



NATIVE AMERICAN WOMEN'S
HEALTH EDUCATION RESOURCE CENTER

Indigenous Women's Reproductive Justice

ROUNDTABLE REPORT ON THE AVAILABILITY OF PLAN B[®]
AND EMERGENCY CONTRACEPTIVES WITHIN
INDIAN HEALTH SERVICE

JANUARY 2009

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In memory of our Grandmothers and a better life for our daughters.



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

INDIGENOUS WOMEN'S REPRODUCTIVE JUSTICE

ROUNDTABLE REPORT ON THE AVAILABILITY OF PLAN B® AND EMERGENCY CONTRACEPTIVES
WITHIN INDIAN HEALTH SERVICE

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Pidamaya to all of the powerful Native American women participants who shared their valuable time to travel and share their experiences and insights at the 2-day Roundtable.

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INTRODUCTION BY CHARON ASETOYER

The Native American Women's Health Education Resource Center works to protect the health and Human Rights of Indigenous women through the Indigenous Women's Health and Reproductive Justice Program. This program spearheaded a national, broad-based coalition of Indigenous women and Allies which include local and national women's health and civil liberties organizations to hold accountable the Indian Health Service to its own policies of providing comprehensive reproductive health services to Native American and Alaska Native women. The Program's goal is to facilitate Native women's legal access to comprehensive health care services, including a focus on the Indian Health Service's (IHS) provision of comprehensive services to sexual assault victims.

The Coalition started with examining the reproductive policies and protocols that govern the services a Native woman would receive when she enters an emergency room for services after a sexual assault. The findings were found to be extremely unacceptable with little or no consistency from one Indian Health Service facility to the next.

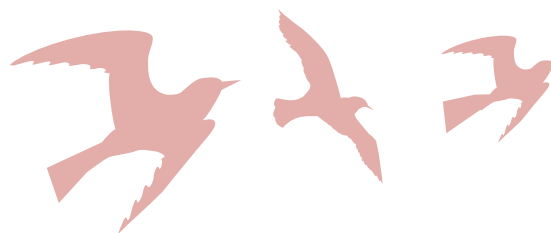
In October of 2005 during the Roundtable on *Sexual Assault Policies and Protocols Within Indian Health Service Emergency Rooms* a draft of the recommended policies and protocols were provided to the participants. Over the next several months, revisions were made and with the finalization of the policies and protocols requests were coming in from Indian Health Service nursing staff asking us to post the recommended policies and protocols on our web site so they could be accessed. By early 2007 a huge ground swell of advocates, health care providers, consumers and community activists were all requesting that Health and Human Service Secretary Mike Leavitt adopt and implement the *Standardized Sexual Assault*

Policies and Protocols for Indian Health Service Emergency Rooms to improve the service Native American and Alaska Native women receive within Indian Health Service facilities. Even with the fact that 44% of Indian Health Service facilities lack trained personnel to perform emergency services in the event of a rape and the fact that Native American and Alaska Native women are sexually assaulted at a rate of 3.5 times higher than all other racial groups in the United States there has been no response from Health and Human Service to implement any kind of standardized policies to improve the quality of services for rape victims.

Even with the passage of the National Congress of American Indians Resolution #TUL-05-101 (November 4, 2005, Annual Convention) in support of adopting standardized sexual assault policies and protocols within Indian Health Service, Health and Human Service has made no movement toward adopting or improving service for victims of sexual assault.

The health and Human Rights of all Native women throughout the United States continues to be denied and perpetrated by the federal government. This Roundtable report brings forth the voices of Native women both victims and advocates that are demanding change.

Charon Asetoyer
Executive Director
Native American Women's Health Education
Resource Center





PARTICIPANT LIST

Desireé Allen-Cruz

Nez Perce, Umatilla, Walla Walla, Cayuse
Confederated Tribes of the Umatilla
Domestic Violence Services Coordinator
Pendleton, OR

“The oppression against women, especially Native women, has been long standing since the coming of the non-indigenous folks. Finding that balance within our tribal community, both male and female, is necessary to address as individuals, as families, as communities and from the systems that serve our people.”

Caroline Antone

Tohono O’ dham
I:MIG, LLC.
Sells, AZ

“We need to learn how to work with wounded children. These are not ordinary children, they are special. They are survivors, like us. There wasn’t anything for us. But we can be there for them. I never thought of myself as an advocate and I never will, but I just want this to stop for the children.”

Charon Asetoyer

Comanche Nation
*Native American Women’s Health Education
Resource Center*
Founder & Executive Director
Lake Andes, SD

“We see so many young women who are victims of sexual assault and are pregnant. The worse case scenario for most of them happened. They were assaulted, got pregnant, didn’t know how to prevent pregnancy, and they are being forced into having a child.”

Deb Blossom

Shoshone-Pauite Tribes
Tribal Coalition, STOP
Woman’s Advocate Coordinator-Director
Owyhee, NV

“I am so happy and honored to be among such wonderful women. I was telling some of the ladies, this is a good time to be here. I think all of us come from different issues in our own community, if not within our own family, and when you get around these women, it’s so empowering to be around all that strength and power that we have.”

Lisa Brunner

White Earth Ojibwe Nation
E.D. Community Resource Alliance
Detroit Lakes, MN

“I look forward to collectively standing together in solidarity. I know that it’s gonna take this further, it’s gonna go back to the National Congress of American Indians, and I know there’s much work to do on that political level, and I’ll do all that I can to help, and I look forward to it.”

Katrina Cantrell

Shoshone
Feminist Women’s Health Center
Director
Round Mountain, California

“When you’re just at a weakened state, and to have what it takes to forge through all this when you’re already depleted, that just puts an additional layer... it makes it worse, to have to fight for it.”

Bonnie Clairmont

Ho Chunk Nation
Tribal Law & Policy Institute
Victim Advocacy Program Specialist
St. Paul, MN

“I am a mother, a grandmother, and hopefully not too soon a great-grandmother. I have two biological children and many, many adopted children, so I have a lot of grandchildren and nieces and so forth. I’m very concerned about this issue.”

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Emily Flute

Lower Brule Sioux Tribe
Family Circle Crisis Shelter
Administrative Director
Lower Brule, SD

"We had a young girl who didn't tell, probably 'cause her grandfather told her not to, she had been sexually assaulted by him. In the meantime she had gotten pregnant. I think if we had something like this Plan B®, we would have been able to...but now it's too late, and she's gonna have to deal with it for the rest of her life."

Lorena Halwood, Navajo
Home for Women & Children
Ajoubu Sexual Assault Services
Shiprock, NM

"I think about networking, collaborating with the youth and the elders. That collaboration between everybody."

Eileen Hudon
White Earth Ojibwe Nation
Advocate/Activist
Welch, MN

"We have a really backwards system in this United States about addressing juvenile victims of sexual violence, male or female. That's a door that gets opened broadly when you look at sexual violence and Plan B® and Native American communities."

Georgia Little Shield
Standing Rock Sioux Tribe
Pretty Bird Woman House
Director
McLaughlin, SD

"There's a lot of things we've heard, I know the advocates have heard, a lot of things we see—things to be changed. I'm glad to be invited."

Corrine Sanchez
Tewa, San Ildefonso Pueblo
Tewa Women United
VOICES Program Manager
Santa Cruz, NM

"I am so grateful to learn every day from the women and children and men that I work with, to strengthen our families and create that vision we want in our communities, to have strong and powerful children, to create the wellness that we want and to have our voices heard."

Julie Watts, Sisseton-Wahpeton Sioux Tribe
Women's Circle
Director
Sisseton, SD

"This discussion has been a positive reinforcement of being a woman and working together toward change. I feel sometimes in our busy lives we don't always get the support we need for critical thinking and developing strategies."

Tammy Young
Tlingit
Alaska Native Women's Coalition
Sitka, AK

"It's so important to me that Alaska Native women's voices are heard. I take that as an honor and responsibility, so I thank you for this opportunity to express what I might be able to offer to help, it's an honor to be here."

