

Indigenous Women's Resistance of Colonial Policies, Practices, and Reproductive Coercion


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Abstract

This analysis of urban Indigenous women's experiences on the Homeland of the Métis and Treaty One (Winnipeg, Manitoba, Canada), Treaty Four (Regina, Saskatchewan, Canada), and Treaty Six (Saskatoon, Saskatchewan, Canada) territories illustrates that Indigenous women have recently experienced coercion when interacting with healthcare and social service providers in various settings. Drawing on analysis of media, study conversations, and policies, this collaborative, action-oriented project with 32 women and Two-Spirit collaborators demonstrated a pattern of healthcare and other service providers subjecting Indigenous women to coercive practices related to tubal ligations, long-term contraceptives, and abortions. We foreground techniques Indigenous women use to assert their rights within contexts of reproductive coercion, including acts of refusal, negotiation, and sharing community knowledge. By recognizing how colonial relations shape Indigenous women's experiences, decision-makers and service providers can take action to transform institutional cultures so Indigenous women can navigate their reproductive decision-making with safety and dignity.

Keywords

resistance, reproduction, gender, marginalized or vulnerable populations, racism, Indigenous, reproductive coercion, reproductive justice, reproductive rights

Introduction

Reproductive¹ coercion is one mode of controlling Indigenous² communities' reproduction, especially through the bodies of women, Two-Spirit,³ and trans*⁴ people. Reproductive coercion has been enacted in various locations globally, both through policy and patterns of healthcare providers' actions. For instance, in Peru during the 1990s, Fujimori's government implemented a family-planning promotion program through which many women were coercively sterilized. Most of the women were poor, Indigenous, and living in rural areas (Boesten, 2007). From the 1960s until the early 2000s, tens of thousands of Romani women were coercively sterilized in former Czechoslovakia and its successor states: the Czech Republic and Slovakia (Cahn, 2004, 2017).

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Indeed, various groups of people, communities, and women have experienced patterns of coercive sterilization, including trans* people (Lowik, 2018), people with intellectual disabilities (Dyck, 2013; Rowlands & Jean-Jacques, 2019), racialized women (Novak et al., 2018; Stern, 2005), Indigenous women (Boesten, 2007; Carpio, 2004; Grekul et al., 2004; O'Sullivan, 2016; Stote, 2012, 2015), women living in poverty (Park & Radford, 2013; Schoen, 2001), women living with HIV/AIDS (Chingore-Munazvo et al., 2017; Durojaye, 2018; Kendall & Albert, 2015), and women who are incarcerated (Roth & Ainsworth, 2015). Healthcare providers have also engaged a range of coercive practices related to sterilization (Braut et al., 2016; Erviti et al., 2010), abortion (Cuca & Rose, 2016), and birth control (Abarbanell, 2020; Guerra-Reyes et al., 2021; Logan et al., 2021) in various locations. These patterns are informed by existing narratives, embedded within government policy as well as media and public discourse, about ideal and deviant motherhood and citizenship.

Global leaders often herald Canada as a champion of human rights; however, as Lightfoot (2018) argues, “when Indigenous peoples’ rights are included in its human rights record, Canada’s reputation loses some of its luster” (p. 166). Indeed, Canada has a long history of reproductive coercion fueled by eugenic ideologies. While Saskatchewan and Manitoba drafted sterilization acts that were defeated in the 1930s (Dyck, 2013), British Columbia (BC) and Alberta each had sexual sterilization legislation in effect in the 20th century—from 1933 to 1973 in BC and from 1928 to 1972 in Alberta. Both Indigenous peoples and women were overrepresented among the cases presented to the Alberta Eugenics Board (Grekul et al., 2004). Further, research shows that healthcare providers subjected Indigenous women in other provinces and territories to coercive sterilization (Cohen & Baskett, 1978; Stote, 2012, 2015), even without such legislation. Stote’s (2015) archival research indicates that between 1928 and 1973, Indigenous women in various locations in Canada—regardless of existing sterilization acts—were subjected to coercive practices related to birth control and abortion procedures. These practices were enabled by colonial narratives that framed Indigenous women as both hypersexual and “unfit” as mothers.

Since the latter 20th century, women of color and Indigenous women working within reproductive rights, reproductive justice, and various women’s organizations in North America have advocated for the end of coerced and forced sterilization and brought wider attention to reproductive coercion (Nelson, 2003; Ralstin-Lewis, 2005; Silliman et al., 2004; Stote, 2017). Research specific to the Canadian context has focused on historical patterns of coercive sterilization (see, for instance, Dyck, 2013; Dyck & Lux, 2016; Stote, 2012, 2015). However, reproductive coercion is not only a problem of the past.

While Indigenous communities and media report anecdotal evidence of ongoing reproductive coercion, analyses of contemporary women’s experiences are missing from the extant literature. Thus, this study explored urban Indigenous women’s experiences of reproductive (in)justice(s). We offer our analysis to prompt institutional and societal change, so that more Indigenous women will be able to access safe reproductive healthcare. First, we briefly introduce the urban centers where we facilitated this study. Then, we summarize this project’s collaborative action-oriented methodology and methods. Next, we offer our analysis of local and national media coverage about forced and coerced sterilization at the Royal University Hospital (RUH) in Saskatoon, Saskatchewan, and related institutional responses. We connect this media coverage to study conversations about coercive practices related to tubal ligations, long-term contraceptives, and abortion procedures. We then discuss further developments in public and media conversations about reproductive coercion since the completion of this study’s fieldwork. Lastly, we consider how this study’s findings can inform advocacy and service provision.

Research Settings: Winnipeg, Regina, and Saskatoon

We facilitated this study with urban Indigenous women living on the Homeland of the Métis⁵ and Treaty One (Winnipeg, Manitoba, Canada), Treaty Four (Regina, Saskatchewan, Canada), and Treaty Six (Saskatoon, Saskatchewan, Canada) Territories.⁶ The cities of Winnipeg, Regina, and Saskatoon were ideal sites to gather and cocreate knowledge about Indigenous women’s reproductive (in)justice(s). The provinces of Manitoba and Saskatchewan were constructed by colonial governments that divided and named territories on which First Nations⁷ (including Nêhiyaw [Plains Cree], Nêhinaw [Swampy Cree], Nîhithaw [Woodland Cree], Dene, Dakota, Nakota, Assiniboine, and Anishinaabe [Ojibway, Oji-Cree, and Saulteaux]) and Métis people lived. There is a long history of colonial displacement from and migration within these lands (Daschuk, 2013; Hogue, 2015),⁸ including to and among Regina, Saskatoon, and Winnipeg. As of 2016, Indigenous peoples comprised 12.2% of Winnipeg’s population, 10.9% of Saskatoon’s population, and 9.3% of Regina’s population according to Statistics Canada. In comparison, Indigenous peoples constitute 4.9% of the Canadian population (Statistics Canada, 2018). Indigenous peoples living in these three cities negotiate conditions of racism and socioeconomic marginalization that have been produced through colonial processes (Environics Institute, 2011a, 2011b, 2011c; Newhouse & Peters, 2003; Peters & Lafond, 2013).⁹ Colonial and classist segregation continue to pervade these three cities.

Various policies and practices push Indigenous peoples and those dealing with harms related to structural inequities (e.g., violence, trauma, and harmful substance use) into areas such as Saskatoon's West Side, Regina's North Central, and Winnipeg's North End, areas known as "inner-city neighbourhoods." Examples of marginalizing policies and practices include inadequate mental health services, a child welfare system that does not sufficiently support Indigenous youth or families, and insufficient housing and programming for those dealing with intimate partner violence.

The cities mentioned above are also spaces for building, sustaining, and protecting Indigenous women and communities. For instance, a group of women in Winnipeg formed a volunteer-based safe ride program in response to taxi-cab drivers' harassment and violence toward Indigenous women (see *Ikwe Safe Rides*). Indigenous women living in these urban centers engage in diverse activist and community work, as illustrated by the emergence of the Idle No More movement in late 2012, which stemmed from teach-ins led by Indigenous and non-Indigenous women in Saskatchewan (Kino-nda-niimi Collective, 2014).

Methodological Approach: Collaborative and Action-Oriented

This article is based on the analysis from a three-phase, collaborative, action-oriented research project we facilitated with 32 urban Indigenous women,¹⁰ Two-Spirit, and ally/accomplice collaborators in Winnipeg, Saskatoon, and Regina between March 2015 and June 2017 (McKenzie, 2020). The study process was guided by an Ojibway Knowledge Keeper.¹¹ The lead researcher (McKenzie) is a white-settler, queer, cis-gender feminist woman, who works as an accomplice¹² to Indigenous peoples in their fight against the colonial heteropatriarchal order¹³ (Arvin et al., 2013; Fornssler et al., 2018; Indigenous Action Media, 2014). Twenty-nine of the 32 collaborators identified as Indigenous, the majority of whom identified as Cree; other collaborators identified with various Nations. The collaborators brought a diversity of educational, professional, and lived/living experiences to study conversations (research circles, interviews, and collaborative meetings). Our study explored (1) how do Indigenous women who are living in three prairie cities (Winnipeg, Saskatoon, and Regina) define and understand reproductive justice and reproductive sovereignty? (2) How do urban Indigenous women claim and exercise their rights to reproductive justice? (3) What changes to social and health services will respect and support urban Indigenous women's rights to reproductive justice? And (4) what political, economic, and community changes will respect and support urban Indigenous women's

rights to reproductive justice? While we approached our research questions through a strength-based framework, much of our study conversations focused on reproductive and sexual violence, including reproductive coercion, which is why we have focused this journal article on the latter.

