ERIKA DYCK AND MAUREEN LUX

Population Control in the "Global North"?: Canada's Response to Indigenous Reproductive Rights and Neo-Eugenics

Abstract: *An historical analysis of reproductive politics in the Canadian North during the 1970s necessitates a careful reading of the local circumstances regarding feminism, sovereignty, language, colonialism, and access to health services, which differed regionally and culturally. These features were conditioned, however, by international discussions on family planning that fixated on the twinned concepts of unchecked population growth and poverty. Language from these debates crept into discussions about reproduction and birth control in northern Canada, producing the state's logic that, despite low population density, the endemic poverty in the North necessitated aggressive family planning measures.*

Keywords: Indigenous peoples, sterilization, population control, health care, housing, state policy, Northern region

Résumé : *Pour faire une analyse historique de la politique en matière de reproduction dans le Nord du Canada au cours des années 1970, il faut examiner soigneusement le contexte local en ce qui concerne le féminisme, la souveraineté, la langue, le colonialisme et l'accès aux services de santé, car celui-ci variait selon la région et la culture. Ces facteurs ont cependant été influencés par les débats internationaux sur la planification familiale, débats qui se focalisaient sur les notions jumelles de croissance démographique incontrôlée et de pauvreté. Les termes utilisés dans ces débats se sont glissés dans les discussions entourant la reproduction et la limitation des naissances dans le Nord du Canada, ce qui a mené l'État à penser que malgré la faible densité de population, la pauvreté endémique dans le Nord exigeait des mesures de planification familiale énergiques.*

Mots clés : peuples autochtones, stérilisation, régulation démographique, soins de santé, logement, politique de l'État, région nordique

On 1 April 1973, the Canadian Broadcasting Corporation's (CBC) national television Sunday news program *The Weekend* led with a sensational story of the involuntary sterilization of Indigenous women. Reporter Charlotte Gobeil interviewed women from two Mackenzie Valley communities who said they were sterilized without their knowledge or

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consent at the federal government's Charles Camsell Hospital in Edmonton. The reporter also heard from a missionary and community activists who implied that the sterilizations were part of a government effort to limit the growth of northern Indigenous populations. Not surprisingly, the CBC program prompted questions in the House of Commons, which triggered a frantic bureaucratic effort to refute the charges. Less than a week later, Minister of Health Marc Lalonde sent a sharply worded denial to CBC president Laurent Picard that was simultaneously released to the press. The minister charged that the public broadcaster had its facts wrong, that the women had indeed signed consent forms, and that the CBC had exploited the "Indian people" for the sake of sensationalism. Lalonde vehemently denied the program's suggestion that the government was "pursuing a deliberate program to sterilize native women in Canada."[1]

It was not the first time that controversy surrounded the federal government's role in supplying contraceptive services for Indigenous people, and it would not be the last. But this particular episode exposed the controversial politics of reproduction in the post-1969 era. While amendments to the Criminal Code in 1969 had liberalized Canadians' access to birth control and abortion, and assured Canadians that the state had no business in their bedrooms, bureaucratic surveillance of, in particular, Indigenous women's reproduction increased.[2] At the same time, in the wake of the government's disastrous 1969 White Paper, "Statement of the Government of Canada on Indian Policy," which proposed the termination of its treaty and customary commitments, resurgent Indigenous political organizations increasingly viewed the state as being intent on what Harold Cardinal termed "cultural genocide."[3] This article examines the shifting meanings of contraceptive technologies for women as they sought reproductive autonomy, while acknowledging that the terms and conditions upon which Indigenous women accessed these technologies were rarely of their own making and that the issue of reproductive rights was complicated by long-standing tensions involving race, gender, and place.[4] We argue that

1 "News Release," M. Lalonde to L. Picard, 6 April 1973, Records of the Department of National Health and Welfare (DNHW Records) RG 29, vol. 2870, file 851–1–5, pt 3a, Library and Archives Canada (LAC).

2 *Criminal Code*, RSC 1985, c. C-46.

3 Harold Cardinal, *The Unjust Society: The Tragedy of Canada's Indians* (Edmonton: MG Hurtig, 1969), 1.

4 In Christabelle Sethna et al., "Choice, Interrupted: Travel and Inequality of Access to Abortion Services since the 1960s," *Labour* 71 (2013): 31, the authors argue that the notion of reproductive choice with its focus on access to abortion is less useful when one considers the eugenic policies aimed at Indigenous, minority, and disabled women. More appropriate is the term "reproductive justice" or access to the range of choices that include not only abortion but also the choice to become pregnant and raise children in healthy circumstances.

despite the federal government's claim to remove the state from the bedrooms of Canadians, for Indigenous women, the state became more invested in their reproductive bodies than ever before, as Indian Health Services began paying much closer attention to reproductive activities in the North along with the implications for extending expensive reproductive health services into this region.[5] Women responded, unsurprisingly, in diverse ways, sometimes embracing the new reproductive health services, which included contraceptives, and other times rejecting these new technologies that some viewed as a further attempt to control Indigenous populations.

Our study offers a close examination of the federal government's response to the shifting cultural ideas about reproductive health services at a historic moment, when feminists and sovereigntists activated the political discourse with the language of fertility and population control, albeit with very different motivations. These debates in the 1970s centred around the decriminalization of contraception and abortion, ushering in technologies that promised women's autonomy over their reproductive bodies. However, those same services also clashed with the language of sovereignty and population control, whether among Quebec nationalists or Red Power activists, who more readily articulated resistance toward contraception as a form of population control.

Population control in the 1970s emerged as critical global issue, requiring careful management by states and moral guidance by religious and political leaders on the world stage. The United Nations convened its first World Population Conference in Bucharest, Romania, in 1974, where 136 nations represented by 1400 delegates renewed Malthusian concerns about a rapidly increasing population with an uneven distribution of resources. India declared a state of emergency in 1975 and introduced a mass sterilization program to dramatically reduce the national birth rate. China responded a few years later with an aggressive policy to limit its population growth by introducing the "one child policy" in 1980. Taking a political stance on the need to invoke permanent, irreversible, and cheap population control measures, these policies also endorsed the idea that poverty and lowered intelligence went hand in hand. Poor people could not be trusted to take care of their

5 The federal government's position is most clearly articulated in the records of the Indian Health Service (IHS), Department of Health and Welfare, with an increased focus and surveys of reproductive health activities in this decade. Moreover, until 1988, the federal government was directly responsible for the health care of all Northwest Territories (NWT) residents, including Indigenous people. The federal minister of health was in fact the health minister for the NWT.

reproductive bodies, and their unchecked and allegedly rampant fecundity threatened to destabilize the global economy. Eugenic philosophies of the nineteenth and early twentieth century found new currency in the 1970s as they re-emerged cloaked in the language of reproductive choice.[6]

The political motivations that divided the politics of reproduction along the axis of rich and poor, developed and under-developed, or North and South, continued to represent fundamental conflicts over issues of autonomy, sovereignty, resources, and health. Mainstream Western feminists celebrated the decriminalization of contraception and abortion as a progressive step toward individual autonomy and a significant improvement in one's capacity to engage in family planning. Governments, however, struggled to balance the macro concerns of population control with growing demands for reproductive health services within an increasingly expensive welfare state. The clash of global and local concerns about family planning produced significant tensions over how to respond to competing demands from local communities who sought individual autonomy and public health services.

Canada's North became a proving ground for testing competing interpretations of population control. Some Canadian scholars have claimed that eugenics programs across the country disproportionately targeted First Nations and Métis people and stretched those programs northward in the 1970s in a less formalized program of neo-eugenics. For example, Yvonne Boyer reports that these people were considered part of the "wrong" social group.[7] She further suggests that residential schools might have been involved in sterilizing First Nations students in western and northern Canada. Similarly, Paul Primeau argues that there was a statistical bias toward sterilizing Indigenous people in the Alberta eugenics program. He combines this programmatic evidence with other historically sensitive studies of childbirth, hospitalization, and colonialism, to illustrate how concepts of race comingled with presumptions about intelligence and mental hygiene, which systematically brought Indigenous people under state surveillance.[8] More

6 For more literature on this cultural shift, see especially Erika Dyck, *Facing Eugenics: Reproduction, Sterilization and the Politics of Choice* (Toronto: University of Toronto Press, 2013); Rebecca Kluchin, *Fit to Be Tied: Sterilization and Reproductive Rights in America, 1950–1980* (New Brunswick, NJ: Rutgers University Press, 2009).

7 Yvonne Boyer, "First Nations, Métis and Inuit Health and the Law: A Framework for the Future" (LLD thesis, Faculty of Law, University of Ottawa, 2011), 184.

