they thought of India. Almost everyone said "dirty," "polluted," "crowded."

In 1990, I spoke to a largely white audience in Illinois on the issues of mining in northern Wisconsin. After explaining the devastating impact mining companies might have on Native peoples and non-Native peoples in the area, the response I received was, "But don't you think the *real* reason Native peoples have environmental problems is because they're having too many children?"

The racism in the population movement, as well as in society at large, is usually more subtle. Consequently, racist ideology is often framed by "race-neutral" language. For instance, anti-immigration activists may argue that they support immigration restrictions, regardless of race. Nevertheless, when mainstream (and far-right) activists are pushing immigration restrictions, they are thinking about protecting "the border." When they talk about population reduction, they usually have Global South women in mind, since the First World is at replacement-level fertility rates.

Often, in my experience, population control groups will assert that they are concerned with eradicating economic inequality, racism, and colonialism. However, since these organizations address these issues through a population paradigm, inevitably their efforts are directed toward reducing population growth of all peoples in theory and of people of color in reality. In 1998, I gave a presentation about population control at the Environmental Law Conference in Eugene, Oregon. Several audience members contended that their groups, while concerned about population growth, were equally concerned about eradicating racism, colonialism, and sexism. So I asked them what percentage of their organizing was actually devoted to working on those issues. Every single person answered "none." With allies like this, it is no wonder that the statement made on this issue at the first People of Color Environmental Justice summit was, "We're not interested in controlling our population for the sake of your population."

Chapter 4

"Better Dead Than Pregnant"

The Colonization of Native Women's Reproductive Health

The notion that communities of color, including Native communities, pollute the body politic continues to inform the contemporary population control movement. People of color are scapegoated for environmental destruction, poverty, and war. Women of color are particularly threatening, as they have the ability to reproduce the next generations of communities of color. Consequently, it is not surprising that control over the reproductive abilities of women of color has come to be seen as a "national security" issue for the U.S.

In particular, Native women, whose ability to reproduce continues to stand in the way of the continuing conquest of Native lands, endangering the continued success of colonization. As Ines Hernandez-Avila notes, "it is because of a Native American woman's sex that she is hunted down and slaughtered, in fact, singled out, because she has the potential through childbirth to assure the continuance of the people."[1] David Stannard points out that control over women's reproductive abilities and destruction of women and children is necessary to destroy a people. If the women of a nation are not disproportionately killed, then that

nation's population will not be severely affected. He argues that Native women and children have been historically targeted for wholesale killing in order to destroy the Indian nations.[2] Indeed, colonizers such as Andrew Jackson recommended that troops systematically kill Indian women and children after massacres in order to complete the extermination. Similarly, in the nineteenth century, Methodist minister Colonel John Chivington's policy was to "kill and scalp all little and big" because "nits make lice."[3] Under colonialism, Native women and women of color have not had any guarantees to bodily integrity; it seems that any form of dangerous contraception is appropriate, so long as it stops them from reproducing. Or, as Chicago-based reproductive rights activist Sharon Powell describes it, women of color are "better dead than pregnant."

Sterilization Abuse

As many Global South countries began to resist the neocolonial economic policies imposed by the World Bank and International Monetary Fund (IMF), U.S. government and business interests blamed the unrest on an "overpopulation problem." In 1977, R. T. Ravenholt of the U.S. Agency for International Development (USAID) announced the plan to sterilize a quarter of the world's women because, as he put it,

> Population control is necessary to maintain the normal operation of U.S. commercial interests around the world. Without our trying to help these countries with their economic and social development, the world would rebel against the strong U.S. commercial presence.[4]

Not surprisingly, during the 1970s the population growth of nonwhites in the Global South and the U.S. was viewed by elites as a "national security risk." One recently declassified federal document, the National Security Study Memorandum 2000, includes a 1976 memo authored by former Secretary of State Henry Kissinger outlining the nature of this threat:

> It seems well understood that the impact of population factors on the subjects already considered—development, food requirements, resources, environment—adversely affects the welfare and progress of countries in which we have a friendly interest and thus indirectly adversely affects broad U.S. interests as well....
>
> Population factors contribute to socio-economic variables including breakdowns in social structures, underemployment and unemployment, poverty, deprived people in city slums, lowered opportunities for education for the masses, few job opportunities for those who do obtain education, interracial, religious, and regional rivalries, and sharply increased financial, planning, and administrative burdens on governmental systems at all levels. These adverse conditions appear to contribute frequently to harmful developments of a political nature: Juvenile delinquency, thievery and other crimes, organized brigandry, kidnapping and terrorism, food riots, other outbreaks of violence; guerilla warfare, communal violence, separatist movements, revolutionary movements and counter-revolutionary coups. All of these bear upon the weakening or collapse of local, state, or national government functions. Beyond national boundaries, population factors appear to have had operative roles in some past politically disturbing legal or illegal mass migrations, border incidents, and wars. If current increased population pressures continue they may have greater potential for future disruption in foreign relations.[5]

In the U.S., the Department of Health, Education, and Welfare (HEW) accelerated programs in 1970 that paid for the majority of costs to sterilize Medicaid recipients.[6] In 1979, 7 in 10 U.S. hospitals performing voluntary sterilizations for Medicaid recipients had violated federal guidelines by disregarding informed consent procedures and sterilizing women through "elective" hysterectomies.[7]

Thus, it is not surprising that Native women became targets of the population craze when Indian Health Services (IHS) initiated a fully federally funded sterilization campaign in 1970.[8] Connie Uri, a Cherokee/Choctaw medical doctor, was one of the first people to uncover this mass sterilization of Native women in the 1970s after a young Indian woman entered her office in Los Angeles in 1972 and requested a "womb transplant." Upon further investigation, Uri discovered that the woman had been given a complete

hysterectomy for birth control purposes when she was 20 years old and had not been informed that the operation was irreversible. The woman was otherwise completely healthy. Initially, Uri thought she had encountered an isolated incidence of malpractice but she continued to hear from Indian women who had been sterilized under duress, or without being informed that the procedure was irreversible. She and other activists pressured Congress to investigate, and eventually Senator James Abourezk, a Democrat from South Dakota, requested a study of IHS sterilization policies.[9]

As a result, in 1976 the General Accounting Office (GAO) released a report studying 4 of the 12 areas serviced by IHS (Albuquerque, Phoenix, Aberdeen, and Oklahoma City). According to this report, 3,001 Native women of childbearing age, or approximately 5 percent of all Native women of childbearing age in these areas, were sterilized between 1973 to 1976.[10] Of these sterilizations, the GAO reported that 36 were performed on women under the age of 21, despite a court-ordered moratorium on such procedures.[11]

Native activists have argued that the percentage of Native women sterilized is much higher. Dr. Uri conducted an investigation of sterilization policies in Claremore, Oklahoma, and charged that the Claremore facility was sterilizing one woman for every seven births that occurred in the hospital. She claimed that 132 women had been sterilized in 1973, 100 of them nontherapeutic. And in July 1974, Uri found 48 Native women, most of them in their twenties, who had been sterilized.

