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The Continuing Struggle against Genocide: Indigenous Women's Reproductive Rights

D. Marie Ralstin-Lewis

> 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 how strong its weapons.
>
> ***Traditional Cheyenne saying***

Women have always been the backbone and keepers of life of the indigenous nations of North America. Most precontact indigenous civilizations functioned as matriarchies, and women of those cultures did not espouse subordination to males, whether such males were Native or from the white/Euro-American culture. Considering their traditional significance in the continuation of Native cultures, it should not come as a surprise that European colonizers often targeted Native[1] women. The assaults on Native women continue to be a goal of some descendants of these European colonizers.

Ironically, while middle-class white America applauded a newfound freedom over reproductive rights during the 1960s and 1970s, many policy makers and physicians targeted Native women for involuntary birth control and sterilization. Estimates indicate that, from the early to mid-1960s up to 1976, between 3,400[2] and 70,000[3] Native

women—out of only 100,000 to 150,000 women of childbearing age—were coercively, forcibly, or unwittingly sterilized permanently by tubal ligation or hysterectomy. Native women seeking treatment in Indian Health Service (IHS) hospitals and with IHS-contracted physicians were allowed neither the basic right of informed consent prior to sterilization nor the right to refuse the operation. IHS also subjected mentally retarded Indian girls and women to a contraceptive known as DepoProvera before it received approval from the Federal Drug Administration (FDA) in 1992.[4]

From 1970 to 1980, the birthrate for Indian women fell at a rate seven times greater than that of white women. This dramatic statistic indicates that the sterilization and birth control campaign was significantly more than an attack on women in general: it was a systematic program aimed at reducing the Native population, or genocide. The United Nations recognizes prevention of births in a target group as a form of genocide. Attacks on the reproductive capacities to indigenous women in the United States continue today through the use of chemical contraceptives such as Norplant and DepoProvera. The latest threat is a new form of nonsurgical permanent sterilization known as quinacrine sterilization.[5]

Was the IHS sterilization abuse prompted by individual racism among doctors? Were their actions a dying gasp of government-sanctioned eugenics in the United States? Or was it a reprisal for gains in indigenous sovereignty? Violations against the reproductive rights of indigenous women did not occur because of the efforts of any one individual or agency, nor can a single explanation or theory account for them. Rather, these violations resulted from sexism and racism, remnants of eugenics, population-control measures, and family-planning programs that drew large subsidies from the federal government. Complicating this situation are the unique political and social realities of indigenous peoples, who were often dependent on the federal government for health care while also demanding federal recognition of their rights to land and sovereignty.

This research examines the Native American and Euro-American cultures' differing views toward women and birth. It provides an overview of eugenics and how it used a combination of biological and racist rhetoric to justify offenses against Native women and their capacity to give birth. In addition, I assert that population-control ideas (ostensibly aimed at ending poverty) legitimated these offenses in the minds of many physicians who performed the procedures. Finally, I investigate the federal government's role in the genocide by examining evidence found in court cases, the Indian Health Service (IHS), the Bureau of Indian Affairs (BIA) records, and reports from Native American community leaders.

WOMEN—A CLASH OF WHITE AND NATIVE CULTURES

Traditionally, Native women held positions of esteem in tribal societies and were thought to be born with certain dispositions toward spiritual guidance, and so could offer important knowledge in many matters. As Paula Gunn Allen states, they held a responsibility to maintain the life of the tribe:

> Women are . . . graced with certain inclinations that make them powerful and capable in certain ways. . . . Their power includes bearing and rearing children . . . cooking and similar forms of "women's work"; decision making; dreaming and visioning; prophesying; divining, healing, locating people or things; harvesting, preserving, preparing, storing, or transporting food and healing stuffs; producing finished articles of clothing; making houses and laying them out in the proper village arrangement; making and using all sorts of technological equipment such as needles, scrapers, grinders, blenders, harvesters, diggers, fire makers, lathes, spindles, looms, knives, spoons, and ladles; locating and/or allocating virtually every resource used by the people.[6]

Within Native cultures, woman derived their influential and powerful status "by virtue of her femaleness, her natural and necessary fecundity, and her personal acquaintance with blood" (meaning menstruation). European settlers who came to North America embracing Christianity and a rigid system of patriarchy, however, had another view of women. In their quest for land and resources, they profoundly disrupted and dishonored the cooperation and balance between tribal men and women, as well as the agency of women.[7]

Native women did not fit into the classification systems of the Christian colonizers. Native communities often functioned harmoniously without the distinction of gendered social ranks that Christians expected. Patriarchy essentially left women dependent and vulnerable to male coercion. Many Native cultures, by contrast, recognized women as autonomous beings existing within a system of mutual responsibility. This equality of gender struck European settlers as odd, if not blasphemous.

At various times, the colonizers sought to transform Indians into mirror images of Europeans. As the nineteenth century progressed, federal policy demanded that Native women abandon their customary roles as familial anchors and accept a life in male-dominated households. These disruptions of Native cultures subsequently increased the power

of Native men at the expense of the women, who not only lost influence in their own domestic sphere but formal voting authority in some tribes as well. Moreover, the influence of Christianity and its redefinition of gender hierarchies decreased women's autonomy by changing notions of sexual propriety.

The differing attitudes of Native American and Euro-American cultures toward women are especially evident in the different ways the two viewed female sexuality and reproduction. Post–Civil War America saw a resurgence among white Americans in the longstanding belief that women were especially liable to insanity and nervous disorders because of their female sexual organs (the polar opposite of the view of most tribal societies). Men often blamed social problems on women's sexuality. In 1866, for instance, Dr. Isaac Gray stated that all women, by virtue of simply being female, "are on the verge of hysteria, insanity, and crime." A woman "was supposed to be dependent, submissive, unquenchably supportive, smiling, imparting an irrelevant morality, regarding sex as something to be endured, and her own organs as somehow a dirty if necessary disease."[8] As the century came to a close, the eugenics movement surfaced as a threat to the Native population.

CONNECTING REPRODUCTIVE ABUSES AND RACISM

In Europe during the late 1800s, Sir Francis Galton, cousin of Charles Darwin, coined the term "eugenics" (literally meaning "well-born"). Galton advocated the regulation of human breeding to ensure the propagation of the more "talented" (essentially members of the upper class and enterprising members of the middle class) of the species. Eugenics is defined as "the method of improving the intellectual, economic, and social level of humans by allowing differential reproduction of superior people to prevail over those designated as inferior." As the eugenics movement spread rapidly throughout Europe in the late nineteenth and early twentieth centuries, its followers established laboratories, international societies, and serial publications to promote their agenda.[9]

