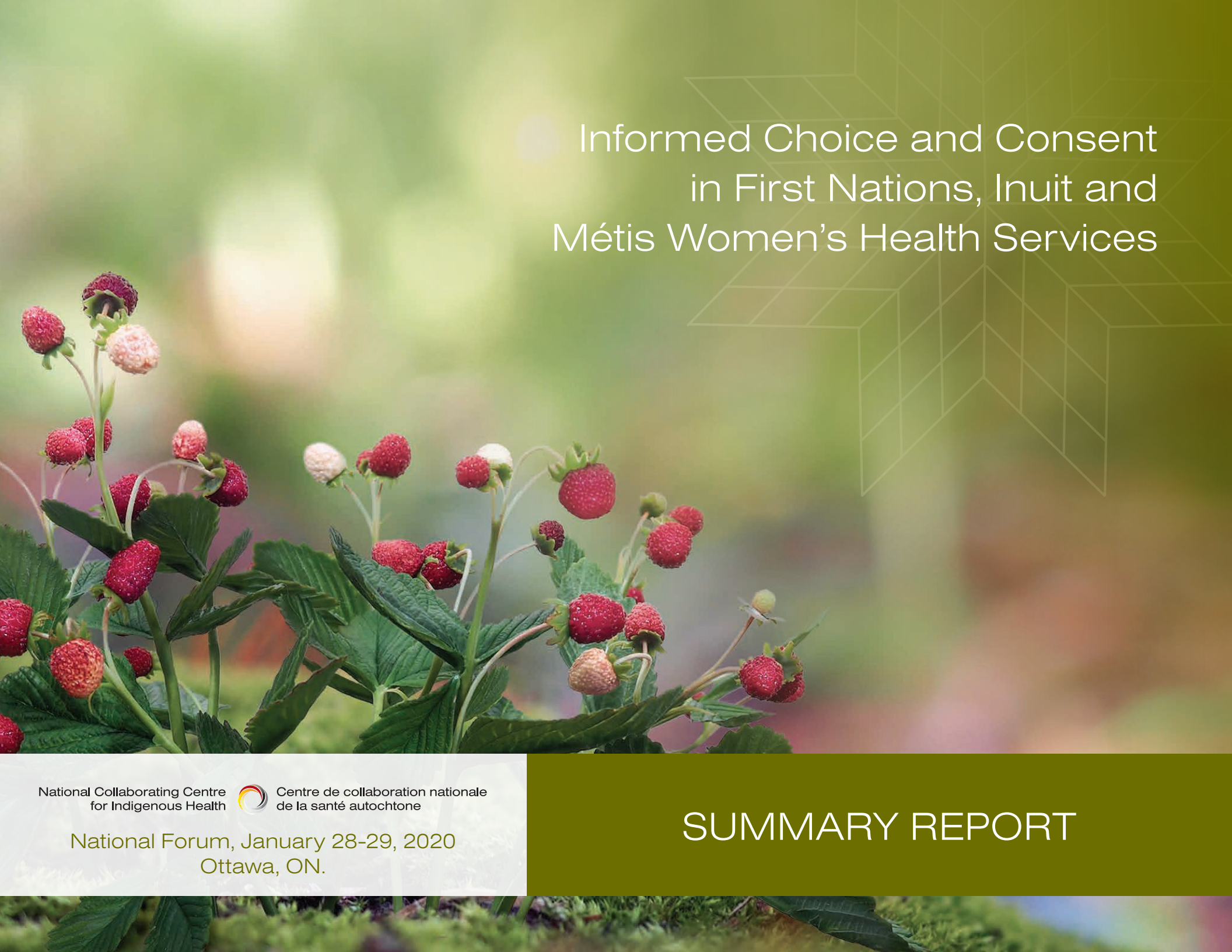
Informed Choice and Consent in First Nations, Inuit and Métis Women's Health Services



National Collaborating Centre for Indigenous Health
Centre de collaboration nationale de la santé autochtone

National Forum, January 28-29, 2020
Ottawa, ON.

SUMMARY REPORT

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January 28-29, 2020
Lord Elgin Hotel, Pearson Room, Ottawa, ON

With support from Indigenous Services Canada (ISC)

Indigenous Services Canada

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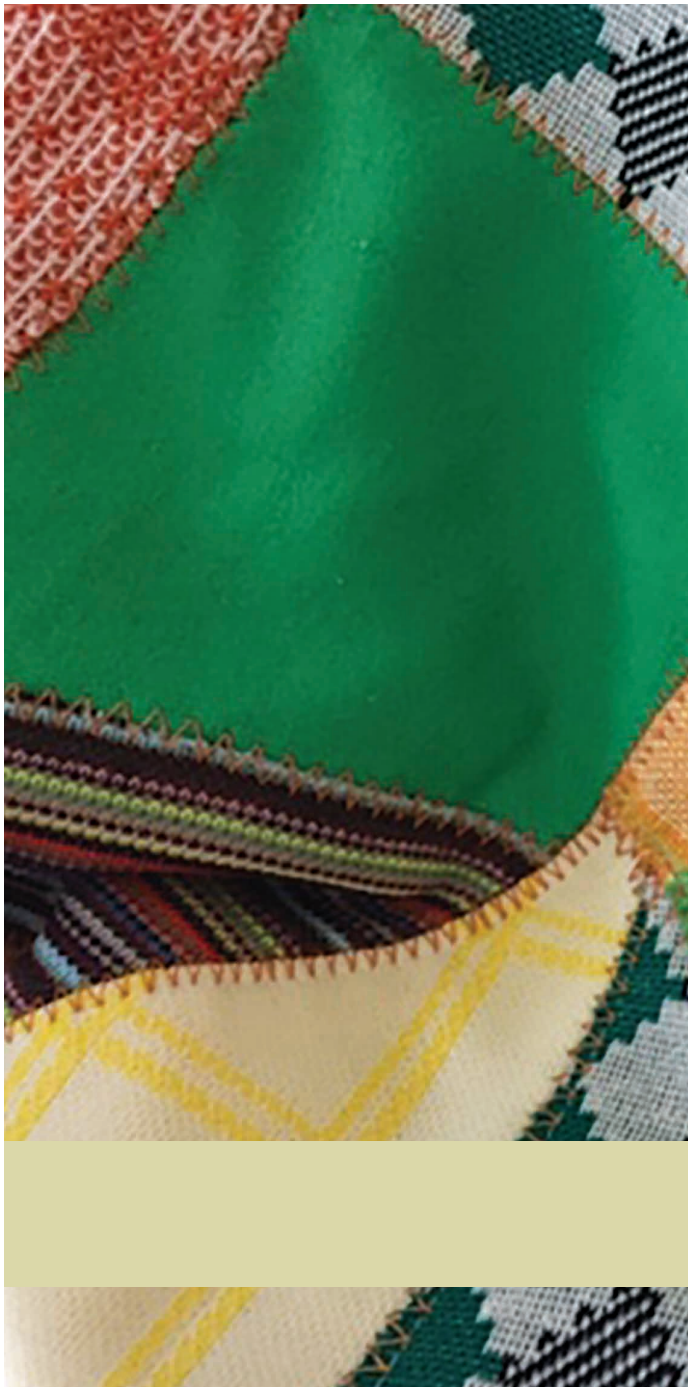
Introduction

On January 28-29, 2020, the National Collaborating Centre for Indigenous Health (NCCIH), in collaboration with the First Nations and Inuit Health Branch (FNIHB) of Indigenous Services Canada (ISC), convened a national knowledge exchange forum on ***Informed Choice and Consent in First Nations, Inuit and Métis Women's Health Services*** in Ottawa, Ontario. The objectives of the 2-day invite-only forum were to:

- Acknowledge the act of coerced or forced sterilization of First Nations, Inuit and Métis women and girls in Canada;
- Explore concepts of informed choice, informed consent, and culturally safe practice for First Nations, Inuit and Métis women and girls' reproductive health;
- Discuss guidelines and key messages for ensuring informed choice and consent in First Nations, Inuit and Métis women and girls' health services, and;
- Identify concrete actions for:
  - Stopping coerced or forced sterilization of First Nations, Inuit and Métis women and girls;
  - Addressing the injustices of coerced or forced sterilization;
  - Supporting women and girls to address their healing, and;
  - Implementing prevention strategies that focus on women and girls' agency over their bodies (Appendix A – Agenda).

The convening of a national forum on informed choice and consent in First Nations, Inuit and Métis women and girls' health services was precipitated by allegations from two Indigenous women in Saskatchewan in 2015 who had experienced coerced or forced sterilization. These allegations led to an external review of tubal ligation in the Saskatoon Health region[1] in 2017 and the filing of a proposed class-action lawsuit on behalf of the women in 2018. With more allegations of coerced or forced sterilization starting to emerge in other provinces and territories, the House of Commons Standing Committee on Health initiated a study in 2019 to better understand the scope of the issue. The study provided 14 recommendations for action by the Government of Canada, one of which was to collaborate with relevant stakeholders to develop information and guidance materials for health care professionals and

1 Boyer, Y. & Bartlett, J. (2017). *External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experiences of Aboriginal Women*. https://www.saskatoonhealthregion.ca/DocumentsInternal/Tubal_Ligation_intheSaskatoonHealthRegion_the_Lived_Experience_of_Aboriginal_Women_BoyerandBartlett_July_22_2017.pdf



First Nations, Inuit and Métis women and girls to support an informed choice model of decision-making with respect to sexual and reproductive health.[2]

The NCCIH national forum brought together over 100 stakeholders from across Canada to examine current realities and future directions for informed choice and consent in Indigenous women and girls' health services, including: First Nations, Inuit, and Métis women's organizations, Indigenous and non-Indigenous health professional associations, health authorities and regulatory bodies, schools of medicine, nursing and social work, midwives, advocacy and human rights organizations, researchers, and federal, provincial, and territorial government employees (Appendix B – Participant List). This summary report provides a brief description of the meeting, including: 1) keynote and panel presentations, 2) facilitated table discussions, and 3) concrete actions identified by participants to stop coerced or forced sterilization, address injustices and support healing, and prevent it from happening going forward.

