



Complex Intersections: Reproductive Justice and Native American Women

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Abstract

This article presents an overview of reproductive justice as a theoretical and activist paradigm developed in response to reproductive oppression in the United States, and focuses on the reproductive justice needs of Native American women, as well as the responses developed by Native American women and their allies to these needs. I make explicit the links between reproductive justice, environmental justice and human rights for Native American communities, 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 IHS to meet the reproductive healthcare needs of Native American women reflects the failure of the federal government to meet its obligations to Tribal nations; further, these failures produce structures of reproductive oppression in Native communities which scholars and activists seek to redress utilizing the rubric of women's reproductive health.

Introduction

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). 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, intersectional and locally grounded examinations of women's embodied experiences, and social and political activism. This synthesis of the concrete and the abstract produces a praxis of alliance building between and among movement actors, scholars in academic institutions and local communities.

This article examines this praxis broadly as it occurs across a variety of locations. Although I note the needs of women of color generally, I focus particularly on the need for and development of reproductive justice work in Native American communities, and most specifically reservation communities. Following a brief explanation of reproductive oppression in the United States, I begin with a general introduction to reproductive justice as a theoretical paradigm, making particular note of the broad applicability of this framework. The links between reproductive justice, environmental justice and human rights are centralized here in order to highlight the intersecting nature of these frameworks, and the relevance of these intersections for Native American women. This is followed by consideration of the role of healthcare in inhibiting or providing for reproductive justice, particularly in Native communities. 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 rights are tied to State obligations. I

conclude with a broad assertion of the applicability of the reproductive justice framework in Native communities, which I also illustrate throughout with examples of some of the needs of Native communities and the work of Native organizations to meet those needs. This article thus offers a broad overview of reproductive justice and a specific case study of reproductive justice in Indian Country, particularly as this is both inhibited and promoted by the State through its provision of healthcare.

Reproductive oppression

As medical sociologists and others recognize, health is profoundly political (see, for instance, Finger 1998; Olafsdottir 2007; Rothman 1989; Williams 2000). The fundamental role of race, class, sex and gender inequalities in contemporary societies, and the histories from which these inequalities derive, necessitate the careful and deliberate consideration of social relations in any effort to understand health and wellness. The growing insistence from women of color that scholars of health and healthcare not only consider reproductive rights from a legal perspective but also investigate the interactions between social, economic and political forces and women's reproductive experiences requires a broad conceptualization of the ways in which women's well-being is shaped by these interacting forces to produce varying forms of reproductive oppression.

The historical roots of reproductive oppression imposed on marginalized communities extend to the political origins of the United States. Collins (2004), Roberts (1997), Springer (2006) and others have explicitly linked the enslavement of African and African-American women and the sexual violence perpetrated against them to ongoing reproductive oppressions in African-American communities as well as other communities of color. Similarly, the forced removal of Native American women, their families and their communities, as well as the deliberate targeting of Native women for genocidal extermination, reflect the violent oppressions enacted on Native communities through the bodies of Native women (Smith 2005; Stannard 1992; Trask 2006). The population control efforts evident in these histories continued through the passage of the 1875 Page Act, the Chinese Exclusion Act of 1882 and other pieces of legislation which restricted the entry of unmarried Asian women into the United States as part of an effort to limit the growing Asian and Asian American population; the passage of miscegenation laws throughout the United States; the sterilization of women of color as well as people deemed medically unfit during the 20th century (Reilly 1991; Stubblefield 2007); increasingly restricted access to abortion counseling and services following the passage of *Roe v. Wade* in 1973, particularly through class-based policies such as those enacted by the Hyde Amendment beginning in 1976; and targeted immigration policies which continue to effect the exclusion of certain communities from the rights and protections of full citizenship, including health safety (Lindsley 2002). The cumulative impacts of these oppressions have particular resonance in reproductive justice work, which relies on a sustained analysis of the ways in which social and political intersections produce particular reproductive realities.

Reproductive justice

In response to these and other women's health needs, increasing numbers of community-based organizations began to emerge in the 1980s which spoke specifically to the health needs of women of color and low income women. These organizations, such as Sister-song: a Women of Color Health Collective and Asian Communities for Reproductive Justice, recognized that the reproductive rights movements, largely dominated by White,

economically advantaged women, did not adequately address the needs of all women. Particularly, the prominence of abortion rights in US-based reproductive rights movements left little social and political space in which to consider other reproductive health needs. The reproductive justice movement emerged in response to this perceived lack of consideration in mainstream reproductive rights movements, and organizes women and their communities to identify and challenge structural inequality and, importantly, effect change in these oppressive structures.