Mia Luluquisen
Ilokano/Heiltsuk
Native American Community Board
Native American Women's Health
Education Resource Center
Oakland, California

"What these reports do is share the voices of what you said, the women whose voices are not usually listened to and brought into policymakers. Maybe changes can take place. With the support of women from around the country and among the different nations, your stories could be brought together and shared with the rest of the world."

Intern: Natalie Millis - Native American Women's Health Education Resource Center - Denver, CO



BACKGROUND: EMERGENCY CONTRACEPTION, PLAN B®, & NATIVE AMERICAN/ALASKA NATIVE WOMEN'S HEALTH

This report is the result of a Roundtable discussion held by the Native American Women's Health Education Resource Center in Vermillion, South Dakota on October 3rd and 4th, 2008. Native American women who have worked in women's health, directors of health centers, and advocates came together to form this Roundtable and to discuss the findings and impact within our communities of the Resource Center's study *A Survey of the Availability of Plan B® and Emergency Contraceptives Within Indian Health Service* published in January 2008, which found a widespread lack of emergency contraceptives and Plan B® available for over-the-counter and emergency room use within Indian Health Services.

Emergency contraception (EC), or the "morning after pill," is a back-up method to reduce the chance of pregnancy after an act of unprotected sex or contraceptive failure. There are two basic types of EC. The first method of EC, which came to be called the Yuzpe regimen, was developed by hospitals in the 1960s for victims of rape.¹ The original Yuzpe regimen directed women to take a series of "off-label" high doses of birth control or estrogen pills for up to five days.² This regimen has largely been discontinued in favor of newer medication due to its comparatively lower efficacy, need for close medical supervision, and high incidence of side effects including severe nausea and vomiting.³

Plan B® is an alternative to the Yuzpe regimen that was developed specifically for use as an EC. It was approved by the federal Food and Drug Administration (FDA) in 1999 and is packaged as two 0.75 mg doses of levonorgestrel to be taken 12 hours apart.⁴ If started within 24 hours of unprotected sex, Plan B® reduces the chance of getting pregnant by approximately 95%. If taken 72 hours after exposure, 75% of pregnancies are prevented.⁵ Side effects include nausea and headache but are minimal compared to the Yuzpe regimen.⁶ Though Plan B® is a superior form of

EC, off-label use of birth control pills is still prescribed in some IHS facilities that do not carry Plan B®.

Both methods of EC work the same way by preventing ovulation, thickening cervical mucus to prevent sperm from reaching the egg, or changing the lining of the uterus to prevent implantation of a fertilized egg. EC *does not* induce abortion if the woman is already pregnant.⁷ A 2006 ruling by the federal Food and Drug Administration made Plan B® available over-the-counter (OTC) for adult women and available with a prescription for women under 18. The over-the-counter status of Plan B® means that it is safe to self-administer without a pregnancy test, doctor's prescription, or pharmacist's permission.⁸

The Indian Health Service (IHS) clinical manual states that "*all FDA-approved contraceptive devices should be available*" to its patients.⁹ However, despite the fact that Plan B® has been FDA-approved for nearly a decade and ruled safe for over-the-counter use since 2006, the Resource Center's January 2008 study *A Survey of the Availability of Plan B® and Emergency Contraceptives Within Indian Health Service* shows that EC and Plan B® are still not adequately available at Indian Health Service facilities.¹⁰ To date, a mere 10% of surveyed IHS pharmacies have Plan B® available OTC. Plan B® was not available—even with a prescription—at 50% of the pharmacies in the study. At 37.5% of these pharmacies, the older Yuzpe regimen was offered instead; the remaining 12.5% of IHS facilities still had no form of EC available at all.¹¹

Adult women, who should be able to access Plan B® over-the-counter, are still required by most IHS facilities to first obtain a prescription contingent on a negative pregnancy test before they will be given Plan B®.

Because IHS refuses to ensure that EC and Plan B® are uniformly available in all IHS facilities and contract health providers, and because IHS has still failed to

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implement standardized sexual assault policies, Native women are being denied access to EC/Plan B® when they ask for it over-the-counter at pharmacies and when it is needed in emergency rooms.

Even more alarmingly, the Roundtable discussion revealed that the sparse availability of EC/Plan B® within IHS is only one of many reasons why access is obstructed to Native women. Of great concern to the Roundtable participants are the state and federal health policies that deny Native women their right to receive the same level of care that other women in the United States receive. These policies continue to be dictated by conservative religious politics, rather than what is best for the patient.

Such policies are exemplified by the proliferation of so-called “conscience clauses” in both state and federal law. These laws are intended to protect medical providers such as doctors or pharmacists from being disciplined if they refuse to provide services or medications they find morally objectionable.¹² In cases of refusal, providers are supposed to refer woman who have been refused the prescription or service to another practitioner.¹³

In reality, not only is compliance with the mandate to refer services that have been refused to another practitioner impossible to measure, the majority of Indian reservations and Alaska Native villages are remote and thus do not have any alternate public or private providers in the area. It is also unclear if IHS would cover the cost of referring a woman to a provider outside of the IHS system.

A conscience clause defining abortion as “any of the various procedures—including the prescription and administration of any drug or the performance of any procedure or other action—that results in the termination of the life of a human being in utero between conception and natural birth, *whether before or after implantation*” is due to be implemented in December 2008 by the Department of Health and Human Services, which is the department that oversees IHS funding and operation.¹⁴

.....
“These policies will pertain across the board to all Health and Human Service-funded programs, so it will be easy for Jane Doe pharmacist in Lake Andes pharmacy-not even just in IHS-to override a physician’s prescription because of their moral or religious beliefs. So now maybe they can do it because they don’t like the color of your skin. That is a civil rights issue. What they’ve been wanting to do for years is to knock out civil rights laws. So now this is another way that they’re chipping them away.”
– Charon Asetoyer
.....

Adopting this clause will write into policy what the IHS has already been unofficially practicing for years: the consistent denial of comprehensive access to emergency contraception and reproductive health services for Native women. The resulting ease with which this conscience clause will allow a practitioner to impose his/her personal biases on the already limited choices of Native women is a dangerous and paternalistic step backward.

The Indian Health Service continues to fail its stated mission “to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.”¹⁵ by denying Native women over-the-counter access to Plan B® and not adopting standardized sexual assault policies and protocols in IHS emergency rooms.

By being forced to take many additional steps to obtain EC/Plan B® if and when they want it, Native women are being treated differently than all other women in the country. It is a violation of the Human Rights of Native women to provide them with a lesser standard of health care than other women. The ongoing indifference of IHS to these issues is another condescending dismissal of Native women’s self-determination in the long history of such behavior by IHS staff and administration.

