



NATIVE AMERICAN WOMEN'S HEALTH EDUCATION RESOURCE CENTER

A PROJECT OF THE NATIVE AMERICAN COMMUNITY BOARD

INDIGENOUS WOMEN'S REPRODUCTIVE JUSTICE

ROUNDTABLE REPORT ON SEXUAL ASSAULT POLICIES AND PROTOCOLS

WITHIN INDIAN HEALTH SERVICE EMERGENCY ROOMS

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PARTICIPANT LIST

.....

Charon Asetoyer

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

"We are going to talk about the intersection of abuse, family violence, and reproductive health and rights, and work on bringing the groups together to join forces to stop some of the things happening to us."

.....

Donna Haukaas

Sicangu Lakota Oyate
Native American Women's Health
Education Resource Center
Reproductive Justice Out Reach Coordinator
Lake Andes, South Dakota

"We need to address the problem, especially for those women who are so badly brutalized that they need care immediately."

.....

Mia Luluquisen

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

"We are talking about comprehensive, sweeping changes across IHS and across all communities, so that every single woman who is sexually assaulted gets treated with dignity and comprehensive care from now on."

.....

Bonnie Clairmont

Ho Chunk Nation
Tribal Law and Policy Institute
Victim Advocacy Program Specialist
St. Paul, Minnesota

"We want to come to the table and help one another do our jobs better, and, maybe, out of it we will get more people to report and more women to come into the emergency room."

.....

Jocelyn Salt

Navajo Nation
Community Representative
Shohto, Arizona

"This is a pressing issue, and we need to change the behaviors and thoughts of individuals."

.....

Anne Batisse

Ojibwe/Algonquin
Indigenous Women's Network
Austin, Texas

"I feel a great amount of love for these young women, but people put them down. There aren't enough safe places in the world."

.....

Gloria Pourier Cournoyer

Oglala Lakota Nation
Cangleska, Inc.
Kyle, South Dakota

"There is a cost being paid by women for what we have to go through because of what we are living in and what we have to survive in. There is connection between our health and our culture."

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Juana Majel Dixon

Pauma-Yuma Band of Mission Indians
National Congress of American Indians
Escondido, California

"We will not stand for our sisters, mothers, and daughters to be assaulted."

Deb Blossom

Shoshone/Paiute
Tribal Coalition, STOP
Coordinator
Owhyhee, Nevada

"IHS is not meeting the needs of our Indian women, so this (the roundtable) is wonderful, and I am happy to be a part of it."

Tammy Young

Tlingit
Alaska Native Women's Coalition
Sitka, Alaska

"This is something I have experienced and my mother went through it; also my grandmother, my sister and, unfortunately, my daughters. I am committed to this issue at a deep level."

Mary Metcalf

Crow Creek Sioux Tribe
South Dakota Coalition Against Domestic
Violence and Sexual Assault
Sioux Falls, South Dakota

"People know what the report says, and I look to the people we are depending on, and it seems to me that we just not that important."

Yvonne Bates

Wichita and Affiliated Tribes
Caddo Nation
Hope House Family Violence Prevention Program
Lawton, Oklahoma

"Emergency policies and procedures are put away in big books and they (doctors and nurses) don't know where to find them. This is a dilemma for the women who need help."

Caroline Antone

Tohono O'dham
Tohono O'dham Justice Center
Rehabilitation Counselor
Sells, Arizona

"We need to find out how to help the men, so they learn not to hurt women and children."

Pat Caverly

Sicangu Lakota Oyate
Pascua Yaqui Tribe Health Programs
Child/Family Therapist
Tucson, Arizona

"I am working with the victims, very young; it's heart-breaking that they are violated like that; there is not an understanding of what happened to them; as they grow older, it wounds the soul."



PARTICIPANT LIST *(continued)*

Arlene Hache

Ojibwe/Algonquin
Indigenous Women’s Network
Austin, Texas

“I have been working with women for thirty years... I started out as a woman that had been treated very badly at a treatment/Shelter... My sister spurred me onto Recovery and now we have developed a Family support program.”

Lea Gilmore

National Abortion Federation
Outreach Director
Washington, DC

“It is more than just domestic violence and sexual violence because there is an overwhelming sense of sisterhood, a shared problem, it is personal and it is important.”

Yohanah B. Leiva

Chinle Comprehensive Health Care Facility
Women’s Health Program Coordinator
Chinle, Arizona

“Women, mothers, sisters, daughters, sexual assault affects everyone.”

GUESTS

Jael Silliman

Program Officer
Reproductive Rights
Ford Foundation
New York, New York

Denise Shannon

Executive Director
Funders Network on Population
Reproductive Health and Rights
Austin, Texas

INTERNS

Emily Blazek

Native American Women’s Health Education
Resource Center
Portland, Maine

Un Ju Kim

Native American Women’s Health Education
Resource Center
Sheridan, Wyoming

Anna Elliot

Indigenous Women’s Network
Amherst, Massachusetts



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INTRODUCTION

The Native American Women's Health Education Resource Center has a long and impressive history of working to protect the reproductive health and rights of Indigenous women. Over the years the Resource Center has worked at the State, Tribal, National and International level to bring forth the reproductive health issues facing Indigenous women.

The Indian Health Service is the federal agency charged with providing health care and services to our Peoples as a Treaty obligation for land seized. For Indigenous Peoples within the boundaries of the United States health care is a right not a privilege. The standard of health care and services provided by the Indian Health Service according to its' mission "is to provide the quantity and quality of health services necessary to elevate the health status of American Indians and Alaska Natives to the highest possible level and to encourage the maximum participation of tribes in the planning and management of those services." Within the Indian Health Service Mission Statement and the actual services provided to Indigenous Peoples there is a huge contradiction. Over the years our focus has been to examine the reproductive health services received by our women. In doing so many violations of health care, lack of standardized policy, below standard services, sterilization abuses, experimentation and human right violations have been documented.

