

CHAPTER SIX

Self-Determination Begins in the Womb

In 1977, elders and young activists from the Six Nations of the Haudenosaunee Confederacy met in Loon Lake, New York, to discuss the meaning of sovereignty. John Mohawk, a Seneca scholar and activist in his early thirties, laid out a five-part definition of sovereignty, in which he identified “control of reproduction” as one of

sovereignty’s “essential elements.” This struck a chord with Katsi Cook, a young Mohawk mother who attended the meeting. Five years earlier, Cook had left Dartmouth College in New Hampshire to dedicate herself to activism. In 1975, despite many logistical challenges, she had insisted on giving birth to her first child at home, much as her mother had done two decades earlier. The meeting at Loon Lake intensified Cook’s emerging mission to reclaim control of Native reproduction, and she soon took these ideas west. By the fall of 1978, Cook wound up in the Great

Plains, where she became involved with the newly established Women of All Red Nations, or WARN.

In the group’s first years, WARN leaders articulated an agenda that should be viewed as an early vision of Native

reproductive justice. Like many Native men and women, WARN members were outraged over allegations regarding coercive sterilizations in government and contract hospitals, as well as various other challenges to Native women’s procreative capacity and maternal rights. As activists throughout the country struggled for sovereignty and survival, WARN and other women presented reproductive control as inextricably linked to these efforts. Cook advocated expanded conceptions of sovereignty—“personal sovereignty” alongside tribal sovereignty—and she

called on women to exercise “sovereignty over our own bodies.” Activists argued that the survival of Native

peoples physically and “as Indians” now more than ever depended on women’s reproductive labor and autonomy. WARN’s message paralleled and at times intersected with that of non-Native feminists who fought for “reproductive self-determination,” as well as that of women involved in the burgeoning women’s health and modern

midwifery movements. Yet WARN women understood their reproductive agendas to be rooted in their historical and ongoing experiences as targets of colonialism and, for them, reproductive control could not be defined narrowly. It had as much to do with spiritual freedom and environmental justice as it did with the legality of and an individual’s access to any given reproductive technology.

This chapter explores Native women’s quest for control of reproduction from the late 1960s through the early 1980s. Years before WARN’s founding, Native women as patients, health workers, and activists navigated the web of evolving, often contradictory, and sometimes coercive family planning policies and practices that they encountered through the Indian Health Service (IHS). They negotiated tensions involving individual women’s needs, bureaucratic procedures, and collective struggles. By the late 1970s, some Native women embraced Katsi Cook’s call for a return to Native midwifery, while greater numbers of women pursued a vision of reproductive

control that demanded new types of practitioners, a change in their own attitudes about reproduction, and/or greater authority in clinics and birthing rooms. WARN's founding emerged from a longer and broader history of Native women's reproductive organizing, and the group's influence extended beyond women who viewed themselves as

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militants or even activists.

Federal Family Planning Policies and Politics

IHS began offering family planning services, excluding abortion and sterilization, in 1965 as part of an expanded commitment to family planning by the Department of Health, Education, and Welfare (HEW). The historian Donald Critchlow has argued that between 1965 and 1974, the federal government's role in family planning shifted "from

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nonintervention to active involvement." Two postwar political movements—one promoting women's right to safe, legal birth control and one promoting population control—facilitated the government's attempt to bring family planning more squarely under its purview. Both movements foregrounded the issue of "control," but the different uses proved telling. As women's historians have demonstrated, artificial contraception could be liberating for women, but it was not inherently so, and many advocates of federal family planning had little interest in women's

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health, bodily autonomy, or sexual freedom. Rather, population control advocates were motivated primarily by fears of global overpopulation and an expanding domestic welfare state. These concerns are similarly evident in

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early studies of IHS family planning services.

As with so much of federal Indian policy, the implementation of family planning services varied by location, and the attitudes of government health workers often shaped Native women's options. Some physicians and nurses refused to provide women with contraceptives or contraceptive information due to moral or religious objections. Other physicians showed little interest in family planning because they viewed the work as less glamorous than other aspects of the job or because they found the consultation process awkward. Still others apparently pushed the

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issue quite aggressively. Native women's reactions to government family planning services were similarly mixed. When a team of social scientists surveyed Omaha women in 1972, they found a strong preference for high fertility,

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which the researchers explained in part by pointing to "Omaha experience retained in tribal memory." The historical experiences the investigators described—epidemics, drastic population loss, and the extraordinarily high birth rates that had been necessary to ensure survival—would have been familiar to men and women throughout Indian Country. Although the history the investigators narrated effectively stopped at 1900, more recent experiences figured prominently in collective memory among Omahas and in other Native communities. A physician who spent two years on the Navajo Reservation observed that as long as Native infant mortality doubled national rates, government officials would have to temper their expectations for family planning. "After all," he argued, "there can

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be no planning if the patient cannot also plan on his [or her] children's likely survival."

A preference for high fertility did not necessarily mean an outright refusal of family planning services, but health workers in some locations did encounter staunch resistance. Often, this resistance reflected distrust of the federal government at least as much as it reflected rejection of birth control technologies. Past violations engendered ongoing suspicion, as was the case on one reservation where, according to a 1971 government report, "an overzealous physician allegedly performed so many unnecessary tubal ligations" that local women shunned all

family planning services. Mary Brave Bird, a Lakota activist involved with the American Indian Movement, later

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recalled, “Birth control went against our beliefs. We felt there were not enough Indians left to suit us.” Brave Bird, as well as other politically engaged women, viewed federal family planning as the latest manifestation of the government’s long-standing effort to wipe out Native populations.

Non-Native observers believed that Native men were more likely than women to oppose family planning

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programs. Physicians and other government officials generally attributed the hostility of male political activists and the disapproval of many husbands to either militancy or social conservatism, but in fact the gendered dynamics surrounding reproduction can be located in earlier colonial processes and policies. One of policy makers’ and social reformers’ objectives in promoting the allotment of tribal land at the turn of the twentieth century, a process that occurred to varying degrees on many, though not all, reservations, was to instill in Native men a proprietary interest in their wives’ sexual and reproductive practices. In some locations, as on the Crow Reservation, government employees pursued this objective blatantly and explicitly, urging Native men to intervene in women’s reproductive decisions and contending that high fertility—rather than any structural or policy changes—was the key to tribal survival.