Although reproductive justice as a distinct approach to women's health emerges from and retains important ties to other reproductive rights and reproductive health movements, reproductive justice simultaneously works from an expanded conceptualization of health, justice, economic security and self-determination. Reproductive justice thus rejects narrow formulations of reproductive health as an individual experience and forcefully expands conceptualizations of health to include community needs and strengths.

Since its emergence in the late 1980s, the model of reproductive justice has been elaborated upon by numerous local and national organizations to reflect diverse identities, needs, oppressions and ambitions, including labor rights, healthcare access (particularly for economically disadvantaged communities) and the rights of gay, lesbian and transgender people. Organizations such as Spark Reproductive Justice Now in the Atlanta, Georgia area, the National Asian Pacific American Women's Forum, the Alliance for Reproductive Justice in Alaska, Voces Latinas in New York and others coordinate local, national and transnational efforts for change predicated on building comprehensive reproductive health and safety for all communities. The wide diversity of social and political locations represented by these and similar organizations reflect the broad focus in reproductive justice on addressing a multitude of community needs through the rubric of women's reproductive health.

Scholars have also increasingly linked the intersections of social, economic and environmental justice with women's reproductive health (see, for example, Cook 2000; Fried 2002; Silliman et al. 2004; and Smith 2005). For example, the adverse relationship between reproductive health and pharmaceuticals in the environment (Becker 2010) and the intersections between community resources and access to adequate healthcare (Cohen 2008; Fried 2002) have been increasingly documented over the last several years. The theoretical integration of these issues works in tandem with the efforts of social movement actors, whose locally grounded labor in turn provides insights to feminist scholarship on women's reproductive rights.

The focus in this article on Native American communities highlights the linkages of environmental justice, human rights, Native women's reproductive health and Native communities' reproductive justice work. These links are relevant in different ways to all communities, but bear a particular significance for Native Americans. The history of colonization in the United States has produced unique effects for Native people, which include high rates of poverty (Ogonwole 2006), limited access to healthcare resources, high rates of violence and particularly violence against women (Amnesty International 2007), and the continuing loss of land rights and environmental integrity. Although scholars, activists and organizations seek to address these issues in a multitude of ways, the focus in reproductive justice on intersectional and local understandings of women's needs within their communities provides a potentially powerful frame to address broad social justice concerns for Native people. Scholars and activists who engage this frame seek specifically to identify the interlocking oppressions which produce restrictions on women's health and wellness, such as environmental degradation, restricted access to quality healthcare, and human rights violations perpetrated against both individuals and communities.

The synthesis of theory and activism in reproductive justice thus produces a feminist praxis of alliance building between the academy and social movement actors.

Environmental justice and reproductive justice in Indian country

The broad attention in reproductive justice on the consequences of social and political oppressions for women's reproductive freedoms has led to a growing understanding of environmental justice as one of the central links between reproductive health and community health. Environmental justice work centralizes the relationships between environmental exploitation and certain socio-demographic characteristics, particularly race and class (Bell 2009; Weinberg 1998).

Reproductive Justice activists and scholars specifically locate the bodies of women as one lynchpin between environmental pollution and community wellness, arguing that the impacts of pollution on women's bodies differs in important ways from the impacts on men's bodies, and further that the impacts of pollution on women's bodies has particular consequences for the community at large (Cook 2000; Silliman et al. 2004; Smith 2005). This is similar to Bell's conceptualization of the 'invironment', 'the zone of the body's perpetual dialogue *with* the environment' (2009, 115, emphasis original). Bell argues that because of this perpetual dialog between body and environment, health becomes a primary location for understanding the social and physical impacts of environmental pollution on whole communities.

The links between environmental justice and reproductive justice are particularly relevant in Native American communities: Native lands are the sites of some of the United States' worst pollution activities and of multinational corporations' dirty mining and toxic dumping practices (Churchill and LaDuke 1992; LaDuke 1999); they are also some of the poorest communities in the country, and frequently lack access to clean water, adequate housing and arable land (Grinde and Johansen 1995; LaDuke 1999). Therefore, much of the reproductive justice work in Indian Country directly addresses environmental concerns and promotes alliances between environmental activists and women's health activists.

