

The Lost Generation: American Indian Women and Sterilization Abuse

Myla Vicenti Carpio

I had been sterilized at the age of eleven, at the IHS [Indian Health Service] hospital here in the early 1950s. I got married in the 1960s and I went to the doctor and he told me that I had a partial hysterectomy. [When I was a child] they were giving us vaccinations and mine got infected and a nurse came and gave me some kind of shot so I wouldn't hurt. When I woke up my stomach was hurting and I was bleeding (Woman speaking on radio show, "Native America Calling," 2002).

NEITHER THIS WOMAN NOR HER PARENTS HAD CONSENTED TO THE STERILIZATION procedure. Many Native women have such stories about being sterilized, either without their consent or through coercive means. Although voluntary sterilization is a popular, safe, and reliable form of birth control for many women, the unauthorized use of sterilization procedures on marginalized women constitutes abuse. Furthermore, numerous women in countries outside the United States have faced sterilization abuse.

Various ideologies have contributed to the involuntary sterilization of women, especially women of color. Imperialism, capitalism, patriarchy, and Malthusianism have shaped social and socioeconomic standards by which many women and their fertility are valued. As capitalism and industrialization have expanded, so too has international interest in fertility control of "lower-class" people. The United States filters monies through agencies such as U.S. Agency for International Development, the Rockefeller Foundation, and the Ford Foundation for population control programs. These agencies were responsible for the sterilization of men and women in regions such as Puerto Rico, Brazil, Guatemala, Africa, and Panama (Mass, 1976). Some abuses continue today. "More than 20 years since testimony against the practice at the United Nations, Indigenous women in Mexico and other Latin American nations are still routinely sterilized without their consent" (Giago, 2000: A5).

Likewise, colonialism intersected with patriarchy to directly threaten American Indian women through sterilization abuse. Scholars, such as Lisa Poupart and

MYLA VICENTI CARPIO (Jicarilla Apache) is assistant professor of American Indian studies at Arizona State University (American Indian Studies Department, Box 870803, Tempe, AZ 85287-0803; e-mail: Vicenti@asu.edu).

Andrea Smith, have examined the ramifications of colonialism and oppression on Indigenous women's bodies, reproductive health, and lives. Poupart (2002) discusses the devastating impact of Western European and American historical domination and oppression on American Indians, which has created and perpetuated injustices throughout Indian Country. The continued political, social, and economic oppression has left American Indian people, especially women, vulnerable to systematic abuse — in this case Indian Health Services (IHS). Paternalistic policies toward American Indians allow the federal government to make decisions on their behalf without their full consent or participation. "Just as a father makes decisions for his children, then, the oppressive structures within patriarchy — particularly those of state bureaucracies and multinational corporations — and those individuals acting as vehicles of authority make decisions for those groups deemed in need of guidance" (Poupart, 1996: 5). Furthermore, Smith (2003) points out that Native women threaten colonial structures through their ability to reproduce the next generation of colonial resistance.

The state and mainstream U.S. society justify themselves in the encroachment upon the private lives of Native women by assuming control over their right to make their own decisions concerning their lives and their bodies. This encroachment has a double-edged blade. One side carries a sharpened edge that has cut away at women's right and ability to bear children, our next generation. It has inflicted invisible abuse and violence upon American Indian women and their cultures and communities because we cannot look at each other and know who has been sterilized. The other edge of the blade is silence. Sterilization abuse has silenced Indian women's voices through fear and shame. Many women do not speak out in fear of retribution through loss of services or other such harms. Moreover, governmental bodies commissioned to investigate accusations concerning involuntary sterilizations by the IHS have cut away their voices and stories by refusing to interview the sterilized women (Staats, 1976). I also encountered this edge of silence when I began to research this topic (Carpio, 1995). Some women, understandably, did not wish to talk about their sterilizations and I am grateful to those women who did talk with me.

Protests and investigations that emerged during the 1970s showed that the public health system, primarily the HIS, was sterilizing American Indian women without their knowledge or informed consent.¹ It is difficult to define involuntary sterilizations or prove instances of coercion because there are many shades of gray. Some medical grounds do warrant therapeutic hysterectomies and other sterilization procedures, but there is evidence that these procedures were performed on Indian women without just medical cause.