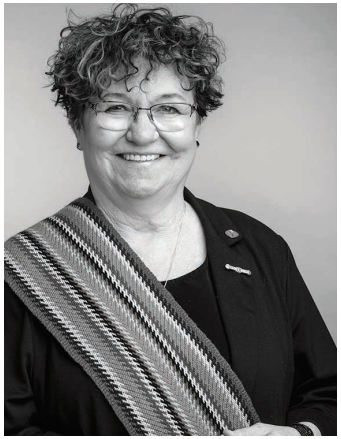
2 https://www.ourcommons.ca/content/Committee/421/HESA/WebDoc/WD10596408/421_HESA_reldoc_PDF/MinisterOfHealth-Final-e.pdf

Day 1 of the national forum began with opening prayers by Elders Annie Smith St-Georges, Sally Webster and Reta Gordon. The meeting facilitator, Kim Scott, of Kishk Anaquot Health Research, provided an overview of the meeting objectives and agenda which was followed by opening remarks from Dr. Margo Greenwood, Academic Lead for the NCCIH. Dr. Greenwood thanked participants for their commitment and courage to engage in these discussions, stating that the work they would do together during the forum would not only "be for the women today, but for those coming behind us, our daughters, granddaughters and those yet unborn." She noted that action must take place simultaneously and at multiple levels – individual/community, policy and structural levels – to ensure immediate, long-lasting and systemic change in First Nations, Inuit and Métis women and girls' health services. With this in mind, she explained that Day 1 would be focused on discussing the current realities of First Nations, Inuit and Métis women and girls' health services across Canada, while Day 2 would focus on future directions and how to move forward together to implement change.

Kim Scott

Margo Greenwood

Judith Bartlett



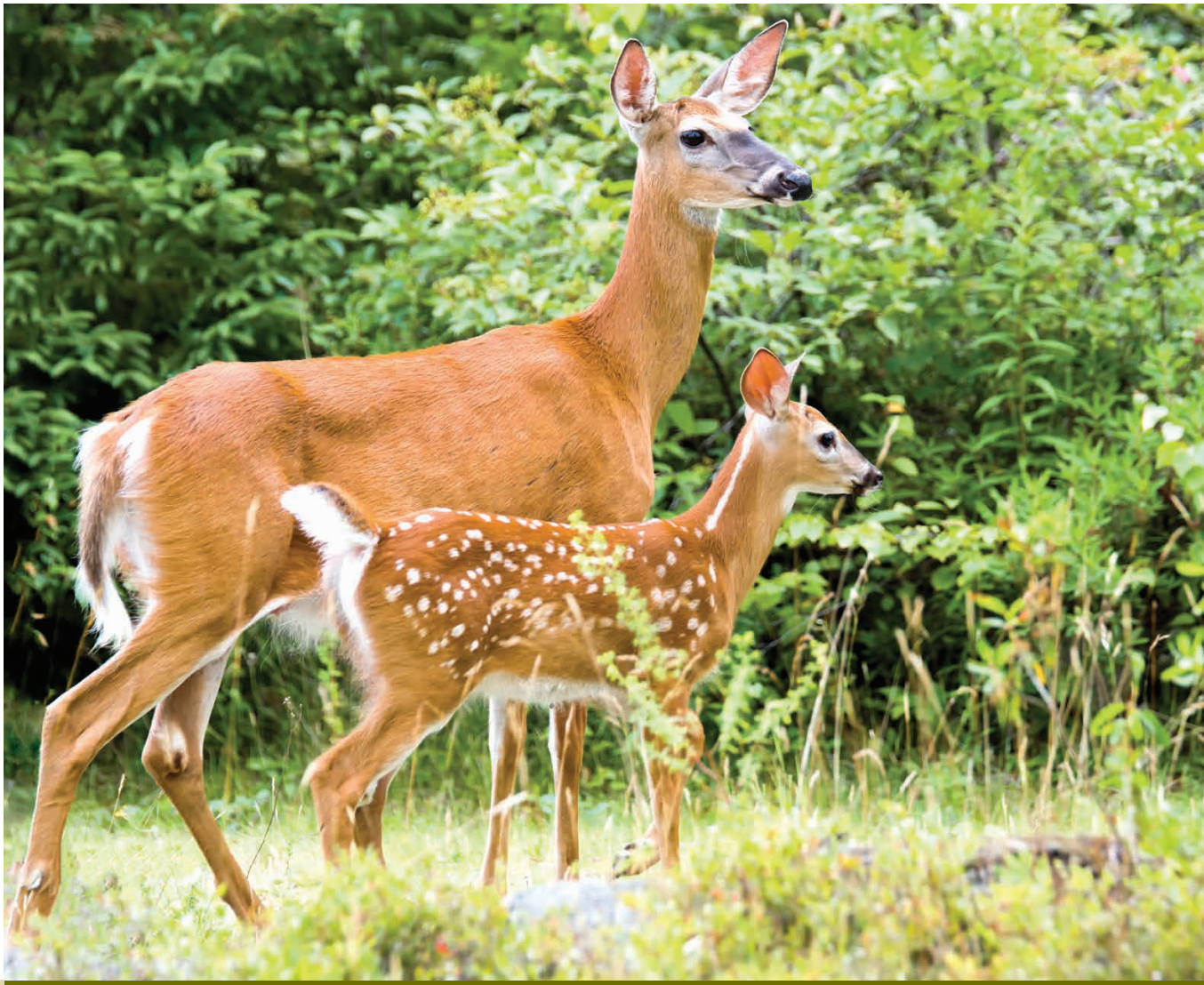
Senator Yvonne Boyer

Keynote and Panel Presentations

Senator Yvonne Boyer and Dr. Judith Bartlett provided a keynote presentation on their report, *External Review: Tubal Ligation in the Saskatoon Health Region: The Lived Experiences of Aboriginal Women*, funded by the Saskatoon Health Authority (SHR), to uncover the coerced or forced sterilization of Indigenous women in Saskatchewan. Using a community-based participatory research approach, Drs. Boyer and Bartlett interviewed Indigenous women who had undergone coerced or forced tubal ligation

as well as healthcare providers. A review of SHR policies was also conducted. Three themes emerged from the interviews with the Indigenous women: 1) they felt invisible, profiled (e.g. birth alerts), and powerless against health professionals; 2) they experienced coercion and tremendous pressure to have tubal ligations; and 3) the experiences had negatively impacted their self-image, relationships, and willingness to seek out health care. Interviews with healthcare providers similarly identified three themes: 1) underlying policy and team challenges, 2) attitudes about Indigenous women (e.g. racism, bias), and 3) internal and external impacts on care. The external review identified ten calls to action focused on policy revision, requirements in Canadian law, restructuring, cultural training, education, creating an Advisory Council with authority, establishing a reproductive centre, reparations for victims, coordination of supports, and full implementation and monitoring of SHR. This presentation is now available as a podcast on the NCCIH website as part of the Voices from the Field podcast series[3].

A keynote presentation by Alisa Lombard, lead counsel of the proposed class action lawsuit,



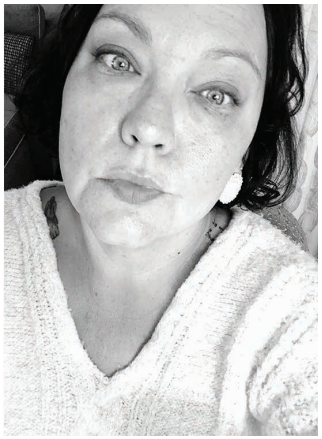
3 https://www.nccih.ca/495/Podcast__Voices_from_the_Field_9_-_Uncovering_the_Forced_and_or_Coerced_Sterilization_of_Indigenous_Women.nccih?id=294

Alisa Lombard

Morningstar Mercredi

and her client and survivor Morningstar Mercredi concluded the morning. Ms. Mercredi began by saying that she came from a long line of strong women and she acknowledged the grandmothers, seven generations past and seven generations yet unborn. She shared her experience of being forced to have a pregnancy terminated at fourteen years old, as well as a stillborn birth, and that she can no longer have children. These experiences have had a devastating impact on her life that she continues to struggle with today. She concluded by saying that denying women the right to conceive children causes life-long scars and that coerced or forced sterilizations need to be criminalized. Ms. Lombard stated that she was extremely grateful and honored that Ms. Mercredi was there to share her words, because these are the words of many women and it is their pain that brought everyone to this forum. She stressed that it is critical that women know their rights and understand they have autonomy over decisions about their fertility. She noted that proper and informed consent must be given voluntarily, that First Nations, Inuit and Métis women and girls must have the capacity to give consent (e.g. not under duress or sedation), that consent must be given specifically to the individual (physician) who will perform the treatment, and that the physician must ensure the patient clearly understands the risks and benefits of the treatment. Ms. Lombard noted that coerced and forced sterilization continues to happen and it is not just because of a lack of cultural competence, it is because of systemic anti-Indigenous racism. She concluded by asking that participants try harder, dig deeper, and do the right thing for Indigenous women and girls and their families.

The afternoon of Day 1 featured a panel presentation with representatives from the national Indigenous women's organizations to discuss their work to address the coerced or forced sterilization of First Nations, Inuit and Métis women and girls. Annie Bernard-Daisley from the Native Women's Association of Canada (NWAC) discussed the sessions they conducted in Nova Scotia with women who had been coerced or forced to undergo tubal ligation and the grief, trauma, and discrimination they shared at those meetings. These sessions were part of NWAC's larger engagement and research activities on this topic, including an expert forum held in March 2019 and an analysis of recommendations made to date in Canada and internationally on coerced or forced sterilization. Noting "that it was our duty to speak up for our children," Ms. Bernard-Daisley called for an immediate end to coerced and forced sterilization. Rebecca Kudloo, President of Pauktuutit Inuit Women of Canada, talked about their environmental scan that found tubal ligations were very common among Inuit women and that many had been told by healthcare providers that they had too many children. She noted that language and



Annie Bernard-Daisley

Rebecca Kudloo

medical interpreters were important, particularly for Inuit women who have to travel south for health services, because many medical terms are not available in Inuktitut. She also acknowledged Inuit midwives and community leaders from across Inuit Nunangat in the room who had participated in Pauktuutit's pre-meeting on January 27, 2020 in preparation for this forum. Victoria Pruden of Les Femmes Michif Otipemisiwak (LFMO) spoke of her great-grandmother who had delivered thousands of babies as a midwife and questioned how, in two generations, we had come to this current situation. She stressed that distinctions-based approaches are needed in research, particularly disaggregated data to better understand specific implications for First Nations, Inuit and Métis healthcare services, child and family services, and the justice system. Participants in the room were invited to take copies of LFMO's *Policy Statement on Forced and Coerced Sterilization* and review its four recommendations for the Government of Canada to move forward.

