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“Their decision, it didn’t take place”: The Forced Sterilization of Native American Women in the
United States

by

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In 2003 the Native American Women's Health Education Resource Center (NAWHERC) published the *Indigenous Women's Health Book, Within the Sacred Circle: Reproductive Rights, Environmental Health, Traditional Herbs and Remedies*. In the introduction of this important book, NAWHERC founder Charon Asetoyer explains that while the United States government provides healthcare to Native Americans as their legal right, the government has a long history of insufficient administration of Native healthcare that has sometimes led to abuses against Native American patients. *The Indigenous Women's Health Book* encourages Native American women to become active participants in their own healthcare. Asetoyer and other members of NAWHERC published this book in the hopes that past medical abuses against Native American women could be prevented in the future as Native American women become more informed about their bodies and their rights as patients. One of the most damaging of these medical abuses that spurred the creation of the *Indigenous Women's Health Book* was the sterilization of Native American women in the late 20th century.¹

A wave of forced female sterilization occurred in the late 1960s and the 1970s in the United States. Puerto Rican, Mexican, black, and Native American women all over the country were coerced, tricked, and forced into having serious surgical procedures that terminated their reproductive capabilities. Tens of thousands of women of all ages were forcibly sterilized in the United States during this time period.² The federal regulations for procedures like tubal ligations and hysterectomies were not thorough enough at this time to prevent abuses from occurring at the hands of physicians and hospitals. Some women were lied to and told that the procedure

¹ *Indigenous Women's Health Book, Within the Sacred Circle: Reproductive Rights, Environmental Health, Traditional Herbs and Remedies*, ed. Charon Asetoyer, Katherine Cronk, and Samantha Hewakapuge (Lake Andes: Indigenous Women's Press, 2003).

² D. Marie Ralstin-Lewis, "The Continuing Struggle Against Genocide: Indigenous Women's Reproductive Rights," *Wicazo Sa Review*, 20:1 (Spring 2005), 71-72.

could be reversed or that it was simply another form of birth control. Other women were falsely told that having more children would be dangerous for them. Even more disturbing, many women were completely unaware they had been sterilized until much later. Those women who were sterilized without their full and informed consent were taken advantage of and deprived of a very personal choice. While Native American women are not the only group in the United States that was negatively affected by the wave of forced sterilizations at this time, they were in a uniquely vulnerable position. A majority of Native American women relied on the government, specifically the Indian Health Service (IHS), for most of their medical needs. This remains true today. It is this unique position of Native women that makes their story particularly noteworthy and complex.³

The Indian Health Service exists today because of past treaties made between different Indian tribes and the United States government in which the government agreed to provide medical care, among other rights and services, to Native Americans in exchange for Native land cession. Not many would argue that the trade-off between Native Americans and the United States federal government was at all fair at any point, but on the surface it seems as if Native Americans were guaranteed some benefits. However, Native Americans were rarely directly involved in the determination of the extent and quality of these benefits, and the government has proved itself inadequate at ensuring the provision of many of these promised services. At the time of the forced sterilizations, the IHS was a division of the Public Health Service (PHS), which was a part of the Department of Health, Education, and Welfare (HEW). Since the IHS was moved from the Bureau of Indian Affairs to PHS in 1955, Native health care has improved

³ This history has been well documented by scholars and activists. See for example: Charon Asetoyer, Andrea Carmen, Myla Vicenti Carpio, Jane Lawrence, D. Marie Ralstin-Lewis, Marie Sanchez, Andrea Smith, Sally J. Torpy, and Dr. Connie Uri.

overall due to better funding under its new division.⁴ However, this increased funding has not proved sufficient to ensure the provision of adequate and ethical medical care for Native American patients. In 1965 the IHS began providing family planning services to its patients. This was when the forced sterilizations began on a large scale, and from the late 1960s into the 1970s far too many Native American women were coerced, tricked, and forced into having sterilization procedures. As this continued to happen, Native women slowly began sharing their stories with trusted friends, family, and community leaders. As Native American communities became increasingly cognizant of the abuses against many of their women, an activist response arose in the hopes of raising awareness and preventing future abuses against Native American women and their reproductive rights.

In this paper I seek to explain how the coerced and forced sterilization of Native American women happened on such a large scale at this moment in history. The personal stories of those Native women who were affected by this phenomenon are quite similar though each uniquely experienced the pain and shock that comes with having the right to have children taken away. Doctors lied to their patients about the nature of sterilization as well as its permanence. They pressured women to sign consent forms that they did not fully understand or, sometimes, could not even read. Some women received tubal ligations or hysterectomies after going into surgery for a completely different reason, and many women were sterilized without their knowledge immediately after giving birth. There is no shortage of horrific examples of how Native American women were taken advantage of at this time.

A discussion of the how and why this happened cannot be separated from a discussion of the sterilization policies themselves and their effects on Native women. It would be easy to

⁴ Jane Lawrence, "The Indian Health Service and the Sterilization of Native American Women," *American Indian Quarterly*, 24:3 (Summer 2000), 401.

blame the IHS and its physicians for their own racist and classist prejudices that influenced them to push such a permanent form of birth control on Native American women. The IHS and the physicians who lied to and pressured Native women can undoubtedly be blamed for the abuses, as they sponsored and performed the sterilizations. However, the idea to purposefully and deceitfully sterilize Native women did not arise from one institution and its employees acting in isolation. The sterilization policies and philosophies of the Indian Health Service, its employees, and the government were made possible by both personal and national ideas, values, and anxieties that converged at this time in the late 20th century.

Their Stories

It is difficult to determine precisely what constitutes coercion. However, the countless personal stories of Native American women who were sterilized at this time provide valuable insight on the damaging situations these women were placed in. Andrea Carmen, current director of the International Indian Treaty Council (IITC), recalls many stories of abuse during her time as a sterilization activist in the 1970s. One of these stories involved a woman who was unable to deliver her baby at full-term because her cervix had formerly been sewn shut without her knowledge.⁵ This anonymous woman's story illustrates the disturbing costs many women bore because of a decision they did not make themselves. It is important to remember the thousands of individuals who suffered at length because of this wave of forced sterilizations.

The forced and coerced sterilizations of Native American women even extended to young girls at times. Forced sterilizations did not occur on a large scale until the late 1960s, but they

⁵ Anne Minard, "Preemptive Genocide: Only Now Are Reparations Being Made to Eugenics Victims," *Indian Country*, June 4, 2012.

were not previously unheard of among the Native American community. One woman underwent a hysterectomy in the early 1950s at age 11. She went to the IHS for a routine vaccination, and while there she was told that hers had become infected. She was given another shot to ease the pain, and then all she remembers is waking up disoriented because her stomach hurt and she was bleeding.⁶ Before she had even become a teenager, this Native American woman's reproductive rights were taken from her without her or her parents' knowledge or consent. In the 1970s in Montana, two girls under the age of 15 went to the IHS for appendectomies and did not realize until later that they were sterilized during the procedures to remove their appendixes as well.⁷ Unfortunately, numerous young girls were targeted for sterilization at this time.

Many of the personal stories that have been shared involve being sterilized during another medical procedure, often childbirth, without informed consent. Scholar Jane Lawrence spoke with a woman who was sterilized in 1974 while giving birth to her first child. The woman remembered signing a form during labor, but she assumed it was for a painkiller at the time. She was not aware that she had been sterilized until her doctors informed her after the birth of her daughter. Consequently, her husband left her because he wanted more children, but she could not give that to him.⁸ Childbirth was not the only medical procedure in which women were unknowingly sterilized. One woman found out that she had a cyst in her womb as well as appendicitis. She went to the IHS to have both the cyst and her appendix removed, and she did not find out until later that she was also sterilized during the surgery. She stated that she remembered signing "a piece of paper that said I have to have the appendix and cyst taken out;

⁶ Myla Vicenti Carpio, "The Lost Generation: American Indian Women and Sterilization Abuse," *Social Justice*, 31:4 (2004), 40.

⁷ Lawrence, "The Indian Health Service and the Sterilization of Native American Women," 400.

⁸ *Ibid*, 414.

that's all they told me and nothing else.”⁹ In an interview published in 1979 one woman shared her story of a forced hysterectomy. When she woke up after giving birth to a son at an IHS facility, she was told that her son was born dead for unknown reasons and that she could never have another child because the doctors had to sterilize her during the cesarean section.¹⁰ In 1975, a 26-year-old woman underwent a hysterectomy immediately after giving birth. She did not sign a consent form before the procedure, and the next day the nurses asked her to sign the form but date it before the cesarean section. She did not do as they asked. She was devastated after losing the ability to ever have children again, but after this traumatic incident she dedicated her life to keeping families together as a lawyer who specialized in medical cases and family law.¹¹ There seem to be very few personal stories, however, that end on any semblance of a positive note.

The tens of thousands of Native American women who were coercively and forcibly sterilized endured long-lasting difficulties, outside of not being able to have children, that have damaged their lives. One 29-year-old woman was harassed at her home six times by social workers who said that she should be sterilized if she did not want any more children at that moment. She finally said yes after the sixth visit, and the very next day she underwent a tubal ligation. It was not until a 1974 demonstration put on by the American Indian Movement (AIM) that she found out that the procedure was irreversible and that she would never be able to have children again. For the next fifteen years of her life, she was treated for depression.¹² In February 1974, one Native American woman had a hysterectomy after she gave birth to her son by cesarean section at the Claremore Indian hospital in Oklahoma. She did not remember signing a

⁹ Carpio, “The Lost Generation,” 46.

