



NATIVE AMERICAN WOMEN'S
HEALTH EDUCATION RESOURCE CENTER

Indigenous Women's Dialogue

ROUNDTABLE REPORT ON THE ACCESSIBILITY OF PLAN B®
AS AN OVER THE COUNTER (OTC)
WITHIN INDIAN HEALTH SERVICE

FEBRUARY 2012



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Written by Pamela Kingfisher and Charon Asetoyer, MA,

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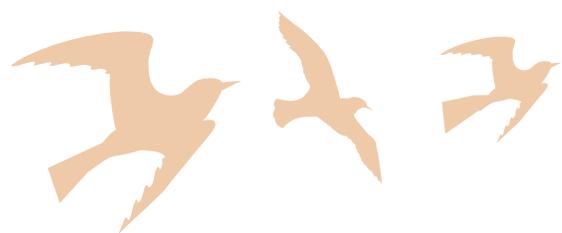
Native American Women's Health Education Resource Center
P.O. Box 572 Lake Andes, South Dakota 57356-0572
(605) 487-7072 * Fax (605)487-7964 * email charon@charles-mix.com
Website * www.nativeshop.org

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INTRODUCTION BY CHARON ASETOYER, MA

What does it mean for a Native American woman to be denied information after a sexual assault that could prevent an unwanted pregnancy; to not be informed of, or offered, Emergency Contraception and at a later date be faced with the dilemma of a pregnancy from a rape? What kind of a Government would impose such a trauma on a woman, to force her to experience such a cruel and emotional life event? For thousands of Native American women this is reality.

Although Plan B® is legal as an “over the counter” (OTC) contraceptive for women age 17 years old and up, Native American women do not have consistent access to it from our primary health care provider, the Indian Health Service. For land based (reservation) Native American women the only pharmacist on most reservations is within the local Indian Health Service. Other options would be to travel to the nearest city to a mainstream pharmacy to access Plan B®, which could be as far away as one hundred miles. Does a woman have the resources to travel that hundred miles to find a pharmacy that carries Plan B®? Does she have a car, gas money, and the \$50.00 to purchase Plan B®? Native women need far more resources than other women to access Plan B®. These barriers prevent access to Plan B® for Native American women.

Unfortunately statistics tell us that Native American women are sexually assaulted at a higher rate than all other women in the United States and receive less health care services and less “due process” after a sexual assault. This situation is unacceptable and must be resolved in order to bring some relief and equality in treatment to Native American women.

As the country debates the access to Plan B® as an OTC for women 16 years and younger, Native American women 17 years and older have yet to receive access to Plan B® as an OTC by their primary health care provider, the Indian Health Service. No one but Native American women are concerned about this denial of service. As Native American women we are the only race of women that is denied this service based on race. To make an exception to a legal form of contraception based on race is not acceptable. To deny a Native American woman access to Plan B® as an OTC when every other woman in this country can access it is a denial to a basic health care

service, which violates her human rights. It is a direct violation to her sovereign right to make decisions for her own health care, it removes her from the decision making process concerning a potential pregnancy resulting from a rape and puts that responsibility of decision in the hands of a government agency.

On a late Saturday night our office called the Sioux San Indian Health Service Emergency room in Rapid City, South Dakota to ask if they would provide Plan B® for a rape victim, the response was “no we do not, if you want it go buy it”, that response was cold, lacking compassion and judgmental. For an advocate to hear a response like that from an Indian Health Service health care provider was very offensive. This situation is not the only incident of denial of Plan B® (EC) within the Indian Health Service system.

Within this report you will hear the voices of Native American women from a diverse number of Tribes discuss their own personal experience with sexual assault either as a victim or as a service provider.

It is important to understand that the issue of access to Plan B® is not a matter to be decided by the predominately male led leadership of our communities, but is a matter of equal access to a legal contraceptive that is to be made by a woman. To use the excuse that access to Plan B® needs to be decided by Tribal leadership is extremely oppressive and is not in the best interest of Native American women. The issue of access to Plan B® has been approved for every other demographic of women in this country, so why continue to deny Native American women access. Traditionally the matters of women were left up to women to decide and not thrown into the political arena.

Taking into consideration the high rates of sexual assault among Native American females, rural isolation and lack of resources to access Plan B® we ask the current Administration to respect our rights, to let actions speak louder than words and take the necessary steps to ensure that Native American women are no longer denied Plan B® as an OTC within the Indian Health Service.

Charon Asetoyer, MA, *Executive Director*
Native American Women’s Health Education Resource Center

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PARTICIPANT LIST

Frances Abeyta

Santa Clara Pueblo
Coalition to Stop Violence
Against Native Women
Training Coordinator
Albuquerque, NM

Yvette Aguilar

Santa Domingo Pueblo
Cochiti Pueblo Special Diabetes Program
Recreation Prevention Coordinator
Pueblo De Cochiti

Bernice Armstrong

Dine
Iowa Tribe of Oklahoma
Social Services-Family Violence
Director, social worker/advocate
Perkins, OK

Charon Asetoyer

Comanche Nation
Native American Women's
Health Education Resource Center
Founder and Executive Director
Lake Andes, SD

Deanne Bear Catches

Standing Rock Sioux Tribe
Pretty Bird Women's
Domestic Violence Shelter
Board Member
McLaughlin, SD

Alyssa Chantel Begay

Dine
Albuquerque, NM

Peggy Bird

Kewa Pueblo
Chief Judge
Laguna, New Mexico

Micah Bitsinnie

Dine
First Nations Community Health Source
Community Health Worker
Albuquerque, New Mexico

Evelyn Lance Blanchard

Laguna/Yaqui
Bernalillo County-Off Reservation Native
American Health Commission Inc.
Community Advocate and Volunteer
Albuquerque, NM

Renee Brewer

Muscogee Creek Nation
Executive Director of Native
Alliance Against Violence, INC.
Oklahoma City, OK

Leslie Brown

Pawnee
Iowa Tribe of Oklahoma
Social Services Department
Crisis Intervention Specialist
Perkins, OK

Donita Buckley

Standing Rock Community Member
McLaughlin, SD

Katrina Maczen-Cantrell

Western Shoshone
The Native American Women's
Health Education Resource Center
Board of Directors, Chairperson
Lake Andes, SD

Cynthia Chavez

San Felipe Pueblo
Domestic Violence Advocate
Santa Fe, NM

Toby Chavez, LISW

Santo Domingo Pueblo
Santa Fe Indian Hospital
Behavioral Health Program
Santa Fe, NM



PARTICIPANT LIST (CONTINUED)

Carmen Ducheneaux

Cheyenne River Sioux Tribe
Sacred Heart Sexual Assault Program
Sexual Assault Advocate Coordinator
Eagle Butte, SD

Billie G. Foreman

Kiowa Tribe of Oklahoma
Wichita and Affiliated Tribes
Social Services/Domestic Violence Director
Anadarko, OK

Chasity Garcia

San Felipe, Pueblo
Coalition to Stop Violence
Against Native Women
Victim Advocate

Tammy Goodwin

Sisseton-Wahpeton Tribal Member
Women's Circle
Sisseton, SD

Linda Gouge

Absentee Shawnee Tribe of Oklahoma
Domestic Violence Dept.
Sexual Assault Advocate
Shawnee, Ok

Anna Gourneau

Crow Creek
Project Safe Administrator
Fort Thompson, SD

Donna Marie Haukaas

Sicangu Lakota Oyate
South Dakota Coalition Outreach
(SDCEDSV)
Outreach Ed. Specialist
Pierre, SD

Delight R. Heminger

Sisseton Wahpeton Oyate
Women's Circle
Outreach Prevention Coordinator
Sisseton, SD

Lisa Thompson-Heth

Lower Brule Sioux Tribe
Wiconi Wawokiya, Inc
Executive Director
Fort Thompson, SD

Brenda Hill

Siksika (Blackfeet)
South Dakota Coalition Ending Domestic
& Sexual Violence
Native Co- Director
Rapid City, SD

Ramona Horsechief

Pawnee Tribal Member
Pawnee Nation Violence Against Women Program
Administrative Assistant
Pawnee, OK

Valura Imus

Hopi
Bureau of Indian Affairs
DOI/BIA Victim Specialist
Phoenix, Arizona

Whisper C.K.

