NO. 19-1392

In the Supreme Court of the United States

THOMAS E. DOBBS, STATE HEALTH OFFICER OF THE MISSISSIPPI DEPARTMENT OF HEALTH, ET AL.,

Petitioners,

v.

JACKSON WOMEN'S HEALTH ORGANIZATION, ET AL.,

Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

BRIEF OF AMICI CURIAE CECILIA FIRE THUNDER; NATIONAL INDIGENOUS WOMEN'S RESOURCE CENTER; THE NATIVE AMERICAN COMMUNITY BOARD; AND ADDITIONAL ADVOCACY ORGANIZATIONS AND INDIVIDUALS IN SUPPORT OF RESPONDENTS

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INTEREST OF THE AMICI CURIAE

Amici curiae[1] are organizations and individuals committed to ensuring that Native women in the United States and Territories have access to comprehensive reproductive health services, *Amici* have a unique perspective on the complicated interplay of federal Indian law and access to abortion services in both urban and reservation settings. Amici represent a variety of organizations and individuals who support access to comprehensive reproductive health care for Native women and birthing people. Amici organizations are committed to the full panoply of reproductive rights, including the right to determine if, when, and how to have a family.

The leading signatory, CECILIA FIRE THUNDER (Oglala Lakota), is a national expert on access to reproductive health services for Native women. Ms. Fire Thunder is renowned as an advocate for wellness and women's issues and for her unique way of reaching the hearts of communities and people. She continues to fight for the rights of Native Americans and for access to domestic violence and family planning support services for all women, stating "As a woman, it's my job to support women. It's my job to support my sisters."

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[1] A full list of amici curiae is appended to this brief. Pursuant to Rule 37.6, Amici certify that no counsel for a party authored this brief, in whole or in part, and that no person other than amici or their counsel have made any monetary contributions intended to fund the preparation or submission of this brief. The parties have granted blanket consent for the filing of amicus curiae briefs.

The second leading signatory, the NATIONAL INDIGENOUS WOMEN'S RESOURCE CENTER (NIWRC), is a Native nonprofit organization whose mission is to provide national leadership to end violence against American Indian, Alaska Native and Native Hawaiian women by supporting culturally grounded, grassroots advocacy. NIWRC provides national leadership in ending gender-based violence in tribal communities by lifting the collective voices of grassroots advocates and offering culturally grounded resources, technical assistance and training, and policy development to strengthen tribal sovereignty. NIWRC staff and board of directors consist of Native women from Tribes throughout the United States. Collectively, these women have extensive experience in tribal courts, tribal governmental processes, and programmatic and educational work to end violence against Native women and children, including domestic violence and sexual assault. Given the outcome of *Dobbs v. Jackson Women's Health Organization* could result in an overturn of *Roe v. Wade*, this case decision poses a threat to Indigenous womens' body sovereignty that would substantially hurt the reproductive rights and health of Native women, girls, and birthing people.

The third leading signatory, the NATIVE AMERICAN COMMUNITY BOARD (NACB), an organization that preserves the Dakota culture, advocates for Native women's rights and reproductive health services from the Indian Health Service and advocates for services and justices for Native women and children who are survivors of violence. Indigenous women have the right to live free from violence and to address the Reproductive Justice issues that we face through the

process of self-determination in order to respect and restore our Indigenous lifeways.

This brief is joined by 32 additional organizations and 226 individuals that share a commitment to ensuring that Native women have access to comprehensive reproductive care. The depth of the *Amici's* experiencing in working with Native people seeking abortion renders them uniquely positioned to offer their views on the unconstitutional Mississippi abortion ban.

SUMMARY OF THE ARGUMENT

The federal government has a historic trust relationship with its Native[2] Peoples that is now embedded in the Constitution of the United States, treaties between the United States and tribes, and in numerous federal statutes. The Trust Relationship manifests in a number of obligations, including the obligation to provide meaningful access to all aspects of reproductive health care, which includes abortion services. This positive obligation uniquely positions Native women vis-á-vis the federal government. Unfortunately, the dereliction of this federal obligation has resulted in a

[2] The terms "Native," "Native American," "Indian," "Indigenous," and "American Indian/Alaska Native (AI/AN)" are used interchangeably to inclusively refer to the Indigenous peoples under the jurisdiction of the United States, including those within the lower-48 states, Alaska Natives, Native Hawaiians, and the Indigenous peoples located within U.S. territories. Native Peoples include federally recognized tribes, which have a nation-to-nation trust relationship with the U.S. federal government.

de facto delegation to private abortion providers subject to state laws. The proposed Mississippi 15-week abortion ban and any subsequent state abortions bans, will deny Native women the right to federally-mandated health care despite this federal obligation. Just as state governments lack authority over the decisions made by a federally recognized tribe, no state should have the authority to determine the reproductive decisions of individual Native people.

The federal provision of health care has accompanied explicit federal policies to assimilate Native people out of existence. Traditional family planning and birthing practices were historically suppressed, while the clinics and hospitals intended to replace those traditional supports were either never built, were poorly outfitted, or have subsequently closed. Many Native parents suffered the pain of the boarding school era, wherein Native children were taken away from their home communities to be raised by strangers. Reaching its peak in the mid-20th century, the Indian Health Service (IHS) has been found to have sterilized at least 3,406 Native women, many without clear, documented consent. The cumulative result is that far from meaningful, self-determined reproductive health care, federal health care has instead largely eroded Native reproductive autonomy.

Petitioners raise a peculiar argument–namely, that American women and girls have succeeded in every avenue of life in the United States and that access to birth control is quick, easy, and free, suggesting that abortions are no longer necessary. Brief for Petitioner at 29-30, *Dobbs, et al., v. Jackson Women's Health Organization, et al.* (July 22, 2021) (No. 19-1392). This could not be further from the truth

for most Native women in the United States regardless of whether they live in rural or urban areas. In fact, Native people are less likely to receive any kind of sexual health service compared to white women. More troubling still, this gap in care impacts a population exposed to disproportionate rates of sexual violence. Native people likely suffer the highest per capita rates of unwanted pregnancies as a result of assault or coercion. Yet Native people have the *least* access to emergency contraception and abortion services.