Facilitated Small Group Discussions

Throughout Day 1, participants engaged in small group discussions focused on their experiences and knowledge about informed choice and consent. There were twelve small group discussions with up to eight people per table. Participants were assigned tables in advance to ensure there was a diversity of expertise and perspectives at each table. Each table had a facilitator to support the discussion and take notes. Tables were also provided an opportunity to report back to the larger group if they wanted to during open plenary sessions. Highlights from small group discussions are provided below and are structured around three main questions.

1) *What does the informed choice and consent process look like in practice (e.g. when is it required, who is involved, contexts in which it occurs, how do we avoid coercion)?*
2) *What are the barriers and the facilitators to informed choice and consent (e.g. power dynamics, language, access to health care)?*
3) *What are the unique considerations for First Nations, Inuit and Métis women and girls (e.g. historical trauma, family and community dynamics, language)?*

Participants discussed how coercion can take place in many forms and settings, from a healthcare provider not giving enough time or information to a patient to make an informed choice, to misrepresenting the procedure and health risks involved or seeking consent when a patient is under duress (e.g. in labor, fear of child protection worker involvement). It was stressed by many participants that consultation does not equal consent. In terms of what informed choice and consent looks like in practice, participants generally agreed that it meant First Nations, Inuit and Métis women and girls are:

- fully informed about options and risks for all forms of birth control;
- fully understand the information provided, and;
- have full control over the decisions they make about their own sexual and reproductive health and bodies.

For this to occur, the information that is provided to Indigenous women and girls needs to be transparent, trustworthy, in plain language and available in their chosen language (Indigenous languages, English, French). First Nations, Inuit and Métis women and girls must be supported and encouraged to ask questions of the healthcare provider and have them answered to their satisfaction before making any decisions. Providing adequate time to make an informed choice was consistently identified as critical to consent with many participants noting that it requires more than one visit because "it is a process, not an event." Participants also agreed that consent is always voluntary and can be revoked at any time without repercussions, shame, stigmatization or threats from the healthcare provider or other professionals such as social workers. Consent was seen as the responsibility of all team members involved and, ideally, should be done at multiple stages throughout the consultation process to make sure Indigenous women and girls fully understand their rights.

To improve the informed choice and consent process, the ongoing and pervasive structural and systemic barriers faced by First Nations, Inuit and Métis women and girls across the full spectrum of health services needs to be addressed. Key barriers to informed choice and consent identified by participants included:

- lack of accountability for healthcare providers who are not culturally safe or who have coerced patients (e.g. role of regulators; duty to report);
- reluctance by some healthcare providers who have witnessed coercion and racism to come forward with complaints (e.g. fear of challenging status quo; protecting the 'old guard'; power dynamics within the health system);
- patient reluctance to come forward with complaints (e.g. fear of reprisal; trauma; sense of powerlessness or lack of control);
- ongoing stigma around sexual and reproductive health;
- anti-Indigenous racism, discrimination, and bias in the healthcare system;
- lack of access to health services, particularly in rural and remote areas; and
- language barriers (e.g. plain language, accessible in Indigenous languages) and lack of understanding of non-verbal communication.

Participants discussed the various ways that the healthcare system can be transformed to ensure First Nations, Inuit and Métis women and girls have self-determination over their health and well-being across the lifespan. Overall, it was agreed that a distinctions-based, human rights, patient-centred, culturally safe, and trauma-informed approach was essential to the process and that transformative change must be supported by ongoing awareness, education and training. As First Nations, Inuit and Métis women and girls have very different experiences in accessing healthcare, participants indicated that a one size fits all approach would not work. It was stressed that distinctions-based approaches are needed and they should be led by First Nations, Inuit and Métis people and organizations.

In terms of human rights, participants agreed that First Nations, Inuit and Métis girls need to learn about sexual and reproductive rights at an early age so that they understand what free, prior, and informed consent is and what birth control options are available to them. Similarly, healthcare providers need to learn about basic human rights (e.g. right to health, right to decide on the number and spacing of children) early on in their medical education to avoid coercion. Participants noted that healthcare providers need mandatory and ongoing education and training on anti-Indigenous racism, cultural safety and trauma-informed care, as well as Indigenous rights under section 35 of the Constitution Act, 1982 and in the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP). Some additional actions to ensure that human rights are understood and upheld included:

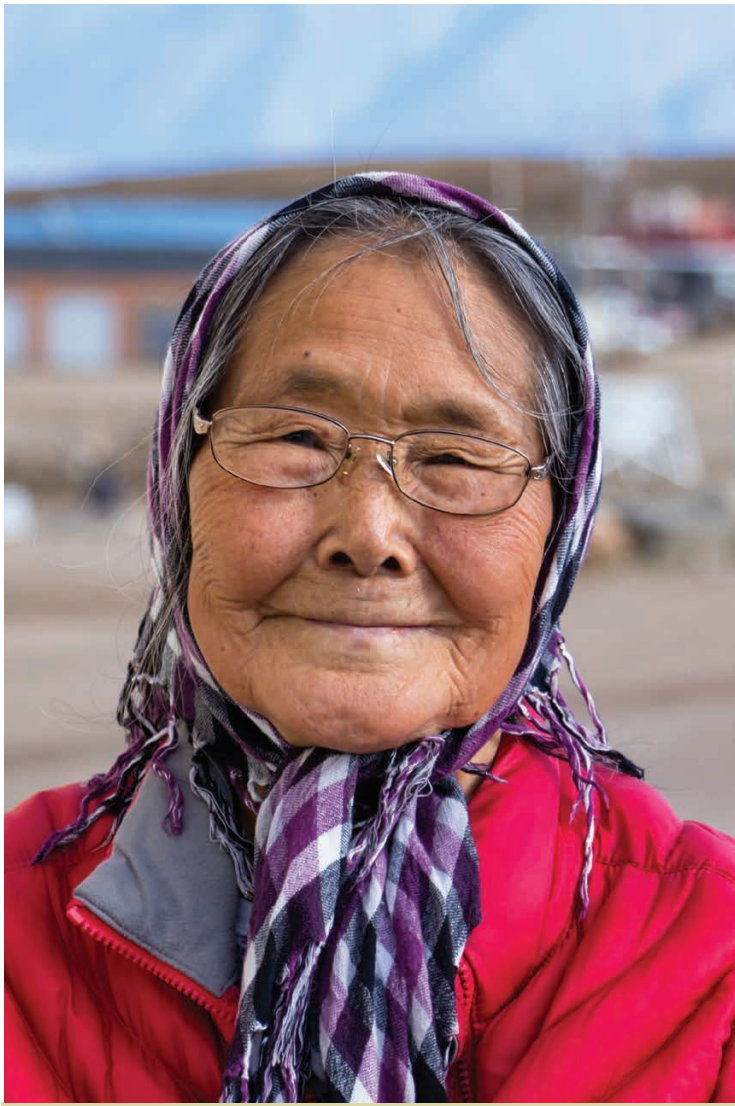
- allowing First Nations, Inuit and Métis women and girls to have either a pro-bono lawyer or other individuals present during the consent process who can defend them, advocate for them or provide support, such as an Indigenous midwife, Elder, interpreter, a cultural liaison, or friends and family;
- having distinctions-based Indigenous ombudsmen for First Nations, Inuit and Métis people to report healthcare issues; and
- considering gender identity in the framing of the issue so that the conversation extends beyond the binary (women/girls).

Self-determination over service provision and building a strong First Nations, Inuit and Métis health workforce were two strategies identified by participants for transforming the healthcare system. Indigenous healthcare providers can facilitate greater access to services in Indigenous languages and improve quality and continuity of culturally safe, trauma-informed care. Participants stressed the importance of Indigenous midwives in the healthcare system. Specific actions related to midwifery included:

- increasing the number of First Nations, Inuit and Métis midwives;
- expanding their scope of responsibilities through changes in provincial legislation and regulation (e.g. midwifery practice to include postpartum care);
- establishing First Nations, Inuit and Métis midwifery apprenticeships in every community, and;
- adopting a national midwifery strategy that is embedded in First Nations, Inuit and Métis history and traditional knowledge and integrated with other healthcare professions.

Finally, to promote more patient-centred care, a number of actions were discussed within the clinical and hospital settings such as:

- giving birth support workers hospital privileges and having doulas work with physicians;
- allowing women access to their own medical records;
- ensuring that women and girls have supports (e.g. a trusted friend, family member, relative, or trained advocate) at medical appointments to help them understand medical information;
- having distinctions-based patient navigators in every hospital who can interact with, protect and advocate for First Nations, Inuit and Métis women and girls and ensure they have positive clinical encounters; and
- allowing First Nations, Inuit and Métis women and girls to choose who is delivering care to them.



The meeting facilitator, Kim Scott, began the morning with an overview of the previous day's discussions, followed by the objectives for Day 2 which focused on concrete actions to stop and prevent coerced or forced sterilization and support healing for those who had experienced it. Day 2 also sought to build consensus around a draft declaration of commitment to ensure informed choice and consent in First Nations, Inuit and Métis women's health services. As with Day 1, a mix of keynote presentations, panel presentations and facilitated small group table discussions were featured.