The Department of Justice statistics report that in Native American/Alaska Native communities rape is 3.5 times higher than among all other racial groups in the United States. Considering those statistics it would seem that the Indian Health Service would prioritize all services relating to sexual assault in order to address this very critical public health issue. However, Indian Health Service does not have a national set of sexual assault policies and protocols in place for their emergency rooms or clinics. Indian Health Service could make a huge impact in reducing the number of sexual assaults committed (through the correct collection of forensic evidence) as well as the trauma to

the women and children who have been violated, by implementing a standardized set of policies and protocols for their facilities.

The Native American Women's Health Education Resource Center convened a Roundtable June 10 – 11, 2005 held in Austin, Texas at the Alma de Mujer Retreat Center. The Roundtable brought together women from several Indigenous Nations of North America to examine the kinds of sexual assault services a woman receives when she appears at an Indian Health Service facility for emergency care. Each participant brought a set of personal and professional experiences that echoed over and over, similarities of unacceptable services that result in additional trauma to either themselves or to the women they were assisting during a sexual assault emergency room visit at their local Indian Health Service. The Roundtable was convened in order to discuss the realities Indigenous women experience when seeking emergency room services after a sexual assault and to develop a plan of action and a set of recommendations that would assist in resolving the aforementioned issues.

Charon Asetoyer

Executive Director

Native American Women's Health Education
Resource Center





NATIVE AMERICAN WOMEN AND REPRODUCTIVE HEALTH CARE AND RIGHTS

In October 2002, the Native American Women’s Health Education Resource Center (NAWHERC) released findings that the Indian Health Service (IHS) was not providing lawful abortion services under the Hyde Amendment to Native American women.¹ The findings underscored that Native American women’s health care and rights are in jeopardy. In 2003, representatives from the U.S. and Canada gathered for a Roundtable on access to abortion and provided recommendations for action at the national, international and community-levels.² Since then, NAWHERC partnered with the National Abortion Federation (NAF), the American Indian Law Alliance, the American Civil Liberties Union (ACLU), Cangleska Inc., the Center for Reproductive Rights and other advocacy and women’s health organizations to ensure that treaty-negotiated women’s reproductive health care through IHS remain accessible to Native American women.

According to the Indian Health Service (IHS) fact sheet, the goal of IHS is to ensure that comprehensive, culturally acceptable personal and public health services are available and accessible to all American Indian and Alaska Native people.⁴ While the IHS mission, in partnership with American Indian and Alaska Native people, is to raise their physical, mental, social, and spiritual health to the highest level, Native American women’s reproductive health and rights are inadequately addressed.

As indicated on the IHS website, IHS provides health services to approximately 1.5 million American Indians and Alaska Natives. The patrons of IHS live in 35 states around the US and belong to more than 557 federally recognized tribes. Most of the funds for IHS are allocated for American Indians who live on or near reservations. U.S. Congress also approved and authorized programs that provide some access for Native Americans who live in urban areas. IHS services are provided directly and through tribally contracted and operated health programs. The Federal system consists of 36 hospitals, 61 health

centers, 49 health stations, and 5 residential treatment centers. Across the country’s urban areas, there consists of 34 Indian health projects that provide a variety of health and referral services.⁴

Of great concern is that according to the Department of Justice statistics, rape in Native American/Alaska Native communities is 3.5 times higher than among all other racial groups. Native Americans suffered 7 rapes or sexual assaults per 1,000 while African Americans suffered 3 per 1,000, Whites suffered 2 per 1,000 and Asian Americans suffered 1 per 1,000 (Department of Justice, 1999). However, NAWHERC found that despite these alarming statistics, Native American women have not been receiving adequate care when they have been sexually assaulted.



“There have only been 25 abortions performed since 1981 to 2001, among all of the 350+ Indian Health Service Units. And, we all know of the high rate of sexual assault and life endangerment/high risk pregnancy among our native women.”

— Charon Asetoyer



Native American women who have been sexually assaulted require comprehensive and quality medical care that ensures thorough diagnosis and treatment for the sexual assault complications and screening for sexually transmitted diseases. Additionally, due to the legal implications related to sexual assault, women must have the proper handling of specimens that can contribute to her legal case. The sensitive and traumatic nature of the woman’s injuries require thoughtful and caring attention from all medical providers, especially at the first point of contact usually in the emergency room setting.

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PURPOSE OF THIS ROUNDTABLE REPORT

This Roundtable Report aims to explore the scope of concerns related to the numerous stories about Native American women receiving inadequate, poor, insensitive care in the emergency medical services (EMS) after being sexually assaulted. Moreover, sexually assaulted women have reported experiencing difficulties with legal proceedings that could protect her from further harm. NAWHERC decided to explore this issue in depth so that solutions can

be generated and acted upon that will prevent Native American women from suffering further tragedies. The aim is not only to understand the problems related to providing comprehensive care to Native American women in the emergency room settings but also to develop sustainable solutions at the policy and community levels.

BARRIERS TO COMPREHENSIVE CARE FOR SEXUALLY ASSAULTED WOMEN

A) System and Policy Level Barriers

These barriers are institutionalized, structural and societal obstacles that Native women face when seeking care after instances of sexual assault within an IHS facility.

1) *Access to medical facilities:* Distance to emergency rooms for immediate treatment is a great concern for many Native American women who live in rural reservation areas such as South Dakota, North Dakota, Montana, Nevada, New Mexico, Utah, Wyoming and Alaska, which are characterized for their wide-open spaces. To aggravate the problem with distance to emergency services, an assaulted woman may also need to find transportation to bring her to an emergency room (ER). It may be that the only person that she knows with access to a vehicle is the person who has assaulted her. If the woman is fortunate enough to own a vehicle, the condition of the car may limit the distance she can travel. Sometimes the woman needs to find an escort to the ER, which can be challenge in a small, tight-knit community. Depending on the





circumstances of her assault, she may or may not find a person supportive enough to help transport her to an ER.