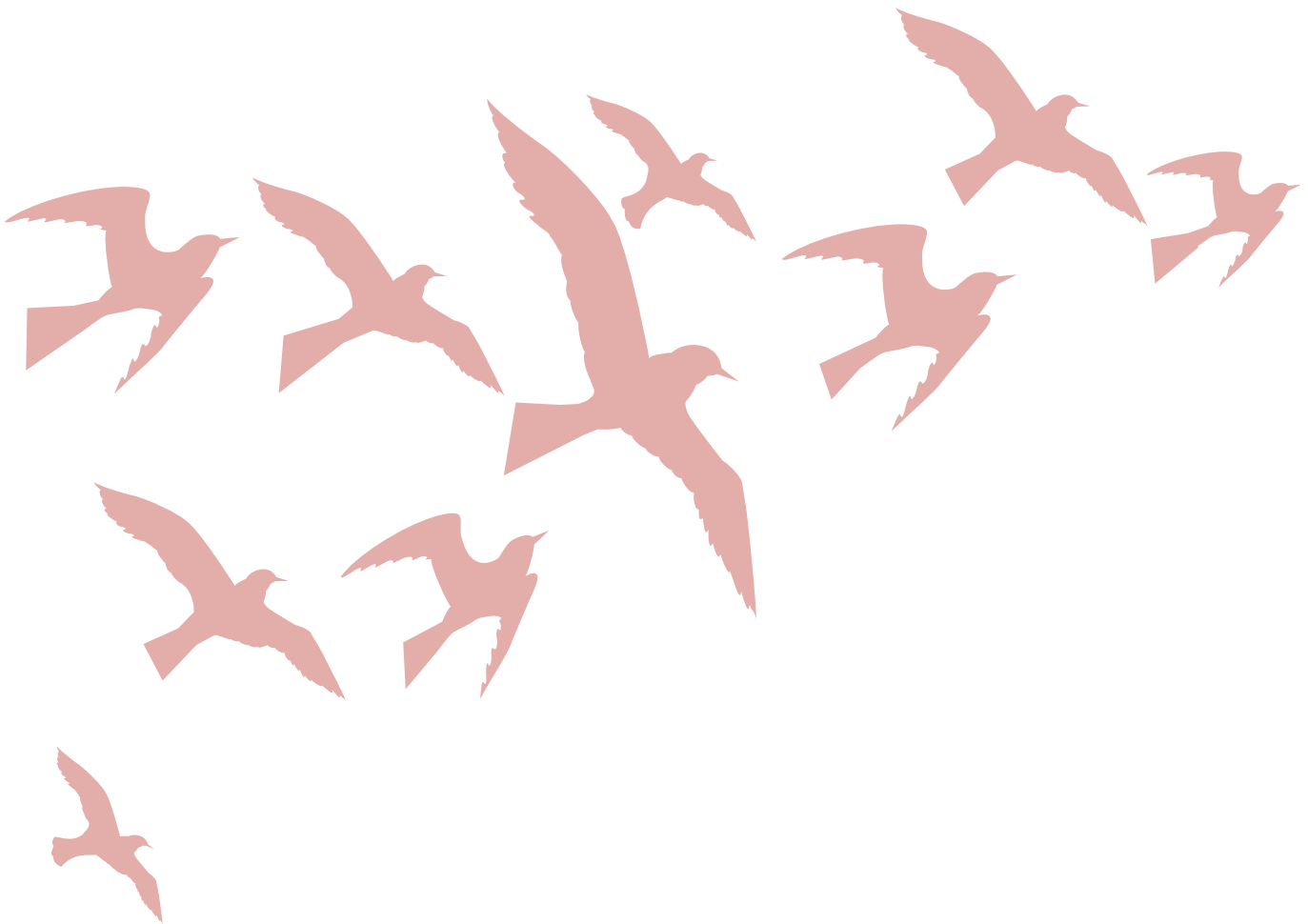


PURPOSE OF THE ROUNDTABLE REPORT

Access to quality healthcare is a legal right in accordance with treaties issued by the U.S. Government in exchange for land seized from Native American and Alaska Natives in North America. The Indian Health Service, as the agency established to carry out these treaty obligations, must live up to its responsibility. This Roundtable met because IHS is not fulfilling its obligations; Native women still do not have uniform access to Plan B® over-the-counter in IHS pharmacies or EC in IHS emergency rooms. Access to these medications is needed to reduce the additional trauma of an unintended pregnancy or possible abortion stemming from unprotected sex, failed contraception, or sexual assault.

The Roundtable discussion found that over-the-counter access to Plan B® and EC in emergency rooms is restricted for Native women by many interlinked boundaries rooted in institutional attitudes, race, class, and geography. The Roundtable participants defined these barriers and present them here to policymakers, IHS personnel, funders, tribal leaders, advocates, and community members, along with suggested actions and solutions so that:

Native women *shall* have access to Plan B® over-the-counter and emergency contraception as needed in a timely and confidential manner in all IHS facilities.



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BARRIERS TO ACCESS OF EC/PLAN B®

The following section is an outline of barriers identified by the Roundtable participants to clearly describe the numerous and complex ways that timely access to EC/Plan B® is obstructed in Indian Country. These barriers are examined at three major levels: institutional, community, and personal. Institutional barriers are those systems, policies, procedures, and protocols based on legislation, laws and administrative policies that have been put in place by IHS, federal, and local governments. Community level barriers are environmental, social, political and economic situations that affect a Native American woman's ability to access EC/Plan B®. Personal barriers are those conditions within a woman's life, including physical, emotional and spiritual situations. A distinction is made between barriers faced by all women, minors under the age of 18, and other vulnerable groups including those that have experienced sexual assault.

.....
"It's still a process. You have to go in, open up a file, get all your paperwork in. You still have to go through their whole process; it's not like going to Walgreen's. But if you go into any clinic we run there's this whole process.... They won't see you unless you have a file, they want a number, tests, want to pull the file and give you the drug."
-Corrine Sanchez
.....

1. Institutional-Level Barriers

A.) Barriers for all Native women:

- Not all Indian Health Service facilities carry EC/Plan B®
- Native women are being denied Plan B® over-the-counter
- Providers using the conscience clause/withholding referral information: the vague definition of "morally objectionable" used in these conscience clauses¹⁶ could potentially allow a medical provider to not only refuse

to perform services found to be morally objectionable, but to refuse to assist a *person* whom she/he finds morally objectionable. Additionally, there is no mechanism to ensure that providers who refuse services to a patient are actually referring that person to an alternate provider. These two conditions easily allow for services to be completely refused based on a provider's "moral objection" to women of a certain race, class, sexual orientation, immigration status, etc.

- IHS bureaucracy and waiting times:
 - Limited urgent-care services; difficult to get same-day appointment
 - A required medical visit—including travel time—may take the whole day
 - The amount of time needed for an IHS visit means that problems arise from missing a work-day and/or finding childcare

.....
"You go to a triage, pick a number, wait a few hours for them to call you in, wait two more hours to see the doctor, then go over to the pharmacy and wait another hour for them to fill it, and it's not a process that is in any way easy access for us as Indian people and is in total violation of those rights to have accessibility to EC in an efficient and confidential manner. Even if it's a non-emergency...it takes the whole day." – Corrine Sanchez
.....

- Lack of access to health services for Native American/Alaska Natives in urban areas or outside of their reservation/village jurisdiction
- Lack of standardized policies and protocols that would provide continuity and consistency in service



.....

“[IHS directors] say, we don’t have to answer to the tribes, we’re in those communities, we provide those services, but we don’t have to answer to the tribes because we are federal. It’s federal law that gives them access to the community, and our tribes still have to negotiate Indian Health Service and the inconsistent policies and practices throughout all the providers.” – Eileen Hudon

.....

B.) Barriers for women under 17:

.....

“In the Violence Against Women Act, the definition of a minor-we worked on that, you know, for a long time, to figure out across the nation who are our minors? 12 and up. I mean, that’s in federal law.” – Tammy Young

.....

- Legal “age of consent” for sexual activity in some states conflicts with the legal age to obtain Plan B® without a prescription as states define “minors” differently
- Minors have lack of access to information about EC/Plan B®
- Minors require parental consent for obtaining prescription for EC/Plan B®
- Lack of transportation to IHS facilities
- Shortage of IHS doctors to provide prescription in a timely manner

C.) Barriers for adult female victims of sexual assault:

.....

“Following sexual assault a woman may be in a weakened state...having to forge your way through bureaucracy and bias puts an additional layer of assault on the woman. Emergency contraception is not something a woman should have to fight for. This battle has already been waged and won...now it’s time to make true access to this option a reality!” – Katrina Cantrell

.....

- Women who have been sexually assaulted may not be provided with information about EC/Plan B® that could reduce the additional trauma of unwanted pregnancy
- Sexual assaults are not always reported
- Sexual assault victim may be mistaken for domestic violence victim and not provided with information about EC/Plan B®
- Women may not seek immediate medical treatment
- Provider insensitivity and bias
- Legal bureaucracy: federal, state, and tribal conflicts over reporting, protocols, jurisdiction

.....