American Indian women are susceptible to uninformed or involuntary sterilizations because of the different ways in which doctors or health care professionals present hysterectomies and tubal ligations. Some women reported that questionable delivery room diagnoses led to their sterilizations. IHS doctors used

consent forms for medically required sterilization procedures rather than forms that distinguished voluntary sterilizations from required ones. Other women were told outright lies about their conditions and treatments. Involuntary and uninformed sterilizations can occur even if a consent form is signed and on file (Dillingham, 1977; Staats, 1976; Jarvis, 1977).

American Indian women, doctors, and Indian publications (for example, the *American Indian Journal* and *Akwesasne Notes*) contributed to the awareness of sterilization abuse. Hospital staff and sterilized women began to speak out about sterilization abuse and other problems within the IHS and public health system. Investigations into sterilization abuse arose from an inquiry made by Dr. Connie Uri and the 1976 General Accounting Office (GAO) investigation requested by Senator James Abourezk of South Dakota. Dr. Uri, Choctaw and Cherokee, became involved when one of her patients asked for a womb transplant. This woman, then 26, was persuaded by her doctor that because she was an alcoholic with two children, she should be sterilized by a hysterectomy for birth control purposes. Six years later, no longer drinking, planning to marry, and having knowledge of kidney transplant procedures, the patient thought her womb could be replaced (Jarvis, 1977). Dr. Uri stated:

At first I thought I had discovered a case of malpractice.... There was no good reason for a doctor to perform a complete hysterectomy rather than a tubal ligation on a 20-year-old, healthy women. I began accusing the government of genocide and insisted on a congressional investigation (Jarvis, 1977: 30).

From these demands came Senator Abourezk's request for a GAO investigation. The GAO investigated four of 12 areas serviced by the Indian Health Service: Aberdeen, South Dakota, Albuquerque, New Mexico, Oklahoma City, Oklahoma, and Phoenix, Arizona. These districts serve a significant number of the total Indian population (Dillingham, 1977). The GAO examined a three-year period, 1973 to 1976, and found that 3,406 Indian women were sterilized. In 1973, 857 sterilizations were performed; 886 sterilizations were done in 1974, 901 in 1975, and 762 in 1976 (Staats, 1976). Of total sterilizations, 3,001 were done during childbearing ages (15 to 44) and 1,024 (30%) were sterilized at contract health facilities. These health care facilities provided additional services that IHS lacked (Staats, 1976; Dillingham, 1977).

The GAO investigation report (1976: 26), released November 23, 1976, stated that it found "no evidence of IHS sterilizing Indians without a patient consent form on file." In 1976, the GAO report focused on "allegations concerning Indian Health Service" and investigated the charge of sterilization abuse. Nothing was confirmed and only a revision of the procedures and requirements of sterilizations was recommended. However, this investigation found weaknesses in compliance with Department of Health, Education, and Welfare (HEW) sterilization regula-

tions (Staats, 1976). Still, these weaknesses are a myopic consideration regarding consent and non-consent. By limiting the evidence to consent forms, investigators ignored possibilities of abuse in the form of coercion or the use of sterilization as a primary diagnosis without options.

The ranges of compliance weaknesses illustrate areas in which women were vulnerable and susceptible to coercion. Moreover, the investigators silenced the women by ignoring their voices. The four areas of weakness are sterilization of persons under 21 years of age, lack of widespread physician understanding of the regulations, inadequately documenting what Indian subjects were told before signing the consent form (largely attributable to the use of consent forms that failed to meet HEW standards), and the lack of definitive requirements for informed consent when sterilizations are performed by contract doctors at contract facilities (Staats, 1976). The investigation looked only at IHS documents. The team did not interview the hospital staff or the sterilized women due to "published research [noting] a high level of inaccuracy in the recollection of patients 4 to 6 months after giving informed" consent (Dillingham, 1977; Staats, 1976: 19-20).

The first weakness cites sterilization procedures performed on individuals under the age of 21. In a telegram sent August 2, 1973, and reconfirmed by a memorandum dated October 16, 1973,

The IHS director informed all IHS area directors that...there is, effective immediately, a temporary halt in the IHS sterilization procedures performed on an individual who is under...21 or who is legally incapable of consenting to sterilization. This policy does not apply when the operation is performed for the surgical treatment of specific pathology of the reproductive organs...(Staats, 1976: 20).