- 2) *Lack of provider confidentiality and sensitivity:* Many Native women expressed hesitance to act after being assaulted because of the problems they may face with confidentiality. A lack of confidentiality could put a woman’s safety at risk and endanger her life. Women noted many factors that can help produce such problems with confidentiality, which include the sensitivity to the subject, the values and beliefs that relate to sexual assault, and even the age of the individuals working on the case.

.....
She (a sexually assaulted woman) has to travel many miles, say in Alaska, by plane. In many remote areas of that state, people cannot drive to the nearest ER; and it is not like planes are just available every day and any time of the week.

— Mia Luluquisen
.....

- 3) *Lack of services offered to a sexually assaulted woman:* This may be due to the providers’ lack of knowledge on appropriate procedures and protocols on how to give medical care. NAWHERC’s recent survey indicated that many IHS emergency units did not post sexual assault treatment protocols.³ IHS health care professionals may still believe that the gag rule is still in effect. (The gag rule, which occurred under the Hyde Amendment in 1976, restricted the use of federal funding for abortion counseling and services unless the life of the pregnant woman was endangered.)² Consequently, Native women may feel hopeless in cases of rape and sexual assault when they are not being held as a priority within IHS and other agencies, despite veracity of the problems they face.

.....
“Several states have mandated reporting for rape and others have not. I don’t know which it is in our service area. That to me is a real dilemma for women and little girls who are being raped, especially in regards to the emergency response.”

— Yvonne Bates
.....

“They don’t speak about abortions because they don’t want to support it, so women have to go to a different facility. The same thing goes for medications, such as emergency contraceptives; they have them, but they won’t give them out.”

— Yvonne Bates
.....

- 4) *Untrained IHS/local hospital/other medical staff:* This issue is related to inadequate and perhaps insensitive care to sexually assaulted women. The already traumatized Native American woman can feel unsupported, distrustful and mistreated; this can result in her not seeking further necessary medical treatments or legal assistance.

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“Sometimes the hospitals do a horrible job. There would be a tray, and on the tray would say “rape kit”, and they (doctors, nurses) would come into the waiting room with the kit and call out the woman’s name. This was after the woman had been in the waiting room for 2 hours, or whatever, and she would then have to talk to who knows how many people. First, there would be someone asking about billing, then the nurse, then the doctor, and then law enforcement. It would be about 10 people she would have to tell her story to by the time the process was over...In a case, one time, the ER called me and said, “We have a woman here who has been raped, and we don’t know what to do. This is the nurse talking, and the physician is on the line as well.” They wanted me to tell them, basically, how to do their job...I had an idea of how it goes, but I wasn’t going to be able to sit there on

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the phone and train them...What they were looking at was a big book and the woman was right there, and they had the rape kit, and it was like, "Where do we begin?"

— Bonnie Clairmont

5) *Uncoordinated services*: Providers in the medical, criminal justice, social service and advocacy systems that do not work together can inflict additional harm to assaulted women. Sexually assaulted women who receive insensitive and uncoordinated services may wonder if their actions have been worthwhile.

"An example is with rape kits. There is not always a uniform policy. If there is an un-uniformed policy, not everyone knows what procedure to follow. Some procedures are so brutal and dehumanizing."

— Tammy Young

"Different IHS service units are not all connected. For example, a woman had a pap smear and at the same IHS facility, couldn't get the contraceptive patch, so she went to a different IHS unit. There she had to get a new pap smear to receive the patch."

— Mary Metcalf

6) *Financial costs*: Native women who are sexually assaulted may have to pay for a variety of treatments, medications and other services due to limited health care coverage through IHS.

"What really upset me was that my daughter uses the contraceptive patch and recently the pharmacist said patches were no longer available through IHS. IHS is controlling what is happening to the young girls."

— Gloria Pourier Cournoyer

7) *Differences in belief systems as a barrier to services*: Native women may suffer when health care professionals act upon their own beliefs and values instead of what is best for the patient. The impact of churches can be problematic when women are seeking care after rape/sexual assault, such as in instances of pregnancy termination. Some IHS contract facilities are owned and operated by religious organizations that have policies against discussing abortion as an option or referring to other providers.

"We don't have the same access to abortions, as other women do whose providers are not IHS. So, they actually discriminate against a race. We are the only race whose primary health care providers is the federal government, which is mandated by treaties."

— Charon Asetoyer

"There are pharmacies in South Dakota that will not supply birth control pills because it is against the pharmacist's religion."

— Donna Haukaas

"I am worried about the population of young women whose mothers take them in and say, "Give them Depo-Provera." They just want to keep their daughters from becoming pregnant instead of providing the girls with education on pregnancy, HIV and STD prevention. The young women are talked into getting this done not knowing what it could mean."

— Charon Asetoyer

B) Community level Barriers

These barriers are also institutionalized and structural in nature at the local community level. Native women may face challenges with tribal policies/tribal law enforcement codes that can only go so far with



prosecution of the perpetrator. Since there is an unspoken code of silence associated with rape and sexual assault and with that, a societal acceptance of the perpetrator's behavior, the victim can be mistreated or maligned by her community. This often occurs because the community is affected as a whole. Women especially face difficulties when perpetrators are decision-makers such as Tribal leaders, Tribal council members or relatives of such, and law enforcement personnel.

Furthermore, community members may lack understanding about topics involving sexual assault and not be able to provide necessary support to the victimized woman.

The community level barriers can also include the impact of local churches and the affects when perpetrators are decision makers in the community, as discussed previously.

