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Upholding Tribal Sovereignty and Promoting Tribal Public Health Capacity During the COVID-19 Pandemic

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SUMMARY. Tribes are sovereign nations with authorities and responsibilities over their land and people. This inherent sovereign authority includes the right to promote and protect the health and welfare of their communities. The COVID-19 pandemic has brought national attention to the health inequities experienced by American Indian and Alaska Native communities. The sovereign legal authority for Tribes to respond to this pandemic has received less attention. This Chapter describes some, but not all, of the urgent legal issues impacting Tribal response to the COVID-19 pandemic. It describes and identifies gaps in federal Indian health policies and highlights how Tribes have exercised their sovereignty to respond and promote resilience in the wake of COVID-19. It also provides examples of intergovernmental challenges. It highlights how ignorance of or animosity to federal Indian law has led non-Tribal governments to infringe on Tribal sovereign rights during the COVID-19 pandemic. It ends by providing a list of recommendations on how law can be better used to support Tribal responses as the pandemic unfolds.

Introduction

Tribes are sovereign nations with authorities and responsibilities over their land and people (Pevar, 2012). Tribes have been exercising this inherent authority since time immemorial. There are 574 federally-recognized Tribes within the United States. There are also dozens of state-recognized Tribes. Some Tribes have both state and federal recognition. Each Tribe's communities, histories, cultures, and laws are unique. Tribal authority includes protecting and promoting the health and welfare of their citizens (Hoss, 2019). Through the exercise of Tribal sovereignty, many Tribal communities have incorporated cultural practices into public health interventions, thus establishing health resiliencies. As sovereigns, Tribes maintain a government-to-government relationship with the United States, states, and other Tribes.

Based on treaties and federal law, the federal government has a legal obligation to provide health care to American Indians and Alaska Natives. Nonetheless, American Indians and Alaska Natives continue to experience health inequalities in areas such as heart disease, diabetes, and certain cancers. In light of such health inequalities, American Indian and Alaska Natives are at higher risk of serious illness if infected with COVID-19 and have been

disproportionately burdened by the pandemic. As discussed below, inequities, memorialized in federal statutes and case law, have created structural barriers preventing comprehensive responses to COVID-19 in some Tribal communities. Tribal law, however, has remained an effective tool in mitigating the failures in federal Indian health policy to respond to COVID-19.

This Chapter describes some, but not all, of the urgent legal issues impacting Tribal response to the COVID-19 pandemic. It first describes how federal Indian law impacts Tribal health systems, particularly in the context of infrastructure and funding. It also provides a brief overview of Tribal public health law and offers examples of the Tribal exercise of their public health authorities. It next identifies select issues that have arisen in the context of the state-Tribal coordination. It highlights how ignorance, or animosity of federal Indian law has led non-Tribal governments to infringe on Tribal sovereign rights during the COVID-19 pandemic. It ends by providing a list of recommendations on how law can be better used to support Tribal responses as the pandemic unfolds. This Chapter contemplates legal responses to support federally-recognized Tribal responses to the COVID-19 pandemic; however, much of the discussion outlined here may also be relevant to other Tribal governments.

In this Chapter, the Indigenous populations of what is now the United States will primarily be referred to as American Indian and Alaska Natives. The terms Native, Tribal, and Indian are also used. Federal law legally defines the Indigenous population of the United States as “Indian,” so this term may be used when describing the law. The United States also colonized Native Hawaiian land, which continues to be occupied today. Native Hawaiians are not considered Indians under federal law but are subject to other laws and policies not within the scope of this Chapter.

Tribes and the COVID-19 Pandemic

Several factors – e.g., health and socioeconomic disparities, lack of water, and food deserts – have made American Indians and Alaska Natives particularly vulnerable to the coronavirus pandemic. Consequently, Tribal communities suffer from some of the highest per capita COVID-19 infection rates in the country (IHS, 2020). To combat the pandemic in Indian country, the federal government has primarily focused on allocating funding to Tribes. In turn, Tribes are utilizing those funds to exercise their sovereignty to its fullest extent and to implement infectious disease control measures. Yet challenges remain, particularly in the context of intergovernmental coordination.

Federal Indian Law and Public Health

Following European colonization and the establishment of the United States, a unique framework of federal law developed to govern the legal relationships between Tribes, states, and the federal government (Fletcher, 2016). Federal law recognizes Tribal sovereignty: the right of Tribes to maintain jurisdiction of their land and people. It allows for Tribes to protect their people, cultures, and environment (Coffey & Tsosie, 2001).