¹⁰ Ibid, 45.

¹¹ Lawrence, “The Indian Health Service and the Sterilization of Native American Women,” 414.

¹² Ibid, 413.

consent form, and yet her signature was on it when she found out she had been sterilized three days later. She had to see a psychologist for depression for ten years after the incident, and she did not feel that she has been able to move on with her life as a mother in a “normal” way. She has never returned to an IHS facility for any reason.¹³ Depression and other mental health issues have plagued the numerous women who have been sterilized. Native Americans already disproportionately experience poor mental health on average, but the odds of sterilized Native American women reporting poor mental health is 2.5 times the odds of Native American women who have not been sterilized.¹⁴ It is clear that being sterilized without their full informed consent drastically affected Native American women’s lives in many ways. Personal stories such as these give voice to the Native American women who were harmed by the IHS and its physicians. They document the widespread abuses against Native American women’s reproductive health at this time and give weight to this paper’s explanation of how the forced sterilizations were able to occur to the degree that they did.

The Influence of Eugenics and Population Control Policies

The ideas at the core of the study of eugenics, a pseudoscience that thrived in the early 20th century, played a large role in the eventual coerced and forced sterilizations of Native American women. The term “eugenics” was first used by English anthropologist Sir Francis Galton in 1883.¹⁵ Galton’s eugenic ideas were influential all over the world and ultimately

¹³ Ibid, 413-414.

¹⁴ Christina J.J. Cackler, Valerie B. Shapiro, and Maureen Lahiff, “Female Sterilization and Poor Mental Health: Rates and Relatedness among American Indian and Alaska Native Women,” *Women’s Health Issues*, 26:2 (2016), 171.

¹⁵ “Origins of Eugenics: From Sir Francis Galton to Virginia’s Racial Integrity Act of 1924,” in

contributed to the momentum gained by the eugenics movement in the early twentieth century.¹⁶ Defined as “the method of improving the intellectual, economic, and social level of humans by allowing differential reproduction of superior people over those designated as inferior,” eugenics was widely promoted and studied by scientists in the United States in the early 1900s.¹⁷ The justification of this differential reproduction relied on subjective ideas about supposed biological superiority and inferiority. At this time, geneticists believed that all human traits, even behavioral traits, were determined by genetics.¹⁸ Therefore, individuals who were immoral, mentally or physically disabled, poor, criminal, or unsuccessful would pass these supposedly innate qualities onto their children. Eugenicists believed that in order to improve society, the reproduction of individuals with an undesirable biological makeup had to be limited and the reproduction of those with more superior traits had to be encouraged.

Racial judgments were also at the core of eugenic ideas regarding superiority and inferiority. Eugenicists believed that whites—specifically white, Anglo-Saxon Protestants of Western European descent—were more advanced than other races and, as a result, were superior.¹⁹ Further complicating matters in the early 20th century, the working class and the poor minorities were reproducing at a faster rate than the successful middle and upper class whites in the United States.²⁰ Supporters of eugenic ideas were alarmed by the gradually declining

the online historical exhibit “Eugenics: Three Generations, No Imbeciles: Virginia, Eugenics & Buck v. Bell,” Historical Collections at the Claude Moore Health Sciences Library, University of Virginia, last modified February 13, 2004, accessed January 20, 2017, <http://exhibits.hsl.virginia.edu/eugenics/>.

¹⁶ Sally J. Torpy, “Native American Women and Coerced Sterilization: On the Trail of Tears in the 1970s,” *American Indian Culture and Research Journal*, 24:2 (2000), 2-3.

¹⁷ Ralstin-Lewis, “The Continuing Struggle Against Genocide,” 74; Torpy, “Native American Women and Coerced Sterilization,” 2.

¹⁸ Ralstin-Lewis, “The Continuing Struggle Against Genocide,” 74.

¹⁹ *Ibid*, 75.

²⁰ “Origins of Eugenics.”

birthrates of white women and the rising birthrates of people of color in the United States—they worried that this would result in “race suicide.”²¹ Eugenics received a positive reaction from white Anglo-Saxon Americans who feared that their race would one day be outnumbered if nothing were done.²² Considering the long history of racism in the United States, it is not surprising that scientists and the public readily accepted the study of eugenics when viewed in light of this information.

Eugenic ideas were not confined to scientific studies at this time. These ideas seeped outside of eugenic circles and influenced public policy in the United States. Proponents of eugenics championed their conviction for selective reproduction through politicians and policy makers, and their success was enabled by the United State’s history of racism as well as the discrimination against the disabled. Eugenicists were involved in the enactment of the 1924 Immigration Restriction Act that limited immigration from eastern and southern Europe.²³ They also supported the push for laws that made it illegal to marry someone of another race.²⁴ Furthermore, they were instrumental in the adoption of compulsory sterilization laws in over thirty American states by the early 1930s after eugenic sterilization was deemed constitutional in the 1927 Supreme Court case *Buck v. Bell*.²⁵ The long-lasting implications of *Buck v. Bell* cannot be understated. Carrie Buck and her mother had both been placed in a mental institution for their supposed “feeble-mindedness,” and when this institution wanted to sterilize Buck, but could not

²¹ Ralstin-Lewis, “The Continuing Struggle Against Genocide,” 75; “Origins of Eugenics.”

²² “Origins of Eugenics.”

²³ “Origins of Eugenics”; “Influence of Virginia’s Eugenic Sterilization Act,” in the online historical exhibit “Eugenics: Three Generations, No Imbeciles: Virginia, Eugenics & Buck v. Bell,” Historical Collections at the Claude Moore Health Sciences Library, University of Virginia, last modified February 13, 2004, accessed January 20, 2017, <http://exhibits.hsl.virginia.edu/eugenics/>.

²⁴ “Influence of Virginia’s Sterilization Act.”

²⁵ Torpy, “Native American Women and Coerced Sterilization,” 12.

do so legally, they took their case to the Supreme Court.²⁶ The Court ruled in favor of compulsory sterilization for those deemed mentally ill, and this decision legitimated eugenicist's beliefs that undesirable qualities were inherited and those who possessed these undesirable qualities had to be prevented from reproducing. Eugenic ideas permeated American society in other ways at this time as well. A large number of schools and universities including Harvard, Cornell, and Columbia offered courses on eugenics.²⁷ Some of the most intelligent and wealthy Americans supported the pseudoscience and enabled its influence to reach all the way to the government.²⁸ Though eugenics remained widely accepted in the early twentieth century, the uncomfortable reality of the Nazi implementation of eugenics during World War II influenced the abandonment of most of the previously enacted compulsory sterilization laws.²⁹ Indeed, eugenics as a legitimate science lost most of its credibility and public support by the 1950s. Despite this, eugenic influences and attitudes remained influential in the United States even after the end of the war.

The attitudes and principles that had governed the pseudoscience of eugenics resurfaced in the United States under a new title in the mid-twentieth century—population control. The merging of eugenic ideas and a fear of overpopulation created the conditions in which the forced sterilization of Native Americans became both possible and probable. At this time, anxieties about overpopulation swelled internationally and within the United States. The global population

²⁶ “Buck v. Bell: The Test Case for Virginia’s Eugenic Sterilization Act,” in the online historical exhibit “Eugenics: Three Generations, No Imbeciles: Virginia, Eugenics & Buck v. Bell,” Historical Collections at the Claude Moore Health Sciences Library, University of Virginia, last modified February 13, 2004, accessed January 20, 2017, <http://exhibits.hsl.virginia.edu/eugenics/>.

²⁷ “Influence of Virginia’s Eugenic Sterilization Act.”

²⁸ Gregory W. Rutecki, “Forced Sterilization of Native Americans: Later Twentieth Century Physician Cooperation with National Eugenic Policies?,” *Ethics & Medicine*, 27:1 (Spring 2011), 36.

²⁹ “Influence of Virginia’s Eugenic Sterilization Act.”

had increased from 1.6 billion in 1900 to 3 billion in 1960, and experts at the time estimated that it would double again by the end of the century.³⁰ Population alarmists held that if the global population continued to grow at this rate, there would be catastrophic consequences. Many believed it would lead to more famine, disease, and general poverty in the world as well as the destruction of the environment and the world's natural resources.³¹ Some even believed that increased impoverishment across the globe would result in many poor nations turning to the Soviet Union for relief, a frightening thought during the Cold War.³² As a result of these anxieties, population control became an enticing solution to what was considered one of the most important issues facing the world at this time.

The fear-provoking consequences of overpopulation grabbed the attention of many wealthy industrial leaders, and they began to form organizations to address overpopulation both in the United States and across the globe. The Population Council, formed in 1952 by John D. Rockefeller was one of the most influential and affluent of these organizations.³³ Six men on the Council's ten member advisory board were associated with eugenics.³⁴ Eugenics and population control efforts were still related even though eugenics as a science was no longer respected by the general public. This may have played a role in the Council's use of fertility control policies to target nonwhites and lower class people.³⁵ Since most population control advocates believed that the size of the population, rather than economic disparity, is what caused a lack of resources for the poor, the increased population of poor minorities in the United States was of particular

³⁰ Elaine Tyler May, "The Population Bomb," in *America and The Pill: A History of Promise, Peril, and Liberation* (New York: Basic Books, 2010), 36.

³¹ *Ibid.*, 37.