Keynotes and Panel Presentations

The morning panel presentation, entitled *Strengths to Build On*, offered diverse perspectives and contexts in which to better understand informed choice and consent in Indigenous women's and girls' health services. Carol Couchie, Co-chair of the National Aboriginal Council of Midwives (NACM), talked about her journey to become a midwife and the valuable role midwives play in supporting women and their families in the ceremony of birth. She stressed that coerced or forced sterilization was everyone's responsibility and that Indigenous communities needed to go back

Carol Crouchie

Jennifer Leason

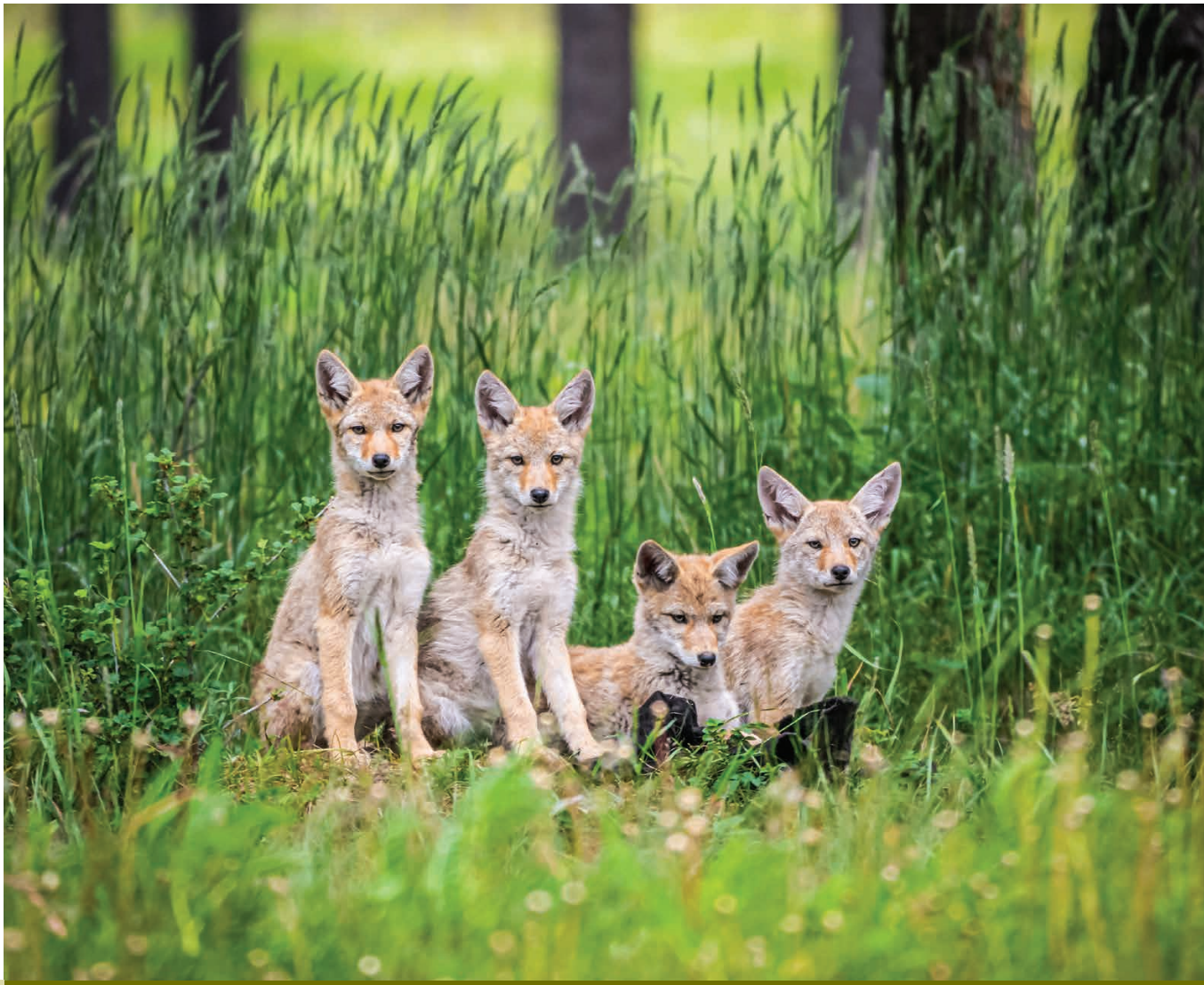
to their old ways to ensure women and girls are protected. She encouraged participants to read NACM's *Position Statement on Forced and Coerced Sterilization of Indigenous Peoples*, available in their meeting packages. Dr. Jennifer Leason, from the University of Alberta, began by saying that when she was asked to speak about strengths to build on, the first thing that came to mind was family. She shared memories of spending summers blueberry picking with her family and how during that time, and through listening to women's stories, she learned about womanhood and motherhood. The panel concluded with a presentation by Dr. Radha Jetty of the Canadian Paediatric Society who discussed some of the key factors that can affect informed choice and consent such as racism, bias, trauma, lack of trust, and power imbalances between healthcare providers and patients. She then offered a number of practical interventions that healthcare providers can take to improve the informed choice and consent process, including: having a series of consultations over time (not one event), asking questions in multiple ways to make sure the information is understood, advocating for change in escort policies so the necessary people are present for these consultations, ensuring patient liaisons and interpreters are present, and building relationships with patients based on equity.

The morning panel presentation was followed by a keynote address from Senator Yvonne Boyer, who began by sharing how she had witnessed racism and discrimination first hand working as a nurse in the Canadian healthcare system. She offered a potential model – based on the Aboriginal Healing Foundation – to support healing

Radha Jetty

and reparations for First Nations, Inuit and Métis women and girls who have been coerced and forced into tubal ligation. Noting that long-term healing and supports are needed going forward, Senator Boyer argued that First Nations, Inuit and Métis peoples should be the ones to lead and administer this type of organization.

The afternoon of Day 2 featured a panel presentation on *Implementing Change*. Dr. Valerie Gideon of Indigenous Services Canada began by discussing some of the Government of Canada's actions to date addressing the issue of coerced and forced sterilization, including providing



Valerie Gideon

Lisa Richardson

testimony to the Standing Committee on Health in 2019 and the establishment of an Advisory Committee on Indigenous Women's Wellbeing, co-chaired by Pauktuutit Inuit Women of Canada and the National Aboriginal Council of Midwives. She stressed the importance of having First Nations, Inuit and Métis women's voices and leadership at the forefront of these processes to ensure appropriate actions are identified and implemented. Dr. Lisa Richardson, from the Indigenous Health Advisory Committee of the Royal College of Physicians and Surgeons, spoke to wise practices for reconciliation in healthcare to support change in institutions. She stated that there are three major levers for educating specialists– curriculum, assessment, and accreditation – and that cultural safety, trauma-informed care, and health equity need to be incorporated into all of these to ensure systemic and structural level changes. She also noted that it is critical that Indigenous health equity be part of strategic planning processes at an institutional level and that First Nations, Inuit and Métis governance and leadership are needed.

Following the implementing change panel presentation, the meeting facilitator, Kim Scott, and NCCIH Academic Lead, Dr. Margo Greenwood, discussed the draft declaration of commitment developed by the NCCIH. The declaration, entitled *Honouring Culturally Informed Choice and Consent in First Nations, Inuit and Métis Women's Health: A Commitment*, was circulated to participants and discussed as part of the facilitated small group discussions.

Facilitated Small Group Discussions

Throughout Day 2, participants engaged in small group discussions focused on actions that could be taken to stop the practice of coerced or forced sterilization, prevent it from happening again, and support healing and justice for Indigenous women and girls who have experienced it. Participants were also asked to share their thoughts on the draft declaration of commitment developed by the NCCIH. As part of this, they were encouraged to post 2-3 best ideas on an "action tree" tool for individual/community level, systems level, and structural level actions. Actions for each category were then organized into a table (Appendix C – Action Tree Table). Participants sat at the same assigned tables as Day 1 for the morning; however, in the afternoon they moved to tables organized by profession (e.g. nurses, physicians, social workers, midwives etc.). Table facilitators continued to support the discussions and take notes. A report back on table discussions was similarly provided during open plenary sessions. Highlights from small group discussions are provided below and are structured around three main questions:

1) *What actions are needed to immediately stop the practice of coerced or forced consent (e.g. safeguards, education and training) and for it happening again?*
2) *What actions are needed to support justice and healing for women and girls who have experienced coerced or forced sterilization (e.g. compensation, lawsuits, counselling, crisis line)?*
3) *How can we hold each other accountable?*

A core theme of the forum was the need for system-level changes to stop the practice of coerced or forced consent. Institutional cultural change, with a focus on holding peers accountable to professional standards, is needed. First and foremost, healthcare providers need to acknowledge that anti-Indigenous racism and coercion is happening. They need to recognize their duty to report racism, bias/discrimination and coerced or forced consent when it occurs, feel supported to speak out about it (e.g. safe environment to report), and have access to a more effective complaints process. To facilitate this process, participants suggested mandatory training and licensing requirements be implemented around informed choice and consent, that accountability is enforced by peers, hiring and regulatory bodies, and that there is ongoing monitoring. Health practitioners also need greater support to engage in informed choice and consent processes. This can be facilitated through increasing the number of care providers overall, improving the work environment (e.g. breaking down hierarchies among healthcare providers), and adopting policies that enable practitioners to prioritize informed choice and consent processes.

Several participants identified the need for timely, accurate data to better understand and stop coerced or forced sterilization, including distinctions-based research and disaggregated data and collection tools (e.g. Indigenous identifier). One participant noted that a national sexual health survey should be undertaken. Research and data collection needs to examine underlying historical factors. It was noted that careful consideration is needed in terms of how the data is disseminated.

To pro-actively address racism at the systems level, participants suggested additional actions such as:

- standardizing the way information is entered into patient records;
- eliminating race-based identifiers on health cards;
- establishing processes to constantly check on the healthcare system (e.g. systematic routine checks, chart audits to ensure patient interviews and conversations about options are documented, and consent processes that are completed fully and clearly);
- reviewing and ending the practice of birth alerts; and
- detaching child welfare systems from hospitals.

To address broader structural barriers to informed choice and consent within the healthcare system and beyond (e.g. interactions with police/justice system, child welfare, education systems), participants suggested implementing provincial legislation around quality healthcare (e.g. Ontario's legislation "Excellent Care for All") and legislation to expand and broaden the scope of midwifery services. It was stressed that meaningful responses to the Calls to Action of the Truth and Reconciliation Commission (TRC) by diverse Indigenous and non-Indigenous sectors across Canada was also needed.

In order to best support First Nations, Inuit and Métis women and girls to heal from the trauma related to coerced or forced sterilization, a number of actions were identified for the justice system. Survivor-centred and rights-based actions included providing survivors with greater access to legal supports, such as pro bono lawyers, and to human rights advocates. Participants noted that individuals working in the justice system should receive training related to cultural safety and trauma-informed practice. Actions to obtain justice and help survivors heal ranged from legal interventions to official apologies to acknowledgements of injustices from both the health and social work sectors. Legal actions spanned from individual lawsuits to class action lawsuits, and involved either incarceration of perpetrators or compensation for the survivors. Participants noted the need for greater funding support for healing and addictions counselling. It was suggested that establishing a community-based foundation, similar in structure to that of the Aboriginal Healing Foundation, might serve as a place to foster healing strategies and ask survivors what they need.

There are multiple actors who need to hold each other accountable to prevent coerced or forced sterilization of First Nations, Inuit and Métis women and girls and ensure that patient-centred, culturally safe, and trauma-informed care is exercised. The following actions can be taken by each of the following sectors.

