The Secretary's Advisory Committee on
Infant and Maternal Mortality
U.S. Department of Health and Human Services

IN-PERSON MEETING
Mystic Lake Center
2400 Mystic Lake Blvd NW,
Prior Lake, MN 55372

Tuesday, September 13, 2022
9:00 a.m.

Court Reporter: Christina DeGrande

C O M M I T T E E M E M B E R S

Edward P. Ehlinger, MD, MSPH
ACTING CHAIRPERSON Minneapolis, MN
Term End Date: December 15, 2022

Michael D. Warren, MD, MPH, FAAP
EXECUTIVE SECRETARY
Maternal and Child Health Bureau
Health Resources and Services Administration
Rockville, MD 20857

Vanessa Lee, MPH
DESIGNATED FEDERAL OFFICIAL
Maternal and Women’s Health Branch
Division Healthy Start and Perinatal Services
Maternal and Child Health Bureau
Health Resources and Services Administration
Rockville, MD 29857

MEMBERS
Sherri L. Alderman, MD, MPH, IMH-E,FAAP
Developmental Behavioral Pediatrician
CDC Act Early Ambassador to Oregon
Help Me Grow Physician Champion

Oregon Infant Mental Health Association
Immediate Past President
Portland, OR
Term End Date: March 12, 2025

Steven E. Calvin, MD
Obstetrician-Gynecologist
Minneapolis, MN
Term End Date: December 31, 2024

Charlene H. Collier, MD, MPH, MHS, FACOG
Associate Professor of Obstetrics &Gynecology
University of Mississippi Medical Center
Jackson, MS
Term End Date: March 12, 2026

Tara S. Lee, PhD
Senior Fellow and Director of Life Sciences
Charlotte Lozier Institute
Arlington, VA
Term End Date: December 31, 2024

Colleen A. Malloy, MD
Assistant Professor of Pediatrics(Neonatology)

Ann & Robert H. Lurie
Children’s Hospital of Chicago
Chicago, IL
Term End Date: December 15, 2022
M. Kathryn Menard, MD, MPH
Upjohn Distinguished Professor
Department of Obstetrics and Gynecology
Division of Maternal-Fetal Medicine
University of North Carolina School of Medicine
University of North Carolina at Chapel Hill
Chapel Hill, NC
Term End Date: March 12, 2025

Joy M. Neyhart, DO, FAAP
Rainforest Pediatric Care, a member of
Southeast Alaska Regional Health Consortium
Juneau, AK
Term End Date: March 12, 2026

Janelle F. Palacios, PhD, CNM, RN
Nurse Mid-Wife Kaiser
Permanente
Oakland Medical Center Labor & Delivery
Oakland, CA
Term End Date: December 15, 2022

Magda G. Peck, ScD
Founder/Principal, MP3 Health Group
Adjunct Professor of Pediatrics &
Public Health
University of Nebraska Medical Center
Richmond, CA
Term End Date: December 15, 2022

Belinda D. Pettiford, MPH, BS, BA
Women’s Health Branch, Head
North Carolina Division Public Health Women’s
And Children’s Health Section
Raleigh, NC
Term End Date: December 11, 2022
Marie-Elizabeth Ramas, MD, FAAFP
Family Practice Physician
Hollis, NH
Term End Date: March 12. 2026

Phyllis W. Sharps, PhD, RN, FAAN
Professor Emerita
Johns Hopkins School of Nursing
Laurel, MD
Term End Date: March 12, 2025

ShaRhonda Thompson
Consumer/Community Member
St. Louis, MO
Term End Date: March 12, 2025

TABLE OF CONTENTS.

Drum/Flag Ceremony. 8
Invocation. 8
Welcome. 11
Tribal Welcome. 17
Welcoming Remarks and HRSA Perspective. 25
HHS Secretary's Remarks. 49
Remarks by Federal and State Officials...79, 100
Meeting Objectives and Format. 103
Setting the Context for Addressing Birth Outcomes for Indigenous Mothers and Infants..109, 120, 132
Lunch break 169
Tribal, State, and Local Challenges and Approaches to Improving Indigenous Birth Outcomes 170, 180, 194, 207
Pressing Issues for Indigenous Women: Incarceration and Violence. 232, 266
Public Comment and Discussion. 285
Committee Reflections. 304
Closing Drum/Flag Ceremony. 303
Meeting Adjourned. 327

P R O C E E D I N G S

(Drumming ceremony)

Welcome And Call to Order

ED EHLINGER: Let's begin:

LEONARD WABASHA: (Speaking indigenous language.)

To all my relatives. I am a Dakota. I come from the place where they marked the trees red. My parents are He Travels the Good Road, and my mother is Good Water Star Woman. My people are called the Dwellers of Spirit Lake, and they call me Second Born. This was a traditional Dakota greeting. We introduce ourselves before people we don't know by introducing and saying who our parents are so that we may be judged by the actions they performed in their lifetime.

Before I say the prayer, I was asked to mention a very significant event in Dakota history and United States history and the history of Minnesota. This event was the 1862 war between the Dakota and the United States government. This year marks the 160th anniversary.

The war began for many reasons. Prior to 1862, the people suffered a harsh winter. The following summer, crops failed due to blight. In addition to this, the people approached the agents and the traders asking for food. They were denied because they knew the treaty payments and provisions were going to be late. This led to starvation and frustration for my people.

So in order to make it through this starvation period, some men left the reservation, and they came upon a place we know as Afton, Minnesota today. There are some settlers who were killed and this, they say, started or ignited that war of 1862. I could spend a lot of time talking about this event, but you have a conference here where you need to talk about some very important things about the children and the babies, and so I'd like to recommend that you visit the Hocokata Ti Cultural Center where you can learn more about this event and Dakota life ways. There's some brochures out there on the table to pique your interest, I guess.

So that being said, I'll say the prayer now.

(Speaking indigenous language.)

Grandfather, thank you for this day, and thank you and Mother Earth for all the things you give to the people in order that we may survive. Today, I ask you for your blessings, for health and for life and for help that we may all get along together in a good way. I also ask you for knowledge, understanding, and wisdom that we may accomplish all those things we need to accomplish.

(Speaking indigenous language.) One other thing I wanted to mention also is this weekend, if you're around and you have time to visit the city of Mankato at Dakota Wokiksuye Makoce, Land of Memories Park. There'll be an event there sponsored by the Mahkato Mdewakanton Wacipi Association. There, they're going to celebrate life and honor and memorialize the 38 men who gave up their lives so that their people could live.

Thank you for your time and have a great meeting and conference.

(Speaking indigenous language.)

LEE WILSON: Good morning, folks. My name is Lee Wilson. I'm acting as the designated general official for this meeting, the Advisory Committee on Infant and Maternal Mortality.

First, I'd like to welcome and thank our chair Ed Ehlinger, but -- Dr. Ed Ehlinger, the committee members, the ex officio members, our esteemed guests and speakers, and the individuals who have signed in virtually as guests and speakers for us for this first hybrid meeting here for the advisory committee.

I have a couple housekeeping items before we begin that I'd like to mention to you, and then we'll open the meeting. First, this is our first in-person meeting in a number of years, so we are very pleased to have all of you here. It is unfortunate that not everyone was able to come for a variety of reasons, but we were deliberate about having this meeting together, also having this meeting here, and it is a great gift that we've been able to share this

meeting in this space to discuss these issues. We encourage you to take the opportunity to share amongst yourselves. We have a number of new members here and we have a number of members who will be graduating off the committee, so please take the time to share with each other, learn of each other's vast experiences and work to continue the good work of the committee.

It is also our first hybrid meeting, and so I would encourage each of you to be mindful of a couple things: One, speak into the microphones as this meeting is being recorded and individuals who are logging in virtually will have difficulty hearing you if you don't. There's one microphone for two individuals. The microphones are very sensitive, so when you are not speaking, please turn the microphone off, and share politely with one another so that everyone can hear you.

Also, knowing that this is a virtual meeting or a hybrid meeting, please be mindful of the screen. We will have all of the external participants projected onto the

screen share when there's an opportunity for them to share and speak. Also, be mindful of the fact that conversations are best done when we try to be inclusive of individuals who are -- who are virtual.

We will be using the hand signal on the -- the virtual platform so that individuals can be recognized. Please be -- be mindful of that as you're having a discussion.

I would also like to say that this is a public meeting. For purposes of our discussions, be mindful that the general public is invited to speak two times during this meeting on the first afternoon and the second afternoon. We have individuals who have registered to speak. All of those will be virtual, and you will have an opportunity to ask questions of those individuals. I'd also like to remind you that when we do have a speaker or when somebody is addressing the committee, those are intended as addresses to you as the committee. Those individuals do not become committee members, so just be mindful of the different roles of the individuals as they present to you and as

they make their -- their recommendations or request to you.

This meeting is being recorded, and we do -- will be transcribing it. We will be providing minutes of the meeting, so you will have an opportunity to make sure that we have collected and recorded your information accurately, so please be sure to attend to the minutes that are provided, and if you have any updates, please let us know.

Also, finally, two -- two additional items: One, recommendations are being made to the Secretary by this committee, so be mindful of that role. This is not recommendations to the president, and it is not necessarily recommendations to the public. Those are opportunities that you -- what you say can be shared in other venues, but the primary purpose of this committee is to make recommendations as an advisory committee to the Secretary.

Finally, in light of the fact that this is a virtual meeting and we all now live in this hybrid space where we have computers, I would, out of respect, encourage each of you

to minimize your multitasking while you're here so that we can focus on the meeting. We have a number of individuals who have chosen to join us for our meeting, and we encourage you to pay attention to the work that this committee is performing.

So welcome to you. Welcome to the public, and thank you for joining us for this meeting. We hope that it's rewarding for you. And now I open the meeting officially as the designated federal official.

ED EHLINGER: Thank you, Lee. And -- and I offer my welcome to everyone, and I would particularly thank the -- the drum group, the Imnizska Drum Group and singers. It was a just wonderful way to start. And the flag, the veterans that provided their time and energy to -- to honor the flags and -- and Leonard Wabasha with the invocation.

And I appreciated the history that we're on land where the largest mass execution in the United States history affected this community directly, and we'll be talking a lot about historical trauma and

its impact ongoing. And so it was nice to be able to have that as the start of our meeting.

This is an important meeting. It's -- we're in sacred space and -- and we're doing sacred duty to -- for the betterment of indigenous mothers and babies, and all mothers and babies throughout our country.

And I would encourage the -- any ex officio members to sit at the table, because I'd like to -- I know we have some in the audience that would be nice to have them at -- at the table as ex officio members. So feel free to -- to move in -- into the spaces. And with that I would like now to welcome Joanna Bryant. She's the tribal health administrator at the Shakopee Mdewakanton Sioux Community. Joanna has been a -- a leader here in Minnesota along with many of the other tribal health directors and -- and really pushing the state and federal government and -- and local communities to improve health and -- and well-being of the tribal community. So Joanna, welcome.

JOANNA BRYANT: Thank you. Good morning, everyone. Wow, right? What a way to start a morning. So if you weren't motivated when you woke up this morning, I certainly hope you are motivated now, right? Very moving.

As Ed said, my name is Joanna Bryant. And I am the tribal public health administrator for the Shakopee Mdewakanton Sioux Community, and we're very excited to have everyone here today to talk about these very, very crucial issues that impact mothers and infants across the board, across our country.

I have my formal direction from my business counsel. On behalf of the SMSC community and our business counsel, which is Chairman Keith Anderson, Vice Chairman Cole Miller, and Secretary Treasurer Rebecca Crooks-Stratton, we'd like to welcome you all to our community, and we encourage you to really take this opportunity to dig in and do what you're -- what you're here to do.

I'm actually, you know, very grateful

for the focus that you guys are looking at doing today. And I think, as we all know, the first step in really addressing a broad issue like this, right, is bringing people to the table, being willing to hear voices and take input across the board. And I do -- I would like to thank the committee for recognizing that and being here today in the -- in this format. I think the one thing I'd like to leave you with is, you know, as a group here, everyone here, you know, we represent not only the potential policymakers, right, policy advocates, but we're all -- and pol- -- people who implement policy, but we also are hoping to hear during this conference of the individuals who are impacted by the policies and recommendations that you make. And that can be a very -- a very heavy burden, I think.

So as you begin your conference and you guys start into this, I think I ask you to open not -- your hearts as well as your minds and so that you can really hear. I think today needs -- this conference needs

to be about hearing, right? You can hear someone, but did you really hear them, right, a difference between hearing and listening in order to help shape your recommendations as they move forward.

So thank you for all of your individual dedication to this cause and improving the lives of mothers and infants, and have a good conference.

ED EHLINGER: Thank you, Joanna. And Joanna is going to be back tomorrow. She's going to be explaining a lot of the programming of the -- from the -- that's done at the Shakopee Mdewakanton Sioux Community, so we will get a chance to hear a lot of -- more of the activities that are going on in this community, and you get to ask some questions. And so that's what I'm hoping we built in enough time for some of those questions, and I know that we're a little bit -- so I'm not sure if the first administrator is for or we can -- there are other things we can do in the meantime while we're trying to find -- I would like just for the committee members -- you know, just

-- we're going to do some introductions in a little bit after we hear some -- from some of our federal officials, but what hopes do you bring to this meeting? What are you hoping to get out of this meeting? What are you hoping to learn? ShaRhonda?

SHARHONDA THOMPSON: For me personally, I hope to hear personal experiences because data can tell you one thing, but life stories, that -- that's really what you need to know in order to make the best decisions.

ED EHLINGER: That's fine. Anyone else? What are you sharing? What are you hoping to hear? What do you hope get out of this? What do you hope comes out of this meeting?

MARIE RAMAS: Yeah. I want to make sure that the recommendations that we set forth really reflect the needs and the desires and the lived experiences of the people that are represented within the recommendations in office.

ED EHLINGER: Excellent.

UNIDENTIFIED SPEAKER: I concur with that. I also want to remove the

invisibility of small numbers or having that drive who matters when it comes to recommendations and acknowledging the weight of the -- the task we have before us and that that changes fundamentally, that this -- native communities, indigenous communities have been ignored and hidden in MCH for a very long time, that even clinical providers are ignorant to what's going on, and we should -- at this -- you know, have that shroud removed and any barrier to highlighting inequities not be limited by the barriers around numbers, and we should be able to move past that. Thank you.

ED EHLINGER: This is an interesting time to meet because just in the last couple of weeks, there have been so many reports about the impact of American Indians, Alaskan Natives, COVID, and longevity and maternal mortality rate. I mean, of the -- it was like it was just set up for this meeting, just, you know, listening to all of the issues that -- that we're facing. So we're coming with that as a background and all of that important information.

Other thoughts, Magda? Where -- it's where the ear --

MAGDA PECK: I should know that. First of all, profound gratitude for this moment. And in being here as we open our hearts and our minds and listen, I hope that we can not only see the data but feel the stories, feel them deeply, feel them in our bones, and the stories will bring to life what the data alone cannot.

And I guess if there's something else in with humility, I want to not just learn, but I want to unlearn. I want to unlearn the stories that I've been told that are convenient and preserve power and systems of oppression. And it is time for unlearning before we can learn anew. So that's what I hope comes out. And if we do those two things together, this will not be just another meeting. It can't be. There's too much at stake. And that is on our shoulders and our hearts and our conscience together to powerfully change the way we do business so moms and babies thrive.

ED EHLINGER: And it's not even -- this

is not just another meeting. I mean, I believe this is the first meeting of the advisory committee that is outside of Rockville, and -- and certainly, the first meeting on tribal land. This is not the usual meeting. And at a time when the -- the needs are so important so we need to take advantage of it, and I'm just hoping that we -- this is an opportunity for us to -- to really come up with some recommendations, and we've -- we've been blessed by having people from across the country come and join us in person. I mean, yes, there will be some who are virtual, but some who have taken the time over these next two days to come in -- in person to make many statements that -- that we will be thinking about and -- and taking in as we ponder the recommendations we make. So this is not just the usual meeting. I have -- I have great hopes that out of this meeting will come some recommendations that will actually make a difference, that will move the needle, that will move us forward in -- in equity and -- and health, particularly

for American Indians and Alaskan Natives, but for all moms and babies.

So glad you're all here, and we'll do some introductions in a little bit, but let's now move to the -- is the administrator on?

CAROLE JOHNSON: I am. Thank you.

ED EHLINGER: Well, let me -- good. I'm glad. Let me introduce you, then. Carole Johnson is the administrator of the Health Resources and Services Administration, the federal agency and the U.S. Department of Health and Human Service focusing on health equity and particularly supporting health care services for historically underserved communities and working to build a robust and diverse health care workforce. She joined HRSA from the White House COVID-19 response team where she led mitigation in surge response efforts.

She previously served as commissioner of the New Jersey Department of Human Services, and during her tenure there, she expanded Medicaid coverage of mental health and substance abuse disorders, created new

Medicaid benefit programs to improve maternal health outcomes, and increased child care rates and expanded food assistance.

She also worked with the Obama White House working on implementation of the Affordable Care Act and combatting opioid epidemic and responding to public health challenges like Ebola, Zika, and advancing health priorities.

It's there where I worked -- started tangentially with Carole Johnson as I was health commissioner also dealing with Ebola and Zika, so our paths crossed. And so I'm glad you're here to join us virtually, and I look forward to your comments, Administrator?

CAROLE JOHNSON: Thank you so much. And thank you, Dr. Ehlinger, and to the committee members for your dedication and for your commitment to infant and maternal health across this country. But for your leadership in really identifying the critical need to dive deep and investigate the challenges the -- faced by Native

American and Alaskan Native women -- American Indian and Alaskan Native women and the importance of having this gathering on tribal lands to be able to really invest and form the recommendations the committee will make going forward.

I really want to thank Administrator Bryant and Director Wabasha for the invocation and welcoming today and to the entire Shakopee Mdewakanton Sioux Community for inviting us and welcoming us to have this meeting on tribal land.

It is so important to us to be able to hear directly from individuals about their lived experience and to have the voices of the community inform the work that we do through this critical advisory committee that has been so instrumental in shaping the federal response to infant mortality crisis in this country.

I also want to recognize Dr. Michael Warren and Lee Wilson, our team from HR -- and our whole team from HRSA who are -- who are day in and day out leading our maternal and child health response efforts and our

federal colleagues both virtually and in the room. I know Dr. -- I'm sorry. I know Liz Fowler from the Indian Health Service will be here later to be able to speak with everyone, and she's a tremendous leader, and she brings so much support to all of us as we work to -- to bring cultural humility to the work that we do. And so I'm grateful for Liz's partnership.

This is, as I'm sure you all have noted, the first time this Advisory Committee on Infant and Maternal Mortality has met on tribal lands. It is a historic moment, and it is a critical moment. It is unacceptable to us that infant mortality rates are more than 75 percent higher in -- among American Indian and Native Alaska child -- infants and that maternal mortality rates are more than two times higher among American Indian and Native -- and Alaskan Native women. These are not numbers that we want to -- we want to be back to you in a few years to tell you that we turned the dial and that we're making progress on these critical issues, and we're only going to be

able to do that with the voices and experience and listening and learning and consulting with those of you in the room who can bring us -- who can help us on a path forward.

I recognize that's a lot to ask. It's a lot to ask a community that has experienced trauma, trauma on these very lands that lives and continues to be in the -- in -- in the experience of -- of all families in the community. And so we are grateful for you to bring that forward and to share that here so that we can learn and we can move forward in ways that reflect that experience.

You know, it is -- it is really an honor as well to recognize the other tribes from Minnesota who are a part of this conversation and to really think about how we might together recognize the knowledge, creativity, and resilience of the community as we build a path forward.

We're delighted that later this morning Secretary Becerra will join us. As you all know, he has been a tireless leader for

health care equity throughout his career and brings that fierce dedication to his role as secretary.

We are very much looking forward to the work of this advisory committee and the recommendations that will come from it. I will say, one of the critical priorities that the president and the vice president have directed us at the Department of Health and Human Services to work on and that the secretary, in turn, has directed all of us across all our agencies and bureaus to focus on is the important need to address the maternal mortality crisis. It is just, frankly, unacceptable that American Indian and Native Alaska women die at two times the rate of white women. That just -- there's -- there's so much that we as a government and as a people in the -- we need to do in government and government relations with tribal communities to better support the work that tribes are doing to be able to turn the tide on this -- on -- on this epidemic.

You know, and our mission at HRSA is to

really help drive and improve health care outcomes to -- to achieve health equity by providing access to high-quality health care and supporting a skilled workforce. And we all know, and I know -- I just had the opportunity last week to be at the Secretary's tribal advisory council meeting in New Mexico where leaders from across our department joined with leaders from across tribal communities, across -- across the country to -- to speak to the challenging issues facing tribal communities at this time, and a lot of those have been workforce means. And so what we do at the Department of Health and Human Services, here at HRSA, is really focused on workforce issues.

We have the opportunity, we are fortunate to be the home of the National Service Board where we help pay for the cost of education either through scholarships or loan repayment to -- for primary care clinicians including primary care providers, pediatricians, dental care providers, OB-GYNs and others who, in turn -- in -- in return -- or in response to our scholarships

and loan repayments practice in high-need communities and we are able through that program to support placement of clinicians in tribal communities across the country. And we know how critical that is to meet the care needs of the community. We also know that it is very important that that -- that investment be respectful of tribal traditions and be a workforce that can actually -- that is well received and a trusted part of -- of tribal communities' needs. So we continue to work on those issues with you, and we welcome your feedback as this committee puts together recommendations for the Secretary going forward.

We also are the home of the Teaching Health Center Graduate Medical Education Program. This is a program where we work to train clinicians in the community. It's very important that clinicians be trained in hospitals. Of course, they need to have experience in hospitals, but primary care providers are going to practice in the community, and we want primary care

providers to, on balance, get more exposure to and more training in communities where we want them to practice. And so the community -- the Teaching Health Graduate Medical Education Program is a way that we are really partnering in communities across the country to sort of rethink how -- how primary care training is happening, and we're very pleased that there are tribal partners in our teaching health center program, and we look forward to continuing to grow that going forward.

We had the opportunity to expand, thanks to the president's investment in the American Rescue Plan, and we're going to continue to focus on how our workforce programs can be supportive of tribals needs.

You know, I think many of you on the committee may recall that in June, our Office of Women's Health was able to meet with the committee to talk about our initiatives on intimate partner violence, and -- which is another important public health issue that the committee has been investigating and working on. We also are

-- are home to a host of other critical programs that serve tribal communities. But what I wanted to really emphasize today and have the opportunity to talk about is the work that our Maternal and Child Health Bureau does. We are the home to the federal resources that support states, tribes, and other jurisdictions in -- in advancing the health and well-being of America's women, children, and families so that everyone can thrive and reach their full potential.

We run what's called our Maternal, Infant, and Early Childhood Home Visiting Program, do that in partnership with one of our sister agencies that supports the tribal version out of the Maternal, Infant, and Childhood Home Visiting Program. And as this committee moves forward on its recommendations, this is a -- this is an important program that we want to make sure is on everyone's radar. This is a voluntary program for families to help identify and pregnant people identify as being open to and supportive of having the kind of critical, social, and health supports early

on during pregnancy and in the early years of their children's lives through home visiting where we're able to identify community needs, identify individual's needs, connect them to critical supports and services. And, really, there are some incredible results associated with this program really making a difference in early childhood language development, in school readiness, and the kinds of things that are meaningful markers of -- of these types of programs, again, a program that we want to make sure is as culturally-appropriate and sensitive as it should be so that it is -- so that families choose to use it should they want it to be able to ensure that their children are getting the best possible support and services as possible.

We also support the Healthy Start program, and this is a program really targeted through our Maternal and Child Health Bureau to communities in highest need. We've been doing some recent work, particularly with the Intertribal Council in Michigan and the Great Plains Tribal

Chairman's Health Board to focus on how this program can best serve tribal communities as well by thinking about things like social determinates of health, things like how do we engage people earlier in prenatal care, how do we address substance use disorder, mental health conditions, other kinds of critical factors that we know are so important here.

We also are the home to the State Maternal Health Innovations Program. I know it's sometimes complicated to -- to focus on state issues when tribal communities have their own self-governance in many cases, but this is a mechanism where we try to create a very broad table to bring together all community leaders so that -- so that we can address disparities in maternal health and prevent severe maternal illness and death. And so later today, you'll hear from our grantee in Arizona who has used this platform as a way to bring together state leaders and tribal communities to -- to work on holistic solutions in the community and across their state.