The area directors and physicians were also contacted on April 29, 1974, and again on August 12 of that year. In August, the area director's memorandum to IHS physicians emphasized the importance of HEW sterilization regulations and included a copy of the HEW regulations and the director's telegram. The IHS area directors also received copies (Staats, 1976). Between July 1, 1973, and March 30, 1976, there were 36 moratorium violations of sterilization of persons under age 21. The explanations for the violations conveyed that,

...most [of the] IHS areas were under the impression that they could either perform sterilization on minors or mental incompetents with proper (72 hour) informed consent and/or that they could employ the age of majority of the respective state in which the procedure was performed (18 years in most cases) (*Ibid.*: 22).

A discussion with the Chief of Obstetrics and Gynecology in Phoenix left some questions unanswered. Twelve violations were explained by legitimate medical reasons with the intent to sterilize. The GAO did question the medical justifica-

tions of the sterilizations and "19 could not be resolved" (*Ibid.*: 25). However, the GAO overlooked this since they determined it to be comparable to what "one would expect to find in a non-Indian Health Service hospital of comparable size" (*Ibid.*). The GAO reported that all the women's ages were over 18 and within weeks of their 21st birthdays (*Ibid.*).

The second area of HEW policy weakness, the lack of widespread physician understanding of HEW regulations, resulted in additional violations of the moratorium. Although area directors were informed of the moratorium by telegraph in August 1972, physicians thought sterilization procedures were admissible preceding the April 29, 1974, memorandum they received from the IHS director. This misunderstanding resulted in 15 sterilizations before April 30, 1974. Yet, a year later, between April and September 1975, three more women were sterilized. A sterilization procedure was "inadvertently" authorized for a 19-year-old woman in Albuquerque, along with two 20-year-old women in the Oklahoma City area. One of the physicians reportedly did not understand "how the HEW sterilization policy was to be interpreted" (*Ibid.*: 22). In addition, the GAO found that IHS did not give direction and guidance for implementing the regulations (*Ibid.*).

The GAO also found that the weaknesses in HEW regulations involving the inadequate documentation of consent forms could be attributed to the failure of IHS area offices to adhere to HEW sterilization regulations and failure to adopt proper consent forms. In fact, of 113 voluntary sterilizations reviewed from Aberdeen, Phoenix, and Oklahoma City, none were in full compliance with HEW regulations (*Ibid.*). An evaluation of consent forms implemented in the above cities showed that, of 113 consent forms used, 91 were form HSM-83, which is used for "medically required, rather than voluntary," or non-therapeutic sterilizations (*Ibid.*: 23).

The forms physicians and staff used for sterilization procedures were the most blatant illustration of misinforming American Indian women about their rights or the necessity of surgical procedures. Form HSM-83 and Standard Form 522, used for all types of surgery, did not comply with HEW regulations. Both forms neglected to show whether the oral presentations to the patient contained the basic elements of informed consent, including the written summaries of the oral presentation. Most important, it failed to contain the required printed statement: "Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects" (*Ibid.*: 24). This statement was absent despite a U.S. District Court order that patients, regardless of the consent form document used, be informed orally that no federal benefits can be withdrawn or withheld if they decide not to be sterilized (*Ibid.*).

Contract facilities also failed to meet HEW requirements for consent forms, allowing room for coercion and uninformed consent. In the Albuquerque area, a review of consent forms found that three of six facilities did not meet HEW standards. Again, the disclosure of basic elements of informed consent or space

for summaries of oral information were left out, as was the required statement, "Your decision at any time not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects" (*Ibid.*: 24). IHS officials from the Albuquerque and Aberdeen areas said they did not regulate the adequacy of informed consent received by contract care doctors or facilities. They also do not stipulate "how HEW regulations for sterilization procedures were to be followed" (*Ibid.*: 24). However, the GAO informed IHS officials that section 50.201 of the regulations makes the IHS responsible for assuring that contract facilities follow HEW guidelines (*Ibid.*).

In addition, GAO investigators failed to interview the hospital staff or sterilized women. Based on one published article on witness unreliability after surgery, the investigators decided not to interview because they felt it would have been unproductive (*Ibid.*). Had these women been interviewed, questions of voluntary, involuntary, or informed sterilizations could have been addressed. For example, in 1970 Chicanas sued the Los Angeles County Medical Hospital for involuntary, coercive sterilizations in the case *Dolores Madrigal et al. Plaintiff v. E.J. Quilligan et al.* These women reported coercion in terms of constant pressuring to sign consent forms while drugged and/or in the throes of labor, or pressuring husbands to approve the procedure (Velez-I, 1980a; *Militant*, 1974a). Interviews with the Los Angeles County Medical hospital staff cited pressuring patients as a standard phenomenon (Velez-I, 1980b; *Militant*, 1974b).

