NO EXCEPTIONS MADE: SEXUAL ASSAULT AGAINST NATIVE AMERICAN WOMEN AND THE DENIAL OF REPRODUCTIVE HEALTHCARE SERVICES

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> We know that rape is a big problem. Our women are being raped . . . And we know sexual abuse crimes are huge in Indian country and we're not getting the kind of services [we deserve]. They are not tying in or linking the consequences and they are not proving the ultimate standard of health care.
>
> - Charon Asetoyer
> Native American Women's Health Education Resource Center[1]

1. NATIVE AM. WOMEN'S HEALTH EDUC. RES. CTR., INDIGENOUS WOMEN'S REPRODUCTIVE RIGHTS: ROUNDTABLE REPORT ON ACCESS TO ABORTION SERVICES THROUGH THE INDIAN HEALTH SERVICE UNDER THE HYDE AMENDMENT 9 (2003) [hereinafter ACCESS TO ABORTION SERVICES].

INTRODUCTION

According to the United States Department of Justice, a staggering 34% of all Native American[2] women have reported being sexually assaulted.[3] Native American women are nearly three times more likely to be sexually assaulted than women of any other ethnic group in the United States.[4] Despite these statistics, sexual assault against Native American women is an epidemic largely ignored by the federal government. Effectively addressing widespread sexual assault against Native American women necessitates a multi-layered approach that appreciates the severity of the epidemic of sexual assault and its impact on

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2. I use the term "Native American" to include both Alaska Natives and tribes in what is now the continental United States. I do this as linguistic shorthand, recognizing that the term "Native American" does not capture the cultural, political, or legal differences among the over 560 tribes and Alaska Natives in the United States.

3. PATRICIA TJADEN & NANCY THOENNES, NAT'L INST. OF JUSTICE, NCJ 210346, EXTENT, NATURE, AND CONSEQUENCES OF RAPE VICTIMIZATION: FINDINGS FROM THE NATIONAL VIOLENCE AGAINST WOMEN SURVEY 14 exh.8 (2006), *available at* http://www.ncjrs.gov/pdffiles1/nij/210346.pdf. I use the term "sexual assault" instead of "sexual violence" throughout this Article to mean nonconsensual sexual intercourse that could result in an unwanted and/or an unintended pregnancy. Sexual assault, as explained by the Office on Violence Against Women within the Department of Justice, is usually defined more broadly to include "any type of sexual contact or behavior that occurs without the explicit consent of the recipient of the unwanted sexual activity. Falling under the definition of sexual assault is sexual activity such as forced sexual intercourse, sodomy, child molestation, incest, fondling, and attempted rape." *The Facts about the Office on Violence Against Women Focus Areas*, OFFICE ON VIOLENCE AGAINST WOMEN, http://www.ovw.usdoj.gov/docs/ovw-focus-areas.pdf (last visited Nov. 28, 2010). Some scholars prefer to use the term "sexual violence" to describe the full range of gender violence facing Native American women. *See generally* Sarah Deer, *Relocation Revisited: Sex Trafficking of Native Women in the United States*, 36 WM. MITCHELL L. REV. 621 (2010). Sexual violence is a broader term—commonly used in international law but used more and more frequently in the domestic context—that captures the full range of gender-based crime suffered by women. *See generally* Amy Palmer, Note, *An Evolutionary Analysis of Gender-Based War Crimes and the Continued Tolerance of "Forced Marriage,"* 7 NW. U. J. INT'L HUM. RTS. 133 (2009). Noting that the definition of sexual violence "may be influenced by cultural values, social norms, human rights, gender roles, legal initiatives and crime and may evolve over time," the National Sexual Violence Resource Center defines sexual violence as "any sexual act, attempt to obtain a sexual act, unwanted sexual comments or advances, or acts to traffic, or otherwise directed, against a person's sexuality using coercion, by any person regardless of their relationship to the victim, in any setting, including but not limited to home and work." NAT'L SEXUAL VIOLENCE RES. CTR., GLOBAL PERSPECTIVES ON SEXUAL VIOLENCE 4 (2004), http://www.nsvrc.org/sites/default/files/Publications_NSVRC_Booklets_Global-perspectives-on-sexual-violence.pdf. Although I would normally use the term "sexual violence" to describe gender-based violence in Indian Country, I specifically use "sexual assault" in this Article to draw the reader's attention to the specific act of non-consensual sexual intercourse that could result in unwanted and/or unintended pregnancy.

4. STEVEN W. PERRY, U.S. DEP'T OF JUSTICE, NCJ 203097, A BJS STATISTICAL PROFILE 1992-2002: AMERICAN INDIANS AND CRIME 5, 5 tbl.7 (2004) ("American Indians were twice as likely to experience a rape/sexual assault (5 per 1,000 persons age 12 or older) compared to all races (2 per 1,000).").

the broader Native American population. Eradicating sexual assault against Native American women will require a coordinated effort by federal, state, and tribal governments, which examines both legal remedies and public health interventions while simultaneously recognizing the marginalization of Native American people within the United States. Generally, the discussions surrounding the eradication of sexual assault against Native American women focus on the legal barriers to the prosecution, the punishment of offenders, and the government's failure to prioritize this issue.[5] While this is a crucial piece of the puzzle, the focus must broaden to recognize that the cycle of violence against Native American women is perpetuated when women are denied access to reproductive healthcare services, including abortion, in the aftermath of sexual assault.[6] Obstacles to accessing reproductive healthcare services re-victimize and re-marginalize Native American women; sexual assault and inadequate post-trauma medical care may force Native American women to live with sexually transmitted infections, long-term mental health problems including an elevated risk of suicide, unwanted pregnancies and, in an ultimate act of violence, carrying unwanted pregnancies to term because they cannot exercise their constitutionally protected right to choose.[7] This Article explores the cycle of violence faced by Native American women not only from the legal perspective but also from the public health perspective. It argues that obstacles put in the path of women seeking comprehensive reproductive healthcare after a sexual assault—often resulting in the denial of treatment—perpetuate violence by jeopardizing and undervaluing Native American women's health.

Before outlining how this Article proceeds, I want to make two important points. First, advocates for tribes and Native American women's rights have focused attention on the crisis of sexual assault in Indian Country[8]—Amnesty

5. *See* Sarah Deer, *Sovereignty of the Soul: Exploring the Intersection of Rape Law Reform and Federal Indian Law*, 38 SUFFOLK U. L. REV. 455 (2005) [hereinafter Deer, *Sovereignty of the Soul*]; Sarah Deer, *Toward an Indigenous Jurisprudence of Rape*, 14 KAN. J.L. & PUB. POL'Y 121 (2004-05); Marie Quasius, Note, *Native American Rape Victims: Desperately Seeking an* Oliphant*-Fix*, 93 MINN. L. REV. 1902 (2009).

6. I strongly believe all Native American women should receive comprehensive reproductive health services, including abortion, not just women seeking services after sexual assault. For purposes of this Article, however, I look solely at ensuring that Native American women have access to abortion services, should they choose an abortion, in the aftermath of sexual assault.

7. Zoe Morrison et al., "*Ripple Effects" of Sexual Assault,* ACSSA ISSUES, June 2007, at 1, 1-2; Lisa A. Goodman et al., *Violence Against Women: Physical and Mental Health Effects, Part 1: Research Findings*, 2 APPLIED & PREVENTIVE PSYCHOL. 79, 80-81 (1993). An estimated 5% of sexual assaults result in pregnancy. Deborah Kacanek et al., *Medicaid Funding for Abortion: Providers' Experiences with Cases Involving Rape, Incest and Life Endangerment*, 42 PERSP. ON SEXUAL & REPROD. HEALTH 79 (2010).

8. "Indian Country" is defined by 18 U.S.C. § 1151 (2006) to include reservations. Specifically, Indian Country is:

> [A]ll land within the limits of any Indian reservation under the jurisdiction of the United States Government, . . . all dependent Indian communities within the borders of the United States whether within the original or subsequently acquired

International released a report detailing the epidemic of sexual assault in Indian Country[9] and, in response, the United States Senate Committee on Indian Affairs held hearings on the matter[10]—but that advocacy has not focused on the reproductive healthcare ramifications of sexual assault. Although I firmly believe that prosecution of the perpetrators of sexual assault is crucial to halting such violence and that restoring concurrent jurisdiction to tribes to prosecute non-Indian[11] offenders is necessary to accomplish that goal, I do not believe that simply remedying the jurisdictional black hole in Indian Country will end sexual assault or its aftereffects. Native American women must have access to comprehensive reproductive healthcare to recover from sexual assault and to achieve gender equality. The lack of reproductive health care services after sexual assault has not been the focus of any major human rights investigations of which I am aware. Nor has the federal government taken up this issue. With this Article, I aim to begin the effort of addressing the reproductive healthcare ramifications of the sexual assault of Native American women.

Second, this Article is intended only to advocate for choice—Native American women who become pregnant as a result of sexual assault should have both the option to terminate their pregnancy if they so choose *and* the option to carry their pregnancy to term with the support they need to do so. The choice should always lie with the individual pregnant woman. I would be remiss if I did not acknowledge that the United States has a shameful history of forced and coercive sterilization of Native American women.[12] Native

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> territory thereof, and whether within or without the limits of a state, and [] all Indian allotments, the Indian titles to which have not been extinguished, including rights-of-way running through the same.

9. AMNESTY INT'L, MAZE OF INJUSTICE: THE FAILURE TO PROTECT INDIGENOUS WOMEN FROM SEXUAL VIOLENCE IN THE USA (2007), http://www.amnestyusa.org/women/maze/report.pdf.

10. *Examining the Prevalence of and Solutions to Stopping Violence Against Indian Women*: *Hearing Before the S. Comm. on Indian Affairs*, 110th Cong. 1 (2007) (statement of Sen. Byron L. Dorgan, Chairman, S. Comm. on Indian Affairs). Additionally, the United Nations Permanent Forum on Indigenous Issues recently called on all States to "take immediate action to review and monitor the situation of indigenous women and provide comprehensive reports on violence against indigenous women and girls, particularly sexual violence and violence in the context of armed conflict." U.N. Permanent Forum on Indigenous Issues, Rep. on its 5th Sess., May 15-26, 2006, ¶ 47, U.N. Doc. E/2006/43, Supp. No. 23 (2006), *available at* http://www.un.org/esa/socdev/unpfii/en/session_fifth.html.

11. "Non-Indian" is a legal term of art used to describe anyone who is not Native American.

12. Lindsay Glauner, Comment, *The Need for Accountability and Reparation: 1830-1976 The United States Government's Role in the Promotion, Implementation, and Execution of the Crime of Genocide Against Native Americans*, 51 DEPAUL L. REV. 911, 939-40 (2002) ("As early as the 1930s, the Bureau of Indian Affairs, under the auspices of the Indian Health Services, began to execute a covert program designed to sterilize all Native American women. As a result, sterilization became a regular practice at various Native American hospitals. The sterilization procedure was carried out under the guise of medical necessity to protect the woman's health, or in the alternative, the procedure was performed without the woman's knowledge or consent. Between the early 1970s and early 1980s, these

American women may be legitimately wary of any relationship between their reproductive capacity and the United States government. In no way do I wish to minimize the impact of this history or discount legitimate misgivings Native American women may feel toward doctors. However, it is my belief that women cannot be truly autonomous until they control their reproductive destiny. Part and parcel of achieving autonomy is giving Native American women control over their own bodies by ensuring access to safe abortion services should a woman elect not to carry a pregnancy to term in the aftermath of sexual assault.

This Article proceeds as follows. Part I examines the reality of sexual assault in Indian Country and the legal regime that governs the prosecution of offenders. Perpetrators of sexual assault are frequently identified as non-Indian.[13] By taking few meaningful affirmative steps to prevent non-Indians from perpetrating violence against Native American women, the federal government has effectively condoned such violence. This part will also address the unique obligation of the United States to provide law enforcement and healthcare to Native Americans as part of the trust relationship between tribes and the United States government.

Part II examines the reproductive health ramifications of sexual assault, focusing on potential unwanted pregnancy, and the health services to which Native American women are entitled, as compared to the services they actually receive from the Indian Health Service (IHS).[14] Specifically, the Hyde Amendment restricts the ability of IHS to provide abortions to Native American women except when pregnancy results from rape or incest, or when the life of the pregnant woman is endangered by carrying the pregnancy to term.[15] However, research by the Native American Women's Health Education Resource Center reveals that women who turn to IHS for medical attention following sexual assault frequently cannot get a rape kit, do not receive emergency contraception, and later may not be able to obtain an abortion should they have an unwanted pregnancy.[16] Access to these services is severely

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programs forcibly sterilized more than forty-two percent of all Native American women of childbearing age. For many small Indian tribes, this led to an almost complete elimination of their entire tribe."); Nancy Ehrenreich, *The Colonization of the Womb*, 43 DUKE L.J. 492, 515 (1993) ("African-American women, along with Latina (especially Puerto Rican) and Native American women, were subjected to forced sterilization in appalling numbers up through the 1970s, a practice that continues in 'milder' forms today.").

13. PERRY, *supra* note 4, at 9-10 fig.2.

14. *See generally* Joan C. Chrisler & Sheila Ferguson, *Violence Against Women as a Public Health Issue*, *in* VIOLENCE AND EXPLOITATION AGAINST WOMEN AND GIRLS 235 (Florence L. Denmark et al. eds., N.Y. Acad. of Sci. 2006), (discussing the reproductive health ramifications of sexual assault); Lori L. Heise, *Reproductive Freedom and Violence Against Women: Where Are the Intersections?*, 21 J. L. MED. & ETHICS 206 (1993).

15. Omnibus Appropriations Act, 2009, Pub. L. No. 111-8, § 508, 123 Stat. 524, 803 (2009).

16. *See* JULIE ANDREWS ET AL., NATIVE AM. WOMEN'S HEALTH EDU. RES. CTR., INDIGENOUS WOMEN'S REPRODUCTIVE JUSTICE: A SURVEY OF SEXUAL ASSAULT POLICIES AND PROTOCOLS WITHIN INDIAN HEALTH SERVICE EMERGENCY ROOMS 6 figs.1, 2 & 3 (2004).

limited because IHS does not have the financial resources or medical personnel necessary to provide sexual assault victims[17] with the reproductive healthcare they need.[18]

Part III argues that the federal government is party to the perpetuation of the cycle of gender-based violence in Indian Country by ignoring the epidemic and by failing to provide necessary healthcare services, including basic reproductive healthcare, to Native American women who have been sexually assaulted. I examine whether the United States has a positive state obligation to take affirmative steps to end sexual assault and unwanted pregnancy in the aftermath of sexual assault. This part further examines *Harris v. McRae*, an unsuccessful challenge to the Hyde Amendment on behalf of indigent women.[19] Considering previous attacks on the Hyde Amendment, I explore the possibility of using an Indian law theory to attack the inability of Native American women who become pregnant after a sexual assault to obtain abortion services through IHS—specifically examining *Lincoln v. Vigil*, a United States Supreme Court case in which a group of Native Americans unsuccessfully attempted to force IHS to continue funding a program for special needs children despite IHS's refusal to do so.[20] Finally, I suggest several policy solutions that could help end sexual assault against Native American women and ensure that victims have access to comprehensive reproductive healthcare.

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17. I have consciously chosen to use "victim" instead of "survivor" when describing women who have experienced sexual assault. For many, "survivor" is the "preferred term because it was used as part of a process to move past the trauma of a sexual assault" and is viewed as a more positive term than is the term "victim." Corey Rayburn, *To Catch a Sex Thief: The Burden of Performance in Rape and Sexual Assault Trials*, 15 COLUM. J. GENDER & L. 437, 441 n.19 (2006). Andrea Dworkin advocates the use of the term "victim" because it denotes the fact that the individual was injured by someone's actions.

> It's a true word. If you were raped, you were victimized. You damned well were. You were a victim. It doesn't mean that you are a victim in the metaphysical sense, in your state of being, as an intrinsic part of your essence and existence. It means somebody hurt you. They injured you.
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> And if it happens to you systematically because you are born a woman, it means that you live in a political system that uses pain and humiliation to control and to hurt you.

Andrea Dworkin, *Woman-Hating Right and Left*, *in* THE SEXUAL LIBERALS AND THE ATTACK ON FEMINISM 28, 38 (Dorchen Leidholdt & Janice G. Raymond eds., 1990). Every person who experiences sexual assault should use the term that properly describes how they wish to be identified. I use the term "victim" in part because it is used throughout many of the sources upon which I have relied in this Article and in part because I am persuaded by Professor Dworkin's argument.

18. *See* U.S. COMM'N ON CIVIL RIGHTS, A QUIET CRISIS: FEDERAL FUNDING AND UNMET NEEDS IN INDIAN COUNTRY 5-6 (2003), *available at* http://www.usccr.gov/pubs/na0703/na0204.pdf [hereinafter A QUIET CRISIS].

19. Harris v. McRae, 448 U.S. 297 (1980).

20. Lincoln v. Vigil, 508 U.S. 182, 184 (1993).

I. SEXUAL ASSAULT IN INDIAN COUNTRY

Before broaching the issue of reproductive rights for Native American women who are the victims of sexual assault, I will explore the sexual assault epidemic facing Indian Country and the jurisdictional issues that hamper prosecution. This foundation is crucial to understanding why the lack of access to reproductive healthcare services is part of a system of victimization against Native American women: first, a Native American woman is sexually assaulted; second, she is unable to seek redress through the criminal justice system; and, third, she is unable to access the reproductive healthcare services she is entitled to in the aftermath of her sexual assault.