Issues of jurisdictional conflicts involving Tribes are complex. In general, Tribal jurisdiction extends over their people and lands, and states generally do not have jurisdiction on Tribal lands. The federal government, however, can exercise concurrent jurisdiction on Tribal lands and can only diminish Tribal jurisdiction by explicit acts of Congress, disfavored in modern Tribal-U.S. relations.

Tribes may extend jurisdiction over nonmember conduct on Tribal lands in certain instances, including when such conduct “threatens or has some direct effect on the political integrity, the economic security, or the health or welfare of the tribe” (“Montana v. United States,” 1981). Although Tribal authority over nonmember conduct is often challenged in court, Tribal authority to assert jurisdiction over nonmembers is at its strongest when responding to public health crises like COVID-19.

The federal government maintains a trust responsibility, a fiduciary and moral duty, towards Tribes based on treaties, case law, and legislation. The federal government must protect Tribal treaty rights, lands, and resources as well as consult with Tribes before taking action that impacts Tribes and their communities.

In exchange for ceded territories, the federal government is also obligated to provide health services to American Indians and Alaska Natives (Newton, 2012). Modern laws, such as the Indian Health Care Improvement Act, affirm this obligation and set forth federal

policy to “ensure the highest possible health status for Indians and urban Indians and to provide all resources necessary to effect that policy.” Indian Health Services (IHS) is the federal agency primarily responsible for delivery of these services and does so either directly through its own facilities and programs, or indirectly through Tribally-operated facilities and programs authorized under P.L. 93-638. IHS also provides funding to over 40 urban Indian health programs to service American Indians and Alaska Natives living in urban areas. It supports Tribal Epidemiology Centers, which, in partnership with Tribes, provide public health surveillance and other support.

Persistent Failure of the Federal Government to Honor Its Treaty Obligations. The health of American Indians and Alaska Natives is intrinsically tied to federal law and reliant upon the federal government fulfilling its treaty obligations and trust responsibilities. The federal government has largely reneged on this responsibility as the federal Indian health system has been overburdened and underfunded for decades. Due to funding shortfalls, IHS expenditures per capita are well below other federal health care programs and cover only a fraction of American Indian and Alaska Native health care needs (Broken Promises, 2018). According to the 2019 National Tribal Budget Formation Workgroup’s Recommendation on the IHS Fiscal Year 2021 Budget, an estimated \$32 billion would be required to fully fund IHS.

Even in areas where the federal government has made progress in better supporting Indian health programming, there remains substantial room for improvement. For example, recent amendments to the Robert T. Stafford Disaster Relief and Emergency Assistance Act of 1988 (Stafford Act) finally allowed Tribes to directly request national emergency and disaster relief resources from the federal government in lieu of funneling such requests through state governors; but, the Stafford Act still requires cost sharing from Tribal governments receiving funds.

As another example, the federal government initiated the Special Diabetes Program for Indians to reduce instances of diabetes in Indian country. Importantly, individuals with diabetes are likely to have worse COVID-19-related outcomes and American Indians and Alaska Natives have long suffered from diabetes at higher rates. Despite being a highly successful program, funding has repeatedly been on the brink of lapsing, avoided only by temporary funding fixes instead of permanent reauthorization. In both emergency assistance and diabetes funding, the federal government is already obligated to provide such health programming under its treaty and trust obligations.

Aside from health care services, the federal trust obligation plays a role in other areas such as criminal justice and public safety, education, housing, and economic development. The federal response to address disparities and meet its trust responsibility in these areas has been lacking as well. In light of these unfulfilled promises, many Tribal communities suffer from a broken infrastructure and lack basic utilities such as running water and electricity. Housing shortages are also rampant, resulting in overcrowded homes. Access to broadband internet is limited, making it difficult for Tribal governments and members to function

remotely (see Chapter 30). All of these factors hinder the ability of Tribes to safeguard against COVID-19.

Furthermore, the federal government's response to Tribal requests for help during the pandemic has been delayed and often grossly deficient. For example, the Sault Ste. Marie Tribe of Chippewa Indians, a Tribe with over 40,000 members, received only two test kits (Hilleary, 2020); and instead of receiving personal protective equipment to fight COVID-19, the Seattle Indian Health Board was sent body bags (SIHB Staff, 2020). Additionally, while state and local governments have accessed the Strategic National Stockpile (SNS) for critical medical supplies, Tribal access has been limited and not guaranteed.

