Women, Health, and Nation
Canada and the United States since 1945
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Spanning the late nineteenth and twentieth centuries, the formidable history of sterilization abuse in the United States is well documented. Early campaigns labelled various groups genetically, mentally, or otherwise “inferior” and advocated their sterilization, but it was during the late 1960s and early 1970s that the most massive sterilization campaign the country has seen targeted poor women of colour. Although Native American, Mexican-origin, and Puerto Rican women were also affected by this egregious medical practice, the extant social history about this particular period of sterilization abuse predominantly documents the forced sterilization of poor African-American women.

While it has provided persuasive documentation of how racial, class, and gender ideologies can fundamentally endanger the reproductive experiences of women, this focus upon the experiences of African-American women has also resulted in an overly generalized understanding of how sterilization abuse occurred and operated. For example, in the extant literature on coercive sterilization during the late 1960s and early 1970s, racialized class interests, expressed as concern about overpopulation and rising welfare rolls, are generally seen as having provided the ideological impetus behind the massive sterilization abuse of poor women and women of colour across the nation. As Federal District Judge Gerhard Gessel acknowledged in his 1974 decision in the case of *Ryf v. Weinberger*, a class-action suit crucial to establishing the requirement of informed consent and federal regulations regarding sterilization, “there is uncontroversial evidence in the record that ... an indefinite number of poor people have been improperly coerced...”
into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization.\textsuperscript{56}

However, while sterilization abuse during this period was undeniably class based and justified by the ideologies of population and welfare control, the coercive sterilization of African-American women in the South and northeast, Puerto Rican and Dominican women in New York, Mexican-origin women in Los Angeles, and Native American women in Indian Health Service clinics across the nation cannot be universally explained by these forces. Although a widespread national practice during the late 1960s and early 1970s, sterilization abuse assumed different characteristics in diverse institutional and regional circumstances and was directed at women of various racial backgrounds.

In this essay I examine the sterilization abuse of Mexican-origin women at the Women’s Hospital of the University of Southern California (USC)-Los Angeles County Medical Center (LACMC) during the late 1960s and early 1970s. Largely unlooked in the social history of sterilization abuse is the fact that, just as with other women of colour, there were social reasons, rather than justified medical rationale, behind the coerced sterilization of these women. However, beyond the rhetoric of overpopulation and rising welfare roles, additional social concerns about increasing Mexican immigration and, in particular, the perceived undue costs of delivering the children of Mexican immigrant women made Mexican-origin women the target group for sterilization in Los Angeles County.\textsuperscript{57} These converging popular discourses not only propelled the massive sterilization abuse of Mexican-origin women at the Medical Center, but also became codified ideological tools utilized by individual medical practitioners to coercively sterilize their patients.

**AN “EPIDEMIC” OF STERILIZATION ABUSE REVEALED**

According to sociologist Thomas Shapiro, two events directly precipitated the coercive sterilization of poor women of colour across the nation during the early 1970s, both of which were manifestations of a newly established federal interest in issues of family-planning policy.\textsuperscript{58}

First, previously stringent medical regulations restricting sterilization options for most women were significantly loosened in 1966–70, substantially expanding the procedure’s availability. Formerly, sterilization was guided by an age-parity formula designed to ensure that women of child-bearing age did not “prematurely” terminate their child-bearing; sterilization was only allowed if a woman’s age multiplied by the number of her children amounted to at least 120 and if two physicians and a psychiatrist advised the procedure. In 1970 the American College of Obstetrics and Gynecology withdrew this standard, offering millions of women access to the procedure.\textsuperscript{59}

Second, governmental financial assistance for reproductive services to the poor increased substantially after 1965, most notably through passage of the Family Planning Services and Population Research Act in 1970. Signalling a dramatic reversal of federal policy on issues of reproduction, which were previously considered a “private” matter outside of the realm of governmental interest, the act committed significant resources to promote research in the areas of reproduction and population growth, and to provide funding for family-planning services.\textsuperscript{60} While in 1965 only $5 million of federal money was allocated for family-planning services to the poor, by 1979 this amount had reached $260 million.\textsuperscript{61} Augmented funding of sterilization procedures was particularly substantial. Prior to 1969, federally supported family-planning services were prohibited from subsidizing sterilization and abortion services. Funds for sterilization became available in 1971, with Medicaid covering 90 per cent of the cost of a sterilization procedure. Most of these federal monies were offered through the Office of Economic Opportunity (OEO), established to fight the war on poverty.\textsuperscript{62}