Dine
INSPIRE HIV Prevention
of First Nations Community Health Source
HIV Preventionist and Sexual Health
Advocate
Albuquerque, New Mexico

Anita Lena

Seminole Nation

Marcy Lesmeister

Cheyenne River Sioux Tribe
Sacred Heart Women's Shelter
Director

Catherine Leston, MS, LPC, CPS

Cherokee Tribal Member
Cherokee Nation W.W. Hastings
Indian Hospital
Clinician & Manager of SANE/SART Grant
Tahlequah, OK

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Summer Lunderman

Sicangu Lakota Tribe
White Buffalo Calf Women's Society
Criminal Justice Advocate

Judith Matthews

Cherokee
Oklahomans for Reproductive
Justice Co Chair, OK4RH Hotline

Cheryl McClellan

Sac and Fox Nation
Second Chief
Stroud, OK

Lyndee McClellan

Sac and Fox Nation
Stroud, OK

Dawn Muir

Pretty Bird Woman House
Executive Director
Mission, SD

Heather Napier

Seminole Nation Tribal Member
Seminole Nation Domestic Violence
Director
Wewoka, OK

Betty Otter Robe

Standing Rock Community Member
McLaughlin, SD

Kelva Peterson

Sacred Heart
Lead Advocate at Women's Shelter
Eagle Butte, SD

Minnie Plenty Chief

Standing Rock Community Member
McLaughlin, SD

Laura Pino

Santa Clara Pueblo
Santa Clara Pueblo Domestic Violence Advocate

Wanda Renville

Sisseton-Wahpeton Tribe
Women's Circle
Administrative Assistant
Sisseton, SD

Sophia Renville Brown

Sisseton- Wahpeton Tribe
Women's Circle
Shelter Manager
Sisseton, SD

Regina Begay Roanhorse

Dine
Court Administrator Navajo
Nation Judicial Branch
Canoncito, NM

Corrine Sanchez

Tewa/San Ildefonso Pueblo
Tewa Women United
Executive Director
Española, NM

Kimberly St. John

Crow Creek
Mita Maske Tiki
Director
Sioux Falls, SD

Kimberly Stevens

Absentee Shawnee Tribe of Oklahoma
Director of the Domestic Violence Program
Shawnee, OK

Heather Dawn Thompson

Cheyenne River Sioux
United States Attorney Office
Assistant United States Attorney

Maya Torralba

Kiowa, Comanche, and Wichita Tribes
Founder/Director, Anadarko
Community Esteem Project
Community Liaison,
Oklahoma Federation of Families
Anadarko, OK



Monica Vigil

Nambe Pueblo
Service Coordinator
Nambe Pueblo, NM

Julie Watts

Sisseton Wahpeton Tribe
Women's Circle, Director
Sisseton, SD

Facilitator and Report Writer

Pamela Kingfisher

Cherokee Nation
Born to the Bird Clan

Observer

Robert Doody

ACLU
Sioux Falls, SD

Presenter

Laura Ross

Consultant
Minneapolis, Minnesota

Interns

Courtney Boyd

Native American Women's Health
Education Resource Center
Intern
Lake Andes, SD

Emily Bieniek

Native American Women's Health
Education Resource Center
Intern
Lake Andes, SD

Kelly Whittier

Native American Women's Health
Education Resource Center
Intern
Lake Andes, SD

Kelly Winton

Native American Women's Health
Education Resource Center
Intern
Lake Andes, SD



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“Let us learn from each other and not be afraid to speak. Let us take the time to share with each other, and be strong because that’s what we need to do to ensure that we get our work done. What we do today has a connection with the other women doing this work and to the people in our communities.” -Peggy Bird

Did you know?

Native American Women experience sexual assault at a higher rate than all other U.S. populations.

- 34.1% or more than 1 in 3 Native American women will be raped in their lifetime.
- 92% of Native American girls who had sexual intercourse reported having been forced against their will to have sexual intercourse on a date.

Background

The Declaration on the Rights of Indigenous Peoples sets out the individual and collective rights of Indigenous Peoples, as well as their rights to culture, identity, language, employment, health, education and other issues.

It also emphasizes the rights of Indigenous Peoples to maintain and strengthen their own institutions, cultures and traditions, and to pursue their development in keeping with their own needs and aspirations. It prohibits discrimination against Indigenous Peoples, and it promotes their full and effective participation in all matters that concern them and their right to remain distinct and to pursue their own visions of economic and social development.

Taking note of the recommendation of the Human Rights Council by which the Council adopted the text of the United Nations Declaration on the Rights of Indigenous Peoples, the General Assembly formally adapted the Declaration on September 13, 2007. You may view the

full text here: <http://www.worldinbalance.net/intagreements/2007-indigenouspeoples.php>

The United States of America was the last of the four nations who opposed the Declaration in 2007. Eventually, the United States of America endorsed the United Nations Declaration on the Rights of Indigenous Peoples on December 16th, 2010. During the White House Tribal Nations Conference on December 16, 2010, President Obama made the following statement:

.....

*“The aspirations it affirms - including respect for the institutions and rich cultures of Native Peoples - are ones we must always seek to fulfill.” “But I want to be clear: What matters far more than words - what matters far more than any resolution or declaration - are actions to match those words.” - **President Barack Obama***

.....

Article 23

Indigenous peoples have the right to determine and develop priorities and strategies for exercising their right to development. In particular, Indigenous peoples have the right to be actively involved in developing and determining health, housing and other economic and social programs affecting them and, as far as possible, to administer such programs through their own institutions.

Article 24

1. Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. Indigenous individuals also have the right to access, without any discrimination, all social and health services.
2. Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with



a view to achieving progressively the full realization of this right.

Our Work – Our Impact

The Native American Women’s Health Education Resource Center (NAWHERC) provides direct services to Native American women in South Dakota and advocates for Native American women at the local, national and international levels to protect our reproductive health and rights. Internationally, we organize Indigenous women and participate in coalitions working on reproductive health and rights policies. As a long-lived "pathfinder" organization, NAWHERC has become the leader in addressing Indigenous women's reproductive health and rights issues in the country. NAWHERC focuses its programs on serving reservation & land based Native American women with ongoing outreach to urban Native American women throughout the United States.

NAWHERC’s reports have been submitted to and used by Congress, the United Nations, the World Health Organization and university and policy institutes to bring awareness of the reproductive health issues facing Indigenous women, and by Amnesty International’s *Maze of Injustice* (released April 2007 and updated in spring 2008), a report that shows the failure to protect Native American women from sexual violence in the United States. NAWHERC’s work has resulted in policy changes such as: improvements in informed consent; providing patients with results for abnormal pap tests; treatment of HIV+ patients; patient confidentiality; and the discontinuation of Norplant. NAWHERC has brought to the forefront Indian Health Services’ (IHS) treatment of rape/incest victims and has documented IHS’s violations of Native American women’s right to health care and to pregnancy prevention/choice. NAWHERC has linked Native American women to federal policies affecting their daily lives, and has promoted their voice and activism to decision makers at the highest levels. NAWHERC works with a national, broad-based and diverse coalition of Native American, women’s health and civil liberties organizations.

Challenges Faced By Native American Women:

The potential for Native American women to need reproductive choice or emergency contraception (EC) because of a violent incident statistically far exceeds that of the general population. Native Americans are raped at a rate nearly double that of rapes reported by all races annually – 34.1%, more than 1 in 3 Native American women will be raped in their lifetime. Three-fourths of Native American women have experienced some type of sexual assault in their lives .

.....
“I’ve heard women ask for information about Emergency Contraceptives so they can talk to their daughters about what to do when they are sexually assaulted, not if they are sexually assaulted, but when.” - Charon Asetoyer
.....

