

## Black Women and the Development of International Reproductive Health Norms

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In the past several decades, nongovernmental organizations (NGOs)<sup>1</sup> have used their consultative status<sup>2</sup> with the United Nations to lobby the UN General Assembly and other organizations affiliated with the UN to pass resolutions, develop treaties, and place new issues on the UN agenda. In their consultative status, NGOs bring important public concerns to the attention of governments, monitor government accountability on various issues, and encourage participation of stakeholders on the community level. They also produce reports with policy recommendations and provide direct assistance to communities.

In September 1994, the UN coordinated an International Conference on Population and Development (ICPD) in Cairo, Egypt. More than 20,000 delegates from various governments, UN agencies, NGOs, and the media gathered for a discussion of a variety of population issues, including immigration, infant mortality, abortion, birth control, family planning, and the education of women. The conference received considerable media attention due to

<sup>1</sup> A nongovernmental organization (NGO) is a not-for-profit organization that is independent from government and is organized on a local, national, or international level to address issues that support the public good. NGOs have been partners in the UN process since 1947. Article 71 of the UN Charter expressly acknowledges the role of NGOs in international law and development: "The Economic and Social Council [hereafter referred to as ECOSOC] may make suitable arrangements for consultation with nongovernmental organizations, which are concerned with matters within its competence."

<sup>2</sup> Through Article 71, the role of NGOs in the UN is limited to one of consultation with governments. Although it is often argued that NGOs are the voice of the people, representing grassroots democracy, many people argue that NGOs often reinforce existing power structures. However, due to the close ties that most NGOs have to the on-the-ground realities of people and the fact that they are required to exclude government officials from their membership, NGOs normally represent the voice of people in a landscape of money and power. To be recognized as an NGO with consultative status with the UN, an NGO must have a democratic decision-making process.

disputes regarding a woman's right to access abortion services.<sup>3</sup> Despite the widely publicized controversy, conference delegates managed to achieve consensus on a variety of issues including (a) universal primary education in all countries by 2015, (b) reduction of infant and child mortality by one-third by 2000, (c) reduction of maternal mortality by 50 percent by 2015, and (d) the need for access to reproductive and sexual health services, including family planning, for all women.<sup>4</sup>

The 1994 ICPD was a milestone in the history of population and development, as well as in the history of women's rights. The Programme of Action<sup>5</sup> that was developed at the ICPD was the first UN document to prioritize reproductive and sexual health services for women.<sup>6</sup> This conference was followed by the 1995 Fourth UN World Conference on Women (FWCW). The NGO Forum for the FWCW<sup>7</sup> lasted more than three weeks and included approximately 30,000 women (and several dozen men) who discussed and

<sup>3</sup> The abortion issue received great media attention primarily because the Vatican sent a representative to the conference to ensure that no consensus regarding a universal right to abortion would ever be accepted. News headlines indicated that the Vatican had "hijacked" the ICPD Cairo conference. See Kim Murphy, *Abortion accord unravels at talks: Population: There are charges that the Vatican has "hijacked" Cairo conference. A new compromise is sought as some Latin nations oppose consensus*, September 8, 1994, LOS ANGELES TIMES, available at [http://articles.latimes.com/1994-09-08/news/mn-36010\\_1.cairo-conference](http://articles.latimes.com/1994-09-08/news/mn-36010_1.cairo-conference). Also see Meredith Marshall, *United Nations Conference on Population and Development: The road to a new reality for reproductive health*, 10 EMORY INT'L. L. REV. 443, 451 (1996). The pope also directly entered the spotlight by sending a written letter to the secretary general of the ICPD. In his letter, the pope condemned abortion as "deliberate and direct killing." The letter denounced murder and genocide and singled out abortion, declaring that "[a]mong all the crimes which can be committed against life, procured abortion has characteristics making it particularly serious and deplorable." The pope went on to assert that protecting the woman's health or ensuring a decent standard of living for other members of the family "can never justify" abortion. See *Letter of His Holiness John Paul II to the Secretary General of the International Conference on Population and Development*, available at [http://www.vatican.va/holy\\_father/hoh\\_paul\\_ii/letters/1999/documents/hf-jp-ii-let-19031994\\_population\\_develop\\_en.html](http://www.vatican.va/holy_father/hoh_paul_ii/letters/1999/documents/hf-jp-ii-let-19031994_population_develop_en.html); and Jyoti Shankar Gingh, *CREATING A NEW CONSENSUS ON POPULATION: THE INTERNATIONAL CONFERENCE ON POPULATION AND DEVELOPMENT* (1998).

<sup>4</sup> Report of the ICPD (94/10/18), available at <http://www.un.org/popin/icpd/offering/poa.html>.

<sup>5</sup> The ICPD Programme of Action (1995) is also referred to as the Cairo Consensus. It is available at [www.unfpa.org/public/site/global/publications/picd/1973](http://www.unfpa.org/public/site/global/publications/picd/1973).

<sup>6</sup> Rebecca Cook, Bernard Dickens, & Mahmoud Fathalla, *REPRODUCTIVE HEALTH & HUMAN RIGHTS: INTEGRATING MEDICINE, ETHICS, AND LAW* 4, 148–49 (2003).

<sup>7</sup> The NGO Forum on Women was held in Hairou, China, at the same time that the official delegates to the FWCW were meeting in Beijing (approximately forty-five miles away). The NGO Forum brought together more than 20,000 women from 170 countries to discuss progress toward the goals of equality, development, and peace. Throughout this article, we refer to the NGO Forum as the FWCW. Participants at the NGO Forum included grassroots activists, educators, students, policymakers, and prominent leaders from all over the world who shared a concern about the human rights of women. Plenary sessions featured speakers from around the world, including Nobel Prize winners and other women who have been active in the

debated human rights issues affecting women and girls around the world.<sup>8</sup> The Beijing Declaration and Platform for Action, approved in September 1995 at the FWCW, is a global commitment to achieving equality, development, and peace for women worldwide. It covers a variety of issues and, with the Programme of Action developed at the ICPD, it is the most important document governing the progress of women's reproductive health worldwide.

Black women from the United States, the Caribbean, and Africa were well represented at the FWCW NGO forum.<sup>9</sup> It was a historic moment for the 45,000 global sisters who gathered for three weeks of open workshops, protests, and symposiums.<sup>10</sup> Not only was the FWCW historic because it was one of the largest UN conferences of its kind, it was also one of the first UN conferences at which African and African-American women were consistently key players on the international front and held the captive attention of their global peers around issues related to reproductive health. Consequently, this chapter examines the impact of Black women on the international reproductive health movement, particularly the infusion of reproductive health principles into the international human rights regime.

#### BLACK WOMEN AND THE INTERNATIONAL REPRODUCTIVE HEALTH MOVEMENT

Three of the forty-five official U.S. delegates to the FWCW were Black women, including Atlanta businesswoman J. Veronica Biggins, who served as vice chair of the American delegation. Of the more than 8,000 Americans attending the NGO Forum, an estimated 1,000 delegates were Black.<sup>11</sup> The largest grouping of Black American women came out of the joint delegation of the Lawyers' Committee for Civil Rights under Law and the National Council

international feminist movement for several decades. The UN Conference brought together heads of state and government officials to debate and draft a Platform for Action to address women's needs and human rights across the globe. Although the Platform for Action is not a binding document, governments are expected to commit resources to enact the policies it outlines on the national level after the conference. Thus, the document is designed to serve as a guide for national legislation and to help shape international priorities in the future. Communication between the NGO Forum participants and the government officials at the UN Conference was constant.

<sup>8</sup> See <http://www.un.org/geninfo/bp/women.html>.

<sup>9</sup> See *Voices of African American women in the United States of America: The unkept promises of the Platform for Action compiled by Lawyers' Committee for Civil Rights Under Law*, Barbara Armwine, Executive Director, Adjoa Aiyetoro, Editor (May 2000); and *Black women and the World Conference*, EBONY (December 1995), available at [findarticles.com/plarticles/mi\\_mto77/is\\_n2\\_v51/al\\_17934730/?tag=content;col1](http://findarticles.com/plarticles/mi_mto77/is_n2_v51/al_17934730/?tag=content;col1).

<sup>10</sup> *Id.* (refers to EBONY article at 43–44).

