The Genocide Continues

Population Control & the Sterilization of Indigenous Women

Karen Stote

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Development editor: Tanya Andrusieczko
Copyediting: Lisa Frenette
Text design: Brenda Conroy
Cover design: Evan Marnoch
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To merely resist is not enough for me any more. I am interested in having a place that feels right and fits right … resistance only gains mere survival. I cannot, and I suppose will not believe that the Creator gave us the walk, gave us life, to have nothing more …

Sometimes we do not resist when we should. Sadly, some of us never learn how to resist or reject beyond resisting or rejecting ourselves … Other times we resist each other because it is safer …

[While] I must sometimes rely on acts of resistance … I must always remember resistance … means the only choice I have is to respond … I do not have free choice about what it is I am going to do …

I grow weary of talking about the pain, the statistics, the crisis. I understand that hope will not be built with these words. A step forward for me … is to begin to imagine humanity, freedom and independence.

—Patricia Monture-Angus (1999a, 68, 72, 80, 87)

Preface

Bringing this book to completion was one of the hardest things I have ever done. This work began shortly after the sudden death of my partner; the grief of which I avoided for another six years. In that time, I was increasingly exposed to the personal and collective grief carried by Indigenous women who were coercively sterilized. In 2016, I was contacted by a woman in Saskatoon, and after by a lawyer acting on her behalf and that of others who were coercively sterilized. I began some of the research informing this book in 2017 to assist with a proposed class action lawsuit. I also came to know another Indigenous survivor who approached me about contributing to an edited collection on coerced sterilization. The first edition of *Sacred Bundles Unborn* was published in 2022, and a second edition in 2024. I refer to the finalization of the first edition of that project as "my undoing" because when faced with the outpouring of grief in those pages it became obvious I could no longer continue without facing my own. Thank you to Morningstar for creating that space, sharing your story, and bringing together a chorus of voices speaking out against coerced sterilization so that none of us feel as alone as we did before. And thank you for all the laughter and learning in times of grief.

The weight of this unfinished manuscript hung over me in the time I left my job to face uncomfortable aspects of my own life experiences. I often wondered if I had the wherewithal to return and finish what I had started. But life went on and struggles continued. I remember Wet'suwet'en resistance to pipeline expansion in their territory and the RCMP being called in to "sterilize the site" by arresting land defenders. Then, there was a COVID-19 pandemic. The "discovery" of unmarked graves of children who attended residential schools followed. Mass demonstrations took place in response to police violence against Black bodies, including the death of George Floyd, one of many Black people killed at the hands of the state. More Indigenous women who were coercively sterilized came forward to share their experiences before

the Senate Standing Committee on Human Rights. The United States Supreme Court overturned *Roe v. Wade* to end or severely restrict abortion access. Queer and trans people have faced the renewal of a longstanding attack against them led by the religious and political right and some governments. There is a war in Ukraine, another in Sudan, longstanding violence in Gaza; and the list goes on.

I have done a lot of thinking about grief. The interconnections between these struggles and my own are more obvious to me today than ever before. I have come to the conclusion that we are all grieving even if our experiences are different, and even if some of us are making out better than others. My inability to tend to my grief, connected to my own experiences as a queer person in this world, was exhausting. It made me fearful and closed off to the possibility of doing differently. Denial and avoidance are strong impulses. Sometimes we tell ourselves this avoidance is a form of resistance. I know from experience when we avoid facing hard things, they rankle and fester and grow to such an extent it becomes difficult to think we could ever deviate from the path to which we have committed. Grief cracks a person open and there is pain in that. It is no wonder we try to avoid. But the cracks have formed and there are lessons in prying them open. In those cracks exist possibilities to do differently. It is only by facing what is uncomfortable, by opening space and shedding light, that things change.

Writing this book has confirmed to me that there are cracks in much of what Canadians hold dear. The institutions we rely on, the jobs we hold, our way of living, and many things we do for pleasure or comfort are embedded in violence and dehumanization. The functioning of this world as it exists depends on our continued denial of this reality, and this denial makes it difficult for us to imagine how things could be different. It is my hope this work is part of the cracking open of Canadian consciousness that is necessary for us to face what is uncomfortable; to acknowledge our own grief and that of others; to think about what is and how we got here; and to see each other in our humanity. It is only when we are taught to deny our own humanity that we become capable of denying it to others. The capitalist social relations under which we live, that link us to people and places beyond ourselves, exist at the expense of all our humanity. We are being tricked if we think otherwise.

If there is one useful thing I learned through countless hours of therapy is that our ways of coping serve a purpose; they allow us to

survive. However, at some point we need to decide if these ways are working. They were not working for me, they are not working for you, and they certainly are not working for Indigenous Peoples. They never were. It is past time we pry open the cracks and re-imagine something new. We cannot continue to cover up the light. There are many trying to do differently despite the personal and collective grief they carry. We cannot let avoidance and fear paralyze us. It is only in doing that we find each other, forge relationships, and learn to do differently. Imagine all we could do if more of us worked together.

The territories we call Saskatchewan are home to Cree, Dakota, Dene, Nakota, Saulteaux, Métis, and an increasing number of Inuit. I want to acknowledge you. I realize I am speaking of you in these pages without you knowing me. It is not my intent to speak for you. I hope this work is useful in some way. I recognize the terms Registered Indian, Status and non-Status Indian, First Nation, Native, Aboriginal, or Indigenous do not reflect who you are. I also know the place names referred to are not your own names for these spaces. Neither does this work engage in the history of responsibilities set out in Treaties 2, 4, 5, 6, 7, 8 and 10, which cover Saskatchewan, how they are eschewed, or their consequences for you.[1] I refer to Indigenous women who have come forward with their experiences of coerced sterilization by their initials even though many names are easily findable in news articles. I do this to leave the decision up to women to identify publicly. This decision can change from day to day, and some have changed their mind after coming forward, partly because of the backlash they received. I want to acknowledge all of you and others who remain unknown to us. I know you are out there.

