part five  Sites of Struggle
I recently completed five years of research on the coercive sterilization of Aboriginal women in Canada. In addition to the well-documented policy of residential schooling, the destructive effects of the Indian Act, and the many other ways in which Canada has failed to respect Indigenous peoples and their lands, resources, and ways of life, I had often been told that Aboriginal women were sometimes subject to sterilizations under coercive circumstances or without their consent. The paucity of research on this topic led me on a journey through government records to begin to formally document this practice. Although the full extent to which sterilizations were carried out and the complete circumstances under which these took place have yet to come fully to light, what I uncovered was consistent with the stories I had heard.

The federal documents I looked at reveal that approximately twelve hundred sterilizations were carried out in federally operated medical services hospitals and Indian hospitals from 1970 to 1976
on Aboriginal women from at least fifty-two northern settlements.\textsuperscript{2} Documents indicate that linguistic barriers and the failure of health workers to use proper interpreters when providing medical services to often isolated communities led women to be sterilized without their informed consent.\textsuperscript{3} In the 1970s, Brian Pearson, then a councillor for the Northwest Territories at Frobisher Bay, stated that it was generally known that a number of women had been sterilized without their full knowledge of what the procedure entailed.\textsuperscript{4} Granting that perhaps this was not an intentional policy, he noted a general climate of paternalism that led doctors to perform the procedure on women “for their own good” in the face of their “enormous” families.\textsuperscript{5}

As my research progressed, it became clear that Aboriginal women had experienced injustices in the provision of other reproductive services as well. The documents I reviewed tell us that prior to the 1969 amendment to the Criminal Code decriminalizing contraceptives, the first controversial birth control pill was distributed to Indigenous women in many areas across Canada and that health workers sometimes persuaded women to take it as a matter of a “departmentally directed course of instruction.”\textsuperscript{6} At least some officials hoped that this measure would prove effective in reducing the Indigenous birth rate, thus enabling a reduction in the size of the homes government would need to provide.\textsuperscript{7} Federal discussions around this time demonstrate that this fiscal concern influenced its decision to decriminalize contraceptives; it was anticipated that making contraceptives available to the whole population would have an effect on certain groups with high birth rates—in particular, Aboriginal peoples.\textsuperscript{8} The Criminal Law Amendment Act, 1968–69, also granted women the ability to procure an abortion if a committee comprising three medical doctors agreed that an additional pregnancy would endanger her mental, emotional, or physical health.\textsuperscript{9} While some continued to be denied access to abortions—namely, those in better financial situations and whose “health” was unlikely to be negatively affected by another child—others were subject to the procedure for economic reasons.\textsuperscript{10} The Badgley Committee, formed in 1975 to study the equitable operation of abortion law in Canada, also found that some women were pressured to consent to sterilization when they were in the vulnerable position of being an applicant for abortion and that sterilization was sometimes a prerequisite to obtaining the service.\textsuperscript{11}

An investigation into abortion in the North began as a result of one Indigenous woman claiming she was forced to undergo an abortion without
anaesthesia at the Stanton Territorial Hospital in Yellowknife. Her revelation led to more than one hundred additional complaints from women who had had similar experiences.\textsuperscript{12} The hospital, which serves primarily Indigenous women, responded that it provided Aspirin for pain relief during abortion procedures. A subsequent medical audit in 1992 confirmed these and other instances of abuse.\textsuperscript{13} This type of situation also existed elsewhere. For instance, a 1994 British Columbia Task Force on Access to Contraception and Abortion found that because of their poverty, many Aboriginal women were pressured by health care providers to have abortions, consent to sterilization, or submit to long-acting contraceptives and that because of these practices, they were being denied the right to make genuine choices about their reproduction.\textsuperscript{14} As recently as the early 2000s, Aboriginal women were being encouraged to use the long-acting, provider-dependent, and potentially dangerous contraceptive Depo-Provera as a first-choice option in what appears to be an attempt to alleviate the strain on inadequately funded public health and social services.\textsuperscript{15}

The above examples demonstrate that reproductive services have been imposed on Aboriginal women in unequal, coercive, and abusive ways. In all of these instances, however, these injustices, which are not part of Canadians’ common knowledge, took place at the same time that other women struggled for increased access to these very same services. Why do these contradictions consistently arise? What is missing from our struggle that allows so-called gains for some to be employed coercively on others? Many thoughtful people have pointed out that we make choices in different contexts and that many factors constrain the options available to us. The prominent focus on individualized choice in Western society denies the contextual nature of decision making and obfuscates the existence of any systematic abuse directed toward certain populations. As Marlene Gerber Fried and Loretta Ross write,