<sup>11</sup> *Id.* at 44.

of Negro Women, which had a combined total of 110 delegates.<sup>12</sup> Hundreds of Black women from Africa and the Caribbean were also instrumental in bringing issues of significance to Black women worldwide to the forefront of discussions at the conference.<sup>13</sup>

It was women of African descent and women from developing countries who lobbied and educated participants at the NGO forums about the ways race and economics impacted reproductive health and overall well-being. Their life stories challenged more privileged women (i.e., White women and women with economic resources) to expand their understandings of what was needed to improve the reproductive lives of all women. It is no coincidence therefore that the definition of reproductive health that came out of the Cairo and Beijing conferences was comprehensive. The definition reads:

Reproductive health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity, in all matters relating to the reproductive system and to its functions and processes. Reproductive health therefore implies that people are able to have a satisfying and safe sex life and that they have the capability to reproduce and the freedom to decide if, when and how often to do so. Implicit in this last condition are the right of men and women to be informed and to have access to safe, effective, affordable and acceptable methods of family planning of their choice, as well as other methods of their choice for regulation of fertility which are not against the law, and the right of access to appropriate health-care services that will enable women to go safely through pregnancy and childbirth and provide couples with the best chance of having a healthy infant.<sup>14</sup>

Furthermore, Chapter 7 of the Cairo Programme of Action includes the right to make decisions concerning reproduction free of discrimination, coercion, and violence, as expressed in human rights documents. In addition, Paragraph 96 of the Platform of Action that was adopted at the FWCW reaffirms the Cairo Programme by stating that “[t]he human rights of women include their right to have control over and decide freely and responsibly on matters related

<sup>12</sup> *Id.* at 44.

<sup>13</sup> *Id.* at 47–48.

<sup>14</sup> UN Population and Development, Programme of Action adopted at the International Conference on Population and Development, Cairo, September 5–13, 1994 (New York: United Nations, Department for Economic and Social Information and Policy Analysis, ST/ESA/SER.A/149, 1994) [hereinafter Cairo Programme], para. 7.2.; UN Department of Public Information, Platform for Action and Beijing Declaration, Fourth World Conference on Women, Beijing, China, September 4–15, 1995 (New York: UN 1995) para. 94.

to their sexuality, including sexual and reproductive health, free of coercion, discrimination and violence.”

Prior to this comprehensive definition of reproductive health, discourse about international reproductive health focused primarily on access to family planning services without adequately considering the safety, affordability, and acceptability of the methods of family planning that were used. Similarly, reproductive health conversations often failed to recognize the fact that many women were more interested in having healthy babies than they were in limiting their reproductive health options to contraception and abortion. These issues were brought into focus at the ICPD and FWCW Conferences primarily by Black women and other women of color from around the globe who offered critiques of the dominant framework of “reproductive choice,” and hence of feminism, in family planning.

In essence, the “reproductive choice” framework emphasized a consumer-oriented approach to family planning. Whereas economically privileged women were primarily concerned with the quantity of “choices” made available to them through their purchasing power (abortion, the pill, the IUD, diaphragms, etc.), less privileged women expressed the fact that the only choices that were made available to them were dangerous ones that resulted in permanent sterilization as a result of unconsented surgery or temporary sterilization as a result of Norplant and Depo-Provera use. Black women argued that the limited options that they were offered were a direct result of their race and/or socioeconomic status, and, by introducing this intersectionality approach, they shifted the focus of the conversation from the quantity of choices to the quality of choices.

As previously noted, this chapter will unearth the variegated contributions that Black women have made toward evolving international reproductive health concerns into international human rights issues through dialogue, advocacy, and technical assistance. It will highlight specifically how such efforts have normatively shaped international human rights standards that focus on the rights to safe birth control, to be informed about the side effects of birth control, to have children (not just to terminate pregnancy), and not to have race and economic status dictate the outcome of reproductive health. Specifically, this chapter concentrates on the way in which Black women’s experience with Depo-Provera, Norplant, and sterilization abuse have impacted the international conversation about reproductive health and how these dialogues contributed to the comprehensive definition of reproductive health used in the Cairo Programme of Action and the Beijing Platform. Special attention is focused on Depo-Provera and Norplant because these contraceptives were used in ethically questionable ways on Black women all

throughout the Diaspora. During the FWCW NGO Forum, a protest demonstration against Norplant and Depo-Provera was staged primarily by women of color from several different countries, including the United States, South Africa, Ghana, Mozambique, Brazil, and Egypt.<sup>15</sup> This chapter focuses on the experiences of Black women in Zimbabwe, South Africa, and the United States because these experiences have been documented by NGOs in those countries and were therefore most accessible in terms of research. Black women in all three of these countries have the common legacy of surviving apartheid, resisting reproductive oppression, and organizing against either Norplant or Depo-Provera in a way that captured international attention.

#### WHAT IS DEPO-PROVERA?

Depo-Provera is an injection of a synthetic version of the hormone progesterone that prevents pregnancy for up to three months by inhibiting ovulation and making cervical mucus uninhabitable for sperm.<sup>16</sup> It is commonly referred to as “the shot.”<sup>17</sup> It is associated with osteoporosis; loss of sex drive; sterility; an increased risk of breast, cervical, and uterine cancer; and severe depression.<sup>18</sup> Depo-Provera use is associated with decreased condom use, which raises women’s susceptibility to sexually transmitted infections (STIs) and HIV infection. Some studies also indicate that Depo-Provera may be an independent risk factor for contracting HIV and other STIs. In September 2004, *The Journal of the American Sexually Transmitted Disease Association* reported that Depo-Provera also causes a threefold increase in the risk of acquiring chlamydia and gonorrhea.<sup>19</sup> This association with STIs and STDs is of great concern to Black women because of the disproportionate number of them who are already at risk.

In 1967, Depo-Provera was denied approval by the U.S. Federal Drug Administration (FDA) because of its link to cancer in laboratory animals.<sup>20</sup>

<sup>15</sup> Bandana Shiva, *Beijing Conference: Gender justice and global apartheid*, available at <http://www.twinside.org.sg/title/just-cn.htm>.

<sup>16</sup> Dr. C. Sathyamala, AN EPIDEMIOLOGICAL REVIEW OF THE INJECTABLE CONTRACEPTIVE DEPO-PROVERA (2000).

<sup>17</sup> *Id.*

<sup>18</sup> “Is Depo-Provera really safe?” *Ms. Magazine*, January/February 1993; at 72–73.

<sup>19</sup> *Hormonal contraceptive USC, cervical ectopy and the acquisition of cervical infections*, 31 (9) *J. AM. SEXUALLY TRANSMITTED DIS. ASSOC.* 561–67 (September 2004), available at <http://www.stdjournal.com>; also see Family Health International, *Depo-Provera appears to increase risk for chlamydia and gonococcal infections*, available at <http://www.nih.gov/news/pr/aug2004/nichd-23.htm> (last accessed on April 10, 2012). This study was funded by the U.S. Agency for International Development (USAID) and the National Institute of Child Health and Development.

<sup>20</sup> *ENCYCLOPEDIA OF BIRTH CONTROL* 145 (Verna L. Bullough ed., 2001).

Despite this lack of FDA approval, Depo-Provera was used on 14,000 women at the Grady Clinic in Atlanta, Georgia, between 1967 and 1978.<sup>21</sup> Fifty percent of the women who served as subjects in this experiment were low-income Black women.<sup>22</sup> Many of the women who served as test subjects in the Depo-Provera experiment did so without their knowledge or consent,<sup>23</sup> and most were not told that there were side effects associated with Depo-Provera.<sup>24</sup> Several of the women were later diagnosed with cancer, and a few women died during the trials.<sup>25</sup> However, reports submitted to the FDA did not include information about these deaths.<sup>26</sup>

In 1978, the FDA denied approval of Depo-Provera a second time because (1) animal studies done on dogs confirmed an elevated rate of breast cancer, (2) an increased risk of birth defects was noted in human fetuses exposed to the drug, and (3) there was no pressing need shown for use of the drug as a contraceptive.<sup>27</sup> In 1983, Depo-Provera was denied approval by the FDA yet again. However, in 1987, the FDA changed its regulations to require cancer testing in rats and mice instead of dogs. Because Depo-Provera did not cause cancer in these animals, the path for approval of Depo-Provera was paved.<sup>28</sup> In 1992, Depo-Provera was approved by the FDA for distribution in the United States.<sup>29</sup> It took Pharmacia and Upjohn Pharmaceuticals, the company that produces Depo-Provera, twenty-five years to obtain FDA approval as a “safe” drug.<sup>30</sup> This approval occurred over the vigilant opposition of major health organizations representing women of color, including the National Women’s Health Network, the Native American Women’s Health Education Resource Center, the National Latina Health Organization, and the National Black Women’s Health Project. These organizations opposed the approval of Depo-Provera not only because of safety concerns, but also because women

<sup>21</sup> Amy Goodman, *The case against Depo-Provera*, 6 (2) MULTINATIONAL MONITOR (February/March, 1985); Dorothy Roberts, *KILLING THE BLACK BODY* 145 (1998).