It is hard to be in this moment in America and not really think about and focus on the critical mental health needs of children, particularly -- and for us that also means focusing on maternal mental health. And so -- so we are -- on Mother's Day this year, we launched our national maternal mental health hotline. This is our free, 24-hour a day confidential hotline to support pregnant and postpartum individuals who are experiencing mental health challenges and their loved ones. It's really a way for us to connect people in a safe space, to create a safe space to connect with qualified counselors, to be able to provide immediate support as well as referrals as needed. And, really, you know, we work hard for these to be culturally confident conversations, and so we welcome the committee's thoughts on these issues as well.

Just for everyone's reference, that hotline number is, 833-9HELP4MOMS. And that is -- we're really excited about that resource. We're excited about getting that

information into more hands. We know that it can be hard and sometimes dignitizing [sic] to raise your hand and ask for maternal health support. So creating a confidential resource is a real priority for us, and we're seeing an incredible demand for that line.

And I just want to talk a little bit about children, pediatric needs and mental health issues. We -- we know that we are not going to be able to meet the incredible needs that we are seeing among children and families unless we create a system where there's really no wrong door for seeking mental health support. And part of that is making sure pediatricians are well-equipped and prepared to help meet children's mental health needs. It is increasingly the case. We all know this anecdotally that pediatricians are seeing more and more needs among their population. And so what we have done is really invested in training pediatric specialists to be able to identify and support and treat as appropriate mental health needs among young children,

particularly if they are of lower complexity where they're the kinds of things that can be managed in a pediatrician's office. We obviously want pediatricians to make referrals to specialists as they need to, but the more we can equip pediatricians to manage lower complexity conditions, the more we'll be able to continue to ensure that our specialists are able to see as many of the complex needs as they as -- as -- as possible.

And one of the ways we do this is through a program that provides real-time teleconsultation to pediatricians so that they can access mental health specialists. Part of this is about making sure that -- you know, we don't -- we're not leaving pediatricians on their own. And then they actually can connect with and get help and support for the cases that they are seeing. And we're seeing over time more and more support for and interest in this from our pediatric partners.

We are really pleased that we have two tribal grantees in this program and we -- we

hope to be able to continue to expand this program going forward. It is one of the places where Congress invested money in the Bipartisan Safer Communities Act, meaning that legislation that they enacted to address gun violence prevention that included significant new resources for mental health. One of them was more investment in this critical program that we run that we already have tribal partners in and we wanted to make sure that tribes are aware of at least as we go forward and try to expand it.

You know, and part -- part of the way we're doing that is by our team here in the room had a virtual listening session recently to talk more about telehealth strategies and increased access and improved pediatric behavioral health care, and we had several tribes participate in that call.

You know, we -- you know, obviously what we hear and what we take to heart and are continuing to work on is the importance of -- of programs being culturally -- and meeting cultural and linguistic needs of

indigenous communities and really another thing that is front and center for us is -- is making it easier to apply for our resources. So we recognize that grant making is sometimes more complicated than it needs to be. We're working very hard to simplify our grant applications process. We're making it -- we're working very hard to make our -- our funding opportunity advancements more approachable and easier to -- to respond to. There's always going to be requirements that are beyond us that have to be included in there. There's always going to be some level of detail and -- and -- and data requirements and the like in order for us to appropriately do our -- our federal fiscal stewardship responsibility with these programs. But they don't need to be as complex as they are. We're continuing to work on -- on making them more approachable so that more and more communities can apply. We recognize that not every tribal community is going to have a grant writer who can dedicate the time and effort to do this. And so we want to

continue to work with that, both what we can do on our end and how we can help with technical assistance in communities across the country to help people understand how our process works and make it more approachable for as many communities as possible.

We don't want to be an agency -- if we're focused on equity and we're focused on continuing to bring down the barriers to care, we don't want to be an agency that just funds legacy entities. We want to be an agency that's continuing to engage new communities in our work and help communities really center and tackle issues together.

You know, it is -- it is our goal to not do this work alone. It is our goal not to be a bunch of folks in Washington, or in our case, Rockville, Maryland, who make policy decisions and that push things out and, you know, hope people balk.

It is our goal to be engaged, to be culturally humble, to be respectful, to be informed by the work of the community and the needs of the community. And this

advisory committee is a key component of that work.

I know I've mentioned the State Advisory Committee in the past, but my -- we are very actively as in this administration, and the president in short, in the American Rescue Plan that this would be the moment when states would be able to expand their Medicaid programs for one year postpartum and gave that option to many states, and many states are taking up that option, and the Secretary has been working very hard to encourage states to take up that option.

Because we all know that inter-conception care is critical. We all know that the risk of maternal mortality doesn't end two months after pregnancy. And so it's a vitally important policy change. And I know that that policy change was recommended by this committee more than a decade ago. So this committee is really at the forefront of what types of policy changes we need to be considering and to continue to challenge us as we do our work so that we really are meeting the moment and

meeting the needs of communities.

And so we are very grateful for all the committee members for the time and -- and effort and creativity and innovation we bring to your recommendations and for your real leadership in convening this meeting on tribal lands and to the tribal communities who are here in the room and with us online for taking what we know is really precious time away from your work to be part of this conversation because we hope and we -- and our commitment to you is that we will continue to try to make a difference informed by the -- the voice and -- and -- and experiences that you bring to the table.

So I am -- with that, I am going to turn it back to the Chairman for maybe a few questions, and -- and before we introduce our next speaker.

ED EHLINGER: And Ms. Johnson, thank you very much for that presentation and listing -- and of all of the things that are going on in HRSA. I have a question, and then I'll see if there are others, but I know that as we particularly dealing with

American Indians and Alaskan Natives, social determinants of health are a major issue, you know, it's not just medical care, and that -- that has impacted -- those social determinants are impacted by all -- all parts of the federal government and state government. I'm just curious from your perspective, how are you interfacing with other parts of the federal government in the work that's being done, in housing, in transportation, in criminal justice, in economic development, and all those kind of things, environmental health, all of those things that particularly affect communities of color and American Indians?

CAROLE JOHNSON: Thank you so much for that question. It is -- it is exactly the right question. It is -- for far too long the health care field has treated health care issues as though they happened inside -- like, you check in for a medical appointment and that's when our responsibility starts, and that is just not the case. What the health and well-being of particularly underrepresented communities is

driven by so much more than that, including the historic trauma that you all recognized at the top of today's meeting as well as those really vital day to day issues like housing and transportation and -- and nutrition. And so I would say there is no -- one of the advantages to this -- to the -- this conversation happening at this moment is that there's no larger advocate, really, than the vice president in this mode, and the vice president convened the first cabinet meeting focused on maternal mortality issues, and Secretary Becerra and I, and this -- the -- the head of our Centers for Medicare and Medicaid Services all joined that meeting to be able to meet with our partners across the Department of Labor, the Department of Veteran's Affairs, the Department of Housing, our transportation colleagues to be able to sit around the shared table and say this is not just a health care issue. This is a well-being of the people of America and the people of tribal communities' issue, and we need to work collectively and together to

tackle these social determinants of health. And that is the -- the footing on which the administration's maternal mortality crisis blueprint was built. And we are together actively working as a whole of government to tackle these issues.

ED EHLINGER. Great. Thank you. Any other questions from the committee? I'm sure there are. ShaRhonda?

SHARHONDA THOMPSON: Hello. You mentioned a program about resources where a family can go to get additional resources about information about additional resources. Is that a national program, or is that statewide or...

CAROLE JOHNSON: Yes, yes, yes. Thank you for the question. This is a national program that we run both -- that we run through resources that we provide to states, but there also is a dedicated tribal version of the program. It's called the Maternal Infant and -- Maternal Health and Infant Home Visiting Program. And we run a national version, and then we partner with our sister agency to run a version that

specifically serves tribal communities. And I will make sure that some of our colleagues in the room are able to follow up with you and provide some information to make sure you get connected to the program.

ED EHLINGER: It looks like the -- the Secretary has joined the -- the meeting. So I will turn it over to -- back to you to introduce the HHS secretary.

CAROLE JOHNSON: Thank you so much. Thank you again to the committee members for your time this morning, and it is really my -- my pleasure to introduce Secretary Xavier Becerra, who is the 15th Secretary of the Department of Health and Human Services and -- and to tell this committee that this wasn't an invitation that we had to sell the Secretary on. The Secretary learned of this meeting and -- and raised his hand and said, "I want to be part of this," because the Secretary is a tireless leader for health equity and has been using his time in office to really work on and tackle the critical issues of maternal and infant mortality and the unacceptable despair -- racial

disparities and -- and disparities we see among indigenous people and white Americans.

And as many of you know, the Secretary served for 12 terms in Congress as a member of the U.S. House of Representatives. He was a critical leader on the powerful -- it's hard to overstate how powerful the House Ways and Means Committee is. And the Secretary really drove policy agenda on the health subcommittee and the social security subcommittee.

Most recently, he was the Attorney General of the State of California where he led time and time again on national issues related to ensuring fairness in the health care system. But, really, the Secretary is the champion of protecting the Affordable Care Act and the incredible expansion of access to health care services that happened during the prior administration. The Secretary led the fight to ensure that the health -- those -- that access to critical health care coverage remained in a very challenging time.

And so we're so delighted that he is

our Secretary now and is really the signature agenda item and the thing that he try -- has charged all of us with is really focused on -- focusing on health equity and how we can leverage our federal resources to make sure that we're listening to the voices of the community, including the American Indian and Alaskan Native community and doing everything we can to ensure that those advantages of health, access and services, reach communities that have, for far too long, been underserved.

With that, I'm going to turn it over to Secretary Becerra. That you so much.

SECRETARY XAVIER BECERRA: Administrator Johnson, thank you very much to you and all the team at HRSA, to Associate Administrator Michael Warren, to Dr. Ehlinger, the acting chair of this advisory committee. And to the Shakopee Mdewakanton Sioux Community, thank you for hosting us today. And to everyone who is in attendance, thank you for believing it was important enough to be here and -- and to make a difference.

I just want to start by mentioning to you something that I learned from my -- my parents. They always told me that it would be my example that gets me to where I want to go. I always tell folks if you want to know where a leader will take you, look to see where that leader came from, and my suspicion is if I were to go around to everyone who is in attendance today, I would find that I -- I have leaders in front of me who, from experience, from lived experience, understand what it means to really address the issue of maternal mortality, infant mortality for a community.

And so I want to thank you, first and foremost congratulate you for being a leader on this issue and for working with us and allowing us to work with you so we can really move this ball forward. It is important, I think we all know, because the issue of maternal mortality and morbidity, infant mortality and morbidity is acute in certain parts of the country and certainly within our American Indian, our native population, it is acute. And so we have to

do much better. And that's what this committee's work is all about.

I hope we can convince you that we understand the -- not only the consequences, the importance and the priority, but in many ways just the fact that we're hosting -- you're hosting this meeting on tribal land in a place with a -- a history, a rich history but also a very painful history at times. I think it's important for us to make sure we're acknowledging that.

So where we come from in trying to address this issue of maternal and infant mortality and morbidity is from understanding that no family wants to experience this but that there are some families that have experienced pain far greater than others unnecessarily. And so I hope I can convey our heartfelt desire to hit it out of the park is probably the best way for me to say it to you, that we want to do well, and we want to show that we will be leaders and take HHS to the right places because of where we've come from.

Having said that, I know that you have

provided a great deal of input. I know that there are certain disparities, certain challenges that we're going to face within the -- within Indian country that are going to have to be dealt with in -- in ways different from other communities in some unique ways. We know that because there are discrete opportunities to do this well that that gives us greater opportunity to make a bigger difference than if you're talking about, you know, a -- a -- the entire nation. We can actually zero in and really focus and make a difference.

And so I hope you recognize that we probably have the best champion we've ever had, at least in my lifetime, sitting in the White House looking forward to doing this because it was through his leadership that we're focused on maternity -- maternal and infant mortality and morbidity in ways that we've never done before. We have gotten more resources to do this work than we've ever seen before. We have more resources to do the behavioral work that we know needs to be done because behavioral health is now

really surfacing as a major consequential challenge that we face throughout America and certainly in Indian country.

And so this is a chance, whether it is getting it right when it comes to the national lifeline 9-8-8 number that has to be there for everyone including those who are calling in or seeking out help from Indian country, whether it is making sure that the extra resources we have for our new strategies on drug misuse, we do it the right way, whether it is making sure that as we try to reach parity for mental health services that we are reaching every corner of the country, including in Indian country. We've got work to do, but we have more resources than we've ever had, so we want to take advantage.

That's all -- all I have to say. To me, as I tell my team, I understand that I'm getting to sit in a position that very few ever thought I would get to, and I suspect that many of you had to convince the disbelievers of what you were able to accomplish as well. So let me just urge you

to -- as I like to tell my team, never do mild when it comes to making a difference because you're -- you're in a place where you could make the greatest difference for so many people. So whether it is on the issue of infant and maternal mortality and morbidity, whether it's the issue of the crisis of missing and murdered indigenous people, whether it is making sure we're preserving our languages, or whether it is simply the issue we are making sure that that young man or woman gets the care they need because they are going through some extremely emotional and distressful times, we could make a difference. And that's why we're here.

I'm thrilled that HHS is going to be a partner in this, and I hope at the end of day what you will say is, we knew where HHS was going to go because we knew the people that were there knew where they came from.

So thank you for letting me participate. Let me turn it over back again to Administrator Johnson.

CAROLE JOHNSON: Thank you so much

Mr. Secretary. I'm going to turn it back to the committee to -- for our next steps here.

ED EHLINGER: Secretary Becerra, thank you very much for taking the time to be with us, and I really appreciate your remarks. I particular -- particularly liked the fact that you reflected on the historical implications, the historical trauma that a lot of folks here are dealing with and also the lived experience and also the -- the commitment of your organization, and I want, before I let you go, to make sure that -- acknowledge that Lee Wilson and Michael Warren went out of their way make sure we had this meeting on tribal land, and if it wasn't for their advocacy at the federal level, this wouldn't have happened, so I wanted you to acknowledge the -- the great work that they've done.

And I know you have just a couple minutes for questions, and -- and I do want to kind of reflect on that lived experience. We only have one member of our committee who's -- has an indigenous background, and that's Janelle Palacios. So I thought it

would be appropriate for her to ask the questions that really come from this committee for -- for your consideration. So I'm turning it over to Janelle Palacios.

JANELLE PALACIOS: Thank you. Thank you for that quick introduction. So if you don't know, I'm Janelle Palacios. (Speaking foreign language.) Welcome and thank you. (Speaking indigenous language.) I am Salish and Kootenai, and that is Kootenai for thank you. And Limlmtx is Salish for thank you.

So thank you for your virtual presence Secretary Xavier Becerra and Administrator Carole Johnson. It is with a heartfelt gratitude that I share with you how HRSA, and CHB moved mountains, just like I had said, in order to be -- for us to be here today on tribal lands within an Indian reservation to hold our special meeting focused on the needs of native families and communities. Being here is important. HRSA's presence says, "I see you. You are not invisible, and you matter."

The briefing book shared a number of resources. Some discussed a brief Native

American history from 1492 onward, that 10-minute YouTube video you should have read -- or should have watched. A number of reports sponsored by the U.S. government demonstrated that traditional health care borne from treaty rights with indigenous people are not meeting the needs of native people from chronic underfunding, delipidated facilities, outdated technology, lacking necessary tools and equipment, to the need for a stable and robust workforce, but also steady leadership where the problem is not passed onward or left for another through the steady revolving door.

As a foundation, we need better data among native populations so we can know regional and local differences exist. IHS was created in 1955. In 1958, the native and maternal death rate was 82.6 per 100,000 while among white women, it was 26.3, meaning native women died three times the rate of white women. Depending upon the reference here, national data would have us believe native women die 2 to 2 1/2 times the rate of white women today. However, as

you could see from the South Dakota 2021 report I submitted in the briefing book, the rate that native women die in South Dakota is seven times the rate of white women.

This information, this data, it exists. We only have to look for it, listen to it, and take action. With that, the data are essential in defining issues affecting the health of any population, but questions about what data are collected and how they are analyzed and used are also important considerations.

The idea of indigenous data native sovereignty, the right of a tribal nation to govern the collection, ownership, and application of its own data has been raised by natives across the country. With that in mind, what can be done to assure meaningful indigenous participation in all consultations on how to collect, analyze, use, and disseminate data related to the health of indigenous people, and how can information on historical and generational trauma, racism, and discrimination or social and economic conditions and lived

experiences be included as part of that data discussion?

Second, given it's important on -- to the medical care to the health of native people throughout the country, what will it take to muster greater resources and sufficient political will to fully fund and support the Indian Health Service and related frontline health and health-care systems so that they become reliably available, accessible, and able to offer the highest standard of care for all indigenous women and their infants?

Thank you.

SECRETARY XAVIER BECERRA: I -- I don't know if you wish me to comment or -- or have Administrator Johnson comment. I appreciate the -- the -- the comments that have been made and powerfully made. But you let me know how you want to proceed.

ED EHLINGER: Yeah. There -- there are two issues, basically one about data, how -- how do we get indigenous input in data, and how do we support Indian Health Service? I mean, two major issues that we've been

struggling with as a committee so I'd really like to -- to get your perspective on that.

SECRETARY XAVIER BECERRA: Yeah. I'll -- I'll just say something briefly on data and see if Carole wants to add something. You know, I definitely want to response to the -- the second part.

On -- on the data issue, one of the things I said to our team throughout HHS is that we have to make sure that we're getting quality data and it's disaggregated, because you get bad inputs, you're going to spit out bad outputs. And what we need to do is collect more of it. We have to make sure that we have the authorities to make -- to get it or at least get external players, the stakeholders to understand the importance of providing us that data. We need to disaggregate it so we can see how various communities are doing within that data because it can mask truths if it's not disaggregated. And so we want to make sure that we are doing a great job on data.

Forgive me. On the second -- what was the second question to make sure I answer

directly?

ED EHLINGER: Really about the IHS, the Indian Health Service --

SECRETARY XAVIER BECERRA: Yes.

ED EHLINGER: -- has been underfunded, and they run out of money when it's, you know, halfway through the year, and if you get care early on, you get it in the year, a lot of part of it, you don't.

SECRETARY XAVIER BECERRA: Yeah.

ED EHLINGER: Totally underfunded.

SECRETARY XAVIER BECERRA: Yeah.

ED EHLINGER: How do -- how do we change that?

SECRETARY XAVIER BECERRA: So I can simply tell you that this is where, as I said before, we've got the best ally we -- we can ask for in White House and president. The president, I believe, is the first ever to make sure that in his budget, he is requesting that funding for IHS be classified as mandatory funding, not discretionary so that every year it would be clear allocation of resources to IHS versus every year having to come up and compete in

Congress and -- and essentially plead for resources for IHS programming. It would be automatic. The way Medicare or the way Medicaid or social security are mandatory programs, IHS funding would be the same.

We've also moved -- if we can't get Congress to give us mandatory funding, then at least give us what we call advanced appropriations so that the appropriations under the discretionary form of allocation would be done with some forecasting so that Indian country wouldn't have to be guessing what kind of resources it would get every year, and especially as we know, especially during the season of September when we are about to end the fiscal year and Congress is always on the edge of having government shut down and not pass a budget, which would put all discretionary programs, including IHS, on the hook for closing, that advanced appropriations, while it wouldn't be a -- a requirement under law to give a certain amount, at least advanced appropriations would give IHS funding in advance, and it would be secured, maybe not long term, but

at least for -- in a future year or two, and there -- therefore, there would not be the guessing. We're hoping for mandatory funding. If we don't get there, we want to get to at least advanced appropriations, but the important thing is that you now have administration that's on record two years in a row saying that IHS should be treated the way we treat other programs that deserve to know exactly how much they're going to get moving forward.

And we also know we just had to boost up the number, and if you take a look at the president's budget, you will see how he has a record investment in IHS that I don't think I've ever seen before from a president in terms of how much we should have. It's not exactly where Indian country would like us to go, but it's far more than we've ever done before.

Let me stop there and see if Carole wants to add anything.

CAROLE JOHNSON: Thank you, Mr. Secretary, and thank you for questions and for the thoughtful conversation to the

committee.

I -- on data, first, I'll say, we have, at HRSA, heard the message that census data is insufficient and that census data doesn't appropriately capture Indian country and have opened up some of our -- our programs and processes for tribes to be able to bring us data directly so that we can actually use the data that -- that you know and you trust.

I would say that's not the most efficient way to do business, so we need to figure out for you or for us, it's not fair to you to have to go collect this data and come to us with it repeatedly for different programs. So we want to identify ways that we might work more systemically, more holistically to get the right data and get the right input so that as the Secretary points out, we get the right -- we're actually serving and meeting your needs.

And so that's our -- that's what we want to drive towards. We welcome, really, this committee and your recommendations that help give us good insights into the best way

to do that.

Similarly, I would just say on IHS, as the Secretary noted, and the Secretary's been an incredible champion for the IHS budget, it is -- you know, as you mentioned at the top, I have been in government for some time. I -- there's never been a proposal like this to give IHS the kind of consistent well-defined, in advance budgeting process that the Secretary has proposed here in working with the president.

ED EHLINGER: Great. Well, I -- I appreciate you taking the time to be with us. I know we've gone over the time that we had allotted, but I want to make one other point. The fact that, you know, Dr. Palacios has been on this committee as the indigenous -- only indigenous member has really influenced the working of this committee. It has allowed us to go in depth in an area where we probably wouldn't have gone in depth, and so I -- one of recommendations is going to -- that will come out of this is that we have some indigenous members on this committee, and I

would -- and I suggest that -- also that all committees within the federal government need to reflect the people that -- that are being served by the -- the various agencies because it really does make a difference and particularly looking at workforce. You know, we -- this is -- through these committees is a way to start to build a workforce, the leadership folks that will come up and be our leaders over the next generation.

I'm at the end of my career, but there are some people on this committee who are at the beginning of their career and really can really help to change the -- the course of -- of public health in this country. So I encourage you to continue to support, you know, getting diversity of opinions on these various committees.

So Secretary and Administrator, thank you for your time. Really appreciate it.

SECRETARY XAVIER BECERRA: Thank you very much.

CAROLE JOHNSON: Thank you, all.

ED EHLINGER: Lots of really good

information and some thoughtful, thoughtful comments. Appreciate that.

Just, you know, while we're just -- before we give introductions, any thoughts about what was said by the administrator or the Secretary? Magda?

UNIDENTIFIED SPEAKER: I'll try not to talk too much, but I will share, I was struck by mandatory, not discretionary. And I think that just stuck with me because it -- some things should be just mandatory, and the fact that it's discretionary is what has to change when it comes to things we say we know work, extension of postpartum Medicaid currently is discretionary, not mandatory. Funding IHS, I'm kind of baffled that that's discretionary. So I think that's at least -- I'd like to see movement, and -- and so I just wanted to, you know, reflect on that -- those, that terms there. But thank you for your -- your very powerful and truthful words.

ED EHLINGER: And then I -- if remember if -- if -- when you're speaking just announce -- give your name so the people on

the -- virtually can know who's talking. Magda, you had a comment?

MAGDA PECK: Yes. Magda Peck. Well, this was historic. To my knowledge, it's been a long time since the Secretary, virtually or in person, acknowledged the importance of this work. So I just want to, again, layer in the historic opportunity when we have champions. And the question is, how do we get -- how do we change our stance from putting up noise to being highly strategic with receptive folks for the recommendations that we make. So the champions piece, we should seize that opportunity.

And -- and an observation: When Carole Johnson spoke, she talked about a maternal mortality crisis, and then she talked about infant mortality. When Secretary Becerra spoke, he spoke about maternal mortality and infant mortality as both being acute. And I think we have been riding a wave of visibility around maternal mortality and raising that up. But the dyad is, what is important. And we know that. So I just en-

-- hope that we can listen to the dual entwined importance of mothers and babies.

And this committee has been around for over three decades, and the numbers have not budged, particularly in Indian country. But this is our chance to lift up both, both women and infants and families and fathers and communities. And it is at our peril from what I heard and it's nuanced that we ride the wave of interest and attention to the maternal mortality crisis and -- and in some way diminish the light on infants. It's our job to raise up both within the context of their full families and their communities because they're listening so we can deliver.

