*).

The ISQ (2011) also reports a general decline in this type of procedure in Quebec since the 1970s. For women aged 40 and older (40 to 44, 45 to 49, and 50 and older), hysterectomy rates (6.7 to 6.8 per 1,000 women) remain comparable to those of 2010.

Tubal ligation and hysterectomy are considered to be permanent sterilization procedures: they render procreation impossible.

2.4.1 Imposed sterilization (IS)

The absence of free and informed consent lies at the heart of the term "imposed sterilization," which has been adopted for the purposes of this research. Findings from Phase I and the current phase indicate that this type of sterilization among participants has been frequently performed during or after childbirth but also during other medical interventions, without medical justification or free and informed consent, rendering the practice illegal (see Section 1.3 for the WHO definition). To that end, Bill S-228, *An Act to amend the Criminal Code (sterilization procedures)*, introduced by Métis Senator Yvonne Boyer, has been tabled in the House of Commons of the Canadian Parliament for first reading on November 18, 2025 (see **Appendix E**).

The initial data collection, conducted in 2021 – 2022, allowed to document 22 cases of IS (with or without other forms of obstetric violence) among First Nations and Inuit women in Quebec. The recent testimonies identified an additional 55 new cases of IS[19], for a total of 77 cases over a period of nearly 50 years (see Table 12). This category of OGV is the most frequently represented in the research corpus. The testimonies refer to IS procedures spanning from 1974 to 2022.

Table 12. Number of IS cases per time period

	Phase I (2022)	Phase II (2026)	Total
Furthest in the past and most recent IS	1980-2019	1974-2022	
Number of documented IS	22	55	77

During this second phase, more than half (59%) of the women interviewed reported having experienced an IS (see Table 13). They were from all five participating Nations. As with the results from Phase I, Atikamekw Nehirowisiw women were more likely to report cases of IS (28), followed closely this time by Innu/Naskapi women (23).

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[19] In total, 60 testimonies reported cases of imposed sterilization. Of these, five were excluded: three described events broadly observed during their work in health care settings, and two came from women who had never received confirmation that they had indeed been sterilized.

Table 13. Ratio of IS per Nation

Nation	**Total of participants**	**Testimony of IS**	
	n	**n**	**%**
Anishnabe	5	1	20%
Atikamekw Nehirowisiw	36	28	78%
Eeyou	3	3	100%
Innu/Naskapi	50	23	46%
Total	**94**	**55**	**59%**

At the time of the procedure, the majority of participants were in their twenties. One woman indicated that she was only 19 years old when she underwent a hysterectomy during an emergency caesarean section (C-section). Of the 55 documented cases, the most represented age group is women aged 19 to 29, with 37 individuals having undergone an IS. This is followed by women aged 30 to 39, among whom 15 underwent an IS.

The data collected also show that the IS has reportedly occurred in various cities across Quebec. There are 12 such cities (five previously mentioned in the Phase I report), spread across several administrative regions of Quebec (and the island of Newfoundland for specific cases) (see Table 14). Once again, these are mainly regions where the First Nations women live or are directed to access health care, particularly for childbirth (see the report by Basile *et al.*, (2023) for more information on these trajectories). Most cases of documented IS, with or without other forms of OGV, are believed to have occurred before the year 2000, particularly between the 1970s and 1990s (40 cases). However, this practice is clearly continuing, as evidenced by the reporting of 15 cases conducted after the year 2000 were reported, including one as recent as 2022[20]. It should be noted that the data presented in this report only reflect the situations of the women who participated in this research and therefore do not fully represent the reality.

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[20] The time periods (1970 – 1990 and 2000 – 2020) serve to highlight the "historical" nature of some events reported and the "contemporary" nature of others.

Table 14. Number of IS listed per city and time period

City	From 1974 to 1999	From 2000 to 2022	Total
Alma	1	0	1
Amos	1	0	1
Baie-Comeau	1	1	2
Joliette	7	3	10
La Tuque	6	4	10
Québec City	4	1	5
Rimouski	1	0	1
Roberval	6	1	7
Sept-Îles	8	3	11
St. Anthony (NL)	3	0	3
Trois-Rivières	0	1	1
Val-d'Or	2	1	3
Total	**40**	**15**	**55**

Imposed sterilizations (IS) figure prominently in the testimonies collected. Consequently, this type of OGV is analyzed separately from the other types of violence mentioned above. It should be noted, however, that these forms of violence (verbal, psychological, emotional, and ethnic-based) often precede imposed sterilizations and exacerbate their negative effects. The following excerpts illustrate the extent of the IS phenomenon in Quebec. They are categorized according to the issues raised by the participants and the frequency of similar statements. They include insufficient communication, inadequate medical escort and interpretation services, sterilization procedures performed without consent, confusion about clipping and "unclipping" (see section 2.4.5 for a definition), cases of sterilization during a C-section, and tubal ligation as a method of contraception.

2.4.2 Insufficient communication

The Viens Commission report (2019) highlights serious shortcomings in communication between providers of certain public services in Quebec and Indigenous users. This is particularly true in the health care system, where patients do not always receive sufficient information about their health condition and the preventive measures they should take. With regard to perinatal care, this absence of or lacking communication has also been documented in Manitoba (Lawford *et al.*, 2019). Indigenous women coming to hospital to give birth reported that they were not properly informed about their own health or that of their babies. The need for clear and transparent communication in this context is highlighted in the latest report from the National Collaborating Centre for Indigenous Health (Webb, 2024). One of the findings presented in this report is that working in silos (characterized by an absence of communication between health and social services professionals and families) may lead to deplorable situations, such as the documented case of a newborn arbitrarily removed from his family. Drawing on the study by Boyer and Bartlett (2017), this report also emphasizes the consequences of the lack of information regarding tubal ligation policies.

The following testimonies, added to those from Phase I (FNQLHSSC, 2022), confirm significant communication failures. This participant's shocked reaction upon discovering she had undergone a tubal ligation illustrates the limited information she received beforehand. At the time of the procedure in 1993, she was 26 years old:

> I never could have imagined that when I gave birth, I'd leave with a tubal ligation. They told me I'd feel good, lighter, and more confident (068-IS).

Several participants report being unsure about the specific type of procedure they had undergone, even years later. In 1978, the first was 24 years old and the second was 29:

> That's what I don't know. He (the doctor) just told me "*tied*," he didn't tell me how (130-IS-OGV).

> He (the doctor) told me, "They're going to put you to sleep." They put me to sleep (…). I didn't ask any questions. Then, (…) I woke up, and he told me he'd had me operated on (and) that I wouldn't be able to have children anymore. Years later, another doctor asks her why I had that (the ligation). (She replied:) "I don't know, but they just tied it. I don't know what they put inside me" (048-IS-OGV).

Many participants only discovered *after the fact* how extensive the procedure had been, or even that it had occurred at all. In some cases, sometimes, they learned they were infertile, but only years later when asking to consult their medical files, on the day following a procedure, or during a subsequent medical consultation. The following testimonies describe sterilizations that took place in 1982, 1985, and 2000, respectively. These women were between 25 and 27 years old at the time of the procedures:

> I saw that I had had a tubal ligation, but much later, in my medical file (072-IS-OGV).

> Q: When they performed the ligation, did they tell you right away that they had done it? The next day?
>
> A: (with an interpreter): No. Later… She had another appointment, a kind of consultation, and (that's when) she found out she had been sterilized (064-IS-OGV).

> I only found out 23 years later that I didn't have anything left to get pregnant with. (…) It was just last week (early August 2024) that I found out that they had removed both my ovaries and my uterus. They saw that on a *scan*, here at (name of hospital) (045-IS).

When women have clips placed on their fallopian tubes during a C-section or a vaginal delivery without their knowledge, they are faced with a *done deal*. The first woman was 23 years old in 1990, and the second was 30 years old in 2002:

> It was two months after (the delivery), that's when they told me about it (132-IS).

> I found out four years later (128-IS).

Other testimonies report the participants' state of confusion about the type of ligation performed because of a lack of transparent communication from the medical staff. With the help of an interpreter, the testimony of a woman who was 23 years old in 1992 speaks volumes:

> It was the doctor who told her she could no longer have children. (She was told:) They tied you up.
>
> Q: Do you know if they mentioned clipping or cutting?
>
> A: No, they didn't say anything (092-IS-OGV).

Two testimonies demonstrate just how much the failure to communicate prior to the procedure leaves lasting impacts. The first woman was 20 years old in 1986, and the second was 38 years old in 1999:

> I didn't know there were two types of sterilization: clipping, cutting and burning. I didn't know. Even today, I don't know which one I had. They didn't explain anything to me (055-IS).

> Q: So, you had your tubal ligation, but they cut and cauterized you.
>
> A: Both at the same time. I thought they were just using clips. But that's not what happened; they cut and cauterized me.
>
> Q: Without explaining to you beforehand what they were going to do?
>
> A: Yes, that's right! (053-IS).

Several women learn of their infertility and the extent of the procedure from other doctors while consulting for other health issues. For some, the language used is incomprehensible, as French or English is a second language. They were 24 years old in 1987, 26 in 1989, 23 in 1994, and 39 in 2011:

> He (a new doctor) read it in my medical file. (…) I was told: "You've been ligated." I said, "What?" Again, I didn't even know what that meant, the word (ligated). And I didn't understand the medical terms, their language.
>
> Q: So, how long after the ligation were you told that?
>
> A: Quite a few years later. Three or four years, I think (039-IS-OGV).

> Then the doctor I saw, the person who took care of me, told me: "You can't have children anymore because the doctor cut you and burned you." But I didn't know that, that wasn't what I wanted! (065-IS-OGV).

> It was only later, when I got cancer maybe twelve years ago, that's when I found out I no longer had… that I couldn't have babies anymore because it had been cut, burned, and tied (052-IS-OGV).

> She (the doctor) told me: "I'm going to ask for your files from the time of the surgery." She got them, she read them quickly in front of me. (…) That's when she said I'd been sterilized. I said, "What?" She looked really uncomfortable. She said to me, "Oh, yes, you didn't know?" Then, she was reluctant to read it in front of me. She stood up (…), and I could tell she was in shock as much as I was. Finally, she came back, looked at my file, and confirmed that I had been sterilized (061-IS-OGV-BA-BT).

2.4.3 Inadequate medical escort and interpretation services

Medical escort[21] services started to appear gradually in the late 20th century. At that time, pregnant Indigenous women witnessed the gradual decline of the midwives' roles due to the widespread adoption of Western biomedical practices. Consequently, many women had to relocate from their home communities because of inadequate local perinatal care. Even today, the evacuation of women living in remote communities or those located far from a hospital may occur up to several weeks (usually four) before delivery (Basile *et al.*, 2023). For many women, being far away from their loved ones and their support network, in an unfamiliar environment where French or English is the primary language, can be a difficult ordeal. These are challenging circumstances that can generate a profound sense of vulnerability. Indigenous women are clearly advocating for the right to be accompanied by a significant other during these required trips. The following testimonies report events that occurred between the 1970s and the early 1990s. The first one, in 1972, is indicative of the recent presence of midwives in certain First Nations communities:

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[21] "Medical escort" is the term used by First Nations people to refer to a person - whether a close family member or someone from the community network - who accompanies them throughout their journey through the health care system, particularly when they need assistance with transportation, daily care, interpretation in Indigenous languages, conveying instructions for home care, or obtaining consent involving a minor or for childbirth (ISC, 2019).

> As for me, I had my first baby when I was 15. Then, Kokom (name), my father's grandmother, told (my father), "You should take her to the hospital; I can't deliver babies anymore." Because she used to be a midwife. (…) It was in January. So, he took me to the hospital (038-OGV).

Three participants who were older at the time of their deliveries recall being left to fend for themselves in a health care system ignoring their needs and where sterilizing procedures can be performed without informing the patients or their families. The first reports having experienced this situation multiple times, and the other two experienced it at ages 18 in 1975 and 34 in 1998, respectively:

> I asked to have someone with me, but they said no. I asked several times. I gave birth alone in 1977, 1980, 1984, and 1989; that makes four births on my own (096-OGV-IA).

> I was sent to (name of city) to give birth. Everything was fine; the doctor said everything was fine. But apparently, I was admitted to (name of city) three weeks or a month before the birth (083-IS-OGV).

> He (the doctor) didn't want my spouse at my appointments. No nurse was present either when he was examining me (110-IS-OGV).

Sometimes, the medical staff will explain the sterilization procedure to the patient even if she is alone, and therefore unable to discuss it with her husband or a family member. The first testimony describes a bladder surgery that took place in 1984, and which became an opportunity to perform a tubal ligation[22]. The second testimony shows how a C-section carried out in 1997 also provided an opportunity to suggest and perform a tubal ligation:

> They did a ligature at the same time as the surgery to lift my bladder. They told me they'd do it at the same time since it was in the same area anyway. They explained that without the tubal ligation, my bladder could drop again if I became pregnant. They cut me. The doctor explained it to me clearly; he even showed me a diagram of where my bladder was and what they were going to cut. They burned and cut. At least he explained it to me (086-IS-OGV).

> Her husband was with her during her third delivery, but he wasn't present during the C-section. He wasn't in the room when they asked her (about the tubal ligation) (125-IS).

After the release of the Viens Commission report, which notably highlighted significant shortcomings in the delivery of health services to First Nations and Inuit in Quebec (PLRP, 2019), and in the wake of the tragic death of Joyce Echaquan at Joliette Hospital, the Government of Quebec allocated funding for the creation of 12 service navigator positions with the objective of improving access to culturally safe health services for Indigenous people (Drouin, 2022). While some health care facilities in regions like Côte-Nord, Mauricie, and Centre-du-Québec have had liaison officers or interpreters for Indigenous languages and English for years, these services appear to have long been overlooked or underused by nursing staff. Out of all the research participants, only one had access to an interpretation service in her Indigenous mother tongue. The others reported lacking access to such a service, either due to its unavailability or because health care staff were unaware of it, as illustrated by two testimonies: one from 1990 and another from 2012:

> No, no one told me; there was no interpreter present. We already had an interpreter, but they didn't call him in to help me understand (132-IS).

> Q.: Weren't you offered an interpreter?
>
> A: No. There wasn't one. Oh, wait, there was, (the service) existed, but it was never offered to me (041-IS-OGV).

---

[22] After consulting with two doctors/gynecologists, it appears that the bladder prolapse is not related to a possible pregnancy.

In a multilingual setting, First Nations women who speak their native language and use English as a second language have had to go to French only medical services, a situation that hinders their ability to exercise their agency (free choice), in 1985 and 1999, respectively:

> Q.: So, this means that you need to use a third language to get access to health services. There were no translators or interpreters?
>
> A.: No. No translator at that time. (…) Sometimes the doctor doesn't speak English, and the (First Nations) people don't exactly speak French (076-IS-OGV).

> And just the experience of having a child and not being able to have a say in how you wanted to have the child... And the French, it was a huge barrier for me (077-OGV).

The presence of support person or interpreter could undoubtedly help women who are giving birth or undergoing a permanent sterilization procedure to better communicate their needs and clearly understand what is being said to them. Such protective measures in vulnerable situations could prevent cases like the following, which occurred in 1989:

> When my youngest was born, the doctor asked me if I wanted to have the procedure (tubal ligation). But I didn't quite understand; I was young and had just given birth and all that (065-IS-OGV).

Amid the context of the International Decade of Indigenous Languages 2022-2032 and the advancement of national and international initiatives focused on issues of communication and reconciliation between Canadian society and Indigenous peoples (Government of Canada (GC), 2024), it is vitally important to ensure that essential services, such as health and psychosocial care, are provided in the appropriate languages.

2.4.4 Sterilization procedure performed without consent

In her seminal work, *An act of genocide. Colonialism and the sterilization of aboriginal women*, published in 2015, researcher Karen Stote sheds light on decades of legal proceedings and events that have undermined the reproductive rights of Indigenous women in Canada. In particular, she draws attention to the power dynamics at play between health care providers and Indigenous women, which can hinder the ability to give or obtain prior, free, and informed consent for sterilization. Similarly, a recent report by the Native Women's Association of Canada states that: "Enforcing sterilization on an individual without free, prior, informed consent is genocidal with the intention to remove someone's ability to reproduce in the future" (NWAC, 2022, p.2). As stipulated in the fourth criterion defining the concept of genocide in International Law (see **Appendix H**), namely, the implementation of "measures intended to prevent births within the group", Indigenous women and girls have been, and may still be today, the primary victims of Canadian policies rooted in colonial practices (NIMMIWG, 2019, p. 3). Finally, a study conducted by McKenzie *et al.* (2022) involving 32 women and Two-Spirit individuals from the Canadian Prairie provinces reveals that if health care providers had complied with existing Canadian laws regarding consent, the blatant violations described by the women interviewed could have been avoided.

The Phase I report of this research documents 16 cases of sterilization (46%) carried out without the presentation or signing of a consent form. It stresses that discrepancies may exist between legal requirements and actual practice in health care settings:

> 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 (FNQL-HSSC, 2022, p. 13).

Of the 55 cases of sterilization heard during Phase II, 21 participants reported that they had not signed a consent form, 16 participants said they were unsure, and 18 participants had signed a consent form under one of these circumstances:

- Under duress
- While under anesthesia
- During a C-section
- During a curettage
- While in active labor
- Believing that the procedure was reversible
- Accepting clips, but undergoing permanent ligation instead
- The day after or two days after the procedure
- Hand physically guided (by healthcare staff)
- Does not know what she signed
- Unable to read French
- Consent form folded in two, concealing essential information

The testimony of a woman who had a tubal ligation at the age of 31, in the 1980s, after having "given her consent" suggests that she had been stripped of her right to make decisions for herself by people in positions of authority. Her interpreter explains:

> It was either the priest or the doctor, they were high-ranking figures for them (women). They (women) had no choice when one or the other decided (for them) (069-IS-IA).

Other testimonies reveal that women were not consulted prior to a sterilization procedure (tubal ligation or hysterectomy) and, as a result, did not sign a form of free and informed consent beforehand. The following excerpts describe events that occurred in 1980, 1982, 1987, 1992, 1993, and 1998:

> That's when I realized they had clipped or tied me; I hadn't even noticed. I didn't sign a consent form for that. He (the doctor) didn't even tell me about it (082-IS).

> You know, when they have you sign and you're half asleep. What did I sign? I don't know (049-IS-OGV).

> Q.: Did they do a tubal ligation?
>
> A.: Yes, a tubal ligation.
>
> Q.: At that moment
>
> A.: Yes. That's when they did it.
>
> Q.: But you didn't know?
>
> A.: No, I didn't know.
>
> Q.: You didn't give your consent before? You didn't talk about it (with the doctor) before?
>
> A.: No (039-IS-OGV).

> Q: Did they take the time to explain why they did that?
>
> A: No, they didn't say anything. (They) (just) told me, "Sign the form" (092-IS-OGV).

> Q.: Did they ask you to sign a form?
>
> A.: Yes, but I didn't want to (068-IS).

> I never said I wanted a tubal ligation; I never consented to that. I wanted to have more children. (…) He (the doctor) had never mentioned it to me before, and I hadn't signed a consent form beforehand either (110-IS-OGV).

One participant reported signing a consent form two days after the sterilization procedure she underwent in 2022:

> They kind of made me sign at the bottom, next to "anesthesia plus tubal ligation." They told me to put my initials there. Just to be sure.
>
> Q: Had it already been done?
>
> A.: Yes.
>
> Q.: Did they make you sign afterward?
>
> A.: They told me to put my initials. I put my initials. I signed at the bottom. Then after that, I saw (the date of the procedure). It was (two days later). That alarmed me (036-IS-OGV-BT).

In some cases, the healthcare personnel even insist that a tubal ligation be performed immediately, despite the patient's explicit request to be given time to consider what the procedure entails. The following incident, reported by an interpreter, involves a 34-year-old woman in 1997:

> After giving birth to her youngest son, the doctor came to see her and said, "You're going to have surgery." And (she) said, "I'll think about it first." There was a nurse (…) who said to the doctor, "Why don't you do it right away?" That's what she said to him. That's what the nurse suggested to the doctor (125-IS).

Other women are offered a tubal ligation just as they are about to give birth, overwhelmed by the intense pain of contractions. The following incident took place in 2014:

> Once inside the operating room… no, (just) before they took me in, they told me, "We're going to tie your tubes." I was frozen; my mind was elsewhere. I wasn't there to discuss my tubes. My mind was elsewhere! (078-IS-OGV).

In 2018, the next participant was restrained and under anesthesia; but she remained resolute and refused the ligature:

> During the operation, the surgeon asked me if I wanted to have a tubal ligation. They (the medical staff) had never mentioned this to me during my appointments. I was frozen, but he commented that my uterus was damaged and that I would face severe complications in future pregnancies. (…) I knew he was supposed to have me sign something before asking me that, while I was giving birth. I could tell something wasn't right. My hands were restrained, and I was in pain (112-OGV).

2.4.5 Confusion about clipping and "unclipping"

One method of female sterilization can be achieved by tubal occlusion with Filshie clips, which are applied on both fallopian tubes (clipping), to obstruct the passage of eggs to the uterus and, thereby, preventing, pregnancy (Chapman and Magos, 2008). This procedure can be reversible, but the chances of success are slim, as the duct of each tube must be resected once the clips are removed (O'Sullivan, 2016). Several of the testimonies reveal that women do not always know exactly what kind of procedure they underwent and have convinced themselves that it is reversible. In fact, many of them agreed to have clips attached, often for lack of a better option because they believed they could have them removed. This confusion regarding the reversibility of the procedure is also documented by Boyer and Bartlett (2017) in their report on the sterilization of Indigenous women in Saskatchewan.

The following testimonies (from women aged 24 and 26, between 1983 and 1993) demonstrate that health care staff perpetuate this confusion and, as a result, succeed in getting women to agree to tubal ligation:

> She was told it would be temporary. She asked if she could have more children. She was told, "We'll take care of that; it's just to give your uterus a rest, to give your body a rest" (062-IS).

> (They said): "Clipped, but you can ask them to take them out." I asked: "And I'll be able to have children later on?" They said: "Yes", so I accepted. (068-IS).

In the following testimony, the participant describes events that took place in 1986 when she was 20 years old. As previously mentioned by other women, she understood at that time that the clip procedure was reversible. She wondered, however, why the medical staff made her sign a document stating that she would not sue the hospital:

> It was at the Centre hospitalier (name of city), I always wondered why they gave me a paper so I wouldn't sue them. First of all, why would I sue them if I was okay with what they had said, that I'd be able to go back to see (the doctor) (to have more children) to unclip (reverse) the tubal ligation one day (055-IS).

