

## **The Failures and Possibilities of a Human Rights Approach to Secure Native American Women's Reproductive Justice**

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### **Abstract**

This article has three purposes: the first is to bring to light current violations of Native American women's basic right to health as these violations are produced by the federal government and imposed through the Indian Health Service. The second is to articulate the challenges of current human rights discourse in articulating and providing for Native Americans' human rights within the United States. Third, this article offers a potential strategy for understanding and redressing the violation of Native women's right to health through the rubric of reproductive justice. Drawing from over ten years of participant observation as well as semi-structured interviews with Native women and Native health activists, descriptive policy analysis, and discourse analysis, I find that the United States has failed to meet its treaty obligations to Native nations as well as its international obligations to the human rights community. Further, the international human rights community has failed to hold the U.S. accountable for these failures. The emphasis in reproductive justice on community identity and the social contexts of health and healthcare, however, offer a possible framework that may be productive in addressing these failures.

### **Key Words**

Human Rights, Reproductive Justice, Native Americans, Accountability

The blatant violations of the fundamental human rights of Native Americans by the United States remain largely invisible in the international human rights arena, producing what Falk refers to as 'normative blindness' and a 'glaring oversight in the protection offered by the international law of human rights' (1992:47). This may be due in part to the United States' 'cloak of sovereignty' (Bennoune 2002) and the mechanisms by which it limits its accountability to the global community (Falk 1992; *American Journal of International Law* 2009). It is also possible that the unique relationships between the United States and Native nations obfuscate the precise obligations and responsibilities of the State to Native Americans.

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This article examines the theoretical applicability of human rights law and instruments to reproductive healthcare for Native American women. I make explicit the links between the fundamental right to health and the rights of Native Americans as outlined in treaties between the United States and Native nations, and articulate the ways in which reproductive healthcare for Native American women as it is provided by the Indian Health Service (IHS) acts as a fulcrum for these links. Ultimately, the failure of the Indian Health Service to meet the reproductive healthcare needs of Native American women reflects the failure of the federal government to meet basic human rights obligations to Tribal nations; further, these failures produce structures of reproductive oppression in Native communities which Native American activists seek to redress utilizing the rubric of reproductive justice, an activist and theoretical framework which both relies on and interrogates liberal notions of individual rights as these intersect with group identities and community needs.

I begin with a summary of my data collection methods, and then, because this article centralizes the relevance to Native American women of the internationally recognized right to health, I turn to a brief discussion of the complexities of this right, particularly as these complexities emerge from the dynamic relationships between Native nations and the State. I argue that Native American women's right to health is consistently violated by the federal government, and offer several examples of this violation. It is my contention that the various instruments in which the right to health is enshrined and elaborated do not provide adequate measures for accountability; additionally, the lack of both domestic and international attention to the postcolonial conditions which contour Native American sovereignty in the early twenty-first century further masks the uneven provision and protection of Native women's right to reproductive health.

However, the emerging paradigm of reproductive justice may offer some recourse to Native women and their allies. Therefore, following a brief description of reproductive justice as a theoretical framework, I highlight the role of human rights in reproductive justice, and the potential efficacy of reproductive justice in asserting Native women's right to health. Throughout, I consider recent efforts by Native activists, non-governmental organizations, and the federal government to more clearly delineate the positive and negative

obligations of the State to Native people's health and to develop appropriate strategies for meeting these obligations.

#### DATA COLLECTION

Following a year of frequent visits to Pine Ridge Indian Reservation in South Dakota, I lived on the reservation from August of 2000 through November of 2001, teaching at a local high school. During this time, I became increasingly aware of the health disparities between Native Americans and non-Natives. My interest in reproductive healthcare emerged during my own pregnancy on the reservation, which produced opportunities to learn from Native women about their personal experiences seeking prenatal and other forms of reproductive healthcare. Sharing stories with women in my community on the reservation about pregnancy and childbirth brought to light the differences between their experiences as Native women and my own as a white woman and led me to pursue a greater understanding of reproductive justice as both a theoretical and activist paradigm.

Following approval from my University and from the Oglala Sioux Tribal Research Review Board, I began an institutional ethnography of the Indian Health Service in June of 2009. Since then, I have conducted nineteen interviews with Native women from across the contiguous U.S., three interviews with Native men from Pine Ridge, and five interviews with Native and non-Native health activists and providers who regularly work with IHS.<sup>1</sup> Many of these informants were women I had met during my time living and working on Pine Ridge, and they introduced me to other informants. This snowball sampling technique was essential to the success of my research, as it allowed me to rely on already existing relationships, an important route to access in Native communities. It also allowed me to focus on Pine Ridge Reservation as a case study, but extend my research into other reservation communities through both formal interviews and dozens of informal conversations. All interviews began as semi-structured life histories with a focus on medical care, but quickly became a loosely structured dialogue around healthcare, reproductive healthcare, and the rights of Native people. This flexibility allowed informants to share what they felt was important, and several themes I had not previously considered emerged during

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these dialogues. The role of international human rights instruments in relation to Native women's reproductive healthcare, the focus of this article, was one such unanticipated theme. The prevailing frame of reproductive justice, discussed further below, was another, articulated both explicitly and implicitly by a number of informants.