ED EHLINGER: Ride -- ride the wave when the ocean is so deep, you know, it's -- you're not just dwelling at the surface. We have to -- we have to deal with the whole ocean.

Any other thoughts?

MARIE RAMAS: Marie Ramas. I'm a physician. I had three things that struck me in their comments: One, I want to thank

the Secretary, the administration for their -- their support and their -- their action in this space of health equity, particular for -- for our indigenous brothers and sisters in the United States.

A few things that struck me: One, primary care is absolutely necessary within this community, and it's lacking. And so how do we continue to support not only just pediatricians, but the -- the role of family physicians and other primary care clinicians in supporting the work of not only access but continuity of primary care. I heard themes of going more upstream and recognizing that if we do not have healthy identifying women, then we cannot have healthy pregnancies, and if we don't have healthy pregnancies, then we're going to have higher complications postnatally as well for both infants and moms. So how do we help to sustain, maintain, retain primary care? And so I'm very glad that we have increased access there.

The other thing that struck me is that there is increasing discussion around

providing telehealth services or leveraging technology to help span the gap of access. So I -- I'm very glad to hear about the maternal -- the behavior health hotline which is wonderful access in opening opportunity for access. Home visit programs, another opportunity for access.

I'd love to challenge the Secretary to take a next step and make it -- make that the default. And so we know that these programs work. Let's just make it part of the default opportunity and assume that all mothers will have access to in-home support postpartum, period. We know that it works. We know that it is -- it's -- it is beneficial both for the mom, the supportive networks around them, the -- the birthing parent, and for the infant thereafter, so let's just make it automatic. That reduces the -- the issue as far as technology gaps that we have and we know is -- is worsened within our indigenous communities as well.

And then the -- the last thing is broadband as a social determinant of health. I think we need to start changing the

framing of how we discuss technology. It -- we should not -- it is very dangerous to assume that everyone has access to broadband. Even if everyone has a cell phone, they may not have coverage within their communities, and if we're now leveraging technology as a potential answer to some of our problems with access, we have to, therefore, then, discuss broadband and how are you going to increase connectivity and assurance of connectivity within our indigenous communities.

So, again, bravo to -- to Mr. Secretary and to our partners in HRSA. I'm looking forward to continuing to challenge progress there.

ED EHLINGER: Sounds like mandatory would be a -- a good thing, and so -- and -- and so those -- keep those ready for our recommendations. Belinda?

BELINDA PETTIFORD: Belinda Pettiford. I agree with Marie. I just wanted to kind of reiterate that because as I was thinking through the comments of both Administrator Johnson as well as Secretary Becerra, I also

want us to use this as an opportunity as a committee to -- to make sure we're thinking through those unintended consequences.

So as we're looking at things like, you know, more telehealth services and things of that nature, it may actually increase our disparity ratio if we're not really looking carefully at those unintended consequences, and I think that's a critical piece to all of our work.

ED EHLINGER: ShaRhonda?

SHARHONDA THOMPSON: ShaRhonda Thompson. So in listening to Carole Johnson and Secretary Becerra, they both mention how important this committee is and yet you mention diversity and need more diversity in the committee. Magna, you mentioned that this committee has been around for over three decades. Me, as a community member, my first time hearing of it was two years ago. So how do we correct that? How do we get more public involved? How do we get more community involved? Because the only way we're actually going to make the changes is to hear their stories. The only way

they'll tell us their stories is if they trust us. How do we do that?

ED EHLINGER: That's a good question, and it's a slow process, but, you know, their -- part of that is us. I -- I challenged you to put our recommendations out the last time. Did you send your -- the recommendation to your senators and to your representatives and to your governor? Did you get the community organizations aware of what the committee is doing? The fact that we're having a meeting here and we've got a whole bunch of folks here because we did a little outreach to folks that -- this is a crash course in maternal and child health among indigenous communities that you don't get this information anyplace else. So it's attendant upon us, but it is also attendant upon the MCHB folks to help leverage this. We need a communication strategy about how to get out the work of the committee other than putting it on the website, you know, because people don't go there, you know. So it is, it's important -- it's an important committee, and we need to take advantage of

it, and it hasn't -- we haven't, as a -- as an organization over these 30 years have not done a good enough job of -- of marketing ourselves. And I think it's a good point. Janelle?

JANELLE PALACIOS: All the comments have been wonderful, and I'm really happy to be here with everyone. I would just ask that in the future that the committee takes into consideration that this conversation about Indian Health Service while it -- I understand and recognize the importance, the words that Secretary Becerra shared today about requesting mandated secured funding, right, that it's -- it would be somewhat time limited. It's not going to be every single year, possibly. That might not be happening. But also, thinking about, like, the amount, right, just so maybe we have it secured but then that amount may not be enough to fill our needs and even if we had the full funding, does it really fill our needs? No, it doesn't. We know that because we know so many any other aspects of our health are -- are -- needed attention

and for such chronic underfunding having, distrust already in the community of using IHS, I myself, felt a lot of distrust using IHS, even as a kid, that it's going to take time for people to even want to go and use it let alone use it again.

So the issue about funding and just so that -- I know this is a crash course as Ed shared, but that -- because of COVID, that is the reason why IHS has had such a huge bump recently in the funding. If COVID had not happened, we would not have the bump that we've had in IHS funding. We would still be lagging far behind, which we still are. So just paying attention to the amount of funding, the duration of that funding and knowing that it's going to take more than just the funding. It's going to take much more than the funding. It's going to take systemic changes throughout our nation for health to happen.

ED EHLINGER: All right. There are three words that struck me when he said the -- the Secretary, "Never do mild." I think that's -- we need to pay attention to that,

"Never do mild." We need a little spice. We need a little heat. We need a little energy. And don't worry. We'll get to in -- or in --the introductions at some point in time. But this was too important to pass up. We'll get to introductions.

But let's -- now we have a -- I tried to get our Lieutenant Governor to come, and she really tried to be here. She's a -- Peggy Flanagan is our Lieutenant Governor in this state. She's a -- a White Earth Ojibwe, and the first Native woman who served as -- in an executive position in our state. So she does have -- she did send in a -- a video welcome, so let's go to that.

LIEUTENANT GOVERNOR PEGGY FLANAGAN: (Via video recording.) (Speaking foreign language.) Good morning, everyone. Lieutenant Governor Peggy Flanagan here.

To our trusted partners at the U.S. Health and Human Services Department, welcome to Minnesota. I also want to thank the Shakopee Mdewakanton Sioux Community for hosting today. Tribal nations in Minnesota and across the nation are critical partners

in the shared goals of this committee. As Minnesota's Lieutenant Governor and as a mother of a nine-year old, I am dedicated to addressing maternal health disparities in Minnesota.

As you know, this work is more important now than ever. The maternal health crisis that we are facing around the country is unacceptable. Nationwide and here in Minnesota, black and indigenous moms are disproportionately more likely to die from a pregnancy related complication. That's why Governor Walz and I believe that working together to address infant and maternal disparity, specifically for black and indigenous moms and babies is a top priority. From expanding access to doula care to investing in a home visiting program, to providing medical assistance coverage for kids under 21 to passing the Dignity in Childbirth Act, we're working to address this crisis across the state.

We also have incredible leaders across our state working to prioritize this work as well. The Black Maternal Health Caucus

where people of color and indigenous caucus, tribal leaders and staff, doctors and health officials, community organizations and more. And we're ready to continue this work in partnership with all of you. Your expertise and experiences will provide invaluable input and advice to improve maternal health outcomes for people here in Minnesota and across our nation. I'm confident we can work together to reduce disparities and create a healthier Minnesota and country together. (Speaking indigenous language.) Thank you so much.

ED EHLINGER: And now I would like to turn it over to Loretta Christensen. Elizabeth Fowler is unable to make it, so Dr. Christensen, I understand you're stepping in for Ms. Fowler?

LORETTA CHRISTIANSON: Yes. Thank you so much. First of all, I'd like to thank our host and for the honored meeting on their sacred land of their ancestors. And good morning, everyone. I am so honored to be able to join you today.

I also want to thank Secretary Becerra

and the committee for your focus to improved birth outcomes in our American Indian and Alaskan Native communities. At the Indian Health Service, we continue to focus on maternal safety and outcomes and the well-being of pregnant persons and children before pregnancy and continuing long after birth. In order to do this, it is essential that we address the underlying vulnerabilities and disparities that lead to poor health status across Indian country. Health promotion, risk reduction, and providing quality health care is a vital part of our maternal and child health programs. Identifying and addressing uncontrolled hypertension in our population before pregnancy will ensure healthier babies. Hyper -- hypertensive disorders of pregnancy observed in over nine percent of all pregnant women that deliver in a hospital are increasingly common and are among the leading causes of maternal disease, death, and morbidity in the United States.

Uncontrolled hypertensive disorders can

have negative implications such as stroke or even death and definitely affects the health of the baby. In early 2022, working closely with our colleagues throughout HHS, we launched a pilot program at six IHS sites to expand utilization of self-monitored blood -- blood pressure management equipment. We are working out in the field with these pregnant persons to spread utilization of these self-monitored cuffs and decrease morbidity from uncontrolled, unmonitored hypertension, essentially heading off morbidity before it even occurs.

We have also worked very hard to strengthen our support for perinatal addiction services for individuals with substance use disorders. Maternal substance use disorder has a very negative consequence both for the pregnant person and postpartum individuals, and, of course, the children.

It is common for some women who achieve and maintain abstinence while pregnant will actually relapse into a postpartum substance use disorder when the child care needs and all those stressors are the highest. Our

infant development is very re- -- reliant on attention and bonding with -- with the mom.

IHS is expanding access to medications for opioid use disorder for pregnant person of reproductive age among tribal nations, tribal communities, and particularly in urban areas. We must remove that stigma and provide the appropriate care for substance use disorders throughout the spectrum of pregnancy.

By December 2022, the IHS is expanding our opioid prescribing dashboard, and we will be including the use of buprenorphine with data that can be drilled down to the OUD in pregnancy. This data then that we're collecting will be used to target opioid interventions, enhance our clinical decision support, and create professional practice evaluation strategies for better care.

I'd like to -- to commend the Northwest Portland Indian Health Board, clinicians, and many people in recovery who helped develop what we call a Plan For Safe Care Toolkit. This toolkit addresses support for those with SUD, help for new parents,

addresses the importance of incorporating culture throughout pregnancy, and even family wellness plans. This is an extraordinary collaborative effort for our population.

We are also supporting trauma informed care within the Indian Health Service. We have created mandatory training with the goal of transforming our organization into a trauma informed care organization. Our required training is due by the end of this month, and it shares best and promising practices to provide trauma, responsive services, and informed approaches to support access to care.

In essence, it's not only important how we speak to people and how we interact, but we have to make our environment and our staff one that people want to seek services. We want them to seek the care that they need, and, therefore, we have to make this transformation.

We train our professionals to identify and manage early warning signs because we know how very vital it is for pregnant

people to deliver healthy babies and to receive that quality care from skilled and well-equipped health care staff.

Across the Indian health system, these professionals have engaged in the implementation of the American College of Obstetrics and Gynecology AIM bundles for many years now with an early emphasis especially on the implementation of obstetric hemorrhage and hypertension bundles, and then we prioritize other bundles and sites asking them to add a new bundle each year.

In addition to ACOG, IHS collaborates with tribal leaders and other partners such as the American Academy of Pediatrics on Native American Children's Health to conduct site visits and improve rural obstetric care through the Indian health system.

To date, over a hundred of our staff have completed the ALSO or Advanced Life Support and Obstetrics course, and many have become trainers as we continue to train everyone who will come in contact with a pregnant person. This strength --

strengthens the skills and the knowledge of the staff who provide care during the delivery of all infants.

At the Indian Health Service, our aim is to save lives, address the issues that contribute to negative impacts on maternal health, and reduce pregnancy-related morbidity and mortality within our American Indian and Alaskan Native communities.

Once again, on behalf of Ms. Fowler and the IHS, I to want thank you so much for having us present to you today. Thank you so much.

ED EHLINGER: Thank you, Dr. Christensen. And now I'm going to -- I'm going to make comment before I ask a question. We have struggled over the last year to get information from IHS. It has not been forthcoming. We are sitting in tribal land with a meeting that has been planned for a year. There's no IHS staff in this room. We then hear at the last minute that Elizabeth Fowler has stepped aside to -- in this presentation, and you're here. I -- we are not getting -- this committee,

this federal committee from HHS is not getting from the IHS what we need in order to really identify what's going on. I know you're the medical director, and you're focusing on the medical issues, but there are policy issues. There are political issues. There are social justice issues that really need to be addressed.

How should this committee work with IHS to try to get the information we need in order to make rational, informed and appropriate recommendations for this community that has been underserved for so long?

LORETTA CHRISTENSEN: Yes. And thank you for those comments. And I think we are starting to make strides to -- to provide that support and assistance. I do apologize. Ms. Fowler was suddenly ill and could not make it. She does send her regrets.

And I -- you know, I -- I would like to say we would love to be on-site for every meeting because they're all vitally important, but we are often overcommitted to

multiple entities who need our attention, and when we're allowed to participate virtually, we can actually cover many more aspects of what we need to with many more organizations. So I do apologize for -- for that inability to travel.

I do -- we now have a full-time maternal child health consultant who I think has been very interactive and will continue to do so. The last meeting we had I thought was very positive in that we are -- we had a very prolonged interaction with the committee, and I hopefully answered many of the questions that you had over time. So we will continue to work to improve this relationship and even though I am the chief medical officer, I work a lot in policy and advocacy, and that does require a lot of time commitment to multiple committees and multiagency meetings to continuously advocate for what we need. So I don't want you to think that is not going on. It is not always possible to bring it to every venue. But there are many parts that we do in the background that are vitally important

to getting better funding, to getting better support, to putting out collaboratives to work with the partners that can help us achieve our goals. So I anticipate that will get stronger as we move forward, and I certainly will share your comments, and -- and I appreciate your -- your honesty with the -- with those questions.

ED EHLINGER: Yeah. We -- we'd like to be a partner with IHS and, really, you know, be supportive of its efforts because we know it's how important it is.

Other questions from the committee? Magda?

MAGDA PECK: Thank you, Dr. Christensen for joining us again. We appreciated your time with us in June.

I too would like to register my profound disappointment in this -- the lack of visibility and priority as expressed by the actions of the participation of IHS in this work, and I would like to respectfully ask you to consider how this meeting in this moment as Secretary Becerra indicated, you know, what makes this meeting different from

other meetings that you're spread so thin for and you to not recognize the historic moment? It is profoundly disappointing and disappointment has been described as a combination of expectation and reality. I'm not going to lower my expectation of the IHS. We should only elevate it. And it's our job together to change the reality so the disappointment doesn't become chronic and endemic. That's my comment.

My question: And in your remarks, you said -- you mentioned the investments in the AAP and ACOG, and you said, "In addition to ACOG," and then you went on to express the investment in the Academy of Pediatrics.

Can you respond once to the question we asked in June about what is this relationship that IHS has with ACOG? What do we have to show for it for over 50 years? What is the return on investment, and how can we have greater understanding and appreciation and accountability for that unique contract that IHS has had with ACOG for so many years? So I was wondering if you could go a lot deeper on in addition to

ACOG and -- and perhaps respond to there's more that we can learn about that unique relationship.

LORETTA CHRISTENSEN: Yes. Thank you again for your -- for your comments, and yes, the relationship with ACOG, which I admit, preceded me by quite a few years. When we're looking at quality in patient safety, we need to look at who can competently review what we are doing and advise on things that we do well, things we can do better, and things we must do better. Looking for a body, and it could be any one of several when you're looking at quality, we look for someone with the expertise with the experience who is intimately knowledgeable about maternal obstetric care, and everything that we want to know to do our job the best we can. So a relationship was created with ACOG as a body that had that expertise. They have multiple experts who have practiced a very long time in the field of obstetrics, and we use them to help us evaluate our programs, very critically, by the way, to tell us what we must do to

make sure we're giving the best care to our patients. So that relationship was formed as -- as a manner of oversight and evaluation very honestly telling us where we need to improve and then telling us how to maintain that improvement. There are not a lot of bodies that do that on a national level, to be quite honest with you.

So as, for example, the American College of Surgeons reviews operations and trauma centers. ACOG reviews maternal health, obstetrics, labor and delivery, and the delivery of women's services. So they are used as our competent guide to assure that we are striving for the highest quality at all times.

In regard to KONOCH, (phonetic) there is a specific body such as yourselves who are dedicated to providing the best care and highest quality for pediatric patients, and again, we get guidance. They are site visits. They come in with a fresh set of eyes. They have no allegiance to the IHS when they're reviewing programs. They are telling us honestly and flat out, this is

what we see that you need to do better. These are the things you're not accomplishing that need to be done for our children, and these are our recommendations to improve that care.

So in both of those instances, a committee that does great work like this committee is telling us recommendations specifically to clinical care and the -- and the maintenance of our program so that it is safe and it is of high quality. And those are the reasons we work with those bodies to do so. So I hope that somewhat answers your question. I'm happy to -- to answer further on it, if you would like.

JANELLE PALACIOS: I have a follow-up. This is Janelle Palacios. I have a follow up-comment and question. I -- I believe that the -- the issue has long been that we have no understanding where IHS is located in obstetrical -- in the obstetrical landscape. Like, what is the foundation?

So if -- if you have ACOG and the Academy of Pediatrics coming in to help tinker and improve with AIM bundles and

different suggestions, then what was the foundation that Indian Health Service for that service site laid at -- upon? So we have no record of reports, and I believe that our committee was interested in understanding more by being able to read these historical reports if they were made available. Because what -- what I'm hearing from today -- from your sharing today, and also from what I remember from June, I have to kind of guess and triangulate, you know, what the status of care giving at a Indian Health Clinic or facility is, and the only way I can do that is by personally asking people, which is an end of a few people, right, and getting their lived experience.

But the other way I can do that is reading other reports, and this -- you know, the ACOG report that makes of IHS, their -- we don't have access to, but I can get access to that sort of information through the government accountability office and reports that they do or when Indian Health Service, you know, pushes their reports, which are few and far between. So it's

trying to understand the foundation from which IHS is working with, and I -- I understand that there are lots of hurdles. I am not here to say that I have all the answers. I certainly don't. I have a lot of understanding, but when we are as a -- as a committee charged with trying to improve the health of native women and children and native infants included that I have no basis for these reports except for having to go outside of IHS when IHS should be the leader in a lot of this information, it's simply not -- not there.

And we've been given reasons. Tribes are very protective of their information. They don't want to be -- they don't want their information shared. Indian Health Service doesn't have enough funding to fund the statisticians that are needed to create these reports. I mean, we've -- we've heard a number of reasons, and I understand they're all, you know, important reasons. But, again, I -- Indian Health Service is not here physically today. Just like we don't have these reports that tell us this

need -- this infor- -- this vital information because we don't have that visibility. We don't have this in our hands right here today. We don't have someone from Indian Health Service right here today. We don't have those reports that should have been written long ago and continued. We have to make decisions using other -- other information. And it also shares with us that this might not be as important. Thank you.

LORETTA CHRISTENSEN: Thank you for your comments. And -- and, obviously, it is very important. I think that -- you know, I have not been in Indian Health Service for a great long time, so some of your comments resonate very well with me. And I do believe it is incumbent upon us to create a -- a -- a of transparent communication within, obviously, some restrictions that we have. Certainly, much of the information can be shared. And so I do think that a lot of my priorities and work that I'm doing with the clinical and public health of the agency is to look at how we do report, how

we do disclose information, and how we even aggregate and analyze that. So that is a priority right now that we are working on, in many fields, certainly maternal child health.

As I said, we hadn't had a full-time person for a while. I'm very happy that we do, and that will be one of the definite priorities for our consultant is to work on those updates, information, sharing what we can definitely aggregate for performance. And so I -- I agree that is a goal that we are working towards.

You know, the reports from ACOG, there are certainly overarching -- the reports that -- the parts that can be shared, and I believe we're in the process of gathering that data. There are some specific site reports that are more patient information oriented that we have to take great care in what we disclose, certainly at the very granular level.

And I know that overall, there -- there needs to be a way to work collaboratively with our tribal and urban sites to provide

the data that's necessary to make sure we're doing what we need to do.

It is certainly true, at least for me. I do definitely respect the sovereignty of tribal data. My -- my answer to that is the hope that in a collaborative and a team approach to what we're doing together across Indian country that we'll be able to share pertinent data and make conclusions and recommendations for improvement. So I hope to see that evolve over the next time that -- that we have at IHS, and so that is also a goal is to improve that conversation and I -- my -- I feel very strongly that we all care for the same patients, and I am happy to collaborate and work together with everyone to try to make each part of the clinical care that we provide better, whether it be a maternal child health or women's health or whatever. I think it's very important for us to share best practices, share challenges that we have, and find ways to support and solve those problems.

So I think in my -- speaking, again,

for myself as the CMO, that is a huge goal of mine is to create this type of communication and kind of collaboration amongst our professionals and our providers and our midwives and to find the best ways and the best pathways to provide the best care.

So all I can -- all I can say is, I appreciate your comments. Again, they resonate with me, and I -- that is what we're working towards.

As far as, again, I do apologize no one could be there in person. I will definitely take that back to senior leadership, and we'll do our best to improve on that. So I appreciate everyone's comments on that as well.

I hope I've answered some of your questions. If I haven't, please let me know.

ED EHLINGER: Dr. Christensen, thank you for -- for your presentation. Thank you for taking those questions and your acknowledgement that they're important issues, and I do expect you to take them

back to the leadership, and -- and we will continue to -- to work with IHS to try to find ways to -- to move forward in a positive way.

So thank you for being with us. I really appreciate it.

LORETTA CHRISTENSEN: Thank you all for the exceptional work that you do. I appreciate it.

ED EHLINGER: The chair is going to take a five -- we're going to take a five-minute break before we move on. So just come on back at five after Central Daylight Time.

(A recess was had from 10:59 a.m. until 11:08 a.m.)

ED EHLINGER: All right. Let's get started. And I had invited the U.S. senators to join us, Minnesota. But they're -- they're in session now, but Amy Klobuchar, Senator Amy Klobuchar, has sent a -- a greeting and one of senator's staff is here. So we appreciate that. Senator Klobuchar has really been a strong advocate for health overall, public health in

particular, and indigenous health.

So let's hear from Senator Klobuchar.

SENATOR AMY KLOBUCHAR (via video recording): Hello, everyone. I'd like to thank Secretary Becerra, the secretary's Advisory Committee on Infant and Maternal Mortality and Minneapolis Indian Health Board and all the tribal health directors attending today's discussion.

All of you've done so much to combat maternal mortality in American Indian and Alaskan Native communities. Together, I know we can build a better future for tribal moms and their babies.

This is important because right now, we're in a maternal mortality crisis, and within that crisis, there are unacceptable disparities. In our state, 87 percent of white women see a provider during their first trimester of their pregnancy, but only 55 percent of native women do the same. 82 percent of white woman report receiving adequate prenatal care, but only 47 percent of Native Americans in Minnesota do. And when you compare the most important

statistic, that will be maternal mortality rates, native women in Minnesota are almost eight times more likely to die from pregnancy-related complications than white women. That's just unacceptable. These tragic outcomes, they're not inevitable. Roughly 60 percent of maternal deaths in this country are preventable. We have got to do more to help moms have the support they need before, during, and after childbirth.

Last year, Senator Smith and I successfully fought to include extended postpartum health coverage for women on Medicaid and CHIP in the American Rescue Plan. As a result, 7,000 women in Minnesota will now have access to Medicaid or CHIP coverage for a full year after pregnancy, at a time they are at most risk of maternal mortality.

That coverage is making a difference, but many tribal communities are also impacted by the lack of health care providers in rural areas. Senator Smith's Rural Moms Act was an important lifesaving

step to increase funding for rural providers, and I was proud to be supportive of that important effort.

Now I'm focused on our health care workforce. We need nurses and midwives and doulas too. There are 30,000 open nursing positions in Minnesota alone. That's why I'm fighting in my legislation to invest in things like high school career and technical education in community college to help students and workers enter this essential high-demand field. We have to realize that in the coming years, we're not going to have a shortage of sports marketing degrees. We're going to have a shortage of nurses. We're going to have a shortage of health care aids. We're going to have a shortage of people in the technology fields and electricians and plumbers and you name it. That's why we need to focus our resources on getting people into those jobs. That's going to make a big difference for the health care workforce.