CARES Act Funding. Of the COVID-19 legislative packages passed, the Coronavirus Aid, Relief, and Economic Security (CARES) Act has been the most significant for Tribes. The original bill included few provisions for Tribal communities, prompting a united effort by Tribal advocates to ensure their voices were heard. The final bill included financial assistance to Tribes and Tribal business entities, funding for federal agencies with set-asides for Tribes and Tribal services, and increased funding for programs in which Tribes and Tribal members can participate (e.g., Child Care and Development Block Grants to provide child care assistance and Fishery Relief to alleviate fishery-related economic losses and other negative impacts). The CARES Act created a Coronavirus Relief Fund of \$150 billion, including \$8 billion in direct assistance for Tribal governments. The IHS also received \$1.032 billion to fund IHS, Tribal, and Urban Indian Organization programs, as well as electronic health record stabilization and support.

While the CARES Act provides much-needed resources to Tribes, the funding comes with restrictions on how and when the funds can be used, limiting Tribal responses. It also authorized funding to non-government entities, such as Alaska Native Health Corporations, thus reducing the amount of money provided directly to Tribes.

Tribal Public Health Law

Tribal sovereignty includes the inherent authority for Tribes to promulgate their own laws and regulations. This authority includes the ability to promote public health in their communities and is further reinforced in Tribal constitutions, Tribal codes, and Tribal policies. Some Tribes expressly reference health protection and promotion as an authority of the Tribal government. Some Tribal codes establish health and emergency management agencies, designate health directors, establish emergency authorities, and require the development of health policies. Regardless of whether such provisions exist in a Tribal code or not, Tribes maintain authority to protect public health as an inherent component of their sovereignty. Codes and other policies, however, can operationalize services and programs to promote public health.

Tribal Infectious Disease Control Measures. As COVID-19 cases continued to increase in Indian country, pressure was placed on Tribal facilities to respond and meet the growing needs of their communities. While these facilities and programs play an important

role in providing essential care and services, Tribal governments remain the proper entity responsible for enacting the public health orders and measures in Indian country.

Many existing Tribal health codes and policies provide Tribal government authority to isolate, quarantine, and contact trace members, in addition to other infectious disease control. Once COVID-19 reached Tribal communities, many Tribal governments began to execute measures to curb its rise, including curfew, quarantine, social distancing, and mask requirements. The Navajo Nation, for example, implemented one of the most restrictive stay-at-home orders, imposing a long-running 57-hour weekend curfew. In the wake of COVID-19, some Tribes adopted more comprehensive policies to ensure that such measures were conducted in a more culturally appropriate way and discussed within traditional learnings and stories, as the Navajo Nation did. The American Indian Health Commission of Washington discusses the importance culturally appropriate responses in its Model Tribal Isolation and Quarantine Plan.

It is critical that federal, state, and local governments respect Tribal authority and jurisdiction to undertake public health measures. The exercise of Tribal legislative and regulatory authority, however, can raise issues of jurisdiction when enforcing them against nonmembers on Tribal lands. This issue is discussed in the subsequent section.

Intergovernmental Coordination

State-Tribal Jurisdiction. As outlined above, federal law outlines jurisdictional relationships between Tribes, states, and the federal government. Responding to public health crises like COVID-19 often implicates jurisdictional issues, particularly when neighboring governments are unfamiliar with federal Indian law.

The conflict between the Oglala Sioux Tribe and the state of South Dakota offers a timely example. In April 2020, the Oglala Sioux Tribe implemented a Tribal Border Management Plan that established checkpoints alongside two Tribal highways to assess the potential COVID-19 risk of travelers entering the Tribe's reservation. At checkpoints, travelers were asked about any COVID-19-related symptoms and whether they were conducting an essential business. The Cheyenne River Sioux Tribe established similar checkpoints.

The state of South Dakota, led by Governor Kristi Noem, opposed these checkpoints, arguing the Tribes were acting outside of their jurisdiction. This argument, however, runs against Tribal sovereignty and established principles of federal Indian law. States do not have jurisdiction within the boundaries of the Tribal lands, including the roads and highways crossing such lands. This legal principle was further recognized by the Bureau of Indian Affairs in an April 8, 2020 letter contemplating such checkpoints to respond to the COVID-19 crisis.