Interviews both followed and preceded intensive analysis of the history of relations between Native nations and the United States, including the provision of healthcare over the last two centuries. Additionally, I conducted focused content and discourse analyses of public documents available through the Indian Health Service, and also conducted descriptive policy analysis of numerous key pieces of legislation. I also examined a number of national reports on Indian health and/or reproductive healthcare initiated by a variety of non-profit organizations, governmental agencies, and academic institutions.<sup>2</sup>

As the links between Native American healthcare and human rights law became increasingly apparent, I turned to numerous international human rights documents as well as various documents published by the World Health Organization and non-governmental organizations.<sup>3</sup> These were analyzed for the ways in which they contour Native-U.S. relations, Native and U.S. understandings of rights and obligations, and Native and U.S. efforts to identify issues of concern and develop appropriate strategies of redress. The synthesis of this intensive document and content analysis, guided by the stories of my informants, brings to light examples of the United States' blatant disregard for the fundamental human rights of Native people as individuals as well as the State's manipulation of collective tribal identities. Importantly, it also sheds light on the responses of Native communities as well as tribal governments to these ongoing violations.

I continue to maintain communications with informants and community members around our shared concerns over women's healthcare in Native America. This has afforded me the opportunity to learn from Native activists and care providers in a variety of venues, from community events such as powwows and prayer ceremonies to local and national health initiatives such as those developed by Woman is the First Environment Collaborative (an international indigenous reproductive justice organization) and

Thundervalley Community Development, Inc. (a local non-profit organization on Pine Ridge Reservation). Prior to the formal phase of this research I attended the United Nations Permanent Forum on Indigenous Issues annual meetings in New York in 2004 and 2008; the Forum's sessions provided a broader context in which to understand indigenous women's access to healthcare and the conditions for health globally as a human rights issue for indigenous peoples. In addition, in 2009 I participated in a three day academic medical conference sponsored by IHS which gave me the opportunity to learn both formally and informally about the needs of Native women and their communities as well as several of the strategies being developed both within and outside of IHS to meet these needs. Thus my own participant observations provide a recurring thread throughout my collection and analysis of data from interviews and document and policy analysis.

#### THE RIGHT TO HEALTH

Since the establishment of the World Health Organization (WHO) in 1946, the links between health and public as well as private conditions have become increasingly articulated, and the role of the State in producing and preserving these conditions has become increasingly recognized. The Universal Declaration of Human Rights elucidates the fundamental right to health in Article 25, asserting that 'Everyone has the right to a standard of living adequate for ... health and well-being of himself and his family, including food, clothing, housing, medical care and the right to security in the event of ... sickness, disability.' The right to health is also prominent in numerous other international treaties, covenants, and agreements, including the Convention on the Elimination of All Forms of Racial Discrimination (Article 5); the Convention on the Elimination of Discrimination Against Women (Articles 10, 12, and 16); the African Charter on Human and Peoples' Rights (Article 16); and the Convention on the Rights of the Child (Article 24). The inclusion of health in the UDHR and other international instruments reflects the increasing recognition that 'the enjoyment of the highest attainable standard of health is one of the fundamental rights of every human being' (WHO Constitution 2006). According to WHO (2010), virtually every country in the world is party to at least one of these agreements, including the United States

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(although the U.S. has failed to ratify almost all of these).<sup>4</sup>

Numerous international treaties and agreements centralize women's reproductive rights in their assertions of the fundamental right to health. For example, the International Covenant on Economic, Social, and Cultural Rights (ICESCR) specifically protects 'the right to control one's own health and body (including reproduction)' and further asserts that 'the right to health is interpreted as requiring parties to respect women's reproductive rights, by not limiting access to contraception or censoring, withholding or intentionally misrepresenting information about sexual health' (Article 12). Similarly, the Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW) requires in Article 12 that 'States Parties shall ensure to women appropriate services in connection with pregnancy, confinement and the post-natal period, granting free services where necessary, as well as adequate nutrition during pregnancy and lactation.'

The United States has signed but not ratified both the ICESCR and CEDAW, thereby simultaneously acknowledging the fundamental rights they espouse, and potentially mitigating its own accountability for providing and protecting these rights. It has, however, ratified the UDHR, which defines the fundamental right to the conditions for health and notes that 'Motherhood and childhood are entitled to special care and assistance' (Article 25). In addition, in 2009 the U.S. supported Resolution 11/8 of the Human Rights Council, which outlined in detail the responsibilities of States to address maternal mortality and morbidity and, importantly, situated these health concerns within the broader contexts of reproductive health and reproductive rights.

Additionally, improving maternal healthcare in order to reduce maternal morbidity and mortality is a primary objective of the internationally recognized U.N. Millennium Development Goals. The United Nations Global Strategy for Women's and Children's Health, launched by Secretary-General Ban Ki-moon in 2010, specifically outlines several commitments which would potentially accelerate global progress toward meeting Millennium Development Goal 5, improving maternal health. These strategies include the development and delivery of a comprehensive, integrated package of interventions and services, including family planning education and services. The

United States' clear endorsement of these initiatives, indeed its active role in developing them, signals its recognition of the need for improving reproductive healthcare internationally and domestically, and its own obligations to actively participate in efforts to do so. These obligations are further strengthened by domestic precedent in treaties and other policies with Native nations, including funding and public health initiatives as well as the formation of the Indian Health Service as a federal agency in 1955.