Other women have also indicated that they underwent a procedure different from the one previously agreed upon with their doctor. The first woman reports consenting to the placement of clips in 1997 at the age of 25, and the second describes a similar agreement in 1998 at the age of 34:

> Then, on the operating table, they didn't put me to sleep right away. They handed me a piece of paper and had me sign it. They told me, "We're not going to tie your tubes. We're just going to put in some clips. That way, you'll be able to have more (kids) whenever you want." But (*damn*!), they burned me. (…) I was shocked when I found out. Because I got cancer (afterward), and then at one point, he (the doctor) said to me, "Didn't you talk about clips?" I said, "Yes." He said, "But you don't have clips. You've been burned" (047-IS-OGV).

> After finding out, I saw another gynecologist, Dr. (name), to ask him to remove the ligation (the clips), and he told me that it wasn't possible; that they had cut the tubes. I wouldn't be able to have any more children. At the hospital in (name of city), I had been told that they had placed clips, but Dr. (name) told me the opposite, that they had cut. (…) He told me, "There's nothing more we can do" (110-IS-OGV).

Likewise, the husband of a woman who was in her twenties in 1980 talks about the moment when they both learned they could not have any more children:

> At some point, we wanted to have a child, and she told me she'd had her fallopian tubes tied. She went in for some tests, and it turned out they'd been cut. We were really disappointed when we found out (123-WI-IS).

Another research participant reported that she had specifically requested to have her tubes tied. She was 28 years old in 1985 when, instead, she underwent an ovariectomy without being told why:

> I asked my doctor, Dr. (name), (to have my tubes clipped and to have them "unclipped" later on so I could have more children). I said (that after giving birth to my last child) that I'd like to have a tubal ligation so I wouldn't have any more. The doctor said, "You don't want any more? OK." But the (other one), Dr. (name), the gynecologist, he removed both my ovaries! (113- IS).

Several of the cases mentioned here involve flawed consent, as the information provided was inadequate and could not have led to an informed decision. In fact the vast majority of the women cited in this section understood that it was possible that "tied" Fallopian tubes could be easily "untied." Others also consented to certain procedures (primarily clips to tie the fallopian tubes) and later learned that another sterilization procedure had been performed, which amounts to an infringement of their physical integrity.

2.4.6 Sterilization during a C-section

A publication by the Native Women's Association of Canada (2022) reports a high rate of C-sections involving unplanned tubal ligation and notes that Indigenous women are terrified at the thought of giving birth without knowing what might happen to them. In 2022, 27.3% of births in Quebec were by C-section (INSPQ, 2024). Among First Nations communities in Quebec for the same year, this rate stood at 29.96% (FNQLHSSC, 2025). These numbers contrast with the testimonies gathered during Phase I, in which women described discovering much later that they had undergone tubal ligation during their last childbirth, which was a C-section. One of them shared:

> 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 (9-IS-9) (FNQLHSSC, 2022, p. 37).

Among the Phase II participants of the research, 30 (28%) have had one or more C-sections. Three participants describe how they learned that the C-section "served as an opportunity" to perform a hasty tubal ligation: the first in 1980 at age 35, the second in 1986 at age 20, and the last in 1989 at age 30:

> Three days later, I think he (the doctor) came to see me in my room. He said, "We performed two procedures at the same time: the C-section and the tubal ligation." I wondered why he did that. And it's always stayed with me. I often asked myself: what did a tubal ligation even do? (057-IS-OGV).

> That was the day of the delivery (of my fourth child). It was a caesarean section. They did tubal ligation during the delivery (055-IS).

> They just told me: "They'll tie your tubes right away, and you won't be able to have any more children." They performed the tubal ligation during the C-section (099-IS-OGV).

A C-section, whether scheduled or performed as an emergency procedure, remains a momentous event for women, particularly when they are left in the dark, without any explanations and that additional procedures, such as a tubal ligation, are conducted concurrently. The first testimony recounts events from 1998 and the second from 2000:

> He cut me here.
>
> Q.: A C-section. And do you think that maybe that's when, after the C-section, they…
>
> A. Yes, they removed something, but I don't know (what) (094-IS-OGV).

> I was 38 weeks along, and they didn't tell me. They just told me afterward, after my C-section. They told me I had signed the consent form. I didn't really understand (what I had signed) because I was in a lot, a lot of pain (051-IS-OGV).

2.4.7 Tubal ligation as method of contraception

The work by Briana Theobald, *Reproduction on the Reservation* (2021), exposes numerous forms of control exercised over Indigenous women in North America throughout the 20th century. She also explains that, in recent decades, the imposition of contraceptive methods and abortions has sometimes led women to "elect for" more permanent methods such as tubal ligation. This option was essentially a way to free themselves from the routine interventions of health care personnel in their reproductive lives. While authors McKenzie *et al.*, (2022) observe a decrease in tubal ligations in Saskatchewan between 2015 and 2017, they also note that Indigenous women still continue to be pressured into terminating their pregnancies or using long-term contraceptives such as IUDs or Depo-Provera. In Quebec, according to the ISQ, the practice of tubal ligation has declined significantly across all age groups between 1976 and 2010 (MSSS, 2025). Temporal trends also demonstrate that this practice was relatively stable in Quebec from 1988 to 1998, followed by a continued decline, although at a slower rate. However, these statistics make no distinctions based on the individuals' ethnic backgrounds; the only detail provided is their age group at the time the ligation occurred. Consequently, it is impossible to draw conclusions specific to First Nations women.

One of the key findings of the Phase I report highlighted the fact that young Indigenous women were solely offered tubal ligation as a method of contraception, even though far less invasive methods existed (FNQL-HSSC, 2022). In Phase II, at least five testimonies indicate that doctors tend to share only limited information and do not offer the most common methods of contraception (birth control pills, implants, or others). Instead, they appear to prefer recommending the most drastic and permanent option: sterilization by tubal ligation (040-IS-OGV-BA-BT, 098-IS-OGV, 101-IS). Other testimonies report events that occurred in the 1980s and 1990s. They condemn the fact that this type of neglect took place when the women were young, suggesting that their age made them not only vulnerable but also less able to cope with the directives of the nursing staff.

One woman talks about events that took place in 1986, when she was just 20 years old:

> There was no pill, no nothing else that was suggested. We only talked about tubal ligation, and I left the doctor's office thinking that I'd be able to have other children (055-IS).

Another woman recalls the lack of alternatives to tubal ligation. She was 25 years old at the time of this event, in 1997:

> Q: So, they told you about tubal ligation, but did they also offer you other forms of contraception?
>
> A: No. Tubal ligation.
>
> Q: That's all?
>
> A: Yes. Just tubal ligation.
>
> Q: No IUD, no pill?
>
> A: Nothing (047-IS-OGV).

Altogether, the 55 cases of IS heard during this phase are added to the 22 cases documented in the Phase I report of this research. These figures certainly capture only part of the reality, since many First Nations women were unable to participate in the data collection, while others likely passed away before their voices could be heard. It is therefore impossible to determine the exact number of First Nations women sterilized without their consent in Quebec. However, it is quite likely that many of them were sterilized without their knowledge.

2.5 Non-permanent contraceptive alternatives

Even when it came to accessing alternative forms of contraception, the women interviewed faced major obstacles. Some felt that their agency was not respected when contraceptive methods were either offered, imposed, or withheld. Others felt they were deprived of control over their own bodies. While the exact timelines of the following events could not be determined, it is important to acknowledge their coercive nature.

2.5.1 Depo-Provera

Depo-Provera (a progesterone injection administered every three months, approved in Canada in 1997) is one of the non-permanent methods of contraception mentioned by 19 participants, either as users or as witnesses. While some women selected this contraceptive as a way to "take a break" after pregnancy, others felt like they were not properly informed about potential side effects or that their consent to its use was undermined:

> It was suggested to me, and they briefly explained the side effects, no periods and (the risk) of weight gain. But I felt pressured to take it; (it was kind of) imposed on me (097-OGV).

> I did consent, yes, but they did everything to convince me, force me (107-IS-OGV).

> After giving birth, the doctor prescribed Depo-Provera. But they wanted to do it right then and there – I thought it would be filled at the drugstore – but when I was discharged, the nurse was running after us in the elevator (and she said:) "You really have to do this!" I knew you weren't supposed to have sex after a C-section, but they gave me the shot at the hospital and we left. I was tired; I just said yes to everything. I hadn't asked for anything. They just prescribed me Depo-Provera. I'd taken it before, but I'd had a lot of (side) effects (104-OGV-BA).

A woman who had just given birth in 2012 describes how the nurses insisted that she take Depo-Provera and the consequences of not being believed by the nurse who was about to mistakenly administer a second dose:

> Plus, when he was born (in 2012), a nurse told me she was going to give me my Depo-(Provera) before I left. She gave it to me, and not long after, another nurse came in and wanted to give me another *shot*! (Laughs) They really wanted to make sure I didn't get pregnant! (…) I told her I'd just had it, and she didn't even believe me. I was covering my arm: "No, you're not going to stick that in me again!" She kept arguing with me: "No, this is your dose." I said: "No! I just had it." The nurse insisted, but she went back to check (the file) and came back to apologize afterward. But it was as if I were still lying. I lived with that for a long time afterward, just angry, no trust (115-OGV-BA-BT).

Among the sampling of testimonies collected, there is a tendency for health care providers to prescribe this contraceptive method specifically to adolescents and young women. Two participants stated that they had witnessed vaccination campaigns targeting barely pubescent girls, particularly in schools. The following testimony describes an event that occurred around 2018:

> Some of the young girls I take in my home are given Depo-Provera injections without their consent, without permission. They might come home from school and say, "Today, the nurses came to school and gave us shots." They didn't even know what it was. I called the school and was told that they were conducting a prevention campaign for young girls with Depo-Provera. I told them that their prevention campaign was so effective that the girl in my care didn't even know what she had received. She thinks it's a vaccine. They answered that she could look it up on the Internet! (114-OGV).

A participant received Depo-Provera injections from ages 13 to 15 (although parental consent is needed for those under the age of 14). At age 15, she will have her first child[23]:

> I have lots of friends who are 17 or 18 and who use Depo-Provera. Nurse (name) was the one who suggested it to me. Then, every three months, I got the Depo-Provera shot (037-OGV-BA-BT).

Another participant talks about choices made under duress, while health care staff cite potential risks of pregnancy marred by prejudice against First Nations people:

> I must have been 13 or 14. (…) Every single time, she wanted to give me a gynecological exam (…) even when it wasn't relevant at all. Let's say I was sick; she'd want to give me a gynecological exam. That really stuck with me… She'd tell me: "As for birth control, you should get Depo-Provera because among First Nations women, there's a higher risk of getting pregnant. And never forget to use a condom because there's a lot of AIDS in the communities." That traumatized me. I was like, "OK, yeah. Sure, I'll get the Depo-Provera." I wasn't even having sex yet (…) and then I was on Depo-Provera (042-OGV-BT).

This participant perceives the advice initially as judgmental, and subsequently as an obligation:

> After having baby, they didn't ask me: "What kind of contraception do you want to use?" It was more like: "You should get Depo-(Provera) and that way, it won't happen again. You won't forget (to take) the pill, so you won't get pregnant again. You're very young." It was that kind of judgment. So, I went on Depo-(Provera) because I felt like this is what they told me to do, the only option (077-OGV).

2.5.2 Intrauterine device

Several participants described the use of an **IUD** (a T-shaped intrauterine device inserted into the uterus, with or without hormones) as problematic, particularly because it can cause heavy bleeding (hemorrhaging) and intense pain, as well as mental health issues. Some also reported having trouble getting the doctor to listen to their concerns:

> Because my bleeding was so heavy, I went to the washroom and when I wiped myself, I felt something scratch (I had IUD before) and then I pulled it – I thought, it can't be a tampon, I don't wear tampons – and I pulled out my IUD because my (blood) clots were huge (075-OGV).

The following is another example of physical pain experienced by a participant:

> At my second (delivery), I had them put in an IUD. But a bit latter, I had really intense stomach cramps. I had to take it out. But the doctor didn't want to (041-IS-OGV).

This testimony suggests that even after developing psychotic symptoms related to an IUD, a woman is concerned her doctor may not agree to remove it.

> Sometimes, I thought to myself (that) my doctor would never believe me. (…) I told my partner, "I have to make a request." (He replied:) "What do you mean, a request? Just make an appointment and tell them you want to have your IUD removed!" Every time I bring it up with her (the doctor), she always tells me it's not the right time, that it's not a good idea (122-OGV-IA-BT).

Similarly, the following testimony illustrates the degree of control exercised by the doctor over the choice of contraceptive:

> Like the doctor who didn't want to remove my IUD. He said the IUD was just out of place. That's why I was in pain. He could put in another one. That's what he told me. I told him I didn't want that. But he was kind of insisting (…) (041-IS-OGV).

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[23] See box 3. on the social value of maternity among First Nations.

2.5.3 Other synthetic hormones

Several participants have used the **contraceptive pill** (a synthetic hormone) as a method of birth control. Since some of them found it difficult to sustain a daily dosing routine, they chose to use either the contraceptive patch or an IUD instead. In short, First Nations women are familiar with contraceptive methods and feel confident in their ability to determine which ones are best for them. This knowledge of the pill and other contraceptive methods is not new. Although contraception was not legalized in Canada until 1969, the contraceptive pill was already being distributed in First Nations communities long before that date:

> My kokom (her grandmother's name) used to get birth control pills. Lots of kokoms used to get birth control pills from the nurses who came here. Back then, around the 1950s, we didn't have a dispensary (085-WI-IS).

Some participants were advised against the use of the **contraceptive patch** (a synthetic hormone patch applied to the skin) due to concerns regarding potential weight gain. Instead, the subcutaneous **contraceptive implant** (a small rod inserted under the skin) was recommended as an alternative. One participant, who had previously used Depo-Provera and who underwent an emergency hysterectomy at age 24 in 2004, stated the following:

> I'd already had implants put in, and when I wanted to have them removed, the doctor refused, claiming he'd done a great job because mine weren't visible. (…) I had to argue a lot to get him to remove them (107-IS-OGV).

The imposition of contraceptive methods on First Nations women reflects a continuum of experiences in which their agency is frequently disregarded, while the government's responsibilities toward First Nations families are limited to the provision of basic services, as illustrated below.

Box 5. Contraception among Kanienkehà:ka women of the Kahnawà:ke community

In a book on colonialism and forced sterilizations of Indigenous women in Canada, researcher Karen Stote (2015) reports that a Caughnwagga (present-day Kahnawà:ke), Kahn Tineta Horn, raised these issues in a letter to the Indian Affairs Branch in January 1966. She had been informed that the doctor serving the Indians of the Caughnwagga community had been given instruction "to issue birth control pills, contraceptives and other means of birth control to Indians that he takes care of, but not to the Roman Catholic French Canadians who are in his practice" (Stote, 2015, p. 64). Miss Horn's question was as follows: "Can you tell me whether the doctors of the Indians in Caughnwagga are treating the Indians differently or the same as their other patients when it comes to birth control?" The reply from the Director of Medical Services to Aboriginal Peoples, H. A. Proctor, who took over the correspondence in February 1966, was addressed directly to community Chief Andrew Delisle, not to Miss Horn, and would reject all allegations and deny any form of responsibility on the subject. Karen Stote's book sheds valuable light on this period when, officially, the Department of Indian Affairs asserted that birth control should not be forcibly practiced, while funding its application on "Indian reserves". It should be noted that contraception was not legalized in Canada until 1969.

Part 3: Survival strategies

3.1 Imbalance of power

In Canada, as in the United States, the eugenics movement influenced the development of public policies, extending even to the management and administration of Indigenous and immigrant populations. This movement, which aims to "improve the race" through the selection, elimination, and sterilization of people deemed "undesirable" for the betterment of the human race (Aryan, and therefore white and superior), shaped the North American colonial project (see **Appendix I** for a comprehensive definition of this movement). Researchers such as Kluchin (2007) have documented the difficulties faced by historians of eugenics in accessing medical records and the archives of American eugenics committees, often the only sources available because the voices of those subjected to sterilization are largely inaccessible. Kluchin also points out that the existing sources were written by those who performed the sterilizations, rather than by those who underwent them, thereby restricting the criticism of choices influenced by eugenic ideologies. Johanna Schoen was the first researcher to access to the archives of North Carolina's archives, where the first birth control program began in 1937 and the state had the highest government-funded sterilizations *per capita* in the U.S. (Schoen, 2001). Of the roughly thirty states that have enacted laws based on eugenic principles, North Carolina stands alone in granting researchers access to its sterilization program archives (Schoen, 2006). In Canada, only Alberta and British Columbia enacted sterilization legislation for individuals deemed "unfit". Those laws were repealed in 1972 and 1973, respectively. Researchers Grekul *et al.*, (2004) explain that after the dissolution of Alberta's eugenics committee, the archives were stored at the Provincial Archives. Unfortunately, most of them were destroyed in 1988, leaving only 18% of the files on site (861 out of 4,785 originals, or 1 in 5 files). Archival documents, such as medical records and reports from British Columbia's eugenics committee, are said to have been completely destroyed (Stote, 2025).

Eugenic principles, together with demographic calculations and economic factors, have also shaped public policies in various countries worldwide by introducing quotas intended to maximize sterilization procedures, thereby exercising coercive control over population size (see the example of the birth control campaign in Greenland in **Appendix F**). The regime of former Peruvian President Alberto Fujimori was particularly active with an estimated 272,028 women and 22,004 men sterilized between 1996 and 2000, the majority of whom were Indigenous (Chirif, 2021). Health care personnel were ordered to meet a monthly quota for the number of people sterilized and used coercive measures, such as threatening to deny access to food and milk programs, to reach this goal (Vasquez del Aguila, 2006). In China, the Uyghur people have been subjected to a policy of "population optimization" through reproductive control, aimed in particular at eradicating their identity and culture (Dyer, 2021). Women who did not even exceed the legal limit of two children were forced to undergo abortions (sometimes in the third trimester), contraceptive injections, IUD insertions, or non-consensual sterilization surgeries (Agence France-Presse in Beijing, 2020). After Canada criticized Chinese authorities, China suggested Canada review its own domestic practices for similar issues. Lastly, the WHO confirms that Indigenous women have been the targets of population control policies in several countries through establishing quotas and compromising their access to respectful health care:

> The United Nations Declaration on the Rights of Indigenous Peoples (2007) (84) specifically guarantees indigenous peoples' equality with respect to the enjoyment of the right to health. In the past several years, however, the population policies of some countries have targeted indigenous women from the most deprived sectors of society. Efforts to meet government-mandated quotas have resulted in thousands of indigenous women being sterilized without consent (81, 85). Often, Indigenous girls and women are not provided with a full choice of contraceptive methods (86). Moreover, information is often not made available in accessible formats and in indigenous languages (87) (WHO, 2014, p.4).

In this research, several participants denounce, either implicitly or explicitly, the imbalance of power and of privilege that has tainted their interactions with health care personnel. Many of them reported experiencing tense consultations tainted by insufficient information, coercion and a climate of fear and hostility (prejudice and bias), all of which contribute to creating unequal relationships of power. The following sections address the obstacles associated with accessing one's personal medical files (3.1.1), the existence of biases and quotas that demonstrate clear imbalances of power (3.1.2) and the deterioration of the bond of trust within the health care system and social services (3.1.3). Section 3.1.4 focuses on the recognition of good care. Although the participants have faced significant traumatic experiences, they continue to demonstrate strength and resilience by acknowledging the quality of care received during specific medical consultations. As a result, they are able to provide a keen assessment of the quality of relationships between care givers and care recipients.

3.1.1 Request and access to personal medical file

The Boyer and Bartlett report (2017) notes that, the women interviewed for their study still suffered the consequences of the destruction of medical files even a decade later. The absence of documentation significantly impedes efforts to pursue justice and truth. In Quebec, an open letter published in December 2022 (Basile *et al.*, 2022) condemned, among other issues, the requirement for women to provide justification to health care personnel when requesting access to their medical files[24] and that families have come up against a lack of cooperation from health care facilities in their efforts to access information about their children who went missing in those same institutions, even though a law was adopted to address this issue (SRPNI, 2025).

Some participants in the research mentioned finding themselves embroiled in the weaknesses of a system perceived as opaque, mainly due to insufficient communication among health care staff, both during an intervention or *a posteriori*, when attempting to obtain medical files, for instance.

Some participants were unaware that they could access their medical file. Six of them describe the obstacles encountered when doing so. The first tried to access her file in 1995 following a hysterectomy she underwent in 1988 at the age of 19:

> Q: Later on, did you ever want to access your medical file to better understand?
>
> A: No.
>
> Q: Did you ever feel like asking for it?
>
> A: I would have liked to, but people said you couldn't. But now, it seems you can (066-IS).

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[24] It should be noted that every person has the right to have access to any information concerning him or her, as stipulated in the *Civil Code of Québec* (art. 38-41), the *Act respecting health and social services information* (art. 17-19 and 32-37) and the *Code of ethics of physicians* (art. 94-102). See **Appendix J** for more information on a research participant's request

Assisted by an interpreter, one participant explains that she would have liked to know more about her health after undergoing a hysterectomy at age 27 in St. Anthony, Newfoundland:

> She never knew that you could request medical files to find out what the surgery was. She felt helpless (098-IS-OGV).

Around the start of the 21st century, another participant contemplated requesting her medical file to better understand why she had a tubal ligation instead of just being "clipped," since she believed the procedure could be reversed. However, she finds the process quite arduous:

> Getting you files is complicated. They (the health care staff) don't want you to, plus I have to write a letter. They make it really, really difficult (047-IS-OGV).

Some participants report being denied access to their medical files. One of them received the following response after undergoing a tubal ligation in 1989, at the age of 26:

> We can't give you that; it's confidential, Ma'am (065-IS-OGV).

Other participants say they received only part of the information they requested, with the rest being "too far back in the archives," or finding no mention of their ligation procedure in the documents. The first describes an incident that occurred in 1980, and the second in 1986:

> A social worker for women in (name of community) had requested my medical file. She must have it. But there was nothing in my file (mentioning the ligature). They may not have even written it down (082-IS).

> I asked for it once, but I didn't get my entire file. It was very small (in size), and it seemed like it didn't contain everything (120-IS).

3.1.2 Biases about number of children and "quotas"

This theme was briefly addressed in section 2.1.4 and in the introduction to this section, but it warrants closer examination. To the best of our knowledge, Quebec never had a formal sterilization board like the one in Alberta, which, citing health, well-being, and economic considerations, applied the following guidelines: "A woman of any age with six children, 25 years of age with five children, 30 years of age with 4 children, and 35 years of age with three children (is a candidate for sterilization)" (Stote, 2015, p.74). However, according to some participants the number "four" was presented by their doctors as the maximum number of children they should have. Several accounts report deep-seated prejudices and a disregard for the parenting and community-building abilities of Indigenous peoples, in addition to references to a "quota" or limit on the number of children that First Nations women are able to have (seven testimonies: 48-IS-OGV, 65-IS-OGV, 92-IS-OGV, 108-IS-OGV, 121-OGV, 122-OGV-IA-BT, and 130-IS-OGV, in addition to those mentioned above). The first participant, who was 28 years old in 1975, was told this after her 5th pregnancy:

> I was going for my next checkup, the doctor suggested I shouldn't have any more kids. He said: "You already have four kids and no way to support them, especially with no home of your own, living in a remote area." That is when he said that they wanted to do an operation on me so I couldn't have no more children (083-IS-OGV).