This work relies on research conducted at Library and Archives Canada, the Provincial Archives of Saskatchewan, and information accessed from the Saskatchewan Ministry of Health and Indigenous Services Canada. It also revisits sources other historians have relied on to tell histories of public health. While writing this book would have been much more difficult without the work of others, I was often taken aback by the lack of mention of Indigenous Peoples in these histories despite their appearance in many primary documents. I still wonder why they were left out. Linda Tuhiwai Smith wrote that if we think history is about justice, we are wrong. History has been about power; the story of the powerful and how they became so. If this is true, Smith asks, why write history at all? To which she responds, because there is unfinished

business. Indigenous Peoples are still being colonized (and know it) and are still searching for justice (1999, 34). It is my hope this contribution is useful in that search. The history in these pages is one missing piece in broader histories of public health and it is unapologetic in seeking justice for Indigenous Peoples. It is also unapologetic in my own desire to live in a better world.

Scholars increasingly refer to the social, political and economic formation of colonialism in Canada as "settler colonialism" to highlight the structure social relations take when settlers assert sovereignty over and make home on lands they are exploiting, how Indigenous Peoples must be "disappeared" as a result, and the profound resulting violence perpetrated by the state and coordinated through its institutions that results in genocide.[2] I acknowledge this important scholarship but refer to "colonialism" throughout to better reflect the language of Indigenous struggles outside academia. Other times I refer to capitalism in a way that assumes colonialism because for Indigenous Peoples in Canada, colonialism cannot be separated from capitalism. It is what brought settlers here and it is the reason colonialism continues.

I highlight the intersections between capitalism and colonialism to stress the ties each has to the other. It has been my experience when many of us hear talk of colonialism, we assume this only involves Indigenous Peoples. We often fail to understand how violence committed against Indigenous Peoples involves other Canadians; that this violence arises from a way of life that impacts us too. We actively impose this violence on Indigenous Peoples through our assertions of ownership over these lands, the institutions we turn to for assistance and depend on for our livelihoods, the ways we think about the world, and how we live our lives. In our failure to locate ourselves within this reality we become complicit in genocide. A central argument in this work is that capitalism and the material requirement for access to Indigenous lands for profit is intimately connected to colonial violence against Indigenous bodies; one leads to the other and each involves us. Until we understand these connections, which form the basis of our collective relationship with Indigenous Peoples, we will not be able to end violence against Indigenous bodies *or* lands. We will not be able to engage effectively in our own struggles either.

I often refer to institutions of health and welfare as public health because each is concerned with the health of society however defined,

and with social welfare issues, and both were drawn into an increasingly complex web of relationship through government policy in managing the effects of colonialism in Indigenous lives. Many problematic terms appear in this history referring to the "feebleminded," "mentally deficient," "retarded," and others. These terms say something about the arrogant disdain many in power held toward those suffering exploitation and marginalization. In terms of citational practices, the reader will find in text citations for published works; archival and other primary sources, and explanatory materials, are in endnotes.

The story in the following pages highlights some of the corporate-federal-provincial intersections that gave rise to coerced sterilization as a cost-effective public health measure. Each exerted influence over ideologies and knowledge produced and legitimated in universities and other public institutions, enacted through laws and policies, carried out in the careers some of us perform, and reinforced in the stories we tell about who we and Indigenous Peoples are. The Rockefeller Foundation features centrally here. Named after the richest man in history at the time, the Rockefeller Foundation is also symbolic of all capitalist interests that shape how society functions and why decisions are made to the detriment of many.

Following the publication of my first book, *An Act of Genocide: Colonialism and the Sterilization of Aboriginal Women* (Fernwood Publishing, 2015), I was accused by some of engaging in conspiracy theories. There is no need for conspiracy when attempting to understand the influence corporate interests have exerted on governments, lands, and people(s), or how these interests shape policies meant to control populations in the interest of the political economy. The connections are documented. Only some of them are highlighted here. The attempt to curb Indigenous reproduction has never been the result of "dark conspiracies"; it is simply the recognition and articulation of class interests (Brown 1982, 139) that some of us reinforce even if we do not like to admit it. To become aware of this reality holds the possibility for us to link struggles and engage in the collective action necessary to build a more just world.

Introduction

> *It is through institution building and the institutionalization of their personal fortunes that … elites perpetuate their influence and give a stabilizing "class effect" to an elite organization — not class in relation to the market, but class as a … legacy of ideas and institutions.* (Marcus 1983, 43)

Indigenous women in Canada have been subject to coerced sterilization since the 1930s. In Alberta and British Columbia, sterilization legislation informed by eugenic theories of population control provided a mechanism to justify a practice that continued over four decades (Grekul, Krahn and Odynak 2004; van Heeswijk 1994; Dyck 2013). By the early 1970s, over three thousand people had been sterilized under eugenic legislation, which disproportionately impacted young Indigenous women. More than one thousand Indigenous women, and some men, were also coercively sterilized in federally operated Indian hospitals and the North, from the late 1960s into the early 1970s (Stote 2015). This history reveals a lack of informed consent, language barriers, inadequate use of interpreters, and racism and paternalism on the part of health and welfare professionals and policy makers that, when coupled with long-standing relations of colonialism, informed the coercive context of these sterilizations. Canadians have only begun to grapple with this history, let alone how it continues.

Since 2015, more than one hundred Indigenous women have come forward with their experiences of coerced sterilization — from the 1970s and as recently as 2019. In that year, an Inuk woman filed an individual claim against a doctor who sterilized her without consent at Stanton Territorial Hospital (formerly Stanton Yellowknife Hospital) in the Northwest Territories (Zingel 2022). The doctor who removed her ovaries and fallopian tubes has since apologized for his "unprofessional conduct" (Kotaska 2023). A Rae Edzo woman sterilized at this hospital in 1986, at the age of fifteen, filed a similar claim in 1997.[1]

In another, a woman was sterilized without consent after giving birth at the Whitehorse General Hospital in 2002.[2] Proposed class action lawsuits are now pending in Saskatchewan, Alberta, British Columbia, and Manitoba, and a civil suit is proceeding in Quebec, each naming different levels of government, health authorities, and physicians as responsible for coerced sterilization.[3] In these cases, women describe their own unique yet similar experiences of coercion, misinformation, and discrimination in health and welfare leading to their sterilization without informed consent.[4]