For most Native Americans, IHS serves as our primary health care provider. IHS is subject to federal policies, including the Hyde Amendment, that exclude abortion from the comprehensive health care services provided to low-income people by the federal government, except in cases of rape, incest, or endangerment of the woman’s life.

From 1973 – 2001 throughout its 157 IHS and Tribal managed Service Units, IHS performed only 25 abortions under the Hyde Amendment. Due to the sexual violence statistics cited above, it is **highly unlikely** that in nearly 30 years, only 25 Native American women nationwide who were victims of rape or incest or whose lives were endangered by pregnancy sought an abortion from IHS. In fact, our documented research revealed that the vast majority – 85% – of IHS Service Units were not in compliance with the official IHS abortion directive, which supports the Hyde Amendment. Despite the existence of directives, services and procedures are not standardized at each IHS unit. The standard of abortion counseling, abortion information provided to interested women and referrals to abortion providers are often left to the discretion of IHS personnel.

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Over the years, IHS has denied Native American women the same options of birth control that are afforded to mainstream women. EC and Plan B® (or their generic forms) are still not adequately available at IHS facilities as an OTC (over the counter). NAWHERC's January 2009 research, "Roundtable Report on the Availability of Plan B® and EC within the IHS" found that: 1) Only 10% of IHS unit pharmacies surveyed have Plan B® available over the counter (OTC); 2) 37.5% of pharmacies surveyed offer an alternative form of emergency contraception; and 3) The remaining have no form of EC available at all.

The minimal availability of Plan B® is due, based on pharmacists' responses to our survey, to Pharmacy and Therapeutics Committees neglecting to put the drug on approved lists (formularies), medical staff deciding Plan B®'s inclusion on the formulary is not necessary, the expense of the drug, the existence of another method of EC of the same efficacy, pharmacies not handling "symptoms" of this nature (despite carrying daily oral contraceptive pills), the drug not being requested by doctors and to the low overall number of requests for EC. The low number of requests for EC despite the high incidence of rape of Native American women indicates that **women are unaware of the existence of EC**. It also illustrates that **IHS doctors and nurses are not informing women of its existence** although it is IHS's duty to provide women with this information.

Many Native American women are not receiving the services to which they are legally entitled. IHS's failure to provide these services to women who are entitled is a violation of our legal right to access abortion/pregnancy prevention services and of our fundamental human rights. These violations have been further highlighted in Amnesty International's *Maze of Injustice* report mentioned above.

Our study illustrates the fact that some IHS units provide EC and some do not, that some use Plan B®, but most use the old formula of several high dose birth control pills. This provides a clear picture of the need for standardized care within IHS Service Units. Women should be able to go into an IHS Service Unit and get the same standard of care no matter where she is being seen. The inconsistency of services from one service unit to another creates a situation that lowers the standard of health care for Native American victims of sexual assault. It violates our right to health services, permits discrimination against Native Peoples and is in direct violation of Article 23 & 24 of the United Nations Declaration on the Rights of Indigenous Peoples.

Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right.

1 American Indian Women's Chemical Health Project report.

2 NAWHERC's January 2005 report, "A Survey of Sexual Assault Policies and Protocols within IHS Emergency Rooms," documented the huge gap in IHS services for Native American women who have been sexually assaulted. A national roundtable in June 2005 brought together Native, health and women's organizations, tribes, violence shelter advocates and Native rape/incest victims. A fall 2005 report published the Roundtable's recommendations and was sent to 350+ organizations, tribes and legislators.

3 Consisting of two pills, Plan B® is a method of EC that is an extremely safe, simple, and effective way to reduce unwanted pregnancy and the possible need to have an abortion. Plan B® is not an abortifacient. Plan B® is safer, easier to use and more effective than the off-label use of birth control pills or other older EC methods. If started within 24 hours of unprotected sex, Plan B® reduces the risk of pregnancy by 95% (and if taken within 72 hours reduces pregnancy by 89%). Plan B® was approved by the U.S. Food and Drug Administration (FDA) in 1999 for prescription use. A 2006 FDA ruling made Plan B® available OTC for adult women and available with a prescription for women under 18. An April 2009 ruling by a U.S. District Court judge lowered the OTC age to 17. (Women under 17 still need a prescription to access the drug. Therefore it must be kept behind the counter. This creates two potential barriers to access, as proof of age must be presented and buyers must interact with a pharmacist (who could refuse to provide the medication on "moral" grounds) in order to obtain the drug.)



History of Standardized Sexual Assault Policies and Protocols:

The Native American Women's Health Education Resource Center (NAWHERC) staff is victorious with this objective. Although it did not occur overnight, it is now reality. Some historical facts: we started working on Standardized Sexual Assault Policies and Protocols within Indian Health Service Emergency Rooms in 2004 and released a report in January of 2005. The report Sexual Assault Policies and Protocols within the Indian Health Service Emergency Rooms revealed that 30 percent of the service units have no protocol in place for the care of women who have been raped or sexually assaulted; although 70 percent of the units report that they have a protocol, only 56 percent of those indicate that the protocol is posted and accessible to staff members.

- In 2005, we convened our Roundtable and released the Roundtable Report on Sexual Assault Policies and Protocols within Indian Health Service Emergency Rooms in October of 2005. Over the course of 2005 – 2010, we formed a coalition of allied organizations and individuals to help us work on this issue. On November 4, 2005, the National Congress of American Indians passed a Resolution in support of our work. NCAI passed Resolution #TUL-05-101 in support of adoption and implementation of these Standardized Sexual Assault Policies and Protocols. When Indian Health Service was asked about Standardized Sexual Assault Policies and Protocols their repeated response is that they respect the sovereignty of tribes and IHS does not impose standardized policies. With the passage of this resolution, which is a collective decision of sovereign Tribes, IHS still did not implement Standardized Sexual Assault Policies and Protocols. This is not respecting the decision or the sovereignty of Tribes; it is undermining the sovereignty of Tribes to work together.
- During 2006-2007, we worked with Amnesty International on the development of the Maze of Injustice Report that documents the failure of the U.S. Government to protect Indigenous women from sexual violence in the United States. NAWHERC Executive Director Charon Asetoyer was appointed to IHS's

National Native American Women's Health Advisory Committee that allowed us some influence on developing and advising on the implementation of IHS' Standardized Sexual Assault Policies and Protocols along with developing guidelines for national level pilot projects for SANEs. NAWHERC and Coalition members met with IHS representatives at IHS Headquarters.

- In 2009, Charon Asetoyer, Executive Director of NAWHERC, was invited to testify in front of the U.S. House Interior and Environment Appropriations Subcommittee on the issue. What was to be a five-minute statement on the issues turned into twenty-minutes of questions and answers by the Subcommittee members. Each question proving farther into the issues of sexual assault against Native American women and the lack of services available for reservation based women through IHS, establishing the need for Standardized Sexual Assault Policies and Protocols within IHS Emergency Rooms.
- In 2009, NAWHERC Executive Director Charon Asetoyer and members of the Amnesty International's *Maze of Injustice* committee met with White House staff to continue with top-level discussions on the issue of sexual assault against Native American women. Issues of priority included but were not limited to the following; standardized sexual assault policies and protocols within IHS, the need for changes in the IHS witness approval process for sexual assault victims and the issues related to EC / Plan B® access for Native American women within IHS.
- In 2008 a call from Senator Tim Johnson's office of (D-SD) came into the NAWHERC requesting Charon Asetoyer to recommend four items of need that would improve the health care services within IHS for victims of sexual assault. It was to be added onto the Indian Health Care Improvement Act. It didn't take long for Charon to contact Attorney Sarah Deer, a coalition member and an expert on the topic of IHS witness approval process. Between the two coalition members four recommendations were sent back to Senator Johnson's office recommending; Standardized Sexual