Woman is the First Environment Collaborative emerged out of the work of Native health activists on Akwesasne Reservation who identified the links between the toxic pollution of the St. Lawrence River and increasing rates of miscarriage, infant mortality, childhood cancer and cancer among women. These findings were established in part through the Mother's Milk Project, in partnership with the US Environmental Protection Agency and Cornell University (Grinde and Johansen 1995; LaDuke 1999; Silliman et al. 2004). The Mother's Milk Project revealed the impacts on the bodies of Mohawk and other women of the legal and illegal dumping of toxic wastes by multinational corporations such as General Motors, Alcoa and Reynolds Metals in and near local water sources. Numerous studies linked increasing rates of miscarriage and birth defects among women who were regularly exposed to toxic wastes in the St. Lawrence River, which runs through Akwesasne Reservation and provides food as well as water for household use and irrigation for local communities (Grinde and Johansen 1995; Silliman et al. 2004).

This work highlighted the roles of corporate interests and inadequate federal and state regulatory practices in producing mechanisms of reproductive oppression through environmental devastation by highlighting the intersectional consequences of environmental destruction on human health; as Mohawk midwife Katsi Cook, founder and Director of Woman is the First Environment Collaborative, explains of Akwesasne, "we're where all of those by-products of industry settle and bioaccumulate, biomagnify, move through the food chain, that sacred web of life that we're all a part of" (2000). Steingraber argues

similarly that “harmful substances have trespassed into the landscape and have also woven themselves...into the fibers of our bodies” (2010, 15), and thus “the environment is not just something else to worry about. It is connected to all the things we already worry about – our children, our health, our homeland” (2010, 289). Bell’s concept of ‘invironment’ and Steingraber’s argument that the harms released on the environment by human activity will eventually find their way into human bodies share the goal of recognizing the impacts of the social world, and specifically environmental pollution, on health. The foundational principle of *Woman is the First Environment* that women’s bodies are the first physical environment of all humans infuses Bell’s concept of ‘invironment’ with a specific focus on reproduction and women’s reproductive bodies.

In this way, alliances between reproductive justice and environmental justice reveal the ways in which Federal, regional state and corporate interests work together to inhibit community wellness through producing or tacitly allowing environmental pollution. *Woman is the First Environment Collaborative* extends this focus to bring together indigenous women leaders from across North America to address the links between environmental health and the safety and well-being of their communities. Women’s reproductive health provides the central focus of the Collaborative’s reproductive justice work, thus synthesizing environmental and reproductive health.

However, for many Native people the issue of environmental justice goes beyond keeping natural resources free from pollution; the history of colonization and land loss/theft throughout Indian Country forcefully restricts Native communities’ access to certain tradition-oriented practices, including cultural ceremonies and culturally relevant food sources (Mankiller 2004; Silliman et al. 2004). Corporate use and abuse of land also severs important cultural links between Native people and their landscape (Akers 1999), further impacting the health and well-being of Native women and their communities through environmental and land-based policies. As Cook explains, “reproduction is not just about reproducing bodies but also, it’s about reproducing culture and society” (2010; see also Grinde and Johansen 1995; Gurr 2011; LaDuke 1999). Restrictive land-based policies which inhibit the abilities of Native communities to engage in tradition-oriented practices limit Native people’s abilities to reproduce their culture, thereby further effecting a reproductive oppression which is enacted through both the physical bodies of women, and also the social bodies of Native communities. Therefore, the synthesis of reproductive justice and environmental justice in Indian Country addresses a multitude of linked oppressions and serves broad cultural needs.

Reproductive justice and human rights

According to Cynthia Soohoo, Director of the US Legal Program at the Center for Reproductive Rights, theories of reproductive justice and human rights 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 grass-roots movements around reproductive health 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.

However, the reproductive justice paradigm's focus on marginalized communities also 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' in reproductive health (see, for instance, Fried 2002; Leonard 2009; Silliman et al. 2004). Many reproductive justice activists have noted an assumption of approximate equality embedded in liberal approaches to reproductive 'rights' (see, for instance, Bridgewater 2009; Fried 2002; Ross 2006; Silliman et al. 2004). These approaches rely on notions of citizenship which centralize a White, masculine ideal (Fried 2002; Roberts 1997; Yuval-Davis 1997) and potentially neglect analysis of gender, race, class and sexuality, as well as structural constraints imposed by social, political and economic inequalities. Ross argues that the limited notion of legal rights which adhere to this construction of citizenship "ignores the intersectional matrix of race, gender, sovereignty, class and immigration status that complicates debates on reproductive politics in the United States for women of color" (2006, 62). Reproductive justice scholars and activists therefore focus on the ways in which intersecting social and political forces impact women's lives in differential and consequential ways (see, for example, Davis 1983, 1990; Roberts 1997; Ross 2006; Ross et al. 2002; Sistersong 2006; Smith 2006).