Despite this relatively recent history, male (and some female) critics of family planning occasionally framed their opposition as a commitment to “traditional” practices. “Tradition” was a negotiated and contested concept in this politically charged historical moment, however. To underscore this point, Katsi Cook often added quotation marks

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to the word when she wrote about gender, reproduction, and related topics. As early as the 1960s, a group of respected female elders known as the “Lakota grandmas” invoked tradition in their efforts to present birth control as a maternal and infant health measure. Before colonization, they argued, large families had not been “the Lakota

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way.” Suspicion of the U.S. government notwithstanding, spacing births or otherwise limiting fertility was a familiar concept to many Native women and a familiar practice to some. In many communities, elders if not younger generations remembered how their mothers, aunts, and grandmothers had relied on breastfeeding and other practices to space births, and in some locations, especially the Southwest, women continued to utilize herbal teas

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that they obtained from healers or older female kin for family planning purposes.

Many Native women demonstrated that they were open to federal family planning services when the circumstances suited them. Contemporary studies suggest that somewhere between one-third and one-half of Native women of childbearing age used some form of artificial contraception in the late 1960s and early 1970s, and women

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reported their perception that many women in their communities used birth control. In some IHS service areas,

including Alaska, Oklahoma, and Billings, Montana, health workers reported acceptance rates of at least 70 percent.

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A Lakota woman who worked at a free Indian clinic in the Los Angeles area estimated that about 80–85 percent of the young women who came through the clinic used artificial contraception: “And they are really for it.... They

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practice it faithfully.”

There was a politics to the provision and availability of birth control methods. The two most frequently prescribed methods were oral contraceptives, more commonly known as “the Pill,” which had been available in the United States since 1960, and the recently redesigned intrauterine device (IUD), which was available by mid-decade. Physicians tended to prefer the latter method, and by 1970 IHS employees prescribed IUDs with more

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frequency than the Pill. IUDs placed reproductive control in the hands of the physician rather than the woman. The physician inserted and removed the device, while the Pill required women’s diligence in ingesting it every day. Some physicians had little faith in the capacity of patients of color to use oral contraceptives successfully.

The high discontinuation rates on many reservations increased their concern. In the Billings area, almost half of

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the women who had accepted family planning services discontinued such services in a fifteen-month period. Discontinuation rates included many women whom health workers labeled “lost to follow-up,” indicating that the woman had not returned for subsequent appointments as instructed. In one government study, health workers speculated that reasons for high dropout rates included family disapproval, miscommunication, transportation difficulties, and migration. Other likely factors included disagreeable side effects, the woman having felt pressure to accept the doctor’s recommendation in the first place, and the possibility that some women had only intended to use

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any given birth control method on a short-term basis. At any rate, physicians recognized that a woman who had been prescribed oral contraceptives and failed to follow up was susceptible to pregnancy, while a woman who had

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agreed to the insertion of an IUD had some protection from an unplanned pregnancy.

High dropout rates, physicians’ concerns about women’s capabilities and reliability, and the speed with which IUDs surpassed birth control pills in IHS family planning raise the possibility of coercion. The historian Virginia Espino has documented the “considerable pressure” physicians placed on Mexican American women to accept the insertion of an IUD at a Los Angeles county hospital in these years. In one extreme case, hospital personnel

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allegedly held a woman at the clinic against her will for hours until she “consented.” Yet coercion was not inevitable, and its potential does not discount the enthusiasm some women showed for the reproductive technology. One Native woman who gave birth to three children in the 1970s recalled that she kept getting pregnant even though she was taking an oral contraceptive: “Then they introduced IUDs.... They told us that that was something new, so I used it, and I never got pregnant after that.” She later reflected, “I’m glad I did it, you know. If I didn’t, I think I would have had ten kids by now.” This woman further expressed appreciation that her reservation hospital had the

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same technologies that were available to non-Native women at the time.

For other women, IUDs proved less reliable, leaving them with limited options in the event of an undesirable pregnancy. Native women reported becoming pregnant while using an IUD, but abortion was not always accessible. Before the Supreme Court’s *Roe v. Wade* decision in 1973, abortion was illegal at the federal level and in most

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states. After *Roe*, Native women obtained abortions at some government hospitals, but the judicial decision made

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no guarantees regarding availability. Surveys by the Alan Guttmacher Institute and Centers for Disease Control,

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for example, revealed that “eight out of 10 public hospitals” provided no abortion services after *Roe*.

In 1976, Congress passed the Hyde Amendment, which eliminated public funding for abortion. The legislation

hinders the ability of all low-income women to terminate a pregnancy and disproportionately affects women of color, but Native activists charge that the act discriminates against them specifically because they receive their

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health care from a federal agency. The amendment did not affect all Native women immediately, however. Until early 1982, IHS was the only Department of Health and Human Services (DHHS) program that did not follow the amendment's restrictions, and instead abortion decisions were "left to the doctor and patient." Under this policy, IHS performed 638 abortions in 1980—fewer, as will be demonstrated below, than the tubal ligations performed annually in the 1970s. The new abortion restrictions brought IHS in line with other DHHS programs and followed

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the Supreme Court's upholding of the Hyde Amendment in *Harris v. McRae*.

The termination of pregnancies garnered more opposition in Native communities than other family planning services, although this reaction was not universal. In surveys of Omaha and Seminole women, researchers found that the "great majority" approved of abortion only in the limited circumstances of rape or endangerment to the

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woman's health, or if there was something wrong with the fetus. It is worth noting, however, that the surveys in question were conducted in 1972, when abortion remained illegal at the federal level; this reality may have shaped women's perception of the issue as well as what they were willing to tell academic researchers. For her part, Mary Brave Bird explained her decision to carry her fifth pregnancy to term despite her poor health as owing to the "subconscious urge to reproduce" felt by her and many other Native women, whose communities had been the target of various campaigns for elimination. Brave Bird argued that "Indian feminists ... think that abortion is all

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right for everyone else, but not for us." Many women simply felt that abortion was not especially relevant in Native communities because of the persistence of "flexible childrearing." These women believed that if the biological mother were unable or unwilling to raise a child, one of the child's many relatives would step in to care

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for him or her.

Yet women's attitudes toward abortion frequently reflected an unwillingness to meddle in others' affairs, a social norm in many Native societies. Navajo women who gave birth at the Gallup Indian Medical Center in New Mexico in the early 1970s displayed a noninterventionist attitude toward family planning more broadly. When asked their thoughts about other women's family planning choices, the women's responses included "I don't know," "Whatever

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they want," and "It's their business." In Montana, an older Crow woman showed similar reticence when an anthropologist solicited her opinion on the liberalization of abortion laws in some states. When asked whether she thought women should be able to procure an abortion in a doctor's office, the Crow grandmother simply stated, "I

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know a lot of them do that." Even Brave Bird, who would not consider an abortion herself, did not extend her

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views to "everyone else." Some women who did not think that they would personally make the decision to abort a pregnancy or who had political reservations about Native women terminating pregnancies nonetheless believed that

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abortion should be available to women and that the decision had to be made by the individual.