In the early 1900s, U.S. scientists focused their research on human heredity, encouraging the growth of the eugenics movement in the United States. Unfortunately, the predominant belief among geneticists was that a single gene controlled most human traits, but little consideration was given to how environment might influence behavioral traits. This nature-over-nurture theory led to the conclusion that those who where mentally ill, poor, criminal, retarded, or simply unsuccessful were not only socially but also biologically inferior. For eugenicists, then, improving society meant identifying and controlling inferior groups and their breeding practices. As eugenics grew in the United States, dis-

agreement increased about whether the movement should focus solely on race or include other "inferiorities" such as insanity, criminality, and physical defects. Many eugenicists, feeling that whites were more advanced than other races in the evolutionary process, viewed higher birthrates among Native Americans and other people of color with alarm. Compounding matters, many whites saw declining birthrates of white women as the harbinger of "race suicide" for whites. Additionally, with the long history of racism in the United States even before the onset of the eugenics movement, eugenicists had little trouble influencing many whites that people of color were inferior.[10]

Many civil rights leaders alleged that, even after the revelation of genocide in World War II, eugenic influences remained strong in the United States.[11] Fredrick Osborn, the secretary of the American Eugenics Society, kept the eugenic philosophy alive from 1928 to 1972. Osborn endorsed programs in Nazi Germany that sterilized Jews, Poles, and others deemed "unsuitable." Although news of Hitler's genocidal acts caused revulsion in America about eugenic ideals, Osborn continued promoting eugenic principles into the 1960s. He even served on the Population Council from 1952 to 1968.

In 1952, John D. Rockefeller III formed the Population Council.[12] The group was made up of some of the most affluent individuals of the time: Fredrick Osborn (secretary of the American Eugenics Society and later a leader of Planned Parenthood), Lewis Strauss (director of Radio Corporation of America [RCA], National Broadcasting Corporation [NBC], and the Rockefeller Center), Karl Compton (trustee of the Ford Foundation), and Detlev Bronk (president of the Rockefeller Institute). Of the ten men on the advisory boards of the Population Council, six had been associated with eugenics. The affluence of the members of both the eugenics movement and the population-control programs is significant *because* the council aimed its fertility control policies toward the lower classes and nonwhites.[13]

Twenty years after the Population Council's formation, its influence could still be seen. During the 1970s in the United States, sterilization rates of black women were more than double that of white women. However, the per capita sterilization rate for Native American women was 42 percent, by far the highest of all ethnic groups. As of 1982 the differences of those sterilized among color lines are startling (see Figure 1).

Ironically, while Native American women and other women of color experienced coercive sterilization, many white Americans fought *for* the ability to have access to voluntary sterilization. Before 1970, most hospitals and government agencies objected to sterilization as a form of birth control for their white patients.[14] No general federal laws regulating voluntary sterilization existed until the late 1970s. In *Jessin v. County of Shasta* (1969), the court ruled that sterilization may be

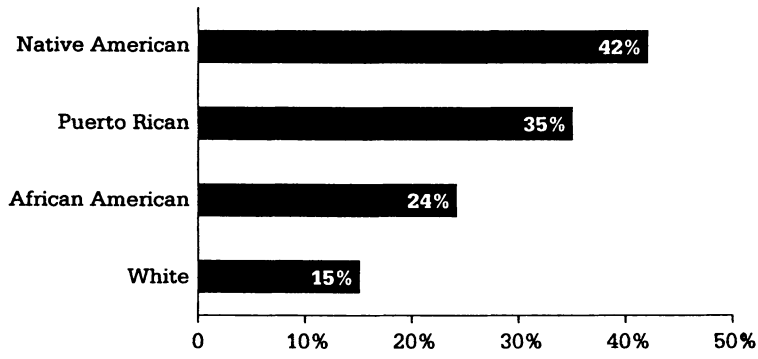

Figure 1. Statistics adapted from Horsburg, *Schrödinger's Cat.*

a fundamental right and that sterilization was legal so long as informed consent had been given. Before this case many physicians assumed that sterilization, for the sole purpose of birth control, was illegal.[15]

However, many doctors (often from white, middle- or upper-class backgrounds) favored sterilizing poor women, especially Native women. An astonishing number of doctors did not think that Native women were competent enough to effectively use birth control. A 1972 study found that six percent of doctors would recommend sterilization as a permanent form of birth control for their private white patients, while fourteen percent of doctors recommended sterilization for poor and minority patients on public assistance. In the case of welfare mothers with three or more children, ninety-seven percent of doctors either recommended or preferred sterilization. Numerous doctors favored punitive action toward women with several illegitimate children, such as withholding welfare benefits and compulsory sterilization. A study the following year revealed that many of these white doctors believed that they were helping society by limiting the births of low-income minority women, and alleviating their own tax burdens.[16]

POPULATION CONTROL OR GENERATIONS OF GENOCIDE?

Many proponents of population control, such as the group Population Connection (formerly Zero Population Growth), assert catastrophic consequences unless quick and decisive actions are taken. A common claim among such groups is that it is the size of population rather than the unbalanced distribution of wealth that causes a lack of resources for the poor. Administrators of population control programs—often members of the upper stratum of society—have wielded and continue to exercise a dangerous level of power. To many of them, coercive sterilization was and is a solution for those who would not otherwise voluntarily con-

form to the dominant ideology of limiting population growth. Indian peoples' historical relationship with the federal government illustrates concretely the development and practice of such coercion.

Deprived of their traditional ways of life through the twin effects of federal policy and U.S. expansion, Native peoples lost their self-sufficiency, experienced dramatic population losses, and were forced to depend on government subsidies and health care to survive. Consequently, Western forms of medicine administered by white doctors became an integral part of Indian life. Receiving inferior health care, Indians suffered from various diseases. D'Arcy McNickle reports that until the 1930s federal Indian policy followed the assumption that the Indians would eventually disappear, and officials referred to the "vanishing Indian" long after the Native population began to increase around 1900. During the Franklin D. Roosevelt administration, the federal government finally realized that the Natives were not headed for extinction. Even so, in 1945 the government passed statutes terminating (dissolving federal recognition of) Indian nations. While many tribes escaped termination, BIA representatives pressured tribal members to migrate to urban communities. Numerous Natives, however, remained on their Native lands. Although some terminated tribes eventually had their federal recognition restored, life and health care on reservations did not improve.[17]

Facing poverty and having few options, many Native women remained almost entirely dependent on the federal government for health care through IHS. In fact, federal policies had left many Natives trapped in a cycle of poverty and landlessness. This dependence has placed them at greater risk than other minority groups for abuses by the medical profession. While other women also became victims of sterilization and reproductive rights abuses, Indian women constitute a unique class of victims. Different social and cultural realities set them apart from other women of color. Because of their dependence on IHS health care and various state medical programs, they were vulnerable to the health personnel practicing medicine in those public facilities. The federal government, through IHS physicians, increasingly targeted Indian women because of the women's high fertility rates. The 1970 census shows that, over a lifetime, Indian women had an average of 3.79 children. This rate was significantly higher than the median fertility rate of all other women in the United States, with only 1.79 children per mother. Apparently, because the government has a responsibility to provide services to those it recognizes as Native American, it would prefer to limit rather than increase that number. From 1970 to 1980 the birthrate for white women fell by .28 children while the birthrate for Native American women declined by 1.99 children.[18]

During the 1960s, industrial leaders (and especially Rockefeller family members) encouraged the Nixon administration to give both