<sup>22</sup> *Id.* See also *Depo-Provera fact sheet*, Committee on Women, Population and the Environment, published January 6, 2007; available at [www.cwpe.org/node/185](http://www.cwpe.org/node/185).

<sup>23</sup> *Id.*

<sup>24</sup> *Id.* See also Warren E. Leary., “U.S. approves injectable drug as birth control,” *NEW YORK TIMES*, October 30, 1992, available at [www.nytimes.com/1992/10/30/us/us-approves-injectable-drug-as-birth-control.html](http://www.nytimes.com/1992/10/30/us/us-approves-injectable-drug-as-birth-control.html).

<sup>25</sup> *Id.* See also Sathyamala, *supra* note 16, at 125.

<sup>26</sup> *Id.* at 124.

<sup>27</sup> *Fact Sheet on Depo-Provera by the Committee on Women, Population and the Environment* (published January 6, 2007), available at <http://www.cwpe.org/node/185> (last visited April 11, 2012).

<sup>28</sup> *Id.*

<sup>29</sup> *Id.* Also see Leary, *supra* note 24.

<sup>30</sup> See Fact Sheet, *supra* note 27.

*Id.*

of color were being coerced and targeted by medical providers to use the drug, signaling to many that it was being utilized as a tool of population control rather than a freely chosen method of birth control.<sup>31</sup>

Although millions of women today have used Depo-Provera, many of them complain that it has had a negative impact on their physical and emotional health.<sup>32</sup> The side effects include hair loss, extreme weight gain (15–30 pounds), severe acne, near-suicidal depression, nervousness, dizziness, heavy menstrual flow, and irregular periods or no periods at all.<sup>33</sup> There is no antidote available for a woman experiencing any or all of these side effects, which could last anywhere from six to ten months after the initial injection.<sup>34</sup> Although the literature produced by Pharmacia and Upjohn claims that within a year of cessation of the injections ovulation should be normal again, many women have reported prolonged periods of sterility. From 1994–2000, USAID provided 41,967,200 units of Depo-Provera into the developing world, at a cost of more than \$40 million. USAID sends more units of Depo-Provera into African countries, including Mozambique, Tanzania, and Nigeria, than to any other part of the world.<sup>35</sup> In the United States, it is

<sup>31</sup> Birth control and population control are two different concepts. Birth control allows individual women to have control over whether and when they will have children. Population control, on the other hand, is a philosophy that states the belief that, for the good of society and in light of overpopulation, certain groups (usually the least powerful and the poor) should reduce their birth rates. Coercion is often implemented in population control programs. Sterilization is viewed as only one tool of population control – immigration restriction and denial of services are other methods utilized by population control advocates. *The inherent racism of population control*, published by LifeSiteNews.com, is available at [www.lifesitenews.com/waronfamily/Population\\_Control/Inherentracism.html](http://www.lifesitenews.com/waronfamily/Population_Control/Inherentracism.html). Sterilization, however, is a permanent solution to the challenges and consequences of unwanted population growth. In the United States, by the 1970s, so many women, particularly Black and Puerto Rican women, have been involuntarily sterilized by doctors that several organizations against sterilization formed, including the National Conference on Sterilization Abuse and the Committee to End Sterilization Abuse. The movement eventually resulted in the passing of federal legislation that set guidelines for sterilizations performed in municipal hospitals. See generally Thomas Shapiro, *POPULATION CONTROL POLITICS: WOMEN, STERILIZATION, AND REPRODUCTIVE CHOICE* (1985).

<sup>32</sup> Marie Cassidy, *Depo-Provera and sterilization abuse overview*, in *BIRTH CONTROL AND CONTROLLING BIRTH: WOMEN-CENTERED PERSPECTIVES* (Helen B. Holmes, Betty B. Hoskins, & Michael Gross eds., 1980) 97–105; Glenda Chui, *Depo-Provera: Safe, effective, private birth control? Groups say drug carries risks, could be misused*, SALT LAKE TRIBUNE, November 8, sec. A (1992); Gena Corea, *The Depo-Provera weapon*, in *BIRTH CONTROL AND CONTROLLING BIRTH*, 107–116; Gena Corea *Depo-Provera and the politics of knowledge*, in *RECONSTRUCTING BABYLON* 161–84 (H. Patricia Hynes ed., 1991).

<sup>33</sup> Boston Women's Health Collective, *THE NEW OUR BODIES, OURSELVES: A BOOK BY AND FOR WOMEN* (1992). See also *supra* note 31.

<sup>34</sup> Ms. Editors, *supra*, note 18, at 73.

<sup>35</sup> See *Fact Sheet*, *supra* note 27.



reported that 33 percent of Depo-Provera users were under the age of 19; 84 percent were Black women; and 74 percent were low income.<sup>36</sup>

The experience of Black women in Zimbabwe, South Africa, and the United States are of particular importance.

### *The Zimbabwe Experience*

In 1981, Minister of Health Herbert Ushewokunze banned the use of Depo-Provera in Zimbabwe.<sup>37</sup> Although the underlying impetus to ban the drug was its harmful side effects, Minister Ushewokunze stated, “[t]he application of Depo-Provera is racist because in Zimbabwe, only Black women are advised to try it. White women do not use it. It is all part of a plot by our former oppressors. It is racism.”<sup>38</sup> The “former oppressors” that the Minister of Health was referring to were the White minority Rhodesian Front, the governing party that ruled Zimbabwe from 1962 through 1978. According to the Minister of Health, the Rhodesian Front used Depo-Provera to keep the African population under control.

Depo-Provera was introduced into Zimbabwe in 1969 through the support of the Family Planning Association of Rhodesia (FPAR), and, by 1974, it became the “most popular” form of birth control. During the 1970s, it was alleged that Depo-Provera was a weapon of the White regime to control the majority Black population by effectively eliminating future generations. Depo-Provera was seen as “a symbol of the intrusion of Western imperialism and racism” into the bodies of Third World women.<sup>39</sup>

By the 1980s, FPAR was spending up to \$1 million dollars a year on Depo-Provera.<sup>40</sup> It was only after Zimbabwe gained independence from the United Kingdom in 1980 that the new government brought the issue of Depo-Provera and its use on Black women to the forefront. It was alleged that, by 1980, between 90,000 and 100,000 Zimbabwean women were using Depo-Provera.<sup>41</sup>

Some people argued, however, that Zimbabwean women welcomed the use of this drug as a powerful tool to control their own fertility, in that they could secretly practice birth control without the consent or knowledge of their

<sup>36</sup> *Id.*

<sup>37</sup> Amy Kaler, *A threat to the nation and a threat to the men: The banning of Depo-Provera in Zimbabwe*, 1981. 24 (2) J. SOUTH AFRICAN STUD. 347–76, 354 (1998).

<sup>38</sup> *Id.* at 354.

<sup>39</sup> *Id.* at 347.

<sup>40</sup> *Zimbabwe bans contraceptive Depo-Provera: A victory for women’s group*, GLOBAL NEWSWATCH, vol. 2, no. 9 (September 1981), available at [www.multinationalmonitor.org/hyper/issues/1981/09/zimbabwe.html](http://www.multinationalmonitor.org/hyper/issues/1981/09/zimbabwe.html).

<sup>41</sup> Kaler, *supra* note 37, at 350.

husbands.<sup>42</sup> This argument, however, was undermined by allegations that the drug was routinely administered to Black women without obtaining their fully informed consent and without advising them of the harmful effects of the drug.