“Our IHS is not an emergency clinic; you have to go in and have an appointment and those types of things in order to get the Plan B®. If women were to utilize the emergency rooms within the counties, White Earth Indian Health Service won’t pay for it if you’re an enrolled member. You first have to go through the system, apply for Minnesota Healthcare, General Assistance, and only if you get turned down for those services, only then will they think about paying for that emergency service, otherwise you’re billed for it.” – Lisa Brunner

.....

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.....
“There was a misinterpretation of the barriers that the community is facing in reference to responding to the young women that have been raped. There is a confusion, a lack of competence from the outside provider, and a lack of respect for that community and understanding what they could do to overcome that barrier. And I think it’s ongoing even to this day.” – Deb Blossom
.....

D.) Barriers for minors who have experienced sexual assault:

- Fear of adults
- Fear of retaliation from perpetrator
- Family member may work at IHS-lack of confidentiality
- Victim blaming from law enforcement and/or medical providers
- Parental presence/consent required at IHS. What if parent is the perpetrator?
- Lack of cultural competency and negative attitudes from law enforcement, teachers, and medical/pharmacy workers

.....
“I know that within our IHS, if they’re minors they have to have the parent there with them at the visit. What if you don’t want the parents to know or the parents themselves are the perpetrators? How do they get into Indian Health Service to get a doctor’s prescription?” – Lisa Brunner
.....

E.) Other vulnerable groups of women:

These are populations identified by the Roundtable participants as having high risk of sexual assault and/or profound difficulty accessing EC/Plan B® thereafter:

- Women who are under the influence of drugs or alcohol
- Women who are incapacitated mentally, emotionally, or physically
- Women in violent relationships
- Elderly women abused while under the care of nursing home/hospital staff or family members
- Homeless, runaway, and trafficked women
- Incarcerated women:
 - Women who have been raped while intoxicated and put in detox without access to medical care
 - Lack of legal representation
 - Guards that perpetrate sex crimes against inmates

.....
“We had a woman who was severely raped, thrown into a local detox center, was assaulted again in the center, groped or whatever by other inmates. She kept saying she needed to see a doctor ‘cause she was in pain, she was bleeding, but they kept her for the weekend without any medical attention, without calling anyone.” – Bonnie Clairmont
.....

2. Community-Level Barriers

A.) Barriers for all Native women:

- Lack of awareness that EC/Plan B® option exists
- Confusion about difference between EC/Plan B® & RU-486 (abortion pill)
- Propaganda disseminated by conservative religious groups in the community
- Internal family abuse



- Belief and value systems
- Fear and reality of non-confidentiality, teasing, and gossip
- Outside providers misinterpret community barriers and problems
- European influence on men’s/women’s roles and responsibilities:
 - Patriarchy in treatment and attitude towards Native women
 - Women are often ostracized for being assertive
 - Sexual objectification of women

- Community and cultural pressure to behave a certain way

.....

“There’s pressure on some young women who think, ‘I can’t prevent my pregnancy’ or ‘I can’t get an abortion because of what my family will think.’ There’s that community/culture pressure around how we value children. It used to be that we held our children as sacred. Now if you hold our children sacred and choose this path of not wanting to have this pregnancy or get pregnant, then you’re looked down upon.” – Corrine Sanchez

.....

D.) Barriers for minors who have experienced sexual assault:

- Disclosing rape or incest to get EC/Plan B® can have horrific consequences: violation of confidentiality, division of family, rejection from community
- Fear of retaliation from perpetrator
- Victim blaming

.....

“A lot of the young women I work with, it’s one of the primary reasons they go to the emergency room, so they can get the morning-after pill. It’s even more important to them than having an exam or making a report. They are terrified of being pregnant. Of course, if someone chooses to, that’s alright too, but it angers me that there are some young women who can just go to the hospital and get it, it’s right there, they don’t have to drive 100 miles, try to figure it out, in addition to grappling with this horrible thing, you know, they can just go get the Plan B® without judgment. And just because our girls are Indian, just because of their age, just because someone says it’s abortion, they have to grapple with all of this too.” – Bonnie Clairmont

.....

.....

“We talk about traditional cultural values and beliefs. Those beliefs have been distorted. When we talk to our community, what are your old time, traditional values and beliefs? A lot of ‘em are gonna go back to boarding school, but not beyond.” – Desireé Allen-Cruz

.....

B.) Barriers for women under 17:

- Fear of disclosing voluntary sexual activity in order to get EC/Plan B®
- Fear of getting into trouble with the law
- Society/provider attitudes
- Fear of parental reaction

C.) Barriers for adult female victims of sexual assault:

- Attitude of normality towards violence in the community
- Attitude that “it’s not my problem”

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3. Personal-Level Barriers

A.) Barriers for all Native women:

- Distance to IHS facility/pharmacy in extremely rural areas
- Lack of knowledge about EC/Plan B®
- Cost and ability to pay-if women choose to or must go to facility other than IHS, cost of Plan B® can be prohibitive (\$35-\$60)
- Pharmacies may not honor Medicaid
- Commercial pharmacies in rural areas may not carry Plan B®; need for additional travel
- Fear of retribution by partner or family member

.....
“There’s another barrier that battered women talked about in the support group. Their abusive partners monitor their menstrual cycles, and if they had used emergency contraceptives in the past, monitoring them so they cannot use it in the future. There’s that threat of violence if you do use it.” – Eileen Hudon
.....

B.) Barriers for women under 17:

.....
“A barrier to young women in our area is fear of adults; a lot of community members work at IHS, so they wouldn’t go there to get it because of lack of confidentiality.” – Corrine Sanchez
.....

- Lack of financial resources and transportation
- Parental consent, values and attitudes of parent or guardian
- Personal ability/comfort to disclose sexual activity

.....
“With the age of consent, I’ve seen situations where she’s of age and is consenting to having this sexual contact yet is afraid of being pregnant. People might not understand that age of consent and might think it was sexual assault, and therefore might compromise her confidentiality to get Plan B®.” -Bonnie Clairmont
.....

C.) Barriers for sexual assault victims:

- Shame, denial, unwillingness to seek medical care

.....
“Back when I was working judicial, one of the girls that told, they didn’t say anything to her, they just split her family apart and the mother and brothers hated her for splitting the family apart. She kept trying to commit suicide, and she kept repeating, I should never have told.” – Caroline Antone
.....

D.) Barriers for other vulnerable women:

- Lack of advocacy services provided to vulnerable women
- Incarcerated women may have fear of retaliation
- Incapacitated women may not have ability to communicate

.....
“I think that whether it’s a one-time situation or 100 times over their life, women that are intoxicated and incapacitated are subjected to added layers of oppression that they sometimes don’t even realize is happening to them.” – Tammy Young
.....



SUMMARY

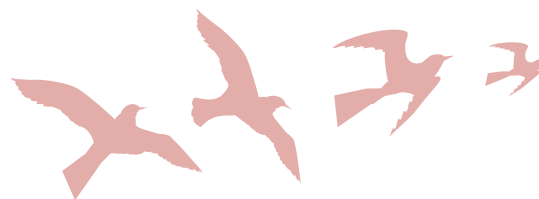
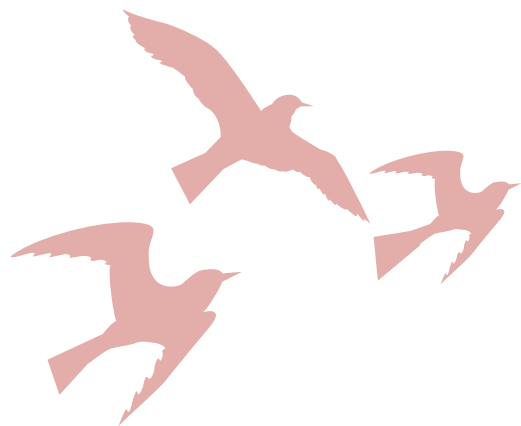
Roundtable participants shared numerous barriers that Native American women face to obtain EC/Plan B®. The Roundtable participants felt very strongly that Plan B® must be made accessible at all IHS facilities without a prescription and EC must be available in all emergency rooms. Over-the-counter availability of Plan B® allows for it to be distributed quickly and with a minimum of inconvenience for the woman and her medical practitioners. Furthermore, quick access to Plan B® is especially critical for women who use IHS for their primary health care. According to the Justice Department, Native women experience sexual violence at a rate that is 3.5 times higher than the national average.¹⁷ Teen pregnancy is also widespread: 42% of Native American and Alaska Native mothers reported having their first child before age 20.¹⁸ It is important that these women be able to access EC/Plan B® after unprotected sex or a sexual assault to reduce the additional trauma that results from an unwanted pregnancy or the decision to have an abortion.

