CRUSHING COLONIALISM

THE MAGAZINE

December 2024 | Edition 05



THE SEEDS IN MY BODY

Seneca Descendancy and PMDD

VOICES OF RESILIENCE

The Fight for Reproductive Justice in Tanzania

FREEDOM CYCLES

Reproductive Justice and Menstrual Dignity

LETTER FROM THE EDITOR

Dear Readers,

As we approach the close of another year, we find ourselves reflecting on the powerful threads that connect our struggles, our resilience, and our hopes for a just world. In this issue of The Magazine, we turn our focus to reproductive justice—a critical and deeply personal battleground where the fight for autonomy, health, and dignity plays out every day, particularly for Indigenous women.

Reproductive justice is not just about the right to choose; it is about the right to live fully, to access comprehensive healthcare, and to be supported in decisions that honor one's body and spirit. For Indigenous communities, these rights are woven into ancestral knowledge and practices that colonial systems have long sought to erase. Today, reclaiming those practices and securing the freedom to make informed, uncoerced decisions about our bodies is a revolutionary act.

In this issue, we journey across three continents to highlight stories of strength and struggle. From the so-called "United States", we bring you the deeply personal account of a Seneca woman confronting her diagnosis of Premenstrual Dysphoric Disorder and possible ovary removal. In Tanzania, three women share powerful testimonies on the state of reproductive health in their country. From Colombia, we showcase four illustrations honoring women's cyclical rhythms, affirming the right to embrace or forgo motherhood, and normalizing menstruation.

These stories are a testament to the resilience of Indigenous women, who have long been at the forefront of reproductive justice movements. They remind us that this fight is not solely about healthcare but about reclaiming our humanity in systems historically seeking to control us. The right to thrive—to be seen, heard, and respected—is central to any vision of justice.

As we read these narratives, I invite you to reflect on the interconnectedness of our struggles. The fight for reproductive justice is global, and it is ongoing. Let these stories ignite a sense of urgency, solidarity, and possibility. Together, we can work towards a future where all people have the freedom and resources to make choices about their bodies, lives, and communities.

In solidarity and celebration,



Isabel María Riofrío Miranda
Editor-In-Chief
Crushing Colonialism





Edna Shaibu sits down for hair braiding in a saloon located on Buswelu Street, in the Mwanza region, Tanzania. Edna calls for the need of comprehensive public education that normalizes discussions about reproductive health and contraception. Photo Credit: George Binagi, November 4, 2024

Editorial Staff
Jen Deerinwater, *Executive Director*
Isabel María Riofrío, *Editor-in-Chief*
Shana Baumgartner, *Editorial Director*
Acee Agoyo, *Board Member*

Graphic Design & Layout
Fabiana Gibim
Beatriz Saraiva

Contact
600 Pennsylvania Ave SE, #15581
Washington, DC, USA 20003
+1 202-996-7848
Info@CrushingColonialism.org
www.CrushingColonialism.org
Facebook: @ircc.resist
YouTube:@CrushingColonialism
Instagram: @CrushingColonialism
TikTok: @CrushingColonialism
Linkedin: @CrushingColonialism
X: @CRSHColonialism

Cover photo: “Cyclical Woman”, illustration by Laura Martínez.

**Throughout The Magazine, we default to using Indigenous place names unless otherwise stated. Colonial names are indicated in quotation marks for context.*

CONTENTS

DISPATCHES FROM OUR RELATIVES

2 Voices of Resilience: The Fight for Reproductive Justice in Tanzania

5 Reclaiming Abortion as Sacred: An Act of Healing and Empowerment

8 Echoes of a Dark History: Reproductive Injustice and Eugenics in the United States

DECOLONIZED BEATZ

11 Cycles of Freedom: Reproductive Justice and Menstrual Dignity

15 The Seeds in My Body: Seneca Descendancy and PMDD

GLOBAL INDIGENOUS NEWS

17 Reproductive Justice in Oaxaca Highlights Indigenous Perspectives

VOICES OF RESILIENCE: THE FIGHT FOR REPRODUCTIVE JUSTICE IN TANZANIA

BY ABELA MSIKULA

Tanzania stands at a critical juncture in its quest for reproductive justice, grappling with alarming maternal mortality rates that underscore the urgent need for comprehensive reproductive health care. According to the World Health Organization (2021), the maternal mortality rate in Tanzania was approximately 342 deaths per 100,000 live births. However, this figure masks significant disparities: rural areas experience maternal mortality rates as high as 500 per 100,000, while urban centers report rates closer to 250 per 100,000 (Tanzania Ministry of Health, 2021). Peri-urban areas often reflect a mix of these challenges, indicating that access to quality healthcare is unevenly distributed across the country.

These statistics represent the lives of women and families caught in a web of inadequate healthcare services, cultural stigma, and restrictive policies surrounding reproductive rights. Indigenous populations in Tanzania are particularly affected by these issues, where traditional cultural practices significantly impact women's reproductive health. In many Indigenous communities, childbirth is often prioritized as a home-based event attended by traditional birth attendants (TBAs), who, despite being respected figures, frequently lack formal medical training. Such reliance on TBAs can lead to increased risks during complications, contributing to the high maternal mortality rates.

Debates over reproductive rights in Tanzania are intensifying as advocates push for reforms that challenge the prevailing narratives around women's health and autonomy. The intersection of poverty, limited access to education, and traditional gender norms complicate these discussions, making it imperative to listen to the voices of those most affected.

In a recent interview, three women from Tanzania's Mwanza region, a port city on the southern shore of Lake Victoria, northwest of the country, shared their views on reproductive health and its broader impact. Their stories provide insight into women's systemic barriers and highlight the urgent need for change.