8 Paul Primeau, "A Social History of the Eugenic Movement: The Enactment of the Sexual Sterilization Act S.A. 1928 and Its Effect on Indian and Metis People" (MA thesis, Lakehead University, 1998).

recently, Karen Stote has argued that Indigenous women "were the most prominent victims of the [eugenics] board's attention," and she suggests that "[t]hose in Canada most likely to fit this categorization [of feeble-mindedness] and on whom Alberta's legislation was disproportionately applied were Aboriginal peoples; more specifically young Aboriginal women."[9] She examines the federal government's Indian Health Services records to suggest that the Canadian government engaged in coercive sterilizations amounting to a genocide in the late 1960s and 1970s in the Northwest Territories (NWT).[10]

This literature identifies Indigenous women as victims within an extended practice of eugenics or population control that targeted women on the basis of race. It overlooks, however, the possibility that some of these women sought access to birth control technologies, including sterilization. Federal health bureaucrats struggled to balance the need to provide services to communities in the northern territories, while minimizing their expenses. The issue of contraception created new complications for Indian Health Services (IHS) bureaucrats, who attempted to comply with the new federal laws but who remained wary of the recent association with eugenics and forced sterilization abuses. They ultimately defended their decisions to make contraception available, particularly as it reduced maternal and infant mortality rates, but they encountered difficulties in distributing clear information. For example, IHS bureaucrats asked a group of Inuit women of "above average education for the eastern Arctic" to translate a consent form for sterilization written in Inuktitut syllabics. Of the nine women asked, two thought it meant to have an abortion, five thought it meant to have an operation and have no more babies, and two had difficulty determining what the message was. As one bureaucrat put it, "under the circumstances it would seem that the form needs a bit of redrafting to ensure that people are fully aware of what they are agreeing to."[11]

Distributing birth control in the 1970s cannot be neatly described as uniformly coercive or unilaterally requested. These conventional divisions of coercion and choice do not sufficiently capture the range of experiences faced by women living north of the 60th parallel, for

9 Karen Stote, "An Act of Genocide: Eugenics, Indian Policy, and the Sterilization of Aboriginal Women in Canada" (PhD dissertation, University of New Brunswick, 2012), 2.

10 Since published as Karen Stote, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women* (Blackpoint, NS: Fernwood, 2015).

11 A.D. Hunt to M.L. Webb, 1 June 1973, DNHW Records, RG 29, vol. 2870, file 851–1–5, pt 3B, LAC.

whom reproductive health services remained limited and whose bodies were also politicized in contemporary political movements activated by the language of sovereignty – movements that cherished women's reproductive roles and emphasized pronatalism as an essential ingredient in self-determination.

Women living in these communities, however, responded in diverse ways, revealing some of the gendered contours of these national and international debates over choice and sovereignty in the 1970s. By mid-decade, the issue of contraception in the north was receiving national publicity, accusing the federal government of coercively sterilizing women. Women in one remote community of approximately 300 people in the eastern Arctic wrote to the federal health minister to counter the claims of genocide:

> We the Health Committee members of the ... Public Health Committee are going to write our minds regarding sterilization. We hear a lot about sterilization. We believe that sterilization should not be judged purely on moral reasons. There are people like us here in ... [Nunavut] who have had such operations done to them so we know the doctors do not perform operations on people without making sure that the person understands what they are being operated for. In this case the doctors do not decide whether to sterilize a person or not. There are those who especially ask for it. There are those who need it but if they do not want it they cannot be operated on. Those people who are talking now on the radios regarding sterilization are saying that the doctors perform sterilizations on people without telling them that they are getting sterilized. We think that those statements are false, because the doctors can operate only after consulting with the patient.[12]

These women's voices encourage us to tease apart the layers of morality and rhetoric to appreciate the complex nature of reproductive politics at this time.

Widening the lens beyond Canadian borders helps to draw other interpretations into the equation, locating the loosely defined Canadian North in the global context of population control. American feminist scholar Laura Briggs published a revealing study in 1998 where she examined the discourses of "forced sterilization" in Puerto Rico. Puerto Rico was one of the testing sites for the birth control pill, is

12 Letter to the Department of National Health and Welfare from Public Health Committee [trans from Inuktitut syllabics; signed by five women, names and location withheld], 19 December 1976, DNHW Records, RG 29, vol. 2870, file 851–1–5, pt 4, LAC.

overwhelmingly Catholic, and has a long and complicated colonial relationship with the United States. She followed the lead of the historiography from US feminists who described Puerto Rican women as victims of vicious US foreign policy that had used these women for experiments and also facilitated sterilization surgeries in accordance with eugenics theories. But Briggs conducted oral interviews and uncovered a local feminist movement that challenged this conceptualization. She found women who had requested sterilizations, in spite of their Catholicism, poverty, and race. In other words, she found women who acted remarkably similar to American middle-class women. The problem, Briggs explained, was that "mainland feminism engaged in what [Gayatri Chakravorty] Spivak has shown us is the problem of speaking on behalf of the subaltern, forcing a narrative from the bodies of poor Puerto Rican women in order to authorize its own politics."[13] The resulting historical interpretation, she contends, inaccurately aligns Puerto Rican feminism with a "nationalism and pronatalism in Puerto Rico [that] had historically been associated with conservative Catholicism, the right wing, and antifeminism."[14]

Canadian Indigenous women's activism and feminism grew in the late 1960s, at times in solidarity with other women's organizations and feminists with a particular focus on the gender discrimination provisions in the Indian Act where Aboriginal women (and their children) lost their "Indian" status upon marriage to a non-Indigenous man.[15] Court challenges based in the discourse of human and civil rights and gender equity continued throughout the 1970s until the Act was finally amended in 1985.[16] But these efforts also directly challenged the nascent National Indian Brotherhood's claims, made in the face of the 1969 White Paper proposals, that the Indian Act, despite

13 Laura Briggs, "Discourses of 'Forced Sterilization' in Puerto Rico: The Problem of Speaking with the Subaltern," *Differences: A Journal of Feminist Cultural Studies* 10, no. 2 (1990): 34.

14 Ibid., 30.

15 The Report of the Royal Commission on the Status of Women in Canada, filed in 1970, included recommendations to end sex discrimination in the Indian Act. Joyce Green, "Taking Account of Aboriginal Feminism," in *Making Space for Indigenous Feminism*, edited by Joyce Green, 24 (Halifax: Fernwood, 2007); the two primary groups that formed were Indian Rights for Indian Women (1970) and the Native Women's Association of Canada (1974). Indian Act, RSC 1985, c. I-5.

16 There were three separate lawsuits: *Lavell v Canada*, [1974] SCR 1349; *Isaac v Bédard*, [1973] SCR 1349; and *Lovelace v Ontario*, [2000] 1 SCR 950; the Indian Act was amended in 1985 by Bill C-31, which reinstated some of the disenfranchised.

its oppressive colonialist agenda, was the sole recognition of the unique legal status of Indian peoples. To amend the Indian Act was to threaten Band governance and the only means available to exercise what Harold Cardinal termed their "sacred rights" as sovereigns.[17] Cast as selfish individualists and "women's libbers," the women's fight for reforms was dismissed at the time by the Indian Brotherhood as anti-Indian, unauthentic, and, indeed, dangerous to Indigenous sovereignty and self-government.[18]

Organizing around individual rights and gender equality created fraught relationships with Indigenous leadership, yet Indigenous activists also found themselves marginalized within the larger liberal feminist movement. What Joyce Green calls the "unthinking racism" of the white, middle-class women's movement erased the economic and political oppressions that Indigenous women faced.[19] Writing in 1989 in a major Canadian feminist journal, Kanien'kehá:ka (Mohawk) activists articulated an explicitly Indigenous women's movement that was critical of both liberal feminism and male-dominated Indigenous leadership. Drawing on cultural teachings as well as broader transnational Indigenous criticisms of colonialism, Skonaganleh:rá noted:

> I understand the nature of being defined as a "feminist," and wanting some sense of equality, but frankly, I don't want equality. I want to go back to where women, in aboriginal communities . . . were treated as more than equal – where man was helper and woman was the centre of that environment, that community. I suppose equality is a nice thing and while I suppose we can never go back all the way, I want to make an effort at going back to at least respecting the role that women played in communities.[20]

Scholar Mary Ellen Turpel built on these foundations to advocate for a social, economic, and political renaissance to counter the colonialism – "patriarchy and paternalism" – of Canadian state and society that

17 Harold Cardinal, *The Unjust Society: The Tragedy of Canada's Indians* (Edmonton: MG Hurtig, 1969), 140, which is cited in Joanne Barker, "Gender, Sovereignty, and the Discourse of Rights in Native Women's Activism," *Meridians: Feminism, Race Transnationalism* 7, no. 1 (2006): 135.

18 Barker, "Gender, Sovereignty," 137.

19 Joyce Green, "Taking Account of Aboriginal Feminism," in *Making Space for Indigenous Feminism*, edited by Joyce Green (Halifax: Fernwood, 2007), 20; Verna St Denis, "Feminism Is for Everybody: Aboriginal Women, Feminism and Diversity," in Green, "Taking Account of Aboriginal Feminism," 33; see also Emily Snyder, "Indigenous Feminist Legal Theory," *Canadian Journal of Women and the Law* 26, no. 1 (2014): 381.