The right to health, including the right to reproductive health, is an inclusive right, inextricably linked with many other basic human rights, including the rights to safe drinking water, education, and adequate housing, among others. Additionally, the right to health produces both positive and negative obligations from the State. In the case of Native Americans, for example, the federal and regional state governments must not only provide for adequate healthcare and the conditions for health; they must also abstain from producing conditions that will adversely affect the health and conditions for health of Native people. Due to the unique relationships of Native nations with the United States, the provision of healthcare by the federal government (guaranteed to Native people through numerous treaties and acts of legislation) is firmly embedded in State mechanisms, and thus works as an explicit fulcrum between reproductive justice and human rights as these are tied to State obligations. The failure of the State to provide for adequate reproductive healthcare for Native women thereby offers an opportunity to consider the links between human rights as an international endeavor, Native sovereignty in the U.S., and the rights of Native women to reproductive freedom.

#### PROVIDING HEALTHCARE TO NATIVE AMERICANS

Provision for Native American healthcare has been generally included in some form in almost all treaties between the United States and Native nations, with few exceptions (these most notably at the beginning of the treaty period in the Eighteenth century). The first mention of healthcare in exchange for land came in the 1836 treaty between the United States and the Ottawa and Ojibwe peoples, in which the federal government promised to provide annual payments for vaccines and other medicines as well as the service of a physician

as long as the Ottawa and Ojibwe remained on their treaty-allotted land. By 1849, treaties between the federal government of the United States and the indigenous peoples with whom it negotiated as sovereign nations increasingly served as a means of resolving armed conflict and negotiating for land cession. It is in this respect that federally funded healthcare can be framed as a market transaction (provided as a 'trade' for land), as it often is by Native people, including several of my informants, one of whom proclaimed, 'they owe us! If they don't want to provide healthcare, then why don't they give the land back?' (Donna) (see also Metcalf 1997; Bergman et al. 1999; and Johnson and Rhoades 2000).

This conceptualization of healthcare as a commodity for which Native people have already paid is echoed in the national ideology of healthcare in the United States as a purchasable product rather than a right (see Vladek 2003 and Carmalt and Zaidi 2004), and has particular implications for Native nations. Treaties between the United States and Native nations serve as legally binding documents which, though unevenly applied, nonetheless outline the positive obligations of the federal government toward the well-being of Native people. However, the framing of these obligations as a pre-paid market transaction rather than a standing legal obligation restricts the abilities of Native people to further negotiate the quality of the healthcare they have already 'purchased'. Further, as the federal government purports to avoid active involvement in the free-market system in which healthcare in the U.S. is located, its legal obligations to provide healthcare to a specifically demarcated population outside of the market system are resisted financially and ideologically.

However, at the same time that these obligations have been resisted they have also been further codified in various pieces of legislation such as the 1921 Snyder Act (which provided discretionary funding for Native healthcare to the Bureau of Indian Affairs), the 1976 Indian Healthcare Improvement Act, and the inclusion of the IHCA in the 2010 Patient Protection and Affordable Care Act, where it remains largely uncontested. Additionally, the federal government has historically invested some measure of resources in Native American healthcare, particularly through the provision of healthcare providers, thus creating legal and economic precedent for this continuing responsibility. For example, prior to the mid-Twentieth



century, responsibility for Native healthcare was met variously by the War Department (which provided Army physicians to Native communities, largely to prevent the transmission of communicable diseases), the U.S. Public Health Service, the Bureau of Indian Affairs, and, beginning in 1955, the Indian Health Service, a federal agency located within the Department of Health and Human Services. Thus for Native Americans, the fundamental right to health is guaranteed not only by numerous international human rights instruments, but also by domestic law as well as domestic precedent.

However, despite these multiple iterations of Native peoples' right to health and the conditions for health, and in fact their explicit right to medical care as outlined in treaties between the U.S. and individual tribal nations, the United States has failed to adequately address the health needs of Native communities, and at times actively participates in the production of these health needs (Smith 2002; U.S. Commission on Civil Rights 2003 and 2004; Amnesty International 2007 and 2010; Gurr 2011a). Below I consider four linked, ongoing violations of Native women's right to health as these are produced by the federal government through IHS: limited access to facilities and services, limited access to contraception, contraception and sterilization abuse, and limited care for survivors of sexual assault. I locate these violations within the broader social contexts of reservation communities, including Pine Ridge Reservation and Cheyenne River Reservation in South Dakota, to illustrate the intersections of Native women's right to health with the conditions for health. I then juxtapose these violations with the specific obligations of the United States in order to make explicit the U.S.'s failure to adequately meet its responsibilities to Native American women.

## VIOLATING NATIVE WOMEN'S RIGHT TO HEALTHCARE

### *Native American Women's Access to Healthcare Facilities*

While women with private insurance and ready physical access to multiple medical resources may be able to seek out a variety of healthcare providers, Native American women who rely on IHS are far more restricted in the care they can access. IHS facilities are located primarily on reservations, thus neglecting care for Native Americans who live off reservations, approximately 60% of all

Natives (U.S. Census 2002). Yet even in reservation communities facilities are inadequate. In fact, it is widely acknowledged by IHS that their facilities are too few, and that many of them are outdated (see, for example, IHS Strategic Vision 2006-2011 and Trujillo 1996), a direct consequence of decades of underfunding by the U.S. government (Harvard Project on American Indian Economic Development 2008; NPAIHB 2008, 2009).