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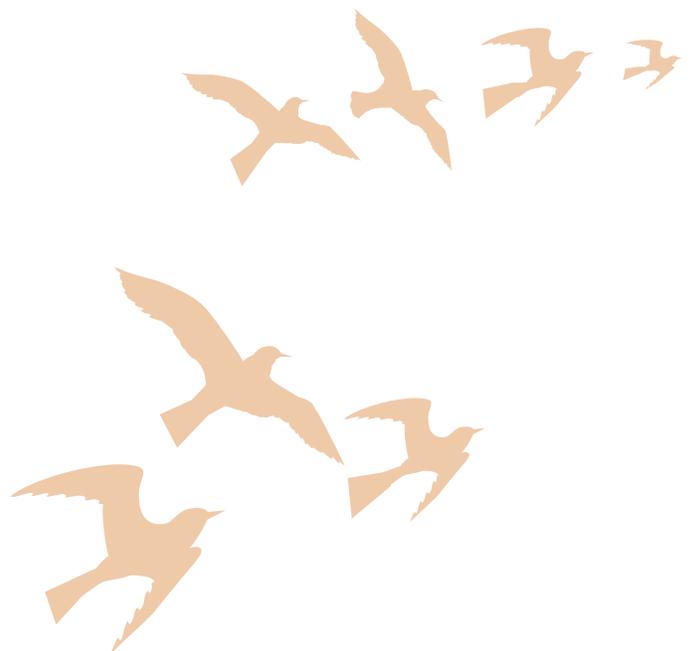
Assault Policies and Protocols within IHS Emergency Rooms, a change in the witness approval process for the health care provider that do the “rape exam”, funding for Sexual Assault Nurse Examiner programs, and modifications in the IHS method of collecting statistics on sexual assaults victims. The recommendations were put into the Bill. However, due to a poison bill provision slipped in by Sen. David Vitter (R-La) that explicitly restricts abortion under IHS programs the bill passed the Senate but did not pass the House. With quick thinking staff from Senator Tim Johnson’s office some of the recommendations were able to get into the 2009 Omnibus Appropriations Act.

- On March 11, 2009, President Obama signed the Omnibus Appropriations Act of 2009. Included in the Act there is language that provides the following: “In order to provide the IHS with additional tools to better address child and family violence in American Indian/Alaska Native communities, the bill includes \$7,500,000 to implement a nationally coordinated domestic violence prevention initiative. With these funds, the IHS is encouraged to further expand its outreach advocacy programs into Native communities, expand the Domestic Violence and Sexual Assault Pilot project already in operation, and use a portion of the funding for training and the purchase of forensic equipment to support the Sexual Assault Nurse Examiner program...The report [required of the IHS] should address the Service’s progress in developing standardized sexual assault policies...” This was a step forward in terms of the Government not only acknowledging there are sexual assault issues in Indian Country that need to be addressed but taking steps to assist in addressing some of these issues.

Through an impressive ground swell of public interest brought on by all of the hard work, community education and advocacy done by the NAWHERC and coalition members, major language was included into the Tribal Law and Order Act of 2010. This bill, when fully implemented, will make major improvements in the way Native

American women receive reproductive health services from the Indian Health Service and will give Tribes more control over law enforcement on Tribal land.

On July 29, 2010, Lisa Iyotte introduced President Obama during the bill signing at the White House, there was not a dry eye in the House when she told her story of being raped in front of her children; “No one asked me about the rape and I had to wait all night for someone to collect the DNA evidence from the attack.” Iyotte said. No federal investigators interviewed Lisa Iyotte. Lisa went on to say in her speech, “The Tribal Law and Order Act will prevent cases like mine from slipping through the cracks, now that we have Standardized Sexual Assault Policies and Protocols within Indian Health Service.” NAWHERC Executive Director Charon Asetoyer was sitting in the audience when Lisa Iyotte made that statement, at that moment all she could think about was all the years of hard work that NAWHERC put into getting people to understand the importance of those few words “Standardized Sexual Assault Policies and Protocols within Indian Health Service Emergency Rooms”. Now the real work begins- we must ensure that these policies are implemented within IHS.





TRIBAL LAW AND ORDER ACT OF 2010
Subtitle F—Domestic Violence and Sexual Assault Prosecution and Prevention

SEC. 17. POLICIES AND PROTOCOL

“The Director of the Indian Health Service, in coordination with the Director of the Office of Justice Services and the Director of the Office on Violence Against Women of the Department of Justice, in consultation with Indian Tribes and Tribal Organizations, and in conference with Urban Indian Organizations, shall develop standardized sexual assault policies and protocol for the facilities of the Service, based on similar protocol that has been established by the Department of Justice.”

Purpose of the Indigenous Women’s Dialogue

The Indigenous Women’s Dialogue brought together Native American women from three states, South Dakota, Oklahoma and New Mexico – all with large Native populations and considered to be bellwether states targeted to be used as springboards by “the opposition” for national

level influence. The activism supplied by Native American women can mean the difference between a restrictive policy being passed or defeated. By meeting “the opposition” on their own territory, Native American women and our allies can prevent their efforts from escalating to the national level. Fortunately, many of these bellwether states also have large Native populations, presenting the Native American Women’s Health Education Resource Center with the opportunity to organize Native American women – and catalyze our allies – in response. Issues addressed by the Indigenous Women’s Dialogue examined the accessibility of emergency contraception (EC) as an OTC (over the counter) by sexual assault victims through Indian Health Service, what understanding women have in terms of what EC is and the impact “the opposition” has had in terms of it’s purpose and accessibility.

INDIGENOUS WOMEN’S DIALOGUE:
Accessibility to Emergency Contraceptive for Native American Sexual Assault Victims

Over the course of the spring and summer of 2011, we convened and listened to over fifty Native American women’s voices joining together in conversation, laughter and tears. They were mainly workers in domestic abuse, women’s shelters and tribal sexual assault programs, and ironically, many were victims of sexual assault themselves. Overwhelmingly, we found evidence of a worsened situation for Native American women (since our 2009 Report) in their attempts to gain access to emergency contraception through the Indian Health Service, and that very little is known about the improved type of emergency contraception (EC) known as Plan B®. Women shared their stories of facing an interlocked system of barriers between themselves and equitable and fair health care. These barriers relate to the control of women’s bodies and lives by government policies and under-funded health care services, coupled with racist,

sexist and religious attitudes embedded within those services.

Education, outreach and open discussion on the facts about sex, sexual violence, incest, birth control, emergency contraception and abortion are minimal. Unless the women have jobs with insurance or live in an urban area, there is scant information available or offered – much less actual services provided.

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“A lot of our women in our communities aren’t aware that Plan B® even exists or they associate it with the abortion pill RU486, they don’t realize the difference because the media and the opposition have projected this: it’s an abortion pill, when it really is a contraceptive.”
- **Charon Asetoyer**
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INDIGENOUS WOMEN'S DIALOGUE

ROUNDTABLE REPORT ON THE ACCESSIBILITY OF PLAN B® AS AN OVER THE COUNTER (OTC)
WITHIN INDIAN HEALTH SERVICE

“I think there is confusion, because the media did speak on RU486 here in Oklahoma. Then, they put it together with Plan B®, where doctors didn't want to prescribe it because of their faith. The doctors had the option to not provide RU486, but Plan B® went out with it. That's what I got from the media here in Oklahoma, and that's what I hear arguments about.” - Maya Torralba

Access to safe, state of the art, emergency contraceptives (Plan B®) for Native American sexual assault victims at their primary health care provider (Indian Health Service, through its parent DHHS/PHS) is more than a legal right in the United States, but a global Human Right as described earlier.

Human Rights are created and adopted to be applicable across the board, but we continue to hear Native American women's stories of restrictive and inconsistent policies, un-funded health care needs, difficulty in accessing preventive and emergency services – whether the institutions are run by the Indian Health Service, a treaty tribe or non treaty tribe, a PL 638 situation, or a “self-governed” tribe. The complexities of sovereignty and the collision of the Indian Health Services with Tribal Nations provision of some or part of those services is a labyrinth too hard to navigate, especially during a crises such as assault, violence and fear.

