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The Indian Health Service and the Sterilization of Native American Women

JANE LAWRENCE

A young Indian woman entered Dr. Connie Pinkerton-Uri's Los Angeles office on a November day in 1972. The twenty-six-year-old woman asked Dr. Pinkerton-Uri for a "womb transplant" because she and her husband wished to start a family. An Indian Health Service (IHS) physician had given the woman a complete hysterectomy when she was having problems with alcoholism six years earlier. Dr. Pinkerton-Uri had to tell the young woman that there was no such thing as a "womb transplant" despite the IHS physician having told her that the surgery was reversible. The woman left Dr. Pinkerton-Uri's office in tears.¹

Two young women entered an IHS hospital in Montana to undergo appendectomies and received tubal ligations, a form of sterilization, as an added benefit. Bertha Medicine Bull, a member of the Northern Cheyenne tribe, related how the "two girls had been sterilized at age fifteen before they had any children. Both were having appendectomies when the doctors sterilized them without their knowledge or consent." Their parents were not informed either. Two fifteen-year-old girls would never be able to have children of their own.²

What happened to these three females was a common occurrence during the 1960s and 1970s. Native Americans accused the Indian Health Service of sterilizing at least 25 percent of Native American women who were between the ages of fifteen and forty-four during the 1970s. The allegations included: failure to provide women with necessary information regarding sterilization; use of coercion to get signatures on the consent forms; improper consent forms; and lack of an appropriate waiting period (at least seventy-two hours) between the signing of a consent form and the surgical procedure. This paper investigates the historical relationship between the IHS and Indian tribes; the right of the United States government to sterilize women; the government regulations pertaining to sterilization; the efforts of the IHS to sterilize American Indian women; physicians' reasons for sterilizing American Indian women; and the consequences the sterilizations had on the lives of a few of those women and their families.³

The IHS evolved out of various government programs designed to address the health care issues of American Indians. Under the auspices of the War Department in the early 1800s, "Army physicians took steps to curb smallpox and other contagious diseases of Indian Tribes living in the vicinity of military posts." Army physicians used vaccinations and other medical procedures to prevent both military men and the Indians they came in contact with from being infected with diseases. The first treaty that included medical services was signed between the United States and the Winnebago Indians in 1832. In 1832 Congress provided funding for Indian health care in the amount of twelve thousand dollars.⁴

In 1849 Congress transferred the Bureau of Indian Affairs (BIA) from the War Department to the Department of the Interior, including all health care responsibilities for American Indians. By 1875 half of the federal Indian agencies had physicians, and the BIA built the first federal hospital for Indians in Oklahoma during the late 1880s. After the turn of the century, the BIA created a separate health division and appointed district medical directors. The health division started special programs to combat tuberculosis and other diseases and established health education classes to support these programs. The Snyder Act of 1921 included congressional authorization for the BIA to provide Indian health care "for the benefit, care, and assistance of the Indians throughout the United States." The BIA contracted with the Public Health Service (PHS) in 1928 to provide sanitation engineers to investigate water and sewage problems at BIA facilities and renewed and expanded that contract through the early 1950s.⁵

In 1955 Congress transferred total responsibility for Indian health from the Department of the Interior to the Public Health Service. The legislation stated that "all facilities transferred shall be available to meet the health needs of the Indians and that such health needs shall be given priority over that of the non-Indian population." The PHS, a division of the Department of Health, Education, and Welfare (HEW), formed the Division of Indian Health, which was renamed the Indian Health Service in 1958. At the time of the transfer, there were not enough physicians or medical facilities available to provide the proper medical care for American Indians. Congress believed that the PHS would be able to recruit a greater number of physicians by offering more attractive salaries and fringe benefits and to increase and improve medical facilities with higher Congressional appropriations for the HEW.⁶

The PHS has greatly improved the health of Native Americans and the governmental medical facilities in the years since it became responsible for American Indian health. The PHS received better funding for Indian health services because Congress appropriated more money for health concerns to the HEW than it ever did to the BIA. Alan Sorkin in *Public Policy Impacts on American Indian Economic Development* reveals that "congressional appropriations in-

creased nearly twelve-fold on a per-Indian basis between 1955 and 1983." Deaths from diseases, such as tuberculosis, have dropped significantly, and infant mortality has also declined dramatically. The majority of Indians living on reservations are using the medical services of the IHS as their primary caregiver. The number of IHS doctors increased from 125 in 1965 to 600 in 1980. Even though there have been increases in the number of medical personnel, statistics show that the number of doctors and nurses in relation to the number of Indians seeking service from the IHS has actually decreased since 1966. The actual number of patients per physician rose from 1,220 in 1966 to 1,500 in 1980 because of the increase in the Native American population. Despite the low ratio of medical personnel to Native American patients, it must be remembered that the IHS improved the overall health of Native Americans following its inception in 1958.⁷