20 "Our World According to Osennontion and Skonaganleh:rá," *Canadian Woman Studies* 10, no. 2 and 3 (1989): 15.

ravaged both First Nations women and men: "I have found that it is difficult for white feminists to accept that patriarchy is not universal."[21]

Historically contingent and rooted in the swirling identity politics of liberal feminism, sovereignty, and self-government, a parallel, though separate, theoretical stance emerged that celebrated Indigenous women's "traditional" and maternalist roles. Using interviews with activist women, Grace Ouellette theorized that Indigenous women inhabit a "fourth world," different from mainstream feminism where a "unique worldview underlies their actions and strategies."[22] Framed around a Circle of Life (or Medicine Wheel) philosophy, where everything has its own place and meaning in nature, women's role as nurturers, caregivers, and child-bearers is taken as a natural phenomenon and not – as many feminists see it – as a social construction.[23] Her research suggested that Indigenous women perceived their multiple oppressions in colonialist policies rather than solely at the hands of patriarchy, eschewing the term "feminism."

Maternalism and motherhood are inherent in a transnational Indigenous reform strategy that invokes "motherwork" or women's unique role in procreation and the nurturing of children and communities. As Indigenous activism, it appeals to traditions of "responsibilities" and a holistic sense of power, and is not rights based, as Western feminists express their power. As American scholar Lisa Udel explains, "in order to do motherwork well, Native women argue, women must have power."[24] Maternalism emerged, in part, in reaction to colonial experiences that degraded Indigenous motherhood generally and, in the American context, the sterilization abuses in the mid-1970s that physically removed the capacity to fulfil this function of mothering.[25]

21 Mary Ellen Turpel (Aki-Kwe), "Patriarchy and Paternalism: The Legacy of the Canadian State for First Nations Women," *Canadian Journal of Women and the Law* 6, no. 1 (1993): 180, 191.

22 Grace Josephine Mildred Wuttunee Ouellette, *The Fourth World: An Indigenous Perspective on Feminism and Aboriginal Women's Activism* (Halifax: Fernwood Publishing, 2002), 85; Ouellette conducted her research in the 1980s and explicitly builds on George Manuel and Michael Posluns, *The Fourth World: An Indian Reality* (Toronto: Collier-Macmillan Canada, 1974).

23 Ouellette, *The Fourth World*, 84; see also Turpel, "Patriarchy and Paternalism," 180–1.

24 Lisa Udel, "Revision and Resistance: The Politics of Native Women's Motherwork," *Frontiers* 22, no. 2 (2001): 45.

25 A US federal investigation in 1976 uncovered the details of sterilizations of over 3000 women between the ages of fifteen and forty-four that ignored or violated safeguards intended to ensure informed consent and prevent coercion. Many of these girls were in fact teenagers who were sterilized under the auspices of appendectomies, without their knowledge or consent. Udel, "Revision and Resistance," 46; see also Jane Lawrence, "The Indian Health Service and the Sterilization of Native American Women," *American Indian Quarterly* 24, no. 3 (2000): 400–19.

But motherwork in the fourth world would also include regaining sexual and reproductive autonomy that was suppressed by the imposition of Christian capitalism.[26] These institutional barriers to motherhood fused elements of patriarchy with colonial and evangelical legacies that had created a different set of dynamics for Indigenous women negotiating their place in the modernizing rights discourse.

At the same time, a small school of Indigenous feminism provides a more explicit critique of colonialism's gendered power relations.[27] It shows how Indigenous women and their communities are directly affected by racism and sexism and examines oppression in colonial as well as Indigenous governance. As Green recounts, in the 1970s, Indigenous feminists "educated" Western feminists who were "unfamiliar" with issues of colonialism, racism, and sexism.[28] But they also deployed their feminism carefully and differently.[29] This plurality of Indigenous feminisms is also conceptualized as an analytical "tool" rather than as "identity politics" in a broad effort to achieve gender justice,[30] underscoring the need to appreciate the fluidity of indigenous feminisms.

In the case of historically examining the sterilization records in the NWT, the politics of motherhood provides an important analytical corrective. While federal health bureaucrats pointed to improvements in maternal and infant mortality as proof that colonial control of Inuit birthing improved health, Inuit women organized to return childbirth to their communities. Pauktuutit (the Inuit Women's Association) prioritized and politicized the revival of traditional midwifery as essential to cultural survival.[31] The loss of control over childbirth was a "metaphor for the loss of political control" and moved from being solely a women's issue to informing the larger Inuit political agenda of self-government.[32]

Women living north of the 60th parallel bore witness to these kinds of debates without necessarily having recourse to many of the

26 Udel, "Revision and Resistance," 45–6.
27 Emily Luther, "Whose "Distinctive Culture"? Aboriginal Feminism and R. v. Van der Peet," *Indigenous Law Journal* 8, no. 1 (2010): 27–53.
28 Green, "Taking Account of Aboriginal Feminism," 23, 24.
29 Green, "Indigenous Feminism," in Green, *Making Space for Indigenous Feminism*, 18.
30 Cheryl Suzack, "Indigenous Feminisms in Canada," *Nordic Journal of Feminist and Gender Research* 23, no. 4 (2015): 262.
31 "Pauktuutit: Inuit Women's Association," *Canadian Woman Studies* 10, no. 2 and 3 (1989): 137–8.
32 Patricia A. Kaufert and John D. O'Neil, "Cooptation and Control: The Reconstruction of Inuit Birth," *Medical Anthropology Quarterly* 4, no. 4 (1990): 439.

provincial organizations or health services available to their southern Canadian counterparts. Canada's northern territories, in these debates, took shape as a region under federal control, requiring health services that mirrored provincial provisions, but as historians have already identified, the public health services in the Northwest Territories languished in scope, accessibility, staffing, and resources.[33] The regional and jurisdictional differences were further complicated by cultural and medical assumptions about Inuit and First Nations populations and their desire to control fertility. As the federal government looked northward to expand health services, it encountered a more diverse set of reactions than officials had anticipated. The issue of providing reproductive health care services in the North moved well beyond a matter of jurisdiction; instead, it embroiled federal civil servants in a much more contested matter of neo-colonial population control. As the debate shifted from one of service provision to birth control for Indigenous women, the regional contours also drifted southward, enveloping provincial communities and reframing the issue as one of Indigenous reproduction, contraception, feminism, and population control. Health bureaucrats meanwhile struggled to find a consistent foothold in the changing rights discourse, without sufficiently appreciating how women in the North experienced this cultural-medical shift in reproductive health services.

HEALTH CARE SERVICES IN THE PROVINCIAL NORTH

In the early 1950s, incidents of surgical sterilization at Miller Bay Indian Hospital near Prince Rupert, British Columbia, came to the attention of IHS bureaucrats in Ottawa.[34] British Columbia and Alberta had passed sexual sterilization acts in 1933 and 1928, respectively, and

33 Mary Jane McCallum, "This Last Frontier: Isolation and Aboriginal Health," *Canadian Bulletin of Medical History* 22, no. 1 (2005): 103–20.

34 For the sake of consistency, the IHS will refer to the bureaucracy responsible for health care. Known as Indian Health Service when it was housed in the Department of Indian Affairs, it retained the name when health services were transferred to National Health and Welfare in 1945. Reflecting an increasing interest in the North, the name was changed to the Indian and Northern Health Service (INHS) in 1955. In 1962, another government reorganization saw the elimination of INHS and the creation of the Medical Services Branch, an amalgamation of seven former independent services – Civil Aviation, Civil Service Health, Northern Health, Quarantine, Immigration, Sick Mariners, and the largest, Indian Health Service; in 2000, it was renamed the First Nations and Inuit Health Branch.

established eugenics boards to recommend and adjudicate decisions for these operations. In British Columbia, the Eugenics Board was ostensibly created to help reduce the costs of maintaining people in expensive state institutions, when they could be cared for in the community after reducing the risk of procreation.[35] Indian hospitals fell within federal jurisdiction and were therefore not subject to routine assessments by the provincial eugenics board members, but the practice of sterilization did not cleave neatly to these jurisdictional distinctions.

Miller Bay was one of twenty-two federally owned and operated Indian hospitals established during and after the Second World War. A redundant military installation initially re-purposed to isolate and treat tuberculosis among Indigenous people, Miller Bay, like the other hospitals, quickly emerged as a general hospital treating all conditions based on race, not disease. Indigenous communities, regularly excluded from local hospitals and left without treatment, welcomed the 1946 opening of Miller Bay Indian Hospital.[36] The influx of wartime American and Canadian military personnel had disrupted Indigenous communities throughout the northwest, including severe epidemics of infectious disease that followed the building of the Alaska Highway and the Canol pipeline.[37] But the government's extension of medical services was prompted by its larger colonializing project to isolate Native people in the interests of settler society.