Contemporary activists and subsequent scholars have argued that the relative accessibility of sterilization versus

abortion constrained Native women's options and encouraged them to "choose" more permanent measures. In 1970, Congress passed, and President Richard Nixon signed, the Family Planning Services and Population Research

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Act, subsidizing sterilizations for Medicaid and IHS patients. Nationally, there had been a decline in eugenic sterilizations during and after World War II. Anecdotally, it is clear that sterilizations still occurred in BIA (Bureau of Indian Affairs) and then IHS hospitals, but it is often difficult to discern the circumstances surrounding the operations. In the 1960s, the federal government's embrace of family planning apparently accompanied an increase in sterilization procedures, a trend that also affected African American and Latina women. On the Crow Reservation, older women privately referred to one physician as "the butcher" for his eagerness to perform such

operations; women's distrust and opposition likely contributed to the physician's removal by the end of the decade.

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Following the Family Planning Act, sterilization rates climbed dramatically. On the Navajo Nation, for example,

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such procedures doubled between 1972 and 1978.

Many women, especially working- and middle-class white women, viewed sterilization as a liberating technology

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in these years, a birth control method worth fighting for in doctors' offices and courtrooms. At an individual level, some Native women accepted sterilization procedures, especially the less invasive tubal ligation, with some relief in the late 1960s and early 1970s. They, too, viewed the procedure as a means of asserting a degree of reproductive control. One Native health aide in Wisconsin later recalled that before 1970, women sometimes came into his office requesting a tubal ligation, and he would have to try to talk them into having their partner get a vasectomy, a less

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expensive procedure.

After passage of the Family Planning Act, sterilization was more accessible for these and other women. In 1972, a young woman relayed the story of an eighteen-year-old from her reservation who had had a tubal ligation after the birth of her second child. Surprised, the interviewer inquired, "And they did that without her knowing it?" The

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young woman was unequivocal in her refutation: "No. She wanted it done." A few years later, a mother of two who had procured two abortions due to contraceptive failure went to her local IHS hospital to request a tubal

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ligation. Christopher Doran, a student at Yale Medical School, reported that four of the thirty women he interviewed at the Gallup Indian Medical Center in New Mexico "were convinced that they had enough children and ... wanted to have their tubes tied." One of the women was pregnant with her eighth child, another with her tenth. According to Doran, these women desired relief from "continual pregnancy" and to ensure that they would

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have no additional children to look after. The historians Maureen Lux and Erika Dyck have documented a more public declaration of control and autonomy in Canada. Representing the local public health committee, a group of women from a small Inuit community in the eastern Arctic emphasized their personal knowledge of women's

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proactivity in seeking sterilization procedures: "There are those who especially ask for it."

Yet the increased legitimacy of sterilization as a form of birth control ironically facilitated coercive uses of the technology, and aspects of the Yale medical student's account would have made activists who were beginning to explore the issue wary. First, Doran noted that the women did not request sterilization themselves. Their decision came only after hospital staff had presented them with the "possibility," and Doran emphasized the need for "a large measure of explanation, patience, and reassurance" on the part of the health workers. Recognizing the potential for coercion in the circumstances he described, Doran felt the need to refute the notion, although some readers likely found his assurances less than convincing. "I am not implying," Doran insisted, "that sterilization is forced on every

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grand-multipara who delivers at Gallup Indian Medical Center." Furthermore, Doran's account underscores the extent to which women's decisions were shaped by their unreliable and inconsistent birth control options, as well as their limited options in the event of an undesired pregnancy. As other scholars have noted, it is difficult to reconcile the politics of choice that ascended in some feminist circles in these years with the colonial context that continued to

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shape many Native women's reproductive lives. In the coming decade, Native women—as patients, professionals, and activists—grappled with this tension.

Consent and Coercion

The potential for coercion in matters of Native reproductive health did not suddenly appear in the 1970s. Decades earlier, Susie Yellowtail's experience as an employee as well as a patient within the government hospital at Crow Agency had alerted her to unethical practices, instilled a sense of urgent vigilance, and sparked a lifetime of reformist activism. As sterilization rates increased after the passage of the Family Planning Act, Native women who worked within the health care system—some of whom would have identified as activists, some of whom would not have—once again occupied the front lines in identifying and protesting unethical procedures and advancing a range of reforms to curtail abuses.

In the late 1960s, IHS began contracting with tribal governments to launch Community Health Representative (CHR) programs. Following successful pilot programs on the Northern Cheyenne and Pine Ridge Reservations, the

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CHR concept quickly spread to other locations. As CHRs, Native women and men acted as health aides and served as liaisons among patients, local health committees, and medical providers. Women often outnumbered men in this work. In Wisconsin, for example, at least three-quarters of the state's CHRs in the late 1960s and 1970s were

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women. CHRs did not always assume an active role in family planning programming, but they did so in some locations, such as the Crow Reservation, where Yellowtail and other women had established the precedent of active

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involvement in maternal and infant health services. When this was the case, female CHRs, through regular and sometimes intimate exchanges with reservation women, were well positioned to remain informed regarding trends in health and health policy.

CHRs had an especially important role to play in the provision of health services for Native peoples in Wisconsin, where IHS did not operate a single service center in the late 1960s, and Native communities had no choice but to use off-reservation facilities. Early CHRs developed their own local programs, but under the leadership of Arvina Thayer, a Ho-Chunk woman who served as the state's first CHR coordinator, Wisconsin's

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thirteen CHRs established statewide committees to tackle priority areas including women's health. Through conversations with women about their reproductive health and family planning needs, Thayer later explained, "the

CHRs are the ones that found out what was going on” with sterilizations in the area. CHRs learned that sterilization procedures were far more common in some institutions than others, and they determined that institutions’ protocols

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surrounding sterilization lacked transparency. “They were sterilizing a lot of women,” Thayer recalled.

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CHRs alerted IHS of their concerns, and according to Thayer, “IHS came down with a rule to the doctors.” Based on the timing and Thayer’s recollection of what the new regulations entailed, it seems likely that she was referring to guidelines HEW published in 1973. In August and then September of that year, HEW issued guidelines that established a moratorium on the sterilization of individuals under twenty-one years of age and those whom physicians deemed mentally incompetent; mandated a signed consent form that included the benefits and costs of permanent sterilization; and imposed a seventy-two-hour waiting period between formal consent and the procedure. In April 1974, HEW affirmed and strengthened these guidelines with the publication of new regulations that further required that the signed consent form specify that family planning decisions had no bearing on a woman’s eligibility for benefits. In issuing these revised regulations in 1974, HEW responded to an order from a U.S. district court following the forced sterilizations of Minnie Lee and Mary Alice Relf, two African American girls who were

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coercively sterilized in Alabama in 1973. Later investigations found that IHS employees implemented these regulations unevenly, and HEW made little effort to ensure that physicians in contract hospitals abided by the new guidelines. Ultimately, the lack of accountability surrounding medical and specifically reproductive health care led

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CHRs in Wisconsin and elsewhere to champion Indian-run health clinics and services.