The IHS began providing family planning services for Native Americans in 1965 under the authority of the HEW and the PHS. Family planning services provide women with information on the different methods of birth control, how the methods work, and how to use them. They are supposed to provide patients with assistance in determining which form of contraceptive is right for them. Family planning methods include the birth control pill, the intrauterine device, spermicidal jellies and creams, and sterilization. Unless there is a medical problem that a specific form of contraception can either alleviate or aggravate, a woman is supposed to choose whether or not she wishes to participate in the program and what type of birth control she wishes to use since only she can know how the usage of a specific contraceptive measure will affect her life overall.⁸

The United States government agency personnel, including the IHS, targeted American Indians for family planning because of their high birth rate. The 1970 census revealed that the average Indian woman bore 3.79 children, whereas the median for all groups in the United States was 1.79 children. The 1970 and 1980 censuses included specific information on Indian tribes, including family size and fertility rates for women in the childbearing years (fifteen to forty-four). The data show that the average number of children per woman in specific tribes were as follows:

The average for white women was 2.42 children in 1970 and that number lowered to 2.14 in 1980; a difference of .28 children in the ten-year span compared to 1.99 for the Native American community. Cheryl Howard, Russell Thornton, and Veronica Tiller, in their separate studies on Navajo, Cherokee, and Apache tribal demographics, contend that higher levels of education among American Indian women, along with the availability of family planning programs, may have contributed to the lower birthrates in 1980.⁹ They do not specify sterilization as a partial cause of the decline, but sterilization must be considered as a factor.

TABLE 1
Average Number of Children per Woman by Tribe
for 1970 and 1980

TRIBE	1970	1980
Navajo	3.72	2.52
Apache	4.01	1.78
Zuni	3.35	1.90
Sioux (combined)	3.41	1.94
Cherokee (Oklahoma)	2.52	1.68
Ponca/Omaha	2.73	1.51 ¹
Average for all tribes	3.29	1.30

NOTE

1. U.S. Department of Commerce, Bureau of the Census, *1970 Census Report of the Population Subject Report: American Indians* (Washington dc: Bureau of the Census, June 1971), 141–47; U.S. Department of Commerce, Bureau of the Census, *1980 Census of the Population Subject Report: Characteristics of American Indians by Tribes and Selected Areas: 1980* (Washington DC: Government Printing Office, 1981), 150–202. The 1980 census records are much more detailed than the 1970 records; therefore, the statistics were combined for all Sioux tribes in South Dakota and for the Ponca and Osage tribes in Oklahoma. These specific tribes were chosen because of their location in the Indian Health Service areas included in the Government Accounting Office report on the Indian Health Service.

Court rulings have played an important role in federal family planning policies that have an influence on IHS family planning programs. The Supreme Court, and lesser courts, set legal precedents regarding informed consent, family planning, and sterilization between 1914 and 1973. *Schloendorff v. Society of New York Hospital* in 1914 concerned a surgeon who performed an operation that left a man partially paralyzed. The court stated that any person who physically touches another individual without that person's consent commits battery. Justice Benjamin Cardozo spoke for the court when he stated that "every human being of adult years and sound mind has a right to determine what shall be done with his own body; and a surgeon who performs an operation without his patient's consent commits an assault."¹⁰

In 1942 the Supreme Court heard the case of *Skinner v. Oklahoma*. Jack Skinner was incarcerated in an Oklahoma prison following his third offense of armed robbery. Oklahoma had passed legislation that allowed habitual criminals to be sterilized. During this time period many states believed that sterili-

zation laws were valid because the eugenics movement advocated sterilization for those deemed “unfit.” The Court recognized “the right to have offspring as a fundamental right but did not declare compulsory sterilization laws totally invalid.” Justice William Douglas wrote the majority ruling stating that Skinner’s crime did not merit sterilization, declared that the Oklahoma sterilization law was unconstitutional under the Fourteenth Amendment, and expressed concern over the possibility of sterilization abuse arising from such legislation. He stated that “the power to sterilize, if exercised, may have far-reaching and devastating effects . . . [and in] evil hands it can cause races or types which are inimical to the dominant group to wither and disappear.”¹¹