There's still so much more to do across our state, urban and rural, to combat health

care disparities. American Indian and Alaskan Native women deserve to have access to the culturally-appropriate health care infrastructure they need to have safe deliveries, and their babies deserve every chance at a healthy birth.

As a mom, this issue is personal for me. When my daughter was born, she was really sick. She couldn't swallow. She was in intensive care for a really long time. We were back and forth into the hospital. We had good doctors. We had good nurses. Everyone deserves the same. That's why I am so devoted to this issue.

I look forward to hearing about the ideas and recommendations. I know we have staff at the meeting, and I can't wait for all the work you will do. And, of course, thank you for the work you have done. Keep up the great work.

ED EHLINGER: My thanks to Senator Klobuchar, and I encourage all of you to get to know your state U.S. senators. They're -- they're good allies, or they can be, and so I really hope that you make that

connection. And I appreciate her taking the time to do that.

So before we start -- this has been a powerful meeting already. We've had some really important discussions, but I want to set the stage for what we're going to be talking about because this meeting is different than other meetings. Yes, we invited people from across the country with lots of expertise and lots of -- of areas of interest to hear. And so in most meetings, we come and listen and try to gather knowledge. But this meeting is really about -- is focused on you as committee members.

The purpose of this meeting is not generally to generally educate everyone. That'll happen. There's no doubt about it. But the purpose of this meeting is help us develop and strengthen and improve the recommendations that we're going to send to the Secretary.

And, as ShaRhonda pointed out, we're also here to gather stories to make our report more impactful. Just having the recommendations out there without something

to really give some muscle to them is not enough. We want a powerful recommendation, but we want them to be read. We want them to generate some interest.

So I have asked all the presenters not to describe their programs, not to describe their activities, but really, what are the issues that they see facing indigenous communities from their unique perspective? What do they see that needs to be done? What recommendations should we be making? You know, they're -- they're going to be, I hope, recognizing what policies and programs what partnerships are needed?

And I've also asked them to imbed a personal story, if they can, into their -- their presentations so -- because this is being videotaped because we're hoping to pull out some of those little stories to help enhance our report. So for the -- that's what I've asked the presenters to do. That's what the focus is.

And for you, I want you to -- to -- what do you need to know from the presenters that will help you improve and strengthen

those recommendations? Think about our recommendations, not about the general theme overall or, you know, other things, but what -- what can we -- what do we need to know from them? What are some of the future issues that particularly the members who are going to be on this committee past December, what are the future issues that this committee needs to work on?

And then -- and as you're thinking and as you're listening to all of these presentations, think of the stories that are imbedded in there so you can highlight some of those, and also because of this, we are -- you know, some people, members of the committee and the audience have their little video cameras. And if there's a chance to videotape some stories from other folks other than the presenters or even the presenters themselves, small little tidbit of -- nibbets of stories, tidbits of stories that we can also use to really enhance that, we will make that available. You know, we'll try to do that over the course of the next couple of days.

So lots of other things are going to happen, you know, because we have a lot of folks here, but that -- I really wanted to focus on what we as a committee need to know, what we need as a committee -- so the focus -- the ultimate focus is on American Indian and Alaskan Native moms and babies. But this focus of this meeting is on what we need to learn and what we need to do to move forward so want to do that here.

So now we have our first panel, and I would like to invite our panel with Jackie Dionne, Stacy Hammer, and Socia Love-Thurman to come up and -- and sit at the table up here. You're -- you should have most of the bios of -- of the folks, so I won't go into the detail. And, you know, I built in some wiggle room in the agenda, particularly towards the end. So we will get caught up on -- on everything, but I think this is a good way to start our -- our conversation with this group because they're going to try to set the context from a state level, from a tribal level, from an urban level, the national organization to really what I

suggested. What -- what do we need to know? What are the issues? What's the context that we need to know? And I -- I particularly, you know, appreciate Jackie Dionne being here because Jackie Dionne worked with me at the Minnesota Department of Health. She was the first American Indian Health director and -- and she changed the relationship that the State health department had with the tribes, all for the better. And that has really been a -- a huge -- huge impact.

And Stacy Hammer is a tribal health director from Lower Sioux and is one of those leaders at the local level. You know, you see the Shakopee Mdewakanton Sioux, a highly-resourced tribe, Lower Sioux, not so much. So we'll get a different perspective, a little context of -- of what's going on.

And Socia Love-Thurman from the Urban In -- the Indian Urban Health Institute. What? 78 percent of American Indians, Alaskan Natives live in urban areas, or, you know, a substantial number. And so there's a unique perspective. We've got the tribal

reservation kind of perspective and the urban level. So we've got three really good presenters to do that.

So I'm going to turn it over to Jackie to -- to kick off.

LEE WILSON: If I can just make a comment? Ladies, you have the microphone there in front of you. If you would be sure to use that and speak into the microphone.

Also, if you prefer standing and making a presentation, the podium is wired for so you can make the presence from there as well. Thank you.

JACKIE DIONNE: (Speaking indigenous language.) Thank you for inviting me here today. (Speaking indigenous language.) My name is Jackie Dionne. I am the director of American Indian Health tribal liaison at the Minnesota Department of Health. I am from the Turtle Mountain Chippewa tribe, which is in North Dakota. It's not a Minnesota tribe. But we're closely related to the Ojibwe bands here in Minnesota in the migration over Canada, North Dakota.

And my family moved here to Minneapolis

under relocation in 1970. And so I lived here since I was about six or seven years old and consider Minnesota my home, but I was born in Turtle Mountain, and that's where I'm a member.

Lots of layers in addressing infant mortality, maternal mortality. Obviously, we know that. We know that there are -- are real complications when it comes to preventing and supporting healthy births in -- in our population, but they shouldn't be. They should be able to be addressed as we would for white women, like Amy Klobuchar said, that, you know, we do really well as a state, and there are a heck of a lot more American -- or white women having babies than there are American Indian women having babies. So there's something wrong in the system in which we support our moms our babies up to the time of conception and -- and after that we can get into data, providers. We could get to into what the tribes do, what they don't do, how we partner, and, you know, who needs to take action.

And so my work at the Minnesota Department of Health has been looking at the system in our partnership with tribes and our urban American Indian. And up until we started to really ask tribes about wanting to be partners, the assumption are most folks working in the system -- and systems are made up of people. We think of them as maybe mechanical. Like, oh, the computer is not doing what it needs to do, right. But it's people. It really is people making decisions about people. And so we have a system who had the assumption that tribes didn't want to partner, or they would come to us if they needed it. And one of the first things that I learned -- and this was true with our urban programs as well is if they don't know what we do, how can they come and ask us for what they would like? So there was a whole part of educating inside the system and -- and externally what does that relationship look like? Obviously, we -- we have layers in the system, and we have folks that we are accountable to within the agency, and so do

tribes. And I think that was one of the challenging -- or one of the things that folks were surprised on -- on the inside is that a tribe is not an individual. A tribe is not a person you go to, and it's not a collective. It's not the tribes. They're not all one voice in which they answer to a question. So there was a lot of learning on both sides, and -- and we understood that.

But when I think about a mom who is American Indian either on a reservation or not, the system, because of the way historically we were put on reservations, relied on governmental services, relied on the government to survive, we think about these families and -- and 80 percent of all women, American Indian women who give birth are on public programs in Minnesota. So already, a child is born into a public program and having to have that medical program provide for that care of that child. So from the time of conception to the time of delivery to after, there's a bunch of systems interacting with us.

I know growing up in my family, my mom

was a single mom raising five children. My -- my parents divorced in '75. Abusive relationship. My mom was very traumatized by both her childhood as well as being in -- in an abusive relationship and yet she decided to raise five children by herself in an urban area without any family support, and it was a real struggle. But she had so many interactions with the system who pretty much told her, they don't -- I don't care about you. I don't care if you survive or if you don't. And she just had to fight her way through. And I think we do as Indian women. We just make the decision to fight the systems because every step of the way somebody's going to say, it doesn't -- you don't matter. And that's what happens to -- to us. And then we need to shut down. We close up. And when there is a warm hand that reaches out, we don't trust it. We don't trust it because of the birth experience we had about, you know, what happened to my mom and then how she instilled that then into us with the messages she says. You know, they just

think we're dirty Indians. You know, and when -- when you're a child and you hear that, it just hits you, right, and you don't trust the system.

So I wasn't going to cry. Making this personal. But we do. I mean, there's no native person in this room that hasn't been told by the system you don't matter. But we can change that. And working within the Minnesota Department of Health, I had to kind of drop my assumptions that nobody in the system cares, and, of course, that's not true. There are people in the system that care, and they do care.

But it's policy and it's the parameters in which we restrict or allow for things to happen. So data. Obviously, there's a lot of decisions that are made, not by us, about data about us. And these decisions can be very complicated, but they're made by the state legislature or a internal administrator or somebody who says, "Well, you know, we -- we -- we can't do this because we don't have the permission to do it." And the thing about it is, we have to

have a conversation before we make the assumption that we have permission or we don't have permission. So data is one of those things where I think within Minnesota, we have talked to the tribal health directors who, for the most part, do have the ability to have these conversations with state agencies like MDH on behalf of tribes because just like commissioners for state agencies, tribal health directors have that same level of being able to speak about this on behalf of the elected officials of the community.

And, you know, one of the conversations we had is, we need the data to be public. We do. We want it to -- we want people to know about it, but we want it to be public for actionable reasons, for people to take action because of the fact that it is so bad. What ends up happening within the agency is we release data. We say, oh, how bad it is, everybody admires it, and then the response from the general public is, what's wrong with those people? And then the stigmatation [sic] comes in that whole

thing.

So yes, we want data out there, and, no, we don't. So it's a very complicated conversation to have, but we have to have it. It moves policy. It makes the decisions about what to do about it, and we also have to have the ability to be respectful of the data and have it be actionable. Have it mean something so that it makes a difference in the system and in the changes that need to happen.

When I look at programs, when I look at different activities that we do, are we really trying to work to support and encourage and -- and be where people are at, or are we trying to change the person to fit our system? And when we try to work to change the person, obviously, over the last 500 years, the government has tried to eliminate us, and it hasn't happened. Trying to accom- -- trying to put programs out there and fund programs that are going to change to people to accommodate better to the white system isn't going to happen. This is why we see what we see today.

So, you know, those are personal comments that I make about the work that I've done at MDH, and, you know, our efforts to partner with tribes. I'm very passionate about it. Obviously, folks can see that, that it's about me. It's about my granddaughters. It's about my -- my -- my daughter.

And if we can change -- if we can have a state with the best health outcomes of anywhere in the country, Minnesota, always until the top ten, always in the -- you know, most healthiest state in -- in -- in the country and yet have some of the worse health disparities for American Indians in the country, there is something that's inherently wrong in the way decisions are made.

Homelessness, babies that are born, you know, through heroic efforts to save a premature baby, we can do, and yay that we can do that, but we release them into a situation of poverty, of not being able to have the supports that this baby needs because they were so premature.

Alcohol and drug abuse is a whole nother issue. It's not a matter of why do we do this to ourselves? It's, what was done to us that led us into this situation that we're in today, and we really have to think about the resources and the funding that goes into the population, not by the number because we will always have the smallest resource because we are the smallest number, but by the level of traumas that are inflicted onto a population. So if you take the population number and multiply it by some factor of something, then fund it at that level. That's really the need of what's happening. And so not easy conversations.

I tend to -- I tend to have some folks look at me and go, we always do counties by the number. The counties with the smallest number get the least amount. The counties with the biggest number, Hennepin County, gets the most money. But that's just not true for us as a population. And I think we have to change the mindset, and we have to change the mindset of the delivery of the

service. And are we looking to change people? Are we looking to change systems to accommodate where people are at? And I know we talk about that, but I don't see the reality of it in the system.

So thank you for that, and I tried to make it more personal than to just rattle off statistics and numbers we have here in Minnesota. So thank you.

ED EHLINGER: Thank you, Jackie. Just one -- one personal reflection before we go on, and -- and that the tribes love to have a nation-to-nation relationship, and they would love to work with the federal government, but that's hard. So they love to work with the governor's office, you know, in the state. The more they can do that, the better.

The fact that -- that I hired Jackie was in my office, and we had a direct relationship between the tribal health directors and the commissioner of health's office. It was a partnership. It made all the difference. It was not -- Jackie was not down far in the organization as, you

know, somebody away from the -- the leadership. She was part of the leadership team. So it just felt differently, our relationship.

So I think about that in terms of in your state, can you have that -- that nation-to-nation sort of relationship that -- that is respectful and mutual, mutually reinforcing. So that was one of the things that I learned that made all the difference in the world. Stacy?

STACY HAMMER: Thank you. Thank you very much, Jackie. I really wish I didn't have to follow that, but -- so, again, I'm Stacy Hammer. I am from the Lower Sioux Indian Community, which is located about two hours southwest of this area. In the state of Minnesota, just for those of you who are -- are aware, there are four Dakota communities here as well as seven Ojibwe or Anishinaabe communities. We are the largest of the four, which really doesn't say a lot because there's around 1100 of us within a 10-mile radius. So just to give you a geographical idea of what our tribe looks

like. I really wish that we could have had an Ojibwe director here as well because their communities are much larger and in a different part of the state.

So I can only share my perspective as a tribal health director working in -- in my community here. I did want to say, I -- I really appreciated receiving the draft recommendations to the Health and Human Services secretary. A lot of it was very profound. A lot of it was items we see directly working in our community.

In just listening to the conversations this morning, you know, I would say, you know, at least for our -- us, I think, relationship building is so incredibly important. I've seen over the last nine years the vast difference between, you know, funding coming from, you know, an organization where we barely talk. It's just reports. They just want quantitative data. That's it. And we can't even get them to come visit our community versus those that actually come and visit our community, learn about the history of our

community. It's just so important. So I really appreciate that you do have an indigenous member on your committee to be that voice, because I think our voice needs to be -- be heard, especially in matters that are -- relate to us. I think that's incredibly important.

You know, capacity within our tribal nations is very different and very unique. So, again, we do not have an IHS facility on our reservation. Six years ago, we had our first ever tribal health clinic, and this is something that was talked about for generations. I know my dad's generation, he was not born in the community because at the time, native people were not allowed to visit or be seen at the clinic hospital system eight miles down the road. They had to drive two hours to the nearest IHS facility. So he was born -- and you had to figure out how to get there. And so we've got a lot of stories of our elders sharing what that felt like. You know, if they had five kids at home and they had to somehow get to that IHS facility to have their baby,

and what if there were complications? So hearing those stories and knowing that my dad was not born in his community, the system opened up, finally, in the mid '50s. And so there's a lot of distrust, I guess I could say, and there still is with our neighboring white community.

We are trying to bridge some of the gaps there now, but I think having our own clinic system has made a -- a profound difference in our community, I think, because, again, you know, a majority of our people in our clinic are from the community or -- or are indigenous, and I think that really makes a big difference.

So when we talk about workforce development, there really is a lot to be said about that. We're really working with our youth in our community. We have one of our RNs came back, had her bachelor's degree in nursing, came back to our community, is now working as one of our nurses. So it's just wonderful now to see the difference in the impact that can make when you have indigenous people working in their

communities, whether it's in their own community or if it's in a different community at the urban setting, it -- it really does make a difference.

Other things I think I -- I thought about in listening this morning is, you know, the aspect of sovereignty, like, has been mentioned. I will share a story I was just mentioning earlier to Dr. Warren is that when we talk about Indian Health Services, I don't really know -- I couldn't even name off of some of those positions at IHS as far as individuals at an individual level because we just don't have those conversations with them. Our conversations and our relationships has been with Jackie Dionne.

And so we have quarterly tribal health directors meetings where we come together -- well, even during COVID it was virtual. It's good to be in person again. But having that quarterly meeting with all the tribal health directors from all the tribes come together at the table and have Jackie moderate that is -- is huge. You know,

during COVID, they were our support. I -- I know IHS was out there somewhere, but our relationship and our acquisition of all the immunizations and all of that, all our support came from the State. So I think in that aspect, I think we're -- we're -- we're very fortunate.

One of the disconnects we also have is with our SNAP benefits. So, you know, this is a conversation we've had multiple times with our County because SNAP benefits as -- even though it's a federal program, it's not the government-to-government relationship. So it goes to the State, to the County, to us. So we are consistently being denied. Our members are being denied based on income eligibility because the -- the way that it is written, we -- we have -- we have a different program within our community that our community members receive. The federal government does not recognize it as an income but the State and the Counties do. So they have to ask those questions and so we are getting -- a lot of our community members, we finally have a SNAP outreach

coordinator. We thought that might be the key. We'll get one of our own people here. They'll be sitting here in our office. They can help our community members. Well, when our community members come in, they're trying their hardest to help them, but it then goes to the County and then it's still denied at the County. So then the County is calling that community member.

So it's a lot for them to step into that door, and they felt like they were going to be welcome because, you know, they had that face, that friendly face, but they're still being denied. So, you know, those are some of the stories that we -- we have in our communities with our -- with our young families because that -- they're the ones that are really impacted the hardest is our young mothers.

Other things that I thought about in -- in listening this morning is, again, we -- we talked about access and access to care. Of course, we're in a rural community, and just thinking off the top of my head of one of our new moms that just gave birth here a

week ago, you know she had to travel two hours up to the metropolitan area because she needed specialty care. So every Friday, we had to get her transported up here for, I believe, it was six weeks, and she had to have her child up here. So just thinking about the capacity of what we have these rural communities and resources that communities have to come up with to ensure that our -- our mothers get the type of care that they should receive, I think, is -- is something I know personally within our community, but I know we're not unique. I know this is something that -- that it happens in a lot of communities that live in the rural areas.

Some of the other things I thought about, you know, we brought up funding, of course. It's interesting. During COVID, you know, we -- the federal government all of a sudden had this magical money that was filtered down into the -- into the tribes. And we thought, gosh, I wish we could have had this all along, you know. Funding isn't always the answer, but when you have this

funding that comes to the community, it finally gets to the community and then you're told you have this many months to spend all this money, and it's like, oh, my gosh. So in the middle of a pandemic, in the middle of our little health department, our little clinic, our -- you know, our clinic CEO and myself are trying to make the decisions with our tribal -- with our tribal leaders who are also dealing with a multifaceted issues of what to do in the community during the pandemic. We now have to figure out how are we going to spend this money in a meaningful way in such a short period of time. So, you know, that just -- that was probably one of the most difficult parts of the pandemic was, you know, it was great that we received that funding, but wow. It's really challenging when you're -- when you're giving -- given so many constraints.

I will say that for the first time ever, at least in our community, we were able to look at our strategic plan that we had just done the year prior to COVID

hitting. We looked at that, and we looked at the needs in our community, and food insecurity was a huge need. We identified that through a food sovereignty assessment. We looked at the results. We knew that we had fam- -- we had families in our community that were getting to the end of month and not -- not having enough food. So we knew we put that at the top of our list and we created our first food shelf program. And so that is something that we have now, thanks to some CARES Act funding.

So, you know, again -- but staffing is always an issue. You know, you can have these beautiful buildings. We visited a -- a -- one of our tribal nations in northern Minnesota recently with a, you know, advisory board that it -- that I'm on. You know, they had an assisted living facility. They had the brand-new building, but they didn't have the staffing, and they had to shut it down. It's only been open for three years.

So, you know, it's just things like that are things that we -- a lot of us are

struggling with in our communities in working in the health departments, you know. We had a lot of these struggles before, but then, obviously, COVID just compounded everything that we've -- we've already known.

Again, I think staffing is -- is really huge, and even with, like you mentioned, I heard mention of, you know, statisticians. I mean, that is something, you know, again, we added another hat to our -- to our heads, you know, because it seems like we're constantly having to add hats to our director hats -- or heads, but we also, as we start to bring in more staff, just having the capacity, how are we going to find a statistician or somebody in epidemiology in rural Minnesota? You know, how are you going to attract someone to move to rural Minnesota to do that kind of work for you?

So they -- you know, a lot of those are some of the issues that I had talked about or thought about.

Lastly, I will mention, you know, I -- heard a lot about, you know, midwives and

doulas and some of the home visiting programs. That is essential too. I -- I -- I definitely agree with that. I think that's where we need a lot more help in that area. I know we do have, through the -- through the state depart -- excuse me -- Minnesota Department of Health through our maternal child health grant, we do have a family spirit program that is more culturally relevant. You know, so again, you know, we have this program but do we have the staffing capacity? Do we have those that can make those changes and get those trainings? If they get the trainings, are they going to stick around?

You know, that's the other problem. So, you know, really trying to get more -- more indigenous people involved in some of the -- these programs, to teach these programs going to the homes of our -- of our community members.

And lastly, I'll leave it with, you know, I can't think of our -- our mothers and our children without thinking of our elders and thinking of those elders that are

raising -- helping to raise a lot of our -- our -- our little ones and so their needs as well. So I always think about all generations when we talk about one particular generation, how we all -- we are all related and we are all -- all part of a family. You know, we all are in our communities, and so we all look out for each other, and I think of a lot of our elders that are now raising their great grandchildren too, so some of those -- some of those things, just personal stories as you mentioned. You kind of wanted to hear at least from our community. Those are -- that's -- that's the reality for us at -- at Lower Sioux. Thank you.

ED EHLINGER: Thank you, Stacy. I love that -- that intergenerational -- health is all about relationships, you know, the mother/baby relationship but also the elders and family and the community. So thank you for bringing that up. Socia?

SOCIA LOVE-THURMAN: (Speaking native language.) Good -- good after -- or early morning to the advisory committee. Thank

you for having me. I am a citizen of the Cherokee Nation of Oklahoma on my mother side and my father's side, and I'm also Yuchi on my mother's side and Delaware on my father's side originally from Tahlequah, Oklahoma.

I currently serve as the chief health office for the Seattle Indian Health board, a federally-qualified health center, an urban Indian organization with a emphasis on care for the Native American and Alaskan Native Community over the past 50 years. I provide direct clinical service as a family medicine physician providing OB and postpartum care for -- and for several -- several years until recently, I provided high -- both high risk and low risk deliveries in the hospital. I'm also a mother of three young boys, 7, 5 and almost 1-year old.

Today, I want to share with you the perspective of the urban Indian health organizations where the majority of the Native American and Alaskan Native people live in the U.S. and share some specific

recommendations. And I'll close with a story.

Today, 76 percent of American Indians and Alaskan Natives reside in urban areas, and as an urban Indian organization, we seek to extend trust and treaty responsibilities to urban American Indian and Alaskan Native people. Many urban American Indian and Alaskan Native communities were established through federal termination and removal policies that began in the 1950s.

This movement to cities directly led to socioeconomic disparities as the promise of a better life, opportunities like jobs, health care, education were not available when they got there. We have faced longstanding historical and cultural genocide that had led to the loss of many of our traditional birthing practices and the racial disparities that we see today. Many of our native pregnant mothers do not seek care right away due to barriers to care such as lack of transportation, financial means, or geographic location. But often, the unspoken reason is their fear of the stigma

and racism that they will face entering a health care system that was not made for them and has actively harmed them.

For those birthing people that do trust us with their lives, I have, unfortunately, witnessed far too many cases in which this is true. Our medical system often rushes and overmedicalizes obstetrical care for our native women leading to uncomfortable and invasive interventions and then worse outcomes such as instrumented deliveries, C-sections, and post-partum complications for mothers that consequently affect their newborns.

Factors for the care that urban Indian organizations can provide are that IS -- that IHS designated urban Indian organizations or UIOs con -- consistently received less than one percent of the entire IHS budget. There are no IHS funds dedicated exclusively to urban maternal and infant health. SIHB, Seattle Indian Health Board, advocates for increased funding for urban American Indian and Alaskan Natives and requests funds not to be diverted from

tribes to UIOs but, rather, funding carve outs be made from state allocations.

Opportunities exist to extend funding and programmatic support to UIOs by advocating for the inclusion of legislative language of tribes, tribal organizations, and urban Indian organizations and policies. This would initiate funding mechanisms that support UIOs in sustainably providing culturally attuned health care for mothers and infants.