Following the increased availability of federal funding and relaxed requirements for the procedure, sterilization rapidly advanced to become the most popular contraceptive in the United States.\textsuperscript{63} By 1973 sterilization was the method of birth control most used by people thirty to forty-four years of age, and in 1976 nearly one-third of American couples reported that they had been sterilized.\textsuperscript{64} Despite the skyrocketing of sterilization rates, the procedure remained unmonitored by medical boards or governmental officials for the first few years of its more widespread practice.\textsuperscript{65} Although OEO-funded family-planning clinics were not to go ahead with the sterilizations until a set of guidelines was in place, no other safeguards to prevent widespread abuses were implemented for the first three years that publicly funded sterilization procedures were available. Such negligent circumstances allowed many coerced sterilizations to occur unhindered before the infamous case of the Relf sisters was brought to public attention.

During June of 1973 twelve-year-old Mary Alice and fourteen-year-old Minnie Lee, two African-American sisters, were unknowingly sterilized in a Montgomery, Alabama, hospital. The hospital covered the cost of these operations using OEO funds. Although Mrs Relf signed an “X” to a consent form that she could not read, neither she nor her daughters were advised of the specific nature of the procedure that the nurse advised was necessary. When they learned that their daughters were permanently sterilized, the parents of the two girls enlisted the
aid of the Southern Poverty Law Center, and a class-action lawsuit demanding the cessation of federal funding for sterilization procedures was filed. Subsequent investigation revealed a striking trend of similar abuses in clinics and federally funded hospitals in the South. Judge Gerhard Gessel, who decided the Relf case, estimated that in the South alone 100,000 to 150,000 poor women annually were sterilized through federally funded programs.13

Following publicity of the Relf case, several in-depth investigations revealed a national trend of sterilization abuse against the poor, and many other lawsuits were filed. One major study, conducted and co-authored by Dr. Bernard Rosenfeld and Dr. Sidney Wolfe and published in 1973 by the Ralph Nader Health Research Group, exposed an "epidemic of sterilization" in teaching hospitals between 1971 and 1973.14 Pointing to glaring class differentials in medical care, the study found that in nearly every major medical teaching hospital in the country the number of elective tubal ligations had at least doubled in those two years. According to the authors, "such abuses ... historically have found fertile climates in the nation's giant, core-city teaching complexes such as the USC-Los Angeles County Medical Center, where medicine is high volume, often impersonal - and practiced on patients who are generally poor, frightened and uneducated."15 While California had long held the highest rates of sterilization in the nation, these rates increased even more during this time.16

Statistics from the Women's Hospital of the Los Angeles County Medical Center exemplify the extraordinary upsurge in the numbers of women obtaining surgical sterilization. During the two-year period between July 1968 and July 1970, the number of elective hysterec- tomies increased by 742 per cent, elective tubal ligation experienced a 470 per cent increase, and post-delivery tubal ligation rose by 151 per cent.17 Most of these women were not adequately informed of alternative birth control options available and of the permanency of the operation, or even aware of their sterilization. Finding that of the thousands of victimized women throughout the nation most were low-income minorities, the report's authors charged that racist attitudes regarding overpopulation and rising welfare costs provided strong motivation for the large push in sterilization.