In many situations pertaining to Native American women's health, religious groups control access and unduly influence policy making through their long-standing and systematic advocacy and control of restrictive contraception uses by owning clinics, and in some cases entire health care systems, etc.

*“In South Dakota, the Benedictine nuns are shrewd businesswomen. They own just about every clinic and health care facility. Even in Lake Andes, which is like a dot on the map - the whole southeast quarter of South Dakota they've bought almost every hospital and every clinic so that they can have control of family planning services. IHS contracts with some of these facilities because they don't have a choice, they shouldn't be allowed to accept federal dollars if they don't provide services.”
- Charon Asetoyer*

In Native American communities women face the added burden of “traditional Native American” roles being played out as women being silent and living in servitude to their husbands and sons. The role of boarding schools operated by churches, especially the Catholic church, means that “sexual abuse may be “traditional” to the Catholics, but not to Native Americans” as one participant put it. This is a learned attitude that many women reported as the “norm” for tribal communities – don't talk about the sexual abuse within your family and do not speak out against it. It is frowned upon, even for the sexual assault workforce, to talk about the extremely high levels of sexual abuse in our communities, as it becomes a black eye on the Tribe itself. After listening to the women in the first two roundtables, Charon Asetoyer said, *“Sexual assault is happening all the time and we need to do something!”* These patriarchal and co-dependent or shameful attitudes are creating the climate for unchecked sexual abuse to spawn serial rapists, who are never brought to justice. Plan B® can prevent abortions through emergency contraception, but this information must be conveyed in language that is “understood and in laymen terms”.

The statistics tell us that one in three Native American women are molested, but the women in our roundtables cautioned that rape statistics are higher in their communities and that young girls have to watch for it, taking the “not if, but when” attitude toward self protection. Many



women in our discussions revealed that a lot of molestations happen within the family and they feel it is important to learn from these mistakes and put a stop to the incest by examining root causes and teach our young ones to not let anyone touch them.

The discussions and findings of the 2011 Indigenous Women’s Dialogue are illustrated in the following five areas of concern:

- Inadequate Systems and Resources Perpetuate the Oppression
- Inconsistency Equals Inequality
- Indigenous Women’s Bodies are Sovereign
- Laws Do Not Change Attitudes
- Women’s Rights are Human Rights

1. Inadequate Systems and Resources Perpetuate the Oppression

There was resounding agreement by roundtable participants that Native American women have never received the same type or quality of health care that other American women receive. Due to the complexities of the tribal and government health care provision, each Native American community has a different set of rules and resources to access. Many of our women’s shelters are not tribal shelters- they may be Native run and operated, but are generally local nonprofit organizations who may also be serving the general public.

We heard from women in four different I.H.S. regions about the barriers in access to safe, emergency contraception through the Indian Health Service and tribal clinics. The inconsistencies, even within the Albuquerque Area were startling. A survey of 15 hospitals and clinics revealed that only two of them dispensed Plan B® as an over the counter medication. Most Native American women, and their service providers, are not aware of emergency contraception like Plan B®, or they have heard of it but have been confused by media coverage to believe it is the abortion pill RU486. Only a few of the health care workers and service providers attending the Roundtables fully understood the difference between the two pills, depending upon their area of services or expertise.



“The next alternative in over-the-counter access comes only if you have the financial resources to purchase Plan B® at a commercial pharmacy, generally for fifty dollars, which is a huge barrier for most Native American women. “If you are living on the reservations or one of the Pueblos without insurance, or money to pay for EC, or transportation to get you to town you are out of luck because you do not have accessibility through our own health care provider.” - Charon Asetoyer



“ It’s important to point out that we have to be concerned about forcing women to jump through so many hoops to provide health care for themselves in crises. If you are forced to undergo a rape exam to prove you have been raped before you can get this medication, which in itself is a tremendous barrier. We should have policies and procedures in place to safeguard the woman who comes to the pharmacy and says, “I was raped”... or she can just say “I had unwanted sex,” because there are so many stereotypes and prejudices associated with sex.” - Evelyn Blanchard



We heard from the participants that in general, the IHS providers do not want to go to court and be forensic witnesses in sexual assault cases, and generally it is impossible to obtain a conviction without a rape kit being performed in the proper way and in a timely manner, and to have a primary provider testify in court. We believe this presents an enormous challenge to Native American women’s health and safety.



INDIGENOUS WOMEN'S DIALOGUE

ROUNDTABLE REPORT ON THE ACCESSIBILITY OF PLAN B® AS AN OVER THE COUNTER (OTC)
WITHIN INDIAN HEALTH SERVICE

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“Why should the FBI come to the reservation to investigate a rape or sexual assault? Especially, if there is no forensic witness, no forensic test, no health care provider to back it up? They will not get a conviction in court. So why come down to the reservation to investigate. We’ve been written off. Doctors don’t want to get involved in local politics at all. IHS has a very complicated process of approving an employee to testify in court, even with the policy changes that came about with the Tribal Law and Order Act. By the time they approve a subpoena it’s too late. And the perpetrators know this; these rapists walk around free to commit crimes again. So we have serial rapists. IHS staff just doesn’t want to have to deal with testifying. IHS is preventing us from our right to due process and we continue to be victimized.”

- Charon Asetoyer

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“It’s a cost issue. Everything is with I.H.S. I have no health insurance and a lot of health problems. I have been on a waiting list for a heart monitor, but they can’t pay it, so I’m still waiting. That’s what I hear from everybody—it’s a cost issue.”

- Maya Torralba

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“You want to talk about cost effective? What’s the cost of having an unwanted child? What’s the cost of having a child to a mother who’s drinking or drugging? The list goes on and on and on.... The fact that President Obama signed an order stating that women 17 years and older can access Plan B as an “over the counter”, why are we being denied Plan B® as on “over the counter” through our primary healthcare provider, when it was the President, who signed the order?”

- Charon Asetoyer

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2. Inconsistency Equals Inequality

It has been shown in a recent National Congress of American Indian’s (NCAI) task force report that thirty percent of Indian Health Care Service Units do not have standardized protocols. We continue to hear this complaint from Native American women as they describe the maze of bureaucracy they must navigate. In each region, the participants were very savvy about the services and how to access them, but we were speaking with health care providers, non-profit directors and law enforcement workers who know the lay of the land much more than the victim of a crime. And yet, most participants were victims of sexual assault in one form or another.

If quality health care is provided, women will receive much more than a rape kit that is collected during a rape exam – the staff are providing women with information about STDs, pregnancy, emergency contraception and abortion options. These are essential services that Native American women are not currently receiving from their primary health care providers.

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“All IHS hospitals and clinics are required to have their policies and medications in place. There was a lot of resistance because IHS does not standardize anything—every Service Unit does their own. We said, “This is of utmost importance, and here are suggested standardized policies and protocols.” If this is the first time, then this will be the first time they have standardized protocols. Now they are required to do this—they received a directive: It has to be standardized and it has to be across the board. If we stay within the norms of what we think is impossible, nothing happens. The need for this was so great we just moved forward, without fear. We did not allow the ever-present government budget concerns limit our vision.”

- Donna Haukaas

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“Our tribal EMT said doctors can give patients lifesaving meds before we take them in the ambulance, but won’t do it. We have had rape victims given prescriptions to get EC, but at IHS they wouldn’t administer it, because the Pharmacy Director and her staff didn’t believe in it, so she wouldn’t administer EC. The only way for our victims to get it was to go to a drug store pharmacy to get it in person and pay for it.” - Lisa Thompson-Heth

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”We need to ask why they aren’t giving our women the same level of care that other women are getting and why they aren’t doing everything they can to help a woman prevent an unwanted pregnancy after a sexual assault? Are women being informed that have been sexually assaulted or raped that they’re entitled to be able to access an abortion in the event that they are pregnant? No, they do not getting that info from I.H.S. What about EC? No, some were and some weren’t, all women should be getting that information - whether they decide to use it or not it is their choice but at least inform them about it.” - Charon Asetoyer

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“When men talk to you about abortion or these pills, you have to say, “Do you have a daughter? What if she is, ten, or eleven? If she was raped, would you want her to have that baby or could it have been taken care of at the hospital? Plan B® is non-invasive, she doesn’t have to think about it again and she can start to heal.” - Catherine Leston

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Participants agreed that someone else’s personal values should not be involved in the process of assisting women during a criminal process. We discussed the drawbacks of the “Conscience Clause” where physicians can refuse to provide contraceptives and doctors can also refuse to work in facilities that provide abortions. In rural areas, this affects women who may receive a referral that might

mean a hundred miles of travel, creating further barriers and burdens. Most tribal and I.H.S. clinics are closed over the weekend, virtually shutting the seventy-two hour time frame a woman has to work within if she is going to be able to use EC.