³² *Ibid.*

³³ *Ibid.*, 41.

³⁴ Ralstin-Lewis, "The Continuing Struggle Against Genocide," 75.

³⁵ *Ibid.*

interest to them.³⁶ Many believed that limiting the number of children a poor family had would make them happier and more financially secure. Despite popular opinion, population size was not the cause of poor people's problems. Furthermore, though concerns about poverty were important to the justification of controlling population growth, humanitarian interests were, for the most part, far from the central motivation for these efforts. Some leaders saw population control as a means to achieve success in the Cold War or curb eventual environmental destruction.³⁷ Many believed that the poor and their children were a financial burden on taxpayers and that limiting their numbers would alleviate some economic problems.³⁸ Regardless of the motivation, poor people and non-whites were the main targets for the population control efforts of these influential organizations in the mid-twentieth century.

The pressure to limit family size from organizations like the Population Council combined with new legislation to produce a situation in which poor and minority women were increasingly targeted for population control efforts. The population control craze began to affect Native American women directly in the 1960s when the provision of contraception to poor Americans became a government policy. This decade saw the beginning of government involvement in population control under President Lyndon B. Johnson. Overpopulation and its effects on the poor was one of the central concerns of President Johnson's War on Poverty.³⁹ Federal funding for domestic family planning programs increased from \$8.6 million in 1965 to \$56.3 million in 1969.⁴⁰ Ranking among the poorest populations in the United States, Native Americans were targeted by Johnson's policies. In 1965, the IHS began offering family planning

³⁶ Ibid, 76.

³⁷ May, "The Population Bomb," 37.

³⁸ Ibid.

³⁹ Ibid, 43.

⁴⁰ Ibid.

services to Native American women, and forced and coerced sterilizations began on a significant scale.⁴¹ Complicating matters for Native American women, during the 1960s the American College of Obstetricians and Gynecologists dropped certain restrictions that prevented women of a young age from choosing sterilization as a birth control method and other restrictions that required a psychiatric consultation and the signature of two doctors before a woman could be sterilized.⁴² Without these restrictions, the potential for physician coercion increased.

While both the government and influential population control advocates did what they could to promote their beliefs through policy, a widespread public concern for overpopulation continued to grow and influence public opinion in the United States. President Johnson's rhetoric on the War on Poverty and the constant reminder of limited resources and a steadily increasing population of poor people certainly contributed to the growing public concern of overpopulation. Arguably even more influential in increasing fears surrounding overpopulation was Stanford University professor Paul R. Ehrlich's book *The Population Bomb* (1968). In his book, Ehrlich predicted that millions would starve to death within ten years and that a nuclear war would be fought over access to resources before the end of the twentieth century.⁴³ These kinds of cataclysmic predictions grabbed the attention of the fearful American public. Ehrlich had a very large following, and by 1974 his book sold two million copies.⁴⁴ Unsurprisingly, the solution Ehrlich presented for preventing these catastrophic, end-of-the-world events was the alleviation of poverty across the globe, which could be done by controlling the birthrates of poor people.⁴⁵ Ehrlich's concern for overpopulation had an elitist flavor to it, and his opinions were influential

⁴¹ Ralstin-Lewis, "The Continuing Struggle Against Genocide," 78.

⁴² Torpy, "Native American Women and Coerced Sterilization," 3-4.

⁴³ May, "The Population Bomb," 44.

⁴⁴ Ibid.

⁴⁵ Ibid.

in convincing the American public that population control for the poor might be a good idea.

Under President Richard Nixon, government sponsored population control efforts were in full force. The wealthy industrial leaders advocating for population control lobbied for policies that addressed overpopulation, and their efforts had a particularly significant impact on President Nixon and his support for population control in the 1970s.⁴⁶ In fact, Nixon's appointment of John D. Rockefeller III to the chairman position of the new Commission on Population and the American Future shows the significant influence wealthy population alarmists had on his administration.⁴⁷ President Nixon even delivered a special message to Congress on Population Growth in 1969, his first year in office, in which he stated that population growth was one of the most important issues facing the nation at that time.⁴⁸ In his message, he also called for an increase in federal assistance for domestic family planning programs aimed at low-income women who may not be able to afford birth control on their own.⁴⁹ Nixon delivered on his promise. During the 1970s, ninety percent of the costs to sterilize poor people each year were paid for by the federal government.⁵⁰

The policies related to population control and family planning services that were enacted under President Nixon were influential to the future of Native American women. In 1970 Congress passed the Family Planning Act by a landslide vote.⁵¹ This Act provided access and resources to low-income families for birth control methods, like sterilization, that would not have

⁴⁶ Ralstin-Lewis, "The Continuing Struggle Against Genocide," 77-78.

⁴⁷ Torpy, "Native American Women and Coerced Sterilization," 4.

⁴⁸ Richard Nixon, *Special Message to the Congress on Problems of Population Growth*, July 18, 1969, accessed January 20, 2017, <http://www.presidency.ucsb.edu/ws/?pid=2132>.

⁴⁹ Ibid.

⁵⁰ Torpy, "Native American Women and Coerced Sterilization," 4.

⁵¹ Ibid.

previously been available to them.⁵² As a result of this act, the Department of Health Education and Welfare (HEW) began providing federal funding to the IHS for sterilizations in 1970.⁵³ The federal campaign to provide sterilizations for poor women reached Native American women who received healthcare through the IHS. The increase in federal funding for sterilizations through the IHS placed Native American women at a steadily growing risk of being pressured or forced into having the procedure.

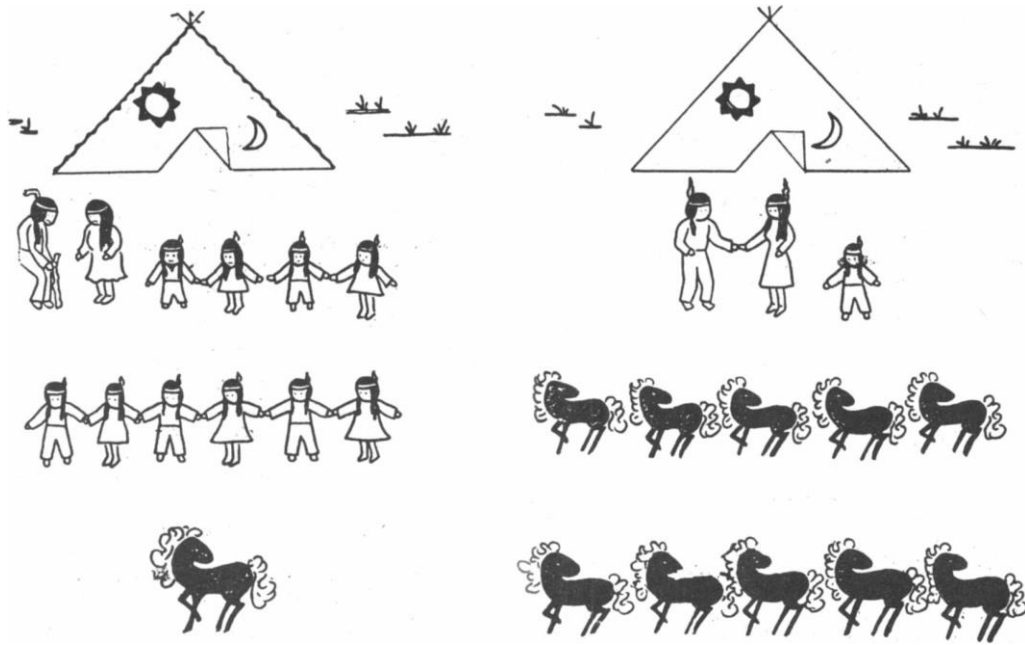
Both the government and a large majority of the American public actively supported population control efforts by the 1970s, and the government policies that this support prompted helped create the conditions in which the coerced and forced sterilizations of Native American women could occur. An image from a 1974 HEW pamphlet titled *Plan Your Family* illustrates the conscious effort on the part of the government to influence Native Americans to limit the size of their families.⁵⁴ HEW distributed propaganda pamphlets with this image in it to Native communities across the United States.⁵⁵ The image shows two Native American families: one “before” and one “after” sterilization. The parents “before” sterilization look distraught with their ten children and single horse, but the parents “after” sterilization are standing upright and holding hands next to their single child and ten horses. The meaning was clear—the fewer children, the happier and wealthier a family would be. The sinister motivations behind the dissemination of this pamphlet cannot be definitively determined, but the influence of eugenics and population control very likely played a role in its creation and distribution.

⁵² Ralstin-Lewis, “The Continuing Struggle Against Genocide,” 78.

⁵³ Andrea Smith, “Better Dead Than Pregnant: The Colonization of Native Women’s Reproductive Health,” in *Conquest: Sexual Violence and American Indian Genocide* (Cambridge: South End Press, 2005), 81.

⁵⁴ Evgenia B., Kathy Schwerin, Pippa Franks, and The San Francisco Women's Health Center, “San Francisco Sterilization Clinic,” *Off Our Backs*, 6:7 (October 1976).

⁵⁵ Ralstin-Lewis, “The Continuing Struggle Against Genocide,” 78.