THE POPULATION "EXPLOSION" AND WELFARE "BACKLASH"

Changes at this time in federal policy relating to family planning were in part a governmental response to mounting concerns that population growth threatened national well-being. Public anxiety about the disastrous consequences of unchecked population growth escalated during the late 1960s, largely sparked by the efforts of environmentalists who feared that the earth's resources were endangered by unencumbered birth rates in the nation and across the globe.18 Members of the population control lobby and the nation's highest governmental officials both adamantly called upon professionals to turn their efforts towards the elimination of excess population growth. For example, President Nixon's science advisor, Dr. Lee A. DuBridge, declared that "the prime task of every human institution should be to halt population growth ... Every human institution, school, university, church, family, government and institutional agency should set this as its prime task."19

Many professional individuals and organizations took this charge seriously, including medical practitioners. Those in the medical community felt a particular call to duty. Many considered that their professional responsibilities rendered the problem of overpopulation explicitly theirs to remedy. Not only was the so-called population bomb hotly debated by the highest-ranking officials and institutions in the health-care profession, it influenced a major reversal of medical policy on issues of reproduction.

While previously it had left matters of family planning to the individual practitioner, in 1966 the American Medical Association (AMA) adopted an official policy regarding population control. Believing that "the medical profession should accept a major responsibility in matters related to human reproduction as they affect the total population and the individual family," the AMA expected all physicians to be prepared to counsel patients on matters of family planning no matter his or her specialty.20 The espousal of such a policy was, of course, controversial, but many doctors agreed that it was in fact their duty to resolve the problem of overpopulation, as issues of human reproduction and birth control fell squarely within their professional obligation. As one wrote in the Journal of the American Medical Association, "Historically, physicians have been leaders in medicine and in the furtherance of human welfare, and only if the medical profession recognizes its opportunity and responsibility can it meet its clear obligation to help solve what is now widely regarded as the world's number one problem."21

During this time, the problem of overpopulation was closely linked to concerns about rising welfare rolls, a trend that also emerged during the 1960s. Owing to the liberalization of eligibility requirements for welfare during the 1960s, the numbers of recipients rose significantly during this period.22 Moreover, the increase in recipients was noticeably racialized; as Gwendolyn Mink notes, "by 1967, a welfare caseload that had once been 86 percent white had become 46 percent nonwhite."23

This increase in the rates of welfare recipiency, not unnoticed by working and middle-class taxpayers, resulted in a piercing racialized
discourse on the program’s (and its clientele’s) legitimacy.24 A 1965 Gallup poll, initiated by the Population Council, demonstrated that by and large the general public believed that welfare recipients were deceitful, lazy, and lacking in initiative. Sixty-three per cent favoured federal funding of state and city family-planning programs, while 20 per cent of respondents were in favour of the sterilization of unwed mothers.25 Decrying rising public assistance expenditures due to increased welfare rolls and “illegitimate” pregnancies, several states considered bills legitimizing the compulsory sterilization of welfare recipients, and in sentencing many women, judges gave them the choice of sterilization or a jail term. Many physicians echoed these sentiments, often even more vociferously. A 1972 survey of physician attitudes about family planning found that by far the most “punitive” medical practitioners were obstetric-gynaecologists, 94 per cent of whom favoured compulsory sterilization or the withholding of welfare support for unwed mothers who already had three children.26

Thus, for some lay activists, policy-makers, and health-care professionals, birth control appeared to be the most effective panacea for both of the imagined social ills of overpopulation and welfare dependency. The comments of Dr Curtis Wood, president of the Association for Voluntary Sterilization, provide one example of how overpopulation, welfare, and sterilization became linked in the medical mind. In an article published in *Contemporary Obstetrics and Gynecology* in 1973, Wood wrote: “People pollute, and too many people crowded too close together cause many of our social and economic problems. These, in turn, are aggravated by involuntary and irresponsible parenthood. As physicians we have obligations to our individual patients, but we also have obligations to the society in which we are a part. The welfare mess, as it has been called, cries out for solutions, one of which is fertility control.”27 As his statement indicates, decreased fertility became the primary way in which advocates envisioned controlling both the impending population bomb and the welfare dependence of poor women. These women’s fertility (and thus, their bodies) was placed at the centre of national interest.