The state continued to oppose the Tribal checkpoints, even appealing to President Trump. Tribal representatives responded to state and media inquiries on the topic, thus taking their time away from other urgent response efforts. Despite threats of litigation from the state, South Dakota did not sue for the removal of Tribal checkpoints.

Inconsistent response measures across jurisdictions can also create challenges for Tribal governments. In their COVID-19 response, some Tribes implemented stay-at-home orders and other requirements on Tribal lands to curb cases. When neighboring states and local governments fail to implement similar measures, it puts Tribal members, who may live or work outside of Tribal lands, at risk as well. Additionally, nonmember failure to comply with Tribal protective measures on Tribal lands puts the entire community at risk. From a public health standpoint, it seems clear that an individual infected with COVID-19 is a direct threat to the health or welfare of the Tribe, and therefore, such Tribal orders are valid and enforceable against members and nonmembers alike.

Intergovernmental communication and coordination can support more comprehensive and consistent prevention measures. Legal tools can be used to facilitate intergovernmental cooperation between Tribes and states. For example, mutual aid agreements or memoranda of understanding can be reached to respond to public health emergencies. Such documents can allow for resource sharing for contact tracing, isolation and quarantine activities, and personnel. They can also facilitate and require data sharing and can establish protocol for intergovernmental communication. Tribes should consult with their counsel to ensure that such documents are written in a way that do not compromise Tribal sovereignty.

Public Health Data Access. Public health data collection and surveillance are essential to public health practice and health emergency responses. Data has been cited as a leading challenge in the Navajo Nation's COVID-19 response, with officials believing that case and death counts have been underreported (Whitford, 2020).

In practice, Tribes have experienced inequities and other challenges in securing health data. Despite being governmental public health authorities, some governments and entities refuse to provide Tribes access to health data, citing privacy concerns. Additionally, data is often housed in different software across organizations, making it difficult, costly, or even impossible to integrate data into existing systems. American Indians and Alaska Natives are also subject to persistent racial misidentification by health care providers, leading to erasure of this population in policymaking at the federal, state, and local levels. This further compromises the ability of Tribes to craft a targeted response. Recent reporting found that American Indians and Alaska Natives are regularly left out of state demographic data classifications in COVID-19 surveillance, being characterized merely as "other" (Nagle, 2020).

Given the long history of government and researcher misuse of health data pertaining to American Indians and Alaska Natives, data usage and ownership is also a priority consideration for Tribal governments. Inaccurate or misleading data presentations can negatively impact policy and funding decisions, and perpetuate stigma and stereotypes that compromise effective public health programming. 🌐

Recommendations for Action

Tribal governments:

- Continue to incorporate culturally appropriate mechanisms when using legal measures to contain the spread of COVID-19.
- If not already in place, consider passing a public health code that contemplates issues of health communications, quarantine and isolation, incident command systems, and a point of contact for public health issues for the Tribe.
- Consider entering into data sharing and mutual aid agreements or memoranda of understanding with neighboring jurisdictions, Tribal Epi Centers, and clinics to support and coordinate COVID-19 responses. Work with Tribal counsel to ensure that Tribal sovereign rights are not compromised in such agreements.

Federal government:

- Honor trust responsibility and consultation requirements as outlined by federal law.
- Provide funding mechanisms directly to Tribes at rates equal to or higher than those provided to states and local governments. Do not delay in the distribution of such funds. Do not use Tribal-serving organizations or entities as proxies for funding directly to Tribes.
- Require state and local government recipients of COVID-19 grants and cooperative agreements to meaningfully consult with Tribes in the area in the disbursement of funds or services. Require documentation of such consultation as a condition of funding.
- Sufficiently fund IHS, Tribal health facilities, and Urban Indian health centers.
- Provide additional funding for other Indian health programs. For example, permanently reauthorize the Special Diabetes Program for Indians. Alternatively, provide a long-term reauthorization of SDPI.

State and local governments:

- If not already in place, enact law that requires consultation with Tribes in the area if the state or local government is making law or policy that impacts the Tribe.
- Work with Tribal governments to enter into data sharing and mutual aid agreements or memoranda of understanding. Do not require Tribes to waive sovereign rights as a condition of these agreements.
- Share COVID-19-related public health data with Tribes.
- Respect Tribal authority and jurisdiction to promote the health and welfare of their communities and to implement COVID-19 response measures on their lands, including curfews, checkpoints, mask wearing, and other requirements.



About the Authors

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