In 1954, Dr G.R. Howell, the hospital's medical superintendent, inquired of his superiors about the legality of sexually sterilizing women: "A few of our patients have asked us whether they could have this operation during the past year and it has been performed on three of them. We are however most anxious to protect ourselves in every way and to know the law on the subject. I would greatly appreciate a legal opinion."[38] Howell's use of the passive voice, "it has been performed" would suggest that he did not perform the surgeries. The doctor, a

35 Act Respecting Sexual Sterilization, SBC 1933, c. 59.

36 Among other local Indigenous dignitaries, Henry Kelly, councillor for the Tsimshian at Port Simpson (Lax Kw'alaams), attended the opening ceremony and spoke of the hospital as a "milestone along the road of progress in the new deal promised by the government of Canada for my people." "Formal Opening of Finely-Equipped Hospital at Miller Bay for TB Cases," *Evening Empire* (Prince Rupert) (17 September 1946).

37 Ken Coates, *Best Left as Indians: Native-White Relations in the Yukon Territory, 1840–1973* (Montreal and Kingston: McGill-Queen's University Press, 1991), 102.

38 G.R. Howell to W.S. Barclay, 9 August 1954, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

former sanatorium patient himself whose health was deteriorating, spent much of his time at home in Prince Rupert, leaving the care of the 175 patients to three staff officers at the hospital, one of whom was "not licensed to practice medicine and probably will not be able to obtain a license," according to a departmental inspector.[39] Howell's disturbingly belated request for direction caused concern in both the regional and national IHS offices. His superiors assured themselves that the women's health status must have surely necessitated the surgery and that Howell must have observed all of the ethical, medical, and surgical considerations. Nevertheless, IHS director Dr Percy Moore claimed to know nothing of the legal implications of surgical sterilization but believed such procedures were subject to provincial authority. He directed the departmental solicitor to look into the matter generally and, specifically, with respect to British Columbia.[40]

Alberta's eugenics program had encountered similar challenges when confronted with cases of men or women from reserves. Indeed, within the context of the most open and aggressive eugenics program in Canada, concerns about sterilizing "Indians" produced considerable debate among program architects and Indian agents. In a case in 1937, an agent with both provincial and federal authorities was uncertain how to proceed:

> The [federal IHS] Department has no power to authorize the sterilization of an insane Indian. It has no objections to the operation and would regard it with approval if carried out in accordance with the laws and regulations of the Province. It cannot, however, agree that any Indian should be sterilized without the consent of his relatives, and of himself as well, if he is mentally competent to understand the results of the operation. It is not beyond the realm of possibility that Indians might get the impression that there was a conspiracy for the elimination of the race by this means.[41]

The Indian agent later stressed that the operation should be deferred until the Eugenics Board had obtained consent from the patient's family.

39 Eric Preston, "Observations: Miller Bay Indian Hospital," 6 June 1956, DNHW Records, RG 29, vol. 2598, file 800–1-D579, pt 1, LAC.

40 P.E. Moore to R.E. Curran, chief legal division, 5 October 1954, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

41 Letter from T.R.L. MacInnes to the Director of Indian Affairs Branch, Department of Mines and Resources, 11 May 1937, Eugenics Board, Minutes (Binder 1); Letter from G.C. Laight, Indian Agent, Edmonton, to the Director of Indian Affairs Branch, Department of Mines and Resources, 11 May 1937, re: Sterilization of Indian Cases, Eugenics Board, Minutes (Binder 1).

As Erika Dyck explains, under the guidelines of Alberta's Sexual Sterilization Act, patients with sufficiently low intelligence quotients were not required to give consent, meaning that patients could be legally sterilized without knowledge or consent.[42] In this case, the provincial authorities responded to the IHS, claiming that "the patient is not willing to be sterilized but, according to the present Alberta Sterilization Act, his consent would not be necessary. Notwithstanding this latter fact it has not been our policy to operate where there are extenuating circumstances, which, in this case, would be the fact that he is an Indian."[43]

Sexual sterilization, difficult to access by putatively normal women and men, was wielded by eugenics boards to protect the province from the progeny of the so-called "mental defectives" and the "feebleminded."[44] Nevertheless, the surgery, whether for health or purely eugenic concerns, required patients (or their guardians or the provincial secretary) to provide written consent for treatment. Director Moore hoped the department's blanket form, which patients signed upon admission to hospital, might be amended to fit the special circumstances of voluntary sterilization. Indeed, Form 7819: Application for Medical Treatment concerned itself with limiting who might access IHS treatment while also limiting the services that might be provided. Moreover, upon admission, patients were required to consent to any and all treatment: "I authorize to be performed on my person whatever examination, treatment or operation is indicated in the opinion of the medical authorities and I undertake to co-operate fully in all measures to maintain treatment and discipline."[45]

The broadly coercive nature of the consent form did not meet the needs of voluntary sterilization, so department solicitor J.C. Hanson sought direction in interpreting the Sexual Sterilization Act from British Columbia's provincial secretary. As Hanson noted, the provincial act allowed that "an operation for sterilization may be performed by certain persons provided that a consent is obtained in writing from various parties."[46] Legal advisors determined that surgical sterilization

42 Erika Dyck, *Facing Eugenics: Reproduction, Sterilization, and the Politics of Choice* (Toronto: University of Toronto Press, 2013), 12. Sexual Sterilization Act, RSA 1928, c. 37.

43 Letter from the Medical Superintendent to the Indian Agent, Department of Indian Affairs, Edmonton, 26 May 1937, Eugenics Board, Minutes (Binder 1).

44 Dyck, *Facing Eugenics*, 3.

45 Form 7819: "Application for Medical Treatment," DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

46 J.C. Hanson, department solicitor to Office of Provincial Secretary, BC Government, 8 October 1954, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

could only be performed if further child-bearing would endanger the life of the mother or adversely affect her health. However, Moore remained concerned about the circumstances that would determine the necessary medical grounds for the procedure. Who would decide?[47] Ultimately, he settled on a policy whereby the patient required separate examinations by at least two physicians who then submitted in writing their reasons for recommending the procedure; written consent by both the patient and her spouse was also required. It seems clear that through negotiation with their doctors, these few women at Miller Bay gained access, albeit briefly, to a reproductive technology that allowed them to control their fertility by subverting the intent of state-sanctioned surgical procedures.

Medical anthropologists and social workers have attempted to bring to light some of the experiences of First Nations and Inuit people through ethnographic research. For example, in the 1980s, anthropologist John D. O'Neil revealed a number of cases, primarily of women, who were sterilized without their knowledge or consent in the 1960s and 1970s. One woman recalled: "The only other time I was sad like this was when I found out I couldn't have any more children. They did a hysterectomy in Churchill [Manitoba], but I didn't know about it. I am still angry about that."[48] These operations often coincided with treatment for other complaints, from depression to tuberculosis or cancer, and were not explained to the women by the physicians who performed the surgeries. In oral histories on the experience of being evacuated for childbirth, Inuit women complained about being separated from their community and about the loss of control over the way in which they gave birth. As Patricia Kaufert and John O'Neil argue, this "colonial penetration" in the Arctic shifted the impact of resettlement, poverty, and disease "to the body of the Inuit woman."[49] Seeking and obtaining health services seemed to coincide with unsolicited reproductive health care interventions by a system that continued to operate under eugenic laws in some cases and in the absence of any law in regions outside of British Columbia and Alberta.

47 P.E. Moore to W.S. Barclay, 8 December 1954, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

48 John D. O'Neil, "Self-Determination, Medical Ideology and Health Services in Inuit Communities," in *Northern Communities: The Prospects for Empowerment*, edited by Gurston Dacks and Ken Coates (Edmonton: Boreal Institute for Northern Studies, 1988), 36.

49 Patricia A. Kaufert and John D. O'Neil, "Cooptation and Control: The Reconstruction of Inuit Birth," *Medical Anthropology Quarterly* 4, no. 4 (1990): 438–9.

However, the issue of sterilization and birth control was not always straightforward or uniformly top-down. The IHS had been receiving throughout 1955 orders from Miller Bay for supplies that "could not be interpreted otherwise than as contraceptives."[50] Bureaucrats were concerned that an unrestricted supply of contraceptives provided through public funds might raise questions about IHS policy, not least since the practice was illegal (and would remain so for another thirteen years).[51] This inherent paradox reinforces the importance of race and region in reproductive health services: contraception remained illegal, and requesting it connoted a degree of criminal behaviour, while laws and medical professionals continued to justify coercive sterilization on the basis of its protective benefits for society as a whole. Indigenous women seeking birth control, much like their non-Native counterparts, were rebuffed as immoral actors, while eugenics board members claimed to have the moral upper hand in sterilizing people who were expected to be a drain on society. As the Ontario Medical Association maintained, "voluntary sterilization of the healthy should never be done."[52]

As historians Angus and Arlene McLaren argue, many Canadians, including several physicians, had increasingly embraced since the 1940s both the practice of birth control and its advocacy once they understood how it might most usefully control the reproduction of "welfare cases" and other marginalized groups.[53] Physician bureaucrats at the IHS understood that they only needed to claim that the contraceptives would be considered necessary as life-saving procedures to protect themselves and their colleagues from any legal liability. As Moore reasoned: "It is my opinion that in certain circumstances prevention of conception may prolong life. I believe that the opinion is

50 "Supply of Contraceptives," handwritten memo, 24 (or 29) December 1955, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

51 Until the 1969 amendments, the Criminal Code stated that "every one commits an offence who knowingly, without lawful justification or excuse ... *(c)* offers to sell, advertises, publishes an advertisement of, or has for sale or disposal any means, instructions, medicine, drug, or article intended or represented as a method of preventing conception or causing abortion or miscarriage." Cited in Brenda Margaret Appleby, *Responsible Parenthood: Decriminalizing Contraception in Canada* (Toronto: University of Toronto Press, 1999), 3. Appleby notes that a defense to the charge could be found in proving the claim that the actions served the public good.