A. The Epidemic of Sexual Assault in Indian Country

In 2006, the National Institute of Justice estimated that 34.1% of Native American women had been victims of sexual assault, whereas 17.9% of Caucasian women had been victims of sexual assault.[21] This statistic translates into the startling fact that one in three Native American women will be a victim of sexual assault. Sexual assault is chronically underreported nationwide; only 16% of sexual assaults are reported to the police.[22] In part because of persistently low reporting rates, legal scholars and advocates on-the-ground argue that Department of Justice statistics regarding sexual assault against Native American women are very low. Professor Sarah Deer noted that "[m]any of the elders [she has] spoken with in Indian Country [explain] that they do not know any women in their community who have not experienced sexual violence."[23]

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21. TJADEN & THOENNES, *supra* note 3. This is consistent with statistics that Native Americans are more than twice as likely as any other racial group in the United States to be the victim of violent crimes. PERRY, *supra* note 4, at 4-5 ("The annual average violent crime rate among American Indians from 1992 to 2001 (101 per 1,000 person age 12 or older) was about 2½ times the national rate (41 per 1,000 persons). The annual average violent crime rate among American Indians was twice as high as that of blacks (50 per 1,000 persons), 2½ times higher than that for whites (41 per 1,000 persons), and 4½ times that for Asians (22 per 1,000 persons).").

22. DEAN G. KILPATRICK ET AL., MED. UNIV. OF S.C., DRUG-FACILITATED, INCAPACITATED, AND FORCIBLE RAPE: A NATIONAL STUDY 2 (2007), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants/219181.pdf. Legal Momentum criticized the federal government's 2008 report on female victims of violence, arguing that flawed methodology woefully underestimated the actual rate of sexual assault: whereas the Bureau of Justice Statistics estimated that 182,000 rapes occurred in 2006, highly regarded researchers in the same field estimated that 1,000,000 rapes occurred. Lynn Hecht Schafran & Jillian Weinberger, *New U.S. Crime Reports: Flawed Methodology Sharply Underestimates Rape Rates against Women and Persons with Disabilities*, LEGAL MOMENTUM (Oct. 26, 2009), http://legalmomentum.typepad.com/blog/2009/10/new-us-crime-reports-flawed-methodology-sharply-underestimates-rape-rates-against-women-and-persons-.html.

23. Deer, *Sovereignty of the Soul*, *supra* note 5, at 456. Professor Deer's observation rings true. In conversations I have had with Native American women, I have frequently heard the same thing—Department of Justice statistics are shockingly low.

In spite of the extraordinarily high rate of sexual assault against Native American women, victims are often denied recourse within the criminal justice system against their attackers. The federal government stripped tribes of the power to prosecute non-Indian perpetrators of sexual assault against tribal members; however, the federal government rarely prosecutes the perpetrator.[24] The Bureau of Justice Statistics found that sexual assault against Native American women was overwhelmingly committed by non-Indians, and reported that over 80% of offenders were described as non-Indian.[25] This statistic is critical to understanding the cycle of violence in Indian Country: in the majority of cases, the federal government has sole prosecutorial authority and, yet, frequently fails to exercise that authority. The absence of meaningful avenues for criminal justice alone constitutes the re-victimization and re-marginalization of Native American sexual assault victims. Not only do Native American women face a heightened risk of sexual assault, but they are also at greater risk because prosecution of the perpetrators of sexual assault in Indian Country is almost unheard of, and because they have very little access to adequate reproductive healthcare services in the aftermath of sexual assault. Before exploring the reproductive healthcare concerns of Native American women in the aftermath of sexual assault, we must first examine the unique relationship between the federal government and tribes as well as the complicated reality of criminal jurisdiction in Indian Country to comprehend the severity of the problem facing Native American women and the legal foundation upon which access to reproductive healthcare lies.

B. The Federal Trust Relationship and Criminal Jurisdiction in Indian Country

The United States, through force and diplomacy, came into existence at the expense of Native Americans. During westward expansion, the United States entered into myriad treaties with tribes, promising food, funding, military protection, shelter, and healthcare, among other things, in exchange for land. The unique relationship between the United States and tribes has come to be understood as the trust relationship, a moral and fiduciary duty owed to tribes by the federal government that is recognized by every branch of the federal government.[26] The legal foundation for the trust relationship exists in United States Supreme Court jurisprudence.[27] In *Cherokee Nation v. Georgia*,

24. *See infra* Part I.C.

25. PERRY, *supra* note 4, at 9.

26. Nell Jessup Newton, *Enforcing the Federal-Indian Trust Relationship After* Mitchell, 31 CATH. U. L. REV. 635, 635 (1982).

27. While difficult to pinpoint its exact origin, both case law and scholars point to a number of 19th Century cases, including *Worcester v. Georgia*, 31 U.S. 515, 517 (1832) and *Lone Wolf v. Hitchcock*, 187 U.S. 553, 564-65 (1903), as the opinions that best define the contours of the federal government's unique trust obligation to tribes. *See* Philip P. Frickey, *Doctrine, Context, Institutional Relationships, and Commentary: The Malaise of Federal Indian Law Through the Lens of* Lone Wolf, 38 TULSA L. REV. 5, 33 (2002); Reid Peyton

Chief Justice John Marshall characterized the relationship between tribes and the federal government as that of a "ward to his guardian."[28] Reid Chambers described the trust relationship "as resembling a guardianship, as a guardian-ward relationship, as a fiduciary or special relationship, or as a trust responsibility."[29] The United States Supreme Court explained the "distinctive obligation of trust incumbent upon the Government in its dealings with these dependent and sometimes exploited people" in *Seminole Nation v. United States*, stating that federal treaties with tribes make "the Government . . . something more than a mere contracting party. Under a humane and self imposed policy which has found expression in many acts of Congress and numerous decisions of this Court, it has charged itself with moral obligations of the highest responsibility and trust."[30]

Part and parcel of the federal trust responsibility is the plenary power of Congress over tribes—the plenary power doctrine gave Congress the ability to abrogate treaties with tribes.[31] Nineteenth-century case law outlined the notion of congressional plenary power over tribes. In *Lone Wolf v. Hitchcock*, the Court held that "[p]lenary authority over the tribal relations of the Indians has been exercised by Congress from the beginning, and the power has always been deemed a political one, not subject to be controlled by the judicial department of the government."[32] The interplay between the trust relationship and congressional plenary power gave Congress power to pass laws affecting Native Americans.

i. Federal and Tribal Criminal Jurisdiction over Sexual Assault Committed by a Native American[33]

Both tribes and the federal government have authority to exercise criminal jurisdiction over sexual assaults occurring in Indian Country and committed by a Native American, though tribal authority has been severely limited by Congress. Exercising its plenary power over tribes, Congress passed the Major Crimes Act (MCA) in 1885 granting the federal government jurisdiction to prosecute certain enumerated major crimes if the crime is committed in Indian

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Chambers, *Judicial Enforcement of the Federal Trust Responsibility to Indians*, 27 STAN. L. REV. 1213 (1975).

28. Cherokee Nation v. Georgia, 30 U.S. 1, 17 (1831).

29. Chambers, *supra* note 27, at 1213-14 (footnotes omitted) (internal quotation marks omitted).

30. Seminole Nation v. United States, 316 U.S. 286, 296-97 (1942) (footnote omitted).

31. Frickey, *supra* note 27, at 6. "*Lone Wolf*, as read against Chief Justice Marshall's earlier cases developing an interpretive paradigm, allowed Congress to call the shots in federal Indian policy so long as it acted clearly." *Id.* at 33.

32. *Lone Wolf*, 187 U.S. at 565.

33. For a more comprehensive view of criminal jurisdiction in Indian Country and the interplay between tribes, the federal government, and states, see Rebecca A. Hart et al., *Honoring Sovereignty: Aiding Tribal Efforts to Protect Native American Women from Domestic Violence*, 96 CALIF. L. REV. 185, 201- 06 (2008).

Country[34] and the perpetrator is Native American.[35] Sexual assault is considered a major crime under the MCA and, therefore, the federal government has prosecutorial jurisdiction over sexual assaults committed in Indian Country when the perpetrator is Native American.[36]

The tribe has concurrent jurisdiction over major crimes committed by a Native American against a Native American in Indian Country, though the penalties that may be imposed by the tribe have been severely limited by congressional exercise of plenary power over tribes.[37] No federal constitutional double jeopardy violations exist as a result of both federal and tribal criminal jurisdiction over major crimes because two separate sovereigns—the United States and the tribe—exercise jurisdiction over the crime.[38] Though United States Supreme Court precedent upholds concurrent tribal authority over all major crimes when the perpetrator is Native American, Professor Deer explained that "one of the practical results of the Major Crimes Act is the elimination of exclusive tribal responsibility for prosecuting major crimes occurring in Indian country."[39]

34. *See supra* note 8 for a definition of "Indian Country."

35. 18 U.S.C. § 1153 (2006). The Major Crimes Act states:

> Any Indian who commits against the person or property of another Indian or other person any of the following offenses, namely, murder, manslaughter, kidnapping, maiming, a felony under chapter 109A, incest, assault with intent to commit murder, assault with a dangerous weapon, assault resulting in serious bodily injury (as defined in section 1365 of this title), an assault against an individual who has not attained the age of 16 years, felony child abuse or neglect, arson, burglary, robbery, and a felony under section 661 of this title within the Indian country, shall be subject to the same law and penalties as all other persons committing any of the above offenses, within the exclusive jurisdiction of the United States.

Id.

36. *Id*.

37. Oliphant v. Suquamish Indian Tribe, 435 U.S. 191, 203 n.14 (1978). Until 2010, the Indian Civil Rights Act prevented tribal courts from issuing jail sentences of greater than one year or fines over $5,000. *See* 25 U.S.C. § 1302(7). In July 2010, President Obama signed the Tribal Law and Order Act into law, which grants tribal courts the authority to impose sentences of up to three years and fines of up to $15,000. Tribal Law and Order Act of 2010, Pub. L. No. 111-211, § 234(b), 124 Stat. 2258, 2280.

38. United States v. Wheeler, 435 U.S. 313, 328 (1978). The tribe is a separate sovereign and does not rely on a grant of power from the federal government to prosecute crimes occurring within Indian Country. *Id*.

39. Sarah Deer, *Expanding the Network of Safety: Tribal Protection Orders for Survivors of Sexual Assault*, 4 TRIBAL L.J. (2003), http://tlj.unm.edu/tribal-law-journal/articles/volume_4/expanding_the_network_of_safety_tribal_protection_orders_for_survivors_of_sexual_assault/index.php.

ii. Federal and Tribal Criminal Jurisdiction over Sexual Assault Committed by a Non-Indian

The federal government has sole criminal jurisdiction over sexual assaults occurring in Indian Country committed by non-Indians. In *Oliphant v. Suquamish Indian Tribe*, the United States Supreme Court held that "[b]y submitting to the overriding sovereignty of the United States, Indian tribes therefore necessarily give up their power to try non-Indian citizens of the United States except in a manner acceptable to Congress."[40] *Oliphant* is an extremely troubling decision, which had the effect of stripping tribes of the ability to hold non-Indians accountable for crimes, including sexual assault, committed in Indian Country.[41] The result is that the federal government has sole authority to prosecute non-Indians who commit sexual assault against Native Americans in Indian Country. For reasons discussed below, the on-the-ground impact of *Oliphant* is that sexual assault in Indian Country frequently goes uninvestigated and rarely results in prosecution.

iii. Criminal Jurisdiction over Sexual Assault in Public Law 280 States

In the 1950s, an assimilationist Congress[42] passed Public Law 280 granting Alaska, California, Minnesota, Nebraska, Oregon, and Wisconsin what was previously federal jurisdiction over major crimes committed in Indian Country.[43] Public Law 280 radically changed the interaction between tribes and the enumerated states by altering the jurisdictional landscape to give states the power to prosecute Native Americans and non-Indians alike for major crimes.[44] For our purposes, Public Law 280 grants states the authority to prosecute sexual assault committed by a non-Indian in Indian Country.

C. The Prosecution of Sexual Assault in Indian Country

The perpetrators of sexual assault against Native American women are overwhelmingly non-Indian—over 80% of offenders are described as non-

40. *Oliphant*, 435 U.S. at 210.

41. Bethany R. Berger, *Red: Racism and the American Indian*, 56 UCLA L. REV. 591, 647-48 (2009). *See generally* ROBERT A. WILLIAMS, JR., LIKE A LOADED WEAPON: THE REHNQUIST COURT, INDIAN RIGHTS, AND THE LEGAL HISTORY OF RACISM IN AMERICA (2005).

42. Ada Pecos Melton & Jerry Gardner, *Public Law 280: Issues and Concerns for Victims of Crime in Indian Country*, AM. INDIAN DEV. ASSOCS., http://www.aidainc.net/Publications/pl280.htm (last visited Nov. 28, 2010).

43. Act of Aug. 15, 1953, ch. 505, 67 Stat. 588 (codified as amended at 18 U.S.C. § 1162, 25 U.S.C. §§ 1321-22 (2006)). Alaska was added to the list of mandatory Public Law 280 states after admission to the Union in 1959. Act of Aug. 8, 1958, Pub. L. No. 85-615, 72 Stat. 545.

44. Carole Goldberg & Duane Champagne, *Is Public Law 280 Fit for the Twenty-First Century? Some Data at Last*, 38 CONN. L. REV. 697, 701 (2006).

Indian.[45] This statistic is startling not only because it reveals that in approximately 80% of cases Native American women must rely solely on the federal government (or the state in a Public Law 280 state) and not tribal governments for criminal redress, but also because it demonstrates to many advocates and scholars that the colonization of Native American women's bodies through the use of sexual assault continues to this day.[46] Tribes were stripped of the authority to prosecute non-Indian sexual predators after *Oliphant*, leaving both the tribe and the victim dependent on federal prosecutors in the aftermath of sexual assault.[47]

Prosecution of all major crimes in Indian Country is woefully inadequate.[48] Professor Kevin Washburn has explored the varied reasons behind the failure to prosecute major crimes in Indian Country, including the lack of financial, investigatory, and personnel resources, a lack of accountability, a lack of media attention to crimes, and the lack of membership in the tribal community.[49] The prosecution of sexual assault is, like all other major crimes in Indian Country, not occurring at a rate commensurate with criminal activity.[50] It is difficult to even gather statistics about the rate of prosecution of non-Indians for sexual assault in Indian Country.[51] The dearth of accurate statistics means it is nearly impossible to determine exactly what is happening when a Native American woman is sexually assaulted: Does she refrain from reporting because she knows that prosecution is unlikely to occur? Does she refrain from reporting because of fear or shame?

Sexual assault occurs with impunity in Indian Country because the federal government has not devoted resources to the prosecution of sexual assault. What results is a jurisdictional safe haven for sexual predators. This is not to say that there are no federal prosecutors who take sexual assault in Indian Country seriously. It is to say that until the federal government, as a whole, takes sexual assault in Indian Country seriously, law enforcement will not be a realistic means of seeking justice for Native American women.

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45. PERRY, *supra* note 4, at 9 tbl.13.

46. ANDREA SMITH, CONQUEST: SEXUAL VIOLENCE AND AMERICAN INDIAN GENOCIDE 3 (2005); Sarah Deer, *Decolonizing Rape Law: A Native Feminist Synthesis of Safety and Sovereignty*, 24 WICAZO SA REV. 149, 150 (2009) [hereinafter Deer, *Decolonizing Rape Law*].

47. Oliphant v. Suquamish Indian Tribe, 435 U.S. 191, 210 (1978).

48. CAROLE GOLDBERG-AMBROSE WITH TIMOTHY CARR SEWARD, PLANTING TAIL FEATHERS: TRIBAL SURVIVAL AND PUBLIC LAW 280 162 (1997) ("In practical application, federal law enforcement agents, particularly the Federal Bureau of Investigation and the U.S. Attorney's Office, have demonstrated a history of declining to investigate or prosecute violations of the Major Crimes Act."); Kevin K. Washburn, *American Indians, Crime, and the Law*, 104 MICH. L. REV. 709, 733 & n.103 (2006).

49. Washburn, *supra* 48, at 728-40.

50. Deer, *Sovereignty of the Soul*, *supra* note 5, at 462-63.

51. *Id*. at 462.