Like the CHRs in Wisconsin, Connie Pinkerton-Uri, a Choctaw and Cherokee physician, became aware of the ethically questionable circumstances surrounding sterilization through her professional experiences. In 1972, a twenty-six-year-old Native woman came into Pinkerton-Uri’s Los Angeles office requesting a “womb transplant.” The woman had had a hysterectomy six years earlier when she was struggling with alcoholism, but she was now sober, engaged to be married, and wanting to start a family. It was clear to Pinkerton-Uri that the woman did not understand the nature or implications of the procedure. As Pinkerton-Uri later explained in interviews, she first thought the woman’s unfortunate experience was an anomaly but soon encountered similar instances and became

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convinced of a broader problem. Pinkerton-Uri’s growing awareness of sterilization abuses changed the physician’s professional trajectory. She went to law school and founded Indian Women United for Social Justice to

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investigate the issue and provide support for women who had been sterilized coercively.

Pinkerton-Uri’s story has been frequently recounted, but scholars have paid less attention to what her story reveals about Native nurses’ contributions to emerging sterilization-related activism. Although the anthropologist Marla Powers later highlighted tensions between Native nurses at Pine Ridge and activists who had become politicized regarding sterilization and other reproductive issues, there is some evidence that when the American Indian Nurses Association (AINA) was formally established in the early 1970s, with Susie Yellowtail as a founding

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member, sterilization abuse was among the group’s earliest priorities. By 1974, Pinkerton-Uri could proclaim, “Now, the Indian nurses ... They do have a movement.” A year earlier, Pinkerton-Uri had visited the IHS hospital in Claremore, Oklahoma, at the invitation of more than a dozen Native nurses who were protesting discriminatory labor practices and poor patient care. At Claremore, the Native physician encountered what she characterized as a

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“sterilization factory.” After reviewing the hospital’s records for 1973, Pinkerton-Uri alleged that out of every four

babies born in the fifty-eight-bed hospital, physicians performed one tubal ligation or hysterectomy. Pinkerton-Uri began interviewing women who had undergone the procedure; some reported having been on medication when they gave consent, others indicated that they did not understand that the procedure was irreversible, and still others

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implied that they had been afraid to argue with the doctor. This provided Pinkerton-Uri with the evidence she needed to present her concerns to legislators.

At a rally in Los Angeles, Pinkerton-Uri cheered the “nurses’ revolt against the forced sterilization of women” at

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Claremore. Without their efforts, the physician explained, her own work would not be possible: “It was the Indian health professionals who called me in, and it’s the Indian health professionals who also are feeding me

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information.” As a result, Pinkerton-Uri emphasized the need for more Native health workers inside the system acting as watchdogs. Her mission thus dovetailed with Susie Yellowtail’s most urgent objective in the 1970s, that of recruiting and supporting Native nurses. Pinkerton-Uri had likely met Yellowtail, the “grandmother of American Indian nurses,” in 1973, when the American Indian Physicians Association (AIPA) held its annual meeting at Crow

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Fair. Frustrated with the complacency of fellow Native physicians—she complained that she was the only AIPA member who supported the American Indian Movement’s occupation of Wounded Knee—Pinkerton-Uri decided to

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give up on galvanizing Indian physicians and instead turn her energies toward the more engaged Native nurses.

Pressure from Pinkerton-Uri, Native nurses, and others eventually forced the federal government’s attention. Senator James Abourezk from South Dakota called for a Government Accountability Office (GAO) investigation into allegations of sterilization abuse in government hospitals. In 1976, after an investigation of IHS service areas in Albuquerque, Phoenix, Oklahoma City, and Aberdeen, South Dakota, the GAO released its report. The government’s investigation relied on medical records and physician testimony, a methodology with inherent limitations because, as one scholar of post–World War II sterilizations has noted, “few sterilizations appear suspect

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when read through the official medical record.” The report stopped short of declaring that the IHS coercively sterilized Native women, but it did highlight several problems with the consent process.

Covering the period from 1973 to 1976, investigators found that HEW’s 1974 regulations had had little effect. HEW failed to provide IHS with sterilization guidelines, and IHS lacked standardized consent forms, resulting in physicians’ ignorance of proper protocol and variation from hospital to hospital. Some hospitals used inadequate consent forms, which did not fully explain the risks of the procedure or alternative birth control methods, and the forms did not clarify that a woman’s birth control decisions had no bearing on her qualifications for government programs. IHS area offices also failed to follow HEW regulations regarding a moratorium on women under the age of twenty-one and a waiting period of seventy-two hours between consent and an operation. Staff at contract facilities violated the moratorium as well, and in almost one-third of these cases IHS authorized payment despite the

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failure to meet requirements.

The GAO report emphasized bureaucratic missteps rather than power dynamics. In contrast, Native activists investigated the allegations by speaking with women who had been sterilized and thus focused overwhelmingly on the latter. Pinkerton-Uri and others reported a handful of incidents in which sterilization procedures appear from the patient’s perspective to have been entirely forced. Native women alleged that they entered the hospital for childbirth or an unrelated surgery and did not learn that they had been sterilized until months or even years later. In one widely reported case in Montana, two young Native women claimed that they had entered a government hospital for appendectomies and received tubal ligations without their knowledge. In this especially tragic case, the women in

question were not yet sixteen years old. Perhaps more typically, coercion stemmed from the context of a colonial health care system and women's limited reproductive options. Some women had the false impression that the procedure was reversible. Language barriers, medical jargon, and, according to Pinkerton-Uri, physicians' deception led some women to assume that tubes that were "tied" could just as easily be untied later. A physician on the Navajo Reservation in the late 1960s remarked that "it is shocking not to find a single trained interpreter in any medical

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facility on the reservation." This left health workers and their patients dependent on the ad hoc assistance of family members, nurses' aides, or clerks, a situation that was particularly regrettable for communication centering on intimate matters like reproduction.