The coerced sterilization of Indigenous women intersects with other forms of reproductive coercion including abusive or forced abortions, the indiscriminate prescription of long-acting contraceptives — intrauterine devices (IUDs) and Depo-Provera — and obstetrical violence more broadly. In the 1980s, more than one hundred women said they were subject to abusive abortions at the Stanton Yellowknife Hospital (Lowell 1995).[5] In 1994, the British Columbia Task Force on Access to Contraception and Abortion found Indigenous women were sometimes pressured to agree to abortions, long-acting contraceptives, or sterilization.[6] More recently, in 2022, researchers spoke to thirty-five Indigenous women who experienced coerced sterilization, forced abortions, and obstetrical violence, with some experiencing all the above, in Quebec hospitals.[7] In one instance, Atikamekw mother Joyce Echaquan, who was previously sterilized against her will (Hachey 2021), died in the Centre hospitalier de Lanaudière, in Joliette, Quebec, moments after live-streaming footage of healthcare staff hurling racist remarks at her. A coroner's inquiry concluded racism and prejudice contributed to her likely preventable death as medical staff assumed she was suffering from drug withdrawal (Nerestant 2021). Still other women in Winnipeg, Regina, and Saskatoon have spoken of coercive experiences crossing multiple contexts including community-based organizations, group homes, and foster homes, in addition to health care (McKenzie, Varcoe, Nason et al. 2022). They too describe being subject to paternalism, racism, and stereotypes from health and social service providers; pressure to submit to sterilization, abortion, or an IUD; and being prescribed Depo-Provera without access to the necessary information to make an informed decision.

The trend on the part of health and welfare professionals to promote Depo-Provera, often to young women, is not new. In the 1990s, the drug was prescribed to Inuit women and girls as young as thirteen years old

as a form of chemical sterilization to curtail the birth rate (Canadian Women's Committee on Reproduction, Population and Development 1995; Scoffield 1993). In the Eastern Arctic, doctors prescribed it as a first-choice option and in at least one instance, to a pregnant woman (Sarkadi 1995). All this, despite it not being approved as contraception until 1997 (Shea 2007). This trend continued into the 2000s (Tait 2008). Métis researcher Caroline Tait stated, "In a hurry, and in an effort to address family planning and high fertility rates … dominant society turns to something like Depo-Provera … there's a feeling of, 'Well, jeez, we've got to stop these people from having all these babies'" (cited in Hawaleshka 2005, 46).

These instances are more than a dark chapter in our history. The coerced sterilization of Indigenous women never stopped; it continued in different form — long after eugenics fell into disrepute. This work provides a context in which to understand this reality through a focus on Saskatchewan — the province from which many Indigenous women have come forward. Saskatchewan did not enact sterilization legislation, but a draft bill was proposed in 1930 (Dyck and Deighton 2017) and a history of eugenics, systemic racism, and colonialism shaped women's experiences.[8] This work demonstrates that population control — a concern with who occupied land and how resources were distributed — not race, was the central thread guiding public health interventions from eugenics to family planning. It traces the historical evolution of an idea, legitimized through a professional class of experts and the institutions in which they worked, that sought to control populations in the interest of the political economy and resulted in the coerced sterilization of Indigenous women.

By the 1930s, corporate interests played a central role in shaping institutions of health and welfare as they supported the training of those necessary to carry out reform work in ways that were beneficial to them. These interests guided the approach taken by the Canadian state and its provinces to public health issues resulting from social relations of exploitation, including those imposed on Indigenous Peoples — the original occupants of the lands and gatekeepers of resources on which the Canadian political economy depends. This historical material context fuels violence against Indigenous bodies in the interest of securing access to Indigenous lands, and makes the coerced sterilization of Indigenous women an act of genocide.

Corporate Philanthropy and the Formalization of Public Health

Eugenics, as one ideology of population control, featured prominently in health and welfare activities in Canada in the 1930s. During this time and to varying degrees across the country, social reformers, policy makers, and health and welfare workers promoted segregation, marriage regulation and sterilization as cost-effective interventions in the lives of those considered a burden to the newly industrialized capitalist state (McLaren 1990). The mental hygiene movement, a self-appointed body of experts — medical professionals, psychologists and psychiatrists — linked mental deficiency, or the arrested or incomplete development of the mind, to poverty, crime, illegitimacy, illness, hereditary defect, and high infant mortality rates (Dowbiggin 1997; McLaren 1990). Those involved in social hygiene — the network of religiously based reformers, charity organizations and social workers — viewed mental deficiency as contributing to sexual promiscuity, illegitimacy, alcoholism, tuberculosis, and venereal disease. Sexual health and racial purity were interlinked indicators of a healthy nation, and reform work reinforced a White Anglo-Saxon Protestant version of morality (McLaren 1990). The activities of each were practically and symbolically linked through public health (Valverde 1991).

While eugenics "meant different things to different people in different settings" (Dowbiggin 1997, 238), all were united in the goal of "efficient social management" (McLaren 1990, 112). Mariana Valverde writes the "synthesis of medicine, morality, and social reform was a powerful one, and the various wings of the movement all had a stake in preventing its fragmentation" (1991, 51). Corporate interests gave the above movements their roots and wings. The rise of organized corporate philanthropy emerged under industrial capitalism, which was impoverishing the working class as wealth was consolidated in the hands of the powerful few (Arnove 1982). This wealth, amassed through the exploitation of people's labour, bodies, and lives — and the expropriation of Indigenous lands — was partly reinvested through philanthropic foundations to shape the direction of public health in Canada and abroad.

No foundation had as much influence on the ideological approach informing public health expansion as the Rockefeller Foundation (RF).[9] John D. Rockefeller Sr., one of the richest people in history, became the first billionaire primarily through investment in oil and gas. When

he died in 1937, he had given away about $550 million of his wealth to various causes — an amount more than any American before him had ever possessed (Folsom 2010). Through the RF, established in 1913 to "promote the wellbeing of mankind throughout the world" (Weindling 1988, 119), he and his successors helped build institutions, promote ideas, and train a class of experts to carry out reform work to keep the world safe for capitalism (Berman 1983; Brown 1979). Science and technology had recently rationalized industry through a focus on efficiency and productivity, and these were relied on to address social problems created by social relations of exploitation. Public health interventions based on medical and social sciences sought to mitigate the negative consequences of a capitalist mode of production on people and populations (Brown 1979) while keeping exploitative relations intact. Richard Brown (1979) explains:

> philanthropic capitalists who supported medical science [for one] believed it would do more than demonstrate their good works. First, reductionist scientific medicine bore a striking, and not incidental, similarity to the capitalist worldview. Second, scientific medicine would help integrate all members of society, whatever their occupations or social standing, into an industrial technical culture, unifying the fragmented and often fragile industrial-capitalist social order. Third, scientific medicine would help replace the widespread class theories of misery with the perspective that inequalities and unhappiness are technical problems susceptible to engineering solutions, thus depoliticizing medicine and legitimizing capitalism. Finally, scientific medicine would help elevate the medical profession, encouraging a stronger identification of its members with the highest class in society and the capitalist order itself. (133)

The goal of corporate philanthropy, by investing in public health, was to develop and strengthen institutions that would "extend the reach … of capitalism throughout society" (Brown 1979, 9).