The additional difficulty that women under the age of 18 have accessing EC is a critical problem. The FDA’s unprecedented¹⁹ decision to make Plan B® prescription-only for patients age 17 and younger came despite an internal FDA review stating that “the benefits of timely access outweighed any risk for all women, including adolescents.”²⁰ This age restriction is unrealistic because the majority of women in this country are sexually active

before the age of 18;²¹ almost 2/3 of Native women have reported having sexual intercourse by 12th grade.²² These young women experience rates of sexual assault that are 3.5 times higher than white women of the same age²¹ and rates of teen pregnancy that are more than twice the national average.²³

The Roundtable participants overwhelmingly felt that timely access to Plan B® is being denied to a large population of young women who may need it most urgently of all—because they have no alternative but to face the limited hours and long waiting times at IHS clinics to see a physician to first get a prescription. The utmost importance of timely access to EC/Plan B® cannot be overstated: the efficacy of emergency contraceptives falls exponentially in proportion to the amount of time elapsed since the unprotected sex occurred.²⁴

.....
“So you know what is the quandary with the accountability from Indian Health Service? If we can’t hold them accountable, who suffers? It’s like a catch-22. How do we hold their feet to the fire when we are being continually victimized?” – Tammy Young
.....



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ACTIONS & SOLUTIONS

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“So here are the things I’m hearing that you want for minors and adults that are victimized by sexual assault, to address the needs of these two groups - all providers will offer Plan B® and emergency contraception information packets to sexual assault victims; there would be available funding or a plan to get funding for emergency contraception. And, all minors in boarding schools will be able to get consent. Racism will not interfere with highest quality of services, and there will be no conscience clause policy or practices. These are the things that you want to make sure happen. Now the question is, what’s it going to take for these things to happen?” – Mia Luluquisen
.....

Access to quality healthcare for Native people is a Human Right as defined in section 21.1 of the United Nations Declaration on the Rights of Indigenous Peoples.²⁵ In particular, special attention must be paid to the needs of Native women, as stated in section 21.2 of the Declaration. To honor the rights of Native women, it is imperative that the barriers to access of EC/Plan B® be immediately addressed by the institutions charged with providing their medical care. Institutional changes must be brought about by Health and Human Services (HHS) policy, the legislation that regulates IHS funding and operations, and directly from the IHS Administration and Service Units themselves.

Roundtable participants made a series of recommendations regarding what needs to be done at the legislative, legal, policy and community levels. These overall actions are necessary to ensure access to EC/Plan B®. The communities receiving this care must also work to educate themselves about EC/Plan B®. Community changes will be most effectively accomplished through the grassroots efforts of family members, advocates, tribal and community leaders, and community agencies, with the strategies and goals listed below.

.....
“Our human right to exist in a healthy way is the responsibility of an individual, but also of the community and the systems at large that exist for us.” – Corrine Sanchez
.....

Section 1. Legislative/Health and Human Services actions to be taken:

.....
“[IHS funding] is also being diverted to contract health. We’re spending these huge dollars on contract services and we’re losing the services within our facilities. I mean, how feasible is it to close down our emergency room and send them to another emergency room that’s going to charge twice as much? ...So many services have been contracted out, and if you look at D.C. and all the lobbying going on for these healthcare contract dollars by these community hospitals, we are keeping some of those hospitals alive with our funding at the discretion of losing our services at the local level. So that whole piece needs to be examined.” – Charon Asetoyer
.....

- Congress will pass the Indian Health Care Reauthorization Act with full funding for all service including women’s health programs
- The secretary of HHS will ensure that standardized sexual assault policies and protocols be developed and implemented at every IHS service unit; legislation will also mandate this if HHS secretary fails to do so. See the Appendix section of this report for a standard policy
- HHS directives and legislation will ensure that Plan B® is available over-the-counter, as per FDA ruling, at every IHS facility
- Plan B® will be added to the National Core Drug Formulary
- HHS will direct IHS facilities to enter into contract healthcare services with non-religiously affiliated medical providers when possible



- If IHS must enter into contract healthcare services with religiously-affiliated medical providers, the contract will stipulate that patients referred from IHS will be exempt from the religious restrictions of those providers
- HHS will immediately eliminate the conscience clause from its policies

.....
“They are writing these regulations so IHS will have to operate under those conditions. We’re being treated differently than all other women. It’s very racist. Senator Johnson’s office is saying, ‘well, it’s not racist, Charon, the military has it!’ Because they’re trying to implement these restrictions uniformly within all federal agencies... and I said, excuse me, the difference is that you chose to join the military and comply with all the rules and regulations. I didn’t choose to be Indian, it’s inherent. I am Indian; I don’t have a choice. Therefore things like the Vitter Amendment are race-based.” – Charon Asetoyer

Section 2. Administrative actions to be taken:

.....
“This should be a big deal for the Indian Health Service. It’s our constitutional right to access it, and this is infringing our rights, and not only that, but these are trust services! We trust them to take care of us, and so they have to take care of us. They have to. There’s no getting around that! We could look at other alternative services, insurance and other stuff, but IHS has the legal responsibility. They have to do it. And we have to hold them accountable. We need to push our leaders, the legislators through the state, and we have to push everybody in the Indian Health Service because they have this trust and responsibility and they have to do it, regardless of whether they want to.” – Emily Flute

- A directive must be issued from the secretary of Health and Human Services to the IHS director to immediately:

- Establish and implement a policy and protocol for the provision of Plan B® OTC in accordance with the FDA ruling
- Rescind any conscience clauses from the policies of all IHS facilities
- Establish a funded culturally applicable and relevant EC training program
- Ensure that uniform policies and protocols for sexual assault are implemented and adopted by all IHS facilities and contracted providers
- Ensure that racism and sexism, especially victim blaming, will *not* occur from the staff and thus interfere with the highest quality of services

.....
“The re-victimization, think about the feds coming in and interviewing a woman of 15, asking ‘what did you do to provoke it?’ And I know that it happens, I’ve heard it. Asking her, ‘Well were you drunk?’ ” – Deb Blossom

- All service providers in Indian Country will give adequate care to victims of sexual assault:
 - All emergency/urgent care intake nurses will inform all women who have been assaulted about the option of EC/Plan B®, and will have Plan B® stocked for on-demand use
 - Plan B® will be in stock for immediate and future use in all school clinics, including government-funded Indian schools
 - All primary care providers, including pharmacists and first responders, will be educated about EC/Plan B® so they can provide information
 - First responders and law enforcement officers will be subject to ongoing education and documentation of abuse

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.....
"I would like a little bit of our authority in this. I get it at home, and I talk to law enforcement officers, and they say, 'well, you don't know that's gonna happen.' I say, yes I do, this is my work, and I'm not an expert, but I'm in this tribe and I know more than you." – Emily Flute
.....

Section 3. Community-level actions to be taken:

In partnership with tribal and local governmental agencies, community organizations and service agencies, especially those that advocate for victims of sexual assault, need to develop plans of action on how to educate the local community about the use of EC with emphasis on Plan B®. This process is important, because EC/Plan B® advocacy and education efforts that are rooted in community-specific knowledge will strengthen community ownership so that tribal government will respect the self-determination of Native women.