Federal government:

- ensure First Nations, Inuit and Métis women's voices and leadership are included in gender-based policy development and action (i.e. bringing birthing back to communities, provision of escorts when travel required for birth, and funding for more midwifery care);
- ensure culturally safe health and social services provision in First Nations, Inuit and Métis communities;
- formulate policies to support First Nations, Inuit and Métis self-determination based on recognition of rights, respect, cooperation and partnership;
- provide guidance and support a coordinated approach to sexual health and reproductive options across disciplines;
- address the broader determinants of health, including policies and funding levels that maintain inequitable access to education, employment, health and social services;
- address data and knowledge gaps relevant to informed choice and consent, including gender-based violence, coerced or forced sterilization, and women and girl's health and well-being (e.g. through Canadian Institutes of Health Research);
- work with provincial and territorial ministries to support a coordinated approach to informed choice and consent.

Provincial and territorial governments:

- change regulations to support the expansion and broadening of professional Indigenous midwifery services in communities;
- ensure the rigorous regulation and licensing of professional bodies and take disciplinary action when coerced or forced sterilization has occurred;
- work with federal ministries to support a coordinated approach to informed choice and consent.

Educators and administrators of medical schools, nursing and other health programs, as well as those involved in professional development and training programs:

- develop trauma-informed, culturally-safe and anti-racist curriculum to provide effective education and training opportunities in Indigenous health for every specialist program around the country;
- continue to grow an Indigenous health workforce by ensuring that First Nations, Inuit and Métis students are well supported throughout their educational programs;

- recruit, retain and mentor Indigenous faculty to support Indigenous midwifery programs and students.

National and provincial professional associations:

- advocate for policy and regulation, and awareness raising (e.g. TRC Calls to Action and the Convention against Torture) – recognizing that this is a responsibility of non-Indigenous organizations;
- promote understanding of cultural differences in treatment and avoiding racist or stereotyping behaviours;
- convene distinct professional associations (i.e. social workers, nurses, etc.) for ongoing education and training on informed choice and consent and to look at the specific actions they can be taking to ensure informed consent within their practice.

Regulatory bodies or colleges:

- ensure that all members, new and ongoing, have the necessary knowledge and skills needed to make patients feel safe in their interactions with healthcare providers and that they can exercise free, prior and informed consent;

- uphold professional accountability when care providers fail to adhere to professional standards and guidelines;
- advocate on behalf of Indigenous patients/clients and speak up when they know something is wrong;
- provide more opportunities for increasing the numbers of First Nations, Inuit and Métis midwives;
- leverage change and reconciliation in Indigenous health.

Indigenous organizations:

- raise awareness of the issue, develop and disseminate information, and advocate for change at provincial and federal levels;
- help First Nations, Inuit and Métis women and girls bring forward their voices and lived experiences.

Individuals and organizations involved in policing and justice:

- help survivors of coerced sterilization heal from trauma;
- ensure those who have engaged in this practice are held accountable for their actions.

Community-level:

- know the standards that healthcare professionals are held to so that they can be aware when breaches occur;
- community members, especially peers, Elders and teachers raise awareness among women and girls of their rights and empower them to advocate for themselves;
- collect data and information to address knowledge gaps around informed choice and consent by creating community-based research ethics boards and giving survivors an opportunity to share their stories and provide feedback.

After discussing how to stop, prevent, and support healing, participants turned their attention to providing feedback on the draft declaration, "*Honouring culturally informed choice and consent in First Nations, Inuit ad Métis women's health: A commitment.*" It was emphasized that the declaration and its commitments should be understood as developed and signed on by organizations involved in health and well-being of Indigenous women and girls, and that it was not led or informed by the survivors themselves. Participants requested that the document be framed in rights-based, gender-neutral language on Canada's obligations to investigate, stop, and provide justice around coerced and forced sterilization of women and girls. It was also suggested that stronger, action-oriented, wording be used throughout the declaration that included obligations and commitments for Calls to Action of the Truth and Reconciliation Commission (Actions 7, 10, 18, 24, 57 and 62) and relevant recommendations from *Reclaiming Power and Place: The Final Report of the National Inquiry into Missing and Murdered Indigenous Women and Girls*. Additionally, participants suggested disciplinary measures and healing be included. Given the diverse changes required to meet the needs of the various organizations at the forum, it was recommended by the NCCIH that the declaration be used as a tool by participants to adapt as needed in their work.

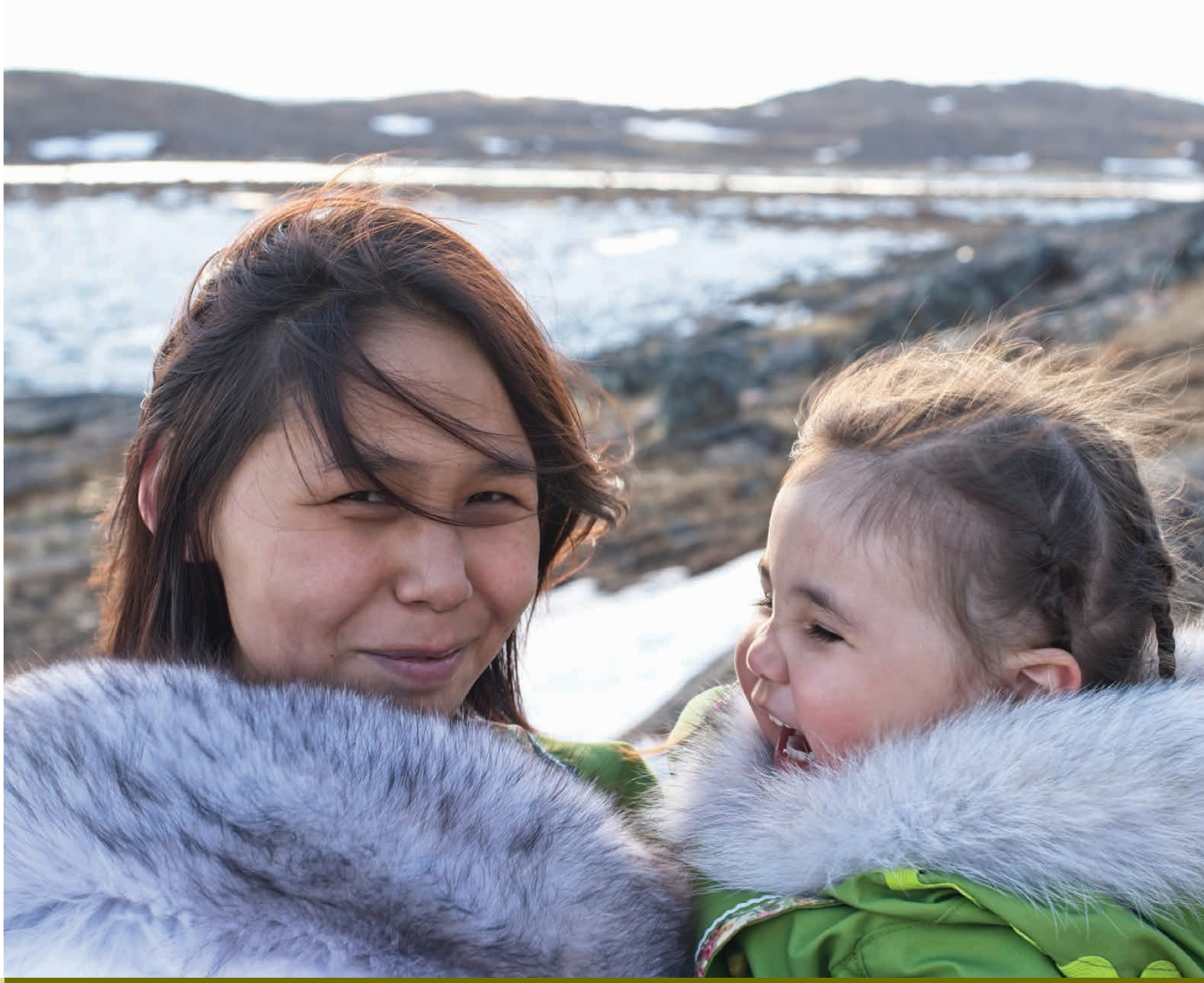
Closing Comments

Dr. Greenwood, Academic Lead for the NCCIH, drew the two-day forum to a close by thanking participants for the courage, commitment and thoughts that they had brought to the discussion. She also thanked Ms. Mercredi, stating that it had been an absolute privilege to meet her and hear her story. Dr. Greenwood

went on to say that although the 100+ people in the room were incredibly diverse, with each bringing a distinct perspective and huge sphere of influence to the topic, not everyone who needed to be part of this conversation was in attendance. She asked participants to help the NCCIH, and to help each other, move the agenda forward by "taking the seeds that we had planted and to make them grow." A first step could be to take the four simple commitments – to stop the practice of coerced or forced sterilization, to empower Indigenous women's rights over their health and well-being, to support healing and reparations for survivors, and to prevent it from ever happening again. She concluded with one specific recommendation, which was to support the survivors to come together in their own meeting to share their experiences and vision their own future.