This study's action-oriented processes aimed to (1) honor Indigenous women's community work, (2) contribute to their ongoing work, and (3) foster Indigenous women's reproductive justice and sovereignty. Our ability to meet these aims was constrained by university processes—informed by colonial relations and histories (Smith, 2012)—and McKenzie's positionality and related experiential knowledge. We simultaneously recognized these constraints and used various strategies to foster decolonial moments¹⁴ among collaborators, Kookums¹⁵ and other community members. For instance, we engaged Indigenous methods, processes, protocols, and principles throughout this project. We also used various strategies to disrupt the politics of academic knowledge production and benefits. For instance, co-authoring academic and community products with collaborators and Guiding Knowledge Keeper, as well as recognizing the Guiding Knowledge Keeper's, collaborators', and other community members' contributions with cash honoraria (Salmon, 2007). These decolonizing interventions are interrelated with this project's knowledge mobilization efforts, which aim to reduce the harms¹⁶ of colonial ideologies, norms, and practices.

Centering Indigenous Women's Narratives Through a Collaborative Action-Oriented Approach

Action-oriented and participatory research methodologies emphasize the need to engage in participatory and collaborative processes that both gather and produce local knowledges about social inequities and take action (Lykes & Hershberg, 2012, 333). Following Reid et al.'s (2006) argument for a broader understanding of "action," this project diverged from predominant action-based processes. Instead, we focused on collaboratively generating and mobilizing knowledge to prompt individual and collective actions. Our methodological approach, decision-making, and analysis were guided by post-structuralist (Ahmed, 2012; Deleuze & Guattari, 1987; Weedon, 2004), decolonial, and Indigenous theorizing (Hunt & Holmes, 2015; A. Simpson, 2007 and L. B. Simpson, 2011, 2017; Tuck, 2009; Tuck & Yang, 2012), particularly feminist theorizing, to cultivate attention to power relations.

Our project's collaborative, action-oriented methodology was informed by Indigenous storytelling (Kovach, 2009), postcritical ethnography (Lather, 2007), Hankivsky's (2012) intersectionality-based policy analysis framework

(IBPF), and Clark's (2012) Indigenous intersectional-based policy analysis framework (IIPF). This project centers Indigenous women's theorizing and narratives. As such, we viewed study conversations as collaborative theorizing rather than research data from which McKenzie later produced theory. We also recognized our time in this co-theorizing space was limited due to academic constraints, so McKenzie led the analysis of study conversations and shared the initial analysis with collaborators, supervisory committee members, and Guiding Knowledge Keeper for further development.

Indigenous Storytelling and Postcritical Ethnographic Approaches

Theorizing often comes through storytelling. Storytelling is an accepted method of sharing knowledge and teachings in Indigenous communities and is one of the most-referenced and theorized Indigenous methodological approaches (Archibald, 2008; Episkenew, 2009; Kovach, 2009). Indigenous methodologies are complex, wholistic approaches that consider both inward and outward knowing¹⁷ as well as the importance of relationships, language, place, and Indigenous/white-settler relations. As such, when approaching stories through an Indigenous framework, they must be related to their context (Kovach, 2009; Wilson, 2008).

Postcritical ethnographic approaches engage post-structuralist thinking to disrupt taken-for-granted critical ethnographic practices and norms while drawing on tools of ethnographic research (Lather, 2007). Within this project, we activated postcritical ethnography in various ways including (a) treating knowledge generated within this project as produced in relation with collaborators and other participants, and thus engaging a process of relational sampling rather than standard ethnographic sampling approaches (Schensul & LeCompte, 2013); (b) drawing on ethnographic tools, including open-ended exploratory interviews, semi-structured interviews, fieldnotes and thematic analysis; (c) adapting our thematic analysis approach from Braun and Clarke (2006), with one significant divergence, rather than considering the interview transcripts raw data we consider them an incomplete archive of time spent theorizing with collaborators¹⁸; (d) engaging a rhizomatic validation process in recognition that study conversations have multiple possible interpretations (Lather, 2007); and (e) presenting our analysis, along with collaborators' stories and other excerpts from study conversations, in a coherent narrative even though multiple voices created it. We made theoretical, methodological, and representational decisions based on their explanatory potential as well as the social and political implications (Weedon, 2004).

Intersectionality-Based Policy Analysis Framework and Indigenous Intersectional-Based Policy Analysis Framework

The focus of our project's policy analysis was how policies shape the material context of Indigenous women's and their children's lives. Various scholars have demonstrated intersecting policies continue to undermine Indigenous women's rights to reproductive justice in Canada (see, for instance, de Leeuw et al., 2010; Hunting & Browne, 2012; Lawford, 2016; Lawford & Giles, 2012, 2013; McKenzie et al., 2016; Salmon, 2011). Therefore, it was necessary to engage a policy analysis within this project. We used IBPF and IIPF because these frameworks are grounded in principles that align with our project's overall methodological approach: intersecting categories, multi-level analyses, power, reflexivity, time and space, diverse knowledges, and social justice and equity (Hankivsky, 2012). Engaging IIPF highlights the relationship between intersectionality and Indigenous thought while foregrounding decolonization and Indigenous self-determination (Clark, 2012) to build a complex understanding of these policies' effects.

Data Collection and Analysis

Our project included three phases: two phases of data collection and analysis and one phase of action-oriented knowledge mobilization activities. Data collection consisted of (a) study conversations: research circles facilitated by local Kookums, interviews, as well as group and individual meetings between McKenzie and collaborators¹⁹; (b) retrieval of policy documents and related secondary sources (e.g., media coverage) identified as relevant during initial interviews and meetings; (c) interviews with people who negotiate policy contexts (policy navigator interviews) to understand how these policy documents play out materially; and (d) a review of related service organizations' websites and interviews with organizations' leadership (environmental scan). We recorded research circles and interviews and transcriptionists transcribed the recordings. We recorded meetings through fieldnotes.

Both phases of data collection were driven by relational²⁰ sampling, as follows: During Phase One, we drew on our experiential knowledge and relations to develop a list of potential collaborators who have professional and community experience related to reproductive (in)justice(s). Then, we approached potential collaborators individually by email. During interviews with Phase One collaborators, we also asked for suggestions of other people to involve. Through this process, thirteen Phase One collaborators (five in Saskatoon, four in Regina, and four in Winnipeg) initially became involved with the project. A Phase One collaborator later withdrew from the

Table 1. Summary of Project Phases and Processes.

Phase	Participants	Methods
Phase One: March 2015–May 2016	12 collaborators with professional experience related to reproductive justice Winnipeg: 4 Regina: 4 Saskatoon: 4	<ul style="list-style-type: none"> • Open-ended interviews • Policy analysis • Meetings with collaborators
Phase Two: September 2016–June 2017	5 collaborators with personal experience related to reproductive justice Winnipeg: 2 Regina: 1 Saskatoon: 2 20 collaborators with personal experience related to reproductive justice Winnipeg: 5 Regina: 7 Saskatoon: 8 Other interview participants Policy navigators: 5 Organization representatives: 34	<ul style="list-style-type: none"> • Research circles • Open-ended interviews • Meetings with collaborators • Semi-structured interviews • Website review • Policy analysis • Study updates
Phase Three: April 2016–ongoing	32 collaborators with professional and personal experiences related to reproductive justice Winnipeg: 9 Regina: 11 Saskatoon: 12	<ul style="list-style-type: none"> • Community forums • Individual and group meetings about knowledge-sharing activities

study and withdrew the information she shared during interviews and meetings. We facilitated open-ended interviews with each collaborator (Schensul & LeCompte, 2013). We chose open-ended interviews because they are flexible and responsive. Open-ended interviews facilitated collaborators' sharing their stories and analytic insights about reproductive (in)justice(s).

Phase Two recruitment focused on involving Indigenous women with personal experience related to reproductive and sexual (in)justice(s), since we broadened the study's focus to reproductive and sexual justice. Phase Two collaborator recruitment consisted of three processes: (a) we shared study information at community forums, (b) we shared study information individually with potential collaborators, and (c) we approached community organization representatives to ask if they would be willing to share study materials with potential collaborators and/or display a study poster at their sites. In Phase Two, 20 additional collaborators joined the study, with five collaborators participating in research circles and all 20 participating in open-ended interviews (Schensul & LeCompte, 2013). We chose research circles because it is a culturally relevant form of gathering and sharing knowledge, which facilitates sharing stories within their context (Kovach, 2009). Similarly, we chose open-ended interviews because of their flexibility and responsiveness.