The pseudoscience of eugenics insidiously left its mark on the United States. Though its ideas were not touted as truth in the 1960s and 1970s, the underlying discriminatory beliefs at its core remained present. Eugenic beliefs lingered in the minds of the public and the handful of important and wealthy Americans who were able to influence public policy on population control under Presidents Lyndon B. Johnson and Richard Nixon. The increased funding and access to sterilizations that these policies provided directly affected Native American women. The IHS had more freedom and ability to offer pregnancy prevention services to Native American women, and the physicians that worked for the IHS often used this freedom in an unethical fashion.

An Unbalanced Doctor-Patient Relationship Characterized by Racism, Elitism, and Sexism

Physician discrimination rooted in racism, elitism, and sexism heavily impacted the

accessibility and quality of healthcare for marginalized people in the United States during the mid-to-late 20th century. The information asymmetry of a doctor-patient relationship sometimes created complications because the patient often did not have the same medical training and knowledge as their healthcare provider. For this reason, it was easy for a doctor to use this unbalanced relationship to influence, coerce, or force a patient to choose one treatment over another. While many doctors did respect the Hippocratic Oath they take, it was unfortunately not uncommon for healthcare providers to change the nature of the medical care they gave based on their personal perceptions of individual patients and the societal groups that patient belonged to.⁵⁶ These perceptions could be negative or positive, and in the case of Native American women in the 1960s and 1970s, they were overwhelmingly negative.

Native American Women sat at the dangerous intersection of racial, economic, and sexual oppression. The sterilization abuse they experienced at the hands of the IHS and its contract-care facilities in the 1960s and 1970s was induced in part by mainstream negative characterizations of poor people, people of color, and women. The status of Native Americans as an impoverished and government dependent population theoretically placed them in the same category as poor people on welfare in the public's opinion, and the negative characterizations of this group were often assigned to them as a result. Furthermore, the IHS and contract-care physicians' social constructions of both the Native American population and women in general played a role in their medical treatment. Those physicians that sterilized Native American women under questionable circumstances decided to determine the extent of the reproductive rights of those women without their full consent. Demeaning stereotypes of Native American women exacerbated the existing fears of overpopulation and influenced physicians to pressure,

⁵⁶ Thomas W. Volscho, "Racism and Disparities in Women's Use of the Depo-Provera Injection in the Contemporary USA," *Critical Sociology*, 37:5 (2011), 676.

coerce, and force Native women into surgical procedures that eliminated their reproductive capabilities.

Some of the legislation pushed through during the feminist reproductive rights movement in the United States, while beneficial for many women, further tipped the unequal balance of this doctor-patient relationship and, as a result, created a situation in which poor and minority women were more vulnerable to sterilization abuse. As middle class white women across the United States fought for the right to have access to family planning methods like birth control pills, abortion, and sterilization, Native American women were deprived of their ability to choose to have children. The mainstream reproductive rights movement emphasized the choice to prevent pregnancy, but this emphasis ignored the social realities that impeded many women from being able to make this choice for themselves.⁵⁷ In the 1960s and 1970s, federal funding for family planning assistance increased, and inconvenient barriers to a quick sterilization were altered so that women could access this method of family planning more easily.⁵⁸ However, the same legislation that was viewed positively by the mainstream reproductive rights movement had serious consequences for Native American women who, along with other marginalized groups of women, became targets for sterilization abuse partially as a result of this increased access to and federal funding for sterilization. Due to their ethnicity and impoverished status, Native American women lacked the political power and agency to ensure that they were not being taken advantage of in the hospital room without the strict age and consultation restrictions to the sterilization procedure that had previously been in place.

On the other hand, some of the legislation related to reproductive rights enacted at this time was viewed in an overwhelmingly negative light even by the mainstream feminist

⁵⁷ Smith, "Better Dead Than Pregnant," 98-100.

⁵⁸ Torpy, "Native American Women and Coerced Sterilization," 3-4.

movement. Both Native women and the activists of the mainstream reproductive rights movement condemned the passage of the Hyde Amendment in 1976, which eliminated the use of federal funds for abortion services except in cases of rape, incest, or danger to the mother's life.⁵⁹ This eliminated abortion services for poor women on Medicaid as well as for Native American women who relied on the federally funded IHS for medical care. At the same time, federal funding was being used to cover ninety percent of sterilization costs for those depending on government assistance.⁶⁰ This created a situation in which abortion was removed as a pregnancy prevention method for Native American women, and government funds made sterilization, a more permanent form of pregnancy prevention, cheaper and more attractive to the IHS and its physicians.⁶¹ This explains, in one way, why IHS and contract-care physicians focused on pushing sterilization on their Native American patients. The Hyde Amendment was meant to appease pro-life advocates by eliminating the use of federal funds for abortion services, but it discriminated on the basis of both race and class and exacerbated the risk of Native American women being forced into more dangerous and permanent options for pregnancy prevention.

Ethnicity and social class often overlap for Native Americans, and it is difficult to separate a discussion of the influence of racism and elitism on the sterilization abuses they suffered at this time. At the core of many of the federally funded family planning policies and programs was the belief that they could be used to help limit the growing population in the United States. However, the arguments for population control in the United States were often racially charged, and the resulting federal programs and policies targeted poor people of color in

⁵⁹ Ibid, 11.

⁶⁰ Ibid.

⁶¹ Ibid.

order to limit their fertility specifically.⁶² For many, the problem was that minority populations seemed to be growing faster than the white population.⁶³ Compounding the situation of discrimination was the fact that Native Americans were and are the most impoverished ethnic group in the United States.⁶⁴ The U.S. government is largely at fault for their destitute situation even though it has made legal promises through numerous treaties and acts of legislation to provide for Native American communities. As the idea of a welfare state and the word “welfare” developed a harshly negative connotation in the mid to late 20th century, Native American communities’ dependence on the government was viewed negatively as well. The image of Native Americans as a welfare dependent group of people influenced the ways in which IHS and contract-care physicians approached their medical treatment. Native American women were being targeted by physicians for sterilization because of the destructive stereotypes that many of these physicians held against poor women.

The effects of these destructive stereotypes on the provision of medical care are illustrated in a 1973 study on the attitudes of physicians at this time. In this study, white Euro-American male physicians stated that they believed that they were helping society by limiting the number of births of poor and minority women.⁶⁵ In these physician interviews, they also revealed that they believed their decisions to limit the reproductive capabilities of poor women directly benefitted themselves because their own tax burden to support Medicaid and welfare programs

⁶² May, “The Population Bomb,” 46-47.

⁶³ Ralstin-Lewis, “The Continuing Struggle Against Genocide,” 77.

⁶⁴ M. Annette Jaimes and Theresa Halsey, “American Indian Women At the Center of Indigenous Resistance in Contemporary North America,” in *The State of Native America: Genocide, Colonization, and Resistance*, ed. M. Annette Jaimes. (Boston: South End Press, 1999), 323-324.

⁶⁵ Lawrence, “The Indian Health Service and the Sterilization of Native American Women,” 410.

would decrease as the programs had less need for funding.⁶⁶ The characterization of poor women as lazy people who had too many children that would eventually have to be supported by taxpayer dollars clearly influenced these physicians' approach to poor and minority women's medical treatment. It most likely influenced the way IHS and contract-care physicians approached Native American women's medical treatment as well. As one anti-sterilization activist later commented, IHS physicians "lacked cultural sensitivity, possessed a middle class attitude toward family planning that favored only two children per family, and promoted the belief that unwed mothers and families that were economically deprived should not reproduce."⁶⁷ Native American women were some of the most economically deprived women in the United States, and the belief that poor women should not reproduce likely influenced physicians to coerce and force Native American women into having sterilizations in order to limit their reproductive capabilities.

Another negative characterization that IHS and contract-care physicians placed on their Native American patients was the belief that the poor are unable to make the best decisions for themselves. Many physicians who believed that their patients were unintelligent and uninformed when it came to family planning decided to make the decision to limit reproduction without the full consent of their patients, believing that limiting the size of poor Native American families would enable them to have a higher standard of living and quality of life.⁶⁸ The high fertility rate of Native American women likely encouraged this thinking. Some healthcare providers compared their own socioeconomic status with that of Native Americans and came to the conclusion that poor Native women could not suitably provide for their children if they had too

⁶⁶ Ibid.

⁶⁷ Torpy, "Native American Women and Coerced Sterilization," 8.

⁶⁸ Lawrence, "The Indian Health Service and the Sterilization of Native American Women," 410.

many.⁶⁹ This echoes the argument made by many population control advocates that the poor live in poverty because of their population size. However, as Native activist and medical doctor Dr. Connie Uri aptly pointed out, “women who are poor don’t get rich by having their tubes tied.”⁷⁰

At this time it was not uncommon for physicians to disproportionately suggest sterilization to poorer patients as a preferred method of pregnancy prevention. While some population alarmists advocated for the birth control pill as a suitable means for limiting the population, other population control advocates and physicians were not convinced that poor, uneducated women would be able to take the pill consistently and believed that it was too expensive and required too much monitoring to ensure its success.⁷¹ Sterilization was then a plausible alternative, as it was a one-time procedure that was also quite inexpensive given increased federal funding for the procedure had increased during the 1960s and 1970s. A study published in 1972 indicated that only six percent of responding physicians would recommend sterilization as a contraceptive method for private patients, but fourteen percent would recommend sterilization as the first birth control method for welfare patients.⁷² The same study also revealed that ninety-seven percent of gynecologists supported compulsory sterilization measures for mothers on welfare who had three or more children.⁷³ This study illustrates how attitudes towards the poor, especially poor women with children, likely influenced many IHS and contract-care physicians’ approach to medical care and family planning methods for Native American women.