Even in urban settings with IHS facilities, restrictions on the use of federal funding make abortion inaccessible for many Native women. The Hyde Amendment presently restricts all federal dollars, including all funds intended to fulfill the trust obligation to provide health care to Native people, from funding abortion services except in extremely rare circumstances. For Native people, this has resulted in a total prevention on access to abortion care since 1976, despite the constitutional guarantee of access enshrined in *Roe v. Wade*, 410 U.S. 113 (1973), and a further shortcoming of federal reproductive health care. Policies restricting access to abortion places Native women at greater risk of violence and fatal outcomes illustrated by current disproportionate rates of maternal and infant mortality.

The federal government's meager steps to address 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 policy of obstructing Native American women's access to comprehensive reproductive health care. The right of Native 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 people. The federal government's failures are a re-victimization and a reviolation of Native American women's bodies.

In addition to being a human rights violation, a state's categorical prohibition of all abortions within their jurisdiction is also the death knell of the lone Native reproductive health care option relied upon by the federal government to fill the gap left by the Hyde Amendment. Because of the federal government's systematic failure to provide their treaty-mandated health care to Native people, this proposed extension of state despotism is not just a constitutional violation, it is also a breach of federal trust obligations.

ARGUMENT

I. THE TRUST RESPONSIBILITY INCLUDES THE OBLIGATION TO PROVIDE REPRODUCTIVE HEALTH CARE TO NATIVE PEOPLE.

A. Traditional Native Reproductive Health Care Included Abortion Care.

Native Peoples within the United States comprise hundreds of tribal nations, cultures, languages, and health care practices. Yet, common threads of reproductive traditions, rituals, practices, and lessons emerge.[3] Native identity is inextricably linked with kinship, shaped by relations and the obligations owed

[3] *See generally* Patrisia Gonzales, RED MEDICINE: TRADITIONAL INDIGENOUS RITES OF BIRTHING AND HEALING (2012).

to each other because of these relations. Birth control, abortion, prenatal care, birth, and maternal care all have rich, contextualized histories and roles within many tribal communities. The provision of this care was frequently overseen by female relations, guided by the autonomy of the individual and the reciprocal obligations of and to the community. They would often practice abstinence during their ovulation period to avoid pregnancies.[4] Women relations and sometimes midwives would accompany and support laboring mothers. Child-rearing duties are often shared by extended family members beyond the nuclear-family unit. The reasons to terminate an unwanted pregnancy could be vastly varied, and would include concerns about limited food supplies or arduous journeys during inclement weather. In this event, Native women knew which plants or medicinal herbs to ingest to induce an abortion or serve as contraception.[5]

Native Peoples approached reproductive health with intention, rooting this care in the reciprocal obligations that Native people owe to each other and the individual's autonomy to be healthy. Meaningful Indigenous reproductive health care, therefore, is

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[4] Kati Schindler, et al., *Indigenous Women's Reproductive Rights The Indian Health Service and Its Inconsistent Application of the Hyde Amendment*, Native American Women's Health Education Resource Center (Oct. 2002).

[5] Briana Theobald, REPRODUCTION ON THE RESERVATION: PREGNANCY, CHILDBIRTH, AND COLONIALISM IN THE LONG TWENTIETH CENTURY, 30 (2019), *citing* Daniel Moerman, NATIVE AMERICAN ETHNOBOTANY, 656, 765 (1998).

that which is responsive to the needs of the entire community, including the individual.

B. The Trust Responsibility Includes the Provision of Health Care to Native People.

The federal government has both a trust responsibility and legal obligations to provide comprehensive, high-quality, and culturally competent health care to the Native Peoples of the United States.[6] This includes the provision of reproductive health care services, that incorporates access to family planning services such as abortion services.

The origins of federal health care programs for Natives can be traced to treaty promises. Treaties are the "supreme Law of the Land" and cannot be disregarded by any state government, including Mississippi. U.S. CONST. art. I, § 8 and art. VI, cl. 2. In many treaties, the United States agreed to take tribes under its "protection" and to provide annuities, supplies, and various health and educational services in exchange for settlement rights to vast quantities of land and commitments of peace.[7] Over time, these treaty obligations evolved into the federal trust responsibility,

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[6] *See* Geoffrey D. Strommer, et al., *Tribal Sovereign Authority and Self-Regulation of Health Care Services: The Legal Framework and the Swinomish Tribe's Dental Health Program*, 21 J. HEALTH CARE L. & POL'Y 115, 116-17 (2018).

[7] *See, e.g.*, Treaty with the Miami, arts. 1, 6, Miami-U.S., Oct. 23, 1826, 7 Stat. 300, 300–01 ("The United States agree to appropriate . . . for the support of poor infirm persons of the Miami tribe . . . ."); Treaty with the Ottawas and Chippewas, arts. 1, 4, Mar. 28, 1836, 7 Stat. 491, 491–92 (promising "[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."); Treaty with the Flatheads, etc., arts. I, V, Flatheads-

reflected in judicial decisions, Acts of Congress, Executive Orders, and other policies that acknowledge the special status of Indian tribes within the federal system and establish a range of programs and services. *See, e.g.*, *Cobell v. Norton*, 240 F.3d 1081, 1086 (D.C. Cir. 2001). The Trust Responsibility to Native Peoples is a fiduciary duty, arising not because Native people cannot care for themselves but because the nature and history of the relationship between the federal government and Indian tribes created certain ongoing obligations. *See, e.g.*, U.S. Dep't of the Interior, Secretarial Order No. 3335, Reaffirmation of the Federal Trust Responsibility to Federally Recognized Tribes and Individual Indian Beneficiaries (August 20, 2014). In 2011, this Court reaffirmed the federal-tribal trust responsibility, noting the federal government "has charged itself with moral obligations of the highest responsibility and trust,' . . . . obligations 'to the fulfillment of which the national honor has been committed. . . . '" *United States v. Jicarilla Apache Nation*, 564 U.S. 162, 176 (2011) (internal citations omitted).