Without evidence showing informed consent, one can conclude that these procedures may have been falsely presented as required sterilizations or that the women were not completely informed of precautions and the permanence of sterilization procedures. IHS was also unable to provide information concerning which procedure doctors performed for therapeutic purposes or for non-therapeutic birth control purposes. Moreover, one can presume coercion since the consent forms used were for medically required sterilizations and did not state that patients could safely withdraw consent for presumably non-therapeutic sterilizations.

In newspapers and article interviews, women told of their difficulties with the IHS hospitals. One woman went to the doctor with stomach ailments and the doctor immediately assumed her vomiting was due to pregnancy. He proceeded to yell at her, asking the woman why she did not have her tubes tied "so she won't get sick anymore" (Jarvis, 1977: 30). Barbara Moore, a Lakota, conveyed her experience:

I was pregnant myself and I went to a public health service to deliver my baby. For one reason or another, I was not able to deliver it in a normal way. They delivered my child by caeserian [*sic*], that is all I remember. When I woke up the next day after the operation I was told that my child was born dead.... Besides this, they told me that I could not have any more children because they have had to sterilize me.... I was sterilized without my knowledge or without my agreement (Podarski, 1979: 11).

Norma Jean Serena was sterilized at a Pennsylvania county hospital. Although she recognized her signature, she had no recollection of signing a consent form. According to her lawsuit, the consent form was signed during labor, and was dated and witnessed the day after the surgery. Since she was coming out of anesthesia and exhausted from a difficult delivery, she was not completely informed or fully cognizant of the consequences of signing such a form. Doctors told Serena that she "had enough children" and if she had more children they would be born with defects. However, it was not until a year later that Serena discovered she was sterilized (Jarvis, 1977: 30).

Serena's story is not unusual. Two women told me that they were unable to have children after having visited IHS facilities. The daughter of one woman said that she was her mother's last child. After her delivery at an IHS hospital, her mother was no longer able to become pregnant, yet she had not requested to be sterilized (Anonymous, 1993). Another woman, "Sarah," said to me,

I had a cyst in my stomach, my womb, and I had appendicitis. I went in for my six weeks check up and he [the doctor] was pushing in my stomach and I started getting pains and that's when he said I had to go to the hospital to get the operation, to have the cyst taken out.... I think I did sign a piece of paper that said I have to have the appendix and cyst taken out; that's all they told me and nothing else (Sarah, 1993).

Furthermore, another woman spoke of being lied to or given misinformation when she went for a doctor's appointment. The physician suggested that she needed vitamins. The "vitamins" turned out to be birth control pills (Podarski, 1979). Had she missed a few days of taking the pills and become pregnant, and then resumed taking the pill, her baby could have developed health risks. Moreover, another woman related that she had gone to see a doctor and was told that her severe headaches were a result of a "fear of pregnancy, that she was afraid to get pregnant" (*Ibid.*: 11). Therefore, she should be sterilized to rid herself of the headaches. In fact, this woman had a brain tumor (*Ibid.*). Some women did not know they had been sterilized because the procedures can be masked through treatment for other diagnoses.

Women can be sterilized in two ways: by hysterectomy or tubal ligation. A hysterectomy consists of the total removal of the uterus. This can be performed at any time, including immediately after childbirth or at the time of a caesarian (Saidi et al., 1980). A laparotomy, the tubal ligation procedure, is one of the easiest forms of sterilization. Women need only a general or local anesthesia, and it can also be performed at the time of delivery. Doctors can perform sterilizations vaginally as a colopotomy or a culdoscopy. These procedures can also be done in conjunction with an abortion, but this increases the chances of developing an infection. There are also more postoperative cautions than with a laparotomy (*Ibid.*). It is troubling that these procedures can be performed without a woman's knowledge.