Physicians’ attitudes towards women in general also influenced the flawed and

⁶⁹ Carpio, “The Lost Generation,” 50.

⁷⁰ Ibid, 50.

⁷¹ May, “The Population Bomb,” 38.

⁷² Rutecki, “Forced Sterilization of Native Americans,” 37.

⁷³ Ibid.

discriminatory approach to reproductive healthcare for Native American women. The sexism Native American women experienced at the hands of their healthcare providers is part of a larger narrative of male physicians' attitudes toward female patients at this time. In the 1970s, ninety percent of all doctors in the United States were men, and almost all medical educators were men as well.⁷⁴ In both medical training and practice, women were viewed in a discriminatory and condescending way. As a result of physician perception of the female sex and the reinforcement of these inaccurate representations of women throughout their medical education, male doctors treated women in an infantilizing and patronizing fashion. In fact, until quite recently, male physicians have taken a paternalistic approach to female healthcare on the whole. The condescending treatment of women by medical personnel actually incited a movement in the 1970s where some women took it upon themselves to write the book *Our Bodies Ourselves* with the intention of providing women with the information many doctors refused to give them.⁷⁵ Unfortunately, physicians' sexist and demeaning attitudes towards women resulted in a serious lack of autonomy and self-determination for Native American women when it came to their reproductive health.

Physician education is key to understanding why most male physicians did not respect the agency or intelligence of their female patients at this time. The 1971 edition of the medical textbook *Obstetrics and Gynecology* was widely used as an educational tool for doctors in North America, and it provides a particularly jarring example of the sexist attitudes that were drilled into a doctor's thoughts and attitudes towards female healthcare before they even graduated from

⁷⁴ Kay Weiss, "What Medical Students Learn" in *Dear Sisters: Dispatches from the Women's Liberation Movement* by Rosalyn Baxandall and Linda Gordon (New York: Basic Books, 2000), 117.

⁷⁵ Boston Women's Health Book Collective, *Our Bodies, Ourselves: A Book By and For Women* (New York: Simon and Schuster, 1976), 11-13.

medical school.⁷⁶ In 1975, feminist activist Kay Weiss wrote an article entitled “What Medical Students Learn” that analyzed this textbook and pointed out the many ways in which it reinforced sexist stereotypes that were far too common among male doctors.⁷⁷ The textbook was full of medical inaccuracies as well as dangerous assumptions that could potentially endanger the health of the mother and child during pregnancy. Weiss talked about the textbook’s attention to women’s “fear of pregnancy” and its supposed role in causing common symptoms of pregnancy like excessive nausea and headaches. The textbook expanded upon this, stating that since these symptoms are only caused by an unjustified fear of pregnancy, it is not necessary to test for any complications.⁷⁸ The textbook also stated that if women were too emotional during a doctor visit or if they asked too many questions, it may be best to refer them to a psychiatrist rather than to address their concerns.⁷⁹ These are only two of the numerous examples in the textbook where it was suggested that a doctor could disregard female patient complaints because of a woman’s supposed propensity to overreact or because of her perceived inability to understand her own body and how it works or feels. Finally, the textbook painted the image of the female patient as a frightened child who needed constant reassurance and knowledge from the “enlightened” physician.⁸⁰ By assuming that women are childlike and emotionally unstable, this textbook suggested that female healthcare should be determined by the physician and that women should not have much say in their own medical treatment. For physicians who were taught these sexist ideas in medical school, the chance for mutual respect between a doctor and a female patient was diminished and made nearly impossible if the doctor decided to prescribe to the ideas the

⁷⁶ Weiss, “What Medical Students Learn,” 118-120.

⁷⁷ Ibid, 117-120.

⁷⁸ Ibid, 118.

⁷⁹ Ibid, 119.

⁸⁰ Ibid, 118.

textbook encouraged.

The impact that an IHS doctor's medical training had on his female patients cannot be overemphasized. During her search for information on the widespread sterilization of Native American women, Dr. Connie Uri encountered one woman who went to the hospital for severe headaches that had been bothering her for a while. The doctor told her that the headaches were brought on by her fear of pregnancy, and in order for them to subside she should be sterilized. She had the procedure, but her headaches did not go away—it was not until later that she learned from another doctor that she had a brain tumor.⁸¹ This story is a striking example of the dangers of the type of reasoning that the *Obstetrics and Gynecology* textbook encouraged. Medical treatment based on these types of sexist assumptions did not place the female patient in a position of agency or capacity to aid in her own healthcare and wellbeing. In another example, a female Native American patient had gone to the IHS for stomach problems in the mid-1970s. In the doctor's office she was berated by her doctor who believed she was sick because she was pregnant and yelled at her, "Why the hell don't you get your tubes tied so you won't get sick anymore?"⁸² This is a particularly arresting example of how physicians often looked down on women patients and spoke to them in a contemptuous manner. The doctor clearly had no respect for his patient. His comment was infantilizing and demeaning—she was spoken to like a child who disobeyed a parent.

These attitudes and assumptions were particularly pervasive when physicians advised women on sexual activity and family planning methods at this time. For example, during a hearing on the safety of contraceptive pills in the 1970s, a physician supported his position

⁸¹ *Concerns of American Indian women*, WNED-TV (Television station: Buffalo, N.Y.) and Public Television Library (Washington: Public Television Library, 1977).

⁸² Smith, "Better Dead Than Pregnant," 84.

against inserting warnings about birth control drugs in the packaging with this statement:

A misguided effort to inform such women leads only to anxiety on their part and loss of confidence in the physician...They want him [the doctor] to tell them what to do, not to confuse them by asking them to make decisions beyond their comprehension.⁸³

This incident is illustrative of the belief that female patients were unintelligent and should be treated as children—women could not make decisions about their own healthcare because they could not comprehend everything that the male doctor can. Dismissing patient complaints, discouraging Native American women from making their own decisions when it came to their reproductive care, actively withholding information about their health, and pressuring women into procedures that they may not have wanted or understood were results of the systematic medical training on how to approach female healthcare.

The story of Norma Jean Serena, a Native American woman of Creek and Shawnee ancestry who was forcibly sterilized through tubal ligation, poignantly illustrates the many racist, elitist, and sexist assumptions that were at play during this period of widespread forced sterilization. Serena's story begins in 1970 when social workers from the Child Welfare Services took away the younger two of her four children, telling Serena that this was necessary because they were ill. However, there was some evidence that the reason Serena's children were taken away from her was the fact that the welfare agency had received reports that Serena was unmarried and living with a black man. The social workers at the welfare agency had decided that this was a dangerous environment for her children. In the same year, on the same day that she gave birth to her fifth child, Shawn, Serena was sterilized without her knowledge. She did not realize she had been sterilized until the next day, and she had no recollection of signing the

⁸³ Weiss, "What Medical Students Learn," 117.

consent forms even though she recognized her signature. If Serena had been asked to sign the consent forms after her delivery, she would not have been fully cognizant of what she was agreeing to, as the defense ultimately argued in her case against Armstrong Country Child Welfare Services and Citizens General Hospital. The only explanation she was given for the involuntary procedure was a statement from welfare officials who told her that future pregnancies could result in mentally disabled or deformed children. Making matters more problematic and distressing, her newborn was immediately taken from her by Child Welfare Services after she gave birth to him.⁸⁴

Fortunately, Serena's case grabbed the attention of the Native American community, feminist and indigenous newspapers, civil-rights related organizations, and Native run organizations. Her story gained an audience, and others with more political power were able to help her seek justice. A task force called the Norma Jean Serena Support Committee was created to solicit funds for her legal fees and raise awareness of her situation. After years of legal battles and disputes with the Child Welfare Agency, Serena finally received custody of her children again in 1974. However, when her case went to court in 1979, the jury did not agree that her civil rights had been violated when she was sterilized because her signature was clearly on the consent form. During Serena's trial, the fact that she was a poor and unmarried woman who had black friends influenced the jury's perception of Serena and her situation. Norma Jean Serena never fully received justice or even validation that what had happened to her was wrong.⁸⁵ The unfortunate reality is that a majority of Native American women did not ever find justice for the discrimination and abuse they suffered at the hands of the IHS and contract-care physicians who

⁸⁴ Carpio, "The Lost Generation," 46; Horan, Jean. "condition: socio economic—treatment sterilization." *Off Our Backs*, 6:10 (January, 1977).; LNS. "Norma Jean Serena." *Off Our Backs*, 5:6 (July 1975).

⁸⁵ LNS, "Norma Jean Serena."; Smith, "Better Dead Than Pregnant," 84.

made the decision to sterilize them without their full consent.



Government Negligence: Unfulfilled Responsibilities

The federal government's relationship with Native Americans has always been unbalanced, troubled, and controversial. Since European settlers first colonized what would become the United States, the relationship between the colonizers and the natives has been contentious at best and brutally inhumane at worst. Over time, U.S. expansion and federal policy deprived Native Americans of their self-sufficiency, decreased their population size on a massive scale, and eventually created a group of people who were forced to depend on the government for nearly everything necessary to their survival.⁸⁶ Colonization and its long-term effects have forced Native Americans into a poverty-ridden situation. The United States has entered into over 370 treaties with Indian tribes in order to claim title to their lands and then send them to live on reservations with minimal government services and benefits in exchange for the loss of their land

⁸⁶ Ralstin-Lewis, "The Continuing Struggle Against Genocide," 77.

and sovereignty.⁸⁷ The political and social realities of life for Native Americans in the United States further complicate the understanding of the wave of forced sterilizations in the 1960s and 1970s.

