

Forced Sterilization and the Ethics of Reproductive Health on the Navajo Nation

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Across the twentieth century, Indigenous women were subjected to sterilization within medical systems that claimed to provide care. These interventions were shaped by colonial power and racial hierarchies, enabling the state to assert authority over reproduction while frequently denying women meaningful consent (Theobald, 2019). Historical records and survivor testimony show that the loss of reproductive capacity reshaped families and communities in lasting ways (Chaparro-Buitrago, 2022). On the Navajo Nation, where reproduction is embedded in ceremonial life, kinship systems, and intergenerational survival, this history carries distinct ethical significance (Wright, 1982). Placing this history alongside contemporary reproductive health systems reveals that ethical care on the Navajo Nation must address not only past abuses but also present institutional structures that continue to shape reproductive choice, access, and authority.

Introduction

For Indigenous communities, reproduction has never been solely a biological event; it is deeply intertwined with social and spiritual practices and the broader demands of survival. Traditional birthing practices recognized women as central to life, with midwives and family networks guiding care throughout pregnancy, childbirth, and the postnatal period (Theobald, 2019). In these systems, women held authority over decisions by drawing on knowledge that balanced personal well-being with the needs of the community. Since the arrival of colonial and federal interventions altered this balance, spaces of care have been transformed into sites of surveillance and control. Under the guise of assistance, medical procedures could be imposed upon women and lead to violations of personal autonomy (Theobald, 2019).

For Indigenous communities, reproduction is embedded within social relationships, spiritual practice, and collective survival. Prior to colonial intervention, reproductive care was organized through family networks and midwifery traditions that positioned women as central authorities in pregnancy, childbirth, and early caregiving (Theobald, 2019). Among the Navajo, reproduction is actively honored through ceremony, education, and kinship obligations that situate fertility within a broader moral and social framework.

One example of this framework is the Kinaaldá puberty ceremony. The ceremony ushers a girl into society, invokes blessings for health and well-being, and offers protection from misfortune. It also teaches proper adult behavior through the model of Changing Woman, a figure associated with Earth, life, and reproduction (Wright, 1982). Through these practices, fertility is understood as a meaningful stage in the life course rather than a medical condition requiring management.

Motherhood further structures social identity and security within Navajo society. Wright (1982) documents that many women described motherhood as central to their sense of purpose and as a source of support in later life. Children carry social meaning and are closely tied to caregiving across generations, shaping how aging, responsibility, and belonging are understood. This framework establishes the ethical stakes of reproductive harm, as fertility interventions reverberate through family roles and social continuity.

Colonial and federal health systems fundamentally altered these reproductive frameworks. Medical institutions reframed reproduction as a problem to be regulated, introducing practices that displaced women's authority and recast care as an instrument of state oversight (Theobald, 2019). This transformation laid the groundwork for sterilization abuses and continues to shape reproductive health care on the Navajo Nation today. Understanding this history

is therefore essential for evaluating contemporary ethical questions surrounding consent, access, and institutional responsibility.

Institutional Authority and the Loss of Reproductive Autonomy

As reservation health systems expanded in the early twentieth century, federal medicine became the primary interface through which Indigenous women encountered healthcare. This shift concentrated authority within medical institutions and reduced patients' control over reproductive decision-making. On the Crow Reservation, physicians performed surgeries that removed ovaries or fallopian tubes without women fully understanding they would become permanently infertile (Theobald, 2019). Consent was often mediated through translators or family members, and procedures were sometimes performed while patients were sedated. For this reason, women had little to no genuine understanding or voluntary agreement regarding surgeries that would result in permanent infertility. This lack of meaningful consent not only violated their bodily autonomy but also reflected broader patterns of coercion and control embedded in federal healthcare systems, which demonstrates how medical authority was used to enforce colonial power over Indigenous lives.

These practices reveal structural imbalances rather than isolated errors. Gurr (2015) documents that sterilization abuse formed part of a broader pattern of reproductive control embedded in federal health policy. Women were asked to sign consent forms while in labor or immediately after delivery, when pain and medication compromised their ability to make informed decisions. Many never received communication from health professionals that the procedures they received would permanently end their ability to have children. Such conditions directly violated ethical principles of autonomy, informed consent, and nonmaleficence.

On the Navajo Nation, these violations carried consequences that extended beyond individual patients. Motherhood and kinship are central to cultural survival, and fertility loss altered women's social standing and future security. Children hold social meaning and are closely tied to caregiving responsibilities across generations. Therefore, sterilization disrupted intergenerational structures

that sustain Navajo life, demonstrating how institutional authority reshaped both medical outcomes and social continuity (Wright, 1982).