IHS does not have, or will not provide, microsurgery procedures to reverse tubal ligations. Voluntarily or involuntarily, these procedures should be considered irreversible. Although continual improvement of microsurgical techniques has increased reversal success rates of tubal ligations, hysterectomies can never be reversed (Shepard, 1980). Successful reversibility of tubal ligations depends upon the extent of damage to the tubes. With certain procedures, such as banding and Pomeroy, where destruction is isolated, the success rate is high (*Ibid.*). Procedures such as laparoscopic coagulation cause electric coagulation and create extensive damage.

The GAO report went beyond the investigation of uninformed sterilizations of American Indian women. The first section highlights a pattern of IHS abuses involving children in Indian boarding schools. Boarding schools were created to assimilate indigenous children into U.S. society by removing them from their families and cultures. Thus, boarding school officials acted as the children's guardian. As guardians, the officials became the focus of the GAO investigation and were accused of failing to inform the children or their parents about procedures and studies, as well as of allowing third parties to perpetuate irresponsible actions. The investigation focused on the use of Indian subjects, mainly elementary to high school children, in projects that involved medical practice, procedures, or drug dosage, that "was not considered usual or customary" (Staats, 1976: 1). The GAO report named four studies: on prediabetics in Pima Indians, on cardiovascular disease (using Indians and non-Indians), a vaccine trial of pneumococcal pneumonia in Navajos, and on trachoma and pediatric pulmonary disease in White Mountain Apache children (Staats, 1976).

The GAO found areas of uninformed consent within the investigated studies, yet did very little with the evidence. In the pediatric pulmonary study, the GAO found that the study had failed to include written summary disclosures about the study in the children's parent or legal guardian's consent forms. Such disclosures explain the purpose of the study to the subjects and their guardians. Although this finding demonstrates uninformed consent, the GAO ignored the discrepancy between the lack of disclosures and the principal investigator's claims that the parents and/or guardians were fully informed (*Ibid.*)

Though the GAO looked askance at discrepancies, the Proctor Foundation understood how their actions indicated abuse. In a study conducted by the Proctor Foundation for Research in Ophthalmology before the GAO investigation, receipt of informed parental consent was at the center of concern. Although it was discontinued, the study covered the school years from 1967 to 1968 and from 1972 to 1973. The Foundation only initiated parental consent in the 1972-1973 school year (*Ibid.*). It reasoned that since the IHS was acting as legal guardian while the children were in boarding schools and only "commonly prescribed drugs in standard doses were used," specific parental consent was not needed (*Ibid.*: 13). According to the GAO report, Proctor stopped their study due to the possibility of

misconstruing the use of “defenseless minority children” without the immediate need for such treatment. They did not want a “trial by publicity” (*Ibid.*: 14).

The conclusion of the GAO report provided recommendations associated with the weaknesses in the HEW regulations, but never acknowledged the pattern of uninformed consent, the possibility of coercion, or their own silencing of the women’s voices by refusing to interview the women who had been sterilized. It addressed the consent forms and contract staff’s comprehension of HEW guidelines by recommending that a standard consent form be implemented that maintains HEW guidelines, with the required information printed on it. The report also encouraged training that would inform physicians and administrators, as well as contract health physicians and other users of HEW regulations, emphasizing information on the age and incompetence moratorium. Furthermore, the GAO advised IHS to monitor non-IHS physicians and the facilities’ contract provisions to ensure compliance of regulations (*Ibid.*).

Concerning benefits and consent, two notable GAO recommendations attempt to close a divide in patient safety. GAO investigators advocated that HEW regulations “be amended to...conform with the ruling of the U.S. district court order that a patient, regardless of the consent form document used, ...be informed orally that no Federal benefits can be withdrawn or withheld if they decide not to be sterilized....” (*Ibid.*: 26). Also, it advocated that physicians and nurses be required to include their signature on the patient’s consent form. These two recommendations attempt to fill critical gaps in hospital protocol that left women vulnerable and the hospital unaccountable. The threat of benefit withdrawal can be a strong tool in seeking a coerced consent. Furthermore, requiring the signatures of hospital employees helps to ensure greater hospital accountability.

The findings in the GAO report focused on consent forms, regulations, and procedures, but nowhere did they address the problem of cultural difference. Not only do indigenous nations differ from each other, but their worldviews also contrast largely with U.S. mainstream culture. One recommendation featured a sample general-purpose consent form, including written explanations of the various sterilization procedures and family planning methods (*Ibid.*). Missing, however, was consideration of the need for translators; many of these women may not have spoken or read English. Further complicating the issue is the unlikelihood of doctors either understanding or speaking one of the many indigenous languages. Even if the women signed the consent form, the exact understanding of the procedure and its ramifications may not have been understood. Such disregard for these women’s cultures and languages was another way in which the women’s voices were excluded.