II. THE ROLE OF THE INDIAN HEALTH SERVICE AFTER SEXUAL ASSAULT

> And us mothers and grandmothers, we don't understand why if we in the treaties. . . gave all our land, [and] our land in the United States of America is worth so much right now. [W]e feel like how come if we gave all that up, why isn't our health care, why hasn't it gone up as well.
>
> - Rebecca Ortega
> Santa Clara Pueblo[52]

Insufficient healthcare for Native Americans is a public health crisis that adversely impacts Native American women: Native American women suffer from inadequate access to routine healthcare, increased risk of cardiovascular disease as compared with the general population, elevated risk of death as a result of cancer, and inadequate access to prenatal care.[53] The lack of funding for and resulting lack of access to reproductive healthcare services at IHS are a component of this public health crisis, particularly for Native American victims of sexual assault. This part explores the role of the federal government in delivering healthcare both to Native Americans generally and Native American women specifically. First, I examine the federal government's obligation to provide healthcare to Native Americans. Specifically, I explore the interplay of the federal trust relationship and healthcare, briefly surveying the federal government's history of providing healthcare to Native American people, and finally examining the role of IHS in delivering healthcare to Native American people. Second, I discuss the impediments Native American women, and Native American people generally, encounter when seeking healthcare. I also describe the barriers to accessing comprehensive reproductive healthcare put in place by the federal government and investigate the specific obstacles to delivering comprehensive reproductive healthcare services to Native American women in the aftermath of sexual assault. I conclude with a state-specific case study that illustrates the barriers Native American women living in South Dakota are likely to encounter when seeking to terminate a pregnancy resulting from sexual assault.

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52. U.S. COMM'N ON CIVIL RIGHTS, BROKEN PROMISES: EVALUATING THE NATIVE AMERICAN HEALTH CARE SYSTEM 21 (2004), *available at* http://www.usccr.gov/pubs/nahealth/nabroken.pdf (footnote omitted) [hereinafter BROKEN PROMISES].

53. *Id.* at 15-20. "Pregnant Native American women are consistently the lowest percentage of women receiving early prenatal care when compared with women of other races and ethnicities." *Id.* at 19.

A. The Role of the Federal Government in Delivering Healthcare to Native American Women

i. The Federal Trust Relationship and Healthcare for Native American People

The United States government has a long-recognized trust, treaty-based,[54] and statutory obligation to provide Native American people with adequate healthcare, which is codified in the Indian Health Care Improvement Act (IHCIA).[55] IHS, an agency of the Department of Health and Human Services,[56] is tasked with fulfilling the United States' unique obligation to provide healthcare to Native Americans.[57] In 2010, IHS provided healthcare to an estimated 1.9 million Native American people in thirty-five states.[58] IHS has worked to identify and treat health issues specific to Native American women, including reproductive health issues. Despite these efforts, the United States has failed profoundly to meet its obligation to provide adequate healthcare to Native Americans. Responding to the reproductive healthcare needs of Native American victims of sexual assault is one area in which the federal government neglects its trust obligation to provide adequate healthcare services to tribes and tribal members.

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54. IHS recognizes the treaty-based obligation of the United States government to provide health care services to Native-Americans, explaining that "[t]reaties between the United States Government and Indian Tribes frequently call for the provision of medical services, the services of physicians, or the provision of hospitals for the care of Indian people." *IHS Fact Sheets: Federal Basis for Health Services*, INDIAN HEALTH SERV. (Jan. 2010), http://info.ihs.gov/BasisHlthSvcs.asp. "[T]reaties contained general clauses promising the support of poor infirm persons, or the support and comfort of aged and infirm Indians. Despite limited specific references to health care in treaties, the provision of health care services to Indians was and is an implied benefit of the treaty process, even in the absence of explicit language." ROBERT JOHN ET AL., THE NICOA REPORT: HEALTH AND LONG-TERM CARE FOR INDIAN ELDERS 12 (1996). For example, the 1836 treaty between the United States and the Ottawa and Chippewa promised (among other things) "[t]hree hundred dollars per annum for vaccine matter, medicines, and the services of physicians, to be continued while the Indians remain on their reservations," in exchange for Ottawa and Chippewa land. Treaty with the Ottawas, etc., art. 4, Mar. 28, 1836, 7 Stat. 491, 492, *available at* http://digital.library.okstate.edu/KAPPLER/Vol2/treaties/ott0450.htm.

55. Indian Health Care Improvement Act (IHCIA), Pub. L. No. 94-437, § 2, 90 Stat. 1400, 1400 (1976).

56. INDIAN HEALTH SERV., http://www.ihs.gov (last visited Nov. 28, 2010).

57. Indian Health Care Improvement Act (IHCIA), Pub. L. No. 94-437, 90 Stat. 1400.

58. *IHS Fact Sheets: Indian Health Service: A Quick Look*, INDIAN HEALTH SERV. (Jan. 2010), http://info.ihs.gov/QuickLook2010.asp [hereinafter *IHS Quick Look*]. It is estimated that in fiscal year 2010, IHS will serve 1.9 million Native Americans, a number that grows 1.7% every year. *IHS Fact Sheets: IHS Year 2010 Profile*, INDIAN HEALTH SERV. (Jan. 2010), http://info.ihs.gov/Profile2010.asp [hereinafter *IHS Year 2010 Profile*]; INDIAN HEALTH SERV., TRENDS IN INDIAN HEALTH: 2002-2003 26 (2003), http://www.ihs.gov/nonmedicalprograms/ihs_stats/files/Trends_02-03_Entire%20Book%20(508).pdf [hereinafter TRENDS IN INDIAN HEALTH].

ii. The Legislative History of Providing Healthcare to Native Americans

As early as 1803, the Office of Indian Affairs within the United States War Department oversaw the provision of healthcare services to Native Americans.[59] In 1849, the Department of the Interior assumed the responsibility for providing healthcare to Native Americans.[60] Even though the federal government extended healthcare services to Native Americans, the government's motivation was not benevolent; rather, the government was motivated by a desire "to prevent disease and to speed Native American assimilation into the general population by promoting Native American dependence on Western medicine and by decreasing the influence of traditional Indian healers."[61]

The United States government codified its unique obligation to provide healthcare to Native Americans as part of the federal trust relationship in the Snyder Act of 1921.[62] Congress, exercising its plenary power over tribes, mandated that the "Bureau of Indian Affairs . . . shall direct, supervise, and expend such moneys as Congress may from time to time appropriate, for the benefit, care, and assistance of the Indians . . . [f]or relief of distress and conservation of health."[63] The Snyder Act both acknowledges the responsibility of the federal government to provide healthcare services to Native Americans and serves as the legislative foundation for healthcare services for Native Americans. However, the Snyder Act neither allocated sufficient federal funds to meet this obligation nor delineated administrative responsibility for the delivery of healthcare services to Native Americans, thereby creating chaos

59. Rose L. Pfefferbaum et al., *Providing for the Health Care Needs of Native Americans: Policy, Programs, Procedures, and Practices*, 21 AM. INDIAN L. REV. 211, 214-15 (1997).

60. Holly T. Kuschell-Haworth, *Jumping Through Hoops: Traditional Healers and the Indian Health Care Improvement Act*, 2 DEPAUL J. HEALTH CARE L. 843, 845 (1999) (citing AM. INDIAN POL'Y REV. COMM'N, TASK FORCE SIX: INDIAN HEALTH, REPORT ON INDIAN HEALTH: 29 (1976)).

61. Kuschell-Haworth, *supra* note 60, at 845. "Health services administered by the Office of Indian Affairs were most often poorly equipped to combat the serious cases of tuberculosis, trachoma, smallpox, and other contagious and infectious diseases on Indian reservations during the late 19th- and early 20th-centuries. The federal government's program of assimilation of Native Americans into white culture dominated reservation health care during this period." *Reservation and Hospital Health Care Under the Office of Indian Affairs (c.1890-1925)*, NAT'L LIBRARY OF MED., http://www.nlm.nih.gov/exhibition/if_you_knew/if_you_knew_06.html (last visited Nov. 28, 2010).

62. Snyder Act of 1921, Pub. L. No. 67-42, 42 Stat. 208 (codified as amended at 25 U.S.C. § 13 (2006)). For an extensive discussion of the historical foundation for IHS, see Pfefferbaum, *supra* note 59. In 1926, shortly after enacting the Snyder Act, the United States government charged the Merriam Commission with investigating the impact of the Dawes Act, which allotted reservation land to individual Native Americans, part of which implicated health care conditions for Native Americans. LEWIS MERIAM ET AL., INST. FOR GOV'T RESEARCH, THE PROBLEM OF INDIAN ADMINISTRATION (1928).

63. Snyder Act of 1921, Pub. L. No. 67-42, 42 Stat. 208.

regarding actual service delivery.[64] Unfortunately, this foreshadowed federal policy toward Native American healthcare for the next nine decades.

In 1955, Congress moved the responsibility for Indian healthcare from the Bureau of Indian Affairs to what is today the Department of Health and Human Services.[65] With the passage of the Indian Self-Determination and Education Assistance Act in 1975,[66] Congress gave tribes the option of receiving healthcare services from what would become IHS or "assuming from the IHS the administration and operation of health services and programs in their communities."[67] The next year, Congress passed the IHCIA, which codified the United States' obligation to provide healthcare services to Native Americans.[68] The IHCIA acknowledged the unique duty of the United States to Native Americans regarding healthcare, stating "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[69] The Act specifically stated that IHCIA aims:

> to provide the quantity and quality of health services which will permit the health status of Indians to be raised to the highest possible level . . . . of providing the highest possible health status to Indians and to provide . . . all resources necessary to effect that policy.[70]

Importantly, the IHCIA appropriated federal funds to ensure delivery of healthcare services to Native Americans, including mandates to construct hospitals and medical service facilities, hire trained medical providers, and address the needs of Native Americans living in urban settings and not on reservations.[71]

Still, at no point in the history of IHS have enough funds been allocated to comprehensively treat the healthcare needs of Native Americans. The United

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64. Pfefferbaum, *supra* note 59, at 215.

65. *Id*.

66. Indian Self-Determination and Education Assistance Act of 1975, Pub. L. No. 93-638, 88 Stat. 2203 (codified as amended at 25 U.S.C. § 450-450(n) (2006)).

67. *IHS Quick Look*, *supra* note 58.

68. Indian Health Care Improvement Act (IHCIA), Pub. L. No. 94-437, 90 Stat. 1400 (1976).

69. *Id*. During hearings for the 1992 amendments to the IHCIA, one Senator stated, "[b]ased upon the Constitution, historical development, treaties, and statutes, the United States has assumed a legal and moral obligation to provide adequate health care and services to Indian tribes and their members." S. REP. NO. 102-392, at 2 (1992), *reprinted in* 1992 U.S.C.C.A.N. 3943, 3944; *see also* Indian Health Amendments of 1992, Pub. L. No. 102-573, 106 Stat. 4526.

70. Indian Health Care Improvement Act (IHCIA), Pub. L. No. 94-437, 90 Stat. 1400 - 1401 (1976).

71. Indian Health Care Amendments of 1980, Pub. L. No. 96-537, 94 Stat. 3173; BROKEN PROMISES, *supra* note 52, at 24.

States Commission on Civil Rights released a report in 2004 outlining the United States government's overwhelming failure to provide healthcare for Native Americans, stating "persistent discrimination and neglect continue to deprive Native Americans of a health system sufficient to provide health care equivalent to that provided to the vast majority of Americans."[72] The Commission explained,

> It has long been recognized in Native American and medical communities that Native Americans are dying of diabetes, alcoholism, tuberculosis, suicide, unintentional injuries, and other health conditions at shocking rates. Beyond these mortality rates, Native Americans also suffer significantly lower health status and disproportionate rates of disease compared with all other Americans.[73]

In fact, Native American healthcare is so poor that Native Americans lag twenty to twenty-five years behind the general population in terms of health status.[74] Despite the striking disparity between the federal government's moral and fiduciary responsibility toward tribes and these abysmal health outcomes, Congress has never allocated sufficient funds to meet the healthcare needs of Native Americans.[75] The United States Commission on Civil Rights found that IHS operated with only 59% of the funds it needed to provide adequate healthcare and, adjusting for inflation, IHS per capita spending on healthcare has fallen.[76] Indeed, the federal government spends 50% more on healthcare services for prisoners and those on Medicaid than it does on Native Americans.[77] The IHCIA was reauthorized every year from 1976 to 2000; after its expiration in 2000, the Bush Administration refused to back reauthorization of the IHCIA.[78] In 2009, however, IHS received more than $500 million from the American Recovery and Reinvestment Act to be used for construction, maintenance and improvements, health information technology, sanitation, and

72. BROKEN PROMISES, *supra* note 52, at 6.

73. *Id*. at 2.

74. A QUIET CRISIS, *supra* note 18, at 42.

75. In fiscal year 2010, IHS received a $4.03 billion operating budget from Congress. INDIAN HEALTH SERV., DEP'T OF HEALTH & HUMAN SERVS., JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES CJ-2 (2010), *available at* https://www.ihs.gov/NonMedicalPrograms/BudgetFormulation/documents/IHS_CJ_2010_Final_Submission.pdf [hereinafter IHS JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES]. I have been unable to find information that would explain how that money is allocated within IHS to serve the specific reproductive health care needs of Native American victims of sexual assault.

76. A QUIET CRISIS, *supra* note 18, at 42.

77. *Id*. at 5-6.

78. Robert J. Miller, *Cutting Native Peoples' Health Care*, TOMPAINE.COM (Mar. 21, 2007), http://www.tompaine.com/articles/2007/03/21/cutting_native_peoples_health_care.php.

health equipment.[79] As part of a comprehensive healthcare reform, President Obama signed the Patient Protection and Affordable Care Act into law in March of 2010, making permanent the IHCIA and no longer subjecting Native Americans' healthcare to annual reauthorization.[80]

iii. The Role of the Indian Health Service in Delivering Healthcare

As mandated by the IHCIA, IHS administers and delivers healthcare services to Native Americans.[81] The mission of IHS is "to assure that comprehensive, culturally acceptable personal and public health services are available and accessible to American Indian[s]"[82] and "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."[83] IHS provides medical services to any enrolled member of a federally recognized tribe.[84] In addition to providing direct healthcare services, IHS functions as a healthcare advocate for Native Americans within the federal government.[85] In testimony before the United States Commission on Civil Rights, Dr. Charles Grim, then-director of IHS, described the healthcare services of IHS as "a program of 'universal eligibility but limited availability.'"[86] The distribution of healthcare funds does not mimic the entitlements common in most United States health insurance programs. Typically, someone with health insurance expects that their health insurance provider will cover necessary doctor visits, tests, and procedures and that the insurance provider will have the funds required to cover the cost of necessary services. However, in the case of IHS, the funds are discretionary in nature, and "[c]onsequently, IHS provides health care services only to the extent appropriated funding allows."[87] That is to say, due to the extraordinarily low level of federal funding for IHS, there is no guarantee IHS will pay for doctor visits, tests, and/or procedures deemed necessary because IHS may not have sufficient funds to pay for the medical service.

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79. American Recovery and Reinvestment Act of 2009, Pub. L. No. 111-5, div.A, tit.7, 123 Stat. 115, 171; *see also Overview of ARRA*, INDIAN HEALTH SERV., http://www.ihs.gov/recovery (last visited Nov. 28, 2010).

80. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221, 124 Stat. 119, 935-36 (2010).

81. Indian Health Care Improvement Act, Pub. L. No. 94-437, 90 Stat. 1400 (1976).

82. *Indian Health Service Introduction*, INDIAN HEALTH SERV., http://www.ihs.gov/PublicInfo/PublicAffairs/Welcome_Info/IHSintro.asp (last visited Nov. 28, 2010).

83. *Id*. The *Indian Health Manual* outlines the criteria for receiving services from IHS. INDIAN HEALTH SERV., INDIAN HEALTH MANUAL § 2-1.1, at 1 (1983), *available at* http://www.ihs.gov/PublicInfo/Publications/IHSManual/Part2/pt2chapt1/pt2chpt1.htm#2 [hereinafter INDIAN HEALTH MANUAL].

84. *IHS Quick Look*, *supra* note 58.

85. *Indian Health Service Introduction*, *supra* note 83.

86. BROKEN PROMISES, *supra* note 52, at 49 (footnote omitted).

87. *Id*.

IHS estimates it will provide healthcare services to over 1.9 million Native American people in thirty-five states in 2010.[88] IHS is divided into twelve service areas, which oversee the distribution of healthcare services to all Native Americans.[89] As of 2010, IHS and its federal employees operated 29 hospitals, 59 health centers, and 28 health stations, as well as 34 service units specifically designed to address the needs of urban Native Americans.[90] There are 16 hospitals, 237 health centers, and 93 health stations operated by tribal governments.[91] This Article focuses exclusively on service units run with federal, and not tribal, monies.

IHS has succeeded in bringing healthcare services to Native Americans living in rural areas who would not otherwise have convenient access to healthcare, particularly to smaller tribes that might not have the resources to undertake the administration of healthcare services.[92] Despite some real successes, IHS faces severe problems related to the management of IHS programs as well as issues surrounding the "geographic location of facilities," "outdated and aging facilities," "extended wait times at facilities for treatment," "retention and recruitment of qualified providers," and "misdiagnosis or late diagnosis of diseases."[93]

B. IHS and the Provision of Healthcare for Native American Women

The IHCIA specifically addressed the distinct healthcare needs of Native American women and established the Office of Indian Women's Health Care to oversee IHS efforts to provide healthcare services to Native American women.[94] The IHS website has a special section devoted to women's health, listing several salient topics on Native American women's healthcare, including access to care, violence against Native American women, sexually transmitted infections, substance abuse, cardiovascular disease, and maternal and child health.[95] There is almost no information on the IHS website regarding access to

88. *IHS Year 2010 Profile*, *supra* note 58; TRENDS IN INDIAN HEALTH, *supra* note 58.

89. *IHS Year 2010 Profile*, *supra* note 58.