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“It’s not illegal for someone to deny serving you EC because of religious practices, that doctor has to refer you to someone who will provide that service. If that is not done it is ILLEGAL.” - Charon Asetoyer

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3. Indigenous Women’s Bodies are Sovereign

Native American women are blessed with a recent history of strong, women leaders and clan mothers who were wise in the ways of the natural world and the world of healing and health. Our grandmothers, midwives and healers knew the women’s ways and the medicines available to us for our use. The women in these roundtables remember their grandmother’s and know their role in carrying forth women’s knowledge within their tribes.

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“I keep telling my 5-year-old granddaughter to ‘have respect for yourself’. And she didn’t know what that meant.” I said, “Don’t let anybody yell at you, don’t let anybody blame you, and don’t you blame anybody else. Try to be nice to people even when they are mean to you.” - Cheryl McClellan

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“Even if you’re a poor tribe, you have a substantial voice. I see how the efforts of organizations like NCAI and the NACB have made on violence against women.” - Heather Thompson

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INDIGENOUS WOMEN'S DIALOGUE

ROUNDTABLE REPORT ON THE ACCESSIBILITY OF PLAN B® AS AN OVER THE COUNTER (OTC)
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“Oklahoma is not pro-choice by any means if you look at it from the legislative standpoint and our laws. We are the Bible belt. I mean “birth control” is like a bad word, heaven forbid you want to get your daughter on birth control at a young age. I made my daughter get on birth control right before she turned 16, and she was mortified. She said, “I’m not even having sex! Why do I have to get on birth control?” and I said, “Because! We want to beat the rush before we have to deal with it. We want to be proactive, not reactive.” When we went to IHS, they weren’t empathetic about her situation at all. They didn’t believe her at all when she said she wasn’t sexually active. The doctor asked her twice how many partners she’s had and then asked, “If mom left the room if you would feel more comfortable?” She said, “No.” I think it’s just the mindset. I’m not even talking about Plan B® or emergency contraceptive or anything—just general birth control for young girls. It is frowned upon from the get go in Oklahoma in general and how women are viewed.” - Renee Brewer

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“I’m southern Baptist so I can talk about it, though after they voted in that a woman cannot be head of the church that’s when I stopped going. Lord, there wouldn’t be a man in church if a mom hadn’t grabbed him, scrubbed him up, and dragged him there. What was that about? I don’t get it!” - Catherine Leston

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“I currently go to different programs and trainings and share my story of what happened to me down to the very detail. My family does ministry work. I’m not for abortion—I’m southern Baptist—but I think it’s important that women hear that it’s not okay, and even if it’s your husband they can be charged and convicted of those crimes. I wasn’t aware of the morning after pill. In a previous marriage, we’d been having problems with our marriage—I told him no and I didn’t want him to be a

part of my life anymore after he had beat me up and attempted to take my life by strangulation and then raped me. After escaping and while at the hospital, the nurse had offered me the Morning after Pill. My sister was there and she encouraged me not to take it, but I didn’t want this man to be a part of my life anymore. She thought it was OK since he was my husband. Well, so what? To this day, I have flashbacks. It’s taken me years to build my self-esteem back up to where it is today. From the time of being a teenager all the way up to adulthood I saw abuse within our family, whether it was in our immediate family such as aunts, uncles—always looked the other way. Then I got into relationships to where I accepted that. They tell you you’re ugly and you’re nothing and you don’t amount to anything and you start to believe it. I’m realizing that I am somebody. I’m not stupid, I’m not ugly, I’m not fat, I’m not dumb, it’s just finally getting to that point to realizing that. A light goes on. We’ve got to save our children to where our little girls and little boys will see that, and then that cycle can be broken. That’s one great thing we push at our tribe—the culture camps and teaching our young women and our young men how to treat women, and how boys should be treated as young men within their families, and their roles in their families. I’m going to go back and share with my colleagues, friends, family and my tribe and tell the IHS coordinating director that this needs to be that choice we offer. It’s not an abortion pill. Plan B is something that can prevent an abortion down the line at a later date. Plan B is an emergency contraceptive. This discussion today is a growing experience for me; it’s another step that I can share in my testimony, my own story, because it was a horrible story. When your ex-husband’s charged with assault and battery and attempted first-degree murder, it’s something you don’t move on from. Seven years later and that night is just like it was yesterday, it’s still there and little things will bring on flashbacks all these years later.”

- Ramona Horsechief

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*“I have three generations of family who have either died, been murdered, or committed suicide. That’s three generations affected in my immediate family. My mother died when I was fifteen from cirrhosis; my sister was running away from an attacker and was hit by a car on the highway; her son a few years ago committed suicide; and her daughter who has a child gave the child away. We believe her daughter is now a prostitute in Las Vegas. That’s four generations of my immediate family that has almost been wiped out. It’s so overwhelming—I have to take it, look at it and get some perspective. How did this happen? When and why? Where did this all come from? It’s from assimilation, government policy, religion, culture, loss of language, subjugation, everything. I have to look at that and see how all that happened. It has led up to today, to my kids and me, and how I have stopped the cycle.” - **Maya Torralba***

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“I got pregnant at sixteen and got married and went through 20 yrs of abuse and I’m ill because of it. I’ve been diagnosed with a rare disease called Raynaud’s, which is offset by stress and cold air. But, I knew I needed to break that cycle and I fought back every time. I had told him before we got married, “Don’t think you’re going to beat on me because I will fight back, I grew up fighting.” I would fight him back, but it was a lot of verbal and mental abuse that you go through along with the physical abuse and it destroyed me health wise. Even to this day. I have two children with him. I’ve apologized to them for making them stay in our home, having to experience that abuse, and now my daughter is in the same situation with an abusive relationship.”
- Billie Foreman

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“When I work with the counseling agency here in Norman, the therapists asked me why Indian men are sexually abusing children, and overall, the answer was boarding schools—they were taught those behaviors and they were abused. These workers were trying to say that it was part of the way we do things in our culture and I had to inform them, “No we don’t.”
- Bernice Armstrong

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4. Laws Do Not Change Attitudes

As our discussion deepened into the unique situations that Native American women find themselves in, it became clear that federal laws do not change the attitudes of families or communities. Native American women hold their men and sons in high regard and respect their fathers, uncles and husbands. But, sometimes this means standing back and keeping quiet. Native communities are very spiritual and religious communities, but once again, mixing of these attitudes can make change hard and put women’s health issues on the back burner of priorities.

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“A lot of these girls are having children at 14, 15 years of age. In the Cochiti Pueblo, the girls are pregnant at 12 and 13 years old. The fact is, even before these girls are 18, they’re on their second or third child. I just found out the CHR program doesn’t even hand out condoms.”
-Yvette Aguilar

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INDIGENOUS WOMEN'S DIALOGUE

ROUNDTABLE REPORT ON THE ACCESSIBILITY OF PLAN B® AS AN OVER THE COUNTER (OTC)
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“Our organization operates support groups for boys and girls who are in middle school and high school. We have found that there is no conversation with their parents with other responsible adults around HIV/AIDS. ...and they have no idea what HIV/AIDS is; what their risks are; or how to avoid the risks. So, we are offering a huge educational piece for our community around all of those different issues. Its not just our area that opens us up to risk, it’s the drug use, the needle sharing, the unprotected sex—these kids need someone to be able to talk with them openly and honestly—to figure out what they’re at risk for and to have adults in their life who are willing to have that conversation with them. Through our Doula program, we know youth who have gotten pregnant and came to us after hiding their pregnancy from their parents. We know that there is that strong family influence of, ‘they’re going to beat me; they’re going to disown me; they’re going to do all these things to me.’ So they are risking their health and the health of their babies because they are still trying to hide that pregnancy from their parents. We offer them support and mediation and talk to them about the risks that not telling their parents puts their babies and themselves at.”