Failure to interview the sterilized women meant investigators could not fully comprehend the impact of weaknesses in regulations or the possibilities of coercion encountered by these women. Many individuals depend on IHS services as their only health care provider. If malpractice or injustices occur, a lawsuit against the

Public Health Service (PHS) and IHS is the only redress. It is an intimidating prospect to sue such large governmental institutions. Patients may sue individual physicians employed by PHS, rather than the service itself, since they are liable for their own negligence (such as malpractice). Private malpractice insurance coverage affords additional protection to PHS employees, physicians, and non-PHS physicians. The burden of proof then is on the complaining party, making it more difficult to sue an individual doctor.

In many cases of uninformed sterilizations, consent forms were signed while the patient was anesthetized or in the throes of labor. Many of these women did not recall signing the form, yet their signature is on it. Proving uninformed or non-consent is thus more difficult, which protects PHS employees against such suits. One avenue to sue IHS and the PHS is torts — legal wrongs committed upon the person or property of another, independent of a contract. The Federal Tort Claims Act of 1946 affords a limited waiver of sovereign immunity by the U.S. government, which provides, with exceptions, a remedy in tort for persons injured by the negligence of government agents acting in the course and scope of their official duties (Bernzweig, 1966). The state law in which the tort is committed is used to determine liability on the facts (*Ibid.*).²

Taking legal action against the PHS or IHS invokes monetary concerns. Litigation can be very costly for individuals, whereas the physician being sued obtains legal defense from the U.S. Department of Justice at no cost. Furthermore, the physician, even if sued personally, “has at his disposal all the legal and investigative resources of the Government, a decided advantage in any lawsuit” (*Ibid.*: 1). The PHS employee is in an “advantageous position in regards to professional liability” (*Ibid.*: 1). As Bernzweig (1966) notes, it is unlikely that a person who is dependent upon the PHS and IHS will be able to retain an attorney and pay the fees needed for professional witnesses. This remains difficult for many Indian women and makes retribution and redress difficult and discouraging, constituting another form of intimidation.

In addition, many women only realized they had been sterilized when they returned for a follow-up appointment, some years later (*The Militant*, 1974a; Podarski, 1979). A woman may not know that she has had a tubal ligation because her ongoing menstruation differs little from when she was fertile (Saidi et al., 1980). Doctors were thus able to sterilize without consent since the women likely did not find out until much later. Moreover, because of their short two-year tour at the HIS, doctors avoided liability, as did the staff (Carpio, 1995).

At the very least, the Public Health Services and IHS were negligent in caring for American Indians, particularly regarding sterilization. Beyond improper procedures, many of the ideologies behind this abuse remain. Most sterilized women did not have a voice in their sterilization procedure. Scholars and community members have examined motivations behind the decision to sterilize American Indian women. Johansen (1998), with much of his work based on Torpy (1998),

contextualized the sterilizations as a further campaign of the eugenics movement. Lawrence (2000) points out that a large number of sterilizations took place in the African-American and Latino communities. It was viewed as an attack on those in poverty, especially during President Johnson's War on Poverty (Carpio, 1995; Lawrence, 2000). Some physicians and hospital staff compared the socioeconomic status of American Indians with their own perspectives and standards of class, often middle to upper-middle class. Therefore, they believed that Native women, with their low socioeconomic status, could not possibly provide their children with a decent life. Similarly, they applied mainstream U.S. societal standards by placing limits on family size, with the optimum family size set at two children per family (Velez-I, 1980a). Commenting on an illustration that focused on family size in relation to socioeconomic status, Dr. Uri stated, "women who are poor don't get rich by having their tubes tied" (McGarrah, 1974: 6).