This second participant, who had a fourth child in the early 1990s, is steered toward tubal ligation on the grounds that she has too many children:

> I signed something, for when they have an opening for a tubal ligation. They just told me that a tubal ligation involves cutting so you can't have children. They also told me that Indigenous people always have a lot of children (097-OGV).

Lastly, two participants, assisted by an interpreter, recount their experiences. The first describes the challenges her mother faced in the early 1980s at St. Anthony's Hospital, while the second talks about her own tubal ligation procedure, performed when she was 28 years old at Blanc-Sablon Hospital:

> I think that the reason they gave (for the abortion) was that they said there was a limit to how many children they could have. There were nine of us in total; this would have been ten if (there hadn't been an abortion) (069-IS-IA).

> Q.: (What were the) reasons for the tubal ligation?
>
> A.: That's what they said, that she had too many children (124-IS-OGV).

3.1.3 Erosion of the bond of trust in the health care system and social services

Whether as a result of imposed sterilization or other forms of OGV, some participants lost trust in the health care system, to the point where they felt compelled to stop attending their prenatal appointments. Between 1978 and 1986, these three women were between the ages of 20 and 29:

> When I was pregnant, I never went to the appointments. I only went to the last one (just) for the delivery (048-IS-OGV).

> I definitely didn't like it (imposed ligation); I never went back to that doctor after that (101-IS).

> I never went back to that doctor. (…) The thought of never having anymore didn't even cross my mind at the time. Because I trusted him. I trusted him with my four others. It's later that I discovered I couldn't have any more babies. (…) Today, I'm disappointed, hurt, angry maybe because I trusted my doctor (055-IS).

The breakdown in the bond of trust is driven by inadequate, or even non-existent, communication between medical teams and the women involved. The following testimony illustrates how a lack of information can deeply affect women, including causing psychological distress, especially if their grief after a miscarriage and its effects on the women's life trajectories are not properly acknowledged (de Montigny *et al.*, (2020):

> After I lost my baby, the surgeon came to see me because I was hemorrhaging. He immediately transferred me to the operating room for a dilation and curettage. When I woke up, I was already in the room. That's when I saw the blood; I never wanted them to give me blood (a blood transfusion) (…). It was probably in 1980, in early June, that I lost my baby. I was 23 years old. (…) I don't even know what they did with my baby. I don't know if they buried it or cremated it. They wouldn't let me take the fetus home. I still wonder where they put my baby. Did they throw it away? Or did they cremate it? I don't know (131-IS).

3.1.4 Positive experiences during medical appointments

A unique proposal for the integration of "intercultural ethics" within occupational therapy services in Quebec highlights that "Indigenous patients experience many significant inequities, which compromise adherence to key ethical principles" (Translation) (Drolet and Viscogliosi, 2019, p. 73). The same study also recommends a series of practical measures to prevent the continuation of paternalistic and colonial practices and attitudes toward Indigenous peoples. One proposed solution is to reassess approaches and delivery of health care for Indigenous peoples, ensuring the thorough and active participation of the most impacted at every stage of the process. The objective also includes enhancing health care trajectories for Indigenous communities and addressing misconceptions by providing education to those less familiar with Indigenous issues and grievances. Documenting the disparities and challenges experienced by Indigenous peoples is necessary, given the persistent presence of systemic racism, which has been repeatedly condemned in Quebec. After the tragic death of Joyce Echaquan, who was ignored, neglected, and insulted by health care staff at Joliette Hospital when she most needed help, the authorities of the Atikamekw Nehirowisiw Nation drafted "Joyce's Principle", a document that reaffirms that members of Indigenous communities have a fundamental right to access safe health care (Conseil des Atikamekw de Manawan and Conseil de la Nation Atikamekw (CAM and CNA), 2020). This document simply reiterates fundamental rights recognized under international law.

In the context of this research, when participants had access to good care (ethical intervention), they were able to compare it to negative experiences they may have experienced in the past. This adds a nuance to the bleak picture painted so far. By their own admission, some women mentioned having interacted with medical staff who treated them with respect and kindness. Throughout their lives, participants have gone through a range of experiences, some positive, some negative, especially during their pregnancies. The first participant describes her positive experience during her first two births, unlike her third, which led to a hysterectomy in 2001:

> But the births of my first two babies were good. I had them C-section, both of them. It was in (name of town). The first doctor that I had was so nice. Very nice to me. But not the last one (044-IS).

The following participant compares the care she received during her 1988 C-section at age 21, which left her with a particularly long scar, with the care provided during a later consultation with another doctor.

> For me, when I gave birth, it was more the doctor. I think he wouldn't have done that if I'd been non-Indigenous. He would have explained things to her and all that. My OB-GYN in (name of city) explained everything really well. He was there for me, he told me everything that was happening with the baby, the baby's heartbeat, but over there, no!
>
> Q: Did you really see the difference here?
>
> A: Oh yes! I really saw the difference, and he (the doctor) was the one who opened my eyes when he told me I'd been "butchered." Otherwise, I thought that was normal. I thought all women (…) had that kind of scar when they talked about C-sections. But when I first saw on TV what a C-section looked like. Boy, just a tiny incision! (084-OGV).

She adds that during her last delivery in 1994, she genuinely felt respected:

> That OB-GYN, he was a gem. He walked us through everything, the options and all that. He brought it up for the last one. We (my partner and I) said that our son would be our last. He (the OB-GYN) said, "Do you want me to perform a tubal ligation right now while we're here?" I said, "No, we'll make the decision calmly, when we're ready." He said, "OK." Wow! My God, if only all doctors could be like that! (084-OGV).

The following testimony illustrates that when health care providers demonstrate compassion and take the time to thoroughly inform women, it can significantly impact how a perceptive message, like discussing the option of sterilization (late 1990s), is delivered:

> The gynecologist came to see me that morning, took my hand, and explained what had happened: that I'd developed salpingitis – an inflammation of the fallopian tubes – and that they'd had to remove one of my fallopian tubes and the ovary. The other fallopian tube – I don't know, I don't remember at all – but right now, I only have one ovary left. I still have my uterus. But that, after 23 years, I wouldn't be able to have children; that there was a 12% likelihood. If I wanted children, the solution would be to resort to in vitro fertilization. When she told me that, she was stroking my hand. I still cried a lot, you know, when you're told right at the start of your life, that you won't have children. She told me she knew I was going to cry. I was all alone with the gynecologist; my mom and dad weren't there. I still appreciated the way she told me (079-OGV).

In 2021, another participant relocated to a city outside of the standard health care corridor to prevent repeating the negative experiences she faced in 2020:

> For my second pregnancy, I didn't want to go there (name of town) because I was scared, I wanted to go to (name of another town). (…) That was in 2021. I asked so many questions before I had the C-section again. So, it went well. There were no incidents. The baby was healthy, and I was also (103-OGV).

Other participants were surprised to discover that they could also receive good care beyond their customary care environments. The first participant describes a generally positive experience from 2004 involving the medical evacuation (MEDEVAC) of her baby, without her:

> And the next day, my daughter was medevaced to (name of city). And the next day, I flew in the late afternoon to (same town), and I told them: "I want to breastfeed my child!" Right away, they took me, they talked to me, they gave me the pumps, they reassured me. I thought: "Ok, this is nice." Because I'm a young mother, I don't know what I'm doing. I read some stuff but, in (name of another city), I felt like I did something wrong (075-OGV).

The second participant explains the difference between the medical care provided at two different hospitals (one within and one outside the standard care corridors), while comparing her two deliveries, and the positive factors that led her to undergo a voluntary tubal ligation in 2021:

> And I can compare, because when I had my son, 22 years later, it was nothing like that. It was in (name of city) at the (name of hospital) in a very supportive environment. (They asked me:) "Where do you want to give birth; what kind of room do you want to stay in; how many people do you want to have in there; do you want your family there?" They gave me a lot of options while (name of another city) was completely different (077-OGV).
>
> But when the time came to decide to have my tubes tied, that was my choice, I felt like the hospital was very supportive. (They asked:) "This is really what you want to do?", "Why don't you want to have any more kids?". They said: "why" and not "you should" and told me that yes, it would make sense since I was 36 at the time (…). I said: "Okay" and we did it and I felt like it was my decision, and I was supported in my choice. (…) After I had my surgery (about six months after my delivery), I didn't regret it. It was my decision, my choice. I was on a waiting list, and I had to go see a nurse, a social worker, a gynecologist. They wanted to check if I was really sure. At some point, they asked me to bring my boyfriend so we could decide together. I appreciated that because it wasn't just me. And he understood why. All this at the (name of hospital); their approach was different than what I experienced at (name of city) (077-OGV).

In 2014, a couple strategically steers clear of one hospital in favor of another to avoid experiencing racism. The young woman's spouse insists that she give birth in his home region, arguing that there is less racism there than elsewhere:

> He (her spouse) wanted us to give birth in (name of city) because he said, to be quite frank, that it wasn't a racist city. And it's true. I gave birth there and had the best prenatal care; I had four weeks to go, and it was the best care compared to everything else I'd had in (name of another city) with my doctor. They told me that anyone can be there for you, and if you're scared, your mom can be there. But in (name of another city), it's just two people; they don't want anyone else. (…) The treatment was really different (122-OGV-IA-BT).

In conclusion, a participant who was 20 years old in 2007 describes the gynecologist's apparent confusion and anger about her three previous C-sections. She felt supported:

> After my first (C-section), my medical record said, "No vaginal delivery." Then she, the gynecologist, was really upset; she said, "I don't understand. You could have given birth (naturally). Sure, at that very moment, if you'd had another child a few months later, yes, I understand, you would have been at risk. They might have asked you to have an abortion, all that. But since you waited two years, and with your whole file (in front of me), I don't understand why." That's when she also told me I was a victim. She was really angry. She was kind (040-IS-OGV-BA-BT).

3.2 OGV related repercussions

Obstetric and gynecological violence can have substantial consequences, significantly impacting the lives of those who experience it, regardless of whether they are Indigenous or not. Bisch (2025), whose works were carried out in France, states that in addition to the loss of trust in the health care system: "OGV leaves deep physical and psychological after-effects that have a lifelong impact on victims' personal and professional lives" (Translation) (p. 15). According to Cardenas-Castro (2023), whose research was conducted primarily in Chile, many women who have experienced OGV are unaware that they have been subjected to violence, and the accidental discovery of this violence leaves them with indelible psychological scars. An analysis of 65 studies conducted in 35 countries reveals that women's trust in the health care system has been undermined by experiences of mistreatment, a given institution's questionable reputation, and mistrust of the care it provides. These factors have led a significant number of women to decide against giving birth in health care institutions (Bohren *et al.*, 2015). In Greenland, the insertion of IUDs without consent in thousands of Inuit girls during the second half of the 20th century led to significant psychological and physical repercussions. Many of these girls reported enduring severe chronic pain and traumatic hospitalizations (Haahr, 2022; Jensen *et al.*, 2025). In Canada, Karen Stote's recent publication (2025) documents the consequences of imposed sterilization among Indigenous women, such as hormonal imbalances, depression, and loss of self-esteem, not to mention the resurgence of past traumas and online bullying for those who dared to speak out.

The analysis of the data collected for this research shows that OGV, including imposed sterilizations, as experienced within the medical environment, have repercussions on families even in their most private spheres, affecting men and women alike, as well as younger and older generations. These once-hidden issues are increasingly prevalent as people are now demonstrating a greater readiness to speak out. Many can also report similar cases among their social or family circle. These may involve members of the nuclear family (grandmother, mother, sister, daughter, granddaughter) or the extended family (sister-in-law, aunt, cousin, second cousin, partner of a relative, etc.)[25]. This type of situation also affects circles of friends, as well as residents of the same community.

3.2.1 Repercussions on their emotional health

The psychological consequences, including a painful mourning of motherhood, are also significant. The following testimonies refer to sterilizations performed between 1990 and 2007, when the participants were 23, 30, and 27 years old, respectively:

> We had planned on having another child when I was around 30. (...) I had a lot of grief to work through. I realized later that I had experienced a trauma (132-IS).

> It took a while for me to accept it because I felt (...) like I had nothing left (after the hysterectomy). I'd say it was almost like a grieving process, because I wanted to have more children (050-IS).

> I was sad, I was crying because after having my baby, I wanted to have another one, but it never worked out. Plus, I didn't know that they (the doctors) had removed it (my uterus). I only found out (recently) (045-IS).

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[25] Because of limited space in this report, references to members of the extended family have been omitted. Still, it is important to note that in Indigenous contexts, family is a central institution in which kinship structures are so broad that great-aunts and second cousins are considered as close relatives, across generations (Guay and Grammond, 2012).

A fourth testimony involves a case of non-consensual ligation at the age of 20, but it wasn't until 10 years later that the events really hit home for the participant:

> I wanted loads of kids. Psychologically, it really hit me hard as I got older. At first, I was kind of upset, angry at them because they told me one thing, while she (another doctor) told me the opposite. Why? In 2017, that really hit me hard. The feeling of having been fooled, (of having been) betrayed (040-IS-OGV-BA-BT).

Cases of imposed abortions, a form of OGV also come with their share of distress and silence. The following testimony describes the first of two imposed abortions, which occurred in 1980 when the participant was 20 years old:

> I kept it secret for a long time. I talked about it with a therapist. I was in therapy for a few years. It felt good to get it off my chest. But other than that, this is the first time I've talked about it with anyone (096-OGV-IA).

In 2001, despite an emergency C-section at the age of 32, the baby did not survive, and it is difficult to come to terms with grief under such circumstances:

> I never had a chance to hold my daughter. I never had a chance to say goodbye to her (044-IS-OGV).

3.2.2 Repercussions on their physical and sexual health

Many testimonies relate experiences of chronic pain; "being in constant pain" seems to be the fate of many women who have undergone sterilization in one form or another. The statements from the following participants clearly illustrate this consequence. The first had an IUD inserted in 2001 at the age of 35, and the second was "clipped" in 2012 at the age of 30:

> Later on, I had a lot of stomach pain, especially with my first IUD; I often ended up in the emergency room with back pain (117- OGV).

> And now, I can say that I'm in constant pain right where I was "clipped".
>
> Q: Do you still feel it today?
>
> A: Well, yes. It hurts here. Ever since I had my C-section, the pain never goes away (041-IS-OGV).

This woman was sterilized in 1974 at the age of 27; she describes her experience through an interpreter:

> After the surgery, she kept getting infections, and then she felt a stinging sensation in her vagina, which bothered her. She was in pain and had trouble urinating. She's been dealing with all sorts of long-term issues ever since (098-IS-OGV).

Some testimonies even mention a "slaughter" involving themselves or a close relative (047-IA-OGV and 081-WI-OGV). In 2004, another participant tried to reschedule a planned C-section to avoid a doctor known as a "butcher", while another recalls a doctor's comments about a hospital:

> I heard the name of one of the OB/GYN surgeons and it just hit me. I said, "No, no, I don't want him!" That's why I rescheduled my delivery (by C-section). My doctor asked me why. (I replied:) "Because he's a butcher. People talk about him, he's a butcher!" (107-IS-OGV).

> Later, during my chemo treatments, a doctor even told me that the hospital in (name of city) was like a "slaughterhouse" (114-OGV).

Other participants feel that their bodies were treated with little respect. This was the case during a second pregnancy in the early 1990s for the first testimony and after a hysterectomy in 2003 for the second:

> Anyway, my gynecologist was pretty clear about it. He said, "He butchered you. That's all I can tell you." He said, "That's not a pretty wound" (084-OGV).

> I don't know what she removed from my body, but I feel like I've been butchered (121-OGV).

Additionally, the sex life of several participants has been directly impacted by sterilization and by various forms of violence (for example, physical violence in the form of being left alone to suffer in pain, or verbal abuse in the form of being called "dirty and savage"). In 2020, a participant learned that she had undergone tubal ligation seven years earlier, and her relationship with her partner changed:

> And then I stopped having sex, too. It's not… clean anymore, I guess you could say. I don't know, it's as if I've been completely dirtied (061-IS-OGV-BA-BT).

These two participants share how their sex lives were impacted by a long list of OGV incidents between 1980 and 1994, and after a hysterectomy in 2003:

> All of that takes a toll on the body and on one's sexuality. It's like trauma. It's terrifying. I told my husband a little bit, but not everything, about what had happened (089-OGV).

> And what I feel is that something changed in my body after that surgery. I've completely lost interest in sex (121-OGV).

3.2.3 Repercussions on femininity and spirituality

Three participants reported that sterilization had impacted their sense of womanhood, describing it as an intimate reality that was hard to put into words. The first was 20 years old, the second was 30, and the third was 23 at the time of the events:

> Because at some point, as I got older, I realized that my feminine identity had faded. I no longer felt like a woman because I could no longer give birth (040-IS-OGV-BA-BT).

> I still have the scar here, the scar from the surgery. It's as if I'd lost my femininity. I felt empty inside. (…) even after the surgery, when I got home, it was very hard to accept (050-IS).

> Recovering from the surgery was a bit difficult; it was as if I had lost something very important to my femininity (120-IS).

This last participant adds a spiritual dimension:

> When you take something away, it really does break a woman. Spiritually speaking, when you look at (it)… (…) at some point, I felt lost. It was as if I no longer knew who I was as a woman. Even today, I'm still searching (041-IS-OGV).

A participant notes that her ligature altered how she relates to her Nation's spirituality, which includes powwows:

> To have that taken away (my ability to bear children). I'm a water carrier; I'm a bearer of life. (…) I felt completely shaken – I haven't danced in three years. I used to dance at powwows, but I stopped dancing, I stopped participating in ceremonies, and I hardly ever wear my skirt anymore. When I do wear a skirt, it's just for decoration; I don't wear it the way I used to (061-IS-OGV-BA-BT).

The significant bond between femininity and spirituality, two aspects of life that are particularly intertwined in Indigenous contexts, is expressed through rituals and ceremonies unique to women, such as those surrounding the role of water carriers. In many Indigenous cosmologies, women who carry children in their wombs also bear responsibility for the health of the earth's water (NWAC, 2020).

3.2.4 Repercussions on the couple and immediate family

The events and discussions at the heart of the following testimonies are difficult to position along the participants' life trajectories, since most of them occurred over time, in the aftermath of reported episodes of violence.

One participant, like many others, explains that discussing her situation can be difficult, even with her spouse:

> I didn't tell him; I never told him (that I'd had both ovaries removed), he doesn't know. I don't know why I didn't tell him. I must have forgotten all about it (113-IS).

Some participants reported that their partners remained supportive, understanding, and empathetic following their imposed sterilization (057-IS-OGV and 058-IS).

A third one says:

> He was also sensitive to that. He didn't like seeing me like that (049-IS-OGV).

One woman recalls how she was able to rely on her partner:

> And the surgery, it was a big ordeal for us as a couple. We were young adults. We supported each other, and thankfully he was there for me (120-IS).

Another woman adds, with the help of an interpreter:

> Her husband didn't take it well either. But he supported her (073-IA-BA).

However, other testimonies reveal a lack of support from a spouse, which can lead to feelings of betrayal and, in certain cases, a separation:

> It changed things; it almost turned into a full-blown domestic dispute (086-IS-OGV).

> He wasn't really thoughtful. He didn't take care of me. I went through it all alone (040-IS-OGV-BA-BT).

The same participant adds:

> I hadn't told him about it, but he found out, and he was angry. He was really angry. He told me I'd done it (imposed ligature) behind his back (040-IS-OGV-BA-BT).

In a context of domestic violence, an IS, in itself an act of violence, can hand the spouse an excuse to commit further violence. Consequently, these women were doubly abused. One of them explains:

> And my partner was quite nasty, cruel even, and say to me, "Oh, you had it done (tubal ligation without consent) so you could go fuck around" (039-IS-OGV).

When separating is the only option, some participants put it this way:

> We weren't as close as we were before. He was kind of distant after. We were never close after that. He didn't help me or anything and he left. I'm not with him anymore. He has another life now with another family (055-IS).

> I knew I couldn't have any more children, so he… He moved on and had other children.
>
> Q: Did you separate after that?
>
> A: Yes (066-IS).

> It wrecked our marriage. My husband looked elsewhere; he made babies with someone else (082-IS).

One participant talks about sharing her grief with family members:

> I saw my daughter, and I hugged her tight and cried and told her everything. She was also crying with me. She cried with me when I told her that they had removed my ovaries and uterus (045-IS).

Another participant intends to accompany her own daughters or sister to ensure that they do not encounter the same negative experience she underwent:

> Q. Do they have children?
>
> A. No, not yet.
>
> Q. OK. Are you going to accompany them?
>
> A. Yes, to make sure everything goes smoothly. I don't want them to go through what I went through. The same goes for my little sister (078-IS-OGV).

3.2.5 A continuum of historical violence

A greater number of testimonies from residential school survivors were gathered during Phase II than in Phase I of this research. One participant's story reveals that the cycle of trauma linked to the forced placement of Indigenous children – described as a cultural genocide by the Truth and Reconciliation Commission of Canada (TRC) (2015) – actually began earlier than official records indicate. This participant was already attending a residential school in 1951:

> I was four when I went to (residential) school. The official papers say that children were sent there at seven... I was four years old and that year I didn't go to school. (…) They kept me in the building, and they locked me up in the closet. (…) We were sent home in June and went back again at the end of August. We were with our parents for only two months (083-IS-OGV).

For the first time, this participant talks about her sterilization and the violence she experienced within her family. Even though these events took place in the 1970s, they continue to impact her life her today:

> I only very recently started talking about (my trauma). I never told my children. I never told them about it (my sterilization). (…) Just like I was prevented from speaking at the residential school (048-IS-OGV).

She goes on to say that, although it is difficult to expose any violence within the family, she was forced to have sex with her spouse and became pregnant each and every year:

> He (my husband) was always abusive. He'd tear my clothes. He'd beat up me. But I didn't say anything. I didn't say a word. I didn't even tell anybody. I kept it all to myself. (…) He once told me not to talk about it, and if I did, he said it would get worse. I never talked about those things. Today, I find it hard; I only say a little bit, and it's really hard for me (048-IS-OGV).

Another participant is convinced that she was subjected to pharmacological experiments at the residential school where she was sent in the early 1960s. These medical or nutrition experiments have been documented in recent years and are now recognized as part of the trauma resulting from forced internment in residential schools (Durant *et al.*, 2024; Mosby, 2013). This participant states, with the help of an interpreter:

> She's a residential school survivor (…) she says that many other women also underwent experiments (taking medication every morning) and that this could have affected their fertility (060-IS).