- Corrine Sanchez

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“Incest and sexual abuse is something that’s not talked about. It’s like DV—something that you don’t talk about. I know that’s something that won’t be talked about in our tribe; it’s like a bad word. The church, abortion, and morning after pill, all of that is not talked about.”

- Ramona Horsechief

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“We have to deal with the religious right. Religion comes up very conveniently when it’s needed to control us. It’s just another form of getting people geared up, something people are passionate about: their beliefs, their god. If they can latch onto that and get a vote, they do it.”

- Catherine Leston

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*“The woman was with an older man and they lived way out in the country in a mobile home. He didn’t allow her off the land, and he didn’t allow her to go in town without him. She had no car and never had any money. She came from up north, lived out there and nobody knew she even existed. They home schooled their two children and he would beat her if she tried to leave off their strip of land. He had her fenced in. She was telling me this and I didn’t believe it until I went out there with the tribal police and she met us by the gate. She said she thought she was pregnant. “I can’t have another baby with this man. He’s going to keep impregnating me—that’s his way of putting a hold on me, how he controls me”. We created a safety plan, so she had choices available to her. She literally had to hide this pregnancy from him until we could get her out of that home, out of state and into a shelter with the children. Then he was charged with domestic assault and battery, and kidnapping.”- **Ramona Horsechief***

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*“Part of the reason I don’t go in a traditional way is that I know in my own family, our male leader was molesting children.” - **Leslie Brown***

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*“They’ll preach against it, but it’s not written. They definitely do preach against it. They come right out and say abortion is like drinking, drugs—it’s a sin. The fetus—they call it a baby. As soon as the seed’s been planted the pastor says that it’s already a human being. It’s talked about, and especially when you see something about it on the news there’s discussion about it, but it’s not like that’s the main topic. It’s brought up in a quiet way because usually in most Southern “Baptist churches the majority of the population that attend are elders and that goes back into the respect thing—you don’t talk about those kinds of things with your elders. They don’t talk about birth control, but they openly talk about abortion.” - **Ramona Horsechief***



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*“I’m from Santa Clara and there’s a lot of Catholics there. I’m also a devoted Catholic but I don’t believe in someone telling me if I was raped or anything else, that I can’t abort that child. There is no one who is going to tell me that, because I think, “My body is my body. And whatever I want to do is what I’m going to do,” but I am Catholic.” - **Laura Pino***

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*“I find myself holding back things I want to say because both sides—mother and father—hold very traditional roles in different parts of the government within our tribe and if I were to say something, I could get either side of my family into trouble, and that plays a big role for women, and for me to speak truly what I feel just because there is that fear of what if somebody else hears... It’s going to go back and my parents, my grandparents, my uncles are going to get in trouble. I held a royalty position for New Mexico State and there were people who asked me questions on what my view was and my response was, “I cannot comment on that”. Because my father was standing behind me—because if I were to say something, I don’t want to make him upset. I have that fear, and, for me, I call it respect, because I respect his views and how he raised me, but I also disagree with him on some issues...and I find that difficult for myself.” - **Yvette Aguilar***

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*“I work with young women, especially teenagers. They’re afraid to go to IHS, because they know Grandma or Auntie’s going to be sitting in the waiting room. They’re going to say, “Well, what are you here for?” It also appears that almost anyone can access IHS medical records—there is no confidentiality!” - **Maya Torralba***

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*“Prayer is so important no matter what religion it is... I don’t think there is anything wrong with that. But, it’s the place where it becomes institutionalized and prevents other people’s voice in that process that bothers me. For instance, in the state police there is a Chaplin, so who decided that? How did that get institutionalized? In hospitals, they have prayer rooms or churches and some are non-denominational. We know that prayer is really powerful—it heals you and it moves us through dark times, but, as native people we do not try to convert other people to our way of being—that is a different way of dividing and conquering. We are moving towards prayer because we need it; the world needs it as earthquakes are happening, governments are falling, and chaos is going on all around. So how do you counter that but through mediation and prayer? What do we offer young people but ourselves?” - **Corrine Sanchez***

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5. Women’s Rights are Human Rights

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*“It’s not an aspirin; it’s not cold tablets, its withholding services from a victim.” - **Charon Asetoyer***

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This series of discussions with Native American women was interwoven with threads of ongoing human rights violations throughout Indian country. It became very clear that the Indian Health Service must standardize their sexual assault policies and protocols, and they should take the lead in working with, not only tribal governments in creating some standardized policies among all of the facilities, but with consumers, in this case Native American women. When the disparity of care among tribal members becomes detrimental to women’s health, it becomes a treaty violation. Native American women should have clear expectations of what types of emergency contraception and care they can access.

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With the Indian Health Service as our primary provider of health care to Native American women, then the standardized sexual assault manual becomes our insurance policy that explains our benefits and rights as Native American women. The same policies should be followed in all facilities and they should be adequately funded to provide basic services. When a Native woman is assaulted, family members and care givers should be able to assist any woman in obtaining optimum health care. We have heard that half of all pregnancies are unplanned, so Native American women wonder why they are not entitled to have medical facilities that treat them fairly.

The group discussed the importance of putting their focus and efforts on young people and teaching the young women about “women’s body sovereignty”. The participants were very interested in creating options and maintaining a choice for women. All three roundtables discussed the truly traditional roles for women and to remember the importance of building our Women’s Society as opposed to reacting to a male dominated political arena (“we need to demand sovereignty”) and to keep these two realms separate. Participants affirmed the need to “keep our realm and knowledge as Native American women” and to continue as advocates for women’s health and human rights by sharing their stories of healing and survival and teaching the young ones.

*“Our work as advocates is about stopping violence against women. That frames the way you do the work. If it’s about specific crimes, the major response is after the crime is committed, and it’s not about social change. But as a coalition we are trying to look at root causes... We need to continue to make the connections between root causes, domestic and sexual violence, reproductive rights and other forms of gender-based violence.” - **Brenda Hill***

“If a woman has been sexually assaulted Plan B® is an ideal thing to have access to. Every woman in the country can access it, except Native American women, who have to see a doctor and then go to the pharmacist. Most IHS will give you the old regime of higher dose birth control, which requires a prescription. It would be much easier to have access to Plan B® as an OTC.”
- **Charon Asetoyer**

“In Oklahoma we’re either self-governing tribes, which means we are not under the BIA’s thumb at all—we govern ourselves by our own tribal codes, our own policies, our own laws, and then we have tribes that are on 638 contracts who have to abide by the code of federal regulations and they are still governed somewhat by the BIA. I’m also a citizen of the United States and I’m a citizen of Oklahoma, but when I step outside of my tribal boundaries and I’m not in my 8 county jurisdiction, at that point, my voice doesn’t hold a whole lot of water.”
- **Renee Brewer**

Exercising our Right to Vote

At the Oklahoma roundtable, we heard from Maya Torrelba, a young Comanche woman who had recently ran for a county political position. She was eventually defeated by the incumbent, “a white, middle aged rancher”, but Maya learned a lot and had her whole family working for her campaign. She was one of the first Native’s to post campaign signs all around the area, but she said, “Everyone is doing it now”! Participants shared that they are able to encourage their immediate family to vote in tribal elections now and then, but rarely does anyone they know vote in mainstream state or national elections.