TESTIMONIES OF STRUGGLE AND RESILIENCE

Magreth Issa, a Nyakato National Street resident in the Mwanza region, shared how an early pregnancy derailed her lifelong dream of becoming a medical doctor. At just 13 years old she became pregnant while attending primary school in her home village of Kiziba in Tanzania's Kagera region The repercussions were swift and severe: her parents expelled her from home upon discovering her pregnancy, and the father of her child vanished, leaving her homeless for several months. According to the traditions of her Kiziba village, an unmarried pregnancy was seen as a curse, and this belief was deeply rooted in the importance placed on dowries. Magreth noted that under these customs, no man would pay a bride price for a woman who had already given birth.

Eventually, a matrilineal aunt secretly accommodated her just weeks before she delivered a baby boy. After years of navigating the complexities of motherhood, she moved to Mwanza, where she first accessed reproductive health services. At the Buzuruga Health Center, she learned about birth control and practiced child spacing. However, even in light of her own reproductive struggles, she remains reluctant to discuss reproductive health openly with her 15-year-old daughter, fearing societal stigma.

Magreth's story illustrates the urgent need for systemic change, particularly in rural areas where reproductive health services are scarce. She calls for government support to expand reproductive health education and services, emphasizing that open discussions about reproductive issues are vital for empowering young girls to make informed choices.

Lenarda Edmund, a 25-year-old mother living in the Kishiri outskirts of Mwanza, offers another perspective on women's challenges in Tanzania. Lenarda has three children and wishes to have no more, but her husband insists on having at least six, just for prestige, to prove his manhood, a demand that has led to significant conflict. In June of this year, after her husband discovered she was taking oral contraceptives, their marriage deteriorated, culminating in separation. Lenarda's experience underscores the financial and emotional toll of restrictive gender norms that prioritize family size over women's health.

Her narrative reveals a critical need for awareness campaigns aimed at dismantling the harmful belief that having many children equates to masculinity. Lenarda is acutely aware of the financial strain her family faces. Their income from pebble crushing barely covers basic needs. Her advocacy for public education on reproductive rights reflects a broader societal need to empower women to make choices that align with their health needs rather than societal pressures.

Edna Shaibu (protected identity), a 17-year-old secondary school graduate, represents the younger generation's struggle to navigate reproductive health issues amidst societal stigma.

Through school clubs, she has learned about contraceptive options and the importance of avoiding early pregnancies. However, she and her peers often feel compelled to hide their use of contraceptives due to the pervasive stigma surrounding unmarried girls' sexual health. Edna emphasizes the need for comprehensive public education that normalizes discussions about reproductive health and contraception.



Edna Shaibu walks around in her home Buswelu Street, in the Mwanza region, in Tanzania: Photo credit: George Binagi, November 4, 2024.

A CALL FOR SYSTEMIC CHANGE

These testimonies weave together a narrative that underscores the urgent need for systemic change in Tanzania's reproductive health landscape. The intersection of cultural beliefs and healthcare access creates a challenging environment for women navigating reproductive health issues. The experiences of Magreth, Lenarda, and Edna highlight the interconnectedness of reproductive rights and women's rights, emphasizing that addressing these issues is not merely a matter of healthcare access but a broader societal challenge requiring a shift in cultural attitudes.

To effect meaningful change, Tanzania must prioritize comprehensive reproductive health services, particularly in rural and Indigenous communities. This includes increasing access to contraception, improving healthcare infrastructure, and enhancing reproductive health and rights education. Public awareness campaigns should aim to dismantle harmful cultural beliefs that perpetuate stigma and discrimination against women seeking reproductive healthcare.

Tanzania's existing legal framework supports reproductive rights, including the National Health Policy and the National Reproductive Health Strategy, which aim to integrate sexual and reproductive health into primary healthcare systems. However, implementation remains a challenge. Civil society organizations play a crucial role in advocating for women's rights and pushing for policy reforms that address the needs of marginalized groups (Tanzania Ministry of Health, 2021).



Magreth Issa arranges the goods in her cloth shop, located on Nyakato National Street, in the Mwanza region, in Tanzania. Photo Credit: George Binagi, Novermber 4, 2024.



Lenarda Edmund fills charcoal in small buckets for sale, at her business area in Kishiri Street, in the Mwanza region, in Tanzania. Photo Credit: George Binagi, November 5, 2024.

REPRODUCTIVE RIGHTS AS WOMEN'S RIGHTS

Ultimately, the stories of Magreth, Lenarda, and Edna serve as powerful calls to action for policymakers, healthcare providers, and society. By amplifying their voices and addressing the systemic barriers they face, we can work toward a future where all women in Tanzania can access the reproductive health services they need and deserve. Reproductive rights must be recognized as fundamental women's rights, integral to achieving gender equity and improving communities' overall health and well-being.

Tanzania stands at a pivotal moment in its quest for reproductive justice. The path forward requires a collective commitment to dismantling the cultural and systemic barriers that hinder women's access to reproductive healthcare. By prioritizing education, expanding services, and promoting open dialogue about reproductive health, we can empower women like Magreth, Lenarda, and Edna to make informed choices that will ultimately lead to healthier families and communities. This is not just a women's issue but a societal imperative demanding immediate attention and action.

About the author

Abela Msikula is a news reporter with Tanzania Standard Newspapers Limited, holding a Bachelor's Degree in Journalism and Mass Communication from Tumaini University of Iringa-Tanzania (currently the University of Iringa), with more than 10 years of experience in the industry.

RECLAIMING ABORTION AS SACRED: AN ACT OF HEALING AND EMPOWERMENT

BY SEREN FRISKIE

For thousands of years, reproductive health care has been an essential part of Indigenous cultural practices, encompassing sacred rites, religious rituals, and the right to choose an abortion. This right to reproductive autonomy was woven into the fabric of our communities, respected as medicine for our spirits, and upheld as part of our connection to land, self, and future generations.