The Aberdeen Area of IHS, which serves Native people in Iowa, Nebraska, South Dakota and North Dakota, defines reasonable access as a two to three hour drive (Aberdeen Area Health Services Master Plan 2003). However, the reservation communities in the Aberdeen Area encompass some of the poorest counties in the country; for example, Buffalo County (located on the Crow Creek Reservation in South Dakota) is the poorest county in the country. Shannon County, which comprises two thirds of nearby Pine Ridge Reservation, is the second poorest County in the country (U.S. Census 2002). In fact, according to the 2000 U.S. Census, seven of the ten poorest counties in the country are located on Native American Reservations; three of the five poorest are on reservations in South Dakota (ibid). In these areas, access to private transportation may be limited and public transportation non-existent, thereby rendering a distance of two to three hours virtually inaccessible.

Pine Ridge Service Unit, located in the Aberdeen Area, has a total of 5 health facilities: one hospital, two clinics which are partially managed by the Oglala Lakota Tribal Nation, and two health centers which are partially managed by the Tribe. Additionally, the Tribe supports in partnership with IHS a mobile school-based clinic which provides adolescents with testing for sexually transmitted infections and pregnancy, as well as other limited services. With the exception of the one hospital, all other health facilities have limited hours. Given the size of the reservation, which is roughly the size of the state of Connecticut, and the dispersed locations of communities across the reservation, these facilities are inadequate to the needs of the Lakota people. Additionally, like many other IHS Areas, Pine Ridge Service Unit is severely understaffed; for example, as of this writing, there are no permanent obstetricians or gynecologists on staff at Pine Ridge Hospital. There is currently only one midwife to serve the entire reservation, which many of my informants perceived as a detriment to

their care.

The greatest complaint informants had about IHS services on Pine Ridge was the difficulty in accessing the services they wanted when they wanted them, although many also expressed dissatisfaction with the way they were treated by care providers and office staff, and with long wait times for appointments. Nancy, a twenty-five year old Lakota woman, complained, 'you can just never get what you need, you know? I mean, it takes forever.' Donna, a sixty-one year old Lakota woman, expressed great anger when discussing her experiences at IHS, particularly clinic wait times. She explained, 'I have a job, I can't just take a whole day off to get to the clinic. We're supposed to be getting real healthcare! They just don't have enough people, or I don't know, maybe all these doctors don't want to work on the rez (reservation).' Other informants shared stories of waiting for months to see specialists (including cancer care), and as long as a year for eyeglasses or dental work.

*The Consequences of Restricted Access: Violating Childbirth*

Women living on the Cheyenne River Reservation to the North of Pine Ridge are even more restricted in the reproductive care they can receive. There is only one small medical facility on the reservation and no hospital, which means there is no birthing facility at all on the reservation. Women must travel approximately ninety miles to reach the nearest hospital in Pierre, South Dakota for prenatal care during their pregnancies as well as for labor and delivery. St. Mary's is a Catholic hospital, and as such further restricts the care that all women can receive there, as it will not provide contraception of any sort, including emergency contraception or tubal ligation.

In late 2009, the American Civil Liberties Union of South Dakota filed a freedom of Information Act with IHS seeking to learn why plans to build a hospital on the reservation, approved in 2002, had not progressed despite recent additional funding from the American Recovery and Reinvestment Act of 2009. In pursuing information about the need for a birthing facility on Cheyenne River, the ACLU learned that many women had been coerced into inducing labor early at St. Mary's in Pierre. These inductions often occurred without prior notice, and thus women were unable to have family present, or to plan for an extended stay away from home. According

to the ACLU suit, 'these women fear that if they refuse to be induced, IHS, which they rely upon for health care, will refuse to subsidize the cost of labor and delivery' (ACLU 2010:5). Further, 'these women also report that they do not receive any counseling regarding the risks and benefits of inducing labor and delivery and forgoing spontaneous labor and delivery' (ibid).

The inherently coercive nature of these fears and lack of information directly violates Native women's right to health and the conditions for health, and belies the federal government's unique responsibility for the health of Native people. Further, by failing to provide an adequate medical facility on Cheyenne River Reservation, but rather contracting with a facility that is both a considerable distance away as well as restricted in the care it can provide, the federal government through IHS not only fails to adequately provide for Native women's reproductive health, but in fact actively produces structures which violate the rights of women who live on the reservation. As of early 2011, IHS had not yet responded to the suit filed by the ACLU in late 2009 seeking information about the delayed construction of the medical facility on the reservation, or the suit filed in late 2010 seeking information about coercive induction. Native organizations such as Woman is the First Environment Collaborative and the Native American Women's Health Education Resource Center are also pursuing further information and developing strategies to address the needs of women on Cheyenne River, for example through the training and provision of local birth assistants as well as working with IHS to improve healthcare delivery.

#### *Restricted Access to Family Planning Services*

Preventing unwanted pregnancies presents an additional set of challenges. Native women's access to adequate contraception through IHS is challenged by a number of factors beyond geographic isolation and inadequate facilities. For example, the decentralized structure of IHS results in uneven availability of different forms of contraception wherein some IHS Areas have different contraceptives available, or different rules governing availability.

