Endangered species: Native American women's struggle for their reproductive rights and racial identity: 1970's-1990's

Sally J. Torpy
University of Nebraska at Omaha
THESIS ACCEPTANCE

Acceptance for the faculty of the Graduate College, University of Nebraska, in partial fulfillment of the requirements for the degree Master of Arts, University of Nebraska at Omaha.

Committee

<table>
<thead>
<tr>
<th>Name</th>
<th>Department</th>
</tr>
</thead>
<tbody>
<tr>
<td>John Carrigan</td>
<td>History</td>
</tr>
<tr>
<td>Philip C. Amies</td>
<td>English</td>
</tr>
</tbody>
</table>

Chairperson: Michael L. Tate
Date: July 9, 1988
ABSTRACT

During the 1970s, the majority of the American protest efforts focused on the feminist, civil rights and anti-war movements. On a smaller scale, Native Americans initiated their own campaign. Network television periodically broadcast scenes of confrontation ranging from the Alcatraz Occupation in 1969 through the Wounded Knee Occupation of 1973. The consistent objective was to regain treaty rights that had been violated by the United States government and private corporations. Little publicity was given to another form of Native American civil rights abuse -- the abuse of women's reproductive rights. Thousands of women and girls were unknowingly sterilized, including hundreds of mentally retarded who were injected with a drug that had not yet been approved by the Federal Drug Administration.

Native American women represented a unique class of victims among the larger population that faced sterilization and abuses of reproductive rights during the 1970s. They had, and continue to have, a dependent relationship with the federal government which has put them at greater risk and made it difficult for them to gain public support and correct such abuses. Yet years of investigation, government hearings and court cases finally aided Native American women’s efforts to organize and address their needs, their rights, and their futures as the cultural forebearers of their race.

This thesis analyzes the events that created national and international concern for Native American rights as individual indigenous cultures, and for their survival as a race. Oversight hearings, trials, news reports, investigative publications, and individual
Interviews with attorneys and Native American women reveal the devastating impact that these events have had upon the individuals, their families and tribal communities. Their struggle to obtain control over reproductive rights has led to a sense of empowerment consistent with the larger Native American effort to free themselves from control by institutions and individuals who know nothing about their unique cultures.
Many people played a significant role in the writing of my thesis. I am especially grateful to my children, Bill, and Chris for their constant support and encouragement. When self-motivation was lacking they urged me on.

I am indebted to my committee for their time, energy, and efforts spent reading my thesis and the positive criticisms they provided. Dr. Phil Smith presented excellent editing skills, along with his friendship and support. I would have had a very difficult time writing my thesis without Dr. Jo Ann Carrigan’s encouragement and honesty, but most of all her belief in me. To my committee chair, Dr. Michael Tate, I am thankful for his passion for and knowledge about Native American history; his skills as a teacher during my undergraduate years led me to my thesis topic.

Last, but not least, my thesis would not have been complete without the personal files and reminiscences that Lehman Brightman shared and entrusted to me. Lehman has his own stories worthy of recording. International Indian Treaty Council in San Francisco, also graciously opened its doors to me and contributed significant data that lent credibility to my topic. I would also like to thank Lorelei DeCora Means, Marie Sanchez and Mrs. Shoulder Blade Magoo for their assistance and the invaluable information they provided me.
## TABLE OF CONTENTS

Introduction ................................................................. 1


2. Native American Women’s Loss of Motherhood ............. 37

3. Depo-Provera: The Shot Heard ‘Round the World .......... 73

4. Native Americans: A Rising Ethnic Force .................. 97

Appendix

Compulsory Sterilization Statutes ................................. 115

United States Total Fertility Rates: 1920-1974 ................. 116

Memo to Karl/Percy/Phil from Patty Marks/Abourezk Office .... 117

Sterilization Procedures 1974 ........................................ 121

Claremore Hospital Surgical Schedule, September 2, 1978 .... 122

Major Health Facilities for Indians 1984 ............................ 126

Baltimore City Hospital Consent Forms ............................ 128

Sterilization Information for Men & Women 1973 ............... 130

HRG'S Recommended Informed Consent for Women and Men1973 132

The Long Walk for Survival, June 1970 .............................. 140

Bibliography .................................................................. 143
INTRODUCTION

Armstrong County Child Welfare Service agents appeared at Norma Jean Serena's home in Apollo, Pennsylvania, in August, 1970, and took her three-year-old daughter, Lisa, and four-year-old son, Gary, out of her custody, stating that the children appeared malnourished and needed medical attention. Later in that same month, Norma Jean, a Native American of Creek and Shawnee ancestry, underwent a tubal ligation after delivering her son, Shawn, whom workers immediately removed to a foster home. She signed the consent form for the surgical procedure the following day. Norma Jean's children would not return home until three years later, after a jury determined that the social workers had placed her children in foster homes under false pretenses.¹

In November, 1970, an unnamed twenty-six-year-old Native American woman entered a Los Angeles physician's office requesting a "womb transplant." Upon examination, the doctor informed her that she previously had been sterilized by means of a hysterectomy, a permanent and irreversible surgical procedure. The young woman, engaged and planning to have a family, was devastated. Unfortunately, she was only one of thousands of poor women and women of color (Puerto Ricans, Blacks and Chicanas) sterilized in the 1970s, often without full knowledge of the surgical procedure performed on them, nor its physical or psychological ramifications.²

A 1987 government investigation revealed that Indian Health Service (IHS) physicians in the late 1970s had prescribed the controversial contraceptive drug Depo-Provera to hundreds of Native American women, the majority of whom were mentally retarded. Even though the Federal Drug Administration (FDA) had never given approval for its use as a contraceptive, IHS felt that Depo-Provera offered a convenient method of birth control, as it freed women from menses, thus requiring less custodial
Physicians failed to inform the patients or their legal guardians of Depo-Provera studies in which some beagle dogs and monkeys had developed breast cancer.

These three situations are examples of human rights violations of Native American women, and reflect the socio-economic climate of the 1970s that led to overt and massive sterilization abuse, irreversibly changing thousands of Native American families' lives forever. The eugenicist doctrine originally introduced in 1883, along with new sterilization surgical procedures such as the vasectomy (surgery that cuts, removes, and ties the ends of the sperm ducts or vas deferens), and salpingectomy (surgery that cuts, removes, and ties the end of the fallopian tubes), enabled modern groups to wield population control policies over minorities.

Expanding on Gregor Mendel's discoveries regarding transmission of common traits in plants, early eugenicists "espoused the theory that a wide variety of individual maladies and even social ills, such as poverty, were eugenic (incurable) in nature and that the best solution was prevention by sterilization."

In 1907, Indiana enacted America's first compulsory eugenic sterilization (CES) law, with fifteen other states enacting similar laws during the following two decades. Although these statutes were eventually declared unconstitutional, the ground-breaking 1927 case of *Buck v. Bell* upheld Virginia's new CES law. This case looked at three generations in which Emma Buck, her daughter Carrie, and Carrie's daughter Vivian were considered slow and provided proof that mentally retarded genes are inherited. The decision justified the state's right to intervene in an institutionalized mentally retarded person's reproductive rights. Eugenic lobbyists declared victory when they learned that Carrie Buck's mother, Emma, had been committed to the Virginia Colony for Epileptics and Feebleminded at Lynchburg four years prior to the case. Also a Red Cross worker, Caroline E. Wilhelm, testified that Carrie's seven month old baby, Vivian, appeared slow
and feebleminded.\textsuperscript{7} This case affirmed eugenicists' beliefs that undesirable qualities in a productive society, such as mental retardation, poverty, and immorality are inherited. Justice Oliver Wendell Holmes' decision to allow the sterilization of Carrie Buck helped launch a "negative eugenics" era. This meant that eugenicists had moved on from a "positive" eugenic attitude, which encouraged those considered the carriers of superior genetic material to reproduce, to a more drastic solution. "Negative" eugenics called for actually controlling the fertility of the "unfit" by segregation in institutions and asylums where they could be monitored or sterilized. Holmes stated that "it is better for all the world, if instead of waiting to execute degenerate offspring for crime, or to let them starve for their imbecility, society can prevent those who are manifestly unfit from continuing their kind. The principle that sanctions compulsory vaccination is broad enough to cover cutting the Fallopian tubes."\textsuperscript{8} Within the following decade, twenty-six more states passed laws allowing involuntary sterilizations. Vivian Buck, however, did not end up in an institution. She attended Venable Public Elementary School in Charlottesville where she even qualified for the honor roll in 1931.\textsuperscript{9}

Even though several states had no statutes to prohibit voluntary sterilization, physicians and hospitals avoided aggressive sterilization practices because of possible malpractice suits. Attitudes changed following the \textsuperscript{1969} Jessin v. County of Shasta, (California) case which determined that no legislative policy existed to prohibit sterilizations.\textsuperscript{10} Another liberalization of sterilization practices occurred when the American College of Obstetricians and Gynecologists (ACOG) dropped its "Rule of 120", an age/parity formula for female sterilization. If a woman's number of living children, multiplied by her age, equaled 120, she could have a sterilization. Though not legally binding, a majority of hospitals observed this formula.\textsuperscript{11} While middle class libertarians
celebrated easier access to and control over their reproductive rights, the poor and women of color became the major targets of coercive sterilization abuse.  

Other significant influences in the late 1960s, such as government concern over growing population, prompted President Richard M. Nixon's appointment of John D. Rockefeller, III as chairman of the new Commission on Population and the American Future. President Lyndon B. Johnson's previous war on poverty reflected the fear that world resources would not be able to provide for the future population. Political and social pressures to limit family size and push sterilization helped lead to the new Office of Economic Opportunity (OEO), an organization that sought federal funds for providing contraception to the poor. The Family Planning Act of 1970 passed the Senate by an overwhelming vote of 298 to 32.

Statistics tell part of the story. During the 1970s, the Department of Health Education and Welfare (HEW) funded 90 percent of the annual sterilization costs for poor people. The rate of sterilization for women increased 350 percent between 1970 and 1975, and approximately one million American women were sterilized during each year.

Inevitably, examples of blatant and subtle coercion became public. The tragic sterilization of two black sisters, Mary Alice Relf (12) and Minnie Lee (14), on June 14, 1973, through the illegal actions of Montgomery (Alabama) Community Action Family Planning Clinic, an HEW funded and controlled agency, shocked the nation. The illiterate welfare mother of these girls had signed an "X" for her name on medical forms that she believed gave doctors permission to administer shots to prevent pregnancy. Federal suits filed by the girls' father, Lonnie, asked for cessation of sterilization funding and the use of experimental drugs. This case ultimately stimulated a backlash from many women's civil rights groups that led to the formation of several anti-sterilization organizations such
as the Committee to End Sterilization Abuse (CESA), and the Committee for Abortion 
Rights and Against Sterilization Abuse (CARASA). 16 

Their studies confirmed that low income women and women of color suffered 
great psychological, physical and emotional pain during this time as a result of the 
sterilization. One study conducted in 1973 indicated that some twenty-five percent of 
sterilized patients in general displayed regret. Hysterectomies had a potential surgical 
complication rate ten to twenty times greater than that for tubal ligations. 17 In Review of 
Law and Social Change, Edward Spriggs, Jr., made the following observation regarding 
involuntary sterilizations: "to the extent that they involve racial or socioeconomic biases, 
[these] are perhaps the best contemporary examples of incipient genocide by private 
persons, often with public sanction, in the United States." 18 

Though all of the victims suffered great loss, Native American women were 
especially accessible victims due to several unique cultural and societal realities that set 
them apart from other minorities. The Indian peoples' dependent relationship upon the 
federal government through IHS, HEW, and the Bureau of Indian Affairs (BIA), instead 
of providing adequate and safe family health services and fostering the continuance of their 
race, robbed them of their children, and persisted in jeopardizing their future as sovereign 
nations. As a result of these differences and their relatively small population percentages, 
Native Americans failed to gain much from the broader feminist movement and the liberal 
attitudes of the late 1960s and 1970s. 

In addition to problems of general invisibility in society, Native Americans have 
been hidden behind an additional curtain of bureaucratic secrecy. Lawyers representing 
Indian women in court could not, because of the government's request, reveal sealed trials 
proceedings. The Federal Freedom of Information Agency refused further release of 
documents regarding IHS facilities sterilization policies of the 1970s, claiming that this
petitioner did not present adequate justification. However, several private and public investigations, congressional hearings, public trials, and abundant newspaper and journal articles provided sufficient documentation of sterilization abuse in the 1970s and 1980s. Unfortunately even today, there remains a need for constant and close surveillance over physicians and health facilities so that all poor women and women of color are allowed to make their own reproductive choices.

The promising news is that some Native American women formed organizations that attempted to monitor medical practices such as the administration of Depo-Provera at IHS facilities. Charon Asotoyer, Executive Director of the Native American Women’s Health Education Resource Center (NAWHERC) in Lake Andes South Dakota, has published documents over several years to reflect the dangers of Depo-Provera. In 1978, Lorelei Decora, a Minneconjou Lakota, met with several other women at the Black Hills to instigate the Women of All Red Nations (WARN), a militant offshoot of AIM, whose mission was to raise the nation’s awareness of the oppression of the Indian culture in many areas of their lives. Loss of women’s reproductive rights, loss of Indian children through coercion, and the ultimate loss of cultural continuity were some of their concerns. These groups, along with several non-Indian organizations such as Boston Women’s Health Book Collective (BWHBC), and National Women’s Health Network (NWHN), reflected the abuse that was occurring during the 1970s and 1980s and the concerted efforts that were made to stop unethical sterilizations and unmonitored use of Depo-Provera. Although there remains today a continued need for vigilance, knowledge and informed consent of current and new contraceptive methods, it is hopeful that Native American women have established within their own culture organizations such as the International Indian Treaty Council (IITC), NAWHERC, and other educational programs like Survival Schools to combat the threats to their health, welfare, and very existence.¹⁹
NOTES


9 Trombley, The Right to Reproduce, 90.


CHAPTER ONE

EUGENICS AND POPULATION CONTROL:
"BETTER PEOPLE THROUGH BETTER BREEDING?"1

The basic issue involved in reproductive freedom is a principle that has very old roots in the tradition of radical individualism, but that has been particularly espoused by the contemporary women's liberation movement: the need to control one's own body, or 'bodily self-determination.' It is primarily this value, and not any 'right to procreate' per se, that forms the aim of reproductive freedom—the freedom to determine when, whether, and under what conditions one will or will not bear children. Along with this intellectual development, control over one's own body is an essential aspect of personality development and hence of the means by which individuals live out their connections to social groups and social purposes.2

Community attempts to control population growth in times of lean resources dates back to ancient times. In South Pacific islands such as the Yikopia, Polynesian elders deliberately set out to sea boatloads of their youth, giving them tasks to perform or places to go, knowing they would never return. Concern for the survival of the broader community prompted this harsh method to establish a balance between "the productive capacity of the environment and the population demands upon the territory for succeeding years."3 Native American tribes also practiced birth control methods to ensure the prosperity of the individual family and the tribe as a whole. Induced abortion, the ingestion of herbal decoctions to prevent conception, and even occasional infanticide provided the three most common ways to control population. In the latter situation, for example, San
Carlos Apache natives condoned smothering an infant or burying it alive if the father was white, Mexican, or a Negro. Although the means by which they limited their family size varied from tribe to tribe, physicians and ethnologists generally agreed that the San Carlos people practiced some form of birth control toward the end of the eighteenth century.

Beside the economic need for limiting births, mankind has also sought to control population to accommodate social order. The Athenian philosopher Plato (428 B.C.-348 B.C.) believed in social stratification through controlled breeding to ensure a genetically superior race. In his *Republic*, he recommended testing and educating everyone from infancy into adulthood in order to place each person in his or her appropriate class. The most intelligent individuals would be philosopher kings who would utilize their superior wisdom to govern and guide the populace, and the worker class would carry out their directions.

Thomas Malthus (1766-1834), British political economist whose doctrines became the foundation of most modern family-planning programs, expanded upon Plato’s ideology. The main premise of Malthus’ philosophy contended that “the number of people grows geometrically while the food supply increases only arithmetically.” Even though future studies revealed weaknesses in his premises, such as failing to recognize that every new mouth to feed was also a person who could produce more food, his theory gained a large following worldwide. Later in the century, Malthus’ followers split into two schools. Traditional Malthusians thought sexual restraint and stronger moral standards would be sufficient to control the rising population rate. Neo-Malthusians believed government and science should be in charge of family-planning programs, and they promoted contraception methods. These two doctrines reflected the increasing debate over who controls reproductive rights. Is it a personal human right, or an issue that demands government intervention?
Population control advocates gained momentum when Sir Francis Galton, the cousin of Charles Darwin, founded the Eugenics Education Society in 1907, based upon his ideas regarding who was fit to reproduce and who was not. Galton first used the word *eugenics* in 1883 to describe "the use of genetics to improve the human race." Born in 1822 in Birmingham, England, Galton displayed from infancy an exceptional intelligence. He could read by age two, solve mathematical problems and write by age four, and translate Latin text at eight years. His father encouraged him to become a physician and arranged for the sixteen-year-old to accompany the renowned physician Sir William Bowman, with whom he had the opportunity to observe many surgical operations. Young Galton’s experiences with surgery in a pre-anesthesia era partially accounts for the detached attitude that he developed towards patients' pain. His disregard for their suffering enabled him to observe and classify types of screams by the nature of the operation. This learned detachment from the suffering humanity likely influenced his future social policies toward the mentally retarded.

Galton’s writings helped produce a new discipline: the science of "race improvement." By 1908, his theories moved increasingly toward utilizing eugenics to check the birth rate of the “unfit.” In 1901, his initially milder philosophy, labeled positive eugenics, called for racial purity through increased reproduction of the fittest. Negative eugenics, Galton’s growing radical belief, demanded a halt to the reproductive rights of those deemed unfit. The British government’s growing concern over the alleged rise of mental degeneracy resulted in a four-year study of unfit people. Those represented in the 1908 report, developed by the Royal Commission on the Care and Control of the Feeble-minded, included, beside the insane, "imbeciles, feeble-minded person, moral imbeciles, and such inebriates, epileptics, deaf and dumb, and blind persons." Initially, segregation from society seemed the appropriate path, but ultimately for the sake of a
superior race of the future, sterilization became accepted as a responsible solution (Appendix I). 13

Many early eugenicists incorporated into their discipline Gregor Mendel’s theories concerning transmission of common traits in plants. They inferred from Mendel’s theory of inherited common physical traits that this theory also applied to human defects such as criminal behavior, drunkenness and immorality, even though scientific investigation had not validated this automatic connection. European proponents of degeneration theories, a similar school of thought that unfit people bore increasingly inferior offspring, favored Galton’s negative eugenics policy. He promoted a society composed only of persons possessing the most desirable genes and also proposed that the governments of the world take upon themselves the responsibility to sterilize those that were considered mentally or physically unfit. 14

The eugenics movement, popular throughout the world by the early twentieth century, prompted some American states to introduce compulsory sterilization statutes. 15 Prior to that time, the government sterilized persons only for punitive reasons. Many professional organizations were formed on shared eugenic concepts. In 1913, the American Breeders’ Association renamed its organization the American Genetic Association which published the Journal of Heredity. Its first editor, Paul Popenoe, a loyal eugenicist and founder of the California branch of the American Eugenics’ Society, promoted sterilization of “defectives.” 16 He went to the extreme of including children who did not show adequate improvement in their schooling by the time of puberty. His association with Californian financier Eugene F. Gosney, a wealthy banker, attorney and stock breeder, led to the founding of the Human Betterment Foundation. In 1929, the two co-authored the book, Sterilization for Human Betterment: A Summary of Results of 6,000 Operations in California, 1909 to 1920. 17 Advancement of eugenic policies
through these various institutions played a large role in securing sterilization legislation in
California. It became the third state to enact a compulsory sterilization law, following
Indiana and Washington.\(^\text{18}\)

New surgical procedures such as vasectomy, a surgical procedure pioneered by Dr.
Harry C. Sharp in 1883, directly influenced sterilization legislation. Safe, inexpensive and
quick, the operation left males with their sexual abilities but without mutilation, through
excision of the vas deferens. This new method won over many borderline eugenics
followers and quelled certain anti-eugenic critics who objected to the more barbaric
castration.\(^\text{19}\) Although Indiana did not pass compulsory sterilization laws until 1907,
Sharp, a physician at the Indiana State Reformatory at Jeffersonville, sterilized 465
inmates between 1899 and 1907. He maintained that approximately one-third of the
inmates asked for the operation and all had retained their health.\(^\text{20}\)

This new surgical procedure played a pivotal role in obtaining eugenic legislation
in not only Indiana, but eventually other states as well. Once Indiana passed sterilization
laws that went unchallenged constitutionally, Washington followed in March 1909, with a
compulsory sterilization law which called for the sterilization of anyone convicted of rape
or sexual abuse of females under the age of ten, and also persons judged to be habitual
criminals. The Washington law, entirely punitive in content, was challenged but upheld as
constitutional in the State Supreme Court on September 3, 1912.\(^\text{21}\)

Pro-sterilization lobbyists could now argue that vasectomy was more humane than
institutionalizing males for life, and in addition, it would save public money. For the next
several years most states passed some form of compulsory eugenic sterilization. Many
states, such as Washington, enacted legislation, but lost on certain technicalities, and later
revised and passed new legislation. For example, Iowa's law called for parole officers and
superintendents of state institutions to consider sterilization of criminals, idiots,
feeble-minded, imbeciles, drunkards, drug addicts, epileptics, syphilitics, and moral and sexual perverts. Aimed at male and female prostitutes, twice-convicted sex offenders, and thrice convicted felons, the statute was unique from others in that it called for sterilization not only on eugenic grounds, but also for punitive and therapeutic reasons. It was found unconstitutional within the year, on grounds of denying due process, and representing cruel and unusual punishment. Not until 1915, did Iowa enact new sterilization laws. Between 1907 and 1930, thirty states and Puerto Rico passed some form of compulsory sterilization legislation.

The lack of formal guidelines to protect reproductive rights inevitably led to two internationally recognized lawsuits - Buck v. Bell in 1927, and Relf v. Weinberger in 1974. The former involved two sisters, Carrie and Doris Buck, who underwent sterilizations within a year of each other. Carrie's took place in June, 1927, at the Virginia Colony for Epileptics and Feebleminded at Lynchburg. The state had her committed at age seventeen because she was pregnant and was diagnosed with "moral imbecility." The state did not take into consideration Carrie's allegation that a relative of her foster parents had raped her. Instead, eugenicist administrators felt that she had prostituted herself and thus fell into that classification deserving sterilization.

Believing that the Buck's case affirmed that imbecility was inherited, the state of Virginia, in 1924, passed a law legalizing compulsory sterilization of "inmates of institutions supported by the State who shall be found to be afflicted with an hereditary form of insanity or imbecility." The Buck sisters' mother, Emma, had also been placed in the Colony four years prior to her daughters' operations. According to the Binet-Simon test, Emma tested at a mental age level of a nine-year-old. In September 1924, when the institution ordered Carrie to be sterilized, it prompted a religious group in Virginia to challenge the action in court. The board of directors at Lynchburg hoped to affirm that
mental disorders were hereditary through the examples of the mother, daughter, and granddaughter. Caroline Wilhelm, a Red Cross employee brought in by the prosecutors, testified that upon examination, Vivian, who was seven months old at that time, had a “look” about her which appeared to be “quite abnormal.” In 1927, the case went to the Supreme Court where Justice Oliver Wendell Holmes, Jr., “placed the state’s interest above the petitioner’s by accepting the negative eugenics approach of the Virginia legislature.”

As a result of this verdict, most attorneys agree that the *Buck v. Bell* case laid the foundation for most compulsory eugenic statutes in the United States. In the 1974 *Review of Law and Social Change*, law student Edward Spriggs, Jr. wrote, “individuals may be sterilized whenever . . . agency, hospital, . . . or judge determines sterilization to be in the best interests of society [and] the way remains open for sterilization on ostensibly eugenic grounds pursuant to a CES statute, but for entirely noneugenic purposes.”

Punitive compulsory noneugenic sterilization (CNES) bills were introduced with less success, but had little impact on future decisions because of the vague language used to define the concept. Justice Holmes had a major impact on the course that the sterilization issue traveled for several decades. He pronounced, “the principle that sustains compulsory vaccination is broad enough to cover cutting the Fallopian tubes . . . . Three generations of imbeciles are enough.”