Such integration of medicinal and ritual care reflects the view that reproductive health is inseparable from our spiritual and cultural worlds. Abortion within this framework honors the individual and the community, allowing for decisions rooted in love, responsibility, and ancestral wisdom. Reproductive choices—including the right to abortion—are a sacred act of self-respect.

In 1973, the U.S. Supreme Court's decision in *Roe v. Wade* established a constitutional right to abortion, framing it as a matter of privacy under the Fourteenth Amendment. This landmark ruling provided federal protections for abortion access, overriding many restrictive state laws and symbolizing a critical victory for reproductive rights advocates. However, on June 24, 2022, the *Dobbs v. Jackson Women's Health Organization* decision overturned *Roe*, eliminating nearly 50 years of federal protections and leaving abortion access to the discretion of individual states. In the aftermath, 15 U.S. states have enacted near-total bans or severe restrictions affecting 18 million women and girls of reproductive age, creating a patchwork of access that disproportionately impacts equity-denied groups, including Indigenous communities.

The Dobbs decision intensifies the risks faced by Indigenous women, women of color, and those living in poverty, further endangering these already vulnerable communities. Over 60% of people seeking abortions in the so-called "United States" are from racial and ethnic minority groups. Indigenous women, who already face higher maternal mortality rates—up to three times higher than white women—zare especially vulnerable. States with restrictive abortion laws are often rural or lack healthcare infrastructure, which exacerbates existing barriers for Indigenous communities.

> *Over 60% of people seeking abortions in the so-called "United States" are from racial and ethnic minority groups.*

For Indigenous people, the loss of federal protections further compounds the challenges of obtaining safe and timely abortion care, intensifying existing inequities shaped by colonialism and systemic racism. The Indian Health Service (IHS) delivers healthcare to over 2.6 million Indigenous people across the "United States." However, its ability to provide abortion care is severely limited. Abortions are only permitted in cases of rape (if reported within 60 days), incest, or if the pregnant person's life is in danger.

This restrictive policy, established by the Indian Health Service, meant that even before the recent repeal of *Roe v. Wade*, hundreds of thousands of Indigenous women faced significant barriers to accessing comprehensive reproductive healthcare, leaving them with fewer options compared to non-Indigenous populations. This disparity underscores the systemic inequities embedded within federal healthcare systems and their impact on reproductive autonomy.

Indigenous communities have long upheld culturally specific practices surrounding reproductive health, rooted in respect for bodily autonomy, interconnectedness, and the sacredness of life. This holistic approach to reproductive health has been guided by traditional knowledge and sacred practices, passed down through generations by Elders and knowledge keepers.



Seren holds an abalone shell with sweetgrass and sage. She also holds a pregnancy test, in Pacific Spirit Park during a private ceremony. Photo credit to Seren Friskie, November 16th, 2024.

Traditionally, midwives, healers, and Elders provided care using plant medicines, ceremonies, and community support. These practices addressed physical, emotional, spiritual, and communal health. First Nations in North America used herbs like red cedar, American pennyroyal, tansy, and Canada wild ginger in reproductive care and as abortifacients. Similarly, Aboriginal people in Australia utilized plants such as giant boat-lip orchid, quinine bush, and blue-leaved mallee, which were ingested, inserted, or smoked alongside Cooktown ironwood. These practices were deeply connected to community care and spiritual well-being.

Abortion has long been an integral part of Indigenous healthcare traditions, deeply rooted in cultural teachings on wellness and sovereignty. Far from being a modern concept, it has been practiced for generations as an act of healing and balance, aligning with the holistic approaches of Indigenous medicine. Recognizing abortion as medicine affirms it as a form of spiritual care and a vital expression of bodily autonomy. For thousands of years, Indigenous practices have nurtured every stage of reproductive health—supporting menstruation, fertility, contraception, abortion, childbirth, and menopause—through approaches that honor the interconnectedness of body, mind, and spirit.
For Indigenous communities, the concept of choice is deeply tied to autonomy and survival, reflecting traditional values of self-determination and holistic health.

But colonization disrupted these practices, replacing them with policies that sought to control Indigenous bodies, especially those of women and Two-Spirit people. Forced sterilizations, denial of care, and the erasure of traditional knowledge have left lasting scars. As legal challenges like the Dobbs decision impact abortion access, the need to protect Indigenous reproductive rights and cultural sovereignty becomes more urgent.

One way Indigenous communities are reclaiming abortion as a sacred practice is through the work of modern-day Indigenous doulas. These doulas are not only supporting families during birth but also helping to reclaim reproductive justice by providing essential abortion care. By integrating traditional knowledge with contemporary practices, they restore cultural values of choice and sovereignty while addressing systemic barriers and trauma.

Modern-day Indigenous doulas are reclaiming reproductive justice by offering vital support to families during birth. These trained professionals provide physical, emotional, and informational care while blending traditional cultural practices like sweetgrass, cedar, and smudging with modern birthing techniques. Their work goes beyond birth support—they challenge colonial systems that have long oppressed Indigenous communities, restoring cultural connections and advocating for health justice. Rooted in the broader framework of reproductive justice, which includes the right to parent in safe and supportive environments, Indigenous doulas help families heal from the impacts of colonialism while celebrating life and community.

For some Indigenous people, abortion can also be a sacred act of healing that transcends the physical process. It is a reclamation of bodily autonomy, offering healing from the historical and



The Pacific Spirit Park is located in so-called "Vancouver, Canada", the ancestral territory of the xʷməθkʷəy̓əm (Musqueam) Peoples. Photo credit Seren Friskie, November 16th, 2024.

ongoing trauma of colonial policies that sought to control Indigenous bodies. Through abortion, Indigenous women have reclaimed their power, resisted systemic oppression, and honored their self-determination.