Our organizations continuously have assisted the needs, especially during the pandemic. In 2020, SIHB noted a 13 percent reduction in prenatal patients and further increases in children coming in for routine care and immunizations. We shifted to establish a Saturday pediatrics clinic to offer a safe space for healthy families to come and receive dental care, immunizations, and routine well child checks. We have continued this and added monthly indigenous vendors markets offering families connection with community, resources, cultural activities, free fresh produce, arts vendors

as a way to honor and celebrate our community.

Our new expansion site in Lake City now provides more accessibility for culturally attuned, high-quality maternal child health in the north end of Seattle when we talk about accessibility.

We also opened a clinic just less than a month ago in downtown Pioneer Square, Seattle, which offers a larger proportion of Native American and Alaskan Native adults who face homelessness and substance use disorders where we will offer more rigorous behavioral health case management and substance use disorder treatment, including medically assisted treatment.

In 2019, non-Hispanic American Indian and Alaskan Native infants were 2.9 times more likely to die before the age of one from Sudden Infant Death Syndrome than non-Hispanic white infants. At SIHB, we host maternal and infant health groups rooted in traditional practices such as talking circles and cradle board making classes to unite and uplift parents by

reinstating cultural practices known to decrease infant mortality. We are scientists.

The Healthy Native Babies Project provided culturally appropriate safe sleeping practices to American Indian and Alaskan Native communities, but it was discontinued by the N -- NIH when their contract ended without renewal in May of 2022. This was a low-cost project that stipend 115 tribes and native-like organizations to produce culturally-specific material. Tribes in UIOs were not consulted prior to the program's discontinuation, and as one of the few federally funded culturally-attuned public health campaigns for American Indian and Alaskan Native people, we recommend that the Healthy Native Babies Project be reinstated but transferred from the NIHC to the CDC's Reproductive Health -- Maternal and Infant Health Division or The Administration for Child -- Children and Families.

Significant improvements of the Women Infants and Children, or the WIC programming

must be made to ensure continued accessibility and support for mothers and infants through the following initiatives: Extend WIC flexibility waivers that were implemented during the pandemic, including participants to virtually enroll. We talk about the importance of accessibility in telehealth without having to visit an in-person provider and to permanently extend the WIC benefits.

Increase federal funding for WIC state grants to fully fund agencies' administrative costs. SIHB's current state granted WIC funding is not high enough to cover even a full-time clerk. We spend an additional 38,000 per year from other funding streams to cover this really important need for our community.

We'd like to see the reduced administrative burdens on agencies by reducing grant reporting requirements that WIC have to do that are so time consuming. We would like to see an increase in WIC breastfeeding peer counselor program funding to support and increase rates of

breastfeeding for Indian country who historically have the lowest breastfeeding rates of any other racial minority group.

To promote representation of breastfeeding peer counselors in WIC, we request WIC funding to be prioritized to promote outreach and training to potential American Indian native providers.

In 2019, 30 percent of community agents lacked a breastfeeding peer counselor program. 30 percent lacked a breastfeeding peer counselor program. This is an evidence-based resource designed to fully provide comfort to mothers and baby to the dyad.

And also, lactation consultants can be overwhelming white reducing culturally-attuned care. That's really important to that, those early periods.

I want to also discuss doulas. Doulas carry ancestral knowledge and are an integral part of strengthening traditional birthing practices as studies have shown evidence-base improvements with decreased rates of cesareans and instrumented

deliveries, like vacuums or forceps and increased breastfeeding rates. They can often identify signs of postpartum depression and anxiety which will help a mother in need of services even before their routine six-week follow-up.

I had only regretted not having a doula until my third pregnancy when I developed Bell's palsy immediately after my deliver and still suffer today from that. And it was through the comm- -- the native community group that reached out and offered that to me as a postpartum doula, and I only regretted not having known about it and used it in all of my other pregnancies.

HRSA announced a $4.5 million carve out for hiring, training, certifying, and compensating doulas in areas with high rates of adverse maternal health outcomes. However, this important funding source was made only available to about 25 entities and is not available to urban Indian organizations like ours.

SIHB has been working instead to increase our access to doula care through

agreements with the Hummingbird Indigenous Family Services Program in Seattle, a grant funded program that offers indigenous doulas trained and supported in our cultural practices to native American, Alaskan Native, Native Hawaiian, and Pacific Islander relatives that we serve.

Not only that, I'm on the advisory committee for Hummingbird in piloting a -- a guaranteed basic income pilot for our Native American, Alaskan Native, Native Hawaiian, Pacific Islander women who are expecting. And we been planning to roll that out at the end of this year.

We serve many pregnant relatives facing intimate partner violence, housing insecurity, and unprecedented rates of substance use, especially opioid and methamphetamine use disorders. A study published last week -- thank you, Dr. Ehlinger, for that read -- revealed astounding rates of pregnancy-associated homicides and suicides in black and brown women with intimate partner violence as a large predictor of death by either homicide

or suicide.

I would like to urge this committee to make the recommendation to fund culturally-based intervention programs for pregnant and parenting people facing these real threats.

Many tribal and native communities struggle to identify funding for inpatient treatment for their members. SIHB is excited that we will be, in the very near future, acquiring a property to reestablish our inpatient treatment facility. It will be a 92-bed inpatient treatment program that we plan to focus on pregnant and parenting people.

Our current inpatient -- our plans for this will be to offer specialized services for pregnant and parenting people, including medically-assisted treatment. Additionally, the inpatient behavior health facility will offer culturally-attuned services including talking circles, drumming classes, on-site sweat lodge, and cultural classes to connect our natives and our non-natives to our rich spiritual and traditional healing way.

As an urban Indian organization, we are working on a local and national level to address institutional racism that impacts health outcomes for Native American and Alaskan Native people.

At the -- at our research arm, the Urban Indian Health Institute, we have developed community health profiles for urban areas which include maternal and child health data for births, breastfeeding, cesarean section, infant mortality, low birth weight, maternal mortality, maternal smoking, NICU admission, premature births, and so on and so on. To improve maternal health data on our -- on Indian Health Country, UIA has developed breast pract- -- best practices for American Indian and Alaskan Native data collection as a guide for institutional data reform.

And lastly, HHS should enhance workforce development approaches to address gaps in filling critical provider roles with historically low rates of representation from indigenous providers. At SIHB, we strive to enhance workforce development

through our 22 training programs, including the first ever family medicine residency program to serve in an urban Indian clinic in which I trained at. 50 percent of our graduates work in IHS tribal or urban Indian organizations and up to 3/4 of us go on to work in community health centers including those as well.

These approaches should include the -- supporting the national tribal budget formulation work group, recommendation for the fiscal year '23 to invest $1 billion in the Indian health care system for workforce development.

And I'd like to close with a story that I have been given permission -- permission to share regarding one of our patients, or as we call our relatives. Her name is Stephanie Snook. She was from the Tsimshian and Tlingit nations. She had been receiving our prenatal care, excuse me, from our clinic where we also cared for her two older children. She found out that she was having twins, and the community couldn't be more excited because of what a loving beautiful

woman and mother she was. Given her twin pregnancy and her congenital heart defects, she was -- had to transfer her care to our maternal fetal medicine specialty clinic at a nearby hospital. I personally knew Stephanie through our local native family gathering where we would come together to have a meal with our kids running around, sharing our cultural teachings with our kids in that urban Indian way that many of us have had to learn.

She had offered to be a part of an NBC feature specifically around the increased rates of maternal mortality in the native population, but she passed away one week before her interview. Her twins did not survive. Their death, as you can see, crushed our Seattle native community, and it further fractured mistrust of our health care system for presumably not acting sooner when she had been developing unusual symptoms of shortness of breath but had not felt like her needs had been taken seriously by her health care team. I would urge all of you to watch the NBC feature. If you

just Google Stephanie Snook, it will pop up, and it's about a ten-minute video that I -- I very, very much would like this committee to watch that highlights her story. The difficult part about the story is that there's another mother from our community that's featured in -- in this clip whose infant also died within a month following her delivery.

This is a real issue that we face day to day and as a family medicine physician taking care of these people, my people, this is the reality that I am facing, that our community is facing. We understand that the honor of caring for and delivering our next generation is a sacred ceremony. Our teachings include the care that a community wraps around a woman to ensure that she is fully prepared that she is listened to and that her body is trusted to do the birthing protocol that it was made to do.

I thank you for this time. And what I would urge is this committee to really invest in the returning of the care and the funding back to our communities because we

know the best for our people. Thank you.

ED EHLINGER: Dr. Love-Thurman, thank you very, very much for your story and thank you particularly for making the effort for being here today. It really added a lot to the committee, to the testimony that we had.

All three of these presenters just told powerful stories, powerful images that came up. What do we need to know? What do you -- what questions do you have? What advice would you like from these three powerful women? ShaRhonda?

SHARHONDA THOMPSON: ShaRhonda Thompson. I actually have a question -- a separate question for all three of you. Jackie, you mentioned loss of trust, and my question to you is, what do you think or what have you seen work in your own experience that maybe we can take and use nationally?

JACKIE DIONNE: So thank you for that question. The lack of trust is the fact that you have this birthing process and you -- you -- you have our whole family surrounded by you, right, it's -- it's a

joyous time for everybody. Kind of we just -- don't matter what the circumstances are around the conception. It's just a wonderful opportunity for this mom and -- and -- and the new baby that's coming. And what ends up happening is if you follow the pathways of that journey for somebody who is American Indian, your family is eroded by the system. You can't have your person here. You can't have your person over there. You're going in to see a doctor who doesn't know you because you've got this transfer from Indian Health Service or a community clinic into a deliver system who doesn't have -- so that pathway, no other woman has that pathway for birth except American Indian women because we generally have private insurance or we have our husband's insurance or some sort of way in which we see a provider. We go to OB-GYN. We have a trusted relationship. We have this delivery, and it's with soft music and low lights and all of that. Where that experience is just not for a lot of us as American Indian women.

And like what was said before, the first trimester prenatal care is the lowest, but I don't want to say that they don't get prenatal care. They're just choosing to go to grandma or to -- to my mom. And yeah, that's -- that's -- that is, you know, the way in which we learn how to go to, you know -- to the -- to the baby and being pregnant. It's very intimate. It's very intimate to talk about how you got pregnant then the delivery of the baby and the baby growing inside of you and all of this that you have to tell that to somebody, and if you've had any kind of abuse in your background and you have to do this to a white doctor, it's just -- it's very -- very intrusive. It's very -- and you don't trust it, so you don't say anything. You know, you don't say things that you want that -- that you want to say about what's going on with you because it could alert the person to then want to report you.

So there's just a lot of those levels, and these are not uncommon stories. And so you may not have -- you might have a very

loving, trusting, OB-GYN, who, you know, will support you all the way, but because your sister got reported, the whole system is negated because of an experience, and it happens in Indian country all over all -- all the time. So that trust has got to be built into the provider no matter who you are because if that provider is working, and I'll pick, you know, some suburb in Minnesota. They're probably not going to see an American Indian patient maybe once in their -- once or twice in their practice, but the care you take for that one is going to improve the care you take for all. And that's the -- that's the challenge I have to the system is, you often will hear people say, but we can't change the system to accommodate to just to one. And my response is yes, you can, because then you accommodate it to all.

Look at curb cuts. You did that for people in -- in wheelchairs. It didn't accommodate to able-bodied people because you can step up on a curb, but it made it easier for moms with strollers, right? It

made it easier for a lot of us to -- to get up on a curb that couldn't do it. So there's -- the system needs to -- the system is set up for white people, right? It's -- who sets up the system? So it's made for that. It's made for that. We have to look at the system to say, this is not okay because it's not serving everybody, and we have to change that, and we'll hear a lot more of that as we -- as we go along.

But the trust is built into what happened to us, and it has to be -- it's not up to us to change that fact that we don't trust. It's up to the system to say what can we do to start to trust.

SHARHONDA THOMPSON: Thank you. And Stacy, you mentioned having your workers match the community. What is it that you suggest that we can do in order to help increase the interest of indigenous people staying and working or coming back and working?

STACY HAMMER: Yeah. That's a -- that's a hard one, and that's one that we grapple with in our own community. How do

we encourage and how do really try to get our youth and, you know, even beyond our youth, some of our adults who, you know, go into this -- into this field. You know, I -- it really starts, again, in the home, you know, and when the home is -- is, you know, not conducive for -- you know, when -- when a child is being raised in the home where there's a lot of trauma and not a lot of support, you know, I think of my -- my sister's Indian Health -- or not Indian Health, sorry -- Indian education director at our local high school where over 25 percent of the students in the high school are Native American are from our tribe. You know, her -- she's -- she like -- she's everyone's auntie there. You know, I mean, without her support, I think we'd lose a lot of our kids at the high school level and in graduation rates, you know. It's -- it's really finding a way to support -- there's just so many pieces of this that it's really hard to nail, like, one area where we could say, yeah, we need -- we need support here and just here. It's really

looking at holistically what's happening, how we can support our families at home, but also if -- if there isn't that support and there is support perhaps, again, like I mentioned, within the school system with some of our Indian education programs, I know they're-- they're here in the metro area as well. I think -- I think that's a really important piece of that is -- is letting these kids know that there's life beyond the boundaries which they're -- they're living in.

Because a lot of our kids -- before we had the clinic said, well, we have a casino on our -- on our reservation. Well, what's the point in going to school? I can just work at the -- you know, casino, you know, but it's opening their eyes to the opportunities. It's getting them outside of our reservation community, visiting colleges throughout the state and letting them know they can accomplish these things. You know, I -- and it's really encouraging them -- them in that way and really empowering them on the education side, I think.

You know, within our clinic, you know, we do job shadowing. We do what we can in our community. You know, even -- even down to different pathways that, you know, some of youth are -- are heading as far as education and helping them understand that it doesn't mean, you know, have to get a four-year degree. You have to get a master's degree. It's not that. It's -- right now, we don't have a medical lab technician. You know, they're impossible to find in our community right now. We're having a struggle. We met with our leadership yesterday because we're trying to figure out how we're going to get one back and be able to pay them what they're being paid eight miles down the road.

So it's like, okay, you know, our tribal -- our tribal council president said, okay. Well, we need to get this out to the community. We need our -- we need our kids to get invest -- invested in and excited about that kind of program. You know, so it's -- it's things like that, I think, that we need to see and just workforce

development, I think, is -- is essential too, you know, just kind of investing in that -- in that piece as well.

SHARHONDA THOMPSON: And I'm sorry. My question for you is, you mentioned the -- the outcomes you saw for the ones that did trust the medical system, and from what you saw, do you think it was a lack of advocacy or a lack of their wishes and concerns not being heard and not taken seriously?

SOCIA LOVE-THURMAN: Yeah. I think having worked on labor and delivery for -- for many years, at least in the hospital system that I worked in, there's just a stigma as soon as our women hit the door that is truly a system of racism that are -- the people taking care of our women in our hospital don't understand us and they don't understand our history, and I don't even know if they care.

I, as a native person, would feel like I was their best advocate and their doctor, fortunately. However, even the way that I was treated is truthfully what led to me really wanting to leave obstetrics, and that

was very disheartening for me because I wanted to continue to be there for my patients, but just seeing how difficult it was for me to even navigate and advocate to not interventionalize all of the people I was taking care of and rush them through this process that is so funded -- so heavily focused on funding in fear of litigation that the system was not built for the way we that we would normally allow people to birth. And I found that very difficult. and so since I've left, it's been eye opening to actually meet with several people I see here in the public that the native community has really come around this together. We have our own committees where we're starting to talk about this, how we need to be open to different ways of birthing, right, that hospital birth is not for everybody, but we've -- we've sort of created such a fear of birthing in our entire nation that women feel like that's the only way, and it may not be the only way.

And that was difficult for me to hear

as a western-trained physician, but it's the truth, that there are other ways that many of our native women are actually low risk, but we often find ways to make them high risk only just because they are native, and that's not enough.

And so I think we need to think about other ways we need to be able to bring back and fund competent certified nurse midwives without all of them. So that also takes to get that for a lot of our indigenous midwives. But in Seattle, I'm looking at that right now. How do we actually create birthing centers, right, that could actually allow our women to come in and have the birth that they truly want that doesn't feel so institutionalized. And I'm really hopeful that more of these conversations are happening, and that -- I hope to see more of that.

LEE WILSON: Kate?

KATHRYN MENARD: Thank you. Kate Menard. I'm a maternal and fetal medicine specialist from the University of North Carolina, Chapel Hill, huge fan of

midwifery, huge fan of team care. And I think a lot about systems. But what I want to ask you all to think about with me right now is kind of this concept that we've been talking about, and HRSA is very greatly invested in workforce development, and when I think of workforce development, I don't know if everybody does, but we sort of shift to, okay. How can we find training for, you know, primary care providers who are going to work in tribal communities, primary providers that are going to, perhaps, have -- or work in -- in urban centers that sort of thing.

I -- and then we talk about doulas and that workforce. And then we talk about midwives and that work, but all -- and sitting at the table, we have public health professionals, clinical professionals. And I think we're in a place now where we have to train together, and -- and our workforce development system, you know, kind of that needs to be different than what we've tangentially done compartmentalizing. And I thought this group might be a place to

comment on that.

When I read the report, I'm thinking that's not really in here so much, and I'm wondering if we can -- you can think with us how we might fold that with the themes that are coming out but with that team training aspect. Thoughts on that?

MAGDA PECK: I -- I -- it touched my heart when you said this poor individual with cardiac disease went to a maternal fetal medicine specialist and then it didn't work out for her. But why? You know, what -- what was missing? What -- how -- what workforce development is missing in our systems?

SOCIA LOVE-THURMAN: Yeah. I think it's -- it's -- thank you for that comment. I think it's -- it's -- it's multilevel and probably depends where you're at, what resources you have. In my experience, you know, a lot of our native people do feel comfortable, very comfortable coming to the clinic where we have primarily native people taking care of our native people, and the minute we ask them to go outside of our

walls, whether that be -- and it could -- it's literally, the hospital -- the maternal fetal medicine specialist is less than a mile away from us, probably -- you know, it's walkable, even, but the barrier is too great, and it's -- it's -- it's the fear. It's the fear of what's going to happen to them when they walk in. There's just too many stories in our community like that that create the fear.

But going back to your question, and I think that there are definitely ways that I have offered, right, my support in the Seattle area even with our specialists to say, you know, who are the people that are really interested in this population? Because we don't -- we don't want to play games. We want to just get people who are truly interested and want to learn and understand our history and our current status of where we're at today, and if we can build those specialty relationships and we know that when we're sending someone to a specialist that we know that they're in a good, safe place, that they're going to be

treated with the same care and respect that they would in our walls. And I know there's a lot of talk about, you know, advocates and none of that's funded either, but maybe that's a good idea is that we -- we offer our women someone who can go with them.

Doulas can really help fill that gap, but are often also poorly funded or overworked, and so I think there is definitely a gap there. We've -- at Seattle Indian Health Board, Urban Indian Health Board also offered to provide more trainings. We've actually offered to go into our hospital systems and look at their data and look at their medical records to identify where those micro-aggressions and those -- those things are coming up for people so that we can then reflect back to them some of the things that we're seeing because I can even look at -- I've shared with my institution that I used to work at clinical documentation specific to people I took care of that were clearly being just falsely accused of for using drugs or looking too tired. There's just things that

I can show that we are willing to share and show, but we're not going to do that for free either, right? So that's something that we've offered, and I think that the more that we ask of our native people to share and show you how we can actually look at your systems the more that should actually be funded too.

JACKIE DIONNE: And I would also add that for tribes here in Minnesota, yes, grow your own. Yes, we need to get kids through high school. Yes, we need to get them into post-secondary and have them trained into doing the jobs and coming back and working in the community and -- and being invested in that. That's -- that's optimal, but we know that's not the reality of being able to hire a trained workforce to do the work that's needed and to do the work needed in a community for no fault of our own is a highly-traumatized community and hard to work with, right? It's like, there's a lot of -- of factors that go into that, but we have to be able to have people who are not native come in and care about our

communities the way we care about them. And that's not trained. That's just something that somebody just says, "I care about you." And there's a need to have that across the systems and to really think about how -- how we can integrate that because we will always have non-native people working in our communities with our native folks and that has to be as important as growing our own, and -- and the -- the need to have more our own kids in -- in -- deciding to go into these fields and become health care or become providers or people of caring, they have to get through a system that doesn't care about them. So that's a whole nother conversation around the educational system to get even a kid to -- to graduate from high school, so there's a lot of -p- of layers here, but it can happen. It can happen. And there's things already in place. They're just here today, gone tomorrow, and that has got to stop.

ED EHLINGER: So thank you. Thank you.

SOCIA LOVE-THURMAN: If I can, can I just speak to one more thing about workforce

development, which I wanted to share was that, you know we also had a horrible time during the pandemic finding medical assistants, dental assistants, dental hygienists, and one thing that I think we, as native people, are good at is being scrappy and thinking outside of the box. And so one of the things that we created with very little support or guidance was finding out that there was an ability to train entry-level medical assistants and dental assistants right on the job. And so we just started it within the last six months, and it's been profoundly effective to where we were able to bring in native people who were interested in health care, whether it was pre-nursing, pre-med, and train them on the job to be medical assistants doing vital signs and rooming patients. And it was so effective at filling our staffing gaps and also fulfilling workforce development that we now have a waitlist of pre-health native students interested in our MADA training programs, and as we -- as those people then

get into -- they're getting into pre-med. They're getting into nursing programs. They're getting into PA programs. And we were at the onset of their entry into health care, and I think that in and of itself is a beautiful thing for native people to have their first foot in the door, not be in our western-trained, completely institutionalized educational systems but -- but to be right with us where they're comfortable and our patients are com -- it's just a win/win all around. So I wanted to share that too.

JANELLE PALACIOS: Thank you. I just wanted to share as a -- you know, harkened to being scrappy. If you don't have scissors, you use a knife. If you don't have a knife, you use your teeth, right? I -- my life changed when an auntie at middle school told me that I should apply to the INMED program. Where's Dawn? I don't see Dawn. I don't see where Dawn is. I'm so sorry, but the Indians Into Medicine, and I was a middle school student, and I informed -- the Flathead Reservation in Montana had

no idea that this was even an option or a thing. And it was auntie in the middle school, an assistant, a secretary assistant who said, "Janelle, you should apply for this," and I did. I went two years in a row, and it piqued my interest in becoming a -- a health professional, a nurse and then a midwife.

So it -- it -- these programs do exist. They need to be funded. These pipelines are there. We just have to, like, fund them and source them and make sure that people are aware they're out there.

And then so I just want to say that this is -- thank you for being here. It's coming full circle for me, especially of having an imposter's syndrome of thinking why am I even here? I should not even be here and then having our stories and our aunties and sisters coming here and sharing all of the -- the good medicine that you're bringing. So thank you very much for everything that you've have all shared. You're making this an amazing meeting, not just a meeting but a human connection, and

culture connection. And thank you very much.

ED EHLINGER: My -- my thanks also. Good -- great -- great presentations. And we have good intergenerational stuff. I'm going to need a Kleenex too.

We're going to take a break, but I -- I hope -- I mean, if you can, I hope you can stick around and -- and interact with any of the committee members over lunch. I know we don't provide lunch, but you know, we'll make due. And you're certainly welcome to stay throughout the day, throughout the meetings, and I'm hoping that we have interaction time to answer some of the questions.

Similarly for the committee members, you know, interact with others that you don't know on the committee so get to know them so that our -- when we finally get to introductions, you say, oh, yeah, I know. We're good.

Anyway, so we're going to take, let's say, about 50 minutes for -- for lunch, and we'll back here at about quarter after 1:00

Central Daylight Time.

(A recess was had from 12:24 p.m. until 1:35 p.m.)

ED EHLINGER: All right. We will get started for our afternoon, and even though the committee only has one officer, and that's the acting chair, I'm sort of functioning sort of as Janelle as vice chair, and so she's going to take over for this part of the agenda with our next panel.

JANELLE PALACIOS: Thank you. So this next panel, we have state, local, tribal challenges that will be shared with us. So please join me as I welcome our next panel. We will hear from five speakers whose work encompassed local community work to statewide programs.

Three panel members work within Minnesota. Marisa Cummings, President and CEO of the Minnesota Indian Women’s Resource Center; Dr. Joni Buffalohead, chair of the Minneapolis Indian Health Board; and Noya Woodrich, director of the child and family health divisions of the Minnesota Department of Health.