In 1921, the Synder Act codified the federal obligation to provide Native people health care "for the benefit, care, and assistance of the Indians throughout the United States . . . ." 24 Stat. 208 (codified as 25 U.S.C. § 13). In 1976, Congress passed the Indian

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U.S., July 16, 1855, 12 Stat. 975, 975–77 (promising to erect a hospital, among other things, "keeping the same in repair, and provided with the necessary medicines and furniture, and to employ a physician" for a period of 20 years); and Treaty with the Klamath, etc., arts. I, IV, Oct. 14, 1864, 16 Stat. 707, 707–09 (promising to erect and maintain a school and hospital on the reservation for a period of twenty years).

Health Care Improvement Act (IHCIA), which established the Indian Health Service (IHS) and recognized that a "major national goal of the United States is 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." Pub. L. No. 94-437, §§ 2, 601, 90 Stat. 1400 (codified as amended at 25 U.S.C. §§ 1601, 1661). In permanently reauthorizing the IHCIA in 2010, Congress declared that "Federal 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." Patient Protection and Affordable Care Act, Pub. L. No. 111-148, § 10221(a), 124 Stat. 119, 935–36 (2010) (codified as amended at 25 U.S.C. § 1601 *et seq.* (Supp. IV 2016)). *Also see Lincoln v. Vigil*, 508 U.S. 182, 194 (1993) (acknowledging IHS's "statutory mandate to provide health care to Indian people."). The obligation to provide competent, physician-led healthcare, a duty created by a treaty and reinforced by the Snyder Act and the IHCIA, was most recently upheld by the Eighth Circuit in *Rosebud Sioux v. U.S., et al.*, No. 20-2062 (8th Cir., August 25, 2021).

Critically, meaningful health care is not just competent care provided in a sufficiently-funded system, but is also a system in which Native people enjoy autonomy and are treated with dignity. Reinforcing the obligation to provide meaningful health care under U.S. law, Article 24 of the United Nations Declaration on the Rights of Indigenous Peoples states that "Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of

physical and mental health. [Nation] States shall take the necessary steps with a view to achieving progressively the full realization of this right." G.A. Res. 61/295, United Nations Declaration on the Rights of Indigenous Peoples, Art. 24 (Sept. 13, 2007). Article 23 contextualizes this nation state obligation, declaring that "Indigenous [P]eoples have the right to determine and develop priorities and strategies . . . [i]n particular . . . to be actively involved in developing and determining health . . . programes. . . ." *Id.* at Art. 23. Under international law, particularly in light of historic settler colonial policies that have suppressed Native autonomy, Native Peoples must be able to self-determine their health care.

The Trust Responsibility is a bedrock principle of modern federal Indian policy and is reflected and reinforced in international law. Yet its necessary companion—retained tribal and individual self-determination, has been suppressed.

II. THE FEDERAL GOVERNMENT HAS HISTORICALLY FAILED TO UPHOLD ITS TRUST RESPONSIBILITY TO PROVIDE REPRODUCTIVE HEALTH CARE.

A. Federal Reproductive Healthcare Policy Has Blamed Infant Mortality on the Native Mother's Failure to Assimilate.

In the 20th century, federal Indian policy caused disruption to the traditional lifeways of many Native Peoples, including their reproductive health care. Mothers and infants proved especially vulnerable, particularly to malnutrition and the spread of disease. One government official estimated in 1916 that approximately three-fifths of Native infants died before age five. U.S., Off. of Indian Aff., *Annual Report of the*

Commissioner of Indian Affairs (Jun 30, 1916). Numerous federal policies sought to address the staggering rates of infant and maternal morbidity and mortality, through continued forced assimilation instead of the rebuilding of Native systems. Turn-of-the-century policies like the criminalization of traditional healers, invasive scrutiny of Indigenous concepts of gender, non-nuclear family structures and kinship, and the forced removal of children to often remote boarding schools, and later adoption, . . . effectively drained many tribal communities of their traditional knowledge and the future receptacles for that knowledge, This disrupted cultural practices and knowledge while institutionalizing federal practices and values. *See* Regulations of Indian Courts, in Rep. of the Comm'r of Indian Aff., Dep't of Indian Aff., 4(c) at 29 (Aug. 27, 1892) ("Any Indian who shall engage in the practices of so-called medicine men, or who shall. . . keep the Indians from . . . adopting and following civilized habits and pursuits . . . or shall . . . prevent Indians from abandoning their barbarous rites and customs, shall be deemed to be guilty . . . ").

Boarding schools wreaked particular damage on the cultural fabric of Native people. *See* Rukmini Callimachi, *Lost Lives, Lost Culture: The Forgotten History of Indigenous Boarding Schools*, NY TIMES (Jul. 19, 2021). Statistics reflecting the high number of children placed in boarding schools in a 1971 school census conducted by the Bureau of Indian Affairs (BIA) were staggering. Approximately 35,000 children lived in such facilities rather than at home. Sally J. Torpy, *Native American Women and Coerced Sterilization: On the Trail of Tears in the 1970s*, 24.2 AM. INDIAN CULTURE AND RES. J. 1, 14 (2000).