Some participants recount experiences of OGV (such as having a child taken away at birth during a stay at a sanatorium in 1956) that their mothers, also survivors of residential schools, had endured, and opened up about their mothers' alcohol consumption as a way to cope with these traumas:

> The way they snatched the child away from my mother, it was brutal. And she's carried that bitterness with her all these years. Sometimes I think it might explain why our parents (…) drank so much, not just because of what happened to them at the residential school, but also because of the loss of a baby, on top of it. We often saw our, when they drank beer, start to cry, and cry, and cry. For me, I saw it as a form of violence. It's a trauma they experienced and were never able to resolve (070-WI-OGV).

Consequently, many First Nations women, over multiple generations, have distanced themselves from the health care system. They avoid prenatal care or have still have negative memories of their hospital visits.

3.3 Protective strategies

One of the protective strategies adopted by victims of OGV is the partial or, in some cases, complete avoidance of health care services. Bisch states that "many are afraid to return for follow-up appointments, while others stop all medical care altogether to avoid the risk of experiencing violence again, even though this is clearly a missed opportunity for their health" (Translation) (Bisch, 2025, p.17). In Quebec, a study on access to midwifery services in Indigenous communities revealed that despite a lack of understanding and, at times, resistance from health care staff, many women arrive accompanied by family members for follow-up appointments or to give birth (Basile *et al.*, 2023). This initiative represents a protective measure implemented by Indigenous patients to preserve culturally safe practices and, by extension, to prevent all forms of violence. The same study demonstrates how the reintroduction of midwifery services within Indigenous nations has not only allowed to lower the costs of accessing perinatal care and also offered more humane and safe care, while reinforcing the connection to the land by bringing back traditional birthing practices and the rituals associated with them.

3.3.1 Proposed strategies

Based on the testimonies gathered, the strategies and methods used to safeguard against OGV reflect a clear awareness of the power dynamics shaping the interactions with health care professionals. Four types of strategies have been identified:

1) Being accompanied to avoid any risk of ill-treatment:

> That's why they say it's important now that people, young girls, even kokoms, should always be accompanied (039-IS-OGV).
>
> In hospitals, I wonder how we can support pregnant women, especially young ones, who are the same age I was. And how they talk to young girls (...) about not being afraid if they want to keep their babies, it's their choice. Don't talk to them about abortion right away. When I think about it, that's what happened to me, and it hurts (126-IA).

2) Establishing a network of family support and monitoring:

> Even my parents and my family told me: "If at any point they want to meet with you in your hospital room, if they come to see you and suggest that (the ligation), you shouldn't agree, you have to say no." But they kind of forced me, and I had to say yes (068-IS).

3) Having a third party read the consent form aloud when unable to give prior, free, and informed consent:

> There should always be two people present so that, at the very least, one person can read what the other person is signing (039-IS-OGV).

4) Mastering the language used by health care personnel:

> Both deliveries took place in (name of city) and went very smoothly. I spoke French well; maybe that's why (114-OGV).

5) Being protected by knowing members of the health care staff

> My mother was a teacher, and the doctors already knew her. (For that reason) I felt somewhat protected (073-IA-BA).

When confronted with perceived impositions, several participants express regret for not voicing their thoughts or preferences. Many also reported wishing they had asked the medical staff more questions regarding the procedures to be performed. Some do find the strength to file a complaint, despite the challenges of such a process[26].

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[26] See **Appendix D** for a summary of the class-action lawsuit filed by Atikamekw Nehirowisiw women following a non-consensual sterilization and **Appendix J** for an example of the challenges encountered during the complaint process.

3.3.2 Decision to file a complaint or not

A number of participants received support while filing complaints about incidents that impacted them. For instance, one participant underwent a "premature" C-section due to an error in identifying the stage of her pregnancy. This support, or guidance, is primarily embodied by nurses, either by motivating women to initiate complaints, or by overseeing the management of the complaint process:

> Then, after my C-section, the nurse (name) came to tell me: "Have this investigated." According to her, and all the other nurses, what had happened to me wasn't normal. It must have been a very serious medical error (061-IS-OGV-BA-BT).

The same participant adds that some people suspected her of using drugs because her baby's low birth weight, that her pain was downplayed, and the administration of pain medicine was limited:

> Then, the next day, when I woke up, I filed a complaint because I was being accused of being a drug addict. The head nurse came to take my statement, and I insisted on being discharged from the hospital, even though I was still in pain (061-IS-OGV-BA-BT).

She goes on to say that she is considering filing a complaint regarding a sterilization she learned about nine years later:

> I did do some work on it, but on my own. Because I was told I had to speak out, that I had to share my story. I've been working on this for three years, but sometimes it's hard. I'll get partway through, then stop because I get too emotional. These are decisions they (the doctors) make, but I don't think they realize what they're taking away (061-IS-OGV-BA-BT).

Here is another example where the participant is encouraged to file a complaint:

> After that examination, I had a miscarriage. I was bleeding afterward. I was bleeding and I was going to school in (name of city) at that time, in 1990, and the doctor I had seen in (name of another city) told me I should file a complaint because he (the other doctor) had not right performing that examination. He told me that's what caused my bleeding (110-IS-OGV).

Women seldom get support from a doctor. However, one participant recalls, via an interpreter, that she received support in 2024:

> (The) current doctor requested (person's name)'s medical records and advised her to file a complaint. She (the participant) was given the phone number for (name of a law firm) (045-IS).

Some participants were unaware that they could file a complaint; others considered doing so at a time when they were unsure about their rights, but ultimately did not take action, either because they lacked support or because they were discouraged:

> Q.: Have you ever filed a complaint after that?
>
> A.: No, I didn't think about it at the time, and I didn't even know that I was allowed to (055-IS).

> Q: Did you consider filing a complaint?
>
> A: Yes, right from the start. I didn't do it because I was alone, with two children to care for. It's a heavy load. I can't do this on my own. At the time, I was dealing with domestic violence; I was always staying at a shelter. I was being monitored by child protective services, my mother had passed away, and I wasn't living in my community. I lived in an urban area where we weren't allowed to be Indigenous. People would *throw* rocks at us just for speaking our language. I had to pick my battles (107-IS-OGV).

> So, I wanted to file a complaint about that. (…) And, I went to file the complaint. I saw Dr. (name); I met with him. I had asked for an appointment with him to see if I could file a complaint, but he told me, "Well, no! You can't!" (053-IS).

Following an unusually long vaginal exam that turned into non-consensual fondling, one participant recalls:

> We wanted to initiate a lawsuit. I was told I was not the only one, there were others. I was told names. But they said: "It'll be a dragged-out process. You'd better just forget about it. The doctor is going to win" (039-IS-OGV).

Lastly, one participant chose not to file a complaint, and she explains why:

> For me, when I said I wouldn't file a complaint, it was like I just put it aside and moved on (047-IS-OGV).

Between those who push through the challenging complaint process until resolution, and others who chose not to pursue this path, there lies a wide range of perspectives that underscore the complexity of this issue. One woman may decide to file a complaint after years of deliberation, while another may not follow the same road, discouraged by the taxing nature of the process. This disconnect arises partly from the unclear information provided to women, who might not be immediately aware of any harm inflicted upon them, only learning about it years later, and a general lack of knowledge regarding their reproductive health rights.

3.4 Measures for reparation

Over the past few years, Indigenous women who have experienced state and religious control over their bodies and reproductive health for centuries, have begun actively demanding for **reparation**. In October 2024, the United Nations (UN) Committee on the Elimination of Discrimination against Women issued a landmark ruling regarding Indigenous women in Peru, stating that the government policy that led to their sterilization may constitute a crime against humanity and urging the Peruvian government to implement a comprehensive reparation program for victims (UN, 2024). Many of the women affected are still waiting for a response to these grievances. In Greenland, following the release of the report on the inquiry into restorative measures for women's health (Jensen *et al.*, 2025), Danish Prime Minister issued an official apology and announced, in the Fall of 2025, the establishment of a "reconciliation Fund" for the victims of the forced IUD campaign. In Canada in 2024, several initiatives offer hope to Indigenous women who have experienced imposed sterilization. These include the creation of the Survivors Circle for Reproductive Justice, and the implementation of a healing support fund, the adoption of an action plan for Consensual, Respectful and Safe Care in Indigenous contexts by the *Collège des médecins du Québec* (CMQ, 2024) as well as the introduction of a federal bill aimed at criminalizing forced sterilization. The adoption of these actions for reparation represents an initial step toward reconciliation between the respective States and Indigenous women.

According to the testimonies heard, some couples, following a sterilization procedure, open their homes to other children, sometimes to compensate for the loss of future pregnancies and to find comfort. This phenomenon is not uncommon among First Nations and Inuit peoples; customary adoption has long been, and still is, a way of caring for one another and maintaining the community support network:

> There was no doubt about it: I couldn't have any more children. But I knew there was still something missing, even though I had children at home. We're a close-knit family. A big family. So, I threw myself into caring for my relatives' children. I became a foster parent, you know, to make up for what had been taken from me. Because I feel that they (the medical staff) had taken away my right to give life (047-IS-OGV).

> That's right, I had brought it up with him (my spouse). I told him, "We're going to do something. We're going to take in some children in." One of my sisters offered (…) She let me care of her daughter for a while. I looked after her (057-IS-OGV).

> I was a foster family (…) I took in babies, teens, in emergency situations. It was to help the community, but also as a way of compensating for the two (children) I didn’t have (108-IS-OGV).

> Well, I used to take in children who were in foster care.
>
> Q: As a foster parent?
>
> A: Yes, I looked after many of them, several (children). I stopped not too long ago (057-IS-OGV).

Finally, ceremonies and rituals related to pregnancy and childbirth hold particular significance for First Nations women. Although they are mostly conducted in the private sphere, these "traditional" ceremonies are fundamental to the perinatal period; they become pillars of identity for Indigenous peoples where "the *in utero* baby occupies a central place in the pregnancy process" (Basile *et al.*, 2023, p. 27). In the following excerpt, a woman expresses the need for a ceremony to help her move on following a third-trimester miscarriage:

> If there would have been a ceremony, I could have had some closure (076-IS-OGV).

Conclusion

The analysis of testimonies collected during Phase II shows that there were more cases of obstetric and gynecological violence (OGV), including cases of imposed sterilization (IS), compared to those reported in Phase I of the research. Specifically, 35 testimonies were heard, with another 20 interviews that could not be conducted at that time. With 97 additional interviews in Phase II, a total of 132 testimonies collected demonstrate that First Nations women experience systemic discrimination, a notion that includes racism, specifically linked to their status as Indigenous people. The numbers and excerpts from testimonies indicate that verbal, emotional, and psychological forms of OGV may have occurred on their own, but that in most cases they are associated with another form of OGV, including imposed sterilization (IS). As observed in Phase I, persistent stereotypes about substance use and the "excessive" number of children that Indigenous women have continue to play a prominent role within the health care system that serves them. According to the testimonies collected, physical and sexual OGV have occurred notably through numerous instances of neglect based on another deep-rooted assumption that Indigenous women have a higher threshold for pain than non-Indigenous women.

The second phase of this research broadened the initial definition of OGV to encompass acts of violence stemming on discrimination based on ethnic origin, such as those explicitly referencing events related to birth alerts, misinterpretation of Mongolian spots, blood tests performed on babies without consent, and imposed abortions, all because they were Indigenous women. Many of these events occurred under the guise of deep-seated paternalism, implicit sexism, and the overt infantilization of Indigenous women by health care staff, thereby reinforcing a glaring imbalance of power between health care providers and patients.

Imposed sterilizations, often carried out within a context of insufficient communication, lack of support and consent, amid confusion over proposed medical procedures, and C-sections, whether scheduled or unplanned, have deeply affected and traumatized the women and their families. Many of these women were told that tubal ligation was the sole contraceptive option, despite the availability of alternative methods. When other forms of contraception (Depo-Provera, IUD, or other synthetic hormones) are either offered or withheld, the women feel that their agency is being disregarded and that they have no control over their own reproductive health.

The imbalance of power between care givers and care recipients, resulting from a limited sharing of information, a climate of fear, and deep-seated biases against Indigenous women, place these women in front of a wall of obstacles they must overcome to access quality and respectful care. Despite everything, the participants were still able to acknowledge the positive care they sometimes received, showing their strength and capacity to evaluate both the favorable and unfavorable conditions they have faced during consultations or while receiving medical care.

The violence experienced repercusses on the psychological, physical, and sexual health of the women interviewed, and it leaves a deep and lasting imprint on their sense of femininity and spirituality, core aspects of identity within an Indigenous context. The reported violence also affects couples, families, and even the broader community. In short, no one is spared. Consequently, trust in the healthcare system is inevitably shaken, and many Indigenous women will choose to avoid seeking care whenever possible.

Obstetric and gynecological violence, including imposed sterilizations, are part of a continuum of violence that Indigenous peoples have faced and continue to grapple with today. The analogous nature of the experiences shared by the women who participated in this research certainly indicates that Indigenous and non-Indigenous women were treated differently, but it also demonstrates that this treatment was very similar across First Nations and regions. In other words, the research findings demonstrate the existence of systemic racism. For these reasons, OGV should now be added to the long list of forms of trauma (the imposition of the *Indian Act*, forced sedentarization, compulsory attendance at Indian residential schools, the Sixties Scoop – the large-scale removal and placement of Indigenous children by social services, the disappearance and murder of Indigenous girls and women, the removal and disappearance of children within the health and social services system, and the withholding of access to the territory and economic resources) suffered by Indigenous peoples in Quebec.

The following citation aptly illustrates the importance of closely examining OGV in order to fully grasp the extent of their impacts:

> Indigenous reproduction remains a threat to the political economy because it is tied to the continuance of Indigenous Peoples with rights, responsibilities, and relationship to lands which others depend on for profit. The direct connection between this and systemic racism against Indigenous people is the historical material context that makes Indigenous women vulnerable to coerced sterilization. (Stote, 2025, p.177)

Recognizing the true journeys and experiences of First Nations women in Quebec's health and social services system is a fundamental step toward ultimately building relationships that are fair, safe and respectful. This commitment to seeking the truth is not only crucial for creating conditions for well-being and restoring trust in institutions, it also holds the promise that, one day, we will be able to say, "All is good."

Research outcomes

The Phase I report of this research, released in November 2022, led to some unexpected outcomes. Alongside the adoption of the Declaration of Commitment to Ensure Free, Prior and Culturally Informed in Health Services for First nations Girls and Women in Quebec (AFNQL, 2022), several factors played a significant role in the decision of the women involved to participate in Phase II:

- The report has been presented over 80 times in French and English, both in person and online, to diverse audiences, including several First Nations communities, the Senate of Canada, the UN Special Rapporteur on the rights of Indigenous peoples, the President of Amnesty International, and the commissioners of the Inquiry into Forced IUD Insertions in Greenland.
- It has attracted significant media coverage, featuring in over 80 articles and broadcasts across radio, television, and online platforms in Quebec, English-speaking Canada, and internationally.
- It has been included in various syllabi and reading lists at CEGEPs and universities in Quebec.
- It has inspired works of art by First Nations women artists, a fictional character in a television show, a film script, and a documentary currently in development.
- It provided the basis for including an OGV indicator in the First Nations Regional Health Survey (RHS4), launched in 2022.
- It was awarded the Université du Québec Excellence in Research and Creation, Achievement category in September 2023.
- It allowed to reintroduce the bill aimed at establishing cultural safety for Indigenous people spearheaded by the *Secrétariat aux relations avec les Premières Nations et les Inuit* (SRPNI). The Act was officially adopted in December 2024.

- It inspired the *Collège des médecins du Québec* (CMQ) to form a focus group (on sterilizations and abortions imposed on First Nations and Inuit women) and adopt an action, including the addition of a preamble to the Code of ethics of physicians in June 2024.
- In 2024, the research team contributed a book chapter, followed by a scientific in 2025 that presented findings from Phase I. In addition, a 2023 publication in the scientific journal *The Lancet* cited Phase I of the research report.

As in Phase I of this research, Phase II participants were accompanied to their interviews by either a close relative or friend, a support worker, or an interpreter. They were also re-contacted one week after the interview to assess their well-being. Several participants told the research team that putting their experiences into words had been therapeutic and had contributed to diminish wa sense of isolation (040-IS-OGV-BA-BT, 041-IS-OGV, 057-IS-OGV, 078-IS-OGV). With the help of an interpreter, one participant shared:

> She kept it inside (the tubal ligation) buried inside… She never had the chance to talk about it, but now she's talking about it (092-IS-OGV).

Other women decided to share their stories after hearing about the research, and they mention expected outcomes:

> I turned it on (the radio) and I hear the former president of the (Quebec) Native Women talking about that (…) and it feels quite personal because it was the doctor who decided when I had the tubal ligation (101-IS).

> Personally, I think that the research you're doing, it's already helping raise awareness. It helps document all of this, and it provides credibility, and we can say: "We're not lying. We're telling the truth." That's something fundamental (046-WI-OGV).

> (I) Would like nothing more than for them (doctors) to realize what they did, really put it in their heads what they did. Because it's never going to leave us. And it's affecting all the families (055-IS).

It is hoped that the Phase II research report will shed a broader light on the impact of colonial history on the lives of First Nations women across several generations in Quebec. It is also important that the voices of Indigenous women no longer be ignored and that their experiences, both negative and positive, within the health care and social services systems be taken into account when introducing new services, laws, and regulations. For example, the *Act to establish cultural safety*, adopted by the Government of Quebec in December 2024, not only failed to involve Indigenous partners in its drafting, but also disregarded the inherent power dynamics between health care providers and patients, thereby increasing the risk of perpetuating health inequities (Belaid *et al.*, 2025). This bill also completely denies the existence of systemic racism, as pointed out and denounced in particular by the Joyce Principle (2020), the AFNQL Action Plan on Racism and Discrimination (2020), and the Declaration of Commitment to Ensure Free, Prior, and Culturally Informed Consent in Health Services for First Nations Girls and Women in Quebec (AFNQL, 2022). Hopefully, research reports such as this one, along with all other academic works, will inform future policy debates and lawmaking initiatives in Quebec and Canada, helping to build a safer society for Indigenous girls and women.

In conclusion, the women in this research exhibited extraordinary resolve in formulating and implementing protective strategies as well as reparative actions. They have demonstrated considerable resilience and have adeptly addressed deep-seated biases against themselves and others, at times intervening between health care personnel and a patient. Despite the diversity of their experiences, they voiced a determination to heal and to make sure future generations of Indigenous women are more knowledgeable about their history and rights. By doing so, they hope that the OGV committed against them are never repeated.

Limitations of the research project

Despite increased research on imposed sterilizations in Canada and globally over the past three years, the number and scope of such studies remain limited overall. The research team was able to obtain certain previously unknown or inaccessible documents and thereby demonstrated that cases of imposed sterilizations and other forms of violence were condemned in Quebec during the 1970s and 1980s. That said, no investigation into medical records (institutional or personal) could be conducted as part of this Phase II. The primary objective of this research (Phases I and II) was to demonstrate that OGVs and IS were indeed practiced in Quebec, by giving a voice to Indigenous women and thereby making their stories accessible.

The issue of OGV lies at the very heart of the reproductive life of the women involved and remains a highly sensitive matter. This observation aligns with their reasoning when considering whether or not to participate in the research. On some occasions, women preferred meeting online after the research team had visited the community, or at an anonymous location outside the community, ensuring that no connection could be made between them and the research. Others, on the contrary, publicly invited other women to participate in the research. Despite preliminary discussions or scheduled appointments, some women were unable to share their stories because they were unavailable when the research team visited. For others, the emotional burden was too heavy to bear, or they were unsure of the nature of the procedures they had undergone and preferred not to open up this part of their lives at this time.

Due to limited space available in this document, the difficult decision had to be made to omit certain themes identified during the interviews. These topics included Indigenous children who went missing or died in health care facilities; experiences in sanatoriums; the burden of religion felt by women; the repercussions of the disappearance of the role of Indigenous midwives, the disposal of the deceased fetus and the placenta; as well as the impact of OGV on the extended family and even the community. It is proposed that this information be presented in the form of a booklet or fact sheet, separate from the research report.

Finally, despite efforts to reach all First Nations in Quebec, some of them are not represented in the research sampling. The research team visited some of these communities to present the results of Phase I, but did not conduct interviews there as part of Phase II. It is to be hoped that they simply have no instances of OGV, including imposed sterilization, to report.

Recommendations

For all organizations

1. Respect and implement Phase I recommendations that have not yet been fully implemented[27].
2. Take all necessary steps to ensure that discriminatory medical practices based on ethnic origin are eradicated.

For First Nations organizations

3. Ensure compliance with and implementation of AFNQL and FNQLHSSC's *Declaration of Commitment to Ensure Free, Prior and Culturally Informed in Health Services for First nations Girls and Women in Quebec* (2022).
4. Establish a monitoring mechanism for sexual and reproductive health care, specifically to document cases of obstetric and gynecological violence (OGV) and imposed sterilizations (IS) among First Nations women.
5. To educate and raise awareness among First Nations women and girls about their right to report ill-treatment experienced before, during, or after childbirth, or for any other reason during gynecological or medical consultations related to their pregnancy.

For government bodies (federal and provincial)

6. Recognize the presence of systemic discrimination in Quebec's healthcare system.
7. Issue formal apologies to First Nations women who have experienced OGV and IS.
8. Recognize OGV and IS committed against First Nations women as a traumatic experience, just as other forms of trauma resulting from colonialism (Indian residential schools, the Sixties Scoop — the mass removal and placement of Indigenous children by social services, missing and murdered Indigenous women and girls, children who went missing from health and social services facilities, etc.).
9. Establish a moratorium on the destruction of medical records that may belong to First Nations people and implement an ethnocultural identifier to facilitate the collection and processing of disaggregated data regarding First Nations people.
10. Ensure that the National Commissioner for Complaints and Service Quality takes into account the health and social service issues facing First Nations.
11. Allocate a portion of the $5 million in annual funding (over five years) from the Quebec government's 2026–2027 budget to create and fund a position dedicated to overseeing and providing training in gynecological and obstetric care within a First Nations body recognized and designated by First Nations policy-makers in Quebec.

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[27] See **Appendix K** to consult the status of progress of Phase I recommendations.

For the *Collège des médecins du Québec* (CMQ) and all professional bodies in the field of sexual and reproductive health

12. Evaluate and disseminate the impacts of the CMQ Action Plan *For consensual, respectful and safe care. Report of the focus group on abortions and sterilizations imposed on First Nations and Inuit women in Quebec*, adopted in 2024.

13. Formally include the introductory statement suggested by the working group in June 2024 to the CMQ *Code of Ethics of physicians.*

14. Facilitate access to and provide support (through an ombudsman) for First Nations women throughout the CMQ and other professional organizations' complaint process.