90. *Id.*

91. *Id.*

92. BROKEN PROMISES, *supra* note 52, at 53. Despite the dismal health outcomes for Native Americans, the creation of IHS has had a positive impact on the health status of Native Americans: "[s]ince 1973, mortality rates have declined for . . . tuberculosis (82 percent); maternal deaths (78 percent); infant deaths (66 percent); accidents (57 percent); injury and poisoning (53 percent); and pneumonia and influenza (50 percent)." *Id.* (footnote omitted).

93. *Id.* at 47.

94. Indian Health Amendments of 1992, Pub. L. No. 102-573, § 223, 106 Stat. 4526, 4559.

95. *Maternal Child Health—American Indian and Alaska Native*, INDIAN HEALTH SERV., http://www.ihs.gov/MedicalPrograms/MCH/index.cfm (last visited Nov. 28, 2010) [hereinafter *Maternal Child Health*]; *Women's Health—American Indian and Alaska Native*, INDIAN HEALTH SERV., http://www.ihs.gov/MedicalPrograms/MCH/W/index.cfm (last visited Nov. 28, 2010) [hereinafter *Women's Health*].

contraception, sex education, and reproductive healthcare that falls outside the scope of prenatal care.[96] The high rate of sexual assault among Native American women gives rise to a unique set of healthcare needs for victims—physical injuries, psychological trauma, exposure to sexually transmitted infections, and unwanted pregnancy.[97] Sexual assault adversely impacts the reproductive health of women, and its effects must be addressed in developing a healthcare strategy that will address the special healthcare needs of Native American women. Specifically, I will examine the impact of the Hyde Amendment on IHS's ability to provide comprehensive reproductive healthcare to victims.

i. The Hyde Amendment and the Indian Health Service

In 1976, Congress passed a rider put forth by Representative Henry Hyde to the Department of Health and Human Services appropriations bill that prohibited the use of federal funds for abortions, except in very limited circumstances.[98] The Hyde Amendment stated that "[n]one of the funds contained in this Act shall be used to perform abortions except where the life of the mother would be endangered if the fetus were carried to term."[99] The Hyde Amendment has been renewed every year since its passage in 1976, and its language has evolved over time. Today, the Hyde Amendment states no federal funds will be used for abortions except in the case of pregnancy resulting from rape, incest, or "in the case where a woman suffers from a physical disorder, physical injury, or physical illness, including a life-endangering physical condition caused by or arising from the pregnancy itself, that would, as certified by a physician, place the woman in danger of death unless an abortion is performed."[100] The Hyde Amendment limits access to abortion by limiting insurance coverage for a host of women who are dependent on the federal government for healthcare, including women in the military, women in federal prisons, women on Medicaid, low-income women in the District of Columbia,

96. *See generally Maternal Child Health*, *supra* note 95. The Maternal and Child Health section of the IHS website appears to be the repository of information about reproductive health care on the IHS website.

97. Chrisler & Ferguson, *supra* note 14; Heise, *supra* note 14.

98. Act of Sept. 30, 1976, Pub.L. No. 94-439, § 209, 90 Stat. 1418, 1434.

99. *Id.* § 209, 90 Stat. at 1434.

100. Omnibus Appropriations Act, 2009, Pub. L. No. 111-8, §§ 507-08, 123 Stat. 524, 802-03. In 1978, Congress changed the Hyde Amendment to include an exception for rape and incest. The Reagan administration removed this exception, returning the Hyde Amendment to its original form. It was not until the Clinton administration that the Hyde Amendment again included an exception for rape and incest. Heather Boonstra & Adam Sonfield, *Rights Without Access: Revisiting Public Funding of Abortion for Poor Women*, GUTTMACHER REP. ON PUB. POL'Y, Apr. 2000, at 8, *available at* http://www.guttmacher.org/pubs/journals/gr030208.pdf.

women serving in the Peace Corps, federal employees, teenagers participating in the State Child Health Insurance Plan, and Native American women.[101]

The Hyde Amendment has a profound impact on the ability of IHS—which relies exclusively on federal funds for its operating budget[102]—to offer comprehensive reproductive healthcare services by denying funding for abortions except in the case of pregnancy resulting from rape or incest or when pregnancy endangers the life of the pregnant woman. The IHCIA specifically references the Hyde Amendment's limitations on performing abortions using federal funds at IHS facilities:

> Any limitation on the use of funds contained in an Act providing appropriations for the Department of Health and Human Services for a period with respect to the performance of abortions shall apply for that period with respect to the performance of abortions using funds contained in an Act providing appropriations for the Indian Health Service.[103]

In response to the Hyde Amendment, IHS promulgated regulations stating that no IHS facility may provide a woman with an abortion unless her pregnancy is a result of rape or incest, or unless the life of the pregnant woman is endangered.[104] If IHS is unable to provide a given medical service, such as an

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101. *Public Funding for Abortion*, ACLU (July 21, 2004), http://www.aclu.org/reproductiverights/lowincome/16393res20040721.html.

102. For specific information on the IHS budget, see IHS JUSTIFICATION OF ESTIMATES FOR APPROPRIATIONS COMMITTEES, *supra* note 75.

103. 25 U.S.C. § 1676 (2006).

104. 42 C.F.R. § 136.51 (2009). In 1996, IHS Director Michael H. Trujillo clarified the circumstances under which IHS provides abortion services:

> The pregnancy is the result of an act of rape or incest and the following conditions are met:
>
> A. An IHS-operated program, tribal health program operated pursuant to Public Law 93-638, or an urban Indian health program operated pursuant to Title V receives signed documentation from a law enforcement agency, a health care facility, or a health care program stating:
>
> (1) That the woman requesting the abortion has reported she was a victim of rape or incest;
>
> (2) The date on which the episode of rape or incest occurred;
>
> (3) The date on which the report was made, which must have been within 60 days of the date on which the episode of rape or incest occurred;
>
> (4) The name and address of the victim and the name and address of the person making the report (if different from the victim); and
>
> (5) That the report included the signature of the person who reported the incident.
>
> B. The incident in question meets the definition of rape or incest as defined by law in the State or tribal jurisdiction where the incident was reported to have occurred.

abortion, federal funds may be allocated to reimburse non-IHS healthcare providers who perform an abortion on a Native American woman who meets these criteria.[105] It is IHS policy that "as in other family planning circumstances," IHS will "comply with State law regarding the provision of services to minors without parental consent."[106] The *Indian Health Manual*, which "is the reference for IHS employees regarding IHS-specific policy and procedural instructions,"[107] states that no abortions may be performed unless the life of the pregnant woman is endangered—this section was last updated in 1992.[108]

In addition to approving surgical abortions in the case of pregnancy resulting from rape, incest, or danger to the life of the pregnant woman, IHS has approved the use of the drug mifepristone "'as a reasonable therapeutic choice' for abortion in cases of life endangerment, rape or incest."[109] Mifepristone is a drug that can prevent pregnancy during the first several weeks of pregnancy and is commonly known as a medical abortion.[110]

Memorandum from IHS Director Michael H. Trujillo, M.D., M.P.H, Assistant Surgeon General, on Current Restrictions in Use of Indian Health Service Funds for Abortions for IHS Area Directors and Associate Directors (Aug. 26, 1996), *available at* http://www.ihs.gov/PublicInfo/Publications/IHSmanual/SGMs/SGM96/sgm96_01/96_01.htm [hereinafter Memorandum from Michael Trujillo]; ACCESS TO ABORTION SERVICES, *supra* note 1, at 4; *see also* INDIAN HEALTH MANUAL , *supra* note 83, § 3-13.14, at 82-83.

105. Native Americans may seek health services at a provider other than IHS, but must meet stringent requirements in order to obtain reimbursement. IHS terms such services as contract health services. 42 C.F.R. § 136a.10 (2009) ("*Contract health services* means health services provided at the expense of the Indian Health Service from public or private medical or hospital facilities other than those of the Service or those funded by the Service."); 42 C.F.R. § 136a.12(c) ("Contract health services will not be authorized when and to the extent that Indian Health Service or Indian Health Service funded facilities are available to provide the needed care. When funds are insufficient to provide the volume of contract health services needed by the service population, the Indian Health Service shall determine service priorities on the basis of medical need."); *see also* B.J. Jones, *In Their Native Lands: The Legal Status of American Indian Children in North Dakota*, 75 N.D. L. REV. 241, 263-66 (1999); Pfefferbaum et al., *supra* note 59, at 234-36.

106. Memorandum from Michael Trujillo, *supra* note 104.

107. INDIAN HEALTH MANUAL, *supra* note 83, at introduction.

108. *Id*. at § 3-13.14. There have been no updates to the *Indian Health Manual* or any additions to the Federal Register indicating that the Obama administration has promulgated new regulations that are more restrictive than the Hyde Amendment.

109. KATI SCHINDLER ET AL., NATIVE AM. WOMEN'S HEALTH EDUC. RES. CTR., INDIGENOUS WOMEN'S REPRODUCTIVE RIGHTS: THE INDIAN HEALTH SERVICE AND ITS INCONSISTENT APPLICATION OF THE HYDE AMENDMENT 5 (2002), *available at* http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/indigenous_women.pdf.

110. Mifepristone is a safe medical alternative to surgical abortions if used early in pregnancy. Mifepristone was approved by the U.S. Food and Drug Administration for use in the United States in 2000. Susanne Pichler, revised by Deborah Golub, *Mifepristone: Expanding Women's Options for Early Abortion*, PLANNED PARENTHOOD AFFILIATES OF NEW JERSEY, http://www.plannedparenthoodnj.org/library/topic/medical_abortion/mifepristone_expanding_options (last updated Oct. 11, 2007).

Emergency contraception, a drug that can prevent pregnancy if administered within 120 hours of intercourse, does not violate the Hyde Amendment because it does not cause an abortion and can be prescribed by IHS regardless of the circumstances of impregnation.[111] Emergency contraception is an effective way to treat victims of sexual assault who wish to avoid pregnancy as a result of the assault and seek medical care shortly after the assault.[112] IHS has not promulgated regulations indicating that the agency believes emergency contraception violates the Hyde Amendment.

ii. The Reality of Obtaining an Abortion after Sexual Assault at an IHS Facility

The overarching theme of post-sexual assault treatment at IHS facilities appears to be inconsistency. There is no standard policy for treating sexual assault victims at IHS facilities, and in the event of pregnancy (or potential pregnancy) resulting from sexual assault, the limited amount of research that has been done reveals that it is extremely difficult to get either emergency contraception to prevent an unwanted pregnancy or an abortion at IHS facilities. The Hyde Amendment should not be a barrier to victims seeking abortions at IHS facilities when pregnancy is the result of sexual assault. In practice, research reveals that the Hyde Amendment coupled with anemic IHS funding levels have resulted in a *de facto* ban on abortion services at IHS for victims of sexual assault—a troubling reality not only because it jeopardizes the ability of women who rely on IHS as their primary healthcare provider to control their reproductive destiny but also because of the startlingly high rate of sexual assault in Indian Country and the unfortunate reality that women might become pregnant after sexual assault. In this section, I will outline the standard treatment for all victims of sexual assault and IHS policy around treatment of sexual assault victims; the specific impact of the Hyde Amendment on abortion care at IHS; and the accessibility of comprehensive reproductive healthcare at IHS facilities according to data collected by the Native American Women's Health Education Resource Center.

a. Treating Victims of Sexual Assault

All women who survive an act of sexual assault require immediate medical care to treat their physical and psychological wounds, to collect evidence in the aftermath of the assault should the victim wish to prosecute her attacker, and to prevent an unwanted pregnancy.[113] The Office on Violence

111. *Morning-After Pill (Emergency Contraception)*, PLANNED PARENTHOOD, http://www.plannedparenthood.org/health-topics/emergency-contraception-morning-after-pill-4363.htm (last visited Nov. 28, 2010) [hereinafter *Morning-After Pill*].

112. Marcia M. Boumil & Dana Sussman, *Emergency Contraception: Law, Policy and Practice*, 7 CONN. PUB. INT. L.J. 157, 182-84 (2008).

113. *See* OFFICE ON VIOLENCE AGAINST WOMEN, U.S. DEP'T OF JUSTICE, A NATIONAL PROTOCOL FOR SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATIONS (2004), *available at*

Against Women within the Department of Justice released *A National Protocol for Sexual Assault Medical Forensic Examinations* (*The Protocols*) in 2004 that described the best practices regarding the treatment of sexual assault victims to aid jurisdictions in creating and implementing specific sexual assault protocols of their own.[114] *The Protocols* favor a "coordinated, multidisciplinary approach" to providing medical treatment after sexual assault, encompassing victim-centered care,[115] training for sexual assault forensic examiners and evidence procedures.[116] *The Protocols* clarify the obligations of healthcare facilities and provide a detailed outline of the actual examination procedures including testing for and treatment of sexually transmitted infections.[117] With regard to potential pregnancy, *The Protocols* recommend discussing the likelihood of pregnancy with a victim, administering "a pregnancy test for all patients with reproductive capability and, finally, discussing options if the victim is pregnant, "including reproductive health services,"[118] however, it may take weeks before a victim can obtain a reliable reading from a pregnancy test, and therefore it may not be possible to administer the exam on the same day that she visits a healthcare facility. Though *The Protocols* do not specifically use the word abortion, the term "reproductive health services" appears in the discussion of pregnancy after sexual assault, and I interpret it to include a host of potential services, including but not limited to prenatal care and abortion.

There is no protocol in the *Indian Health Manual* for treating victims of sexual assault who seek healthcare immediately after the assault at IHS facilities in spite of the fact that over 30% of Native American women will be sexually assaulted in their lifetime and the majority of these women rely on IHS for healthcare.[119] A survey conducted by the Native American Women's

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http://www.ncjrs.org/pdffiles1/ovw/206554.pdf [hereinafter A NATIONAL PROTOCOL FOR SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATIONS].

114. *Id*. at 3.

115. *Id*. at 23-50.

116. *Id*. at 53-70.

117. *Id*. at 73-115.

118. *Id*. at 111.

119. I searched the *Indian Health Manual* and was unable to find any sexual assault protocols. *See* INDIAN HEALTH MANUAL, *supra* note 84; TJADEN & THOENNES, *supra* note 3. There is, however, a sexual assault protocol available from the Warm Springs Health and Wellness Center, an IHS facility located in Oregon. *See* WARM SPRINGS HEALTH & WELLNESS CTR., SEXUAL ASSAULT PROTOCOLS, *available at* http://www.ihs.gov/MedicalPrograms/MCH/W/WHdownloads/WSSexualAssualtProtocols.doc (last Nov. 28, 2010). This protocol is designed to aid medical professionals in treating sexual assault victims. *Id*. One of the objectives of the protocol is to prevent pregnancy that is a result of sexual assault, should the victim so choose. *Id*. The protocol states that "[e]very survivor will be offered prophylactic treatment for pregnancy prevention." *Id*. Prophylactic treatment is defined as emergency contraception. *Id*. The protocol makes no mention of providing an abortion for the victim of sexual assault who seeks treatment at an IHS facility days, weeks, or months after surviving the assault and is pregnant as a result of her assault. *Id*. Although it is encouraging that the Warm Springs facility has a progressive policy standardizing treatment for victims of sexual assault, it is problematic that IHS has not

Health Education Resource Center found that, of the IHS facilities they investigated, only 70% stated that their facility had a sexual assault protocol, and only 56% of those facilities had sexual assault protocols that were readily available, *i.e.*, posted and accessible to staff members who treated sexual assault victims.[120] The result was that women who turned to IHS for healthcare in the aftermath of sexual assault were not offered consistency of treatment for potential sexually transmitted diseases,[121] physical trauma, emotional trauma, or potential pregnancy.[122] Since care following sexual assault is not standardized and women are not offered comprehensive reproductive healthcare, the need for both emergency contraception and abortion services to prevent unwanted pregnancy is even greater. In July 2010, President Obama signed the Tribal Law and Order Act into law, mandating the Director of the Indian Health Service, in coordination with other tribal and federal organizations, develop "standardized sexual assault policies and protocol for

promulgated a policy for all IHS facilities. This, of course, means that the standard of care fluctuates between facilities.

120. ANDREWS ET AL., *supra* note 16, at 6 fig.2.

121. The reported rate of chlamydia, gonorrhea, and syphilis is between 1.7 and 4.5 times higher for Native Americans than for white Americans, making the threat of infection after sexual assault very real. CTRS. FOR DISEASE CONTROL & PREVENTION & INDIAN HEALTH SERV., U.S. DEPT. OF HEALTH & HUMAN SERVS., INDIAN HEALTH SURVEILLANCE REPORT: SEXUALLY TRANSMITTED DISEASES 2007 14 (2009), *available at* http://www.cdc.gov/std/stats/IHS/IHS-SurvRpt_Web508Nov2009.pdf.