Considering the long history of government negligence and abuse against native peoples, the government's role in the sterilization abuse of Native women in the 1960s and 1970s is not surprising. The status of Native Americans as an impoverished and government dependent population meant that Native Americans did not have access to the same medical and legal resources and opportunities as other groups in the U.S. and thus were more vulnerable to this sterilization abuse. As previously explained, the federal government actively promoted sterilization policies and contributed to sterilization abuse by relaxing restrictions on sterilization procedures in the 1960s and 1970s. The government is further culpable in the sterilization abuses of Native American women because it did not fulfill its legal responsibilities to provide adequate healthcare to the Native American people and it was also negligent in preventing sterilization abuse in ways that it could have.

Though medical care is one of the benefits promised to Native Americans in the many treaties and acts of legislation established between Indian tribes and the federal government, the U.S. government has proved itself wholly inadequate at providing sufficient healthcare services to Native Americans. Since many Indian tribes live in remote areas without access to private or state health services, IHS facilities were established in these areas to provide needed access to healthcare for Native Americans living on reservations.⁸⁸ While the IHS has significantly improved the health of Native Americans since its creation, the funding and upkeep of their

⁸⁷ Ibid, 82.

⁸⁸ Torpy, "Native American Women and Coerced Sterilization," 10.

facilities has historically been subpar.⁸⁹ In 1955 the IHS was transferred from the Bureau of Indian Affairs (BIA) to the Public Health Service because it did not receive enough funding under the BIA.⁹⁰ Even after funding increased for the IHS in the years after 1955, its facilities still did not meet government hospital standards. There were not enough facilities in general, and the ones that did exist were outdated and in poor conditions. In 1975, a study by the Joint Committee on the Accreditation of Hospitals found that over two-thirds of the Indian Health Service's 51 hospitals were "obsolete and in need of complete replacement."⁹¹ Furthermore, in the 1970s the number of IHS facilities was gradually decreasing.⁹² It was estimated that an increase in \$40 million in funds would be necessary in order to bring the level of Native medical care up to the national average at the time.⁹³ The lack of sufficient funding for the IHS created difficulties in ensuring that its facilities were safe and up to date. The U.S. government was required to provide adequate healthcare to Native Americans; it was a legal right, not a privilege. Yet compared to the rest of the nation, Native American healthcare was perilously lagging behind.

Staffing of facilities has also been a significant problem for the IHS. Not only were there a lack of hospitals, there was also a lack of physicians. The low pay, long hours, and rural isolation of IHS facilities made it difficult to induce interest in physician employment. The starting salary for an IHS physician was about \$17,000 to \$20,000 per year, and their average workweek for this pay was a long 60 hours.⁹⁴ Up until the military physician draft ended in 1973, the IHS had long relied on this negative incentive to recruit physicians for IHS facilities in

⁸⁹ Lawrence, "The Indian Health Service and the Sterilization of Native American Women," 402.

⁹⁰ Ibid, 401.

⁹¹ Torpy, "Native American Women and Coerced Sterilization," 10.

⁹² Ibid.

⁹³ Ibid.

⁹⁴ Rutecki, "Forced Sterilization of Native Americans," 37.

remote areas.⁹⁵ When the draft ended, the IHS had even more difficulty than ever convincing physicians to work in their facilities.⁹⁶ This had devastating impacts on Native access to health services. In 1974, for every 1,700 Native Americans on a reservation there was only one doctor.⁹⁷ Faced with a lack of physicians and, as a result, increased difficulty in providing adequate care for Native Americans, the IHS contracted private physicians to provide supplemental care and surgical procedures that could not be provided by the resources of the IHS.⁹⁸ The problem with contracted care was that these private physicians were reimbursed in full for each surgery or procedure they performed, and there was no cap on the amount of procedures they could be paid for.⁹⁹ They were motivated by monetary rewards to perform surgeries, which raises ethical concerns that were not addressed by the IHS. Furthermore, the contracts stipulating private care supplemental services did not state that the contract-care facilities had to abide by the HEW regulations regarding informed consent for procedures like sterilization.¹⁰⁰ By ignoring the potential for ethical gray areas and coercion, the IHS did not protect the very people their institution was created to serve. The federal government did not provide the IHS with sufficient funds, and this inadvertently led to unchecked sterilization abuses.

The complications and difficulties that Native American women encountered in the legal system further compounded government negligence to protect Native Americans and provide

⁹⁵ C.L. Holstetter and J. D. Felsen, "Multiple Variable Motivators Involved in the Recruitment of Physicians for the Indian Health Service," *Rural Health*, 90:4 (July-August 1975), 319.

⁹⁶ *Ibid*, 319.

⁹⁷ Torpy, "Native American Women and Coerced Sterilization," 10.

⁹⁸ *Ibid*, 11.

⁹⁹ Rutecki, "Forced Sterilization of Native Americans," 38-39.

¹⁰⁰ U.S. Government Accountability Office, *Investigation of Allegations Concerning Indian Health Service* (HRD-77-3), November 4, 1976, accessed January 16, 2017, <http://www.gao.gov/products/HRD-77-3>, 26.

them with adequate medical and legal resources. Native women who considered pursuing legal action once they were made aware that they were sterilized either by coercion or without their informed consent did not have an easy task ahead of them. Most of the women who experienced sterilization abuse did not choose to seek legal remedies, and those who did either settled out of court or had their cases dismissed.¹⁰¹ Suing an institution within the federal government like the IHS or the PHS was enormously difficult and intimidating, and thus rarely attempted. Patients had a much better chance of redress if they were to sue individual physicians for negligence.¹⁰² However, it was still very difficult to pursue justice and compensation using this route.

Hiring a lawyer and taking legal action was an extremely expensive undertaking. If the Native woman who wanted to sue relied on the federal government for most of her needs, it is unlikely that she would have been able to easily afford the costs of hiring a competent lawyer and taking a physician to court. Furthermore, even if she had the money to do so, the physician was unlikely to have been convicted. It was extremely difficult for Native American women and their lawyers to prove a lack of informed consent if the consent form had her signature on it.¹⁰³ It was challenging to prove exactly what happened between a doctor and patient in a hospital room when the only clear evidence that the patient gave consent exists in its proper form. Further complicating matters, physicians who worked for the IHS received expert legal defense at no cost when accused of malpractice.¹⁰⁴ All of these legal complications combined to disenfranchise poorer plaintiffs, like Native American women, who did not have the resources or capability to pursue redress. The U.S. government did not fulfill its legal obligations to provide adequate medical care to Native American women, and the complications of the legal process of filing a

¹⁰¹ Ralstin-Lewis, "The Continuing Struggle Against Genocide," 83-84.

¹⁰² Carpio, "The Lost Generation," 49.

¹⁰³ Ralstin-Lewis, "The Continuing Struggle Against Genocide," 83.

¹⁰⁴ Carpio, "The Lost Generation," 49.

lawsuit against IHS physicians further compounded the government's responsibility in the forced sterilizations of Native American women. The government did not take action to protect Native American women on its own, so Native leaders and activists began to respond on their own terms in the 1970s.

Response and Resistance

The mass sterilization of Native American women affected the entire community, and in response Native leaders and activists rallied together to bring attention to this horrific phenomenon. In 1972, Native activist and physician Dr. Connie Uri began to document these abuses after a 26-year-old female patient asked for a womb transplant; six years earlier the woman had been pressured into a hysterectomy and told that it was a reversible procedure.¹⁰⁵ Her doctor suggested that since she had a drinking problem she should not have any more children, so she was sterilized at age 20.¹⁰⁶ Dr. Uri was alarmed that a young woman's uterus had been removed for non-health related reasons, and after more women came to her with similar stories she realized that these were not isolated incidents of malpractice.¹⁰⁷ Dr. Uri was influential in raising awareness of the forced sterilizations of Native American women at this time. In 1974 she set out to assess the extent of the sterilizations and conducted a study of sterilization policies in Claremore, Oklahoma, she found that approximately one in four Native American women in the area had been sterilized without their consent.¹⁰⁸ This would be the first of many studies

¹⁰⁵ *Concerns of American Indian women.*

¹⁰⁶ *Ibid.*

¹⁰⁷ *Ibid.*

¹⁰⁸ Anne Minard, "Preemptive Genocide."

conducted by scholars and activists to attempt to measure the damage done to the Native American population.

Before Dr. Uri's study had even been published, Native Americans were organizing and resisting as they began to realize how prevalent forced sterilizations were at the time. The influential Red Power movement of the 1960s inspired some Native American women to branch off and create their own organizations focused on protecting Native women and their rights. One of the first organizations formed in response to the forced sterilizations was the Coalition Against Sterilization Abuse (CASA). Native activists Lehman Brightman, Andrea Carmen, and some of Carmen's classmates formed CASA in the early 1970s in order to raise public awareness of the sterilization abuses committed against Native American women as well as against African American, Puerto Rican, and Mexican women.¹⁰⁹ In 1974, female members of the American Indian Movement (AIM) saw a need for further investigations into the forced sterilizations of the women in their communities and created Women of All Red Nations (WARN), an organization that focused specifically on issues affecting Native American women.¹¹⁰ Native resistance against forced sterilization was on the rise and continued to grow later in the 1970s after the issue garnered further attention and exposure from a congressional investigation of the Indian Health Service and its sterilization practices.