In addition to the targeting of indigent African-American women in the South, Native American women suffered from rampant sterilization abuse at Indian Health Service (IHS) clinics. A study requested by Senator James Abourzek and conducted by the General Accounting Office (GAO) revealed that many Native women were coercively sterilized by the Indian Health Service, most of them believed that their welfare benefits would be retracted if they did not agree to the operation. In the four IHS areas examined in the GAO study, 3,406 sterilizations were performed between 1973 and 1976, approximately one-quarter

of all Native Americans sterilized during those years.28 Many of these coercive sterilizations were conducted on women under the age of twenty-one, some of them in violation of the moratorium called by the U.S. Department of Health, Education and Welfare (HEW) in 1974.

**FORCED STERILIZATION AT LOS ANGELES COUNTY MEDICAL CENTER**

Prior to the promulgation of the 1974 HEW guidelines, there was no official policy regulating the practice of sterilization at the Women’s Hospital at the USC-Los Angeles County Medical Center.29 During the late 1960s, the Women’s Hospital received substantial federal funds for the development and strengthening of the Department of Obstetrics and Gynecology; these funds were in large part funnelled towards the rebuilding of the hospital within which these specialist services were housed. During this period several prestigious doctors joined the Women’s Hospital staff under the direction of newly appointed Dr Edward James Quilligan. With these changes in facilities, staff, and funding, the upsurge in the promotion of birth control for the women whom the hospital serviced began.30

As commonly occurred in teaching hospitals across the nation, students at the Los Angeles County Medical Center were encouraged to conduct surgical procedures to refine their skills. According to Dr Bernard Rosenfeld, co-author of the Health Research Group report and a resident in the obstetrics-gynaecology department at Los Angeles County Medical Center, staff doctors would often congratulate residents on the number of postpartum tubal ligations accomplished within a week’s time.31 Similarly, residents reportedly encouraged interns to press women into agreeing to a sterilization procedure. In one instance, a resident whose solicitations for sterilization were refused by a patient was told by his supervisor: “Talk her into it. You can always talk her into it.” In June 1973 a resident told new interns: “I want you to ask every one of the girls if they want their tubes tied, regardless of how old they are. Remember everyone you get to get her tubes tied means two tubes [i.e., an operation] for some resident or intern.”32 Rosenfeld estimated that 10 to 20 per cent of the physicians at the Los Angeles County Medical Center “actively pushed sterilization on women who either did not understand what was happening to them or who had not been given all the facts regarding their options.”33

Women were most often approached for sterilization while in the last stages of labour, during their wait in the active labour room, where they stayed until actual delivery. Here, women in the most painful stages of labour were placed on beds side by side, attached to fetal
monitors. Dr. Karen Benker, who was a student at the University of Southern California Medical School and employed by the Women's Hospital when the sterilization abuses occurred, described a typical scene: "The general picture ... was of crying, screams of pain, bright lights, lack of sleep by patients and staff, and an 'assembly-line' approach so that many women were literally terrified of what was happening at the time they signed the consents. Of course, this was especially true of non-English-speaking mothers who were left with no explanation of what was happening."

Dr. Benker's recognition that "of course" Spanish-speaking women were more likely to experience medical mistreatment points to the critical role of language in perpetuating the sterilization abuse occurred at USC-Los Angeles County Hospital. Residents and doctors were not bilingual; most knew but a few obstetrical-related words. There was "virtually no one available" to interpret for Spanish-speaking women, and often "these women were sterilized on the basis of the question, 'More babies?'" said in either English or broken Spanish." While some nurses or translators tried to communicate with Spanish-speaking women, as illustrated below, doctors often took advantage of their patients' inability to understand English to manipulate them into consenting to sterilization.

Women needing a Caesarean-section delivery were most at risk of coercive sterilization. According to Dr. Benker,

Once it became clear that a C-section was going to be necessary the resident staff was extremely aggressive in pushing for sterilization, virtually without exception ... On almost a daily basis I saw the following types of coercion being used: the doctor would hold a syringe in front of the mother who was in labor pain and ask her if she wanted a pain killer; while the woman was in the throes of a contraction the doctor would say, "Do you want the pain killer? Then sign the papers. Do you want the pain to stop? Do you want to have to go through this again? Sign the papers."