Zimbabwean women reported that they were being coerced to take Depo-Provera under threat of losing their employment on White-run commercial farms; that Depo-Provera had been administered to their bodies without informed consent; and that when they took their children to medical clinics, they were threatened that if they did not accept the Depo-Provera injection, their children would not receive medical treatment.<sup>43</sup> The decision to ban Depo-Provera in Zimbabwe was prompted by African women's complaints about the administration of the drug, as well as by the fact that Depo-Provera did not receive the safety stamp of approval by the U.S. FDA and was therefore considered by many to be unsafe. In addition, the fact that Depo-Provera was being used as a political tool by the South African apartheid regime to control the Black population<sup>44</sup> raised suspicion that it was, in many ways, indicative of the global sentiment that Depo-Provera was a tool of colonial power used to control the bodies of African women.<sup>45</sup>

As a result of the lack of respect for the autonomy and human rights of Black women in Zimbabwe, Depo-Provera developed a nefarious reputation for being a form of population control rather than birth control.<sup>46</sup> Consequently, the decision of the new government to ban the use of Depo-Provera in 1981 was seen as a move in the right direction.<sup>47</sup>

### *The South African Experience*

The history of the use of Depo-Provera against Black South African women was eerily similar to the stories of Black Zimbabwean women. Allegations of coercion, deception, lack of consent, and threats associated with the Depo-Provera injection, as well as stories of threats made by employers against Black women who refused to use Depo-Provera, abounded. Like Zimbabwean

<sup>42</sup> Because Depo-Provera is an injection, there is no interruption during sexual intercourse to insert contraception, and it is therefore easy for the male partner to be unaware that his female partner has decided to prevent pregnancy by using contraception.

<sup>43</sup> Kaler, *supra* note 37, at 347–56.

<sup>44</sup> *Id.* at 354.

<sup>45</sup> *Id.* at 351. See also Paula C. Johnson, *Danger in the Diaspora: Law, culture and violence against women of African descent in the United States and South Africa*, 1 J. GENDER RACE & JUST. 471, 488 (1998).

<sup>46</sup> *Id.* at 488.

<sup>47</sup> *Id.*

women, South African women were forced to use Depo-Provera to keep their jobs in White-owned factories. Just like the women who worked on the White-run farms in Zimbabwe, Black women in South African factories were threatened with the possibility of losing their employment if they refused the Depo-Provera injection.<sup>48</sup> Many women also received a compulsory injection after giving birth.<sup>49</sup> The apartheid government targeted almost exclusively Black and mixed-race women for Depo-Provera use in an “effort to reduce the growth rate of the Black African population (and concurrently increase the number of whites).”<sup>50</sup> In many instances Depo-Provera was the main, and often the only contraceptive offered to Black women.<sup>51</sup>

The ideology that permeated South Africa during the apartheid era was very similar to the racist thinking in colonial Rhodesia. These governments feared that the unchecked growth of the Black population posed a direct threat to the White power structure, as well as a threat to the safety and profits of White society. Although the South African government family planning program instituted in 1974 appeared on its face to be nondiscriminatory, it was evident from the use of intensive advertising campaigns in urban South Africa that Black women were the targeted group for Depo-Provera use.<sup>52</sup> This led many to assume that the implicit goal of the apartheid government was population control and not family planning.<sup>53</sup> These terms were artfully defined by author Monica Bahati Kuumba when she wrote, “Population control is markedly different from the concepts of family planning, access to birth control or reproductive rights. While these latter concepts rest on the notion of equality and informed decisions in the midst of multiple options, population control philosophically is an ideology rooted in inequality, racism and patriarchy.”<sup>54</sup>

It was not until the apartheid regime ended that Black women in South Africa began to raise concerns about the impact of Depo-Provera. The timing of the end of legal apartheid in South Africa coincided with the international conversations about reproductive health at Cairo and Beijing, and so the complaints about Depo-Provera use in the Black community in South Africa received an international stage. Unfortunately, South Africa did

<sup>48</sup> *Id.*

<sup>49</sup> Betsy Hartmann, *Depo-Provera: Keeping an eye on the needle*, in *REPRODUCTIVE RIGHTS & WRONGS: THE GLOBAL POLITICS OF POPULATION CONTROL*, 200, 206 (1995).

<sup>50</sup> *Id.*

<sup>51</sup> *Id.*

<sup>52</sup> Barbara Brown, *Facing the “black peril”: The politics of population control in South Africa*, 13 (3) *J. SOUTHERN AFRICAN STUD.* 256, 268 (1987), available at <http://reproductiverights.org/sites/default/files/documents/SRSouthAfrica98en.pdf>.

<sup>53</sup> *Id.*

<sup>54</sup> Monica Bahati Kuumba, *Perpetuating neo-colonialism through population control: South Africa and the United States*, 40 (3) *AFRICA TODAY* 79.

not closely examine its family planning policies as they pertained to Depo-Provera until 2009.<sup>55</sup>

The only way the world became aware of the failings of the new government was through the work performed by key human rights organizations. Specifically, it was a collaborative effort between the Center for Reproductive Law & Policy (CRLP) and the Women's Health Project of South Africa. These organizations jointly prepared a Shadow Report for the Nineteenth Session of the Committee on the Elimination of All Forms of Discrimination against Women. The goal of this report was to challenge South Africa's assertions that the government was committed to protecting the reproductive rights of all women in South Africa. Based on the diligent efforts of NGOs in South Africa, these assertions were challenged, calling into question South Africa's commitment to reproductive rights as "inadequate and inequitable." These NGOs, through their critical research, alleged that there were great discrepancies between the treatment of Black women and White women in South Africa. The NGOs alleged that there was a lack of quality treatment for women of color and that a lack of access to a wide range of contraceptives for Black women essentially forced them to use injectable contraceptives like Depo-Provera. The NGOs also alleged that there was a lack of information on alternative forms of contraception, such as barrier methods. In another similarity to Zimbabwe, a study of eighty-six South African women from various class and racial backgrounds, conducted by the Women's Health Project, found that 81 percent had used contraceptives without proper knowledge about what they were taking. Without the critical research and work done by these NGOs, the reproductive oppression of Black women would not have been addressed as swiftly as it was. By publishing their shadow report and publicizing the stories of these women, these organizations brought the facts to the forefront and forced the state to come into alignment with the normative standards of international human rights laws.

#### BLACK WOMEN IN THE UNITED STATES

Black women in the United States, like their counterparts in Zimbabwe and South Africa, have also experienced reproductive oppression. To provide a better understanding of this shared history, it is imperative to first understand

<sup>55</sup> See generally, *Women's reproductive rights in South Africa: A shadow report*, June 1998, prepared by The Center for Reproductive Law & Policy (CRLP) and Women's Health Project, available at <http://reproductiverights.org/sites/default/files/documents/SRSouthAfrica08en.pdf>.

the effect of the eugenics movement. *Eugenics* is the study of and belief in the possibility of producing a highly gifted race of people by encouraging people with superior genes to breed while discouraging “undesirable” and “defective” individuals from having children.<sup>56</sup> In essence, American eugenicists aimed to eliminate all “defective” people from the population. Included among those who were deemed “defective” were Black people, immigrants from Southern and Eastern Europe, the poor, the homeless, the physically disabled, and the mentally ill.<sup>57</sup> The methods of eugenic elimination included marginalization, institutionalization, and incarceration, as well as restrictions on immigration and miscegenation and laws permitting forced sterilization.<sup>58</sup>

Beginning in the early 1900s, movies, magazines, and journals romanticized the philosophy of eugenics.<sup>59</sup> Major philanthropic foundations such as the Carnegie Institution and the Rockefeller Foundation financed eugenics research. By 1928, there were 376 separate eugenics courses in some of the United States’ leading universities, enrolling more than 20,000 students.<sup>60</sup> By 1910, there was a large and dynamic network of scientists, reformers, and professionals engaged in national eugenics projects. These projects produced eugenic legislation that supported forced sterilization and prohibited marriages between the “fit” and “unfit.” State legislatures all across the country sponsored this legislation.<sup>61</sup> Through a series of laws and practices, the United States engaged in one of the most pernicious population-control endeavors in history.<sup>62</sup>

Several early feminist organizations also promoted eugenic philosophy. One of the most prominent feminists to champion the eugenic agenda was

<sup>56</sup> Edwin Black, *WAR AGAINST THE WEAK: EUGENICS AND AMERICA’S CAMPAIGN TO CREATE A MASTER RACE* (2003); Paul A. Lombardo, *Eugenics sterilization laws*, available at [www.Eugenicsarchive.org/html/eugenics/essay8text.html](http://www.Eugenicsarchive.org/html/eugenics/essay8text.html).

<sup>57</sup> K. Garver & B. Garver, *Eugenics past, present, and the future*, 49 (5) *AM. J. HUM. GENET.* 1109 (1991).