Policies to assimilate Native children later transitioned from boarding school to adoption. Between 1958 and 1967, the Children's Bureau, the BIA, and the Child Welfare League of America facilitated the Indian Adoption Project. Press Release, U.S. Dep't of the Interior, Bureau of Indian Affs., Indian Adoption Project Increases Momentum (Apr. 18, 1967). Native children were identified and tagged for adoption, cultivating an adoption market specifically for Native children. *Id.* ("It was a record year for the project . . . Temporarily, because of increased interest, there are more prospective parents than there are Indian children referred to the project for adoption."). During this time, child welfare systems were shockingly successful in removing children from their parents and cultures. *Problems That American Indian Families Face in Raising Their Children: Hearings Before the Subcomm. on Indian Aff. of the Comm. on Interior and Insular Aff.*, 93d Cong., 2d Sess., 4 (1974) (reporting rates of roughly 25 to 35 percent of Native young people that had been separated from their families). These removals were a form of cultural genocide. G.A. Res. 61/295, Art. 7 (Sept. 13, 2007) ("Indigenous peoples have the collective right to . . .not be subjected to any act of genocide . . . including forcibly removing children of the group to another group.").

The federal government filled the void of lost Native reproductive health care and the traumatic removal of children with policies aimed at remedying the perceived inadequacies of Native mothers.[8] The

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[8] Theobald, *supra* note 5, at 30, *citing* Kim Anderson, A RECOGNITION OF BEING: RECONSTRUCTING NATIVE WOMANHOOD (2000) and Jennifer Denetdale, *Chairmen, Presidents, and*

field matron program, established by the Office of Indian Affairs in 1890, was charged with imparting lessons in "civilized" domesticity and Victorian gender norms. Infant mortality was frequently seen as the product of individual Native mother ignorance rather than the systemic issues of economic, environmental, nutritional, or cultural loss contributing to worrisome reproductive health.

> The simplest rules of motherhood applied under intelligent and friendly direction would save most of the Indian babies who annual fill untimely graves. . . . [G]ood results, if obtained, will scarcely continue unless the Indian parents exchange indolence for industry and are awakened to the use and beauty of personal and environment cleanliness.

U.S., Off. of Indian Aff., *Annual Report,* 7-8 (Jun 30, 1916).

B. Institutionalized Sterilization and Forced Contraception Become the Norm.

The perceptions of inherent Native deficiencies coupled with a general move towards the medicalization of reproductive health care, reinforced a federal sense that Native reproduction needed to be medically "controlled." This was most disturbingly realized in the institutionalized sterilization of Native Peoples, many without meaningful consent. A review of Indian service social worker reports in the 1930s and early 1940s suggests that some social workers became actively involved in the sterilization of Native women,

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Princesses: The Navajo Nation, Gender, and the Politics of Tradition, WICAZO SA REVIEW 9 (2006).

and less, frequently, men. Briana Theobald, REPRODUCTION ON THE RESERVATION: PREGNANCY, CHILDBIRTH, AND COLONIALISM IN THE LONG TWENTIETH CENTURY, 41 (2019), analyzing Social Workers' reports, Records of the Welfare Branch, National Archives and Records Administration, Washington, D.C., Record Group 75. IHS family planning services evidence fears of global overpopulation and an expanding welfare state. Health Serv. Div., *Family Planning and the American Indian*, Westinghouse Learning Corporation (1971). Federal employees, including many physicians, held the belief that Native parents were inherently deficient and dysfunctional. Others believed it was best if Native family size shrunk. Figure 1 displays federal efforts to encourage lower birth rates, in this case by suggesting that smaller families could have more horses, in an absurd and racist presentation.

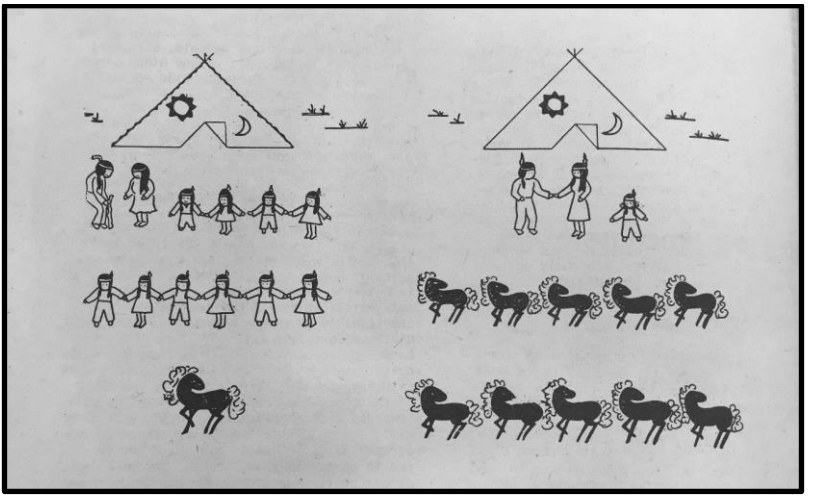

FIGURE 1: *Planning Your Family*
pamphlet image, produced by Dep't of Health, Education, and Welfare (1974).

By 1976, 97.8 percent of Native births occurred in IHS facilities. U.S. Dep't of Health, Education, and Welfare, Health Service Administration, Indian Health Service*, The Indian Health Program of the U.S. Public Health Service* 19 (U.S. Government Printing Office, 1978). Meanwhile, the U.S. Government Accountability Office (GAO) found that between 1973 and 1976, at just four IHS regions (Aberdeen, Albuquerque, Oklahoma City, and Phoenix) 3,406 American Indian women were sterilized, most of which took place during birth and other gynecological procedures. U.S. Gov't Accountability Office, *Investigation of Allegations Concerning Indian Health Service*, HRD-77-3, 18 (Nov. 4, 1976). Of the 3,406 sterilizations, 3,001 were of childbearing age, or 5.1 percent of the female childbearing age population. *Id.* Moreover, the GAO investigation revealed significant "weaknesses" in obtaining patient consent for these sterilizations. *Id.* at 19. The GAO found 36 women under age 21 that had been forcibly sterilized during this period despite a court-ordered moratorium on sterilizations of women younger than 21. *Id.* at 21. 42 C.F.R. 50.201-50.204 (Apr. 18, 1974). This limited examination of four facilities over a forty-six month period correlates with anecdotal reports of covert and coerced sterilizations of Native women across the country. *See e.g.* Dr. Connie Uri, *Statement Prepared for the Jackson Hearings*, September 16, 1974, Costco Archive, MS 170, Box 34, Folder 034.001.001, Special Collections & University Archives, University of California, Riverside (in which Dr. Uri testifies to have found that one of every four women who gave birth at a Claremore, Oklahoma IHS facility had been subsequently sterilized).