Nurses or residents often approached women to sign consent forms while she was in active labour and sedated, usually immediately before or after childbirth. Women in labour were given a shot of Valium in preparation for the operation, and consent forms were shoved into their hands while they were too groggy to understand or notice that they were granting permission for their own sterilization.

Moreover, often the hospital staff did not fully explain the irreversible nature of the sterilization procedure. Many women agreed to the surgery believing that their tubes were being tied and that their fertility could easily be restored when they decided to reverse the proce-
The doctors would also make use of the patients' race and immigration status to coerce them into sterilization. Many physicians would express prejudiced remarks about patients who did not speak English—Mexican-American patients, and referred to them as "beans." After remaining in the delivery room for hours, they could not provide a large family. Mrs. Hernandez resisted her doctor's urging and did not deliver her fourth child. Other women were sterilized according to the law. Miss Hernandez declined a sterilization offer, but the doctor performed it anyway, saying, "We'll do it, pal."

We now call the federal government officials and get them involved in the case. The experiences described above provide a compelling glimpse into the sterilization of Mexican-origin women. The expectations described above provide a compelling glimpse into the sterilization of Mexican-origin women. As done in other instances of sterilization, multiple manipulations of power and privilege that converged at the decision to sterilize. In the case of Los Angeles County Medical Center, sterilization was a common practice. In the case of a woman from Mexico, it was clearly evidenced in the report that the patient was sterilized "on the basis of the patient's own request," and that she was sterilized "because she is afraid she will have another child."

The idea of sterilization, as provided in the new insight into the ways in which sterilization was justified, further examined below.
Policing "Pregnant Pilgrims"  

In one Los Angeles County hospital alone, the story continued, some 45-50 per cent of all maternity cases involve illegal aliens. Forcing birth to such aliens costs taxpayers nearly $1 million per year in health services for illegal or undocumented aliens, as some bureaucrats refer to these illegals.  

Reports of growing numbers of births to illegal aliens put the Los Angeles County hospital administrators in the awkward position of having to pay for the costs of delivery of these babies. In one Los Angeles hospital, the administrators told the Los Angeles Times that they had found that 53 per cent of the women giving birth there were illegal aliens. The Times reported that the county hospitals cost taxpayers millions of dollars per year. According to a recent Los Angeles Times survey, 60 per cent of the births at these hospitals were to illegal aliens. According to some officials, this figure is significantly higher.  

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Center. Funds raised through educational outreach efforts, demonstrations, and the fundraising efforts of Comisión Femenil enabled the filing of a class-action civil-rights lawsuit on behalf of the women coerced sterilized at the Medical Center. Although data showed that hundreds of Mexican-origin women were forcibly sterilized at the facility, only ten represented the plaintiff class at the trial. For many of the women, the expiration of the statute of limitations barred their participation in the lawsuit; others were simply not interested in becoming involved in the judicial process or were afraid to take part in such an action. Others were wary of the judicial process and doubtful that their case would be believed. For those who were undocumented or whose family members were not yet documented, however, legal redress was not a viable option. Most were hesitant to even talk to the lawyers or make any formal complaint to the hospital for fear of being located and deported by the Immigration and Naturalization Service.

On 18 June 1975, a class-action civil-rights suit was filed in the federal district court in Los Angeles. The suit, Madrigal v. Quilligan, named usc–Los Angeles County Medical Center, twelve doctors (including the head of the Department of Obstetrics and Gynecology and the Medical Center itself), the State of California, and the U.S. Department of Health, Education and Welfare as defendants. In addition to financial compensation, the plaintiffs requested that the Department of Health, Education and Welfare require federally funded hospitals to provide thorough sterilization counseling and consent forms in Spanish.