In Phase Two, we also conducted an environmental scan and policy navigator interviews. The environmental scan gathered public information about available services and consisted of a review of service organizations' websites as well as email and telephone semi-structured interviews with organizational leadership from 32 organizations who provide services related to reproductive and sexual (in)justice(s) (Schensul & LeCompte, 2013). We also facilitated semi-structured interviews with five participants whose work involves negotiating some of the policies we analyzed (policy navigator interviews). We contacted potential policy navigators and environmental scan participants individually with information about the study and asked if they would be willing to participate in an interview. We used semi-structured interviews for environmental scan and policy navigator interviews because the primary purpose of these interviews was to gather specific information about (a) available services and (b) how policies play out in practice, respectively. The secondary purpose was to gather information about reproductive and sexual (in)justice(s) that came up during the interviews. We chose semi-structured interviews to meet these purposes because they provide more direction than open-ended interviews and allow more flexibility than quantitative questionnaires. These phases, participants, and methods are summarized in Table 1.

To make meaning from study conversations, policy navigator interviews, and this environmental scan, we (a) used an adapted thematic approach (Braun & Clarke, 2006) that is grounded in postcritical ethnography (Lather, 2007) and (b) condensed stories gathered through an Indigenous storytelling lens (Kovach, 2009). We also used descriptive and transformative questions grounded in IBPF (Hankivsky, 2012) and IIPF (Clark, 2012) to analyze policy documents and secondary sources.

Thematic Analysis, Condensed Stories, and Rhizomatic Validity

Transcriptionists transcribed all the interviews verbatim. McKenzie then reviewed the transcripts and interview fieldnotes while listening to audio recordings of interviews to identify repeating ideas and concepts, their relationships, as well as particular quotes that illustrated these ideas and concepts. McKenzie also identified pertinent stories collaborators shared and summarized them into condensed stories. This level of analysis was deductive and inductive (Braun & Clarke, 2006). It was deductive because McKenzie framed the coding through the study's research questions as well as our methodological and theoretical approaches. However, since there is limited research about how local Indigenous women define reproductive justice and experience reproductive (in)justice(s), the coding also was an inductive process. Next, McKenzie developed a narrative about these themes and their relationship. McKenzie shared this narrative with collaborators through follow-up phone and in-person meetings and email. As well, McKenzie discussed this narrative and themes with the Guiding Knowledge Keeper and supervisory committee. McKenzie incorporated the collaborators', Guiding Knowledge Keeper's, and supervisory committee's insights into this analysis. Then, McKenzie asked collaborators to review and provide any feedback on quotes and condensed stories that we shared in academic and community products, and McKenzie revised them as directed.

Following Lather's (2007) articulation of rhizomatic validity these discussions fostered multiple possibilities and generated local, context-specific theories and actions. Lather frames rhizomatics as "a journey among intersections, nodes, and regionalizations" (p. 124). Indeed, during this analysis, McKenzie explored possible interpretations of collaborators' stories and quotes and discussed some of these interpretations with collaborators, the supervisory committee, and the Guiding Knowledge Keeper. These conversations produced an analysis grounded in study conversations with the strongest social and political potential for change.

Policy Analysis

In study conversations, we identified relevant policy documents to analyze. Then, we analyzed policy documents and secondary sources from media outlets (*Saskatoon Star-Phoenix*, *Regina Leader Post*, *Winnipeg Free Press*, *CBC*, and *APTN*), and reports. We gathered print media articles and transcripts of *CBC—The National* through the Canadian Newsstream database and other broadcast video and audio pieces through APTN's and CBC's websites. We adapted descriptive and transformative policy analysis questions from Hankivsky's (2012) IBPF. Principles of IBPF and IIPF (Clark, 2012; Hankivsky, 2012) guided our analysis. For instance, we asked these descriptive questions: "What are the current policy responses to the problem? How do these policy responses shape Indigenous women's access to reproductive justice?" As another example, we asked this transformative question: "Where and how can interventions be made to improve the problem?"

Collaborative Process

During McKenzie and collaborators' initial meetings, McKenzie asked Phase One (and later, Phase Two) collaborators if they would like to (a) receive study updates every few months by phone and/or email so they could provide feedback, (b) participate in in-person collaborator meetings to contribute to the analysis and plan knowledge mobilization activities, (c) work with McKenzie and other collaborators on community and academic products, and (d) other possibilities. For instance, some collaborators preferred to meet more frequently with McKenzie individually.

Phase Three focuses on knowledge mobilization efforts and we have completed the following activities: (a) Phase One and Phase Two community reports and presentations, (b) a policy brief addressing coercive sterilizations of Indigenous women at the Royal University Hospital in Saskatoon, (c) fact sheets focused on reproductive and sexual rights, patients' rights to free, full and informed consent, accessing abortion services in Saskatoon, SK, and parents' rights when negotiating the child welfare system in Manitoba (see www.hollyanmckenzie.ca/Indigenous-RJ). Collaborators continue to contribute to knowledge-sharing activities as co-authors and co-presenters. Collaborators chose to be identified by either their name or a pseudonym in study products; however, this journal required we removed their names and pseudonyms. Collaboration was most concentrated during Phases One and Two and continues throughout Phase Three, which is ongoing as of 2022. Collaborators hold different roles in this study than environmental scan

and policy navigator participants, as they have had opportunities to (a) contribute to the analysis, (b) provide direction for Phase Two and knowledge mobilization activities, and (c) contribute to knowledge mobilization activities as co-authors and/or co-presenters.

Ethics

Our study was guided by the *Tri-Council Policy Statement for Ethical Research Involving Humans 2nd Edition [TCPS 2]*, particularly “Chapter 9: Research Involving the First Nations, Inuit and Métis Peoples of Canada” (Canadian Institutes of Health Research et al., 2014) as well as culturally relevant ethical principles grounded in our social justice orientation: collaboration, inclusion, respect, relevance, reciprocity, responsibility, and reflexivity (Kirkness & Barnhardt, 1991; Walters et al., 2009). McKenzie and collaborators discussed and developed our interpretation of these ethical principles within the context of this study. For instance, we interpreted responsibility as:

Responsibility to everyone involved in the project, particularly to collaborators and all Indigenous women (including two-spirit, trans*, lesbian, bisexual, queer and other gender and sexual diverse women) within the Métis Homeland and Treaty One (Winnipeg), Treaty Four (Regina) and Treaty Six (Saskatoon) Territories. Practically, this means working so that a) the results shared reflect collaborators’ diverse perspectives, and b) the actions taken foster Indigenous women’s reproductive justice.

Our study was reviewed and approved by the University of British Columbia Behavioural Research Ethics Board.

Our project followed both Indigenous and university cultural protocols for informed consent. For example, in alignment with Kovach’s (2009) research, McKenzie presented potential participants with tobacco as part of the consent process. In recognition of some Métis people’s preference for the gift of tea when asked to share stories, knowledge, or teachings (Campbell, 2012 as cited by Lavallee et al., 2016), McKenzie also offered tea. McKenzie and potential participants first went through the university consent form and collaborators provided their oral or written consent. Then, McKenzie presented potential participants with gifts of tobacco and tea and asked them to become involved in the project. During the consent process, McKenzie shared with collaborators they could withdraw from the study at any point until the publication of McKenzie’s dissertation. This consent process was repeated at the beginning of each study conversation (e.g., collaborator meetings). As discussed above, one Phase One collaborator withdrew from the study.

This article draws on our analysis of (1) study conversations with collaborators and (2) policy documents

and secondary sources, including institutional policies about tubal ligation procedures and informed consent, media coverage, and the United Nations Declaration on the Rights of Indigenous Peoples (UNDRIP) (United Nations, 2008). We present an analysis of media and study conversations as well as institutional policies while foregrounding Indigenous women’s stories and experiences. Accordingly, we first describe media coverage about service providers subjective Indigenous women to coercive sterilization and related institutional responses during this study’s fieldwork.

Burgeoning Media Coverage About Indigenous Women’s Stories of Forced and Coerced Sterilization and the Health Region’s Response

Media Coverage

During a Phase One collaborator meeting in late 2015, we discussed media coverage on the coercive sterilization of Indigenous women in Saskatchewan in particular and in Canada more broadly. Collaborators identified both an increase in media coverage and a resonance between this coverage and the content of our study conversations. We thus analyzed media coverage produced during data collection (March 2015 to June 2017) to determine patterns of representation and to provide further context for our study. In October 2017, just after the end of our data collection period, two Indigenous women filed a class-action lawsuit concerning acts of forced and coerced sterilization against all health regions in Saskatchewan, the federal and provincial governments, and individual medical professionals (Adam, 2017). There is a related ban on publishing the names of the representative plaintiffs or any information that could identify them. Recognizing this ban and, more importantly, the representative plaintiffs’ decision to remain anonymous, we briefly summarize our media analysis findings below without referencing any information that might identify them.