<sup>58</sup> It is noteworthy that much of the inspiration for the Nazi programs of sterilization, euthanasia, and genocide of the Jewish population was derived from the U.S. eugenics movement. Paul Lombardo, *The American breed: Nazi eugenics and the origins of the pioneer fund*, 65 *ALBANY L. REV.* 743 (2002). See also *A CENTURY OF EUGENICS IN AMERICA: FROM INDIANA EXPERIMENT TO THE HUMAN GENOME ERA* (Paul Lombardo ed., 2011); Edwin Black, *Eugenics and the Nazis – the California connection*, *SAN FRANCISCO CHRONICLE*, November 9, 2003, available at [www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2003/11/09/ing9c2Qsk81.dtl](http://www.sfgate.com/cgi-bin/article.cgi?f=/c/a/2003/11/09/ing9c2Qsk81.dtl).

<sup>59</sup> Judith Scully, *Eugenics, women of color and reproductive health: The saga continues*, 1 (1) *AFRICALOGICAL PERSPECTIVES* 167, 168 (January/February 2004).

<sup>60</sup> Lombardo, *Breed*, *supra* note 59, at 743; see also *CENTURY OF EUGENICS*, *supra* note 59; Steven Selden, *Transforming better babies into fitter families: Archival resources & the history of the American eugenics movement 1908–1930*, 149 (2) *AM. PHILOSOPHICAL SOC’Y.* 199–225.

<sup>61</sup> Scully, *supra* note 60, at 168.

<sup>62</sup> *Id.* at 167–69.

Margaret Sanger, the leader of the American birth control movement and founder of Planned Parenthood.<sup>63</sup> Sanger saw birth control as a means to prevent unwanted children from being born into a disadvantaged life, and she incorporated eugenics rhetoric into the birth control movement.<sup>64</sup> Like traditional eugenicists, Sanger believed “defective” people would pass on mental disease or serious physical defects to their children.<sup>65</sup> Through the persistent lobbying of a committed group of individuals including Sanger, sterilization laws proliferated throughout the United States in the early 1900s. Since feminist organizations advocated both birth control and eugenics-based sterilizations, many Black people in the United States distrusted White feminist organizations and accused them of using contraceptives, abortions, and sterilizations to eliminate the Black population.<sup>66</sup> Consequently, in certain segments of the Black community across the United States, birth control was considered just another tool in the eugenics toolbox.

By the 1950s and '60s, the ideology of eugenics and population control was used by policymakers in the United States to justify disseminating birth control internationally.<sup>67</sup> They claimed that controlling the fertility of poor women, especially in the “developing” world, was necessary to avert poverty, prevent the spread of communism, and increase the ability of the United States to govern world affairs.<sup>68</sup>

It has been estimated that, in 1974, between 100,000 and 150,000 poor American women had been surgically sterilized under federally funded programs either against their will or without consent.<sup>69</sup> Nearly half of the

<sup>63</sup> Darci Burrell, *The Norplant solution: Norplant and the control of African American motherhood*, 5 UCLA WOMEN'S L. J. 401, 419 (Spring 1995)

<sup>64</sup> *Id.* at 419–22.

<sup>65</sup> *Id.*

<sup>66</sup> See generally Jennifer Nelson, *WOMEN OF COLOR AND THE REPRODUCTIVE RIGHTS MOVEMENT* (New York Press 2003); Angela Y. Davis, *WOMEN, RACE & CLASS*, 1, 202–22 (1981).

<sup>67</sup> Hartmann, *supra* note 49, 93–112.

<sup>68</sup> Linda Gordon, *WOMAN'S BODY, WOMAN'S RIGHT* 355 (1990).

<sup>69</sup> In 1974, the Southern Poverty Law Center filed a class-action lawsuit in the U.S. District Court for the District of Columbia demanding a ban on the use of federal funds for sterilization. *Relf et al. vs. Weinberger et. al.*, Civil Action No. 73–1557 U.S. District Court, Washington DC, March 15, 1974. See also <http://www.splcenter.org/get-informed/case-docket/relf-v-weinberger> and *Relf v. United States*, 433 F. Supp. 423 (D.D.C. 1977). In this lawsuit, it was estimated that between 100,000 and 150,000 women had been sterilized using federal funds. These sterilizations were alleged to be against the will and without the consent of the women. Among the “women” sterilized during this time period were the plaintiffs in this case – fourteen-year-old Minnie Lee Relf and her twelve-year-old sister Mary Alice Relf. These young African-American girls were sterilized after nurses asked for permission to admit the girls to the hospital for injections of the long-acting experimental contraceptive Depo-Provera. Roberts, *supra* note 21, at 93.

women who were sterilized were Black.<sup>70</sup> Although eugenic sterilization laws impacted several segments of the population, primarily low-income people, a disproportionate number of sterilizations were performed on Black women.<sup>71</sup> Most of them were sterilized shortly after giving birth.<sup>72</sup> Many of the Black women who were sterilized were told that if they did not “consent” to sterilization they would no longer be eligible for welfare benefits.<sup>73</sup> In the southern part of the United States, these involuntary surgeries were so prevalent that they became known as the “Mississippi appendectomy.”<sup>74</sup> Unfortunately, forced sterilizations were not confined to the South or to Mississippi. They were performed throughout the country.<sup>75</sup> For example, in 1975, the acting director of obstetrics and gynecology at New York Municipal Hospital

Mrs. Relf unable to read or write, signed the consent form. She later discovered, however, that her daughters had been surgically sterilized. This case is tragic not only because forced sterilizations had been performed, but because Depo-Provera, a drug that had not yet been approved for contraceptive use in the United States, was at the center of this controversy. As a result of their decision to pursue their legal rights, widespread sterilization abuse funded by the federal government and practiced for decades was exposed. The lawsuit also led to the requirement that doctors obtain “informed consent” before performing sterilization procedures, and it also prohibited the practice of threatening women on welfare with benefits reductions if they refused to “consent” to sterilization.

<sup>70</sup> In May 2001, the governor of Virginia issued an official apology to individuals who had been forcibly sterilized by the state. Michael Ollove, *Lessons of Lynchburg*, BALTIMORE SUN, May 6, 2001. In January 2003, South Carolina also apologized for decades of forcibly sterilizing women – particularly Black women – from the 1930s through the 1960s. Jaymi Freiden, *South Carolina issues apology for years of sterilizations forced procedure used into the 60's*, KNIGHT RIDDER NEWS SERVICE, January 9, 2003. In March 2003, the governor of California issued a public apology for forced sterilizations performed in that state. Carl Ingram, *State issues apology for policy of sterilization*, LOS ANGELES TIMES, March 12, 2003. In North Carolina, the governor issued a similar apology to 7,450 individuals forcibly sterilized between 1924 and 1979 by their state eugenics board. Reparations to the sterilizations victims were proposed, but the North Carolina Senate rejected a plan for compensation. Gann, Carrie et al., *North Carolina senate denies funds for sterilization victims*, June 22, 2012, available at <http://abcnews.go.com/Health/WomensHealth/north-carolina-senate-blocks-compensation-sterilization-victims-eugenics/story?id=166285158&page=2>.

<sup>71</sup> Loretta Ross, *THE COLOR OF CHOICE: WHITE SUPREMACY AND REPRODUCTIVE JUSTICE* (2006).

<sup>72</sup> Roberts, *supra* note 21, at 93.

<sup>73</sup> *Id.*

<sup>74</sup> *Id.* Ross, *supra* note 72; the phrase was originally used by civil rights leader Fannie Lou Hamer to refer to involuntary sterilizations. See generally Harriet Washington, *MEDICAL APARTHEID: THE DARK HISTORY OF MEDICAL EXPERIMENTATION ON BLACK AMERICANS FROM COLONIAL TIMES TO THE PRESENT 202–05* (2007).

<sup>75</sup> Committee to End Sterilization Abuse, *STERILIZATION ABUSE OF WOMEN: THE FACTS* (1975). See also Roberts, *supra* note 21. Similarly, a study by Dr. Bernard Rosenfeld of Los Angeles County Hospital, released in 1973, confirmed that many poor Black women were being subjected to surgical sterilization without informed consent. Bernard Rosenfeld, Sydney Wolfe, & Robert E. McGarrath, *A HEALTH RESEARCH GROUP STUDY ON SURGICAL STERILIZATION: PRESENT ABUSES AND PROPOSED REGULATIONS* (1973) (focusing on sterilization procedures in Baltimore, Boston, and Los Angeles).

reported that in most major teaching hospitals in New York City, medical residents were encouraged to do “elective hysterectomies” on poor Black and Puerto Rican women as part of their training experience.