While Indigenous communities have endured the violent erasure of cultural and spiritual practices, a powerful resurgence in traditional knowledge, especially around reproductive health, is taking root. Across North America, Indigenous people are revitalizing ceremonies like the Ojibwe berry fast and the Hoopa Valley Flower Dance—rites of passage honoring menstruation, bodily autonomy, and connection to the community as acts of decolonization. Similarly, the rise of Indigenous doulas and the resurgence of cultural birthing practices underscore a deep commitment to preserving our ancestral knowledge in the face of ongoing challenges.

Yet, the U.S. Supreme Court's decision to overturn *Roe v. Wade* threatens to deepen the inequities Indigenous people face in accessing both Western and traditional reproductive care. For those in states that have banned or severely restricted abortion, and for those who already navigate barriers within reservation-based healthcare, this decision imposes even greater obstacles. It raises urgent questions about how these new restrictions may impact the use of traditional medicinal practices and Indigenous rights to cultural and religious autonomy.

In this time of uncertainty, reclaiming our knowledge and fighting for accessible, culturally rooted reproductive care become acts of both resilience and resistance. As we build a future that honors the sacredness of our bodies, we affirm the right to live and heal on our terms. We carry forward a vision of care, grounded in respect and liberation, that endures despite the barriers we face.

> ***We carry forward a vision of care, grounded in respect and liberation, that endures despite the barriers we face.***

About the author

Seren Friskie (She/They) is an Equity & Engagement Specialist at *Foundry BC*, a Research Associate at the Stigma and Resilience Among Vulnerable Youth Centre (SARAVYC), and an Indigenous Wellness Educator, Speaker, and Advocate. With Néhiyaw, Sto:lo, and European heritage, Seren is committed to advancing health equity, social justice, and systems change. Their work includes fostering Black community spaces, expanding gender-affirming care, and advocating for improved mental health services across Turtle Island. Seren lives on the unceded territories of the xʷməθkʷəy̓əm (Musqueam), Sḵwx̱wú7mesh (Squamish), and sḵwx̱wú7mesh (Tsleil-Waututh) Nations in so-called "Vancouver, British Columbia".

ECHOES OF A DARK HISTORY: REPRODUCTIVE INJUSTICE AND EUGENICS IN THE UNITED STATES

BY SHANA BAUMGARTNER

The deaths of 28-year-old Josseli Barnica (2021) and 18-year-old Naveah Crain (2023) made headlines as preventable fatalities that occurred as a result of delayed medical care during miscarriages. Both Barnica and Crain sought medical treatment in their home state of Texas where an abortion ban has been in effect since 2021, criminalizing intervention when there is no proof of a detectable fetal heartbeat (Jaramillo & Surana; Presser & Surana). On June 24, 2022, the "U.S." Supreme Court decision in *Dobbs v. Jackson Women's Health Organization* overturned *Roe v. Wade* (1973) and *Planned Parenthood v. Casey* (1992) when it argued that the Constitution did ***not*** protect a birthing parent's right to an abortion. Following the *Dobbs* decision, several states doubled down on limiting reproductive rights. At the time of this article, 13 states have banned abortion outright and 8 more have severely restricted abortion (Choi & Cole). In post-*Roe* "U.S.," reproductive decisions have been placed in the hands of lawmakers and prosecutors, putting birthing parents' lives at greater risk. In Texas, where abortions have been banned since 2021*, the maternal mortality rate has risen by 56% between 2019 and 2022 (Edwards, Essamuah, & Kane).

Using laws to control reproduction and limit bodily autonomy is not new. Neither is using science as a guise to legitimize racist, sexist, and anti-semitic policies. The so-called "United States" has a long history of doing both. While it is commonly known that during World War II, Nazi policy focused on eliminating "undesirables" to propagate a pure Aryan race, this view was not isolated to the Third Reich. Eugenics, the unethical pseudoscience that had its heyday from the 1880s to the 1950s, was a popular movement in the "U.S." (Agtuca; Black; Manjeshwar). Adolf Hitler, in fact, looked to American eugenics laws as models and praised the American eugenics movement in his 1924 autobiography, *Mein Kampf* (Black; Ko).

The biological determinism of the eugenics movement led to the state of Indiana passing the first sterilization law in 1907 giving institutions the right to sterilize marginalized populations deemed unfit to reproduce. Thirty-one other states passed similar laws (Stern). In 1927, Carrie Buck, a teen involuntarily institutionalized for "feeble-mindedness" filed suit after being sterilized upon giving birth to a child born out of wedlock. In the case of *Buck v. Bell*, the "U.S." Supreme Court upheld a state's right to force sterilization (Agtuca; Ko; Manjeshwar). This ruling, which still stands today, paved the way for state laws permitting the involuntary sterilization of marginalized people.



Carrie Buck (left) and her mother, Emma Buck (right) at the Virginia Colony for Epileptics AndFeebleminded in November 1924. Photo by A.H. Estabrook.

*In 2021, The Texas Tribune reported that Texas Governor Greg Abbott signed into law a measure that "prohibit[s] in Texas abortions as early as six weeks—before some women know they are pregnant—and open[s] the door for almost any private citizen to sue abortion providers and others." In 2022, Texas passed a stricter law banning abortion without exception and enacting penalties for anyone performing an abortion. According to the Texas State Law Library, healthcare professionals could be charged with a first or second-degree felony, lose their medical license, and pay a minimum civil penalty of $100,000.

After World War II, eugenics was prohibited under international law, but that did not end the efforts to control and limit reproductive rights in the "U.S." In 1970, Congress passed the Family Planning Services and Population Research Act, which, under the guise of "family planning," federally funded sterilizations for low-income or uninsured families (Agtuca; Bolton & Unger; Knispel).