We will also hear from the southwest, in particular, two representatives of the -- from the Arizona Department of Health Services; Lynn Lane who is manager of the tribal maternal health innovation program, and at the Arizona Department of Health; and Heidi Christensen, manager of the Maternal Health Innovation Program at Arizona Department of Health.

I will ask that we hold questions for the end. Welcome.

MARISA CUMMINGS: All right. Can you all hear me? Okay. So I'll introduce myself. (Speaking indigenous language.) So my name is Mia Conda. My English name is Marisa Cummings, and I'm Mahar or Omaha and belong to the Buffalo Clan of the Sky People.

I currently serve as the president and CEO of the Minnesota Indian Women's Resource Center or MIWRC, as I'll say for the rest of my presentation, where our mission is to empower native women and families to exercise their cultural values with integrity and to achieve sustainable life

ways while advocating for justice and equity.

MIWRC is located in the Phillips neighborhood on the south side of Minneapolis, which houses the third largest urban Indian population in the United States, and I just would like to say that, you know, sitting with this morning's presentation, it was pretty triggering and re-traumatizing, I think, for all of us and it would be remiss not to -- not to say that. I know some of us shed some tears in hearing those stories.

The health and wellness of our women and children is our core part of our mission-driven work at MIWRC, and I also think that we need to talk about this in a historical context. We know that native people are the top of every disparity that exists in education, health, blah, blah, blah. What we don't often talk about is that the that the root cause of these disparities is colonialism and white supremacy.

The country -- this country built its

wealth and status as a world superpower through stolen land and stolen people, and the industrial revolution would not have taken place without the extraction of our land and resources and the extraction of free labor. The lack of resources infused into our communities is a continuation of genocide. Hundreds of years of federal Indian policy has had a direct horrific effect on our health and well-being. We are taught to have a scarcity mindset and that there are never enough resources. In reality, we live a country of extreme wealth, and the hoarding of this wealth is both unethical and immoral when our people are literally dying. The hoarding of resources directly impacts our people's health, wellness, and the quality of life.

The Phillips neighborhood is a historically native neighborhood that evolved from the relocation era as a survival mechanism for recently displaced American Indian people. Here, we created a physical environment where we could access support and resource, many of which is

through native nonprofits. Because this area is so severely historically underfunded and under resourced, we struggled with -- we struggle now with the opioid epidemic. An example of this would be that we have the highest opioid overdose rate in the state of Minnesota in our neighborhood. MIWRC is one of the fewest places that offers facilities for traditional wakes and funerals, and we are seeing two to three funerals a week with the majority due to overdose or gun violence.

Last month, our VP of community engagement and impact, who is with me today, was car jacked at gunpoint outside of our building during daylight hours. If you drive past our building late at night, you will see men soliciting sex work lined up in cars outside of our building. You will see young native and black girls getting in and out of these vehicles. Predators use drugs to hook young girls for survival sex work and trafficking. Many of these women come to our drop-in center for basic life resources.

Recently, we had a mom who was sober and in treatment, and she had a ten-year old daughter who no longer had care or a place to go. Mom did not want social services involved for fear of removal and fear of systems, so shelters were called, but of course, shelters don't take kids under the age of 18 alone, and we had to temporary house her at -- at our Hotel to Homes Program because there was no immediate housing for women with children who have a high need for inpatient treatment.

We have had a mom who had a baby while incarcerated and staying at a shelter. She was sober but struggling with supportive services. She moved into a house that we have where we also offer intensive outpatient treatment, and now she receives those wrap around services and healing.

We are meeting moms on their worst day with critical immediate needs that almost always include lack of housing, lack of financial support and resources, and lack of human resources and family support.

Prevention of relapse involves

intersectionality of all of our social systems including housing, financial support, life skills development, substance abuse management, traditional teachings, and reconnection, traditional healing from generational trauma, and skill development.

What we heard today is a lot of talk about IHS, and I'm going to say something that's probably really unpopular, but IHS isn't our answer. We're sicker now than we ever have been. IHS has never saved us, and to act like we didn't have health service pre-ISH is disrespectful to our ancestors who carry traditional medicines.

We share birth stories as part of our birth work, and for many of our women, it's traumatic to even share these stories of our own birth. And I -- I know we were asked to share personal stories. So I'm going to try and -- and wrap this up.

I was born at Indian Health Service in Winnebago, Nebraska at the Omaha Winnebago Service Unit. I believe now it's not anymore. It's 638.

But at that time, I was with my mother.

My dad was out drinking, and my great grandmother came to the hospital to name me. And that might seem like a little thing, but in her naming she set forth the projection of my entire life. My identity, my purpose is all rooted in my name, and she was a midwife, and she gave me her name.

And so for me, knowing that love that she showed, that -- that love because it wasn't easy to get to the IHS hospital, right? Like, people didn't have cars. She had to walk, this old little grandma. And her -- her unconditional love, that is the love of our grandmas and aunties as we bring life into this world. And she thought of me as this little person that she didn't even know yet, this great grandchild, and she made that effort for me.

And so I ended up, when my sisters had their babies, between them, there's 12, being the one that was there, even when I was 18 years old, helping deliver those babies and acting as a doula. I didn't even know what a doula was. It was just natural for me. And they also had to have an

advocate because where I'm from, Indians didn't go to the hospital without advocates because they don't listen to you, and if you're not educated and you can't talk about the letters behind your name, they don't even value what you have to say. And this was is a city. This was in Sioux City, Iowa.

So my -- just recently delivered my grandson, who is about eight months old now. And what I noticed when he was born is the midwife and the doulas in the room actually just backed away and they let me take care of him. His first words were in our language. He was acknowledged to Creation, and he's the first one in four generations that had that traditional way of being brought into the world. And his life looks different.

So when we talk about funding resources, and I'm -- I'm going to wrap it up here. We have a traditional birth work program that we've just started. It was just conceptualized at the Minnesota Indian Women's Resource Center. Iktòmi Favel is

here, and she's our director of traditional birth work. And we're not looking at a clinical model. And so all the talk about clinical numbers, data, it doesn't mean anything to us because we know what happens with the work that we do in community. And we really need to ensure that this committee, there's more people that look like me on it, because our stories are what matters, and you're not going to hear these stories if you aren't in our communities. You're not going to hear the reality of our people's experience in the health care system and this is all interconnected with the social determinants of health.

If I have a mom, and she doesn't have a place to live and she just had twins at the hospital and the hospital won't release the twins to mom because she has nowhere to go, where -- where's the gap? Where is the social worker helping her find a place to live? What do we do when that mom comes to us? Because we're where she comes. She doesn't go to the system. She comes to us.

And so I would then encourage you in a

few recommendations: One, when you're looking to expand and diversify the workforce that that is done through a non-IHS model, that you're looking at -- we have an apprenticeship program that we're doing with traditional birth work where Iktòmi is then training up these younger women. And these younger women are craving this information. We have young native women that want to know how to do this work, but they need to know that there's jobs out there for them once they -- they get that training, right?

We also need it to be nonclinical. They don't need to be certified. They can be certified through our traditional practices. And we had talked earlier about when my daughter was pregnant, she didn't go to the doctor until she was four months pregnant because we don't do that. But she came to me, and I guided her through that process.

So there needs to be an acknowledgement of our traditional wisdom, our understanding that we were scientists. We were

mathematicians. We are intelligent people that are capable of running our own lives, and we are also capable of taking care of our communities as we know best. But we need the funding to do it, and if we talk about equity in funding, that means the money follows the disparities, disparities that we didn't create, disparities that were forced upon us over 200 years. And it's time that this is flipped by sending us the funds to take care of our people.

So thank you. I know that was long, and I'll -- I'll pass it on now.

JONI BUFFALOHEAD: Thank you. My name is Joni Buffalohead. I'm Bdewákhathunwan Dakota, and my family is originally from this area and because some of the history such as 1862, my family was forced to be in South Dakota. So I'm a citizen of the Sisseton Wahpeton Oyate in South Dakota. And I reside here in the Twin Cities.

I'm -- I'm here today to talk about the Indian Health Board Clinic of Minneapolis. I've been on the board since 2015, and I've been working in health for a couple decades,

and I'm saddened to learned from some of our providers that a lot of things have not changed from their perspective.

Before coming here, I did some homework. Sat down with my medical director, maternal health and pediatrician and -- and shared with them why I was coming here today. And, you know, after talking with them, they asked me, you know, do you think our recommendations are going to matter? Are our voices going to matter? And these are the providers who have been there at IHB, one was there for 24 years, one 14, and one 4, and it was really disheartening to hear that because usually you hear that from patients and from the communities, but to see the providers going through this day by day.

But, of course, for folks who know me, I always, you know come off on positive. I said, yes, this is going to be a great opportunity. Times are changing. There's going to be a bunch of native folks coming together, and we're making changes today.

One thing I wanted to share before is

-- you know, so to make sure for those who don't understand. I'm not sure if it was covered earlier but why we even have urban clinics, urban Indian health clinics. And I won't go into much detail, but it has to do with one of the federal policies, relocation act, you know, to -- to get rid of us, to get rid of our land, take it all away and assimilate us so they can tax our land and -- and develop it and make profit, et cetera, et cetera.

One of the things that they also wanted us, you know, to move to the cities. They wanted us to disappear and then assimilate us. And, again, you'll keep hearing this assimilation, genocide, over and over throughout a lot of these presentations today, but it's what we are living every day. And, you know, back when the relocation act occurred in the '50s, our life expectancy was 44 years old, 44 years old. For white folks, it was 77 years, and this is in the '50s. And, of course, you've heard now our life expectancy's deteriorated again because of the pandemic. And so the

economics and psychological trauma are still visible today and nearly all the measures out there, education, employment, and health, native people are either at the bottom or near the bottom of those measures.

Some of the data that was shared with me from Minnesota Department of Health -- you know, it -- I'm sorry. It's really hard for me to go over this over and over again, so I apologize, everybody.

So American Indian, Native Alaska babies die their first year of their life at the twice rate of white folk -- white babies. Sorry.

American Indian and Native Alaska youth have the highest rates of obesity.

Intimate partner violence affects 11 to 21 percent of high school seniors, high school.

Unemployment is the highest among American Indians and people of color and people who live in rural Minnesota. This is, again, from Minnesota Department of Health.

And American Indians and Alaskan

Natives have the lowest rate of on-time high school graduation. Well, it took me ten years to do my undergraduate, so I can kind of relate, but we're talking high school.

American Indians and Alaskan Native are incarcerated nine times the rate of whites. So this is what we're -- we're dealing with today still.

And after talking with some of our physicians at the Indian Health Board Clinic of Minneapolis, which we're neighbors by the MIWC clinic as well, you know, they -- they talked about data right off the bat, and I was like, okay. What I didn't understand was that to this day, even though I know the Indian Health Board invested a lot of money to get a new electronic health record, they're not able to access data from the other health systems that they're, you know, getting care from. And they made the comment that they believe, and this is a native physician, that accessing health care at the urban areas is harder than being at IHS facility. And, you know, honestly, I would never send any of my -- sorry -- my

loved ones, even my -- my four-legged little relatives to Indian Health Service today.

What I'm hearing from our physicians that they're also aware of the data outside of Minnesota due to the changes in abortion. So we haven't even -- even touched that whole iceberg that's come -- you know. And a needs assessment, analysis on the streets of who those are marginalized. They -- they think -- they want the voices. You know, we know data. You know, you need a sample and need this many in order to make it valid and all that stuff. But they want to learn from the folks who are there right now what is working, what isn't working, what got you to this place.

Housing is a huge deal. They -- they need safe housing for young moms and dads because they're going to have children, right? Access to birth control and productive health is an issue. Education about alcohol use, especially those would are in their woman bearing years. You know, they need to understand, what does this do when I put it in my body, and how is that

going to affect my children and on and on.

You know, 2022 we -- we're still having to educate folks and make sure people are getting that education.

Transportation, in the Phillips neighborhood, what I'm hearing is that -- you know, Indian Health Board has two vans. Like, that's pretty cool. That -- that's great. They look wonderful. The issue is, is that is that a lot of our folks are moving outside of Phillips area because of the crime, because of the drug use, everything that's going on. So they're moving out in the suburbs, and they can't take two vans to go out and get their patients because that takes up so much time. It could be a half hour to an hour just one way to pick up a patient. So that's another challenge.

Missing and murdered indigenous women and relatives. Again, this is from our providers. They said this is not working. It's right in front of their eyes. It's across the street where there's an encampment, and they can see the origin of

how this is happening and -- and affecting the women and babies. They're watching them being trafficked. They're watching these drug dealers just come right there and -- and -- and in tents. They're entering these tents, the guys with the mom and the baby. The child is right there in the middle of this. You know, what -- what -- sorry.

And -- and then -- so the question came up when we were talking about this topic is, how do we measure that? How do we even know what is happening to them to get to that point again? What are some of the alternatives for them. We all say, you know, education. They say it's safe housing, but how do we get to them before they're even at that state?

Drug addiction is the main cause of infant and maternal morbidity. They say they don't see that much of mortality in the community. This is just one little clinic, though. And, of course, they say lack of prenatal care is a result of extreme addiction, and then it's pre-indicator of that their life is totally out of control.

They've seen teenage pregnancy go up since the pandemic, and one of the recommendations they had for -- to address that is to see more school clinics. I think in the Twin Cities you only have, like, seven clinics right now.

And, you know, what they're doing today at the Indian Health Board is that they are developing sexual health programs. They have caregivers who are older relatives who are taking care of these babies when mom is incarcerated or if they get lost in the system. They recommend interviewing these caregivers. How do they capture -- how do we capture their stories? How do we learn more, and how do we share this with our communities?

And, again, education. There's a lot of mistrust. It's hard to convince their patients to take medications or even injecting something into their body. And again, there we go with no traditional collaboration with our traditional healing practices.

And so, you know, they said, yes, we

need to build trust relationships. I heard that earlier this -- to this morning.

And they do have care coordinators. They have a few, but the issue with care coordinators who are the ones that go out in the community and be -- build these relationships, a lot of them are just there for the paycheck. They really don't care. And that was really hard to hear.

They're developing group visits for prenatal and for all native women and girls. And some of the questions that surprised me that they want from this committee is to know, like, what are the top causes of infant mortality in our area, and can they set a standard of testing. Just test everybody for drugs in their system that just -- like, you look at the family or you just kind of guess, oh, they must be on drugs because they're native or whatever but to make it a standard and then they're saying that mortality is definitely drug related, and they gave me a list of recommendations. So they -- they asked for -- to educate younger -- educate younger

folks on pregnancy, health, housing, safety for girls and boys.

Can we find incentives that people care about before they get pregnant? Like, can we -- is it even ethical to try to give them other options rather than -- rather than getting pregnant at such a young age?

The whole issue with the workforce, rural areas. You're talking about retired providers, welcome teams, traveling team. Maybe that's more familiar with maternal health. Can you somehow, you know, utilize those teams into some of the rural areas?

Set up protocols to care. That seemed be a huge important concern for the docs. And then to catch them where they are. So when you have your patient who happens to come in trying to take care of all their needs right then and there. They always -- for IHB Minneapolis, they lose their patients when they say, well, come back and see so and so in three weeks or go over downtown to the Hennepin County and get this test done or something. It's -- it's gotta be holistic. It's gotta be where they're

at.

And then as far as the men, I ask about the men. What's going on with the men? They said that, you know, most of the times when babies are born, the guys take off. They think it's too much. And -- and -- and this is generalizing. But men, you know, in the urban area, they lack employment. They lack meaningful employment, and this hurts their psyche. And then it's hard to show these young men the value of elders. So we're losing that disconnect, those oral traditions that we've had for generations, generation. Again, we're in the urban. Some of these kids don't even know what tribe they belong to anymore, you know. Thank you federal government. You know, there are -- there has been some impact. You guys have -- have been succeeded -- successful at.

The pandemic has hurt people coming together. They used to do meals together and try to make it more like a family community feeling, not just we're the clinic. They really believe that behavior

-- behavioral health needs to be integrated and part of the team all care for both mothers, infants, everybody and indigenize baby programs to try -- they -- they're actually changing making it more cultural relevant in tuned for the communities.

And, again, Indian Health Board gets one percent of all of them. There's 44 in the nation, get one percent of IHS funding not that IHS, you know, is the answer because what I see as a board member is I see our docs spending more time looking for partnerships, funding, lobbying, getting on a soap box and talking to our legislators every year. We're -- we're spending a lot of money on just lobbyists, and that should not be the way.

For a personal story, like I said, there's quite a few, so how do you even choose one? I'd say the most recent one I have that affects me today is my younger sister, my baby sister, she's eight years younger than me, and she got pregnant, and I was gone. I was in school. And before I even knew, they set her up. My parents,

they -- they set her up. They were living in St. Paul in the Cities here and convinced her to set the baby up for adoption. And I'm like, wait a minute. I can do it, you know. And -- and by that time, it was too late. Couldn't do anything. My sister then got into more trouble, suicidal. She was raped. Dropped out of school but went back. Got her GED. Had gotten married. Had a couple children, and then struggled with alcoholism. And so she was the closest to me to have to deal with that and to learn the systems of someone who has all this trauma, who is native, and with alcoholism. I learned the systems were not there to cure you or support you. It was, you do this for 30 days or you fail. Do it again or fail. Medicaid, you -- you're done. You know, and she ended up passing away two years ago this month, and she was only 44 at the time. And this is something that she carried on from her from when she was 16 all the way to 44 and the systems failed them. And us being in urban areas and having lack of family support also has failed us as well. Thank

you.

LYNN LANE: Good afternoon, everybody. We have a presentation. So just need to have that brought up. Can you hear me better? (Speaking an indigenous language.) Good morning. Or good afternoon, everybody. My name is Lynn Lane. I am of the Native Mountain Towering House People. I am born into the Deer Water Deer Springs Clan. My maternal grandparents are of the Rock Gap people, and my paternal grandmother is from the Red House Clan.

It's just customary for me to introduce myself. We also would like to pay respects to, you know, the seven Ojibwe tribes and the four Dakota tribes who have steward this land since time and memorial.

HEIDI CHRISTENSEN: Yes. I'm sorry. I'm Heidi Christensen. I work alongside Lynn at the Department of Health in our maternal invitation -- maternal health innovation program. Okay. Next. All right. Thank you. I'm not going to go completely into all of this because you don't need to know all of that. It's just

to say that when we started out back in 2018 working on some maternal health efforts with the State, we really wanted to focus from the beginning on our tribal communities and partnering with them intentionally. And okay.

Next slide. So why improve maternal health outcome for AI/AN in communities?

Next slide. All right. Because of the data. We work -- Lynn and I worked really close with our maternal mortality review and we were seeing that the data that comes out of that committee and -- which I'll talk just a tiny bit about, but one of the other things was our review committee. When we started, the contractors we were working within our tribal communities, we purposely sought out their participation in this review process because our tribal communities weren't being represented. And then our most recent program manager for this program also continued to increase representation including family voice on the committee.

All right. Next slide. All right. So

this is some of the data. We've talked a lot about the data. This is Arizona specific data, so I won't get too much into it. As you can see on this one, our American Indian/Alaskan Native women account for nearly 12 percent of all the pregnancy associated deaths.

And next slide. And just overwhelmingly, deaths were preventable that were reviewed.

And next slide talks a little bit about -- skipped one. Sorry. From 2016 to 2019, for every 10,000 Arizona residents, American Indian or Alaskan Native delivery hospitalizations, there were 300 and -- 303 severe maternal morbidity cases among our American Indian/Alaskan Native women.

And next slide. And you can see across the board the data continues to show we're not reaching and serving our native communities like we need to because the rates continue to be higher in those communities and I think in Arizona, it's three times -- three times the rate of non-Hispanic white women.

LYNN LANE: Okay. Go ahead and next slide. Next one. Okay. So the -- the tribal components might mirror the major strategies outlined in our overall maternal health improvement program. So as you can see on this slide, we have three pillars of activities. First we have a tribal maternal health task force. As Heidi stated earlier, in 2018 when we had these tribal engagement conversations, the tribes specifically asked for a tribal maternal health task force so that we were very intentional in creating their own space to talk about maternal health outcomes, you know, within their own group.

We also are -- sorry -- are trying to improve data collection. The state MHI program and MMRP work closely to improve the collection analysis and application of state-level data of maternal mortality and severe maternal morbidity.

Some of the conversations that haven't been included is data sovereignty training, where and who has AI/AN data. How is that data accessed? Are non-tribal

organizations/entities upholding data sovereignty principals and identifying data sovereignty checks in Arizona?

We are already promoting to exicate -- exit -- promote and execute innovation. This includes working to increase awareness, reduce disparities, improve access of care, support workforce capacity and systems of care.

Next slide. So in early 2021, the maternal health team, we met with tribal communities and identified community champion -- champions that work in birth work. What cultivated from these conversations were community driven and cultural humility session to improve maternal health -- maternal health outcomes for indigenous families for those. Within these sessions was birth and maternal health and family wellness from an indigenous perspective trainings. These sessions were specifically requested from tribal communities. They identified specific people who they wanted to bring into their community to talk about improving maternal

and infant outcomes from these sessions, we had -- we had over 120 sessions take place simultaneously throughout the state. We reached over 1500 community members who actively engaged in any of these sessions.

We had four indigenous doula trainings which have -- which all had 20 -- 200 -- 200 applicants apply for each session. We had two -- two advanced indigenous doula sessions, six indigenous breastfeeding counselor courses. You know, and that's just, you know, talking about the bigger -- some of the really big sessions that we had that had, like, over 40 people that they could accommodate. But like I said, we had 120 sessions that happened in 2021.

To date, we've had over 200 sessions of these -- of the maternal health and -- maternal health and family wellness from and indigenous perspective trainings. We've reached over 2,000 community members, and still, with our indigenous doula trainings and our indigenous breastfeeding trainings, we -- we've -- we've replicated those trainings. And every time we advertise for

those classes, we have a waitlist of 300 people. So we are working -- you know, people are hungry for this information. They want to be at the table. They want to know -- they want to reclaim those birth ways. So we're trying really hard to create that space for them.

It also should be noted that during these entry-level conversations, it was very hard to sit down with tribes to get their buy in. It was extremely hard. They vetted me, you know. It's because of my past -- you know, my past work history, some community members knowing me that they allowed me into their communities. They vouched for me. They talked among themselves. They literally had meetings about me. Who is this girl, this maternal health girl walked -- coming in here trying to do all this stuff, you know. And when I had these conversations, it was about I'm giving you this space, and I'm giving you this platform. I have the money to do this. I don't even have to be at these sessions. If you need my Zoom account, I'll set it up

for you, give you host abilities, and I'll exit them -- exit the sessions. I gave them that space. That was the one thing that they wanted is they didn't want us to take this information and say this is ADHS's now. So, you know, we really were very careful and protective of ensuring that we listened to what they say.

Next slide, please. So this slide is really just to show you that we do -- we do have a maternal health task force structure. We have a steering committee, which is inclusive of tribal representation. The individual implementation teams identify strategies under each of -- each of their areas which are presented to the steering committee who informs the maternal health action plan. For purpose of this presentation, we'll just focus on the work that's being done at the Tribal Maternal Task Force.

Next slide. So current work right now: The Tribal Task Force consists of representation from multisector people. You know, we have providers there. We have

executive directors, doulas, community health workers, people with lived experiences, grandmas, aunties. You know it's an open-door policy. We don't turn anybody away. The work that's being done. You can see that we have identified four -- top four priority areas.

So we meet quarterly for two hours. The objective of the meeting is that our task force number is system identifying activities within these priority areas. Within these task force, it should also be noted that we -- they're facilitated, and our facilitator is a Navajo and Havasupai. So it's a -- you know, like, we wanted to make sure we had that representation also during the facilitation process.