Many Native health activists assert that the full range of non-surgical contraceptive options are not available through IHS and attribute the lack of contraceptive options directly to physician

preference (NAWHERC 2008; see also Arons 2007). There seems to be some evidence of this at least in terms of emergency contraception (EC), given the ongoing debate amongst IHS pharmacists (EC Discussion 1604; Pittman 2006). As my own research and other studies reveal (see for example NAWHERC 2008 and Smith 2002), EC is not uniformly available to Native women across the country. According to a recent study conducted by the Native American Women's Health Education Resource Center (NAWHERC) (2008), 12.5% of IHS facilities do not dispense EC at all, despite official IHS policy to make available all FDA-approved medications. At this time, Plan B, which is better tolerated (with a lower incidence of side effects such as nausea) is available for women on Pine Ridge who have been raped; Plan B is not available for women seeking emergency contraception who have not experienced a sexual assault, but the less well tolerated Preven is.

Condoms are relatively the easiest form of contraception to access in reservation communities, as they are made available through IHS and for purchase in local convenience stores. However, as numerous studies have shown (see for example Parikh 2004 and Crosby, et al. 2008), condoms potentially limit women's agency in their sexual relationships. This is particularly relevant when understood within the context of the high rates of sexual assault against Native women, who are 2.5 times more likely to be raped than non-Native women (Amnesty International 2007; Bachman, et al. 2008). As Christine, an anti-violence activist on Pine Ridge, pointed out in our interview, 'women don't always get a chance to say 'let's put a condom on.'" Sexual violence against Native women is discussed further below. Oral contraceptives are also relatively easily accessed in reservation communities, although the rules for its distribution vary between IHS Areas. On Pine Ridge Reservation, oral contraceptives are only dispensed one month at a time; this presents a potential added challenge for women seeking this form of contraception given the difficulties in accessing facilities and the limited pharmacy hours on Pine Ridge. Nancy, who was pregnant with her second child at the time of our interview, explained that she relied on oral contraceptives in high school, but eventually stopped because 'no one explained all those side effects to me. Besides, it was just a pain to go and get them all the time, and sometimes I didn't have 'em with me when I needed

'em.' Both of Nancy's pregnancies were unplanned.

*Contraceptive and Sterilization Abuse*

The use of long-term chemical contraceptives in Native communities has risen since the mid-1980s, and Depo-Provera in particular has become increasingly commonly used in IHS facilities, despite adverse side effects and the potential for abuse. According to Ralston-Lewis (2005), Depo-Provera was being used by IHS physicians to manage menstruation in Native women with cognitive disabilities for close to two decades before it was approved as a contraception by the FDA in 1992 (see also Smith 2002). Further, Ralston-Lewis (2005) and Smith (2002) both assert that many, possibly most, Native women are not fully informed of side effects, which may include depression, osteoporosis, sterility, cervical cancer and headaches. This was the case for Anne, a 30 year old mother of three from Pine Ridge, who explained to me that she had relied on Depo-Provera when she was younger because she 'didn't want to get pregnant, y'know? You just go for that one shot, and then you're good for a while, what is it, three months? But I had to get off it, cuz my moon' (menstrual period) 'would still come, but at weird times, and I never knew when it was coming. I didn't know that would happen. And besides, I started getting these wicked headaches, so I didn't go on it no more after that.' Norplant, no longer available in the U.S., presented similar problems for many women, including similar side effects. Additionally, the doctor-patient relationship was particularly crucial in the use of Norplant, which is inserted into the upper arm by a physician and must be removed by a physician. However, because IHS has a very high turnover rate (U.S. Commission on Civil Rights 2003; IHS 2006), Native women may have had difficulty developing a trusting relationship with a regularly accessible care provider. Smith (2002) asserts that many Native women have had trouble having Norplant removed, particularly if they choose to do so before the end of their prescribed five year period.

Difficulties in accessing contraception can lead to permanent solutions for many Native women. NAWHERC argues that permanent sterilization can become the most tenable recourse for many Native women whose agency in avoiding pregnancy is severely curtailed due to a lack of other contraceptive options or to the limited

nature of those options (2008). Similarly, Betty, a midwife who worked for IHS on Pine Ridge for three years, explained in our interview that many women come into IHS seeking tubal ligation because it's 'the easiest way to avoid getting pregnant again.'

Rates of surgical sterilization among Native women are disproportionately high; according to Volscho (2010), in 2004 33.9% of Native women were using tubal ligation as a form of contraception. African American women had a similarly high rate of tubal ligation at 30.1%; the rate for non-Hispanic white women was 18.7%. Volscho argues that these utilization differences must be understood as a form of 'sterilization racism', pointing out that even controlling for variables such as socioeconomic class, the odds of pursuing tubal ligation as a form of contraception are 123% greater for Native women than for white women (2010).

Current rates of surgical sterilization among Native women must be understood as not only linked to limited contraceptive options, but also, importantly, as they emerge from a history of coercive sterilizations performed throughout Native America in the 1960s and 1970s. Although IHS neither confirms nor denies this history on its website<sup>5</sup>, the occurrence of coercive sterilizations in IHS and its contracted facilities has been increasingly documented since the late 1990s (Johansen 2001; Langston 2003; Lawrence 2000; Smith 2002; Torpy 2000).