When Dr. Connie Pinkerton-Uri, a physician of Cherokee and Choctaw descent, had a 26-year-old Indigenous woman come to her in 1972 requesting a "womb transplant" after having a hysterectomy at age 20, she realized something was amiss. Dr. Uri learned that the reason the young woman was sterilized without her informed consent was due to her alcoholism and the determination that she was unfit to parent her two children ("Woman; 442; Concerns of American Indian Women"). Dr. Uri started noticing a pattern among Indigenous women, which prompted her to investigate the sterilizations provided by Indian Health Services (IHS), a federal health care provider for Indigenous people in the "U.S." Dr. Uri discovered one in four Indigenous women were coercively, forcibly, or unknowingly sterilized, and suggested that the IHS specifically targeted full-blooded Indigenous women (Bolton & Unger; Hoeman; "Woman; 442"). While the IHS provided a high number of sterilizations to the Native population since its inception in 1955, the number increased once the "U.S." government-subsidized sterilizations per the 1970s act. On the Diné ("Navajo") reservation alone, the number of sterilizations doubled between 1972 and 1978 (Knipsel).

Under growing pressure from Indigenous women activists, the U.S. Government Accountability Office (GAO) conducted an investigation and confirmed that 3,406 sterilizations were performed between 1973 and 1976 (Rutecki). However, the GAO only investigated four of 12 IHS facilities, did not interview any of the women who had actually been sterilized, and overlooked sterilizations that were contracted out to non-IHS doctors. This incomplete report prompted additional investigation. Further independent research found that between 1970 and 1976, at least 25% of all Native women of childbearing age were sterilized, with some evidence pointing to a percentage as high as 50% (Bolton & Unger; Knipsel; Rutecki; Theobald).

In 1977, Marie Sanchez, a Chief Judge of the Northern Cheyenne Tribe at the time and a founding member of the activist group Women of All Red Nations (WARN), addressed the United Nations in Geneva at the Conference on Indians in the Americas to bring attention to this "'modern form' of genocide" taking place in the "U.S." (Bolton & Unger; Theobald).

> *"An already vulnerable population became even more vulnerable."*

For Sanchez, forced sterilization of Indigenous women was part of a Long history of colonialism and, ultimately, part of the government's centuries-old attempt to eradicate the Indigenous population to gain control of land (Bolton & Unger; Theobald; "Woman; 442").

The westward expansion in the early 19th century led to the displacement of Indigenous people from their ancestral lands. As white settlers moved west, laws were enacted to forcibly remove Native people and relocate them to "reservations" ("Indian Reservations"). Through targeted attacks and the spread of disease, the Indigenous population dwindled. Infants and children were especially vulnerable and, on many reservations, "women responded by bearing more children despite their compromised health" (Theobald).

At the same time, there was an effort to diminish access to traditional reproductive care. Before the Civil War (1861–1865), abortions and contraceptives were legal and most reproductive health care services were provided by female midwives, who were primarily Black, Indigenous, and white (Goodwin). But after slavery was abolished, white male gynecologists sought to exclude Black and Indigenous women from the field by advocating for midwifery bans and deeming midwifery "a relic of barbarism" (Goodwin; "Impediments to Reproductive Justice"). This forced many birthing parents to seek reproductive care from hospitals and white male physicians (Goodwin). For the Indigenous population, "treaties signed before 1871, and executive orders and other agreements thereafter, established federal responsibility for the provision of health care for tribal members" (Theobald). As poor health conditions permeated reservations, the "U.S." government set up hospitals to serve the Indigenous population. This growing reliance on non-traditional reproductive care offered to Indigenous people by federal government hospitals further removed them from their ancestral traditions.

While efforts were being made to diminish the legitimacy of and access to traditional forms of reproductive care, the 19th-century assimilationist movement focused on "Americanizing" the Native youth through education. From 1860 to 1978, the "U.S" government funded Indian Boarding Schools for the explicit purpose of removing Native children from their land, language, and traditional customs. Conditions were often poor and Native children were susceptible to diseases like tuberculosis, measles, and flu. Without access to adequate food or medical care, many children died (Mejia).

By the 1950s, most Indigenous birthing parents received reproductive care from the federally funded IHS hospitals (Theobald). The Civil Rights movement advocating for Black rights was growing momentum during this time. Since reproductive injustice has a pattern of aligning with civil rights advances in the "U.S.," there was a renewed effort to control reproduction through sterilization practices. By this point, Native women had become more reliant on federally funded hospitals for childbirth. When the federal government started to reduce funds and eliminate services that primarily benefited Native populations, reservation hospitals started to dwindle and an already vulnerable population became even more vulnerable (Theobald).



Native American children in a classroom at Carlisle Indian Boarding School in Carlisle, PA circa 1901. Photo by Frances Benjamin Johnston.

Marie Sanchez and other WARN activists saw reproductive injustice as another form of genocide. Their efforts along with the efforts of Black and Latina activists to call attention to the forced sterilization practices in marginalized communities led to new regulations in 1979 that, among other things, required healthcare providers to obtain patient consent before performing the procedure and increased wait time between consent and operation (Paz; Theobald).

The history of racism and sexism in the "U.S." is pervasive and reproductive rights continue to make headlines. While activists' efforts in the 1970s led to some wins, forced sterilization continues among marginalized people. Reproductive injustices persist for incarcerated populations in the "U.S." In the 21st century, there have been reports of women in prison subject to sterilization without consent and birthing parents denied adequate reproductive care ("Impediments to Reproductive Justice"). In 2020, a nurse working at an Immigration and Customs Enforcement (ICE) detention center filed a whistleblower complaint alleging forced sterilizations were being performed on detained immigrant women ("Impediments to Reproductive Justice"; Manjeshwar).