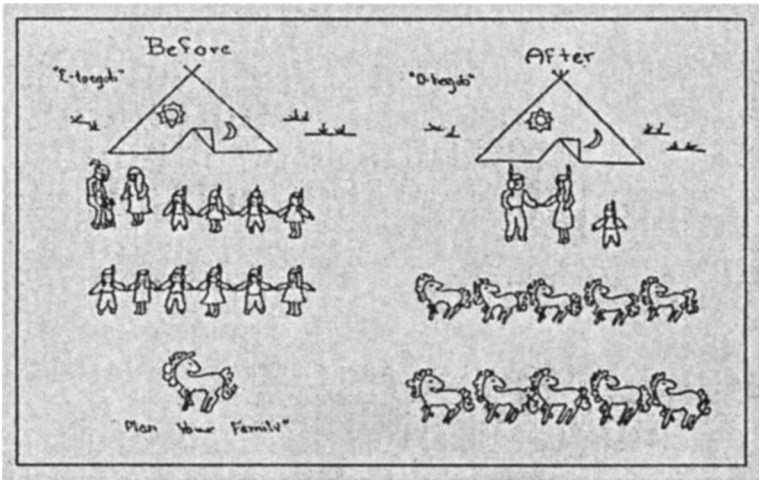

Figure 2. A 1974 Department of Health Education and Welfare pamphlet titled *Plan Your Family.*

ideological and financial support to the cause of population control. In 1969, the American College of Obstetricians and Gynecologists began to ease restrictions on sterilizations. In 1970, with the Family Planning Act, Congress officially authorized sterilization for the poor. IHS began offering family planning services in 1965 and officially launched its sterilization campaign in 1970 with federal funding. Between 1969 and 1974, the Department of Health, Education, and Welfare (HEW) greatly escalated funding programs, paying ninety percent of the costs to sterilize poor Native women.[19]

With public and federal support for eugenics (now known as population control), both the federal government and its doctors strongly suggested sterilization to Indian women, even resorting to the use of propaganda. In 1974, the HEW circulated pamphlets among Indian communities extolling the benefits of sterilization. One, called "Plan Your Family," contains a cartoon depiction of Indians "before" and "after" sterilization. The Indians before sterilizations appear sad and downtrodden. The couple has ten little Indian children and only one horse, implying they are poor because they have too many mouths to feed. In contrast, the Indian couple in the "after" picture is happy; they one have one child and many horses (see Figure 2).[20]

INFORMED CONSENT: LEGAL REQUIREMENT OR LEGAL THEORY?

In the early 1900s, doctors had the power to make judgments about appropriate medical treatment for their patients. The 1914 landmark decision of *Schloendroff v. Society of New York Hospital* began to shift power

away from doctors toward patients. The Supreme Court asserted in that case that "every human-being being of adult years and sound mind has a right to determine what can be done with his own body, and a surgeon who continues to operate without his patient's consent commits an assault for which he is liable for damages." This decision not only allowed patients to control their own medical treatment but became the foundation for the doctrine of informed consent. Forty-four years later, another landmark case, *Salgo v. Leland Stanford Jr. University Board of Trustees* (1957), further defined the elements of informed consent by declaring that it must include any pertinent facts (such as risks of the procedure and alternatives) necessary for a patient to make an informed and intelligent decision. Thus, the patient must not only consent but must be properly informed, and this information must be relevant and unbiased.[21]

Despite these rulings, IHS facilities continually violated Native women's rights to informed consent. Today (and during the time of the sterilizations), the elements of informed consent are: (1) the patient must be of sound mind and have decision-making capabilities (Native American women were often asked to sign forms while under the influence of medication and/or in the throes of labor); (2) adequate information must be presented—in other words, the patient needs to be told what a "reasonable patient in similar circumstances would need to know in order to make informed decisions" (IHS providers often did not tell Native women that they were being sterilized at all); (3) an appropriate amount of facts must have been discussed with the patient, which includes diagnosis, the nature of the procedure to be done, risks of the procedure, likelihood of success, anticipated benefits, and alternative treatments (many Native women were told by IHS doctors and nurses that they could have their tubes "untied" whenever they desired); and (4) the patient's decision must be voluntary, not based on coercion, duress, or fraud (time after time Native women were told they would lose their welfare and/or health benefits if they did not agree to undergo tubal ligation).[22]

Many Native American women were coerced, rather than forced, to sign consent forms. In "Informed Choice and Population Policy," L. M. Cirando defines coercion:

> It may be useful to conceptualize voluntariness along a continuum, from one end, where persuasion merely facilitates decision making, to the other end, where coercion precludes voluntary decision-making. Between these two extremes exist varying degrees of manipulation, some more harmful to voluntariness than the others. With this framework in mind, a patient persuaded to accept medical treatment voluntarily consents to treatment, while a patient coerced into accepting medical treatment does

not voluntarily consent. If the patient does not consent to treatment voluntarily, the consent is invalid.[23]

A physician with racist and paternalistic beliefs may possess the power of an authority figure over the patient. A physician could simply exert this power in "recommending" sterilization of a woman patient. This patient is not literally forced to sign this consent form. However, a Native woman in this situation may feel that she has no other choice.[24]

In "Sterilization Abuse: Current State of the Law and Remedies for Abuse," Dick Grosboll further clarifies consent as it applies to sterilization abuse. Consent has not truly been given if a woman is sterilized (1) without being given the information that the procedure is irreversible, (2) devoid of knowledge of all risks and benefits of and alternative options to the procedure, (3) due to a threat of termination of benefits such as welfare or medical services, (4) by hysterectomy unless it is medically necessary, (5) lacking comprehension of the gravity of the procedure because of a language barrier, (6) because of coercion by a physician who imposes her or his own values on the woman. Examples of every one of these violations are present in the history of sterilization abuse against Native women.[25]

When federal sterilization policies were relaxed in the 1970s,[26] the medical profession leaned toward having no restrictions at all on sterilization, allowing a decision to be solely between doctor and patient. To some, this may seem like a logical and ideal policy. However, doctors have a status that enables them to exert a strong influence over their patients. A doctor's attitudes and practices toward those he or she counsels in a family-planning context must be scrutinized to ensure there is no subtle or overt coercion of the patients. Moreover, even if a patient is fully informed, they may not be able to make a voluntary decision if their doctor has subjected them to subtle coercion.

THE DISCOVERY OF STERILIZATION ABUSE IN INDIAN COUNTRY

In 1974, Constance Redbird Pinkerton-Uri, a Choctaw/Cherokee physician, upon hearing complaints from women sterilized against their will, launched her own investigation into the forced and coerced sterilization of Native American women. After several years of examining IHS records and interviewing medical staff and victims, Dr. Uri convinced Senator James Abourezk (Democrat, South Dakota) of the Senate Interior Subcommittee on Indian Affairs to look into the matter. Senator Abourezk prompted a General Accounting Office (GAO) study of IHS records.