Unlike the GAO report, her investigation did not rely only on hospital records, but on interviews with women who had been sterilized. Consequently, her numbers are much higher than the GAO's report of Native women in the Oklahoma City IHS area.[12] Her investigations led her to conclude that 25 percent of Native women had been sterilized in that same area without their informed consent.[13] She also charged that "all the pureblood women of the Kaw tribe of Oklahoma have now been sterilized."[14] Other activists have reported even higher numbers. Women of All Red Nations (WARN) issued an alert stating that close to 50 percent of Indian women had been sterilized in the 1970s. Native rights

activist Lehman Brightman asserts that 40 percent of Native women and 10 percent of Native men were sterilized during the decade.[15] Pat Bellanger of WARN contends that sterilization rates were as high as 80 percent on some reservations.[16]

One study of sterilization rates in Montana, which focused on the Blackfeet Reservation and the urban Indian population of Great Falls, found that Indian women were twice as likely to be sterilized as were white women.[17] Another study of sterilization rates on the Navajo reservation found that tubal ligations increased by approximately 61 percent from 1972 to 1977.[18]

Most of these numbers, such as Dr. Uri's, are based on sterilizations at one or two IHS hospitals, from which activists extrapolate sterilization rates. It is also difficult to come up with accurate data, because IHS did not have uniform protocols for sterilization procedures until after the uproar over sterilization abuses forced the agency to adopt one. As a result, sterilization policies fluctuated greatly from region to region, varying due to philosophies of the particular administrators in IHS areas.

Given that the population of Native peoples did increase in this period, it might seem unlikely that 50 percent of Native women of childbearing age had been sterilized. However, a study of sterilization rates in Montana found that on average Native women who were sterilized already had three or four children, which might explain how high sterilization rates might not lead to a population decrease in Native communities.[19] And some data strongly suggests that Indian women were targeted for sterilization without their informed consent. For example, Uri discovered that many of the women sterilized in Claremore were sterilized within a day or two after having given birth, which means physicians may have violated federal regulations requiring a 72-hour waiting period between consenting to the operation and having it performed. One woman informed Dr. Uri that she was advised to be sterilized for headaches. "The doctor told the woman her head hurt because she was afraid of becoming pregnant, and advised sterilization. The woman agreed, but the headaches persisted. She later learned she had a brain tumor."[20] Another woman went to a doctor for stomach problems. The doctor assumed she was ill

because she was pregnant and yelled, "Why the hell don't you get your tubes tied so you won't get sick anymore?"[21]

Maria Sanchez, former chief tribal judge of the Northern Cheyenne, reported that two 15-year-old girls were sterilized during what they were told were tonsillectomy operations.[22] In another story, Norma Jean Serena (Creek/Shawnee) was pressured by welfare caseworkers to undergo a tubal ligation after the birth of her third child. These caseworkers also removed all her children into foster care because she was an "unfit mother." Three years later, she sued Armstrong County for damages from the sterilization and to have her children returned to her. The jury found that the children had been taken away under false pretenses, but the jury did not support her claim that her civil rights had been violated through the sterilization procedure. During the court proceedings, the major complaint against Serena was that she was "dirty and unkempt" and that she had Black friends who, in the minds of the social workers, were also inherently polluting to the body politic.[23]

Interestingly, the 1976 GAO report sidesteps the issue of informed consent because "we believe such an effort would not be productive."[24] But the GAO did note that IHS was "generally not in compliance with IHS regulations. Although there were consent forms in the medical files, most of these forms did not comply with IHS requirements."[25] These consent forms did *not*

> (1) indicate that the basic elements of informed consent had been presented orally to the patient; (2) contain written summaries of the oral presentation; and (3) contain a statement at the top of the form notifying subjects of their right to withdraw consent. One consent form document did meet the Indian Health Service requirements, but when used was filled out incorrectly.[26]

IHS was also out of compliance with specific HEW regulations, and these regulations were also problematic. By the time of the report (1976) HEW had eliminated a requirement mandating that "individuals seeking sterilization be orally informed at the outset that no Federal benefits can be withdrawn because of failure to accept sterilizations."[27] Further, HEW did not require that the signature of the patient appear on the consent forms, so we must rely upon the word of the doctors that informed consent was given.[28] In addition, the informed consent sheet is highly technical and would not necessarily be understandable to someone who was not fluent in English. Further complicating matters, over half of the sterilizations were performed by contract facilities, which do not have to abide by federal procedures regarding informed consent.[29]

Eventually, IHS strengthened its sterilization policies. Today sterilization procedures must meet "the standard set forth in Sub-section F of Section 3-13.12 of the IHS Manual and regulatory policy and legal requirements for informed consent and performance of sterilization procedures."[30] Additionally, "the area/program director must dispatch all data and statistics to headquarters on time."[31] The current IHS policy regarding sterilization is as follows:

> IHS will neither promote nor discourage sterilization or fertility of the population it serves. Its overall policy is geared to the enhancement of life through assuring the availability of legally, ethically and medically acceptable information and services that afford families and individuals the opportunity to assure that each child is a wanted one. In addition, before discharge following delivery the mother will be offered an opportunity for counseling, guidance and/or services for family planning.[32]