With renewed focus on reproductive rights as a result of the Dobbs decision, it is critical now to take an active part in advocating for justice. Reproductive justice is not a woman's burden to bear. Reproductive rights are human rights. And the fight for them is all the more important when the humanity of certain people is continuously questioned.

REFERENCES

Agtuca, Jacqueline. "Past and Current United States Policies of Forced Sterilization." *Restoration Magazine*. National Indigenous Women's Resource Center. Nov. 2020.

Black, Edwin. "The Horrifying American Roots of Nazi Eugenics." History News Network, September 2023.

Bolton, Marie and Nancy Unger. "Barren Lands and Barren Bodies in Navajo Nation: Indian Women WARN about Uranium, Genetics, and Sterilization" in *Medicine and Health Care in the Countryside: Historical Approaches and Contemporary Challenges* (Peter Lang, 2019): 373-392.

Choi, Annette and Devan Cole. "See Where Abortions Are Banned and Legal–and Where It's Still in Limbo." *CNN*. 8 Nov. 2024.

Dobbs, State Health Officer of the Mississippi Department of Health, et al. v. Jackson Women;s Health Organization et al. Supreme Court of the United States. 24 June 2022.

Edwards, Erika, Zinhle Essamuah, and Jason Kane. "A Dramatic Rise in Pregnant Women Dying in Texas After Abortion Ban." *NBC News*. 20 Sept. 2024.

"Eugenics: Its Origin and Development (1883-Present)." *National Human Genome Research Institute*. 30 Nov. 2021.

Goodwin, Michele. "The Racist History of Abortion and Midwifery Bans." ACLU. 1 July 2020.

Harvey, S. Marie, Annie E. Larson, and Jocelyn T. Warren. "The Dobbs Decision–Exacerbating U.S. Health Inequity." *The New England Journal of Medicine*, vol.. 388 no. 16, 15 April 2023.

Hoeman, Carolyn. "Genuine Justice: Sterilization Abuse of Native American Women." KRUI. 17 Oct. 2016.

"Impediments to Reproductive Justice: The Criminal Legal System and American Carceral State." *Harvard Law Review*, vol. 132 no. 8, June 2024.

Mejia, Melissa. "The U.S. History of Native American Boarding Schools." The Indigenous Foundation.
Knipsel, Sandra. "Native Americans, Government Authorities, and Reproductive Politics." *News Center*. University of Rochester, 23 Oct. 2019.

"Indian Reservations." History.com. 9 July 2023.

"Is Abortion Illegal in Texas?" Texas State Law Library.

Jaramillo, Cassandra and Kavitha Surana. "A Woman Died After Being Told It Would Be a 'Crime' to Intervene in Her Miscarriage at a Texas Hospital." *Propublica*. 30 Oct. 2024.

Ko, Lisa. "Unwanted Sterilization and Eugenics Programs in the United States." PBS. 29 Jan. 2016.

Lutterman, Sara. "31 States Have Laws that Allow Forced Sterilizations, New Report Shows." *The 19th*, 4 Feb. 2022.

Manjewshwar, Sanjana. "America's Forgotten History of Forced Sterilization." *Berkeley Political Review*. 4 Nov. 2020.

Najmabadi, Shannon. "Gov. Greg Abbott Signs Into Law One Of Nation's Strictest Abortion Measures, Banning Procedure As Early As Six Weeks Into A Pregnancy." *The Texas Tribune*. 19 May 2021.

Paz, Stephanie. "History of Sterilization of Native Women." We R Native.

Presser, Lizzie and Kavitha Surana. "A Pregnant Teenager Died After Trying to Get Care in Three Visits to Texas Emergency Rooms." *Propublica. Texas Tribune*. 1 Nov. 2024.

Rutecki, Gregory. "Forced Sterilization of Native Americans: Late Twentieth Century Physician Cooperation with National Eugenic Policies." *The Bioethics Podcast*, Season 10, ep. 19. 8 Oct. 2010.

Stern, Alexandra Minna. "Forced Sterilization Policies in the US Targeted Minorities and those with Disabilities—and Lasted into the 21st Century." *The Conversation*. 26 Aug. 2020.

Theobald, Brianna. "A 1970 Law Led to the Mass Sterilization of Native American Women. That History Still Matters." *TIME*. 18 Nov. 2019.

"Woman; 442; Concerns of American Indian Women." 1977-04-15. WNED, American Archive of Public Broadcasting (GBH and the Library of Congress), Boston, MA and Washington, DC. 25 Nov. 2024.

About the author

Shana Baumgartner is an enrolled member of the Oglala Sioux Tribe and a descendant of an off-reservation "Indian" Boarding School survivor. She is an educator, writer, and editor and resides in the U.S. with her partner and three children.

ILLUSTRATIONS

CYCLES OF FREEDOM: REPRODUCTIVE JUSTICE AND MENSTRUAL DIGNITY

BY LAURA MARTÍNEZ

Each illustration is a visual testimony that reproductive justice goes beyond isolated choices. It encompasses the ability to live our experiences without impositions or taboos. This body of work celebrates reproductive justice by respecting our own cyclical rhythm, the right to desire maternity or not, and even the normalization of menstruation and the reminders that each stage is part of our identity and deserves the same respect and dignity. All together, they invite one to question the stigmas and promote a world where each person's reproductive and emotional well-being is a priority.



DESIRED MATERNITY

Illustrates the desire for motherhood, a choice that should be respected and supported. Many women face barriers that hinder their access to prenatal health services, financial support, and an environment that allows them to raise their children in dignified conditions. The play, therefore, not only shows the tenderness inherent in motherhood but also reveals the resilience of those who, even in the face of obstacles, seek to fulfill this dream. It reminds us that the desired motherhood should be an accessible and safe experience for all, regardless of their economic situation or context.