The GAO report (HRD-77-3) has been called "only the tip of the iceberg of United States government sponsored sterilizations con-

ducted on American Indians,"[27] and it gave an idea of the severity of the problem, although it was plagued with limitations. Although the GAO report only investigated four of the twelve IHS hospitals, the number of sterilizations was still staggering. In just over three years (1973–1976) in these four hospitals, 3,406 women were sterilized. Senator Abourezk commented that, considering the small number of Native Americans in the population, sterilizing 3,406 Indian women would be comparable to sterilizing 452,000 white women. There is little doubt that the number would actually be larger if the investigation had covered all the IHS facilities (and private facilities with IHS contracts). Additionally, the GAO failed to interview women who had been sterilized, nor did it ask Indian communities for information regarding sterilizations. Its investigators only considered documents provided by IHS officials. The GAO conducted the investigation in an attempt to discredit Dr. Uri. However, the number of sterilized women was too significant to be coincidental.[28]

While the report never fully established that the IHS had actually coerced women into having sterilizations, it did stress that there were deficiencies in the informed consent process. The report revealed that IHS consent forms ignored problems of cultural and language differences. There is no indication that an appropriate explanation was given for sterilization, a word that does not exist in some tribal languages. The women often lacked an understanding of the finality of the procedure or even the nature of the procedure itself. Additionally, the report exposed that, while not forced, many women thought they *must agree* to the procedure. The report also found that the consent forms used by IHS *did not inform the women that they had the right to refuse to be sterilized.* Some of the sterilizations were performed on women under the age of twenty-one, some were done by way of an unnecessary complete hysterectomy rather than a simple tubal ligation, and many of the basic elements of voluntary, informed consent were missing from the consent forms the hospitals used.[29]

Female members of the American Indian Movement (AIM) established Women of All Red Nations (WARN) in 1978 after seeing a need for more independent investigations into the sterilizations of Native women and with a concern about the issues of Native women in general. WARN, along with other women's organizations, publicized the sterilization campaign, charging that many of these procedures were performed by way of pro forma consent. They pointed out that the consent offered often was not in the woman's language and was couched with threats of depriving welfare benefits if the women had more children. Other reports, such as those where teenaged girls had their ovaries removed after being told they would undergo only a tonsillectomy, illustrate the blatant deception that was used in the sterilization of some Native women.[30]

As news of the sterilizations spread, many Native American community leaders, including Cheyenne tribal judge Marie Sanchez, conducted their own inquiries. Sanchez and a Northern Cheyenne tribal member, Mary Ann Bear Comes Out, found that, over a three-year period, the IHS had sterilized 56 out of only 165 women of childbearing age on the Northern Cheyenne Reservation and Labre Mission grounds. They estimated that these sterilizations resulted in reducing births within this group by half or more over a five-year period. After spending much of his life investigating the sterilization campaign, Lehman Brightman (Lakota) estimated that forty percent of all Native women were sterilized.[31]

EXTINGUISHING ABORIGINAL TITLE

Was the IHS sterilization abuse prompted by doctors' individual racism or was this one of the last gasps of government-sanctioned eugenics in the United States, perpetrated to acquire remaining Native land? Since the establishment of the first European colonies on the continent of North America, control of land and natural resources have been the fundamental source of conflict between the settlers and indigenous nations. The federal government has utilized several tactics to disenfranchise Indian people from their rights to claim an Indian identity, the source of Indians' rights to aboriginal title. This long-term strategy of the federal government has removed Indian people from their aboriginal homelands and subjected them to coercive medical practices, including sterilization, with the intent of reducing the number of Indians that can claim rights to Native land.[32]

Over the course of its history, the United States government has entered into more than 370 treaties with numerous Indian nations in order to claim "legal" title to their lands. Indian nations were consequently disenfranchised from their land and sent to live on reservations, radically changing their way of life. Additionally, while the stated purpose of the allotment acts of the late nineteenth century and the early twentieth century was to encourage Indian "self-support" and agriculture, the eventual result of these acts was a continued disenfranchisement of millions of acres from Indian ownership. Indians were granted individual allotment rights but were unprepared to compete with the surrounding settler societies. Finally, pressure from white settlers for more land soon prompted the opening of more reservations for the express purpose of giving the Native allotments to whites, who were thought to be best suited to make use of the lands. In exchange for the land, and to assist the Indians in surviving the economy while on reservations, the federal government offered Native populations health care and other federal services.[33]

While late-twentieth-century Indian leaders began questioning

the effectiveness and effects of the healthcare and other federally provided services in their community, a contemporary reincarnation of the principles of Manifest Destiny began to emerge. Corporations seeking rich natural resources began prospecting Indian reservations, lands formerly set aside for the sole use of Indian nations and deemed worthless by the government. Many reservations are rich in oil, natural gas, copper, coal, and uranium. The demand for these resources began, once again, to encroach on Native land rights. One tactic for acquiring the remaining Native lands and consequently reducing the need for expensive government programs was to prevent or diminish the birth of the next generation of Indians and so reduce the number of Native people who could claim title to the lands.[34]

Sterilization of Indian women, and the resulting loss of children, endangers the sovereignty and economies of Indian nations. Because all titles to land in the United States must, at some point, follow a path from the aboriginal inhabitants of this country to the United States government, the property can only be owned after the aboriginal title has been extinguished.[35] Leaders in Indian Country, therefore, assert that the sterilization campaigns are schemes to get remaining Indian land and constitute a backlash against gains in Native sovereignty. President of United Native Americans Inc., Lee Brightman, claims that "the sterilization campaign is nothing but an insidious scheme to get Indians' lands once and for all." Others charge that the sterilizations were sought to reduce sovereignty and acquire natural resources on Native lands.[36]

ACCOUNTABILITY?

Most Native women who were forcibly or unknowingly sterilized did not seek legal remedies, due to embarrassment or shame over their lost fertility. Of those who did, most cases were dismissed or settled due to pressure from defense attorneys. Physician coercion is often hard and expensive to prove, and for these reasons legal remedy is not often sought out by women as poor as those who were victimized. Furthermore, if action were taken against an IHS physician, the doctor being sued would be able to obtain legal defense, at no cost, from the United States Department of Justice.

In any event, no monetary award can compensate for a woman's stolen fertility. Among white women who obtain tubal ligation, between ten and thirty percent of them regret the decision. However, studies show that women of color experience a much higher level of regret than white women.[37] Such regret stems from several causes, with maybe the most significant being the essential irreversibility of the procedure. Though operations for reversal of tubal ligation now exist, they are very costly, not covered by insurance, and are not always

effective. In the 1960s and 1970s such procedures were highly experimental, not readily available, and only effective ten to twenty percent of the time.[38]

A woman who is forcibly sterilized suffers permanent psychological damage. One consequence of sterilization for Native women is fewer available marriage partners. Women who were sterilized prior to marriage or were trying to remarry found that the inability to have children became a problem for prospective partners. In other cases the damage appears in difficult family relations. Many times the shame experienced by sterilized Indian women prevents them from coming forward to their loved ones. Many Native cultures are based on the value of the family, and for a Native woman to admit that she had unknowingly relinquished her reproductive capabilities would be devastating, not only for themselves but to their relations as well.[39]