Carrie’s sister, Doris, also was sterilized, but she and her husband had never been informed of the operation. She only knew that she and her husband had been attempting in vain to have a family for thirty-five years. They even consulted three physicians at different hospitals who were unable to explain her inability to have children. She never doubted that the scar on her stomach was anything but the result of an appendectomy she had at age sixteen, or so she had been told by Colony nurses. Finally, in 1979, K. Ray
Nelson, then director of the Lynchburg Training School and Hospital, the former Colony, contacted Doris and informed her that she also had been sterilized at Lynchburg.\textsuperscript{30}

Vivian Buck, determined a third generation imbecile in 1927, grew-up and attended Venable Public Elementary School in Charlottesville where she qualified for the honor roll in 1931, and excelled in all subjects except math. Stephen J. Gould, a biologist who wrote \textit{Carrie Buck's Daughter}, stated “there were no imbeciles, not a one, among the three generations of Bucks.”\textsuperscript{31} The impact of Holmes’decision trickled down through the court system for decades, influencing states to create and expand their own criteria for persons meriting sterilization. Even though the granddaughter displayed normal intelligence and this refuted the belief in inherited mental retardation, as recently as 1976, the \textit{Buck} case has been cited in court as precedent for sterilization.\textsuperscript{32}

The court’s ruling stimulated a new wave of eugenic organizations, including the renowned American Eugenics Society (AES) founded in 1921, at the Second International Conference on Eugenics held in New York.\textsuperscript{33} Frederick Osborn, secretary of AES from 1928 to 1972, kept alive the original eugenic philosophy, while also broadening the aim of the organization to include education through exhibitions, essays, and sermon contests. His belief in the inherent inferiority of women permeated his writings.\textsuperscript{34} Osborn condoned Nazi Germany’s sterilization programs, professing that “increased urbanization and mobilization of her people” indicated “the need for eugenic measures.” The popularity of eugenic sentiment declined when knowledge of Hitler’s genocidal acts became known, but Osborn continued to promote eugenic ideas into the 1960s, even serving as trustee of the Population Council from 1952 until 1968, and as its president from 1957 to 1959.\textsuperscript{35}

Although the Eugenics Movement did not end the social problems of society, nor the population growth it had predicted, it did leave its legacy throughout the world. Alan
Chase, author of *The Legacy of Malthus* (1977), discovered many international congresses held in the late 1800s and early 1900s that focused their attention on eugenic principles, and through the years their ideas grew more radical in theory and practice. Influential and distinguished individuals who sponsored those congresses included Winston Churchill, Herbert Hoover, and several presidents from prestigious universities. Chase wrote, "these congresses advanced the cause of the compulsory gelding of the poor in many ways," and were the precursors of the sterilization abuse epidemic in the 1970s. The gatherings resulted in treatises on creating programs that would steadily wipe out the population of degenerates by compulsory gonadal (ovarian or testicular) surgery. Chase presented his findings at the National Council of Churches' Interreligious foundation for Community Organization (IFCO) held in Washington, D.C., in September of 1978. The conference drew more than sixty representatives of organizations such as the Native American, Black, Hispanic and feminist civil rights organizations, along with religious groups, lawyers and legislators. They came to share real stories of present and past sterilization abuse and child-stealing practices, with the hope to unite and plan litigation and legislative policies to halt the sterilization epidemic.

Beginning in the early 1920s the United States witnessed a noticeable rise in female sterilizations. The state of Oregon sterilized 1,654 persons between 1921 and 1944, 1009 of them women. In Michigan, by 1932, 476 women had been sterilized, as compared to 153 men. The number of Michigan women sterilized during twelve years quadrupled, with the ratio of three women to one man sterilized. Eugenic legislation thrived in 1925, with Idaho, Utah, Minnesota, and Maine passing sterilization legislation. Of these four, Minnesota had the highest sterilization figures, with women once again the preferred choice. Out of 508 Minnesota operations, only 48 were male by 1932, and during the following decade, the state sterilized 1,679 females and only 478 males.
Law Professor Lisa C. Ikemoto contended in a 1992 article that lingering beliefs from the Social Purity Movement of the late eighteenth and early nineteenth centuries had made women into natural targets for abuse. She concluded that women who expressed their sexuality, women who suffered from postpartum depression, and women of color were more often deemed disturbed and in need of institutionalization. As a result, laws lent institutions creative license in determining who should be sterilized. Consequently these women - victims of "ethnic elitism, classism, and racism - all contribute to the fact that the sterilization rates for poor women and women of color are higher than for white people." 39

The rise in live birth rates following World War II and the Korean War further alarmed family planning and fertility control advocates. Although the live birth rate had steadily declined since 1820, the delayed family syndrome, a natural occurrence following a war, temporarily led to a "population explosion" between 1945 and 1957 (Appendix II). 40 Consequently some influential individuals conducted meetings that led to the formation of the Population Council in 1952. John D. Rockefeller, III founded this group which was comprised of some of the wealthiest people at that time: Frederick Osborn, former AES secretary and retired financier; Detlev Bronk, president of the Rockefeller Institute; Karl T. Compton, trustee of the Ford Foundation; and Lewis Strauss, director of RCA, NBC, and the Rockefeller Center.41 As products of this new era, these men sincerely sought to provide solutions, money, and their own skills to curb the growth of the poor through education, new medical technology and research. Donations from some of the members created a budget of $500,000 for the first three years of operation. Their goals included establishing world stability over a twenty-year span, motivating other prosperous or powerful people also to pledge money and support, educating the public...
regarding fertility control, and developing an ideology geared towards improving the quality of life.42

Of considerable note was the female gender focus of their research projects. More effective contraceptive techniques appeared such as female contraceptive implants, vaginal rings, injectable contraception for women, a weekly pill, a monthly menses-inducing pill, sterilization procedures and equipment, postcoital pills, and male contraceptive implants. The council also had led the way through testing, manufacture, and selling of forms of the intrauterine device (IUD). Thomas M. Shapiro noted in his book *Population Control Politics*, "just as technological developments have been strongly influenced in any society by the class that is in power, so too are patriarchal interests embodied in the search for scientific solutions."43 Women were the major targets for fertility control, especially poor women, members of a minority group, and the mentally retarded.

Rockefeller’s increasing concern over population growth, coupled with scientists’ theories of rising ecological imbalance in the 1960s, prompted him to enlist President Lyndon B. Johnson’s support to create the Committee on Population and Family Planning in 1968. Johnson, known for his “war on poverty” policies, expressed fear that dwindling world resources would not be able to provide for the future population. Consequently, he created the Office of Economic Opportunity (OEO), an agency unique because it was the first to use federal funds to provide family-planning services to the poor in the mid-1960s. The OEO issued a federal grant in 1971 that funded clinics’ initial sterilizations.44

The Council’s influence carried over into Richard M. Nixon’s administration. He appointed John D. Rockefeller, III as chairman of the first Commission on Population and the American Future. “Population growth” soon became referred to as “population
explosion,” and State Department reports warned of the potential for international political instability. The press inundated the public with population growth statistics and the ramifications it could have on the nation. In 1967, new organizations arose such as the Hugh Moore Fund and the Campaign to Check the Population Explosion, which prompted an advertising campaign financed by several Council patrons to make the public aware of the seriousness of the situation. One-and two-page advertisements that ran for years in the *New York Times*, the *Washington Post, Fortune, Harper’s, Saturday Review,* and the *Wall Street Journal* warned the public that the population explosion was the most important problem they faced. The rise in crime, shortage of food, and other threats precipitated fear and a sense of panic among the population. Nixon shared these and Rockefeller’s concerns and subsequently released a statement that reflected support of family planning legislation. In 1970, the Family Planning Services and Population Research Act went into effect. This legislation authorized the Department of Health, Education and Welfare (HEW) to give grants to states and public or private entities to help them establish family planning programs. The money included the expenses for training staff, research, and the dissemination of educational material to the public.

The effects of these programs in the United States has been staggering. Between 1969 and 1974, HEW increased its family budget from $51 million to over $250 million. By 1970, HEW released statistics reflecting 90 percent funding of the sterilization costs of poor people, and between 1970 and 1977, female sterilizations had increased almost 300 percent, with anywhere from 192,00 to 548,000 performed each year. This is a dramatic change from the 63,000 people in the United States who had been sterilized between 1907 and 1964.

The federal government also became actively involved in global population growth as well, indicating the new political and commercial importance of the issue. Dr. R. T.
Ravenholt, Director of United States Agency for International Development's (AID) office on population control, stated in 1977 that the United States had plans to sterilize one-fourth of the world's approximately 570,000,000 fertile women. The director believed that population control was necessary in order to maintain the "...normal operation of U. S. commercial interests around the world."\(^4^8\) At St. Louis' Washington University Medical School, AID financed the Program for International Education in Gynecology and Obstetrics (PIEGO), a course that trained foreign doctors in advanced "fertility management techniques," which included sterilization. Critics suggested improving poor countries' standards of living by promoting economic development rather than forcibly reducing their populations. Controversy over sterilization education programs conducted also at Johns Hopkins University in Baltimore and in certain Third World countries culminated in Ravenholt's appearance before the House Appropriations Subcommittee on April 6, 1978, where he affirmed that "surgical clinics should be able to provide the 50,000 sterilizations needed to reach the level of 25 percent among the 200,000 women of reproductive age in a general population of 1 million." He also admitted that PIEGO involved training for only female sterilizations.\(^4^9\) He never volunteered comment on the blatant lack of male fertility control.

New legislation, medical advancements such as a simpler form of tubal ligation, and court decisions also stimulated an increase in female sterilization. In 1969, a California court of appeal ruled in the *Jessin v. County of Shasta* case 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."\(^5^0\) Apparently, prior to this time, hospitals and physicians were hesitant to perform sterilizations at patients' requests, fearing malpractice suits even if they were in jurisdictions that had no statutes prohibiting voluntary
sterilization. The Jessin decision relieved physicians' concerns when the judge concluded that "no legislative policy existed prohibiting sterilization," thus encouraging them to liberalize their positions on performing sterilizations.51

The new direction that medical policies took in the 1970s promoted many more voluntary and involuntary sterilizations. In 1965, the federal government had supported family-planning programs, but forbade abortion or sterilization. However, in 1969, it lifted the ban on sterilization.52 In that same year, the American College of Obstetricians and Gynecologists (ACOG) discarded the age-parity rule which was a formula employed to determine a woman's need for sterilization. If a woman's age multiplied by the number of her children equaled 120, she was deemed an acceptable candidate for sterilization. Many hospitals employed this method, and when they abandoned it, sterilizations became more widely available. Also advances in tubal ligation procedures encouraged sterilization as an increasingly popular form of birth control.53 In 1970, ACOG also dismissed its recommendation for two physicians' signatures, along with the rule that a psychiatric consultation be acquired before scheduling a sterilization procedure.54

These liberalizations of restrictions occurred at a unique time when women's roles were also changing. The new feminist attitudes encouraged married women with children to find a career and establish their separate identities apart from family. Working women, worried about unwanted pregnancies, now had a choice of birth control including sterilization which was permanent, federally approved, and widely available. While middle class career women looked at sterilization as their natural right, poorer women did not necessarily share this view. These new family planning measures were liberating for the middle class, but freedom for them meant vulnerability for the poor. For the willing group, however, improvements in surgical techniques and the permanence of sterilization appealed broadly, and, for the first time, government funding was available. Middle class
women desired easy access to sterilization. They also sought control over their reproductive rights without government interference such as requisite consent forms and examining boards.  

Sheila M. Rothman, author and research assistant at the Center for Policy Research, believed that reformers of the 1970s did not understand the importance of large families among low income people. She especially criticized the concept that if poor people would have fewer children they would escape poverty, and she saw this as a cynical way to argue that the poor have only themselves to blame for their situation. This attitude fostered and encouraged federal intervention in regards to family planning for the poor. She also attacked the misconception that lower-income groups lacked access to contraception and knowledge of family limitation techniques. It would seem that it never occurred to the middle-class that they preferred not to use them. Psychiatrist Robert Cole spent several years interviewing migrant workers and sharecroppers. From these conversations he learned that having a large family fulfilled basic psychological needs for the poor: “To parents who eke out a subsistent living children are one of the few available sources of gratification.”  

Physicians and social workers found themselves in a potent situation in which they could use, but in reality abuse, their authority in dealing with poor and minority families and their reproductive rights. Inevitably paternalistic and racist beliefs regarding who should reproduce led to widespread compulsory sterilization of those who could least defend themselves. These conflicting needs and rights between women of different economic background and color, coinciding with new fertility laws, medical advancement, and tenacious eugenic lore, inevitably culminated in disaster for many women. In 1973, a Black migrant farmer and his family became the tragic example of misuse of authority. The sterilization of Lonnie Relf’s two daughters would shock the nation and lead to a one
million dollar damage suit against HEW and OEO. This led to the subsequent discovery of
massive violations of thousands of women's reproductive rights, notably among welfare
mothers, women of color, mentally retarded women, and even among girls as young as
twelve-years-old. It would require twenty-seven months from the first publicized report
of illegal sterilizations to the time when new regulations were finally sent out to all
federally funded birth control clinics.\textsuperscript{57}

Lonnie and his wife Minnie Relf worked on a farm near Montgomery, Alabama,
attempting to eke out a living as did many other illiterate southern Blacks in the 1970s.
Hoping to find better wages than five dollars a week, Lonnie moved his wife and six
children into the city where they lived at a garbage dump until a local newspaper wrote a
feature story on their hard life. The Community Action program learned of their condition
and moved them to a housing project in 1971.\textsuperscript{58} The welfare program also provided free
medical care, including family-planning services through the OEO.\textsuperscript{59}

Soon after they moved in, Family-Planning Service representatives began frequent
and unsolicited visits to the Relfs and over the next two years injected Katie, their
fourteen-year-old daughter, with Depo-Provera (Medroxyprogesterone acetate). This was
a drug that had not been approved by the Federal Drug Agency (FDA) for use as a
contraceptive, and, in fact, was known to produce tumors in laboratory beagles. This had
led to its removal from the market in pill form in 1970, and its total ban three years later.
In 1971, Mary Alice (aged ten), labeled trainable mentally retarded by school officials,
and Minnie (aged twelve), considered of normal intelligence, also received injections.\textsuperscript{60}

In March of 1973, without asking parental permission or offering any explanation,
family-planning representatives arrived at the Relf's and took Katie away to the family
clinic to be fitted with an Intrauterine Device (IUD) against her will. On June 17, 1973,
two nurses from the family-planning clinic returned to escort the two youngest daughters,
Mary Alice and Minnie, along with their mother, first to the doctor's office and then to the hospital for more birth control shots. Believing them, Minnie marked her “X” on a document that in reality gave permission to the hospital to tie the tubes of both daughters. Before the mother returned home from the hospital, the same nurse went back to take Katie away, but she locked herself in a bedroom and refused to come out. Meanwhile, Minnie had borrowed money from a fellow patient and called a neighbor to ask her mother to come back and take them home. Mrs. Relf had no means of transportation. The following day, under general anesthetic, the two young girls were sterilized by an irreversible operation.61

When later questioned why the hospital had sterilized the sisters, one of the nurses replied that staff members had received reports that “boys were hanging around” their house. The clinic had been trying to convince the parents to have their girls sterilized so they would not produce illegitimate children, but they had refused. Subsequent OEO investigations found no indication of improper or promiscuous behavior. Federal funds paid the hospital and the doctor for their services.62

At the time of OEO’s inception in 1965, federal funding to states for abortions or sterilizations was banned. However, after 1968, when President Nixon came into office, the ban on sterilization was lifted, provided that informed consent was obtained. Sterilizations took place even though protective guidelines had not been written. However, during the 1972 presidential campaign, concern about possible alienation of the Catholic vote, caused Nixon to postpone guidelines. Dr. Warren Hern, the young public health physician and head of the Program Development and Evaluation Branch of the Family Planning Division at OEO, had attempted two separate times to release 200 copies of the guidelines, but he had been stopped both times.63 Unnamed officials had ordered him to place the 200 copies in a safe. When he complained to the White House,
Dr. Leon Cooper, the OEO's Head of Health Affairs, instructed him to stop calling or he would have to resign. On June 2, Hern resigned.64

Thomas L. Littlewood's *The Politics of Population Control* presents damning evidence surrounding the White House's failure to implement guidelines. Charles Colson, referred to as Nixon's "Catholic liaison specialist," worked on gaining Catholic votes by opposing abortion policies. When Colson realized that 25,000 copies of sterilization guidelines had been printed and were ready to distribute to family services, he, along with John Ehrlichman's office, quickly sent word to Wesley L. Hjornevik, the deputy director of OEO, not to associate himself with OEO activities on sterilization or abortion. They, along with many other staff members, were not even aware that sterilizations had been taking place without guidelines since 1968. Hern testified at a hearing conducted by Senator Edward M. Kennedy's health subcommittee in 1973. There he testified: "on numerous occasions I made attempts to find out when the guidelines would be issued and why they were being held up....I was never given any explanation of what the 1972 election had to do with it. I felt that many peoples' lives were at stake. We knew that some programs were going ahead without the guidelines....we felt this was a very dangerous situation."65 In 1972, after his re-election, one of Nixon's first tasks was to dismantle OEO. The guidelines that could have protected Mary and Minnie's from sterilization were never released due to narrow political considerations.66

On July 31, the Southern Poverty Law Center filed a class action suit in U. S. District Court on behalf of Katie, Mary Alice and Minnie Relf, to cease all federally funded sterilizations and experimental birth-control programs until national guidelines could be established.67 However, when the attorneys learned that Judge Robert Varner had received the case, the Relfs' attorneys feared that he bore prejudice against Blacks. They sought dismissal when Varner would not step down. Varner dismissed without
prejudice the class action portion that would allow them to file individual claims against several national antipoverty officials and others, including Nixon administration officials John Dean, John Ehrlichman, Wesley Hjornevik, Dr. Leon Cooper, Dr. George Contis, Phillip Sanchez, Howard Phillips and the United States. But the judge did allow for a possible future damage suit against Dr. A. E. Thomas, the physician who had sterilized the girls.

The day after this decision, the girls’ attorneys, Morris Dees and Joe Levin, Jr. of Montgomery, filed suit in federal court in Washington, D. C. They asked for no monetary damages, but called for an immediate cessation of federal funding of sterilizations and use of experimental drugs until appropriate regulations were drawn and filed within ninety days. Due to the girls’ young ages, the suit was filed by their father on their behalf. The plaintiffs desired to represent the class of people who need protection from sterilization: minors, illiterates, and mentally incompetents who could not legally represent themselves. They also represented the poor who rely on federal welfare services “who, for various reasons, might be deprived of their constitutional rights by the agencies’ birth control arms.” The attorneys had federal records from 1972 which indicated 24,714 sterilizations on “public and private sector patients.” They did file a $5 million administrative claim against OEO, HEW, and the Food and Drug Administration (FDA), and also requested medical and psychological treatment for Minnie and Mary Alice, along with “remedial surgery.”

Although the Reif case was not settled for several years, HEW took steps in July 1973, imposing a moratorium on the federal funding of sterilizations of minors and the mentally disabled. Judge Gerhard Gesell of the U. S. District Court for the District of Columbia found that the guidelines HEW issued on February 6, 1974, did not protect minors or people incapable of giving consent. In March 1974, Gesell ruled them
"inconsistent with the statutory requirement of voluntariness insofar as they permitted the provision of sterilization to persons who could not give legally effective consent under State law." As a result, Gesell banned any funding of sterilizations of persons fitting this classification. HEW appealed his decision and fought rulings which placed it in violation of sterilization regulations for the next several years. These delays allowed thousands more people to be sterilized since firm and clear definitions of legal and medical terminology left minority and poor women especially at risk at public teaching hospitals, family-planning clinics, and Indian Health Service facilities across the nation.

Due to the publicity that the two Relf girls received, numerous other cases became known of women being coerced into having their tubes tied or being force to undergo a hysterectomy. Considerable documentation verifies not only spectacular increases in female sterilization, but also questionable ethics regarding informed consents of sterilizations. The most revealing study occurred in 1973, when Health Research Group, a non-profit public interest organization based in Washington, D. C., funded by consumer advocate Ralph Nadar's Public Citizen, Inc., conducted several studies on surgical sterilization. The survey revealed that men and women were being sterilized at a rate of two million per year, and the federal government had financed more than 100,000 of those sterilizations. Less than 95,000 were performed on mentally incompetent individuals or patients under age.

This investigation revealed that physicians required patients undergoing sterilization to sign a brief consent form, one which reflected that "only the doctor is fully informed and the patient consents." All but three states left it up to the physician to determine what constituted "informed" status. The 1970s thus became known as the decade of physicians "selling" sterilizations to patients. In the case of Native American women at Indian Health Service (IHS) hospitals, physicians and/or social welfare workers
would threaten to take their children or their benefits away if they did not readily consent to go under the knife. Seldom did patients know of the risks involved and the irreversibility of the procedure. Surgeons preferred to use benign phrases such as “bandaid surgery,” or “a stitch in the vagina” to protect her from pregnancy. HRG found that surgeons, as a result of their specialized education along with surgical experience, felt empowered to determine which patients should have surgery: “the training of a surgeon is an initiation into a system which holds cutting sacred and gives little or no credit for ‘abstinence.’”

HRG sent its fifty-nine-page report to the President of the American Hospital Association (AHA) on October 30, 1973, urging him to implement informed consent standards for all AHA hospitals that performed sterilizations. The HRG reminded J. Alexander McMahon, the president of AHA, of his agency’s own Patient Bill of Rights, and encouraged him to adopt the sample informed consent booklet that HRG had compiled, and to make it available to all prospective sterilization patients.

These studies precipitated dozens of private and public investigations into sterilization operations. In 1974, Native American physician Constance Redbird Pinkerton-Uri, a Choctaw-Cherokee, conducted her own inquiry as a result of complaints lodged against Stella Richards, supervisor of nursing at the Claremore, Oklahoma IHS hospital. Native American nurses there felt that Thomas Talamini, the hospital administrator, and Richards, discriminated against Indian personnel. Indian staff also charged that certain nurses performed minor surgeries on patients, such as circumcisions on infants, without permission of the parents or medical license to give them the authority. Pinkerton-Uri had heard of numerous abuses from Indian women at powwows and Indian events where she provided medical care. One case involved a twenty-six-year-old woman who had visited a Los Angeles doctor requesting a “womb transplant.” The woman had
agreed to a sterilization in 1970 when she was an alcoholic with two children in foster homes. The presiding physician never explained the ramifications of a total hysterectomy, and these were catastrophic for the woman who overcame her alcoholism and prepared to marry and to have children barely six years later. As a physician, Pinkerton-Uri could not understand why a doctor would perform a total hysterectomy upon a healthy twenty-year-old woman when a tubal ligation would have been simpler, safer, and less costly.79

What Pinkerton-Uri discovered over the next several years through examination of IHS records, interviews with staff and victims, would not have a tremendous impact on the press or even the federal government. Only after she and Senator James Abourezk, (Democrat, South Dakota) of the Senate Interior Subcommittee on Indian Affairs demanded a General Accounting Office study of hospital records did the government respond. Yet even then they limited their study to only four of the ten IHS hospitals, and never conducted an interview with any one of the 3,406 women sterilized between 1973 and 1976.80 Interviews would have verified the unethical manner in which many came to be sterilized. Tragically, the irreversible effect these sterilizations had on Native American culture, family life, and the patients’ mental health could never be repaired.
NOTES


5 M. D. Holder, "Gynecic Notes: Taken from the American Indians," *American Journal Obstetrics*, 26 (1892), 760.


33 Shapiro, *Population Control Politics*, 45.


44 Shapiro, *Population Control Politics*, 112.

46 Shapiro, *Population Control Politics*, 78.


48 Paul Wagman, “U. S. Goal: Sterilize Millions of World’s Women,” *St. Louis Post Dispatch* (April 22, 1977), 1A, 6A.


52 Shapiro, *Population Control Politics*, 87.


1975, 1.