In 1965 the Supreme Court heard the case of *Griswold v. Connecticut*. In 1879 the state of Connecticut had passed a law forbidding the distribution and usage of drugs, articles, or instruments used to prevent contraception, including information on birth control. The law was not vigorously enforced, but in 1963 state officials arrested the executive director and the medical director of the Planned Parenthood League of Connecticut. Family planning and free speech advocates then challenged the law in court. Associate Justice William O. Douglas wrote that a state could not “consistently with the spirit of the First Amendment, constrict the spectrum of available knowledge” in the majority decision. The most important factor of the ruling, however, was that it defined the right to privacy as part of the First Amendment, thereby providing citizens with a constitutional right to select birth control as a method to control their family size and to receive information on the various methods of birth control.¹²

In 1969 a federal court of appeals heard the case of *Jessin v. County of Shasta* that alleviated the fears of many physicians who were wary of performing sterilization procedures and encouraged doctors to perform more of the operations during the 1970s. The case involved a woman who sued her county hospital for performing a sterilization operation on her after she had signed a consent form. The judge ruled that “voluntary sterilization is legal when informed consent has been given, that sterilization is an acceptable method of family planning, and that sterilization may be a fundamental right requiring constitutional protection.” Prior to this case, many physicians had assumed that sterilization as a birth control method was illegal.¹³

In March 1974, the district court in the District of Columbia combined two cases that directly concerned the Department of Health, Education and Welfare’s sterilization regulations. The two cases were *Relf et al. v. Weinberger et al.* and *National Welfare Rights Organization v. Weinberger et al.* Judge Gerhart Gesell declared that “Regulations of Department of Health, Education and Welfare governing human sterilizations are arbitrary and unreasonable” because “they fail to implement congressional command that federal family planning funds not be used to coerce indigent patients into submitting to sterilization.”

He continued with the statement that “federally assisted family planning sterilizations are permissible only with the voluntary, knowing, and uncoerced consent of individuals competent to give such consent.”¹⁴ Judge Gesell then explained that the legislation providing funds for low-income family planning services did not mention sterilization, but that the secretary of the HEW, Casper Weinberger, considered sterilization to be covered by the statute. The judge ordered that “the regulations must also be amended to require that individuals seeking sterilization be orally informed at the very outset that no federal benefits can be withdrawn because of a failure to accept sterilization. This guarantee must also appear prominently at the top of the consent document already required by the regulations.”¹⁵

All of the above cases dealt with the issue of informed consent and the patient’s right to make an informed decision about what could be done to his or her body. For informed consent to be given, a doctor must fully impart the nature and purpose of the procedure to the patient along with the possibility of success, the risks involved, and any alternative treatments. It is then up to the patient to decide if the procedure is the right treatment for his or her own personal well-being. Marc Basson and Eli Bernzweig, specialists in medical law and ethics, both argue that it is the physician’s obligation to reveal all necessary information to the patient and that the failure to provide such information is a violation of the doctor-patient relationship and, therefore, a form of malpractice. Marc Hiller, another expert on medical law and ethics, asserts that “informed consent reflects one of our highest ethical values—individual autonomy; it implicates strong emotional needs both for control over our own lives and for dependence upon others; and it deals with a subject of fundamental importance, our health.” Accurate information is a vital component of informed consent, and although there were court decisions that proclaimed the necessity of providing informed consent before 1973, the HEW did not publish any guidelines for providing family planning services or any directives protecting an individual’s right to receive informed consent for family planning or sterilization procedures until that year.¹⁶

The HEW publishes its regulations in the *Federal Register* and, as subsidiaries of the HEW, the PHS and IHS are required to follow those regulations. On 3 August 1973 the HEW published regulations establishing a moratorium on the sterilization of anyone under the age of twenty-one and on anyone doctors had declared mentally incompetent. Another HEW notice, published on 21 September 1973, announced that the secretary had approved the proposed regulations with minor amendments to the original guidelines. The regulations stated that competent individuals must grant their informed consent, that there must be a signed consent form in the possession of the agency performing the sterilization showing that the patient knew the benefits and costs of sterilizations,

and that a seventy-two-hour waiting period must occur between the time of consent and the surgical procedure.