In Phase Two, we used CBC’s and APTN’s websites and the *Canadian Newsstream* database to search popular news sources—the *Saskatoon Star-Phoenix*, *Regina Leader Post*, *Winnipeg Free Press*, and *CBC’s The National*—for media coverage published between March 1, 2015, and June 30, 2017 (28 months). Within these parameters, we identified 27 items of media coverage regarding forced and coerced sterilization of Indigenous women. To provide a numerical comparison, we searched the *Saskatoon Star-Phoenix*, *Regina Leader Post*, *Winnipeg Free Press*, and *CBC’s The National* through the *Canadian Newsstream* database for coverage during the 28 months immediately preceding our fieldwork (November 1, 2012, to February 28, 2015).²¹ This latter search identified only

one article on coercive sterilization of Indigenous women, published in the *Winnipeg Free Press*. Thus, we concluded that there was a substantial increase in media coverage about coercive sterilization during this study's fieldwork.

Much of this burgeoning media conversation about coercive sterilization was prompted by Indigenous women sharing their stories with journalists. In particular, coverage highlighted women's experiences of healthcare and social service²² providers subjecting them to coerced or forced sterilization at the Saskatoon Health Region's (SHR) Royal University Hospital (RUH) in Saskatoon. During interviews, women framed their experiences of reproductive coercion in various ways, including as racist and/or colonial practices, as undermining their Indigenous rights, and as compromising their identities as women. Media outlets also published coverage about SHR's institutional responses to these stories, such as the SHR launching, canceling, then re-launching an external review into "concerns raised by Indigenous women who felt pressured to consent to tubal ligations after the birth of their child" (Saskatoon Health Region, 2017, Jan 20, para 1).

Health Region responds: Policy Changes and External Review Process

In response to these public and formal complaints, Jackie Mann, Vice President of Integrated Services at SHR, initially stated to journalists that SHR had changed their postpartum tubal ligation policy and intended to hire an external reviewer (Adam, 2015a, 2015b). These articles reported that SHR's policy changed so "only women who have decided with their physicians before coming to the hospital will undergo tubal ligation following vaginal delivery" (2015a, p. A1; 2015b, p. A10). In addition, Mann provided statistics demonstrating a decrease in the number of tubal ligation procedures completed after vaginal births in Saskatoon, with 95 performed in 2010–2011 and 24 performed in 2014–2015 (Adam, 2015b). Leanne Smith, Director of Maternal Services, framed this decrease in tubal ligations as the likely result of increased long-term contraceptive options (Adam, 2015b). Since media coverage only discussed coercive practices related to postpartum tubal ligation following vaginal delivery, this reported decrease also implies a decrease in coercion by service providers.²³ Neither article addresses the possibility of service providers engaging in coercive practices related to long-term contraceptives or other reproductive procedures.

The health region's external review process was not straightforward. While the health region hired an external reviewer in early 2016, SHR had canceled the review by June of that year. In response to public and media pressure, SHR reopened the external review in January of

2017. This time, it was led by Yvonne Boyer, Métis lawyer and Canada Research Chair at Brandon University, and Judith Bartlett, Métis doctor and former professor at University of Manitoba (Saskatoon Health Region, 2017). The review process was thus ongoing when this study's fieldwork (including policy analysis) concluded. This external review used a community-based methodology that involved interviews with Indigenous women who had experienced coercive practices related to postpartum tubal ligations, interviews with service providers, and a review of women's medical charts and SHR policies. While SHR's decision to re-launch the review was shaped by pressure from outside sources, its decision indicates a potential willingness to produce structural change and foster more responsive and inclusive care.

As alluded to earlier, SHR's RUH changed their postpartum tubal ligation policy in late 2015. However, RUH did not revise their written policy until October 2016 and did not share this policy with members of the public until SHR announced the re-launch of the external review on January 20, 2017 (Saskatoon Health Region, 2017). The October 2016 policy focuses on facilitating tubal ligations after vaginal and caesarean deliveries only if healthcare providers have previously discussed this procedure with patients and documented patients' intention to have the procedure before they arrive at the hospital for childbirth (Royal University Hospital, 2016). RUH's 2016 policy also included a statement asserting individuals' rights to reproductive autonomy and considerations about free, full, and informed consent within the context of postpartum tubal ligation procedures. Similar to a recommendation the interagency statement from the OHCHR, UN Women, UNAIDS, UNDP, UNFPA, UNICEF & WHO (2014)²⁴ on *Eliminating Forced, Coerced and Otherwise Involuntary Sterilization*, RUH's revised postpartum tubal ligation policy stated, "The best time to make a decision about permanent sterilization is not while in the hospital, in labour, immediately following delivery or during the birth process" (2016, 1.3).

In comparison, previous versions of RUH's Tubal Ligation Policy (RUH's, 2009, 2010) focused primarily on facilitating the procedure with limited discussion about consent. The strengthened written emphasis on informed consent and considerations specific to tubal ligation procedures brings to the foreground healthcare providers' obligation to respect the patient's right to informed consent and provides practical guidance. However, as with any surgical procedure, tubal ligation procedures had already been subject to Canadian law and the health region-level policy about free, full, and informed consent (Evans, 2006; Saskatoon Health Region, 1995, 2007, 2015). If healthcare providers had been followed existing Canadian law and region-level policies regarding consent,²⁵ overt violations such as those described by women

speaking with journalists in late 2015 and early 2016 would have been prevented. While SHR reopening the external review suggests a willingness for institutional change, RUH's changes to its postpartum tubal ligation policy and Mann's statement about the decrease in tubal ligations after vaginal delivery frames the issue of reproductive coercion as being confined to a single procedure. Focusing on tubal ligation as the sole site of reproductive coercion reflects the Euro-Western biomedical approach of isolating and treating individual concerns (Scheper-Hughes & Lock, 1987).

Study Conversations: Indigenous Women's Experiences of, and Resistance to, Reproductive Coercion

Study conversations resonated with women's stories of coerced and forced sterilization reported in the media. Indeed, this media coverage may have prompted some collaborators to reflect on and share their stories about reproductive coercion or offered a discursive frame for their experiences. Collaborators shared stories about healthcare practitioners and other service providers who coerced them to agree to tubal ligations, long-term contraceptives (particularly intrauterine devices [IUDs]), or pregnancy terminations across all three study sites. Collaborators also discussed using various strategies to negotiate these coercive encounters.

During study conversations, collaborators described healthcare providers' or social service providers' harmful practices in three distinct ways: (a) pressuring, rushing, or tricking women into making these decisions; (b) proceeding as if women had already consented to the procedure or treatment; and/or (c) referring to racist and colonial stereotypes to justify their actions or convince women to follow their recommended practice. While there was an increase in media coverage about Indigenous women's experiences of coercive sterilization at RUH and institutional responses to those experiences during this fieldwork (March 2015–June 2017), there was no media coverage about coercive practices related to long-term contraceptives and abortion procedures in the *Saskatoon Star-Phoenix*, *Regina Leader Post*, *Winnipeg Free Press*, *CBC*, and *APTN* during the same timeframe—issues to which the collaborators drew attention.

During study conversations, one collaborator spoke about multiple experiences where healthcare providers pressured her to make certain reproductive decisions or proceeded as if she had agreed to a procedure or treatment when she had not consented. For instance, when she was 20 weeks pregnant, a doctor repeatedly asked her if she wanted to have an abortion. She explained that she did not want to terminate her pregnancy. When the doctor continued to ask this question, she accessed support from an

Aboriginal Liaison Worker at the healthcare organization who advocated for her with the doctor. In her words, the Aboriginal Liaison Worker “finally got them off my back.” Then, when she gave birth to her son, her doctor asked her if she wanted a tubal ligation. When she responded that she did not want the procedure, the doctor stated, “Well, we are going to do it.” This collaborator and her sister both intervened and prevented the doctor from proceeding. Her story illustrates that both formal and informal liaisons and advocates can support Indigenous women to assert their rights within coercive encounters.

She soon had to negotiate another coercive encounter. Shortly after she had her child, her gynecologist gave her a prescription for Mirena after very little discussion. Mirena is an IUD, a long-term, reversible form of birth control that is inserted into the uterus to prevent pregnancy. She explained:

My gynecologist, he said, “Well because you are Aboriginal, because you are Native, you should be on birth control.” He had a nursing student with him, and the student looked at him and I was like, “Oh.” I just wanted to get out of there because my baby was with me.

She further described her interaction with the physician:

He didn't ask me anything, he just said, “So, I talked to your doctor and we decided that you are going to take Mirena.” I was like, “I am going to take Mirena?” And he said, “It is like an IUD, it is plastic.” He showed me it and he said, “Your doctor will show you more and you wear it for five years.” I am like, “Okay,” like he didn't ask me if I wanted to be on Depo-Provera or needles.

She shared that she did not fill the prescription for the IUD and did not engage in further dialogue with this doctor about the IUD. She articulated her reasons:

I just didn't want to sit there and be lectured because I knew he was going to say, “Well”...I mean he already said “You are Native, you are Native, so...” you know. I knew he was being racist, but I was just trying to pretend like he wasn't.

Her reflections about her experiences resonate with women's framing of reproductive coercion as racist and/or colonial practices in the media coverage discussed above. Her experience with multiple practitioners also suggests a pattern of healthcare providers subjecting Indigenous women to reproductive coercion, further illustrated by other collaborators' stories shared below. They also highlight one of the techniques Indigenous women use to assert their rights within constraining contexts: refusal.²⁶ She exercised her agency by refusing care that was informed by colonial stereotypes—that is, by not filling her

prescription—and by avoiding further dialogue with this doctor.