Next slide. It was also -- you know, due to the -- in early 2020, due to what we were in the midst of the pandemic, the maternal health reviewed -- identified areas where we were missing in our efforts to improve maternal health outcomes across Arizona. So there were three gap areas that were identified. So the American

Indian/Alaskan Natives in urban Arizona was one of the areas that we identified that was -- there was a place that we weren't really providing, you know, I guess, like, assistance with, and this was very evident because of the closure of Phoenix Indian Medical Center's labor and delivery facility in the midst of the pandemic. No notification was given to anybody. We -- we found this out through social media TikTok videos, Instagram videos, that pregnant women were in active labor showing up to the hospital being told they can't -- they can't deliver here. Go somewhere else. Like, don't -- don't tell me that racism and -- and communication doesn't happen. It's happening right now. You know, it -- it was -- it's -- we've never even been given an explanation from IHS as to what's happening, what the plan is, you know, like, even saying this is the plan. This is our -- so you know we could have helped with an awareness campaign. We could have helped with education. None of that. To this day, nothing has been provided to us. So I share

your, you know, frustrations with IHS as well.

Next -- next slide. All right. And next slide. And just -- I just really wanted to briefly show that these are some of just very, very limited amount of people that we partner with on a monthly basis we're having conversations with.

Next slide. So a critical -- a critical partnership to improving maternal child health among tribal communities areas was with Diné College, Northern Arizona University, and Navajo Epidemiology Center, and the Intertribal Council of Arizona.

In our most recent Title V needs assessment, ADHS wanted to make sure to include the voice of tribal communities and partnered with these organizations to prepare the first ever Tribal Maternal and Childhood Needs Assessment which was incorporated into the overall Title V needs assessment. So these are on our website if you guys would like to, you know, read them, you're more than welcome to.

Next slide, please. Within our

maternal health innovation program, we have two contracts, one with Intertribal Council of Arizona who is contracted to work with 21 of the 22 tribes in Arizona. We also are working with Diné College with support from the Navajo Department of Health. Because of pandemic efforts, they are -- the Navajo Nation Department of Health are -- currently just do not have the infrastructure to take on this grant, so they've asked to work with Diné College.

When these conversations were happening, we were very intentional in keeping the money with tribes. You know, when they came back to us and they said that they didn't have the infrastructure in place, we asked them who can we work with? Who can we work with to continue these efforts? So we were very intentional in not -- in keeping the money in the tribal communities.

As mentioned earlier, a key recommendation was that we engage more tribal partners into the conversation and that our agency, we have a tribal liaison.

So any time we had any engagement with our tribal communities, we always had him at the table with us, so, you know, just so that there was transparency there.

We're also happy to -- to note that both of these two contracts have been executed. There have -- there was some, you know, speed bumps and everything like that because of the pandemic, but we have two executed -- executed contracts with them.

Next slide. So I just wanted to show a few examples of how Navajo Nation and Diné College are improving maternal health outcomes. So from the needs assessment, Diné College finalized their priority areas. It -- it's important to mention that these priority areas were identified by the Navajo Maternal Health Advisory Committee. They have podcast, the Navajo K'é with K'é's families. It shares information and resources on Navajo infant, child, adolescent, maternal, and overall family health addressing priority -- priority areas set in their needs assessment report.

Diné also hosts Navajo Nation -- hosted

a Navajo maternal health Webinar, and ITC is currently in their final stages of their -- drafting their final stages of their strategic plan that they'll be implementing next year.

Next slide. Some of the work that we're doing also at the State is we're also working to have the maternal health messaging's translated into some of the tribal languages. So the flyers that you see up on the presentations are specifically in Navajo. So these translations are both written. We're working on getting those translated orally as well. We're -- we're trying to get three other translations completed, one in Hopi, O'odham, one of the O'odham dialects and the Apache dialects as well.

We understand that, you know, the written language is extremely hard and people don't -- there's not a lot of people who can read the language, but also tribes are going through this revitalization and reclaiming of language, so this is our way of trying to, you know, provide them some

resources that, you know -- that their -- their language is available to them.

We also have audio streamings that have been played on the tribal radio stations in border town on stations and some of those awareness messages are also being translated within those -- on those native language.

Next slide, please. Arizona is an AIM state as of 2018, and we launched a severe hypertension and pregnancy bundle in April of 2019 -- 2020, 2020 -- '21, sorry. And we're happy to let you guys know that we have two tribal -- we have two hospitals from the tribes that are a part of this AIM initiative. One is an IHS labor and delivery facility and one is a tribal 836 facility. So we have two on board. We're actually currently in conversations to recruit one other one, which will be -- which, if we did get this pers- -- this one tribe or this hospital, we'll have reached all the labor and delivery facilities in Arizona.

Next slide. So our recommendations are kind of lengthy, but I just really want you

guys to know that, you know, the recommendations that we're going to be sharing with you are from our Tribal Task Force, so they're specifically from our community members. So yeah.

Next slide. So as an agency, specifically the bureau that I work in, the Bureau of Women and Children's Health, you know, we want to make sure that our contract's written to provide tribes with flexibility to develop community-driven solutions to maternal health priorities and needs. We also know that translation is important. We want to honor the voice. When doing translation. Please consult tribes. Please get approval processes. Do not upload those pieces until you get permission from them. It is their language, not -- not ours, not mine. So please allow them to be a part of that conversation.

Be intentional. Be intentional. Don't include language about evidence-based or evidence-informed programs because these activity -- these -- because evidence-based for the effectiveness of these programs are

nonexistent within tribal communities. Use practice-based or community-driven and culturally humility language. A contract should not be a laundry list of ideas, demands about work that -- what they need to do. It should be a -- it should really be a conversation of what can you do. What will you provide? How can we assist you? How can we, you know, support you in these measures?

And again, inclusion of our tribal liaison is highly encouraged at the inception of any possible contracts about amendments, negotiation of contracts, or assisting with strengthening partnership with sovereign nations.

Next slide, please. So radical transparency and trusting partnerships. Please remember that you are working with sovereign nations and that the history of relationships between the U.S. government and tribal nations has been a history of broken promises, lies, and manipulation. And without getting into other negative aspects of these relationships like

genocide, violence, abuse, political and cultural margin -- marginalization, tread softly, be humble, and listen. Listen. Hear what they are saying. Don't interpret what they said. Listen to what they say. Ask questions to seek clarity. See what -- say what you will do and do what you say. Make sure that you take time to share any information you have about the contract, any up -- upcoming changes or expected challenges. Make sure that you have the right people in the room for these conversations. Provide stable, reliable guidance, funding, and payment. And, again, be patient.

During the pan -- so I started right before the pandemic, March 20 -- 2020. I was literally in the office for a week. They gave me this computer and said, "You're working from home now." It was the hardest transition I've ever made in my life, you know. I also wanted to speak to -- that's why I had -- I advocated strongly that my coworker here, Heidi, come with me. She has been my strongest support system in this --

in this work that I'm doing in with working with tribes. Had I not had this support system, I would have left. I would have left that first year. None of this stuff would have come to fruitation [sic]. So, you know, identify those champions and really supply that support system for them.

There are other recommendations. I'm going to hand over to Heidi.

HEIDI CHRISTENSEN: Next, slide. Next -- all right. Around professional development, we're looking at, you know, trusted health partners, professionals that align with cultural values, increasing grass root BIPOC birth workers, community-based directed services, recruiting BIPOC and indigenous providers, compassionate care providers, cultural education from medical staff, customer service, implicit basis training for clinic and hospital staff, and assistance for trainings.

And one of the interesting things that I learned in some of the sessions that we held with communities was that there was a difference in what they were wanting in

facilities located on tribal lands and -- and hospital systems outside of that, really wanting those who were practicing on tribal lands to do their work, understand who the people they're serving are, and understand traditions around birth and -- and reflect that in their work. And when in those urban settings in hospital systems outside of IHS and more private hospitals and stuff like that, that just wanting people to ask questions, realizing that every physician isn't going to know, and they may not serve many American Indian or Alaskan Native patients, but to just ask the questions, ask if there's -- you know, open-ended questions. Is there anything that you need? Is there anything that you need differently? So they were thoughtful about what they were asking for.

And next slide. And with access to care, we're really promoting our high risk perinatal program and consultation line in our state because we've got -- most of our tribes are in very rural areas without the -- the medical providers that they need and

-- and this is a great resource for all of those communities.

Accessible and high-quality medical care and coverage and more time with the patient and provider, that was, across the board, gets brought up all the time, that the ten-minute visit just -- you can't build a relationship and -- and trust your -- your provider.

More mobile clinics, advocate to reopen the OB unit at Phoenix Indian Medical Center. This comes up continually because nobody has answers in the communities. Very passionate about having this reopened and en -- and -- and getting answers.

Engage family in perinatal care, doulas, home visits, and opportunities for engagement to access traditional and cultural practices, to not just have standard western medicine.

Okay. Next slide. So with integrated and coordinated systems of care, traditional practices, and cultural values incorporated with the health care system, opportunities for engagement and access to traditional --

traditional cultural practices, identify safe and sustainable and accessible affordable child care options and transportation options, and engage family -- oh, we have talked about this one -- and health care systems to build trust with the community. One of the things -- you know, for some of our moms in our rural communities, they're driving more than two hours to get to both prenatal care and to a birthing center. And if they're high risk, that just increases the -- the problems with mortality and morbidity.

With awareness, we've had awareness campaigns. We've really tried to target rural communities, and -- and they want that back. They -- they want more of that consistent and cultural -- culturally-appropriate, joint physician and tribal member PSAs, prenatal care, education on chronic disease associated with perinatal risks, and understanding that impact of unmanaged chronic disease has on a pregnancy and increased preconception and prenatal education, before, during, and after

pregnancy, reduce stigma around substance abuse, normalize mental health and education to -- education advocating an appropriate adequate health care.

Next slide. Oh, next slide. There we go. Community unity. Community empowerment that can lead to positive system changes. Community engagement of grandmothers, support circles, and in -- in the education, messaging, and listening sessions from both patients and providers on knowledge and beliefs regarding chronic disease and perinatal risks.

Next slide.

LYNN LANE: Yeah. So we also just recently met and we had conversation around data surveillance. You know, I think our state is really trying to identify data sovereignty champions, people that we can go to to understand these principles, people who honor -- how do you honor, you know, those data sovereignty principles? Developing questions and standards to capture indigenous determinates of health from a holistic approach, surveillance data

101 trainings for local and rural organizations that collect AI/AN data, and also increasing awareness and knowledge of what data -- what kind of data is collected.

Data surveillance is something that I feel like I need to go back to school for. It's a whole different universe that is kind of -- I don't know much about. I ask a lot of questions, so yeah, identifying a champion would be great.

Next slide. Oh, the end. Thank you.

JANELLE PALACIOS: Thank you. So we will have our last speaker. And just on record as well, thank you Arizona for showing up and bringing home the -- a number of common themes and issues that we've heard. And to the point about the Phoenix Indian Health -- the hospital and the closure, we have asked IHS, and the answers have always been vague.

NOYA WOODRICH: All right. Thank you. I know we're running up against the end of our time, so I'll keep it short and sweet. Just kidding.

My name's Noya Woodrich. I'm the

division director for child and family health at the Minnesota Department of Health, a position I've held just four and a half months. I think my story in terms of this work starts 30 years ago.

I was a young person -- let me back up. I'm Alaskan Native, Athabascan. However, I grew up here in the Midwest. And so I am a member of this native community here in Minneapolis and St. Paul. And I'm so grateful to have been welcomed in and allowed to be part of this community and do the work that I do in this community.

30-some years ago, I was a senior in college working on my social work degree. I was doing an internship with this organization called Division of Indian Work. It's a nonprofit organization in south Minneapolis. It serves the native community. The executive director there said, "Hey, would you like to work for us?" And I said, "Yeah, I would." She's like, "Well, we need a director of the Teen Indian Parents program." And I'm like, wow, director, parenting, not a parent. At that

point, had never really babysat, wasn't a fan of that. But I'm like, hey, I'm don't to have to go look for a job. She's offering me one. So I'm like, "Yeah. I'll take the job."

It was not long after that I participated in my first infant mortality review process. And, I believe, Ed, you were at the City of Minneapolis coordinating that first infant mortality review process that I participated in. And it was there in that process that I landed on this as a passion issue, and it's been the one constant throughout my 30-year career. I've done a lot of work in a lot of different places on a lot of different issues, but maternal and child health, and specifically, the prevention of infant mortality has been my guiding star.

A lot of stories. So I started as a home visitor from a social work perspective when home visiting was just beginning to be recognized as a model, right? This is in the early '90s. And I remember going out to visit with these young mothers and knocking

on the door and not being allowed in for two, three weeks. And I finally get in. I said, "Hey, you know, what's -- what's going on?" "Well, we thought you were a public health nurse, and we didn't want to meet with that person." And I filed that away again and again. And at that time, I wasn't working in public health, so I'm like, ah, not a ton I can do about it, but, you know, put that away in the Rolodex. That's a thing that you put phone numbers in, if you're a younger person.

I would go out and meet with these young girls, who one of my first clients, she was 11 years old. She was pregnant as a result of a rape, and it happened at a party that her mom was hosting at the house. They lived three doors down from where I was working. Her mom wouldn't let her walk to that building unescorted. She was that young. And we're trying to help her get through a pregnancy. We're trying to help her be a parent, be a mother. We're trying to help her figure her way out of that system. Years later, we had moved

physically. Our building had moved. And I saw her out working the corners of south Minneapolis.

There are so many stories like that that I've accumulated over my career. That infant mortality review process in the early '90s is the first of four or five that I've participated in over the years. I remember with Stephanie Graves back there sitting up in Mille Lacs participating in the first Indian-only infant mortality review process that the Minnesota Department of Health was hosting, and it was the first time where the majority of people sitting around the table were American Indian. The majority of people sitting there and reviewing these deaths and talking about the circumstances that surrounded those deaths and talking about solutions and recommendations were American Indian people, and that's the way it should be done. When we're talking about health disparities, whether it be in my community or any other community, those people that are impacted need to be part of the conversation, and they need to be the

strongest and biggest voice in those conversations.

I had the opportunity -- I -- I was so fortunate to spend 25 years in the Division of Indian Work. That really is my heart home. That's where I grew up professionally, personally. But since then, I went and worked for the Mille Lacs Band of Ojibwe for about 18 months where I also got to work on these issues.

I went and spent four years with the Minneapolis Health Department where I worked again with Stephanie on trying to keep maternal and child health front and center for the work of that health department. And now I'm with the Minnesota Department of Health.

I feel fortunate to be in the -- the type of position where hopefully I can have an impact. Because I'll tell you, it's been a long 30 years. And guess what? Nothing's changed. The infant mortality rate back then is the same as it is now. Nothing's changed. Somewhere along the way, I came to this realization. We were in a

conversation. I asked, "In Minnesota, if we saved three native babies every year, there would be no disparity, three." Why can we not save three native babies ever year in this state? It's shameful that we can't.

Also, somewhere along the way, I think as part of an MDH process, I think it was a -- a -- part of a group to make the infant mortality prevention plan, we were looking at a bunch of statistics, and if an American Indian woman gets a college degree, the disparity goes away. If an American Indian woman gets a master's degree, their birth outcomes are better than anybody else's. So, again, the answers are right there. The answers are right there. This is a solvable problem, and why we can't get it solved, again, we need to -- we need to -- we need to do more. We need to do better.

So my work at the Minnesota Department of Health: I -- you know, I have some challenges. Funding, of course, right? I mean, none of us have enough money to do the work that we're doing. Our work is largely driven by the Title V, maternal and child

health block grant funding. In the Child and Family Health Division at the Minnesota Department of Health, we have home visiting. We have WIC. We have children and youth with special health needs. And we have maternal and child health. And the manager for that particular section is back here, Karen Fogg. That maternal and child health block grant isn't enough. We need more by way of that block grant.

Now, fortunately, we have a -- you know, like, a jackpot of grant writers at the Department of Health who are very successful in bringing other grants in the door to support this work that we're doing, which allows us to put more money out the door to tribes and community organizations, but we could use more, and we could use it consistently. I think that's one of the -- the challenges, particularly with infant mortality prevention is when it gets bad enough, people throw a bunch of money at it, and then two years down the road, they pull all that money back. We need to consistently work on this issue, and having

consistent funding is a big part of that picture.

Staffing. We need more staff. Yes, we need more American Indian staff, definitely. We need for those American Indian staff that are working in systems to be supported in those positions that they have. I heard you saying this, Lynn. I've experienced that. I know a lot of native people who worked in systems, and they decided to leave because it's just too damn hard. It's too hard to be a person of color in those big systems where you're not respected, where you're not valued. We need to do better for those people, those Indian people, those black people, Latino people, Asian people who have made the choice to go do their career in public service. Let's support them. Let's help them do the important work that needs to be done.

Knowledge and awareness. I think even today, right, I was talking to Lisa a little bit earlier. She said, "We're unicorns as American Indian people yet. People don't see us as part of today's reality. We're

still in the movie. We're still in those teepees out on the plains. We're still killing buffalo."

We're part of this society. Are we huge in number? No, we're not. But we've been around the longest, and we need to be recognized for that. And people need to know our history, the good and bad, not the sexy, romanticized part of our history, all of it.

We don't have enough supporters in this work at the policy level, right? This is not the type of work that's going to land on the front page. This is not the type of work that's going to land on the big national news stations, and, therefore, I think policymakers don't always pay enough attention to it. We need some investment from our policymakers on these issues. If we improve maternal and child health outcomes for American Indian people, for African Americans, those outcomes will improve for everyone.

And if we look at maternal mortality, the United States is the worst in the world.

That's just maternal mortality, right? If we dig down into the disparities, of course that gets more depressing.

Community engagement and partnerships is my thing. That's how I grew up, right? Grew up out in community, listening to community, engaging with community, partnering with community has to be done by governmental organizations.

I'm making -- I've made a commitment to that at the City of Minneapolis. I'm making a commitment to that at the Minnesota Department of Health. I think another one of my panel mates up here said this. We need to listen. We need to watch. We need to hear, authentically, not because a funder has told us we have to, not because it's the politically correct thing to do, but because we want to and because we really care.

I'm not going to come out to you and say I think this is the solution in your community. Are you interested in doing this program in your community? I'm going to come out and say, "What's going on in your community? Where are the challenges? What

are the problems? How can we work together to help?"

I know what's going on with Noya Woodrich on a day-to-day basis. I know pretty well what's going on in my community here in Minneapolis-St. Paul area. I might know a little bit what's going on at the Mille Lacs Band of Ojibwe way because I worked there for a period of time. But I still need to go and listen. As a member of this community, I still need to be authentic in my listening and my hearing and my watching, and I don't need to be the loudest voice at the table. I don't need to be the only voice in a room. In fact, I should be the quietest person, because I should be busy listening. Having those relationships with tribes, having those relationships with urban Indian organizations, having those relationships and partners with individuals, with networks, with coalitions, with collaboratives, whoever is working in this area, that's who we should be connecting with as a state organization.

Some of the things that I've seen in

the four-and-a-half-months at MDH, we've just finally published our maternal mortality review report, three weeks ago, I think, maybe a month ago at most it got published. We need to continue doing things like that because those mortality reviews inform the work. They allow us to dig down in the individual situations, understand what going -- what is going on with those families, what is going on with our communities, what is going on with our systems.

We no longer, in Minnesota, have a statute that allows for fetal infant mortality reviews. I'm a huge fan of those. I think the information that comes out of those and the exercise of people sitting down and talking and having conversation about those is really important. I'm not going to be able to make it happen this year, probably not next year, but I'm going to continue working on that because I think that that's really important that we continue to be able to do those here in the State of Minnesota.

Data. Jackie and Karen, and Myra, and I were on the phone last week talking about putting together the first in awhile kind of data sheet, data fact sheet on maternal and child health here in Minnesota in our American Indian community. So it's exciting that we'll be able to get that updated and get that out there so that people can have that information easily at hand.

Continue our current work, right? I mean, we have a grant to work with doulas and promote doulas in the -- in -- in communities, so let's do that, that continuing of that gathering of data so that we can share that with others who need it. The funding. We will continue to seek grants so that we can give money back out to the community. We are -- in a couple-- the items that we are proposing for the legislative process this year, we are carving out a certain portion of the money for American Indian Communities. So we're going to the legislature and saying we want this money. This much of it's going to American Indians. We need to do more of

that.

Oh, and the last thing I wanted to touch on, one thing that we saw in this maternal and mortal -- maternal mortality review process is that a lot of our mothers are not dying due to pregnancy complications. They're dying because of substance use disorder or traffic fatalities. So one of the things that I'm going to try to do as I work with the different sections and folks at the -- in the child and family health division is try to keep substance use disorder a part of the conversation. Mental health needs to be part of the conversation. Violence that our Indian women are experiencing needs to be part of the conversation. And I went a little bit over my time. But thank you very much.

ED EHLINGER: Give -- given the time, I think we're going to move on to the -- the next panel. So if you could stick around, though, after, I'm hoping we have some conversations at the end of -- near the end of the day to get some of the questions

answered that I'm sure people have.

So while we're transitioning, let's all sit up -- or stand up in our places and move just a little bit.

All right. Let's come back together again. You can tell it's a really good meeting when you're running over and having lots of really good stuff and lots of questions.

But this is one session that -- that really came about because at our last meeting we talked about incarceration as a major issue that a lot of people hadn't recognized as being such a major problem. And the missing and murdered indigenous women and girls also came out as one of the issues. So thought we would revisit this topic, and we have the Prison Doula Project here. Rebecca Shlafer is here, and I think will introduce this topic, and then we will, following that, talk about the missing and murdered indigenous women and girls. So let's turn it over to Rebecca.

REBECCA SHLAFER: Thanks so much for the opportunity to be here today.

So I am privileged to be joined by three amazing women who I will introduce in just a moment. As I mentioned, we did have an opportunity to talk about this topic briefly at the last meeting. I appreciate the opportunity to have presented then.

Before I turn it over, I want to just give some context for this topic. As I shared last time, there has been a nearly 700 percent increase in the number of women incarcerated in this country since 1980.

We know that most women behind bars are of child bearing age, and incarcerated women have high rates of chronic health conditions. We also know that the people that we lock up in this country are disproportionately women of color, majority of whom are black and/or indigenous. We know that black and indigenous women are disproportionately represented in both the criminal/legal and child welfare systems. And in the little bit that I've heard about today, really critical to think about the forced separation and what white supremacy has done for mothers and children of

indigenous families. It is these two systems coming together from -- for many of our clients with the Minnesota Prison Doula Project that have separated moms and babies across generations in horrific ways.

At the Minnesota Correctional Facility Shakopee, our state's only women's prison, which is only five miles down the road, it is not lost on me that we are very close to the prison, 20 percent of the women in that facility identify as American Indian and Alaskan Native. Among pregnant people at the prison, 35 percent of them are American Indian. The disappropriation rates are really astronomical.

The Minnesota Prison Doula Project is part of the Ostara Initiative, and our mission is to collectively transform systems by re-imagining justice, advancing health, and reclaiming dignity in our policies and practices for all pregnant and parenting people.

Our ultimate goal is to end prison birth in America. I am truly honored to be here today with three, as I said, incredible

people, two of whom are doulas, and two of whom are formerly incarcerated clients of ours who are bringing their survival stories, really. Bravery, tremendous courage to get up here and share those stories, and I encourage you to all do what we were just told, which is listen with an open heart and open ears.

I'm going to first turn it over to Jocelyn Brieschke who is one of our amazing doulas. And then we'll hear from Autumn Mason and Lanice Antel-White.

So without further adieu, I'll turn it over to you, Jocelyn.

JOCELYN BRIESCHKE: Thank you for having me. (Speaking indigenous language.) Oh, I'm, like, so nervous. I don't even know why because there's literally, like, ten people in the room. Clearly, nobody cares about this issue but us, like.

(Speaking indigenous language.) And I am Jocelyn, and I am from Minneapolis, and I am from Leech Lake Band of Ojibwe.

I wasn't quite sure what would come out of my mouth today, but I've been here all

day listening to everybody else, and basically, it's -- it's the same thing. We need, like, culture. We need cultural programs for our indigenous women. We need, like, funding that actually is attainable where you don't have to jump through 25 hoops to get a little tiny bit of money and then it's gone in the next few months. Like, that -- the program in Phoenix, like, I'm -- I didn't even know that, and I have friends in Phoenix. So, I mean, stuff like that happens all the time for funding, with whatever -- whatever their funding for indigenous, like, in the moment, and then all of a sudden, it's not funded anymore. And then -- I mean, and there's no, like, guidance from anybody to show us, like, here. How -- how do you continue funding, you know?