15. Collaborate with First Nations to co-develop and implement mandatory training on consent, cultural safety, and discrimination based on ethnic origin for all physicians, midwives, and other health and social services professionals working in the field of sexual and reproductive health.

16. Provide university midwifery education in English.

17. Propose the signing of a joint declaration by the relevant professional associations in Quebec. The purpose of this action is to decolonize practices in health care, social services and social justice. It would contribute to the implementation of cultural safety across professional environments, supporting the recognition of self-determination in reproductive health.

List of references

Agence France-Presse in Beijing. (2020, June 20) China sterilising ethnic minority women in Xinjiang, report says. *The Guardian*. https://www.theguardian.com/world/2020/jun/29/china-sterilising-ethnic-minority-women-in-xinjiang-report-says

Amnistie internationale (AI). (2015). *Solidarité avec les femmes autochtones : Ne fermons pas les yeux.* Amnistie internationale.

Anderson, K. (2011). *Life stages and Native women. Memory, teachings, and story medicine.* University of Manitoba Press.

Assembly of First Nations of Quebec and Labrador. (2014). *First Nations in Quebec and Labrador's Research Protocol.* Assembly of First Nations of Quebec and Labrador. https://apnql.com/wp-content/uploads/2024/02/protocole_recherche_fr_web.pdf

Assembly of First Nations Quebec-Labrador (AFNQL). (2022, November 24). *Declaration of Commitment to Ensure Free, Prior and Culturally Informed Consent in Health Services for First Nations Girls and Women in Quebec.* Assembly of First Nations Quebec-Labrador. https://cssspnql.com/en/produit/declaration-of-commitment-to-ensure-free-prior-and-culturally-informed-consent-in-health-servicesin-health-servicesfor-first-nations-girls-and-women-in-quebec/

Association des femmes autochtones du Canada (AFAC). (2020). *Les femmes autochtones et l'évaluation d'impact. Rapport final.* Association des femmes autochtones du Canada. https://nwac-afac.ca/assets-knowledge-centre/Indigenous-Women-and-Impact-Assessment-Final-Report-FRN-1.pdf

Basile, S., Bouchard, P. et Brodeur-Girard, S. (2022, December 14). (Lettre ouverte) Les pratiques médicales imposées aux femmes autochtones doivent cesser. *Espaces autochtones – Radio-Canada.* https://ici.radio-canada.ca/espaces-autochtones/1941217/femmes-autochtones-sterilisation-dossier-medical-colonialisme-suzy-basile

Basile, S., Comat, I. and Cornellier, F. (2023). *Access to midwifery services for Indigenous communities in Quebec.* (Research report) Université du Québec en Abitibi-Témiscamingue. https://depositum.uqat.ca/id/eprint/1520

Basile, S., Comat, I., Montambault, P. and Cardin, S. (2023). *Consolidation of the connexion to the land of Innu and Atikamekw women through pregnancy and childbirth.* (Research report). Université du Québec en Abitibi-Témiscamingue. https://depositum.uqat.ca/id/eprint/1513

Begay, R. C. (2004). Changes in childbirth knowledge. *American Indian Quarterly*, 28(3/4), 550-565. http://www.jstor.org/stable/4138922

Belaid, L., Garakani, T. et Maillet, L. (2025). La sécurisation culturelle est-elle suffisante pour prévenir le racisme systémique et réduire les iniquités en santé ? Regard critique sur le projet de loi 32. *Santé Publique, 37* (1), 53-58. https://shs.cairn.info/revue-sante-publique-2025-1-page-53

Bisch, S. (2025). Les Violences Obstétricales et Gynécologiques (VOG) au cœur des Violences Sexistes et Sexuelles (VSS). *Journal de droit de la santé et de l'assurance maladie*, (43), 15-22. https://hal.science/hal-05050688

Bohren, M. A., Vogel, J. P., Hunter, E. C., Lutsiv, O., Makh, S. K., Souza, J. P., Aguiar, C., Coneglian, F. S., Diniz, A. L. A. et Tunçalp, Ö. (2015). The mistreatment of women during childbirth in health facilities globally: A mixed-methods systematic review. *PLoS medicine, 12 (6)*, e1001847. https://journals.plos.org/plosmedicine/article/file?id=10.1371/journal.pmed.1001847&type=printable

Bohren, M. A., Vazquez Corona, M., Odiase, O. J., Wilson, A. N., Sudhinaraset, M., Diamond-Smith, N., Berryman, J., Tunçalp, Ö. et Afulani, P. A. (2022). Strategies to reduce stigma and discrimination in sexual and reproductive healthcare settings: A mixed-methods systematic review. *PLOS Global Public Health*, 2 (6), e0000582. https://journals.plos.org/globalpublichealth/article?id=10.1371/journal.pgph.0000582

Bouchard, P., Basile, S. et Brodeur-Girard, S. (2026). Violation des droits fondamentaux, stérilisations imposées et évitement des services de santé pour des femmes autochtones au Québec. *FéminÉtudes*, 25, 120-147.

Boyer, Y. et Bartlett, J. (2017). *External review: Tubal ligation in the Saskatoon health region: The lived experience of Aboriginal women*. https://senatorboyer.ca/wp-content/uploads/2021/09/Tubal-Ligation-in-the-Saskatoon-Health-Region-the-Lived-Experience-of-Aboriginal-Women-Boyer-and-Bartlett-July-11-2017.pdf

Cable, E. (2023, June 29) Traumatic birth experiences at Anna Laberge. *The Eastern Door*, 32(25). https://eastern-door.com/2023/06/29/traumatic-birth-experiences-at-anna-laberge/

Cable, E. (2023, August 23). Continued complaints at Anna Laberge. *The Eastern Door,* 32(33). https://easterndoor.com/article/continued-complaints-at-anna-laberge

Cárdenas-Castro, M. et Salinero-Rates, S. (2023). The continuum of violence against women: Gynecological violence within the Medical Model in Chile. *Sexual & Reproductive Healthcare, 37*, 7 pages. https://doi.org/10.1016/j.srhc.2023.100891

Chambers, C., Hasebe-Ludt, E., Donald, D., Hurren, W., Leggo, C. et Oberg, A. (2008). Métissage: A research praxis. In J. G. Knowles et A. L. Cole (Eds.), *Handbook of the arts in qualitative research. Perspectives, methodologies, examples, and issues* (p. 141-154). SAGE Publications Inc.

Chapman, L. et Magos, A. (2008). Female sterilization. *Expert Review of Medical Devices, 5* (4), 525-537. https://doi.org/10.1586/17434440.5.4.525

Chirif, A. (2021). *Perú: Las esterilizaciones forzadas, en la década del terror. Acompañando la batalla de las mujeres por la verdad, la justicia y las reparaciones.* Grupo Internacional de Trabajo sobre Asuntos Indígenas, IWGIA et Demus. https://iwgia.org/en/documents-and-publications/documents/535-iwgia-perú,-las-esterilizaciones-en-la-década-del-terror-publicacion-2021/file.html

Collège des médecins du Québec (CMQ). (2023). *Mémoire Projet de loi n° 32 : Loi instaurant l'approche de sécurisation culturelle au sein du réseau de la santé et des services sociaux.* https://cms.cmq.org/files/documents/memoires/mem-cmq-pl-32-securisation-culturelle.pdf

Collège des médecins du Québec (CMQ). (2024). *For consensual, respectful and safe care. Report of the focus group on abortions and sterilizations imposed on First Nations and Inuit women in Quebec*. Collège des médecins du Québec. https://cms.cmq.org/files/documents/Avis-et-prises-de-position/rap-inter-grossesse-sterilisations-202406-EN.pdf

Commission des droits de la personne et de la jeunesse (CDPDJ). (2021). *Document de réflexion sur la notion de «racisme systémique»*. Commission des droits de la personne et de la jeunesse. https://www.cdpdj.qc.ca/storage/app/media/publications/document_reflexion-racisme-systemique.pdf

Connor, J. T. H. (2019). "For her own safety and the good of society at large": Eugenics, sterilization, and Anglo-American transnationalism in Newfoundland, 1928–1934. *Acadiensis: Journal of the History of the Atlantic Region / Revue d'histoire de la région atlantique, 48* (1), 32-59. https://muse.jhu.edu/article/724301

Conseil des Atikamekw de Manawan and Conseil de la Nation Atikamekw (CAM and CNA). (2020). *Joyce's Principle*. Conseil des Atikamekw de Manawan and Conseil de la Nation Atikamekw. https://principedejoyce.com/sn_uploads/principe/Joyce_s_Principle_brief___Eng.pdf

Cree Women of Eeyou Istchee Association (CWEIA). (2018). *Statement on ashtemhaagaanawao experienced by women during birthing*. Cree Women of Eeyou Istchee Association. https://cweia.ca/images/CERP_Birthing_issue_statement_Oct_2018._Final1.pdf

de Montigny, F., Zeghiche, S. et de Montigny-Gauthier, P. (2020). Le décès périnatal comme bifurcation temporelle : Les parcours de vie de femmes après une fausse couche. *Aporia, 12* (1), 36-46. https://uottawa.scholarsportal.info/ottawa/index.php/aporia/article/view/4836/3935

Desrosiers, G. (1999). Le système de santé au Québec bilan historique et perspective d'avenir : Conférence inaugurale du 51e congrès de l'Institut d'histoire de L'Amérique française, octobre 1998. *Revue d'histoire de l'Amérique française, 53* (1), 3-18. https://id.erudit.org/iderudit/005395ar

Drolet, M.-J. et Viscogliosi, C. (2019). Ébauche d'une éthique interculturelle pour l'ergothérapie en contexte autochtone : sur la base des résultats d'une recherche empirique et d'une recension des écrits. *Ethica, 22* (2), 63-104. https://www.uqar.ca/app/uploads/2024/06/Drolet__Viscogliosi.pdf

Drouin, C.-É. (2022) Les navigateurs de services, pour la santé des patients autochtones. *Radio-Canada*. https://ici.radio-canada.ca/nouvelle/1920665/securisation-culturelle-sante-innu-accompagnateur-stanley-vollant

Durant, S., Jeyamohan, A. E., Campbell, E. et Lawford, K. (2024). Conceptualizing risk for pregnant Indigenous peoples accessing maternity care in Canada: A critical interpretive synthesis. *Social Sciences & Humanities Open, 9*, 8 pages. https://www.sciencedirect.com/science/article/pii/S2590291123003789

Dyck, E. et Lux, M. (2016). Population control in the "Global North"?: Canada's response to Indigenous reproductive rights and neo-eugenics. *Canadian Historical Review, 97* (4), 481-512. https://doi.org/10.3138/chr.Dyck

Dyck, E. et Lux, M. (2020). *Challenging choices. Canada's population control in the 1970s*. McGill-Queen's University Press.

Dyer, C. (2021). China forced Muslims in Xinjiang to be sterilised and have abortions, concludes tribunal. *BMJ, 375*, 1 page. https://doi.org/10.1136/bmj.n3124

Ferron-Parayre, A., Bernier, D., Bedard, M.-J. et Lacroix, M. (2024, July 9). Voici comment reconnaître et prévenir la violence obstétricale et gynécologique. *The Conversation*. https://theconversation.com/voici-comment-reconnaitre-et-prevenir-la-violence-obstetricale-et-gynecologique-227990

Finestone, E. et Stirbys, C. D. (2017). Indigenous birth in Canada. Reconciliation and reproductive justice in the settler state. Dans H. Tait Neufeld et J. Cidro (Eds), *Indigenous experiences of pregnancy and birth* (p. 176-202). Demeter Press.

First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC). (2022). *Free and informed consent and imposed sterilizations among First Nations and Inuit women in Quebec. Final report*. First Nations of Quebec and Labrador Health and Social Services Commission. https://files.cssspnql.com/s/CGKiiNtINdTYkGF

First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC). (2025). *Assisted delivery rate among vaginal deliveries*. First Nations of Quebec and Labrador Health and Social Services Commission.

Gaumer, B. et Desrosiers, G. (2004). L'Histoire des CLSC au Québec : Reflet des contradictions et des luttes à l'intérieur du Réseau. *Ruptures : Revue Transdisciplinaire en Santé, 10* (1), 52-70. http://pascal-francis.inist.fr/vibad/index.php?action=getRecordDetail&idt=16937282

Giger, J. N. and Haddad, L. (2020). *Transcultural Nursing - E-Book: Assessment and Intervention* (8th ed.). Elsevier Health Sciences. https://books.google.ca/books?id=XCWKCwAAQBAJ&pg=PA176&redir_esc=y#v=one-page&q&f=false

Government of Canada. (2024). *Canada's National Action Plan for the International Decade of Indigenous Languages (2022-2032)*. Government of Canada. https://www.canada.ca/en/canadian-heritage/campaigns/celebrate-indigenous-languages/international-decade/national-action-plan.html

Grekul, J., Krahn, A. et Odynak, D. (2004). Sterilizing the "Feeble-minded": Eugenics in Alberta, Canada, 1929–1972. *Journal of Historical Sociology, 17* (4), 358-384. https://doi.org/10.1111/j.1467-6443.2004.00237.x

Guay, C. et Grammond, S. (2012). Les enjeux de l'application des régimes de protection de la jeunesse aux familles autochtones. *Nouvelles pratiques sociales, 24* (2), 67-83. https://www.erudit.org/fr/revues/nps/2012-v24-n2-nps0633/1016348ar/

Haahr Pedersen, S. (2022, May 21). Appel til Danmark: Undersøg ansvaret for spiralkampagnen. *KNR - Kalaallit Nunaata Radioa. Greenland Broadcasting Corporation*. https://knr.gl/da/nyheder/appel-til-danmark-unders%C3%B8g-ansvaret-spiralkampagnen?fbclid=IwAR0kEKwssIgcktDvUlFj3rHm_jX6KgNz8Jikrbijv-VZw7zfJWPmQN_HgBw

Heidinger, L. (2022). *Violent victimization and perceptions of safety among First Nations, Métis and Inuit women and among women living in remote areas of Canada*. Statistics Canada. https://www150.statcan.gc.ca/n1/en/daily-quotidien/220426/dq220426b-eng.pdf?st=lsabbAId

Heino, A. N. (2018). *Toward a better understanding of the chronic pain experiences of Indigenous women who experience violence: Implications for nursing education, practice and research.* (Master's thesis). University of British Columbia. https://open.library.ubc.ca/collections/42591/items/1.0365526

Indigenous Services Canada (ISC). (2019). *Non-Insured Health Benefits Program for First Nations and Inuit: Medical Transportation Policy Framework (Interim).* Government of Canada. https://www.sac-isc.gc.ca/eng/1579891130443/1579891286837

Institut national de santé publique du Québec (INSPQ). (2022). *Déterminants de la consommation d'alcool chez les jeunes Autochtones vivant en communauté et en milieu urbain.* Institut national de santé publique du Québec. https://www.inspq.qc.ca/sites/default/files/publications/3235-determinants-consommation-alcool-jeunes-autochtones.pdf

Institut national de la santé publique du Québec (INSPQ). (2024). *Portrait des accouchements au Québec.* Institut national de santé publique du Québec. https://www.inspq.qc.ca/information-perinatale/fiches/preparation-accouchement/portrait

Jensen, T., Jensen, B., Bang Bourup, E., Reimer, G. A., Olesen, I., Herrmann, J. R., Christiansen, M. et Seidelin, M. (2025). *Uvildig udredning af antikonceptionspraksis i Kalaallit Nunaat i perioden 1960-1991.* Statens Institut for Folkesundhed et Ilisimatusarfik - Grønlands Universitet. https://www.sdu.dk/da/sif/rapporter/2025/uvildig_udredning_af_antikonceptionspraksisi_kalaallit_nunaat_i_perioden_1960_1991

Kamel, G. (2021). *Rapport d'enquête. Loi sur la recherche des causes et des circonstances des décès POUR la protection de LA VIE humaine concernant le décès de Joyce Echaquan.* Bureau du coroner, Gouvernement du Québec. https://numerique.banq.qc.ca/patrimoine/details/52327/4645546

Kluchin, R. M. (2007). Locating the voices of the sterilized. *The Public Historian, 29* (3), 131-144. https://www.jstor.org/stable/10.1525/tph.2007.29.3.131

Lawford, K., Bourgeault, I. L. et Giles, A. R. (2019). "This policy sucks and it's stupid:" Mapping maternity care for First Nations women on reserves in Manitoba, Canada. *Health Care for Women International, 40* (12), 1302-1335. https://doi.org/10.1080/07399332.2019.1639706

Lévesque, S., Bergeron, M., Fontaine, L. et Rousseau, C. (2018). La violence obstétricale dans les soins de santé : Une analyse conceptuelle. *Recherches féministes, 31* (1), 219-238. https://doi.org/https://doi.org/10.7202/1050662ar

Lux, M. K. (2016). *Separate beds: A history of Indian hospitals in Canada, 1920s-1980s.* University of Toronto Press. https://utorontopress.com/9781442663114/separate-beds

McKenzie, H. A., Varcoe, C., Nason, D., McKenna, B., Lawford, K., Kelm, M.-E., Wajuntah, C. O., Gervais, L., Hoskins, J. et Anaquod, J. (2022). Indigenous women resistance of colonial policies, practices and reproductive coercion. *Qualitative Health Research, 32* (7), 1031-1054. https://doi.org/10.1177/10497323221087526

Mercredi, M. et Fire Keepers. (2024). *Sacred Bundles Unborn* (2nd ed). Friesen Press.

Ministère de la Santé et des Services sociaux (MSSS). (2025, March 12). *Statistiques de santé et de bien être selon le sexe - Tout le Québec.* Ministère de la Santé et des Services sociaux. https://www.msss.gouv.qc.ca/professionnels/statistiques-donnees-sante-bien-etre/statistiques-de-sante-et-de-bien-etre-selon-le-sexe-volet-national/taux-d-hysterectomie-et-de-ligature/

Mosby, I. (2013). Administering colonial science: Nutrition research and human biomedical experimentation in Aboriginal communities and residential schools, 1942–1952. *Histoire sociale/Social history, 46* (1), 145-172. https://doi.org/10.1353/his.2013.0015

Naître et grandir. (2025). *Les taches de naissances.* Naître et grandir. https://naitreetgrandir.com/fr/etape/0_12_mois/soins/taches-naissance/#_Toc530132467

National Collaborating Center for Indigenous Health (NCCIH). (2013). *Understanding racism.* National Collaborating Center for Indigenous Health. https://www.nccih.ca/495/Publication_view.nccih?id=103

National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG). (2019). *A Legal Analysis of Genocide – Supplementary Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. National Inquiry into Missing and Murdered Indigenous Women and Girls. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Supplementary-Report_Genocide.pdf

Native Women's Association of Canada (NWAC). (2022). *Misconduct, Missing, and Murdered: The Experiences of Anti-Indigenous Racism in Reproductive Healthcare among Indigenous Women, Girls, Two-Spirit, Transgender, and Gender-Diverse People, and the MMIWG2S+ Genocide*. Native Women's Association of Canada.

Native Women's Association of Canada (NWAC). (2020). *Indigenous Women and Impact Assessment. Final Report*. Native Women's Association of Canada. https://www.canada.ca/content/dam/iaac-acei/documents/research/nwac-impact-assessment-final-report-en.pdf

Neufeld, H. T. et Cidro, J. (2017). I*ndigenous experiences of pregnancy and birth*. Demeter Press.

Ordre des infirmières et infirmiers du Québec (OIIQ). (2021). *Améliorer les soins aux Premières Nations et aux Inuit en contrant le racisme*. Ordre des infirmières et infirmiers du Québec. https://www.oiiq.org/documents/20147/237836/5537-enonce-position-premieres-nations-inuit-web.pdf

O'Sullivan, M. D. (2016). Informing red power and transforming the second wave: Native American women and the struggle against coerced sterilization in the 1970s. *Women's History Review, 25* (6), 965-982. https://doi.org/10.1080/09612025.2015.1083229

Pérez D'Gregorio, R. (2010) Obstetric violence: A new legal term introduced in Venezuela. *International Journal of Gynecology & Obstetrics,111* (3), 201-202. https://www.redehumanizasus.net/sites/default/files/figo_-_violencia_obstetrica_-_legislacao_na_venezuela.pdf

Pickles, C. (2024). "Everything is obstetric violence now": Identifying the violence in "Obstetric Violence" to strengthen socio-legal reform efforts. *Oxford Journal of Legal Studies*. 29 pages. https://doi.org/10.1093/ojls/gqae016

Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec: Listening, reconciliation and progress (PLRP). (2019). *Public Inquiry Commission on relations between Indigenous Peoples and certain public services in Québec: listening, reconciliation and progress. Final report*. https://numerique.banq.qc.ca/patrimoine/details/52327/4001540

Regroupement naissances respectées (RNR). (2019, May 28). *Stop VOG - Violences obstétricales et gynécologiques*. https://stopvog.fr/

Standing Senate Committee on Human Rights (SSCHR). (2022). *The scars that we carry: Forced and coerced sterilization of persons in Canada - Part II*. Senate of Canada. https://sencanada.ca/content/sen/committee/441/ridr/reports/ridr_forcedsterilization_e.pdf

Schoen, J. (2001). Between choice and coercion: Women and the politics of sterilization in North Carolina, 1929-1975. *Journal of Women's History, 13* (1), 132-156. https://doi.org/10.1353/jowh.2001.0034

Secrétariat aux relations avec les Premières nations et les Inuit (SRPNI). (2025). *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. Annual report 2024-2025*. Secrétariat aux relations avec les Premières nations et les Inuit. https://cdn-contenu.quebec.ca/cdn-contenu/adm/org/secretariat-premieres-nations-inuit/plans-rapports/en/2024-2025-Annual-Report_Children-who-went-missing.pdf

Shaheen-Hussain, S., Lombard, A. et Basile, S. (2023). Confronting medical colonialism and obstetric violence in Canada. *The Lancet, 401*, 1763-1765. https://doi.org/https://doi.org/10.1016/S0140-6736(23)01007-3

Simpson, L. B. (2006). Birthing an Indigenous resurgence. Decolonizing our pregnancies and birthing ceremonies. Dans D. M. Lavell-Harvard et J. Corbiere Lavell (Eds), "*Until our hearts are on the ground*". *Aboriginal mothering, oppression, resistance and rebirth* (p. 25-33). Demeter Press.

Statistics Canada and Assembly of First Nations (SC and AFN). (2021). *A snapshot: Status First Nations people in Canada*. Statistics Canada and Assembly of First Nations.

Stote, K. (2015). *An act of genocide. Colonialism and the sterilization of aboriginal women*. Fernwood Publishing.

Stote, K. (2022). From eugenics to family planning: The coerced sterilization of Indigenous women in post-1970 Saskatchewan. *Native American and Indigenous Studies, 9* (1), 102-132. https://doi.org/doi:10.1353/nai.2022.0013

Stote, K. (2025). *The genocide continues. Population control & the sterilization of Indigenous women*. Fernwood Publishing.