Similarly, another collaborator shared she feels a doctor tricked her into having a tubal ligation at 23, after the birth of her second child. Reflecting on her experiences with this doctor and other healthcare providers, she discussed how she would respond differently in a similar situation today:

Nowadays, if I was to go back in there and I was still able to have children I probably would like to know why they think I shouldn't have any kids. What is their reason? Because I know for a fact that if I am going to have a baby then I am going to want to make sure that I am going to love this child and I am going to make the best life that I could for them that I never had. But to come and tell me, "I want you to get your tubes tied, you shouldn't have any kids." Well, first of all, who are you to tell me why I shouldn't have kids? You know, it is my choice.

In this quote, she shares her vision of an alternative pathway where she claims her rights through challenging service providers' opinions and trusting her own capacity to raise her children. She also alludes to the difficulty of negotiating coercive interactions.

Collaborators' stories suggest that practitioners have violated both their rights as Canadian patients to receive free, full, and informed consent (Evans, 2006) and their rights as Indigenous peoples to free, prior, and informed consent (FPIC) (United Nations, 2008). In Canada, patient consent is based on three requirements (Evans, 2006): (1) the patient must have voluntarily agreed to the procedure or treatment, (2) the patient must have the capacity to consent to the procedure or treatment, and (3) the patient must have all of the necessary information, including the risks and benefits of the procedure and alternatives.

Collaborators' stories also suggest that healthcare providers' actions have violated their rights to FPIC as asserted in the UNDRIP. Canada endorsed UNDRIP in 2010 and announced its intention to fully implement the declaration at the United Nations Assembly in 2016 (Fontaine, 2016; Indigenous and Northern Affairs Canada, 2017, United Nations, 2008). UNDRIP recognizes Indigenous individual and community rights to self-determination and repeatedly asserts Indigenous peoples' collective rights to FPIC. While UNDRIP does not explicitly outline how FPIC should be interpreted within healthcare settings, Andrea Carmen, Executive Director of the International Indian Treaty Council, defined FPIC in the context of medical procedures as "the right to feel fully informed (while awake), to hear the pros and cons, the right to have a waiting period if you want it, and hear about other options," all without pressure or coercion (cited in Yee, 2011, p. 15).

Collaborators spoke about acts of coercion crossing contexts, including in community-based organizations, group homes, foster homes, and healthcare settings. For instance, one collaborator shared a social service provider told her she should be on Depo-Provera and threatened, "If you get pregnant, I'm going to take you to have an abortion." She talked to someone else at the organization about this person's actions, and this service provider was reprimanded. Similarly, various collaborators raised concerns about youth in group homes, foster homes, and other contexts being pressured to terminate pregnancies and/or being prescribed long-term contraceptives without being meaningfully involved in the decision-making process. For instance, one collaborator shared:

...we were talking about it and [a work colleague] had come across a girls' group home and Depo was kind of what the girls are all being injected with and I think it is big on reserves. It is being pushed big for teenagers, right? You don't want your kid to get pregnant, get your kid on Depo.

Similarly, another collaborator reflected on how she has witnessed people working in social services respond to youth in foster care who become pregnant or are planning to become pregnant:

It is normalized for people in social services you know to try to caution kids against having kids while they are in social services, instead of supporting that idea and maybe tailoring a plan towards healthy choices and carrying to term. Usually the first comment is about birth control or the first comment is, "Have you talked to your family doctor?" [Implying that the youth should discuss an abortion procedure with their family doctor].

As this quote highlights, service providers often start and focus their conversations with youth about reproductive decisions with youth on medical prevention and/or ending existing pregnancies. These collaborators' quotes illustrate how insidious these problematic practices related to birth control and long-term contraceptives can be. The first collaborator highlighted that service providers often supply youth with long-term contraceptives, such as Depo-Provera, without sharing the information necessary for free, full, and informed consent and FPIC. Similarly, the second collaborator described how many service providers begin and consistently return the conversation to a youth's birth control or abortion options while omitting adoption or parenting options, which influences what youth will consider, or even view, as options. Our analysis in the study highlights the range of problematic practices related to various reproductive technologies and procedures.

Indigenous women navigate these coercive contexts in various ways including sharing community knowledge and/or refusing and negotiating problematic interactions. Collaborators shared community knowledge about reproductive coercion and how they draw on this knowledge to support other women. For instance, one collaborator shared:

My friend said to me, “Oh, I am pregnant” and I am like, “Really, congratulations! I am really happy for you because I want more kids but I can’t have any kids and I wouldn’t mind having a daughter because I don’t have any daughters, I just have boys. Then she tells me, “Oh, this doctor wants me to have an abortion.” And I said “Why? Don’t listen to them,” I said. “It is not their choice,” I said. “It is your body, you know.” I told her, “How I see things, Creator gave me a life and I am going to carry through with it.” Then I said, “What happened? Why are they trying to make you have an abortion?” She says, “Oh, they are saying that there is something wrong with my baby like it is not growing, there is no heartbeat or something like that.” Then I told her, “Don’t listen to them, like they are probably just trying to say that to you because right now there is a struggle with the government and Aboriginal people, and they don’t want our people to be successful and strong and grow. They want to try and limit us so that they can control us and who we are. They look down at our people, because they want stuff that they can’t take from us and they want it for their own use” and I just told her “Just go through your pregnancy if you want this baby.” I said, “If it is going to be too much for you, just let me know and I will be there to help you.” Then I didn’t hear from her for a long time and then time had passed already like she had her baby and then she told me, “You know I am so happy that I listened to you.” I asked, “Why?” She said, “Because I have a beautiful daughter.”

This collaborator’s story explicitly connects this doctor’s advice to her friend to colonial fears about Canadian control and access to Indigenous lands. Her analysis of this healthcare interaction resonates with longstanding critiques leveraged by Indigenous peoples, allies, and accomplices against Canadian governments and systems: white-settler society and colonial governments are enacting genocide against Indigenous peoples. These genocidal practices include taking measures to limit the number of Indigenous children and undermine Indigenous peoples as a distinct group (Dyck & Lux, 2016; Stote, 2015; Woolford, 2015). Notably, in sharing her knowledge and offering support, this collaborator supported her friend to form her own decision, which led to the refusal of the biomedical advice that had been informed by colonial relations.

Various collaborators shared that they and other Indigenous women feel they cannot trust many healthcare

practitioners’ care and information. Some linked this distrust to acts of reproductive coercion (such as collaborators quoted above), while others spoke about other healthcare interactions that were informed by colonial stereotypes. One collaborator shared her cousin’s partner faced delays and barriers when trying to access care related to pregnancy complications and how her cousin and her cousin’s partner experienced this (lack of) care. She explained:

They had a miscarriage and there are so many question marks and so much hurt and anger in their mind about could that have been prevented? And why was that the response to our care? They really felt like they were put off because they were a young First Nations couple and this was going to be her fifth child, his first, but her fifth, and so they felt like they were like... we can’t do anything for you and they didn’t really feel supported or cared for.

Collaborators discussed ways they negotiate and refuse colonial influences on healthcare interactions, including reinterpreting the care provided through the context of colonial relations or refusing to engage with these providers (discussed above by collaborators). Similarly, another collaborator shared:

After the experience of the first miscarriage, I just was done with talking to people from the health community, because of the way I got treated. I’m First Nations, I’m Aboriginal, why would I need to be treated with disrespect? When you ask something like that, they’re gonna say “Oh, you’re sleeping around are you?” or something like that and make you feel like you’re a slut or something just because you want to find out about reproductive health in a way that’s healthy and it’s really frustrating, because I’m sorry, I’m 44 and I’m just now getting more real information and it took a Black doctor to help me sort through all of this. It just was a bit discouraging that it took this much to heal.

This collaborator’s quote makes visible what she believes lies behind multiple healthcare practitioners’ harmful treatment towards her, the distilling of her from a dynamic, complex person to a stereotype that frames Indigenous women as hypersexual and irresponsible (Dell & Kilty, 2012; Denison et al., 2014; Million, 2013; Simpson, 2017). In response to providers subjecting her to judgment and stereotyping, this collaborator avoided healthcare to protect herself from further harm. Then, she utilized another strategy that many collaborators discussed: engaging with supportive and responsive healthcare providers to negotiate the healthcare system to access useful information. Her difficulty accessing safe and respectful biomedical further demonstrates a pattern of healthcare

provision influenced by colonial stereotypes, a pattern resisted by this physician who supported her and other healthcare providers.

This analysis of study conversations highlights healthcare and social service providers' actions continue to be influenced by colonial narratives framing Indigenous women as hypersexual, irresponsible mothers and blaming them for their own victimization. While media coverage during this study's fieldwork and SHR's initial policy responses implied tubal ligations are the sole context where reproductive coercion takes place, our analysis highlights that Indigenous women are at risk of coercion across various contexts, technologies, and procedures. Healthcare and social service providers' acts of reproductive coercion coalesce with multiple other genocidal processes to undermine Indigenous peoples as a collective and their relationships to land. Indigenous women negotiate these coercive contexts in various ways including acts of refusal, reinterpretation, and negotiation as well as by sharing community knowledge and personal stories. To contextualize our analysis, we briefly summarize how media, public, and institutional conversations have evolved since the completion of this study's fieldwork.