Judge Gesell's ruling in *Relf et al. v. Weinberger et al.* required the HEW to correct deficiencies in the guidelines, including the need for a definition of the term "voluntary," the lack of safeguards to ensure that sterilizations were voluntary, and the absence of prohibitions against the use of coercion in obtaining consents.¹⁷ The HEW published revised regulations on 18 April 1974. The new requirements included the changes that Judge Gesell required in *Relf et al. v. Weinberger et al.* The amended regulations define informed consent as "the voluntary, knowing assent" of any person undergoing sterilization procedures verified with a consent form that includes information on the actual procedure, any possible risks or discomforts, any benefits of the operation, information on alternative methods of birth control along with an explanation that sterilization is an irreversible procedure, and a statement "that the individual is free to withhold or withdraw his or her consent to the procedure at any time prior to the sterilization without prejudicing his or her future care and without loss of other project or program benefits to which the patient might otherwise be entitled." The revised regulations also dictated that every sterilization consent form exhibit prominently at the top of the form the legend, "NOTICE: 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." The HEW restricted the performance of any sterilization unless the patient voluntarily requested the operation and unless agency personnel advised the patient verbally, as well as in writing, that no benefits would be denied if he or she refused to be sterilized.¹⁸

Congress and the general public believed that the revised regulations would help protect women from involuntary sterilizations but accusations soon arose that the IHS was sterilizing women without their informed consent and was not following the HEW regulations. Native American doctors and hospital personnel from Oklahoma and New Mexico sent letters to Senator James Abourezk of South Dakota, chairman of the Senate Interior Subcommittee on Indian Affairs about sterilization abuses. After his staff conducted an initial investigation the senator requested the Government Accounting Office (GAO) to conduct an investigation on both Indian sterilization and the experimental use of drugs on reservations on 30 April 1975.¹⁹

On 6 November 1976, the Government Accounting Office released its report (hereinafter referred to as the GAO Report). The GAO Report did not verify that the IHS had performed coerced sterilizations, but it did state that the IHS had not followed the necessary regulations and that the informed consent forms did not adhere to the standards set by HEW.²⁰

The GAO conducted its investigation of IHS sterilization practices in four of the twelve IHS program areas: Aberdeen, Albuquerque, Oklahoma City, and Phoenix. The GAO investigators examined IHS records and found that the IHS performed 3,406 sterilizations during the fiscal years 1973 through 1976. These numbers did not include those conducted in the Albuquerque area because contract physicians performed all sterilizations in that IHS region. GAO personnel did not interview any Native American women who had been sterilized during this period because they said they “believe[d] that such an effort would not have been productive.” The foreword of the GAO Report revealed that the IHS performed twenty-three sterilizations of women under the age of twenty-one between 1 July 1973 and 30 April 1974, despite the HEW moratorium on such sterilizations. It was also reported that thirteen more under-age sterilizations occurred between 30 April 1974, when the HEW published new regulations in the *Federal Register*, and 30 March 1976, when the actual GAO study ended. The report stated that the violations occurred because “(1) some Indian Health Service physicians did not completely understand the regulations and (2) contract physicians were not required to adhere to the regulations.” The GAO discovered that the sterilization consent forms used did not comply with HEW regulations and that IHS medical providers used several different forms. The majority of the forms “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 the subjects of their right to withdraw consent.” The GAO Report then proceeded to add detail to the initial overview.²¹

The IHS records did not specify whether the sterilizations that had taken place were voluntary or therapeutic. The HEW defined voluntary, or nontherapeutic, sterilizations as “any procedure or operation, the purpose of which is to render an individual permanently incapable of reproducing.” When the purpose of a sterilization is to treat a woman for a medical ailment, such as uterine cancer, it is a therapeutic sterilization. The GAO Report revealed that “as of August 1976, however, IHS was unable to supply us with complete and statistically reliable data on whether or not the sterilizations were voluntary or therapeutic.”²²

The HEW regulations required that a waiting period of at least seventy-two hours elapse between the signing of the consent form for a voluntary sterilization and the actual operation. The investigators found thirteen infractions of the regulations applying to the required seventy-two-hour waiting period. Medical records reveal that “several” consent forms were dated the day the woman had given birth, usually by Cesarean section, while she was under the influence of a sedative and in an unfamiliar environment. Medical documents

also disclose that a “few” women signed consent forms on the day following their sterilization operation.²³

Despite the claims that some physicians did not understand the regulations, the notice sent to the area directors on 2 August 1973 stated clearly that “there is, effective immediately, a temporary halt in the IHS sterilization procedures performed on an individual who is under the age of twenty-one 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.” A memorandum to the area directors reconfirmed the moratorium on 16 October 1973 and again on 29 April 1974. The IHS sent all of these notices by telegram so that there was no delay in receiving them.²⁴