Sterilization abuse, while curbed, is certainly not dead, either in IHS or society at large. One woman I know went into IHS in the 1990s for back surgery and came out with a hysterectomy. In Peru, the Health Ministry recently issued a public apology for sterilizing 200,000 indigenous people (primarily Quechua and Aymara) without consent during the presidency of Alberto Fujimori. One witness reported that a group of doctors visited her Andean village promising its residents a new era of well-being and improved health. "Later, they threatened us and practically forced us to [accept sterilization]," she said. "They shut me up in a room and forced me to get undressed. Everything that happened was because they used force. I didn't want to go through with it."[33] Several women died during sterilization operations, which were carried out under non-hygienic conditions. The majority of operations were undertaken without anesthesia and without aftercare. Some experts estimate that only 10 percent of the sterilizations

conducted from 1996 to 2000 in Peru were voluntary. The number of sterilizations during this period were three times higher than during the previous four-year period, and sterilizations increased each year to meet Fujimori's "family planning" targets. The rural villages that were targeted now face a shortage of young people that threatens their future.[34]

In 1997, Barbara Harris started an organization called CRACK (Children Requiring a Caring Kommunity, sic) in Anaheim, California, which gave women money to have sterilizations.[35] Harris's mission is to "save our welfare system and the world from the exorbitant cost to the taxpayer for each drug-addicted birth by offering effective preventative measures to reduce the tragedy of numerous drug-affected pregnancies."[36] Some of CRACK's initial billboards read, "Don't let a pregnancy ruin your drug habit."[37]

Over the last decade, CRACK has opened offices in several cities around the country, and changed its name to Project Prevention to present a less inflammatory image. Nonetheless, its basic message is the same: poor women who are substance abusers are the cause of social ills, and that the conditions that give rise to poor women becoming substance abusers do not need to be addressed. It further trades on a racist image of women of color in particular being the cause of social ills, as CRACK/Project Prevention primarily advertises in communities of color. Yet Barbara Harris defends herself against charges of bias by arguing that she cannot be racist because her husband is a Black man. Says Harris, "people don't know anything about me. I'm the only white person in my house."[38]

CRACK/Project Prevention also conveys the message that women who are substance abusers should be criminalized, not treated, for their addiction. As race and reproductive scholar Dorothy Roberts notes, women of color are more likely to be criminalized for their drug use because they are more likely to be in contact with government agencies where their drug use can be detected. While white pregnant women are more likely to engage in substance abuse than Black pregnant women, public health facilities and private doctors are more likely to report Black women to criminal justice authorities.[39]

The Seattle-based group Communities Against Rape and Abuse, (CARA), a leading organization that opposes the politics of CRACK/Project Prevention, notes how such efforts disproportionately impact survivors of sexual violence since survivors are more than 10 times more likely to abuse alcohol and drugs.[40] Finally, as community organizer and CARA staffer Joelle Brouner notes, the organization's message is based on an able-bodied supremacist notion of "value," which asserts that babies born to women who are substance abusers are "damaged" because they are "burdens to society." The assumption behind these claims, asserts Brouner, is that lives are of value to the extent that they meet capitalist expectations of self-sufficiency and productivity.[41]

Meanwhile, pregnant women who would like treatment for their addiction can seldom get it because treatment centers do not meet their needs. One study found that two thirds of drug treatment centers would not treat pregnant women.[42] Furthermore, the criminalization approach is more likely to prevent pregnant women who are substance abusers from seeking health care for fear of being reported to the authorities.[43] Roberts critiques communities of color for often supporting the criminalization of women of color addicts; she sees this criminalization as a strategy that elides the effects of poverty and racism and supports white supremacy.

Similarly, Native scholar Elizabeth Cook-Lynn (Crow Creek Sioux) critiques Native communities for supporting the criminalization of pregnancy. She says that at the same time Native peoples were rallying around Leonard Peltier, no one stood beside Marie Big Pipe in South Dakota when she was incarcerated on a felony charge of assault with intent to commit serious bodily harm because she breast-fed her child while under the influence of alcohol. Big Pipe was denied substance abuse services and access to abortion services when she became pregnant. Nevertheless, her community supported her incarceration. In doing so, Cook-Lynn argues, the community supported the encroachment of U.S. federal jurisdiction on tribal lands for an issue that would normally be under tribal jurisdiction.[44] Meanwhile, the federal government, which is supposed to prosecute "major

crimes" on Indian land, prosecutes virtually no cases of rape committed against Indian women.

Cook-Lynn also charges that this demonization of Native women was assisted by the publication of Michael Dorris's *Broken Cord*, which narrates his adoption of a Native child who suffered from fetal alcohol syndrome.[45] While this book has been crucial in sensitizing many communities to the realities of fetal alcohol syndrome, it also portrays the mother of the child unsympathetically and advocates repressive legislative solutions targeted against women substance abusers. As Cook-Lynn notes,

> Dorris directs his frustrated wrath toward some of the least powerful among us: young childbearing Indian women. He says they must pay the price for the health crisis and family disintegration that can be observed not only on Indian reservations but in cities and rural areas throughout the country. Forcing these young women, as much the victims as their martyred children, into detention centers is presented as a solution to failed health care systems, inadequate education, poverty, and neglect.[46]

Within Native communities, the growing demonization of Native women substance abusers has prompted tribes to collude with the federal government in whittling away their own sovereignty.

Abuse of Long-Acting Hormonal Contraceptives

While sterilization abuse in the U.S. has ebbed since the 1970s, state control over reproductive freedom continues through the promotion of unsafe, long-acting hormonal contraceptives like Depo-Provera and Norplant for women of color, women on federal assistance, and women with disabilities. As the population scare and the demonization of poverty moved to the mainstream of the dominant culture in the U.S., Norplant and Depo-Provera became frontline weapons in the war against the poor and populations of color.

For instance, state legislatures considered bills that would give women on public assistance bonuses if they used Norplant.[47] In California, a Black single mother convicted of child abuse was given the "choice" of using Norplant or being sentenced to four years in prison.[48] In 1991, the *Philadelphia Inquirer* ran an editorial suggesting that Norplant could be a useful tool in reducing the underclass.[49] Over 87 percent of Norplant implants were paid for by government programs, indicating that poor women have been targeted for Norplant.[50]

Depo-Provera and Norplant were approved for contraceptive use, in 1992 and 1990 respectively, by the Food and Drug Administration (FDA). However, as the National Women's Health Network points out, FDA approval does not necessarily guarantee the safety of a drug.[51] The FDA relies upon the manufacturer's data regarding animal and human testing and does not routinely double-check the manufacturer's data. The agency also does not permit consumer groups to double-check research studies; data are prepared by researchers who are often funded directly or indirectly by manufacturers. FDA advisory committees are not composed of experts who are knowledgeable about the wide variety of drug side effects. Instead, the FDA relies upon the manufacturer for information on adverse effects. Physicians are not required to report adverse drug reactions to the FDA, and the FDA seldom follows up on adverse-reaction reports from consumers.[52] In fact, FDA commissioner Jaime Goddard estimates that "one percent or less" of the adverse reactions to any drug are ever reported to the FDA by the doctors.[53]