Epilogue: Continuing Conversations about Coercive Sterilization

Since this study's fieldwork, there has been growing media and public discussion about forced and coerced sterilization of Indigenous women. This is particularly true of coercion at the RUH in Saskatoon and other healthcare institutions in cities across Canada, and of institutional responses from SHR. As discussed earlier, after the initial external review was canceled in 2016, and in response to public and media pressure, SHR reopened the external review in January of 2017 led by Boyer and Bartlett. In July 2017, they released their final report, which emphasized pervasive systemic racism within SHR and offered several calls to action to promote institutional change. Some of these calls to action are (1) restructuring of SHR and the Saskatchewan Ministry of Health so that Indigenous peoples are equal partners in health governance²⁷; (2) mandatory culturally appropriate training, human rights, and UNDRIP workshops; and (3) reparation for women who experienced forced and coerced sterilization. When the report was released, the Saskatchewan Health Authority (SHA) apologized to Indigenous women who felt coerced into a tubal ligation (*Toronto Star*, 2017). Since then, media has also reported that SHA is introducing cultural training of staff (*Martin*, 2019), and has implemented an Indigenous Birth Workers program (*Short*, 2019). It is imperative that the RUH and Saskatchewan Health Authority implement all calls to action and evaluate institutional culture change over time

to demonstrate further accountability to those who have been subjected to reproductive coercion.

As alluded to earlier, in October 2017, two Indigenous women launched a class-action lawsuit against the federal and provincial governments, Saskatchewan Health Regions, and three doctors "alleg[ing] their charter rights were breached and that they were subjected to institutional systemic racism" (*Adam*, 2017). As of June 2021, the firm representing women in this class-action lawsuit had been contacted by more than 100 Indigenous women about service providers subjecting them to coerced and forced sterilization. These 100 women are from six provinces and the Northwest Territories, including 64 from Saskatchewan and 12 from Manitoba (*Standing Senate Committee on Human Rights*, 2021). The National Inquiry on Missing and Murdered Indigenous Women and Girls explicitly addressed this proposed lawsuit and forced sterilization more broadly in their final report, referring to forced sterilization as "directed state violence against Indigenous women" (2019, p. 267). Yvonne Boyer, now a Canadian Senator called for the Canadian Senate to investigate the forced sterilization of Indigenous women in November of 2018 (*Kirkup*, 2018a), and the Senate Standing Committee on Human Rights released their initial report in June 2021, which (1) documented coerced and forced sterilization of Indigenous women continues and (2) recommended further study (*Standing Senate Committee on Human Rights*, 2021).

Burgeoning media and public conversations about these reproductive injustices have also drawn the attention, and concern, of the United Nations Committee Against Torture. A report released in December 7, 2018, recommended that the Canadian government

- (a) Ensure that all allegations of forced or coerced sterilization are impartially investigated, that the persons responsible are held accountable and adequate redress is provided to the victims;
- (b) Adopt legislative and policy measures to prevent and criminalize the forced or coerced involuntary sterilization of women, particularly by clearly defining the requirements of free, prior, and informed consent with regard to sterilization and by raising awareness among Indigenous women and medical personnel of that requirement (p. 12).

The Assembly of First Nations passed a resolution in early December 2018 "to support the class action claimants of forced sterilization in seeking redress and to advocate for changes to the *Criminal Code of Canada* to criminalize forced sterilization in Canada" (*Canada NewsWire*, 2018); however, as of this writing, these changes have not yet occurred. Instead, federal government representatives have stated that forced sterilization is

already criminalized through the existing Criminal Code provisions and asserted they are taking a “public-health approach to the issue” (Saskatoon StarPhoenix, 2018). While coercive sterilization and coercive abortion are technically already criminal acts, we support revising the *Criminal Code of Canada* so that forcing or coercing someone to (1) have a tubal ligation or abortion procedure and/or (2) to use contraceptives are directly and explicitly criminalized. While Indigenous women often experience revictimization when accessing the Euro-Western justice system (Balfour, 2008; Dylan, Regehr, & Alaggia, 2008; Hunt, 2014), these changes to the *Criminal Code of Canada* would open up another, albeit problematic, avenue through which women could hold perpetrators accountable.

Discussion and Implications

While we are cautiously optimistic about the potential for change in light of the institutional responses by SHR, the proposed class-action lawsuit, and growing national and international attention to this pressing issue, it is necessary to temper this optimism by recognizing that Canada’s colonial genocidal disposition involves controlling and denying Indigenous women’s reproductive futures. As part of the larger project of disrupting these genocidal relations, we recommend multiple interventions to bring further attention to reproductive coercion and to reduce the harms Indigenous women are subjected to within healthcare and social service systems: (a) expanding media and public conversations about reproductive coercion; (b) interrogating healthcare decision-makers’ and practitioners’ policies, practices, and individual biases for colonial narratives; and (c) expanding inclusive, responsive, wholistic, and culturally relevant supports.

This is one of the first studies in Canada that has gathered and shared Indigenous stories and community knowledge about reproductive coercion from service providers and strategies of resistance. Our findings indicate that Indigenous women have recently been subjected to coercive practices to limit their reproductive futures; this resonates with feminist and queer scholarship that demonstrates colonial heteropatriarchal narratives, policies, and practices have continually denied, regulated, and degraded Indigenous motherhood and reproduction as well as the caregiving roles of two-spirit and other gender- and sexually diverse people (Carter, 1997; Driskill et al., 2011; Evans-Campbell et al., 2007; Kelm, 1998, 2005; Lavell-Harvard & Lavall, 2006; Million, 2013; L. B.; Simpson, 2017).

Colonial forces continue to erase, manage, and regulate Indigenous reproduction as part of the colonial genocidal disposition: to undermine and eliminate Indigenous people—and therefore, Indigenous people’s governance systems—and claims to their lands (Stote, 2015; Thielen-

Wilson, 2014; Woolford, 2015; Woolford et al., 2014). Indigenous individuals’, families’, and communities’ self-determination cannot be fully achieved without deconstructing colonial genocidal relations and returning Indigenous lands to Indigenous peoples. As Tuck and Yang (2012) assert, decolonization will only be achieved through the repatriation of land to Indigenous people and the recognition that Indigenous and white-settler societies have different relationships with these lands. Simultaneously, it is critical that we also intervene in colonial genocidal relations to reduce the harms experienced by Indigenous women in the healthcare and social service systems.

Most Canadian and international literature addressing reproductive coercion focuses on coercive sterilization. Similarly, media and public conversations in Canada thus far remain focused on reproductive coercion related to tubal ligations, with limited discussion about coercive practices related to abortion procedures (for instance, see Kirkup, 2018a, 2018b). Our analysis illustrates the need to broaden media, public, and institutional discussions about reproductive coercion and the stereotypes that enable and justify these acts. The similarities among collaborators’ stories of reproductive coercion in study conversations, stories shared through media coverage about coercive sterilizations at RUH, and international literature about reproductive coercion (Abarbanell, 2020; Boesten, 2007; Brault et al., 2016; Cahn, 2004, 2017; Carpio, 2004; Chingore-Munazvo et al., 2017; Cuca & Rose, 2016; Durojaye, 2018; Erviti et al., 2010; Grekul et al., 2004; Guerra-Reyes et al., 2021; Kendall & Albert, 2015; Lowik, 2018; O’Sullivan, 2016; Stote, 2012, 2015) highlight the need to connect the local to the global, which can facilitate sharing and co-creating strategies of resistance.

Euro-Western biomedical care often problematizes Indigenous women’s lack of engagement with healthcare services (see, for instance, Wang et al., 2005) without meaningfully considering the problem of colonial healthcare relations (Varcoe et al., 2013). Our analysis indicates a pattern of healthcare and other service providers’ problematic practices, informed by colonial narratives of Indigenous women as hypersexual, irresponsible, and “unfit” to parent. Importantly, these women’s stories suggest healthcare and social service providers’ cultures of practice continue to normalize eugenic and colonial narratives, which undermine Indigenous women’s rights to free, full, and informed consent and FPIC within reproductive healthcare contexts and beyond. Collaborators’ quotes and stories highlight the integral role of refusal, reinterpretation, and the negotiation of care influenced by colonial narratives to determine healthy pathways for themselves and their families. We simultaneously hold up individual advocacy efforts and offer our recommendations to transform institutional cultures to foster Indigenous access to safe reproductive care.