Unlike private patients, who had some flexibility in selecting a provider with whom they felt comfortable, Native women were generally limited to the government services on or near their reservation or city. Women reported feeling considerable pressure to consent to an operation, and some of them were reluctant to argue with the medical

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staff. Reliance on other federal or state services increased their susceptibility to pressure, as they feared authorities might strip them of their welfare benefits or remove their children. Mary Brave Bird alleges that physicians and social workers repeatedly asked women pointed questions: "Wouldn't it be better for you not to have more children

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rather than have them wind up in a faraway foster home?" Even if the threat was not explicit, by the late 1960s Native children were removed from their homes and placed in white foster or adoptive homes at high enough rates

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to make this outcome a reasonable fear.

Many Native activists also argued that the government report's quantitative findings were inadequate, in large part because the GAO restricted its investigation to four of the twelve IHS service areas. In these four service areas, investigators concluded that 3,001 American Indian women of childbearing age had been sterilized between 1973

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and 1976, and about one-third of the documented sterilizations occurred in contract hospitals. Pinkerton-Uri argued that if one extrapolated the government's own numbers to include all service units, it would be reasonable to

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estimate that physicians had sterilized at least 25 percent of Native women of childbearing age. In some locations, activists suggested that the percentages climbed still higher. For example, Marie Sanchez, chief tribal judge on the Northern Cheyenne Reservation, interviewed women in her community, which had not been included in the GAO investigation. She learned that twenty-six of the fifty women she spoke with had been sterilized; many of these

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procedures occurred at the Crow Agency Hospital. One group of activists frequently cited their estimate that 42

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percent of Indian women had been sterilized.

These startling percentages do not mean that all sterilizations of Native women in these years were coercive. Permanent sterilization, especially via tubal ligation, was not an inherently oppressive reproductive technology, and there is reason to believe that in assessing available options, individual women determined that this birth control method met their needs. As Native communities became aware of the scope of the issue, however, many identified a need for analyses that moved beyond the individual. When Susie Yellowtail reflected in these years on the coercive sterilizations on the Crow Reservation decades earlier, she understood the injustice on multiple levels—as deeply

upsetting and sometimes traumatic for individuals, “devastating” to families, and threatening to the tribe’s future. Activists understood the circumstances surrounding 1970s sterilizations as similarly multilayered. In the context of a national movement for Native sovereignty and self-determination, Native women and some men advanced an analysis that underscored the centrality of reproduction to ongoing political struggles in Native America.

Political and Personal Sovereignty

In 1968, Native men and women in Minneapolis founded the American Indian Movement (AIM). AIM rejected the assimilationist pressures of preceding decades and envisioned a movement capable of unifying political struggle

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with cultural resurgence and spiritual rebirth. AIM was characterized by its youth, but the organization also facilitated alliances between young people and elders, some of whom had spent years struggling for Native rights in different capacities. Local chapters appeared in cities from San Francisco to Cleveland, and while not welcomed on all reservations, AIM made inroads in reservation communities where tribal members had a thirst for a more militant style of Native activism. Although postwar federal policy had intended to divide urban and reservation Indians, AIM’s response to these policies provided a potential avenue for coordination and shared purpose. AIM formed alliances with Six Nations activists, many of whom gathered at Loon Lake in 1977, and helped promote the five-point definition of sovereignty that came out of that meeting, which included “control of your own reproduction.” In part a response to growing awareness of sterilization abuses, reproductive control encompassed a

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broader vision, and men and women agreed that on this issue “the women must lead.”

In the following decade, WARN led the public charge in the reclamation of reproductive control. Women from more than thirty Native nations gathered in Rapid City, South Dakota, for the group’s founding conference in 1978,

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and more than 1,200 women attended a second conference in Seattle the following year. The group’s founding leaders had been active in AIM, and as the historian Brenda Child has demonstrated, many of these women had

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ample experience advocating for Native children and families. WARN women emphasized that the decision to form a group for women was not akin to the separatism being championed by some white feminists at the time. Rather, as the historian Elizabeth Castle has argued, WARN allowed women to continue AIM’s work at a moment

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when government repression had constrained the latter organization.

The sex-segregated organization also facilitated work on issues that pertained to what Cook characterized as the

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“female side of life,” foremost among them reproduction. Cofounder Phyllis Young (Lakota) explained that the decision to organize separately was about restoring gender balance and “regaining our strength as women.” An early

promotional brochure proclaimed, “Indian women have always been in the front lines in the defense of our nations.”

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WARN was not alone in this effort. Along with the often-compatible efforts of Native health workers and

reformers, other militant women's groups emerged in these years, such as the Northwest Indian Women's Council. Founded by WARN member Janet McCloud (Tulalip and Nisqually), this regional organization functioned to

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expand WARN's geographic reach.

WARN was dedicated to ending sterilization abuse in government and contract hospitals, which members viewed

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as a blow to tribal sovereignty as well as to what Cook referred to as "personal sovereignty." Between annual meetings and speaking tours, members studied the issue locally. In Minnesota, WARN partnered with the National Lawyers' Guild Committee on Reproductive Rights to form the Sterilization Abuse Task Force, which documented coercive sterilizations in the Twin Cities. As Connie Pinkerton-Uri had done a few years earlier, the task force advertised its contact information, encouraging women to call if they had been sterilized coercively or if they

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needed sterilization-related counseling. These efforts enabled WARN women to identify local institutions with particularly egregious records, and it provided them with enough evidence to conclude that coercive sterilization was a serious problem in the Twin Cities—and this in a community that had been battling the removal of Native

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children from their homes for at least a decade.

When Pat Bellanger (Ojibwe) reported these early findings at WARN's second annual meeting, however, she emphasized the challenges that she and others faced in gathering these data. "*Being sterilized is a really tender and emotional issue,*" Bellanger explained. "It's not anything where we can sit in a crowd and say how many of you

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have been sterilized and get any kind of information you need." Women were reluctant to speak publicly about their experiences, as many felt shame and embarrassment and did not want their families and communities to know. The process of completing the questionnaire that task force members had created proved upsetting for some women, so Bellanger and others had to move slowly and dedicate significant time and energy to arranging counseling

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services for women who were "really ripped apart because they're no longer women in the way that they know."