The culpability of the IHS in the large number of sterilizations of Native American women was broadcast in 1976 when the Government Accountability Office (GAO) released a report titled "Investigation of Allegations Concerning Indian Health Service."¹¹¹ Pressure from Native American activists, especially from Dr. Uri, compelled Senator James Abourezk of South

¹⁰⁹ Ibid.

¹¹⁰ Ralstin-Lewis, "The Continuing Struggle Against Genocide," 81.

¹¹¹ From this point onward, this report will be referred to as the GAO Report.

Dakota, chairman of the Senate Interior Subcommittee on Indian Affairs, to request an investigation on the sterilization policies of the IHS.¹¹² Though the motives of Abourezk's call for an investigation were questionable—Dr. Uri believed that it was requested in order to discredit her claims that forced sterilizations were systematic and widespread—the GAO Report was a clear yet conservative illustration of the extent of the sterilizations of Native American women at this time.¹¹³ The investigation examined four IHS facility areas: Aberdeen, Texas; Albuquerque, New Mexico; Oklahoma City, Oklahoma; and Phoenix, Arizona.¹¹⁴ The report found that 3,406 female sterilization procedures had been completed between 1973 and 1976 at these four facilities.¹¹⁵ Of these procedures, 3,001 were performed on women of childbearing ages, and 1,024 were performed at IHS contract-care facilities.¹¹⁶ Considering the already small population of Native Americans in the United States, these numbers were alarming. The investigation only examined four of twelve IHS facility areas, and it only covered a period of three years in the 1970s. If the investigation had covered all IHS and contracted facilities, there is little doubt that the number of female sterilizations recorded would have been much larger. In fact, scholars and activists have done their own studies to support the idea that a much higher percentage of Native American women were sterilized than the GAO Report led the public to believe. These independent studies estimated that somewhere between 25% and 50% of Native

¹¹² Torpy, "Native American Women and Coerced Sterilization," 6.

¹¹³ *Concerns of American Indian women.*

¹¹⁴ U.S. Government Accountability Office, *Investigation of Allegations Concerning Indian Health Service*, 3.

¹¹⁵ *Ibid.*

¹¹⁶ *Ibid.*, 4.

American women had been sterilized during this time period.¹¹⁷ It is clear that far more Native American women were sterilized during these three years than the GAO Report implies.

One of the most important takeaways from the GAO Report is the lack of compliance with HEW regulations for sterilization procedures and consent forms on the part of the IHS facilities. The investigation found thirteen violations against a HEW moratorium on sterilizing people under the age of 21.¹¹⁸ Though the investigation did not find evidence that patients were sterilized without signed consent forms, the report stated that the consent forms found on file “were generally not in compliance with the IHS regulations.”¹¹⁹ They did not

(1) indicate that the basic elements of informed consent had been presented orally to the patient, (2) contain written summaries of the oral presentation, and (3) contain a statement at the top of the form notifying subjects of their right to withdraw consent.¹²⁰

The HEW consent form requirements were supposed to help prevent coercion by forcing the physician to provide information about consent, the procedure as well as its benefits and risks, and the rights of the patient to refuse the procedure. The findings of the GAO investigation raised serious questions as to why IHS facilities were not complying with HEW sterilization regulations. Furthermore, the larger importance of the GAO investigation lies in the obvious question of how it is possible that the IHS and its physicians were able to skirt government regulations without consequences for such a long period of time. As the previous section of this paper argues, the federal government was supposed to monitor IHS facilities, but it did not do so until claims of forced and coerced sterilizations became so numerous that it was impossible to

¹¹⁷ Lawrence, “The Indian Health Service and the Sterilization of Native American Women,” 410.

¹¹⁸ U.S. Government Accountability Office, *Investigation of Allegations Concerning Indian Health Service*, 4.

¹¹⁹ *Ibid.*

¹²⁰ *Ibid.*

ignore. Yet again, the government did not adequately fulfill its responsibilities to the Native American community in regards to their safety, health, and well-being. The investigation's reasoning given for the deficiencies outlined in the report was that some doctors did not completely understand the regulations, contracted facilities were not required to follow HEW regulations, and HEW did not adequately develop specific or standardized sterilization guidelines and consent forms for all IHS facilities to use.¹²¹ However, these excuses were not sufficient in explaining the lack of compliance with clear HEW regulations, and Native American activists have criticized the GAO Report for not going far enough to investigate these abuses.

One of the major activist critiques of the GAO investigation is that it failed to address the issue of coercion. The report established that a substantial number of Native American women were sterilized in this three-year period, but it did not provide clear evidence of the factor of coercion. Today, many scholars agree that the GAO investigation did not go far enough to address the real problem at hand—government employees were using their power to force or persuade patients, in a number of ways, to be sterilized.¹²² At the time the GAO Report was released, Native American activists shared this same concern that the investigation did not dig deep enough at the time. As explained in the report, the government investigators “did not interview patients to determine if they were adequately informed before consenting to sterilization procedures” because they believed it would be unproductive.¹²³ The investigation

¹²¹ Ibid, 4 & 25.

¹²² Carpio, “The Lost Generation,” 48; Torpy, “Native American Women and Coerced Sterilization,” 7-8; Ralstin-Lewis “The Continuing Struggle Against Genocide”, 81; Smith, “Better Dead Than Pregnant,” 84-85.

¹²³ U.S. Government Accountability Office, *Investigation of Allegations Concerning Indian Health Service*, 4.

only considered documents provided by IHS officials.¹²⁴ This prevented the investigators from hearing firsthand about the many coercion tactics that IHS and contract-care physicians used to influence women to choose sterilization. By limiting the evidence to consent forms and official hospital documents, the investigation ignored the possibility of coercion.

Another important critique of the government's inadequate attempt to hold one of its institutions accountable was that the investigation did not acknowledge the cultural differences often found between doctors and their patients at IHS facilities. Many of the Native American women who were sterilized did not speak, read, or write English, and their doctors were not likely to have spoken or understood any of the indigenous languages.¹²⁵ This would have complicated the oral and written aspects of informed consent for sterilization procedures. At this time, there were no interpreters employed by the IHS to properly explain a patient's healthcare options if there was, indeed, a language barrier.¹²⁶ The GAO Report should have considered the input of the patients themselves as well as the potential cultural and language barriers that may have influenced the large number of sterilizations that occurred during this time period.

While the faults of the GAO investigation remain significant, the report was beneficial because it spurred even more activist response. The GAO investigation brought attention to a problem that many Native communities had not yet realized was going on. Chief Judge of the Northern Cheyenne tribe Marie Sanchez was one of these Native activists who was roused to action after the publication of the GAO Report. Sanchez interviewed women in her community personally about the issue, and in less than a week she had spoken to 26 women who had either

¹²⁴ Ralstin Lewis, "The Continuing Struggle Against Genocide," 81.

¹²⁵ Carpio, "The Lost Generation," 48.

¹²⁶ Torpy, "Native American Women and Coerced Sterilization," 13.

been coerced or forced into a sterilization procedure.¹²⁷ Soon after she conducted these interviews, Sanchez launched an investigation on the Northern Cheyenne Reservation and found that the IHS had sterilized 56 out of the 165 women of childbearing age in that area.¹²⁸ Sanchez was not the only major player after the release of the GAO Report. Lehman Brightman, member of CASA and former president of the United Native Americans, dedicated his life to investigating and exposing sterilization abuses after the release of the GAO Report.¹²⁹ One of his most significant contributions to the resistance movement was the two marches on Washington D.C. he coordinated in 1978 and 1980.¹³⁰ Native response and resistance was important and influential in eventually pushing for the revision of the HEW and IHS sterilization regulations.

Unfortunately not every attempt to achieve justice for Native American women succeeded. As discussed earlier, the challenges in seeking justice and compensation through the legal system deterred most Native American women from bringing charges of coercion and abuse to the courts. However, in 1997 three Northern Cheyenne women filed a class action lawsuit against the hospital physicians that sterilized them in Montana.¹³¹ This was the only lawsuit brought against the IHS and its physicians for the forced sterilizations that occurred at this time. The case almost made it to the Supreme Court, but it was never heard because the physicians' attorneys persuaded the three Cheyenne women to accept a cash settlement.¹³² The plaintiffs' attorney Michael Zavalla was dismayed by the settlement, but he believed that it had much to do with the shame and embarrassment that the women felt about the loss of their

¹²⁷ *Concerns of American Indian women.*

¹²⁸ Ralstin-Lewis, "The Continuing Struggle Against Genocide," 82.

¹²⁹ Torpy, "Native American Women and Coerced Sterilizations," 16.

¹³⁰ *Ibid.*

¹³¹ *Ibid.*, 8.

¹³² Ralstin-Lewis, "The Continuing Struggle Against Genocide," 84.

reproductive capabilities.¹³³ Many Native American cultures are based on the value of the family and the potential to preserve their cultures through future generations.¹³⁴ It is possible that they did not want their names released because it would only draw extra attention to themselves and their families. Marie Sanchez hoped to persuade more women to file lawsuits against the IHS and the physicians that have sterilized them, but she understood that many women felt embarrassed and traumatized and likely did not want to broadcast the fact that they unknowingly gave up their reproductive capabilities.¹³⁵ Though legal resistance would have been a beneficial addition to the Native response to forced sterilization, the difficult legal challenges and the context of many Native American cultures made the filing of lawsuits problematic.