On 12 August 1974, the IHS sent a memorandum directly to the IHS physicians stressing the importance of the HEW regulations, along with a copy of the regulations and copies of the director’s telegrams to the area directors. On 15 December 1975, the IHS director again notified the area directors and hospital and health center personnel that the HEW regulations must be followed and that the sterilization of women under the age of twenty-one or women judged mentally incompetent, “is permissible only when ‘the procedure is carried out for medical reasons unrelated to the primary intent to sterilize the individual.’” The IHS justified the exceptions to the sterilization moratorium reported to the GAO in several ways: IHS doctors continued to believe that they could perform these sterilizations until they received the notice dated 29 April 1974; they misunderstood the policy; they performed the sterilizations for medical reasons but intended to render the patients incapable of having children; or the patients would be turning twenty-one in a few weeks time. Two cases were not included in these numbers, increasing the total sterilizations in violation of the moratorium to thirty-eight. The deputy director of program operations reported to the investigators that, while the IHS had established surveillance over the sterilizations of women under the age of twenty-one, physicians may not have reported these cases knowing that there was a moratorium against them.²⁵

The GAO investigators examined 113 of the 3,406 consent forms for sterilization procedures. They discovered that IHS medical facilities used three different versions of the form and that all three forms were variations of the short form. Two of these forms did not provide all of the necessary information required by the HEW regulations. The consent forms did not record whether or not medical personnel orally informed the patient of the risks, dangers, and alternatives to the procedure; they did not include written summaries of any oral information that may have been given; and they did not incorporate the required statement alerting patients to their rights if they decided to forego sterilization. IHS personnel used the third form, Form HSA-83, in twelve cases, and this form appeared to the GAO to comply with most of the HEW regulations;

although the GAO revealed that Form HSA-83 was also inadequate because it did not contain enough detail to ascertain whether the patients received all of the necessary information. The form also did not have a written disclosure of all of the elements of informed consent and did not include a section where medical personnel could add a summary of the oral presentation.²⁶

In order to assess the justification for the surgeries, the GAO investigating committee reviewed fifty-four sterilizations performed at the Phoenix Indian Medical Center between 1 April and 30 September 1975. While the GAO Report stated that most of the cases revealed valid cause, the reasons behind nineteen were questionable. The GAO Report recounted that investigators discussed these sterilizations with the chief of obstetrics and gynecology at the center and that the reasons for the nineteen sterilizations remained unresolved. The GAO did not explain why the nineteen cases were questionable.²⁷

The GAO Report gave two causes for deficiencies found in the sterilization practices of the Indian Health Service. First, the IHS area offices failed to follow the HEW regulations pertaining to sterilization procedures. Second, IHS headquarters did not provide specific directions to the area offices, neglected to create a standard consent form for all of its facilities, failed to revise its manual to reflect the new HEW regulations, and did not provide guidelines for the area offices to use in implementing the procedures. The GAO Report also stated that IHS headquarter officials attributed the above deficiencies to the HEW's "inability to develop specific sterilization guidelines and a standardized consent form for all its agencies to use."²⁸

The weaknesses in the sterilization consent forms included the failure to divulge fully the required information on the risks involved in the procedure and the alternative methods of birth control that the individual could use. The GAO Report declared that "The forms also failed to include the required statement 'Your decision at anytime not to be sterilized will not result in the withdrawal or withholding of any benefits provided by programs or projects.'" The IHS officials in the areas examined did not monitor the sterilization practices of contract care facilities. The contracts they signed with outside doctors did not stipulate that those doctors had to follow the HEW regulations. Yet the regulations declared that "the provisions of this subpart are applicable to programs or projects for health services which are supported in whole or in part by federal financial assistance, whether by grant or contract, administered by the Public Health Service." The regulations required that the IHS monitor the sterilization activities of the doctors with whom they had contracts.²⁹