Depo-Provera is a long-acting injectable contraceptive made by the Upjohn Company. This injection prevents pregnancy by stopping the production of progesterone and estrogen, which in turn inhibits ovulation and prevents the lining of the uterus from being prepared to accept a fertilized egg. Also, the drug can cause a mucus plug to form in the cervix, preventing contact between the sperm and ovum.[54]

Side effects that have been linked to Depo-Provera include irregular bleeding, depression, weight gain, osteoporosis, loss of sex drive, breast cancer, sterility, cervical cancer, and headaches.[55] Upjohn, not surprisingly, denies the link between the more

extreme conditions and Depo-Provera. The National Women's Health Network maintained a registry of reported Depo-Provera side effects and recorded over 100 related symptoms.[56] The *Ultimate Test Animal*, a documentary on Depo-Provera, interviewed several women who suffered from blood clots in the lungs, extreme bleeding (one woman eventually had to undergo a hysterectomy to address this symptom), and cervical cancer after using the drug.

In tests on animals in 1968, Depo-Provera was linked to increased risk for breast and uterine cancer.[57] The FDA Public Board of Inquiry stated in 1982 that "never has a drug whose target population is entirely healthy people been shown to be so pervasively carcinogenic in animals as has Depo-Provera."[58] Many health-care activists have argued that Upjohn has suppressed much of the information from these animal tests, and that these tests indicate that Depo is even more carcinogenic than reported.[59] Upjohn argued that beagles were not an appropriate test subject for Depo-Provera because beagles are very susceptible to breast cancer. Dr. Solomon Sobel of the FDA, however, testified that there are no other contraceptives which are carcinogenic in beagles which have reached the U.S. market.[60]

The largest test on humans was conducted for 11 years beginning in 1967, through the Grady Clinic, affiliated with Emory University in Atlanta. The *Ultimate Test Animal* documents the widespread abuses in this clinical trial. Robert Hatcher, who directed the study, admits that there was no established protocol for the study. In 1978, FDA sent investigators to Grady. They found that many women were not told they were part of an experiment or that there were side effects associated with Depo. Several women developed cancer during the trial, but these cases were not reported to the FDA as was required. Women with medically contraindicated conditions, such as cancer, were still given the shot. And record keeping was sloppy; over half of the 13,000 women in the trial were lost to followup. Hatcher's response to the critiques of his clinical trial was that these mistakes "did not have any detrimental impact on patients."[61]

The Black Women's Health Project tracked some of the women who had been lost in the trials, and found that they were suffering from extremely adverse effects. Many young women had uterine, cervical or breast cancer, or had undergone hysterectomies as a result of hemorrhaging.[62] Several women had also became clinically depressed from Depo, and had attempted suicide as a result.[63] Upjohn's response to this side effect was, "headaches, depression and loss of libido mostly require reassurance from a trusted and respected friend or counselor."[64]

Sobel concluded that the Grady study was "not a carefully controlled trial, but rather... a treatment program in which the drug was dispensed without the usual care and monitoring that we associate with a controlled clinical trial. The patient followup was not good, and the FDA could not really accept this as a study of the quality that we require in the drug approval process."[65] And because of the side effects, several national women's health organizations, including the National Women's Health Network, the Native American Women's Health Education Resource Center, the National Latina Health Organization, and the Black Women's Health Project, have condemned the drug and urged women not to use it. In 1978 the FDA denied approval for Depo-Provera as contraception on the grounds that animal studies confirmed an elevated rate of breast cancer; there appeared to be an increased risk of birth defects in human fetuses exposed to the drug; and there was no pressing need shown for use of the drug as a contraceptive.[66]

Yet in 1987, the FDA changed its regulations and began to require cancer testing in rats and mice instead of dogs and monkeys, and Depo-Provera did not cause cancer in these animals.[67] The World Health Organization added its endorsement in 1991, concluding that there was "no evidence for increased risk of breast cancer with long duration of use" after a nine-year study.[68] It is important to note, however, that nine years does not necessarily constitute a "long duration," and no other tests proving the long-term safety of Norplant or Depo-Provera exists. Furthermore, as the Women's Health Education Project points out, all of these studies were conducted by Upjohn. And as with animal studies and the Grady study, it was reported that women with extreme side effects were eliminated from the data, and some of the trials were conducted on sample sizes too small to be statistically significant.[69] In spite of all of this, Depo-Provera was approved by the FDA for contraceptive use in 1992.

Before Depo was approved in 1992, it was routinely used on Native women by IHS, particularly on Native women with disabilities. According to area director Burton Attico, the Phoenix IHS had already begun to substitute Depo for sterilization on patients with mental disabilities in the 1980s because by then sterilization had been prohibited. Said Attico, "We use it to stop their periods. There is nothing else that will do it. To have to change a pad on someone developmentally disabled, you've got major problems. The fact they become infertile while on it is a side benefit."[70] Raymond Jannett of the Phoenix IHS suggested that Depo-Provera aided young women dealing with PMS-like symptoms. "Depo-Provera turned them back into their sweet, poor, handicapped selves. I take some pride in being a pioneer in that regard," he said.[71] But, while Jannett did not have any reservations about using it on Indian women, he said he did not plan to use it "on attractive 16-year-old girls who one day hope to be mothers."[72] Patrick Gideon, with the IHS in Oklahoma City, said it would be appropriate to prescribe the drug to "women who are unable to care for themselves. For hygienic reasons, we will go ahead and give it."[73] Apparently, keeping Native women "clean" by sterilizing them is more important than protecting Native women's health; in this way, Native womens bodies are viewed as inherently dirty, in need of cleansing and purification *at any cost.*

Often, the IHS distributed Depo-Provera without the informed consent of patients or their caretakers. Attic claimed that doctors obtained oral consent but admitted they did not use written consent forms. Jannett similarly said that he never offered consent forms to his patients or explained the potential risks or side effects of Depo-Provera. "I don't tell them that rhesus monkeys did strange things, no...Most parents don't have rhesus-monkey children...I don't go into a great deal that it's carcinogenic...Instead, I tell them it's a drug that helps combat cancer."[74] Cecile Balone, executive director of "A School for Me," a Navajo reservation facility, reports that Depo-Provera was used for two years in the community before written consent forms were developed. And Balone says even after they were developed that they were not circulated to parents or guardians of the girls on Depo-Provera.[75]