52 "The Legal Aspects of Sterilization, reprinted from the Ontario Medical Review," *Alberta Medical Review* 14, no. 3 (1949): 53.

53 Angus McLaren and Arlene Tigar Mclaren, *The Bedroom and the State: The Changing Practices and Politics of Contraception and Abortion in Canada, 1880–1997*, 2nd edition (Toronto: Oxford University Press, 1997), 123.

open to argument depending on religious background and training."[54] As he further explained, the IHS would provide contraceptive materials, while individual medical officers and contracting physicians would be free to prescribe as they saw fit. "It is assumed," he argued, "that a qualified practitioner knows what he is about, conforms both with the accepted teachings of his school and the accepted practice in the province in which he resides, and shall at all times attach due importance to the religious beliefs of the individual." Moore claimed his policy also upheld the "cardinal rule" of the IHS, "not to interfere between a physician and his patient."[55] His latter claim was more than a little misleading since the IHS regularly refused to authorize (and therefore fund) services or procedures that it deemed unnecessary or costly.[56] Nevertheless, the IHS fully embraced the opportunity to provide birth control in keeping with many socially conservative institutions, including the medical and legal professions and social welfare agencies, which, as historian Brenda Appleby argues, increasingly accepted the utility of contraception to mitigate class and racial tensions while preserving their privileged social positions.[57]

With the development of oral contraceptives, and Canada's 1961 Food and Drug Directorate approval of "the pill" for therapeutic use, women had access (through an accommodating physician) to birth control that was nearly 100 percent effective and did not require the cooperation of their male partners. A year later, when accounts from drug stores for prescriptions for Indigenous women began appearing on the IHS regional superintendent's desk in Edmonton, Dr W.L. Falconer refused to compensate the druggists. Citing "controversy on the use of this drug and probably some detrimental effects," Falconer advised that nurses should not distribute contraceptives, and as an elective procedure, physicians should be required to complete a special treatment form indicating medical necessity. Only once the required paperwork was complete would the IHS provide the pills from its own stocks. Moore added a handwritten note: "I don't think this is a good directive."[58]

54 Dr D. Blake, "Policy re Supply of Contraceptive Materials," memo to file, 3 January 1956, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

55 Ibid.

56 The "Application for Medical Treatment" form explicitly states that "no one except the Director may approve elective surgery, treatment for cosmetic purposes only, or the use of expensive materials." HIS, "Application for Medical Treatment," DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

57 Appleby, *Responsible Parenthood*, 6.

58 W.L. Falconer to all Zones in Foothills Region, "Drugs – Contraceptives," 7 August 1962, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

Indeed, less than a month later, Moore informed all of the regional superintendents that "the hormone preparation Enovid" was available through IHS stocks and "supplies have been sent to quite a few field establishments on requisition." He did warn that "in view of the great hew and cry that resulted from the Thalidomide episode," physicians should understand the "possible toxic reactions."[59] Of particular concern was thromboembolic disease, or the formation of blood clots in the veins, a warning issued in August 1962 by Ortho Pharmaceuticals regarding its progestin-estrogen preparation, Ortho-Novum Tablets.[60] It appears the IHS chose to stock Searle Pharmaceuticals's Enovid (which posed the same health risk) because it was marginally cheaper at $824.50 for 10,000 tablets packaged in 120 tablet bottles, compared to $976.78 for Ortho-Novum.[61] Moore considered that the reports of a connection between thromboembolic disease and oral contraceptive use might indeed be a coincidence, nevertheless he suggested Enovid should not be "given out by the nurses alone" but, instead, issued by, or on the order of, a medical officer; that the drug should not be given to women living in remote areas infrequently visited by a field nurse; and that nurses should be reminded of the common symptoms of phlebitis (inflammation of the vein).[62]

59 Thalidomide, a sedative, first appeared in West Germany in 1957; the connection between thalidomide and severe birth defects convinced the German developers to recall the drug in November 1961. In Canada, the Food and Drug Directorate had approved thalidomide for sale in April 1961, and it was not finally taken off the market until February 1962. Barbara Clow, "'An Illness of Nine Months' Duration': Pregnancy and Thalidomide Use in Canada and the United States," in *Women, Health, and Nation: Canada and the United States since 1945*, edited by Georgina Feldberg et al., 45–66 (Montreal and Kingston: McGill-Queen's University Press, 2003).

60 Ortho Pharmaceutical (Canada) Ltd., "Important – Drug Caution Ortho-Novum Tablets," 9 August 1962; P.E. Moore to all Regional Superintendents, "Enovid," 10 September 1962, both documents in DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

61 "How Do These Prices Compare with Enovid?" Memo, 6 September 1962, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

62 P.E. Moore to all Regional Superintendents, "Enovid," 10 September 1962; other side effects included nausea, gastrointestinal disturbances, breast tenderness, weight gain, and breakthrough bleeding. In the United States, by August 1962, there were twenty-eight reported cases of death and disease from blood clots linked to Enovid, the only brand on the American market at the time. Although acknowledged by physicians, the pill's dangerous side effects were not widely understood by the public until after 1969. Elizabeth Siegal Watkins, *On the Pill: A Social History of Oral Contraceptives, 1950–1970* (Baltimore, MD: Johns Hopkins University Press, 1998), 81, 103.

It is clear that contraceptive information and technologies were made available to physicians and their Indigenous patients, but what is less clear is how and why the technologies were promoted by health care workers and how this information was received. That both Moore, and Falconer before him, felt compelled to specifically warn against the distribution of oral contraceptives by field nurses may indeed point to a widespread practice. Women, particularly in smaller communities with nursing stations, were far more likely to receive medical services and advice from nurses than from physicians. Moreover, women were more likely to have very personal discussions about their reproductive health with another woman. In northern British Columbia, nurses continued to dispense oral contraceptives "if the husband and the priest are in agreement."[63] Nevertheless, as a reversible form of contraception, where women could chose to continue taking the prescription, birth control pills may have provided some measure of reproductive autonomy.[64]

In 1963, A.R. Kaufman, the rubber manufacturer and birth control advocate, whose Parents Information Bureau in Kitchener, Ontario, had provided contraceptives and surgical sterilization for the working classes since the Great Depression, offered to provide the IHS with free birth control advice and supplies to manage the "tragic conditions … aggravated by pathetic overcrowding due to high birth rates" in Inuit villages. Recommending surgical sterilization for Inuit men, Kaufman made clear his continued interest in eugenics: "Welfare work without family limitation is not going to be sufficient. Three generations of reliefees [sic] in one family should be convincing evidence for those who wish to consider the problem impartially." Moore thanked Kaufman for his interest and assured him that "any Eskimo who requests information regarding birth control is provided with same by our doctors who are at liberty to order contraceptive drugs if it is in the interest of the patient or the family."[65] But, in the 1960s, birth control took on far wider dimensions as "population control" when uncontrolled fertility

63 M.E. Gordon, Assistant Pacific Zone Superintendent to Zone Superintendent, Miller Bay Indian Hospital, 24 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1a, LAC.

64 Some remained suspicious of the government's motives and methods. In 1974, the government had to answer the unanswerable question posed by a Mr B.D.G. Bell of Toronto: "Are you still permitting the pill being passed off as a vitamin pill to the Indians, Metis and Inuits [sic]?" Letter, 14 December 1974, DNHW Records, RG 29, vol. 2870, file 851–1–5, pt 3b, LAC.

65 A.R. Kaufman, Kitchener, ON to P.E. Moore, 28 November 1963; P.E. Moore to A.R. Kaufman, 6 December 1963, both documents in DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

came to be most closely associated with the poor and racialized in Canada and abroad.

CANADA'S NORTH GOES SOUTH

In the aftermath of the Second World War, a neo-Malthusian spectre of "population explosion" in the Third World captured the attention of many who saw unchecked fertility as both an economic and a Cold War geo-political threat.[66] A transnational network of public and private interests, including the American-funded and controlled Population Council and International Planned Parenthood Federation (IPPF), emerged in the 1950s and 1960s to identify and meet the threat of overpopulation.[67] In common with these interests, population control movements had the tendency to characterize social and political problems as pathologies with a biological basis; people in the post-war decolonizing world were viewed not as individuals but, rather, as populations that could be shaped by science and politics.[68] Population control became associated with progressive campaigns to alleviate poverty, which fused race and economic status together. The language of population control in the Global South emphasized a strain on resources and overpopulation, features that did not resonate in the Canadian North. The Canadian government's reaction reveals that population control in Canada had more to do with managing its Indigenous citizens than with concerns for overcrowded regions.