While most Native women who were sterilized have not sought a formal legal remedy, three Northern Cheyenne women did file suit against the hospital that sterilized them in Montana. The plaintiffs' complaint reflected the deep cultural value placed on motherhood among the Cheyenne. The women, deeply ashamed that they had lost their fertility, had been either sterilized without their knowledge or without full understanding of the procedure. While the case did reach the Supreme Court, attorneys for the defendants persuaded the women to accept a cash payment to settle the case, and the case consequently was never heard in the Supreme Court.[40]

A key case in the fight for sterilization regulation and against forced sterilization for nonwhites was *Relf v. Weinberger* (1977). The Relfs were a poor black family in Alabama. They and their six children lived in public housing and received free health care from the state. Among their six children were two teenaged daughters, Minnie and Mary Alice. With no actual or provable cause, nurses from a community action agency suspected the two girls of promiscuity and regularly took them for DepoProvera shots until the FDA banned the drug. In June 1973, the nurse came to take the girls again, under the pretense they would receive more DepoProvera shots, but instead took them to be sterilized. The nurse had previously approached the mother for permission to sterilize her daughters, but she refused. The Relfs eventually filed a $25 million suit against various public officials.[41]

The court in *Relf* recognized the coercive possibilities that existed in leaving decisions such as these solely between the doctor and the patient:

> Although Congress has been insistent that all family planning programs function on a purely voluntary basis, there is uncontroverted evidence in the record that minors and other incompetents have been sterilized with federal funds

> and that an indefinite number of poor people have been improperly coerced into accepting a sterilization operation under the threat that various federally supported welfare benefits would be withdrawn unless they submitted to irreversible sterilization. Patients receiving Medicaid assistance at childbirth are evidentially the most frequent targets of this pressure.[42]

The court ruled that "federal family planning funds not be used to coerce indigent patients into submitting to sterilization," and further proclaimed, "The dividing line between family planning and eugenics is murky."[43]

After the *Relf* case, the government was ordered to produce sterilization guidelines. To be included in these guidelines was the direction that prospective sterilization candidates be advised that their welfare benefits did not depend on their decision about sterilization, in contrast to the pernicious status quo of medical advisement in cases involving Native women. Perhaps not surprisingly, these guidelines had already been written but had been tabled prior to the 1972 election for fear that their release would cause Richard Nixon to lose the Catholic vote. These guidelines, if they were followed, could have prevented the Relfs' sterilizations and, given the medical history, many sterilizations of Native women as well.[44]

The question remains: How do we hold governments accountable for a violation of human rights of this magnitude? Anika Rahman, a staff attorney in the International Program of the Center for Reproductive Law and Policy, concludes that,

> When considering accountability, the central inquiry is: How can governments be forced to deal with these very concrete problems that millions of women around the world face? Obviously, these are enormous problems—and not just within the reproductive-rights framework, but in all human rights areas. The first issue that must be considered relates to the human rights standard by which to hold governments and other players accountable for their actions. This important determination necessitates inquiries regarding the definition of the right to health care, assessments of women's enjoyment of this human right, and the progress made in this field.[45]

The right to reproductive freedom should not only include the right to birth control. It should include the right to natality and the right to choose when to procreate. However, the issues that are dealt with in this realm are more than just rights to birth control, choice, and

natality—they are human rights. Additionally, within the context of racially motivated sterilization, not only are the human rights of the individual violated but a people's right of existence.

TODAY'S STERILIZATIONS: ABUSES OF DEPOPROVERA, NORPLANT, AND QUINACRINE

It is ironic, but not surprising, that soon after Native American women and other women of color had brought sterilization scandals to light, they seemed powerless in preventing the next abuse of reproductive freedom: DepoProvera and Norplant. In the years before 1973, while DepoProvera[46] was still pending approval from the FDA for use in birth control, hundreds of Native American women (the majority of them mentally retarded) were injected with DepoProvera.[47] DepoProvera gained clearance from the FDA, however, only in 1992, and its longer-lasting counterpart, Norplant,[48] won acceptance in 1990. The Population Control Council developed Norplant, which was also heavily promoted by Indian Health Services both in the past and present. Many side effects plague women using DepoProvera and Norplant. These problems have prompted more than 400 lawsuits representing about 500,000 women nationwide. The makers of Norplant settled many of these cases for a meager amount: 36,000 women were offered $1,500 each.[49]

Unfortunately, DepoProvera and Norplant, while seemingly perfect solutions to the perceived "Indian problem," can only be seen as abuses against Native women's reproductive rights. Most women were not given information about the drugs' possible side effects, one of which is the cessation of the menstrual cycle. Menstruation, deeply important to the religious lives of both men and women in traditional Native cultures, allows women to go through a process of spiritual transformation and cleansing. Native men must undergo rituals to enable them to participate in this process. Removing this natural process, in effect, places Native women on the same level as men spiritually. Some women, after discontinuing their use of DepoProvera, wait up to two years before returning to a normal menstrual cycle. Some are rendered totally infertile.[50] Another significant problem associated with the use of Norplant and DepoProvera is excessive bleeding. Some studies cite continuous bleeding episodes of eighty days or more. Another study revealed bleeding episodes ranging from eleven to thirty days per month. Such bleeding, when attributed solely to DepoProvera or Norplant, can mask serious conditions such as cervical or endometrial cancer (which occur among women of color at a higher rate than among white women). Culturally, excessive menstrual bleeding is just as traumatic as the loss of menses altogether. Participation in traditional religious activities is limited for a Native woman who is

menstruating (and sometimes her husband). Women who are bleeding cannot attend sweat lodge ceremonies, Sundances, or other spiritual ceremonies such as Native American Church meetings. They cannot go anywhere a sacred pipe is being used. And, they must often refrain from sexual activity.[51]

The Native American Women's Health Education Resource Center in South Dakota uncovered serious problems in the distribution of DepoProvera and Norplant to Native women. The center's director, Charon Asetoyer, has fought for a uniform protocol for DepoProvera since 1993, after uncovering numerous abuses through personal interviews.[52] One major abuse, inadequate screening, is very problematic to the physical health of Native women especially. Norplant is contraindicated in cases of diabetes, high blood pressure, liver disease, and smoking, which occur at higher-than-normal levels on most reservations and in Indian communities.[53]

While Norplant can be seen as an empowering advance in reproductive technology, it is also highly susceptible to governmental abuse. Compared to other contraceptive devices, it is easily monitored by government or population-control officials. The rods can be located readily in the upper arms, and removal by a patient would be obvious to a medical worker. Since the decision to utilize Norplant is a one-time affair (the devices are inserted only once every five years) the doctor-patient relationship is critically important. Also, both insertion and removal must be done by a trained medical professional, so some personal control is relinquished in using this method of contraception.[54] The challenge comes in balancing access to Norplant for those who authentically choose it while not coercing others, by intimidation or incentives, to use the device. A woman cannot start and stop using Norplant whenever she chooses; she must depend on her doctor to abide by her reproductive decisions. If her doctor refuses to remove the Norplant inserts, a scenario that occurs with alarming frequency on many reservations today, a woman effectively has no control over her fertility.[55]

