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Barriers to Women's Access to Voluntary Sterilization in Canada

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Abstract

Introduction: In Canada, any adult who is aware of the permanent consequences of a tubal ligation is allowed to receive it, yet many doctors refuse to perform the procedure on women, especially those from marginalized communities. The purpose of this report is to investigate and identify some of the barriers that impede Canadian women's ability to access voluntary sterilization. There is a particular focus on how Canada's history of eugenics and coerced sterilization shapes the current conditions under which women seek and are too often refused access to permanent contraception.
Methods: Six qualitative, semi-structured interviews were conducted with scholars and activists in the field of Reproductive Justice (RJ) and reproductive healthcare. The interviews facilitated discussions about reproductive autonomy, patient rights, and patriarchal attitudes in medicine. An RJ framework and thematic analysis were used to uncover systemic barriers from the interview responses.
Results: As discovered through the interviews, the most prevalent barriers to access to voluntary sterilization in contemporary Canada include race, class, language, ethnicity, disability, age and parity. An RJ framework identifies historical parallels to these present-day barriers by looking at the historical and colonial forces that disempower intersectional marginalized communities and influence their reproductive decisions today.
Discussions: Canada's eugenics attitudes from the past seep into the current barriers to access faced by women of colour, low-income women, female newcomers, women with disabilities, and young or nulliparous women. The assumption that these women are not capable of deciding the right course of action for their own bodies and thus should not be trusted by healthcare providers in making these decisions is a consistent problem in both time frames.
Conclusion: The restrictions and modes of disempowerment placed on variously positioned women in the past come back in a new form that leads to those same groups being doubted and denied reproductive justice in the present. Many of the interviewees believed that increasing diversity in the medical field is necessary to help alleviate the discrepancies in how contraceptive healthcare is given.

Keywords: tubal ligation; reproductive justice; sexual sterilization; eugenics era; barriers; Canada

Introduction

Reproductive health services are an important component of our healthcare. This is especially the case for people with uteruses as they may have distinct healthcare concerns related to controlling their reproduction [1]. People with uteruses who would like to become infertile can achieve this through surgical sterilization procedures such as tubal ligations, salpingectomies, or hysterectomies [1–3]. Although it is possible to attempt a tubal ligation reversal, it is still unlikely that the patient could have a successful pregnancy afterwards [4,5]. Nonetheless, many women seek surgical sterilizations regardless of their parity or marital status [6–8]. Their reasons for seeking sterilization can include a risk of adverse pregnancy outcomes; an objection to long-acting reversible contraception (LARC), or a desire to have no children or no additional children [7,9–13].

In Canada, any adult who is aware of the permanent consequences of this type of service is allowed to receive it [6]. Yet, many doctors refuse to perform the procedure on women, particularly those who are young and nulliparous [6,14], often due to the physicians' fear that the patient will regret the procedure and may want children later on [7,13,15,16]. For those individuals who are in relationships, doctors may warn that if a current relationship ends, the patient may desire to start a family with a subsequent partner [17–20]. In each of these examples, doctors undermine women's ability to make decisions about their own bodies, thereby raising serious questions about self-advocacy, patient rights, and bodily autonomy [6,7,13].

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Methods

The purpose of this study was to investigate some of the barriers that stand in the way of Canadian women who desire access to voluntary sterilization. The Principal Investigator (PI) chose against interviewing women who were denied tubal ligations from their service provider due to the risk of resurfacing any trauma associated with having one's reproductive choices rejected. Instead, the barriers to access could be explored through discussions with activists who have experience in providing support for these women and with scholars who are knowledgeable about the evolution of reproductive healthcare in Canada. Online searches were conducted to find organizations based in Canada that provide reproductive or contraceptive services, reproductive counseling, and sexual health education to community members. The inclusion criteria for potential participants were 1) employees at said organizations who have a management or leadership position (ex., Executive Director, Special Projects Coordinator) or a patient- or client-facing position (ex., Pregnancy Options Counsellor); and 2) employees whose contact information was publicly available on the organization's website. Candidates who fit these criteria were directly contacted by the PI over email and asked to participate in a virtual semi-structured interview for the study. The interviews consisted of ten open-ended discussion questions about the barriers to access for voluntary sterilization, how those barriers differ for variously positioned women, and how the contemporary discussion is impacted by Canada's eugenics history. Examples of the questions include:

1. What are some of the specific challenges for women who are marginalized when they seek access to fertility control?
2. How does Canada's history (and current practice) of coerced sterilization affect your understanding/approach to access to voluntary sterilization?
3. What are some factors that determine access or lack of access to sterilization for differently embodied folks?