73 Rosenfeld, et. al., *Health Research Group Study*, preface.

74 Rosenfeld, et. al., *Health Research Group Study*, 7.


76 Rosenfeld, et. al., *Health Research Group Study*, 2.
77 Rosenfeld, et. al., *Health Research Group Study*, preface.


CHAPTER TWO
NATIVE AMERICAN WOMEN'S
LOSS OF MOTHERHOOD

The U. N. Convention on Genocide states that imposing measures intended to prevent births within a group of people ... are acts of genocide ... [such as] sterilization of women are direct attacks on nationhood. Sterilization must continue as a birth control choice for women, but for Native people it should be seen in the context of national identity. If an Indian woman is a member of a 3,000 member nation, sterilization has serious consequences for the survival of the people as a whole.¹

"A Question of Genocide" June, 1997
International Indian Treaty Council

In 1970, three years prior to the Relf sisters' sterilization, Norma Jean Serena, a Native American woman of Creek-Shawnee ancestry, lost her reproductive rights through a sterilization procedure following the birth of her son. The thirty-seven-year-old divorcee also lost custody of her infant son in that same year. Child Welfare and Board of Assistance authorities of Pittsburgh, Pennsylvania convinced Serena that she was too ill and exhausted to care for a baby, and they placed Shawn in a foster home.² Months prior to this incident, social workers had come to Serena’s home and demanded that she accompany her two-year-old son and her three-year-old daughter to Children’s Hospital in Pittsburgh for medical examinations; once there, the caseworkers told the mother that the two children were seriously ill and needed to stay at the hospital. Shortly after,
however, they were placed in homes with foster parents who were led to believe they could adopt the children.

When Serena’s repeated attempts to visit and regain custody of her three children failed, the distraught mother employed legal assistance from the Council of Three Rivers American Indian Center in Pittsburgh. She eventually filed a civil suit, the first of its kind, to address sterilization abuse as a civil rights issue. She sued Citizen’s General Hospital of New Kensington, Westmoreland County, Pennsylvania; two Citizen General Hospital physicians; three Armstrong County Child Welfare Service agents; and a Pennsylvania Department of Public Welfare employee on grounds of (1) conspiracy to violate her civil rights by illegally taking away her three children, and (2) taking away her right to bear more children by sterilizing her without her knowledge or consent. She asked for $20,000 in damages from the Department of Public Welfare for the violation of her civil rights.

Richard Levine, an attorney for the Neighborhood Legal Services who served as her legal counsel, stated that he had never encountered such a blatant denial of civil rights. The first part of Serena’s suit began on January 5, 1973, at which time the official medical reason for Serena’s sterilization was given as “socioeconomic.” Levine told the jury his client’s sterilization had to do with her being poor, being Native American, and living with a Black man. Additional testimony revealed that welfare authorities were more concerned about her relationships with Black people than about the welfare of her children. Child Welfare Service workers claimed that reports from an unidentified person complained about “black men” coming to and leaving the home, and the unidentified person feared for the safety of neighborhood children. Also, Jean Burgess, the first caseworker to have visited Serena in April 1970, alleged to have found her apartment “dirty and unkempt.” She observed that the children appeared “undernourished and dazed,” not able to walk,
speak, or use eating utensils. However, the doctor who examined Gary and Lisa at Children’s Hospital found them alert and in good health. Disregarding his medical opinion, the social workers placed the children with foster parents and told them they could apply for their adoption in August 1970.\(^5\)

The all-white jury of six men and two women found the two Welfare Department’s social workers “guilty of misrepresenting Serena’s case and placing her children in foster homes under false pretenses.”\(^6\) Serena received $17,000 in damages in this initial part of her suit which the Pittsburgh press considered a great victory. However, it would take the threat of contempt of court before Armstrong County Child Welfare authorities released her children in March 1974. By this time, Gary and Lisa had spent three years away from their natural mother, and the baby Shawn had been absent for two years.\(^7\)

The second part of Serena’s case took place in January 1979, and involved the blatant abuse of her reproductive rights. Welfare agents and doctors claimed that Serena agreed to the sterilization and looked forward to having no additional babies. She had no clear recollection of signing the consent form, and, yet, testimony in court indicated that she had signed a consent form dated the day after the sterilization surgery and childbirth had taken place.\(^8\) Levine recalled that the jury had sympathy for a mother being separated from her children, but they did not experience similar feelings over the loss of her fertility. Instead, Levine believed, the jury did not approve of an unmarried woman living with a Black man even though her civil rights obviously had been denied. The attending physician convinced the jury that he had explained the operation adequately and that she had agreed to it. The jury decided Serena had given consent, and its members acquitted the doctors and a male social worker.\(^9\)

Although Serena lost the second part of her suit, Levine and many Pittsburgh newspapers considered the guilty verdict for the illegal removal of her children a victory.
Levine stated that the decision, the first of its kind, finally held social workers accountable to the poor. In addition, Serena's case exposed the American public to the reality of epidemic numbers of Native American children being taken from their families, coupled with an equally staggering number of sterilizations of Native American women of childbearing age during the 1970s. A coalition of women's support groups and American Indian organizations, such as Women Against Sterilization Abuse, Women's Health Collective, and the Native American Solidarity Committee, rallied around the mother, raising money for her trial through benefits such as a concert held in her behalf.

As a result of the publicity generated from this case, along with suspicious sterilizations at the Claremore, Oklahoma, Indian Health Service (IHS) hospital, Constance Redbird Pinkerton-Uri, a physician and law student of Choctaw/Cherokee ancestry with the IHS in Oklahoma, began calling Senator James Abourezk's office in South Dakota, to inform him of this situation. She, along with registered nurse Phyllis Jackson and Milo Fat Beaver, an inhalation therapist, had held clinics in a tipi to provide services for patients who did not want to seek medical attention at IHS facilities, or because the services were unavailable to them. It was during these sessions that questionably unethical sterilization practices were revealed to the team. Pinkerton-Uri was not the only concerned person to seek Abourezk's expertise. The senator, Chairman of the Senate subcommittee on Indian Affairs, also received phone calls from Charlie McCarthy, then an IHS employee in Albuquerque, regarding the same issue. Joan Adams, an intern on Abourezk's staff, handled these calls, and subsequently investigated the allegations that Indian women were being sterilized without their consent and under duress. After interviewing tribal leaders and Indian women's groups, as well as examining IHS records, Adams concluded that some of the complaints were legitimate and merited further investigation. Abourezk's intern called for a General Accounting Office (GAO)
The GAO study -- which involved Albuquerque, New Mexico; Phoenix, Arizona; Aberdeen, South Dakota; and Oklahoma City, Oklahoma -- found that between 1973 and 1976, IHS facilities had sterilized 3,406 Native American women. Of these, 3,001 involved women of child-bearing age, (ages 15-44); and, of these, 1,024 were performed at IHS contract facilities. Since the records of only four of the twelve IHS hospitals were examined over a forty-six-month period, and only 100,000 Native American women of child-bearing age remained, the ramifications of these operations were staggering. The data reflected the following. In Oklahoma City, 1,761 out of 15,000 Native American women of child-bearing age were sterilized; in Aberdeen, 740 out of 9,000 women of child-bearing age were sterilized; and Phoenix had 78 women out of 8,000 child-bearing age sterilized. After studying the report, Senator Abourezk commented that given the fact of the small population of Native Americans, 3,406 Indian sterilizations would be comparable to 452,000 non-Indian women. He noted that the study itself revealed some significant weaknesses in the report. For example, only four of the twelve IHS service areas were examined, and during those three years of investigation, not one woman was ever interviewed to find out whether she had received adequate counseling and education beforehand and had consented to the procedure.

The report found that although some kind of informed consent had been acquired from these women, no one common consent form was used, and the majority of the forms did not adequately satisfy the federal regulations of informed consent. The U. S. District Court defined "informed consent," as the "voluntary, knowing assent from the individual on whom any sterilization is to be performed," and only after she has been given information pertinent to the operation (Appendix IV). In addition, the GAO study
discovered that thirty-six females either under the age of twenty or who were judged mentally incompetent had undergone sterilizations. This was in direct violation of moratoriums that HEW had sent to all IHS Directors on August 2, 1973. HEW had ordered this moratorium primarily to protect these two vulnerable groups. In fact, continued violations had forced HEW to reconfirm the moratorium in memorandums and a telegram on October 16, 1973, April 29, 1974, and in another memorandum sent directly to IHS physicians and directors on August 12, 1974, including copies of revised HEW regulations.

New requirements for obtaining informed consent applied to an individual when that person was considered “at risk” in regard to his health. Six basic elements comprised HEW’s revised consent forms:

1. A fair explanation of the procedures to be followed, including an identification of those which are experimental.
2. A description of the attendant discomforts and risks.
3. A description of the benefits to be expected.
4. A disclosure of appropriate alternative procedures that would be advantageous for the subject.
5. An offer to answer any inquiries concerning the procedures.
6. An instruction that the subject is free to withdraw his consent and discontinue participation in the project or activity at any time.

The GAO study noted that these HEW regulations did not comply with U. S. District Court Judge Gerhard Gessel’s 1974 court order that any individual contemplating sterilization should be advised orally at the outset that at no time could federal benefits be withdrawn because of failure to agree to sterilization. Gessel’s rulings were published in the April 14, 1974 Federal Register, and they specifically addressed this issue to protect individuals from sterilization coercion. The GAO report recommended to the Secretary the development of a revised and uniform consent form as soon as possible; a program for
educating and training physicians regarding sterilization regulations and eligibility; and more frequent monitoring of physicians' compliance with new regulations. GAO investigators called for HEW regulations to come into compliance with the U. S. District Court's ruling that patients be informed orally that they could not lose their welfare benefits. The consent form was also required to have the signature of the person obtaining a patient's permission on the same document. 19

After reviewing the GAO report and conversing with several IHS health planners, Patty Marks, staff member on Abourezk's U. S. Senate Select Committee on Indian Affairs, believed that IHS physicians' attitudes played a significant role in sterilization abuse. She felt they lacked cultural sensitivity, possessed a middle-class attitude towards family planning which favored only two children per family, and promoted the belief that unwed mothers and families who were economically deprived should not reproduce. She agreed with the GAO study proposals and strongly advocated consistent and thorough monitoring and enforcement of regulations, along with adequate counseling for individuals who were considering sterilization as a means of birth control. 20 Marks said that some tribes, such as the Navajos, already had counselors, but areas such as Montana, South Dakota and Oklahoma had only the doctor explain to the patient what sterilization involved, and that could result in misunderstandings. 21

Pinkerton-Uri's reaction to sterilization abuse was not as empathetic as Marks. She scathingly attacked the Association of American Indian Physicians (AIP) for ignoring her initial requests for records from the Claremore Indian Hospital. Everett Rhoades, vice-Chairman of the Kiowa tribe, and a member of AIP, denied knowledge of the request. Pinkerton-Uri addressed the Indian Health Advisory Board in 1974, expressing the urgent need to improve Indian health care, and the real threat to the continuance of Indian tribes' blood line if sterilizations went unchecked. The physician commented, "we have a new
enemy and the enemy is the knife."22 Through her own investigation of Claremore Hospital records, she discovered that 132 native women had been sterilized at Claremore, and, of that number, 100 of the sterilizations were labeled non-therapeutic, meaning sterilization was the sole purpose.23

In a press release following the Indian Health Advisory Board meeting, Rhoades, president-elect of API, threatened that they might have to close the Claremore area IHS if Indian activists continued to complain about problems there. In retaliation, and to show support for Pinkerton-Uri’s allegations, an unidentified group of Native Americans pitched a tipi on the hospital lawn alongside the American Indian Movement (AIM) flag, representing a more defiant stand in the future.24

The first legal response to the GAO study came in the form of another class action suit filed against HEW. It went before the Supreme Court in 1977, and represented three Northern Cheyenne women from Montana. This case reflected the deep cultural beliefs and attitudes that Native American women possessed regarding motherhood. Michael Zavalla, a Tucson, Arizona attorney, remembered the sensitivity of the case, and the young women’s embarrassment and shame over loss the of their reproductive rights. He alleged that they were sterilized without their full consent or knowledge of the surgical procedure and its ramifications. Their names were withheld from the media out of their fear of public condemnation within their tribes. Zavalla filed the case in Washington state with the hope that a favorable decision would send a message to hospitals and physicians about the need to obtain proper informed consent and provide full knowledge regarding any operation.25

Zavalla directed his suit only against the hospital physicians who allegedly coerced the women into sterilization by implying they would lose their benefits, they needed the surgery, or that the surgery could be reversed at a future date. By these actions, the
doctors failed to comply with federal consent regulations. The case, however, never went to trial. Each of the three women was approached by the defendants’ lawyers and offered a cash settlement on the condition that the terms of the agreement would remain sealed, along with their names. The women’s attorney believed the lawsuit ended this way in order to avoid further publicity which might encourage further litigation by other victims. Zavalla expressed frustration and disappointment over the outcome of the case, but respected and sympathized with the victims’ hesitancy to pursue their suit.26

Marie Sanchez, Chief Tribal Judge for the Northern Cheyenne reservation in Lame Deer, Montana, having heard of these lawsuits and other similar allegations from her tribe, conducted her own investigation on her reservation, and found that thirty women had been sterilized between 1973 and 1976. Sanchez learned from her interviews that two girls under the age of fifteen were told that they were having their appendix taken out, only to discover later that they had been sterilized. Another woman who had complained to a physician about migraine headaches, was told that her condition was a female problem, and was advised that a hysterectomy would alleviate the problem. Her headaches continued, however, until she was diagnosed with a brain tumor.27

Sanchez had hoped she could motivate these women into filing lawsuits against the IHS, but, unfortunately, the women’s traumatized emotions resulting from their sterilizations kept them from coming forward. Sanchez empathized with them and explained that the Native American culture is based on the value of family. For them to publicly admit that they had unknowingly given up their reproductive rights would be devastating for themselves and their relations. She concluded that “even more discouraging than high legal bills, is the risk of losing one’s place in the Indian community, where sterilization has particular religious resonance.”28
Native American women were not the only minority to encounter an unsympathetic legal system. Ten Mexican-American women with minimal knowledge of the English language were sterilized between 1971 and 1974, at County-University of Southern California Medical Center in Los Angeles. The two million dollar civil lawsuit claimed that these women were sterilized against their wills and they did not comprehend the nature of the consent forms. In addition, the plaintiffs’ attorneys, Charles Nabarrete and Antonia Hernandez, argued that the women were in no position to make that type of decision. They were undergoing hours of painful childbirth, and some of them had been medicated and were too confused to even remember signing the form. The attorneys testified that three of the women never did sign a consent form for tubal ligation. U. S. District Judge Jesse W. Curtis exhibited little empathy for the women’s situation. He believed that the hospital would have provided translators if needed and that the doctors had followed their professional instincts and had obtained legitimate consent. Even though he conceded that miscommunication had occurred, he sided with the physicians and believed they were of sincere intent.29

Although few sterilization cases actually came to court, sterilization abuse gained international attention through press releases. Because of her experience with sterilization, the Society for Threatened Peoples (Gesellschaft fur bedrohte Volken) invited Barbara Moore, a Dakota Native American, to the society’s meeting in West Germany, in May 1978. Their interview with her appeared in the January/February 1979 issue of the German magazine Pogrom. Moore traced the beginnings of sterilization abuse in the United States as she had experienced it in 1975. She became actively involved with sterilization and women’s rights to reproduce following her own questionable hysterectomy and death of her baby. Feeling victimized, Moore, a public school teacher
and also dean at the Crow Dog's Indian Way School on the Rosebud Reservation, dedicated her time to educate organizations regarding reproductive rights.\textsuperscript{30}

Moore contended that greed over Native Americans' natural resources motivated the federal government to instigate sterilization programs. Lehman Brightman, United Native American (UNA) President agreed with Moore's accusations of deliberate government sterilization politics, calling it a "genocidal campaign against the Indian." He did not provide documentation, but personally estimated approximately forty-two percent of Indian women of childbearing age and ten percent of Indian men had been rendered sterile by 1979. When Brightman visited Claremore IHS in 1978, he collected data over a six month period. The total number of operations performed between November 1978 and April 1979, totaled 232. Over one-third of the operations, eighty-one, were sterilizations. The UNA President had also received a letter from June Echo-Hawk in September 1978, including hospital records from the Claremore Indian Hospital. Echo-Hawk had heard Brightman speak at the Capitol steps in Washington D. C., and was concerned about the number of sterilizations performed on Native American women. She taped his speech and provided it to the nurses at Claremore. Several nurses she spoke to validated that sterilizations were occurring and with greater frequency. Daily surgical records covering a four day period at the hospital provided very little information, and ages, sex and blood type were seldom recorded. Of the twelve surgical operations performed during that time, eight were sterilizations (Appendix IV).\textsuperscript{31}

What Brightman, Pinkerton-Uri, Abourezk, and many other Native American advocates attempted to accomplish through government investigations, rallies and the media was twofold. They realized the need not only to put an end to further sterilizations of a people who could ill afford them, but also to preserve their culture and traditions as an indigenous people. An understanding of this unique culture and its special relationship
with the federal government examines three important factors: (1) how and why Indian women were more vulnerable to sterilization abuse than other minorities; (2) what motivated physicians' abuse of Indian women's reproductive rights; and (3) how social welfare workers' attitudes affected Native American families.

In 1831, Supreme Court Justice John Marshall designated Native Americans as "domestic dependent nations," comparing the relationship as that of a guardian to its ward. Originally the Bureau of Indian Affairs (BIA), within the Department of the Interior, had sole responsibility for medical and health-related issues. In 1955, IHS transferred over to the Public Health Service (PHS), claiming to provide a "full health program including curative, preventive, rehabilitative, and environmental health services through an integrated system" of hospitals. IHS hospitals were built for Native Americans because most tribes lived in areas where no private medical care or state health services were available. In order to qualify for Indian health care, a person had to "live on or near a reservation or on or near trust or restricted land under the jurisdiction of the Bureau, be a member of a tribe, band, or group of Indians the Federal government recognizes, and be of one-fourth or more Indian descent."

As of 1977, IHS facilities consisted of fifty-one hospitals, eighty-six health centers (including twenty-six in schools), and several hundred other health stations across the nation. But the health facilities were often located miles from major hospitals and Native communities. A map of the United States, including Alaska, illustrates the various major health facilities as of April 1984. The number of hospitals had dropped to forty-eight, and health centers had been reduced to seventy-nine. (Appendix V). Although it would appear that IHS had an organized, functioning health care package for Native Americans, a 1977 study prepared by the American Indian Policy Review Commission for the United States Congress found the system antiquated and lacking in (1) adequate policy to solve
the problems of Indian health, (2) adequate appropriations, (3) adequate mechanism for delivery of services, (4) responsiveness on the part of state and local agencies toward Indians, and, (5) oversight and accountability at all levels of Indian Health Service. In 1975, the Joint Committee on Accreditation of Hospitals found over two-thirds of the IHS fifty-one hospitals “obsolete and in need of complete replacement.” Only twenty-four, less than half, met their standards, and just twelve of the fifty-one hospitals met the fire and safety codes.

Senator Abourezk, longtime advocate for Native Americans, found their health situation disgusting and blamed President Richard Nixon’s administration for impounding funds for Indian health care during four out of five years of his term. Abourezk stated that the $15.5 million appropriated and impounded by the Nixon Administration “literally is forcing IHS to play Russian Roulette with the lives of Indian people.” By the administration’s actions, thousands of people requiring medical attention would have to go without help. Abourezk’s office reported that as of June 1974, a waiting list of 20,000, including 13,000 children, existed for corrective surgery. The Senator estimated that approximately $40 million more was needed to bring up the level of IHS medical care to the national norm, and an additional $10 million was needed to staff hospitals. In 1974, while the United States had one doctor for every 650 people in the general population, there was only one doctor for every 1700 reservation Indians. To add to the problem, most of the 492 doctors then assigned to IHS hospitals, were recruited from the military draft. When the doctor draft terminated in 1976, IHS lost many physicians, resulting in a severely understaffed IHS medical staff. In addition, the U. S. Senate’s decision to exclude PHS personnel from acquiring a bonus of up to $10,000 for every year that military doctors served past their minimum tour of two years further discouraged recruits.
Dr. Jim Felsen, an IHS physician, expressed grave concern regarding the 200 physicians who would be finishing their tours of duty in June, leaving already understaffed hospitals. Felsen felt fortunate that he was able to recruit three physicians for the Rosebud reservation in South Dakota beginning on July 1, the same day that four of the six physicians there were finishing their terms. Without a new staff, he would have been forced to close the hospital, thus creating a disastrous situation for Native American’s health care.41

According to Dr. Everett Rhoades, vice-chairman of the Kiowa Tribal Council and one of the only thirty-eight Indian physicians in the United States in the 1970s, the isolation in rural communities, long hours and low pay, and lack of quality housing, schooling and recreation left physicians disinterested and unenthusiastic about working at an IHS hospital.42 The following statistics reflected the critical need for IHS medical staff positions between 1974-1975.43

(1) Doctors needed  160
(2) Dentists needed   340
(3) Nurses needed     570
(4) Pharmacists       160
(5) Inpatient care    1,160
(6) Other support personnel  1,790
Total            4,200

To compensate for the lack of physicians in the IHS system, to provide supplemental specialty care, and to complement the basic services available to Indian people, the IHS paid for the use of alternative health service facilities. For example, in Claremore, Oklahoma, the IHS hospital had just thirty-five beds to accommodate 33,000 northeastern Oklahoma Indians. Director Thomas Talamini said that because of these figures the hospital must treat the majority of patients on an out-patient basis. As a
supplement, the hospital was allotted $373,000 to contract health services with other university medical centers, county hospitals and private physicians. Unfortunately, Talamini claimed that their quarterly allocation was often spent within six weeks. Because of inadequate health care, the quality of life on most Indian reservations also suffered. Infant mortality was three times the national average, and the tuberculosis rate was eight times the national average. The life expectancy for Native Americans in 1977 was forty-seven years compared to 70.8 years for the general population. For every seven babies born, one Indian woman was sterilized. With a total Native American population of approximately 800,000 as of 1976, sterilizations within the many tribes could have a devastating impact on a particular tribe's survival. Pinkerton-Uri made the observation that "there are about only 100,000 women of child-bearing age left total. A 200 million population could support voluntary sterilization and survive, but for Native Americans it cannot be a preferred method of birth control. Where other minorities might have a gene pool in Africa or Asia, Native Americans do not; when we are gone, that's it." Lack of staff, quality care, and accessibility to hospitals or clinics, along with the rekindled 1970s interest in eugenics, created an explosive situation for women of color and low income. Family planning workers eagerly introduced Native Americans to sterilization as a form of birth control in the 1960s through HEW pamphlets such as "Plan Your Family." The booklet illustrated a before -- sterilization caricature of haggard parents with only one horse and eleven children next to an after -- sterilization cartoon of happy erect parents surrounded by one child and many horses. This type of paternalistic mindset was widespread throughout the nation.
Other federal agencies, such as the Bureau of Indian Affairs (BIA), were indifferent to inquiries into the quality of Native Americans’ lives. In November 1972, the *American Indian Law Newsletter (AILN)* devoted a special edition to the “Study of the Problem of Discrimination Against Indigenous Populations,” conducted by the Subcommittee on Prevention of Discrimination and Protection of Minorities of the Commission on Human Rights of the United Nations Economic and Social Council. The committee sent out questionnaires to the pertinent nations which had indigenous populations within their boundaries, with the intention of discussing the problems these groups had and possibly offer suggestions to various issues.48 The United Nations Assembly defined indigenous as:

Populations composed of the existing descendants of the peoples who inhabited the present territory of a country wholly or partially at the time when persons of a different culture or ethnic origin arrived there from other parts of the world, overcame them and, by conquest, settlement or other means, reduced
them to a non-dominant or colonial condition; who today live more in conformity with their particular social, economic and cultural characteristics of other segments of the population which are predominant.49

The questionnaire consisted of three major sections: (1) General Information concerning the indigenous population; (2) Basic Principles which govern the country's treatment of the indigenous population; and (3) Information on Discrimination Against Indigenous Populations and the Elimination Thereof.50 The bulk of the questionnaire addressed ten major categories in which discrimination was most likely to take place. The AILN was most concerned about the BIA's lack of substantial response to the form. The BIA answered many of the general questions, but avoided any in-depth information on the actual living conditions of Native Americans in the United States. AILN considered the BIA's actions an embarrassment to a free society and felt that the federal government misled the world community regarding its nurturing guardian/ward relationship with the indigenous people. Instead, general disregard toward Native Americans' issues existed, especially in the IHS department. The BIA's lack of interest indicated to the journal's staff that either the BIA was too embarrassed to address the problems of Native Americans, or its administrators just did not care.

This lack of concern for Native Americans' welfare filtered down through the government agencies and directly affected the health and well-being of Indians. An example of this could be found in legislation passed in 1970 that had a direct impact on the economic and sociological attitudes of many eager physicians fresh out of their residencies. President Jimmy Carter approved the Hyde Amendment which cut off ninety-eight percent of all federal funds for abortions but maintained reimbursement to hospitals or physicians of ninety percent of sterilization costs. An HEW study reported that if all federal funding for abortions was eliminated, an estimated 250 to 300 deaths could be expected each year and 25,000 serious medical complications would result from
self-induced or illegal abortions. With fewer options for Indian and non-Indian women to exercise control over their reproductive rights, physicians took the initiative and pushed the risky surgical sterilization rather than safer alternative means of birth control.