Norplant, another long-acting contraceptive, was approved for distribution in the U.S. in 1990. Norplant is implanted through five rods into a woman's arm and prevents pregnancy for five years by maintaining low-level doses of progesterone in the system, suppressing ovulation and thickening the cervical mucus so that it is impervious to sperm. As with Depo-Provera, there are no studies which demonstrate Norplant's long-term safety. Instead, use of Norplant has been correlated with several side effects, with constant bleeding—sometimes for more than 90 days—being the most common. About 82 percent of Norplant users experience irregular, usually heavy, bleeding during the first year of use.[76] This side effect is particularly problematic for Native women, since women are often excluded from ceremonies while they are bleeding. And as irregular bleeding is a symptom of endometrial and cervical cancer, Norplant use can mask those symptoms. Other reported side effects include blindness, hair loss, dizziness, nausea, headaches, strokes, heart attacks, tumors, and sterility.[77]

Prior to its approval, Norplant had been tested in several Global South countries. The BBC video *The Human Laboratory* (1995) documented how women receiving Norplant in Bangladesh without their informed consent were not able to have it removed when they developed side effects. (Distribution of the drug in Bangladesh began in 1985.) Furthermore, when they attempted to report side effects, doctors scolded them and refused to record the information. One woman attempting to get it removed told her doctor, "I'm dying, please help me get it out." Her doctor responded "OK, when you die you inform us, we'll get it out of your dead body."[78] Similar stories have been reported in Haiti, India, and many other Global South countries.[79] Nevertheless, Wyeth-Ayerst continued to report that "Norplant is a highly effective, safe and acceptable method among Bangladeshi women."[80]

Because of the extreme side effects, approximately 30 percent of women on Norplant wanted it removed within one year,[81] and the majority wanted it out within three years.[82] While Norplant is still being used in IHS, Wyeth-Ayerst withdrew the drug from the market in 2000, after paying a reported $54 million to more than

36,000 women in 1999. These women had sued the company claiming that their health had been damaged by the drug. But Wyeth-Ayerst refuses to discontinue its promotion of the drug, or warn women of the risks associated with it. The U.S. Food and Drug Administration (FDA) continues to carry Norplant on its list of approved drugs and devices, as a substance for regulating pregnancy. Moreover, many doctors know how to insert Norplant but they do not know how to remove it. (Medicaid typically paid for Norplant insertion, but not its removal.)[83]

Yet despite the evidence indicating that Depo-Provera and Norplant are dangerous, when the Native American Women's Health Education Resource Center (NAWHERC) conducted a study of IHS policies regarding the drugs in 1993, it found that IHS was aggressively promoting them in many Native communities. NAWHERC concluded that IHS policies regarding Norplant and Depo-Provera are similar to its sterilization policies in the 1970s, before uniform policies and procedures were instituted. For example, prior to FDA approval of Depo-Provera in 1992, IHS maintained a registry of women using it. This practice was discontinued after its approval, and now women on Depo-Provera or Norplant are not monitored or tracked in a systematic manner.[84] Given the high turnover within IHS and the periodic monitoring required by Norplant (it must be removed after five years to avoid life-threatening ectopic pregnancies) and Depo-Provera (it must be administered quarterly to be effective), these practices are highly problematic. Women in India were not tracked during clinical trials of Norplant, and encountered great difficulty in having it removed after the five year period. Native women may face similar circumstances.[85]

NAWHERC found that not all IHS areas were lax in their protocol regarding Norplant and Depo-Provera distribution. It applauds the Crow service unit for its detailed protocol which ensures that "the more complex tasks of counseling and documentation are extensively supervised, and that the counseling is performed by each provider in a standardized, acceptable fashion."[86] However, NAWHERC suggests that IHS adopt a uniform policy on Depo-Provera that ensures all women using the contraceptive receive informed consent and are monitored to ensure that any side effects they suffer from are addressed promptly.

While NAWHERC's study is useful, the organization questioned the providers of Norplant and Depo-Provera, not the recipients. A study which focuses on the recipients might reveal different information about IHS policies regarding informed consent. When I worked with WARN in Chicago, which provided much educational material on these contraceptives to the Native community, I routinely heard from women who said they were pressured by either their welfare case workers or IHS doctors to take Norplant. They also informed me that were not told of its side effects.

In 1996, I attended NAWHERC conference on reproductive rights in Rapid City, South Dakota. At the workshop on Depo-Provera, the room was filled with distraught Native women who were hearing for the first time about the side effects of the Depo-Provera injections they had been receiving. The documentary *Under Her Skin* reports how Native women in one IHS area were told that Norplant has no side effects, and yet women receiving Norplant were suffering from hair loss, tumors, depression, and constant bleeding. In the film *Ultimate Test Animal*, a woman enters an urban clinic with a hidden camera pretending to seek contraceptive counseling. Following is a transcription of the information she received:

> Your body gets mixed up when it's on Depo-Provera so your monthly period may not return right away. Another thing you need to know about this shot is that it is not approved for birth control by the FDA, which we think is stupid...There was this one study that was done on beagle dogs and they gave a bunch of beagle dogs this medicine, though in much higher dosages than you will be getting, and some of the dogs developed breast cancer. Now, this study was not a good one because beagles are susceptible to breast cancer anyway. You're obviously not a beagle dog; you're obviously not going to get as high dosage, but we're obligated to tell you this anyway.[87]

This transcript demonstrates that it is possible for health-care providers to provide information that conveys a misleading and incomplete sense of the issues involved with these contraceptives.

Furthermore, even when women receive information on the side effects of contraceptives, they assume that their doctors will not provide them with drugs that could be unsafe. As one victim of the Grady clinical trial stated in *The Ultimate Test Animal*: "I felt anything Grady would give me would be for my better, and not experimental."[88]

Abortion and Sterilization

Government policies couple the promotion of sterilization or dangerous contraceptives with restrictive abortion policies. As a result of the Hyde Amendment, which eliminated federal funding for abortion services in 1976, IHS cannot provide abortions unless the mother's life is in danger or the pregnancy is the result of incest or rape. Because most Native women rely almost exclusively on IHS for their healthcare, and IHS does not provide abortion services except under these limited circumstances, it is clear that the Hyde Amendment discriminates on the basis of race. Thus, all racial justice groups should be opposing the Hyde Amendment as a racial justice issue.