The interviews were conducted virtually over Zoom due to the COVID-19 pandemic. With the participants' consent, audio-only recordings of the discussions were created and stored remotely on the PIs computer. These recordings were uploaded to a dictation software (Otter.ai) to be transcribed. The audio recordings and transcriptions underwent thematic analysis using a Reproductive Justice (RJ) framework to evaluate the barriers to access. At the heart of the framework is the protection of three interconnected rights: the right to have children under one's chosen conditions, the right to not have children by using contraceptive services, and the right to raise children in a healthy and safe environment without coercion [21]. RJ was the chosen theoretical framework to underpin the study because it highlights the historical, economic, and social context for the social injustices that prevent marginalized groups from seeking or accessing necessary reproductive healthcare. A proper conversation about voluntary sterilization in Canada cannot take place without considering the historical impacts of coerced sterilization at the hands of health care providers empowered by state priorities. The RJ framework is helpful for drawing connections between the ideologies of the eugenics era and the barriers faced by women currently.

Results

A total of six semi-structured interviews were conducted. Twenty activists were identified across four reproductive health organizations in Canada (three Ontario-based and one Saskatchewan-based) and invited for an interview via email. Six responded and provided informed consent to participate. The interviewees will be referred to by their number (ex., Participant 1-6) to maintain anonymity. The interviewees identified several barriers, including race, socio-economic status or class, language, ethnicity, disability, age, and parity. Due to the intersectional nature of a lot of these barriers, many of them have been grouped together in the following discussions. Using the aforementioned barriers and the historical analysis, the author argues that the restrictions and modes of disempowerment placed on variously positioned women in the past come back in a new form that leads to those same groups being doubted and denied reproductive justice in the present.

Discussion

Historical Context

The intersection of social, economic, scientific, and colonial beliefs in the early 20th century provided the perfect environment from which the eugenics era flourished. At its heart was the persistent fear of a "race suicide" for the middle or upper class, Anglo-Saxon Canadian [22]. The early 1900s marked the rise of eugenic sciences grounded in Social Darwinism and pioneered by Francis Galton in 1883 [23]. Galton believed that ideal traits such as intelligence, high income, and good health inherently belonged to the middle and upper classes. Furthermore, he believed that these traits were hereditary and were indicative of this population being further along the path of evolution [24]. Subsequently, Galton and his followers believed that the social vices and undesirable qualities of society were traits that originated from the lower classes and other marginalized groups, and were also hereditary. In Galton's eyes, it was necessary for the evolution of humanity that the upper classes reproduced at a faster rate than the lower classes [22]. Eugenicists proposed a solution that would accelerate this process - if the reproductive capacity of the lower-class population was reduced, undesirable traits would not be transmitted to the next generation and those phenotypic traits would disappear from the human population [22,23,25].

Eugenics programs emerged from this set of beliefs and thrived in the social and economic environment of the early 20th century. The most significant legal framework for enacting eugenics in Canada was the Alberta Sexual Sterilization Act in 1928. Between 1928 and the law's repeal in 1972, 4725 individuals were referred to the Eugenics Board, and 2822 were sterilized [22]. The program in Alberta was justified on the grounds of fiscal conservatism and reducing the burden of "feeble-minded" citizens on the government and society. On the one hand, the government sought to reduce its expenditure on maintaining institutions for the physically and intellectually disabled. On the other hand, politicians and public health leaders posited that they were ultimately benefiting the population by preventing the reproduction of children born to "unfit" parents who would share the same mental deficiencies [22]. The decision to sterilize a person was rooted in that individual's supposed limited intelligence, which was measured using standard Intelligence Quotient (IQ) tests. Soon after the creation of the program, the requirement for informed consent was stripped away if the patient was deemed "mentally defective" [24]. For the cases where consent was still required, many patients or their guardians were pressured into giving consent in order to receive social benefits or healthcare for themselves or their families [22].

Race and Class

The barriers of race and economic class are grouped together because of the great overlap of these positions with the other barriers that will be mentioned. People of colour are disproportionately impacted by poverty, Indigenous peoples even more so [24,26]. As noted, the eugenics policies of the early 20th century meant that people who were poor and non-white were discouraged from reproducing and were sometimes subject to attacks to their reproductive capacity through forced sterilization. The use of the IQ test to measure intelligence has largely worked against racial minorities, poor people, and Indigenous peoples by falsely categorizing them as "mentally deficient" [24]. These campaigns were largely fueled by a combination of Social Darwinism, racism, colonial beliefs, and financial conservatism. So, the beliefs that these groups were of lower intelligence, more primitive, and unfit to parent were used as justifications for the eugenics policies.