List of Appendices

- Appendix A – Agenda
- Appendix B – Participant List
- Appendix C – Action Tree table



Culturally Informed Choice and Consent in Indigenous Women's Health Services

AGENDA

January 28-29, 2020
Lord Elgin Hotel Pearson Room Ottawa, ON

Objectives

- To acknowledge the act of coerced or forced sterilization of Indigenous women and girls in Canada
- To explore concepts of: informed choice, informed consent, and culturally safe practice
- To discuss guidelines and key messages for ensuring informed choice and consent in Indigenous women and girls' health services
- To identify concrete actions for:
    - Stopping coerced or forced sterilization of Indigenous women and girls
    - Addressing the injustices of coerced or forced sterilization
    - Supporting women and girls to address their healing
    - Implementing prevention strategies that focus on women and girls' agency over their bodies

Outcomes

- Identification of potential strategies for change, including:
    - Structural (organizations, standards and regulations)
    - Systemic (policies, programs, and services)
    - Practice (or individual) actions

Schedule - Day 1
Current Realities

Tuesday Morning, January 28, 2020

7:30 AM — **Hot Breakfast and Registration**

8:30 AM — Opening Protocol

- Elder Annie Smith St. Georges
- Elder Sally Webster
- Elder Reta Gordon

8:50 AM — Welcome to the Gathering

- Margo Greenwood - Academic Lead, NCCIH

9:05 AM — Meeting Objectives and Overview

- Facilitator - Kim Scott, Kishk Anaquot Health Research

9:20 AM — Participant Introductions at Tables
Roundtable self-introductions

9:40 AM — Keynote Address

Uncovering the Forced and/or Coerced Sterilization of Indigenous Women

- Senator Yvonne Boyer and Judith Bartlett
- Comments and Questions

10:45 AM — **Health Break**

11:00 AM — Keynote Address

- Alisa Lombard and Morningstar Mercredi
- Comments and Questions

11:45 AM — **Lunch (provided)**

Tuesday Afternoon, January 28, 2020

1:00 PM — Panel Presentation

Conversations from the National First Nations, Inuit and Métis Women's Organizations

- Moderator: Margo Greenwood
- Annie Bernard-Daisley, Native Women's Association of Canada
- Rebecca Kudloo, Pauktuutit Inuit Women of Canada
- Melanie Omeniho, Les Femmes Michif Otipemisiwak
- Comments and Questions

2:00 PM — Art Activity Facilitators

- Charis Alderfer-Mumma, Sarah de Leeuw, Laura McNab-Coombs

2:45 PM — Small Group Discussions

- What experience and knowledge do you have about this topic (informed choice and consent)?
  - *What does the informed consent process look like in operation? What is required in this process? Who is involved in the process? How can we avoid coercion?*
- What barriers are there to achieving informed choice and consent and how might we overcome them?
  - *What safeguards are needed to guarantee informed choice and consent for young First Nations, Inuit and Métis women and girls? For marginalized women? For women who have been traumatized? What is needed to build awareness, guarantee transparency, and strengthen accountability?*

Tuesday Afternoon, January 28, 2020

2:45 PM **Small Group Discussions**

- What are some facilitators for ensuring informed choice and consent?
  - *How do we address systemic inequity? What are the unique cultural considerations for First Nations, Inuit or Métis women and girls?*

Health Break

4:00 PM **Open Plenary**

4:30 PM **Closing Comments for Day 1**

Schedule - Day 2
Future Directions

Wednesday Morning, January 29, 2020

7:30 AM **Hot Breakfast (provided)**

8:30 AM **Overview of Day 1**

- Facilitator: Kim Scott, Kishk Anaquot Health Research

8:45 AM **Panel Presentation**

Strengths to Build Upon

- Moderator: Margo Greenwood
- Jennifer Leason, University of Calgary, Forwarded CIHR CRC Tier II Indigenous Maternal Child Wellness
- Carol Couchie, National Aboriginal Council of Midwives
- Radha Jetty, Chair of the Canadian Paediatric Society First Nations, Inuit and Metis Health Committee
- Comments and Questions

Schedule - Day 2
Future Directions

Wednesday Morning, January 29, 2020

10:00 AM **Keynote Address**

Moving Forward Together

- Senator Yvonne Boyer

10:20 AM **Small Group Discussions**

- Stopping
  - *What actions need to be taken to apply safeguards and guarantees for informed choice and consent? Who should be doing this work?*
- Healing
  - *What strategies and actions need to be taken to support justice for the forced/coerced sterilization of First Nations, Inuit and Métis women?*
  - *What actions need to be taken to support women in their individual healing?*
- Preventing
  - *What actions are needed to recognize and protect the rights of First Nations, Inuit and Métis women and girls?*
- Overarching Question:
  - *How do we hold each other accountable?*

Health Break

11:40 AM **Open Plenary**

12:00 PM **Lunch (provided)**

Schedule - Day 2
Future Directions

Wednesday Afternoon, January 29, 2020

12:45 PM — Panel Presentation

Implementing Change

- Moderator: Margo Greenwood
- Lisa Richardson – Royal College of Physicians and Surgeon's Indigenous Health Advisory Committee
- Valerie Gideon – First Nations and Inuit Health Branch, Indigenous Services Canada
- Comments and Questions

2:00 PM — Taking Action

Draft Declaration of Commitment

- Kim Scott and Margo Greenwood

2:30 PM — **Health Break**

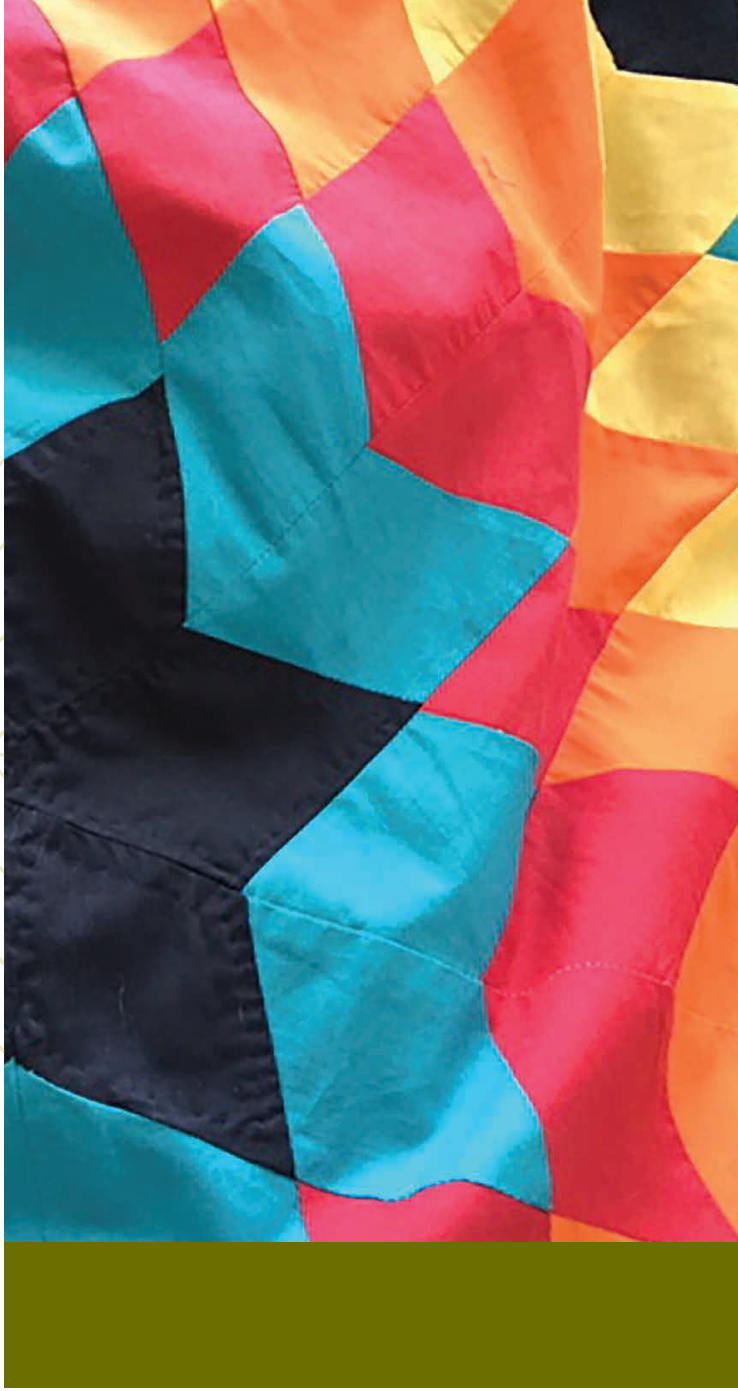
2:45 PM — **Open Plenary**

3:15 PM — Getting to Consensus

- Committing to a declaration of commitment on informed choice and consent

3:45 PM — **Presentations from the Federal Minister(s) · To be confirmed**

4:15 PM — **Closing Protocol**



Appendix B – Participant list

LAST NAME	FIRST NAME	JOB TITLE	ORGANIZATION
Abbott	Mary Catherine		First Nations and Inuit Health Branch, Indigenous Services Canada
Aerts	Louise	Registrar and Executive Director	Registrar of Midwives in BC
Alderfer-Mumma	Charis	Art Therapist	Consultant
Aldred	Terri-Leigh	Physician	University of British Columbia's Indigenous Family Medicine Program SD, Carrier Sekani Family Services Family Doctor
Aloupa	Lizzie	Inuit Rights Officer	Makivik Corporation
Ashton	Savanah	Manager, Healthy Policy and Programs	Pauktuutit Inuit Women of Canada
Atkinson	Donna	Manager	National Collaborating Centre for Indigenous Health
Baptiste	Crystal	Director, Income Assistance	Poundmaker Cree Nation
Bartlett	Judith	Retired Associate Professor, Faculty of Health Sciences	University of Manitoba
Basile	Suzy	Professor	Universite du Quebec en Abitibi-Temiscamingue
Bernard-Daisley	Annie	President	Nova Scotia Native Women's Association
Betker	Claire	President	Canadian Nurses Association
Boyer	Yvonne	Senator	Senate of Canada
Breton	Jennifer	Past-chair	Canadian Council for Practical Nurse Regulators
Burgoyne	Storm	Women's Counselor	Minwaashin Lodge
Carrozzi	Veronica	Parliamentary Affairs Advisor	Senate of Canada - Senator Boyer
Chisholm	Ashley	Senior Advisor	Canadian Medical Association
Clayton	Patti	Early Resolution Specialist	Patient Ombudsman Ontario
Cooper	Rose Mary	Political Advisor to the Executive	Pauktuutit Inuit Women of Canada
Couchie	Carol	Co-Chair	National Aboriginal Council of Midwives
Daley	Dennis	Assistant Commissioner, Contract and Indigenous Policing	Royal Canadian Mounted Police

LAST NAME	FIRST NAME	JOB TITLE	ORGANIZATION
Dearham	Alex	Senior Advisor, Ethics and Professional Affairs	Canadian Medical Association
Delaney	Teri	Administrative Assistant	National Collaborating Centre for Indigenous Health
de Leeuw	Sarah	Research Associate	National Collaborating Centre for Indigenous Health
Dion-Fletcher	Claire	Co-Chair	National Aboriginal Council of Midwives
Dixon	Lisa	Manager	Health Canada
Donaldson	Richel		University of Northern British Columbia
Dornstauder	Carrie		Saskatchewan Health Authority
Enuaraq	Sipporah		Pauktuutit Inuit Women of Canada
Epoo	Brenda	Midwife	Nunavik Health Board
Evic-Carleton	Reepa	Counselor	Inuuqatigiit Centre
Fontaine	Lorena	Professor	University of Winnipeg
Forestell	Alison	Executive Director	Canadian Medical Association Foundation
Gideon	Valerie	Senior Assistant Deputy Minister	First Nations and Inuit Health Branch, Indigenous Services Canada
Gordon	Anita	Wellness worker	Tulattavik Health Centre, CLSC, Wellness Program
Gordon	Connie	HSW/EDP	Government of NWT
Gordon	Reta	Metis Elder	
Goudie	Joan	Community Health Nurse	Nunatsiavut Government, Department of Health and social Development
Greenwood	Margo	Academic Lead	National Collaborating Centre for Indigenous Health
Halseth	Regine	Research Associate	National Collaborating Centre for Indigenous Health
Hansen	Jacqueline	Gender Rights Campaigner	Amnesty International Canada
Hay	Anne-Marie	Parliament Research Assistant	Senator Bernard's Office
Hayden	Jessica	Assistant Director, Early Years Program	Martin Family Initiative
Howard	Sandi	Registered Midwife	Northern Health Region

