



NATIVE AMERICAN WOMEN'S  
HEALTH EDUCATION RESOURCE CENTER

# Indigenous Women's Reproductive Justice

A SURVEY OF SEXUAL ASSAULT POLICIES AND PROTOCOLS  
WITHIN INDIAN HEALTH SERVICE EMERGENCY ROOMS

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NATIVE AMERICAN WOMEN'S HEALTH EDUCATION RESOURCE CENTER  
A PROJECT OF THE NATIVE AMERICAN COMMUNITY BOARD

# INDIGENOUS WOMEN'S REPRODUCTIVE JUSTICE

A SURVEY OF SEXUAL ASSAULT POLICIES AND PROTOCOLS WITHIN INDIAN HEALTH SERVICE EMERGENCY ROOMS

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## INTRODUCTION

The Native American Women’s Health Education Resource Center has worked on the reproductive justice issues of Native American women for eighteen years. Over time the Resource Center has addressed such issues as sterilization, contraceptive abuses pertaining to the Copper 7 IUDs, Depo-Provera and Norplant, lack of public health education and services concerning STD’s, RTI’s and HIV/AIDS, the increase in cesarean births, a lack of education on breast feeding combined with the promotion of commercial formula, Fetal Alcohol Syndrome and the lack of abortion services provided to Native women within the Indian Health Service.


The Indian Health Service has a long history of providing reproductive health services to Native American women in a manner that challenges a woman’s right to services and violates her basic human rights. Human Rights abuses have included but are not limited to: forced sterilizations, failure to remove Norplant on demand, withholding critical medical information, denial of abortion services and more.

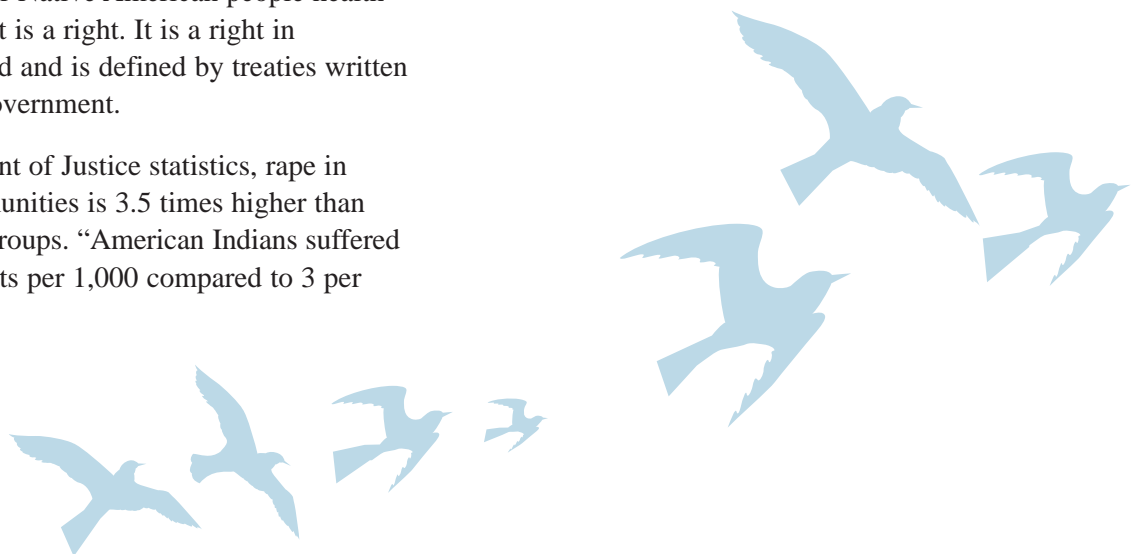
It is important to understand that for most Native American women, private health care is unaffordable and therefore the Indian Health Service serves as our primary health care provider. For Native American people health care is not a privilege, it is a right. It is a right in exchange for land seized and is defined by treaties written by the United States Government.

According to Department of Justice statistics, rape in Native American communities is 3.5 times higher than among all other racial groups. “American Indians suffered 7 rapes or sexual assaults per 1,000 compared to 3 per

1,000 for African Americans and 2 per 1,000 for Whites and 1 per every 1,000 for Asian Americans” (1999).<sup>1</sup>

It would seem from these findings that the Indian Health Service would make sexual assault services a priority by ensuring that every Service Unit have trained personnel to attend to victims when they arrive at the emergency room. In addition, the development of policy and protocol within emergency rooms would further demonstrate a commitment by Indian Health Service to addressing the reality of sexual assault within Native American communities.