C) Personal Level Barriers

These barriers are obstacles that victims of sexual assault must overcome internally so that they pursue the most comprehensive and highest quality of care possible. However, women who have been sexually assaulted may feel shame, fears of revictimization and/or retaliation, and mistrust of the health care system. Women often have to conquer numerous emotional obstacles, including anxiety and worry as they seek necessary medical care, counseling and legal advice. They can also face difficulties with making appropriate courses of action when there is lack of necessary and accurate information regarding the full range of care and services available to them.



.....

“We have had experiences where these men are spiritual leaders, have apologized publicly on behalf of their abusive “brothers”, and even cried about the abuses. Then we find out somewhere down the road that this guy is a perpetrator himself! When we say we will believe women, then we need to follow through with that philosophy.”

— Donna Haukaas

.....

“When this young man (perpetrator) came home, he moved in right across the street because there was nothing to prevent him from doing so. My daughter was home for two weeks after treatment, and that was when the young man, her rapist, got out of jail. She was so happy to be home for two weeks, and then she had to go and live somewhere else. Our women are having to leave the only safety or support system that they know.”

— Tammy Young

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RECOMMENDATIONS FOR ACTION

The following section addresses the question: “*What are the components of what it is going to take to do this so that every single woman who is sexually assaulted gets treated with dignity and comprehensive care from now on?*”

Roundtable participants had numerous recommendations for dealing with the previous set of concerns, issues, and problems faced by Native American women who have experienced sexual assault.

Overall goals for action

1) Guarantee Native American women who have been sexually assaulted access to comprehensive reproductive health and follow-up, especially emergency medical services within the Indian Health Services.

- 2) Ensure that uniform policies and protocols (such as the Warm Springs protocol) on rape/sexual assault treatment are implemented and adopted as official policy within Indian Health Service units and their contract facilities.
- 3) Underscore and redress the denial and limitation of reproductive health services for Native Americans, which is a violation of basic treaty and human rights.
- 4) Develop a national public education campaign for the prevention of rape/sexual assault in the Native American community.

WORKING WITH INDIAN HEALTH SERVICE

IHS is a government agency with these responsibilities:

- 1) To raise the physical, mental, social and spiritual health of American Indians and Alaska Natives to the highest level.
- 2) To ensure that comprehensive, culturally acceptable personnel and public health services are available and accessible to American Indian and Alaska Native people.
- 3) To uphold the Federal Government's obligation to promote healthy American Indian and Alaska Native people, communities and cultures and to honor and protect the inherent sovereign rights of Tribes.

What can IHS do regarding sexual assault policies and protocols?

- Issue communications memo to all IHS units and contract facilities that there is NO GAG order on comprehensive reproductive health services, including discussion on contraception and abortion with Native

American women who have been sexually assaulted.

- Develop and adopt a sexual assault protocol such as the Warm Springs Health and Wellness Center Sexual Assault Protocol (see Appendix A) as policy by IHS emergency facilities and their contact hospitals.
- Provide training for IHS staff on the importance and details of the Warm Springs Protocol on Sexual Assault treatment at all direct care facilities.





- Provide training and establish sexual assault nurse examiners and sexual assault forensic examiners (SANE/SAFE) at all direct care facilities. In the United States, nurses and forensic specialists who are trained in the proper collection of medical evidence and on issues concerning sexual assault are called Sexual Assault Nurse Examiners (SANE) and sexual assault forensic examiners (SAFE). These SANEs and SAFEs are on-call in emergency rooms, agencies, clinics, or independent SANE and SAFE centers. They must all follow specific protocols concerning evidence collection and treatment and care of the victim, as indicated by the Stop Violence Against Women website.⁸
- The protocol must include, but not be limited to, forensic collection, protective chain of custody evidence, STD screening with PEP, (Prophylaxis means disease prevention. Post-exposure prophylaxis (or PEP) means taking antiviral medications as soon as possible after exposure to HIV, so that the exposure will not result in HIV infection. These medications are only available with a prescription. PEP should begin within 24 to 36 hours after exposure to HIV, and treatment should continue for 4 weeks, if tolerated. Also, provide treatment as desired on STDs/HIV/AIDS, information on what has been done, counseling on emergency contraceptives with informed consent.⁹
- Include an indicator of the Government Performance Results Act (GPRA) related to improving the response to Native American/ Alaska Native people who experience sexual assault. The purpose of the act as described by the Office of Management and Budget is to: (1) improve the confidence of the American people in the capability of the Federal Government, by systematically holding Federal agencies accountable for achieving program results; (2) initiate program performance reform with a series of pilot projects in setting program goals, measuring program performance against those goals, and reporting publicly on their progress; (3) improve Federal program effectiveness and public accountability by promoting a new focus on results, service quality, and customer



- satisfaction; (4) help Federal managers improve service delivery, by requiring that they plan for meeting program objectives and by providing them with information about program results and service quality; (5) improve congressional decision making by providing more objective information on achieving statutory objectives, and on the relative effectiveness and efficiency of Federal programs and spending; and (6) improve internal management of the Federal Government.¹⁰
- Counsel on STDs (sexually transmitted disease) and emergency contraceptives
- Have a rape kit and the proper equipment
- A kit recommended by (SANE/SAFE)
- A safe, private space designated for the exam
- Participate in SART (Sexual Assault Response Team). According to the Violence Against Women website, these teams are, “coordinated sexual assault response

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teams or programs designed to ensure that victims are provided with a broad range of necessary care and services (legal, medical, social services) and to increase the likelihood that the assault can be successfully prosecuted. Often, such programs or teams include a forensic examiner, a sexual assault advocate, a prosecutor, and a law enforcement officer. All responding actors follow specific protocols that set out their responsibilities in treating and providing services to victims of sexual assault.”⁸

- To have all women who are brought into the ER for sexual assault/injured/battered interviewed for sexual violence