122. For purposes of this Article, I focus on the obstacles facing women seeking either emergency contraception or an abortion to terminate an unwanted pregnancy in the aftermath of sexual assault. I do not focus on the need for evidence collection at IHS facilities in the aftermath of sexual assault in order to aid prosecution, though this is an issue worthy of its own article. Until rape kits are stocked in all IHS facilities and nurses are trained as Sexual Assault Nurse Examiners (SANE), evidence collection after the sexual assault of Native American women will continue to be nearly non-existent, prosecutors will not be able to navigate complicated issues of jurisdiction, and victims will not see justice until rape kits and SANE nurses are standard issue at IHS facilities. The Department of Justice promulgated a set of best practices for medical practitioners and hospitals to follow when caring for the victim of rape or sexual assault. A NATIONAL PROTOCOL FOR SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATIONS, *supra* note 113. Included among the list of best practices are guidelines for the collection of evidence, necessary equipment, the importance of informed consent and strict confidentially, and emergency room procedures. *Id*. at 3-12; *see also* Kristin Little, *Sexual Assault Nurse Examiner (SANE) Programs: Improving the Community Response to Sexual Assault Victims*, OVC BULL. (Office for Victims of Crime, Washington, D.C.), Apr. 2001, at 1, *available at* http://www.ncjrs.gov/ovc_archives/bulletins/sane_4_2001/186366.pdf ("Those who work with sexual assault victims have long recognized that victims are often retraumatized when they come to hospital emergency departments for medical care and forensic evidence collection. Not only have victims had to wait for a long time to be examined, but those who perform the exams often lack training and experience in working with sexual assault victims and in gathering forensic evidence."). All of the recommendations emphasize the importance of "victim-centered care." A NATIONAL PROTOCOL FOR SEXUAL ASSAULT MEDICAL FORENSIC EXAMINATIONS, *supra* note 113, at 3.

Indian tribes."[123] This was a very important step toward treating the victims of sexual assault with greater dignity. However, the mandate was unfunded, and there was no timeline for implementation attached to it. Therefore, it remains to be seen when sexual assault protocols will be issued.

b. The Impact of the Hyde Amendment on Treating Native American Sexual Assault Victims and the Obstacles to Obtaining an Abortion

In addition to a lack of sexual assault protocols within IHS facilities, the Hyde Amendment has had an unmistakable impact on the level of reproductive healthcare available to Native American women, even though it should not impact women seeking abortion care in the aftermath of sexual assault. Research by the Native American Women's Health Education Resource Center revealed that, in practice, IHS neither consistently provided abortions nor provided reimbursement for abortions, regardless of whether the abortion was permissible under the Hyde Amendment.[124] I hypothesize that because the Hyde Amendment prohibits elective abortions, IHS has no incentive to seek out professionals qualified to provide abortions or maintain facilities necessary for abortion care. That is to say, the Hyde Amendment creates an artificial healthcare marketplace in which there is no demand for abortion and, therefore, IHS has no incentive to provide a service that is severely circumscribed by federal funding restrictions.

A 2002-2003 qualitative study of reproductive healthcare services provided by IHS and conducted by the Native American Women's Health Education Resource Center found that "since 1981, the 352 IHS [facilities] across the country have only provided 25 abortions."[125] The overwhelming majority of IHS medical staff reported that they did not raise the option of an abortion if a woman entered the clinic seeking services after sexual assault.[126] The fact that IHS facilities, as the main healthcare provider for Native American women, are not providing abortion services which are permissible under the Hyde Amendment is troubling in itself, but even more troubling is the fact that 85% of IHS facilities surveyed stated that they were not able to conform to the official IHS policy allowing them to perform abortions using federal funds for qualifying women.[127] Additionally, the report found that none of the IHS facilities contacted stocked emergency contraception—a drug that does not contravene the Hyde Amendment and can prevent an unwanted pregnancy at lower cost and with significantly less risk to the woman.[128]

123. Tribal Law and Order Act of 2010, Pub. L. No. 111-211, § 17, 124 Stat. 2258, 2300.

124. ANDREWS ET AL., *supra* note 16, at 3.

125. ACCESS TO ABORTION SERVICES, *supra* note 1, at 6.

126. *Id*.

127. SCHINDLER ET AL., *supra* note 109, at 5. In addition, 62% of service facilities surveyed stated that in the case of danger to the life of the pregnant woman, they had neither the capacity nor the funding to provide a woman with an abortion to save her life. *Id*.

128. *Id*.; *see Morning-After Pill*, *supra* note 111.

Finally, none of the facilities contacted stocked the medications necessary for a medical abortion, a viable medical alternative to surgical abortions early in pregnancy.[129] According to the study, the startling reality was that only 5% of IHS facilities were even capable of performing abortions.[130] The study found that:

> The standard of abortion counseling, the information provided to a woman interested in abortion, and the referrals to alternative abortion providers are often left to the discretion of the IHS personnel in charge. In many IHS Service Units, no standardized protocol is followed . . . .
> . . . IHS personnel frequently demonstrated uncertainty as to which services Native American women are legally entitled.[131]

This study demonstrated that, even if a Native American woman qualified for an abortion at IHS, the facility was unlikely to have the funding, staff, and/or equipment to perform the procedure.

The same study revealed that IHS service personnel were unaware of alternate funding sources for women seeking abortions in cases of sexual assault.[132] Abortions are extremely expensive, costing an average of $350 to $900 for an abortion in the first trimester.[133] The cost of an abortion increases with each week of pregnancy.[134] Getting an abortion is not as simple as walking into a clinic and scheduling an appointment for the procedure. There are several factors that may delay obtaining the procedure which, in turn, increase the costs and risks associated abortion care: some states have very few clinics able to perform abortions, and reservations may be hundreds of miles away from the nearest clinic; several states do not have resident doctors willing to perform abortions; and some states have mandatory pre-abortion waiting periods.[135] Regardless, a Native American victim of sexual assault seeking abortion services should be able to readily obtain either an abortion or a referral for an abortion at no cost from IHS. The reality is much different.

The surveyed IHS facilities reported that, if denied a legally permissible abortion at an IHS facility, a Native American woman would be covered by Medicaid—a federal and state government-sponsored healthcare program for

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129. SCHINDLER ET AL., *supra* note 110, at 5.

130. *Id*. at 6.

131. *Id*. at 5.

132. *Id*.

133. *In-Clinic Abortion Procedures*, PLANNED PARENTHOOD, http://www.plannedparenthood.org/health-topics/abortion/in-clinic-abortion-procedures-4359.htm (last visited Nov. 28, 2010).

134. *Id*.

135. PLANNED PARENTHOOD FED'N OF AM., INC., FACT SHEET: ABORTION AFTER THE FIRST TRIMESTER IN THE UNITED STATES 1-2 (2010), *available at* http://www.plannedparenthood.org/files/PPFA/fact_abortion_1st_tri_2010-09.pdf.

low-income Americans[136]—and could obtain an abortion using Medicaid funds and services.[137] This is extremely misleading. It is logical to assume that *some* Native American women who seek healthcare at IHS facilities do not have private health insurance and might qualify for Medicaid.[138] Compared with all other United States citizens, more than twice as many Native Americans live below the poverty line[139] and, therefore, frequently lack the means to purchase comprehensive private health insurance or request it from an employer; therefore, they cannot look to a private insurer to cover the cost of an abortion outside of IHS, regardless of whether that abortion is permissible under the Hyde Amendment or not. Consequently, Native American women whose primary healthcare provider is IHS must either pay for an abortion out-of-pocket or, if they qualify, seek state Medicaid assistance[140] if they choose an abortion and are not the victims of rape, incest, or their life is not endangered because of the pregnancy.[141]

However, telling Native American women that they can seek funds for an abortion through Medicaid, a federal healthcare program also subject to the Hyde Amendment's restrictions, is inaccurate.[142] First, simply because a Native American woman receives healthcare from IHS does not necessarily mean that she will qualify for Medicaid; IHS and Medicaid are two different federal programs and meeting the federal eligibility requirements for one in no way

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136. According to the Center for Medicare and Medicaid Services, "Medicaid is available only to certain low-income individuals and families who fit into an eligibility group that is recognized by federal and state law." *Overview*, CTR. FOR MEDICARE & MEDICAID SERVS., http://www.cms.hhs.gov/MedicaidGenInfo/ (last visited Nov. 28, 2010).

137. *See id*.

138. BROKEN PROMISES, *supra* note 52, at 28.

139. STELLA U. OGUNWOLE, U.S. CENSUS BUREAU, WE THE PEOPLE: AMERICAN INDIANS AND ALASKA NATIVES IN THE UNITED STATES 12 & fig.8 (2006).

140. Considering their eligibility, Native Americans are under-enrolled in Medicaid. Barriers to enrollment include a deep distrust of the federal government; the geographic location of the Medicaid office as compared with the geographic location of the individual Native American; lack of access to consistent communication; a lack of cultural awareness among Medicaid eligibility workers who misunderstand the application of eligibility rules to Native Americans; language barriers; the complex Medicaid application process; and a perception among many tribal leaders and Native Americans that enrollment in Medicaid (or other similar programs) could invalidate the federal government's trust responsibility, which would lead to a decline in funding for IHS. KATHRYN LANGWELL ET AL., AMERICAN INDIAN AND ALASKA NATIVE ELIGIBILITY AND ENROLLMENT IN MEDICAID, SCHIP AND MEDICARE 43-47 (2003), *available at* http://www.cms.hhs.gov/Reports/downloads/langwell3_2003_5.pdf.

141. Omnibus Appropriations Act, 2009, Pub. L. No. 111-8, § 508, 123 Stat. 115, 803. Worth noting, however, is that a 2010 qualitative study of abortion providers' experience receiving Medicaid reimbursement for abortions that should qualify for funding indicated that more than half of qualifying abortions were not reimbursed. Kacanek et al., *supra* note 7, at 79-80. "Of the 245 reported abortions that should have qualified for Medicaid reimbursement, 143 were not reimbursed. Of the 102 that were reimbursed, 99 were in one state; within that state, 27 qualifying abortions were not reimbursed. Eighteen respondents reported that no qualifying abortions were reimbursed." *Id*. at 80.

142. Kacanek et al., *supra* note 7; Boonstra & Sonfield, *supra* note 100.

guarantees meeting the eligibility requirements for the other. Second, assuming a Native American woman does meet the federal Medicaid eligibility requirements, there is no guarantee that her state Medicaid program will provide funding for the reproductive healthcare services she seeks.[143] Currently, thirty-two states provide Medicaid funding for abortions solely in the case of pregnancy resulting from rape or incest, or when the life of the pregnant woman is endangered.[144] Only seventeen states and the District of Columbia supplement federal Medicaid funds to provide for most medically necessary abortions[145]—that is, abortions necessary to preserve not only the life but also the health of pregnant women.[146] Finally, South Dakota—a state with a sizeable Native American population currently restricts abortions using Medicaid funds to those instances in which the life of the pregnant woman is endangered, in an apparent violation of federal Medicaid law.[147] Therefore, if we assume that IHS

143. Kacanek et al., *supra* note 7.

144. GUTTMACHER INST., STATE POLICIES IN BRIEF: STATE FUNDING OF ABORTION UNDER MEDICAID 1 (2010), *available at* http://www.guttmacher.org/statecenter/spibs/spib_SFAM.pdf.

145. *Id*.

146. *Id*. Though states define "medically necessary abortions" differently for purposes of Medicaid, in *Doe v. Maher*, a Connecticut court explained some of the numerous situations in which such an abortion is indicated. 515 A.2d 134, 154-55 (Conn. Super. Ct. 1986).

> The cruelty of the regulation is demonstrated by a sampling of the medically necessary abortions which would not have been eligible for funding under a life-endangerment standard but were funded by the state pursuant to the temporary mandatory injunction ordered by the court. For example: a thirteen year old girl who began vomiting five times a day, and developed an acute state of depression which was characterized by frequent crying spells and which interfered with her progress at school; a woman whose pregnancy was the result of rape and who was acutely depressed; a woman who was at risk of septic abortion because she became pregnant with an intrauterine contraceptive device in place which could not be removed; a woman with a reaction of anxiety and stress who also had hepatitis; a woman with an anxiety reaction who also had hypertension; a woman who had lupus erythematosus; a woman with pancreatitis; a woman with serious threats to her health from a failed prior attempt at an abortion with subsequent pain, bleeding and probably severe infection; a woman at risk because of a cardiac valve lesion who is also on medication known to have ill effects on pregnancy; a woman whose fetus could not survive outside of the womb because it had anencephaly; a woman who was at risk because she was both hypertensive and asthmatic; a woman who was at risk and whose fetus was also at risk because she had a history of drug abuse and was currently on a methadone program; a woman with a history of psychiatric illness who became emotionally unstable during pregnancy and needed medication for her mental health; and a woman who was at risk because she had sickle-cell anemia which is associated with a high rate of complication during pregnancy.

Id.

147. GUTTMACHER INST., *supra* note 144, at 1-2; POPULATION ESTIMATES PROGRAM, U.S. CENSUS BUREAU, ST-99-46, STATES RANKED BY AMERICAN INDIAN

does advise a qualifying Native American woman to use Medicaid services for an abortion in the case of pregnancy resulting from rape, incest, or endangerment to the life of the pregnant woman, this woman will not be able to get an abortion using Medicaid funds if she lives in South Dakota unless her pregnancy endangers her life. As such, referral to Medicaid does little to ease the difficulty of obtaining a legal abortion through IHS in the aftermath of sexual assault.

Considering that "most of the reproductive health care to Native American women [are] provided by the Indian Health Service,"[148] IHS is not providing Native American women with the comprehensive healthcare they deserve and that is mandated by the IHCIA. For women who are victims of sexual assault, IHS is failing to provide basic healthcare services permitted by federal law. Native American women are denied access to prescription drugs and medical procedures that allow them to make reproductive healthcare choices and to exercise control over their own reproductive destiny.

iii. A Case Study: Obstacles to Obtaining an Abortion in South Dakota

Putting the information collected by the Native American Women's Health Education Resource Center in concrete terms is useful. The impact of sexual assault on Native American women in South Dakota and the barriers to obtaining reproductive healthcare services is particularly illustrative. According to the 2000 census, South Dakota had 60,335 Native American state residents and ranked eleventh for states with the largest Native American populations.[149] There are eight reservations in South Dakota, including the Cheyenne River, Crow Creek, Lower Brule, Pine Ridge Oglala, Rosebud, Sisseton-Wahpeton, Yankton, and Flandreau Santee.

I will consider a hypothetical Native American woman living on a reservation in South Dakota who is sexually assaulted and for whom IHS is her primary healthcare provider. This woman goes to an IHS facility immediately after the sexual assault seeking emergency services and encounters numerous obstacles to obtaining comprehensive reproductive healthcare. The first obstacle she encounters is that only 30% of all IHS facilities have the necessary services for sexual assault victims. The local IHS facility may or may not have any sexual assault protocols and may or may not have the capacity to collect evidence with a rape kit that could later be used to prosecute her attacker.[150] If the facility does not have the ability to collect evidence with a rape kit or get emergency medical services to treat her physical injuries, our hypothetical

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AND ALASKA NATIVE POPULATION, JULY 1, 1999 (2000), *available at* http://www.census.gov/population/estimates/state/rank/aiea.txt.

148. ANDREWS ET AL., *supra* note 16, at 6 fig.1.

149. POPULATION ESTIMATES PROGRAM, *supra* note 147.

150. ANDREWS ET AL., *supra* note 16, at 6 fig.1 & 2. "Although 70% of respondents [IHS service units] indicated they have a protocol, the percentage of Service Units with a protocol posted and accessible to staff members is only 56%. The statistics reflect a discrepancy between policy and practice." *Id.*

woman may still want to discuss potential pregnancy with a nurse or doctor at IHS.[151] For the sake of argument, we will assume that the medical professional attending to her care is aware of the IHS policy on abortion and of the various medical options available to her.

Assuming the hypothetical victim is certain she does not want to carry a pregnancy resulting from sexual assault to term, emergency contraception—which can be used up to 120 hours after unprotected intercourse to prevent pregnancy and does not contravene the Hyde Amendment—is an option.[152] Unfortunately, there is no evidence that any IHS facility in the country carries emergency contraception, and it is likely that although the hypothetical victim might be legally allowed to obtain emergency contraception through IHS, she will not be able to do so.[153] If she tries to find a pharmacy that stocks emergency contraception outside of IHS facilities in South Dakota, she will be hindered by the South Dakota law allowing pharmacists to refuse to dispense or stock emergency contraception if they believe that the medication would be used to cause an abortion.[154] Finding either a pharmacy or pharmacist willing to dispense emergency contraception will likely prove difficult given that South Dakota is an extremely rural state,[155] and South Dakota law does not mandate that a pharmacist or pharmacy refusing to dispense emergency contraception refer their refused patient to a pharmacist or pharmacy who will provide emergency contraception.[156] The two Planned Parenthood clinics in South Dakota reliably provide emergency contraception but these may be hundreds of miles from the victim's home.[157] Moreover, if the victim is under seventeen,

151. It is important to note that the victim of a sexual assault has just suffered extreme trauma. Assuming she is capable of inquiring with a nurse or doctor about her options should she become pregnant as a result of the rape is a very big assumption. The victim may be so traumatized she might not be thinking about her options with regard to a potential pregnancy, the victim might not know about the existence of emergency contraception, cultural barriers might prevent the victim from asking such pointed questions, and the victim might be a teenager who is afraid to assert herself with medical personnel.

152. *Morning-After Pill*, *supra* note 111.

153. ANDREWS ET AL., *supra* note 16, at 7; SCHINDLER ET AL., *supra* note 109, at 5. No service units have Mifeprex available for patients. *Id*.