In the interviews, the activists noted that poor women and non-white women today can still be seen as unfit parents who should not have children that "they cannot afford" (Participant 1). In fact, Indigenous women are still experiencing coerced sterilization [27]. Younger Indigenous women are also being recommended contraceptive pills despite there being no indication of sexual activity. Participant 2, an Indigenous scholar, revealed that parents in her community often have to teach their children about the importance of self-advocacy and prepare them for the inevitable attempts at coerced infertility by doctors. She likens this to the experience Black parents often face when they warn their children about police brutality:

> "it's kind of like how [Black] fathers talk to their sons, Black sons, on how to behave around police. In reality, [this] is how moms talk to their daughters about doctors and what they're going to try to do to them and how they have to defend their body." (Participant 2)

Yet despite this pressure to reduce the fertility of poor women of colour, there are systemic barriers that greatly limit their access to voluntary sterilization. This can include the inability to access health insurance, lack of money to fund the procedure, lack of community support, or lack of transportation to the service providers (Participant 1). Some of the interviewees also believed that service providers were less likely to take women of colour and poor women seriously when they stated their desire to be sterilized. So, both the pressure to reduce fertility and the pressure to not have access to reproductive care stem from the assumption that marginalized women do not have the ability (or right) to control their bodies in ways that they see fit.

Language and Ethnicity

Language and ethnicity played a two-pronged role in determining who is coerced into having their fertility controlled and who is denied access to voluntary services. In the historical case, there were numerous assumptions made by the healthcare provider about clients who were the cultural "other", such as being more likely to have more children than English-speaking, Canadian-born citizens and being more likely to be on welfare [22]. This led to doctors being more inclined to refer them to the eugenics board as a way to "cure" their unbridled fertility and reduce the population of non-English ethnic groups. When evaluated by doctors or scientists, the language barrier would lead to false assumptions about their intelligence and ability to parent [24]. Language barriers also allowed doctors to withhold information about the permanent consequences of sterilization, or overemphasize its "possible benefits", in an attempt to persuade the patient or their translator into consenting to the procedure [22]. In the contemporary situation, language and ethnicity are additional barriers to access, especially for non-English speaking newcomers who want access to sterilization. Whereas the assumption that families were "too large" was used in the past to limit women's reproductive capacity, in the contemporary context doctors are more reluctant to sterilize certain cultural or ethnic groups because they assume that the patient has an inherent desire for a bigger family and is more likely to regret their decision (Participant 3). Language differences lead to additional barriers because of communication issues with the service provider. Assuming that the doctor makes the effort to communicate with the patient, it is still difficult for the patient to comfortably advocate for themselves. In the circumstance that an interpreter is needed, there are extra concerns about whether the patient can speak or inquire freely and comfortably with that translator in the room, especially if that role is taken up by a family member:

> "We see a lot of new Canadians and if they're not fluent in English, then they might have a difficult time self-advocating…Especially if it's not a translator, but it's a family member who's doing the translation for them, that might affect what they feel comfortable talking about the questions they feel comfortable asking." (Participant 1)

Disability

The de-sexualization and undermining of people with disabilities was another barrier that translates from the past to the present. There is a historical (and present) treatment of disabled folks, especially disabled women, as 'eternal children' [28,29]. At the time, policy-makers and healthcare practitioners believed that stripping these groups of their fertility was beneficial for them because it relieved them of the risks and responsibilities associated with their reproductive capacity [22]. Contrast this with the contemporary case of disabled people being denied sterilization, and there appears to be the same rationale with the opposite objective. Women with disabilities who are seeking voluntary sterilization, or other forms of reproductive contraception, are not offered it due to the assumption that they are not sexual beings [29].

> "In many cases, they were discouraged from having sterilization operations because there was a sense that the hospitals could be sued for performing these surgeries on women with disabilities. Even though they said 'yes, I'm a sexually active person, and I would like to have sex. I don't want to have a pregnancy'… It was almost like denying sexuality, or a sexually active lifestyle for women who fit into particular categories" (Participant 4)

As explained by a number of reproductive justice scholars [7,21,30], the ability to take risks for oneself and make mistakes runs counter to the fundamentally paternalistic ideals of medicine, especially when it concerns the care of disabled people.