Why did these sterilizations take place? In order to understand the reasons behind the sterilizations it is necessary to remember that physicians were performing large numbers of sterilizations not only on American Indian women, but also on African American and Hispanic women. The number of women on

welfare had also increased dramatically since the mid-1960s with Lyndon Johnson's War on Poverty. The main reasons doctors gave for performing these procedures were economic and social in nature. According to a study that the Health Research Group conducted in 1973 and interviews that Doctor Bernard Rosenfeld performed in 1974 and 1975, the majority of physicians were white, Euro-American males who believed that they were helping society by limiting the number of births in low-income, minority families. They assumed that they were enabling the government to cut funding for Medicaid and welfare programs while lessening their own personal tax burden to support the programs. Physicians also increased their own personal income by performing hysterectomies and tubal ligations instead of prescribing alternative methods of birth control. Some of them did not believe that American Indian and other minority women had the intelligence to use other methods of birth control effectively and that there were already too many minority individuals causing problems in the nation, including the Black Panthers and the American Indian Movement. Others wanted to gain experience to specialize in obstetrics and gynecology and used minority women as the means to get that experience at government expense. Medical personnel also believed they were helping these women because limiting the number of children they could have would help minority families to become more financially secure in their own right while also lessening the welfare burden.³⁰

Various studies revealed that the Indian Health Service sterilized between 25 and 50 percent of Native American women between 1970 and 1976. Dr. Connie Pinkerton-Uri conducted a study that revealed that IHS physicians sterilized at least 25 percent of American Indian women between the ages of fifteen and forty-four. Cheyenne tribal judge Marie Sanchez questioned fifty Cheyenne women and discovered that IHS doctors had sterilized twenty-six of them. She announced her belief that the number of women the GAO reported sterilized was too low and that the percentage was much higher than 25 percent. Mary Ann Bear Comes Out, a member of the Northern Cheyenne tribe, conducted a survey on the Northern Cheyenne Reservation and Labre Mission grounds. She found that in a three-year period, the IHS sterilized fifty-six out of 165 women between the ages of thirty and forty-four in the survey area. She wrote that "the data indicate that the same rate of sterilizations would reduce births among this group by more than half over a five-year period." The sterilization of Indian women affected their families and friends; many marriages ended in divorce, and numerous friendships became estranged or dissolved completely. The women had to deal with higher rates of marital problems, alcoholism, drug abuse, psychological difficulties, shame, and guilt. Sterilization abuse affected the entire Indian community in the United States.³¹

In September 1977, the National Council of Church's Interreligious Foundation for Community Organization (IFCO) held a conference in Washington DC to plan strategies for a "fight for survival" against sterilization abuse. Over sixty delegates from Native American, African American, Hispanic, civil rights, religious, and other groups attended the conference. While the conference addressed the abuses that all minority groups faced, it focused on those that Native American and Hispanic women underwent.³²

The IHS damaged tribal communities in several ways. Tribal communities lost much of their ability to reproduce, the respect of other tribal entities, and political power in the tribal councils. Tribal communities represent sections of the entire tribe, much as counties represent specific areas within a state. The population of a community reflects the number of representatives it can elect to the tribal council and to national pan-Indian organizations. Therefore, a community's level of power within the tribal government is affected by the number of people in the community. A lowered census number might also affect federal services a tribal community receives. Finally, a tribal community that suffers a great number of sterilizations can lose the respect of other tribal communities because of its inability to protect its women.³³

Some Indian leaders believe that the sterilization of Native American women also affects the tribe's economic base and sovereignty. Lee Brightman, president of United Native Americans Inc., argues that "the sterilization campaign is nothing but an insidious scheme to get the Indians' land once and for all." Everett Rhoades, past president of the Association of American Indian Physicians, argues that there is a non-Indian backlash that "seems to have arisen from the recent gains made by Indians in the sale of natural resources." The Women of All Red Nations state that "the real issue behind sterilization is how we are losing our personal sovereignty" as Native Americans. Members of the organization assert that communities having large numbers of sterilizations lost the respect of other tribal communities because of their inability to protect Native American women.³⁴

In 1974, Choctaw-Cherokee physician Dr. Connie Pinkerton-Uri conducted a study that indicated that twenty-five thousand Native American women would be sterilized by the end of 1975. The information she gathered revealed that IHS facilities singled out full-blood Indian women for sterilization procedures. Based on her findings, Pinkerton-Uri stated that "we have only 100,000 women of child-bearing age total—that's not per anything. The Indian population of this country is dwindling no matter what government statistics say to the contrary." Pinkerton-Uri's study also discovered that Indian women generally agreed to sterilization when they were threatened with the loss of their children and/or their welfare benefits, that most of them gave their consent when they

were heavily sedated during a Cesarean section or when they were in a great deal of pain during labor, and that the women could not understand consent forms because they were written in English at the twelfth-grade level. Dr. Pinkerton-Uri related that she did not believe the sterilizations occurred from “any plan to exterminate American Indians,” but rather from “the warped thinking of doctors who think the solution to poverty is not to allow people to be born.” At a meeting held with IHS officials in Claremore, Oklahoma, Pinkerton-Uri criticized the argument that “a poor woman with children was ‘better off’ sterilized.” She maintained that “She’s still going to be poor. She just won’t be able to have children.”³⁵