The RF funded eugenic activities like the Eugenics Records Office in Cold Spring Harbor, the epicentre of American studies on purported racial characteristics among groups (Black 2003), and a German program that included Nazi doctors and research with "distinct eugenic undertones"

(Weindling 1988, 130–1) which, whether fully anticipated, culminated in a Holocaust and the death of millions along ethnic, political, religious, ableist, and heterosexist lines, including Jews, Romani, Slavic, Polish, and Ukrainian people, queer people, people with disabilities, and leftists. It enabled studies seeking to locate the genetic and neurological basis of criminality; surveys on inherited diseases and the link between heredity and alcoholism; investigations into mental diseases through study of body fluids, brain cells, and "racial" variations based on blood group; twin studies of "illegitimate" children; and projects to eliminate feeblemindedness, the "social evil" linked to prostitution, venereal disease, and sexual promiscuity (Weindling 1988, 122; Kühl 1994).

In correspondence with Charles Davenport, director of the Eugenic Records Office, John D. Rockefeller Jr. wrote that to incarcerate "feebleminded" women would keep them from "perpetuating [their] kind … until after the period of child bearing had passed" (cited in Black 2003, 93). Segregation may represent "an immense economy to the city and the state" (Rockefeller Jr. cited in Gunn 1999, 108), but it could not be relied on to manage entire populations. Birth control could address fertility differentials between groups and "fit" nicely (Gunn 1999, 111) under the RF mandates of public health and medical education. Population control was the "de facto organizing principle" and "unspoken mandate" (Gunn 1999, 97–8, 101) of the RF, and its support for eugenics and broader birth control activities were means of promoting its own self-interests by managing the impact of dispossession and exploitation on populations and as it sought to ensure unimpeded access to lands for profit.

In the first half of the twentieth century, the RF helped mobilize popular opinion on birth control by enticing public health officials, sociologists, social workers, demographers, professors, government functionaries, and other philanthropic foundations to support "voluntary family planning" along "eugenically desirable lines" (Gunn 1999, 110). From 1921–35, it offered grants toward the study of populations in the fields of behavioural and physiological sex research, child development, mental hygiene, and birth control (Gunn 1999). It also funded activities carried out by Margaret Sanger through her Clinical Research Bureau, the first birth control clinic in the United States, and the American Birth Control League (ABCL), founded in 1921, until the early 1940s (Gunn 1999; Zunz 2012).[10]

In *The Pivot of Civilization*, Sanger (1922) wrote on the "emergency problem" of feeblemindedness needing to be faced. The ABCL could help educate the public on the dangers of "uncontrolled procreation" and the "necessity of a world program of birth control," enable collaboration between scientists, statisticians, investigators, and social agencies on the relationship between "reckless breeding" and "delinquency, defect and dependence," and assist in studying how these affected maternal and infant mortality. It could also promote the education of medical professionals while encouraging the sterilization of the "insane," "feebleminded," and those afflicted with "inherited or transmissible diseases." Finally, it could enable the cooperation of legal advisers, statesmen, and legislators in the removal of statutes that discouraged "dysgenic breeding" and contributed to the "population problem" and "national and racial conflicts" (281–3). The ABCL joined Sanger's Clinical Research Bureau to form the Birth Control Federation of America and in 1942, it became the Planned Parenthood Federation of America.

In 1943, Raymond Fosdick, president of the RF, who had served as counsel to the ABCL, endorsed a proposal that population work should become a top priority (Gunn 1999). He wrote:

> the problem of population constitutes one of the great perils of the future, and if something is not done along the lines that these people are suggesting, we shall hand down to our children a world in which the scramble for food and the means of subsistence will be far more bitter than anything we have at present. Scientists are pointing hopefully to such methods as Mrs. Sanger and her associates are advocating. (Cited in Zunz 2012, 94–5)

The program he and Sanger elucidated was pursued through public health expansion in Canada and abroad, and in this, the RF and various iterations of Planned Parenthood played central roles (Bashford 2014; Mass 1974; Stote 2022; Takeuchi-Demirci 2018).

By the time the horrors of Nazi Germany came to light, eugenic claims that sterilization would "solve the problem of hereditary defect, close up the asylums for the feebleminded and the insane, [and] do away with prisons" were mostly considered unrealistic — sterilization on its own was unlikely to have much of an effect in the next generation (Dowbiggin 2008, 29). Post–World War II, the motivations of eugenicists

in preventing the reproduction of the unfit merged with neo-Malthusian ideas focused on the need to reduce the fertility of some through birth control (Chase 1977; Connelly 2008; Hartmann 1995). They were joined by environmentalists who argued fertility regulation was necessary to ensure the capacity of the earth to support itself; and demographers, who studied fertility trends between populations — all of which were "so significantly enabled" (Bashford 2014, 289) by Rockefeller funding that by the 1960s their arguments were "more or less indistinguishable" (329). These arguments infiltrated the thinking of government officials and policy makers in Canada, as did the studies they produced.

In other words, population control was not a mid-century creation; it drove eugenics from the beginning (Bashford 2014). Alison Bashford highlights how the desire to control the quality *and* quantity of the population were questions of political economy — of land, resources, and the prevention of war — and these concerns were shared by traditional eugenicists, other population theorists, capitalist interests, and Western nation-states (2014, 328–9). A shared concern with who was doing the reproducing, based on notions of race, class, and gender, drew them together. Birth control, as population control, delivered under the banner of family planning, was compatible with the system of public health envisioned by corporate interests. Corporate backing gave scientific and medical legitimacy to these ideas, and by making contraceptive decisions dependent on the advice of physicians, medical professionals were positioned as the ultimate "arbiters" of population policy (Gunn 1999, 113).