Many Native activists argue that the number of Native women coercively or forcibly sterilized during this period is much higher than originally estimated by the General Accounting Office in 1976. Gonzales, Kertesz, and Tayac (2007) assert that 'documented sterilizations performed by the Indian Health Service...indicate widespread sterilization abuse due to coercion, improper consent forms, and by failing to provide appropriate waiting periods' (59). They further assert that in 1975 alone, IHS performed approximately 25,000 sterilizations (Gonzales et. al. 2007:59), equivalent to approximately 15% of the female Native population of child-bearing age. Dr. Connie Pinkerton-Uri, who conducted her own research into coercive sterilization of Native women, estimated that up to 25% of Native women of childbearing age were sterilized in some IHS Areas (Torpy 2000). Women of All Red Nations, an indigenous women's organization, contends that sterilization rates were as high as 80% on

some reservations (Lawrence 2000; Ralston-Lewis 2005; Smith 2005). Due to inadequate and missing records, it is unlikely that exact numbers will ever be determined. Additionally, IHS did not adopt a standard protocol on tubal ligations until after the mid-1970s, and therefore efforts to ascertain accurate sterilization rates are further complicated by the decentralized structure of IHS, which allows different service Areas to define and meet the needs of their constituents differently.

Nonetheless, despite the potential risks and adverse side effects as well as the alleged history of abuse, long-term and surgical contraception may present an authentic choice for Native women who are fully informed of possible risks and side-effects. Today it is federal policy that all women seeking a federally funded tubal ligation such as those provided by IHS receive standard counseling followed by a thirty day waiting period, a move prompted in part by the work of Women of All Red Nations and other indigenous organizations. In fact, Betty, a former midwife with IHS on Pine Ridge, was adamant that no sterilizations can be performed through IHS without this counseling and waiting period. However, although this policy may serve to reduce sterilization regret or possible feelings of coercion amongst Native women and is particularly important in light of allegations of sterilization abuse, without concurrently providing adequate alternatives for family planning, this mandatory waiting period simultaneously restricts Native women's reproductive rights.

#### *Caring for Sexual Assault Survivors*

Native American women are over 2.5 times more likely than other U.S. women to be raped or beaten (Amnesty International 2007; Bachman et. al. 2008); more than one in three will be sexually assaulted in her lifetime, and in some states such as Oklahoma and Alaska, these rates are even higher (Amnesty International 2007). Because survivors of sexual assault require unique treatment which includes not only physical care and psychological counseling but also the collection of forensic evidence, the role of IHS in providing this care is critical. Yet according to Amnesty International (2007), many IHS facilities do not have clear protocols for treating survivors of sexual assault and do not consistently provide sexual assault forensic examinations (see also U.S. Commission on Civil Rights 2003).



Additionally, NAWHERC (2005) found that forty-four percent of IHS facilities lacked personnel trained to provide emergency care to survivors of sexual violence. Several of my informants work on issues of violence against Native women and have worked for or closely with IHS, and they confirm this. Betty told me that when women arrive at Pine Ridge Hospital after a sexual assault, they may be turned away completely because 'no one wants to mess up any evidence!' At the time of my research, there was virtually no one on staff at Pine Ridge Hospital who was trained to provide care to sexual assault survivors.

The consequences of this lack of care for Native women are many; for example, Native women who wish to press charges against their assailant may have trouble doing so or be actively discouraged from doing so due to inadequate or complete lack of forensic evidence. More importantly, however, women simply cannot access the care they need after being sexually traumatized, and/or cannot access this care without fear of possible arrest. NAWHERC reports that in IHS areas that do not provide emergency services for rape victims, women may need to travel up to 150 miles round trip to reach a facility where a forensic examination can be performed and appropriate medical care provided (2005). Given the dearth of care available in IHS facilities, Native women may need to be transferred to an unfamiliar facility, possibly without family or friends who may have otherwise been available; further, this transfer requires transportation, which is not provided by IHS; as well, care received in non-IHS facilities may not be culturally appropriate. All of these impediments to care result in Native women simply not being able to access appropriate care in a timely manner.

Since the release of Amnesty's 2007 report and also following criticism from the U.S. Commission on Civil Rights (2003), and due largely to the efforts of Native activists such as Cecilia Fire Thunder and Sarah Deer, increased attention to the epidemic of violence against Native has prompted several moves from the federal government which may yield positive results for Native women. For example, in President Obama's Omnibus Appropriations Act of 2009 he allocated \$7.5 million for IHS to further expand its outreach advocacy programs in Native communities. Importantly, a major portion of these funds were intended to expand Domestic Violence and Sexual Assault projects already in operation, including further

training and the purchase of forensic equipment to support the Sexual Assault Nurse Examiner program. More recently, in October 2011 Senator Daniel Akaka of Hawai'i proposed the Stand Against Violence and Empower Native Women Act, intended to directly address the causes of violence as well as increase services to survivors. Many of the proposals in the Act were drafted in close consultation with Tribal governments and with the National Congress of American Indians. However, just two weeks after this Act was introduced Congress cut approximately ninety million dollars from Tribal Justice budgets, effectively prohibiting not only the growth of future programs, but even the efficacy of existing ones.

#### THE CHALLENGES OF ACCOUNTABILITY

The U.N. Human Rights Committee (1989) has noted that the prohibition of discrimination espoused in the International Covenant on Civil and Political Rights (which the United States ratified in 1992 with numerous reservations, declarations, and understandings attached) encompasses both intention and effect (although U.S. courts generally protect only against demonstrably intentional discrimination); therefore policies which effectually differentiate care based on racial or citizenship status are potentially in violation of international law. Based in part on this interpretation, the Committee on the Elimination of Racial Discrimination has found that the U.S. fails in its responsibilities to eliminate racial inequalities generally, and that 'wide racial disparities continue to exist in the field of sexual and reproductive health' (cited in Amnesty International 2010), a finding that is also confirmed by the Center for Reproductive Rights (2009), and the U.S. Commission on Civil Rights (2003 and 2004).