154. S.D. CODIFIED LAWS § 36-11-70 (2004); *see also* NARAL PRO-CHOICE SOUTH DAKOTA FOUND., PLAN B IN SOUTH DAKOTA (2009), http://www.prochoicesd.org/assets/files/planbinsd09web.pdf.

155. Holly Teliska, Note, *Obstacles to Access: How Pharmacist Refusal Clauses Undermine the Basic Health Care Needs of Rural and Low-Income Women*, 20 BERKELEY J. GENDER L. & JUST. 229, 245 (2005) ("According to Kate Looby, the South Dakota State Director of Planned Parenthood, the pharmacist refusal clause law is 'very hurtful' to women throughout the state because many communities have only one pharmacy. If a woman is denied contraception in Harding County, population 1,288, or Jones County, population 1,087, it is very unlikely that she will have convenient or feasible access to another provider.").

156. *See* S.D. CODIFIED LAWS § 36-11-70.

157. Planned Parenthood of Minnesota, North Dakota, and South Dakota operate clinics in Rapid City and Sioux Falls, South Dakota. *Health Center Locations*, PLANNED

she will not be able to obtain emergency contraception without a prescription, thereby creating another barrier to access.[158] Finally, the victim will likely have to cover the cost of emergency contraception herself and the cost can vary in price from $10 to $70.[159] There is no guarantee that IHS will reimburse her because IHS patient reimbursement is dependent upon IHS funding levels.[160] Considering that IHS is profoundly underfunded, reimbursement is unlikely.[161] Given that Native Americans frequently live below the poverty line,[162] it is not outside the realm of possibility that emergency contraception will be prohibitively expensive for the victim. Because of this, the victim may choose to play a game of Russian roulette: forgoing emergency contraception with the hope that she does not become pregnant from her sexual assault.

If the victim becomes pregnant as a result of her sexual assault, she may choose to terminate the pregnancy. She should be able to receive abortion services through IHS.[163] She would likely have two options: medical or surgical abortion. A medical abortion uses a combination of two to three drugs to terminate a pregnancy but is only recommended for women who are no more

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PARENTHOOD OF MINN., N.D., S.D., http://www.plannedparenthood.org/mn-nd-sd/15574.htm (last visited Nov. 28, 2010).

158. Press Release, U.S. Food and Drug Admin., FDA Approves Generic Prescription-Only Version of Plan B Emergency Contraceptive for Women Ages 17 and Under (Jun. 24, 2009), http://www.fda.gov/NewsEvents/Newsroom/PressAnnouncements/ucm168870.htm.

159. *Morning-After Pill*, *supra* note 111.

160. In describing the impact of contract health care on Native American children seeking services at IHS, Professor B.J. Jones explains:

> [T]he Indian Health Service theoretically provides a level of medical services to Indian children necessary to sustain their well being. However, funding for the Indian Health Service has always operated on the premise that IHS is a payor of last resort. This is an often misunderstood concept, and one which has led to Indian children being denied medical services by the Indian Health Services and the other primary source of medical services for impoverished children, Title XIX of the Social Security Act. Because both IHS contract health services and Medicaid purport to be payors of last resort for medical services, questions frequently arise regarding the responsibility of each to pay for services received by Indian children. . . .
>
> This has frequently led to situations in which IHS has been severely underfunded and frequently expends its contract health monies before the expiration of a fiscal year. This results in IHS, on many occasions denying payment on a legitimate bill because it had simply ran out of money for the year. Sometimes, these bills would be paid out of the next fiscal year's appropriation but more often than not the bills would not be paid resulting in lawsuits against the Indian child's family.

Jones, *supra* note 105, at 264 & n.150.

161. A QUIET CRISIS, *supra* note 18, at 5-6.

162. OGUNWOLE, *supra* note 139, at 12. It is estimated that nearly 40% of the Lakota in South Dakota live below the poverty level. *Id*. at 12 fig.8.

163. *See supra* Part.II.B.i.

than nine weeks pregnant.[164] In most states, only a physician may dispense the medication for a medical abortion.[165] Because the Native American Women's Health Education Resource Center study revealed that many IHS facilities do not stock the medications for medical abortion, our victim will have to find a doctor willing to dispense the medication to her.[166] In South Dakota, this means a trip to Planned Parenthood in Sioux Falls, the only clinic in the state that stocks mifepristone.[167] Medical abortions cost between $350 and $600 in South Dakota.[168] Again, our victim will face obstacles because she must travel great distances to find abortion services; she will also incur tremendous out-of-pocket expenses in order to obtain these basic, legally permissible services, and it is unlikely she will be able to obtain reimbursement from IHS.

Our victim may either prefer or have no option but to have a surgical abortion. As explained above, the likelihood that she will be able to get a surgical abortion at an IHS clinic or be reimbursed for the cost of an abortion is slim.[169] Even if the victim qualifies for South Dakota state Medicaid, South Dakota prohibits public funding for abortion unless the procedure is necessary to preserve the woman's life.[170] Therefore, she is faced with two options: pay

164. *What is Medical Abortion?*, NAT'L ABORTION FED'N, http://www.prochoice.org/pubs_research/publications/downloads/about_abortion/medical_abortion.pdf (last visited Nov. 28, 2010).

165. *Laws and Regulations Affecting Medical Abortion*, CTR. FOR REPROD. RIGHTS (July 1, 2003), http://reproductiverights.org/en/document/laws-and-regulations-affecting-medical-abortion.

166. *See* ANDREWS ET AL., *supra* note 16, at 7; SCHINDLER ET AL., *supra* note 109, at 5. Testimony to the House of Representatives Committee on Small Business in 2005 emphasized that pharmacists and physicians are increasingly refusing to either dispense birth control or write prescriptions for birth control citing religious, moral, and ideological objections to contraception. *Freedom of Conscience for Small Pharmacies: Hearing Before the H. Comm. on Small Business*, 109th Cong. (2005). South Dakota is one of five states with a pharmacist refusal statute, allowing pharmacists to refuse to dispense contraception. GUTTMACHER INST., STATE POLICIES IN BRIEF: REFUSING TO PROVIDE HEALTH SERVICES 1 (2010) *available at* http://www.guttmacher.org/statecenter/spibs/spib_RPHS.pdf. The South Dakota pharmacist refusal statute states, "[n]o pharmacist may be required to dispense medication if there is reason to believe that the medication would be used to: (1) Cause an abortion; or (2) Destroy an unborn child as defined in subdivision 22-1-2(50A)." S.D. CODIFIED LAWS § 36-11-70 (2004).

167. *Sioux Falls Clinic—Sioux Falls, SD*, PLANNED PARENTHOOD, http://www.plannedparenthood.org/health-center/centerDetails.asp?f=2738&a=90720&v=details (last visited Nov. 28, 2010).

168. *The Abortion Pill (Medication Abortion)*, PLANNED PARENTHOOD, http://www.plannedparenthood.org/health-topics/abortion/abortion-pill-medication-abortion-4354.htm (last visited Nov. 28, 2010).

169. Teliska, *supra* note 155, at 231 ("If a pharmacist is allowed to put his or her own beliefs above the health care needs of a patient, some women will be unable to fill their contraceptive prescription if they have a limited choice of pharmacy providers or limited ability—financially or logistically—to travel to another pharmacy for service.").

170. S.D. CODIFIED LAWS § 28-6-4.5.

for an abortion out of her own pocket, which ranges from $350 to $900 in the first trimester,[171] or remain pregnant.

In addition to the high cost of an abortion, women in South Dakota must endure onerous, potentially unexpected barriers to exercising their constitutionally-protected right to choose including a waiting period and a lack of doctors willing to perform abortions in the state. South Dakota has a mandatory twenty-four hour waiting period for abortions.[172] Whether in person or by telephone, abortion patients are subjected to state bias-counseling requirements mandating that the abortion provider tell patients that abortion ends "the life of a whole, separate, unique, living human being."[173] Although Planned Parenthood operates two clinics in South Dakota, only the clinic in Sioux Falls performs abortions.[174] To provide women with abortions, a doctor flies in once a week from Minnesota to perform abortions.[175]

A Native American woman who goes to Planned Parenthood seeking an abortion in South Dakota has more likely than not driven hundreds of miles to reach a clinic that performs abortions only once a week: a woman traveling from the Pine Ridge Reservation must traverse over 350 miles to reach Sioux Falls. She may or may not know that she will face a mandatory twenty-four hour delay before obtaining the abortion and may be forced to remain in Sioux Falls for twenty-four hours after the mandatory bias-counseling. The cost of obtaining an abortion will include the actual cost of the medical procedure, travel costs, housing costs, the cost of childcare if the victim has children at home, the cost of food, and the cost of taking time off of work to have the abortion. Obtaining an abortion in South Dakota is not an easy task—the Hyde Amendment and South Dakota's restrictive anti-choice laws create real barriers for women seeking to exercise their constitutionally protected right to choose.

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171. *In-Clinic Abortion Procedures*, *supra* note 133.

172. *Mandatory Delays and Biased Counseling for Women Seeking Abortions*, CTR. FOR REPROD. RIGHTS (SEPT. 30, 2010), http://reproductiverights.org/en/project/mandatory-delays-and-biased-counseling-for-women-seeking-abortions; *Government-Mandated Delays Before Abortion*, AM. CIVIL LIBERTIES UNION (Jan. 15, 2003), http://www.aclu.org/reproductiverights/abortion/16397res20030115.html.

173. S.D. CODIFIED LAWS §§ 34-23A-10.1-10.3, 22 (2004); Planned Parenthood Minn., N.D., S.D. v. Rounds, 650 F. Supp. 2d 972, 976 (D.S.D. 2009). Providers must tell the woman that abortion ends "the life of a whole, separate, unique, living human being," *id*., but do not have to tell the woman that she has an existing relationship with the "unborn human being," *id*. at 977-79, or that abortion increases the likelihood of suicide, *id*. at 983.

174. *Find a Health Center*, PLANNED PARENTHOOD, http://www.plannedparenthood.org/health-center/findCenter.asp.

175. Drew Griffin & Kira Kay, *Doctor Flies into South Dakota to Perform Abortions*, CNN (Apr. 5, 2006) http://www.cnn.com/2006/US/03/31/griffin.abortion/.

III. THE FEDERAL GOVERNMENT'S OBLIGATION TO END THE CYCLE OF VIOLENCE AGAINST NATIVE AMERICAN WOMEN

> "We are talking about comprehensive, sweeping changes across IHS and across all [Native American] communities, so that every single woman who is sexually assaulted gets treated with dignity and comprehensive care from now on."
>
> - Mia Luluquisen
> Native American Women's Health Education Resource Center[176]

A. The Impact of Sexual Assault on Native American Women

The practical effect of the Hyde Amendment on Native American women's reproductive healthcare in the aftermath of sexual assault coupled with the negligent manner in which the federal government administers healthcare to Native Americans amounts to a re-victimization of Native American women after sexual assault. A Native American woman is victimized by her attacker; victimized by the failure of the criminal justice system to prioritize, investigate, and prosecute her sexual assault; victimized by the federal government's failure to provide adequate reproductive healthcare to sexual assault victims; and, finally, victimized by the possibility of an unwanted pregnancy because of the federal government's inability to fulfill its trust obligations to meet the healthcare needs of Native Americans and to end the centuries old cycle of violence against Native American women. The Hyde Amendment permits IHS to provide abortions when pregnancy results from sexual assault or to reimburse a woman who seeks an abortion outside of IHS for such a pregnancy if IHS does not provide the services to which she is entitled. However, the qualitative study done by the Native American Women's Health Education Resource Center reveals that the restrictions imposed by the Hyde Amendment are having a far-reaching impact on women seeking to exercise their right to an abortion after sexual assault—very, very few IHS facilities perform abortions at all and, even when a woman qualifies for an abortion at IHS under the exceptions to the Hyde Amendment, she is virtually unable to receive one. The Hyde Amendment's impact on Native American women's access to abortion coupled with state laws that further obstruct access have made obtaining an abortion nearly impossible for many Native American women. Carrying an unwanted pregnancy to term may become the only option for Native American women when no other meaningful options exist.

Sexual assault and the unwanted pregnancies that may result are neither isolated acts of violence nor mere failures of the healthcare system to provide comprehensive reproductive healthcare service; they are part of a system that

176. NATIVE AM. WOMEN'S HEALTH EDUC. RES. CTR., INDIGENOUS WOMEN'S REPRODUCTIVE JUSTICE: ROUNDTABLE REPORT ON SEXUAL ASSAULT POLICIES AND PROTOCOLS WITHIN INDIAN HEALTH SERVICE 4 (2005).

undervalues and overlooks Native American women.[177] Victims of sexual assault experience both physical and psychological trauma after the assault, including but not limited to physical injuries, panic attacks, self-mutilation, eating disorders, depression, loss of self-esteem, suicidal ideation, substance abuse, and psychological disorders.[178] Professor Sarah Deer delved more deeply into the singular experience of sexual assault for Native American women: "[r]ape is more than a metaphor for colonization—it is part and parcel of colonization. . . . Sexual assault mimics the worst traits of colonization in its attack on the body, invasion of physical boundaries, and disregard for humanity."[179] By expanding our understanding of the impact of sexual assault against Native American women—from solely an analysis of the physical act of violence and the dismal rate of prosecution of sexual assault in Indian Country to one that includes the impact sexual assault has on Native American women as well as the ramifications of carrying an unwanted pregnancy to term as a result of the federal government's failure to provide Native American women basic reproductive healthcare—we can view sexual assault through the lens of race and gender-based discrimination and examine the state's distinct failures and obligations.[180] The federal government, which has a trust-based moral and fiduciary duty to tribes, has taken few meaningful steps to end sexual assault against Native American women. Furthermore, it puts so many obstacles in front of their constitutionally protected right to terminate a pregnancy that the right is rendered virtually meaningless, and Native American women may have no choice but to carry to term a pregnancy resulting from sexual assault. The trust relationship is a positive state obligation that should compel the federal government to take affirmative steps to end sexual assault against Native American women and provide comprehensive reproductive healthcare to victims.

B. The Government's Positive Obligation to End Violence Against Women: Where Feminism and Federal Indian Law Intersect

The federal government's meager steps to end the epidemic of sexual violence in Indian Country coupled with the restrictions enshrined in the Hyde Amendment and the chronic under-funding of IHS constitute a *de facto* policy of obstructing Native American women's access to comprehensive reproductive healthcare. The federal government's failures are a re-victimization and a re-violation of Native American women's bodies. Native American women are in a unique position vis-à-vis the federal government:

177. *See* SMITH, *supra* note 46.

178. *Sexual Assault*, NAT'L CTR. FOR VICTIMS OF CRIME, http://www.ncvc.org/NCVC/main.aspx?dbName=DocumentViewer&DocumentID=32369#3 (last visited Nov. 28, 2010).

179. Deer, *Decolonizing Rape Law*, *supra* note 46, at 150.

180. Professor Andrea Smith explains, "[p]utting Native women at the center of analysis compels us to look at the role of the state in perpetuating both race-based and gender-based violence." SMITH, *supra* note 46, at 3.

because of the trust relationship, the government has a positive obligation to take steps to end both sexual and reproductive violence against Native American women.[181] It is my contention that viewing the trust relationship as a positive state obligation fits squarely within the intersection of Indian law and feminist legal thinking and allows us to expand our notion of how to achieve justice for Native American victims of sexual assault.

The epidemic of sexual assault against Native American women is not a result of a state-sponsored campaign of sexual assault; however, "private violence that is pervasive and without legal remedy contributes to political oppression in a way that is increasingly and appropriately regarded as implicating the state."[182] There can be little doubt that sexual assault in Indian Country and the denial of access to reproductive healthcare, including abortion, are at such crisis levels that they implicate the federal government. This crisis should compel the federal government to embrace its positive obligations to end violence against Native American women. Even if the United States Supreme Court is unwilling to embrace positive state obligations toward Native American women wholesale, under the trust relationship the federal government has the duty—which has been routinely recognized in international human rights law and in the jurisprudence of other countries—to take affirmative steps to end the crisis of sexual and reproductive violence.

i. Positive State Obligations

In the United States, we typically conceive of harms that constitute a deprivation of liberty as exciting "no constitutional concern unless the proximate active perpetrators of the harm include persons exercising the special authority or power of the government of a state."[183] That is to say, the state has no positive obligation to intervene in and end constitutional deprivations unless

181. That said, I do not believe that the federal government has a policy of forcibly impregnating Native American women as did the governments in Bosnia or Rwanda. Article 7(2)f) of the Rome Statute of the International Criminal Court defines forced pregnancy as the "unlawful confinement of a woman forcibly made pregnant, with the intent of affecting the ethnic composition of any population or carrying out other grave violations of international law." Rome Statute of the International Criminal Court, art. 7(2)(f), July 17, 1998, 2187 U.N.T.S. 90, *available at* http://untreaty.un.org/cod/icc/statute/romefra.htm. The International Criminal Tribunal for Rwanda understands forced pregnancy more broadly: "[i]n patriarchal societies, where membership of a group is determined by the identity of the father, . . . a woman of the said group is deliberately impregnated by a man of another group, with the intent to have her give birth to a child who will consequently not belong to its mother's group." Prosecutor v. Akayesu, Case No. ICTR-96-4-T, Judgment, ¶ 507 (Sept. 2, 1998), *available at* http://www.un.org/ictr/english/judgements/akayesu.html. Forced pregnancy can include both forcing a woman to give birth against her will and forcibly impregnating a woman by a man from an ethnic group distinct from that of the woman to prevent the birth of child from the woman's ethnic group.