In New Mexico, we heard of an even more complicated political landscape for the Pueblo women. Some of the Pueblos do not elect their leadership at all; in others only the men vote for leaders, while women may vote on issues; and in a few Pueblos everyone votes for all seats



and issues, including the women. We found an extremely high level of political awareness and activism among the women in New Mexico compared to other regions, with active voting in state and federal elections. Their knowledge of bills and propositions affecting women’s health was deep and inspirational!

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*“At Santo Domingo Pueblo nobody votes for leadership. Zia Pueblo has no voting - this idea of choosing leadership is a very new idea to Pueblo people...it’s very new, and a lot of older people say that we don’t choose our leaders. But, then we have people in there who you hope are not power hungry and will do it for your people as a sacrifice, not as a career.” - **Frances Abeyta***

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*“My clients don’t think they can make a difference when they vote - they’re so busy surviving from day to day that they don’t think about things like that...Natives are so downtrodden that it’s hard to get them moving. The professional women and men do vote, but not our clients- the people in poverty or people who just survive day to day, do not vote.” - **Bernice Armstrong***

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*“The first people to vote are the elders...some elders watch TV and understand, but we have an interpreter. The hard thing about that is how do you explain some things in Indian, or in English? There are some things you cannot interpret...so us younger ones have to help out. My first language is Navajo, so English was second, but the elders kind of get mad because you use words that you have to makeup yourself...it hard trying explain to the elders about anything political or like Plan B@!” - **Chastity Garcia***

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ACTIONS AND SOLUTIONS

In the three states we visited, there was consensus on many issues, but generally discussions about action steps were bound by various threads relating to education and sharing stories. Education of all women, but especially the younger ones, care givers, tribal leaders and women’s health advocates and allies - about the barriers for Native American women to emergency contraceptives. As a group, they agreed it will require a community groundswell to activate a set of national policies that will be applicable and affordable throughout Indian Country. The leaders at the roundtables understand the importance of creating strong allies, and the critical networking to be done. Participants felt that if they could pool their resources they would get more accomplished, and to this end the New Mexico group selected a point person, committees, a strategy and timeline for actions. Their immediate plans included setting up a Navajo tribal council presentation with follow up question sessions. These ladies encourage others to “educate your tribal First Lady” as a beginning strategy!

Participants agreed that it is critical to educate and empower the Native youth to understand and make healthy choices for themselves. They discussed the importance of building “resiliency” for young people and their families by sharing information and personal stories. Our stories are very powerful and Native American women learn from each other in this way. We must be up to the minute with the technology utilized in getting women’s health information out there where young people will see and share it. As one participant said, “Do this for the young people – there are too many children having children, and too many rapes”.

Some of the young women are advocating the creation of their own systems, operating outside of the Indian Health Service. They are operating non-profit organizations and providing unique services to Native people who are falling through the cracks in urban areas, especially where there is no tribal affiliation in the regions.

INDIGENOUS WOMEN'S DIALOGUE

ROUNDTABLE REPORT ON THE ACCESSIBILITY OF PLAN B® AS AN OVER THE COUNTER (OTC)
WITHIN INDIAN HEALTH SERVICE

*“We have to be watchdogs and stay in their face, continually asking them, “Where are the protocols? Are they posted? When will they be posted?” We have to really make sure that we talk to our health boards at the local level, our health representatives, our doctors, our tribal leadership, about making sure these Standardized Sexual Assault Policies and Protocols are in place, and going beyond that and talking to our area Tribal Health Boards as well.” - **Charon Asetoyer***

*“We haven't made the connections between sexual assault and reproductive rights. We should have those discussions... The downside of VAWA if you read the act is it has been de-gendered. The word "women" is rarely used. Rather than the emphasis on ending violence against women, it is now focused on specific crimes—reactive, rather than proactive.” - **Brenda Hill***

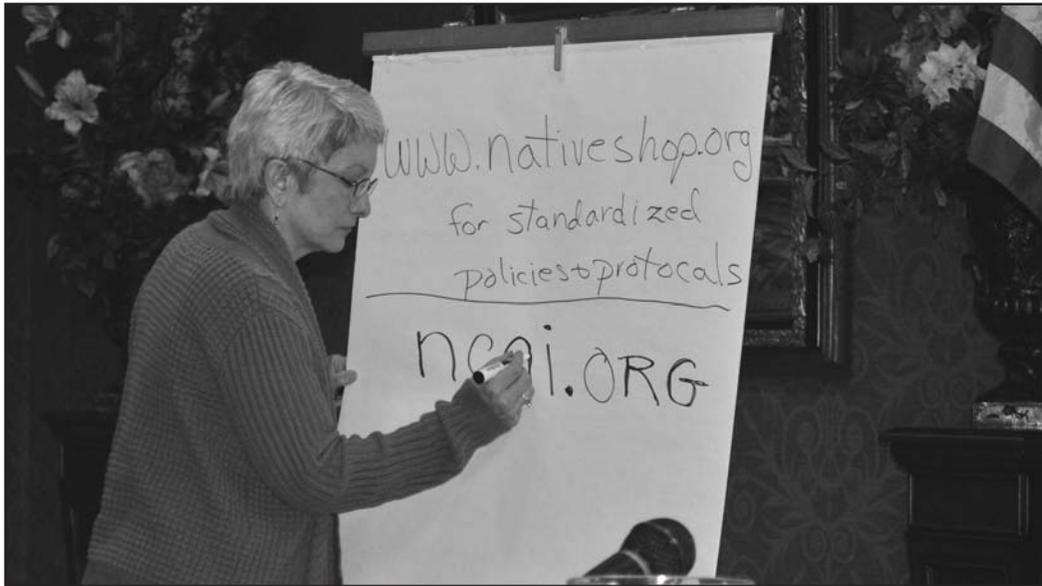
KEY POINTS FOR GAINING ACCESS ON DEMAND

- Lower the cost with generic options for Plan B® and purchase in bulk through Indian Health Service
- Debate the economics argument by presenting the cost of an unwanted pregnancy
- Promote the adoption of national Standardized Sexual Assault Policies (SAPPS)
- Create an alliance with physicians – have and attend group meetings especially with the educators and allies
- Ensure Medicare coverage for women who cannot afford Plan B® over the counter
- Educate tribal leaders so they understand the options for women in crises
- Advocate for “Reproductive Safety” – it's a powerful concept that should be included in assault victims' procedure manuals.
- Conduct community education campaigns to inform community members about Plan B®.
- Demand that Indian Health Service include consumers in the process of consultation in the development of Standardized Sexual Assault Policies and Protocols and other health issues of Native American women by restating the Native American Women's Health Advisory Committee.
- Demand that Indian Health Service use the process of consultation with the inclusion of consumers and review the Standardized Sexual Policies and Protocols every 3-5 years for updates.





INDIGENOUS WOMEN'S DIALOGUE ROUNDTABLE, 2012



Top Picture: Brenda Hill – Rapid City, South Dakota Dialogue

Second Row Picture: Left photo, Catherine Leston - Oklahoma City, Oklahoma Dialogue. Right photo, Corrine Sanchez – Albuquerque, New Mexico Dialogue

Third Row Picture: Left photo, Maya Torralba – Oklahoma City, Oklahoma Dialogue. Right photo, Evelyn Blanchard – Albuquerque, New Mexico Dialogue



INDIGENOUS WOMEN'S DIALOGUE

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Top Picture: Pamela Kingfisher – Oklahoma City, Oklahoma Dialogue

Second Row Picture: Left photo, Frances Abeyta & Peggy Bird – Albuquerque, New Mexico Dialogue. Right photo, Rapid City, South Dakota Dialogue

Third Row Picture: Left photo, Billie G. Foreman – Oklahoma City, Oklahoma Dialogue. Right photo, Ramona Horsechief, Oklahoma City, Oklahoma Dialogue



For more information contact:
The Native American Women's Health Education Resource Center
P.O. Box 572, Lake Andes, South Dakota 57356-0572

(605) 487-7072 • Fax (605) 487-7964 • email charon@charles-mix.com