.....
"I was talking to women in the community about what would help and they said, 'educate us and we will educate our daughters. Everyone has their own large family network. If you put on a training like you do for advocates, and you educate us, we're gonna reach all of our families.' If you educate community women about this, and have them determine the agenda, talking about Plan B® could be a kind of rally. We've been talking community education around sexual assault for a long time; our women want that information." – Eileen Hudon
.....

Goals for community organization/network/centers:

- Provide information and support to women who have been sexually assaulted, as well as any woman who wants Plan B®
- Emphasize values and beliefs that honor both men and women

- Inform tribal leadership so that they will actively support EC/Plan B®
- Elders will be knowledgeable and supportive of women's reproductive rights
- All Native American women, especially youth, are informed of EC/Plan B®

.....
"Our health boards should be doing a lot more. They should be actively supporting and ensuring that women have access to reproductive rights and services."
– Emily Flute
.....

- Community health boards should be mobilized in order to:
 - Actively support EC/Plan B® with mandates and resolutions
 - Pressure the local IHS director to adopt acceptable Plan B® policy
 - Ensure that local providers such as school nurses are aware of EC/Plan B®
 - Demand that administrations of residential schools provide information and consent for Plan B® use
 - Make community resources and/or revenues available for women who need EC/Plan B®

.....
"If we talk about victim service providers, we should be asking that they create a plan to have resources available for victims. Undesignated monies or other ways of making Plan B® available for the victim right through the victim advocacy program. If they can't make Plan B® available at their victim advocacy program, they should have a plan in place to get gift cards or some form of funding that can be used directly for women, no strings attached. A plan B for Plan B®." – Eileen Hudon
.....



National campaign for awareness and access to EC/Plan B®:

- Educate all tribal communities and Alaska Native villages
- Involve National Congress of American Indians, other national Native organizations
- Target office of Health and Human Services: utilize civil rights laws
- Organize awareness and protests against the conscience clause

.....
“Truly, this knowledge is a gift to the community. Information is power. This is how we change things, through knowledge and clarification. Let’s get accurate information to women so they can make an informed consent and decision.” – Charon Asetoyer

As part of community education efforts, the Resource Center is providing a customizable template of easy-to-understand information that can be edited by each local tribe/Native village so that local knowledge and resources can be incorporated. The template includes an introduction endorsed by the women of the Roundtable, the Native American Women’s Health Education Resource Center, and other organizations. The information in the template will ensure that:

- EC/Plan B® is explained-what it is/isn’t, what your rights are
- All locations within the community that carry EC/Plan B® are listed, including IHS and other local clinics/pharmacies/organizations

.....
“Well the template can be ours within every community. But maybe the brochure could have all the organizations and stuff...we’re going to have to have something solid for them to believe us. The tribal council won’t believe a woman!” - Georgia Little Shield

.....
“I talked to a Grandma about this stuff, I said, well what happened? And she said that we used to have a root for stuff like that, if they knew the birth wasn’t gonna be right or whatever. They had stuff to take care of themselves if it wasn’t gonna be healthy. So we could look at this as our right and our need to have options available. There are other options available. We have a right to them.”
 – Emily Flute

The Resource Center’s community information template could be disseminated via:

- Elders, mothers, leaders
- Nonprofit/organizations/churches, Tribal Health Programs, Community Health Representatives, and all health networks
- Advocates, HIV/domestic violence counselors, teachers, shelters for sexual assault/domestic violence/homelessness
- Internet: Organization websites, Youtube, Myspace, Bebo, etc.
- Media: video/radio/TV shows, school and community newspapers, with emphasis on youth-produced media

.....
“As grandmothers, mothers, and as community members, yes we have a traditional responsibility, but there’s also a professional responsibility. By holding the positions that we do, there is a lot of responsibility there. We need to stand up in our communities and address our Tribal Health Boards, Business and Claims Committees, the Tribal Councils, and get them to understand and to stop IHS... There is a groundswell of acknowledgement coming from tribal governments that this is a huge problem, sexual assault, and not getting the services that we want or should have access to. Whether they believe in them or not, they are realizing that this is a federal government control issue and they are not going to allow that to continue to happen. I think a lot of them don’t know what to do or don’t know how to go about it and they are looking to us. That’s why we have this

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responsibility to inform the residents of our shelters, to talk about it and educate each other and our coalition members. And to demand that we have the right to access within whatever healthcare services we are using, whether it's Indian Health Service or tribal clinics, to honor our right to decide for ourselves and to have access to things we need if

we choose to use it, like Plan B®. So all I want us to do is encourage everyone to talk about this, to educate ourselves, pass this information on to coworkers and other agencies. We just have to do it. We have to stop the silence.” – Charon Asetoyer

.....

CONCLUSION

The continuing unavailability within Indian Health Service of Plan B® over-the-counter and the lack of standardized sexual assault policies and protocols in IHS emergency rooms is a violation of the Human Rights of all Native women to control their fertility, especially in cases of sexual assault.

Additionally, the conscience clause and other policies that legitimize discrimination must be eliminated at once from all Health and Human Services policy, IHS facilities, and the medical providers that IHS utilizes for contract health services. Continuing to allow racist and negligent policy to dictate availability of critical health care services to the women for whom IHS has a legal obligation to provide medical care for is a denial of the right of Native women to be free of all forms of discrimination as stated in Article 22 of the United Nations Declaration on the Rights of Indigenous Peoples.²⁵

It is also important to consider that making Plan B® comprehensively available simply makes sense from a public health perspective. Plan B® is an extremely safe, simple, and effective way to reduce unwanted pregnancy and the possible need to have an abortion for women who have had unprotected sex, contraceptive failure, or been sexually assaulted. The FDA has made it available without a prescription so that women may access it as quickly as possible, which is crucial to its efficacy. It is therefore critical that the FDA ruling and guidelines for Plan B® to be offered over-the-counter be immediately implemented by the Indian Health Service to improve the reproductive health outcomes for Native women.

The Indian Health Service also needs to develop and implement standardized policies and protocols to better serve sexual assault victims in both IHS emergency/critical care services and the contract health facilities utilized by IHS. These policies must include counseling for EC and then providing it if the patient gives informed consent (refer to the Appendix section of this report for an example of a standard protocol). The EC offered should preferably be Plan B®, because it is safer and more effective than the off-label use of birth control pills or other older methods.

The denial of these basic medications and services to Native American and Alaska Native women who ask for them demonstrates that the racism and paternalism that have long pervaded IHS policy and practice are very much alive and well today. By making comprehensive reproductive healthcare available to Native women, the Indian Health Service has the opportunity to begin to correct its ongoing problematic attitudes and finally rise to the mission it was created to achieve: *“to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level.”*

.....

“It’s a woman’s choice. We Native women want this power back, we want this self-determination; we had these policies that were forced on us, and now I want to take the responsible approach to this and say it’s my choice now. It’s my self-determination.” – Corrine Sanchez

.....



APPENDIX: PROPOSED INDIAN HEALTH SERVICE GUIDELINES & PROTOCOLS FOR PROVISION OF REPRODUCTIVE HEALTH CARE

The purpose of this policy is to provide guidance for medical professionals in the care of women's reproductive services including timely services for survivors of sexual assault. This policy shall be adopted and enforced by the Indian Health Services headquarters (hereinafter "IHS Headquarters") and pertain to and be followed by all Indian Health Service Units and Emergency Rooms, Direct Care Facilities and Contract Health Services (hereinafter "IHS Facilities").