The RF, through its International Health Division, shaped the global public health agenda by expanding the network of experts and agencies "fully co-ordinated through conferences, institutional cooperation and political programmes" (Barona 2021, 51). This included the League of Nations and its two arms, the League of Nations Health Organization and International Labour Organization, since their inception in 1919, and after 1945, the World Health Organization and the United Nations (Bashford 2014; Berridge 2016; Tournès 2014).[11] It funded public health campaigns against contagious diseases; promoted efforts against tuberculosis, influenza, and malnutrition; and institutionalized public health "country by country" by supporting local health units and national ministries, helping establish twenty-five schools and institutes of public health, and sponsoring 2,500 nurses, doctors, and engineers to study in public health (Birn 2014, 130).

The principle guiding its work was that public health was a function of government, but the RF would assist by providing expert advice, financial resources, and facilities to train health professionals (Iacobelli 2022). Support would be withdrawn when governments controlled their own operations (Birn 2014). The "scientific medicine" guiding public health became a powerful "ideological weapon" exonerating "capitalism's vast inequities" and "reckless practices" that shortened the lives of workers (Brown 1979, 10). The expansion of public health was also a form of imperialism (Arnove 1982; Navarro 1981) enabling Western medicine, its functionaries, and ideological approach to social problems to infiltrate an area and remain in the absence of military intervention, or after soldiers had left.[12] It was imposed on Indigenous Peoples in Canada as a tool of colonialism.

The Expansion of Public Health in Canada

Corporate philanthropy was instrumental in shaping the aims, purpose, and direction of public health in Canada. In 1911, Alice Chow, Secretary of the Kingston Charity Organization Society, which relied on corporate philanthropy to help people living in poverty, stated: "our charity, although intended for the victims of the present industrial system, sometimes indirectly benefits the employers … let me say, what the poor want is not charity, but justice" (cited in Valverde 1991, 158). Neither did those living in poverty only want birth control; they wanted to be able to support the children they already had (Richardson and Fisher 1999).

In 1919, John D. Rockefeller Sr. offered a $5 million gift to the RF with the suggestion it use these funds to support medical education in Canada (Fedunkiw 2005). The RF promoted cooperation between different levels of government and universities in mental hygiene and the social sciences. This included the University of Toronto and its School of Hygiene and Public Health (Brison 2005), a central institution training experts in public health; McGill University, including a Social Science Research Project through which scholars, some of whom directly informed the expansion of the welfare state, conducted studies on health, welfare, and the political economy (Brice 1984); and the universities of Montreal, Manitoba, Saskatchewan, Alberta, and British Columbia.[13]

Between 1913 and 1950, RF funds helped establish the Social Sciences Research Council, the National Research Council, provincial departments of health, and field offices across Canada (Brison 2005; Fisher

1991; Mullally 2009; Twohig 2002). Donald Fisher explains, institutions like the Social Sciences Research Council served as "intermediaries" or a "buffer state" between social scientists and philanthropy, the state, and ruling class interests (1999, 75). RF funding shaped the work of the intellectual elite while creating a network of "like-minded" experts who could reform society in ways congruent with corporate interests (Brison 2005, 54). It also invested in the Canadian National Committee for Mental Hygiene (CNCMH), another intermediary, to encourage surveys on mental health and the training of students.[14] The RF supported the CNCMH until 1939, after which time it sought direct relationships with the universities and research institutions it helped expand (Pols 1999).

This work considers how corporate interests influenced federal-provincial intersections in public health expansion and its impact on Indigenous Peoples, with Saskatchewan as a case study. The period from 1944–61, under the premiership of Tommy Douglas, was an important one in the expansion of public health and the professionalization of experts who could intervene in social problems. In one sense, Saskatchewan, as home to the first state-funded health insurance scheme, was a "pilot project" (MacDougall 2009, 307) for the expansion of public health across the country. In 1933, Douglas had written his master's thesis on the problem of the "subnormal" family, which he defined as one exhibiting some combination of "mental defectiveness," questionable moral standards, delinquency, and "social disease," who may be reliant on state support (1933, 1). While he is said to have given up on his eugenic tendencies once taking office, as Premier and Minister of Public Health, Douglas supported restrictive marriage legislation and other policies that increased the segregation and pathologization of those labelled "mentally defective." Eugenics was not always openly promoted in Saskatchewan, but this work shows how the system of public health built under Douglas's tenure achieved similar goals by enabling the continued policing of people along race, class, gender, and ableist lines in the interest of the economy. The ideas guiding Douglas were informed and supported by corporate interests, and the federal government was influenced by these same interests as well.

In the post–World War II period, health services were positioned as one arm of the welfare state and the RF took a step back as governments invested more directly in public health expansion. The welfare state sought to place "a floor on the standard of living" for some as it managed

an "upsurge of radicalism" (Finkel 1995, 222), but without reducing the power of capitalist interests. It also became one solution to the "Indian problem" in Canada — a means to undermine Indigenous connections to the land and reduce federal obligations. The system of public health in Saskatchewan initially excluded most Indigenous people, who were often segregated on reserves and in residential schools and Indian hospitals. This changed following revision of the Indian Act, in 1951, which increased the application of provincial laws to Indians and established a more complex administrative structure to manage Indigenous lives, one involving federal-provincial collaboration. The federal government sought to minimize treaty responsibilities as it supported the expansion of a provincial system of public health that further entrenched colonialism and systemic racism. The longstanding jurisdictional dispute on which level of government was financially responsible for the delivery of services informed Indigenous experiences, and as the federal government delegated responsibility to the province, each viewed Indigenous people as a fiscal burden.

The system of public health in Saskatchewan intersected in Indigenous lives to blame them for problems created by colonialism and federal neglect. Indigenous Peoples were forced into the choice between willingly participating in their own assimilation or facing continued segregation, now through a newly expanded provincial child welfare system, or in psychiatric institutions and jails. However, as both Rockefeller Jr. and Sanger pointed out, segregation only went so far in controlling a population. Birth control was more effective in the long term and by the early 1960s, as part of its War on Poverty — the policy approach underpinning the expansion of the welfare state — Canada began taking steps toward decriminalizing contraception.