Theobald, B. (2021). *Reproduction on the reservation: Pregnancy, childbirth, and colonialism in the long twentieth century*. University of North Carolina Press. https://uncpress.org/book/9781469653167/reproduction-on-the-reservation/

Truth and Reconciliation Commission of Canada (TRC). (2015). *Honouring the truth, reconciling for the future: Summary of the final report of the Truth and Reconciliation Commission of Canada*. Truth and Reconciliation Commission of Canada. https://nctr.ca/wp-content/uploads/2021/01/Executive_Summary_English_Web.pdf

United Nations (UN). (2024). *Convention on the elimination of all forms of discrimination against women*. United Nations. https://docs.un.org/en/CEDAW/C/CAN/CO/10

United Nations WOMEN (UN Women). (2025, November 19). *Facts and figures: Ending violence against women*. United Nations WOMEN. https://www.unwomen.org/en/articles/facts-and-figures/facts-and-figures-ending-violence-against-women

Vasquez del Aguila, E. (2006). Invisible women: Forced sterilization, reproductive rights, and structural inequalities in Peru of Fujimori and Toledo. *Estudos e Pesquisas em Psicologia, 6* (1), 109-124. http://pepsic.bvsalud.org/pdf/epp/v6n1/v6n1a10.pdf

Webb, D. (2024). *Forced and coerced sterilization of Indigenous women and girls in Canada: Understanding the practice and how to end it*. National Collaborating Center for Indigenous Health. https://www.nccih.ca/495/Forced_and_coerced_sterilization_of_Indigenous_women_and_girls_in_Canada__Understanding_the_practice....nccih?id=10455

World Health Organization (WHO). (2014). *Eliminating forced, coercive and otherwise involuntary sterilization: An interagency statement*. World Health Organization. https://apps.who.int/iris/bitstream/handle/10665/112848/9789241507325_eng.pdf?sequence=1&isAllowed=y

World Health Organization (WHO). (2015). *The prevention and elimination of disrespect and abuse during facility-based childbirth*. World Health Organization. https://iris.who.int/server/api/core/bitstreams/a287bfd1-97c0-4af6-ba57-a4469f1d3ed8/content

Appendix A – Obstetrical and gynecological violences denounced in the past in Quebec

Instances of obstetrical and gynecological violence (OGV) against Indigenous women have been documented and denounced on multiple occasions in the 1970s and 1980s. Some cases were reported directly to the attention of the *Collège des médecins du Québec* (CMQ), while others appeared in fact-finding reports and subsequently gained media attention.

In the early 1970s, for example, Dr. Richard Nelson, a physician who practiced medicine in several Indigenous communities in Quebec, including Mistissini, discovered that episiotomy repairs were being performed without anesthesia on Eeyouch (Cree) women at Chibougamau hospital. This practice was justified by the belief that Indigenous people were insensitive to pain[28]. Dr. Nelson reported the situation to the *Collège des médecins*. Several months later, he was informed that an investigation had been conducted and that the doctors involved were instructed to administer local anesthesia before stitching to repair an episiotomy. To everyone's satisfaction, the hospital subsequently established a health care framework for Indigenous patients and developed a communications network between the communities and the hospital (Nelson *et al.*,1978).

In 1980, Thérèse Lagacé authored a document entitled *Historique de l'Association des femmes autochtones du Québec 1974-1980*, in which she listed impacts of the *Indian Act* on Indigenous women, as well as many shortcomings in various sectors, including health care. She referenced multiple investigations conducted in Quebec and denounced, among other things, "medical experiments carried out on the Indigenous population" (Translation) (Lagacé, 1980, p. 78) and the lack of interpreters (p. 79). She also argued that "tubal ligation should only be done for medical reasons and as a last resort, not for social purposes. The patient should give her informed consent only following a month of careful consideration" (Translation) (p. 81). Evidence clearly indicates that, even then, sterilization practices targeting Indigenous women were widespread, and attracted much public criticism.

Two major studies conducted in 1975 and 1982 provided further understanding of care services and health conditions in Indigenous communities across Quebec. These resulted in the publication of two reports – *Rapport sur la santé et les services de santé des Indiens du Québec à l'Association des Indiens du Québec* (Remis *et al.*, 1975) and *Étude sur les services de santé des réserves attikameks et montagnaises – Des services communautaires, ça se prend en main…* (Dagenais, 1982). Both reports described experiences of mistreatment in obstetric and gynecological care, though they did not use those terms at the time.

The first report, commissioned by the Indians of Quebec Association[29], involved a team of physicians visiting 14 Indigenous communities to draw up a comprehensive picture of available health care and services. They noted at the outset the significant disparity between the infant mortality rate among Indigenous Peoples (24.56 per 1000 births) and that of Quebec in general (16.4 per 1000 births). They also identified many shortcomings in the care and treatment provided to Indigenous women and their infants (Remis *et al.*, 1975). For instance, "in at least three dispensaries", pregnant women did not undergo any blood tests "during the entire prenatal period", which is solely the responsibility of the nurses in remote posts (Remis *et al.*, 1975, I-5 - I-6). Yet these samples are essential for detecting sexually transmitted infections (then referred to as "venereal diseases"), determining blood type and identifying the presence of antibodies. As a result, they can contribute to the prevention of diseases such as congenital syphilis and erythroblastosis fetalis (Remis *et al.*, 1975). The authors further observed that gynecological cytologies (PAP tests) were conducted only in certain communities, despite the

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[28] See the article by Shaheen-Hussain, S., Lombard, A. and Basile, S. (2023). Confronting medical colonialism and obstetric violence in Canada. *The Lancet*, *401*, 1763-1765. https://doi.org/10.1016/S0140-6736(23)01007-3. These violences are reminiscent of Dr Marion Sims' gynecological experiments on enslaved women in the United States in the 1840s, without anesthesia or consent. Sims has long been considered the "father" of American gynecology and revered as a benefactor in the field of women's health (Washington, 2006, p. 128).

[29] This association is the ancestor of the Assembly of First Nations Quebec-Labrador (AFNQL).

established efficacy of these tests in preventing cervical cancer and reducing related mortality at the time (Remis *et al.*, 1975).

The Atikamekw-Montagnais Council commissioned the second study, which was conducted in eight Innu and three Atikamekw communities under the direction of Dr. Louis Dagenais. Based on extensive sources, including interviews with community members and care personnel working in the dispensaries, this study denounced several infringements on Indigenous women's rights. For example, Dr. Dagenais' team discovered that breastfeeding among Atikamekw women was significantly discouraged in hospital settings. The section of the report regarding Opitciwan highlighted that "the wishes of mothers to breastfeed their babies are not respected" in the hospitals serving the Opitciwan community (Translation) (Dagenais, 1982, p. 113). The section about Wemotaci similarly reported that "women who have given birth face challenges in breastfeeding because the infants are not brought to them" (Translation) (Dagenais 1982, p. 144).

Dr. Dagenais' study also strongly condemned the sterilizations imposed on Indigenous women. An interview conducted with the Wemotaci health committee revealed, among other findings, that the lack of a liaison officer and interpreter at the La Tuque hospital:

> "(led) to improper situations. For example, some people were often unaware of why they had surgeries or their consequences. We learned about women who had hysterectomies or tubal ligations without knowing they would lose their periods or would be sterile, which is extremely serious" (Translation) (Dagenais, 1982, p. 144).

The report categorically established that the consent obtained from patients who did not speak French or English and came from cultural contexts unfamiliar to the nursing staff, was invalid. The report's general conclusion underlined that "off-reserve services are marked by numerous misunderstandings: for instance, the gravity and repercussions of certain surgical procedures are not fully understood, meaning that we are a long way from informed consent" (Translation) (Dagenais, 1982, unpaged conclusion).

At that time, the publication of the study commissioned by the AMC received a fair amount of media attention (Gaudreault, 1982; Tourangeau, 1982a, b, c, d, e, f, g, h; Trudel, 1982). In June 1982, *Le Soleil*, *La Presse*, and *Le Droit* featured an article by journalist Pierre Tourangeau discussing, among other things, sterilizations imposed on Indigenous women. The journalist himself had visited the Atikamekw community of Opitciwan, where he had "met several women who had experienced similar situations or who knew of others who had". So, these were "not just a few isolated cases" (Translation) (Tourangeau, 1982a). Years later, he recounted that sterilized Atikamekw women "were under the age of 30, often closer to 24 or 25, and with 4 or 5 children, they were considered as having had enough children" (Translation) (Tourangeau, quoted in Josselin, 2022). Tourangeau had also met the study's director, Dr. Dagenais, who explained that "many women were surprised that they were no longer having children and assured us that although they had agreed to undergo surgery, they did not want to be sterilized". Dagenais felt that "doctors (were) at fault" in this respect. Beyond "language and cultural barriers", he blamed "certain attitudes and racism, to be frank", which meant that the information provided to Indigenous women was "insufficient" for them to give their free and informed consent to the procedure (Translation) (Dagenais, quoted in Tourangeau, 1982a,).

The publication of the report, and the media attention it received, suggest that the relevant parties at the time (provincial and federal governments, *Collège des médecins du Québec*, *Ordre des infirmières et infirmiers du Québec*) must have been minimally informed about the sterilizations imposed on Indigenous women.

References

Dagenais, L. (1982). *Étude sur les services de santé des réserves attikameks et montagnaises. Des services communautaires, ça se prend en main…* Conseil Attikamek-Montagnais.

Gaudreault, L. (1982, May 10). Des services de santé «sous-développés». *Le Soleil*, A-5.

Josselin, M-L. (2022, December 22). Stérilisation forcée de femmes autochtones : une amnésie collective. *Espaces autochtones – Radio-Canada*. https://ici.radio-canada.ca/espaces-autochtones/1942566/sterilisations-autochtones-rapport-quebec-gouvernement-sante-presse.

Lagacé, T. (1980). *Historique de l'Association des femmes autochtones du Québec 1974-1980*. Femmes autochtones du Québec.

Nelson, R., Brunet, J., and Raymond, R. (1978). *Services de santé auprès des Indiens du Québec*. Secrétariat des activités gouvernementales en milieu amérindien et inuit (SAGMAI), Gouvernement du Québec.

Remis, Stewart and Gill (1975). *Rapport sur la santé et les services de santé des Indiens du Québec à l'Association des Indiens du Québec*, Caughnawaga, Québec.

Tourangeau, P. (1982a, June 16). Le massacre tranquille d'un peuple. *Le Soleil*, A-5.

Tourangeau, P. (1982b, June 17). Le tiers-monde au Québec. *Le Soleil*, A-5.

Tourangeau, P. (1982c, June 17). Les Indiens survivent de peine et de misère dans de minuscules réserves. *La Presse*, C-2.

Tourangeau, P. (1982d, June 18). À l'endroit des Indiens : les attitudes discriminatoires. *La Presse*, C-1.

Tourangeau, P. (1982e, June 19). Maintenus dans le sous-développement : les Indiens traqués par la tuberculose. *La Presse*, E-2.

Tourangeau, P. (1982f, June 22). Un peuple meurtri, mais bien déterminé. *Le Droit*, 1-14.

Tourangeau, P. (1982g, June 22). Santé : un pays sous-développé. *Le Droit*, 1-14.

Tourangeau, P. (1982h, June 23). Des conditions qui deviennent meurtrières. *Le Droit*, 1-43.

Trudel, C. (1982, April 29). Le Conseil Attikamek-Montagnais réclame l'autodétermination en matière de santé. *Le Devoir*, 8.

Washington, H. A. (2006). *Medical apartheid: The dark history of medical experimentation on black Americans from colonial times to the present*. New York: Doubleday.

Appendix B – Declaration of Commitment to Ensure Free, Prior and Culturally Informed Consent in Health Services for First Nations Girls and Women in Quebec

Declaration of Commitment to Ensure Free, Prior and Culturally Informed Consent *in Health Services*

for First Nations Girls and Women in Quebec

> "Your grandmothers and great grandmothers commanded the highest respect in our communities as the givers of life. They were the keepers of our traditions, practices, and the customs of our nation. (...) It was well understood that all women held a sacred status as they brought new life into the world. Women were revered for their capacity not only to create new life but also by providing a new connection with Creator. The babies that were born were given the law of the Creator and were given the responsibility to enter into new relationships in a balanced and good way. The grandmothers, mothers, and women made important decisions about family, property, and education. Underlying principles of balance between men and women and the roles they played within society formed the basis for a good life." (Boyer, 2021: 13)
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> *Boyer, Y. (2021), Fairy wings and Gossamer: The forced sterilization of Indigenous women in Canada, in Sacred bundles Unborn, M. Mercredi (dir.), Friesen Press, p: 12-18.*

All First Nations girls and women have the right to free, prior and informed consent, without prejudice, for any procedure performed on their bodies and specifically concerning sexual and reproductive health. Any decision made by First Nations girls and women must come about through respectful medical consultation, without pressure or violence, and without discrimination. They have the right to make a decision based on their own value systems, culture and beliefs.

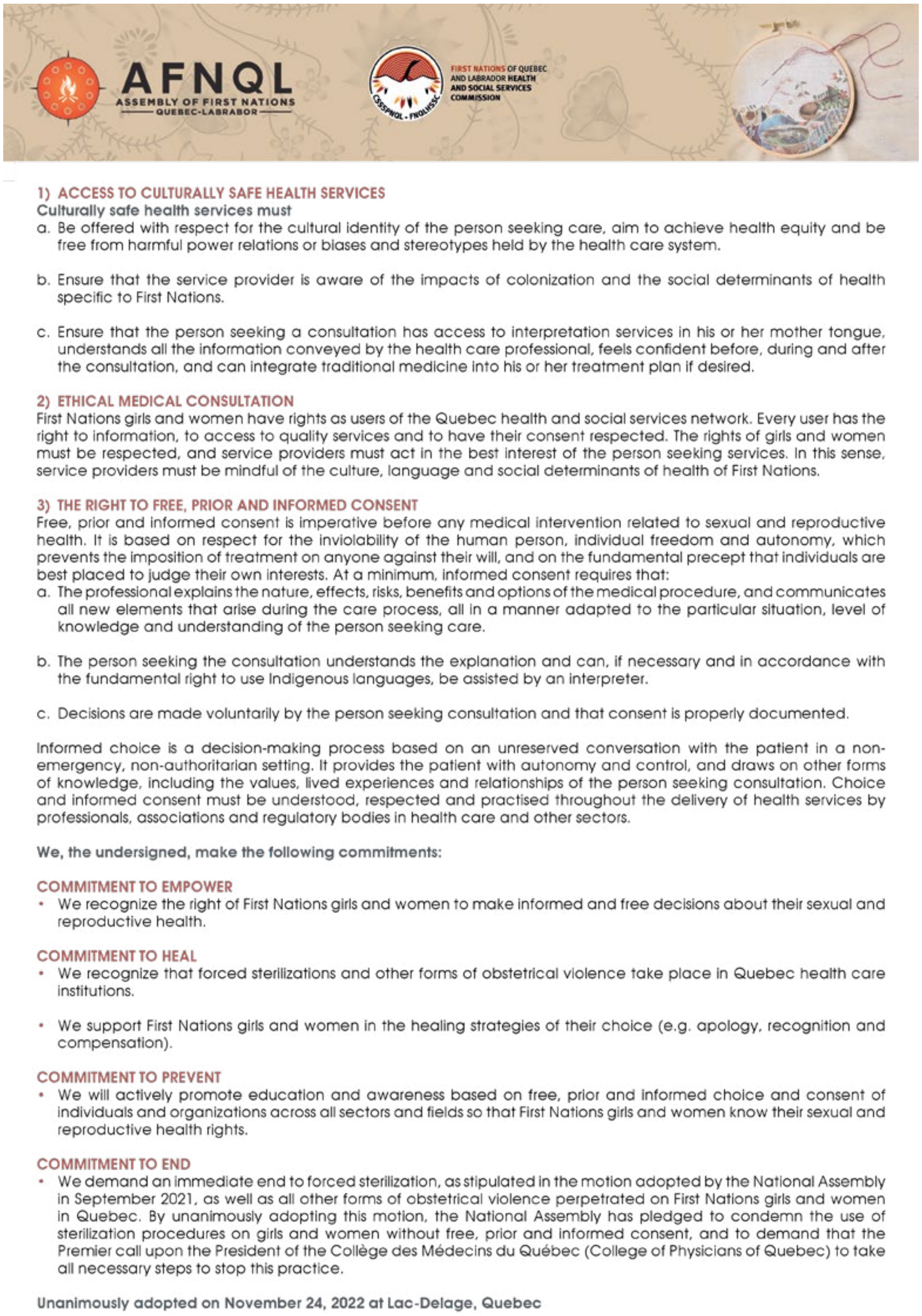
Sexual and reproductive health rights, including protection from forced sterilization and other forms of obstetric violence, are protected by various legal instruments. Internationally, Article 24 of the *United Nations Declaration on the Rights of Indigenous Peoples* provides for the right to health; Indigenous peoples have the right to have access, without discrimination, to all health and social services and have an equal right to the enjoyment of the highest attainable standard of physical and mental health. Article 3 provides that Indigenous peoples have the right to self-determination, which includes the inherent right to self-government, including in matters of sexual and reproductive health.

At the national and regional levels, the *Canadian Charter of Rights and Freedoms* and the *Quebec Charter of Human Rights and Freedoms* recognize the rights to integrity, to life and security, to non-discrimination and to information. The person responsible for carrying out the medical intervention has an obligation to provide the necessary information, but also to ensure that the person receiving the information has understood it. The person receiving the information must therefore be able to accept or refuse the medical intervention, "in full knowledge of the facts." First Nations girls and women also have the inherent right to receive the necessary explanations in their own language about the nature, purpose and possible consequences of the prescribed medical procedure, treatment or intervention. This obligation to properly inform is even stronger in the case of non-essential, non-urgent and possibly irreversible surgical procedures such as sterilization. Without consent, an intervention on the body of another person is a criminal act of assault.

The deficiency and inequity in service delivery to First Nations have been documented for many years. The Royal Commission on Aboriginal Peoples (1991–1996) reported on this, as did the Truth and Reconciliation Commission of Canada (2008–2015) and the National Inquiry into Missing and Murdered Indigenous Women and Girls (2016–2019), which denounced the practice of forced sterilization and highlighted its impact in the legal analysis of genocide. In Quebec, the Public Inquiry Commission on relations between Indigenous Peoples and Certain Public Services in Québec (2016–2019) and the *Rapport d'enquête concernant le décès de Joyce Echaquan* (*Report of the Inquiry Into the Death of Joyce Echaquan*) (2021) have also clearly demonstrated systemic racism in the health care setting.

Continuing the work done at the national level regarding forced sterilizations in Quebec, research was conducted in collaboration with several Indigenous organizations. The First Nations in Quebec are drawing upon the rights of Indigenous peoples to vigorously denounce the situation revealed by the research findings on forced sterilizations of Indigenous women and to ensure that measures are taken to put an end to situations of forced sterilizations and obstetrical violence.

We, the Chiefs of the First Nations in Quebec, who make up the Grand Circle of our Nations (AFNQL) as leaders, policy-makers, decision makers and members of a nation, reaffirm the right of girls and women to culturally safe health services that meet the highest ethical standards, including free, prior and informed consent to any medical intervention. This commitment is essential to the safety and protection of all our people, especially First Nations girls and women. This declaration of commitment is rooted in the following principles: 1) access to culturally safe health services; 2) ethical medical consultation; and 3) the right to free, prior and informed consent.



AFNQL
ASSEMBLY OF FIRST NATIONS
QUEBEC-LABRADOR

FIRST NATIONS OF QUEBEC AND LABRADOR HEALTH AND SOCIAL SERVICES COMMISSION

1) ACCESS TO CULTURALLY SAFE HEALTH SERVICES

Culturally safe health services must

a. Be offered with respect for the cultural identity of the person seeking care, aim to achieve health equity and be free from harmful power relations or biases and stereotypes held by the health care system.

b. Ensure that the service provider is aware of the impacts of colonization and the social determinants of health specific to First Nations.

c. Ensure that the person seeking a consultation has access to interpretation services in his or her mother tongue, understands all the information conveyed by the health care professional, feels confident before, during and after the consultation, and can integrate traditional medicine into his or her treatment plan if desired.

2) ETHICAL MEDICAL CONSULTATION

First Nations girls and women have rights as users of the Quebec health and social services network. Every user has the right to information, to access to quality services and to have their consent respected. The rights of girls and women must be respected, and service providers must act in the best interest of the person seeking services. In this sense, service providers must be mindful of the culture, language and social determinants of health of First Nations.

3) THE RIGHT TO FREE, PRIOR AND INFORMED CONSENT

Free, prior and informed consent is imperative before any medical intervention related to sexual and reproductive health. It is based on respect for the inviolability of the human person, individual freedom and autonomy, which prevents the imposition of treatment on anyone against their will, and on the fundamental precept that individuals are best placed to judge their own interests. At a minimum, informed consent requires that:

a. The professional explains the nature, effects, risks, benefits and options of the medical procedure, and communicates all new elements that arise during the care process, all in a manner adapted to the particular situation, level of knowledge and understanding of the person seeking care.

b. The person seeking the consultation understands the explanation and can, if necessary and in accordance with the fundamental right to use Indigenous languages, be assisted by an interpreter.

c. Decisions are made voluntarily by the person seeking consultation and that consent is properly documented.

Informed choice is a decision-making process based on an unreserved conversation with the patient in a non-emergency, non-authoritarian setting. It provides the patient with autonomy and control, and draws on other forms of knowledge, including the values, lived experiences and relationships of the person seeking consultation. Choice and informed consent must be understood, respected and practised throughout the delivery of health services by professionals, associations and regulatory bodies in health care and other sectors.

We, the undersigned, make the following commitments:

COMMITMENT TO EMPOWER

- We recognize the right of First Nations girls and women to make informed and free decisions about their sexual and reproductive health.

COMMITMENT TO HEAL

- We recognize that forced sterilizations and other forms of obstetrical violence take place in Quebec health care institutions.

- We support First Nations girls and women in the healing strategies of their choice (e.g. apology, recognition and compensation).

COMMITMENT TO PREVENT

- We will actively promote education and awareness based on free, prior and informed choice and consent of individuals and organizations across all sectors and fields so that First Nations girls and women know their sexual and reproductive health rights.

COMMITMENT TO END

- We demand an immediate end to forced sterilization, as stipulated in the motion adopted by the National Assembly in September 2021, as well as all other forms of obstetrical violence perpetrated on First Nations girls and women in Quebec. By unanimously adopting this motion, the National Assembly has pledged to condemn the use of sterilization procedures on girls and women without free, prior and informed consent, and to demand that the Premier call upon the President of the Collège des Médecins du Québec (College of Physicians of Quebec) to take all necessary steps to stop this practice.