In addition to coerced sterilizations, IHS physicians started prescribing long-acting reversible contraception (LARC), like injections and implants, with increasing frequency despite health concerns. In fact, IHS physicians prescribed Depo-Provera birth control injections in the 1970s before the FDA approved it for use as birth control. *Use of the Drug, Depo Provera, by the Indian Health Service, Oversight Hearing Before the H. Subcomm. on General Oversight and Investigations of the Committee on Interior and Insular Aff.*, 100th Cong. 1 (Aug. 6, 1987). Depo is associated with an increased rate of diabetes, obesity, and depression—health conditions that are already elevated in Native people, as well as long-term fertility problems (even after the shots are stopped). Birth control implants, such as Norplant, were over prescribed in the 1990s. Native American Women's Health Education Resource Center, *Native American Women Uncover Norplant Abuses*, Ms. Magazine, 69 (Sept. 1993). In the 1980s, the House of Representatives investigated allegations that Native women were being injected with Depo without their informed consent. The Navajo Nation Attorney General sent a letter to the local IHS area critiquing their consent form. "This in a sense smacks of chemical sterilization as opposed to surgical (illegal) sterilization." *Oversight Hearing*, 100th Cong. 1 (memorandum to file of Dec. 13, 1985, from Navajo attorney re IHS prescription of depo provera). Ultimately, the IHS Director admitted to the House leadership that their consent forms were deficient. *Id.* As of 2012, Native women ages 15-24 are still more likely to be on LARC than other women their age. Shira Rutman, et al., *Reproductive Health and Sexual Violence Among Urban American Indian and Alaska Native Young Women: Select Findings from the National Survey of*

Family Growth, 2 MATERNAL CHILD HEALTH J. 347-52 (Dec. 16, 2012).

In April 2021, IHS released a formulary brief indicating that it still regards LARC to be an effective way to prevent pregnancies, including for adolescents. Indian Health Service, Formulary Brief: Long Acting Reversible Contraception (April 2021). The brief advocates that LARC should be offered in the *immediate* post-partum and *immediate* post-abortion settings. *Id.* (emphasis added). This guidance does not provide patients, particularly adolescents, the opportunity to weigh the pros and cons of LARC nor does it discuss the need to obtain "informed consent," despite explicit past concerns over the nature of consent and family planning services. Given the historical context of LARC in IHS facilities, this formulary brief suggests that, even in 2021, IHS goals are to reduce the number of Native pregnancies absent meaningful consent.

Even today, sterilization continues to play a significant role in the lives of Native people. A 2015 study found that nearly 25 percent of Native women reported (purportedly consensual) female sterilization, the highest rate in the country. Christina J.J. Cackler, et al., *Female Sterilization and Poor Mental Health: Rates and Relatedness among American Indian and Alaska Native Women,* 26 WOMEN'S HEALTH ISSUES 168, 172 (2016). Research suggests that the memory and historical context of forced sterilization may play a role in mental health challenges faced by Native people after sterilization. *Id.* Abortion services, like sterilization and long-acting reversible contraception, are reproductive health care that require respect for the recipient's bodily autonomy and their ability to meaningfully consent. Such reproductive health care

must be offered free from paternalistic goals to control and "save" Native people, by making choices on their behalf. The failure to provide such robust and self-determined care has resulted in a legacy of distrust and poor health outcomes.

III. THE DISTRUSTED AND UNDERFUNDED FEDERAL PROVISION OF HEALTHCARE TO NATIVE PEOPLES CAUSES HARM AND COMPELS OUTSOURCING TO PRIVATE PROVIDERS.

As a result of a targeted control over Native reproduction, coupled with woefully underfunded health care, Native women experience disproportionately poor health outcomes, including high rates of maternal and infant mortality and morbidity. The federal government's failure to provide comprehensive reproductive health care, including abortion care, to Native communities forces Native women to seek such care from private providers. Petitioner's 15-week ban not only violates decades of binding precedent, but also undermines the federal government's treaty obligations to Native communities.

A. Indian Health Service is Detrimentally Underfunded and Under-Resourced.

The suppression of traditional healthcare systems and explicit efforts to control and assimilate Native Peoples have been coupled with anemic support for the federal-mandated IHS. Towards mid-century, reproductive health needs were increasingly diverted from in-home providers to IHS hospitals. Unfortunately, these federally preferred hospitals either never came to fruition in many tribal communities, or were woefully underfunded.

Today, IHS continues to be grossly underfunded and understaffed. U.S. Gov't Accountability Office, *Indian Health Service: Spending Levels and Characteristics of IHS and Three Other Federal Health Care Programs*, GAO-19-74R (Dec. 10, 2018) (comparing funding levels between IHS, the Veterans Health Administration, Medicare, and Medicaid). (noting that in 2016, IHS health care expenditures per person were only $2,834, compared to $9,990 per person for federal health care spending nationwide); *Also see* U.S. Comm. on Civil Rights, *Broken Promises: Briefing Report*, 1 (Dec. 2018) and U.S. Gov't Accountability Office, *Indian Health Service: Agency Faces Ongoing Challenges Filling Provider Vacancies*, GAO-18-580 (Aug. 2018) (finding an overall 25 percent IHS vacancy rate for providers). IHS has also been found to have provided substandard, and even harmful care. As recently as 2020, the IHS was found to have limited ability to oversee provider misconduct and substandard performance. U.S. Gov't Accountability Office, *Indian Health Service Provider Misconduct*, GAO-21-97, 26 (Dec. 2020).