LAST NAME	FIRST NAME	JOB TITLE	ORGANIZATION
Jetty	Radha	Chair, Canadian Paediatric Society First Nations, Inuit and Metis Health Committee, Consultant Pediatrician	Canadian Pediatric Society, Children's Hospital of Eastern Ontario
Johnson	Shelly	Professor	Thompson River University
Jumah	Naana	Obstetrician/Gynecologist	Thunder Bay Regional Health Sciences Centre
Kalay	Anifa		Society of Obstetricians and Gynecologists
Kicknosoway	Elaine	Counselor	Minwaashin Lodge
Killough	Greg		Royal College of Physicians and Surgeons
Kirkland	Antonia	Global Lead, Legal Equality & Access to Justice	Equality Now
Kudloo	Rebecca	President	Pauktuutit Inuit Women of Canada
Leason	Jennifer	Assistant Professor	University of Calgary
Leggett	Rod		Senator Yvonne Boyer's Office
Lemire	Francine	CEO	College of Family Physicians Canada
Loft	Shelby		University of British Columbia
Lombard	Alisa	Barrister & Attorney-at-Law	Semaganis Worme Lombard Barristers and Solicitors
Losier	Sky		Senator Yvonne Boyer's Office
Marchand	Victoria	President	Canadian Nursing Students' Association
Matthews	Karina	Board Member	Nova Scotia Native Women's Association
McDonald	Shannon		First Nations Health Authority
McNab-Coombs	Laura	Research Manager	Health Arts Research Centre
Mercredi	Morningstar		
Mitchell	Laura	Senior Policy Advisor	First Nations and Inuit Health Branch, Indigenous Services Canada
Morningstar	Melanie	Manager, Family Wellness	Assembly of First Nations
Nowgesic	Earl	Assistant Scientific Director	Canadian Institutes of Health Research – Institute of Indigenous Peoples' Health

LAST NAME	FIRST NAME	JOB TITLE	ORGANIZATION
Nowgesic	Marilee	CEO	Canadian Indigenous Nurses Association
Omeniho	Melanie	President	Les Femmes Michif Otipemisiwak
O'Watch	Heather	Research Assistant	Morning Star Lodge
Pambrun	Nathalie	President	Canadian Association of Midwives
Pate	Kim	Senator	Senate of Canada
Paynter	Martha	Chair	Women's Wellness Within
Petiquan	Alex	M.D., Senior Policy Analyst	First Nations and Inuit Health Branch, Indigenous Services Canada
Picek	Jennifer	Health System Navigator	Inuvialuit Regional Corporation
Pigeau	Lisa	Senior Political Advisor	Les Femmes Michif Otipemisiwak
Powell	Kelley	Policy Analyst	First Nations and Inuit Health Branch, Indigenous Services Canada
Pruden	Victoria	Vice President; Minister of Women	Les Femmes Michif Otipemisiwak; Metis Nation BC
Richardson	Lisa	Physician	University of Toronto, Faculty of Medicine/University Health Network
Ryan	Chaneesa	Director of Health	Native Women's Association of Canada
Scott	Kimberly Ann	Facilitator	Kishk Anaquot Health Research
Shawana	Christine	Sexual and Reproductive Health Specialist	Native Women's Association of Canada
Sioui	Marjolaine	Executive Director	First Nations of Quebec and Labrador Health and Social Services Commission
Smith St-Georges	Annie	First Nations Elder	
Smylie	Janet		Well Living House, St. Michael's Hospital
Stote	Karen	Assistant Professor	Wilfred Laurier University
Stout	Roberta	Research Associate	National Collaborating Centre for Indigenous Health
Sutherland	Julie	Research Associate	National Collaborating Centre for Indigenous Health
Teitel	Darrah	Campaigns Officer	Action Canada for Sexual Health and Rights
Thomas Bernard	Wanda Elaine	Senator	Senate of Canada

LAST NAME	FIRST NAME	JOB TITLE	ORGANIZATION
Thorp	Leah	Coordinator, Perinatal Outreach Education	Saskatchewan Health Authority
Van Sickle	Christina	Director of Professional Practice	Canadian Council of Social Work Regulators
Wakeford	Kim	Policy Analyst	National Association of Friendship Centres
Wallace	Isabelle	RN, MScN	Independent Consultant, Member of the Madawaska Maliseet First Nation
Webster	Sally	Inuit Elder	
Wong	Tom	Executive Director and Chief Medical Officer	First Nations and Inuit Health Branch, Indigenous Services Canada
York	Emily		Health Canada
Young	Shauna-Marie	Director of Programs	Pauktuutit Inuit Women of Canada
Zannis	Alexandra	Social Policy and Communications Coordinator	Canadian Association of Social Workers

Appendix C – Action Tree table

Priority Area	Actions	Individual & Community Level	Systemic Level	Structural Level
Policy and Practice for Sexual and Reproductive Health	Fund a national strategy for Indigenous midwifery education			✓
	Implement policies and practices to allow presence of families and Indigenous advocates/navigators in clinical encounters	✓	✓	
	Make culturally-relevant and traditionally-based approaches available to First Nations, Inuit and Métis maternal child health	✓	✓	
	Provide access to Indigenous midwives and doulas in all hospitals	✓	✓	
	Provide referrals to appropriate services post natal care (ie. Breastfeeding)	✓	✓	
	Provide financial incentives for referral to midwives and extend financial support for length of time midwives can support families	✓	✓	✓
	Provide prenatal workshops in First Nations, Inuit and Metis communities that bring pregnant and new mothers together	✓		
	Develop a national prenatal strategy that ensures pregnant women are not giving birth alone		✓	✓
	Provide funding to support midwives in every hospital		✓	✓
	Increase the number of midwifery birth (physicians, provincial government, hospitals)		✓	✓
	Reassess the birthing close to home SOGC guideline		✓	
	Provide adequate resources (e.g. funding, policy) for Indigenous maternal child health to allow women to give birth in the supportive environment of their families and communities		✓	✓
	Change provincial policy and legislation so as to enhance Indigenous midwives and their scope of practice			✓
	Integrate Indigenous ways of knowing and traditional practices into models of sexual and reproductive models of care		✓	

Priority Area	Actions	Individual & Community Level	Systemic Level	Structural Level
Policy and Practice for Sexual and Reproductive Health	Change policy re: escorts and make navigators available to help address power imbalances in health care		✓	
	Include Indigenous leadership into decision-making and priority setting for health care organizations		✓	
	Engage with First Nations, Inuit and Métis communities and leadership in a respectful way	✓	✓	
	Ensure distinctions-based approaches in informed choice and consent		✓	✓
	Change institutional policies and practices to immediately stop and prevent forced and coerced sterilization and remove racist and discriminatory practices		✓	
	Standardize medical record documentation to eliminate stereotyping and racist language		✓	
	Change the health care model to an interdisciplinary team approach to ensure collective competence		✓	
	Promote patient-centred, trauma-informed care to improve relationships between patients and providers	✓	✓	
	Develop multiple levels of oversight in the consent process and ban the practice of seeking consent during labor		✓	
	Provide timely access to the full spectrum of birth control options for First Nations, Inuit and Métis women and girls	✓	✓	
	Implement policy mandate to have information on informed consent provided in language of choice	✓	✓	
	Standardize a requirement for informed consent on family planning and include in patient's chart – ensuring that it is consistently applied	✓	✓	
	Require hospital mandated reporting of cases of coerced or forced sterilization		✓	
	Recruit certified First Nations, Inuit and Métis interpreters and translators, with adequate, to work within clinical settings		✓	
	Establish Healthcare Advisory group to support learning and change		✓	

Priority Area	Actions	Individual & Community Level	Systemic Level	Structural Level
Policy and Practice for Sexual and Reproductive Health	Provide an exemption in Bill 101 for Indigenous patients in Quebec			✓
	Develop a consistent approach to eliminate jurisdictional issues for healthcare provision to First Nations and Inuit women			✓
	Adopt provincial health legislation that promotes high quality equitable care		✓	✓
	Review existing provincial laws on medical consent and ensure requirement that consent be obtained by person performing the procedure			✓
	Ensure health professionals have an understanding of Indigenous rights to health enshrined within UNDRIP		✓	✓
	Enact legislation that includes all internal reproductive organs in informed choice/ consent			✓
	Support and fund hospitals in isolated First Nations, Inuit and Métis communities, with specialized care			✓
Self-determination and self-governance	Implement community-based and Nation driven (self-determination) autonomy			✓
	Provide equitable funding to First Nations, Inuit and Métis governments to support access to equitable health services			✓
	Fulfill treaty obligations related to health			✓
Accountability for forced sterilization and coercion	Investigate complaints on coerced or forced consent and follow up with appropriate repercussions within health organizations, judicial system, and regulatory bodies		✓	
	Install and fully fund an Indigenous ethics officer in hospitals to investigate complaints on coerced or forced consent and follow up		✓	
	Provide access to lawyers free of charge to assist First Nations, Inuit and Métis women and girls who have been coerced or forced to consent to sterilization		✓	
	Criminalize the practice of coerced or forced sterilization			✓
	Provide ongoing monitoring and regulation of medical practitioners	✓	✓	
	Change complaint process to resolution process	✓	✓	