Robert E. McGarrah, a staff attorney for Public Citizen's Health Research Group, wrote that surgeons were trained to look upon surgery as a powerful tool, a talent that they were encouraged to use with freedom. The American Board of Surgery fostered this attitude by establishing required numbers of operations that residents had to assist or perform to complete their residencies. McGarrah believed that these early rewards for performing operations on the poor or minorities in the form of residency certification and specialty board qualifications translated into later financial rewards whereby the more a doctor cut the more he or she could earn.

A study published in 1971 involving a southeastern town of 200,000 inhabitants appeared to corroborate McGarrah's beliefs. Researchers questioned physicians regarding their birth control policies and attitudes. Only six percent of the responding physicians recommended sterilization as a birth control method for their private patients, yet fourteen percent favored sterilization as the first method of contraception for welfare patients. In that same poll, ninety-four percent of gynecologists approved compulsory sterilization for welfare mothers who had three or more children. Physicians were convinced that welfare patients were unreliable and not intelligent enough to properly use other methods of birth control such as contraceptive devices or pills. Physicians played God, deciding for the poor or minority what they felt would provide a higher standard of living by limiting the size of families. Many physicians, government administrators, and health corporation planners felt that sterilization provided an inexpensive and permanent method of controlling population, reducing poverty, and insuring who could reproduce. The
reality was that many doctors failed to explain to women the surgical procedure, its risks and its permanency. They also often neglected to obtain appropriate informed consent.

Another factor that fostered sterilization abuse was the increasing difficulty of teaching hospitals to obtain willing subjects. McGarrah stated that in the 1970s, “teaching programs are having increasing difficulty in finding subjects to learn on because they greatly depend on the availability of ward or indigent patients, and with increased third-party payments, the number of such patients is shrinking.” As a result, “pushing” and “hardselling” of elective sterilization became common. Health Research Group’s 1973 study on surgical sterilization demonstrated that men and women were sterilized at a rate of two million per year, and the federal government financed more than 100,000 of those operations. Less than 95,000 were performed on “mentally incompetent patients” who were under age.54

The 1973 study obtained copies of the consent forms for sterilization procedures and for another surgical operation, both elective procedures at Baltimore City Hospitals, to demonstrate the minimal amount of information a patient was given regarding sterilization (Appendix VI). Although some lawsuits had been filed for lack of informed consent for the intravenous pyelogram, no suits had ever been filed for lack of informed consent for sterilization. Approval for sterilization was often left blank or rubber stamped without a physician seeing or speaking to the patient. The only requirement was that the patient sign in front of a witness, and at the Baltimore Hospital that was often the same doctor who would perform the operation.55

At the Los Angeles County Hospital (L. A. County), a teaching hospital found to have had the most flagrant abuse of patients’ rights, a consent form for sterilization similarly lacked adequate information. Staff did provide the patient with a booklet, *Voluntary Sterilization for Men and Women*, published by Planned Parenthood, but the
booklet dealt only with information and diagrams of tubal ligation, vasectomy, or the use of an IUD. The explanations were adequate, but knowledge of risks involved and ramifications were not available except for the IUD (Appendix VII). It was easier to obtain information on taking the birth control pill or using an IUD than for surgical operations. Dr. Bernard "Buddy" Rosenfeld, an obstetrics resident at L. A. County in 1973, quoted a doctor's guideline at that hospital: "Unless we get those tubes tied before they go home some of them will change their mind by the time they come back to clinic."  

Rosenfeld, co-author of the 1973 study, noticed sterilization coercion during his residency, but when he questioned his house staff, conducted his own investigation, and spoke to newspapers, he was denied renewal for his second year of training. In 1975, he would again appear along with journalist Claudia Dreifus at L. A. County hospital to determine whether the 1974 federal guidelines against sterilization abuse were being observed. Besides banning sterilizations of minors or the mentally incompetent, the 1974 regulations banned sterilizations on women until seventy-two hours after they had signed consent forms. It also required adequate counseling to ensure informed knowledge of the operation and its consequences, and offered other alternative birth control choices. Of the twenty-three doctors interviewed, nine admitted witnessing coercion or working under conditions that fostered conditions that led to misinformation, or hard-selling, or on-the-job racism.

In one situation a student questioned a resident about why he encouraged hysterectomy over tubal ligation. The resident explained that the hospital liked to do a hysterectomy. "It's more of a challenge . . . . You know a well-trained chimpanzee can do a tubal ligation . . . and it's good experience for the junior resident." Statistics from one of the major teaching hospitals that investigated the Women's Hospital of the Los Angeles
County Medical Center, recorded the increase of hysterectomies versus tubal ligation over a two-year period between July of 1968 and July of 1970:59

<table>
<thead>
<tr>
<th>Procedure</th>
<th>Increase</th>
</tr>
</thead>
<tbody>
<tr>
<td>Elective Hysterectomy</td>
<td>742%</td>
</tr>
<tr>
<td>Elective Tubal Ligation</td>
<td>470%</td>
</tr>
<tr>
<td>Tubal Ligation After Delivery</td>
<td>151%</td>
</tr>
</tbody>
</table>

Health Research Group sent a copy of its fifty-nine page report to J. Alexander McMahon, the President of the American Hospital Association (AHA) on October 30, 1973, with the urgent message to implement their suggested informed consent forms in all AHA hospitals that performed sterilizations. The writers also encouraged the president to adopt the sterilization informed consent booklets that they had compiled and to give copies to any prospective sterilization patient (Appendix VIII).60 Abbreviated contents of the informed consent booklet covered the following issues:

1. Distribution of patient information booklet at least thirty days before surgical sterilization is to be done. (Sample booklet including comparison of methods, general discussion of surgical sterilization and questions to be answered by doctors is included as Appendix A).
2. Showing educational movies to patients.
3. Obtaining second surgical opinion if a medical indication is given as the reason or part of the reason for the sterilization
4. Having patient sign form after all steps have been completed.61

Physician studies reflected that hysterectomies were the most frequently performed major surgery in the United States, and the most rapidly increasing operation. Between 1968 and 1973, the nation witnessed a twenty-six percent increase. The American Journal of Obstetrics and Gynecology (AJOG) credited the increase to elective decisions for sterilization in the treatment of certain medical conditions such as menopausal problems and prophylactic treatment of uterine cancer. However, a medical audit in 1956, and gynecological studies in 1974, found thirty percent of hysterectomies unnecessary.62
The dramatic rise in this surgical procedure precipitated much discussion and opinion within the medical world. Many hysterectomy advocates claimed that a woman's uterus was useless except for procreation, and they recommended the abdominal hysterectomy versus the vaginal hysterectomy or a tubal ligation for the majority of women over thirty-five years or after their last planned pregnancy. Oophorectomy, the removal of a woman's ovaries, was also an advised inclusion with hysterectomy as an added protection against cancer. Proponents rationalized that women would be relieved of the fear of cancer and thus prolong their lives, and also erase the fear of unwanted pregnancies and discomforts of menses. However, AJOG pointed out that it was impossible to estimate what number of women would have acquired cancer before some other disease or accident took their lives.

Those opposed to the radical hysterectomy versus tubal ligation conducted their own studies and found that though sterilization by hysterectomy would eliminate the threat of cancer of the uterus, the actual death rate from uterine cancer was less than the mortality rate from hysterectomy. For every one million hysterectomies performed in a year, 600 women died, and this was a conservative mortality figure. The Halothane Study claimed 900 died. National statistics from the Commission of Professional and Hospital Activities (PAS) indicated thirty-three percent had post-operative fevers, the average length of hospital stay was 10.3 days, 15 percent required blood transfusions, and 48 percent needed antibiotics. Also surgical and hospital costs were four to five times greater than other surgical operations.

In New York, a hysterectomy cost $800 in 1970, as opposed to $250 for a tubal ligation, and recovery could take six or more weeks, depending on complications, as opposed to a few days following a tubal ligation. Even the simpler vaginal hysterectomy had a complication rate of ten to twenty times higher than that of the tubal ligation. Ralph
Nader’s 1973 HRG study concluded that the vaginal hysterectomy or tubal ligation should be the primary method, as opposed to abdominal hysterectomy. Dr. Lester Hibbard, Professor of Obstetrics and Gynecology at University of Southern California, agreed and added that abdominal hysterectomies were indicated for women who manifested secondary operative indications. These included cancer of the cervix, and/or uterus, intractable uterine bleeding, severe infection, and obstruction from foreign bodies such as large fibroid tumors. The studies conducted on elective hysterectomy indicated this more complicated procedure was the routine method of sterilization on women, and the vast majority had no secondary operative need. McGarrah published the following comparison of birth control methods and their complications:

<table>
<thead>
<tr>
<th></th>
<th>Tubal Ligation</th>
<th>Pill</th>
<th>IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy Rate*</td>
<td>0</td>
<td>10,000</td>
<td>5,000</td>
</tr>
<tr>
<td>Deaths*</td>
<td>1,000</td>
<td>1,000</td>
<td>31</td>
</tr>
<tr>
<td>Serious Complications*</td>
<td>150,000</td>
<td>15,000</td>
<td>600</td>
</tr>
</tbody>
</table>

(*per million women) 66

The HRG report mentioned male sterilization as a possible option for birth control and provided some illuminating facts. Statistics indicated that men who underwent vasectomies required only a local anesthetic, and most were able to return to work after the thirty-minute procedure conducted in a physician’s office. The cost of a vasectomy was $50. The advantages of undergoing a vasectomy versus hysterectomy or tubal ligation were obvious. 67

Other significant counter-indications for hysterectomy, though less tangible, included headaches, fatigue, insomnia, persistent hot flashes related to endocrine disease
and aging process, osteoporosis, and depression. The HRG study reported regret among sterilized women as high as twenty-five per cent. Philip Cole, professor in the Department of Epidemiology at Harvard School of Public Health, wrote in the *American Journal of Obstetrics and Gynecology* that over a three-year period, women after hysterectomy were twice as likely to succumb to depression as women undergoing other abdominal surgery, and almost five times as frequently as women having no surgery. The depression that women experienced often was serious enough to necessitate treatment. Cole wrote that enough evidence indicated that "post-hysterectomy syndrome" was a reality and that it occurred in many women, even after the less radical hysterectomy. Although knowledge of how hormones affected women’s physical and emotional life had yet to be fully documented, many physicians observed a correlation between symptoms and hysterectomies. Those physicians recognized that women who maintained normal ovarian functions were at a much lower mortality rate if they incurred atherosclerotic vascular disease. If this role was compromised through a surgical hysterectomy, then even a small rise in mortality (one to two per cent) from vascular diseases would be counteractive to the gains from uterine cancer prevention. Also psychosexual complications had been noted among sterilized women who later had misgivings, resulting often in frigidity. The National Organization for Women (NOW) said they received dozens of calls a year from women complaining about the emotional and physical pain and discomfort from their surgery, and the lack of information or preparation for undergoing it.

Moreover, the majority of the victims’ feelings of shame and guilt over their sterilization hindered greater awareness of their ordeal. They were afraid of peoples’ condemnation. Laurie Nsiah-Jefferson, a consultant for the Bureau of Maternity Services and Family Planning in New York, wrote an insightful article for the *Women’s Rights Law Reporter* in 1989, regarding minority women’s self-image. She stated that
women of color usually possessed low self-esteem, especially if they were of low income also. For these women, asserting any of their rights, let alone reproductive rights, was foreign to them. Nsiah-Jefferson found that women of color and poor women simply had fewer choices than other women.\textsuperscript{70} They lacked the money, support of appropriate organizations, assertiveness and opportunity.

One of the most common violations of Native American women's right to informed consent was the lack of an interpreter to explain in their own language about the surgical procedure. Frequently, physicians also refrained from explaining its irreversibility or offering optional means of birth control. In many cases, doctors worked in conjunction with a social worker, threatening to withdraw patients’ welfare benefits or to take their children from them unless they underwent sterilization. Those most affected during the 1970s were Black, Puerto Rican, Chicana, and Native American women.\textsuperscript{71}

Physicians who claimed that they had orally informed Native American women about the surgical procedure and obtained consent were not taking the time or precaution to have a witness who spoke the woman’s language. This was an area that created enormous misinformation and neglect of a woman’s right to know and understand in her own language what the operation involved. However, it would almost be impossible for a physician to learn Native American languages because, unlike the Spanish language of Hispanics, there is no one common language for American Indians. Today there are approximately 287 tribal entities, at least ten major cultural-linguistic groupings, and 252 living languages. Consequently, considerable confusion occurred in communicating the necessary information on sterilization.\textsuperscript{72}

Women interviewed later verified that public and private welfare agencies had threatened to cut off their benefits if they had additional children. In other situations, welfare agents and surgeons tried to convince a mother to agree to sterilization during
labor when she was vulnerable and often medicated. The threat of losing one's children to
social welfare agencies if the mother did not agree to sterilization, however, proved the
most persuasive and coercive technique. Native American women scattered throughout
the nation on reservations with little if any access to the pro-choice movement which
might have raised their consciousness, were especially vulnerable to manipulation. Their
population — already devastated by diseases, inadequate health care and education, wars,
removal, cultural genocide through assimilation, broken treaties, and now sterilization —
placed a high priority on children as their one hope of survival. Native Americans had and
still have a deep sense of family and the importance of extended families.

For example, when Guadalupe Acosta discovered that she was incapable of
bearing more children, the distress led to divorce. Pinkerton-Uri believed most sterilized
Indian women did not understand the irreversibility of the operation, and when they did,
they felt violated. The emotional and psychological effects could go on for years and lead
to nervous disorders, suicides, alcoholism, and prostitution. Sterilization thus affected the
entire family.73

To appreciate a Native American woman's deep-rooted fear of losing her children
to a foster family, boarding school, or adoption, one can look back in history and find
ample examples of families losing their children. The phrase "kid catching" in the 1930s
on the Navajo reservation will always reverberate through time among Indian families. It
meant that it was time for stockmen, police, farmers, and mounted men to come on their
reservation and literally round-up school-age children for the far-away government
boarding schools. These children, often roped like cattle, were sent to white man's
schools where they were given white man's names and clothing, forbidden to speak their
native tongue, and often prevented from returning home for three years, sometimes never.
Dande Coolidge, a Navajo eyewitness to the yearly rounding-up of Indian children,
recalled that many parents would hide their children when they heard the sound of a truck approaching.74

By the 1970s, horses and ropes were no longer used. Instead, formal education, socialization, and acculturation were the ties. Welfare workers replaced the stockmen and police and removed thousands of children from their natural culture and families. William Byler, author and executive director of the Association of American Indian Affairs (AAIA), conducted studies in 1977 of states with large Indian populations that had documented welfare agencies removing 25-35% of all Indian children from their families and placing them in foster homes, adoptive homes or institutions. Many of these children were taken away without due process of the law. Byler called this removal of children from their Native way of life "cultural genocide," and he believed the greatest influence on Indian emotional life was the threat that their children would be taken away from them.75

The following is a chart prepared by the Association on American Indian Affairs, Inc. which appeared in the December 1976 issue of their publication, Indian Family Defense. It listed the ten states with the highest rates of Indian children placed in foster homes compared to non-Indian children.76

<table>
<thead>
<tr>
<th>State</th>
<th>Foster care placements per-thousand Indian children</th>
<th>Foster care placements per thousand non-Indian children</th>
<th>Per Capita rate of Indians in foster care compared to non-Indians</th>
</tr>
</thead>
<tbody>
<tr>
<td>Idaho</td>
<td>77.5</td>
<td>12.1</td>
<td>640%</td>
</tr>
<tr>
<td>Maine</td>
<td>75.8</td>
<td>4.0</td>
<td>1,910%</td>
</tr>
<tr>
<td>Minnesota</td>
<td>58.1</td>
<td>3.5</td>
<td>1,650%</td>
</tr>
<tr>
<td>Wisconsin</td>
<td>53.5</td>
<td>4.0</td>
<td>1,340%</td>
</tr>
<tr>
<td>South Dakota</td>
<td>45.5</td>
<td>2.0</td>
<td>2,240%</td>
</tr>
<tr>
<td>Utah</td>
<td>37.2</td>
<td>2.5</td>
<td>1,500%</td>
</tr>
<tr>
<td>North Dakota</td>
<td>36.1</td>
<td>1.8</td>
<td>2,010%</td>
</tr>
<tr>
<td>Oregon</td>
<td>36.1</td>
<td>4.4</td>
<td>820%</td>
</tr>
</tbody>
</table>
In 1972, the Wisconsin Potawatomi community filed a lawsuit in the U. S. District Court at Marquette in an effort to stop Michigan’s placement of Indian children in white homes. The suit specifically addressed the children of Leroy Wandahsega who, upon the death of both parents, were taken away by the juvenile officer of the Menominee Probate Court. Even though their paternal uncle, Jake McCullough, along with their paternal grandmother and closest relative, had petitioned for adoption, the children were placed in foster homes and later sent to far away non-Indian distant relatives in Florida. Sally Halfaday, a relative of the children, stated that the Menominee and Delta County Social Services Agency would not even permit visits from tribal relatives or friends, claiming that it would upset the children and that it was better for the children to live away from the Hannaville Reservation. Due to the tremendous increase in white adoption of Indian children, the Michigan Indian Adoptive Council was founded to gain control of all the Indian children taken away.77

In the same issue of *Akwesasne Notes*, Michael Dollard from Albany, New York, responded to the minority adoption question based on his own personal experience and sensitivity. He had adopted two Black children, as had several others in his community, and the consensus of the several parents was the strong belief that their adopted children would have been better off remaining in their own cultural and ethnic backgrounds. He admitted to being part of a movement for several years that believed in minority adoptions, but he and other adoptive parents had come to realize there were no appropriate homes for minority children because no one had actually sought out the children’s extended family.78 Bernice Appleton, vice-president of the Native American Child Protection
Council (NACPC), explained that in the 1970s, there was a shortage of white babies, and white couples preferred Indian babies over Black babies.  

Appleton stated that it was typical for welfare agents to come into an Indian home and declare it unfit for living simply because siblings shared beds. "Indians are different," she claimed. "It isn't necessary for Indian children to have one bed apiece. Our children you see, learn sharing right from the start." The NACPC espoused the philosophy that the Indian concept of family was an extended one that included many relatives, all of which played a part in the child's cultural and spiritual growth. Appleton maintained that just because a child might not be staying with its mother continuously did not indicate neglect. Many relatives shared the responsibility for the upbringing of a tribal child, and this did not deprive the child a healthy family life; rather it gave him a rich and integrated variety of experiences he would take through life.

Various churches also threatened Native American families through organizations such as the Mormon Church "Placement Program." Joan Rose, a Ute woman from Nevada remembered the Mormons taking in children from poverty-stricken Indian families. There was great concern for the children's religious education as it was common knowledge that Mormons believed Indians were sinners and "Lamenites" (one of the lost tribes of Israel), who could become white and immediately be saved if they accepted the Mormon faith. Dr. Jane Van Heusen, a pediatrician from Tuba City, Arizona, recalled:

in the 60s it was practically a black market adoption racket. I remember once a clerk came to me about a family who were being talked to by Mormons about their children. They gave the parents a piece of paper and said it was just to let them go to school. But the paper was an adoption form. The clerk and I told the parents what adoption was, and they said they didn't want that . . . . The Mormons were absolutely furious with us because we told these people the truth.
As many as two thousand children per year left their homes to live with a culture that held Native Americans as "dark and loathsome," "cursed by God because of their moral turpitude and ancient wickedness." They believed that as the children became indoctrinated into the Mormon faith, they actually believed their skin would lighten.83

Pat Ballenger, a Chippewa mother, social worker, and teacher in an Indian Survival School in Minnesota, explained that children are the Indian peoples' first priority. She could not understand why extended families were not given the right to take in Indian children instead of utilizing white foster placement. She said that the Indian family considered it an honor and a tradition to adopt homeless Indian children, but instead the government routinely took them away from their culture and security.84

Dr. Joseph Westermeyer of the University of Minnesota Department of Psychiatry believed social workers had no skills or understanding when relating to Indian families and did not attempt to keep families intact. They ignored the extended family concept, poor conditions at mental health facilities, and Indian community resources. Indian societies were founded on the extended family concept, whereby an Indian child could potentially have scores of, perhaps more than a hundred, relatives to rely on.85 Westermeyer found that when welfare workers were involved in a family crisis, they were all too eager to remove the children from the home and place them in foster care. He said these children were often shifted from one white home to another, and consequently had difficulty in adapting to family and adult life later. Especially in their adolescent years, youths would recognize that they were not fully accepted in white society, and were excluded from dating and other social activities. Jobs were also difficult to obtain as employers held stereotypical notions about them. With no peer group to depend upon and with low self-esteem, these Indian youths were more likely to have social problems, be imprisoned,
or suffer mental illness. Conversely, Indians who stayed within the family structure more likely found employment, had a good family life, and were well adjusted.86

Statistics reflecting the high number of children placed in boarding schools in a 1971 school census conducted by the Bureau of Indian Affairs (BIA) were staggering. Approximately 35,000 children lived in such facilities rather than at home.87 The 1973 BIA school census recorded that sixty-eight percent of all Indian children attended public school; twenty-six percent attended federal boarding schools; and six percent were at mission or private schools. Of the total number of Native children attending federal schools, over two-thirds (33,672) were in boarding schools.88 Native Americans expressed grave concerns about the impact that BIA schools had on their children since classes were conducted only in English, and the intent was to assimilate them into the white man’s world. Of even larger concern was the distance between the boarding schools and the childrens’ homes. Suicide rates among the teenagers were as high as 100 times that of the national average. Children as young as ten-years-old attempted suicide. In the late 1970s, two BIA boarding school boys ran away and froze to death in their attempts to reach home, fifty miles away. Another school on the Northern Cheyenne reservation reported twelve attempted suicides in an eighteen month period among a 200 student enrollment.89

Thousands of Native American women in the 1970s were faced with either the fear of losing their children, or the fear of losing their ability to have more children. Even if they agreed to sterilization there was no guarantee that they could keep their children. During this same time period, still another form of sterilization abuse was taking place, especially in the institutions for mentally impaired Indian women. These women, who were the most vulnerable, deserving the best protection against sterilization coercion, were given injections of Depo-Provera to stop their menses. The drug had not been approved by the
FDA as a contraceptive, and little knowledge of exactly how many women were given this drug will never be known because records were not kept regarding its administration and dosage. Due to the lack of adequate studies and the question of its long term safety, Depo-Provera was continually banned for use as a contraceptive for over a period of fifteen years while hearings and investigations were underway. The fact remained that Depo-Provera was the only contraceptive drug at that time that resulted in cancerous breast tumors in animal studies.90

What was shocking about this presumption of power to override FDA's restrictions and to use Depo-Provera injections on mentally retarded Indian women was the lack of consideration regarding its carcinogenic risk and the severe side effects. A 1987 government oversight hearing on Depo-Provera indicated IHS physicians never asked for permission nor kept reliable records of individual administration of the drug. Informed consent forms did not alert the patients or their guardians to the potential risks.

The interaction between FDA, IHS physicians, and pharmaceutical companies created a dangerous situation in which IHS was able to prescribe drugs for years without any monitoring. Varying dosages were administered to stop periods for admitted lessened janitorial work. In addition, UpJohn, involved in marketing Depo-Provera to Third World countries, was linked to unethical means to make their contraceptive available around the world. Physicians claimed they were making responsible choices in the best interest of the patient, when, in reality, many Indian women categorized as non-institutionalized were also injected. The sad fact remains that no one will ever know the exact number of injected women, handicapped or healthy, because physicians were not held accountable to register with the FDA for supplies of Depo-Provera, and few patient records were kept.
NOTES


2 "Native Woman Sues Over Illegal Sterilization, Seizure of Children," *Akwesasne Notes* (Late Summer 1975), 8; Patricia A. Moore, “Indian Woman’s Sterilization Suit Starts,” *National Catholic Reporter* (January 19, 1979), 1.


5 Moore, “Indian Woman’s Sterilization Suit Starts,” 1.

6 “Involuntary Sterilization Case,” 23


8 “Involuntary Sterilization Case,” 23.

9 Richard Levine interview by Sally Torpy (Fall 1995); “Involuntary Sterilization Case,” 23-24.


15 Bill Wagner, "Lo the Poor and Sterilized Indian," *America* (January 29, 1977), 75.


20 "Memo to Karl, Percy, and Phil," 3-4.