> Individual freedom of choice is a privilege not enjoyed by those whose reproductive lives are shaped primarily by poverty and discrimination.\ldots

There are common threads in public policies that restrict abortion, coerce birth control, advance population control and criminalize pregnant women. In each area the government uses the ideology of individual choice to escape responsibility for the conditions of people’s lives. It locates the cause and the blame of poverty in women’s
individual choices—women are poor because they have too many children. This mentality also legitimizes state control when individual decisions are not to the liking of those in power.16

Unequal relations exist between the Indigenous peoples of Canada and non-Indigenous Canadians and between Western medical practitioners and Indigenous women. The context in which Indigenous women make choices continues to be one characterized by colonialism and assimilation. The reproductive violence experienced by Indigenous women cannot be separated from the larger systemic violence perpetrated as a result of the past and current colonization of Indigenous peoples and their lands.17 Nor can the lack of control that non-Indigenous women experience over their reproductive lives be separated from the larger capitalist and patriarchal society in which we live.18 The reproductive rights movement must move beyond reformist strategies and single-issue struggles and work to transform this larger context, both to avoid reproductive options from being wielded coercively on Indigenous and other marginalized women and to ensure real choice for all women.19

This transformation must involve the reproductive rights movement critically assessing the types of choice that women are being offered. If women are, in any way, denied control over our reproduction, how does increased access to state-provided services work to affect this reality? Are those services that are offered truly gains, or do they pale in comparison to the control and understanding that we could hold and have held, historically, over our bodies under different modes of social organization?20 Our enforced dependence on state-provided services in the absence of a transformation of the very system that has been built on the exploitation of women results in our “choices” sometimes being manipulated in ways that further perpetuate exploitive and oppressive relations. We also need to consider that many reproductive services have been developed at the expense of women’s well-being and are often harmful to our bodies and that instances of their coercive use are now increasingly concealed behind doctor-patient privilege and the rhetoric of individual choice.

Maria Mies argues that only by revolutionizing the relations upon which exploitation and oppression are based can the reproductive abuses experienced by women be overcome.21 Nearly thirty years ago, Betsy Hartman also argued that two basic sets of rights are at issue in attempts to gain reproductive freedom for women. Women have a fundamental right to control our
own reproduction, but to achieve this, the relationship between the provider and recipient of reproductive services must be transformed: control must be taken out of the hands of the medical profession and placed back into the hands of women. Yet, as Hartman points out, reproductive freedom is predicated on women having greater control over our economic and social lives. This brings us to the second set of rights: everyone on earth today has the right to a decent standard of living through access to food, shelter, health care, education, employment, and social security. Notwithstanding the birth rate in any community, it is possible to create such a society. The question we need to ask is whether this can be achieved from within a system based on values and principles that are antithetical to this vision.

To this we must add another crucial point. The abuses experienced by Indigenous women have been perpetrated by a foreign government with the help of Western institutions, including Western medicine. Aboriginal women have the right, as members of their own peoples, to decide what types of reproductive options to employ, whether these originate in Western or Indigenous ways. To create a context in which choice becomes a meaningful concept, Aboriginal peoples must have their lands, resources, and freedom returned to them. Then they can choose to provide subsistence without stipulations. As Justine Smith writes,

In the Native context, where women often find the only contraceptives available to them are dangerous . . . where they live in communities in which unemployment rates can run as high as 80 percent, and where their life expectancy can be as low as 47 years, reproductive “choice” defined so narrowly is a meaningless concept. Instead, Native women and men must fight for community self-determination and sovereignty over their health care.

This is indeed where the struggle must be differentiated for non-Indigenous Canadian women and the Indigenous peoples on whose lands all non-Indigenous Canadians now depend. Indigenous voices have consistently challenged the relevance of a feminist movement that has often found itself on the wrong side of history, especially when it comes to the lived realities of Aboriginal women. If social justice advocates are to pursue goals that are good for all women, we must acknowledge, and prioritize active resistance to, the long-standing colonial relations between Indigenous peoples and settlers. We need to enlarge our view of what control over our bodies
truly looks like and what steps are needed to achieve this. But we must also envision what type of world we want to live in and what the fundamental requirements are to get us there. Justice will never be achieved by settling for only those rights that an oppressive and exploitive system is willing to grant. What is given too often falls short of what is truly needed and is constantly under threat of being taken away. As Linda Gordon pointed out three decades ago, to win real justice for all women is to ask for profound societal change, and it is best to recognize the radical implications of this type of project.\(^\text{26}\)