Structural Vulnerabilities and Federal Responsibility

The ethical failures surrounding sterilization must be understood within the broader context of federal responsibility for Native healthcare. Health services for Native peoples are guaranteed through treaties and legislation, establishing a legal obligation rather than a discretionary benefit (Gurr, 2011). However, chronic underfunding and weak oversight created conditions in which coercive practices could persist without accountability (Warne & Frizzell, 2014). These failures represent political as well as medical negligence.

During the 1960s and 1970s, family planning initiatives were promoted as public health measures but often relied on racialized narratives of poverty and dependency. Native women were portrayed as burdens on public resources, making their fertility a target of population control (Gurr, 2015). Bolton and Unger (2019) show that U.S. Indian public health policies explicitly encouraged sterilization during this period, linking reproductive intervention to economic efficiency and welfare reduction. These narratives framed reproductive control as rational governance rather than ethical harm.

For Navajo activists, sterilization was understood as a direct threat to collective survival. Members of Women of All Red Nations (WARN), a grassroots organization of Indigenous women advocating for reproductive rights and the protection of Native communities, described sterilization as a continuation of colonial violence. They emphasized that women's reproductive power is foundational to future generations (Bolton & Unger, 2019). By framing sterilization in this way, WARN linked reproductive autonomy to broader questions of sovereignty, illustrating how federal health policies not only controlled individual bodies but also undermined the self-determination and long-term survival of Native nations.

Survivor Testimony and the Normalization of Sterilization

Survivor testimony provides critical insight into how sterilization became normalized within routine medical care. Accounts from Indigenous women in

the 1970s note that hysterectomies performed on young patients without medical justification were framed as necessary or reversible (Women, 1977). These testimonies reveal how medical authority flowed in one direction, with doctors proposing procedures and institutions sanctioning them while patients were expected to comply.

Investigations later uncovered dozens of cases within small communities, suggesting that official records dramatically underestimated the scope of harm. Fear spread beyond individual patients and reshaped how entire communities viewed hospitals and clinical care. Theobald (2019) documents that stories of unintended sterilization circulated widely, leading many women to avoid hospitals and rely instead on midwives and community networks. These responses functioned as protective strategies grounded in collective experience rather than misunderstanding.

Bolton and Unger (2019) further demonstrate how sterilization was often concealed within other medical interventions. Women and teenage girls were sterilized without their knowledge as an added step during childbirth or unrelated surgeries. This integration of reproductive control into routine care made resistance difficult and delayed discovery of harm until consent could no longer be meaningfully addressed.

Living with Harm and Paths toward Repair

The long-term social consequences of sterilization remain visible within Navajo communities. Wright (1982) explains that children provide social meaning and security in old age, so fertility loss disrupted women's status and place within kin networks. By contrast, menopause is understood as a normal stage of the life cycle and is often associated with increased respect and spiritual authority. This distinction underscores how biomedical interventions that targeted fertility interfered with Navajo understandings of aging, status, and social continuity.

Despite this history, Navajo women continue to rebuild reproductive authority through cultural knowledge, storytelling, and community-led health initiatives. Leason (2021) documents how these practices function as forms of resistance and reclamation within reproductive health. Programs such as Centering Pregnancy, supported by the

Indian Health Service on the Navajo Reservation, alongside Native-led birth support organizations, show that outcomes improve when authority is situated within the community (Gurr, 2011).

Structural barriers within contemporary healthcare systems continue to constrain reproductive choice. Espey (2003) reports that approximately half of pregnancies among Navajo women are unplanned and that access to long-acting reversible contraception varies widely across providers. After most IUDs were removed from the U.S. market in 1986, these devices effectively ceased to be available to Navajo women, contributing to a measurable increase in birth rates. Providers' disproportionate fears about IUD safety further limit options, shaping reproductive decisions through institutional constraints rather than patient preference.

Given the history of forced sterilization, these limitations raise serious ethical concerns. When reversible methods are unavailable or discouraged, women may face increased risk of unintended pregnancy or pressure toward permanent solutions. These dynamics reproduce patterns of reproductive control through structure rather than overt coercion. Therefore, ethical reproductive care on the Navajo Nation requires attention to how institutional design continues to shape reproductive outcomes.

Conclusion

The history of forced and coerced sterilization demonstrates how medical authority has functioned as a tool of colonial governance, particularly in relation to Native women (Gurr, 2015). On the Navajo Nation, where reproduction is closely tied to ceremony, kinship, and cultural survival, these harms affected not only individual bodies but collective social life (Bolton & Unger, 2019).

Because this history was systemic, ethical reproductive health care cannot be neutral or ahistorical. It must actively address institutional structures that continue to shape consent, access, and reproductive decision-making. Protecting access to reversible contraception, supporting community-led care models, and recognizing mistrust as a rational response to medical violence are essential steps toward ethical repair. Only by centering both individual autonomy and collective sovereignty can reproductive health care on the Navajo Nation move beyond historical harm and toward genuine accountability.

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