B. Native Communities Experience High Rates of Maternal and Infant Mortality.

As the 21st century begins, the infant and maternal mortality rates of Natives is still disastrously high. Maternal mortality rates from 2016 to 2018 among Native women was 31.4 deaths per 100,000 live births, 1.2 times the rate for non-Hispanic white (NHW) women (25.8). Rutman, at 347-52. According to the CDC, between 2011 and 2015 American Indian and Alaska Native (AI/AN) women had the second-highest rate of pregnancy-related death, with 32.5 deaths per 100,000 women, 2.5 times the rate that

White women experience. Emily E. Petersen, et al., *Vital Signs: Pregnancy-Related Deaths, United States, 2011-2015, and Strategies for Prevention, 13 States, 2013-2017*, 68 MORBIDITY AND MORTALITY WEEKLY REP. 423 (2019). *Also see* Urban Indian Health Institute, *Community Health Profile: National Aggregate of Urban Indian Health Program Service Areas*, 37 (Oct. 2016). Native infant mortality rate is also alarmingly high. In 2018, the AI/AN infant mortality rate was 8.15 deaths per 100,000 live births, 1.8 times the rate for NHW women (4.63). Danielle M. Ely and Anne K. Driscoll, *Infant Mortality in the United States: 2018: Data from the Period Linked/Infant Death File*, 69(7) NATIONAL VITAL STATISTICS REP. 1, 4 (Jul. 16, 2020).

In 2020, the HHS Office of Inspector General audited a sample of 48 IHS labor and delivery patients and found that 56 percent received care that did not follow national clinical guidelines, with a quarter of those patients experiencing harm as a result. The Report recommends that IHS undertake a comprehensive assessment of its labor and delivery practices. Christi A. Grimm, *Instances of IHS Labor and Delivery Care Not Following National Clinical Guidelines for Best Practices*, OEI-06-19-00190, 9-10, 16 (Dec. 2020). In recent years, IHS hospitals have reduced or eliminated obstetric services, forcing women to drive up to two hours to give birth. *See* Dalton Walker, *Birthing Center Closure: "My Baby and I Felt Abandoned."*, INDIAN COUNTRY TODAY (October 23, 2020) and Aaron Cantú, *Shutdown Pummels Native American Health*, SANTA FE REPORTER (January 7, 2019). Whereas a significant majority of Native births took place in IHS facilities in the 1970s, by

2018, over 90 percent of Native births occurred outside of IHS facilities. Indian Health Service, *Maternal Mortality and Morbidity in Indian Country*, *Fact Sheet*, U.S. Dep't of Health and Human Serv. (2018). As the availability of federal reproductive health care dwindles, Native people are forced to travel greater distances and increasingly rely on non-federal providers.

The lack of access to comprehensive women's health care is life-threatening to Native women, trauma-and poverty-inducing for families and communities, and costly for economies and health systems. Loss of life due to pregnancy in particular initiates a series of consequences for families, communities, and society at large. AI/AN women lost 2,488 years of life due to maternal mortality from 2016-2018. Centers for Disease Control and Prevention, National Vital Statistics System (2019). This equates to an estimated cost of lost economic productivity of more than $600 million. Matthew Adler, *What Should We Spend to Save Lives in a Pandemic? A Critique of the Value of Statistical Life.* DUKE LAW SCHOOL PUBLIC LAW & LEGAL THEORY SERIES No. 2020-40 (2020). The effects of premature death are, of course, far more reaching for families, communities, and tribes suffering from grief. Abortion restrictions and consequentially reducing access to women's health care initiates a ripple effect in the lives of Native women and those surrounding them, creating substantial economic losses.

Maternal and infant mortality rates are but one metric for understanding maternal and infant health. Atop a foundation of sub-standard care coupled with disturbing efforts to control Native reproduction and birth, Native reproductive care has essentially been

outsourced away from IHS. Moreover, some healthcare providers are not competent in serving the needs of Native women, or even behaving decently. *See* Bryant Furlow, *Federal Investigation Finds Hospital Violated Parents' Rights by Profiling, Separating Native Mothers and Newborns*, THE NM POLITICAL REPORT (Aug. 24, 2020). Abortion clinics provide a wide array of reproductive health care services, including preventative screenings and education, infertility treatment, contraception counseling, well-woman exams, and hormone therapy. Increases in abortion restrictions ultimately leads to the closure of women's health clinics, a vital source of health care for many women, including increasingly Native women, further increasing the risk of even higher rates of Native maternal and infant mortality.

C. Native People Suffer the Highest Rates of Sexual Violence.

As acknowledged by this Court in *United States v. Bryant*, 136 S.Ct. 1954, 1959 (2016), Native people suffer the highest rates of violent victimization in the United States. Indeed, all three branches of the federal government have taken action in an attempt to resolve this crisis.[9] A 2016 U.S. Department of Justice report concluded that over half of Native women have experienced sexual violence and over 80 percent

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[9] *See e.g.* Donald Trump, *Establishing the Task Force on Missing and Murdered American Indians and Alaska Natives,* Exec. Order No. 13898, 84 Fed. Reg. 66,059 (Dec. 2, 2019) and Press Release: U.S. Department of the Interior, *Secretary Haaland Creates New Missing & Murdered Unit to Pursue Justice for Missing and Murdered American Indians and Alaska Natives* (April 1, 2021).

of Native women will be victims of domestic violence in their lifetime. Andre B. Rosay, *Violence Against American Indian and Alaska Native Women and Men: 2010 Findings from the National Intimate Partner and Sexual Violence Survey*, Nat'l Inst. of Justice, Office of Justice Programs, U.S. Dep't of Justice, 44 (2016). In a study of 148 Native women in Seattle, Washington, 94 percent reported being raped or coerced in their lifetime with 42 percent attempting suicide, and 34 percent binge drinking on a weekly or daily basis after their initial attack. Urban Indian Health Institute, *Our Bodies, Our Stories* (2018). Women in violent relationships are more likely to experience an unintended pregnancy and seek abortion services. Christina C. Pallitto, et al., *Intimate Partner Violence, Abortion, and Unintended Pregnancy: Results from the WHO Multi-country Study on Women's Health and Domestic Violence*. 120(1) INT. J. GYNECOLOGY & OBSTETRICS 3-9 (2013). The high rate of sexual assault among Native women gives rise to a unique set of health care needs for victims—physical injuries, psychological trauma, exposure to sexually transmitted infections, and unintended pregnancy. Sexual assault disproportionately adversely impacts the reproductive health of Native women.