I. GENERAL PROVISIONS

- a. All IHS Facilities shall either provide or make referrals for reproductive health services on request. IHS shall pay for the cost of services resulting from all such services or referrals.
- b. IHS Headquarters shall establish standardized protocols for the delivery of information regarding all IHS coverage for reproductive health care services.
- c. IHS Headquarters shall establish a Sexual Assault Management Protocol and mandate that each IHS Facility post a copy of the Sexual Assault Management Protocol for attending medical staff to reference.
- d. IHS Headquarters shall establish standardized protocols mandating that all IHS Facilities provide reproductive health care in a culturally acceptable, gender-sensitive, respectful, unbiased and confidential manner.
- e. All IHS Facilities shall strictly maintain patient confidentiality.
- f. Memoranda of Understanding between IHS Headquarters and contracted facilities shall reflect and be subject to this policy.

II. CONTRACEPTIVES

- a. IHS Facilities shall inform women seeking to prevent pregnancy verbally and in writing of the full range of FDA-approved contraceptive options, including emergency contraception.
- b. IHS Facilities shall provide women with the contraceptive method of their choice, including an advance prescription for emergency contraception.

III. PREGNANCY-RELATED CARE

- a. IHS Facilities shall provide, in writing and verbally, all women who request information related to pregnancy options with the relevant information in a comprehensive, non-directive, unbiased and confidential manner. This will include information on:
 - i. Prenatal care and delivery;
 - ii. Infant care, foster care and adoption; and
 - iii. Pregnancy termination (surgical and medical).
- b. IHS Facilities shall inform women who request information about an abortion, provision of an abortion, or a referral for an abortion of the following:
 - i. IHS shall pay for an abortion where the pregnancy results from rape or incest or endangers the woman's life;
 - ii. Whether the Medicaid program in that state is required to cover abortions in additional situations (e.g., instances of fetal anomalies or medically necessary abortions);
 - iii. Whether IHS and/or Medicaid are required to cover transportation costs associated with obtaining an abortion; and
 - iv. Available support services at IHS Facilities, such as counseling and aftercare.
- c. IHS Facilities shall provide all needed assistance to access abortion services on-site or through contracted services to all women who request such assistance and whose pregnancy results from rape or incest or endangers the woman's life.
- d. IHS Facilities shall assist women who wish to seek Medicaid coverage of an abortion in enrolling in Medicaid if eligible and in obtaining a Medicaid covered abortion.

IV. SEXUAL ASSAULT SURVIVORS

- a. IHS Headquarters will establish standardized, written protocols for the delivery of information and services to sexual assault survivors in a culturally acceptable, gender-sensitive, respectful, unbiased and confidential manner for all IHS Facilities. IHS Headquarters will develop these protocols in consultation with representatives of the Native American community and national groups with expertise in assisting sexual assault survivors. These protocols should be adapted from the

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Department of Justice's National Protocol for Sexual Assault Medical Forensic Examinations (see <http://www.ncjrs.gov/pdffiles1/ovw/206554.pdf>), with the important addition that all sexual assault survivors be informed about and offered emergency contraception.

b. IHS Facilities shall develop sexual assault treatment services by working in consultation with representatives of the Native American community served by that IHS Facility and with local community groups involved in assisting sexual assault survivors (e.g., rape crisis centers, rape response teams, women's domestic violence shelters/programs).

c. IHS Facilities shall offer emergency contraception to all survivors of sexual assault and provide such contraception upon request. Providers must document this offer by having each sexual assault survivor sign a form, to be kept in her confidential patient file, acknowledging that she has been offered emergency contraception.

d. IHS Facilities shall provide screening for Sexually Transmitted Infections (STI) and Reproductive Tract Infections (RTI) and shall provide STI treatment and RTI treatment to all survivors of sexual assault.

e. IHS Facilities shall provide testing for HIV and shall inform all rape and incest survivors about PEP (Post-Exposure Prophylaxis).

f. IHS Facilities shall inform all rape and incest survivors that IHS Headquarters provides coverage for abortions where the pregnancy results from rape or incest; document the provision of this information by having each rape and incest survivor sign a form, to be kept in her confidential patient file, acknowledging that she has received this information.

V. TRAINING

IHS Facilities shall provide training to all relevant staff regarding the provision of reproductive health care and treatment for sexual assault patients, which includes the following requirements:

a. All IHS Facility service providers shall be appropriately trained to provide services in a culturally acceptable, gender-sensitive, respectful, unbiased and confidential manner. This training shall be specific to the nation/tribe being served.

b. Trainings shall be revised, updated, and re-administered to all relevant staff as any changes in delivery of services occur and as technological changes occur that would affect a sexual assault survivor or reproductive health patient.

c. Every IHS Facility shall have one Sexual Assault Nurse Examiner or Sexual Assault Forensic Examiner (SANE/SAFE) on staff and/or on-call at all times.

d. All IHS Facilities' medical staff that has occasion to treat sexual assault victims shall be familiar with medical protocol acronyms relevant to such treatment, such as SANE (Sexual Assault Nurse Examiner); SAFE (Sexual Assault Forensic Examiner); SART (Sexual Assault Response Team); Chain of Custody (Protocol followed when working with the Sexual Assault kit.); SOR (Sexual Offense Report, specific to region's hospital); SAER (Sexual Assault Exam Report) and SO/SA (Sexual Offense/Assault).

e. IHS emergency room medical professionals shall administer rape kits on-site without requiring travel or transfer to a contracted facility to perform the rape kit.

f. IHS Facilities shall include current information regarding the provision of information and delivery of reproductive health services and treatment for sexual assault survivors within a staff manual.


g. IHS Facilities shall promptly inform patients and all relevant staff when new reproductive health services or services for sexual assault survivors become available and when coverage of services changes.

h. IHS Facilities shall establish policies, procedures, and protocols for training all relevant staff regarding the provision of information and the delivery of services described under Sections II and IV above.

VI. DISSEMINATION OF INFORMATION TO PATIENTS AND I.H.S. STAFF

All IHS Facilities shall:

a. Inform all patients and relevant staff of what reproductive health services IHS Facilities provide and what reproductive health services IHS Headquarters covers (including, but not limited to abortion, emergency contraception, the full range of



FDA-approved contraceptive drugs and devices, services and treatments for survivors of sexual assault).

b. Amend the Patients' Bill of Rights to inform women of their right to obtain the full range of FDA-approved contraceptives (including emergency contraception), non-directive pregnancy options counseling, PEP and IHS coverage of abortions (surgical and medical) in certain circumstances.

c. Post the amended Patients' Bill of Rights in every IHS Facility throughout all patient waiting rooms or other areas where patients are regularly received for intake and/or provided care.

d. All policies, procedures, and protocols must be posted and accessible to medical staff in the emergency room. Emergency room medical personnel shall receive sexual assault treatment protocols upon new hire and appropriate training/understanding of protocols. Staff shall be required to review policies, procedures and protocols on a regular basis.

VII. RECORD KEEPING

IHS Facilities shall maintain and report to IHS Headquarters the following data, in a manner that maintains the confidentiality of all patient records and identifying information:

a. The number of women who came in for health services after experiencing incest, rape, or other sexual assault, how many of those women were offered emergency contraception, and how many of those women accepted emergency contraception.

b. The number of women who requested information about an abortion and the number who requested an abortion. For those women who requested an abortion, the number of women who:

- i. Received a referral for an abortion;
- ii. Had an abortion performed at an IHS Facility;
- iii. Sought an abortion because they were pregnant as a result of rape;
- iv. Sought an abortion because they were pregnant as a result of incest;
- v. Sought an abortion because continuation of the pregnancy endangered their life;
- vi. Were Medicaid-eligible and received assistance from an IHS Facility in obtaining an abortion; and
- vii. Obtained Medicaid coverage of an abortion.

c. The gender identity of each sexual assault patient.