The staff of the Native American Women’s Health Education Resource Center is known for taking on the role of activist in order to help Native American women receive better and improved health care. The Resource Center has put together this briefing paper on emergency room services and policies for Native American women who go to an Indian Health Service facility for assistance after a rape or sexual assault. The findings of this survey are alarming and document a substantial gap in services for Native American women. 



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## HISTORY OF THE ISSUE

With the Supreme Court's historic *Roe vs. Wade* decision in 1973, abortion services were made legal and accessible to women in the United States. This decision also mandated that Federal dollars could be used to pay for abortion services within federally funded facilities, including the Indian Health Service, Public Health Service and Medicaid, as well as for women in the Military. Of particular importance to Native American women, this decision granted access to free abortion services through the Indian Health Service (IHS). This was revised, however, in 1976 when the U.S. Congress passed the Hyde Amendment, restricting the use of federal funds for abortion services to cases in which the pregnancy threatened the woman's life. This amendment affected all entities funded by the Federal Government including the Indian Health Service facilities, a division of the Department of Health and Human Services. Native American women, now, could no longer receive abortion services through IHS unless the pregnancy threatened the woman's life.

In its current version, enacted in 1997, the Hyde Amendment includes two additional provisions for abortion services: rape and incest. This now means that a woman can access abortions paid for by federal dollars in the event that a pregnancy endangers a woman's life or if the pregnancy is the result of an act of rape or incest. At the time of this last revision, a directive was issued by Dr. Trujillo, the Director of Indian Health Service, informing all staff of the changes that would occur in IHS and the services that were to be offered under this new policy.<sup>2</sup>

The Native American Women's Health Education Resource Center (NAWHERC) has researched the implementation of this legislation in IHS units throughout the country and published a report in two parts, "*The Indian Health Service And Its Inconsistent Application of the Hyde Amendment*" (2002) and the "*Roundtable Report on Access to Abortion Services Through the Indian Health Service Under the Hyde Amendment*" (2003). The NAWHERC reports of 2002 and 2003 reveal that, despite having the freedom to provide abortion services (limited

as they are by the Hyde Amendment), IHS has failed to provide these services to Native women. According to statistical data provided by the Indian Health Service regarding the number of abortions performed at or funded by IHS clinics in cases of rape, incest, or endangerment of the woman's life (as stipulated under the provisions of the Hyde Amendment), only 25 abortions were performed at or funded by the IHS within all of its 352 Service Units in the United States from 1981 — 2001. Furthermore, the 2002 report found that 85% of the surveyed Service Units were noncompliant with the official IHS abortion policy, which provides abortions under the Hyde Amendment.<sup>3</sup> IHS was also found to be inconsistently administering other emergency services, including emergency contraception and treatment for sexually transmitted diseases (STDs) in the event of sexual assault or incest.

The Roundtable Report conducted by the Resource Center revealed widespread concern over the attitudes of many IHS healthcare providers regarding abortion. In many cases it has been found that the extent to which abortion services are provided to Native American women is dependent upon the beliefs and practices of individual healthcare providers within the IHS. The ACLU has stepped in and spoken out about this biased reality, "Religious or other objections should not outweigh the interests of these victims and their access to basic emergency care" (ACLU, 2002). Victims of rape and incest are particularly vulnerable to the withholding of reproductive health services including information, emergency contraception (EC) and abortion services by health care workers.

This reality is *not* unknown to IHS headquarters. The Indian Health Service website reveals that IHS is aware that services are not being provided to victims of sexual assault, acknowledging the influence of the personal beliefs of certain providers, pharmacists, and facilities on the services being offered to Native women.