Notes


2 For a more in-depth discussion of the information included in this chapter, see Karen Stote, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women.* For a general overview of some of these findings, see Karen Stote, “The Coercive Sterilization of Aboriginal Women in Canada.” These sterilizations are in addition to those we already know about. Under legislation in effect in Alberta from 1928 to 1972, Aboriginal women were disproportionately targeted relative to their numerical significance in the general population. They were also the most likely to be defined as mentally incompetent: hence, their consent was not required. In British Columbia, similar legislation was in effect from 1933 to 1973. Although records are said to be lost or destroyed, Aboriginal people were institutionalized in facilities where sterilizations took place, and at least two out of nine women involved in a class action lawsuit in 2005 were of Aboriginal descent. There is also evidence of sterilizations occurring in other provinces, including Ontario, Manitoba, and Québec. See Jana Grekul, Harvey Krahn, and Dave Odynak, “Sterilizing the ‘Feeble-Minded’: Eugenics in Alberta, Canada, 1929–1972”; Gail Van Heeswijk, “An Act Respecting Sexual Sterilization: Reasons for Enacting and Repealing the Act”; Kathleen McConnachie, “Science and Ideology: The Mental Hygiene and Eugenics Movements in the Inter-war Years, 1919–1939”; and Angus McLaren, *Our Own Master Race: Eugenics in Canada, 1885–1945.*


4 LAC, RG 29, “Birth Control,” vol. 2870, file 851-1-5, pt. 3A, correspondence from Marc Lalonde to Laurent Picard, president, Canadian Broadcasting


6 Enovid, the first hormonal contraceptive on the market, was controversial because of its high hormone levels and because it had been tested on Puerto Rican women in unregulated clinical trials during the late 1950s and early 1960s. See LAC, RG 29, “Birth Control,” vol. 2869, file 851-1-5, pt. 2, correspondence from J. H. Wiebe, MD, director, Medical Services, to regional directors, 8 October 1971; and Annette B. Ramírez de Arellano and Conrad Seipp, *Colonialism, Catholicism, and Contraception: A History of Birth Control in Puerto Rico*.


9 The Criminal Law Amendment Act, 1968–69 (S.C., 1968–69, c. 38), which originated as Bill C-150, received royal assent on 27 June 1969. The section of the law dealing with abortion was eventually overturned in 1988 with the *R. v. Morgentaler* ruling, which left abortion governed only by provincial and medical regulations.

10 The rationale was that an additional child born to an impoverished woman would cause a strain on her mental or emotional health. See Geoffrey Stevens, “Warning on Abortion,” *Globe and Mail*, 23 October 1974, and “A Strange View of Law,” *Globe and Mail*, 24 October 1974.

These complaints were received by the Northwest Territories Status of Women Council. One woman quoted her doctor as stating, after the abortion was completed: “This really hurt, didn’t it? But let that be a lesson before you get yourself into this situation again.” See Mary Williams Walsh, “Abortion Horror Stories Spur Inquiry—Canada: Questions Raised After Women Alleged Hospital Denied Them Anesthesia as Punishment,” Los Angeles Times, 3 April 1992; and JoAnn Lowell, “NWT Abortion Review Puts Spotlight on the Politics of Medicine,” 27.


For a historical understanding of the connections between capitalism and patriarchy in Western European society, how these relations were imposed, and the consequences for women and their knowledge of and ability to control their reproductive lives, see Silvia Federici, Caliban and the Witch; and Maria Mies, Patriarchy and Accumulation on a World Scale: Women in the International Division of Labour.

20 For an outline of some of the knowledge historically held by Western women and how it was undermined, see Barbara Ehrenreich and Deirdre English, Witches, Midwives, and Nurses: A History of Women Healers; and John Riddle, Contraception and Abortion from the Ancient World to the Renaissance, and Eve's Herbs: A History of Contraception and Abortion in the West.

21 Maria Mies, “‘Why Do We Need All of This?’ A Call Against Genetic Engineering and Reproductive Technology,” 553.


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———. “‘Why Do We Need All of This?’ A Call Against Genetic Engineering and Reproductive Technology.” *Women’s Studies International Forum* 8, no. 6 (1985): 553–60.


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