In the end, the attention gained by the GAO investigation as well as the many forms of Native activism and resistance in the 1970s forced HEW to upgrade and change many of its regulations related to sterilization for its IHS facilities.¹³⁶ In March 1979, HEW instated the following changes:

- (1) The waiting period after consent changed from 72 hours to 30 days;
- (2) new consent forms were made clearer with simpler language;
- (3) an interpreter must be provided;
- (4) the distinction must be made between medical (therapeutic) and family-planning (non-therapeutic) sterilizations;
- (5) no federal money will be used or provided for a hysterectomy without medical reason or any procedure on an individual under 21.¹³⁷

Furthermore, all protocols regarding sterilization, including requirements for informed consent, must meet the legal and regulatory requirements outlined in the Indian Health Manual, which

¹³³ Torpy, "Native American Women and Coerced Sterilization," 8-9.

¹³⁴ *Ibid.*, 9.

¹³⁵ *Ibid.*

¹³⁶ Carpio, "The Lost Generation," 50.

¹³⁷ *Ibid.*, 50-51.

was updated in 1978.¹³⁸ The Manual states that sterilizations may not be performed until informed consent is obtained and documented in writing and that the patient's consent cannot be obtained during labor or childbirth.¹³⁹ While all of these changes in regulations are beneficial and an act of good faith by the government in efforts to protect a vulnerable population from physician negligence and abuse, much work remains.

The Abuse Continues

Though government regulations following the GAO investigation of the IHS and its sterilization practices have curbed potential sterilization abuse, these regulations have not been enough to protect Native American women from other types of physician abuse related to their reproductive freedom. The Indian Health Service's more recent use and promotion of the contraceptives DepoProvera and Norplant illustrate the fact that Native women's control over their own reproductive freedom is still at risk. DepoProvera and Norplant are both long acting hormonal contraceptives available in the United States today. DepoProvera is an injectable contraceptive that prevents pregnancy for three months by inhibiting ovulation,¹⁴⁰ whereas Norplant prevents pregnancy for five years through cylindrical rods implanted beneath the skin.¹⁴¹ The Food and Drug Administration (FDA) approved the use of Norplant and DepoProvera as contraceptives in 1990 and 1992 respectively, even though both have been linked with several dangerous side effects, the most serious of which are excessive bleeding,

¹³⁸ Indian Health Service, "Maternal and Child Health," in the *Indian Health Manual*, last modified March 20, 1992, accessed February 13, 2017, https://www.ihs.gov/IHM/index.cfm?module=dsp_ihm_pc_p3c13.

¹³⁹ *Ibid.*

¹⁴⁰ Volscho, "Racism and Disparities in Women's Use of the Depo-Provera Injection," 674.

¹⁴¹ Smith, "Better Dead Than Pregnant," 93.

cancer, and sterility.¹⁴² Other common side effects include weight gain, hair loss, headaches, nausea, osteoporosis, an increased risk of sexually transmitted diseases, blindness, heart attacks, and strokes.¹⁴³ The extreme nature of many of these side effects has prompted many of the women previously using the contraceptives to discontinue their use.¹⁴⁴ Women have also pursued legal action as a result of the negative side effects they experienced while using the two contraceptives. DepoProvera and Norplant have prompted over 400 lawsuits in the United States alone.¹⁴⁵

In spite of their dangerous side effects, both DepoProvera and Norplant have been used and promoted by the IHS. Beginning in the 1980s DepoProvera was used as birth control on hundreds of Native American women, particularly on Native women with mental disabilities.¹⁴⁶ At this time the FDA had only endorsed DepoProvera for kidney and uterine cancer treatment—the drug had not been approved as a contraceptive because of numerous studies showing that it caused cancer in animals.¹⁴⁷ However, physicians may legally prescribe approved yet questionable drugs for any medical treatment as long as they are willing to accept liability.¹⁴⁸ IHS employees reasoned that the use of DepoProvera on mentally disabled Native women was beneficial for “hygienic reasons.”¹⁴⁹ Burton Attico, area director of the Phoenix IHS, said, “We use it to stop their periods. There is nothing else that will do it. To have to change a pad on someone developmentally disabled, you’ve got major problems. The fact they become infertile

¹⁴² Volscho, “Racism and Disparities in Women’s Use of the Depo-Provera Injection,” 674-675.

¹⁴³ *Ibid.*, 675.

¹⁴⁴ Thirty percent of women on Norplant in the United States wanted the implant removed within a year, and within three years the majority wanted it removed as well (Smith, “Better Dead Than Pregnant,” 93).

¹⁴⁵ Ralstin-Lewis, “The Continuing Struggle Against Genocide,” 86.

¹⁴⁶ *Ibid.*

¹⁴⁷ “Depo-Provera and the Indian Women,” *New York Times*, August 17, 1987.

¹⁴⁸ *Ibid.*

¹⁴⁹ Smith, “Better Dead Than Pregnant,” 92.

while on it is a side benefit.”¹⁵⁰ Attico’s belief that infertility is a “benefit” reflects decades old beliefs about Native American women and those with disabilities. His comment illustrates the racist, elitist, and sexist discrimination discussed at length in this paper and shows that these attitudes have not changed much since the sterilization of Native American women.

DepoProvera abuse has not been limited to Native American women with mental disabilities; IHS doctors have also actively promoted it as a desirable form of birth control since its FDA approval in 1992.¹⁵¹ Norplant has also been aggressively used and promoted by IHS physicians since its approval in 1990 regardless of its questionable safety. In fact, over eighty-seven percent of Norplant implants have been paid for with federal funds.¹⁵² Women who depend on the government for healthcare, largely Medicaid recipients and Native American women, are far more likely to be using Norplant than other groups of women. IHS physicians may find it easier to recommend Norplant as it lasts for five years and only needs to be inserted once.

The problems related to the IHS’s promotion and use of these two contraceptives are all too familiar. The unethical nature of distributing DepoProvera to disabled women before the FDA approved it as a contraceptive is sadly not shocking considering the past abuses of Native Americans in the United States. Furthermore, the lack of rules and regulations in place to combat the information asymmetry between doctor and patient created a similar situation to the sterilization abuses of the 1960s and 1970s. Some Native American women reported being pressured into using Norplant by IHS doctors and welfare caseworkers in the 1990s.¹⁵³

¹⁵⁰ Ibid.

¹⁵¹ “The Failing State of Native American Women’s Health: Interview with Charon Asetoyer,” *Center for American Progress*, May 16, 2007.

¹⁵² Smith, “Better Dead Than Pregnant,” 89.

¹⁵³ Ibid, 95.

Additionally, many Native American women using DepoProvera or Norplant were not adequately informed of the negative side effects or the contraindications that could make them poor candidates for the two forms of birth control.¹⁵⁴ Many of the contraindications for DepoProvera and Norplant are health issues, such as diabetes, high blood pressure, and smoking, that occur at a higher-than-normal rate for the Native American community.¹⁵⁵ In this case, inadequate information from the physician suggesting the use of either DepoProvera or Norplant could create serious consequences for Native women with any of these prior health issues. Lack of informed consent was also a principal issue for Native American women who were prescribed DepoProvera and Norplant. Both before and after their official FDA approval, informed consent from the patient was rarely properly received.¹⁵⁶ As previously mentioned, many women were not informed of the dangerous side effects related to the two contraceptives. Furthermore, no written consent forms were used in the contraceptive's distribution process because there are no regulations requiring the use of written consent forms for these two types of birth control.¹⁵⁷ Understanding the coercion that took place in the 1970s allows us to see that a lack of requirements for documented informed consent allows for coercion in these instances as well.¹⁵⁸ The use of DepoProvera and Norplant by IHS physicians illustrates that not much has changed and that the reproductive rights of Native American women are still at risk today.

The coerced and forced sterilizations of Native American women in the late 1960s and 1970s in the United States arose from a combination of both personal and national ideas, values,

¹⁵⁴ Ibid, 92-95.

¹⁵⁵ "The Failing State of Native American Women's Health."

¹⁵⁶ Smith, "Better Dead Than Pregnant," 92-94.

¹⁵⁷ Ibid, 92.

¹⁵⁸ It must be noted that not all IHS facilities regard informed consent in such a flippant manner. For example, the Crow service unit painstakingly records consent and provides counseling services for women looking to use contraceptives (Smith, 94).

and anxieties that converged in the late 20th century. These issues and ideas are still significantly influential in the provision of Native healthcare today. As exemplified by the unethical implementation of new pregnancy prevention methods, the discriminatory ideas at the core of eugenics and past population control policies continue to influence the attitudes and beliefs of IHS physicians who have continued to take it upon themselves to determine the extent of their Native patients' reproductive rights. The U.S. government has not done enough to make reparations for and rectify the sterilization abuses that it indirectly encouraged by not providing sufficient medical services for Native Americans. Native American leaders and activists have done their best to address and bring attention to this horrendous chapter in American history, but incidents like the sterilization abuses of the late 1960s and 1970s will continue to happen until the U.S. government takes responsibility and ensures the protection of Native American patient rights. The all-too-familiar abuses of DepoProvera and Norplant illustrate that a uniform policy, like the one that now exists for sterilization practices and procedures, must be put in place for these two birth control methods, and any new drug or procedure created to prevent pregnancy, in order for medical abuses such as these to end.

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