With further knowledge about the ways colonial relations continue to shape Indigenous experiences of healthcare, healthcare decision-makers and service providers must take action to further shift their institutional cultures and build supportive and respectful relations with Indigenous women patients. In order to promote institutional cultures that foster safe, respectful, and antiracist care, it is vital for decision-makers and service providers to interrogate their policies, practices, and individual biases for colonial narratives, and to ensure the staff and leadership have the necessary training, resources, and meaningful partnerships with Indigenous-led organizations to do this work. This training should address:

- a) Racism, colonialism, and heterosexism within healthcare institutions and broader society (Allan & Smylie, 2015; Brown et al., 2011; Browne, 2007; Browne et al., 2011; Denison et al., 2014; Epstein, 2017; Varcoe et al., 2013);
- b) Trauma- and violence-informed care that explicitly addresses colonial violence (Browne et al., 2015; Browne et al., 2016; Poole, Urquhart, Jasiura, Smylie, & Schmidt, 2013),
- c) Care for pregnant and parenting people who use substances that is grounded in harm-reduction approaches (Benoit et al., 2014; Marshall et al., 2005; Wright et al., 2012);
- d) Processes by which care providers can recognize individual and institutional bias and foster safe care (Gerlach et al., 2014; Harding, 2013; Varcoe & Browne, 2015);
- e) Ensuring voluntary and informed consent (Boyer & Bartlett, 2017; Molina, 2001; Sherlock & Brownie, 2014; Zite & Wallace, 2011); and
- f) Indigenous peoples' rights to FPIC (Boyer & Bartlett, 2017; United Nations, 2008).

Simultaneously, institutions must ensure they have accessible and safe mechanisms for people to report experiences of coercion and receive reparations for these violations of their human rights. It is also necessary for institutions to develop mechanisms to hold individual providers accountable for violations of informed consent and FPIC. Further, study conversations illustrate the importance of expanding formal liaison and advocacy roles at healthcare institutions, and of training people in these roles about informed consent and reproductive justice. Expanding these roles to include funded doula and/or reproductive and maternal healthcare liaison roles and the provision of information, resources, support, and advocacy for people who are in the hospital for childbirth will further foster Indigenous women's meaningful reproductive decision-making. Simultaneously, decision-makers can use creative strategies to share resources

and decision-making power with Indigenous-led organizations and networks through which Indigenous women build self-determining pathways. Through these interventions, we can work toward futures where more Indigenous women can access reproductive care with safety and dignity.

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Notes

1. McKenzie's affiliation has changed from the University of British Columbia to the University of Saskatchewan since this study was completed. McKenzie led the study as part of her doctoral program. She also led this article's analysis and writing. Varcoe, Nason, and Kelm supervised McKenzie's doctoral study and contributed to the study's methodology, as well as this article's analysis and writing. McKenna is the Guiding Knowledge Keeper for this study and contributed to the study's methodological approach, as well as the article's analysis and writing. Lawford, Wajuntah, Gervais, Hoskins, Anaquod, J. Murdock, R. Murdock, Smith, Arkles, and Acoose contributed to this article's analysis and writing. Arisman contributed to this article's writing.

2. We follow the United Nations definition of Indigenous people as the original inhabitants of the land we are discussing (2008). Within Canada, Indigenous people include people who identify as First Nations, Métis and Inuit people (Canada, 1996), and many others (e.g., Indigenous people with First Nations ancestry who are accepted by their Indigenous community and do not have status under the *Indian Act* or membership at a Métis local).
3. Two-Spirit is an English translation of an Anishinaabeg term *niizh manitoag* (Jacobs et al., 1997). At the Third Annual Native American Gay and Lesbian Gathering in 1994, delegates made the decision to engage *two-spirit* as a pan-Indigenous term that includes a diversity of Indigenous LGBTQ+ (lesbian, gay, bi-sexual, trans*, queer, and other gender- and sexually diverse) identities, as well as culturally specific non-binary gender identities and expressions (Hunt, 2014).
4. The term trans* recognizes the multiple ways people embody and express transgenderism and gender variance (Halberstam, 2016).
5. The Métis emerged as a distinct cultural group during the 18th and 19th century in Western Canada. The Métis are rooted in development of mixed-ancestry communities. These communities included distinct Métis Red River settlements, which were the site of the 1869 Red River Resistance led by Louis Riel (Hogue, 2015), and colonial forces later renamed as Winnipeg.
6. The Canadian government and First Nations negotiated various treaties, including what are referred to as “numbered treaties,” including Treaty One, Treaty Four, and Treaty Six. While the Canadian government’s written record of these negotiations stated First Nations ceded their title to land in exchange for specific benefits, First Nations’ oral histories indicate (1) the Canadian government actors told First Nations they would have rights and benefits not included in these written documents and (2) First Nations interpreted these negotiations as agreements they would share land with settlers rather than a surrender of title to the land (Lux, 2001).
7. First Nations are historically distinct Indigenous societies that predate colonial forces arrival on, and renaming of, these Indigenous lands as Canada.
8. The Canadian government has introduced various strategies to displace and disconnect Indigenous peoples from their territories as part of their overall project to claim sovereignty on Indigenous lands (Thielen-Wilson, 2014). These strategies include, but are not limited to, displacing First Nations from their traditional territories and requiring them to live on small tracts of reserve lands (Daschuk, 2013; Kelm, 1998; Lux, 2001), residential school policies (Kelm, 1998; Truth and Reconciliation Commission of Canada, 2015), the Sixties Scoop, and the continuing apprehension of Indigenous children from their families and communities by a punitive child welfare system (McKenzie et al., 2016; Sinha, Trocmé, Fallon, & MacLaurin, 2013).
9. For instance, many Indigenous peoples in Winnipeg, Regina, and Saskatoon reported that non-Indigenous people perpetuate racist stereotypes that Indigenous people are prone to addictions, lazy, and live in poverty (Enviroics Institute, 2011a; 2011b; 2011c). Indigenous peoples use creative strategies to resist and navigate these conditions. For instance, as discussed in the main text of this article, a group of women in Winnipeg formed a volunteer-based safe ride program in response to taxi-cab drivers’ harassment and violence toward Indigenous women.
10. In this study, rather than relying on the colonial heteropatriarchal system of gender/sex that naturalizes the connection between feminine-female and women, we emphasized the openness of this category and worked to involve a diverse group of collaborators, including Two-Spirit and trans* people who also identified (in some way) with the category of women.
11. The roles of Guiding Knowledge Keepers or Guiding Elders depend on the people involved and the study context. The Guiding Knowledge Keeper’s role in this project included holding ceremonies at different stages of the research projects, sharing teachings with McKenzie and collaborators, instructing McKenzie about how to approach this work, as well as contributing to community and academic presentations and products.
12. The lead author uses the term accomplice to describe my role working solidarity with Indigenous peoples to break down the systems of white supremacy and settler colonialism that structure our current worlds and privilege me in various ways (Indigenous Action Media, 2014).
13. Colonial heteropatriarchy is a system of gender/sex and sexuality colonial forces imposed upon Indigenous communities. This system normalizes and naturalizes heterosexuality and patriarchy, framing egalitarian, matriarchal, and queer relations as abnormal and aberrant (Arvin et al., 2013). The system relies on a naturalized gender binary (male-masculine/female-feminine) and associates the male-masculine with a group of qualities (stable, rational, and strong) constructed as superior to the female-feminine and associated qualities (vulnerable, irrational, and weak) (Butler, 1990; Juschka, 2009). Gender identities and expressions outside this gender binary (e.g., Two-Spirit and genderqueer) are rendered invisible or demonized (Driskill et al., 2011). As Emberley (2001) argues, the imposition of this system of gender/sex/sexuality normalizes colonial relations of governance. Within Canada, colonial heteropatriarchy operates as a part of settler colonialism, which seeks to (a) eliminate Indigenous people as a distinct, collective group and (b) replace Indigenous people with a settler collective to (c) appropriate Indigenous lands (Wolfe, 2001).