Activists like Pinkerton-Uri and Sanchez had hoped that Native women who had been sterilized would come forward with lawsuits as women of Mexican descent had done in Los Angeles. But only one Native woman carried a legal suit to completion, and this suit was against physicians and social service workers in western Pennsylvania. It did not involve either the BIA or IHS. In 1970, a social worker with Armstrong County Welfare Services arranged the removal of two of Norma Jean Serena's children from her home. The same year, Serena discovered that she had been sterilized without her consent when she gave birth to her fifth child. Serena initiated legal proceedings to challenge both actions, and a jury ruled in her favor in 1973 that the removal of her children had been unwarranted. Her children were returned, and she received \$17,000 in damages. In 1979, however, Serena lost

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the case regarding her sterilization when the operating doctor contradicted the plaintiff's claims. Serena's lengthy and ultimately unsuccessful legal challenge underscores the obstacles Native women faced in taking their fight to the courts. In 1977, three Northern Cheyenne women began legal proceedings but then accepted a cash settlement so that they would not have to deal with the emotional stress and publicity of a trial. The United Native Americans

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also threatened to file a lawsuit, but this does not seem to have made much headway.

Sterilization policies and abuses became central to WARN women's indictment of the federal government, which they broadcast nationally and internationally. The group's leaders embarked on a speaking tour with the recently created Reproductive Rights National Network, an umbrella organization that linked about fifty feminist

organizations. Two years earlier, Sanchez, along with a handful of women who would be present at WARN's first ⁹⁸

meeting, provided testimony at the United Nations in Geneva, and many returned to the U.N. in 1981. In these venues, women lambasted the federal government's domestic and international involvement in population control. Their analysis of how and why abuses occurred also dovetailed with critiques advanced by Native health workers and activists throughout the decade—and by women such as Susie Yellowtail and Annie Wauneka at the local level decades earlier. They complained that IHS lacked adequate funding and that medical staff lacked cultural sensitivity. They resented the high physician turnover rates and a health care system that relied on inexperienced doctors learning their trade on the bodies of Native peoples. As Barbara Moore, Mary Brave Bird's sister, charged, ⁹⁹

“They use Indians as guinea pigs.” Moore spoke publicly about her own sterilization, which occurred without her knowledge.

By mid-decade, Pinkerton-Uri publicly proclaimed that the federal government was “using the vehicle of health care as a way of genocide,” and a few years later Sanchez argued that sterilization represented the “modern form” of ¹⁰⁰

genocide. WARN women continued this charge at the end of the decade, advancing a gendered analysis of ¹⁰¹

genocidal processes. Like other Native activists, WARN cited the definition adopted by the United Nations ¹⁰²

Convention on the Prevention and Punishment of the Crime of Genocide in 1948. The U.N. definition identifies five acts that if “committed with intent to destroy, in whole or in part, a national, ethnical, racial, or religious group, as such” constitute genocide. Scholars have documented a number of actions on the part of American settlers and soldiers, including mass killings and imposed starvation, that could be considered genocidal, but Native women pointed to the two identified acts that resonated most clearly with their own experiences and agendas. The U.N.'s fourth and fifth genocidal acts read: “Forcibly transferring children of the group to another group” and “Imposing ¹⁰³

measures intended to prevent births within the group.”

While the U.N. Convention placed the burden on victims of genocide to “prove” intent, many Native activists did not see the intent provision as a barrier. In interviews, WARN leaders argued that the removal of Indian children to foster care and the high sterilization rates in Native communities were part of a “planned” government effort to free up reservation land for energy development. “It's called intent to destroy,” cofounder Pat Bellanger argued. “That's ¹⁰⁴

what genocide is, intent to destroy.” Lehman Brightman (Lakota and Creek) spent much of the decade studying sterilization abuses and concluded that “the sterilization campaign is nothing but an insidious scheme to get Indians' ¹⁰⁵

land once and for all.” Others approached the issue somewhat differently. Pinkerton-Uri, for example, did not think that the sterilizations she had discovered resulted from a government plan “to exterminate American Indians,”

yet she did not hesitate to use the label “genocide.” For her, as for many others, the outcomes—a sterilization rate of 25 percent or higher among women of childbearing age and the removal of as many as 25 percent of Native

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children in some locations from their homes—spoke for themselves.

In the aftermath of the GAO report and subsequent organizing by communities of color and many feminists, HEW issued new sterilization regulations in 1978, the year of WARN’s first meeting. Following a period of public comment, the regulations went into effect in February 1979. The regulations continued the moratorium on sterilizations of persons under the age of twenty-one and specified that consent must include oral and written assurance that an individual’s decision was not linked to welfare or other benefits. The most notable changes were an extended waiting period—from seventy-two hours to thirty days—between consent and an operation and

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increased oversight in the form of regular audits. Not all women’s organizations were on board with the new regulations. As the historian Rebecca Kluchin has argued, “Liberal feminists’ self-interest—fear of having the right to sterilization on demand removed and fear of the loss of abortion rights—led them to oppose the waiting period

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and age minimum in the proposed policy.” These feminists viewed the waiting period in particular as an infringement on a woman’s reproductive “choice,” and their opposition contributed to women of color’s growing

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emphasis on “freedom” and “justice.”

For its part, WARN supported and promoted the new regulations, as did other Native women. Pinkerton-Uri, Sanchez, and Rayna Green (Cherokee), for example, served on the advisory board of the National Women’s Health

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Network, an organization that dedicated tremendous energy to publicizing and promoting the new regulations. The ultimate adoption of the 1979 regulations was a victory for Native women and for the many feminist organizations that lobbied for them. For individuals desiring a tubal ligation, the second hospital visit and, in some cases, the second surgical procedure could at times be an obstacle or burden; the anthropologist Marla Powers

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reported that some women on the Pine Ridge Reservation found the extended waiting period “annoying.” But most felt that the additional protections outweighed any inconvenience. In the short term, however, Native women had no reason to believe IHS would adhere to the 1979 regulations any more than practitioners had to the regulations HEW had adopted five years earlier. Activists called for continued vigilance.

A Whole Way to Be a Woman

Native women demanded that the federal government address inadequacies, abuses, and injustices within government and contract facilities, but they did not look to the federal government as the solution to the problems they had identified. When more than 1,200 Native people, mostly women, gathered for WARN’s second annual meeting in 1979, they tackled a pressing question: “How will we strengthen ourselves and our families so that we may survive?” Theirs was a woman-centered vision, but the focus was on women’s roles and relationships within families and communities. As one cofounder explained, “The women define the family and the family is the base of

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our culture and our culture, our families are under attack at every level, in every way.” Decolonization, as WARN women understood it, required the restoration of women’s strength and the reclamation of their reproductive control.

With WARN’s support, Katsi Cook launched the Women’s Dance Health Program (often abbreviated as DHP in

program documents) in the Twin Cities in November 1978. DHP's work consisted of four primary components. First, the program promoted Native women's health education through local classes and the production and distribution of informative materials. Second, DHP prioritized the training of Native midwives, who then served as primary care providers at home deliveries, sometimes with the backup or support of an OB-GYN from Minneapolis–St. Paul New School of Family Birthing. They also sometimes acted as labor coaches for hospital births. Third, Cook and a handful of other women ran a small health clinic that provided obstetric and gynecological care to Native women. Finally, DHP supported WARN's effort to study and document sterilization abuse in the

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Twin Cities and to provide “counseling and advocacy” services for women who had experienced such abuse.