Importantly, the application of international human rights law to the conditions of Native women's health may be obstructed by the liberal enlightenment tenets embedded in these instruments. Leary (1992) describes liberalism as the 'predominant philosophical foundation for the concept of human rights in the West' and argues that the liberal ideology which undergirds international human rights law 'emphasizes the freedom of individuals, civil and political rights, contractually based obligations and, in particular, property rights' (105-6). However, as the Indian Law Resource Center (1988) asserts, for

many Native communities, group rights supersede individual rights (see also Zion 1992 and Gurr 2011b); the well-being of the individual is defined in part by the healthy existence of the whole community. It is therefore the collective identity embedded within Native nations, rather than the rights which adhere to the individual, which drive Native conceptualizations of 'human rights', in ways starkly different from those found in most (though not all) international human rights instruments which privilege the individual's rights against the State. As Falk (1992) argues, the development of collective rights, indeed, the right to develop collective rights, is essential to indigenous protections.

However, although certain international instruments privilege or at least acknowledge group rights (such as the International Convention on the Elimination of All Forms of Racial Discrimination and the U.N. Declaration on the Rights of Indigenous Peoples, which the United States signed in early 2011 after attaching several reservations and understandings), collective rights and rights based on collective identities remain insecure globally and in the U.S. Therefore, acknowledging and protecting the collective rights of Tribal nations, both individually and as a pan-tribal collective, within the United States continues to challenge international human rights law.

Regardless of the reasons for the United States' seeming impunity in its treatment of Native women, close examination such as that offered in this article reveals that violations occur, that they are frequently egregious, and that the United States has failed in its responsibilities to protect and provide for Native peoples' rights to health and the conditions for health as both positive and negative rights and as treaty rights. However, the failure or inability of the international human rights system to hold the U.S. adequately accountable for the violations it incurs, and the challenges of synthesizing international human rights instruments with Native needs and ideologies in meaningful ways, does not render the human rights frame meaningless for Native peoples. The prevalence of human rights as one aspect of the reproductive justice paradigm strengthens Native women's claims to health as a fundamental right by re-situating these claims in a shared location with the social, political, economic, and spiritual contexts from which the conditions for health derive.

## REPRODUCTIVE JUSTICE AND HUMAN RIGHTS

Reproductive justice is broadly understood as ‘the complete physical, mental, spiritual, political, social, environmental and economic well-being of women and girls’ (Sistersong 2006:5). Thus it shares with the World Health Organization a recognition of the holistic nature of health and wellness. Importantly, the reproductive justice framework is simultaneously a theoretical paradigm and an activist model. As such, it brings together in cogent ways theories of human rights and inequality with intersectional examinations of women’s embodied experiences, and locates these in local social contexts.

According to Cynthia Soohoo, Director of the U.S. Legal Program at the Center for Reproductive Rights, the reproductive justice and human rights paradigms share many common principles, including a ‘recognition of the right to health and health care access and a recognition that governments have an affirmative obligation to address and reform policies and programs that have a disparate impact on women and communities of color’ (2009). The synthesis of the international human rights frame and local reproductive justice work links the violations of women’s reproductive rights in the United States, and most specifically in marginalized communities, and the obligations of the State to address these violations – and in some cases, to cease from producing them. This grounding of international human rights law in locally-driven conceptualizations of women’s health needs expands understandings and applications of the fundamental right to health.

Importantly, by situating women’s fundamental right to health in the broad social contexts of spiritual, environmental, and economic well-being, reproductive justice asserts the links between all of these areas and resists false isolation of the right to health from the conditions for health. The focus in reproductive justice on marginalized communities explicitly recognizes that women’s reproductive ‘rights’ are meaningless without addressing the social contexts in which these rights are exercised, including historically oppressive structures of racial and economic inequality. Therefore, although reproductive justice incorporates human rights as an organizational framework, it simultaneously complicates prevailing liberal ideologies of ‘rights’ and ‘choice’ which fail to adequately

consider the broad social conditions in which rights are exercised by centralizing the ways in which intersecting social and political forces impact women's lives in differential and consequential ways (see for example Fried 2002; Ross, et al. 2002; and Silliman, Fried, Ross, and Gutierrez 2004).

This contextualization also produces room to understand women's health needs outside of a strictly Western paradigm of evidence-based delivery systems. For example, Woman is the First Environment Collaborative works closely with local and national organizations to provide culturally competent care to women on the Akwasasne reservation in upstate New York and Canada; one of their initiatives follows the Centering Pregnancy model of group prenatal care and relies on local indigenous knowledge to intertwine health, culture and identity. This model has been well received on Akwasasne, and is being considered for use by IHS in other reservation communities. The Collaborative is also partnered with Running Strong for American Indian Youth, a national organization which provides food, educational supplies, and other services to some of the most impoverished reservation communities in the country, thus demonstrating its commitment to the broad range of issues which impact Native communities and Native women in particular.