"Contrary to some claims, the medication does not induce abortion; research suggests that emergency con-

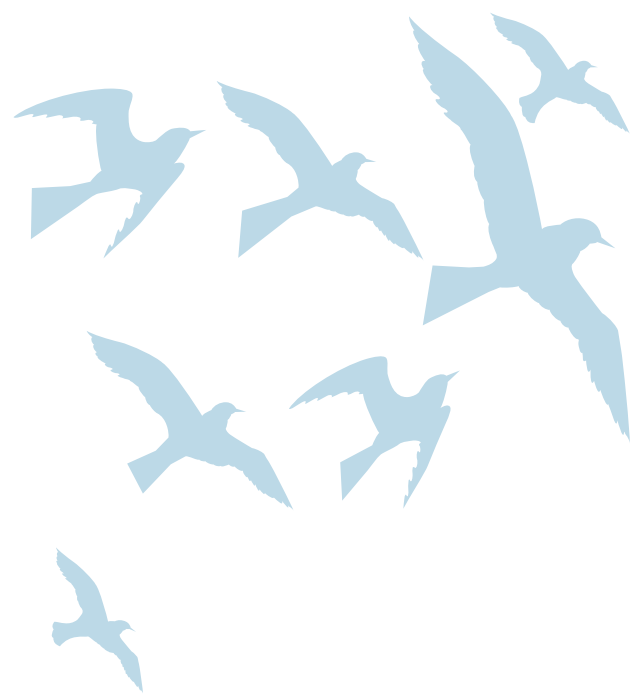


trapection acts via interruption of ovulation or tubal function, some providers have construed emergency contraception to be an abortifecient. Some facilities refuse to prescribe or dispense prescriptions after it is prescribed by the provider... personnel are obliged to refer patient to a provider or facility... at a minimum of inconvenience” (Indian Health Services 2003).

It is clear that communication among IHS administrators and potential health care providers is vital, especially in agreeing upon a common understanding of “minimum of inconvenience.” Surely the obstacles women are currently facing in order to receive basic services from IHS are not *minimal*. The biases of IHS personnel are magnified by the high turnover rate of physicians within IHS facilities. Many physicians come into their positions at the Indian Health Service from outside communities or countries, and often only stay for a limited time. Thus it is necessary for administrators to encourage understanding and respect for cultural differences from all personnel. Health care providers as well as administrators must commit to not allow personal agendas, values, or beliefs from interfering with the administration of services to Native American women. It is imperative to command respect for Native American women’s cultural values and moirés, and to demand an end to gender, religious and cultural biases.

In response to the results of the Indigenous Women’s Reproductive Rights publications Charon Asetoyer, Director of the NAWHERC, developed a coalition working group in order to place pressure on IHS to ensure the administration of timely, culturally sensitive reproductive services to Native American women. The working group is comprised of the Center for Reproductive Rights, the American Civil Liberties Union’s Reproductive Freedom Project, Sacred Circle National Resource Center, White Buffalo Calf Woman Society, Women’s Health Specialists, the Aberdeen Tribal Chairman’s Health Board, American Indian Law Alliance, Indigenous Women’s Network, the National Abortion Federation and the South Dakota Coalition Against Domestic Violence & Sexual Assault.

This coalition is taking an aggressive, proactive approach in ensuring that Indigenous women’s reproductive rights are honored. A meeting has been requested with the Director of Indian Health Services, Charles W. Grimm D.D.S., and relevant staff in order to develop the most effective strategy in ensuring that Native American women are provided with culturally appropriate and timely access to reproductive services in emergency situations. In order to aid in this process, the NAWHERC prepared and conducted the following survey of IHS Service Units to determine whether facilities had an IHS policy and protocol accessible to personnel for emergency services in the event of life endangerment, sexual assault or incest. 



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## BACKGROUND OF IHS SEXUAL ASSAULT POLICY

Whether or not services are contracted out or are provided directly through IHS, it is the responsibility of Area and Unit Directors to ensure the adherence of all personnel to IHS policies. This may best be attained through the development of protocol. One such example can be found on the IHS website's Women's Health page, which outlines a protocol for the treatment of victims of sexual assault. This protocol is borrowed from the Warm Springs Health and Wellness Center in Oregon as an example for IHS facilities to view and/or upon which they may model their own protocol. The protocol, which provides for medical professionals in the care of the Sexual Assault Survivor, was based upon recommendations from the American College of Emergency Physicians, current Oregon and Local Tribal Law.