- Add a sexual violence screening questionnaire

Emergency care components for all sexually assaulted individuals

The following considerations must be addressed to ensure that complete, sensitive and appropriate services are provided:

- Safety
- Confidentiality/informed consent
- Emotional and spiritual resources/support
- Medical care-need to ensure reproductive health and rights
- Legal criminal justice support while addressing diverse locations and conditions
- Family and community attention
- Advocacy
- Addressing the relationship context
- Ensuring personal integrity and control

Planning and implementing this overall strategy

Phase 1: Development

- 1) Form a coalition of advocates, health care providers, law enforcement and justice departments
- 2) Use existing models, such as the *Warm Springs Health and Wellness Center Sexual Assault Protocol*, the *National Protocol for Sexual Assault Medical Forensic Examinations*, produced by the US Department of Justice, Office on Violence Against Women, and/or the *Ramsey County Adult Sexual Assault Response Protocol* to expand and adopt for culturally specific national use with Native American communities.
- 3) Modify existing models on jurisdictional and culturally specific needs

Phase 2: Implementation and Evaluation

- 1) Work with NCAI and other policy makers to support tribal leadership
- 2) Develop partnerships with IHS, communities, and tribal governments
- 3) Train staff (i.e. first responders, SANE, SART, SAFE)
- 4) Have SART teams work together
- 5) Provide an evaluation process





.....
“Coalitions have developed a relationship with NCAI, and I can say to you all, without a doubt, that the leadership we have been involved with has been very supportive, not only on national issues but also on individual issues with us, as people, and with what we are going through in our communities.”

— Tammy Young
.....

.....
“I worked in an urban community in Tucson, and a lot of the domestic violence and sexual assault cases went through case managers, who were funded by Title 5. With these grants that the case managers were allocated they could manage all types of cases from substance abuse, to sexual assault to mental health. I think we could develop some kind of partnership like they were able to do with their grants, and I am all for collaboration.”

— Jocelyn Salt

WORKING WITH NATIVE AMERICAN COMMUNITIES

This section addresses the question: “What can be done to prevent occurrence of sexual assault within Native American communities?”

- Advocate for:

- 1) National priority to address sexual assault, reproductive health and rights
- 2) Powerful messages to be sent out to all communities about the importance of the discontinuation of sexual assault
- 3) Marches to protest sexual assaults against Native American women

- Make reproductive health and rights a human rights issue
- Address colonization and the resulting treaties; government-government relationships
- Partner up with National Congress of American Indians (NCAI)
- Re-claim traditional values
- Work with offenders (such as incarcerated men)
- Provide preventive education for the youth
- Utilize the media
- Utilize the theory of detention and re-entry



.....
“We need to look inside of our baskets for those things that are part of our traditions. We need to rely on what is closest to us, to rely on those natural places...There are some answers out there that we have not thought of. We should take this to that spiritual place and look to our natural surrounding because that is what our ancestors did. That is where they found their solutions.”

— Tammy Young
.....

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.....
“We need to ask our prominent leaders in the Indian world to form a man association or man tribal leadership group that is willing to go after male leader perpetrators.”

— Juana Majel Dixon
.....



Planning and implementing this overall strategy

- Discuss reproductive health and rights in community settings
- Break the codes of silence
- Address diverse locations – in reservation, outside, etc.
- Do not accept sexual assault
- Address colonization and the subsequent treaties

- Change tribal policies to decrease likelihood of sexual assault
- Especially concerning the justice system
- Look at traditional healing models and practices
- Utilize the media to provide the public with awareness on sexual violence
- Utilize community members to...
- Develop and conduct activities to foster empowerment among these groups:
- Address the needs of youths in detention
- Create programs
- Encourage young women to get counseling services
- Provide in-services for the administration sexual assault protocols and policies and awareness
- Parents programs to
 - End guilt
 - Provide tools to move forward
 - Make them a part of solution
- Victims
 - Support systems such as relatives mentoring

.....
“In addition to traditional community organizations, some communities have non-political women’s groups, like quilting groups. This is where the information can be shared. I see that as the whole purpose of these groups--for women to come together and talk about women’s business and issues while they are being creative.”

— Donna Haukaas
.....



WORKING NATIONALLY

Proposal to conduct a “National Butterfly Campaign”

.....

“We have developed a plan for a campaign to end sexual violence against Native women. The butterfly image came up with Caroline and the butterfly tree, and the NAWHERC Teen Dating Violence Prevention Curriculum for Native American Girls. Then Tammy was talking about the cocoon and to be able to come out of that. It is relevant because so many of us have been violated, and so we surround and protect ourselves, we may never come out of that cocoon. But, we can come out, and we can reclaim our precious selves.”

— Donna Haukaas

.....

Reasons for the National Butterfly Campaign include:

- Butterflies are in many Native stories
- Each butterfly can represent a person who died young

- Indigenous beliefs that butterflies represent healing and rebirth
 - Means there are not orphans within the Native American culture
 - The dreams of self
 - Butterflies represent the reclaiming of beautiful humanness
 - Each nation’s butterfly symbol joining with others can represent many nations with one voice
-

“And with the butterflies we are talking about unity. So, we thought of shawls, the same colors but each with our own butterflies. And we stand across the lawn and open up our butterflies. We are all connected, and we are coming out of our cocoons because we need to heal.”

— Caroline Antone

.....



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Planning and implementing this overall strategy

- Involve the Native elders
- Choose a day or days to campaign based on days and times that are traditionally important to Native Americans
- Compile stories and songs to represent the day/days
- Provide education to:
 - Staff at Treatment Centers
 - Legislators
 - Colleges/high schools/middle schools/Head Start programs

- TV commercials
- Theatres (before-the-movie advertisements)
- Newspapers
- Magazines

.....
"A nation is only as strong as it's leadership, and its leadership is derived by its people."

— Charon Asetoyer
.....