Yet, there are tremendous barriers for a Native person to receive health care and forensic examination in the aftermath of sexual assault, in part due to the remote nature of some reservations. A 2014 study of sexual assault services coverage on reservations concluded that only 30.7 percent of reservations are within a 60-minute driving distance from sexual assault forensic exam services. Ashley Juraska, et al., *Sexual Assault Services Coverage of Native American Land*,

10 J. OF FORENSIC NURSING 92 (2014). 381 tribal lands do not have access to a sexual assault examiner program within a 60-mile driving distance. *Id.* This means that a significant number of Native sexual assault victims may not even have access to Plan B, an emergency contraception option to prevent pregnancy, since Plan B is primarily offered by a health care provider in the aftermath of sexual assault. *See* The Native American Women's Health Education Resource Center, *Indigenous Women's Dialogue: Roundtable Report on the Accessibility of Plan B As An Over the Counter (OTC) within Indian Health Service*, Native American Community Board (2012).

It is difficult to determine how many victims become pregnant as the result of sexual assault or reproductive coercion. There are limited studies on rates of sexual-assault related pregnancies specific to Native women. Generally, various studies have concluded that between 3.1 percent and 7.9 percent of sexual assault cases (involving penetration) result in pregnancy.[10] But to the extent that we can extrapolate from the high Native victimization rates, Native people also likely suffer the highest per capita rates of unwanted pregnancies as a result of assault or coercion. The high prevalence of intimate partner violence among Native women additionally suggests

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[10] *See e.g.* Kathleen Basil et al., *Rape-Related Pregnancy and Association with Reproductive Coercion in the U.S.* 55 AM. J. PRV. MED. 770 (2018); Jonathan A. Gottschall & Tiffany A. Gottschall, *Are Per-Incident Rape-Pregnancy Rates Higher Than Per-Incident Consensual Pregnancy Rates*, 14 HUMAN NATURE 1, 4 (2003); Allen J. Wilcox, et al., *Likelihood of Conception with a Single Act of Intercourse: Providing Benchmark Rates for Assessment of Post-Coital Contraceptives*, 63 CONTRACEPTION 211, 212 (2001).

disproportionate impacts in maternal and infant mortality are attributed to intimate partner violence. Rosay at 44.

Native adolescents are particularly vulnerable to assault and unwanted pregnancies. One study concluded that nearly half of Native women gave birth under the age of 20. Shaye Beverly Arnold, *Reproductive Rights Denied: The Hyde Amendment and Access to Abortion for Native American Women Using Indian Health Service Facilities*, 104(1) AM. J PUB. HEALTH 1892 (2014). According to a 2017 CDC survey, 50 percent of non-Hispanic AI/AN high school students engaged in sexual intercourse. Centers for Disease Control and Prevention, Youth Risk Behavior Surveillance System (2019). Approximately 8 percent of AI/AN high school students had sexual intercourse for the first time before the age of 13, as compared to only 2 percent of NHW high school students, with 21 percent of AI/AN high school students reported being physically forced to have sexual intercourse compared to 7 percent of NHW high school students. *Id.*

Simply, policies restricting access to abortion places Native women and their children at greater risk of violence and fatal outcomes. The federal government is failing to provide Native women with the comprehensive reproductive health services they need, including abortion, in the aftermath of sexual assault. *See e.g.* The Native American Women's Health Education Resource Center, *Free the Pill: Native American Women and the Need for "Over the Counter" Access to Birth Control Pills!*, Native American Community Board (2019) and The Native American Women's Health Education Resource Center, *Indigenous Women's Reproductive Justice: A Survey of the Availability of*

Plan B and Emergency Contraceptives Within Indian Health Service, Native American Community Board (2008).

D. Native People Face Socioeconomic Barriers That Are Exacerbated by Lack of Access to Reproductive Health.

Socioeconomic factors are among the most common reasons for seeking an abortion. *See* M. Antonia Briggs, et al., *Understanding Why Women Seek Abortions in the U.S.*, 13 BMC WOMEN'S HEALTH 29 (2013). Rates of unintended pregnancy are higher among those with lower socioeconomic status. According to the U.S. Census, more than 25 percent of Native women are living in poverty. U.S. Census Bureau, *Poverty Status in the Past 12 Months by Sex by Age, 2013-2017 American Community Survey 5-Year Estimates*, Table B17001C and B17001 (2017). Numerous studies illustrate the relationship between abortion and the economic wellbeing of women and their children. Anna Bernstein and Kelly M. Jones, *The Economic Effects of Abortion Access; A Review of the Evidence*, Center on the Economics of Reproductive Health, Institute for Women's Policy Research (2019). Abortion access has been shown to increase a woman's participation in the workforce and the ability to continue education. Restrictions on abortions can have a downstream effects which result in increased lifetime debt, bankruptcies, and evictions. Sarah Miller, et al., *The Economic Consequences of Being Denied an Abortion*, NBER WORKING PAPERS 26662, National Bureau of Economic Research, Inc. (2020). Research shows children born to women with abortion access had lower rates of poverty and recipient of public assistance during childhood. Bernstein and Jones at 10.

Native women are already disproportionately impacted by inequities in education and employment. Abortion restrictions further compound socioeconomic stressors contributing to poor financial stability. For Native women, this means exacerbating longstanding disparities and jeopardizing the health of future generations.