Perhaps the most alarming new form of nonsurgical sterilization to date is quinacrine sterilization (QS). Quinacrine, a medication historically used for the treatment of malaria, is a known mutagen. When these capsules are inserted into the uterus they dissolve and spread to the fallopian tubes. The medication then destroys a portion of the tubes' lining. The resulting scar tissue blocks the tubes and prevents future pregnancy. More than 104,000 quinacrine sterilizations have occurred in twenty countries. This new procedure is distressing in many ways. First, nurses, midwives, and even untrained personnel can perform a QS. Next, the dose of quinacrine can be inserted without a woman's knowledge, even during a gynecological exam. Finally, quinacrine costs only pennies a capsule. The dangers of quinacrine are a

central controversy in the medical and reproductive fields. Proponents of quinacrine claim the drug has no major side effects. However, opponents are concerned about long-term effects of the drug and its links to cancer of the uterus. There is an increased risk of ectopic (or tubal) pregnancy—a life threatening condition—with the use of quinacrine. Moreover, a risk of birth defects exists if quinacrine is inadvertently administered to a pregnant woman.[56]

Quinacrine sterilizations have been used for more than a decade in third world countries, without animal testing. In the late 1990s, the use of quinacrine for sterilizations was banned in India and Vietnam due to unethical medical practices. Nevertheless, the FDA recently approved testing of quinacrine in the United States. Family Health International in North Carolina has received funding from private population-control programs to begin the laboratory tests necessary to go ahead with FDA approval for human testing and use of quinacrine for sterilization in the United States. Pending the results of this testing, the FDA has not yet approved quinacrine sterilizations. Clinical trials of QS began in the United States in 2002. However, its distributors hope to encourage more American doctors to offer it to their patients. Even now a doctor can legally prescribe quinacrine in the United States for off-label use (i.e., sterilization).[57]

Considering the low cost, easy administration and concealment, and the history of both the drug's use and its makers' connections with racist and population control groups,[58] reproductive rights groups are legitimately concerned. Will the next quinacrine sterilizations occur in marginal communities of the United States that have been previously subject to other population-control methods? Will low-cost quinacrine be the next sterilization option of choice for the perpetually underfunded IHS?

HUMAN RIGHTS AND THE RIGHT TO NATALITY

The right to reproductive freedom is indeed hollow if it only applies to those wishing to avoid having children (i.e., rights to contraception and abortion). The right to choose then becomes a weapon to conceal coerced and forced controls against those who might be considered undesirable to reproduce. For decades this has been the case for Native women and other women of color in the United States.

Native peoples recognize women's natality as being powerful. Pregnancy and motherhood are viewed as normal, natural conditions. The almost universal identification with motherhood, fecundity, and kinship ties can be hard to balance with the use of contraception and sterilization. Preventing the birth of children, by either forced birth control or sterilization, threatens what remains of one of the most positive

and stable forms of identity for Native women (despite repeated attempts to eradicate their fecundity, culture, and people). As a means to combat the genocide that has plagued Native American communities, many of their inhabitants are having more children than they did before genocidal birth control and sterilization practices became prevalent.[59]

The paternalism and elitism of the U.S. government has infiltrated the private, reproductive lives of Native women and threatened to usurp control over their bodies. The noncompliant female body has become the central point of contention for conservative fury about the welfare state. Additionally, apathetic public attitudes toward this segment of society—due to stereotypes and propaganda—have contributed to an increasing tolerance of regulating human reproduction by people not of their social and ethnic background. Every woman should have the right to safe, convenient, and effective birth control, but every woman should also have the right (and choice) to bear and raise children. Governments must begin to understand that women are human beings empowered with human choice and not just reproductive machines.

Women's bodies have become a battleground in the area of reproductive health care. White feminists during the 1970s chose to ignore issues of sterilization abuse, focusing instead on a woman's right to abortion; after all, many of the victims of sterilization abuses were women of color. One line of thinking was that any controls in the area of reproductive rights would set back gains in the area of the right to choose. However, insofar as the state cannot interfere with reproductive autonomy, a woman's right to choose can be used against them to permit other procedures she may not want. The reproductive capabilities and rights of women of color are at best overlooked by the government, and at worst blamed for everything from the rise in entitlement programs (such as welfare and Medicaid) to the national debt and the decline of the "native-born" population of the nation. In order to receive an equal access to the right of natality, women of color must be recognized for their innate humanity. Native women must be recognized for their traditional role as the keepers of life. By attacking the traditional status of women in indigenous nations, sterilization strikes at the very core of the value and uniqueness of women.

A handful of groups today challenge abuses of reproductive rights, continuing the work begun by Women of All Red Nations (WARN). One of the most active groups in the fight for Native American reproductive rights is the Native American Women's Health Education Resource Center in South Dakota. Founded in 1985 by a group of Native Americans living on the Yankton Sioux reservation and surrounding areas, the center also addresses health issues, land and water rights, and economic devolvement. The Resource Center has produced several publications regarding the abuse of reproductive rights of Native American women. In addition,

the Women of Color Partnership of Religious Coalition for Abortion Rights of Washington D.C. has supported Native women's reproductive issues. Several other organizations work to end reproductive rights violations in general. These organizations work to assist women in the United States as well as in other countries. Associations such as the Women's Global Network for Reproductive Rights (Red Mundial de Mujeres por los Derechos Reproductivos) and the Committee on Women, Population, and the Environment are but two of these groups.[60]

Returning to the epigraph at the beginning of this paper, we must recognize that Native women (and Native people in general) continue to persist and flourish in an environment characterized by racism, poverty, and the legacy of genocide. The fact that long-guarded information about sterilization and forced birth control has come to light is progress toward curbing further abuses. Native women and men have vigorously defended the rights of women and mothers. There is much more to be done, but the hearts of the Native women are not yet on the ground.

NOTES

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1 The terms "American Indian" and "Native American/Alaska Native" are glosses. They refer to the diverse aboriginal inhabitants of North America and are fraught with political and social quandaries. In this paper the terms "Native," "Native American," and "Indian" will be used for brevity's sake but are by no means meant to be all-inclusive or demeaning to the diversity within this admittedly broad grouping.

2 Federal government–recognized figures.

3 Figures estimated by Indian researchers.

4 WARN, "The Theft of Life," *Women of All Red Nations (WARN) Newsletter. We Will Remember Group,* 1977, 13; Jane Lawrence, "The Indian Health Service and the Sterilization of Native American Women," *American Indian Quarterly* 24, no. 3 (2000): 400–19; Sally Torpy, "Endangered Species: Native American Women's Stuggle for Their Reproductive Rights and Racial Identity, 1970s to 1990s," (Master's thesis, University of Nebraska, Omaha, 1998).