This evolution from a liberal approach which centralizes individual rights to a more comprehensive incorporation of social, economic and political structures and histories which include group needs has expanded both local and national conceptualizations of reproductive health as a human right. Importantly, 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 US government (Noriega 1992; Smith 2005; Stannard 1992).

Additionally, it is this very group identity which provides Native Americans access to healthcare through the Indian Health Service (IHS). Treaties between Native nations and the United States as well as numerous pieces of legislation such as the Snyder Act of 1921 and the Indian Healthcare Improvement Act of 1976 [2010] produce and recognize a responsibility on the part of the federal government to provide healthcare for Native people; however, access to this healthcare is contingent on enrollment in a federally recognized Tribal nation. Historically, federal rules for this enrollment date to the 1887 Dawes Allotment Act, and relied on a blood quantum formula which mandated a minimal percentage of Native heritage in order to enroll in a Tribal nation. In 2011, federal recognition requirements for Native nations continue to consider blood quantum to some degree, and the rules for enrollment in an individual federally recognized Tribal nation, which have become more flexible, also commonly continue to incorporate blood quantum. This biological understanding of race as a measurable quantity contradicts scholarship emerging from scholarly communities such as the American Sociological Association, which has long argued that race is a social construction with no basis in biology (see also Bobo 2001; Lee 1993). Similarly, the American Anthropological Association (AAA) released in 1997 a critique of the conflation of race and ethnicity found in federal classification systems such as the US Census. The AAA asserted that race must be understood socially rather than biologically and further, that reliance on genetic measurements to determine racial classifications in fact 'show clearly how vague and social, rather than biological, are categorical terms for people' (AAA 1997). Since 2000, the US Census has

allowed respondents to identify as more than one racial category, and in 2010 listed 15 racial categories as well as providing space for respondents to write in specific races not listed on the form. Nonetheless, despite scholarly challenges to biological conceptualizations of race and recent adjustments made by the US Department of the Census, blood quantum continues to frame Native American identity to varying degrees.

Thus the complex and unique relationship between Native nations and the federal government, which relies on a cultural group identity, synthesizes both individual human rights and group rights to health and healthcare. In this way, the role of elite State institutions is deeply implicated in protecting and providing for the basic right to health for Native Americans on the one hand, and producing certain structural oppressions which impact Native women's access to reproductive health on the other. Durazo refers to this contradictory logic as the 'double discourse' of care: 'expressed interest in the provision of care, while making people of color sick' (2006, 183). Given these complexities, it becomes imperative to consider the role of the State, and particularly the IHS, when examining reproductive justice for Native American women.

Reproductive justice and the role of healthcare

Across the country, women of color suffer disproportionately high rates of cervical cancer, sexually transmitted infections, HIV/AIDS, unintended adolescent pregnancies, and diabetes, among other health concerns (Durazo 2006; IHS 2008; Kaiser Family Foundation 2009; Silliman et al. 2004). Durazo attributes these disparities to "overexposure to toxic environmental conditions, limited access to healthy foods, and migrant displacement from land and families" (2006, 186), a finding supported by the Kaiser Family Foundation (2009). Silliman et al. (2004) situate these health disparities within population control policies which control women's fertility through a variety of legal, social, medical and economic means, such as welfare reform, immigration policies and housing segregation (see also Neubeck and Cazenave 2001; Ross 2006; Smith 2002, 2005).

The reproductive justice framework recognizes the role of healthcare in providing for or inhibiting women's reproductive health. Asian Communities for Reproductive Justice (ACRJ) (2005) asserts that healthcare is an integral aspect of reproductive justice, and further, that concerns around access to care and quality of care must be articulated in ways that highlight, rather than ignore, the links between healthcare and social, economic and political environments. Durazo expands ACRJ's understanding of healthcare access as central to reproductive justice, arguing that "(m)edical care is structured for whites to access it earlier...whereas people of color often cannot access care until the disease is too advanced for successful treatment" (2006, 186; see also Belluck 2009 for a discussion on delayed care in Native American reservation communities). She further asserts that "the institution of (western) medicine has served the interests of colonial, slavery, capitalist and racist systems by excluding (women of color) from needed care" and that "medicine, as a tool of social control...bears the interests of the (medical industrial complex) – the relationship between medicine, capital, and the state" (Durazo 2006, 181). Thus although in many ways the concept of reproductive justice moves past a limited focus on healthcare delivery, it simultaneously requires an acute understanding of the role of health institutions, particularly in marginalized communities, in providing for or even directly inhibiting women's well-being.