Unfortunately, this issue has not been addressed by either racial justice or pro-choice organizations. In fact, in the early 1990s, pro-choice organizations such as NARAL (National Abortion Rights Action League) and Planned Parenthood made the conscious choice to sell out the interests of Native women, poor women, and women of color when they supported the Freedom of Choice Act, which retained Hyde Amendment provisions. In fact, one of NARAL's petitions stated, "The Freedom of Choice Act (FOCA) will secure the original vision of Roe v. Wade, giving *all* women reproductive freedom and securing that right for future generations [emphasis added]."[89] Apparently, poor women and indigenous women do not qualify as "women."

Furthermore, when NAWHERC studied IHS abortion policies in 2002, it found that 85 percent of surveyed IHS service units were not compliant with official IHS abortion policy. Sixty-two percent of the units did not provide abortion services when the mother's life was in danger. In fact, only 5 percent of service units performed abortion procedures at their facilities.[90]

Unfortunately, racial justice groups have generally not addressed racism in reproductive rights policies, marginalizing them as "women's" issues. For example, these issues were almost completely absent at the 2001 United Nations World Conference on Racism, where a variety of issues related to racism—including reparations, the colonization of Palestine, and caste discrimination—were addressed. And as Dorothy Roberts notes, some activists refuse to address racism in abortion policies, arguing that abortion access represents "genocide" for communities of color. These advocates fail to consider that restrictions to abortion can become another strategy to coerce Native women or women of color to pursue sterilization or long-acting hormonal contraceptives. The strategy of coupling restrictive abortion with sterilization policies is evident within a bill considered but eventually defeated by the North Carolina legislature in 1993: "The Department of Human Resources shall ensure that all women who receive an abortion funded through the State Abortion Fund receive Norplant implantation and do not remove it unless the procedure is medically contraindicated."[91] This legislation sought to target women during a vulnerable period, while facing an unwanted pregnancy, to pressure them into accepting long-acting hormonal contraceptives.

In the Northwest Territories of Canada, the Status of Women Council uncovered similar punitive abortion policies at the Stanton Yellowknife Hospital, which services Inuit women. Women were denied anesthesia during abortion services as punishment for seeking abortions. One woman was told by her doctor: "This really hurt, didn't it? But let that be a lesson before you get yourself in this situation again."[92] This controversy was uncovered when a rape victim, Ellen Hamilton, went to the media saying that her abortion had been worse than the rape: she was given no counseling, pinned down, and given no anesthesia during the procedure.

Hamilton's experience was publicized in the Northwest Territories, prompting a flood of responses from women who had

suffered a similar fate. The hospital responded that it had provided all the women with aspirin, making them the only hospital in Canada to provide only aspirin for pain relief during abortion procedures.[93] The Canadian government ordered an inquiry into the hospital's procedures, forcing the hospital to issue a statement that it had developed a new plan "for providing patients with choices in pain control during abortion procedures."[94]

These policies appear to punish the women for having abortions. One woman who went in for an abortion and a tubal ligation the same day reported that she was told, "The anesthesiologist does not believe in abortions, we will administer the anesthetic following the abortion, for the tubal ligation."[95] By increasing the pain and trauma associated with abortion, or by making it inaccessible, the health care establishment exerts even more pressure on Native women to agree to sterilizations or dangerous contraceptives.

Beyond Choice

The history of Native women and colonial reproductive policies demonstrates the political bankruptcy of the "choice" paradigm for articulating a reproductive rights agenda. As Native activist Justine Smith states,

> The reproductive rights movement frames the issues around individual "choice"—does the woman have the choice to have or not to have an abortion. This analysis obscures all the social conditions that prevent women from having and making real choices—lack of health care, poverty, lack of social services, etc....In the Native context, where women often find the only contraceptives available to them are dangerous...where they live in communities in which unemployment rates can run as high as 80 percent, and where their life expectancy can be as low as 47 years, reproductive "choice" defined so narrowly is a meaningless concept. Instead, Native women and men must fight for community self-determination and sovereignty over their health care.[96]

A variety of scholars and activists have critiqued the choice paradigm because it rests on essentially individualist, consumerist notions of "free" choice that do not take into consideration all the social, economic, and political conditions that frame the so-called choices that women are forced to make.[97] Historian Rickie Solinger contends that in the 1960s and 1970s, abortion rights advocates initially used the term "rights" rather than "choice," rights understood as those benefits owed to all those who are human regardless of access to special resources. By contrast, argues Solinger, the concept of "choice" is connected to possession of resources, thus creating a hierarchy among women based on who is capable of making legitimate choices.[98] As Solinger writes,

> "Choice" also became a symbol of middle-class women's arrival as independent consumers. Middle-class women could afford to choose. They had earned the right to choose motherhood, if they liked. According to many Americans, however, when choice was associated with poor women, it became a symbol of illegitimacy. Poor women had not earned the right to choose.[99]

What her analysis suggests is that, ironically, while the pro-choice camp contends that the pro-life position diminishes the rights of women in favor of "fetal" rights, the pro-choice position actually does not ascribe inherent rights to women either. Rather, women are ascribed reproductive choices if they can afford them or if they are deemed legitimate choice-makers. Building on this analysis, I would argue that while there is certainly a sustained critique of the "choice" paradigm, particularly among women of color reproductive rights groups, the choice paradigm continues to govern much of the policies of mainstream groups in a manner which continues the marginalization of women of color, poor women, and women with disabilities.

One example of this marginalization is how pro-choice organizations narrow their advocacy to legislation that affects the right to choose to have an abortion—without addressing the conditions that put women in the position of having to make the decision in the first place. Consequently, politicians, such as former president Bill Clinton are heralded as "pro-choice" as long as they do not support legislative restrictions on abortion regardless of their stance on other issues that may equally affect the reproductive choices

women make. Clinton's approval of federal welfare reforms that place poor women in the position of possibly being forced to have an abortion because of cuts in social services, for instance, while often criticized, was not criticized as an "anti-choice" position. On the Web sites for Planned Parenthood and NARAL, there is little mention of welfare policies in their pro-choice legislation alerts.