.....
"I did a 'Native America Calling' radio interview about abortion and the Hyde Amendment. Well, the men were calling in, and they were saying it was about time someone stood up for this, and they were going on saying my sister, my mother, my daughter and so on, all need to have the right to decide for themselves."

— Charon Asetoyer
.....

- Utilize the media to spread awareness about sexual assault
- Radio (local and national)
- Billboards
- Walks/marches
- Bumper stickers
- Pow wows
- T-shirts
- Churches

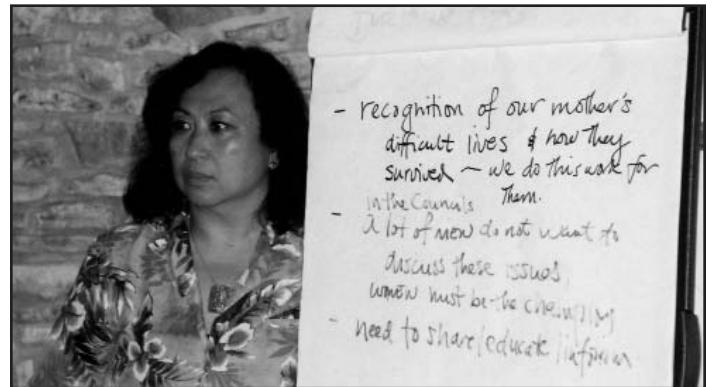




**Dakota Roundtable, 2005
Group Photograph**

Back Row L-R:
Charon Asetoyer, Gloria Pourier
Cournoyer, Pat Caverly, Jocelyn
Salt, Yohanah Leiva, Bonnie
Clairmont, Tammy Young

Front Row L-R:
Donna Haukaas, Deb Blossom,
Jael Silliman, Mia Luluquisien,
Anne Batisse, Mary Metcalf,
Yvonne Bates, Arlene Hache



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ENDNOTES

- 1 Native American Women's Health Education Resource Center. *Indigenous Women's Reproductive Rights: The Indian Health Service and its Inconsistent Application of the Hyde Amendment*, 2002.
- 2 Luluquisen, M, M. Roberts & C. Asetoyer, *Indigenous Women's Reproductive Rights: Roundtable Report on Access to Abortions Services Through the Indian Health Service Under the Hyde Amendment*, Native American Women's Health Education Resource Center. Lake Andes: 2003.
- 3 Native American Women's Health Education Resource Center. *Indigenous Women's Reproductive Rights: A Survey of Sexual Assault Policies and Protocols Within Indian Health Service Emergency Rooms*, 2005.
- 4 Indian Health Service. <http://www.ihs.gov/>, 2005.
- 5 7 per 1000 Native American Women were the victims of rape in 1996 compared with 2 per 1000 women of all races. *American Indians and Crime*, 1996.
- 6 Indian Affairs: Laws and Treaties. <http://digital.library.okstate.edu/kappler/index.htm>, 2005.
- 7 Indian Health Service: Violence Against Native Women Policy and Procedures, Sexual Assault Protocols. <http://www.ihs.gov/Medicalprograms/MCH/W/DV05.cfm#top>, 2005.
- 8 Stop Violence Against Women. http://www.stopvaw.org/Sexual_Assault_Response_Teams.html and [http://www.stopvaw.org/sexual_Assault_Nurse_Examiners_\(SANE\)](http://www.stopvaw.org/sexual_Assault_Nurse_Examiners_(SANE)), 2005.
- 9 AIDS.org fact sheet. <http://www.aids.org/factSheets/156-Treatment-After-Exposure-to-HIV-PEP.html>, 2005.
- 10 Office of Management and Budget. <http://www.whitehouse.gov/omb/mgmt-gpra/gplaw2m.html#h2>, 2005





APPENDIX A: SEXUAL ASSAULT PROTOCOLS, WARM SPRINGS HEALTH AND WELLNESS CENTER

<http://www.ihs.gov/Medicalprograms/MCH/W/DV05.cfm#top>

The purpose of these protocols is to provide for medical professionals in the care of the Sexual Assault Survivor. The goal is to ensure that compassionate and sensitive delivery of services and care, are provided in a non- judgmental manner. The following protocols are based on current Oregon and Local Tribal Law, American College of Emergency Physicians recommendations for the prophylactic treatment of sexually transmitted diseases, pregnancy prevention and the “Best Practice” in the Care of the Sexual assault survivor. These Protocols are divided into three sections: Standards, Recommendations and Resources. The physical, emotional and psychological well being of the sexual assault survivor is given precedence over all other matters.

STANDARDS

These are the protocols that represent the basic standards in the care of the sexual assault survivor.

I. ADVOCACY

- a. The survivor is informed that they have the right to speak to a sexual assault advocate. If the survivor decides to speak with an advocate, notification may be made by law enforcement or a medical professional.

II. LAW ENFORCEMENT NOTIFICATION

- a. If the survivor is 17 years of younger, law enforcement must be notified.
- b. If the survivor is 18 years or older and is a dependent person or diminished mental capacity or 65 years of age or older, law enforcement must be notified.

III. CONSENT

- a. Informed consent for all procedures, evidence collection and treatments is obtained in all cases
- b. Survivor 14 years and older may sign their consents
- c. Survivors 13 years and younger, a parent or guardian must sign consent

IV. EVIDENCE

- a. Standard Forensic Evidence Collection Kit, provided by Oregon State Police Crime lab, is used for evidence collection.
- b. Standard Documentation Forms, Provided with the kit, are used in the evidence collection process.
- c. The evidence collection exam is done by a nurse examiner or physician currently licensed in their state of practice. The preferred examiner would be a sexual assault forensic examiner.



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V. RELEASE OF INFORMATION

- a. Release of information /documentation is not done without first informing the survivor of the reasons for release and obtaining a signed consent.