Children are very important to Native American women for economic reasons, tribal survival, and to secure their place in the tribe. Marie Sanchez, a Cheyenne tribal judge, declared that “the Native American woman is the carrier of our nation.” Mary Crow Dog, a Lakota member of the American Indian Movement (AIM), claimed that most of the women of AIM did not accept the use of birth control because they did not believe that there were enough Indians left in the United States. She stated that “like many other Native American women . . . I had an urge to procreate, as if driven by a feeling that I, personally, had to make up for the genocide suffered by our people in the past.” Emily Moore and Ann Clark, in their separate studies of numerous Native American cultures and family structures, found that children were important not only for the joy they gave the parents but also because group survival was an important aspect of tribal culture. At a conference on birth control in 1979, Katsi Cook, of the Mohawk Nation, declared that “women are the base of the generations. Our reproductive power is sacred to us.”³⁶

Family planning personnel who believe that American Indian women are incapable of adhering to the instructions for contraceptive methods such as the birth control pill do not recognize that Native American women have centuries of experience using various natural methods to prevent conception. Some Indian tribes recognized that a woman’s menstrual cycle related to fertility, and the women in these tribes did not have intercourse during their fertile period. Other tribes used the dried and crushed roots of the red cedar and juniper plants in a tea or concoctions prepared from other plants such as deer’s tongue to prevent births. Henry de Laszlo and Paul Henshaw reported in 1954 that Indians used oral contraceptives including the boiled roots of dogbane or wild ginger, beverages made from milkweed, arum, Indian paintbrush, or rosemary, and the dried roots of thistle, squaw root, and the Mexican wild yam. The basic material that pharmaceutical companies use in birth control pills is diosgenin from the Mexican wild yam. Indians also used derivatives from plants to induce abortions and cause sterility. Native Americans used a variety of birth control methods, and they understood how to use the methods that were

available in their homeland. Even in the late 1970s, in the Southwest and other regions, Indian women used herbal teas and brews to prevent pregnancies.³⁷

Native Americans' use of commercial contraceptives depends, in large part, on tribal attitudes and personal beliefs. Many Indian women either do not believe in contraception themselves or their husbands or extended family do not believe in it. In general, tribal traditions and beliefs work against the use of commercial contraceptives. A woman's age and number of children also helps to determine whether she will use birth control. For example, Navajo women tend to use contraceptives when they are in their latter childbearing years and already have four or five children. Fertility studies conducted on Indian women from the Hopi tribe in Arizona, the Seminole tribe in Florida, the Sells Reservation Papago in Arizona, the Blackfeet in Montana, and Alaskan Natives reveal the same tendencies.³⁸

Native American women do not often reveal their feelings about family planning or sterilization, but one author conducted several interviews with women whom IHS practitioners had sterilized. The interviews reveal the ways in which these women believe the procedure directly affected their lives and what their responses to the IHS has been following the sterilizations.

Employees from a nearby IHS hospital approached Janet about sterilization in 1973. Janet [pseudonyms are used to protect the identity of the interviewees] was twenty-nine and had three children. The social workers came to Janet's home six times when her husband was at work. "They told me that I should be sterilized because I didn't want any more babies right then, so I said yes and signed a consent form. My tubes were tied the next day." Janet found out that the sterilization was irreversible during an American Indian Movement demonstration against IHS sterilizations at Claremore, Oklahoma, in 1974. For the next fifteen years a psychiatrist treated Janet for severe depression. Her youngest daughter still refuses to use the IHS for any type of medical care.³⁹

In February 1974, physicians at Claremore Indian hospital in Oklahoma performed a hysterectomy on Diane right after she gave birth to her son by Cesarean section. Diane does not remember signing a consent form, but believes she must have signed one since they performed the surgery on her. When she found out three days later that the doctors had sterilized her, Diane "told them they had to fix it. They told me they couldn't, that they'd done a hysterectomy." Diane saw a psychologist for ten years following the sterilization because she had problems with depression. "I still get really depressed about it when I think about it. But now I get angry, too." The sterilization caused Diane to fear that something "deadly" would happen to her two sons. That summer she refused to take her nine-year-old's bicycle out of the garage because she "was afraid he'd get hit by a car or something." She described how she "was really protective of the baby and now he's having problems adjusting to being an

adult. I didn't let him learn to make decisions on his own. And it's all my fault. I was never like that before they did this to me." Diane has never returned to the IHS facility in Claremore and sees a private physician in Tulsa.⁴⁰