Unanimously adopted on November 24, 2022 at Lac-Delage, Quebec

Appendix C – Courses of action taken by the *Collège des médecins du Québec* (CMQ)

Released in November 2022, the report *Free and informed consent and imposed sterilizations among First Nations and Inuit women in Quebec* generated significant attention and responses across media and political circles both within the province and beyond. The *Collège des médecins du Québec* (CMQ), the professional order that regulates the medical practice, promptly acknowledged the findings of the report as well as the incidents it detailed. In a notice entitled "*Consentir, point!*"[30] Collège President Dr. Mauril Gaudreault points out that:

> Try as one might to cite language or cultural barriers, the fact remains that the fundamental principle of informed consent between doctor and patient seems, in these cases, to have been overlooked. The doctors' comments, as reported, are totally inappropriate. The doctor's job is to care, not to judge. Attempting to obtain consent for sterilization while the patient is in labor, as reported, is totally outrageous (Translation) (CMQ, 2022a, p. 1).

In a second text published in December 2022, Dr. Gaudreault underlines the "deontological duties" governing the exercise of free and informed consent and indicates that a meeting will be held between CMQ authorities and Professor Suzy Basile, co-author of the report (CMQ, 2022b). Then, in February 2023, the CMQ created a *Focus group on abortions and sterilizations imposed on First Nations and Inuit women in Quebec*. The group includes key players in the Indigenous health sector and CMQ professionals to follow-up on the Basile-Bouchard report. The mandate consists of five components (CMQ, 2024a, p. 8):

- Define a position for the CMQ.
- Develop actions to be taken as part of an action plan.
- Propose potential positions that would allow the CMQ to offer its consulting expertise to First Nations and Inuit communities and organizations.
- Evaluate the need to amend the *Code of Ethics of Physicians*.
- Identify a procedure that would allow First Nations and Inuit women to make reports and submit inquiry requests safely.

In June 2023, the CMQ created a survey on the issue of free and informed consent that was sent to all physicians in Quebec. A total of 361 physicians responded to the survey (*Ibid.*, 2024a). Analysis of the quantitative and qualitative data highlights various significant issues, revealing bias, both implicit and explicit, among the respondents:

> Several of them recognized the problem of imposed sterilizations and abortions; some justified it with medical arguments or by referring to the social context. Others denied the issue, believing that it was an extreme generalization or that these events were a thing of the past (*Ibid.*, 2024a, p.10).

After several months of work, the focus group published the report *For consensual, respectful and safe care* in June 2024 (*Ibid.*, 2024a). In all, seven recommendations are put forward, including the need to establish a relationship of trust with Indigenous patients, to raise awareness and provide training to health care professionals on issues relating to consent and cultural safety, in order to prevent such situations in the future. The CMQ has developed various communication tools to publicize this initiative, including a press release, an opinion letter co-signed by Dr. Gaudreault and Professor Basile, and a web page detailing the organization's commitments and positions. (CMQ, 2024b; Gaudreault and Basile, 2024). It has been proposed to add the following preamble to the *Code of ethics* (CMQ, 2024b, p. 14):

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[30] "Consent, the bottom line!" (Translation)

"As part of its mission to protect the public, the *Collège des médecins du Québec* recognizes that the cultural, Western and patriarchal origins of medicine in Quebec may be responsible for biases in the construction of the health and social services network, health care structures and the practice of medicine.

The *Code of ethics of physicians* must be in keeping with the Collège's mission and reflect its values. To this end, three premises were retained to reaffirm the importance of establishing a relationship of trust with patients and the population. These premises are reflected in each section of the Code and are as follows:

1. Recognition of the historical, social and cultural factors that are specific to First Peoples and which influence their health and wellness as well as the health care that must be provided to them.

2. Recognition of respect for a person's culture and identity, including their gender identity.

3. Recognition of systemic discrimination and racism and of any system or structure that reproduces and creates power imbalances with the population, patients, the health care team and medical staff.

References

Collège des médecins du Québec (CMQ). (2022a, November 29). *Consentir, point !* (Avis). https://www.cmq.org/fr/actualites/consentir-point.

Collège des médecins du Québec (CMQ). (2022b, December 2). *Le consentement et le respect ne sont pas négociables* (Avis). https://www.cmq.org/fr/actualites/le-consentement-et-le-respect-ne-sont-pas-negociables.

Collège des médecins du Québec (CMQ). (2024a). *For consensual, respectful and safe care. Report of the focus group on abortions and sterilizations imposed on First Nations and Inuit women in Quebec*. Collège des médecins du Québec. https://cms.cmq.org/files/documents/Avis-et-prises-de-position/rap-inter-grossesse-sterilisations-202406-EN.pdf

Collège des médecins du Québec (CMQ). (2024b). *Fin des stérilisations imposées : passer de la parole aux actes*. Collège des médecins du Québec. https://www.cmq.org/fr/proteger-le-public/infocmq/fin-sterilisations-imposees.

Gaudreault, M. and Basile, S. (2024, June 11). *Stérilisations imposées : des actions pour regagner la confiance – Lettre ouverte*. https://cms.cmq.org/files/documents/Avis-et-prises-de-position/let-strelisations-imposees-202406.pdf.

Appendix D – Class action *U.T. et M. X. c. Richard Monday et al.*

On August 16, 2023, the Superior Court of Quebec authorized a class action lawsuit on behalf of Atikamekw women who were allegedly sterilized without their consent at the Joliette hospital since 1980, as well as their relatives (2023 QCCS 3180) (Superior Court of Quebec, n.d.). This is the first class action lawsuit in Quebec relating to the imposed sterilization of Indigenous women (Radio-Canada, 2023).

A **class action** is a legal procedure that allows one or more persons, called *representative* plaintiff(s), to start a lawsuit on behalf of people who have similar claims. All the people who have similar claims are called *members*. If the court rules in favor of the representative(s), all members of the class action may receive a sum of money in compensation (Lafond, 2022; Éducaloi, s.d.). In this class action, the representatives are Atikamekw women who claim to have undergone tubal ligation without their consent.

A class action generally involves three main stages. A judge must first authorize the class action. To do so the judge must determine whether the alleged situation is one that may be pursued through this type of proceeding. If authorization is granted, the case then proceeds to the merits stage that is the trial itself. This stage comprises several phases and can extend over several years. It normally ends with a settlement or final decision. If the decision is in favor of the representatives, the judge determines the amount of money to be paid as compensation. The class action then moves onto the third stage, recovery, which allows class members to receive the sums to which they are entitled (Lafond, 2022).

While the Quebec Superior Court judge granted authorization for the Atikamekw women's class action in August 2023, this ruling is currently under appeal. After hearing the parties in November 2024, the Quebec Court of Appeal handed down its judgment on February 12, 2025, upholding the authorization of the class action and confirming that the lawsuit could be brought against both the doctors involved and the Centre de santé et des services sociaux (CISSS) de Lanaudière (Dionne Schulze, 2025; Josselin, 2025).

Class action eligibility

To verify if you are eligible to join the class action or to be informed of future developments, you can contact the Dionne Schulze law firm or fill out the form on the class action web page available in Atikamekw, French and English. https://www.dionneschulze.ca/imposed-sterilizations/?lang=en

References

Dionne Schulze (2025, February 27). The Court of Appeal issued its decision in the class action brought by Atikamekw women. https://www.dionneschulze.ca/2025/02/27/la-cour-dappel-a-rendu-son-arret-concernant-laction-collective-des-femmes-atikamekw/?lang=en

Éducaloi. (s.d.). *What Is a Class Action?* https://educaloi.qc.ca/en/capsules/what-is-a-class-action/

Josselin, M.-L. (2025, February 21). Stérilisations non consenties : Deux Atikamekw pourront poursuivre le CISSS de Lanaudière. *Espaces autochtones – Radio-Canada*. https://ici.radio-canada.ca/espaces-autochtones/2142612/sterilisation-joliette-atikamekw-autochtone-hopital

Lafond, P.-C. (2022). Fascicule 20. Définition de l'action collective, parties et tribunal compétent. In *JurisClasseur Québec*, collection « Droit civil », *Procédure civile II (2nd ed.)*. LexisNexis.

Radio-Canada. (2023, August 22). Stérilisations forcées : la Cour supérieure autorise une action collective. *Espaces autochtones – Radio-Canada*. https://ici.radio-canada.ca/espaces-autochtones/2005278/sterilisation-femmes-autohtones-cour-superieure-action-collective

Superior Court of Québec (s.d.). Overview of Application 705-06-000011-214. *Registry of class actions*. https://www.registredesactionscollectives.quebec/fr/Consulter/ApercuDemande?NoDossier=705-06-000011-214

Appendix E – Bill to support the criminalization of forced sterilization

First introduced on June 14, 2022, Bill S-250, also called *An Act to amend the Criminal Code (sterilization procedures),* is an initiative within the Canadian parliament to amend the *Criminal Code* to add a provision expressly stipulating that forced sterilization be a criminal act. This bill was presented by Senator, and member of the Métis Nation of Ontario, Yvonne Boyer (Radio-Canada, 2024). Such an amendment to the *Criminal Code* would be consistent with recommendations from a number of committees and legislative bodies that have studied this form of violence (SSCHR, 2022, p. 31; Casey *et al.*, 2019, p. 11; Government of Canada, 2023, p. 28).

Potential impacts of Bill S-250: Sterilization without consent is already a criminal act in Canada: a person performing such an act could be charged with aggravated assault under section 268 of the *Criminal Code*. However, at no time in Canadian history has anyone been charged with aggravated assault for performing a sterilization without consent. The amendment to the Criminal Code would ensure that forced sterilization "can no longer be ignored by the criminal law system" and can be more easily prosecuted (Dalphond, 2023).

More specifically, the bill proposes the addition of a new section to the Criminal Code, namely section 268.1. This section would provide a definition of "sterilization procedure" as an act that wounds or maims a person for the purposes of subsection 268 on aggravated assault. Any person who performs a sterilization procedure without first obtaining the "legal consent" of the person concerned could be liable to imprisonment for a term of up to fourteen years (*Criminal Code*, s. 265(1)(2) and 268(2)). As stated by Senator Boyer, the legal consent required is defined by multiple criteria. First of all, consent must not be obtained by fraud or coercion; the patient must also have received sufficient information about the intervention (e.g. possible risks, alternatives, etc.). Then, the patient must be able to understand the nature of the procedure, which, a priori, makes it illegal to perform a sterilizing procedure on people under 18 years of age or suffering from cognitive impairments (Boyer, 2024).

Unlike other legal measures, such as class action suits, Bill S-250 does not seek to compensate victims of forced sterilization. Instead, its focus is on penalizing individuals who carried out these procedures without securing a patient's free and informed consent. This bill is one of several initiatives designed to dissuade health care professionals from performing forced sterilizations, thereby aiming to eliminate this practice completely.

Current progress of Bill S-250: On October 8, 2024, Bill S-250 was officially passed by the Senate at the Third reading. The proposed amendments to the Criminal Code were extensively reviewed between First and Third readings to address several concerns, notably that doctors might be reluctant to intervene during emergency surgery (Boyer, 2024; FNQLHSSC, 2024). The bill was then scheduled to continue its journey through the House of Commons, but the prorogation of Parliament on January 6, 2025, followed by the calling of a general election on March 23, led to its death on the Order paper. Senator Boyer has indicated, however, that she intends to reintroduce the bill as soon as possible (Antunes, 2025), which she did with a first reading before the Senate on June 5, 2025. The new bill retains its original title, *An Act to amend the Criminal Code (sterilization procedures)*, but now bears the number S-228. It was adopted on third reading in the Senate and was given a first reading by the House of Commons on November 18, 2025, and a second on February 26, 2026.

References

Antunes, J. (2025, March 17). Senator plans to revive bill to outlaw forced sterilization. *Nunatsiaq News*. https://nunatsiaq.com/stories/article/senator-plans-to-revive-bill-to-outlaw-forced-sterilization-under-new-government/.

Boyer, Y. (2024, October 8). The Criminal Code. An act to amend the Criminal Code, Third reading. *Senate debates (Hansard)*, 1st Session, 44th Parliament, *153*(226), 7178-7184.

Casey, B. (2019, August 2). Study on the forced sterilization of women in Canada. Standing Committee on Health of the House of Commons. https://www.ourcommons.ca/content/Committee/421/HESA/WebDoc/WD10596408/421_HESA_reldoc_PDF/MinisterOfHealth-Final-e.pdf

Standing Senate Committee on Human Rights (SSCHR). (July 2022). *The Scars that We Carry: Forced and Coerced Sterilization of Persons in Canada – Part II*. Senate of Canada. https://sencanada.ca/content/sen/committee/441/ridr/reports/ridr_forcedsterilization_e.pdf

First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC). (2024, September 18). *Bill on Coerced Sterilization: So It Never Happens Again. Brief on Bill S-250, An act to amend the Criminal Code (sterilization procedures). Submitted to the Standing Senate Committee on Legal and Constitutional Affairs*. First Nations of Quebec and Labrador Health and Social Services Commission. https://sencanada.ca/Content/Sen/Committee/441/LCJC/briefs/LCJC_S-250_Brief_CSSSPNQL_e.pdf

Dalphond, P. J. (2023, April 18). Second Reading of Bill S-250, An Act to Amend the Criminal Code (sterilization procedures). *The Progressives Senate Group*. https://sencanada.ca/en/content/sen/chamber/441/debates/112db_2023-04-18-e

Government of Canada. (2023). *United Nations Declaration on the Rights of Indigenous Peoples Act. Action Plan*. Government of Canada. https://www.justice.gc.ca/eng/declaration/ap-pa/

Radio-Canada. (2024, March 1st). La stérilisation forcée au cœur d'un projet de loi au Sénat. *Espaces autochtones – Radio-Canada*. https://ici.radio-canada.ca/espaces-autochtones/2053539/sterilisation-forcee-senat-infraction-criminelle-projet-de-loi-auditions

Legislation

Bill S-228: *An Act to amend the Criminal Code (sterilization procedures*. (2025). 1st Session, 45th Parliament https://www.parl.ca/legisinfo/en/bill/45-1/s-228

Bill S-250: *An Act to amend the Criminal Code (sterilization procedures)*. (2024). 1st Session, 44th Parliament https://www.parl.ca/LegisInfo/en/bill/44-1/s-250

Criminal Code. R.S.C. (1985), c. C -46. https://laws-lois.justice.gc.ca/eng/acts/c-46/page-38.html

Appendix F – Anticonception campaign in Greenland

Worldwide, birth control policies aimed specifically at Indigenous populations are part of an assimilation strategy and have been legitimized through a host of harmful prejudices circulated by colonial authorities (Alsheikh, 2023; McKenzie *et al.*, 2022; Stote, 2022;). The political class has always based its arguments on purely economic reasoning, claiming that these populations represent a significant financial burden for the State (Lechat, 1976; Park et Radford, 1998; Sullivan, 2001). As a result, Indigenous women's fertility is perceived as a social problem likely to grow if authorities do not take action to contain it through various policies (Pegoraro, 2015; Ralstin-Lewis, 2005; Torpy, 2000). It is also important to point out that this violation of Indigenous women's fundamental rights is a contemporary phenomenon, and that numerous survivors in different countries are currently seeking justice and redress in several countries (Getgen, 2009; Schoen, 2006). This is particularly true of Inuit women in Greenland, a territory under Danish government rule for several decades (Graugaard Dyrendom and Ambrosius Høgfeldt, 2023; Greve Møller, 2024).

In Greenland, the phenomenon is known as the "spiral scandal", in reference to the spiral shaped intrauterine devices used at the time (Bryant, 2024). In the 60s and 70s, the modus operandi of the Danish health authorities was as follows: while at school, young Greenlandic girls (some as young as 12) were summoned and sent to a nearby hospital for a gynecological examination. They are then fitted with an IUD (often the largest model to ensure the utmost effectiveness) in the uterus without their consent or that of their parents (Graugaard Dyrendom and Ambrosius Høgfeldt, 2023; Lacoursière, 2022). This procedure not only causes significant pain during insertion but also leads to chronic pelvic pain and severe reproductive system disorders due to the young age of the patients (Greve Møller, 2024). Often, following years of diagnostic delay, the women affected are stunned to learn that an IUD is the source of their issues, and that its removal can lead to significant complications, including infertility (Jung, 2022). It is important to note that the transfer of health care competencies from Denmark to Greenland was only implemented in 1991 (Bryant, 2024).

In 2022, it was the radio podcast "Spiralkampagnen" that brought to light the fact that some 4,500 Greenlandic women and girls had been victims of this policy, which halved the population growth of Greenland (Greve Møller, 2024; Jung, 2022). These revelations create a wave of indignation, and many survivors resoundingly denounce the treatment they received in Greenland's health care institutions (Lacoursière, 2022). In 2023, the Greenlandic government and the Danish state launched a joint impartial inquiry into the practices carried out between 1960 and 1991 (Bryant, 2024; Ilisimatusarfik – University of Greenland, 2023). Tenna Jensen, head of the research team, underscores that:

> We look forward to beginning uncovering this important matter. The study will build on the general knowledge of the institutions and professionals, relevant historical sources, and interviews with those who were impacted either directly or indirectly. It is important that all the affected women get the opportunity to testify as to their individual accounts (Ilisimatusarfik – University of Greenland, 2023, p. 1).

Concurrently, a group of 143 survivors has opted for legal action against the Danish state by filing a class action lawsuit in 2024 (Bryant, 2024). In August of the same year, a second inquiry was set up by the Greenlandic government to examine the human rights issues underlying the "spiral scandal" (Lybert, 2024). This inquiry is led by four experts from different countries (*Ibid.*, 2024). Then, in November 2024, it was announced that a first series of compensation payments had been issued by the Greenlandic government to 15 women who were victims of the practice after 1991 (Agence France-Presse, 2024). But it was only from September 2025 that the women were able to claim compensation.

The final report of the impartial inquiry was submitted on September 9, 2025, after receiving testimony from 354 women. As of this writing, the English version of the report was still unavailable for review. On September 24, 2025, Danish Prime Minister Mette Frederiksen visited Greenland to offer a formal apology to the victims of the forced contraception campaign. The creation of a Reconciliation Fund was also announced, and on December 10, 2025, the Danish government confirmed that compensation of 300,000 Danish kroner (approximately 60,000 Canadian dollars) will be provided to each eligible woman beginning in April 2026.

References

Agence France-Presse (AFP). (2024, November 26). Contraception forcée : Le Groenland va indemniser 15 victimes. *Radio-Canada*. https://ici.radio-canada.ca/nouvelle/2122566/groenland-contraception-forcee-indemnisation-victimes.

Alsheikh, B. (2023). Reproductive abuse and the sterilization of women of color. *History in the Making, 16* (1), 1-30. https://scholarworks.lib.csusb.edu/cgi/viewcontent.cgi?article=1282&context=history-in-the-making.

Bryant, M. (2024, March 4). Greenlandic women sue Danish state for contraceptive 'violation'. *The Guardian*. https://www.theguardian.com/world/2024/mar/04/greenlandic-women-sue-danish-state-for-contraceptive-violation-coil.

Getgen, J. E. (2009). Untold truths: the exclusion of enforced sterilizations from the Peruvian Truth Commission's final report. *BC Third World LJ, 29* (1), 1-34. https://scholarship.law.cornell.edu/cgi/viewcontent.cgi?article=1021&context=facpub.

Graugaard Dyrendom, N., et Ambrosius Høgfeldt, A. (2023). The silenced genocide: Why the Danish intrauterine device (IUD) enforcement in Kalaallit Nunaat calls for an intersectional decolonial analysis. *Women, Gender & Research, 36* (2), (p. 162-167). https://doi.org/10.7146/kkf.v36i2.137309.

Greve Møller, A.-S. (2025, December 10). Kvinder fra spiralskandalen får erstatning fra den danske stat. *Kalaallit Nunaata Radioa*. https://knr.gl/da/nyheder/kvinder-fra-spiralskandalen-faar-erstatning-fra-den-danske-stat.

Greve Møller, A.-S. (2024). A vicious campaign of birth control in Greenland. In M. Mercredi and Fire Keepers (Eds.), *Sacred Bundles Unborn*, (p. 151-165). (2nd ed.). Friesen Press.

Ilisimatusarfik – University of Greenland (IUG). (2023). *Denmark and Greenland launch independent study into the IUD case*. Ilisimatusarfik – University of Greenland. https://uk.uni.gl/news/2023/may/denmark-and-greenland-launch-independent-study-into-the-iud-case/.

Jensen, T., Jensen, B., Bang Bourup, E., Reimer, G. A., Olesen, I., Herrmann, J. R., Christiansen, M. et Seidelin, M. (2025). *Uvildig udredning af antikonceptionspraksis i Kalaallit Nunaat i perioden 1960-1991*. Statens Institut for Folkesundhed et Ilisimatusarfik - Grønlands Universitet. https://www.sdu.dk/da/sif/rapporter/2025/uvildig_udredning_af_antikonceptionspraksisi_kalaallit_nunaat_i_perioden_1960_1991

Jung, E. (2022, December 7). 'Doctors fitted a contraceptive coil without my consent'. *BBC News*. https://www.bbc.com/news/world-europe-63863088.

Lacoursière, A. (2022, November 28). Un stérilet malgré elle à 14 ans. *La Presse*. https://www.lapresse.ca/actualites/sante/2022-11-28/la-presse-au-groenland/un-sterilet-malgre-elle-a-14-ans.php

Lechat, R. (1976). *Omfattende sterilisation blandt candiske eskimo-kvinder*. The Diocese of Churchill-Hudson Bay.

Lybert, N. (2024, November 14). *Intrauterine devices (IUD) Campaign in Kalaallit Nunaat: The quest for justice of 143 Greenlandic women*. Presentation during an Indigenous luncheon conference at the Université du Québec en Abitibi-Témiscamingue, Val-d'Or. https://www.youtube.com/watch?v=MtDYnV1Ta0U

McKenzie, H. A., Varcoe, C., Nason, D., McKenna, B., Lawford, K., Kelm, M. E., and Arisman, K. (2022). Indigenous women's resistance of colonial policies, practices, and reproductive coercion. *Qualitative Health Research, 32* (7), 1031-1054. https://journals.sagepub.com/doi/pdf/10.1177/10497323221087526.

Park, D. C., et Radford, J. P. (1998). From the case files: Reconstructing a history of involuntary sterilisation. *Disability & Society, 13* (3), 317-342. https://www.tandfonline.com/doi/pdf/10.1080/09687599826669?casa_token=2jl-zkiyL-jgAAAAA:JYplowKHSoeVfl5PhcrGiDTi--_bVq-Yj7Y6ezNtn8ly8-3VbqwvMaoLFry-1sqJ9yrASeBKy1NNuMSe.

Pegoraro, L. (2015). Second-rate victims: The forced sterilization of Indigenous peoples in the USA and Canada. *Settler Colonial Studies, 5* (2), 161-173. https://www.tandfonline.com/doi/pdf/10.1080/2201473X.2014.955947?casa_token=hojgLgA7ubwAAAAA:UuTwWnhkKlXTHd_nd1U6V1rhHIA7Ea2yAHHxCG7wknJ-plA89JlT6v0744qEaEbh-vKEUd-V42HAHcAfv.