The Politics of Reproduction in Modern Times

Reproductive politics were transformed by the 1960s as social conservatives, eugenicists, demographers, economists, and politicians spoke more openly of the need to decriminalize birth control to limit the reproduction of some (Appleby 1999; Dyck and Lux 2020; McLaren and McLaren 1986). The eugenic discourse of "race betterment" by preventing the reproduction of the "unfit" was replaced with the view that "unregulated population growth" caused poverty, resource scarcity, and social tensions that threatened political economic stability and

corporate access to raw materials and cheap pools of labour (Mass 1974, 651, 656). This, despite a crude birth rate in Western nations that had been decreasing since the 1950s.[15]

Eugenicist C.P. Blacker described family planning as an attempt "to fulfill the aims of eugenics without disclosing what you are really aiming at and without mentioning the word" (cited in Kühl 2013, 148). However, any effort to manage the fertility of populations would be more effective if "grafted onto freedom, not force" (Bashford 2014, 331). Francis Galton, who coined the term eugenics, emphasized as much when he said, "eugenic reform must chiefly be effected … [by] Popular Opinion" (cited in Gunn 1999, 102). Birth control was increasingly couched in human rights discourse (Bashford 2014), setting the stage for decriminalization.

Women have always desired the means to control their reproduction. Erika Dyck tells us that married women, whom she defines as "healthy" and "middle class," were seeking out birth control and sterilization as a means of fertility control by the 1950s, as others continued to be sterilized under eugenic legislation (2013, 92). Prior to legislative change, birth control was often available to those of "average means" if their private family physician was willing to offer it, but for low-income, single, or otherwise marginalized women, it was only available from health and welfare departments willing to break the law (Appleby 1999, 20). Brenda Appleby (1999, 14–16) points to slowing economic growth, rising unemployment, an increase in the federal deficit, and overburdened health and welfare departments as factors informing a reconsideration of the legal status of contraception. Family planning could reduce government budgets and long-term reliance on social welfare.

Family planning came to encompass a range of birth control methods, including sterilization, fertility and genetic counselling, marriage and family counselling, adoption, and associated assessments, diagnostics, referrals, and follow-up functions.[16] The concepts "family planning" and "planned parenthood" sought to highlight what voluntary organizations, namely Planned Parenthood, could do to encourage the spacing of children in the interest of ecological and economic stability while distancing the issue from the horrors of Nazi Germany (Bishop 1983, 105). "Free choice" was assumed, but family planning continued to intersect with issues of race, class, ability, and gender, including eugenics and fears of a "world population explosion" (Bain 1964; Dyck and Lux 2020; Stern 2005; Shapiro 1985), poverty and high infant mortality rates

(Palko, Lennox, and McQuarrie 1971), and societal views on promiscuity, illegitimacy, and adolescent births (Gurr 2015; Thomas 1998).

Population control policies, organized and funded by world elites, were the ideological and material catalyst for family planning activities in Canada and abroad (Connelly 2008; Gordon 2002; Hartmann 1995). The Population Council, founded by John D. Rockefeller III in 1952, was the "preeminent institute" for the study of contraception and family planning, and a hub for other players in the field (Connelly 2008, 159). The RF introduced birth control into the United Nations agenda with the assistance of aligned supporters who, as diplomats and other influential persons, sometimes continued to espouse eugenic ideologies as they took up central positions on the international stage (Mass 1976; Weindling 2012).

Family planning was declared a human right at the United Nations International Conference on Human Rights in Tehran in 1968. For the first time, a global agreement outlined that parents had a human right to determine "freely and responsibly" the number and spacing of their children.[17] Despite a very real want on the part of women to control their fertility, Alison Bashford tells us it is a mistake to say the expansion of family planning came at the behest of women. This "Rockefeller-led overture" (2014, 346) resulted from men involved in eugenics and population control who were invested in maintaining the status quo (347–50). The pretense of concern with the health of a mother, child, or family was an attempt to avoid "potential problems" from being overt about their goals (324–5). Population control was increasingly enjoined with feminist ideas of fertility control as a reproductive choice under a "modern project" — the responsible citizen central to the "economic planning of nations" (351).

The liberatory or coercive potential of reproductive technologies always depends on who has the power to control them, under what conditions, and for what ends, and through decriminalization the federal government increased the "bureaucratization, professionalization, medicalization and commercialization" of fertility control (McLaren and McLaren 1986, 141–2) as it intensified the possibility for coercion. Post-legislative change, family planning became an explicit feature of public health involving federal and provincial departments of health and welfare. The federal government engaged in family planning activities in jurisdictions under its control as it helped coordinate the uptake of

activities on a provincial level. The notion of "responsible parenthood" focused on married couples and their social duty to limit their families to the number of children they could support, as non-married women continued to be deprived of the requisite conditions for exercising their responsibilities in a voluntary manner (Appleby 1999, 7–8, 56, 222–38). In this, class structures based on heteronormative, ableist, and racist assumptions of family life tied to a heterosexual nuclear family unit continued to be reinforced (Appleby 1999; Gurr 2015). These "ruling relations of reproductive health care" — which further marginalized those who were living in poverty, differently abled, transgender, and queer, along with women of colour — were imposed on Indigenous Peoples as a form of "imperialist medicine" (Gurr 2015, 157).

In the 1970s, the Indigenous birth rate was characterized as the "most important demographic trend in Saskatchewan for the next 25 years."[18] The provincial approach to family planning consistently framed Indigenous women as irresponsible parents due to poverty, sexual immorality, and a higher incidence of "illegitimate" births, often to young women (Gurr 2015, 99–134) — but also due to the political nature of their reproduction and the systemic racism resulting from material exploitation. As the original occupants of the lands upon which the political economy depends, Indigenous Peoples hold relationships, responsibilities, and forms of life linking them to these lands; Indigenous reproduction is one means of reproducing these linkages (Tuck and Yang 2012, 5–6). The province, in wanting to ensure continued access to Indigenous lands for development, and as it too sought to reduce government expenditures, focused on reducing the Indigenous birth rate. This resulted in the increased surveillance, criminalization, and sometimes, coerced sterilization of Indigenous women.

These themes are taken up, beginning in Chapter 1, which explores corporate-federal-provincial intersections, tensions, and congruities in public health expansion from the 1940s to 1960s through a focus on Saskatchewan. It shows how a series of interlinked health and welfare laws, policies, and practices worked to identify some as problematic while seeking to ensure economic efficiency. Premier Douglas relied extensively on the financial support and guidance of the RF and its trained advisors and mental hygiene experts — who were sometimes committed eugenicists but more centrally concerned with population control — to build a system which obfuscated the root causes of social

problems by blaming individuals for their circumstances. The federal government shared connections with, and was influenced by, these same interests as it formulated a federal agenda to guide public health expansion in collaboration with the province. Here, the reader is challenged to reflect on the role of Western medicine as a tool of colonialism, but also how the system of public health worked to mitigate damages caused by exploitative social relations embedded in capitalism that, in the end, are detrimental to all of us.