Following over three years of preparation, the attorneys for the plaintiffs in Madrigal v. Quilligan, Charles Nabarette and Antonia Hernández, began their case in court on 31 May 1978. The lawyers argued that the sterilization of the women without their informed consent was a violation of their civil rights and their constitutional right to bear children. Over the course of the two-and-a-half-week trial, Hernández and Nabarette called upon the plaintiffs, hospital personnel, and several expert witnesses to establish that the custom and practice of the doctors at the usc–Los Angeles County Medical Center was to approach women during labour and “push” them into giving their consent to sterilization. However, after hearing extensive testimony, on 8 June 1978 Judge Jesse Curtis handed down his decision in favour of the defendant doctors, concluding that they were acting in “good faith” and with a “bona fide belief” that they were performing the sterilization operation with the knowledge and voluntary consent of each patient. The judge attributed the sterilization of the plaintiffs to a “communication breakdown” between the doctors and their patients rather than to any improper conduct by the staff at Los Angeles County Medical Center. In his extensive opinion, Judge Curtis stated: “There is no doubt that these women have suffered severe emotional and physical stress because of these operations. One can sympathize with their inability to communicate clearly, but one can hardly blame the doctors for relying on these indicia of consent which appeared to be unequivocal on their face and are in constant use in the Medical Center.”

Despite the ultimate judgment of the court against the Madrigal plaintiffs, because of the mobilization by community members, significant gains towards the reproductive freedoms of all women were won. As a direct result of Dr Rosenfeld’s complaints, the organizing efforts of Chicana activists, and public media attention given to the alleged abuses, the Los Angeles County Medical Center began to enforce compliance with the federal sterilization regulations.

Additionally, as a direct result of the lawsuit, significantly revised regulations and guidelines for sterilization surgery were established at the state level. Working together, the Chicana Rights Project of the Mexican American Legal Defense and Education Fund and the Coalition for the Medical Rights of Women filed a petition with the California State Department of Public Health calling for the implementation of more strenuous regulations guaranteeing the uncoerced, informed consent for every person undergoing sterilization in California. Members of both organizations drafted what eventually became the state’s official guidelines for the procedure. They mobilized a coalition of organizations and individuals that travelled to the sterilization regulations hearings across the state to voice their experiences of forced sterilization and other medical mistreatment to state officials, ensuring that the process surrounding the establishment of the state guidelines was accountable to and addressed the concerns of Mexican-origin and other poor women of colour in the state. These efforts led to the eventual acceptance of guidelines that required that consent forms be written in the woman’s native language and at the sixth grade reading level.

Moreover, as a result of the Madrigal case and similar trials across the nation, new regulations issued by the Department of Health, Education and Welfare ensured that a patient opting for sterilization would be supplied with sufficient information to make a decision under “legally effective informed consent.” These guidelines required that surgical sterilization candidates be formally advised that federal benefits would be available to them regardless of their choice to sterilize or not, that patients be thoroughly informed of the procedure, its risks, and its permanence, and that they be counselled on the range of birth
The forced sterilization of Mexican immigrant women at the Los Angeles County Medical Center during the late 1960s and early 1970s not only provides rare insight into the medical abuses poor women of colour faced during that period, but uniquely demonstrates how particular cultural and regional issues like language—cultural and social services. Often overshadowed by racist, classist, and sexist health experiences, often overlooked, the case of the forced sterilization of Mexican immigrant women at the Los Angeles County Medical Center raises pressing questions about the historical and ongoing legacies of forced sterilization in the United States.
deny immigrant women prenatal care (this was one of the primary concerns of Proposition 187, a referendum on barring undocumented immigrants from public entitlements and services such as non-emergency health care, welfare, and public school education; it was passed in California in 1994 but was overturned in 1996), have revitalized the image of the "pregnant pilgrim."

During the heyday of Proposition 187's advocates, dozens of major metropolitan newspaper accounts attested to the "widespread" phenomenon of Mexican women illegally crossing the border to deliver their children on United States soil, surreptitiously planning their migration around their upcoming delivery. For example, in February 1994 the San Diego Union-Tribune ran a multi-article series titled "Born in the USA" that looked into the purportedly common occurrence of Mexicans delivering their children in California hospitals with the expectation that the state would pay for it. Together the articles accentuated the problematic nature of the issue, running under headlines such as "Births to Illegal Immigrants on the Rise: California Taxpayers Finance Soaring Numbers of Foreigners' Babies" and "Blockade at Border Hasn’t Cut Births." The prevalence of these images in the mainstream media helped to circulate a stereotype in the larger public domain.