VI. COST OF EVIDENCE COLLECTION

- a. Survivors will not be charged for the cost of the forensic evidence exam as long as they are reporting the assault to law enforcement or an exam has been requested by law enforcement.

VII. TREATMENT

- a. Every survivor will be offered prophylactic treatment for gonorrhea, chlamydia, trichomonas and hepatitis B if available. Survivors should be informed in addition, they may be at risk for having contracted HPV and herpes and be offered information about these STDs. Survivors may be offered tetanus vaccine if indicated.
- b. Every survivor will be offered prophylactic treatment for pregnancy prevention. If the survivor declines pregnancy prophylaxis, obtain refusal consent.

RECOMMENDATIONS

I. EMERGENCY CONTRACEPTION IN THE NON-PREGNANT SURVIVOR

- A. Pregnancy prophylaxis: all female survivors will be assessed for pregnancy. For survivors who have a negative pregnancy test and are at risk for conception from this assault, do the following:
- i. Offer Emergency Contraception. Provide education to the survivor about Emergency Contraception so that she can make an informed choice.
 - ii. Obtain the survivors signed consent for emergency contraception.
 - iii. Dispense the pills to the survivor and encourage the first dose be taken as soon as possible.
 - iv. Listed here are the medications used for Emergency Contraception.

1. Plan B
2. Preven
3. **Orval** (available in clinic pharmacy, 2 now 2 in 12 hours)
4. Ogestrel
5. Alesse
6. Aviane
7. Levlite
8. Nordette
9. Levlen
10. Levora
11. Lo/Ovral
12. Low-Ogestrol
13. Triphasil
14. Tri-levlen
15. Trivora
16. Orvette



Plan B is the preferred drug as it contains no estrogen and side effects are greatly reduced. The treatment of choice is one dose within 72 hours after unprotected intercourse and another dose 12 hours later. However, current research indicates that EC remains highly effective for 120 hours (5 days) after intercourse and survivors should be offered the choice of taking EC up to 120 hours.

B. Anti-emetic medications may be used when giving Emergency Contraception. Listed below are medications recommended for this use:

- i. Metoclopramide 10 mg PO q 6 hours prn
- ii. Meclizine 25-50 mg PO q 6 hours
- iii. Diphenhydramine 25-50 mg PO q 6 hours
- iv. Promethazine 25 mg PO or PR q 6 hours prn
- v. Dramamine 25-50 mg PO q 6 hours prn

Doses of anti emetics should be altered according to the patient's weight, age and other current medications.

II. INFECTIOUS DISEASE PROPHYLAXIS IN THE NON-PREGNANT SURVIVOR

Review allergies with the survivor and dispense accordingly. Do not use Ciprofloxacin in pregnancy.

A. Gonorrhea Prophylaxis:

- i. Cefixime (Suprax) 400 mg PO x 1 dose
- ii. Cefpodoxime (Vantin) 200mg PO x 1 dose
- iii. Ciprofloxacin (Cipro) 500mg PO x 1 dose
- iv. Ceftriaxone 125mg IM x 1 dose
- v. Spectinomycin 40 mg/kg IM x 1 dose (max 2 g)

B. Chlamydia Prophylaxis:

- i. Azithromycin (Zithromax) 1 gram PO x 1 dose.
- ii. Doxycycline 100 mg PO BID x 7 days

Do not use doxycycline in pregnancy

C. Trichomonas Prophylaxis:

- i. Metronidazole (Flagyl) 2 grams PO x 1 dose



D. Hepatitis B Prophylaxis:

- i. If the survivor has never been immunized to Hepatitis B, you may initiate the first dose of the Hepatitis B vaccine in the Emergency Department.
- ii. If the survivor is unsure of their immunization status or has been partially immunized, draw Hepatitis B antibody titer. At the time of discharge provide the patient with instructions for appropriate follow up of titer results and completion of the vaccine series.

E. Tetanus Prophylaxis:

- i. If the patient has skin abrasions or other wounds and the immunization status is unknown or greater than 10 years, for low risk wound and greater or 5 years for high risk wound, give the dT immunization.

INDIGENOUS WOMEN'S REPRODUCTIVE JUSTICE

ROUNDTABLE REPORT ON SEXUAL ASSAULT POLICIES AND PROTOCOLS WITHIN INDIAN HEALTH SERVICE EMERGENCY ROOMS

- ii. If the survivor has never been immunized, give Tetanus Immune Globulin (Hypertet) 250 units IM and dT immunization. Give each IM injection in a different extremity. Refer the patient for follow up to complete the immunization series.

III. INFECTIOUS DISEASE PROPHYLAXIS IN THE PREGNANT SURVIVOR

Review allergies with the survivor and dispense accordingly.

- A. Gonorrhea Prophylaxis:
 - i. Cefixime (Suprax) 400 mg PO x 1 dose
 - ii. Cefpodoxime (Vantin) 200mg PO x 1 dose
 - iii. Ceftriaxone 125mg IM x 1 dose
 - iv. Spectinomycin 40 mg/kg IM x 1 dose (max 2 g)
- B. Chlamydia Prophylaxis:
 - i. Azithromycin (Zithromax) 1 gram PO x 1 dose.
- C. Trichomonas Prophylaxis:
 - i. Metronidazole (Flagyl) 2 grams PO x 1 dose
- D. Hepatitis B Prophylaxis:
 - i. If the survivor has never been immunized to Hepatitis B, you may initiate the first dose of the Hepatitis B vaccine in the Emergency Department.
 - ii. If the survivor is unsure of their immunization status or has been partially immunized, draw Hepatitis B antibody titer. At the time of discharge provide the patient with instructions for appropriate follow up of titer results and completion of the vaccine series
- E. Tetanus Prophylaxis:
 - i. If the patient has skin abrasions or other wounds and the immunization status is unknown or greater than 10 years, for low

risk wound and greater or 5 years for high risk wound, give the dT immunization.