With its legal prohibitions against birth control at home, Canada was forced to abstain from a 1962 United Nations vote to support contraceptive use in the Third World.[69] But British expats George and Barbara Cadbury worked to change this decision the next year by founding the Canadian Federation of Societies for Population Planning, an alliance of birth control societies that subsequently joined the IPPF.[70]

66 Laura Briggs, *Reproducing Empire: Race, Sex, Science, and US Imperialism in Puerto Rico* (Berkeley, CA: University of California Press, 2002), 116.

67 The Population Council, using Rockefeller and Ford Foundation funds, promoted contraceptive research centres and supplied national programs with technology and expertise. By 1968, 90 percent of International Planned Parenthood Federation funds originated in the United States. Matthew Connelly, "Seeing beyond the State: The Population Control Movement and the Problem of Sovereignty," *Past and Present* 193 (2006): 221–2, 226.

68 Connelly, "Seeing beyond the State," 202.

69 McLaren and McLaren, *Bedroom and the State*, 134.

70 Appleby, *Responsible Parenthood*, 47.

The federation changed its name to the less explicit Family Planning Federation of Canada, while George Cadbury became director of the IPPF.[71] In 1963, Robert Prittie, New Democratic Party member of parliament and an executive member of the Family Planning Federation, introduced the first private member's bill, Bill C-64, calling for the decriminalization of birth control. Structured like the IPPF with formal decentralization, the Family Planning Federation of Canada included a range of advocates, from women's rights to population planning groups. Like the IPPF, its informal coordination by key leaders such as the Cadburys kept the ostensibly independent groups headed in the same direction.[72] The Family Planning Federation's brief to the House of Commons Standing Committee, considering changes to the Criminal Code, outlined four objectives. The first was created to "encourage good citizenship through responsible family life"; the other three objectives were all concerned with limiting population growth, including aiding international population control efforts.[73] Enjoying a post-war economic and baby boom, Canadians across the political spectrum increasingly accorded the freedom of "responsible parenthood" to the middle and upper classes. The poor (globally and locally) continued to produce the wrong kinds of families with far too many children because women either would not, or could not, control their fertility.

Borrowing the language of American President Lyndon Johnson's 1964 "War on Poverty," Canada's special planning secretariat of the Privy Council announced its own "war on poverty among the Indians" in 1965. Linking poverty and over-crowding to families with too many children, rather than to house size, the planning secretariat sought input from IHS experts. With convoluted logic, the secretariat explained that in a study of the "desirable size of the Indian home under present circumstances," it wondered whether the size of the required prototype home "could be reduced if birth control techniques were actively advocated amongst the Indian population." Read another way, the query's sub-text directed that house sizes be reduced in order to compel people to limit family size. In any case, the IHS was asked to "express an opinion as to whether birth control techniques would actually affect the size of Indian families in general and hence the size of the house required." Acknowledging the hypothetical nature of the question

71 C.P. Blacker, "The International Planned Parenthood Federation: Some Aspects of Its History," *Eugenics Review* 56, no. 3 (1964): 135–42.

72 Connelly, "Seeing beyond the State," 220.

73 Cited in Appleby, *Responsible Parenthood*, 45.

since the prohibitions under the Criminal Code remained, the IHS director sent the inquiry to his senior officers for their opinions on "the medical aspects of the problem and not with theological, legal or other aspects."[74] While most replied that the typical two-room "Indian house" was already so small that it could not be further reduced, many recognized the inquiry as subterfuge to explore the extent of birth control use. The physician bureaucrats' replies provide a telling commentary on medical attitudes to poverty, reproduction, and the "Indian problem." Their opinions also reflect prevailing notions that the "right" women – the more advanced – were already controlling their fertility, while problem women required a more coercive approach.

Bureaucrats, responding promptly to the director's request, supported birth control for their Indigenous patients for the most part. They likewise agreed that the best methods were the ones the professionals could control. J.D. Galbraith at Coqualeetza Indian Hospital in Chilliwack, east of Vancouver, cited with approval the 40 percent increase in the number of birth control pills prescribed by contracting physicians and supplied from IHS stocks. However, he noted that a certain percentage of women "will not take sufficient care and interest in the regular use of birth control pills," and they should be fitted with an intrauterine device (IUD). Among these "less co-operative" women, he included "unmarried mothers who go on to have sizeable families."[75] Dr M.L. Webb, who had only recently taken over as medical superintendent at North Battleford Indian Hospital in Saskatchewan, agreed that active promotion of birth control techniques would indeed reduce the size of the average family but that it would take a number of years "depending on how actively one pursued the program." He likewise recommended IUDS for women who would not, or could not, follow a birth control regime. While he could not see how the already inadequate houses could be made smaller, he argued: "There are many other benefits to be derived from actively pursuing a birth control program, as we well know."[76]

At the Charles Camsell Indian Hospital, the medical superintendent, Dr G.D. Gray, explained that the hospital "advocate[ed] for

74 Director H.A. Proctor to all Regional Superintendents, "Birth Control," 27 August 1965, RG 29, vol. 2869, file 851–1–5, pt1, LAC; Percy Moore retired in July 1965 after twenty years as director and was replaced by his long-serving assistant, H.A. Proctor.

75 J.D. Galbraith to Regional Superintendent, 8 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

76 M.L. Webb to Director General, 13 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

control only after the fifth child has been born, this for medical and socio-economic reasons." He did not elaborate on the method of "control," whether sterilization or contraceptives.[77] Dr S. Mallick at the Sioux Lookout Indian Hospital in northern Ontario was more explicit. He explained that it was hospital policy to distribute Enovid birth control pills directly to women with "an excessively large number of pregnancies with no means of support except relief." For women in poor health, "we have carried out sterilization."[78] But Mallick argued that for First Nations women the pill was less than satisfactory because when their four-month prescription ran out they "are either too late or too lazy to ask for it." Citing favourably the International Planned Parenthood's use of IUDs in Asia and India, Mallick advocated a large-scale experiment on First Nations women. As a birth control method "more suited" for families with low incomes, the IUD "obviates the necessity and moral objection to sterilization."[79] Hospital-based physicians had considerable authority and opportunity to press their views on women who were deemed to have had "excessive pregnancies." Women who gave birth in IHS Indian hospitals, often far from home, were physically and emotionally vulnerable to such state-sanctioned efforts to control their subsequent reproduction.

Physician bureaucrats with less direct access to women endorsed the view that Indigenous birth rates indeed required their control; their neo-eugenic solutions focused on the social and economic need to control fertility.[80] Dr T.J. Orford in Regina reckoned that there was no incentive to restrict fertility; indeed, universal social programs and social assistance worked as obstacles: "The man with the large family is in better position to gain by virtue of family allowance and social aid assistance. The female role is, by and large, still that of child bearing."[81] Further north in Prince Albert, Saskatchewan, Dr M.P.D. Waldron admitted that some patients "on the more advanced reserves either

77 G.D. Gray to Zone Superintendent, 3 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

78 S. Mallick to Director, 15 December 1964, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

79 S Mallick to Director, 15 December 1964; S. Mallick to Regional Superintendent, 8 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

80 Rebecca Kluchin argues that neo-eugenics in the post-Second World War period, like eugenics before it, rested on definitions of reproductive fitness. For neo-eugenicists, certain "defects," such as poverty, illegitimacy, and criminality, were reproduced, but culture, rather than genes, were the methods of transmission. Kluchin, *Fit to Be Tied*, 3.

81 T.J. Orford to the Director, 3 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

on the doctor's instructions or at their own request are using birth control tablets and appear to be successful." For many, he continued, education and integration were necessary since they had "no sense of responsibility and the size of the family is of no consequence."[82]

The Pacific region's superintendent R.D. Thompson agreed that the "sophisticated and better educated Indians" already used birth control, but an effective reduction in the birth rate would only be accomplished by more coercive measures for the isolated and "those of a lower educational standard."[83] At Inuvik, the zone superintendent reported that a good number of both Catholic and non-Catholic patients had prescriptions for the pill. But, as he noted, the abject economic conditions that contributed to continuing high infant mortality rates convinced many women that it remained necessary to have fourteen children in order for two to survive.[84] Dr R.A. Sprenger in the Yukon zone endorsed the popular view that medicine's successes, and public health measures in general, raised the standard of living, thus contributing to the current "population explosion." Medicine had a duty to provide education in family planning.[85] IHS bureaucrats' assessments of the "Indian problem" reflected broader middle-class Canadian and international reproductive politics that retained a definite eugenic cast.