As we continue to live this history, equal attention must also be paid to the continued efforts of Mexican-origin women to secure their procreative freedom. As important as it is to document and analyse the atrocious abuses that have occurred, it is also incumbent upon us to remember that Mexican-origin women have been more than mere victims of efforts to construct and constrain their reproductive practices. Their willingness to bear witness and seek redress for their coerced sterilization and the grassroots organizing of Chicana activists have been fundamental to the implementation of safeguards that, if complied with, will help ensure that other women will never confront such violent intrusions upon their reproductive lives.

NOTES

1 Although it is focused on the first half of the twentieth century, the most comprehensive account of sterilization abuse is Philip R. Reilly's The Surgical Solution: A History of Involuntary Sterilization in the United States (Baltimore: Johns Hopkins University Press 1991). During the 1950s Puerto Rican women also suffered a disproportionate amount of sterilization abuse at the hands of the U.S. government; 33% of Puerto Rican women living on the island were sterilized. See Annette B. Ramirez de Arellano and Conrad Seipp, Colonialism, Catholicism and Contraception (Chapel Hill: University of North Carolina Press 1983). See also Iris Lopez, "Agency and Constraint: Sterilization and Reproductive Freedom among Puerto Rican Women in New York City," Urban Anthropology 22, nos 3-4 (1993): 299-323.


4 Throughout this essay, Mexican-origin women and Mexican immigrant women are used interchangeably to refer to the women coerced sterilized at Los Angeles County Medical Center. While it is not known if all of the women who were ever sterilized there were indeed immigrant women, all of the plaintiffs in the trial of Madrigal v. Quilligan, from which I have drawn my primary data, are Mexican immigrants. I use the term Chicana, which designates women of Mexican origin born in the United States, only in reference to the activists who organized against sterilization abuse, as this was their chosen self-referent.

5 Shapiro, Population Control Politics, 87.


8 Shapiro, Population Control Politics.

9 A 1967 study conducted by the oeo determined birth control as the most cost-effective method of poverty prevention. In 1968 Congress declared family planning a "special emphasis" program of the War on Poverty. James Reed, "Public Policy on Human Reproduction and the Historian," Journal...


9 Not until 22 February 1974 was it specified that "patients will not be approached for the first time concerning sterilization when they are in active labor"; this instruction was given in a memo dispersed to all staff by Dr Quilligan. Deposition of Roger Freeman, 29 June 1977, 12, *Madrigal v. Quilligan*, No. CV-75-2057-EC. I am indebted to Carlos Vélez-Ibáñez, who generously shared his personal collected materials from the *Madrigal* case. Documents from his personal collection will be acknowledged as Carlos Vélez Personal Collection (hereafter Vélez Personal Collection).

While definitive statistics are unavailable, it was reported by the head of obstetrics/gynaecology, Dr Quilligan, that the "predominate race" that frequented LACMC was Mexican American. *Madrigal v. Quilligan*, trial
transcript, 740. The trial transcript and other case pleadings are available in the Carlos Vélez Sterilization Archive, Chicano Studies Library, University of California, Los Angeles (hereafter Vélez Papers).

31 Rosenfeld documented his personal observations while a resident at Los Angeles County Medical Center, and his accounts were utilized by the attorneys for the Southern Poverty Law Center in the Relf case against Hew over the adoption of sterilization guidelines.

32 Health Research Group, Study on Surgical Sterilization, 7–8.


34 Karen Benker Statement, 5, Vélez Personal Collection.


36 Juan Nieto, an intern at LACMC, reported that he had observed similar treatment — particularly of Mexican-Americans — at a hospital in Colorado, where he had completed his medical training. Suggesting a pattern of abuse of Mexican-origin women throughout the Southwest, Nieto was sure that Spanish-speaking patients "had no idea the procedure urged on them was permanent." Quoted in Mariana Hernandez, "L.A. Women Protest Forced Sterilizations," Militant, 20 December 1974: 17.