25 Michael Zavalla interview by Sally Torpy (September 25, 1995).

26 Harley, "Indian Women Plan to Sue," 6; Zavalla interview.


Caduceus (Winter 1992), 51-52.


30 “An Interview with Barbara Moore on Sterilization” Akwesasne Notes, (Spring 1979), 11-12.

31 Documents obtained from the personal files of Lehman Brightman, during interview (October 31, 1997), in the possession of Sally Torpy.


35 “Newly-Passed Indian Health Act Could signal Better Programs,” Akwesasne Notes (Early Summer 1975), Newsbank, 23: G9.


39 “Shortage of Doctors and Money Poses Serious Indian Health Threat; Nixon Impounds Funds 4 out of Last 5 Years” (N. Y.) Liberation News Service (July 6,
1974), Newsbank, 23: G5.


43 “The History of the Indian Health Services,” 5.


45 “Involuntary Sterilization Case,” 25.

46 Mark Miller, Judith Miller, and Chris Szechenyi, “Native American Peoples on the Trail of Tears Once More,” Akwesasne Notes (Spring 1979), 18.


49 “Special Edition,” American Indian Law Newsletter, Annex II.


55 Rosenberg et. al., Health Research Group Study, 21.

57 Dreifus, “Sterilizing the Poor,” 16.

58 Rosenberg et. al., *Health Research Group Study*, 3.


68 “Elective Hysterectomy,” 120.


74 Mark Miller, Judith Miller, and Chris Szechenyi, "Native American Peoples on the Trail of Tears Once More," Akwasasne Notes (Spring 1979), 18.


77 "The Latest in the 'Social Genocide; Field: Adoption of Indian Children by White Families," Akwesasne Notes (Early Autumn 1972), 31.

78 "There Are No Other Homes for These Children," Akwesasne Notes (Early Autumn 1972), 31.


80 Native American Women, 32.


83 Weyler, Blood of the Land, 149.


86 "The Theft of Life," 32.
Native American Solidarity Committee in coordination with the American Indian Treaty Council Information Center, “The Systematic Genocide of Native Nations by the United States Government” (June 1977), 130.

Native American Solidarity Committee, 130, 131.

“Use of the Drug, Depo-Provera, By the Indian Health Service,” Oversight Hearing before the Subcommittee on General Oversight and Investigations of the Committee on Interior and Insular Affairs House of Representatives, 100th Congress, 1st session (August 6, 1987), 1-3.
CHAPTER THREE
DEPO-PROVERA: THE SHOT HEARD 'ROUND THE WORLD

Put them [Native Americans] under the Fish and Wildlife Service, and declare them an endangered species; along with . . . the yellow scissor tailed flycatcher. When threatened with extinction, no Federal program can infringe on the critical habitat of the endangered species, which it requires in order to survive. Violation of this law is a felony. 1

Never has a drug caused such intense reaction among physicians, scientists, population control advocates, women rights supporters, and its victims as has the contraceptive Depo-Provera. Twenty-five years of intense scientific scrutiny, government hearings, women’s reproductive rights forums, and international media coverage culminated in widespread confusion and lack of strict guidelines for its use. It was ironic that just as women of color struggled against sterilization abuse in the 1970s, the same minority groups of women felt powerless to ban physician prescription of Depo-Provera. Although the Federal Drug Administration (FDA), had not approved of the drug for birth control, another federal agency, the Indian Health Service (IHS), had injected dozens of Indian women, the majority of them mentally retarded, with Depo-Provera for years before 1973. Eventually government subcommittee hearings called for an explanation from Upjohn Company, the manufacturer of Depo, and from several mental institutions and family planning clinics, and found them in violation of FDA’s regulations. 2

Depo Medroxyprogesterone Acetate, more commonly known as Depo-Provera or DMPA, is an artificially produced oil-based drug having some properties like naturally
occurring sex hormones called progesterones. In the mid-1950s, an Upjohn Company scientist experimented with the various compounds of progesterone which led to the brand name Depo-Provera. In 1967, Upjohn marketed the drug as a deterrent for threatened miscarriages and, in 1972, for the treatment of endometriosis. The company finally withdrew its claims in 1973 when a FDA review determined there was insufficient evidence that it was effective for those uses. It was also approved for the treatment of advanced endometrial and kidney cancer in high doses. During this time, Upjohn’s testing in Brazil revealed its potential for use as a contraceptive which launched decades of the company’s determined efforts to obtain FDA approval.3

Intramuscularly injected in a 150 milliliter dose, Depo-Provera’s contraceptive capacity lasts for at least three months, preventing pregnancy in 99.7% of its users. The synthetic hormone inhibits ovulation by suppressing production of the hormones progesterone and estrogen. This results in the thickening of cervical mucous and the thinning of the endometrial lining, further reducing the chances of the eggs’ fertilization or implantation.4 The simplicity in taking the drug was very appealing to women who did not want to deal with barrier methods such as the IUD; or for medical reasons such as proclivity toward blood clots; or for sexually active women whom physicians considered sexually irresponsible; as well as for women who did not want to undergo sterilization but also did not want additional babies. Family planning center physicians, sociologists, politicians, and economists saw a market for Depo-Provera in Third World countries, as well as in the United States for women who had little income, education, or opportunity for quality health care. Once every three months women could easily return to their family clinics for their shot. While this scenario sounded like an ideal solution for birth control, the reality was that inadequate screening of women’s health history, lack of adequate patient information, and lack of informed consent led consumer advocates, politicians, and
women's rights activists to the floors of Congress petitioning for legislation to protect
women from potentially severe adverse drug reactions, and to provide adequate informed
consent. Women's organizations such as the National Women's Health Network have
been particularly active in maintaining a registry of women who have ever been injected
with Depo. Sister to that affiliation is the Native American Women's Health Education
Resource Center (NAWHERC), based in Lake Andes, South Dakota, which conducted its
own studies of IHS facilities' use of Depo-Provera in 1993 and 1995.5

Unknown to the majority of Depo users were the results of studies conducted by
Upjohn revealing a link to cancer in dogs and monkeys injected with the drug. Its first
clinical study on human subjects was instigated in April 1967, at the Grady Hospital in
Atlanta, Georgia, under an Investigative New Drug (IND) application. The hospital,
affiliated with the Emory University School of Medicine, operated a thriving family
planning clinic serving an over 90% black clientele.6 The study revealed many potentially
serious side affects when taking Depo-Provera. The most serious were cervical
cancer-in-situ, a localized cancer that can spread rapidly at up to 9.1 times the national
rate.7 This potential was discovered when FDA statistician Bertram Litt analyzed
Upjohn's June 1974 safety data. Litt based his conclusions on just twenty-two of the
thirty-five total number of known carcinoma-in-situ cases that occurred during the
Depo-Provera trials.8

Another significant drawback was the length of time required before a woman would
resume her periods and was able to become pregnant. In some cases women were
rendered infertile, while others waited up to two years before they resumed a normal
menstrual cycle. Also once Depo-Provera was injected, there were no antidotes to reverse
complications such as hair loss, weight gain or depression. Affected women had to wait
until the synthetic hormone finally left their systems before being symptom-free. Patients
also were rarely informed that although the drug prevented pregnancies, it did not protect them from sexually transmitted diseases and AIDS. 

Thomas J. Vecchio, Manager of the Medical Development section of the Upjohn Company and later Chief of Clinical Research in Upjohn’s International Division, published his own book on the troubled history of Depo-Provera, defending its use and denying any serious health hazards. Vecchio wrote that the Grady study, which took place from April 1967 to May 1979, administered the contraceptive to approximately 11,400 women. According to Vecchio, the study showed that at the end of one year, 56.8% of the clients continued to use Depo-Provera. Approximately 13.5 percent quit the study due to irregular vaginal bleeding, one of the most common complaints from women. Depo-Provera users in the study numbered 656 in 1974, and doubled to 1,216 by 1978. Vecchio felt these increased numbers reflected the confidence that women had in the drug.

The study failed, however, to include other pertinent information such as patient follow-ups, which is essential in most accredited drug studies. In addition, the Grady Study, considered the largest epidemiological study ever conducted in the United States, was financed by Upjohn from 1967 to 1971, which raised legitimate concerns about unbiased conclusions regarding the safety of Depo-Provera. The FDA ordered Upjohn to terminate further testing in 1971 because, according to Upjohn, it had submitted enough studies for approval. Yet conflicting testimony at Senate Health Subcommittee hearings indicated that the FDA had called for the drug study’s termination because studies on animals reflected serious side effects. Depo-Provera was deemed too dangerous for human experimentation.

A further on-site audit in 1978 reflected serious deficiencies in the quality of the Upjohn study. Rep. Ted Weiss (Democrat-NY), chair of the House Subcommittee on
Intergovernmental Relations, examined the audit and sent his findings and recommendations to the FDA. Some of the more flagrant abuses included:

(1) On average the study lost fifty and gained fifty subjects per month, resulting in an overall turnover rate of seventy-five percent. Despite the large number of drop-outs, no provision was made for patient follow-up, including long-term follow-up with regards to cancer.

(2) The Grady study did not submit any of the requisite annual reports on its study.

(3) Although a 1973 protocol called for a total of 1,100 subjects, FDA personnel estimated that 4,400 women took the drug between 1973 and 1978.

(4) Required reports to the FDA of deaths and adverse reactions to subject were not made. In addition, mandatory annual reports were not evaluated by the Grady clinical investigators.

(5) Women did not receive adequate protection as experimental test subjects. For example, although the drug was known to cause infertility, it was administered to teenagers, women without children, and women wanting more children. Some women received injections as much as one year before signing the required investigational drug trial consent forms. Patients were kept on the drug despite the development of serious conditions. One woman developed terminal ductal hyperplasia, inflammation and stromal fibrosis.12

Dr. Robert Hatcher, director of the Grady Family Planning Clinic, Associate Professor of Gynecology and Obstetrics at the Emory University School of Medicine, and an “active participant” in the Depo-Provera program, testified before the Public Board of Inquiry hearings in 1983 that he had never seen the protocol that the clinic was supposed to be following until 1978. He admitted to the board that the clinic was not a research unit.13 The continued conflicts between pro-Depo-Provera and anti-Depo-Provera advocates had international implications which were closely linked to Upjohn’s pharmaceutical relationships with Third World countries, the Agency for International Development (AID), and population control advocates. Those promoting use of the injectable contraceptive envisioned its implementation in certain societies as the panacea for starvation, overpopulation, poverty, and economic instability by relieving the world from the burden of too many children.
The lucrative international market for this contraceptive was enormous. Countries with the highest rate of use included Jamaica, Thailand, New Zealand, Mexico and Sri Lanka. New Zealand was the only high-use non-Third World Country. Upjohn circumvented the ban on exporting Depo to these countries in 1978, by manufacturing the drug at subsidiary plants such as in New Zealand, and shipping it directly from there to the receiving countries. This also affected AID funds previously available for its marketing in other countries. According to Phillida Bunkle, a New Zealand history professor, and certain unnamed researchers, AID funds were passed to the IPPF at its headquarters in London, where in turn IPPF purchased Depo-Provera for world-wide supply to national family planning associations. International pharmaceutical bribery was not a recently discovered practice. Paying ministers and officials to turn a blind eye to unsanitary drug manufacturing plants, or to allow the importation of banned drugs was considered by many countries and drug companies as a normal business practice, according to John Braithwaite, a contributor to *Corporate Crime in the Pharmaceutical Industry*.

In the twenty-seven interviews Braithwaite conducted with U. S. pharmaceutical executives, none denied that widespread bribery had taken place in the past, while twenty-one believed it was still taking place. No positive proof exists that indicates Upjohn bribed Third World officials to supply Depo-Provera to their family planning clinics. In 1976, however, Upjohn filed a financial report with the U. S. Securities and Exchange Commission that indicated $4,245,948 had been paid to twenty-nine countries between 1971 and 1976. Elizabeth Clark, Upjohn spokesperson, stated that in exchange for voluntarily disclosing the payments and pledging to discontinue future payments, the SEC promised not to prosecute.

Senator Kennedy, subcommittee chair at the 1973 *Quality of Health Care-Human Experimentation* hearings, conducted interviews with several mental institution officials,
Upjohn representatives, and women’s advocacy groups regarding the responsible and ethical use of Depo-Provera. Kennedy especially focused on patients which physicians prescribed Depo-Provera for, and questioned how they justified using an experimental drug on those patients. In his opening statement, Kennedy remarked that the lack of monitoring practices, the proliferation of new drugs each year, and the physicians’ freedom to prescribe drugs considered still investigative, “encourages the development of patterns of medical practice that may well be premature and based on an inadequate understanding of the new technique or new drug.”

The injectable drug first came under scrutiny because of Marcia Greenberger, an attorney with the Center for Law and Social Policy, a public-interest group in Washington, and Dr. Nathan Kase, Chairman of Department of Obstetrics and Gynecology at Yale University School of Medicine. The center had learned that the Arlington Hospital and School, a state institute, had administered Depo-Provera to women for contraception, the majority without informed consent. Greenberger and Kase went to Cumberland County, Tennessee on January 18, 1973, to look into these allegations. They found that patients rarely knew of the side effects nor the drug’s experimental standing. It was estimated that 1,500 women in Tennessee, including 250 mentally retarded women at the Arlington institute, had been injected. Kase and Greenberger presented their findings and offered suggestions to protect patients’ rights during the 1973 oversight hearings.

Also attending the 1973 hearing was Dr. Robert Hutcheson, Director of the Tennessee Department of Health and Department of Family Planning in Memphis. Unlike Kase and Greenberger, Hutcheson supported the use of Depo-Provera as a contraceptive for women who were unable to use other methods. James S. Brown, Superintendent of the Arlington Hospital, concurred with this concern for the severely and profoundly retarded and the need for some form of birth control policy for them. However, in his
letter sent to guardians or parents of all post-pubertal women seeking their consent for the injections, Brown cited his initial concern was for "reducing time in taking care of the personal hygiene of females" during their menses. In addition, if these women were profoundly retarded and physically handicapped, many were non-ambulatory which prompted some critics to ask how could there be a threat of becoming pregnant?19

As a result of the hearing, the FDA approved only limited use of Depo-Provera because its experts believed the drug to be linked to an increase in breast cancer, and because it could potentially cause permanent sterility. That they allowed it at all, explained FDA commissioner Alexander M. Schmidt, was to allow for those who had no other reliable contraceptive options, and for women who willingly subjected themselves to its potential risks and adverse effects.20

Kennedy voiced his disapproval of the FDA’s conclusions, questioning the newly established guidelines requiring physicians to sign all Depo prescriptions and for pharmacists to send their records of Depo prescriptions to Upjohn so that these would be available to the FDA for future inspection. Kennedy believed it impossible to guarantee that these restrictions would be enforced. Health Research Group Director Sidney M. Wolfe called FDA’s regulations “mere verbage” and felt their actions were an insult to women, further entrenching a two-class system of drug prescribing “with poor people being those least likely to be informed by doctors of adverse effects of any medical treatment.”21

Wolfe also believed there was not enough conclusive evidence to indicate the drug did not cause cancer. Dr. J. A. Miller, a renowned cancer specialist, agreed and added that it would be highly probable that if cancer occurred in animal species, it also would occur in humans. Former FDA Commissioner Donald Kennedy stated that humans shared most basic biological mechanisms with other mammals and one of those mechanisms
happens to be susceptibility to cancer. Critics argued that beagle dogs were not a good specimen for the drug study because they metabolize substances in different ways than humans. Upjohn chose these animals, however, as an adequate species for their drug studies. It had been demonstrated that in the metabolizations of progestins, dogs were considered like humans.22

Less severe adverse reactions to Depo-Provera reported by women included sterility, irregular bleeding, decreased libido, depression, high blood pressure, excessive weight gain, breast tenderness, vaginal infections, hair loss, stomach pains, blurred vision, joint pain, growth of facial hair, acne, cramps, diarrhea, skin rash, tiredness and swelling of limbs. In addition, Depo-Provera use has been linked with birth defects, osteoporosis, diabetes and thrombosis. National Women's Health Network (NWHN), a non-profit advocacy organization in Washington, established a registry in 1979 encouraging women to share their experience with Depo-Provera use. Since 1979, more than 800 women responded to NWHN's registry, with ninety percent of that 800 stating that they had never been informed that the FDA had not approved Depo-Provera as a contraceptive. Approximately half of the women had received injections to either treat endometriosis or prevent miscarriage, while the other half took it as a form of birth control. Over half of the women complained of adverse side effects such as irregular bleeding, depression, weight gain, imbalance and decreased sex drive. 23

While Upjohn repeatedly applied to the FDA for Depo-Provera use as a contraceptive, each time the FDA cited inconclusive data in drug studies to indicate the drug's safety, and sometimes cited a new study linking it to a serious health problem, such as breast cancer in rhesus monkeys in a 1978 test. FDA denied approval of the drug as a means of birth control in 1974, 1978, 1984, and 1987. An FDA-appointed Federal Board of Inquiry found in its investigation that long term consequences of the use of
Depo-Provera with regards to osteoporosis and arteriosclerosis were also of particular concern due to the proclivity of women in the United States to those diseases. The Board did not feel that data on the human was adequate to confirm or refute whether Depo-Provera would increase women's risk of obtaining cancer. The 1987 Board of Inquiry had the same reservations and still maintained its limited use status. It was left up to physicians to use their knowledge of the guidelines to determine which women they could target for Depo-Provera use. The fact was, and still is, that once the FDA has approved a drug for whatever medical indication, a physician is able to prescribe that same drug for any other purpose he might see fit, such as for cessation of periods.24

Needless to say, given the laxity of restrictions and monitoring of physician prescription of Depo, rampant misuse of the drug occurred across the nation. Many mentally retarded women were given injections with no effort to try to explain to them the possible dangers of the drug. Parents and guardians received little knowledge of the nature of the drug and its experimental standing. The 1973 hearings did attempt to restrict the use of the drug and encouraged doctors to obtain informed consent from their patients. One group was never recognized as victims of indiscriminate drug misuse and abuse, however, until two reporters published a series of articles focusing on Depo-Provera as a contraceptive among the poor and minorities. That group was Native American women, including the mentally retarded. In 1986 and 1987, Mike Masterson's and Patricia Guthrie's revealing seven-part series of articles regarding the Indian Health Service (IHS) records of Indian women injected with Depo-Provera quickly led to a government oversight hearing in August, 1987.25

The investigative team from The Arizona Republic discovered that between 1976 and 1986, IHS physicians had injected profoundly retarded Indian women in Arizona, New Mexico, Utah, Nevada, Oklahoma, and southern California with Depo-Provera not only
for contraceptive use, but also for hygienic management. Masterson questioned Upjohn's spokesperson Jessyl Bradford concerning the use of Depo-Provera for sanitary purposes on Native American retarded women. She contended that Upjohn did not recommend Depo-Provera as a contraceptive, nor endorse its use on mentally retarded people. She also said that studies had never been conducted on the mentally handicapped to indicate the product's safety as a means of birth control.26

Nevertheless, the IHS prescribed the drug to approximately 150 to 200 Indian women between 1976 and 1986. In his opening statement at the 1987 oversight hearing, Sam Gejdenson, chairman of the subcommittee, expressed his concern that the very people who should be protected from uninformed consent were these mentally retarded women. This perhaps explained IHS's lack of any written requirements for informed consent. IHS doctors also injected women not considered mentally retarded but who were unable to use other forms of birth control. Gejdenson's intention was to understand why IHS facilities used Depo-Provera on Native American women without any restrictions, and denied them or their guardians full and informed consent.27

Masterson's detailed accounts of the six IHS facilities that dispensed the contraceptive revealed a widespread disregard for keeping track of the number of women who received shots. Doctors from the Phoenix Area, Navajo Nation Area, and Oklahoma City Area offices admitted to injecting approximately fifty women with Depo-Provera who ranged in ages from fifteen to fifty, but were unsure of exact numbers. Dr. Patrick Gideon, acting chief medical officer in the IHS Oklahoma City Area, saw no harm in injecting about a dozen mentally handicapped women with Depo, and he admitted administering it for hygenic reasons. He related to The Arizona Republic that he had heard stories about beagles developing cancer when given Depo-Provera shots, but he expressed his disbelief about the testing method and wondered why such stories persisted.
Gideon was apparently unaware of the 1973 legislation that established patient labeling requirements, including a warning to physicians about the potential carcinogenic link of Depo-Provera to certain animals. The legislation, in fact, issued a charge to doctors to make these facts known to patients.28

Other IHS physicians such as Dr. Douglas Peter, chief medical director for the Navajo Nation Area at Window Rock, Arizona, claimed to be providing thirty-two women on the reservation with Depo-Provera. Even mentally handicapped children at A School For Me, a Navajo facility in Tohtchi, New Mexico, were given injections over a two year period, again without any written consent form regarding the drug and its risks. Until 1985, only a general contraceptive-consent form was used by the IHS, which gave the physicians the authority to use whichever birth-control method they chose. In 1985, Cécilia Belone, executive director of A School For Me, and other concerned teachers voiced their concerns regarding the lack of information about the contraceptive. Consequently, new consent forms did contain information on some of the adverse reactions to the drug, and did mention the studies which indicated a risk of breast tumors in beagle dogs. However, Belone stated that none of the revised consent forms ever reached the children’s parents. After his further pursuing the IHS about this neglect, the students were taken off Depo-Provera injections.29

Further interviews with other IHS physicians indicated a confused and disorganized approach to the use of Depo-Provera. Dr. Alan Waxman, chief of obstetrics and gynecology at the Gallup Indian Medical Center, which handled approximately 150,000 Navajos, claimed that his hospital never used Depo to stop periods for the sake of hygiene. “It’s a hygienic indication, and we don’t use drugs for social or hygienic reasons,” he stated. Yet, in 1985, revised consent forms at the Gallup Indian Medical
Center, as well as Tohatchi Clinic doctors recommended Depo-Provera shots to help stop girls' monthly bleeding, and also to protect them from becoming pregnant.30

During the 1987 oversight hearing, testimonies that seemed to reflect IHS physicians' detached attitude regarding Depo-Provera came from Dr. N. Burton Attico, Director of Maternal Health and Family Planning. Like Gideon, Attico did not hesitate to state that he used the drug solely for hygienic reasons, and he considered it a "bonus" because it also rendered them temporarily infertile. Seemingly unaware of FDA's dictate of limited use for certain women, Attico claimed to have injected other women with the contraceptive because the IHS forbade the sterilization of mental patients. Doses higher than recommended were given, and with greater frequency, in order to stop menses. Instead of 150 milligrams every three months, the patient might initially receive 200 milligrams every two months, with reduction in quantity and frequency when complete cessation took place.31

Another concern for Native Americans taking experimental drugs was the fact that they were never part of a study pertinent to their race. Some studies had differentiated between black and white races, which led to some interesting conclusions. In 1974, FDA statistician Bertram Litt analyzed Upjohn's Depo-Provera safety data and discovered that cervical carcinoma-in-situ occurred at far greater rates than the Third National Cancer Survey had previously calculated. He also found more carcinoma-in-situ in whites than nonwhites. In fact, white women who took supplemental estrogen along with the injection showed 9.1 times more carcinoma, while blacks experienced 4.8 times more cases of cancer. This situation led Wolfe and other physicians to question the effect Depo-Provera might have on Native American women. Physicians and scientists previously had found through studies on Indian populations that they have a proclivity to certain diseases, such as diabetes. Lorelei DeCora, a nurse on the Pine Ridge Reservation, founded the
Porcupine Clinic to educate, as well as care for her people who had been stricken with diabetes. She still believes that Native Americans do not have the genetic background to handle foods rich in carbohydrates, fats, and white sugar, and that they need to return to the old ways of raising crops and preparing food. For example, the Pima Indians in Arizona have been part of a study for twenty-five years because of the unusually high incidence of diabetes which claimed the lives of 11.7 times the rate of the United States, in 1980.32

Norma Swenson, representative from the Boston Women’s Health Book Collective (BWHBC) and consultant for the World Health Organization (WHO), expressed similar concern for the health of Native Americans. As a consultant for WHO, Swenson focused on finding adequate reproductive health services for women throughout the world, and upon ways these services might be improved. She was in contact with women’s health advocates, as well as government officials at the BWHBC, regarding Depo-Provera. She had also spoken with representatives from Third World countries and industrialized English-speaking countries about the drug, and was involved in the FDA Board of Inquiry hearing about its effects. Swenson believed that there were too many unanswered scientific questions regarding the safety of its use and that it would be impossible to obtain ethical informed consent. In addition to other adverse reactions and links to disease with the use of Depo-Provera, Swenson was concerned about resulting depression, which could potentially lead to suicide. She also spotlighted the effect of the drug on the immune system and greater susceptibility to tuberculosis, AIDS and other diseases. Swenson, who is of partial Native American ancestry, advised that minority groups, like developing countries, already have severe health problems such as high rates of tuberculosis and liver disease. If Depo-Provera was considered risky for healthy white
women, than its unique impact on Native American women certainly warranted further study.33