The Warm Spring's document describes basic standards of care for victims of sexual assault, stating "The physical, emotional and psychological well being of the sexual assault survivor is given precedence over all other matters."<sup>4</sup> The recommendations section notes emergency contraception and infectious disease treatment as important components of maintaining basic standards of care. "The goal is to ensure compassionate and sensitive delivery of emergency services and care provided in a non-judgmental manner."<sup>5</sup> Two other copies of IHS protocols were obtained from the Navaho Area Indian Health Service and the Cherokee Indian Hospital Authority, which contained similar directives. ✈

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## METHODOLOGY OF SURVEY

Healthcare for Native Americans can be administered in any of three ways: through clinics and hospitals that are directly managed by IHS, through facilities that are contracted by IHS to provide services, and through tribally operated healthcare programs. This survey focused on facilities directly managed by the Indian Health Service. Prior to developing questions for the survey, four Service Units in the Aberdeen region were contacted in order to request copies of IHS policy and protocols for emergency services in cases of life endangerment to the woman, sexual assault and incest. Two Service Units responded by fax. In addition, the IHS Warm Springs protocol was used as a reference. Survey questions were devised also using the protocols from the Navaho Area IHS and the Cherokee Indian Hospital Authority.

The NAWHERC conducted a systematic phone survey of 50 randomly selected Indian Health Service hospitals and clinics from all of IHS's twelve regions: Aberdeen, Alaska, Albuquerque, Bemidji, Billings, California, Nashville, Navajo, Oklahoma, Phoenix, Portland and Tucson. If no contact was made, another facility was chosen from the remaining Service Units. Thus the survey only reports on units that responded to phone calls.

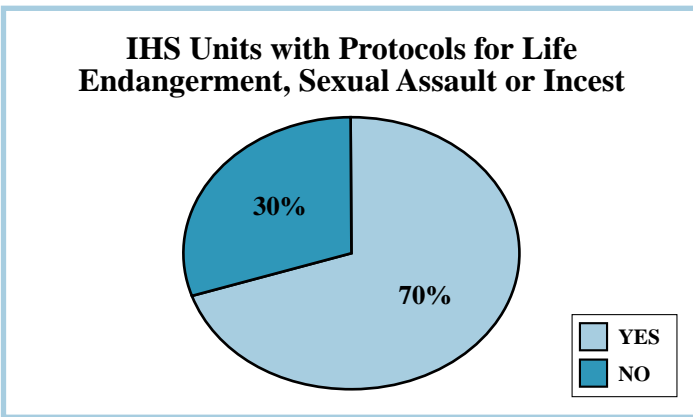
The conductor of the survey requested to speak with the nursing supervisor of the emergency room or urgent care. Some facilities responded in a positive, forthright manner while others were evasive, transferred the surveyor to various departments including administration, and did not return messages. Once a responder was located, the following questions were asked.

1. Do you have an IHS policy/protocol for emergency room services in cases of life endangerment to a woman, sexual assault or incest?
2. Is the policy/protocol posted and accessible to staff members?
3. Is your staff trained in the IHS policy/protocol for emergency room services in cases of life endangerment to a woman, sexual assault or incest?
4. If you do not provide the emergency services, how far away is the facility they are referred to?

# RESULTS OF SURVEY

**FIGURE 1.**

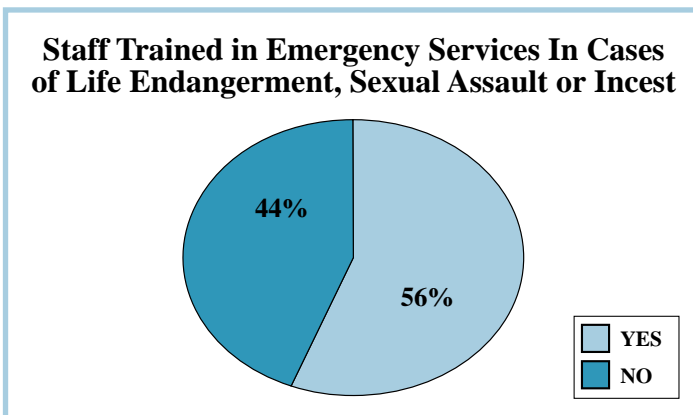
IHS SERVICE UNITS WITH POLICY/PROTOCOL IN CASES OF LIFE ENDANGERMENT, SEXUAL ASSAULT OR INCEST



The survey reveals that 30% of Service Units surveyed reported that they do not have a protocol in place for emergency services in cases of life endangerment, sexual assault or incest. Seventy percent reported knowledge of the existence of a protocol.