182. Tracy E. Higgins, *Reviving the Public/Private Distinction in Feminist Theorizing*, 75 CHI.-KENT L. REV. 847, 863 (2000).

183. Frank I. Michelman, *Conceptions of Democracy in American Constitutional Argument: The Case of Pornography Regulation*, 56 TENN. L. REV. 291, 306 (1989).

those deprivations occur because of state action. The United States Supreme Court has declined to use the Fourteenth Amendment's property and liberty guarantees to enforce positive state obligations, repeatedly finding that where private action is the proximate cause of a deprivation, the state has no positive obligation to act to end the deprivation and cannot be held to account for any failure to act. In finding that the state had no positive obligation to prevent the death of a child returned to the custody of a parent who the state knew was abusive and whose return resulted in the child being beaten into a vegetative state, the Court in *DeShaney v. Winnebago County Department of Social Services.* explained:

> [N]othing in the language of the Due Process Clause itself requires the State to protect the life, liberty, and property of its citizens against invasion by private actors. The Clause is phrased as a limitation on the State's power to act, not as a guarantee of certain minimal levels of safety and security. . . .
> . . . [T]he Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual.[184]

The proximate cause of the harm suffered by Joshua DeShaney was not, according to the Court, the state delivering the child to the custody of his father but the actual beating the child suffered[185]—essentially, the Fourteenth Amendment creates no positive state obligation to protect a child from a beating it had good reason to suspect would occur. The Court recognized positive state obligations under the Fourteenth Amendment as occurring only when the state deprives a person of liberty, for example, by incarceration, and only then does the state have a positive obligation under the Fourteenth Amendment to guarantee that a person's basic human needs are met.[186]

The Court reaffirmed this position in *Town of Castle Rock v. Gonzales*, finding that no Fourteenth Amendment property interest existed in a Colorado

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184. DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189, 195-96 (1989).

185. *Id*. at 201. To support this proposition, the Court cited *Harris v. McRae*—a case that challenged the constitutionality of the Hyde Amendment as applied to indigent women—holding that the government has no obligation to fund abortion services for low-income women because those services are not an entitlement. *Id*. at 196 (citing Harris v. McRae, 448 U.S. 297, 317-18 (1980)).

186. *Id*. at 200 ("[W]hen the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—*e. g*., food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause. The affirmative duty to protect arises not from the State's knowledge of the individual's predicament or from its expressions of intent to help him, but from the limitation which it has imposed on his freedom to act on his own behalf." (internal citations omitted)).

law that mandated the enforcement of restraining orders.[187] Jessica Gonzalez's husband violated a permanent restraining order against him by taking their three children without her consent.[188] Gonzalez repeatedly contacted the local police department requesting enforcement of the restraining order; the police repeatedly declined to enforce it, and her husband murdered her children while they were in his custody.[189] The *Castle Rock* Court found that Colorado's law mandating arrest for violations of temporary restraining orders was not mandatory in the true sense of the word but, rather, coexisted with "[a] well established tradition of police discretion."[190] Accordingly, Gonzalez had no Fourteenth Amendment property interest in the restraining order,[191] no positive state obligation existed, and she could not hold local police accountable for failing to enforce the restraining order.

Feminists frequently reject the negative obligations conceived of by the Court in *DeShaney* and *Castle Rock*, arguing that until the state embraces its positive rights obligations to end violence from both public *and* private actors, women will not be able to truly enjoy liberty and equality. The distinction between private and public actions must be deconstructed in order to achieve the goal of equality and freedom from violence.[192] It is not that the private actor, for example a sexual predator or abusive partner, acts under color of state law, but rather that true equality for women—including freedom from violence, the right to privacy, the right to bodily integrity, and freedom from discrimination—obligates the state to ensure that women have meaningful remedies against both public and private violence.[193] Men and women frequently (though not exclusively) experience violence differently: men typically experience violent oppression at the hands of state actors whereas women frequently experience it in intimate relationships at the hands of private actors.[194] If the ultimate goal is women's equality, the private/public distinction must be rendered meaningless. Therefore, many feminist legal scholars reject the outcomes of *DeShaney* and *Castle Rock* because they do not hold the state appropriately accountable for its role in ending violence against women and promoting equality.[195] As applied to *Castle Rock*, Professor Kristian Miccio explains, "[t]he Court ran rough shod over a fundamental precept of American political theory; Jessica Gonzales had the right to governmental protection

187. Town of Castle Rock v. Gonzales, 545 U.S. 748, 759-62 (2005).

188. *Id*. at 752-53.

189. *Id*. at 752-54.

190. *Id*. at 760.

191. *Id*. at 767.

192. *See* Higgins, *supra* note 182, at 863.

193. *Id*. at 858-59.

194. *See* CATHARINE A. MACKINNON, TOWARD A FEMINIST THEORY OF THE STATE 161 (1989).

195. *See e.g*., G. Kristian Miccio, *If Not Now, When? Individual and Collective Responsibility for Male Intimate Violence*, 15 WASH. & LEE J. CIVIL RTS. & SOC. JUST. 405, 423 (2009).

because as a member of the body politic she had delegated that enforcement to the government."[196]

Increasingly, international human rights law has rejected the notion that the mere lack of state-sponsored action relieves the state of its duty to end violence against women. Article 1 of the Convention to End All Forms of Discrimination Against Women (CEDAW) includes violence against women in its definition of discrimination against women.[197] CEDAW General Recommendation 19 endorses a positive rights framework for state obligations to end violence against women, stating:

> [D]iscrimination under the Convention is not restricted to action by or on behalf of Governments . . . . [u]nder article 2 (e) the Convention calls on States parties to take all appropriate measures to eliminate discrimination against women by any person, organization or enterprise. Under general international law and specific human rights covenants, States may also be responsible for private acts if they fail to act with due diligence to prevent violations of rights or to investigate and punish acts of violence, and for providing compensation.[198]

The Beijing Declaration also endorses this view, stating that "[g]overnments should take urgent action to combat and eliminate all forms of violence against women in private and public life, whether perpetrated or tolerated by the State or private persons."[199]

Forcing a woman to carry an unwanted pregnancy resulting from sexual assault to term because she has no meaningful option to terminate the pregnancy is a form of violence against women that explicitly denies women equality and discriminates against women based on their gender. Native American women's access to abortion after sexual assault must be recognized and embraced as a positive state obligation—a condition necessary to Native American women's access to full equality—just as such state obligations have been recognized in international fora. Colombia is one of the first countries to

196. *Id*. at 423 (footnote omitted).

197. *See* Convention on the Elimination of All Forms of Discrimination Against Women, G.A. Res. 34/180, U.N. GAOR, 34th Sess., Supp. No. 46, U.N. Doc. A/RES/34/180 (Dec. 18, 1979) (entered into force on Sept. 3, 1981) [hereinafter CEDAW]; Rep. on the Comm. on the Elimination of Discrimination Against Women, General Recommendation 19, ¶ 7, U.N. Doc. A/47/38; GAOR, 47th Sess., Supp. No. 38 (1992) ("Gender-based violence, which impairs or nullifies the enjoyment by women of human rights and fundamental freedoms under general international law or under human rights conventions, is discrimination within the meaning of article 1 of the Convention.") [hereinafter General Recommendation 19].

198. General Recommendation 19, *supra* note 197, ¶ 9.

199. Rep. of Fourth World Conference on Women, Sept. 4-15, 1995, *Beijing Declaration and Platform for Action*, ¶ 225, U.N. Doc. A/CONF.177/L.1, Annex 1 (May 24, 1995).

recognize the correlation between freedom from violence and access to abortion.[200] In 2006, the Constitutional Court of Colombia invalidated the Colombian prohibition and criminalization of abortion in three instances: (1) when the life or health of a woman is endangered; (2) when the fetus has a condition that is not compatible with life outside the womb; and (3) when pregnancy is a result of a criminal act such as sexual assault or incest.[201] This decision was among the first to acknowledge "the connection between discrimination and lack of access to abortion, emphasizing the disproportionate impact of forced pregnancy and unsafe abortion on adolescent, poor, rural, and indigenous women."[202] The Court explained that "sexual and reproductive rights . . . emerge from the recognition that equality in general, gender equality in particular, and the emancipation of women and girls are essential to society."[203] The decision recognized that Colombia's complete denial of abortions for marginalized women was a rejection of the state's positive obligations under international human rights law to provide comprehensive reproductive healthcare services, particularly after acts of sexual assault. "[A]t a minimum, [the state has] an obligation to mitigate the effects of sexual violence by providing abortion and other protective health services to save women from being forced to endure unwanted gestation."[204]

ii. Due Process and Positive State Obligations to Native American Women

Despite forward movement in international law, the United States Supreme Court has explicitly rejected any positive obligations with regard to providing abortions to women dependent on the federal government for healthcare.[205] In doing so, the Court shrugged off any positive obligations to ensure women's equality by guaranteeing women access to healthcare choices to determine their reproductive destiny. In *Harris v. McRae*, the Court heard a class action lawsuit challenging the Hyde Amendment brought on behalf of all indigent and pregnant and/or potentially pregnant women in the State of New York in 1980.[206] Nowhere in the decision did the Court address the impact of the Hyde Amendment as applied to Native American women.[207] Still, an examination of the case is useful in establishing the federal government's

200. Emilia Ordolis, *Lessons from Colombia: Abortion, Equality, and Constitutional Choices*, 20 CANADIAN J. WOMEN & L. 263, 263-64 (2008) (citing Corte Constitutional [C.C.] [Constitutional Court], mayo 10, 2006, Sentencia C-355/2006 (Colom.)). I relied heavily on Emilia Ordolis' translation of the decision of the Constitutional Court of Colombia and am grateful for her extremely helpful Article.

201. *Id*. at 263-64.

202. *Id*. at 264.

203. *Id*. at 272.

204. *Id*. at 274.

205. DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189, 196 (1989); *see also* Town of Castle Rock v. Gonzalez, 545 U.S. 748, 768 (2005).

206. Harris v. McRae, 448 U.S. 297, 303-04 (1980).

207. *Id*. at 297.

failure to embrace its positive obligations with regard to Native American women.

Advocates for the class of indigent women argued, "the funding restrictions of the Hyde Amendment violate several rights secured by the Constitution . . . [including] the right of a woman, implicit in the Due Process Clause of the Fifth Amendment, to decide whether to terminate a pregnancy."[208] The Court rejected this reading of the Due Process Clause, despite noting that *Roe v. Wade* established the right of a woman to terminate a pregnancy based on the Fourteenth Amendment's liberty guarantee.[209] States, the Court explained, have a right to protect "potential human life."[210] As a result of *Roe*, states cannot enact criminal statutes prohibiting abortion or requiring spousal consent to obtain an abortion, as this would be an undue burden on a woman's right to terminate a pregnancy.[211] *Roe* and its progeny do not bar states from making "a value judgment favoring childbirth over abortion, and . . . implement[ing] that judgment by the allocation of public funds."[212] Based on this reasoning, the Court held that

> The Hyde Amendment . . . *places no governmental obstacle in the path of a woman who chooses to terminate her pregnancy*, but rather, by means of unequal subsidization of abortion and other medical services, encourages alternative activity deemed in the public interest. . . .
> . . . [R]egardless of whether the freedom of a woman to choose to terminate her pregnancy for health reasons lies at the core or the periphery of the due process liberty recognized in *Wade*, it simply does not follow that a woman's freedom of choice carries with it a constitutional entitlement to the financial resources to avail herself of the full range of protected choices.[213]

In upholding the constitutionality of the Hyde Amendment, the Court in *Harris v. McRae* asserted that an indigent woman's financial position restricted her access to an abortion and not the federal government's prohibition on using federal funds for abortions.[214] In sum, the Court held "that the Hyde Amendment does not impinge on the due process liberty recognized in [*Roe v.*] *Wade*."[215]

As a result of *Harris*, Native American women have no basis upon which to use the Fourteenth Amendment to challenge not only the Hyde Amendment

208. *Id*. at 311.
209. *Id*. at 312-18.
210. *Id*. at 313.
211. *Id*. at 313-14.
212. *Id*. at 314 (quoting Maher v. Roe, 432 U.S. 464, 474 (1977)).
213. *Harris*, 448 U.S. at 315-16 (emphasis added).
214. *Id*.
215. *Id*. at 318.

but also their lack of access to abortion after sexual assault. Likely, such a challenge would result in the Court finding that it is not the Hyde Amendment or a lack of funding for IHS that create barriers to obtaining an abortion, but rather the individual woman's financial position. Forcing positive obligations on the federal government to end sexual assault against Native American women and to ensure access to comprehensive reproductive healthcare—both of which are part of a pattern of private actor discrimination that inherently implicates the state—via the Fourteenth Amendment is no longer an option after *Harris*. *Roe* stands for the legal principle that the government may not interfere with a woman's right to an abortion on the basis of a governmental policy of preventing abortions[216]—a woman has a right to terminate a pregnancy free of "unduly burdensome" governmental intrusion.[217] *Harris* and its progeny stand for the proposition that "[w]omen with privileges get rights."[218] If Native American women wish to force the government to guarantee access to abortion after sexual assault, could they turn to the federal trust responsibility to vindicate their rights?

iii. The Trust Relationship and Positive State Obligations to Native American Women

The right of Native American women to be free from sexual assault and have meaningful access to abortion must be viewed through the lens of the federal government's trust relationship with Native American people. The origin of the federal government's responsibility to Native Americans is the trust relationship—a moral and fiduciary obligation owed to Native Americans.[219] The trust relationship is, at its core, a positive state obligation to Native Americans: a challenge based on the trust relationship would allege that because of the unique relationship between Native Americans and the federal government, the failure to provide comprehensive reproductive healthcare, including abortions if desired, after sexual assault is, in light of the trust relationship, the very state action that the Court was unable to find in *DeShaney* and *Castle Rock*.

Unfortunately, the Court disfavors legal attacks using a pure trust relationship theory, and the theory has all too often proven an unsuccessful means to vindicate the rights of Native Americans.[220] Any case brought before

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216. Michael J. Perry, *Why the Supreme Court Was Plainly Wrong in the Hyde Amendment Case: A Brief Comment on* Harris v. McRae, 32 STAN. L. REV. 1113, 1115-17 (1980).

217. *Id*. at 1117.

218. Catharine MacKinnon, Roe v. Wade*: A Study in Male Ideology*, *in* ABORTION: MORAL AND LEGAL PERSPECTIVES 45, 52 (Jay L. Garfield & Patricia Hennessey eds., 1984).

219. Chambers, *supra* note 27, at 1213-14.

220. Tribes have successfully sued the U.S. government for violations of the trust relationship. The Court in *United States v. Mitchell* found a violation of the trust relationship resulting from federally mismanaged allotments to Native Americans. United States v. Mitchell, 463 U.S. 206, 210-11 (1983). The *Mitchell* Court explained that the trust

the Supreme Court on a trust violation theory has, at best, a tenuous chance of success. The Court has only granted relief to individual Native Americans or tribes on a theory of breach of the trust relationship in cases where the tribe or individual could point to a specific, narrow, and concretely enumerated breach of trust.[221] The courts have never granted relief in cases where tribes or individuals have sought relief based on a general trust theory.[222]

A specific trust-based attack on the failure of IHS to provide comprehensive reproductive healthcare services is very unlikely to succeed. The trust relationship is codified in the IHCIA: Congress stated, "[f]ederal health services to maintain and improve the health of the Indians are consonant with and required by the Federal Government's historical and unique legal relationship with, and resulting responsibility to, the American Indian people."[223] However, legal attacks on the provision of healthcare services by IHS grounded in general trust violations have failed. In *Lincoln v. Vigil*, a group of children who received services from the Indian Children's Program—an IHS-run program providing services to mentally and physically disabled Native American children in the Southwest—challenged the authority of IHS to terminate the program.[224] The children challenged IHS on two grounds. First, they claimed that any change to the program by IHS was not only subject to judicial review under the Administrative Procedure Act (APA), but also subject

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relationship did not arise from the General Allotment Act—the Act that originally divided tribal land into parcels for individual Native Americans—but arose from the federal statutes setting forth regulations for the management of allotment, regulations designed specifically to help manage fractional shares from intestate allottees. *Id*. at 225. These statutes expressly authorized the Secretary of the Interior to manage timber of allotment lands despite the fact that there was no statute that expressly created such a trust. *Id*. at 224-25. As a result of this finding, the Court held the federal government liable for breach of the trust. *Id*. at 226. In 2003, the Court in *United States v. White Mountain Apache Tribe* found the federal government violated its statutory trust obligation to care for a fort on the White Mountain Apache reservation, finding that the Indian Tucker Act expressly created a trust for management of the fort. United States v. White Mountain Apache Tribe, 537 U.S. 465, 474-76 (2003).

221. In the most famous example of breach of trust, the federal circuit court found a breach of trust and resulting fiduciary liability as a result of the mismanagement of Individual Indian Money trust accounts. Cobell v. Norton, 240 F.3d 1081, 1110 (D.C. Cir. 2001).