VIII. REVIEW AND AUDIT

IHS Headquarters shall require all IHS Facilities to establish a review/audit process by which it will ensure that the protocols developed pursuant to the above items are followed at all IHS Facilities. The review/audit process should include, but not be limited to, an evaluation of whether these facilities have kept records or can provide proof to establish that:

a. Patients seeking to prevent pregnancy have received emergency contraception information/prescription;

b. Sexual assault victims have been offered counseling;

c. A sexual assault victim's advocate was contacted and whether or not she/he was present when a sexual assault patient was treated;

d. The number of sexual assaults presenting annually in the emergency room;

e. Patients have been informed that if a pregnancy resulted from a rape, IHS will provide coverage for an abortion;

f. The number of requests for abortion and/or information requests regarding abortion;

g. The number of abortions provided by an IHS Facility;

h. A SANE/SAFE is in place or on-call at every IHS Facility; and

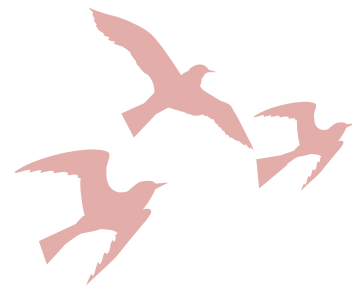
i. SANE/SAFE training is current and comprehensive and occurs on a yearly basis.



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DAKOTA ROUNDTABLE, 2009



Back row L-R:
Tammy Young, Rolene Provost, Katrina Cantrell, Charon Asetoyer, Natalie Millis, Bonnie Clairmont, Lisa Brunner, Lyn Archambeau, Georgia Little Shield, Emily Flute, Desireé Allen-Cruz, Deb Blossom

Front Row L-R:
Caroline Antone, Lorena Halwood, Eileen Hudon, Julie Watts, Colleen Fast Horse, Corrine Sanchez, Mia Luluquisen



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WORKS CITED

- 1 Weiss, D. "Emergency Contraceptives History and Access" 2008. *Planned Parenthood Action Issues*. Retrieved 9/26/08 from <http://www.plannedparenthood.org/issues-action/birth-control/emergency-contraception-6549.htm>
- 2 Yuzpe, A. et al., "Post Coital Contraception-A Pilot Study" 1974. *Journal of Reproductive Medicine* 13:53-58
- 3 Long, P. "FDA Approves Progestin-only Emergency Contraceptive" 1999. *Women's Capital Corporation Press Release*, Bellevue, WA. Retrieved 9/28/08 from <http://ec.princeton.edu/news/planbpressrelease.html>
- 4 Federal Food and Drug Administration. "Plan B (0.75mg levonorgestrel) Tablets Information" 2006. *Federal Food and Drug Administration Center for Drug Evaluation and Research*, Washington, DC. Retrieved 9/22/08 from <http://www.fda.gov/cder/drug/infopage/planB/default.htm>
- 5 "Task Force on Postovulatory Methods of Fertility Regulation" 1998. *Lancet* 352:428-33
- 6 Pruthi, S. "Morning-after pill: Emergency birth control" 2008. *Mayo health clinic*, Rochester, NY. <http://www.mayoclinic.com/health/morning-after-pill/AN00592>
- 7 IBID
- 8 Federal Food and Drug Administration. "Plan B (0.75mg levonorgestrel) Tablets Information" 2006. *Federal Food and Drug Administration Center for Drug Evaluation and Research*, Washington, DC. Retrieved 9/22/08 from <http://www.fda.gov/cder/drug/infopage/planB/default.htm>
- 9 Indian Health Service, "Indian Health Manual: Part 3, Chapter 13, section F, paragraph 2" 2007. *Indian Health Service Practitioner Resources*, Washington, DC. Retrieved 10/22/08 from <http://www.ihs.gov/PublicInfo/Publications/IHSMannual/Part3/pt3chapt13/pt3chpt13.htm>
- 10 Gattozzi, E. "A survey of the availability of Plan B and EC within IHS" January 2008. *Native American Women's Health Education Resource Center Reproductive Justice Report*, Lake Andes, SD
- 11 IBID
- 12 The Guttmacher institute, "Conscience Clause: State Policies in Brief" 2008. *Guttmacher Policy Review*, New York, NY. Retrieved 12/26/08 from http://www.guttmacher.org/statecenter/spibs/spib_EC.pdf
- 13 Fede, Jody. "The History and Effect of Abortion Conscience Clause Laws: CRS Report for Congress" 14 January 2005. *University Of Maryland Law School*, Baltimore, MD. Retrieved 11/20/08 from <http://www.law.umaryland.edu/marshall/crsreports/crsdocuments/RS2142801142005.pdf>
- 14 Web, A. "Provider conscience clause sees increased opposition" 1 December 2008. *Planned Parenthood Minnesota, North Dakota, South Dakota Action fund*, Minneapolis, MN. Retrieved 12/3/08 from http://ppsd.bluestatedigital.com/content/provider_conscience_clause_sees_increased_opposition
- 15 "Emergency Contraception Is Just That, Contraception: EC Reduces Abortion by Preventing Unintended Pregnancy" 2006. *National Family Planning and Reproductive Health Association Press Release*, Washington, DC
- 16 Gold, R.B., "Department of Health and Human Services Proposed Rule at 30: the Implications of Defining When a Women Is Pregnant" 2005. *Guttmacher Report on Public Policy* 7:7-8. Retrieved 11/14/08 from <http://www.guttmacher.org/pubs/tgr/08/2/gr080207.pdf>
- 17 U.S. Department of Justice, "Number of victimizations and victimization rates for persons age 12 and over, by type of crime and gender of victims" 2005. *U.S. Department of Justice Reports*, Washington, D.C. Retrieved 11/14/08 from http://www.ojp.gov/bjs/abstract/cvus/rape_sexual_assault190.htm
- 18 Asetoyer, C. "Indigenous Women's Reproductive Health and Rights Are Human Rights" 2005. *Presentation by the Native American Women's Health Education Resource Center at the Annual Funder's Network On Population, Reproductive Health, and Rights Meeting*. Cuernavaca, Mexico
- 19 Center For Reproductive Rights. "Access to Emergency Contraception for Minors" 16 October 2008. *Hot Topics in Reproductive Rights*, 14. New York, NY. Retrieved 11/12/08 from http://www.reproductiverights.org/pdf/hot_topics_final_for_formatting_for_public_102808.pdf
- 20 IBID
- 21 Guttmacher Institute, "Plan B Decision by FDA a Victory for Common Sense" 24 August 2006. *Guttmacher Institute News*, Washington, D.C. Retrieved 11/14/08 from <http://www.guttmacher.org/media/inthe-news/2006/08/24/index.html>
- 22 Asetoyer, C and White, J., "Teen Dating Violence In Native Communities: Dynamics And Legal Strategies." 2007. *Southwest Center For Law And Policy Articles*, Tucson, AZ. Retrieved 12/4/08 from [http://www.swclap.org/pdfs/Teen Dating Violence In Indian Country.ppt](http://www.swclap.org/pdfs/Teen%20Dating%20Violence%20In%20Indian%20Country.ppt)
- 23 U.S. Department of Justice, "Number of victimizations and victimization rates for persons age 12 and over, by type of crime and gender of victims" 2005. *U.S. Department of Justice Reports*, Washington, D.C. Retrieved 11/14/08 from http://www.ojp.gov/bjs/abstract/cvus/rape_sexual_assault190.htm
- 24 The National Campaign to Prevent Teen Pregnancy. "Fact Sheet: Teen Sexual Activity, Pregnancy, and Childbearing Among Native Americans" November 2005. *National Campaign to Prevent Teen Pregnancy: Resources*, Washington, D.C. Retrieved 11/24/08 November from <http://www.teenpregnancy.org/resources/reading/pdf/NativeAmericanFactSheet.pdf>
- 25 "United Nations Declaration on the Rights of Indigenous Peoples: Adopted by General Assembly Resolution 61/295" 13 September 2007. Report to the General Assembly on the first Session of the Human Rights Council, New York, NY. Retrieved 11/24/08 from <http://daccess-ods.un.org/access.nsf/Get?Open&DS=A/HRC/1/L.10&Lang=En>
- 26 IBID

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