37 Karen Benker Statement, 3.

38 Ibid.


40 Trial transcript, 370. All following quotes from the women involved in the Madrigal case are taken directly from the court transcript. During the trial the women all testified in the Spanish language, with their words translated by a court translator, then transcribed by the court reporter.

41 Ibid., 568.

42 Ibid., 583.

43 Karen Benker Statement, 4.

44 Trial transcript, 453–4.

45 Karen Benker Statement, 3.

46 Trial transcript, 665.


48 Ibid., 406.

49 Ibid., 416.

50 Ibid.


52 Karen Benker Deposition, 58–9.


54 Kistler, "Women 'Pushed' into Sterilization," 2.

55 Karen Benker Statement, 5.


61 Kuhn, "Aliens Give Birth."


63 The Madrigal suit was not the only one filed against the USC–LACMC for the sterilization abuse of Mexican-origin women. In Andrade et al. v. Los Angeles County–USC Medical Center, six other women and their husbands sued the Medical Center and Los Angeles County for permanent sterilization without the women's knowledge or consent. For a short account of the case, refer to Patti Garcia, "Forced Sterilization of Third World Women," Razon Mestiza, Summer, special edition (1975). In an article published in the Militant, Mariana Hernandez writes of a $6-million suit filed by five women against the Medical Center, but it is unclear whether this is a different case than that filed by Andrade et al. Mariana


65 According to Hernandez, “We could have had many, many more plaintiffs on the lawsuit, but the women were afraid of the Immigration and Naturalization Service.” Antonia Hernandez, personal interview.

66 Robert Rawitch, “11 Latin Women File Suit on Sterilization: Claim They Were Coerced or Deceived into Having Operation at Medical Center,” Los Angeles Times, 19 June 1975.


68 Trial transcript, 789.

69 Madrigal v. Quilligan, court opinion, 19. I examine the trial proceedings in this case, which were laden with racial, class-based, and gendered dynamics as the events that occurred in the hospital, elsewhere.

70 Based on the contention that Judge Curtis erred in his application of the law to the case, the decision was taken to the Ninth Circuit Court of Appeals. The appeal claimed that Judge Curtis abused his judicial authority in his decision by unilaterally overlooking the testimony of several key witnesses for the plaintiffs. When the Ninth Circuit Court of Appeals denied the appeal, lawyers involved with the case decided not to take the appeal to the U.S. Supreme Court. See Narda Zacchino and Kris Lindgren, “Plaintiffs Lose Suit over 10 Sterilizations,” Los Angeles Times, 1 July 1978; and Narda Zacchino, “10 Women Will Appeal Ruling on Sterilization,” Los Angeles Times, 8 July 1978: 26.


72 See California Coalition for the Medical Rights of Women et al. v. California Department of Health, “Petition for Regulations to Prevent Coerced Sterilizations in All Licensed Health Facilities,” n.d., in RG 5, box 10, folder 6, MALDEF Archives.


74 Despite the promulgation of these guidelines by HEW, however, a 1975 study found “gross noncompliance” with the regulations. Elissa Krauss, “Hospital Survey on Sterilization Policies” (American Civil Liberties Union 1975).

75 Theresa Aragon de Valdez, “Organizing as a Political Tool for the Chicana,” Frontiers 5, no. 2, (1980): 7–13. For a more in-depth analysis of Chicana activism against sterilization abuse during this time and how it demonstrates a distinct Chicana ideology that differs from that of the Chicana/o and women’s rights movements, see, Espino, “Women Sterilized as You Give Birth.”


77 On 23 November 1974 the Committee to End Forced Sterilization, a coalition of “feminists and community groups,” staged a 250-person demonstration against the sterilization of minority women. Protesters held placards reading “Que se ponga fin a la esterilización involuntaria” (Stop forced sterilization) and “Que paren las practicas experimentales de medicina con la gente pobre” (Stop medical experimentation with poor people). Hernandez, “L.A. Women Protest Forced Sterilizations.”