In 1974 an IHS facility in Minnesota sterilized Julie when she was twenty-eight. While she was in labor, she signed a form that she thought was for a painkiller. Julie stated that she does not remember exactly what she signed because she "was in pain at the time and wasn't paying too much attention to [the forms]." She revealed that the nurses told her about sterilization throughout her pregnancy and while she was in labor. While Julie had a second healthy daughter in the hospital, she revealed that she and her husband wanted three children. Her husband left her shortly after he found out about the sterilization because he "wanted a real woman. He didn't think I was a woman anymore without my uterus. What was I? An it?" Julie no longer trusts the IHS and goes there only for routine health problems such as the flu or strep throat.⁴¹

Debra is from Montana, and an IHS physician sterilized her in the spring of 1975. At the age of twenty-six she underwent a hysterectomy immediately following a Cesarean section. She related that "they came in the next day and said they needed me to sign some forms that hadn't been signed before the c-section. And they wanted me to date it the day before, but I put the right date on it." Debra believes that hospital personnel did not inform her about the sterilization, or about other methods of birth control, because she had already completed several years of college and was better informed than the majority of Indian women. She stated that the sterilization "made me change my life in important ways. I didn't become an alcoholic or go berserk like some women did. I changed my major at college and went on to become a lawyer. I specialize in medical cases and family law." Debra claimed that the sterilization made her more aware of the problems that Native Americans face, especially in the breakup of Indian families: "I try to keep families together. Not so much from divorce, but from the social services trying to separate children from their parents. I know I've made a difference in some lives, but I wish could do that for more of them."⁴²

The experiences of these four women, along with other evidence provided earlier in the paper, reveal that the IHS sterilization procedures drastically affected all aspects of Native American life. IHS practices harmed the relationships between Native Americans and the government and between tribal communities, husbands and wives, and mothers and their children. The operations also caused an inordinate amount of harm to the individual Native American women whom the Indian Health Service physicians sterilized.

In 1976, Congress passed the Indian Health Care Improvement Act. This measure gave tribes the right to manage or control Indian Health Service programs. Native American tribes have taken over many IHS facilities and have

started their own health services. While the sterilizations that occurred in the 1960s and 1970s harmed Native Americans, Indian participation in their own health care since 1976 has strengthened their tribal communities. Sterilization abuse has not been reported recently on the scale that occurred during the 1970s, but the possibility still exists for it to occur. The Department of Health, Education, and Welfare does not audit Indian Health Service programs; it only audits the computer records on reported sterilizations that do not meet the guideline's requirements. Until the department conducts full audits on all sterilizations that the federal government funds, sterilization abuse will continue to concern Native Americans.

NOTES

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5. U.S. Department of Health, Education, and Welfare, *The Indian Health Program*, 17; Sorkin, "Health and Economic Development," 145; J. G. Townshend, "Indian Health—Past, Present, and Future," in *The Changing Indian*, ed. Oliver LaFarge (Norman: University of Oklahoma Press, 1942), 31; U.S. Department of Health, Education, and Welfare, *Evaluation Report: The Indian Health Service's Implementation of the Indian Self-Determination Process*, by the National Indian Health Board and American Indian Technical Services (Washington DC: Government Printing Office, April 1984), 4. The Public Health Service was originally created in 1798 to provide for the health care of mariners. The service's responsibilities expanded in the late 1800s to include the health care needs of the nation, and in 1953 Dwight D. Eisenhower placed the Public Health Service under the control of the Department of Health, Education, and Welfare.

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7. U.S. Department of Health, Education, and Welfare, *The Indian Health Program* (1978), 20–21; and Sorkin, "Health and Economic Development," 146, and 149–52.
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25. *Ibid.*, 20–21. (The footnote to this information states that the figures do not "include two cases in which an administrative error was made but cases were performed for medical reasons with intent to sterilize.")

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27. *Ibid.*, 25.

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29. *Ibid.*, 25–26.

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41. *Ibid.*, 98–99.

42. *Ibid.*, 99–100.