ABORTION

The piece presents a naked woman in her vulnerability and strength, facing a decision that embodies her right and responsibility. Far from a narrative of victimization or regret, this work explores the emotional weight that accompanies reproductive decisions, respecting the autonomy of each person. It is neither an apology nor an exaltation, but a visual contemplation that acknowledges the personal process of healing and inner understanding, framing the experience within a context of dignity and respect for the rights of all.



CYCLICAL WOMAN

Honors the wisdom of our phases, showing that, as cyclical beings, we are in constant renewal. In the context of reproductive justice, this work invites us to recognize that these cycles should not limit or stigmatize female life, but, on the contrary, should be recognized and respected in health systems and in individual decisions about one's own body.



MENSTRUATING VIRGIN

This work breaks stigmas. A menstruating virgin reminds us that menstruation is natural and dignified and that nothing about it is impure. By representing a menstrually active sacred figure the piece seeks to normalize this stage of the cycle that has been labeled as “dirty” for years and questioning deeply rooted taboos.

About the artist

Laura Martínez was born and raised in the Colombian Caribbean and identifies herself as a sentimental artist. Her work stands as a political bet, where social criticism and protest art are the pillars on which she builds her narrative.

Laura firmly believes in the transformative power of art and in the capacity of each individual to contribute to social change. She has a clear commitment to what she loves and believes in and therefore trusts in the construction (for many utopian) of a better future. “The social function of the artist is to provoke and encourage humanity, that's why I decided from full awareness that my task in this world is to CREATE instead of answering.”

PERSONAL ESSAY

THE SEEDS IN MY BODY: SENECA DESCENDANCY AND PMDD

BY RACHEL ARLENE REDEYE PORTER

For Indigenous women of matrilineal nations, our ovaries are the future of our peoples. We carry the seeds of the next generations within our bodies. For my people, the *Onöndowa'ga:'* ("Seneca") of the Haudenosaunee Confederacy, this sacred responsibility is why women hold an elevated status in the community. Since I was a young child, I have understood that Haudenosaunee women are responsible for passing on their clan and, by extension, their citizenship, to their children. The importance of upholding our matrilineal clan system has long weighed heavy on me as I honor it. I am of Seneca blood, but my mother was non-Native, leaving me—and my descendants—without a clan and a political voice in my nation.

Even without status, I can feel the voices and experiences of my ancestors shaping my own. My connection to my Seneca ancestors is the reason that when I was diagnosed with Premenstrual Dysphoric Disorder (PMDD) at age 31 and learned that the only true cure was to surgically remove my ovaries, I paused. Haudenosaunee women have always had full autonomy over our bodies. I paused because I knew then, as I know now, that my ovaries do not only carry the potential of my future children. My ovaries also carry the truth of my existence and identity as a Seneca woman.

According to the International Association of Premenstrual Disorders, PMDD affects about 1 in 20 people who menstruate. It is an abnormal brain sensitivity to normal hormone fluctuations across the menstrual cycle. I experience it as raging, sudden tears, irritability, muscle aches, and darkness that dips toward suicidality. I feel as if I am floating above my body watching these symptoms happen to me without my consent. I spent 12 years trying every treatment available before I leveled with my gynecologist and questioned out loud whether or not I could psychologically and physically handle having a period this severe ever again.

At that point, my gynecologist offered two options for alleviating PMDD: have an oophorectomy or take a medication called *Lupron Depot* to temporarily induce a menopausal state by completely suppressing ovulation. One of these options was a necessary precursor to the other. I could trial the *Lupron Depot* and prepare for surgery while still leaving open the possibility of suspending treatment and pursuing pregnancy. I wasn't sure what I would ultimately decide, but I knew I needed relief as soon as possible.

I dropped into menopause immediately and the relief came shortly after. What didn't subside was the ever-twisting agony in my stomach about what to do long-term. The effects of *Lupron* can wane over time and after two years of injections every twenty-eight days, I am beginning to feel my original symptoms return at the end of each month. The question of whether or not I will have a biological child imminently requires an answer. Each month, I am losing energy, time, and freedom to live my own healthy life as I contemplate whether or not to bring new life into the world.



Rachel Arlene Redeye Porter smiles in front of Michigami ("Lake Michigan"). Photo Credit: Adriano Kalin, June 11, 2024.

There are times when it feels like there is nothing more important that I could do as a Seneca woman than give birth. In Haudenosaunee culture, to be a life-giver—one who births the next generation—is to protect the existence of our people and to carry forward the legacy of our ancestors. The knowledge of women and mothers is centered within the Haudenosaunee community because women have an inherent connection through reproduction to all living beings. Bringing forth new life is also vital to our survival. As I contemplate whether or not I should pursue surgery, a path not without risks, I wonder who I will be as a Seneca woman without my ovaries. I crave a permanent solution to my PMDD and yet I fear that putting my health above my people will betray them in some way. Even though my child would not be enrolled as a Seneca Nation citizen, they would forever be a part of the legacy of the Seneca Nation of Indians.

Embodying my Haudenosaunee ancestors' dreams today means remembering what they endured for me to be here. Our strength as Haudenosaunee women has always been apparent to colonizing powers. In an attempt to control and eradicate Indigenous peoples, colonizing powers waged sexual warfare, conducted forced sterilization operations, and assimilated our children through the Native American boarding school system. Despite this, the Haudenosaunee matrilineal clan system has existed continuously for over 1,000 years. This is the history that I inherit regardless of clan status and that I feel in my body with each breath. When I think of my great-grandmother who attended the *Friends Indian School* at Tunessasa and was scolded for speaking Seneca, I feel it in my body. My ovaries hurt. My uterus cramps. My pelvic floor tightens, and my chest feels hollow.