**FIGURE 3.**

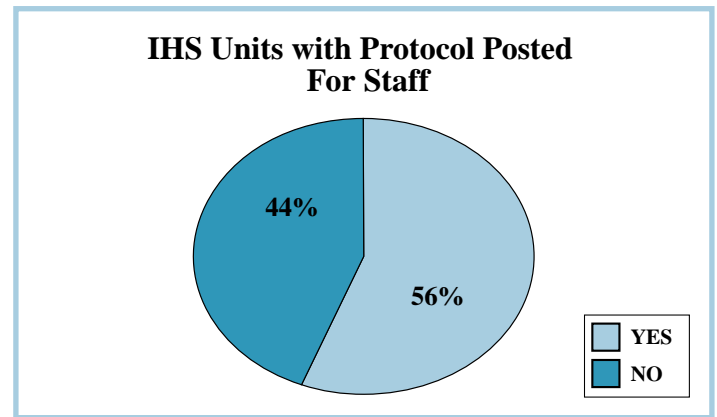
IHS SERVICE UNITS WITH TRAINED STAFF IN CASES OF LIFE ENDANGERMENT, SEXUAL ASSAULT OR INCEST



Forty-four percent of facilities lack trained personnel to perform emergency services in the event of life endangerment, sexual assault or incest. This indicates a need for more rural areas, in which most of Indian country is found, to provide necessary services. It is necessary that IHS mandate the training of personnel in order to insure compliance with the law and IHS directives.

**FIGURE 2.**

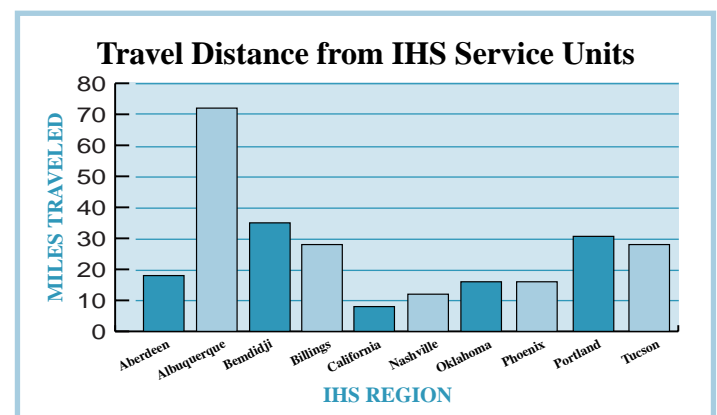
IHS SERVICE UNITS WITH PROTOCOL/POLICY POSTED AND ACCESSIBLE TO STAFF MEMBERS



Although 70% of respondents indicated they have a protocol, the percentage of Service Units with a protocol posted and accessible to staff members is only 56%. The statistics reflect a discrepancy between policy and practice. It is the responsibility of Area and Service Unit Directors to ensure that services are being provided.

**FIGURE 4.**

IHS SERVICE UNITS REQUIRING TRAVEL FOR EMERGENCY SERVICES IN CASES OF LIFE ENDANGERMENT, RAPE OR INCEST



Those facilities that do not provide emergency services require victims to travel an average of 28 miles, while some have to travel up to 150 miles roundtrip. California has the shortest travel distance while Albuquerque requires the longest travel distance to receive services.



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## IMPACT OF SURVEY RESULTS

The findings from this survey indicate a need to prioritize reproductive health reform among public healthcare providers in Native American communities. It can be seen that Native American women, for whom IHS is the primary healthcare provider, are not being granted access to basic reproductive health care in the event of life endangerment for the woman, sexual assault, or incest. A quick look at Department of Justice statistics will demonstrate the prevalence of sexual assault within Native American communities, and thus the urgency of ensuring these services for Native women.