The imposition of mainstream social standards and the sterilization of large numbers of American Indian women support the outcries regarding Indian genocide. At the time of these investigations, the American Indian population was cited as less than 800,000, within an overall U.S. population of 220 million (U.S. Census Bureau, 1970; Kraft, 1981). According to WARN (Women of All Red Nations) and Dr. Uri's estimates, up to 42% of American Indian women of childbearing age had been sterilized (*Akwesasne Notes*, 1977; Jaimes, 1992; Jarvis, 1977). In addition, I spoke to a woman whose mother had been sterilized in 1961, 12 years before the GAO investigation (Anonymous, 1993). Since the GAO investigated only four of 12 IHS service areas between 1973 and 1976, its findings of 3,406 sterilized women misrepresent the actual number of Indian women sterilized. Charges of genocide are enhanced by the higher estimation of the number of sterilized Indian women.

The sterilizations had repercussions in terms of the loss of a generation of children and the consequences for the sterilized women and their cultures. For some indigenous nations, sterilization also affected cultural participation in ceremonial practices. In certain Pueblo tribes, for instance, a woman must be a participant in religious ceremonies, where "woman" is defined as those who have had children (Vicenti and Pino, 1990). Furthermore, for the Cree people, if a family does not have many children, the Cree hold that this family is paying for some wrong that has been committed (Deiter-McArthur, 1993).

Prompted by the numerous charges, investigations, and lawsuits in the early 1970s, the HEW, effective on March 8, 1979, announced a change in regulations regarding sterilizations that attempted to address and prevent coercion. The procedures for sterilization were changed in the following ways: (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 (National Women's Health Network, 2000; World Health Organization, 1980). Although these new guidelines have helped to curb sterilization abuse, it was up to HEW to enforce these new regulations.

These were positive steps, but changes must go beyond policies. General intolerance toward American Indians, and the specific practice of the HIS, must be addressed. The GAO investigation cast a formal spotlight on the problem of sterilization abuse, but it only scratched the surface. Sterilization abuse is less likely to occur with the new policy, but attitudes that perpetuate the subjugation of women's bodies are not as easily changed.

The legacy of sterilization abuse for American Indians is a missing generation of children who may have learned and passed down tribal traditions, ceremonies, and language and continued the fight for cultural and political self-determination. Some women who can no longer conceive have replaced their loss by adopting or taking in foster children, or devoting more time to existing children and grandchildren (Sarah, 1993). Other women have learned from their experiences and found their voices and strength to question procedures and diagnosis at every medical visit. Many still wonder why they were sterilized.

Concerning women's voice and strength, Carol (1993) told me about her prescribed sterilization at an Indian health facility. She had been having abnormal uterine bleeding for "months on end," causing chronic and severe anemia. Her physician told her that if she did not respond to hormone medication, a hysterectomy would be performed. Carol wrote that the doctors tried "to talk me into a hysterectomy," but she felt it was wrong to get a hysterectomy prescribed so quickly. She declined the hysterectomy and began to research her own medical history. From reading medical journals and investigating her family's medical history, she found the doctor's diagnosis to be wrong and the prescribed hysterectomy to be unnecessary. The "culprit" was a hormonal problem originating from the thyroid gland, hypothyroidism. Therefore, she was prescribed a thyroid hormonal replacement and returned to a regular menstrual cycle. I later learned that she had become pregnant and was expecting her first child.

NOTES

1. The Indian Health Service was transferred from the Department of Interior to the Public Health Service within the Department of Health, Education, and Welfare in 1954. It is now an agency under the Department of Health and Human Services.

2. One suit filed for improper treatment and medical services is *Dillion v. United States of America* (480 F. Supp. 862 1979), but limitations to sovereign immunity exist in the federal Torts Claims Act (Bernzweig, 1966).