The consequence of the "choice" paradigm is that its advocates often take positions that are oppressive to women from marginalized communities. For instance, this paradigm often makes it difficult to develop nuanced positions on the use of abortion when the fetus is determined to have abnormalities. Focusing solely on the woman's choice to have or not have this child does not address the larger context of a society that sees children with disabilities as having lives not worth living and that provides inadequate resources to women who may otherwise want to have them. As Martha Saxton notes, "Our society profoundly limits the 'choice' to love and care for a baby with a disability."[100] If our response to disability is to simply facilitate the process by which women can abort fetuses that may have disabilities, we never actually focus on changing economic and social policies that make raising children with disabilities difficult. Rashmi Luthra notes, by contrast, that reproductive advocates from other countries such as India, who do not operate from this same "choice" paradigm, are often able to take more complicated political positions on issues such as this one.[101]

Another example is the difficulty pro-choice groups have in maintaining a critical perspective on dangerous or potentially dangerous contraceptives, arguing that women should have the "choice" of contraceptives. Mainstream pro-choice organizations have not generally taken on the issue of informed consent as part of their agenda.[102] One reason these groups have not taken a position on informed consent on potentially dangerous contraceptives is because they are invested in population control. Yet, as Betsy Hartmann has argued, while contraceptives are often articulated as an issue of "choice" for white women in the First World, they are articulated as an instrument of population control for women of color and women in the Global South.[103] Indeed, in her book *The War on Choice,* Gloria Feldt, president of Planned Parenthood,

equates opposition to Norplant and Depo-Provera as opposition to "choice."[104] Planned Parenthood and NARAL opposed restrictions against sterilization abuse, despite the thousands of women of color who were being sterilized without their consent, because such policies would interfere with women's "right to choose."[105]

Some of these organizations have been supported by the Center for Research on Population and Security, the purveyor of Quinacrine. The Fund for a Feminist Majority featured this organization at its 1996 Feminist Expo because, I was informed by the organizers, they promoted "choice" for women. Then in 1999, Planned Parenthood nearly sponsored a Quinacrine trial in the U.S., until pressure from groups such as the Committee on Women, Population and the Environment and the Boston Women's Health Book Collective forced it to change its position.[106]

The prevalent ideology within the mainstream pro-choice movement is that women should have the "choice" to use whatever contraception they want. Yet mainstream activists often do not consider that a choice among dangerous contraceptives is not much of a choice. In a study commissioned in 1960, Planned Parenthood concluded that poor people "have too many children,"[107] and something must be done to stop this trend in order to "disarm the population bomb."[108] Today, Planned Parenthood is particularly implicated in this movement, as can be seen by the groups it lists as its allies on its Web site: Population Action International, the Population Institute, Zero Population Growth, and the Population Council. A central campaign of Planned Parenthood is to restore U.S. funding to the United Nations Population Fund (UNFPA). In addition it asserts its commitment to addressing "rapid population growth." As Hartmann documents, the UNFPA has long been involved in coercive contraceptive policies throughout the world. The Population Council assisted in Norplant trials which were conducted without informed consent of participants in Bangladesh and other countries.[109] In fact, trial administrators often refused to remove Norplant when requested.[110] All of these population organizations generally share the goal of promoting long-acting hormonal contraceptives of dubious safety around the world.[111]

Of course Planned Parenthood does provide valuable family planning resources to women around the world as well, but it does so through a population framework that inevitably shifts a focus from family planning as right in and of itself to family planning as an instrument of population control. Groups that advocate population control, such as Planned Parenthood, have become increasingly more sophisticated in their rhetoric and often talk about ensuring social, political, and economic opportunity. However, the "population" focus of this model still results in its advocates focusing their work on reducing population rather than in actually providing social, political and economic opportunity.

Another unfortunate consequence of uncritically adopting the "choice" paradigm is the tendency of reproductive rights advocates to make simplistic analyses of who our political friends and enemies are in the area of reproductive rights. That is, all those who call themselves "pro-choice" are our political allies while all those who call themselves pro-life are our political enemies. An example of this rhetoric is Gloria Feldt's description of anyone who is pro-life as a "right-wing extremist."[112] As I have argued elsewhere, this simplistic analysis does not actually do justice to the complex political positions people inhabit.[113] As a result, we often engage uncritically in coalitions with groups who, as antiviolence activist Beth Richie states, "do not pay us back."[114] Meanwhile, we often lose opportunities to work with people with whom we may have sharp disagreements, but who may, with different political framings and organizing strategies, shift their positions.

To illustrate: Planned Parenthood is often championed as an organization that supports women's right to choose, and one with whom women of color should ally. Yet, the roots of the organization are in the eugenics movement. Its founder, Margaret Sanger, collaborated with eugenics organizations during her career, and linked the need for birth control to the need to reduce the number of those in the "lower classes."[115]Today Planned Parenthood is heavily invested in the population establishment, and continues to support population control policies in the Global South.

In contrast, the North Baton Rouge Women's Help Center in Louisiana, a crisis pregnancy center, articulates its pro-life position from an antiracist perspective. It argues that Planned Parenthood has advocated population control, particularly in communities of color. It critiques the Black Church Initiative and the Religious Coalition for Reproductive Choice for contending that charges of racism against Sanger are "scare tactics."[116] It also attempts to provide its services from a holistic perspective—it provides educational and vocational training, GED classes, literacy programs, primary health care and pregnancy services, and child placement services. Says one of the Help Center's leaders, "We cannot encourage women to have babies and then continue their dependency on the system. We can't leave them without the resources to care for their children and then say, 'Praise the Lord, we saved a baby.'"[117]

While both groups support some positions that are beneficial to women of color, they both support positions that are detrimental to women of color. So, if we are truly committed to reproductive justice, why should we presume that we should necessarily work with Planned Parenthood and reject the Women's Help Center? Why would we not instead position ourselves independently from both of these approaches and work to shift both of their positions to a stance that is truly liberating for all women?