The powerful image of "population explosion" as a looming threat to order and stability offered a ready discourse both to explain the problem of poverty in Indigenous communities and provide its solution. In late 1967, despite the legal prohibition, the NWT Council passed a motion calling on the commissioner to "immediately undertake ... a formal universal and intensive scheme for the dissemination of information about birth control and family planning ... and develop a system through which various birth control devices can be made freely available to anyone wishing them."[86] Framing the problem in the language of population explosion, Lloyd Barber, appointed member of council and the dean of commerce at the University of Saskatchewan, urged quick and decisive action to control the birth

82 M.P.D. Waldron to the Director, 2 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

83 R.D. Thompson to Director General, 13 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

84 Zone Superintendent, Inuvik, to Regional Superintendent, 8 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

85 R.A. Sprenger to Regional Superintendent, 7 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

86 G.C. Butler, Chief Medical Officer to S.M. Hodgson, Commissioner, "Brief on Birth Control," 11 June 1968, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

rate: "Trends imply our population explosion is on a collision course with the ability of the relatively fixed level of renewable resources to support the increasing population."[87] With fewer than 30,000 people in an area of more than 3.3 million square kilometres, the NWT was hardly over populated.[88] But, as the only Canadian jurisdiction with Indigenous people in the majority, the territorial birth rate was a growing concern for the non-Indigenous council. Characterizing the region's high birth and infant death rates as "Canada's Shame," a newspaper editorial applauded the decision of the NWT Council to distribute freely birth control literature and technologies, asking "is this India or Latin America?"[89]

DECRIMINALIZATION

In June 1969, the same month that Omnibus Bill C-150 legalizing birth control and abortion became law, the Liberal government under Pierre Trudeau introduced its Statement of the Government of Canada on Indian Policy, better known as the White Paper.[90] More than mere coincidence, policy-makers in the newly elected government saw themselves as charting a new liberal course for Canadians. Individual choice and individual rights would deliver the social justice and civil rights promised in Trudeau's 1968 "just society."[91] The White Paper became a touchstone in national Indigenous political resurgence. Couched in the liberal language of equality and "non-discrimination," the White Paper maintained that Indians' disadvantaged social, economic, and political position in Canada stemmed not from unfulfilled

87 Lloyd Barber, "NWT Will Offer Birth Control Facts," *Journal* (Edmonton) (n.d. November 1967), DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC. Before 1974, the governing Council was composed of a mix of elected members and Ottawa appointees.

88 See http://www.statcan.gc.ca/pub/11-516-x/pdf/5500092-eng.pdf (accessed 26 April 2015).

89 "Canada's Shame," *Journal* (Edmonton) (n.d. November 1967), DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

90 Statement of the Government of Canada on Indian Policy (1969), http://www.aadnc-aandc.gc.ca/DAM/DAM-INTER-HQ/STAGING/texte-text/cp1969_1100100010190_eng.pdf (accessed 4 May 2015) (White Paper).

91 According to Pierre Trudeau, "the Just Society will be one in which our Indian and Inuit population will be encouraged to assume the full rights of citizenship through policies which will give them both greater responsibility for their own future and more meaningful equality of opportunity." Cited in Pierre Trudeau, *The Essential Trudeau*, edited by Ron Graham (Toronto: McClelland and Stewart, 1998), 16–20.

treaty promises or systemic discrimination but, rather, from their different legal status.[92] To create legal equality, the policy proposed to dismantle the Indian Affairs bureaucracy, repeal the Indian Act, and nullify the treaties; it was the logical culmination of the century-long policy of assimilation.[93] Indigenous groups across the country responded with a clear rejection of the badly flawed policy, instead articulating a defence of treaty and Aboriginal rights and demands for greater economic and educational development.[94] The widespread denunciation of the White Paper, supported by the press, led to its withdrawal by early 1971. But its legacy, aside from the impetus for regional groups to organize into a national Indigenous voice, was the deepening distrust of government and a lingering suspicion that termination, or what Harold Cardinal called "cultural genocide," remained the hidden agenda in policy-making.[95] A somewhat chastened bureaucracy learned that to avoid controversy it might consult with community leadership before openly distributing birth control information and technologies. Nevertheless, the amended Criminal Code raised the stakes; reproduction remained a vital state interest and the IHS continued its efforts to control Indigenous women's fertility to produce a "normal" family size.

In 1970, the Department of National Health and Welfare established its Family Planning Division that directed information and public funds to non-governmental organizations, particularly the Family Planning Federation, to promote birth control programs.[96] Provinces had jurisdiction for health services, so the federal government did little more

92 Statement of the Government of Canada on Indian Policy, 1969.

93 Indeed, foreshadowing the White Paper, for much of the previous decade the IHS had been attempting to off load its responsibilities for health care to the provinces by restricting services and closing its Indian hospitals. Indigenous organizations, particularly in Alberta and Saskatchewan, were politically active in resisting government attempts to abrogate their treaty rights. "Amendments to the Medical Services Program," regional director memorandum, 26 February 1968, DNHW Records, RG 29, vol. 2936, file 851–1-X400, pt 2(b), LAC; Harold Cardinal to All Chiefs and Band Councils, 13 June 1969, DNHW Records, RG 29, vol. 2936, file 851–1-X400, pt 3(a), LAC.

94 Along with the Alberta Chiefs' response, its 'Red Paper' or *Citizens Plus*, other counter-proposals to the White Paper included: Union of British Columbia Chiefs' *A Declaration of Indian Rights* (1970); Manitoba Indian Brotherhood, *Wahbung: Our Tomorrows* (1971); Association of Iroquois and Allied Indians' *Position Paper* (1971). Cited in Sally Weaver, *Making Canadian Indian Policy: The Hidden Agenda, 1968–70* (Toronto: University of Toronto Press, 1981), 188–9.

95 Harold Cardinal, *The Unjust Society* (Edmonton: Hurtig, 1969), 1, 126, 139; Weaver, *Making Canadian Indian Policy*.

96 It produced pamphlets targeting two groups in particular, "Birth Control … Facts for Teenagers" and "To Live and Be Free," which were suitable for use by "lower socio-economic groups." Brian Stehler, Family Planning Federation, to

than encourage them to establish birth control services. But, as much as John Munro might have wanted to leave policy to private agencies, in his capacity as federal minister of health he was also the health minister of the NWT. With its responsibility for health services for Indigenous people and the NWT Council's now annual motions to develop a "universal and intensive scheme for dissemination of information about birth control and family planning," which was intended to curb what it deemed unchecked population growth among the Indigenous community, the IHS developed its confidential "Family Planning Policy" in October 1971. Its "principles and philosophy" for family planning in the "Indian Health Context" began: "Balance between population size and available natural resources and productivity is necessary for human happiness, prosperity and peace." The second principle stated that "[a] balance between family size and family income is necessary for raising standards of living and improving health."[97] Not until Principle 5 (of ten) was an individual's right to exercise free choice in the practice of family planning assured.[98] Not surprisingly, the policy was drafted on the advice of the Family Planning Federation and International Planned Parenthood Federation, among others.[99] It raises what historian Matthew Connelly calls the critical question of "who would actually do the 'planning' in 'family planning.'"[100]

The IHS policy set out one objective: the reduction of "abnormally high birth rates." It began by noting that a relationship between the number of "unwanted children" and high infant mortality rates "probably exists," eliding the question: "unwanted" by whom? A lowered

Dr Lennox, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 2, LAC; it also directed the Canadian International Development Agency to provide assistance to population control programs in the Third World. Appleby, *Responsible Parenthood*, 217.

97 J.H. Wiebe to Professional Staff "Confidential, Family Planning Policy," 8 October 1971, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 2, LAC.

98 The other principles stated that planning could not be freely undertaken without sufficient information, education, and instruction. J.H. Wiebe to Professional Staff "Confidential, Family Planning Policy," 8 October 1971, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 2, LAC.

99 The memo states that the policy was developed at a February 1971 meeting with departmental officials and representatives of "national agencies which were active in support of family planning programs," which also included the Canadian Medical Association, the Association of Canadian Social Workers, the Canadian Nurses Association, and the short-lived Centre de planning familial du Québec.

100 Connelly, "Seeing beyond the State," 222.

birth rate would also reduce infant mortality, the incidence of unwanted children, and child abuse and neglect. It carefully avoided making a causal link between high birth rates and the consequences; instead, implying simply that fewer babies meant fewer problems and an "improvement in family comfort and nutrition." Sexual sterilization was not to be withheld when requested or when deemed medically necessary as long as both partners understood the "likely result" and signed their consent. The policy memo also noted that advice and explanations might need to be translated into a "native language." Alongside sterilization, the IUD was the only other birth control technology mentioned and only to advise that physicians should insert the device (although the following year, northern nurses were trained to insert IUDs).[101] The policy promised that family planning would benefit communities, but "its introduction to sensitive native groups could have diverse social, economic, religious and political consequences ... [F]irm backing is therefore necessary from native organizations to avoid commotion." The deputy minister cautioned regional directors to consult with "Native organizations (bands)" before publicly promoting birth control in their communities. However, "low key" efforts should encourage personal demands for medications and contraceptive technologies, which would be met through existing medical and gynaecological arrangements and would be dispensed free of charge.[102]

Even as the Liberals had been preparing their Criminal Code amendments in early 1969, Minister of Health and Welfare John Munro referred to the "genocide question – which arose in a certain form when Harry Cardinal was here." He cautioned that they should avoid American mistakes where birth control programs were "so obviously pointed at Negro areas." He advised that if the government established openness and credibility in its discussions of birth control aimed at the whole Canadian community, the "message would at least partially get through to sub-groups like our Indians."[103] Nevertheless, the 1971 Family Planning Policy, informed by population control arguments, strove to produce "normal" birth rates. The policy acknowledged that, while some Indigenous communities might welcome their efforts, "[o]thers may feel that the strength of the Indian race

101 M.L. Webb, assistant deputy minister to Ian Watson, member of parliament, 28 February 1972, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 2, LAC.