IV. THE HYDE AMENDMENT DISPROPORTIONATELY RESTRICTS NATIVE REPRODUCTIVE HEALTH.

Contrary to Petitioner's argument that women no longer need abortion because they have achieved full gender parity and contraception is widely available, Native people are less likely to receive any kind of reproductive health service compared to white women. Brief for Petitioner at 29-30, *Dobbs,* (No. 19-1392) and Megan A. Cahn, et al., *Use of Sexual Health Services Among American Indian and Alaska Native Women. Women Health.* 59(9) NATIONAL LIBRARY OF MEDICINE 953-966 (2019). Moreover, the barriers preventing Native peoples from accessing reproductive health are rarely even acknowledged.

In 1976, Congress passed a rider put to the Department of Health and Human Services appropriations bill that prohibited the use of federal funds for abortions, except in very limited circumstances, now known as the "Hyde Amendment". Act of Sept. 30, 1976, Pub. L. No. 94-439, § 209, 90 Stat. 1418, 1434. Limited circumstances include 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." Omnibus Appropriations Act, 2009, Pub. L. No. 111-8, §§ 507-08, 123 Stat. 524, 802-03.

The Hyde Amendment has a profound impact on the ability of IHS—which relies exclusively on federal funds for its operating budget—to offer comprehensive reproductive health care services. The IHCIA specifically references the Hyde Amendment's limitations on performing abortions using federal funds at IHS facilities. 25 U.S.C. § 1676. In response to the Hyde Amendment, IHS promulgated regulations stating that no IHS facility may provide a woman with an abortion unless the life of the pregnant person is endangered. 42 C.F.R. §§ 136.51, 136.54. *Also see* Indian Health Serv., INDIAN HEALTH MANUAL § 3-13.14(B)(1). In the case of rape or incest, the alleged rape or incest must be reported to authorities by the survivor. 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. 12, 1996). Moreover, the 1996 memorandum introduced additional barriers not required by the Hyde Amendment. Under the current rules, Native patients who become pregnant as a result of assault cannot self-report their assault to access abortion services. Instead, the IHS policy requires that a law enforcement agency or health care provider verify and document the report, essentially giving law enforcement and health care providers veto power over a pregnant person's request for abortion services. Moreover, this documentation must be made within 60 days (less than nine weeks) of the reported assault. *Id.* Even worse, a 2002 study concluded that

various different IHS facilities and individuals are not familiar with this policy.[11] Victims of sexual assault are the least likely of all violent crime victims to report their case to authorities, further reducing the likelihood they can access care.

The federal government has abdicated its treaty obligations to provide abortions to women dependent on the federal government for health care. In *Harris v. McRae*, this Court upheld the constitutionality of the Hyde Amendment. 448 U.S. 297, 303-04 (1980). Despite treaty rights and federal trust responsibility to Native people, the Court did not address the impact of the Hyde Amendment as applied to Native American women. *Id*. The Court held "that the Hyde Amendment does not impinge on the due process liberty recognized in [*Roe v.*] *Wade*." *Id.* at 318, reasoning that an indigent women's access to abortion is restricted by her financial position, not the federal government's prohibition on using federal funds for abortions. Yet, for Native women, both their financial status and their political status prevent their ability to access abortion services. The Hyde Amendment violates the federal obligation to provide health care services to Native people.

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11 Kate Schidnler et al., *supra.*

V. PREVENTING, INSTEAD OF PROVIDING ACCESS TO MEANINGFUL REPRODUCTIVE HEALTH CARE, IS A HUMAN RIGHTS VIOLATION AND A VIOLATION OF THE TRUST RESPONSIBILITY.

The Hyde Amendment hinders the ability of all low-income women to terminate a pregnancy and disproportionately affects women of color. But it discriminates against Native women specifically because they are entitled to receive health services from a federal agency. In 2002, researchers found that sixty-two percent of IHS service units did not provide abortions, even when the mother's life was in danger. That year, only five percent of IHS facilities performed abortions. Native American Women's Health Education Resource Center, *Indigenous Women's Reproductive Rights: The Indian Health Service and Its Inconsistent Application of the Hyde Amendment*, Native American Community Board (2002) and Heidi Guzman, *Roe on the Rez: The Case for Expanding Abortion Access on Tribal Land,* COLUM. J. RACE & L. 9, 95 (2019). A review of available data from the Epidemiology Data Mart, which houses patient registration and health care visit information from IHS, reveals that only 7 AI/AN women visited an IHS-funded facility for an abortion nationally from 2002 to 2021. This data is limited to information from 33 reporting. U.S. Dep't of Health and Human Services, Indian Health Service, Epidemiology Data Mart, 2002-2021. The low number of visits to an IHS facility for abortion over two decades suggest abortion services are primarily outsourced to states, which are filling a gap in federal obligations to provide meaningful healthcare to Native people.

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. This is a troubling reality not only because it jeopardizes the ability of women who rely on IHS as their primary health care 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. Native women are forced to rely on private providers for abortion care, the banning of which would further decimate Native women's access to this critical component of reproductive health and self-determination.

CONCLUSION

Despite the obligations embedded in the Trust Responsibility, Native people are the heirs of a legacy of forced assimilation, child removal, forced sterilization, and sub-standard care that includes an effective ban on abortion due to the Hyde Amendment. They experience alarming rates of sexual violence, infant and maternal morbidity and mortality, and attendant mental, physical, and socioeconomic trauma. And instead of stepping forward, the federal government has stepped back, delegating its fiduciary duty to provide reproductive health care to private healthcare providers who are subject to state abortion laws.

States, including Mississippi, have no authority to determine the reproductive decisions of Native people. Upholding the proposed Mississippi pre-viability abortion ban will open yet another dark chapter of depriving Native people the right and dignity to choose if, when, and how to have a family. The decision of the Fifth Circuit should be affirmed.

Respectfully submitted,

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