Chapter 2 shows the influence of the RF coming to fruition in Canada through the expansion of the welfare state, shaped by experts it helped trained and the ideological approach it promoted, which informed the research studies and policy recommendations that guided federal and provincial Indian policy in the post–World War II period. The welfare state established a more organized means of intervening in poverty while reducing dependency on government supports and ensuring conditions conducive to capitalism. For Indigenous Peoples, it was a tool of colonialism. In a period of transition towards the integration of Indigenous people into Canadian society, the province worked in concert with federal Indian policy goals. It adopted a series of measures to "empty the reserves" by encouraging migration to urban centres where Indigenous people might be more easily induced to integrate, but where many faced continuing poverty as they increasingly relied on provincial services. Under the pretense of a humanitarian concern, and through extension of citizenship rights (Leslie 1999), newly trained experts in health and welfare were given a more direct role in managing these "dependent peoples" by attempting to enact development "with surgical precision" (Jahanbani 2023, 54, 46). Indigenous people who could not be induced to help themselves out of poverty often faced continued segregation.

Chapter 3 examines how the War on Poverty became a war against Indigenous births partly enabled through family planning. It revisits federal parliamentary debates culminating in the decriminalization of contraception in 1969, and a first federal family planning program in 1970, to show the extent to which legislative and policy change was influenced by broader concerns with population control — of who occupied land and how resources were distributed. In concert with international trends, the rhetoric employed by government officials and advisors centred on fears the Indigenous birth rate contributed to overpopulation and this, coupled with a culture of poverty and dependency among

them, replaced eugenics as the central ideological tool justifying the need to curb Indigenous births through family planning — the most cost-effective public health measure. To decriminalize birth control and make it available to all would help avoid allegations of genocide.

Planned Parenthood features prominently in this history, guiding the federal approach until the provinces could take up their own activities. The Royal Commission on the Status of Women, established in 1967 to make recommendations on how to improve women's lives, also features. Its support for the expansion of family planning, assisted by Planned Parenthood, and its influence over second wave feminism more broadly, is as an example of how some women were incorporated into the work of creating the responsible citizen central to economic planning (Bashford 2014). The focus on reproductive rights and responsible choice erased Indigenous concerns as it reinforced a coercive context in which women were expected to make choices.

Chapter 4 shows how all this carried over in Saskatchewan, since the 1970s, to inform family planning policy and practice. A thirty-year review of family planning activities reveals how health and welfare professionals, by focusing on those considered "at risk" of poverty and dependency, consistently approached Indigenous reproduction as something needing to be curbed. Family planning became a cost-effective solution to public health problems created by colonialism; jurisdictional disputes on who was financially responsible for health and welfare services for Indigenous people; fears of a rising birth rate as Indigenous people migrated to urban centres and strained provincial services; and a desire for continued access to Indigenous lands.

In Chapter 5, demographic trends in Saskatchewan are considered together with health utilization data that reveals the number of deliveries, abortions, and sterilizations for Registered Indian women and Other Residents from 1972–2018. This comparative analysis shows Registered Indians, who are identified through a declaration of Indian Status on provincial health cards, were disproportionately represented among those sterilized and accessing abortions from the late 1970s onward. This data is considered squarely within the broader context of colonialism and systemic racism, a history of all levels of government approaching Indigenous reproduction as something to be curbed, and the ways family planning policy has sought to do this. This inherently coercive context — which informs, and is informed by, longstanding

violence against Indigenous lands and bodies — leads to the coerced sterilization of Indigenous women.

Chapter 6 considers federal-provincial responses to the coerced sterilization of Indigenous women, and what is being done to address the practice. This includes an apology by the Saskatoon Health Region to women who were sterilized in its hospitals; a wave of class action lawsuits filed across Canada, including Saskatchewan; a focus on cultural competency and safety in health care; efforts to criminalize the practice through proposed legislation; and a push for government to respect Indigenous rights. This chapter critically engages each in turn to consider their effectiveness in achieving justice for Indigenous women and their peoples when each remains embedded in ongoing relations of dispossession and exploitation.

A Note on Reproductive Agency and Choice

It is important to ground instances of coerced sterilization and other forms of reproductive violence against Indigenous women within the broader context of colonialism, the oppression of women, and the denial of Indigenous sovereignty (Stote 2022; 2015). In one of the few works that engages the history of family planning in Indigenous lives in Canada, Erika Dyck and Maureen Lux (2016) consider the extent to which Indigenous agency intersected with "neo eugenics" to shape reproductive policy in the Global North (481). They write, while Indigenous reproduction was a "proving ground" for "competing interpretations" of population control (484), by the mid-1970s, reproductive politics were complicated by those who may have willingly sought out sterilization. They cite a 1976 letter to federal officials signed by five Indigenous women to support the view that access to family planning was desired by some and the wave of sterilizations engulfing Indigenous communities was not solely motivated by political and economic concerns:

> There are people like us here in … [Nunavut] who have had such operations done … 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 … Those people who are talking now on the radios regarding sterilization are saying that the doctors perform sterilizations on people

> without telling them … We think that those statements are false, because the doctors can operate only after consulting with the patient. (Cited in Dyck and Lux 2016, 487)

This letter was subsequently cited by Brianna Theobald (2019, 154) as evidence of proactivity in seeking sterilization by Indigenous women. Reproductive justice scholars, in centring racialized, marginalized, and Indigenous women's experiences of reproductive violence and abuse, tell us reproductive options have different meanings for those facing systemic oppression, and while women exercise agency, they do not do so under conditions of their own choosing (Ross, Derkas, Peoples et al. 2017). This letter, then, and interpretations of history that engage Indigenous agency as choice must be approached critically.

In their work on the forced relocation of Inuit, which sometimes led to starvation and death, Frank Tester and Peter Kulchyski (1994) discuss other letters written to federal officials by Inuit who spoke favorably about their relocation and asked for their relatives to join them. Tester and Kulchyski argue there are good reasons to doubt the interpretation, based on these letters, that they viewed relocation favorably, whether because deference to authority was a "central trait" of Inuit or simply because they were aware if they wanted something from officials, it was important to tell them what they wanted to hear in a way that gave them the respect they were supposed to deserve (401, note 40). The fact that some women may have wanted sterilization does not mean others did not experience coercion, which the 1976 letter implies, or that the proliferation of family planning did not have larger intentions or implications.