14. Our use of the term “decolonial moments” is informed by L. B. Simpson’s (2011) exploration of *biskaabiiyang*, a Nishnaabemowin word that refers to the process of deconstructing colonialism within individuals and communities. Simpson discusses how *biskaabiiyang* involves the creation of spaces of new and just ways of relating, “even if those spaces only exist for fragments of time” (p. 52).
15. Kookum is a Cree and Sauteaux word that translates to grandmother in English.
16. We are informed by Tuck and Yang’s work (2012) which considers “the curricular-pedagogical project of critical consciousness as *settler harms reduction*, crucial in the resuscitation of practices and intellectual life outside of settler ontologies” (p. 21) and expand interventions to reduce the harm of settler colonialism to various institutions. As such, our knowledge mobilization efforts seek to reduce the harms of settler-colonial healthcare and social services.
17. Inward and outward knowing refers to developing knowledge both through looking inward (self-reflexivity, coming to know through ceremonies, and other methods) as well as looking outward (interviews, observation, and other methods) (Kovach, 2009).
18. Salmon (2007) highlights that opportunities for group analysis can democratize research and challenge the privatization of mothering; similarly, within this study group, collaborator meetings provided opportunities to democratize the research process and undermine the individualization of reproductive decision-making and reproductive coercion.
19. This archive is incomplete because video and audio recording cannot adequately capture a moment in time-space (for instance, even if recording the visual and audio aspects of an interview, we cannot see what is beyond the visual frame nor can we revisit the tone of the room). McKenzie’s memory did not serve to accurately bridge the gaps since, as Walker (2014) articulates, “the past is continually reimagined in its present invocations” (p. 47). At the same time that McKenzie recognized the limits of this archive and McKenzie’s knowledge, this limit is not a reason to abandon analysis, but rather we follow Lather’s (2007) lead in undertaking analysis and simultaneously troubling it.
20. Relational, relationality, and relationships are integral to Indigenous and feminist ontologies and epistemologies and this text. We draw primarily on critical feminists’ and Indigenous scholars’ work about relational and relational context (Absolon & Willett, 2005; Doane & Varcoe, 2015; McLeod & Sherwin, 2000; Sherwin & Stockdale, 2017; Wilson, 2008), to conceptualize the web of relations humans grow and live within to include kin, animals, communities, lands, and spirits, structured by political and social understandings. When describing Phase One and Two collaborators, we treat professional, community, and personal experiences as discrete even though this does not align with our conceptualization of relationality. During study recruitment, we utilized those terms to involve women with diverse experiential knowledge.
21. CBC and APTN websites do not facilitate searching for coverage within specific timeframes. Therefore, we did not replicate our search on these websites during the 28 months preceding this study’s fieldwork. In direct comparison, according to our search of the *Canadian Newsstream* database of the *Saskatoon Star-Phoenix*, *Regina Leader Post*, *Winnipeg Free Press*, and *CBC’s The National*, during the 28 months of this study’s fieldwork, there were seventeen items published related to coercive sterilization, while in the 28 months directly preceding this study’s fieldwork, there was one item published in these new sources related to coercive sterilization.
22. Social service provision may include various forms of formal services and informal supports including child welfare, housing, income assistance, group and individual counseling, meal programs, and life-skills programs.
23. There was no media coverage about coercive practices related to long-term contraceptives and abortion procedures in the *Saskatoon Star-Phoenix*, *Regina Leader Post*, *Winnipeg Free Press*, *CBC*, and *APTN* during the study’s fieldwork.
24. The full names for these international organizations are Office of the High Commissioner for Human rights (OHCHR), United Nations Entity for Gender Equality and the Empowerment of Women (UN Women), Joint United Nations Program on HIV and AIDS (UNAIDS), United Nations Development Programme (UNDP), United Nations Population Fund (UNFPA), United Nations Children’s Fund (UNICEF), and World Health Organization (WHO).
25. The Regina Qu’Appelle Health Region and Winnipeg Regional Health Authority also had similar policies (Regina Health District, 2001; Winnipeg Regional Health Authority, 2007).
26. While collaborators did not utilize the term *Indigenous refusal*, their stories and analytical insights resonate with this term as it has been articulated by Indigenous scholars (A. Simpson, 2014; L. B. Simpson, 2017), which L. B. Simpson has articulated as refusing colonial heteropatriarchy and generating alternative lifeways.
27. In 2017, Saskatchewan’s health governance was restructured from twelve health regions to one provincial health authority. Boyer and Bartlett (2017) recommended restructuring health governance so that Indigenous people are equal partners during this provincial transition.

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Colleen Varcoe, RN, PhD, is a Professor and Associate Director of Faculty Development in the University of British Columbia School of Nursing. Her work aims to decrease inequity and violence, including interpersonal and structural forms of violence such as racism and poverty. Colleen uses critical, decolonizing, antiracist, and intersectional approaches in her teaching, research, and service. Her completed research includes studies of risks and health effects of violence and how to promote health for women who experience violence, especially Indigenous women. She has studied how to promote equity-oriented health care (cultural safety, harm reduction, and trauma- and violence-informed care) at the organizational level and worked with various Indigenous communities, organizations, and issues, including in health care and criminal justice contexts.

Dory Nason, PhD, is an Associate Professor of Teaching at the University of British Columbia in First Nations and Indigenous Studies and Institute for Gender, Race, Sexuality and Social Justice. Dory is Anishinaabe and an enrolled member of the Leech Lake Band of the Minnesota Chippewa Tribe. Her areas of research include contemporary Indigenous Feminisms and related Native women's intellectual history and literature. Dory recently co-edited the volume *Tekahionwake: E. Pauline Johnson's Writings on Native America*. She is currently at work

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Betty McKenna is Ojibway from Shoal River and the Guiding Knowledge Keeper on this study. She generously shares with others the traditional teachings she learned from her grandmother and other Elders. She is the Elder in Residence with First Nations and Métis Education at the Regina Public SchoolBoard, as well as the Guiding Elder for RESOLVE (Research and Education to End Violence and Abuse) Saskatchewan and the Canadian Virtual Hospice. She also is an instructor at First Nations University of Canada, an author on various articles and books, and advises many research projects.

Karen Lawford, PhD, RM, AM, is an Assistant Professor in the Department of Gender Studies. She is an Aboriginal midwife (Namegosibiing, Lac Seul First Nation, Treaty 3) and a Registered midwife (Ontario). Her research focuses on comprehensive, gender-inclusive sexual and reproductive healthcare for Indigenous Peoples with a particular focus on the provision of maternity care for those who live on reserve. Karen seeks to identify the barriers to achieving equitable health services for Indigenous Peoples. She is an author and co-author on various articles. She was the 2020 Indspire Laureate in Health for her research and policy work on mandatory evacuation for birth and in 2021 she was elected to the Royal Society of Canada.

Mary-Ellen Kelm, PhD, is a Professor and Associate Dean of Research and International in the Faculty of Arts and Social Sciences at Simon Fraser University. Her work focuses on the history of health research in Indigenous communities. She is the author and editor of five books, the latest with co-editor Keith Smith entitled *Talking Back to the Indian Act: Critical Readings in Settler Colonial Histories*. Away from Simon Fraser University, Mary-Ellen plays the canine sport of agility with her dog Dixie (a miniature poodle).

Cassandra Opikokew Wajuntah, PhD(c), is an Assistant Professor at the First Nations University of Canada in Indigenous Health who explores policy theory, Indigenous health policy and Indigenous governance with a focus on policy model development. She is also a PhD candidate in the Johnson Shoyama Graduate School of Public Policy. Cassandra is from Canoe Lake Cree First Nation and lives near Fort Qu'Appelle, SK with her husband, a menagerie of animals and four children.

Laverne Gervais, MA, is an Anishinaabe (Dakota/French colonial settler) woman and grew up in Winnipeg and Montreal. Laverne completed a Master of Arts in First Nations Studies at the University of Northern British Columbia. Laverne now lives and works in Winnipeg. She

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Jannica Hoskins is a Métis two-spirit woman who grew up in Vancouver and has Indigenous and newcomer roots. Jannica moved to Saskatoon a few years ago and lives here with her young daughter. She is a single mother, an independent filmmaker, educator and a former foster mother. She sits on various non-profit Boards of Directors. In 2021, Jannica became a Manager with First Nations and Métis Relations with the Saskatchewan Health Authority.

Jaqueline Anaquod, BHS, is a Nêhiyaw and Saulteaux woman. Jaqueline is pursuing her Master of Arts in the Social Dimensions of Health Program and an Indigenous Nationhood certificate in the Indigenous Governance Program at the University of Victoria and lives and works on Muscowpetung Saulteaux Nation. Jaqueline has also worked at non-profit and grassroots organizations with Indigenous women and families.

Jasmond Murdock is a Cree woman. Jasmond is a member of Fisher River Cree Nation and lives in Winnipeg with her son. She is a single mother. She studied Urban and Inner City Studies at the University of Winnipeg and attained her Business Administrative Assistant Certificate from the Manitoba Institute of Trades and Technology in 2019. She has worked in employment and training, Indigenous child welfare, and she now works at *Ka Ni Kanichihk* with the *Kisewatisiwin* Youth Hub.

Rebecca Murdock is a Cree woman. Rebecca is a member of Fisher River Cree Nation and lives in Winnipeg. She has been involved various Indigenous women's groups.

Katryna Smith, BA(Hons), is a Cree/Dakota/Saaimi/Metis First Nations Woman who is from Onion Lake Cree Nation. Her spirit name is *kihew iskewew* (Eagle Woman). She engages Nêhiyaw cultural teachings and practices in various ways in her life. Katryna has a Bachelor of Arts (Honours) in Indigenous Studies and a Diploma in Theology, along with a Bachelor of Arts in Women's and Gender Studies. She is the author of a book of poetry *What the Heart Wants (Freedom Book 1)*. She has worked as a Continuing Care Aid, a research assistant and in various roles with youth.

Jillian Arkles, MA, is a white-settler who grew up in Treaty Four territory and completed a Master of Arts degree at the University of Toronto in Women's and Gender Studies. Jillian is the former Executive Director of Saskatoon Sexual Health and currently lives in Vancouver where she is the Operations Director for Public Health Response with the BC Centre for Disease Control.

Sharon Acoose, PhD, is a Saulteaux woman and a member of Sakimay First Nation. Sharon lives in Saskatoon with her grandchildren and she is a Professor of Indigenous Social Work at First Nations University of Canada. Sharon engages Nêhiyaw and Saulteaux cultural practices within her teaching and research. She has worked with women and girls involved in sex work and

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Kayla Arisman, BA(Hons), is a MA student in the Department of Sociology at the University of Saskatchewan. Her research interests focus on rural social issues, intimate partner violence, addictions, and the human-animal bond.