In the 1990s, when hormonal contraceptives causing temporary sterilization (e.g., Norplant and Depo-Provera) were approved by the FDA, eugenic philosophy once again reared its ugly head in the United States. Unlike Depo-Provera, which can be administered through an injection, Norplant must be surgically implanted.<sup>76</sup> Like Depo-Provera, it causes temporary sterilization, but instead of lasting three years, Norplant sterilization lasts for up to five years.<sup>77</sup> Almost as soon as these temporary forms of sterilization became available in the United States, several state legislatures attempted to compel women on welfare and women whose babies were exposed to drugs as a result of their mothers’ prenatal drug use to use Norplant.<sup>78</sup> Several state legislatures and the media touted Norplant as the panacea for reducing poverty in America’s Black urban areas. The media endorsed the view that Norplant was well suited for “inner city” young women, the poor, mothers on welfare, and the “less educated.”<sup>79</sup>

In more than twenty states, legislators proposed laws that would offer financial incentives to women on welfare who “agreed” to use Norplant. Judges gave low-income women convicted of child abuse or drug use during pregnancy the “choice” of taking Norplant or serving jail time.<sup>80</sup> Luckily, the legislative initiatives did not receive enough support from public officials to be

<sup>76</sup> Rachel Stephanie Arnow, *The implementation of rights: An argument for unconditionally funded Norplant removal*, 11 BERKELEY WOMEN’S L. J. 19 (1996).

<sup>77</sup> Burrell, *supra* note 54; Charlotte Rutherford, *Reproductive freedoms and African American women*, 4 YALE J. L. & FEMINISM 255 (Spring 1992); Laurie Nsiab-Jefferson, *Reproductive laws, women of color, and low income women in REPRODUCTIVE LAWS FOR THE 1990S*, 17, 49 (Nadine Taub & Sherrill Cohen eds., 1988).

<sup>78</sup> Meredith Black, *Welfare and coerced contraception: morality implications of state sponsored reproductive control*, 34 U. LOUISVILLE J. FAM. L. 311 (1995–1996); Melissa Burke, *The constitutionality of the use of the Norplant contraceptive device as a condition of probation*, 20 HASTINGS CONST. L. Q. 207 (1992); Rebecca Dresser, *Long-term contraceptives in the criminal justice system*, MED. HEALTH NEWS (January 1995); Barbara Bemier, *Class, race and poverty: Medical technologies and sociopolitical choices*, 11 HARV. BLACKLETTER L. J. 115 (1994).

<sup>79</sup> Ollove, *supra*, note 71.

<sup>80</sup> The “reproductive choice” paradigm also divides women up into good-choice makers and bad-choice makers. Bad-choice makers are deemed to be “unfit” to be mothers. And when a woman makes a bad choice and is therefore a bad mother, society is justified in punishing her, limiting her welfare eligibility, imprisoning her, and/or terminating her parental rights. Women making “bad choices” therefore become easy targets for sterilization and incarceration. Rickie Solinger, *PREGNANCY & POWER: A SHORT HISTORY OF REPRODUCTIVE POLITICS IN AMERICA* (2007). The concept of “reproductive choice” divides women against each other and judges women’s suitability for motherhood and reproduction. It is the opposite of reproductive justice based on the fundamental human right to reproduce safely and with dignity.



enacted into law, and the judicial sentences were widely criticized.<sup>81</sup> However, legislation was not needed to force young African-American women living in low-income communities to use Norplant or Depo-Provera. For example, young Black women in Charleston, South Carolina and Chicago, Illinois reported that they were pressured by medical providers to use either Norplant or Depo-Provera immediately after giving birth<sup>82</sup> and immediately following abortion – when women were most vulnerable and least likely to make clear decisions.<sup>83</sup> In most of these scenarios, doctors often failed to take the personal health history of these women into consideration before they made their “choice.”<sup>84</sup> In addition, women were not informed of the side effects or the fact that nothing was known about the long-term consequences of using these drugs. This intentional failure to fully inform women about their choices and the practice of recommending only Norplant or Depo-Provera when women are most vulnerable was and is unethical and unlawful. Whereas eugenics was clearly practiced in the United States against Black women,<sup>85</sup> it is equally apparent that it was used to control the reproductive capacity of Black women (as well as other women of color) throughout the Diaspora.<sup>86</sup>

#### BLACK WOMEN REJECT THE “CHOICE” PARADIGM

Black women’s experiences with Depo-Provera in Zimbabwe, South Africa, and the United States demonstrate how discrimination based on race and economic status can impact women’s reproductive choices. Prior to the ICPD in Cairo, population planners focused on how to keep the world’s

<sup>81</sup> Kristyn Walker, *Judicial control of reproductive freedom*, 78 IOWA L. REV. 779 (1993); Dorothy Roberts, *The future of reproductive choice for poor women and women of color*, 12 WOMEN’S RTS. L. REP. 59 (1990) reprinted in 20th Anniversary Edition 14 WOMEN’S RTS. L. REP. 305 (1992); Roberts, *supra* note 21.

<sup>82</sup> Roberts, *supra* note 21, at 128–30.

<sup>83</sup> *Dangerous Contraceptives: Norplant and Depo-Provera*, a Committee on Women, Population and the Environment (CWPE) fact sheet, available at <http://cwpe.org/files/norplant%20and%20depo-provera.pdf>.

<sup>84</sup> *Id.*

<sup>85</sup> See Angela Y. Davis, WOMEN, RACE & CLASS 215–21 (1981). In North Carolina alone, from 1933 to about 1973, 7,500 women were sterilized, supposedly due to mental deficiency. About 5,000 of them were Black. *Id.* at 217. North Carolina reparations for forced sterilizations: Sheryl Huggins Salomon, *An outrage: NC black women were sterilized*, The Root.com (November 7, 2011), available at [www.theroot.com/buzz/outrage-nc-black-women-were-sterilized](http://www.theroot.com/buzz/outrage-nc-black-women-were-sterilized) (accessed on April 12, 2012); Scully, *supra* note 60.

<sup>86</sup> Coerced sterilizations and sterilizations performed without the consent of women have been recently reported in Namibia, Democratic Republic of Congo, Zambia, and South Africa. See generally David Smith, *African women with HIV coerced into sterilization*, THE GUARDIAN, June 22, 2009, available at [www.guardian.com/UK/world/2009/Jun/22/africa-hiv-positive-women-sterilization](http://www.guardian.com/UK/world/2009/Jun/22/africa-hiv-positive-women-sterilization).

poorest women from having more babies.<sup>87</sup> The Cairo Conference, however, focused not just on population control but on development strategies. The major development strategy relevant here was one that offered a broader range of reproductive health services.<sup>88</sup> Unlike other international population conferences, the ICPD “did not emphasize numerical goals or targets, such as the number of contraceptives to be delivered or births to be averted.”<sup>89</sup> Instead, the ICPD focused on the need for greater access to information and more accessibility to reproductive health services so that women could be in a better position to make informed decisions.<sup>90</sup> It recognized that women needed to be empowered to control their reproductive health.<sup>91</sup> When addressing the UN General Assembly, a representative from the Netherlands commented on the successful people-centered approach taken at the ICPD, saying “(it was) built on a formula which essentially amounted to common decency; to face the population problem not through coercion and discrimination, but by giving people the means to follow the path of their choice, freely and responsibly.”<sup>92</sup>

Much of this change in perspective from coercion and discrimination to a respect for human rights was a result of increased participation by and attention to the needs of Black women and women of color in the reproductive rights movement. This shift in perspective was accomplished by NGO debates at Preparatory Committee (PreCom) meetings prior to the ICPD meeting in Cairo. For the first time, reproductive health organizations like NARAL, NOW, and Planned Parenthood<sup>93</sup> gave voice to the concerns of Black women and other women of color.<sup>94</sup> Prior to the PrepCom meetings, these organizations developed women of color projects, which largely focused on the reproductive oppression that women of color experienced as a result of racism and discrimination based on their economic status. Norplant, Depo-

<sup>87</sup> Marshall, Meredith, *United Nations Conference on population and development: The road to a new reality for reproductive health*, 10 EMORY INT'L. L. REV. 451 (1996).

<sup>88</sup> See Mahmoud F. Fathalla, *From family planning to reproductive health*, in BEYOND THE NUMBERS: A READER ON POPULATION, CONSUMPTION, AND THE ENVIRONMENT 143, 148 (Laurie Ann Mazur ed., 1994).

<sup>89</sup> Marshall, *supra* note 3, at 443.

<sup>90</sup> *Id.* at 443.

<sup>91</sup> *Id.*

<sup>92</sup> *Id.* at 492 citing Speakers in General Assembly Hail ICPD Outcome, ICPD (International Conference on Population and Development, New York), October 1994, 4.