The incident rate of rapes in Native American communities, according to Department of Justice statistics, is 3.5 times higher than among all other racial groups. "American Indians suffered 7 rapes or sexual assaults per 1,000 compared to 3 per 1,000 for African Americans and 2 per 1,000 for Whites and 1 per every 1,000 for Asian Americans" (1999). Based upon these numbers, Native American women are suffering from sexual assaults at rates three times higher than other races. It is important also to remember that reported numbers often vastly under represent actual incidences of sexual assault, and so we must assume the numbers are even more devastating. Rape in Indian Country is so prevalent that IHS can no longer allow its facilities to neglect this area of care. A participant of the 2003 NAWHERC Roundtable commented: "Look at the trends in Indian health and the statistics and we'll see girls, 12, 13, 14, all the way up to 18 years of age, that are pregnant and deliver children. That means rapes that were never prosecuted as rape" (2003). ACLU's Laura W. Murphy notes, "Tens of thousands of women become pregnant every year from rape or incest."<sup>6</sup> It is unacceptable to continue to allow this lack of policy and protocol for emergency services within IHS.

The legislation resulting from the Hyde Amendment allows hospitals that receive federal funding, such as IHS, to provide emergency contraception (EC) to survivors of sexual assault and incest, in order to ensure reproductive

justice to these survivors. Emergency contraception, also known as post-coital contraception, has been proven highly effective in preventing unintended pregnancy when taken within 72 hours of unprotected intercourse. In many areas where Native Americans live, the only option for victims is to drive long distances after having suffered the indignity of sexual assault to find a service that provides E.C. Often this can take longer than the 72 hours within which emergency contraception is most successful. When the actions of IHS personnel delay access to emergency services, many Native women are forced to make the decision not to use these services.

This survey also shows IHS Service Units citing lack of facility availability and necessary equipment as reasons for the lack of provision of services. The reality is that much of the necessary equipment to provide services are common to emergency rooms, including slides for cultures, swabs, and those items typical of a routine pelvic exam or Pap smear. Furthermore, the materials needed to maintain the chain of custody for forensic evidence are readily available through the Department of Justice, or state law enforcement. Aside from a need for improved training for staff members, nurses and physicians, it is clear that "necessary equipment" and "facility availability" are flawed excuses for the lack of provision of services.

There are several programs available that may be used as models by which IHS can train its personnel in the provision of treatment for victims of sexual assault. Two examples of such programs include the Sexual Assault Nurse Examiner (SANE) and the Sexual Assault Response Team (SART) programs. Several states in the country still do not have a SART or SANE program. A SANE is a registered nurse who has been specifically trained to provide care to victims of sexual assault and is capable of conducting forensic exams. SART is an organization that is formed as a community response to child and adult victims of sexual assault. The team is comprised of hospital staff, sexual assault victims' advocates, law enforcement, prosecutors,

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judges and other professionals in the community who are concerned with the well being of a victim of sexual assault.

Sexual assault and incest are at epidemic proportions in Indian Country, and the need for the implementation of Reservation-wide SART and SANE programs is urgent. The fact that fewer than fifty percent of IHS service units provide these basic standards of care highlights the need for IHS to mandate training for IHS personnel in order to ensure compliance with the law and IHS directives.

It is clear that a huge gap in services exists within the Indian Health Service for Native American women who have been sexually assaulted. When there is no trained staff to collect evidence it allows Indian Health Service to deny that a crime has occurred and therefore avoid reporting. It also allows Indian Health Service to deny a standard of health care to women that would include providing emergency contraception (EC), tests and treatment for STDs and abortion services, to which survivors of sexual assault are entitled. Without these services, IHS cannot ensure that Native American women are not being forced to have children against their will. This serves as a way for the Federal Government to further diminish the status of Native American women. These services must be incorporated into a standard of health care provided to Native American women in order to respect their self-determination and to ensure that the basic human rights of Native American women are protected.

Tribal Governments, National organizations and Community agencies have to put pressure on IHS, policy makers, and legislators to allocate funding for the mandatory sexual assault training of Indian Health Service health professionals. IHS must make this a priority in all Service Units, in order to improve the level of health care for all Native American women. 🐾

## ENDNOTES

- 1 Bureau of Justice Statistics, American Indian Crime, (1999)
- 2 Trujillo, Michael H. (1996, August 16th)
- 3 Indigenous Women's Reproductive Rights Roundtable Report (2003)
- 4 Warm Springs Health and Wellness Center Sexual Assault Protocol, <http://www.ihs.gov/MedicalPrograms/MCH/W/DV05.cfm#top>
- 5 Ibid.
- 6 ACLU, 2003





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