As with much of AIM's activism, DHP emerged in an urban center—one with a long history of Native presence and the distinction of having been AIM's birthplace—and spread to reservations. The following year, a version of the program was adopted by the Oneida in Wisconsin, and Cook introduced the Women's Dance to her community

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after she returned to Akwesasne to give birth to her third child. Its influence extended still further, as program staff and volunteers supported and coordinated with women-led community-based programs in other locations, including a well-teen clinic on the Crow Reservation. WARN viewed the DHP as “a project aimed at the

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development of a new consciousness in health care for Native American women.” As such, it aspired to reach far beyond the localities in which the program was based.



Katsi Cook attended WARN's first annual meeting in 1978 and quickly emerged as a leader in the movement to reclaim Native midwifery first in the United States and later in Canada. Photo by Millie Knapp. Reprinted with permission. Katsi Cook Papers, Sophia Smith Collection, Smith College (Northampton, Massachusetts).

The nature and objectives of DHP reflect Cook's response to the coercive sterilizations WARN worked to publicize and eliminate. She shared other activists' outrage, but she also challenged her peers to consider Native women's responsibility for what happened to the women in their families and communities: "Where were we when
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our own sisters, mothers, grandmothers, aunts, friends were under the knife, being sterilized?" Drawing inspiration from self-help models advanced by feminist health activists with whom Cook had made earlier connections, she viewed DHP as a mechanism for reversing the "absolute dependency on medical systems
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responsible for the sterilization of over 1/3 of Native American women." Not only was sterilization inextricably connected to other contemporary Native struggles, a point WARN women made frequently. For Cook, sterilization abuse was a symptom of a more fundamental problem: colonialism had diminished women's personal and social power and destabilized their understandings of the meaning of Native womanhood. "What does it mean to be a Mohawk woman? What does it mean to be a Lakotah woman? What does it mean to be a Nez Perce woman?" She explained that the answer was "a little bit different for each area but the basic underlying concepts are always the
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same."

DHP's emphasis on women's health education in some ways mirrors the priorities of the all-female Crow Health Committee described in chapter 5. In contrast to the Crow committee's work in the 1950s, however, DHP existed outside the auspices of the federal government, and it was less concerned with promoting medical care than with

restoring the ways women had historically cared for themselves and others. DHP's diagnosis of the situation—that Native women had become so reliant on professional medical authorities that they had become ignorant of their own bodies—paralleled the arguments that feminists were making through organizations such as the Boston Women's Health Book Collective, but with important nuances. Colonization was the culprit, and most answers would be found in tribal cultures. Furthermore, women's increased knowledge about their bodies, health, and sexuality was not simply about personal liberation or self-actualization. It was, many activists argued, a matter of survival. In the Twin Cities and later at Akwesasne, DHP staff and volunteers led women's health classes at Native-run survival schools as well as in women's homes, and they disseminated their curriculum and materials as widely as they were

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able. Cook hoped to bring the curriculum together in a Women's Dance Health Book—an Indigenous take on the popular *Our Bodies, Ourselves*. Although she and a handful of others dedicated a couple of years to the project, the

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book did not come to fruition.

The ultimate objective of this health education was to renew women's knowledge of their bodies and reproductive powers, and the curriculum approached topics such as family planning, which could sometimes be controversial, from this perspective. For example, through DHP health classes, women learned the various types of sterilization procedures, as well as their medical indications, side effects, and consequences. DHP also encouraged women to consider the topic politically: "How has sterilization become a political issue, how is it genocidal to

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Native people and how does it threaten the survival and sovereignty of our People?" Above all, women learned their rights as patients in making these decisions. Regarding contraception, women discussed their own feelings about family planning as well as what they knew about the attitudes and practices of their grandmothers and great-grandmothers. The curriculum included detailed information on the various contraceptive methods available, instructions for use, and potential side effects, although WARN women tended to favor birth control methods that

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they viewed as "in keeping with our basic philosophy." DHP documents specifically point to diaphragms, the rhythm method, foams, and condoms. At Akwesasne, the program partnered with a nearby feminist health center to make cervical caps available to Mohawk women. Cook explained in a funding proposal for the Akwesasne program in the early 1980s that "our women have to know that it is okay to use contraceptives, and that a support group will

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be available to her for the use of contraceptives which are culturally acceptable."

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For Cook, midwife-assisted home birth was the ultimate "expression of sovereignty" for Native women. At WARN's first meeting, she called for a resurgence of Native midwifery. In the context of a meeting focused to a large degree on sterilization abuse, Cook's call parallels Susie Yellowtail's response to coercive sterilizations decades earlier. In the three years since the birth of her first child, Cook had received hands-on training at The Farm, a countercultural community in Tennessee that was emerging as a prominent location in the modern midwifery movement. She then proceeded to the University of New Mexico, where she completed a women's

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health specialist training program. Once in the Plains in the late 1970s, she supplemented this training with the more culturally oriented education she received from her in-laws at Pine Ridge. Among other teachings, her mother-in-law, a CHR and a member of the Native American Church, introduced her to peyote as a powerful medicine to facilitate birthing. Cook incorporated the medicine into her midwifery practice when she felt it would

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help the mother. When Cook moved to the Twin Cities, she began training Native and a few non-Native women

to serve as midwives and labor coaches. Like the midwives at The Farm, these women became known as the Birthing Crew. They provided family planning services, offered prenatal care that encompassed a woman's

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emotions, dreams, spirituality, and personal circumstances as well as physical care, and delivered babies.

Although a minority of Native women opted for or even had access to midwife-assisted childbirth in the 1970s and 1980s, Native midwifery, like the modern midwifery movement more broadly, was fueled by an intensity that surpassed its numbers. Cook had not been the only Native woman whose political activism and growing cultural consciousness had led her to seek out a new—and yet in some ways old—way of giving birth. AIM members and sympathizers on reservations in South Dakota had had similar impulses. The Lakota activist Mary Brave Bird famously gave birth during AIM's occupation of Wounded Knee in 1973. In part a response to the coercive sterilization of her sister, Brave Bird recalled, "I was determined not to go to the hospital.... I wanted no white doctor to

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touch me." Two years later, another Lakota woman opted to deliver outside the hospital for similar reasons. She did not trust the government doctors, and, as the sociologist Barbara Gurr explains, her desire for a birth experience

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that she understood as "traditional" can be viewed as "a political assertion of identity." The establishment of WARN and the founders' endorsement of Cook's message helped channel women's heretofore disparate

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experiences: WARN's second-annual gathering in Seattle included a midwives' meeting. By the early 1980s, the Women's Dance program among the Oneida in Wisconsin and the Mohawks at Akwesasne included a midwifery

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component, and women in other locations displayed a similar urge to restore a sense of birthing as ceremony.