Ralstin-Lewis, D. M. (2005). The continuing struggle against genocide: Indigenous women's reproductive rights. *Wicazo Sa Review, 20* (1), 71-95. https://www.jstor.org/stable/pdf/4140251.pdf?casa_token=mou_Nqc-P34AAAAA:wMM7EYDYY1JXQlP2gNALCpuO3kJEde3jqOJrjYDblFyOdGox8n4oe5c2x8jTvVQljohmgOwGqFbci-HJ9MkyyrpCiRyPE7Cl1PgzbvuC_f9WTlbsX9LgH_A.

Schoen, J. (2006). From the footnotes to the headlines: Sterilization apologies and their lessons. *Sexuality Research and Social Policy, 3*, 7-22. https://doi.org/10.1525/srsp.2006.3.3.7

Stote, K. (2022). From eugenics to family planning: The coerced sterilization of Indigenous women in post-1970 Saskatchewan. *Native American and Indigenous Studies, 9* (1), 102-132. https://doi.org/doi:10.1353/nai.2022.0013

Sullivan, M.A. (2001). *Healing bodies and saving the race: women, public health, eugenics, and sexuality 1890-1950.* (Doctoral thesis). University of New Mexico.

Torpy, S. J. (2000). Native American women and coerced sterilization: On the trail of tears in the 1970s. *American Indian Culture and Research Journal, 24* (2), 1-22. https://pdfs.semanticscholar.org/e218/3e80bf4869264ad4850106f-465cd04401d6c.pdf

Appendix G – Birth Alerts

In Canada, reports to youth protection, also called "birth alerts", have garnered a great deal of attention in recent years and have been openly criticized by First Nations authorities (Fallon *et al.*, 2023; FNQLHSSC, 2023) as well as by the National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG, 2019). Involving child welfare services, this practice aims to: "flag expectant parents to hospitals in advance of a child's birth when it is believed that the newborn may be at risk of harm and in need of protection after delivery" (Sistovaris *et al.*, 2022, p. 1). Without the knowledge or consent of the parents, hospital staff notify child welfare authorities before or at the birth of the baby, which could lead to the newborn being removed and taken into care (*Ibid.*, 2022, p. 1). In other words, from its very first moments of life, the infant is likely to be taken away from its parents, who are suddenly deprived of their role and responsibilities. A recent study on access to midwifery services for Indigenous communities in Quebec recommends preventive measures, including accompaniment during childbirth, as a way to counter this practice:

> Community health centres, Indigenous organizations and women themselves are mobilizing to prevent the alerts. For example, "Some women want to be accompanied to the hospital to make sure they are not discriminated against or subject to prejudice, so as not to have birth or baby alerts, just because they are Indigenous" (Translation) (ORG04), (Basile *et al.*, 2023, p. 45).

This intervention, while traumatic for all families, is consistent with colonial practices that have devastated the family fabric of First Nations communities (FNQLHSSC, 2023). The over-representation of First Nations children in youth protection is significant, and the phenomenon of birth alerts has a lot to do with it (Hélie *et al.*, 2022). In fact, according to figures published for the first time in Quebec in 2019, First Nations children aged 0 to 3, i.e. 19% of infants (0 to 1 year) and 9% of children aged 1 to 3, are part of the age group most evaluated by youth protection services, "whereas among non-Indigenous children, the group with the highest investigation rate consists of children ages 4 to 15" (Hélie *et al.*, 2022, p. 10). An investigation by *APTN News* journalist Sylvie Ambroise demonstrates that, on average, about 30% of birth alerts in the northwestern Quebec region of Abitibi-Témiscamingue target Indigenous newborns, while Indigenous people only make up about 4% of the region's population (Ambroise, 2021).

Although controversial, the practice of birth alerts was only recently eliminated in most provinces, notably in British Columbia in 2019 (Elbouidaïni, 2021) and in Ontario in 2020 (Ontario Ministry of Children, Community and Social Services, 2020). In Quebec, the ministère de la Santé et des Services sociaux du Québec (MSSS) did not adopt this position until 2023. From now on, "any professional or person with concerns about an unborn child will no longer be able to refer a child's situation to the DYP before birth" and the person should prioritize early intervention for parents facing difficult situations (Translation) (MSSS, 2023, p. 2).

References

Ambroise, S. (2021, March 18). Signalements à la naissance en Abitibi : « je crois qu'il y a un profilage racial ». *Aboriginal People Television Network*. https://www.aptnnews.ca/reportages/signalements-de-la-naissance-en-labitibi-quebec/.

Basile, S., Comat, I. and Cornellier, F. (2023). *Access to midwifery services for Indigenous communities in Quebec*. (Research Report). Université du Québec en Abitibi-Témiscamingue. https://depositum.uqat.ca/id/eprint/1521/2/basile-2023-midwifery_services_Indigenous_communities.pdf

First Nations of Quebec and Labrador Health and Social Services Commission (FNQLHSSC). (2023). *Reference Guide: Appointing a Competent Authority for Customary Adoption and Tutorship in First Nations Communities and Nations*. First Nations of Quebec and Labrador Health and Social Services Commission. https://files.cssspnql.com/s/UmvljP4aEakBC1r?_gl=1*1gaogvp*_ga*MjU5MzUzODk5LjE3NTA3MjAyOTk.*_ga_906VEPXQGV*czE3NzA5NDQ2ND-MkbzgkZzEkdDE3NzA5NDQ4NTkkajYwJGwwJGgw

Elbouidaïni, A. (2021, January 15). La C.-B. savait que les alertes à la naissance étaient « illégales » avant de les abolir. *Radio-Canada Colombie Britannique*. https://ici.radio-canada.ca/nouvelle/1763599/alerte-naissance-illegale-indiginews.

National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG). (2019). *A Legal Analysis of Genocide – Supplementary Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. National Inquiry into Missing and Murdered Indigenous Women and Girls. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Supplementary-Report_Genocide.pdf

Fallon, B., Chabot, M., Fluke, J., Blackstock, C., MacLaurin, B. et Tonmyr, L. (2013). Placement decisions and disparities among Aboriginal children: Further analysis of the Canadian incidence study of reported child abuse and neglect part A: Comparisons of the 1998 and 2003 surveys. *Child Abuse & Neglect, 37* (1), 47-60. https://doi.org/10.1016/j.chiabu.2012.10.001.

Hélie, S., Trocmé, S., Collin-Vézina, D., Esposito, T., Morin, S. et Saint-Girons, M. (2022). *Volet Premières Nations de l'Étude d'incidence québécoise sur les situations évaluées en protection de la jeunesse en 2019. Rapport EIQ/PN-2019*. Institution Jeunes en difficulté, https://files.cssspnql.com/s/17wpWzsyMzBOhNV.

Ministère de la Santé et des Services sociaux (MSSS). (2023). *Lettre-Directive qui confirme la fin des avertissements de naissances*. Ministère de la Santé et des Services sociaux.

Ontario Ministry of Children, Community and Social Services (OMCCSS). (2020, July 14). *Ontario Eliminating the Practice of Birth Alerts*, https://news.ontario.ca/en/release/57580/ontario-eliminating-the-practice-of-birth-alerts

Sistovaris, M., Sansone, G., Fallon, B. et Miller, S. (2022, January). *The efficacy of birth alerts: Fact sheet*. Fraser Mustard Institute of Human Development et University of Toronto. https://socialwork.utoronto.ca/wp-content/uploads/2022/08/Fact-Sheet-Birth-Alerts-Jan13.pdf.

Appendix H – Genocide

In 1948, the United Nations (UN) introduced the Convention on the Prevention and Punishment of the Crime of Genocide. Before it's adoption, the convention was the subject of bitter discussions among countries with a colonial history, including Canada (Palmater, 2014; Rowlands *et al.*, 2024; Stote, 2015). The five acts, "committed with the intent to destroy, in whole or in part, a national, ethnical, racial or religious group", specified in Article II of this Convention (United Nations, 1948, p. 1) are reflected in various assimilation policies implemented across Canada towards Indigenous Peoples. These acts are as follows:

1. Killing members of the group.
2. Causing serious bodily and mental harm to members of the group.
3. Deliberately inflicting on the group conditions of life calculated to bring about its physical destruction in whole or in part.
4. Imposing measures intended to prevent births within the group.
5. Forcibly transferring children of the group to another group.

This definition is included in the *Crimes Against Humanity and War Crimes Act* adopted by Canada in 2000, which confirms the illegality of genocide in the country. From this perspective, many studies by researchers as well as Indigenous activists draw parallels between the five acts that define a genocide, as mentioned above, and Canada's colonial history, specifically the mandatory attendance of residential schools, the number of missing and murdered Indigenous women and girls, and cases of forced sterilization. (Asher BlackDeer, 2023; NIMMIWG, 2019; Smith, 2003; Stote, 2015).

It is worth noting that Canadian diplomats have lobbied for the removal of the term "cultural genocide" while drafting the first version of the Convention (NIMMIWG, 2019). In short, the adoption of the Convention reveals many fault lines between Canada's commitments at the international level and the situations experienced by Indigenous Peoples at home.

References

Asher BlackDeer, A. (2023). Violence, trauma, and colonialism: A structural approach to understanding the policy landscape of indigenous reproductive justice. *Journal of Trauma & Dissociation, 24* (4), 453-470. https://www.tandfonline.com/doi/pdf/10.1080/15299732.2023.2212402?casa_token=QrB13qIPqMUAAAAA:OpozexOotLxFx-rh5s4DBdYAEYQl0UuwoK6rtumeaqhTDYMhdWOpU1IqhXwMut7C4eJPS0AgAFDSQ.

National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG). (2019). *A Legal Analysis of Genocide – Supplementary Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. National Inquiry into Missing and Murdered Indigenous Women and Girls. https://www.mmiwg-ffada.ca/wp-content/uploads/2019/06/Supplementary-Report_Genocide.pdf

United Nations. (1948). *Convention on the Prevention and Punishment of the Crime of Genocide.*
United Nations. https://www.ohchr.org/en/instruments-mechanisms/instruments/convention-prevention-and-punishment-crime-genocide

Palmater, P. (2014). Genocide, Indian policy, and legislated elimination of Indians in Canada. *Aboriginal Policy Studies, 3* (3). 27-54. http://dx.doi.org/10.5663/aps.v3i3.22225

Rowlands, S., Heaslip, V., Felske-Durksen, C., Carranza Ko, Ñ., Albert, G., Rich, R., Black, K.A. et Szilvási, M. (2024). The forced sterilisation of Indigenous and racialised Peoples: Origins, nature of abuses, impacts and responses. *International Perspectives on Health Equity. 1* (1). 3-22. https://doi.org/10.1108/IPHEE-01-2024-0003

Smith, A. (2003). Not an Indian tradition: The sexual colonization of Native peoples. *Hypatia, 18* (2), 70-85. https://onlinelibrary.wiley.com/doi/pdf/10.1111/j.1527-2001.2003.tb00802.x?casa_token=jGKG3na62ggAAAAA:DilbZ-RpAdtXu-c49rcu824WdUebT968KmZTWhFttJTJoNRXg-a_cfQC0T2Cp1C1p29tF8jXrOFmQ3w.

Stote, K. (2015). *An act of genocide. Colonialism and the sterilization of Aboriginal women*. Fernwood Publishing.

Appendix I – The Eugenics movement

To understand the various issues surrounding the forced sterilization of Indigenous women in Canada, one must examine both the ideology underlying it and the eugenics movement. Galton (1883) defined eugenics as "the science of improving stock" which, "especially in the case of man", takes cognizance "of all influences that tend, in however remote a degree, to give the more suitable races or strains of blood a better chance of prevailing speedily over the less suitable" (p.17).

By borrowing concepts from various disciplines, Galton and his followers develop theories on heredity and the social reproduction of deviancy. Special attention was focused on the economic burden brought about by certain groups deemed "feebleminded", i.e. individuals unable to manage their fertility and likely to produce offspring with social and moral deficiencies (Acevedo Guerrero, 2016; Barr, 2012). For eugenicists, people perceived as socially "undesirable" based on their origin, mental and/or physical condition, or failure to uphold the strict codes and norms of the time (e.g. pregnancy out of wedlock), needed to be regulated by political and health authorities (Sebring, 2012).

In the collective imagination, the example of Nazi Germany, its promotion of the Aryan race and the ideology-related crimes against humanity is one of the most chilling reminders of eugenic policies.

> Those who were not considered to be the ideal Aryan were either killed *en masse*, put into concentration camps, and/or forcibly sterilized. The Nazis had entire list of diseases, and their sufferers would be sterilized. Physicians examining these individuals during their professional duties were required to comply, or face a fine. These diseases included schizophrenia, manic-depressive insanity, and hereditary forms of epilepsy, blindness, and deafness (DHDI) (Kantrowitz, 2022, p. 32).

The eugenics ideology paved the way for legislation legitimizing the forced sterilization of people from minority and marginalized groups (Jean-Jacques and Rowlands, 2018). For example, the province of Alberta adopted *The Sexual Sterilization Act* in 1928, while British Columbia followed suit with *An Act Respecting Sexual Sterilization* in 1933. The works of several researchers tend to demonstrate that Indigenous women were targeted by eugenic policies, leading to their over-representation among the individuals having undergone sterilizing surgery without their consent in both Canadian provinces. (De la Cour, 2013; Grekul, 2008; Stote, 2021, 2025).

From this perspective, the eugenics committees responsible for enforcing these laws ruled on sterilizations without requiring the consent of the patient. It is important to note that despite the absence of enabling legislation in a province, evidence suggests that forced sterilizations also occurred within health establishments, a phenomenon referred to as "quiet eugenics" (De la Cour, 2013).

References

Acevedo Guerrero, N. (2016). *The medical discourse and the sterilization of people with disabilities in the United States, Canada and Colombia: From eugenics to the present.* (Doctoral thesis). McGill University. https://escholarship.mcgill.ca/concern/theses/pr76f630z.

Barr, A. M. (2012). *The never-ending story: The lengthy history of sterilization surgery in Alberta and California.* (Master's thesis). University of Alberta. https://ualberta.scholaris.ca/items/e9ed9084-7746-4da6-857e-50fa02c3eb93.

De La Cour, L. (2013). *From 'Moron' to 'Maladjusted': Eugenics, psychiatry, and the regulation of women, Ontario, 1930s-1960s.* (Doctoral thesis). University of Toronto. ProQuest Dissertations & Theses Global. https://tspace.library.utoronto.ca/handle/1807/70070.

Galton, F. (1883). Inquiries into human faculty and its development. Macmillan and Co. https://psycnet.apa.org/PsycBOOKS/toc/14178

Jean-Jacques, A. et Rowlands, S. (2018). Legalised non-consensual sterilisation - eugenics put into practice before 1945, and the aftermath. Part 1: USA, Japan, Canada and Mexico. *European Journal of Contraception & Reproductive Health Care, 23* (2), 121-129. https://doi.org/10.1080/13625187.2018.1450973.

Grekul, J. (2008). Sterilization in Alberta, 1928 to 1972: Gender matters*. *The Canadian Review of Sociology, 45* (3), 247-266. https://doi.org/10.1111/j.1755-618X.2008.00014.x.

Kantrowitz, J. N. (2022). *The abuse of Darwinism (and social Darwinism) for the purposes of discrimination* (Doctoral thesis). Kutztown University of Pennsylvania. https://research.library.kutztown.edu/cgi/viewcontent.cgi?article=1009&context=honorspapers.

Sebring, S. (2012). *Reproductive citizenship Women of color and coercive sterilization in North Carolina 1950–1980.* (Doctoral thesis). Duke University. https://dukespace.lib.duke.edu/items/c8448b23-778a-4f7d-bc07-f5a84b2551ee.

Stote, K. (2025). *The genocide continues. Population control & the sterilization of Indigenous women. Fernwood Publishing.*

Stote, K. (2021). Reflexions on the coerced sterilization of Indigenous women: Toward seeing the humanity of Indigenous peoples. Dans M. Mercredi et Fire Keepers (dir.), *Sacred bundles unborn,* (p. 110-123). (2nd ed). FriesenPress.

Appendix J – Procedure for filing a complaint and challenges faced when requesting access to one's medical records

In 2022, a First Nation women from Quebec who took part in this research initiated, with specialized legal support, a process with a CISSS/CIUSSS to file a complaint following a non-consented sterilization. She has also initiated a procedure with the *Collège des médecins du Québec* (CMQ), filing a request for an inquiry.

Her first course of action was to formally request access to her medical record, allowing her to gain a comprehensive understanding of the procedure performed. While this should have been a mere formality in accordance with access-to-information laws and the *Code of Ethics for Physicians*, this woman reported being questioned several times by nursing staff about the reasons for her request. Such interventions, regardless of their motives, can be worrying and even intimidating for women seeking access to their medical records. In fact, this situation was denounced in December 2022 by the authors of this report in an open letter published in *Le Devoir* newspaper, stating that "it is of great concern that it may be difficult for Indigenous women to obtain their own medical records, and even more so if they have to justify their request to a concerned medical staff member" (Translation) (Basile *et al.*, 2022, p. 2). Despite these unexpected obstacles, the participant eventually obtained her medical file and the complaint process was allowed to run its course.

The medical and administrative authorities concerned, namely those of the CISSS/CIUSSS and the CMQ, conducted an investigation in accordance with established procedures, including meetings with the complainant and her spouse, who was present at the time of the events. Without going into the details of the case, the participant's complaint was finally rejected by the two authorities concerned. According to the latter, the contradictory versions on obtaining consent to proceed with the sterilization led to the dismissal of the complaint. The authorities considered that the burden of proof had not been met, as both versions were deemed credible yet did not establish a clear preponderance in favor of one or the other.

This case demonstrates the challenges encountered when complaints involve conflicting statements, making it difficult to establish the objective truth required by legal standards. Existing complaint processes in case related to consent seldom succeed because they demand clear and convincing evidence, which is frequently shrouded in uncertainty. Sometimes, facts are based solely on statements, without corroborating witnesses or tangible proof to establish guilt unequivocally. This highlights the shortcomings of the existing complaints system and its lack of effective measures for handling such cases.

Reference

Basile, S., Bouchard, P. et Brodeur-Girard, S. (2022, December 14). (Lettre ouverte) Les pratiques médicales imposées aux femmes autochtones doivent cesser. *Espaces autochtones – Radio-Canada*. https://ici.radio-canada.ca/espaces-autochtones/1941217/femmes-autochtones-sterilisation-dossier-medical-colonialisme-suzy-basile.

Appendix K – Status of implementation of Phase I recommendations

Based on the research team's knowledge at the time of writing Phase II of the report.

Legend

Completed	Actions that have been carried out and are now completed
In progress	Actions that have been initiated and are still in progress
In part	Some actions have been completed while others have yet to be initiated
Under discussion	Actions under discussion but not yet implemented
No follow-up	To date, no known actions have been taken

Recommendations – Phase I	**Progress March 2026**
For all organizations	
Listen to, hear and believe First Nations and Inuit women who speak out about imposed sterilizations, obstetric violence and imposed abortions.	In part
Support efforts to initiate class action lawsuits involving First Nations and Inuit women who have undergone imposed sterilization or experienced obstetric violence.	In progress
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.	In progress
For First Nations and Inuit organizations	
Support First Nations and Inuit women who have been victims of imposed sterilization, obstetric violence and forced abortions through health and legal counselling.	Completed
Inform First Nations and Inuit patients of their rights.	No known actions
Develop information tools on reproductive health (pamphlet, Facebook page, phone line, radio capsule in several languages) that are available at all times in places such as hospitals, family medicine groups (FMGs), family planning clinics, community health centres and nursing stations.	In part

Recommendations – Phase I	Progress March 2026
For First Nations and Inuit organizations (continued)	
Promote the implementation of a holistic approach to health and wellness intended to help rebuild the self-esteem of First Nations and Inuit women.	No known actions
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.	Completed
Launch an awareness and information campaign on free and informed consent, imposed sterilizations and obstetric violence.	In part
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.	Completed
Adopt a declaration to promote and protect the healthcare rights of First Nations and Inuit women.	Completed
Continue to generate new knowledge on the subject of consent and imposed sterilization by:	Completed
a. 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;	Completed
b. Conducting research on imposed sterilization and obstetric violence in collaboration with medical staff;	Completed
c. Developing research on the experience of First Nations and Inuit people in sanatoriums in Quebec in order to check whether imposed sterilizations were carried out in these institutions.	Under discussion
For government bodies (federal and provincial)	
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.	No known actions
Call on the *Collège des médecins* (CMQ) to put an end to the practices of imposed sterilization, imposed abortion and pressuring First Nations and Inuit women to accept such procedures.	Completed
Impose penalties and revoke permits to practice when such acts are perpetrated.	No known actions

Recommendations – Phase I	Progress March 2026
For government bodies (federal and provincial) (continued)	
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.	In part
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.	No known actions
Convene the *Collège des médecins* for the purpose of ensuring that all necessary steps are taken to put an end to this practice:	Completed
a. 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;	Completed
b. 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.	In progress
Examine how the Quebec government's Bill 19 (*An Act respecting health and social services information and amending various legislative provisions*) could allow family members to access their mother's medical records to document past cases of imposed sterilization.	No known actions
Implement recommendations 23 and 24 of the Truth and Reconciliation Commission of Canada (TRC), calls to action 3.1 to 3.7 of the National Inquiry into Missing and Murdered Indigenous Women and Girls (NIMMIWG) as well as calls for action 74 to 76 of the Public Inquiry Commission on relations between Indigenous Peoples and certain public services (PLRP), which propose the integration of Indigenous knowledge and practices into health care.	No know actions
Respect article 24 of the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP), which stipulates that Indigenous people have the right to access health services without experiencing discrimination.	No known actions
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 issue and the review of consent forms for tubal ligation procedures.	No known actions

Recommendations – Phase I	Progress March 2026
For government bodies (federal and provincial) (continued)	
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.	In progress
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.	In part
Provide adequate funding for interpretation services for Indigenous languages in Quebec hospitals.	In progress
Support the implementation of the Assembly of First Nations Quebec-Labrador's (AFNQL) Action Plan on Racism and Discrimination Against First Nations Peoples – Health component.	No known actions
Adopt Joyce's Principle.	In part
Acknowledge the existence of systemic racism in Quebec.	No known actions
For First Nations and Inuit women	
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.	In part
For professional bodies in the medical profession	
Review the training offered to the medical profession on free and informed consent, particularly in the fields of obstetrics and gynecology.	In part
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.	Completed

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.

CSSSPNQL • FNQLHSSC
FIRST NATIONS OF QUEBEC
AND LABRADOR HEALTH
AND SOCIAL SERVICES
COMMISSION