Age and Parity

Institutionalized young women were also not seen as capable of handling their own reproductive capacity or being fit for potential motherhood [22]. This premature judgment on parenting capabilities resulted in these women and girls being stripped of their bodily and reproductive autonomy through coerced sterilization, although it was disguised as beneficial to the patient [22]. Young women who were seen as sexually promiscuous or had already experienced pregnancies in the past were also subject to the same harsh judgement, especially young Indigenous women [22,24].

In contrast, the contemporary parallel is characterized by the denial of services and premature assumptions in favour of the woman's parenting capabilities. To start, some of the interviewees have encountered clients who have been rejected for voluntary sterilization due to their age and parity:

> "We've had clients in the past who were under 30, and [who are] coming in and needing support because they couldn't find anyone who would provide sterilization for them. And absolutely the line from health care providers regularly is 'but you're young.' Particularly if they weren't partnered, [physicians] say 'maybe your future husband is going to want kids'." (Participant 3)

The age at which a woman chooses to control her fertility or reproduce is heavily scrutinized by medical professionals and the general public. Women can be deemed too young or too old to have children, with each situation being criticized based on arguments grounded in morality. Women who fall between the extremes of too young and too old face scrutiny if they choose not to have children (Participant 6). Some of the most common arguments according to the interviewees are the fear that the woman is too young to permanently end her fertility track and will want children later; or that her future partner or spouse may want children and cause relationship problems. So, while a woman is seen as old enough to make the life-changing decision of having a child, she is still too young to make the permanent choice of ending her reproductive capacity. While a doctor is reluctant to believe the woman's desire to not have children, they are also trusting their potential ability to parent.

Call to Action

There are changes that need to be made to the medical field to make it more accessible to people with uteruses from all backgrounds. First, there needs to be increased diversity in the field so that patients can interact with doctors who have similar lived experiences as them:

> "It's a power piece as far as having our needs and concerns and voices heard…unless you get someone who has a similar lived experience to you or understands medicine in just a very special intimate way that I think a lot of doctors don't get because of how our medical system is set up." (Participant 5)

Second, there are long-overdue changes that need to be implemented to medical school curricula that inform students on the colonial history and harmful uses of medicine, and how biases impede patient rights and autonomy:

> "Universities are failing to train health professionals about any kind of history, let alone indigenous [history] or culture… know that you can't work with the public unless you understand the public you're working with, including First

> Nations as a priority because of the history." (Participant 2)

Finally, the testimony and reproductive desires of women, especially intersectional marginalized women, need to be respected and assessed with the same degree of trust as any other form of healthcare:

> "When you [as a marginalized person] go see a health care provider, they are much more primed to not believe that you are able to make decisions about your body and know what you want because they look at the other factors in that person's life and say that it's too turbulent for them." (Participant 3)

Conclusions

It is apparent disparities exist in the accessibility of reproductive health services for variously positioned women in Canada. The use of a RJ lens allows for a more meaningful investigation on how those barriers impact specific groups of women by looking at the historical and colonial forces that disempower intersectional marginalized communities and influence their reproductive decisions today. Canada's colonial and Social Darwinist attitudes from the past seep into the current barriers to access faced by racialized or poor women, non-English speaking women and female newcomers, women with disabilities, and young or nulliparous women. The assumption that these women are not capable of deciding the right course of action for their own bodies and thus should not be trusted by healthcare providers in making these decisions is a consistent problem underpinning both contexts. Through an RJ lens, these views prevail in parts of the medical community, which is rooted in systems of patriarchy, colonialism, classism and racism. When discussing possible changes that need to be made to the field in order to reduce barriers to access for voluntary sterilization, many of the interviewees believed that increasing diversity was a great first step. Lived experiences allow for better physician-patient relationships because the healthcare provider is able to understand, and subsequently believe the patient's testimonies.

List of Abbreviations Used

LARC: long-acting reversible contraception
PI: principal investigator
RJ: reproductive justice

Conflicts of Interest

The author declares that they have no conflict of interests.

Ethics Approval and/or Participant Consent

This study was approved by the McMaster Research Ethics Board (reference number 5193). All subjects participated voluntarily. Upon initial contact, candidates were given an information letter that detailed the purpose of the study and all potential risks and benefits associated with participating. Participants who agreed to an interview received a copy of the interview questions prior to the scheduled meeting. Participants provided written and verbal consent before the interviews and were informed of their right to withdraw from the study at any point without consequence.

Authors' Contributions

AA: made substantial contributions to the design of the study, the collection of data as well as interpretation and analysis of the data, revised the manuscript critically, and gave final approval of the version to be published.

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