- ii. If the survivor has never been immunized, give Tetanus Immune Globulin (Hypertet) 250 units IM and dT immunization. Give each IM injection in a different extremity. Refer the patient for follow up to complete the immunization series.

RESOURCES

I. FOLLOW UP

- A. Appropriate medical follow up will be given for evaluation of possible sexually transmitted diseases, pregnancy and any physical injuries the survivor may have sustained during the assault.
- B. Follow up counseling information will be provided to the survivor by the sexual assault advocate or the forensic medical examiner.
- C. Information on area resources concerning: medical follow up, crisis intervention phone numbers, rape crisis centers, shelters, Crime Victims Compensation Program, law enforcement and the district attorney's office will be given to the survivor at the time of discharge.





APPENDIX B: NCAI (NATIONAL CONGRESS OF AMERICAN INDIANS) RESOLUTION

Resolution 01

Title: Native American Women's Roundtable on Sexual Assault Policies and Protocols Within Indian Health Service Emergency Rooms

Re: A historic convening of Indigenous women was convened June 10 to June 11, 2005 at the Alma de Mujer Retreat Center, owned and operated by the Indigenous Women's Network in Austin, Texas. Following are the Tribal Nations and Organizations participating:

Comanche Nation, Sicangu Lakota Nation (RST), Oglala Lakota Nation, Navajo Nation, Tlingit Nation, Ilokano/Heiltsuk, Ho Chunk Nation, Ojibwe/Algonquin Nation, Pauma-Yuima Band of Mission Indians Nation, Shoshone/Paiute Nation, Crow Creek Sioux Tribe, Wichita and Affiliated Tribes/Caddo Nation, Tohono O'dham Nation.

Organizations: Native American Women's Health Education Resource Center, Tribal Law & Policy Institute, Indigenous Women's Network, Cangleska, Inc., National Congress of American Indians, Alaska Native Woman's Coalition, Great Basin Coalition, South Dakota Coalition Against Domestic Violence and Sexual Assault, Hope House Family Violence Prevention Program, Tohono O'dham Justice center, Red Sun Institute.

WHEREAS, a roundtable was convened to discuss the report, *Indigenous Women's Reproductive Justice: A Survey of Sexual Assault Policies and Protocols Within Indian Health Service Emergency Rooms* done by the Native American Women's Health Education Resource Center, based in Lake Andes, South Dakota on the Yankton Sioux Reservation, released in January 2005 (Attachment A).

WHEREAS, this survey documents substantial critical health care services for Indigenous women seeking treatment for rape, incest and sexual assault within Indian Health Service Emergency Rooms is not being provided.

WHEREAS, according to the Department of Justice statistics, rape in Native American/Alaska Native communities is 3.5 times higher than among all other racial groups. "American Indians/Alaska Natives suffered 7 rapes or sexual assaults per 1,000 compared to 3 per 1,000 for African Americans and 2 per 1,000 for Whites and 1 per 1,000 for Asian Americans." (Department of Justice, 1999)



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WHEREAS, the Bureau of Justice Statistical Profile indicates that the violent victimization among American Indian/Alaska Native women was more than double that among all women. Further American Indians/Alaska Natives were more likely to be victims of assault and rape/sexual assault committed by a stranger or acquaintance rather than an intimate partner or family member.

Approximately 60% of American Indian victims of violence, about the same percentage as of all victims of violence, described the offender as white. (American Indians and Crime, A BJS statistical profile, 1992-2002)

WHEREAS, this historic convening of Indigenous women assembled to discuss the impact of the findings of this survey within their communities and across the Indigenous lands of North America. The discussions concurred with the findings of the survey and expanded to include a set of recommendations to improve the level of rape, incest and sexual assault services provided by Indian Health Service Emergency Rooms.

WHEREAS, A plan of action was laid out that would establish a working group where by this body would partner with the National Congress of American Indians and their constituents to assist with moving forward policy recommendations supported by the National Congress of American Indians to Indian Health Services for implementation and any other governmental agency or body that would work toward ending rape, incest and sexual assault against indigenous women.

NOW THEREFORE BE IT RESOLVED, the working group of the Dakota Roundtable will develop a national policy/protocol on rape/sexual assault to be implemented within Indian Health Service units (direct care facilities).

BE IT FURTHER RESOLVED, the working group of the Dakota Roundtable has laid out the framework for a national public education campaign for the prevention of rape/sexual assault; and

BE IT FURTHER RESOLVED, the working group of the Dakota Roundtable will partner with National Congress of American Indians by providing them the necessary information: the national policy/protocols on rape/sexual assault and a national public education campaign for the prevention of rape/sexual assault, and

BE IT FURTHER RESOLVED, that National Congress of American Indians will urge the adoption and implementation of the national policy and protocols on rape/sexual assault within the Indian Health Service Unites (Direct care facilities).

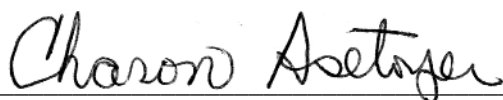


INDIGENOUS WOMEN'S REPRODUCTIVE RIGHTS

ROUNDTABLE REPORT ON SEXUAL ASSAULT POLICIES AND PROTOCOLS WITHIN INDIAN HEALTH SERVICE EMERGENCY ROOMS

CERTIFICATION

The foregoing resolution was adopted at the Native American Women's Roundtable on Sexual Assault Policies and Protocols Within Indian Health Service Emergency Rooms, held at the Alma de Mujer Retreat Center, Austin, Texas, on June 10 and 11, 2005.



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

ATTEST:



Recording Secretary
Donna Haukaas

Adopted by the Convening Organization, Native American Women's Health Education Resource Center, held in Austin, Texas, from June 10-11, 2005.