## CONCLUSION

The evolution from a liberal approach which adheres 'rights' to the individual to a more comprehensive incorporation of social, economic, and political structures and histories which necessarily includes community needs thereby expands both local and national conceptualizations of reproductive health as a human right. This expanded analytical framework produces theoretical space for the consideration of group rights, in conjunction with individual rights. This shift is particularly relevant to many Native American women, whose group identity has been historically targeted for removal and assimilation by the U.S. government (Noriega 1992; Stannard 1992; Ralston-Lewis 2005), and whose reproductive freedoms have been similarly assaulted (Smith 2002 and 2005; Gurr 2011a). Additionally, it is this very group identity which provides Native Americans access to healthcare through the Indian Health Service, as they are formally required to be enrolled members of federally recognized Tribal

nations before they can access care through IHS. It is also salient in the responses to reproductive health crises from Native organizations such as Woman is the First Environment Collaborative, which foregrounds tradition-oriented practices in its reproductive justice work. While collective rights remain contested in the international human rights arena, the reproductive justice paradigm centralizes these rights through its linking of women's needs with community needs, and in doing so offers a powerful analytic and activist frame from which to understand and address the violations of Native women's right to health.

The role of the federal government, of which IHS is a recognized agency, in the perpetuation of multiple linked violations of Native women's fundamental human right to reproductive health reflects the complexities of Native-U.S. relationships in ways which must be made explicit if they are to be adequately addressed. Thus far, human rights scholars have failed to meaningfully address these complexities or the violations embedded within them, and international human rights instruments continue to struggle with both accountability mechanisms and the theoretical development of collective rights which might better serve Native Americans. This is further complicated by the failure of the U.S. to ratify numerous international treaties, thus protecting itself from international mechanisms.

For Native American women, the confluence of historical oppression and current social conditions which include high rates of poverty, high rates of sexual violence, and complex legal relationships intersect with the federal government's failure to provide adequate healthcare despite its obligations to do so as outlined in both domestic treaties and international instruments which it has signed, though not ratified. As this study reveals, the consequences include restricted access to healthcare facilities, coercive health practices, inadequate access to contraception, inadequate care for survivors of sexual assault, and widespread challenges to Native people's right to the basic conditions of health.

The obligations of the State to protect and provide for the inclusive right to health and the conditions for health have been widely recognized, including by the United States through its role in the development of and its signature of numerous international

treaties which enshrine these rights. Equally important, the failures of national governments globally and the need for international support in achieving adequate measures for maternal health have also been brought to international attention. Yet the complexities of these failures in the U.S. and the needs of Native women elude both global attention and global accountability, due in part to the U.S. resistance to ratification of international treaties. The emerging theoretical paradigm of reproductive justice, however, may offer opportunities for human rights scholars and activists to situate Native American women's reproductive health needs within a broad framework of domestic individual and collective human rights. The emphasis in reproductive justice on meeting the needs of individuals as they emerge from and intersect with community needs expands our opportunities to address the needs of Native Americans as distinct groups, and Native women as individuals. It remains to be seen how sociologists of human rights as well as sociologists of reproduction will utilize these opportunities.

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## Endnotes

1. Informants ranged in age from twenty-two to sixty-seven, and sixteen of the twenty-five Native informants were Lakota, originally from Pine Ridge Reservation, Rosebud Reservation, or Cheyenne River Reservation (all three of these reservations are located in South Dakota). Two informants were non-Native, one a midwife who had formerly worked for IHS, and one a reproductive rights activist who works on Native issues. Three Native informants are also anti-violence activists and educators. Other Native informants came from the Navajo Reservation in Arizona and Akwasasne Reservation in New York. The majority of participant observation was done on or around Pine Ridge Reservation in South Dakota.

2. Key pieces of legislation examined included: the Indian Healthcare Improvement Act of 1976 and 2010; the Snyder Act of 1921; the Indian Self Determination and Education Assistance Act of 1976; and the Patient Protection and Affordable Care Act of 2010. National reports included the 1928 Meriam Report and the U.S. Commission on Civil Rights 2003 Report *A Quiet Crisis: Federal Funding and Unmet Needs in Indian Country* as well as its 2004 follow-up report *Broken Promises: Evaluating the Native American Healthcare System*.

3. International human rights instruments included: the Convention on the Elimination of all Forms of Racial Discrimination (1965); the Convention to End Discrimination Against Women (1979); and the United Nations Declaration on the Rights of Indigenous Peoples (2007). I also examined reports from non-governmental agencies such as Amnesty International, the American Civil Liberties Union, and Owe Aku, an indigenous environmental rights organization located primarily on Pine Ridge Reservation in South Dakota, as well as documents released by Tribal governmental organizations such as Black Hill Sioux Nation Treaty Council.

4. ‘signature’ and ‘ratification’ are two distinct, but related processes in the international human rights arena. When a State signs a treaty, it indicates its willingness to abide in good faith by the articles of the treaty; however, it withholds itself from international imposition of the treaty’s articles in its territories. Ratification, which commonly follows signature and approval by the State’s ruling apparatuses, binds the State to a measure of international oversight.

5. In response to the question of involuntary sterilizations in its Frequently Asked Questions section, the IHS website provides links to several resources which ‘discuss evidence that refutes that hypothesis’ (IHS/MCH 2010); one of these links leads to an undergraduate term paper.

**Barbara Gurr’s** research highlights the intersections of race, class, gender, sexuality, citizenship, and the body. Her dissertation utilized a reproductive justice framework to examine the consequences of locating Native American women’s healthcare in a federal agency, the Indian Health Service. Her current research considers family identity tasks for cisgender parents with young transgender children. She is currently an Assistant Professor in Residence in the Women’s, Genders, and Sexualities Studies Program at the University of Connecticut and her work has been published in *The International Journal of Sociology of the Family*, *Sociology Compass*, *The Journal of the Association for Research on Mothering*, and other locations.