When I learned that a majority of people with PMDD report having experienced early life trauma, I was not surprised. Trauma always finds a home within the body and sometimes even the most sincere and earnest healing journeys are unable to dislodge it. This is especially true for intergenerational trauma, whose pathways you are born with and when activated permeate every cell of your body. As much as trauma lives within me, so too does strength and resilience. In the darkest moments that PMDD causes, I connect to my purpose as a Haudenosaunee woman to honor and defend our lifeways, and that pulls me through. The interplay between my brain and my ovaries may bring me to my lowest, but it is also the precise relationship that keeps me here, earthside.

The time when I will finally have to choose whether or not to pursue surgery or continue taking *Lupron* gets closer. As my PMDD symptoms return, administering Lupron shots more frequently is a medically safe option. Even with systemic



Rachel Arlene Redeye Porter engages in conversation with her gynecologist as she weighs her PMDD treatment options. Photo Credit: Adriano Kalin, November 2, 2024.

limitations beyond my control, I still don't know what to do. I vacillate nearly every day between the promise of a life free from PMDD and the sacrifice of living with it a little bit longer—long enough to get pregnant and delay the final decision until postpartum.

Alternative solutions such as in *vitro* fertilization and surrogacy do exist, but they feel as out of reach as ridding my body of artificial hormones and hoping that my cycle regulates naturally. I'm not sure that I could physically tolerate either process well enough to make it worth it. Parenting a child who is already here and needs care is a truly viable option and something that I think about often and makes my heart smile. The only thing that I know for certain is that I long to be healthy enough to give the best parts of myself to my people—and the truth is that those parts may not be my ovaries or the children that I may not be able to bear.

Peace lives in the quiet relationship between me, my body, and my ancestors. It is a relationship that no doctor could ever surgically remove and one that is intimately my own. It is the way that when I hear the Seneca language spoken, my feet ground more securely into the Earth. No question that living with PMDD is a seemingly never-ending labor, but it is no one's life in its entirety. If I choose to become a mother—whether through adoption, foster care, or pregnancy—I will teach my children how to honor this relationship within themselves. If they are born with ovaries, I will tell them giving birth is their choice just as I learned from the Haudenosaunee women before me, and that many gifts give life to the world. In the meantime, I will continue to speak these words to myself.

About the author

Rachel A. R. Porter is a queer, disabled, chronically ill Seneca descendant and storyteller of mixed ancestry. She earned her Master's in Human Security and Gender Analysis in International Affairs from *The Fletcher School* at Tufts University. She is the Founder of the *Indigenous Enough Project,* an initiative honoring the breadth of contemporary Indigeneity, and Co-Founder of *Kneading Change*, a narrative justice company.

REPRODUCTIVE JUSTICE IN OAXACA HIGHLIGHTS INDIGENOUS PERSPECTIVES

BY CRUSHING COLONIALISM

Reproductive justice in Oaxaca is a critical issue deeply tied to the experiences of Indigenous women, who face unique challenges stemming from systemic inequities and cultural dynamics. Despite the state's progressive step in legalizing abortion in 2019, many Indigenous women remain marginalized in conversations about reproductive rights. Historically, they have endured abuses such as forced sterilizations, reflecting the long-standing neglect of their autonomy and agency.

For Indigenous women, reproductive justice is not just about access to legal abortion but about reclaiming control over their bodies within a framework that respects their cultural identities. Traditional practices, communal decision-making, and deeply rooted gender norms influence how reproductive health is understood and practiced in these communities. The tension between state policies and these cultural contexts often leaves Indigenous women underserved by public health systems that fail to address their specific needs.

Advocating for reproductive justice in Oaxaca requires addressing these systemic gaps while empowering Indigenous women to articulate their needs and rights. Recognizing their voices is essential for creating policies that not only guarantee access to reproductive health services but also honor their cultural traditions and lived realities. This struggle reflects broader global challenges in ensuring reproductive rights for marginalized groups.

Holly Dygert, an anthropologist at Bryant University, is conducting a study on Indigenous perspectives regarding reproductive rights in Oaxaca, Mexico. Her research focuses on how cultural and historical contexts, such as colonialism and systemic marginalization, influence Indigenous communities' attitudes toward reproductive justice. This includes examining issues like forced sterilization and the impact of Oaxaca's 2019 abortion legalization.

Dygert's work delves into how reproductive rights are perceived through the lens of Indigenous identity, particularly among women. She highlights how these rights intersect with broader struggles for autonomy and cultural preservation. Her goal is to explore whether contemporary policies adequately address the unique needs of Indigenous communities and empower their voices.

The study also raises questions about how legislation aligns with traditional values and gender roles in Indigenous societies. Dygert investigates the balance between promoting universal human rights and respecting cultural practices, aiming to bridge gaps between state policies and local realities.

This research contributes to global discussions on reproductive justice, illustrating the complexity of applying universal frameworks to diverse cultural contexts. By amplifying Indigenous voices, Dygert seeks to redefine justice in a way that resonates with marginalized populations.

Source: Bryant University

Call for submissions!

The Magazine is seeking submissions for our March issue which will focus on the importance of spirituality on indigenous communities. We invite Indigenous journalists, artists, and content creators to submit pitches for thought-provoking stories, insightful articles, and powerful narratives that embody this topic. Whether it's a personal anecdote, cultural analysis, or artwork – we want your unique voice to be heard!
Submit your pitches to: info@crushingcolonialism.org



“Desired Maternity,” illustration by Laura Martínez.

DONATE TO SUPPORT OUR MISSION

VISIT OUR ONLINE EDITION

As a non-profit organization (501c3 in the “U.S.”), your donations go directly towards supporting our small but growing organization, and its mission to produce high-quality news that is free and accessible to Indigenous communities and their allies around the world. Please consider contributing today at CrushingColonialism.org/donate.