222. In *Osage Tribal Council v. U.S. Dep't of Labor*, the Tenth Circuit failed to find enforceable breach of the trust responsibility which would prevent the enforcement of the Safe Water Drinking Act against the Osage. Osage Tribal Council v. U.S. Dep't of Labor, 187 F.3d. 1174, 1183-84 (10th Cir. 1999). In *Skokomish Indian Tribe v. F.E.R.C.*, the Ninth Circuit rejected the argument that the Federal Energy Regulatory Commission violated the federal trust responsibility by denying a Skokomish application for a permit for a hydropower facility. Skokomish Indian Tribe v. F.E.R.C., 121 F.3d 1303, 1308-09 (9th Cir. 1997). The Court stated that "the Tribe's permit application is barred by FERC's regulations, and the federal trust responsibility does not compel its acceptance." *Id*. at 1309.

223. Indian Health Care Improvement Act, Pub. L. No. 94-437, § 2, 90 Stat. 1400, 1400.

224. *See* Lincoln v. Vigil, 508 U.S. 182, 184 (1993).

to judicial scrutiny for the agency's failure to follow notice and comment rulemaking regulations under the APA.[225] In the alternative, the children argued that the federal government and, by extension, IHS had a special duty to them because the trust relationship prohibited discontinuance of the program.[226] The *Lincoln* Court, in a unanimous decision, refused to find either a statutory mandate for judicial review of the Indian Children's Program under the APA or a duty to the children emanating from the trust relationship.[227]

The language of *Lincoln* makes it extremely difficult to conceive of a successful judicial challenge to IHS funding priorities involving access to abortion after sexual assault. The *Lincoln* Court explained that IHS received lump sum appropriations from Congress with no specific congressional appropriation for the Indian Children's Program.[228] Finding that the allocation decisions resulting from lump sum appropriations should be considered discretionary agency decisions, the Court held that "as long as the agency allocates funds from a lump-sum appropriation to meet permissible statutory objectives, [the Administrative Procedures Act] gives the courts no leave to intrude."[229] The Court deferred to the agency's expertise in meeting its statutory mandate in light of often inadequate funding resources IHS received from Congress.[230] The Court gave short shrift to the argument that the trust relationship should compel IHS to reestablish the program. The Court cited its 1908 ruling in *Quick Bear v. Leupp*,[231] a case "distinguishing between money appropriated to fulfill treaty obligations, to which trust relationship attaches, and 'gratuitous appropriations'" to which the trust relationship does not attach.[232] From this, the Court reasoned, "[w]hatever the contours of that relationship . . . it could not limit the [Indian Health] Service's discretion to reorder its priorities from serving a subgroup of beneficiaries to serving the broader class of all Indians nationwide."[233] Currently, IHS receives a significant amount of lump sum appropriations; after *Lincoln*,[234] it is likely that the Court

225. *Id*. at 189-90.

226. *Id*. at 194.

227. *Id*. at 193-94.

228. *Id*. at 193.

229. *Id*.

230. *Id*.

231. Quick Bear v. Leupp, 210 U.S. 50, 80 (1908).

232. *Lincoln*, 508 U.S. at 194-95.

233. *Id*. at 195.

234. *Id*. at 184. Although the United States Supreme Court rejected the view that health care is an entitlement in *Lincoln v. Vigil*, most Native Americans view IHS as an entitlement that is part of the federal trust responsibility. BROKEN PROMISES, *supra* note 52, at 49 n.14.

> [M]any Native Americans believe that they bargained for health care when they signed treaties giving up their land. Therefore, whether the government should finance the IHS is not the question; annual appropriations decisions should not be subject to congressional discretion. When the federal government accepted the responsibility, it became an "entitlement" for Native American peoples.

will reject attempts to force IHS to allocate funds for women seeking Hyde Amendment-compliant abortions because the Court does not view Native American healthcare as an entitlement. The Court will not only defer to agency discretion but, unless a tribe is able to produce a treaty that specifically mandates that IHS allocate funds for healthcare in a way that can be interpreted to include abortions, the Court is unlikely to find an abrogation of the trust relationship or any positive obligation to provide comprehensive reproductive healthcare.[235]

C. Concrete Steps the Federal Government Can Take to Aid Native American Victims of Sexual Assault

It is unlikely that any branch of the federal government will embrace what I believe are its positive obligations to Native American women to end sexual assault and ensure access to comprehensive reproductive healthcare services in the aftermath of such violence. Although a suit based on violations of the trust relationship is unlikely to succeed, advocates can encourage the government to

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Id. at 107. This view is supported by the fact that numerous treaties between the United States and tribes contain specific provisions that guarantee the cessation of land in exchange for money and services from the United States, including health care. For example, Article 10 of the Puyallup Treaty of Medicine Creek of 1854 states that "the United States further agree to employ a physician to reside at the said central agency, who shall furnish medicine and advice to their sick, and shall vaccinate them." Treaty with Nisquallys, &, art. 10, Dec. 26, 1854, 10 Stat. 1132, 1134, *available at* http://digital.library.okstate.edu/kappler/vol2/treaties/nis0661.htm. Although there is great variation among treaties regarding provisions for health care, the historical record demonstrates that such treaties were not uncommon. Betty Pfefferbaum et al., *Learning How to Heal: An Analysis of the History, Policy, and Framework of Indian Health Care*, 20 AM. INDIAN L. REV. 365, 369 (1995-96). "Increasingly, treaty agreements provided for medical services and supplies in exchange for land and promises to remain on reservations, establishing a precedent for the creation of a separate system of health care for Indians. While some treaties specified time limits of from five to twenty years, the government frequently provided services beyond such treaty dates." *Id.* at 369 (footnotes omitted) (citing THE INDIAN: AMERICA'S UNFINISHED BUSINESS, REPORT OF THE COMMISSION ON THE RIGHTS, LIBERTIES, AND RESPONSIBILITIES OF THE AMERICAN INDIAN 159-160 (William A. Brophy & Sophie D. Aberle eds., 1966).

235. In 1994, a federal district court in *Yankton Sioux Tribe v. U.S. Dep't of Health & Human Services* distinguished *Lincoln* and prevented IHS from closing a health care facility that served the Yankton Sioux. 869 F.Supp. 760, 765, 767 (D.S.D. 1994). The *Yankton Sioux* court found that IHS had an obligation to operate the health care facility based both on statutory grounds, a mandate to construct health care facilities found in the IHCIA, and an obligation to consult with the tribe about construction because of a specific congressional appropriation for the construction and maintenance of such facilities. *Id.* at 765. This statutory obligation and the congressional appropriation gave the court room to evaluate the IHS decision under the APA. A tribe with a treaty-based right to health care could use similar rationale to challenge IHS under-funding of comprehensive reproductive health care services in the aftermath of sexual assault. While this argument would not invalidate the Hyde Amendment as-applied to Native American women, it could open up a meaningful funding stream dedicated to giving Native American sexual assault victims the option to terminate a pregnancy should they so choose.

take several meaningful steps to begin to reverse the epidemic of sexual assault and unwanted pregnancy. These steps include a far-reaching study of reproductive healthcare at IHS, the prioritization of prosecuting sexual assault and allocating the funds necessary to do so, and, short of repealing the Hyde Amendment, providing IHS with the funds needed to provide comprehensive reproductive healthcare services to the victims of sexual assault.

i. Undertake a Study of Reproductive Healthcare at IHS and Financially Enable IHS to Provide Comprehensive Reproductive Healthcare

The qualitative studies completed by the Native American Women's Health Education Resource Center[236] are an excellent step in understanding the scope of the reproductive healthcare crisis that Native American women face and, in particular, women who are the victims of sexual assault who use IHS as their primary healthcare provider. From their work, it is evident that Native American women are not being provided with the comprehensive reproductive health services they need, including abortion should they so choose, in the aftermath of sexual assault. First and foremost, a quantitative study must be undertaken to determine the full scope of the reproductive healthcare crisis in Indian Country so policymakers have the data necessary to accurately assess what must be done to remedy the lack of comprehensive reproductive health services for sexual assault victims.[237]

The Hyde Amendment is a discriminatory funding ban that places obstacles between a woman and her constitutionally protected right to an abortion. The Hyde Amendment disproportionately impacts many women of color and low-income women, profoundly impacting Native American women in particular.[238] The federal government should not intrude on any woman's decision to terminate her pregnancy and should play no role in a woman's healthcare decisions solely because she is dependent on the federal government for that healthcare. Unfortunately, the Hyde Amendment has been in place for thirty-four years; it is extraordinarily unlikely that it will be repealed, even under a pro-choice president.[239]

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236. ACCESS TO ABORTION SERVICES, *supra* note 1; ANDREWS ET AL., *supra* note 16; SCHINDLER ET AL., *supra* note 109.

237. All Native American women should receive comprehensive reproductive health care, but so long as the Hyde Amendment is annually renewed they will not.

238. Heather D. Boonstra, *The Impact of Government Programs on Reproductive Health Disparities: Three Case Studies*, GUTTMACHER POL'Y REV., Summer 2008, at 9, *available at* http://www.guttmacher.org/pubs/gpr/11/3/gpr110306.pdf; Sarah Horsley, *Dignity and Justice for Some?: The Devastating Impact of the Hyde Amendment*, CTR. FOR AM. PROGRESS (Oct. 13, 2006), http://www.americanprogress.org/issues/2006/10/hyde_column2.html.

239. Garance Franke-Ruta, *A New Push Against Hyde Amendment Faces Some High Hurdles*, WASH. POST. (Mar. 22, 2010), http://voices.washingtonpost.com/44/2010/03/a-new-push-against-hyde-with-h.html.

Short of repealing the Hyde Amendment, Congress can and should take steps to ensure that Native American women seeking abortions permissible under the Hyde Amendment have meaningful access to abortion. Congress should fund IHS at a rate that would allow all IHS facilities to provide the medical services women need in the aftermath of sexual assault, including stocking emergency contraception, employing doctors trained in performing medical and surgical abortions, and stocking rape kits with nurses trained to administer them. The recently enacted Tribal Law and Order Act of 2010 requires the Director of IHS to create standardized sexual assault policies and protocols for tribes in consultation with federal and tribal officials.[240] This is an extremely important step toward remedying treatment failures within the IHS system. Congress should adequately fund IHS so that it has the resources to provide comprehensive reproductive healthcare to victims of sexual assault. Until they do, Native American women will be forced to carry unwanted pregnancies resulting from sexual assault to term because the barriers to accessing abortion services elsewhere remain high.

ii. Provide Law Enforcement with the Resources Needed to Prosecute Sexual Assault in Indian Country

The Department of Justice can take important steps to eradicate sexual assault against Native American women while IHS works to ensure that they have access to comprehensive reproductive healthcare, including abortion, in the aftermath of such violence. The federal government must give the Department of Justice the resources it needs to prosecute offenders. One key to ending sexual assault against Native American women is ensuring that law enforcement has the tools it needs to respond to the crisis. Currently, tribal law enforcement and tribal courts are hamstrung because of the jurisdictional maze that makes prosecution of non-Indian offenders impossible unless undertaken by the federal government and hampers prosecution of Native American offenders. It appears unlikely that Congress will override the Supreme Court's decision in *Oliphant v. Suquamish Indian Tribe*, holding that tribes gave up their power to try non-Indians for crimes committed on the reservation except in a manner acceptable to Congress.[241] However, positive steps to empower tribal communities and respond to the needs of crime victims are being taken. In 2010, Congress and the Obama Administration took a significant step toward giving tribal law enforcement agencies a greater measure of control over local law enforcement and holding federal agencies accountable for ensuring public safety in Indian Country by enacting the Tribal Law and Order Act.[242] Included in the bill was (1) a mandate for coordination between the Department of

240. Tribal Law and Order Act of 2010, Pub. L. No. 111-211, § 265, 124 Stat. 2258, 2300.

241. Oliphant v. Suquamish Indian Tribe, 435 U.S. 191, 210 (1978).

242. Tribal Law and Order Act of 2010, Pub. L. No. 111-211, § 202, 124 Stat. 2258, 2261.

Justice and tribal law enforcement;[243] (2) a requirement that United States Attorneys whose districts include Indian Country appoint "not less than 1 assistant United States Attorney to serve as a tribal liaison for the district";[244] (3) an expansion of tribal court sentencing authority;[245] (4) a directive to establish the Indian Law and Order Commission that will "conduct a comprehensive study of law enforcement and criminal justice in tribal communities . . . [and] develop recommendations on necessary modifications and improvements to justice systems at the tribal, Federal, and State levels";[246] (5) authorization of grants for a host of tribal justice systems;[247] (6) a mandate for training Indian law enforcement to "properly interview victims of domestic and sexual violence and to collect, preserve, and present evidence to Federal and tribal prosecutors to increase the conviction rate";[248] (7) a mandate to take steps to prevent the sex trafficking of Indian women;[249] and (8) a requirement directing "the Director of the Indian Health Service, in coordination with [other tribal and federal organizations, to] develop standardized sexual assault policies and protocol for the facilities of the [Indian Health] Service."[250] In addition, Attorney General Eric Holder has taken important steps toward prioritizing the prosecution of crimes occurring in Indian Country, including hiring more Assistant United States Attorneys, creating the position of National Indian Country Training Coordinator who is tasked with liaising between prosecutors and law enforcement in tribal communities, and establishing the Tribal Nations Leadership Council to advise the Attorney General on issues critical to tribal communities.[251]

The Tribal Law and Order Act and Attorney General Holder's attention to Indian Country are not a panacea, but they are meaningful steps in the right direction. More must be done. Professor Matthew Fletcher noted, "the law doesn't do anything to solve the practical limitations that federal prosecutors

243. *Id*. § 211, 124 Stat. at 2264-65.

244. *Id*. § 213, 124 Stat. at 2268.

245. *Id*. § 234, 124 Stat. at 2279-82.

246. *Id*. § 235, 124 Stat. at 2282-86.

247. *Id*. § 243, 124 Stat. at 2292-94.

248. *Id*. § 262, 124 Stat. at 2299.

249. *Id*. § 264, 124 Stat. at 2299.

250. *Id*. § 265, 124 Stat. at 2300.

251. Working Group on the Universal Periodic Review, Human Rights Council, Rep. submitted in accordance with ¶ 15(a) of the annex to Human Rights Council resolution 5/1: United States of America, ¶ 40, U.N. Doc. A/HRC/WG.6/9/USA/1 (Aug. 24, 2010), *available at* http://www.state.gov/documents/organization/146379.pdf; Press Release, U.S. Dep't of Justice, Department of Justice Announces Allocation of 33 New Prosecutors, Launches 3 Community Prosecution Pilot Teams in Indian Country (May 4, 2010) (on file with author), *available at* http://www.justice.gov/opa/pr/2010/May/10-ag-511.html; Press Release, U.S. Dep't of Justice, Attorney General Holder Announces Creation of Tribal Nations Leadership Council (Feb. 19, 2010) (on file with author), *available at* http://www.justice.gov/opa/pr/2010/February/10-ag-165.html.

face in prosecuting crimes against women."[252] Until the federal government makes the prosecution of sexual assault in Indian Country a top priority, returns meaningful concurrent jurisdiction to tribes, and raises the funding level of tribal law enforcement agencies and tribal courts, Native American women will not see justice.

CONCLUSION

Sexual assault is a reality in Indian Country; according to federal government statistics, one in three Native American women will be sexually assaulted in their lifetime.[253] The United States government has a moral and fiduciary obligation to provide healthcare services to Native American women as codified in the IHCIA. As part of that duty, the federal government should ensure that Native American women receive comprehensive reproductive healthcare. However, the profound lack of resources facing IHS shapes the ability of the federal government to respond to the healthcare needs of Native American women after being sexually assaulted and results in a failure to fulfill the government's trust responsibility. The inability of many sexual assault victims to access abortion services results in their re-victimization while the federal government is complicit in continuing the cycle of violence against them—the stark reality is that the process of colonizing Native American women's bodies has not ended and cannot end until Native American women are free from sexual assault and unwanted pregnancy. The federal government must be held accountable for preventing Native American sexual assault victims from accessing legal abortion services.

Harris and *Lincoln* are not only barriers to enforcing the federal trust responsibility to provide adequate healthcare services; they also impede the federal government's positive state obligations to end a pattern of sexual assault and forced pregnancy that, while committed by private actors, is at such epidemic levels that it implicates the state. In *DeShaney* and *Castle Rock*, the Supreme Court declined to read positive state action into the Fourteenth Amendment.[254] Though a legal challenge attacking the failure to provide comprehensive reproductive healthcare services under the Hyde Amendment is unlikely to succeed, the obligations imposed by the trust responsibility represent an opportunity to encourage the federal government to see the trust responsibility as a positive state obligation. This would compel IHS to give Native American sexual assault victims meaningful access to reproductive healthcare after their assault. The trust responsibility does and should impose

252. Matthew L.M. Fletcher, *Tribal Law and Order Act's Limitations*, TURTLE TALK (Apr. 16, 2009, 11:09 PM), http://turtletalk.wordpress.com/2009/04/16/tribal-law-and-order-acts-limitations/.

253. TJADEN & THOENNES, *supra* note 3.

254. Town of Castle Rock v. Gonzalez, 545 U.S. 748 (2005); DeShaney v. Winnebago County Dep't of Soc. Servs., 489 U.S. 189 (1989).

positive obligations on the federal government—the cycle of re-victimization and re-marginalization of Native American women cannot end until it does.