<sup>93</sup> Faye Wattleton, one of the leading advocates for women's reproductive rights and the first African-American and youngest president of Planned Parenthood, helped usher in this phase of the evolution of the reproductive rights movement. For many years, Wattleton was the face of diversity within the predominantly White mainstream abortion rights movement. See Faye Wattleton, *LIFE ON THE LINE* (1996).

<sup>94</sup> Nelson, *supra* note 67.

Provera, and sterilization became a regular part of reproductive health care discussions. Through the PrepCom meetings, women of color helped define the themes, issues, and objectives of the Conferences, and, in doing so, broadened the agenda.<sup>95</sup>

Black women at the NGO caucuses from both the United States and developing countries began to push the issue of how limited their contraceptive and reproductive health care choices were. The realization that Black women in the United States had so much in common with Black women in African countries when it came to reproductive health created a transnational force to be reckoned with.<sup>96</sup> Questions were constantly being raised by Black women (and other women of color) in NGO forum discussions at the FWCW: How can we ever achieve “complete physical, mental and social well-being” when we must confront racism and classism in addition to sexism every day? How can we achieve this objective when health care providers do not provide the same level of care to us as they do to White patients? How can we achieve this objective when our “choices” are limited by our economic status, and we are coerced into making decisions? In many ways, these questions culminated in one burning question: Can a human rights approach emerge that will assist women facing multiple levels of oppression in their attempt to achieve reproductive freedom?

In many ways, the questions raised at the NGO forums by Black women were not new. Organizations like the National Black Women’s Health Project (NBWHP)<sup>97</sup> had been raising these questions for quite some time. Founded in 1984 (ten years prior to the ICPD), the NBWHP, one of the oldest organizations formed to advance the sexual and reproductive rights of Black women in the United States, had adopted in their vision statement the following

<sup>95</sup> The first Preparatory Committee (PrepCom) met in New York in 1991. A second meeting, PrepCom II, was held in 1993; it was followed by the 49th UN General Assembly, which reviewed the proposals put forth in PrepCom II and made recommendations to strengthen the document. In April 1994, planners met for the third PrepCom session, PrepComIII, to complete the final draft of the document to be ratified at Cairo. See *Summary of the International Conference on Population and Development*, EARTH NEGOTIATIONS BULLETIN (International Institute for Sustainable Development, Winnipeg, Manitoba, Canada), September 14, 1994, at 1. See also Gita Sen, *Development, population and the government: A search for balance*, in *POPULATION POLICIES RECONSIDERED: HEALTH, EMPOWERMENT, AND RIGHTS* 63, 68 (Gita Sen, Adrienne Germain, & Lincoln Chen eds., 1994).

<sup>96</sup> In addition to limited choices for contraception, Black women in the United States as well as in African suffer from poor access to health care, high rates of maternal mortality, high rates of infant mortality, high rates of birthing low-birth-weight babies, and high rates of HIV infection as compared to their White counterparts.

<sup>97</sup> For a comprehensive history of the National Black Women’s Health Project, see *Founding the National Black Women’s Health Project: A new concept in health*, in *UNDIVIDED RIGHTS: WOMEN OF COLOR ORGANIZE FOR REPRODUCTIVE JUSTICE* 63 (Joel Silliman et al. eds., 2009).

statement of what “good health” consisted of: “Health . . . is not merely the absence of illness, but the active promotion of emotional, mental, economic and physical wellness of this and future generations.”<sup>98</sup>

This statement regarding health reflects the reality that economic wellness, as well as emotional wellness (including the absence of discrimination), is a necessary ingredient in the recipe for good health. Since its founding, the NBWHP<sup>99</sup> had been bringing its concerns, voices, and perspectives to national and international attention. Byllye Avery, the founder of the NBWHP, sought to understand the lives of Black women and the fact that we often live in a conspiracy of silence.<sup>100</sup> She brought poor Black women and middle-class women, rural and urban women into dialogue around reproductive health issues to break this silence.<sup>101</sup> In 1985 (just one year after opening its doors), the NBWHP participated in the UN Third World Conference for Women in Nairobi, Kenya. This experience allowed African-American voices to be heard on a broad range of women’s health issues at the national and international level. Of the 20,000 women who attended the Nairobi conference, 1,100 were African-American women. Through the 1980s and 1990s, the NBWHP was intensely engaged in negotiating its place and creating space for other women of color in the women’s health movement. In 1992, the NBWHP started a campaign on unsafe contraceptives that focused on educating African-American women about Norplant and Depo-Provera. In 1993, the NBWHP co-organized a coalition of women of color to work on both the 1994 ICPD in Cairo and the 1995 FWCW in Beijing.

The impact of the public education and organizing efforts of NBWHP on unsafe contraceptives helped Black women throughout the Diaspora focus many of the NGO forum dialogues on the differences between Black women’s reproductive lives and the reproductive realities of White women. These differences were of global significance because the impact of racism and economic status discrimination in health care existed not only in the United States but all across the world. What made this experience so noteworthy was

<sup>98</sup> National Black Women’s Health Project Vision Statement (1984). See also *BODY AND SOUL: A BLACK WOMEN’S GUIDE TO HEALTH AND WELL-BEING* (Linda Villarosa ed., 1994). See also the WHO Constitution upon which the NBWHP vision statement was apparently based. *WORLD HEALTH ORGANIZATION CONSTITUTION* (45th ed. Oct. 2006), available at [www.who.int/governance/eb/who\\_constitution\\_en.pdf](http://www.who.int/governance/eb/who_constitution_en.pdf). The Constitution was adopted by the International Health Conference held in New York by representatives of 61 countries. It was originally entered into force in 1948.

<sup>99</sup> *UNDIVIDED RIGHTS*, *supra* note 98.

<sup>100</sup> Byllye Avery, *A question of survival/a conspiracy of silence: Abortion and black women’s health*, in *FROM ABORTION TO REPRODUCTIVE FREEDOM: TRANSFORMING A MOVEMENT* 75 (Marlene Gerber Fried ed., 1990).

<sup>101</sup> Silliman, *supra* note 98, 63–85.

that the voices of women connected to the NBWHP in the United States were augmented by Black women's voices in NGOs from all over the world at the ICPD and the FWCW.

In several workshops at the NGO forums, Black women throughout the Diaspora told their stories of how they had been coerced, tricked, and deceived into being sterilized either permanently or temporarily through the use of Depo-Provera and Norplant. They stressed the need for the concept of reproductive health to incorporate their concerns regarding informed consent, safety, and affordability of services. They distinguished their experiences from those of White women living in first-world countries, and they established a sense of connection with each other as they realized their reproductive health narratives were eerily similar to each other despite the fact that their governments were different, their languages varied, and their homes were separated by thousands of miles and large bodies of water. It was this shared sense of experience and history that connected Black women and women of color from all over the world. And it was this powerful connection that made it possible for the women gathered at the NGO forum to collectively define reproductive health in a way that would forever change the dialogue around the concept of choice.

The spoken word is powerful. It can change minds and make people think and rethink their positions. Sometimes spoken words have to be repeated over and over again before their significance is understood. In the case of Black women and reproductive health, the reoccurring narratives of sterilization abuse, contraceptive abuse, and the lack of autonomy and dignity that Black women faced in their relationship to their health care providers was echoed globally. Black women in the United States, in African countries, in the Caribbean, and throughout the world realized that, in many ways, their experiences were the same. By insisting on having their experiences recognized by NGOs, Black women helped to change the dialogue around reproductive health.<sup>102</sup> Their narratives and advocacy moved the agenda from the rhetoric of "choice" into the international human rights framework that emphasized freedom from coercion and respect for informed consent, as well as a stated value for the principle of self-determination as it pertains to reproductive health.

The conversations, particularly at the FWCW NGO forums, focused on the false "choices" being offered to Black women (and women of color) all over the world. Black women's health advocates throughout the Diaspora made it clear at the FWCW that reproductive health issues cannot adequately be

<sup>102</sup> Nelson, *supra* note 67.

addressed through the “choice” paradigm.<sup>103</sup> In essence, the choice paradigm is an individualistic consumer market concept. Under this paradigm, one has only as much “choice” as she can afford. Consequently, the human dignity that should be intimately intertwined with the delivery of reproductive health services is only guaranteed to those who can afford to choose such services. Concomitantly, safety, which should be at the heart of all reproductive health decisions, is also available only to those who have adequate purchasing power. Under this “reproductive choice” approach, women do not have a right to decide whether and when to become mothers – they merely have a consumer’s choice.<sup>104</sup> It was for these reasons that many women of color in general, and Black women in particular, joined together to critique and ultimately reject the “choice” paradigm. Nowhere was this rejection more obvious and significant than at the ICPD and the FWCW, where the definition of reproductive health was expanded as a result of the concerns expressed by Black women and women of color. The history of Black women and their struggle for reproductive freedom is now reflected in the language and goals of international human rights conferences, declarations, and plans of action that represent normative international law in the reproductive health arena.