REFERENCES

- Anonymous
1993 Personal Communication: March 26–27. American Indian Family and Tribal Community Conference. Western Michigan University, Kalamazoo, Michigan.
- Akwesasne Notes*
1977 "Killing Our Future: Sterilization and Experiments." *Akwesasne Notes* 9: 4–7.
- Bernzweig, E.P., LL.B.
1966 *Legal Aspects of PHS Medical Care*. Office of the General Counsel. United States, Department of Health, Education, and Welfare, Public Health Service, Bureau of Medical Services. Washington D.C.: Government Printing Office.
- Carol (pseudonym)
1994 Personal communication. May.
1993 Personal communication. July 21.
- Carpio, M.
1995 "*Lost Generation*": *The Involuntary Sterilization of Indian Women*. M.A. Thesis, Arizona State University.
- Deiter-McArthur, P.
1993 "Plains Cree Women in Saskatchewan." Unpublished conference paper: 1–28.
- Dillingham, B.
1977 "Indian Women and IHS Sterilization Practices." *American Indian Journal* 3,1: 27–28.
- Dillion v. United States of America* (480 F. Supp. 862 1979).
- Giago, Tim
2000 "Editorial." *Indian Country Today* 19 (June 14): 52.
- Jaimes, M.A. (ed.)
1992 *State of Native America*. Boston: South End Press.
- Jarvis, G.M.
1977 "Theft of Life." *Akwesasne Notes* (September 30).
- Johansen, B.E.
1998 "Reprise/Forced Sterilizations: Native Americans and the 'Last Gasp of Eugenics.'" *Native Americas* (Winter): 44–47.
- Kraft, M.E.
1981 "Policy Implications of U.S. Population Stabilization." M.D. Hiller (ed.), *Medical Ethics and the Law: Implications for Public Policy*. Cambridge: Ballinger Publishing Co.: 309–325.
- Lawrence, J.
2000 "The Indian Health Service and the Sterilization of Native American Women." *American Indian Quarterly* 24,3: 400–419.
- Mass, B.
1976 *Population Target: The Political Economy of Population Control in Latin America*. Ontario: Charters Publishing Co.
- McGarrah, R.E., Jr.
1974 *Akwesasne Notes* (Early Winter): 6.
- The Militant*
1974a "Forced Sterilization: Chicanas Fight Back in Los Angeles." December 20.
1974b "Los Angeles Women Protest Forced Sterilizations." December 20.
1972 April 14 issue.
- National Women's Health Network
2000 "Sterilization." Washington, D.C.: National Women's Health Network.
- Podarski, F.
1979 "An Interview with: Barbara Moore, on Sterilization." *Akwesasne Notes* 11.
- Poupart, L.M.
2002 "Crime and Justice in American Indian Communities." *Social Justice* 29,1–2: 144–159.
1996 *Silenced Voices: Patriarchy, Cultural Imperialism, and Marginalized Others*. Ph.D. dissertation, Arizona State University.

- Saidi, M.H., M.D., and Carla M. Zainie
1980 *Female Sterilization: A Handbook for Women*. New York and London: Garland STPM Press.
- Sarah (pseudonym)
1993 Personal Communication. November 19.
- Shepard, M.K.
1980 "Methods of Sterilization in Men and Women." R.N. Shain and C.J. Pauerstein (eds.), *Fertility Control: Biologic and Behavioral Aspects*. Cambridge: Harper and Row: 103-117.
- Smith, A.
2003 "Not an Indian Tradition: The Sexual Colonization of Native Peoples." *Hypatia* 8,2: 70-85.
- Staats, E.B.
1976 *Report to Senator James Abourezk. Investigation of Allegations Concerning Indian Health Service*. Released November 23. Washington, D.C.: General Accounting Office.
- Torpy, S.J.
1998 "Endangered Species: Native American Women's Struggle for Their Reproductive Rights and Racial Identity: 1970's-1990's." Master's thesis, University of Nebraska at Omaha.
- U.S. Census Bureau
1970 *Subjects Reports: American Indians Census of Population*. Washington, D.C.: U.S. Government Printing Office.
- Velez-I, C.G.
1980a "The Non-Consenting Sterilization of Mexican Women in Los Angeles." M.B. Melville (ed.), *Twice a Minority: Mexican American Women*. St. Louis, MO: C.V. Mosby: 235-248.
1980b "'Se Me Acabó la Canción': An Ethnography of Non-consenting Sterilizations Among Mexican Women in Los Angeles." M. Mora and A. Del Castillo (eds.), *Mexican Women in the United States: Struggles Past and Present*. Los Angeles, CA: Chicano Studies Research Center, UCLA: 71-91.
- Vicenti, M. and L. Pino
1990 Personal Communication.
- Vicenti Carpio, Myla
2004 "Involuntary Sterilization of American Indian Women." (Guest) KUMN Radio Albuquerque, New Mexico.
- World Health Organization
1980 "Female Sterilization: Guidelines for the Development of Services." Geneva, Switzerland: World Health Organization.

Copyright of Social Justice is the property of Social Justice and its content may not be copied or emailed to multiple sites or posted to a listserv without the copyright holder's express written permission. However, users may print, download, or email articles for individual use.