The social particularities of Native women's health and healthcare reflect historic and ongoing tensions between Native nations and the federal government as well as race, class and gender conflicts in the broader society. Thus although similar in some ways, in others

the reproductive healthcare available to many Native women differs significantly from the reproductive healthcare accessed by women in other US citizenship categories. The differences rest in part on the role of the IHS, which provides healthcare to approximately 1.9 million Native Americans in federally recognized Tribal nations (IHS 2010a). Here I outline the role of the IHS in both seeking to meet the reproductive healthcare needs of Native women and at the same time producing forms of reproductive oppression through inadequate and restricted provision of care. This is followed by a brief examination of the efforts of several Native women's organizations to address the reproductive oppressions produced by State actors such as IHS.

Indian Health Service and the consequences of financial neglect

Indian Health Service became a federal agency in 1955, following decades of growing health disparities between Native Americans and the general US population. However, the provision of healthcare to Native Americans by the federal government actually has its roots in the early Treaty period, and relies on the special government-to-government relationship between the United States and Tribal Nations. The stated mission of IHS is

to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level; to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian and Alaska Native people (and) to uphold the Federal and Government's obligation to promote healthy American Indian and Alaska Native people, communities, and cultures and to honor and protect the inherent sovereign rights of Tribes (IHS 2010b).

Accomplishing this mission, however, is complicated by a number of factors, including the complexity of serving the needs of almost 600 distinct Tribal nations and social factors such as the high rates of poverty and geographic isolation of many reservation communities. Perhaps the greatest obstacle for IHS in meeting the health needs of Native Americans, however, is that it has been consistently underfunded by Congress and the President (Harvard Project on American Indian Economic Development 2008). In fact, IHS has historically been funded at lower levels than similar programs within the Department of Health and Human Services, such as Medicaid and the Veteran's Program (Harvard Project on American Indian Economic Development 2008). The US Commission on Civil Rights asserts that "the anorexic budget of the IHS can only lead one to deduce that less value is placed on Indian health than that of other populations" (2003, 49), and further, that the failure of Congress and the President to meet the government's obligations and responsibilities to Native people in the provision of healthcare can only be attributable to either 'intentional discrimination or gross negligence' (U.S. Commission on Civil Rights 2004, 96).

This chronic underfunding illustrates the failure of the State to protect and provide for the basic human right to health for Native people, a right which is further codified through historic treaty relationships and past legislation. The accumulating impacts of this underfunding have resulted in outdated facilities and resources; understaffing; and deferred and delayed services (McSwain 2009). The consequences of financial neglect by the federal government are acute for Native women, whose access to the full range of reproductive healthcare, including contraception, abortion counseling and services, prenatal care, and birth services, is often restricted by the financial demands of other health concerns within IHS (U.S. Commission on Civil Rights 2003, 2004). The tension between providing care, but providing it inadequately, fractures the ability of IHS to meet its mission

and produces the double discourse of its logic of care. Here, I briefly consider three consequences of this double discourse for Native women.

Childbirth services

It is widely acknowledged by IHS that its facilities are too few, and frequently outdated (IHS 2006; Trujillo 1996). The lack of adequate healthcare facilities for Native women profoundly restricts their reproductive rights and freedoms, as they are frequently unable to obtain the services they need, or must travel considerable distances to obtain these services at facilities contracted by IHS. In late 2009, this failure to provide care resulted in a Freedom of Information Act suit brought against the IHS by the South Dakota American Civil Liberties Union. The FOIA suit alleged that IHS was failing to provide adequate birth services to Native women in the State, and particularly on Cheyenne River Reservation, which has no birthing facility. This suit remained unanswered by IHS, and in 2010 the South Dakota ACLU filed a second suit which included allegations that IHS and its contracted facilities have coercively induced labor in Native women for the past several years (Kolbi-Molinas and Doody 2010).