Loretta Ross, another African-American pioneer in the women’s health movement, motivated thousands of Black women and women of color to reject the “choice” paradigm and demand not just reproductive freedom but reproductive justice.<sup>105</sup> Formerly the Executive Director of the National Center for Human Rights Education (NCHRE), Ms. Ross has helped infuse human rights language into the women’s health agenda and has helped

<sup>103</sup> *Id.*

<sup>104</sup> Rickie Solinger, *The incompatibility of neo-liberal “choice” and reproductive justice*, available at [www.protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf](http://www.protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf).

<sup>105</sup> Loretta Ross, et al., *The Sister Song Collective: Women of color, reproductive health and human rights*, in *Health of Women of Color*, special issue, 17 *AM. J. HEALTH* 85 (2001). The term “reproductive justice” was coined in 1994 by the Black Women’s Caucus at a national pro-choice conference sponsored by the Illinois Pro-Choice Alliance in Chicago. See generally Sarah London, *Reproductive justice: Developing a lawyering model*, 13 *BERKELEY J. AFR.-AM. L. & POL’Y.* 71 (2011). The conference took place two months after the women had returned from the 1994 International Conference on Population and Development in Cairo, Egypt. The caucus was formed as an attempt to move away from the “choice” framework and to adapt the Cairo Programme of Action in the context of the United States. *Reproductive Justice Lens Toolkit*, *infra* note 108. Utilizing the human rights framework of the Cairo Programme of Action, the caucus created the term “reproductive justice,” which was originally defined as “reproductive health integrated into social justice.” Loretta Ross, *What is reproductive justice?*, *REPRODUCTIVE JUSTICE BRIEFING BOOK: A PRIMER ON REPRODUCTIVE JUSTICE & SOCIAL CHANGE*, available at [www.protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf](http://www.protectchoice.org/downloads/Reproductive%20Justice%20Briefing%20Book.pdf). Not wanting to use the language of “choice” because they represented communities with few real choices, they integrated the concepts of reproductive rights, social justice, and human rights to launch the term reproductive “justice.” *Id.*

transform the landscape of the women's health movement in the United States and internationally. It is no coincidence that she was also instrumental in providing training on the human rights framework to women attending the FWCW NGO Forum. She is currently the executive director of the Sister Song Women of Color Reproductive Health Collective (founded in 1997), which is at the forefront of the Reproductive Justice Movement in the United States.<sup>106</sup>

Members of the Reproductive Justice Movement argue that women cannot have full control over their reproductive lives unless issues such as racial discrimination, inequalities in wealth and power, and differential access to resources and services are addressed.<sup>107</sup> Consequently, reproductive justice will not be achieved until "women and girls have the economic, social and political power and resources to make healthy decisions about their bodies, sexuality and reproduction for themselves."<sup>108</sup> This cannot occur until the cultural and reproductive lives of Black women are inculcated into the majority-centered reproductive rights approaches. In this sense, the Reproductive Justice Movement marks another phase in the evolution of the women's health movement.

#### BEYOND BEIJING

It has recently been reported that Depo-Provera is being used to limit the reproductive capacity of Black Ethiopian women living in Israel. Rachel Mangoli, an advocate of the rights of Ethiopian children in Israel,<sup>109</sup> noticed that, in 2008, there was a significant drop in the number of children being born in the Ethiopian community.<sup>110</sup> Seeing this as a red flag and suspecting that a birth-reduction policy might have been instituted against Ethiopian women, she approached a local clinic and was advised by the manager that "they had been instructed to administer Depo-Provera injections to Ethiopian women of child-bearing age."<sup>111</sup> In 2010, a women's rights organization, Woman to Woman (Isha L'Isha), reported that Israel had an unwritten policy

<sup>106</sup> Zakiya Luna, *From rights to justice: Women of color changing the face of U.S. reproductive rights organizing*, 4 SOCIETIES WITHOUT BORDERS 343–65 (2009).

<sup>107</sup> See *Reproductive Justice Lens Toolkit*, available at [forwardtogether.org/assets/docs/acrj-rj-lens-toolkit.pdf](http://forwardtogether.org/assets/docs/acrj-rj-lens-toolkit.pdf).

<sup>108</sup> *Id.*

<sup>109</sup> Jonathan Cook, *Israel's treatment of Ethiopians "racist,"* THE NATIONAL, January 6, 2010, available at <http://www.thenational.ae/news/world/middle-east/israels-treatment-of-ethiopians-racist> (accessed on April 18, 2010).

<sup>110</sup> *Id.*

<sup>111</sup> *Id.* at 5.

of promoting the use of Depo-Provera in Ethiopian females who immigrated to Israel.<sup>112</sup> The report indicated that the use of Depo-Provera had risen to 57 percent in a community that accounts for less than 2 percent of the entire population.<sup>113</sup> When Woman to Woman sent non-Ethiopian women to doctors asking for Depo-Provera, they were all advised that Depo-Provera is only prescribed in highly unusual cases.<sup>114</sup>

The Ministry of Health's official policy toward Depo-Provera is that it should only be used when other methods of birth control are not suitable and only if there is a medical need; other than under these conditions, the use of Depo-Provera is not a recommended contraceptive method.<sup>115</sup> In fact, the Israeli Ministry of Health, in 2008, labeled Depo-Provera as a drug of last resort, only to be used when other methods fail or where there is a medical necessity for its use.<sup>116</sup> Despite these attestations, it is reported that when Ethiopians living in Israeli camps are subjected to a conversion process,<sup>117</sup> they are lectured on various topics including family planning and the use of contraceptives.<sup>118</sup> Ethiopian women have reported that the only contraceptive method that was discussed during these "workshops" was Depo-Provera.<sup>119</sup> No other form of birth control was mentioned. They also reported that they were not advised about the potential side effects of the use of Depo-Provera.<sup>120</sup>

As immigrant women, Ethiopians in Israel are one of the most vulnerable groups of women in the world. Immigrant women encounter discrimination on a regular basis. Such discrimination is complex because it occurs on multiple levels that include race, education, language, poverty, and socio-cultural barriers. Immigrant women, like all women, deserve an equal opportunity to fully participate in society, the freedom to determine the course of their lives, and the right and ability to access basic reproductive health services free of discrimination, harassment, and shame. Without respect for these rights, individual rights have little meaning, particularly the fundamental rights to live a dignified existence and to have children.

<sup>112</sup> Hedva Eyal, et al., *Depo-Provera: A contraceptive method given via injection, a report on its prescription policy among women of the Ethiopian community in Israel* (2010), available at [www.isha.org](http://www.isha.org).

<sup>113</sup> *Id.* at 8–13.

<sup>114</sup> *Id.*

<sup>115</sup> *Id.* at 7.

<sup>116</sup> *Id.* at 7.

<sup>117</sup> Ethiopians were housed at makeshift camps located in the Gondar region of northern Ethiopia where they were subjected to a conversion process, were introduced to all modern conveniences, and their African surnames were changed and replaced with Hebrew names.

<sup>118</sup> Eyal, *supra* note 113, at 7.

<sup>119</sup> *Id.* at 7.

<sup>120</sup> *Id.*



By placing the experience of Ethiopian women in Israel in context with Black women's experiences worldwide, we have the opportunity to push the reproductive justice framework forward by incorporating the experiences of immigrant women and standing in solidarity with them. Although Black women have played a key role in the normative development of the reproductive rights regime, those rights expressed in the Cairo Programme of Action and the Beijing FWCW Platform will mean little to the well-being of women unless national, regional, and international human rights instruments are used to ensure state compliance with the Cairo and Beijing commitments. The Universal Declaration of Human Rights, the International Covenant on Economic Social and Cultural Rights, the Convention on the Elimination of Discrimination against Women (CEDAW), and the International Covenant on Civil and Political Rights (ICCPR) can all be used to effectuate these goals. This remains the challenge to the reproductive health and reproductive justice movements – movements that have been and will continue to be heavily influenced by the life experience and advocacy of Black women worldwide.

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