Data from twelve IHS Administrative Areas submitted to the February 1987 hearing through Everett Rhoades, Assistant Surgeon General and Director of Indian Health Services, showed a vagueness about the numbers of women who took Depo-Provera in the past, and actual wrong accountings at some facilities of how many women were currently taking the shot, indicating no records were kept. The data also indicated a lack of consistency in consent forms and formal policies, if in fact, they were even used.(Appendix VII)34

For example, in the Aberdeen, South Dakota Area, some five to ten women were thought to have been given Depo-Provera for contraception in the late 1970s and early 1980s, but these women were not developmentally disabled. No reason was provided for their decision to take the shot. In Alaska, thirty to forty women had taken Depo-Provera and, in 1987, six to eight women were using Depo-Provera, although one might question the term “woman” since the ages of users, ranged from twelve to thirty-five. The Alaska Area Office did use a consent form, but no written policy existed. The Nashville, Tennessee Area had no current users but officials thought that perhaps five or fewer women had used Depo-Provera in the late 1970s. The largest distributor of the contraceptive drug was the Phoenix Area Office which reported that approximately eighty women had been injected between 1979 and 1981. In 1987, ten to twelve women were using Depo-Provera. The Phoenix Area Office had no formal written policy, but did require written informed consent35

The Navajo Area Office had thirty women, some developmentally disabled, on Depo-Provera from 1979 to 1981. In 1987, ten to twelve women used the drug. The Navajo Area was the only jurisdiction that had a formal written policy, but this might
appear suspect when one looks back on past records regarding the Navajo Area. On December 13, 1985, Deborah S. Hunt, Attorney for the Department of Justice, filed a memo concerning a phone call she had received from a physician at the Gallup-Lovelace Medical Clinic. A patient of his, who worked at A School for Me in Tohatchi, wanted him to know that several residents at the school were being injected with Depo-Provera. The physician knew that the drug was not approved by the FDA as a contraceptive and that it also was linked to uterine cancer in monkey and dogs. Upon inquiry, Hunt learned that nine residents were receiving quarterly shots at the Gallup Indian Medical Center. IHS physicians informed Hunt that Depo-Provera was safe, and they had been using it for some thirty years with parental consent. At this point Hunt called for a meeting with IHS representatives from the Navajo Area.36

Hunt met with IHS Director Mike Lincoln and Chief Medical Officer Dr. Doug Peter regarding the use of Depo-Provera by IHS physicians on Indian women. When questioned about how many women were currently on the shot, both agreed that a total of thirty-three women were taking it. Hunt noted that they both conceded that the current consent forms were inadequate, and not enough information was provided to guardians or parents to give authority for the injections. The two men would not discontinue the use of the drug on principle, but did agree that they would discontinue its use if the Navajo Tribe did not approve new consent forms within the next five months.37

A series of correspondence took place between Hunt and Peter in an effort to establish an informed consent form. Hunt’s main concern was that the guardians/parents of women should be adequately informed. She felt that Peter’s initial revised consent form required several changes as the forms’ content minimized or dismissed the seriousness of the potential dangers of Depo-Provera. She condemned Dr. Peter for the language by which he explained the benefits of taking the shot. She noted that Peter’s comments were
consistent with that of Chairman of the Subcommittee on Health and the Environment, Dr. Henry A. Waxman, who felt that Depo-Provera was the drug of choice for complete cessation of periods and that it was "necessary for psychological or hygienic reason." Hunt, however, felt that these ideas smacked of chemical sterilization and were not unlike illegal surgical sterilization.  

Hunt’s last letter to Peter on March 31, 1986, repeated past suggestions that the form should emphasize more emphatically the FDA’s non-approval of the drug, include a description of the risks when taking Depo-Provera, and mention the alternative methods of birth control. She informed Peter that she was leaving her current post, but that Britt E. Clapham would be replacing her and handling his case. Clapham reviewed another version of the consent form and found that Peter continued to ignore the suggestions made by Hunt. Clapham was uncertain whether the lack of inclusion of certain facts was intentional or an oversight. This was the last correspondence before the August 6, 1987 hearing.

This was not an unusual case. Many other IHS facilities had few or no guidelines for informed consent policies specific to Depo-Provera, and investigations since 1973 had proven that these guidelines were definitely needed for the women who received the shots and for the physicians who provided the services. Sybil Shainwald, representing the National Women’s Health Network (NWHN), presented several cases of women who had been given Depo-Provera at their physician’s recommendation and had suffered physically and emotionally. These women had either been given the shot with inadequate knowledge of their medical history, or physicians had not informed them of the risks involved.

Rhoades defended the IHS use of Depo-Provera based on its use by forty other countries, along with the endorsement of the WHO, ACOG, and the American Academy of Pediatrics. As Director of IHS, he justified his lack of monitoring and enforcement of
the FDA-restricted Depo-Provera by stating that he “entrusted to the conscience and character of its physicians the responsibility to make the most appropriate recommendation in this and other difficult matters.”

Problematic to the determination of women’s side effects when injected with Depo-Provera was the subjectivity of some of the reactions such as bleeding, depression and lack of sexual drive. How did a study quantify heavy bleeding, for example, one of the most common side effects. Various investigations into this area revealed significant discrepancies and some manipulation of the facts. Upjohn admitted one to two percent of women would have heavy bleeding on Depo. The debilitating effects that bleeding can have upon women’s lives has seldom been recognized in medical literature. However, a WHO study in 1978 reflected that women who discontinued use of Depo-Provera “positively correlated with bleeding episodes of eighty days or more.” A 1975 Nash and a 1978 Toppozada study also reported bleeding episodes of eleven to thirty days a month.

In seeming contradiction to Upjohn’s reported one to two percent bleeding statistic, a more recent 1994 Upjohn study indicated that one-third of all women who received one shot of Depo-Provera bled for more than ten days a month. The NWHN’s 1995 Depo-Provera Contraceptive Packet reported twelve percent of Depo-Provera users bled for more than ten days. In addition to the inconvenience of irregular and/or heavy bleeding, continuous bleeding could mask serious illnesses such as endometrial and cervical cancer, which occur among Native American women and other women of color with greater frequency than among whites. These and other diseases can be easily overlooked and they could potentially lead to later hysterectomies for some women.

Charon Asotoyer, Executive Director for the Native American Women’s Health Education Resource Center, explained the social and cultural consequences that erratic
and heavy menstrual cycles can have for the traditional Native American culture. These upheavals affect their participation in many traditional religious activities:

They do not attend Sundances, sweats, or other spiritual ceremonies or go any place where the pipe is used or to meetings of the Native American church. They also refrain from sexual activity. Ironically, the primary purpose of contraception . . . [for Native Americans] the ability to be sexually active without fear of pregnancy . . . then becomes a moot point.44

In view of these facts, it is apparent that the Native American culture needs protection from the technological power Depo-Provera has given certain groups such as the ACOG, WHO, and especially the IHS. The 1987 hearings once again resulted in new legislation with more explicit informed consent forms, a call for monitoring of physician use of the contraceptive, and restrictions on which groups of women could be injected. (Appendix VIII)

These issues, from coerced sterilization to uninformed contraceptive injections, have all revolved around the reproductive rights of the Native American women. Threats to their families' preservation through withdrawal of benefits, or by removal of their children, have placed them in tragic circumstances with few choices. Although Native American women did not find a national voice to represent them at the various hearings, they did find support in several regional and state ad hoc organizations. Groups such as Women of All Red Nations had sister organizations throughout the United States. Charon Asetoyer's NAWHERC continues to this day to keep a check on IHS facilities' use of Depo-Provera. Some of these institutions exist today, while others have faded away for lack of support.

This support was not limited to women. Lehman Brightman and Senator Abourezk stand out as examples of men who realized the devastating impact sterilization could have on the Indian population. In addition, Indian women benefited from the era in
which abuses were taking place. Reproductive rights were a major issue for the many feminist groups from the 1970s onward. Women such as Norma Swenson from the Boston Women’s Health Book Collective and Sybil Shainwald of the National Women’s Network represented Indian women before Senate Oversight Hearings and they had a major impact on the committee’s decisions.45

Increasingly, Native American women have become more aware of their individual rights, and they continue to struggle to protect them for the survival of their families and their culture. Swenson eloquently expressed Indian women’s needs at the 1987 hearing:

After all, most women take contraception in order to preserve their fertility for future use, not to end it altogether. In the case of Native Americans, these considerations have an even more powerful dimension. Native Americans are in constant danger of losing their population base altogether, due to poor health, economic conditions, and many other factors. They have every human right to know and to determine the risks of permanent infertility to their childbearing women and to future generations.46
NOTES

1 Mark Miller, Judith Miller and Chris Szecheny, "Native American Peoples on the Trial of Tears Once More," America (December 9, 1978), 422.


5 Krust and Asetoyer, A Study of the Use of Depo-Provera, preface.


10 Vecchio, "Birth Control by Injection," 31-32


20 “FDA’s Approval of Depo-Provera ‘An Insult to Women,’” 80: G2.


25 “Use of the Drug, Depo-Provera, by the Indian Health Service,” 100th Congress,
1st session, 1987, 1; "Suspect Drug Given Handicapped, Poor Despite Cancer Fear," 1,29.

26 "Suspect Drug Given Handicapped, Poor Despite Cancer Fear," 1.


28 "Suspect Drug Given Handicapped, Poor Despite Cancer Fear," 3.

29 "Suspect Drug Given Handicapped, Poor Despite Cancer Fear," 3.

30 "Suspect Drug Given Handicapped, Poor Despite Cancer Fear," 3.

31 "Suspect Drug Given Handicapped, Poor Despite Cancer Fear," 4.


33 "Use of the Drug, Depo-Provera, by the IHS," 121-122.


36 "Use of the Drug, Depo-Provera, by the IHS," 229-231.


38 "Use of the Drug, Depo-Provera, by the IHS," 113-114.


43 Ellen H. Chen and Charon Asetoyer, A Review of the Use and Effects of
Depo-Provera on Native American Women within Indian Health Service and Other Federal Agencies (Lake Andes, South Dakota: Native American Women’s Health Education Resource Center, 1995), 10-11.

44 Krust and Asetoyer, A Study of the Use of Depo-Provera, 10.

45 “Use of the Drug, Depo-Provera, by the IHS,” 126,159.

46 “Use of the Drug, Depo-Provera, by the IHS,” 132.
CHAPTER FOUR
NATIVE AMERICANS: A RISING ETHNIC FORCE

Indian people, whether residing on a reservation or not, are immersed in an environment which is in most respects antithetical to their traditions. Furthermore the cultural diversity among Indian tribes is unquestionably profound yet often not fully appreciated or adequately protected in our society. Our Constitution recognizes 'the distinct and unique cultural heritage of the American Indians and is committed in its educational goals to the preservation of their cultural integrity.' Preservation of Indian culture is undoubtedly threatened and thereby thwarted as the size of any tribal community dwindles. In addition to its artifacts, language and history, the members of a tribe are its culture. Absent the next generation, any culture is lost and necessarily relegated, at best, to anthropological examination and categorization.¹

The majority of men and women who exposed sterilization abuse of minority women in the 1970s sought solutions through federal legislation, such as monitored enforcement of informed consent forms and more explicit explanation of sterilization procedures. Feminist groups such as the Boston Women's Health Book Collective and the National Women's Health Network obtained results by appearing at congressional hearings, and they provided certain Native American groups with financial and political support. Native Americans, however, believed that they needed to address their own reproductive rights, to retain their own identity and to address the specific issues endemic to their culture. They also saw a connection between protecting their population growth as a way of protecting their land rights. Consequently, during the turbulent 1960s and 1970s, Native American women and men from different tribes throughout the nation
initiated their own method of preventing further loss of reproductive rights. Influenced by other activist groups within society, they assumed the title "Red Power," following a meeting of the National Congress of American Indians in Denver during 1967. Their goals were to demonstrate a committed and patriotic fight for their own self-determination and freedom from oppressors. "Red Power" activists took on slogans such "we shall overcome," and "Custer died for your sins." Pan-Indian movements arose across the country uniting tribes in a common purpose that continues today.²

Several powerful national and international organizations emerged in the 1970s, such as United Native Americans, Women of All Red Nations (W.A.R.N.), and the International Treaty Council (IITC), that launched campaigns against the Indian Health Service (IHS), and other government institutions. Marie Sanchez and Lehman Brightman represented those who believed that the United States sought possession and control over Indian land rich with natural resources. In order to prevent suspected federal plans to reduce the Indian population, Brightman, Sanchez, and many other Indian leaders, fought battles on several fronts. They also realized the need to prevent the further removal of their children to foster homes and to protect the reproductive rights of their people.³

In 1968, Lehman Brightman founded the United Native Americans, Inc., with the intention of joining people across tribal lines, promoting their general welfare, and establishing their legal rights of self-determination. Brightman, a militant activist who led numerous rallies, demonstrations and investigations during the 1970s, also expressed UNA's radical viewpoints through his newspaper Warpath. As early as 1971, he exposed the inadequate health standards at the Rosebud Hospital in South Dakota. Brightman, along with UNA members Jim Burnette and Louis World Wind Soldier, found the hospital dirty, over-crowded and understaffed. Air-conditioning was available for administrative offices, but the hospital wards, delivery rooms and the kitchen went without. Only two
dentists accommodated the entire reservation of approximately 8,000 people. Patients complained that physicians referred to them in derogatory terms and refused medical treatment after daylight hours. Brightman published his findings in a South Dakota newspaper with a circulation of only ten subscribers. As a consequence of that article, a $100,000 libel suit was filed against him and UNA Inc., Dr. David McGuire, a physician at the Rosebud IHS during Brightman's investigation, instigated the lawsuit in January 1973. Under libel law only one person was required to see an article before a libel suit could be filed. Brightman commented that he was unaware of a trial date because of his many travels away from home. By the time he learned of it, the South Dakota state court ruled against him for failure to appear at the hearing, and he had to pay $100,000 in damages.4

These challenges did not discourage the Contra Costa College instructor. When Brightman learned of the GAO report on IHS reservations, he became actively involved in exposing sterilization abuse, linking it to legislation before the Senate that would prevent Native Americans suing for the return of lands guaranteed them through treaties. To the majority of Native Americans these two issues appeared to have a common link. They realized that Native Americans owned only 3% of their original land base, yet owned over one-third of North American coal and almost 80% of North American uranium.5

Brightman spent the next several years conducting speaking tours on talk shows such as the Phil Donohue program, as well as press conferences, and letter writing campaigns throughout the world asking for political and financial support for Native American issues, including sterilization abuse. Correspondence contacts included President Jimmy Carter, Teng Hsia-Ping, Vice Premier of the Peoples Republic of China, and activist magazines such as Ms. and Mother Jones. Brightman was convinced that Indians should be in charge of their own destiny, but he admitted needing non-Indian support in order to succeed in
their goals. In 1978, he helped coordinate the “Longest Walk,” a three-thousand mile march from San Francisco that began on February 11, and ended at the Washington Monument on July 25. The sterilization of thousands of Native American women was one of the main reasons for the walk. On June 1, 1980, Brightman led another march, "The Long Walk for Survival: A Spiritual Walk for World Peace and the Preservation of Mother Earth," to Washington, D.C. Their arrival date was planned to coordinate with the eve of the National Elections on November 1, and the same issues were still the focus of the walk (Appendix IX).6

The American Indian Movement, another militant group founded in Minneapolis in 1968, also addressed Indian land rights and health concerns. In 1974, Russell Means, one of its leaders, appointed Jimmie Durham, of Cherokee ancestry, to establish the International Indian Treaty Council (IITC) to secure a United Nation II (Consultative) Non-Governmental Organization (NGO) status. IITC was first conceived at Standing Rock Reservation in June of 1974. At that momentous meeting, there were representatives from sixty Indian Nations and Peoples, including from the United States, Canada, and thirteen South American countries. Their goals were similar to other movements, with the exception that they intended to gain international attention and status for Native Nations. This included all indigenous "Redmen of the Western Hemisphere," and the group sought to initiate negotiations with the United States government through the State Department. Their biggest achievement came in 1977 when Jimmie Durham achieved NGO status for IITC. Theirs was the first indigenous entity in the world to acquire that status. Durham succeeded in scheduling a hearing on Native American rights through the United Nations Commission on Human Rights. The meeting, which took place in Geneva, Switzerland, on September 20-23, 1977, drew representatives from ninety-eight indigenous nations from North, Central, and South America. As a result of
these hearings, the UN created a Working Group on Indigenous Population in 1982, which produced a Universal Declaration on the Rights of Indigenous Peoples. 7

Marie Sanchez, an active member of the Northern Cheyenne resistance to corporate development of reservations and a representative for Native American women, organized a group of North American Indians from the IITC office in New York to attend that same UN conference in Geneva. She addressed the group regarding Native American women's sterilization, accusing multinational corporations for being indirectly responsible for this abuse by targeting 500 billion tons of coal on Indian land. She stated that in order for Native Americans to survive, they must gain back control of their lands, and she beseeched the conference to recognize North and South Americans as sovereign nations. “As a woman, I draw strength from the traditional spiritual people. . . . from my nation. The oil and gas companies are building a huge gas chamber for the Northern Cheyenne,” she said.8

This worldwide exposure led to investigations by the Special Committee Investigations of the Senate Select Committee on Indian Affairs, formed in 1987. Chaired by Senator Daniel Inouye, the committee responded to allegations of rampant mismanagement and corruption in the Bureau of Indian Affairs. Author Rebecca L. Robbins hoped that the committee’s “New Era of Agreements” would validate old treaties between the Indians and the government, and initiate return of all or substantial portions of land, along with the resources. Robbins hoped this would give Native Americans the necessary economic base to make self-government a reality.9

In that same year, the Arizona Republic published an eight-day series of articles disclosing federal Indian programs as rife with incompetence and deceit. In a six month investigation, three staff members uncovered government failures to prevent the thefts of an estimated billion dollars and "questionably cozy relationships between oil companies
and some public officials." Steven Moore, a Denver-based lawyer who represented Native Americans issues, explained that oil companies were expected to act in good faith and pay individuals an honest amount for the lease of their lands. The Bureau of Indian Affairs and two other Interior agencies were responsible for managing the federal oil and gas program that, since 1979, had allowed oil companies to pump millions of barrels of oil from Indian and federal land on an "honor system" that cost Indians and taxpayers an estimated $5.8 billion. *Arizona Republic* reporters learned that the BIA had approved contracts which allowed companies to mine coal on Indian lands at ridiculously low lease rates. According to a Federal Energy Administration report from 1975, "over 2.7 billion dollars of oil and gas; 187 million dollars of coal; 349 million dollars of uranium have been produced from Indian lands."11

In addition to the exposure achieved through Brightman's UNA and IITC, W.A.R.N., an influential and successful international Native American women's group, had a dramatic impact on Native American women. W.A.R.N. was established at Rapid City in September, 1978. Three of the founders, Lorelei DeCora Means, a Minneconjou Lakota, and Madonna Thunderhawk and Phyllis Young, Hunkpapa Lakota, had all been active members of AIM, but they felt that women needed to have their own separate voice.12 Women from over thirty native nations attended this historic occasion where they unanimously recognized that "truth and communication were among our most valuable tools in the liberation of our lands, people, and four-legged and winged relations."13 The most important issues they agreed to address included sterilization, deteriorating health care systems, the incarceration of Indian political leaders, education for survival, adoption and foster care abuse of their children, and the destruction and erosion of the native land base. The organization published its own newsletter, conducted conferences, and participated in speaking engagements at meetings such as the
International Year of the Child Native Conference and Cultural Festival, held in Seattle. They worked closely with IITC, at that time headquartered in New York, which assisted the organization in distributing WARN newsletters nationally and internationally.\textsuperscript{14}

DeCora Means and other W.A.R.N. activists, although appreciative of feminist groups and their support, wanted to be identified separately because of their own issues. DeCora Means believed in these feminist issues and recalled traveling to Boston to speak with the BWHBC about sterilization. She expressed gratitude toward that group for sharing their resources with W.A.R.N. through posters and financial support for the Rosebud Reservation. She credited the feminist movement with having the "political clout" to bring about federal regulations to protect women against further sterilization abuse. However, some Native American women were insulted when certain feminist members implied that Native American women needed to move beyond their culture, become liberated, and avoid "self-hatred as women." Oneida Tribal scholar Pam Colorado sensed a presumption among feminist writers that the acculturation of Native Americans should continue for their own good, regardless of the paternalistic mechanisms employed to achieve their goals. These judgmental attitudes caused many Indian women to realize that they needed to become "more Indian." If they needed support from outside groups, they felt it more appropriate to obtain support from other minority women who had experienced similar abuse and had their own ethnic ties.\textsuperscript{15}

In order to preserve their cultural identity, Native Americans realized that their children had to be taught the languages and traditions of their individual tribes. W.A.R.N. founders Phyllis Young and Madonna Thunderhawk were instrumental in providing Indian children with an alternative educational opportunity to BIA schooling. Launched in the 1970s, these autonomous Indian-taught schools called "Survival Schools" saved many children from the dreaded boarding schools and gave students an opportunity to be taught
by Native Americans who could also provide knowledge of their cultural heritage. By teaching about traditional ways, Indian educators hoped to bolster self-esteem and pride in their race, giving students strength and knowledge to become self-governed indigenous nations. Survival School supporters hoped this would motivate students to acquire a sense of ethnic identity and stability that might equip them with the tools to better address any future violation of Native American rights. In a report sent to the 1977 NGO conference, Clyde Bellecourt, a Chippewa father and Director of the Confederation of Survival Schools, testified that such schools were essential for Indians to maintain their own languages, cultures and values. These schools still exist today, are independent of BIA support or staff, and have greatly diminished the fear of boarding schools.16

It must be noted that federal regulation played a significant role in providing protection for children from another major threat - adoption agencies and foster care. In the 1970s, occurred a heightened awareness about Native American culture and concern over the mass displacement of their children to non-Indian foster and adoptive homes and institutions. To ensure the continuance of their race and the preservation of families, Senator James Abourezk sponsored the Indian Child Welfare Act. It took approximately four years of congressional hearings and investigations before President Jimmy Carter signed the bill in 1978. The congressional committee that introduced the bill stated its goals: 17

It is the policy of this Nation to protect the best interests of Indian children and to promote the stability and security of Indian tribes and families by the establishment of minimum Federal standards for the removal of Indian children from their families and the placement of such children in foster or adoptive homes which will reflect the unique values of Indian culture, and by providing for assistance to Indian tribes in the operation of child and family service programs.18
The act established that the extended family is the primary means by which Native Americans maintain their complex culture, and in order to preserve the family, minimum Federal standards for the removal of Indian children to foster or adoptive homes must be established. The Act also acknowledged that Indian tribes, as sovereign governments, should have a vital voice in any decisions made regarding removal of children from their families. The legislation gave back parental and some tribal authority in regards to the children's welfare. Although this legislation did abate physicians' and social workers' threats to remove Indian children if mothers did not agree to sterilization, there remained a powerful group that went unchallenged. The Mormon Church, which was excluded from the act, was allowed to adopt Indian children through its placement program. When Senator Abourezk was questioned why the church was exempted, he claimed that the Mormon law firm of Wilkinson and Barker, Mormon Congressman Gunn McKay, and the Mormon Deputy Commissioner of Indian Affairs, M. E. Seneca, lobbied for and won exemption from the regulations. American Indians feared the secretive nature of the Mormon placement program and the fact that no records were kept. Parents realized the "brainwashing" effect the religious sect had on youths during their formative years and the intent of Mormon leaders to then send them back to their families to recruit others. Instead, what often happened was a collision of the two cultures, resulting in the death of both. The true victims were the children who were left confused and misguided, alienated from their tribes, and often from mainstream society at the same time. When they returned to their families, they were treated as Indians, but they no longer knew how to respond as Indians.19

Despite some setbacks, Native American women generally feel more secure over their reproductive rights with regard to sterilization procedures. DeCora Means observed that on the Rosebud Reservation, it was a policy now to have Indian midwives or a nurse
advocate file reports on hysterectomies and from there a committee reviews these reports every three months. Census figures are encouraging, reflecting a steady rise in births from 27,542 in 1975 to 45,871 in 1988.20

Although Native Americans and other special interest groups believe they have succeeded in stopping overt sterilization abuse through closer monitoring and more uniform consent forms, suspected Depo-Provera abuse continues. Years of debate in government hearings, and investigations did not prevent the FDA from eventually approving the drug in 1992 as a contraceptive despite public health consumer advocate Sidney Wolfe's opposition to the drug. NWHN also continues to question the safety of Depo-Provera, and as recently as June 1994, Cindy Pearson, a representative of the women's health organization, testified at the FDA's Fertility and Maternal Health Drugs Advisory Committee regarding Depo-Provera's link to breast cancer in drug studies on women. NWHN considered it a "questionable drug contained within a problematic delivery system."21 Another organization that has persistently and publicly attacked the use of Depo-Provera since 1993 is the Native American Women's Health Education Resource Center (NAWHERC), located in Lake Andes, South Dakota. Director of NAWHERC, Charon Asetoyer, believes that IHS physicians still do not administer Depo-Provera responsibly to Native American women. Due to the years of controversy over its safety, Asetoyer believes it necessary to establish a registry of all women who use the drug in order to keep track of its potential problems. Given the history of IHS abuses of its patients, Asetoyer believes it is in the best interest for the physicians, as well as the patients, to have some method of control via accountability to protect both parties from future problems.22
Asetoyer's surveillance of Depo-Provera use in the Native American communities became even more intense after recent testimonies from women who had taken the drug. She uncovered serious problems through personal interviews such as:

(1) The targeting of adolescents.
(2) Directed, subtle coercive counseling.
(3) The lack of information given about the drug and its health effects before injection (informed consent).
(4) Inadequate screening before injection; the distribution of the drug to women who are contraindicated or precautioned against it.
(5) The seriousness and frequency of experienced side effects and health problems.
(6) Insufficient and unsatisfactory treatment and provider response to health problems caused by Depo-Provera.23

Asetoyer continues to fight for a uniform protocol regarding Depo-Provera, and has grave concern over its distribution within a federal agency. She feels that physicians often are contracted into the IHS facilities and have little knowledge or regard for policy. Another deep concern involves follow-up care of patients who have been injected. With many Native Americans scattered throughout rural areas, it is difficult, often impossible, to realize any problems with the shots. The IHS hospital at Wagner, South Dakota is just one example of resident accessibility to health care facilities with a size equal to one-half of the state of New Jersey. Without quality care, Asetoyer worries about the potential negative impact of Depo-Provera on Native American women's health in general, and specifically on their reproductive health.24

Native Americans generally believe they have ample reason to fear for the extermination of their people through the perceived carelessness of health care and/or government officials. They feel that their unique relationship with the government lends itself to neglect and lack of quality health care, in addition to greed over their land. As a result of these fears, Native Americans have struggled and been motivated to gain recognition as a sovereign nation through organizations such as IITC. Its current director,
Andrea Carmen, continues to actively work on international policies "protecting human rights, biological diversity, self-determination and traditional cultures." Invited to address the UN at its "Earth Summit II" in June, 1997, Carmen spoke on globalization and the commodification of life under international trade and patenting laws.\textsuperscript{25} W.A.R.N. founder Lorelei DeCora continues to work on the Rosebud Reservation in South Dakota as a health care advisor, encouraging people to return to traditional foods and food preparation. Asetoyer hopes that through her NAWHERC investigations health care systems will realize the need to improve the quality of care for their economically devastated population. All of these women are having a dramatic impact on their people.