5 Charon Asetoyer, *The Impact of Norplant in the Native American Community* (South Dakota: Native American Women's Health Education Resource Center, 1992); Ward Churchill, "Forbidding the 'G-Word': Holocaust As Judicial Doctrine in Canada," *Other Voices* 2, no. 1 (2000), http://www.othervoices.org/2.1/churchill/denial.html; B. Dikens, "Forced Sterilization Is a Nice Name for Genocide," *Northwest Passage* 22, no. 9 (1982): 10–11; General Accounting Office, HRD-77-3: General Accounting Office, 1977; Sally Jacobs, "Norplant Draws Concerns over Risks, Coercion," *Boston Globe,* December 21, 1992: 21; Bruce Johansen, "Reprise/Forced

Sterilizations: Sterilization of Native American Women," 1998, http://www.ratical.org/ratville/sterilize.html; Judith Scully, "Maternal Mortality, Population Control, and the War in Women's Wombs: A Bioethical Analysis of Quinacrine Sterilizations," *Wisconsin International Law Journal* 19 no. 2 (2001): 103–52.

6 Paula Gunn Allen, *The Sacred Hoop: Recovering the Feminine in American Indian Traditions* (Boston, MA: Beacon Press Books, 1992), 254.

7 Ibid.

8 G. J. Barker-Benfield, "Sexual Surgery in Late-Nineteenth-Century America," in *Seizing Our Bodies*, ed. C. Dreifus (New York: Vintage Books, 1977), 14, 27.

9 Michael Cummings, *Human Heredity: Principles and Issues* (New York: West Publishing, 1993), 9; Beverly Horsburg, "Schrödinger's Cat, Eugenics, and the Compulsory Sterilization of Welfare Mothers: Deconstructing an Old/New Rhetoric and Constructing the Reproductive Right to Natality for the Low-income Women of Color," *Cardozo Law Review* 17 (1996): 531–82.

10 Cummings, *Human Heredity*; Stefan Kuhl, *The Nazi Connection: Eugenics, American Racism, and German National Socialism* (New York: Oxford University Press, 1994); Nancy Ordover, *American Eugenics: Race, Queer Anatomy, and the Science of Nationalism* (Minneapolis: University of Minnesota Press, 2003).

11 See Steven Trombley, *The Right to Reproduce: A History of Coercive Sterilization* (London: Weidenfeld and Nicolson, 1988), where both Malcolm X and Dr. Julian Lewis publicly accused the government of genocidal policies in concentrating birth-control services in Black communities. Studies showed the placement of family-planning facilities in counties of the United States, while not correlated by income, corresponded directly to the number of Black residents in that community. See also Horsburg, *Schrödinger's Cat*; Isabel Karpin, "Legislating the Female Body: Reproductive Technology and the Reconstructed Woman," *Columbia Journal of Gender and Law* 3, no. 1 (1992):325–48; and Kuhl, *The Nazi Connection*.

12 This group is distinguished from the Commission on Population and Family Planning, of which Rockefeller was appointed chair in 1970.

13 Thomas Littlewood, *The Politics of Population Control* (Chicago: University of Notre Dame Press, 1977); also see Elizabeth Liagin, *The Greatest Threat to Genuine Reproductive Freedom*, http://www.fnsa.org/v1n2/liagin1.html. Large companies and elite classes see population control as a way of controlling the growing labor classes who might be threatening in too great a number.

14 Many middle-class white women wishing to be sterilized by choice were either denied or made to present their case to a review board of psychiatrists and doctors to receive permission for the voluntary operation.

15 Dick Grossboll, "Sterilization Abuse: Current State of the Law and Remedies for Abuse," *Golden Gate University Law Review* 10 (1980):1152–53; Horsburg, *Schrödinger's Cat*; *Jessin v. County of Shasta*, 1969 274 Cal.App.2d 733; Lawrence, "The Indian Health Service."

16 Emily Diamond, "Coerced Sterilization under Federally Funded Family Planning Programs," *New England Law Review* 11 (1976): 589–614; Dikens, "Forced Sterilization"; Lawrence, "The Indian Health Service."

17 Myla Carpio, "Lost Generation: The Involuntary Sterilization of American Indian Women," (Master's thesis, Arizona State University, Tempe, 1995); M. Annette Jaimes and Theresa Halsey, "American Indian Women: At the Center of Indigenous Resistance in Contemporary North America," in *The State of Native America: Genocide, Colonization, and Resistance*, ed. M. Annette Jaimes (Boston: South End Press, 1992); D'Arcy McNickle, *The Indian Tribes of the United States: Ethnic and Cultural Survival* (London: Oxford University Press, 1962).

18 The white birthrate was 2.42 children in 1970 and 2.14 children in 1980. See Anti-Genocide Committee of the Native American Solidarity Committee, "Genocide by Surgery," *Northwest Passage* (1978): 11; Carpio, "Lost Generation"; Jaimes and Halsey, "American Indian Women"; Lawrence, "The Indian Health Service"; Torpy, "Endangered Species."

19 Johansen, *Reprise/Forced Sterilizations: Sterilization of Native American Women.*

20 Robin Jarrell, "Native American Women and Forced Sterilization 1973–1976," *Caduceus* 8, no. 4 (1992): 45–58; Lawrence, "The Indian Health Service"; Torpy, "Endangered Species."

21 L. M. Cirando, "Informed Choice and Population Policy: Do the Population Policies of China and the United States Respect and Insure Women's Right to Informed Choice," *Fordham International Law Journal* 19, no. 2 (1995): 611–62; Derek Kroft, "Informed Consent: A Comparative Analysis," *Detroit College of Law Journal of International Law and Practice* 6 (1997): 457–77; *Salgo v. Leland Stanford Jr. University Board of Trustees*, 1957. 317 P. 2d 170; *Schloendroff v. Society of New York Hospital*, 1914. 211 N.Y. 125.

22 Kroft, "Informed Consent," 461.

23 Cirando, "Informed Choice and Population Policy," 634.

24 Ibid.

25 Grossboll, "Sterilization Abuse," 1152–53.

26 Johansen writes: "In 1970, when the IHS initiated its sterilization campaign (paid 100 per cent by federal funds), the Department of Health, Education, and Welfare vastly accelerated programs that paid 90 per cent of the costs to sterilize non-Indian poor women, following enactment of the Family Planning Act of 1970. The rate of sterilization for women as a whole in the United States then jumped by 350 per cent in five years, according to Torpy's research." See also Torpy's "Endangered Species."

27 Brint Dillingham, "Sterilization Update," *American Indian Journal* 4, no. 9 (October 1977): 25.

28 Carpio, "Lost Generation"; Brint Dillingham, "Indian Women and IHS Sterilization Practices," *American Indian Journal* 3, no. 1 (1977): 27–28; Brint Dillingham, "Sterilization of Native Americans," *American Indian Quarterly* 3, no. 7 (1977): 16–19; Torpy, "Endangered Species"; Western New York Educational Television Association, *Woman: Concerns of American Indian Women* (Washington, D.C.: Public Television Library, 1977).

29 Lawrence, "The Indian Health Service"; Torpy, "Endangered Species"; WARN, "The Theft of Life."

30 "Sterilization of Young Native Women Alleged at Indian Hospital—48 Operations in July, 1974 Alone," *Akwesasne Notes*, Summer 1974, 22; Torpy, "Endangered Species."

31 Carpio, "Lost Generation"; Johnansen, *Reprise/Forced Steriliza-*

tions; Lawrence, "The Indian Health Service."