Relatedly, in June of 2010, the Senate Committee on Indian Affairs initiated an investigation to consider allegations and evidence of medical malpractice and financial malfeasance within the IHS, as well as the impacts of these on Native people reliant upon IHS for healthcare (Senate Committee on Indian Affairs 2010). The Committee Chairman found “deficiencies in management, employee accountability, financial integrity, and oversight of IHS’s Aberdeen Area facilities,” and determined that “these weaknesses have contributed to reduced access and quality of healthcare services” (Senate Committee on Indian Affairs 2010, 4). Specific findings included unanswered allegations of sexual harassment; missing or stolen narcotics; diverted and reduced health services; financial malfeasance; healthcare providers with expired licenses; and numerous facilities at risk of losing their accreditation (Senate Committee on Indian Affairs 2010).

Care for survivors of sexual assault

A key area of reproductive healthcare in which IHS has been historically lacking is in the provision of care to survivors of sexual assault. Native American women are 2.5 times more likely to experience a sexual assault than non-Native women (Amnesty International 2007), and in some communities the rates are considerably higher (Amnesty International 2007). Yet IHS lacks an adequate number of qualified staff to treat sexual assault survivors; the Native American Women’s Healthcare Resource Center (NAWHERC) reported in 2005 that 30 percent of responding IHS facilities did not have a clear protocol in place for the treatment of sexual assault survivors or the collection of forensic evidence. Of the facilities that did have a protocol in place, only 56 percent reported that it was posted and accessible to staff members (NAWHERC 2005). Additionally, NAWHERC found that 44 percent of IHS facilities lacked personnel trained to provide emergency care to survivors of sexual violence (NAWHERC 2005). In those areas that do not have adequate staff, a woman seeking care after a sexual assault may be required to find alternative facilities, often at her own expense (Bachman et al. 2008). Given the reliance of Native women on IHS for care, particularly in reservation communities which are often isolated from other healthcare resources, the failure of the State to require and provide adequate sexual assault care for Native women through IHS presents acute challenges to Native women seeking care.

Limited access to contraception

Native women's reproductive freedom is restricted by their reliance on IHS in other ways as well. For instance, although IHS claims to make available all medications approved by the FDA (IHS NCDF Workgroup 2002), this is not the case with emergency contraception (EC); according to a 2008 study conducted by NAWHERC, EC was not available at that time through 12.5 percent of IHS facilities (2008; see also NAWHERC 2003 and Smith 2005). Other forms of contraception may be equally difficult to access; for example, in some reservation communities oral contraceptives are only distributed through IHS facilities 1 month at a time, which presents an obstacle to Native women who may not have regular access to transportation or who are located in geographically isolated areas. Conversely, according to Ralston-Lewis (2005), the long-term contraceptive 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).

For many Native women, limited options may lead to permanent solutions; according to Volscho (2010), in 2004 Native women had the highest rate of tubal ligation in the country, followed closely by African-American women (33.9 and 30.1 percent respectively). In fact, even controlling for variables such as socioeconomic class, the odds of pursuing tubal ligation as a form of contraception are 123 percent greater for Native women than for white women (Volscho 2010; see also Gurr 2011). Although surgical sterilization exists on a continuum of contraceptive choices, the high rates among Native women must be understood as linked to limited alternatives; the Native American Women's Health Education Resource Center (NAWHERC) argues that permanent sterilization becomes the most tenable recourse for many Native women whose agency in avoiding pregnancy is severely curtailed by a lack of other contraceptive options or the limited nature of those options (2008).

Native women meeting the need

Although the existence of IHSs can be understood as an affirmative effort on the part of the federal government to address the reproductive health needs of Native women (as well as the health needs of the general Native American population), and thereby meet its obligations to ensure Native peoples' right to health, the failure of the President and Congress to provide adequate resources to IHS undermines these goals and ultimately contributes to the reproductive oppression of Native women who cannot access adequate healthcare. Further, the failure of IHS to respect the rights of Native women to exercise choice and freedom in their reproductive experiences directly contradicts its mission to provide for the health and well-being of Native people. From a reproductive justice perspective, this 'double discourse' inhibits Native women's basic human right to access healthcare and healthy communities for themselves and their families.