Priority Area	Actions	Individual & Community Level	Systemic Level	Structural Level
Accountability for forced sterilization and coercion	Ensure linguistic inclusion in complaints process (e.g. forms available in Indigenous languages)		✓	
	Encourage a culture of advocacy for clients and support for whistle blowers		✓	
	Provide 'bystander' training to reduce incidents of coerced or forced consent and facilitate accountability		✓	
	Provide a robust complaint system with concrete actions to address and bring about change to coerced or forced consent		✓	
	Enact a policy of obligation of healthcare providers to report coerced and forced sterilization		✓	
Build Awareness and Support Engagement	Bring awareness of coerced or forced sterilization to medical/health community through knowledge translation events (i.e., at national meetings, webinars, etc.)		✓	
	Meet with presidents and advisory boards of appropriate regulatory bodies to promote necessary changes to stop and prevent coercion in professional regulations, including requirement for ongoing cultural safety, cultural humility, and informed choice and consent professional development		✓	
	Develop resources for Indigenous organizations to engage survivors and develop distinctions-based action plans for stopping, healing and preventing coerced and forced sterilizations	✓	✓	
	Promote awareness of coerced or forced sterilization among public through campaign of awareness (web, radio, paper, statements from First Nations, Inuit and Métis political bodies)	✓	✓	
	Incorporate change within health professional standards of practices and curriculum to reflect the voices of survivors and stakeholders (ie. Informed consent, cultural safety, trauma-informed care, patient-centred advocacy)		✓	
	Implement similar changes within social work professional standards and curriculum		✓	
	Establish more healthcare professional specialty networks (ie. NSWOCC)		✓	
	Incorporate First Nations, Inuit and Métis practices around sexual and reproductive health and well-being into social work and medical training programs		✓	
	Allow midwives to refer to doctors other than just OB Gynaecologists		✓	

Priority Area	Actions	Individual & Community Level	Systemic Level	Structural Level
Community-based supports and resources	Support First Nations, Inuit and Métis women (survivors) to address trauma, shame, fear and stigma and promote empowerment	✓	✓	
	Educate First Nations, Inuit and Métis women and girls about their rights in relation to sexual and reproductive health	✓	✓	
	Develop sexual and reproductive health resources and supports	✓		
	Provide family support workers in communities	✓		
	Provide funding and resources to support healing and addiction programs in First Nations, Inuit and Métis communities	✓		✓
	Provide funding and support for more wrap around /integrated services for First Nations, Inuit and Métis women and their families	✓		✓
	Provide Well Woman clinics in First Nations, Inuit and Métis communities	✓		
	Remunerate knowledge holders as integral to supporting emotional and mental well-being and healing of Indigenous women and girls	✓	✓	✓
	Re-introduce ceremony in First Nations, Inuit and Métis communities to support health and healing of women and girls			✓
	Make available First Nations, Inuit and Métis ceremonies and traditional practices in all hospitals	✓	✓	
	Provide distinctions-based (First Nations, Inuit and Métis) community programming and resources	✓	✓	✓
	Promote patient self-advocacy and health literacy in communities	✓	✓	
	Offer full range of contraceptive options to ensure informed choice	✓		
Training and education	Integrate Indigenous curriculum and pedagogy into health sciences education		✓	
	Educate Indigenous women and girls about their rights in relation to sexual and reproductive health	✓	✓	
	Incorporate ongoing cultural safety, cultural humility and anti-racism training and education through both formal and informal "experiential learning" opportunities for students in healthcare programs	✓	✓	
	Provide training programs (e.g. residencies or practicums) for social workers and medical professionals that place them in First Nations, Inuit and Métis communities		✓	

Priority Area	Actions	Individual & Community Level	Systemic Level	Structural Level
Training and education	Train, recruit and retain Indigenous healthcare professionals through supportive policies and funding	✓	✓	✓
	Provide instruction on a more nuanced understanding of consent and what it means to give and receive consent in health education programs		✓	
	Support First Nations, Inuit and Métis learners in getting into medical schools and acquiring competencies		✓	✓
	Change medical/nurse training to stop depersonalizing First Nations, Inuit and Métis women and focus on building relationships		✓	
	Institute mandatory training on consent for OB/GYNs, family doctors and general surgeons regulated by RCPSC CCFP		✓	
	Develop education models that allow First Nations, Inuit and Métis women to receive training in their communities for midwifery/nursing and doula training		✓	
	Implement educational curriculum for social workers to have mandatory training in cultural safety/humility		✓	
	Revisit licensing exams to address the disproportionate rates of failure for Indigenous students		✓	
Research and data collection	Utilize community-based research, participatory action research and Indigenous methodologies in research and data collection on coerced or forced sterilization of First Nations, Inuit and Métis women		✓	
	Collect data in hospitals on C-sections, tubal ligation and child apprehensions to identify harms and assess magnitude		✓	✓
	Build an alternative evidence-base that highlights Indigenous best practices		✓	✓
Address injustices, healing and restitution for forced or coerced sterilization	Address specific injustices of coerced or forced sterilization to First Nations, Inuit and Métis women and girls		✓	✓
	Adopt an "Aboriginal Healing Foundation" model for engaging in research on forced sterilization and coercion			✓
	Develop healing supports tailored that are survivor centred and distinctions-based	✓	✓	✓
	Provide financial compensation for coerced or forced sterilization of First Nations, Inuit and Métis women and girls			✓

Priority Area	Actions	Individual & Community Level	Systemic Level	Structural Level
Address injustices, healing and restitution for forced or coerced sterilization	Issue official apology to Indigenous women and girls who have been coerced or forced to give consent to sterilization, including from government and health organizations		✓	✓
	Provide justice for survivors (ie. Government funded in vitro fertilization or other fertility treatments)			✓
	Adopt nation-to-nation approach to discussions about stopping and preventing coerced or forced sterilization			✓
	Ask First Nations, Inuit and Métis survivors what they need to help heal	✓	✓	✓
	Develop federal guidelines on consent			✓
	Provide strong government condemnation of coerced or forced sterilization of Indigenous women and girls and a commitment to end coerced or forced sterilization of First Nations, Inuit and Métis women and girls			✓
	Launch national inquiry into coerced or forced sterilization of First Nations, Inuit and Métis women and girls			✓
	Develop advocacy body to convene stakeholder groups		✓	✓
	Create federal policies on how/when/who asks about wanting tubal ligation			✓
	Implement audit billing practices and crack down on fraudulent billing practices associated with the NIHB			✓

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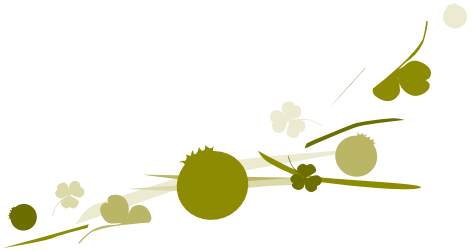

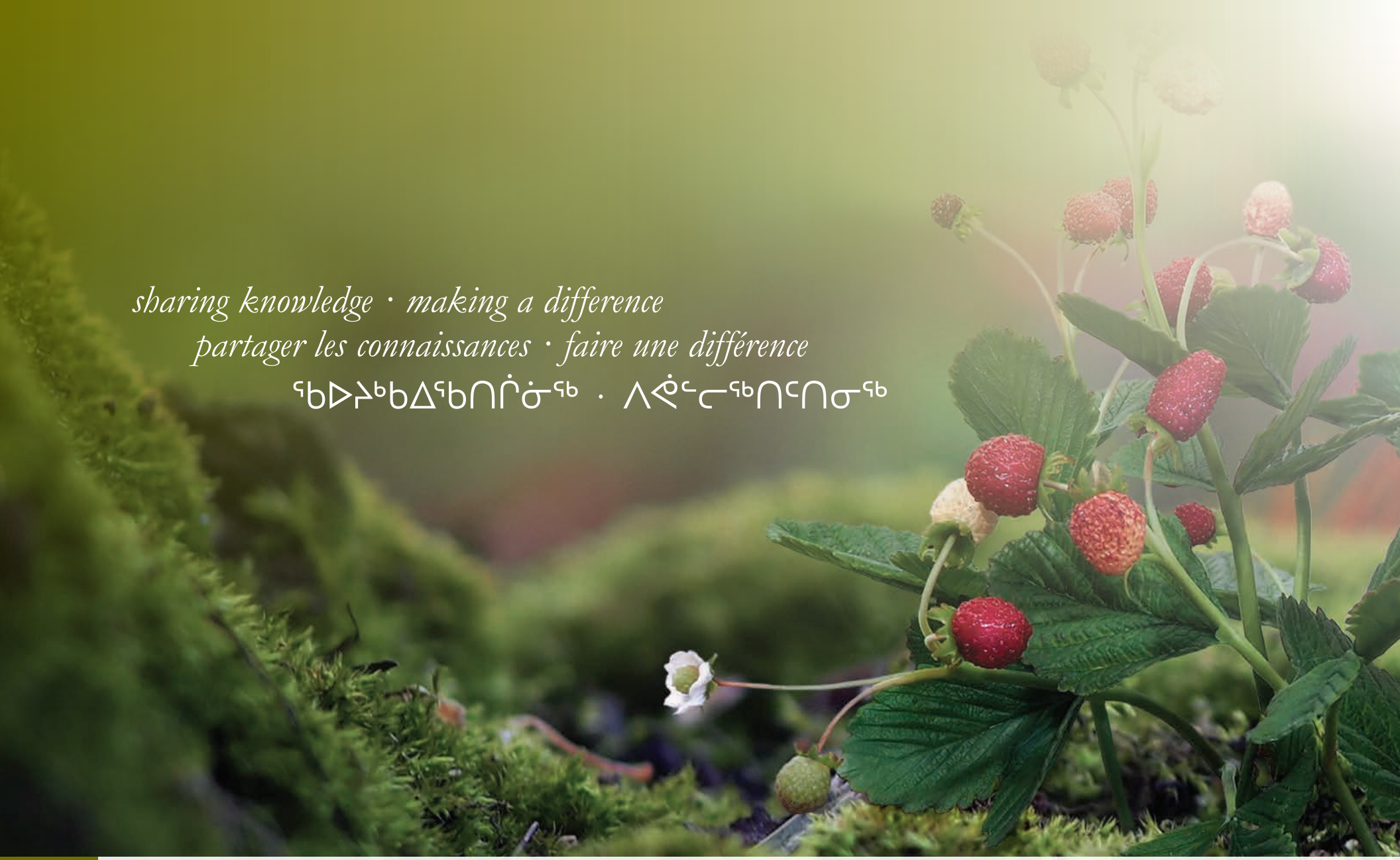

National Collaborating Centre for Indigenous Health

Centre de collaboration nationale de la santé autochtone

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