102 J.H. Wiebe to Professional Staff, "Confidential, Family Planning Policy," 8 October 1971, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 2, LAC.

103 Minister to J.N. Crawford, deputy minister, 12 February 1969, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC.

may be affected."[104] The emergence of revitalized Indigenous political organizations, highly critical of the state, suggested to policy framers that the document should remain "confidential."

Sterilization abuse accusations accompanied the Criminal Code amendments. In early October 1970, Member of Parliament David Lewis rose in the House of Commons to ask the minister why five Inuit women from the small Arctic community of Holman Island underwent sterilization, an "unnecessary and inhumane program, in view of the availability of birth control methods."[105] Minister of Indian Affairs Jean Chrétien assured the House that the women and their spouses consented to the procedure after consultation with two physicians.[106] IHS officials explained that requests for sterilization in the North were handled as they were in any province; women consulted their physicians, who would then make the determination. The high number was due to a backlog of requests built up for a number of years because the only available surgeon was Roman Catholic and he had refused to perform the operation.[107] Lewis, who stated he had no reason to doubt his information, accused the government of forcing women to undergo sterilization. Although IHS bureaucrats insisted that the allegations were unfounded, they immediately refined policy directives to limit access: "[N]ative associations are critical of any methods of birth control being imposed on native people of Canada. They are particularly sensitive about permanent methods of birth control such as tubal ligation and vasectomy." Policy for sterilization reiterated the need for a "definite medical indication" for the procedure, written consent by both partners in the presence of an interpreter and an Indian Affairs welfare officer, and prior bureaucratic approval. Explaining the directive, regional director G.C. Butler stated he did not want to "deny native patients the same rights as non-native," but in his opinion patients did not understand the implications of sterilization, it was "most important that we protect him from his own ignorance in this matter."[108]

104 J.H. Wiebe to Professional Staff- Confidential, Family Planning Policy, 8 October 1971.

105 Canada, *House of Commons Debates* (9 October 1970), 16.

106 Canada, *House of Commons Debates* (14 October 1970), 111.

107 "Eskimo Sterilization Inhumane – Lewis," *Journal* (Edmonton) (15 October 1970).

108 G.C. Butler, regional director to zone directors, 29 October 1970, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 2, LAC.

CONCLUSION

Class, region, and race shaped women's access to contraceptive information and technologies around the globe. The NWT Council's demands for widespread dissemination of birth control in Indigenous communities resonated with politicians and "family planning" experts who considered the economic implications of a population explosion to be too vital an issue to leave to women. White, middle-class physician bureaucrats developed policies based on the assumption that Indigenous women were not sufficiently motivated to effectively control their own reproduction. Ironically, as soon as birth control was legalized, women's access to it became increasingly constrained. The distribution of birth control information and education, as a part of maternal health care, was limited both by inadequate community health care facilities and by concerns that it would provoke an Indigenous nationalist backlash. Coercion underscored the medical and political discourse of Indigenous women's reproduction. As historian Rebecca Kluchin argues in the American case, contradictory trends of surgical sterilization emerged in the post-war as white women struggled against pronatalist medical practice to gain access to the technology, while poor women of colour struggled to resist coercive sterilization.[109] In an effort to shield it from criticism and liability, the IHS policy for sterilization of Indigenous women required the approval of two physicians and the written consent of both partners. Yet, until 1977, IHS policy for the NWT stated that

> all primagravida [first pregnancy] and grand multiparae (fifth and subsequent infants) [are] evacuated to a hospital for delivery as are all complicated pregnancies or anticipated complications. Provided no complications ensued at the birth of the first infant or if all else is well, second, third or fourth babies are delivered in nursing stations.[110]

In unfamiliar hospitals, and often unable to understand the language, Inuit women's reproductive choices were routinely compromised by physicians, nurses, or private agencies recommending sterilization.[111]

109 Native American women were particular targets of sterilization abuse in the 1960s and 1970s in the United States. Rebecca Kluchin, *Fit to Be Tied*, 8, 108–9.

110 By the early 1980s, all women were evacuated to hospitals for childbirth. Patricia A. Kaufert and John D. O'Neil, "Cooptation and Control: The Reconstruction of Inuit Birth," *Medical Anthropology Quarterly* 4, no. 4 (1990): 431.

111 G.D. Gray to Zone Superintendent, 3 September 1965, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 1, LAC; the Yellowknife Family Planning Clinic, a member of the Family Planning Federation, visited all postpartum patients in

As noted at the outset, in early April 1973, CBC national television broadcast an exposé of sterilization abuse of First Nations and Inuit women at the hands of the federal government's IHS. Journalist Charlotte Gobeil interviewed a non-Indigenous woman who shared a hospital room at Charles Camsell Hospital in Edmonton with a distraught Indigenous woman who was sterilized against her will. Asked why she thought women were being sterilized, "Anna," whose mother had been sterilized, claimed: "I think they're [white people] afraid of the Indian people ... Because a few years ago the Indian people, they were so quiet, but now they are starting to become aware of all their rights ... I work with the Indian Brotherhood of the Northwest Territories, I'm in contact with these Indian people every day, and I think the white people are afraid of the Indian people."[112] Gobeil next interviewed a community chief who suggested that white people might need population control, but in the north "we've got lots of room." A local priest also claimed that the government was intent on a deliberate plan to "cut down on the population as quick as they can" in order to have a free hand to develop the North.

The Canadian North and, by extension, the Indigenous population, became visible in the 1970s, and federal bureaucrats scrambled to extend their surveillance over this population at the same moment when the state was ostensibly retreating from the domestic spaces of non-Indigenous Canadians. Their actions were buoyed by the increasingly intense international debates over the balance of resources and population. In spite of the lack of density in the NWT, Canadian officials reasoned that the lack of resources placed its population in circumstances similar to those of the so-called Global South, where more dramatic policies justified aggressive family planning measures to reduce the population bomb that went hand in hand with the war on poverty.

the Yellowknife hospital. Director of the northern region to assistant deputy minister, 24 February 1972, DNHW Records, RG 29, vol. 2869, file 851–1–5, pt 2, LAC. For more information on the practice of health care workers urging Indigenous women to undergo tubal ligation after giving birth continued in 2015, see http://thestarphoenix.com/opinion/editorials/editorial-sterilization-pressure-odious (accessed 17 November 2015.

112 Transcript of the CBC's *Weekend*, 1 April 1973, DNHW Records, RG 29, vol. 2870, file 851–1–5, pt 3a, LAC. "Anna" is not her real name. It is not clear that the television broadcast identified all of the individuals interviewed, though their names, communities, and personal medical histories appear in the archival record. For that reason, we decline to identify communities or individuals by name.

ERIKA DYCK is a professor at the University of Saskatchewan and a Tier 2 Canada Research Chair in the History of Medicine. She is the author of *Psychedelic Psychiatry: LSD from Clinic to Campus* (University of Manitoba Press, 2011) and *Facing Eugenics: Reproduction, Sterilization and the Politics of Choice* (University of Toronto Press, 2013), which was nominated for the John A Macdonald Award.

MAUREEN LUX is professor at Brock University. She is the author of *Medicine that Walks: Disease, Medicine, and Canadian Plains Native People, 1880–1940* (University of Toronto Press, 2001), winner of the CHA's 2002 Clio Award and the Royal Society's 2002 Jason A. Hannah Medal, and *Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s* (University of Toronto Press, 2016).

ERIKA DYCK est professeure à l'Université de la Saskatchewan et titulaire d'une chaire de recherche de niveau 2 en histoire de la médecine. Elle est l'auteure de *Psychedelic Psychiatry: LSD from Clinic to Campus* (University of Manitoba Press, 2011) et de *Facing Eugenics: Reproduction, Sterilization and the Politics of Choice* (University of Toronto Press, 2013), ouvrage mis en nomination pour le prix John A. Macdonald.

MAUREEN LUX est professeure à l'Université Brock. Auteure de *Medicine that Walks: Disease, Medicine, and Canadian Plains Native People, 1880–1940* (University of Toronto Press, 2001), qui lui a valu le prix Clio 2002 de la SHC ainsi que la médaille Jason A. Hannah 2002 de la Société royale, elle vient de publier *Separate Beds: A History of Indian Hospitals in Canada, 1920s–1980s* (University of Toronto Press, 2016).