In this context Native Americans have survived and continue to challenge the institutions with which they must co-exist, especially the IHS and the BIA. It remains to be seen what the future holds for Native Americans. Certainly they have gained greater unity and political stature as a result of IITC and W.A.R.N. Self-awareness as a culture has grown and the desire for education and preservation of traditions is evident through their survival schools and efforts to achieve national and international recognition of sovereignty.

However, the reality is that Native Americans are a small minority of the nation's population and they will always struggle to have a voice and to be recognized as the First People. The impact of Native American efforts not merely to exist but to thrive and multiply as an indigenous and sovereign people remains to be seen. W.A.R.N.'s The Cheyenne Nation has an old saying in which they believe: "A nation is not conquered until the hearts of its women are on the ground. Then, it is done, no matter how brave its warriors nor strong its weapons."\textsuperscript{25}
NOTES


5 W. A. R. N., from the files of the IITC at San Francisco, Calif., in the possession of the author, 11-12.


11 IITC, "A Question of Genocide," from the Native American Studies Center,
University of New Mexico, Albuquerque, 16.


13 "Who Are These Women?" 4.


20 Interview with Lorelei DeCora Means, July 1997; Marlita A. Reddy, edit., *Statistical Record of Native Americans* (Detroit: Gale Publishers), 663.


22 Krust and Asetoyer, “A Study of the Use of Depo-Provera and Norplant by the Indian Health Services,” 22-23.


<table>
<thead>
<tr>
<th></th>
<th>Oklahoma</th>
<th>Oregon</th>
<th>Pennsylvania</th>
<th>South Carolina</th>
<th>South Dakota</th>
<th>Tennessee</th>
<th>Texas</th>
<th>Utah</th>
<th>Virginia</th>
<th>Washington</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

**APPENDIX I**

<table>
<thead>
<tr>
<th></th>
<th>Oklahoma</th>
<th>Oregon</th>
<th>Pennsylvania</th>
<th>South Carolina</th>
<th>South Dakota</th>
<th>Tennessee</th>
<th>Texas</th>
<th>Utah</th>
<th>Virginia</th>
<th>Washington</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

**Complusory Sterilization Statutes**

<table>
<thead>
<tr>
<th></th>
<th>Oklahoma</th>
<th>Oregon</th>
<th>Pennsylvania</th>
<th>South Carolina</th>
<th>South Dakota</th>
<th>Tennessee</th>
<th>Texas</th>
<th>Utah</th>
<th>Virginia</th>
<th>Washington</th>
<th>Wisconsin</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td></td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>

**Individials Affected**

<table>
<thead>
<tr>
<th>Michigan</th>
<th>Maine</th>
<th>Iowa</th>
<th>Indiana</th>
<th>Idaho</th>
<th>Georgia</th>
<th>Delaware</th>
<th>Connecticut</th>
<th>California</th>
<th>Arizona</th>
<th>Alaska</th>
</tr>
</thead>
<tbody>
<tr>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
<tr>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
<td>x</td>
</tr>
</tbody>
</table>
Figure 2. As can be seen from the data, the Fertility Rate of the U.S. fell below the 2.1 replacement level -- the so-called zero population growth level -- in 1972, and has remained below 2.1 since then. The U.S. Bureau of the Census did not start to collect Fertility Rate data until 1920. Note how both the desire for smaller families and the cautionary effects of the Great Depression combined to push the fertility rate toward the 2.1 mark by 1935. Delayed family starts after World War II and Korean War caused sharp rise between 1945 and 1957, which was followed by the even sharper drop in the two decades that followed.
APPENDIX III

Memo to Karl/Percy/Phil from Patty Marks/Abourezk Office

To: Karl, Percy, Phil
From: Patty MARKS/ABOUREZK'S OFFICE
Regarding: Background information on Indian sterilization

Investigation into Indian sterilization was begun back in 1975 when Joan Adams, then an intern on Abourezk's office staff first started receiving calls from an Indian M.D., Dr. Connie Uri, then stationed with I.H.S. in Oklahoma, and from Charlie McCarthy, then an I.H.S. employee in Albuquerque. These callers stated that I.H.S. physicians were performing sterilization operations on Indian women. After doing intense investigation into the complaints, Ms. Adams came to the conclusion that at least some of the complaints were well founded. (i.e., she had talked to tribal leaders, Indian women's groups, and examined I.H.S. records).

Ms. Adams then called for a G.A.O. report in April of 1975, requesting that the G.A.O. investigate both Indian sterilization and experimental use of drugs on reservations. A study by the Children's Defense League had just reported some serious concerns in this area.

The G.A.O. report was received some 10 months later on Nov. 4, 1976. The report stated that 3,406 Indian persons had been sterilized in I.H.S. facilities located in I.H.S. service unit areas. G.A.O. reported that in all instances some form of consent documentation was available but that in the majority of cases these consent forms did not adequately satisfy the federal requirements of "informed consent." 1. Some 13 minors under the age of 21 were sterilized despite a moratorium on the sterilization of persons under 21 years of age. 2. Consent forms used did not indicate that consent had been orally explained or contain summary of the oral consultation process. 3. Did not indicate that the patient had been informed.

that he or she could withdraw their consent at any time.

While G.A.O. did not interview patients to determine whether or not they had been adequately informed before consenting to the procedure, it did find the above discrepancies from the legally required procedure, and these discrepancies did match closely with the reports which we had been receiving from Dr. Uri and other constituents.

After reviewing the information and having numerous conversations with Indian health planners and constituents, my personal opinions are as follows:

1. Problems clearly exist within the I.H.S. sterilization programs.
   These problems can be attributed to a number of factors:
   a. inadequate translators in I.H.S. offices
   b. Lack of preparation and training (cultural sensitivity) of I.H.S. doctors
      Dr. have middle class attitude towards family planning
      i.e. they believe in the 2 children family and they are
      in favor of sterilization as a safe effective method of
      birth control. Many feel that families which can not
      adequately support children should not have children.
      They also have a tendency to be opposed to unwed Indian women
      having children and raising them. Therefore reports have
      stated that they tend to encourage sterilization procedures
      immediately after delivery on many of the about types
      of patients.

2. It is my feeling that "sterilization does not have to be planned genocide
   in order to have the impact of genocide on certain Indian reservations". Inadequate counseling and poorly trained physicians who exert pressure on individuals to act in the way they feel is best can result in the same conclusion.
   i.e. a large number of sterilized Indian women who do not have a real concept
   of what has happen to them and who have, because of the fear of losing federal
numerous consent forms are signed during labor or immediately after delivery; that are the reality of the situation. I know someone who went into the hospital to have a baby and came out sterilized."

In early March 1978 the Department of H.E.W. proposed new regulations which would greatly improve the sterilization procedure. These regulations included such requirements as increased waiting periods, required translation of consent. They are weak in three areas:

1. They did not appear to provide any monitoring or enforcement provisions. Note- most of the preventive regulations were on the books, but I.H.S. offices still performed sterilization procedures without adequate consent.

2. The regulations do not provide for counseling sessions as a mandatory requirement.

3. The regulations do not explicitly provide for contract care compliance with the regs.

New regulations are expected to be printed in final in early fall. H.E.W. is reluctant to give us an exact date at this time. The C.A.S. is presently preparing an analysis of the proposed changes suggested in comments on the regs and that will be completed by August 25th.

Phil wrote a letter to Dorey Johnson asking for figures of sterilization procedures performed since the release of the G.A.O. report. (A copy is attached). The figures show that sterilization of minors has continued and that I.H.S. sterilization figures have remained somewhat constant.

One factor which I feel it is important to be aware of is the fact that in responding to the G.A.O. report I.H.S. consistently pointed to the H.E.W. regs which prohibited sterilizations without counseling, waiting periods and other informed consent. They fail to admit to inadequate monitoring of area office
activities and refuse to acknowledge the fact that inadequate counseling may possibly exist. I strongly feel that without adequate monitoring it matters very little what is printed in the regs. Those personnel who are concerned with adequate consent will provide it and those personnel who are not will not make the effort or take the time. I.H.S. must be forced to once again take responsibility for the actions of all of their staff and to closely review and monitor all activities and investigate immediately all accusations of wrong doing.

Leman Brigham, an Indian professor in California has been accumulating files on actual cases of illegal sterilizations. He has also been able to obtain funding and will be traveling beginning in the middle of Aug to obtain more information on specific cases of sterilization abuse. He will be forwarding us a copy of his files and we should have that material available to us within two weeks. At this time this will be, if it is accurate, the first first hand documentation of specific instances of sterilization abuse.
Social and Rehabilitation Service

MEDICAL ASSISTANCE PROGRAMS

Sterilization Procedures

Notice is hereby given that the regulation set forth in tentative form below is proposed by the Administrator, Social and Rehabilitation Service, with the approval of the Secretary of Health, Education, and Welfare. The proposed regulation will implement the guidelines approved by the Secretary and published in the Federal Register on August 3, 1973 regarding procedures to be followed in safeguarding individual rights in cases of sterilization under title XIX of the Social Security Act.

The provisions of 45 CFR 249.10(a)(11) and 45 CFR 249.10(c)(2) setting forth requirements which must be met in order for a state plan to meet conformity criteria and for federal financial participation to be available in expenditures for sterilization, will be made applicable to services under Titles IVA and VI of the Social Security Act and included in the social services regulations when those regulations are published.

Prior to adoption of the proposed regulations, consideration will be given to any comments, suggestions, or objections thereto which are submitted in writing to the Administrator, Social and Rehabilitation Service, Department of Health, Education, and Welfare, 330 Independence Avenue SW., Washington, D.C. 20201, on or before October 23, 1973. Comments received will be available for public inspection in Room 5224 of the Department's offices at 301 C Street SW., Washington, D.C., on Monday through Friday of each week from 8:30 a.m. to 5 p.m. (area code 202-962-4451).

(Sec. 1102, 49 Stat. 647 (42 U.S.C. 1302).)

(Catalog of Federal Domestic Assistance Program No. 13.714, Medical Assistance Program.)


JAMES S. D'WIGHT, JR., Administrator, Social and Rehabilitation Service.

Approved September 17, 1973.

CASPER W. WEINBERGER,
Secretary.

Section 249.10, Part 249, Chapter II, Title 45 of the Code of Federal Regulations is amended to add subparagraphs (a)(11) and (c)(2) as follows:

§ 249.10 Amount, duration and scope of medical assistance.

(a) State plan requirements. A State plan for medical assistance under title XIX of the Social Security Act must:

(11) provide that (i) any non-emergency procedure which will have the effect of rendering an individual permanently incapable of reproducing is supported by evidence that the recipient or some other legally authorized individual acting on the recipient's behalf voluntarily consents in writing to the performance of such procedure and (ii) any procedure or operation the primary purpose of which is to render an individual permanently incapable of reproducing and which is not a necessary part of the treatment of an illness or injury;

(a) In the case of any recipient who is under age 21 or legally incapable of giving informed consent has been reviewed and approved by a committee designated by the State agency,

(b) In the case of any recipient who is legally incapable of giving informed consent, has been determined by a court of competent jurisdiction to be in the individual's best interest.

The committee referred to in paragraph (a) (11) (ii) (a) of this section shall be composed of no less than five members competent to deal with the medical, legal, social and ethical issues involved in sterilization and shall include at least one member of the population served by the agency. The committee shall have both male and female members. No member shall otherwise be an officer, employee or other representative of the State agency or its local subdivision, or of the institution, agency or physician providing the proposed sterilization. The duties of the committee shall be to review medical, social, and psychological information concerning the recipient, the feasibility of utilizing alternative family planning methods, and the adequacy of consent; to interview or otherwise consult with individuals who in its judgment will contribute relevant information; to determine whether the proposed sterilization procedure is in the best interest of the recipient; and to record its findings and determinations, collect supporting documentation, and transmit these records to the agency.

(c) Limitations

(2) Federal financial participation is not available in expenditures for procedures for sterilization unless the requirements in paragraph (a) (11) of this section have been met.

[FR Doc. 73-20128 Filed 9-20-73; 8:45 am]
<table>
<thead>
<tr>
<th>GEN</th>
<th>179</th>
<th>1799</th>
</tr>
</thead>
<tbody>
<tr>
<td>S/C</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Claremore Indian Hospital Daily Surgical Schedule

August 21-24, 1978

Claremore Hospital Surgical Schedule, September 2, 1978
<table>
<thead>
<tr>
<th>Date</th>
<th>gen</th>
<th>s/c</th>
<th>T.P.</th>
<th>Lawes, G.</th>
<th>37905</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>s/c</td>
<td>T.P.</td>
<td>Lamp, Tubal</td>
<td>57726</td>
<td></td>
</tr>
<tr>
<td></td>
<td>gen</td>
<td></td>
<td></td>
<td>13610</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>12626</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td>22871</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Date</th>
<th>gen</th>
<th></th>
<th>s/c</th>
<th>T.P.</th>
<th>Lawes, G.</th>
<th>37905</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>gen</td>
<td></td>
<td>s/c</td>
<td>Lamp, Tubal</td>
<td>57726</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>gen</td>
<td></td>
<td>13610</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>gen</td>
<td></td>
<td>12626</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>gen</td>
<td></td>
<td>22871</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>gen</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>gen</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Major Health Facilities for Indians 1984

LEGEND

- IHS Headquarters, Rockville, Maryland
- IHS Area Offices
- IHS Program Offices
- IHS Operated Hospitals
- Tribally Operated Hospitals
- IHS Operated Health Centers
- Tribally Operated Health Centers
- School Health Centers
- Urban Indian Health Program Facilities
- California Rural Tribal Health Programs

Lesions have been keyed with numbers.

### Major Health Facilities for Indians and Alaska Natives

#### U.S. Areas of Operations

<table>
<thead>
<tr>
<th>Area</th>
<th>Facilities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Delaware</strong></td>
<td>Hospitals: Wilmington. Health Centers: Wilmington.</td>
</tr>
<tr>
<td><strong>Florida</strong></td>
<td>Hospitals: Miami, Jacksonville. Health Centers: Miami, Jacksonville.</td>
</tr>
<tr>
<td><strong>Iowa</strong></td>
<td>Hospitals: Des Moines, Cedar Rapids. Health Centers: Des Moines, Cedar Rapids.</td>
</tr>
<tr>
<td><strong>Kentucky</strong></td>
<td>Hospitals: Louisville. Health Centers: Louisville.</td>
</tr>
<tr>
<td><strong>Michigan</strong></td>
<td>Hospitals: Detroit, Ann Arbor. Health Centers: Detroit, Ann Arbor.</td>
</tr>
<tr>
<td><strong>Mississippi</strong></td>
<td>Hospitals: Jackson. Health Centers: Jackson.</td>
</tr>
<tr>
<td><strong>Missouri</strong></td>
<td>Hospitals: St. Louis, Kansas City. Health Centers: St. Louis, Kansas City.</td>
</tr>
<tr>
<td><strong>Montana</strong></td>
<td>Hospitals: Billings, Great Falls. Health Centers: Billings, Great Falls.</td>
</tr>
<tr>
<td><strong>Nebraska</strong></td>
<td>Hospitals: Omaha, Lincoln. Health Centers: Omaha, Lincoln.</td>
</tr>
<tr>
<td><strong>New Jersey</strong></td>
<td>Hospitals: Newark, Trenton. Health Centers: Newark, Trenton.</td>
</tr>
<tr>
<td><strong>New Mexico</strong></td>
<td>Hospitals: Albuquerque, Santa Fe. Health Centers: Albuquerque, Santa Fe.</td>
</tr>
<tr>
<td><strong>Ohio</strong></td>
<td>Hospitals: Columbus, Cleveland. Health Centers: Columbus, Cleveland.</td>
</tr>
<tr>
<td><strong>Oklahoma</strong></td>
<td>Hospitals: Oklahoma City, Tulsa. Health Centers: Oklahoma City, Tulsa.</td>
</tr>
<tr>
<td><strong>South Carolina</strong></td>
<td>Hospitals: Columbia. Health Centers: Columbia.</td>
</tr>
<tr>
<td><strong>South Dakota</strong></td>
<td>Hospitals: Sioux Falls, Rapid City. Health Centers: Sioux Falls, Rapid City.</td>
</tr>
<tr>
<td><strong>Texas</strong></td>
<td>Hospitals: Houston, Dallas. Health Centers: Houston, Dallas.</td>
</tr>
<tr>
<td><strong>Utah</strong></td>
<td>Hospitals: Salt Lake City. Health Centers: Salt Lake City.</td>
</tr>
<tr>
<td><strong>Virginia</strong></td>
<td>Hospitals: Richmond. Health Centers: Richmond.</td>
</tr>
<tr>
<td><strong>West Virginia</strong></td>
<td>Hospitals: Charleston. Health Centers: Charleston.</td>
</tr>
</tbody>
</table>

*Note: Tribal Health Centers are indicated with "TRIBAL TRIBAL WORK PROGRAMS."*

---

**School Health Centers**

### School Health Centers

<table>
<thead>
<tr>
<th>Area</th>
<th>Facilities</th>
</tr>
</thead>
</table>

*Note: Tribal Health Centers are indicated with "TRIBAL TRIBAL WORK PROGRAMS."*
APPENDIX VII

Baltimore City Hospital Consent Forms

Baltimore City Hospitals
Baltimore - 21224 MD.

PERMISSION FOR STERILIZATION

We, the undersigned, hereby request and authorize the surgeons of the Baltimore City Hospitals to sterilize

by operation. We fully realize that in all probability

she will never bear children in the future. We consider that this operation will be for her best interest

and well being. The patient has come to the hospital voluntarily and is voluntarily submitting to this

operation.

This paper has been read to us ( ); we have read this paper ( ); and we fully understand what it

means. We are signing of our own free will.

Witness

Patient

Witness

Husband

(If husband is not available, responsible member of patient's family or legal guardian may sign)

Reason for

Approved:

M.D.

M.D.

Bernard Rosenfeld et. al. "Present Abuses and Proposed Regulations," Public Citizen
DEPARTMENT OF RADIOLOGY  
BALTIMORE CITY HOSPITALS  

CONSENT FOR INTRAVENOUS PYELOGRAM  
(Excretory Urogram)

Dear Patient:

Your doctor has referred you for an intravenous pyelogram (or excretory urogram) which is a study of your kidneys. This is one of the more accurate studies we can make concerning the condition of your kidneys. As with any medical procedure, it carries some risks, about which we think you should be informed.

In this procedure, a needle is introduced into one of your blood vessels. This needle is usually placed in your arm. Through this needle, a solution will be injected which is excreted by your kidneys and this will enable us to see your kidneys, ureters and bladder on X-rays.

Patients, understandably, wonder what complications can occur from this procedure. It involves the injection of a solution into your bloodstream. The usual side effects which we would consider relatively minor, but nevertheless can be distressing to patients, are a metallic taste in the mouth, nausea and a warm flush. Sometimes, a patient may have hives or itching. There are less frequent complications which we consider more serious, such as asthmatic attack, convulsions or shock.

Very rarely, complications from the procedure have resulted in death. It has been estimated that this occurs once in every hundred thousand examinations. Less serious reactions are more frequent.

It would be impractical, and probably misleading to the average person, to describe in detail all the complications which might possibly result from this procedure. Your doctor is aware of these risks and has determined that the benefit obtained in diagnostic information from the pyelogram far outweighs the potential risk of the procedure.

If you would like more detailed information, or if you do not understand this form, we will be glad to discuss it with you.

Sincerely yours,

CONSENT FOR INTRAVENOUS PYELOGRAM

I, ____________________________________, have read the above and give my consent to have an intravenous pyelogram.

(Name of Patient)

__________________________
Witness

__________________________
Signature of patient

__________________________
Date

I, ____________________________________, have read the above and give my consent to have an intravenous pyelogram performed on ____________________________________.

(Parent/Guardian)

__________________________
Witness

__________________________
Signature (Parent/Guardian)

__________________________
Date

This form should be completed by patient’s physician or hospital staff at the time the procedure is scheduled with the Radiology Department. The form should accompany patient to the Radiology Department.
STERILIZATION FOR WOMEN

Q. What does the doctor do?
A. He makes a small incision in the abdomen and ties and cuts tiny tubes through which the ovum (egg) passes each month. This blocks passage of the eggs. Thus, the woman's egg and the man's sperm can’t meet and there can be no pregnancy.

Q. What happens to the egg?
A. The tiny ovum*, too small to see with the naked eye, is harmlessly absorbed in the body—the same process that happens every month when there’s no pregnancy.

Q. How do doctors rate this operation?
A. As effective as vasectomy but more complicated to perform. Although it is both common and safe, tubal ligation usually requires a few days' stay in the hospital. A new method, laparoscopy tubal ligation, has been introduced in some sections of the country. This procedure requires only a few hours in the hospital and is less expensive.

Q. Does the operation hurt?
A. No. The doctor uses a painkiller (anesthetic). But there is a little abdominal soreness for a few days.

Q. Will it interfere with sexual interest and enjoyment?
A. No. Women can’t detect any difference from before the operation. Actually, they often find sex is more pleasant because there is no reason to worry about becoming pregnant.

Q. Will menstrual periods still continue?
A. Yes, as before. The ovaries and womb are unchanged by the operation. The ovary continues to release an egg each month. Tying the tubes merely prevents the egg from moving along to the womb. Neither periods nor the age when menopause starts (change of life) is affected.