Native women, however, have begun in recent years to address their reproductive health needs through the development of community-based, indigenous-oriented programs. While organizations such as Woman is the First Environment explicitly link reproductive justice with environmental justice, other organizations focus more closely on reproductive healthcare needs, particularly pregnancy and childbirth services. Efforts to address prenatal care for Native women are particularly urgent, as they are less likely to access adequate prenatal care than the general population; between 1999 and 2001, 67.3 percent of Native women began prenatal care in the first trimester as opposed to 83.2

percent for all US races combined (IHS 2008). The Centers for Disease Control finds that American Indian/Alaska Native mothers are twice as likely as all US races combined to delay prenatal care until the 3rd trimester or not receive prenatal care at all (2007). The complications that arise from delayed or inadequate care extend beyond pregnancy and birth experiences; delayed or limited prenatal care has been linked to low birth weight and infant mortality (Centers for Disease Control 2007; Healy et al. 2006). Infant mortality among Native Americans is 28 percent higher than all US races combined (Healy et al. 2006).

Tewa Women United in the Northern New Mexico pueblo community provides tradition-oriented training to doulas (birth assistants) and provides pregnancy and birth support to Native women in culturally appropriate ways. Tewa Women United also provides new families with ongoing social support which incorporates indigenous practices. This work occurs largely outside of the purview of IHS, and evolves to meet the needs Native women themselves identify. Similarly, the Turtle Woman Project of the American Indian Family Center in St. Paul Minnesota also trains both Native American and non-Native doulas to provide culturally appropriate pregnancy and birth support to Native women in and around St. Paul. On Akwesasne Reservation in upstate New York and Southeastern Canada, tradition-oriented midwives and doulas provide prenatal care through a model known as Centering Pregnancy, which allows for meaningful incorporation of the social and medical needs of women and families in the program. The Centering Pregnancy model has also met with success on the Navajo Reservation, where it has been supported by IHS in its efforts to improve Native women's prenatal care (Allee 2008).

Conclusion

The reproductive justice paradigm highlights social and political environments of control and regulation by making explicit the relationships between reproductive health and reproductive oppression. The roles of the federal government, corporate interests and local community structures in constructing and imposing reproductive oppressions on particularly identified women – for instance, racialized women, low income women and queer (lesbian, bisexual and transgendered) women – has come increasingly to the attention of scholars and activists since the late 1980s, and has pushed forward both social movements around reproductive rights and theoretical analyses of the centralization of women's bodies in various forms of oppression and inequality. These expansions of the mainstream narrative of reproductive healthcare offer sociologists an opportunity to better understand the delivery of healthcare, particularly outside of a mainstream account which fails to recognize the complexities of multiple social locations. Importantly, explicit use of a reproductive justice framework also allows sociologists to further analyze the intersections of social inequalities and human rights as these organize the health experiences of women, their families and their communities.

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 corporate exploitation and degradation of the environment intersect with the federal government's failure to provide adequate healthcare despite its obligations to do so, and the IHS's failure to provide adequate care for Native women. The consequences of this double discourse include a lack of care for survivors of sexual assault; inadequate access to contraception; coercive health practices; and widespread challenges to Native people's right to the basic conditions of health.

The development in recent years of a reproductive justice framework among scholars and activists across the United States has broadened the opportunities for Native women to identify their own healthcare needs, particularly as these needs are shaped and organized by intersecting issues of environmental justice and human rights. The strategies developed by Native women and their communities to address broad reproductive health concerns reflect the interactive nature of social and political inequalities, while maintaining a focus on the particular needs for Native women which derive from these inequalities. In this way, the paradigm of reproductive justice in Native communities provides a broad framework within which to understand the impacts of existing inequalities on women's reproductive healthcare and produce the dynamic conditions for true reproductive justice and freedom in all communities.

Short Biography

Barbara Gurr's research focuses on sociology of the body and highlights the intersections of race, class, gender, sexuality and citizenship. She has authored or co-authored papers in these areas for *The International Journal of Family Studies*; *The Association for Research on Motherhood*; *Sage Reference*; and the edited collection *In Our Own Backyard: Human Rights, Injustice, and Resistance in the United States*. She is the former Director of Women's Studies at Southern Connecticut State University and the former Assistant Director of Women's Studies at the University of Connecticut, where she is currently a graduate student in Sociology. Her dissertation "Restrictive Relations: Native American Women, Reproductive Justice, and the Indian Health Service" utilizes a reproductive justice perspective to examine the failure of the federal government and the IHS to provide safe, adequate reproductive healthcare for all Native American women. She will continue this project to examine multiple responses from Native communities to produce reproductive justice for Native women.

Note

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