32 Ward Churchill, "The Earth Is Our Mother: Struggles for American Indian Land and Liberation in the Contemporary United States," in *The State of Native America: Genocide, Colonization and Resistance*, ed. M. Annette Jaimes (Boston, MA: South End Press, 1992); Jaimes and Halsey, "American Indian Women"; Francis Paul Prucha, *The Great Father: The United States Government and the American Indians* (Lincoln: University of Nebraska Press, 1993).

33 Jaimes, "Federal Indian Identification Policy"; Lawrence, "The Indian Health Service." The IHS developed out of numerous government efforts to deal with Indian health care.

34 Jaimes, "Federal Indian Identification Policy."

35 Vine Deloria Jr., "The Application of the Constitution to American Indians," in *Exiled in the Land of the Free: Democracy, Indian Nations, and the U.S. Constitution*, ed O. Lyons (Santa Fe, NM: Clear Light Publishers, 1992); Lawrence, "The Indian Health Service," 441.

36 "Others" includes Women of All Red Nations (WARN) and Everett Rhoades, past president of the Association of American Indian Physicians.

37 Claudia Dreifus, "Sterilizing the Poor," in *Seizing Our Bodies*, ed. Claudia Dreifus (New York: Vintage Books, 1978). Studies show that women of color have a higher rate of regret after sterilization than white women. 51.7 percent of Hispanic and 40 percent of black women regretted the surgery. The study also shows an overall 38.4 percent of women regret the procedure. No formal studies have been conducted on Native women.

38 Stephen Trombley, *Sterilization and Informed Consent*, http://www.hsph.harvard.edu/grhf/WoC/reproductive/trombley.html.

39 Ibid.; Torpy, "Endangered Species."

40 Ibid.

41 Littlewood, *The Politics of Population Control*; *Relf v. Weinberger*, 1977. 184 U.S. App. D.C. 147; 565 F. 2d 722.

42 *Relf v. Weinberger*.

43 Ibid.

44 Trombley, *The Right to Reproduce*.

45 Anika Rahman, "Women's Rights As International Human Rights: Toward Government Accountability for Women's Reproductive Rights," *St. John's Law Review* 69 (1995): 203–15.

46 DepoProvera is an oil-based drug that mimics naturally occurring hormones called progesterones. An intramuscularly injected dose of DepoProvera could give 99.7 percent effective contraception for three months. The drug inhibits ovulation by suppressing the body's production of progesterone and estrogen. The simplicity of the drug was the initial attraction, and many saw a market for DepoProvera in third world countries and for poor women in the United States who had inadequate heath-care coverage.

47 Governmental subcommittees eventually found the manufacturer, several family-planning clinics, and mental institutions in violation of the FDA's regulations. IHS justified its use in claiming "DepoProvera offered a convenient method of birth control, as it freed women from menses, thus requiring less custodial maintenance." However, doctors failed to advise the guardians of these patients that the drug had caused

breast cancer in laboratory animals.

48 Norplant consists of surgically inserted silicone rubber tubes. These tubes release chemicals and hormones similar to Depo-Provera, but last for approximately five years.

49 Christina Lopez, "Norplant & DepoProvera," *Freedom Socialist* 20, no. 3 (1999), http://www.socialism.com/fsarticles/vol20no3/Norplant.htm. The makers of Norplant were also the makers of the disastrous diet drug fen-phen.

50 Some other detrimental side effects of DepoProvera include irregular bleeding, decreased libido, depression, high blood pressure, excessive weight gain, vaginal infections, hair loss, stomach pains, blurred vision, joint pain, growth of facial hair, cramps, diarrhea, and skin rashes. In addition, DepoProvera use has been linked with birth defects, osteoporosis, diabetes, and thrombosis.

51 Carpio, "Lost Generation"; Gunn Allen, *The Sacred Hoop*; Jaimes and Halsey, "American Indian Women"; Laura Klein and Lillian Ackerman, eds., *Women and Power in Native North America* (Norman: University of Oklahoma Press, 1995); Torpy, "Endangered Species."

52 Some of the abuses uncovered though personal interviews reveal (1) 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 and the distribution of the drug to women who are contraindicated or precautioned against it; and (5) the seriousness and frequency of experienced side effects and health problems.

53 Asetoyer, "The Impact of Norplant." Cirrhosis, a contraindication for Norplant, is much higher due to a high rate of alcoholism on reservations. Native Americans are eight times as likely to have diabetes and a high rate of smoking and obesity among Native Americans can attribute to a higher incidence of cardiovascular disorders, all of which are contraindicators for use of Norplant. An additional concern is that Native women, in general, often tend to be heavier than the average woman in the U.S. population. This can be both a genetic and cultural phenomenon. Obesity decreases the effectiveness of Norplant. If the patient weighs more than 154 pounds, the potency of the chemical preventing pregnancy can be decreased and can continue to decrease with increased weight of the patient. Finally, there is evidence that heavier women on Norplant experience more bleeding as a side effect than other women.

54 Providers often belittled women's complaints about side effects and refused to remove the implants, even for interference in religious practices. Furthermore, removal training of Norplant is terribly inadequate and removal is much more difficult than insertion. Finally, most insurance companies, including state Medicaid, will not cover removal unless there is some adverse reaction to the implant or infection.

55 Asetoyer, "The Impact of Norplant"; National Organization of Women, *The New Eugenics: A Legal and Policy Analysis of State Proposals to Control Poor Women's Reproduction through Norplant* (New York: NOW Legal Defense and Education Fund, 1993).

56 See Scully, "Maternal Mortality," 105–7, which reports that side effects of quinacrine sterilization

include uterine adhesions, cervical abnormalities, toxic psychosis, abnormal bleeding, and pain both during the procedure and chronically occurring afterward.

57 Scully, "Maternal Mortality"; Express News Service, "Government Bans Quinacrine," 1998, http://www.expressindia.com/fe/daily/19980818/23050434.html.

58 See Global Reproductive Health Forum, "Quinacrine Alert: Stop Quinacrine Chemical Sterilizations!" (http://www.hsph.harvard.edu/Organizations/healthnet/contra/docs/quin.html), which quotes one of the distributors (Stephen Mumford) as saying "this explosion in human numbers, which after 2050 will come entirely from immigrants and the offspring of immigrants, will dominate our lives. There will be chaos and anarchy."

59 Leda Hulsman, "Socio-Cultural Influences on Contraceptive Decisions among Native American Women: A Health Belief Model Approach" (thesis, University of Washington, Seattle, 1979); Bea Medicine, *Learning to Be an Anthropologist and Remaining "Native": Selected Writings* (Urbana: University of Illinois Press, 2001).

60 See "About the Native American Women's Health Education Resource Center," http://www.nativeshop.org/nawherc.htm; Women Of Color Partnership, "Broken Treaties, Empty Promises," http://www.rcrc.org/wocp/native.html; Women's Global Network for Reproductive Rights, http://www.wgnrr.nl/main.htm; and Committee of Women, Populations and the Environment, http://cwpe.org.