Q. Could the operation make a woman less womanly?
A. Not at all. Feminine attractiveness continues as before. Hormones determine femininity and the body’s production of female hormones is not interrupted by tying and cutting the tubes.

Q. Is there a preferred time for sterilization?
A. Yes, whenever the husband and wife are certain they don’t want any more children. Doctors often do this operation on request, right after a woman has had a baby. The doctor waits an hour or perhaps a day after delivery, then ties and cuts the tubes. This makes it unnecessary for the mother to return for surgery later and it may not add to her hospital stay. Of course, tube tying can be done safely and easily at other times as well.

Q. How soon after the operation may the woman have sex?
A. She should check with her doctor on this. Circumstances vary and medical advice may vary too.

Q. Will there be any reason to use contraceptives for a time after sterilization?
A. No.

Q. Who is eligible for sterilization?
A. Not too long ago, doctors would recommend tubal ligation mainly when there were medical reasons to avoid pregnancy. Now the operation is often recommended to healthy women when they are certain they do not want additional children.

Q. How is the operation arranged?
A. Seek out an experienced doctor. If you need a referral, the Planned Parenthood Affiliate in your area will have a list of doctors, clinics or hospitals offering this service. Local hospitals (Gynecological Service) or the public health department can also help.

Q. What about the cost?
A. On a private basis, fees vary from doctor to doctor. So it is difficult even to indicate a range of costs. It would be wise to ask about the doctor’s bill and hospital charges during your first visit. If your medical costs are normally covered by Medicaid or private health insurance companies, all or part of sterilization charges may be covered the same way. Check locally to find out. If Welfare pays your medical bills, it may also pay for sterilization.

STERILIZATION FOR MEN

Q. What is vasectomy?
A. A minor, 15-30 minute operation under local anesthesia in the doctor's office, clinic or hospital.

Q. What does the doctor do?
A. He closes the tiny narrow tubes through which the sperm (male seeds) travel. This tube, the vas deferens, gives the operation its name.

Q. How does closing the tubes prevent pregnancy?
A. Sperm have to travel through the tubes to enter the semen (the fluid in the man's sexual discharge). Blocking the tubes prevents the sperm from reaching the semen. Because it lacks seeds, his discharge cannot cause pregnancy.

Q. Does the operation affect his sex organs?
A. No. Neither the penis nor the testicles are affected. Semen and male hormones are produced as usual.

Q. What happens to sex enjoyment?
A. Sex continues as enjoyable as ever. Since the fear of unwanted, accidental pregnancy is removed, many find sterilization actually adds sexual pleasure.

Q. Does sterilization interfere with a man's ability to reach a climax?
A. No. There is no change.

Q. Does the operation hurt?
A. With local anesthesia, there is no pain.

Q. After sterilization, when a man "comes" does he have a "dry run"?
A. No. He still produces his fluid. The only change is that it does not contain any sperm.

Q. Suppose the couple wants children after all. Can the vasectomy be undone?
A. Some success has been recorded in reconnecting the tubes surgically. But no one should count on reversing the operation. Couples should use sterilization only when they are certain they want no more children.

Q. How soon after can the couple have sex?
A. As soon as they wish.

Q. Is there any risk of pregnancy after vasectomy?
A. Yes, in the beginning. It takes a little while to be sure there are no sperm remaining in the man's semen from before the operation. Be sure to continue using your preferred contraceptive until your doctor tells you they are no longer needed.

Q. Do many people use this method?
A. About two million men now living in the U.S. have had vasectomies. The American Medical Association says: "voluntary sterilization of a man is safe, quick, effective and legal...sexual potency is unaffected."

Q. What do the laws say?
A. Sterilization is legal in all 50 states. In Connecticut and Utah, its use is limited to reasons of "medical necessity." (Connecticut's restriction has been repealed, effective October 1971.)

Q. Are there any special requirements?
A. Doctors feel that both husband and wife should be mature emotionally, sure that they don't want any more children and have a good understanding of the operation. Doctors will expect husband and wife to give written consent, although the consent of the wife is not legally necessary.

Q. How is a vasectomy arranged?
A. Seek out an experienced doctor. If you need a referral, the Planned Parenthood Affiliate in your area will have a list offering this service. Check the telephone book to find Planned Parenthood. Your local hospital (Urology Department) and your local public health department also can help.

Q. What does a vasectomy cost?
A. On a private basis, the cost of everything (interview, operation and sperm counts) probably will be about $150. Of course, fees vary from doctor to doctor and are subject also to adjustment depending on income. Part or all of vasectomy costs may be covered by Medicaid and private health insurance companies. Check locally to find out. In many communities, if Welfare pays your medical costs, it also will pay for a vasectomy.
INFORMED CONSENT FOR SURGICAL STERILIZATION
FOR WOMEN AND MEN

(Should be handed out at least 30 days before planned date of sterilization procedure).

INFORMED CONSENT FOR SURGICAL STERILIZATION
FOR WOMEN AND MEN

It is important that you carefully read and consider the following information. If a family feels quite sure they desire no more children they have four options.

1. Surgical sterilization, either male or female.


3. Disciplined use of the pill.

4. Moderately effective contraception like the diaphragm and/or foam combined with abortion for contraceptive failure.

It is felt that an individual family (or man or woman) can best decide for themselves which of these methods they will be happiest with now and in the future only after they carefully consider the advantages and disadvantages of each. It is the purpose of the booklet to supply accurate information about each method so a family can make an informed decision about which method would be best for them.

This booklet will take some time and work to go through. However, the decision to be sterilized is a very serious and important decision in your life and you should do it only after carefully considering and understanding the advantages and disadvantages of other methods of birth control that are now available. It is your decision and only you can try to assure it will be a good one by spending the time it will take to carefully go through this booklet and carefully thinking about the information in this booklet.

What Are the Minimum Things a Man or Woman Should Consider Before Undergoing Sterilization?

All sterilization operations are considered permanent, non-reversible. If another child is desired by the family later, the chances of getting the operation successfully reversed are very small (less than 1 out of 10), costly (at least $2,000), and a major operation requiring usually a week's hospital stay. Because the operation is so final it is important that those under 30 and especially those under 25, because in the past this group has been more likely to regret the operation, carefully consider such things as:

1. The possibility of divorce and remarriage. In the United States approximately 1 in 3 marriages end in divorce with the vast majority of these people remarrying.

2. For families with only a couple of children it is important that they consider the small chance of an existing child dying. The most dangerous time in a child's life is from birth to one year. Today, with legalized abortion and good contraception available, very few newborn children are placed for adoption; and, since almost 1 in 10 families cannot have their own children, it is almost impossible for a family that already has a child to adopt a baby.

3. The likelihood of changing your mind in the future. You should carefully consider, is sterilization being chosen because of stress, either financial or emotional, that may not exist in the future? If you are young, it is important to try to think how you might feel in 5 to 10 years.
The Advantages and Disadvantages of Male and Female Sterilization Operations.

There are no physical consequences of a sterilization operation that will alter a man's or a woman's nature, sex drive, or feelings. There are two major advantages of a sterilization operation:

1. It is a one-step procedure in which afterwards a family no longer need be concerned about birth control (except for tubal ligation failures).

2. In general, it is the surest way to avoid unwanted pregnancies (there are fewer slip-ups in the long run than with other birth control methods) which can be very important, especially to those families who feel they already have too many children or for those families who would not consider using early abortion in case of a contraceptive failure.

There are two major disadvantages of a sterilization operation:

1. A man or woman could regret the operation. The vast majority of men and women do not regret having been sterilized. However, those who seem to have the highest risk of regretting the operation are: (a) young people, those less than 30 and especially those less than 25; (b) those people to whom the idea of sterilization was first suggested by someone else (a friend, a doctor, or a nurse, for example); (c) those people who make a hasty decision to be sterilized; and (d) those people who feel sterilization will solve any marital problems, sexual problems, or physical problems they are having.

2. In some people sterilization operations can have minor psychological effects. It has not been shown that sterilization operations by themselves have ever caused anyone to become psychotic (crazy). However, psychiatrists have suggested that the ability to have children, even if never used, may be important in how some people feel about themselves. This may be particularly true among the young. The vast majority of people who do not regret sterilization adjust quite well to the operation.

The accompanying table has been compiled from a number of medical references, some of which are listed at the bottom of the page.

Its purpose is to put into perspective the benefits and risks of each of the 5 types of birth control.

Since many patient booklets and package inserts exist which give information about the pill and IUD, it is critical for someone considering surgical sterilization to see how all methods compare with one another.

If your hospital has a better (or worse) record in performing these surgical procedures (deaths, failures, complications) than indicated in the chart - THE BURDEN IS ON YOUR DOCTOR to prove it by filling in the information at the end of this booklet.
TYPES OF STERILIZATION FOR WOMEN

Tubal Ligation as Sterilization.

Post-partum ligation. In this operation a woman is taken to the operating room within 24 hours after she delivers. Each fallopian tube is cut, a small section removed and then tied off. This procedure only requires an additional one to two days of hospital stay than would be normal after the delivery. For families with only one or two children, however, the very small possibility exists that the newborn baby will die within the next six months, and especially the next six days, since this is the most dangerous time in a child's life. The opportunity for a pregnancy to compensate or replace this child would be lost.

Interval tubal ligation - sterilization at any time.

A. Transvaginal tubal ligation. In this operation, the fallopian tubes are cut and tied by entering the abdomen through the vagina. The period of hospitalization is from one to three days.

B. Laparoscopic tubal ligation. In this new procedure, the surgeon makes a small hole into the abdomen and through this fills it with about three to four liters (about a gallon) of a gas (carbon dioxide). Then he puts in a metal cylinder through which he can visualize the fallopian tubes and the other abdominal organs. Through this metal cylinder he can first cauterize (burn) and then cut the tubes, one at a time. A few surgeons have used local anesthesia, but the majority prefer to use general anesthesia because they feel the procedure warrants it. The advantage of this procedure is that it can be done on an outpatient basis, the patient can return home the same day or following morning.

Hysterectomy for Sterilization.

Hysterectomy is the removal of the uterus (womb) and leaving the ovaries. The abdominal hysterectomy is the removal of the womb through the abdominal wall, with subsequent abdominal scar. Vaginal hysterectomy is the removal of the womb through the vagina, with no subsequent scar.

Many gynecologists now recommending hysterectomy for sterilization give the following reasons:

1. Hysterectomy and tubal ligation have the approximately same death rate. The death rate is usually 1 per 1,000 to 1 per 4,000 for both operations.

2. Some women who have had a tubal ligation report a higher incidence of abnormal periods, and may have to undergo subsequent D&C's (scraping of the womb) or a hysterectomy.

3. Women who have had a tubal ligation may get an ectopic pregnancy (a pregnancy in a tube, which can be life threatening). The chance of this happening is very small, however, about pregnancies.

4. Tubal ligation has a failure rate of between 1 in 100 to 1 in 1,000; between 1 woman in 100 to 1 woman in 1,000 will still get pregnant after a tubal ligation. The failure rate for a hysterectomy is essentially zero.
5. A hysterectomy removes the possibility of developing cancer of the womb (although the risk of the operation is more than the death rate from uterine cancer).

The disadvantages of hysterectomy sterilization versus tubal ligation are:

1. Psychological. Some psychiatrists feel hysterectomy is psychologically slightly more traumatic than a tubal ligation as a woman must accept the fact that she is sterile immediately, since she no longer has menstrual periods.

2. Hysterectomy involves greater blood loss, more chance of infection, more chance of damage to other body organs, and a longer hospital stay.

Sterilization and Cesarean Section.

It was formally thought that a woman should be sterilized at the time of her third cesarean section. However, today, because of the increased safety of the operation, it is generally agreed that a woman can have as many children as she pleases by cesarean section, and many women have had five to six cesarean sections, a decision which is solely up to the woman and her family. There is an absence of increased risk above that of cesarean alone.

Sterilization and Abortion.

Early abortion is now legal in all states. A woman can be sterilized at the same time the abortion is done. Since an unwanted pregnancy and having an abortion are stressful periods in a woman's life, a decision to be sterilized made during this time may have a higher chance of being regretted. It is usually best to avoid making such a permanent decision as sterilization while under stress. If a woman chooses she can have the abortion and then if she still desires sterilization can easily get the operation a few months later.

If a woman thought about being sterilized before becoming pregnant and deciding on an abortion her chances of being happy with the operation would naturally be much greater than a woman who made the decision while under the stress of pregnancy.
STERILIZATION FOR MEN

Vasectomy.

A vasectomy is a permanent sterilization operation on a man in which the narrow tubes through which the sperm (male seeds) travel are cut and tied. There is nothing about the operation that physically will change a man, reduce his sexual desires, or his ability to climax. As with all sterilization operations, vasectomy is considered permanent; and, if circumstances happen in a man's life to make him change his mind and he desires to have more children, he will be unable to.

The advantage of vasectomy is that the operation takes usually less than 30 minutes and the man can go home the same day. The chances of slip-ups causing subsequent pregnancies are very small. One disadvantage is that since the operation is permanent, men can regret it. One psychiatrist feels that men younger than 25 may not have the range of experience necessary to choose such a permanent operation. Also, in a few men, there may be psychological effects due to the man losing his ability to reproduce. Thus, a man should seriously consider how the loss of his ability to reproduce may effect him. Counseling sessions before and after vasectomy have been shown to help a man adjust to the operation.

Some men who have had a vasectomy develop antibodies to their sperm when it is released from the vas deferens at the time of surgery. Most doctors feel these antibodies will not harm a man in later years; however, a few doctors think a man having a vasectomy may develop an enhanced vulnerability to developing such ailments as multiple sclerosis, rheumatoid arthritis, or thrombophlebitis (blood clots in the veins of the legs). There has been no substantial evidence to prove or disprove this hypothesis.

ALTERNATIVE METHODS OF BIRTH CONTROL

The Pill

The pill contains chemical hormones which resemble the natural hormones that the woman's ovaries naturally produce. When the pill is taken as directed, which is usually one pill every day, it is almost 100% effective in preventing pregnancies. Some women find it easier to remember to take a pill every day if they leave the package of pills out where they will see it every day, perhaps by their toothbrush, coffee cup, or even tape the package to their bathroom mirror.

Birth control pills, like most drugs, have side effects on some women. Most of these, like nausea or irregular bleeding, will lessen or disappear as a woman uses the pill for a few months or changes to a different type. Some side effects of the pill are dangerous. It has been estimated that 1 to 4 per 100,000 women per year may die as a result of blood clots caused by the pill. Women less than 35 years of age have less of a chance of developing this problem than women over 35. It is felt by some doctors today that the low dose estrogen pill that is in wide use today may be safer. It has also been estimated that 1 in 10,000 women per year will develop a stroke and 1 in 200,000 women will die as a result of that stroke each year. The blood sugar and fatty substance in the blood may also be elevated in a few women taking the pill.
A woman taking the pill may also run a higher risk of getting gonorrhea (a venereal disease) if she is exposed to it. Gonorrhea is most serious in the fact that if she does get an acute attack she has almost a 1 in 5 chance of becoming sterile (unable to have babies afterwards).

These risks are mentioned so that if a woman chooses the pill and subsequently develops such symptoms as pain in her legs, migraine headaches, or an abnormal discharge, she will report these symptoms promptly to her doctor so if a problem does develop it can be caught and treated early.

The pill has not been shown to cause cancer in humans; however, cancer takes 10-20 years to develop and, at this point, it cannot be safely said that the pill doesn’t cause cancer in humans. It does cause cancer in several species of animals.

The I.U.D.

The I.U.D. is a small plastic or metal device that fits deep within a woman’s womb. When well-fitted neither the woman nor her husband feels the I.U.D. The I.U.D. can be inserted six weeks after a woman delivers or at any time a woman is having a menstrual period. The insertion takes only a few minutes and usually only causes slight to moderate cramps in women who have already had a baby. If for any reason a woman desires another baby, the I.U.D. can be removed easily by the doctor. The I.U.D. does not cause any birth defects or cancer.

The I.U.D. is one of the best methods of birth control available but it is not 100% effective. One to 3 per 100 women will get pregnant per year with the I.U.D. in place. There is a higher chance of miscarriage if a woman becomes pregnant with the I.U.D. in place. Some doctors have suggested that if a woman is willing to use contraceptive foam when she has sexual intercourse between the 10th and 17th day of her cycle the effectiveness of the I.U.D. is almost 100%.

In the first three months after insertion, there may be some discomfort or cramps, bleeding between periods, and periods that are heavier than usual. In rare instances, within the first week after insertion, an infection can develop which should be treated as soon as possible. In very rare instances the I.U.D. may travel through the wall of the uterus into the abdomen. There is a possibility that the I.U.D. may come out of the uterus into the vagina or out of the body entirely. In that case, a woman should use another method of birth control, such as foam or condoms, until another I.U.D. can be inserted by the doctor.

One to 4 per 500,000 women could die from the result of an infection caused by the I.U.D.

The I.U.D., like the pill, does not cause gonorrhea. However, if a woman is exposed to gonorrhea there is a slight possibility that the I.U.D. may make her more susceptible to the infection.

The I.U.D. is considered a safe, convenient method of birth control. The majority of women who try an I.U.D. like it and many women have used it for years without significant problems. Some women may have to have their I.U.D. changed every year or two. A woman can use an I.U.D. for as long as she desires; there is no time limit.
The Diaphragm.

The diaphragm is a small rubber device placed across the mouth of the womb by the woman herself before intercourse. A nurse will show a woman how to use it in a doctor's office to make sure she is inserting it correctly. After a short time most women can easily insert one in a matter of seconds.

The diaphragm is safe and has no side effects. It has been shown that if a woman uses the diaphragm conscientiously it is 97.4% effective in preventing pregnancy (i.e. 2 to 3 pregnancies per 100 couples per year). If a woman does not use it conscientiously, then its effectiveness drops to about 80% (i.e. 20 pregnancies per 100 couples per year).

Abortion.

Early abortion is now legal in all states. It has not been shown to have any long-term psychological effects on women who are not pushed into getting an abortion by someone else. However, it is felt that it is much safer and better to use good birth control than to get an abortion every year in order to prevent having unwanted children.

Summary of the Safety of These Methods.

No birth control method is considered completely safe. It is generally agreed that all these methods are far safer and better for a family than having unwanted children.

It is a family's decision which method they feel is best for them. A family can try these various methods and can switch from one to another without any problems. A family can also choose surgical sterilization at any time in their life.
THE LONG WALK FOR SURVIVAL

A Spiritual Walk For World Peace And The Preservation Of Mother Earth

On June 1, 1980, approximately 250 people began a historical 3,500 mile walk across the United States to Washington, D.C. with an estimated arrival date on the eve of the National Elections on November 1, 1980.

This walk for World Peace and the Preservation of our Earth is being led by Indian people with representatives from over 80 different Indian tribes.

Other members of the walk include non-Indians from different parts of the United States, as well as from Germany, France, Denmark, and Canada, plus a delegation of Japanese Buddhist Monks from Japan.

The Long Walk will visit Indian reservations (where most of the uranium is mined in the United States), urban Indian Centers, Community centers, and Churches as they pass through the different states on their way to Washington, D.C. Special stops are also planned at Albuquerque, New Mexico, Tulsa, Oklahoma, and Marion, Illinois.

We are walking to alert the people of this nation to the threat to all life by Nuclear Development and call for an end to:

1. The sterilization of Indian Women
2. Uranium mining on Indian land
3. Nuclear Development
4. The military draft and war machine
40-50% OF ALL INDIAN WOMEN HAVE BEEN STERILIZED.

Evidence of massive sterilization of American Indians has been revealed by the (GAO) General Accounting Office in a study for ex-Senator James Abourezk from South Dakota in 1976.

- Most of these women were sterilized without their informed consent.
- The same GAO Report also revealed that Indian children are being used as "human guinea pigs," by the Federal Government in 56 different medical experiments (in most cases without parental consent).
- The Abourezk Report found that approximately 3,406 Indian women had been sterilized in a three year period between 1973 and 1976, in only four states.

Lehman L. Brightman, President of United Native Americans, Inc. estimates that between 60,000 and 70,000 Indian women have been sterilized in the last twelve years.

- Most of the Indian women were sterilized "unknowingly," and without their informed consent, and in many cases by outright intimidation.
- In many cases women were told they were going to die if they had more children, that they had cysts on their ovaries, or that the operation was reversible.
- Two Indian women on the Rosebud Sioux Reservation went in to the Indian hospital to have their appendix removed and came out without their ovaries.

Voluntary sterilization among the general population of the U.S. of some 200 million people isn't going to wipe out the country, but in smaller groups of people like the American Indians, it could wipe them out forever, as an example:

- If every white woman in the state of California was sterilized, the white race in North America would not be in danger, but if every California Indian woman was sterilized, the Genocide of California Indians would be permanent.

President Carter has refused on 3 different occasions to stop the sterilization and to remove Dr. Emery Johnson, the Director of the Indian Health Service...The man most responsible for Indian Sterilization.
THE LONG WALK FOR SURVIVAL

127 MILLION TONS OF CANCER INDUCING URANIUM WASTES LIE EXPOSED ON NAVAJO LANDS.

Indian Lands contain 55% of U.S. uranium reserves. As of 1979, 1,185,000 acres were under lease for mining.

In the 1950's, 100 Navajos mined uranium at a Kerr McGee mine near Ship Rock, New Mexico. By 1980, 25 of the 100 died of lung cancer, 30 have terminal cancer and 15 are expected to die of cancer.

The mining community of Edgemont, South Dakota, 80 miles North West of Pine Ridge has over 30 sites of contamination from uranium mill tailings (mill tailings are a fine sandy waste that exists after the uranium has been removed, it is about 85% radioactive).

New Mexico has some 250 acres of mill tailing piles some are 60 feet high. Grants, New Mexico, considered the uranium capital of the world, has 22 abandoned uranium tailing piles with over 26 million tons of radioactive wastes.

Birth defects have reached alarming proportions to peoples living near mining sites. In one month of 1979, 38% of pregnant women have suffered spontaneous abortions and 60-70% of newborns suffer breathing complications as a result of underdeveloped lungs and/or jaundice on the Pine Ridge Reservation in South Dakota.

WE NEED YOUR SUPPORT

We urge all people who are concerned about the future safety of the earth and its people to organize and support this historical walk either through participation or financial help.

Contributions may be sent to:
The Long Walk for Survival
627 35th st.
Richmond, California, 94805

For further information call:
Dennis Banks (916) 758-0470
Lehman Brightman (415) 527-3302
BIBLIOGRAPHY

GOVERNMENT DOCUMENTS


_____. *Hearings Before the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce.* "Volume I Quality of Surgical Care," 95th Cong., 1st sess., April 25, 29, 1977.

_____. *Hearings Before the Subcommittee on Oversight and Investigations of the Committee on Interstate and Foreign Commerce.* "Volume II Quality of Surgical Care," 95th Cong., 1st sess., October 6, 28, November 1, 1977.


_____. *Indian Health Hearing Before the Select Session Committee on Indian Affairs on Indian Health.* 95th Cong., 1st sess., July 1979


_____. “Requirements Applicable to Sterilizations (Hysterectomies),” Vol. 47, April 4, 1982.


INTERVIEWS


Phone interview with Richard Levine, attorney for Norma Jean Serena, Fall 1995.
Personal interview with Mrs. Shoulder Blade Magoo, Northern Cheyenne, librarian in the Native American Studies Center, University of New Mexico, Albuquerque, New Mexico, July 1997.


Phone interview with Marie Sanchez, Chief Tribal Judge for the Northern Cheyenne, June 1997.

Phone interview with Michael Zavala, attorney for three Cheyenne women, September 1995.

PUBLIC DOCUMENTS


“The History of the Indian Health Service,” n. d.

“Indian Reservations,” n. d.


“Results of Investigation on the Rosebud Sioux Reservation,” n.d.


“Memo to Karl/Perry/Phil from Patty Marks/Abourezk Office, re: Native American Sterilization,” 1978.


**BOOKS**


**NEWSPAPERS**


"An Interview with Barbara Moore on Sterilization." *Akwesasne Notes,* Spring 1979, 11-12.


“Native Woman Sues Over Illegal Sterilization, Seizure of Children.” *Akwesasne Notes*, Late Summer 1975, 8.


"There Are No Other Homes for These Children.” Akwesasne Notes, Early Autumn 1972, 31.


Wagner, Bill. “Lo, the Poor and Sterilized Indian.” America, January 29, 1977, 75.


NEWSBANK


**JOURNALS**