Not all women were comfortable with the thought of giving birth outside a hospital or of giving birth without the supervision of a trained physician, but reclamation of control of reproduction extended beyond childbirth itself. In an era in which Native men and women were reclaiming Indianness and reincorporating cultural and spiritual knowledge and practices, women reintroduced puberty and prenatal rituals that had not disappeared but had fallen

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out of common practice. At Crow, women called on hospital personnel to be more respectful of community members' postnatal rituals. This required, for example, that medical staff cut the umbilical cord at a length long

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enough for it to be taken home and beaded into a small bundle to be worn by the child to ward off illness.

As it happened, IHS's introduction of nurse-midwifery in these very same years facilitated some women's quest for greater control. IHS began hiring certified nurse-midwives (CNMs) in some service units in 1969 as a cost-cutting measure and a means of mitigating continuing physician shortages. CNMs differed from many of the women who worked on Birthing Crews in Minneapolis, Akwesasne, and other locations. The latter were more likely to be lay, or direct-entry, midwives, while the former had completed academic training in nursing as well as midwifery. Most of the early CNMs were white, but a few Native women completed nurse-midwifery programs in the 1970s. Ursula Knoki-Wilson, the daughter of a Navajo midwife, graduated from the University of Utah's nurse-midwifery program in 1976 and went to work in the IHS service unit in Chinle, Arizona. Wilson recalls CNMs being welcomed into the community because women appreciated receiving care from female providers and

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because CNMs worked closely with Native healers to ensure women's needs were met.

If Native midwifery represented the most straightforward means of reclaiming control over childbirth, Cook later emphasized that the most important outcome was for women to be "healthy enough" to exert control over their

reproductive lives regardless of their birthing decisions. WARN's emphasis on health—the health of women, children, families, and communities—led its work in directions that were sometimes difficult for non-Native women to understand but that made perfect sense to the women themselves, who believed that their lives could not be

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compartmentalized. “We can't fragment the issues as the White man would have us do,” Cook insisted. Nowhere was this clearer than in WARN's increasing attention to the environmental degradation of reservation land, a phenomenon that activists linked to negative reproductive health outcomes.

Marie Sanchez, the Northern Cheyenne activist who worked with AIM as well as WARN, was well positioned to illuminate connections between biological reproduction and the environment, as she worked simultaneously on both issues in the 1970s. Sanchez was among the Native activists who organized to stave off the invasion of private energy corporations that, with the federal government's assistance, opened vast swaths of reservation land to mining

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operations in postwar decades. As the historian James Allison has demonstrated, “energy firms had gained control of hundreds of thousands of acres of Indian land” by 1973, and a second uranium mining boom a few years later

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accelerated this trend. Economic pressures convinced some tribal leaders to favor energy development, but tribal nations were inadequately compensated in these deals and prior to the early 1980s had little control over the process. These circumstances led Sanchez and some WARN leaders to view the coercive sterilization of Native women as a means of wiping out the Native population to meet the nation's seemingly insatiable hunger for tribal resources.

Activists identified additional intersections between environmental and reproductive politics. WARN and other Native women protested water pollution, uranium mining, and other forms of environmental degradation on reservations, all in the name of protecting their reproductive health. In 1980, WARN released a health study that revealed that uranium mining on the Pine Ridge Reservation had both long-term and short-term consequences for community health, destroying the tribal land base and exposing tribal members to low-level radiation and/or contaminated resources. Once again, the impetus for this line of inquiry came from an “insider” within the government health care system. Lorelei Decora Means (Ho-Chunk), WARN cofounder and registered nurse at the IHS hospital, spearheaded the study after she observed high rates of spontaneous abortions and birth defects in hospital patients. The resulting study alleged that in one month's time, more than one-third of pregnancies reported to IHS ended in spontaneous abortion, and more than half of children born on the reservation suffered some form of

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birth defect. Activists discovered similar trends in other locations. Women on the Laguna Pueblo Reservation in New Mexico discovered that miscarriage rates increased after the onset of uranium mining. Native women further

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attributed the increase in reproductive cancers to the nuclear fuel cycle.

In the coming decade, these issues would be at the forefront of many Native reproductive agendas, reflecting

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Cook's oft-repeated conviction that “women are the first environment.” Reclaiming control over reproduction was no simple matter. Native women's ability to exercise “sovereignty over their own bodies” required shoring up the political sovereignty of tribal nations to protect reservation lands and women's bodies from plunder.

THE INCREASED AVAILABILITY of the reproductive technologies of birth control, abortion, and sterilization in government and contract hospitals in the late 1960s and 1970s heightened the urgency of Native women's long-standing demands regarding competent and culturally sensitive health services. Women's attitudes toward and experiences of these technologies were shaped by individual needs, familial and community beliefs, and their political commitments—as well as their personal experiences with government health services and medical staff. By

the mid-1970s, the coercive sterilization of Native women became a focal point of some women's activism in the early self-determination era, from health workers to community leaders to militant activists. In response to this and similar abuses and in the context of a broader feminist challenge to American birthing culture, women within and outside of WARN called for a reassessment of Native biological reproduction and a reincorporation of historical practices and beliefs. For some, this required a rejection of the physician or obstetrician as the foremost authority on birthing and/or a rejection of the hospital as the preferred location for childbirth.

In 1979, proponents of reproductive freedom secured a victory with HEW's adoption of regulations that established new protocols to protect women from coercion. By most accounts, coercive sterilization via tubal ligation or hysterectomy declined significantly in the aftermath of the regulations—and the public protests that produced them. Yet Native women's reproductive organizing expanded in subsequent decades. In 1990, Native women from more than eleven Northern Plains Nations descended on Pierre, South Dakota, for a three-day “collective decision-making process” in which they established an agenda for future action. The women's nineteen-plank reproductive agenda included the “right to all reproductive alternatives and the right to choose the size of our families”; the “right to give birth and be attended to in the setting most appropriate, be it home, community, clinic or hospital”; and the “right to active involvement in the development and implementation of policies concerning reproductive issues.” The women further insisted that domestic violence, sexual assault, and

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AIDS be recognized as pressing reproductive issues. This struggle for reproductive justice continues—and continues to evolve—in the twenty-first century.