To develop an independent position, it is necessary to reject the "pro-choice" framework. Such a strategy would enable us to fight for reproductive justice as a part of a larger social justice strategy. It would also free us to think more creatively about whom we could work in coalition with while simultaneously allowing us to hold those who claim to be our allies more accountable for the positions they take. To be successful in this venture, it is not sufficient to simply articulate a women of color reproductive justice agenda—we must focus on developing a nationally coordinated women of color movement. There are many women of color reproductive rights organizations, relatively few actually focus on bringing new women of color into the movement and training them to organize on their own behalf. And such groups that do exist are not generally coordinated into national mobilization efforts. Rather, national work is generally done on an advocacy level, with heads of women of color organizations advocating for policy changes but often working without a solid base to back

their demands.[118] Consequently, women of color organizations are not always in the strongest position to negotiate with power brokers and mainstream pro-choice organizations or to hold them accountable.

As an example, many women of color groups mobilized to attend the 2004 March for Women's Lives in Washington, D.C. to push the march beyond a narrow pro-choice abortion rights agenda to a broad-based reproductive rights agenda. While this broader agenda was reflected in the march, it became co-opted by the pro-choice paradigm in the media coverage of the march. My survey of major newspaper coverage of the march indicates that virtually no newspaper described the march as anything other than a pro-choice, abortion rights march.[119] To quote New Orleans health activist Barbara Major, "When you go to power without a base, your demand becomes a request."[120] Such base-building work, which many women of color organizations are beginning to focus on, is very slow work, which may not show results for a long time. But maybe one day, we will have a march for women's lives in which the main issues addressed and reported on include repealing the Hyde Amendment; stopping the promotion of dangerous contraceptives; decriminalizing women who are pregnant and who have addictions; and ending welfare policies that punish women, in addition to other such issues that speak to the intersections of gender, race, and class in reproductive rights policies.

In 1991, I attended a meeting of the United Council of Tribes in Chicago, and representatives came from the Chicago Pro-Choice Alliance to inform us that we should join the struggle to keep abortion legal or we would lose our reproductive rights.[121] A woman in the audience responded, "Who cares about reproductive rights? We don't have any rights period." Her response suggests that a reproductive justice agenda must make the dismantling of capitalism, white supremacy, and colonialism *central* to its agenda, and not just principles added to organizations' promotional material designed to appeal to women of color, with no budget behind making these principles a reality. We must reject single-issue, pro-choice politics of the mainstream reproductive rights movement as an agenda that not only does not serve

women of color but actually promotes the structures of oppression which keep women of color from having real choices or healthy lives.

Today, Native women have organized under a more holistic analysis of reproductive justice. A leading organization in this area is NAWHERC, based on the Yankton Sioux reservation in South Dakota. It provides comprehensive services and advocacy to Native women in the areas of reproductive health, including contraceptive information, environmental advocacy, violence against women, and advocacy around abortion policies. It has also organized a number of Native women's reproductive rights round tables, through which it articulated a reproductive rights platform. The principles include:

1. The right to knowledge and education for all family members, concerning sexuality and reproduction that is age, culture, and gender appropriate.
2. The right to all reproductive alternatives, and the right to choose the size of our families.
3. The right to affordable health care, including safe deliveries within our communities.
4. The right to access safe, free, and/or affordable abortions, regardless of age, with confidentiality and free pre- and post-counseling.
5. The right to active involvement in the development and implementation of policies concerning reproductive issues, including, but not limited to, pharmaceuticals and testing.
6. The right to include domestic violence, sexual assault, and AIDS as reproductive rights issues.
7. The right to programs which meet the nutritional needs of women and families.
8. The right to programs to reduce the rate of infant mortality and high-risk pregnancies.
9. The right to culturally specific, comprehensive chemical dependency prenatal programs including, but not limited to, prevention of fetal alcohol syndrome and its effects.
10. The right to stop coerced sterilization.

11. The right to a forum for cultural/spiritual development, culturally-oriented health care, and the right to live as Native women.
12. The right to be fully informed about, and to consent to, any forms of medical treatment.
13. The right to determine who are members of our Nations.
14. The right to continuous, consistent, and quality health care for Native peoples.
15. The right to reproductive rights and support for women with disabilities, including emotional disabilities.
16. The right to parent our children in a non-sexist, non-racist environment.
17. The right of Two Spirited women, their partners, and their families to live free from persecution or discrimination based on their sexuality and/or gender, and the right to enjoy the same human, political, social, legal, economic, religious, tribal, and governmental rights and benefits afforded all other indigenous women.
18. The right to give birth and be attended to in the setting most appropriate, be it home, community, clinic, or hospital, and to be able to choose the support system for our births, including, but not limited to, traditional midwives, families, and community members.
19. The right to education and support for breastfeeding that includes, but is not limited to, individuals and communities that allow for regrowth of traditional nurturing and parenting of our children.[122]

Conclusion

The attacks on the reproductive rights of Native women are frontline strategies in the continuing wars against Native nations. These attacks metaphorically transform Native people into pollution or dirt from which the body politic, to ensure its growth, must constantly purify itself. Herbert Aptheker describes the logical consequences of population control movements:

> The ultimate logic of this is crematoria; if people are themselves constituting the pollution and inferior people in particular, then crematoria becomes really vast sewerage projects. So only may one understand those who attended the ovens and concocted and conducted the entire enterprise; those "wasted" – to use U.S. army jargon reserved for colonial hostilities – are not really, not fully people.[123]

Patricia Hill Collins observes that the state's interest in limiting Black population growth coincided with the expansion of post-World War II welfare provisions that allowed many African Americans to leave exploitative jobs. As a result, the growing numbers of unemployed people of color were no longer simply a resource of cheap and convenient labor for white America; now these people of color are considered "surplus" populations.[124]

While Native people constitute a relatively small workforce, it is important to remember that the majority of the energy resources in this country are on Indian lands, so the continued existence of Indian people is a threat to American capitalism. Senate testimony by Utah politician Scott M. Matheson in 1989 opposing the protection of Indian sacred sites, on behalf of the mining industry, offers evidence of this fact. "Much of the country's natural resources are located on federal land. For example, federal lands contain 85 percent of the nation's crude oil, 40 percent of the natural gas, 40 percent of the uranium, 85 percent of the coal reserves, and 47 percent of the standing soft wood timber," said Matheson. "Thus it is obvious that [federal protection of sacred sites] by creating a Native American veto over federal land use decisions, will ...severely interfere with the orderly use and development of the country's natural resources."[125]

As the ability of Native women to reproduce the next generations of Native people continues to stand in the way of government and corporate takeovers of Indian land, Native women become seen as little more than pollutants which may threaten the well-being of the colonial body. In the colonial imagination, Native women are indeed "better dead than pregnant."