Bashford (2014) cautions against wanting to clearly differentiate between population control and birth control as a reproductive right — this differentiation is "aspirational" more than "historical" (350) — one which separates family planning from its broader political and economic history which, for Indigenous Peoples, is embedded in colonialism. The material need on the part of the state to ensure access to Indigenous lands and resources in the interest of the political economy should never be underestimated. Neither should we underestimate the role this plays in shaping the choices presented to women — especially when Indigenous Peoples are considered "formidable and effective barriers" (Levitan and Cameron 2015, 270) to the development of industrial resource extraction. The material requirement for land and resources

on the part of capitalist states has always required Indigenous Peoples to be "destroyed, removed, and made into ghosts" (Arvin, Tuck, and Morrill 2013, 12) and Indigenous women, in their ability to reproduce future generations, have long been targeted to these ends (Boyer 2014b; Stote 2015).

Despite children being valued in Indigenous communities, women have always had their own ways of regulating fertility, inducing abortions, and causing sterility (Anderson 2011, 40–2). Kim Anderson (2003) points to the role of the church in introducing large families, of Western medicine in suppressing Indigenous knowledge, and colonialism's undermining of the ability of women to raise children in their communities as factors upsetting Indigenous family planning. Mohawk midwife Katsi Cook highlights how a government attempt to create an "absolute dependence" (cited in Theobald 2019, 8) on Western medicine has left Indigenous women vulnerable to abuse. She views coerced sterilization as a symptom of "a more fundamental problem," how colonialism diminishes women's personal and social power and destabilizes "understandings of the meaning of Native womanhood" (Theobald 2019, 166–7).

Indigenous women do make use of Western forms of fertility control. However, to speak of reproductive agency as choice is to overlook a swath of feminist literature that critiques the tendency under capitalism, and within a liberal feminist discourse, to view the individual as paramount as it disregards the context in which women make choices, the options from which they must choose, and the role of private interests in crafting and constraining these. It also obfuscates any systematic abuse directed toward certain populations, or how tools considered central to reproductive freedom are the same tools that result in reproductive oppression (Hartmann 1995; Ross, Derkas, Peoples et al. 2017; Smith 2005; Solinger 2001; Stote 2017).

This work is not concerned with those who may have willingly sought out sterilization or any other Western form of reproductive control based on the options presented to them — but their choices too, are constrained. This work illuminates the historical, political, economic, and policy context in which agency is enacted, that informs choice *and* coercion for all Indigenous women. To quote the Committee to End Sterilization Abuse, formed the 1970s in response to the coerced sterilization of Indigenous and racialized women in the United States:

> Forced infertility is in no way a substitute for a good job, enough to eat, decent education, daycare, medical services, maternal infant care, housing, clothing, or cultural integrity … when society does not provide the basic necessities of life for everyone, there can be no such freedom of choice. (Quoted in Shapiro 1985, 144)

The attempt on the part of government to create an "absolute dependence" on Western medicine under ongoing social relations of colonialism, as Cook describes, fundmentally limits freedom of choice for Indigenous women as it contributes to the coercive potential of what is offered.

Dyck and Lux (2016) acknowledge how Indigenous women in their area of study have consistently struggled for the return of reproductive and political control to their communities. Theobald highlights how control over one's reproduction is an "essential element" of Indigenous sovereignty (2019, 147). Despite some Indigenous women making use of Western family planning options, many continue to view them with suspicion due to past violations and ongoing attempts to "wipe out" their populations (Theobald 2019, 149). Others may "choose" more permanent methods due to a lack of other options (153; also Gurr 2015, 125–6). Indigenous women have always wanted to control their fertility but have insisted this be on their own terms, based on their own cultural and value systems, and embedded in Indigenous sovereignty.

A reproductive justice approach asks us to consider how reproductive abuses like coerced sterilization are not only individual harms but are the tools of systems of oppression relied on to regulate entire populations (Silliman 2004, 1). Theobald writes, "colonial politics have been — and remain — reproductive politics" (2019, 4). In the United States, where Indigenous women were subject to coerced sterilization, scholars link the proliferation of family planning in the 1970s to funding priorities of governments, a lack of concern for the welfare of communities, and the theft of lands and resources — as part of a genocide against Indigenous Peoples (Ralstin-Lewis 2005; Smith 2005; Torpy 2000). The Canadian context is not so different. To discuss reproductive agency without centring how this context shapes women's choices amounts to "agency without choice" (Mann and Grzanka 2018, 334) — a misnomer to say the least.

We also need to consider that, for Indigenous and other marginalized women, the struggle is often for the choice to have children and raise them in safe and healthy communities (Ross, Derkas, Peoples et al. 2017), a reality so often erased in liberal feminist approaches to reproductive agency and choice. In Saskatchewan, women describe scare tactics by health and welfare professionals and being told sterilization was in their best interest, while others did not know they had a right to bodily autonomy.[19] Still others faced threats, and the reality, of having their babies apprehended at birth.[20] Yvonne Boyer and Judith Bartlett point to systemic racism in Western health care as central to understanding coerced sterilization — a systemic racism that needs to be grounded within the historical and material context of colonialism.[21] Violence against Indigenous bodies is connected to violence against Indigenous lands.[22] To focus on this reality, rather than agency and choice, is not to identify Indigenous women only as "victims" (Dyck and Lux 2016, 485), but to stress fundamental change is urgently needed for Indigenous bodies *and* lands to be respected.

Federal-provincial intersections in family planning policy and practice in Saskatchewan indicate that for Indigenous women, coerced sterilization remains a symptom of a broader context, one where the desire to undermine Indigenous connections to land and reduce obligations to Indigenous Peoples remains central. The lands of Cree, Dakota, Dene, Nakota, Saulteaux, and Métis, and the home to an increasing number of Inuit, continue to be contested in the interest of capital. In the process, Indigenous sovereignty — including reproductive sovereignty — is undermined. We must centre this historical and material context in our attempts to understand why the coerced sterilization of Indigenous women continues and what is required to stop the practice. This context must be *transformed* if we are to speak in any meaningful way about reproductive agency and choice for Indigenous women. Transformation requires the dismantling of colonialism and the political economy that supports it to ensure respect for Indigenous sovereignty — over lands, resources, forms of life, *and* bodies. Short of this, a genocide against Indigenous Peoples continues.