Oh, I hate this one. Oh, okay. So is this better? I feel I'm going to do some sort of song in a second. Like, hi. Welcome to the meeting.

Well, okay. Here's my song and dance. I -- honestly, I mean, I feel like where do

we start with this? Like -- and my first initial thought is, well, let's just decolonize the whole system and burn it all down and start over. But it's really hard when nobody wants you to do that and people are benefitting off, like, the death of our children and our, you know people being in treatment and our people being in prisons. So since we can't do that, we're going to go with the funding answer. Like, that's -- I can't stress that enough. Like, we need funding for indigenous, like, complete perinatal care, not just like, oh, here's a doula, here's an underpaid doula. You know, go work yourself to death while you have ten other jobs. You know, or let's just do funding for, like -- let's train millions of doulas and still not pay them well, which is what's basically happening.

And it's also -- you know, it's hard because for indigenous people, like, we will do the work for free, and we will do the work without funding. We will do the work. Like, we'll make it up. Like, if we don't have it, like, we just kind of get tired of,

like, begging around for money. And we're like, you know what? F it. I'll just do it myself. And then that's what happens a lot of times, when you just say, like, there's so much money out there thrown at ridiculous stuff, especially -- I can't even get started about what the DOC throws away. Like, if we're talking about incarcerated -- incarcerated women, like there's so much misuse of funds just between me, you, and whoever sees this tape. But, like, it's really bad. And, you know, like, I've seen exactly what everybody's already talked about here today, you know, the racism, the institutionalized racism in the hospitals and the mistreatment of our women. And then if you -- on top of that, if you -- you're a, quote-unquote, "prisoner," it's then it's like triple that because not only can they mistreat you like that, but they can justify their mistreatment of you, you know, and your family and your child and your whole birth experience, and -- oh, and your medical care, which is a big -- a big part of it.

I mean, so what -- I mean, what I would like to see -- I would love to see whoever's above the DOC be able to, like, fund an indigenous doula project specifically for indigenous women and actually, you know, I don't know, like, make the DOC behave. I don't know. Make them understand that our work is valued as it pertains to infant mortality, but I -- I think that's it.

I don't -- I literally wrote those notes in my car, guys. So I think that's the basis of, like, what I have to say, and then I'm going to turn to over to Autumn.

AUTUMN MASON: Hi. Thanks for inviting me. My name is Autumn Mason. I am a doula, a parenting peer support professional in a program facilitated with the Minnesota Prison Doula Project. However, prior to achieving those acclimations, which I am proud to say I have, I was an incarceration survivor. Thank you. I was an incarceration survivor. I was incarcerated about, what five miles away for two-and-a-half years, and I was actually committed to Shakopee at seven-and-a-half

months pregnant.

The woman that I sit next to, to my left, is someone who I adopted in that journey as a little sister. At me being 26 years old and her being several years younger than that, we both faced someone that I hope that no one else in this room has ever had to face, and I hope that we can all take our professions and our interests and make sure that many less -- many fewer people have to encounter this experience as well.

But during that two-and-a-half years of incarceration, I was actually able to study -- to study from the inside out how the system has affected the lives of many and how it has disrupted so many different cultures, particularly the indigenous culture. So Lanice and I are going to share a little --

UNKNOWN SPEAKER: Hi. This is Siri Helget. I'm trying to mute the Zoom.

AUTUMN MASON: All right. Lanice and I are going to share some of our personal experiences together, and I appreciate your

guys's attention. But these are real lives -- experiences and these are things that have devastated us, our children, our families, and we continue to experience the -- the repercussions of that trauma. And I want to specify that word because, again, this experience has altered my life and the lives of many in so many ways that I can't even describe.

So first I'll let her introduce herself, and we'll carry on in our conversation.

LANICE ANTEL-WHITE: If you guys have that program, it's not Latice. I don't know why they wrote that. It's Lanice.

But I'm from Fond du Lac up -- way up north. And my name's Lanice, and I'm 28 years old. And I had my daughter in Shakopee, and I had my son -- I was pregnant with my son the whole entire eight months and then got right out before I had him too. So I went through two pregnancies incarcerated.

AUTUMN MASON: And just to specify, with your son, where were you incarcerated

at?

LANICE ANTEL-WHITE: St. Louis County jail.

AUTUMN MASON: Okay. So when I was committed to Shakopee, I think it was April of 2014. And about, what, you got there shortly before that?

LANICE ANTEL-WHITE: Yeah, right before you, in November.

AUTUMN MASON: In November. And tell us about your pregnancy and how your first few -- the -- the months before we were introduced to each other, how that went for you.

LANICE ANTEL-WHITE: Well, I went into the office, and they're like, do this pregnancy test because it's mandatory. And so I did a pregnancy test, and they're like, you're having a baby. I was like, oh, no. I'm sentenced to three years in prison. So I had to spend my whole entire pregnancy, and then I had my daughter in there. And I got out when she was two.

AUTUMN MASON: And so once we got to Shakopee, I specifically remember seeing you

and recognizing, obviously, we both had pretty prominent stomachs at the time. I think you were only about three-and-a-half, four months in between our pregnancies. So I was about eight months, and you were, what, about four? But one thing that I did recognize is that we both had the same fears, I think, and we both were facing the same struggles. And so we were able to connect and actually were -- ended up being roomed together so that we could support each other through that journey. Then we -- we were able to build a sisterhood.

Lanice, you are mixed with -- well --

LANICE ANTEL-WHITE: I am half black and half native.

AUTUMN MASON: So we identified a lot with our cultures on the African American side, but you actually taught me a lot about your indigenous culture. And one thing that I noticed that we had in similarity is that our ancestral -- our ancestral -- ancestral mentors and our -- our -- our elders have also been known to work together, gather together, eat together. Like, we -- we come

from a very collective type of past and background, right?

One of the things that I think was the most devastating about that experience at Shakopee, especially being someone that was going through something so emotionally troubling was that there was a policy against any kind of touch, whether that be handshakes, any type of passing, and when I say, "passing," we couldn't even give each other a piece of paper, you know. So it was very difficult when you come from a family and a history of being very emotionally and physically connected and supportive of each other to having that opportunity literally snatched from you.

But I remember, also, prior to -- I delivered my daughter in June, and prior to you having your daughter, us just having conversations about how this is going to go and us not even knowing and believing that we were in that situation. But we both were also able to connect with the Doula Project and get some parenting support from inside. But there was a lot of different things that

I feel were taken from us rather than were given to us in that experience, right?

So I did come up with a few questions that I kind wanted to, you know, discuss in front of you guys to elaborate on how that would feel and how that experience went.

So for me, I want to speak on behalf of being an incarcerated person and also being a doula in support of incarcerated people. And that is both in prison and in the local jails in the state of Minnesota.

So I ask you, describe the difference in your pregnancies and your birthing experience from when you were in prison and when you were in community. And I ask that because -- for obvious reasons in my own personal experience, I do know -- you know, some of those -- those -- those differences are obvious. You don't -- you're not able to choose your own medical provider. You're not even able to set your own medical appointments. You're not able -- you don't have any autonomy over your medical care. You don't have a privileged or opportunity to share that experience with the -- your

partner or the person who actually helped create the life that you are carrying.

Many things. Your -- your food access is limited. You have very, if any, emotional support, you know, and all of that.

Is there anything else that you think was difference -- different in your pregnancy versus -- your pregnancy inside of a facility versus your pregnancy in the community?

LANICE ANTEL-WHITE: Yeah. So in the community, we -- you know, on Fond du Lac, I know everywhere, we're dealing with a lot of overdoses in young kids, like, very young kids. Like, I know a 13-year old that just passed away from doing a Percocet, and it was fentanyl. So, like, all my life growing up, I've had to deal with being an addict and dealing with people around me being addicts too.

So when I first had my -- had my daughter, I was worried that she wasn't going to be -- she wasn't going to be tooken [sic] care of, right, like, you're going

back to the rez that I grew up on, and it's obviously not the most ideal place you want to raise your child. You go out to a playground, and there's needles everywhere. You know what I mean? Like, that's scary. Like, I didn't -- I never wanted children, but I couldn't -- they didn't give me the opportunity to abort either in prison. So it couldn't be like, hey, go have an abortion. So I didn't do that.

So the difference is for me, the medical -- the medical for me was -- was good because I live on the rez. I was an addict. I didn't make any appointments when I was out. So that was a plus for me. Like, when I did -- when I was in prison, I was able to go to all -- and jail, I was able to go to all my appointments and have healthy babies, and who knows. If I wasn't in prison, I could have been using or dead on the street with a child, you know. So that -- in that way, it saved my life, so...

AUTUMN MASON: And I really appreciate you sharing that insight because, again, there are a lot of different views that if

you haven't experienced this or you haven't been in contact or you're not familiar with anyone who has, there's a lot of things that you wouldn't probably think about or assume, and I'm very glad that you were able to be transparent about that.

I think we also talked about how in our communities, both on Fond du Lac and then also in the urban communities here in the metro area, resources are very, very few and slim and -- and far between. It's very hard to get the support that you need. So as easy as it may sound to make a doctor's appointment and to just go to the doctor's appointment, we also have other issues that we face to count -- like, that jeopardize us being able to get that medical care.

Maintaining medical care -- insurance and being able to qualify for that, you know, that's very difficult in many people's situations, and sometimes it's just something that you can't afford or are not eligible to have. That impacts a lot my clients who I've worked with who actually are -- feel privileged, like Lanice shared,

to have the medical care through their jail.

However, we also have other clients of mine who have had medical who if their medical issues are not addressed and they're -- when they're making these -- expressing these concerns, they're not viewed as having valid opinions or input on their own medical care. So there are -- it is on both sides an issue, you know, that we need to face.

But I think, you know, when we were talking this morning, we discussed how the limited resources really impacts how all of our lives -- like you said, on the -- on the reservations and in the urban community, how we live our lives and why we are so more -- more -- much more likely to be subjected to physical violence, to incarceration, and to substance use and -- and even sales. You know, when your -- your resources are limited and you're very -- you're struggling just to maintain, sometimes it's a choice between making illegal activity or being able to feed your children, you know. And I don't condone either one, but I definitely understand when clients of mine, even

myself, have had to be faced with those decisions.

One of the things we talked about is what is different or why -- why do we feel like there are more issues with substance use, physical violence, and incarceration in our community? Is there anything you want to share on that?

LANICE ANTEL-WHITE: So I'm half Native American and half black, but I grew up on the reservation. So I can say that as an indigenous woman, we are angry. Like, we don't even have voices. It's not fair. Like, you have people just shutting us up just because they don't want us to have a voice. And that's what's hard about it. Like, I was going somewhere with this. So -- so -- yeah. We get angry.

So in prison -- we have ceremonial things, like, when you have a baby. First of all, I wanted to keep my placenta. They did not let me keep my placenta or give it to my mother. That wasn't even -- my doula tried, but I don't know.

So another thing is, I like to -- I

smudge. You know, we want to smudge. I wanted to smudge my baby and cleanse my baby right after he was born because my sister's done it, so didn't think that it was going to be a problem. Absolutely not. They did not let me do that. And so as soon as we got back to the -- as soon as we got back to the prison -- I only got eight hours with my daughter after I had her. But when we got back to the prison, I was explaining to Autumn, because we were roommates at the time, how I didn't get to smudge, so an older lady named Dawn Peele brought me out into yard and she smudged with me, but it wasn't the same because I was not smudging with my child. I wasn't sharing that -- I wasn't sharing that bond with her, you know, like.

Also having a baby in prison -- I have four kids now, and the bonds are completely different. Like, my mom raised my daughter for two years, and we don't -- it -- it totally messed us up a little bit. Like, that's her mother, and I'm her mom. So it's, like -- it's not fair, but is it my

fault, you know what I mean, like, because I went to prison? So it just sucks because when you do have kids and that bond is severed. It's -- it's cut. I don't know.

You know, people always say the babies will remember you, but that's not really true. That's not the case.

AUTUMN MASON: Thank you. Thanks for sharing that. Yeah. We talked about, you know, some of the things that you felt, some of the ways that we felt like the prison could have been more respectful and more supportive of your cultural beliefs and practices, and I'm glad that you mentioned that.

Some of the things that I've seen with some of my clients that are still incarcerated is, you know, they're getting what they feel is harassed because of wanting to practice their religious beliefs and not having that accessibility. And even now with COVID, you know, we might, be speaking specifically about the indigenous culture and their practices, but in general, almost none of the religious groups or

churches or any practices have been able to regain access to the prison. And you know, I think about with such a strong cultural background, how that could be impacting people in one of most traumatizing times of their life.

You know, I feel like I've seen people at their lowest and when they -- what they only had was their spirituality, and when you take that from a person, what do you have left? What incentive do you have to really fight against a system that was created to deteriorate you, your culture, and your family life?

LANICE ANTEL-WHITE: Is it fair that you get to have a Wiccan -- a Wicc- -- they get to meet every weekend and week there, this Wiccan in the prison just helps fund it and gives them cupcakes and books and they can do time in the yard, extra time in the gym but natives can't have a ceremony? It's not. Maybe once a year. Like, how is that fair? You know, like...

AUTUMN MASON: So, you know, I know we're having kind of a passionate

conversation, and, you know, this is because this, like I said, is a real live ex- -- real lived experience, and sometimes it's very hard to verbalize the impact that it has had on so many people.

Like I say, I'm privileged to be able to serve as a doula and a parenting peer support professional at Shakopee prison, and I'm glad to be able to be there to support the women who are walking in the journey that I've had to walk in or similar. But I also want to be able to em- -- empower them and encourage them and give something to look forward to. And when we're having conversations like this, I feel the only thing we that can do is be completely raw and genuine about what we've seen, how it's tearing people down, and what we need to do, most importantly, what we need to do to be able to end these type of traumatizing experiences.

Like you shared with -- about your experience with -- with Nala, you know, having a child and having that separation at such an early age is so abrupt to that

child. And I remember always saying, "If you don't care about me, I understand I made a mistake and I can live with that, but if you don't -- and if you care about me, please have consideration for my child." There's so many women whose families are so far a place from where Shakopee is located that they go years without seeing their children. And we are struggling to even be able to provide supportive visitation, you know, at the prison for these people virtually. We're offering to give any type of support that we can to keep these families connected. But when we're sitting down having these conversations, we have to think, what is it that we -- each and every one of us individually can do to try to counter this system that has been so traumatically -- so devastating -- devastatingly traumatic on so many different families?

So I appreciate everyone being here. Is there anything else that you want to share about your experience or what your hopes are?

LANICE ANTEL-WHITE: I just want to say also, like, so -- so a lot of native women have to go back to their reservations after they have their -- after they get out of prison. So some -- especially if you just had a baby in there and you had to give your baby up and you have to relearn and get to know your baby again, so come hand in hand with substance abuse. Like, I don't know, like I'm not one to talk. Like, I'm shaking up here. I don't even leave my bed. Like -- I like to stay home, but -- so like when women -- for myself, I got out. I was angry, like, being a native woman, didn't get to do my stuff and do the things I want, plus I'm also black so I get the best of both worlds, you know, like woo-hoo. No. I'm proud to be who I am, but -- so it's hard.

When I got out of prison, the first thing I wanted to do was get to know my daughter, but when I see that she wasn't gravitating toward me like she should, I gravitated away from her as well and gravitated towards the drugs again. So I --

that ended up me having my son, Huey. I was only out for about eight months when I got out of prison and got sent right back to jail and did another eight months, and I found out I was pregnant in there again with my son Huey.

So thankfully, I got to -- what's that called? Yeah. I got to do the process of keeping my baby overnight and giving a bath myself and not being handcuffed or having three guards in the room, three male guards, two male guards and a female guard while I'm having my baby for the first time. Like, that's just -- that's the hardest part. Like, when you look up to have a baby, you think that your family's going to be around, and you think that you're going to have the support that you -- that mothers get. But I did not have that. I had three guards, and two of them were males. And I was unruly, so I was handcuffed to the bed.

But it was, really, I was just angry. I was mad. I had to give my baby up in a few hours, you know. Like, it's hard. It's definitely something that we have to live

with for the rest of our lives, like, our bond, and everything is messed up because of it. It would be like if we were able to see our babies more or maybe if there was, like, some kind of way that -- I don't know, something, something different.

The guards are ruthless there. They don't care. Just having a baby, stitches and stuff, you can barely walk, and you have to go back -- right back to work. Like, that's hard. They don't care at all, like, at all, nothing.

AUTUMN MASON: Thank you for being so vulnerable. And I want to just say, I'm very proud of you because I remember how traumatized you were when you came back from having Nala, not just the fact that you didn't have the physical support, but you were still very, very young and just being away from everything that was familiar to you and not having that support. I remember when you were gone and knowing that, you know, you were coming back, and your family was so far in distance. We didn't know if there was going to be a chance for anyone to

drive her down. And so a lot of the -- the women -- I'm glad you brought up Dawn Peele because she was definitely one of the elders that even I respected. A lot of us just kind of thought, like, what can we do? What can we do to support her right now? We can't even hug her when she walks in that door. No one can even pat her back when she's crying. Like, what can we do? And I thought about these things because I just lived it. I was still living it.

You know, and what do we do? We gather as much as we could, the necessities, you know from pads and T-shirts, bras, panties, you know, and -- and -- and photo tickets. You know, we were able to share phone times, you know, illegally. Let's make sure that she has a couple PINs so she can call and check on her baby. These are the things -- this is how we had to create community within the system ourselves to support ourselves in the way that we were.

And I also want to mention, when I was sentenced to Shakopee, the impression that I had was that I was going to walk into an

environment that reflected the population of the state, which, in my eyes is mostly white, brown, and black, put primarily white. When I got there, how shocked was I to find that it was primarily black and brown with a few specks of white in there? I was -- and I'm not trying to be funny, but I was really, like, mind boggled, and I -- like, I'm not a mathematician or anything, but I was really trying to understand, how is this possible?

But then I realized, you know, first of all, we have -- we live in a sys-- we live in a society where when you don't have money and you don't have means, you're automatically less likely to have certain opportunities, which is even -- can include defending yourself or have a proper rep -- representation. Okay? So that's a fact. We know that.

Also, I recognize that, you know, these sisters that are in here are just like me. The majority of the sisters that I met that were black and brown were there for one of two things: They were either in there for

having a drug-related offense or having an offense that was either physical with someone who was a -- a -- an abuser or a partner in their life at some point. And I came to the conclusion that, one, we have to fight our way out of most of our situations, and unfortunately, society doesn't recognize what -- how much of a fight we are up against and how that reflects in the carceral system.

And two, we have so many issues in our communities, and a lot of us don't know where to turn, so we turn to drugs, alcohol. Very unhealthy. And I'm not making any excuses, but this my rationale.

I know what I see on a regular basis, and it's struggle, and it's despair. And a lot of us are just happy to make it out of that, but sometimes it's hard to just cope with that. So I recognize, how many of these young sisters are in here for a 5th degree possession? It was a whole lot. And then I recognize, well, how many of these people 5th -- 5th -- people with 5th degree possessions are going to get time to go to

treatment? Barely of any of them.

So if you're -- and I'm glad that you mentioned this. If you're going out on any work release or parole, early release, you have to go back to your county of commit. How many people have come here and had self healed and gone through their own process of sobriety and treatment on their own without any support from the system and then thrown back into the very place that made them sick? And you expect them to succeed with all the extra consequences, subsequential consequences, all the extra responsibilities. You're asking them to be in classes and groups at times that are -- they're also supposed to be parenting or working to support their families. How are we expecting these people to succeed and not feeling responsible for giving them the tools and the skills to be able to do that? So we're not going to see any change. And I'm realizing that this is more likely to happen in communities where people look like us.

So I'm sorry. I'm glad that we're

here, that we're having this conversation, and it's not -- it's a very heavy conversation to have, but this definitely needs to be had, and then we also need to have a conversation on where we go from here.

LANICE ANTEL-WHITE: But also, our own people are fighting each other. Like, the blacks are fighting the blacks. The natives are fighting the blacks. The natives are fighting the natives. The natives are hurting the natives. The blacks are hurting the blacks. And then we blame the white man, but -- I mean, yes.

UNIDENTIFIED SPEAKER: It is their fault.

LANICE ANTEL-WHITE: It is their fault. I agree. I agree at the same time, but at the same time, like, the -- the chairmen on the Fond du Lac are greedy. Like, I'm not going to -- they have all that money, and all this stuff, and we can't even get funding for a kids' youth group out there. Like, that's hard. Like you guys, got this big old casino and all this per cap money

and everything, but we can't even get a center for kids to go to or anything. But the only thing they have left to do is turn to the streets. Like -- and what they think is normal.

I lost my brother to gun violence. He was 16 years old. He got shot in the head last -- about two years ago. He was 16, 16. If -- I feel like if there was, like, a community center or if he had more -- more indigenous males to look up to instead of them clashing with the youth all the time, then we would -- I wouldn't -- I probably -- I wouldn't have lost my brother. We probably wouldn't have lost all these young kids to fentanyl overdoses. You know, it -- it's all about being cool and wanting to be from the streets, but they have no guidance. That's what's hard.

Like, if you have money, and you're just being greedy with it and you don't want to help your people out, that's a problem. You're a problem, you know, especially if that's what the money is for. Like, the casino money is not for the golf course to

get new golf carts. Like, why not use that money to make a basketball team for the kids or something, anything, like, for children of youth? That's -- that's where the problem is now. We went through what we went through. The problem is now is our younger kids, they have nobody to look up to. They have nothing. They have nobody. So they just lose hope. That's what's sad. That's what we see going on on our rez.

Like, all the elders, everybody, they want to argue with the younger kids, like, it's their fault, and is it, really? No one else. Is it, really? They just want some way to cope. They want to cope too. You know, they have nothing. Like, their father's an addict. Their mom's a drunk. You know, their mom had them in prison and can't bond with them right.

They get angry too. Children are angry too. It's not just the adults. It's really our youth. And that's what's -- that's what needs to change in our community, for real.

JANELLE PALACIOS: Thank you.

AUTUMN MASON: Thank you, guys.

ED EHLINGER: You said you were thankful that you were here. Well, we're thankful that you're here. Thank you for these stories. As -- as powerful and as tragic and as painful as they are, they're stories that we need to hear, so thank you for the courage for coming in and sharing your story. Really appreciate it.

So now we have one more presentation, probably in a similar vein. Is -- I hope, Gwendolyn Packard is on the line?

GWENDOLYN PACKARD: Yes, I'm here.

ED EHLINGER: All right. Gwendolyn is a senior housing specialist for the National Indigenous Women's Resources Center. So Gwendolyn, take it away.

GWENDOLYN PACKARD: Thank you. And thank you for putting up the PowerPoint.

That was really a powerful panel presentation. Thank you. I'm really glad I was part of this panel.

Good afternoon, everyone. And -- and thank you for the opportunity to be part of this important panel presentation.

My name is Gwendolyn Packard I'm

Ihanktonwan Dakota and a survivor of domestic violence, and a senior housing specialist with STTARS, the indigenous safe housing center, a project of the National Indigenous Women's Resource Center.

Next slide, please. STTARS stands for Safety, Training, Technical Assistance, Resources, and Support. We are a new resource center funded this year by the Family Violence Prevention Services Administration to response to housing insecurity and homelessness for American Indian, Alaskan Native, and Native Hawaiian victim survivors of domestic violence.

Our mission is to advocate for safe housing for all our relatives, and we do this through centering indigeneity in our indigenous life ways throughout the housing spectrum, acknowledging our relationship to Earth Mother, recognizing and challenging the impacts of climate change on housing and violence, building on each other's gifts, understanding and resisting oppression and erasure, and acting upon the prayers of all our ancestors to honor diversity and create

belonging for us all.

The lack of safe, available, accessible, and affordable housing for indigenous survivors of domestic violence is one of the most critical factors as they weigh the risks of leaving or staying, and as they work to keep themselves, their children, and their pets safe.

We approach this work through a human rights lens that housing is not a conditional right but, rather, a human right. Our work centers on creating more comprehensive housing solutions for all survivors of domestic and sexual abuse, including trafficking. Safety, self-sufficiency and self-determination for survivors should not be unreasonable expectations.

Next slide, please. Prevention is another cornerstone of our work. Housing is prevention. We know that inadequate housing is often the primary reason for removing children from their families and that housing insecurity and homelessness are both the precursor to and the result of domestic

and sexual violence, mental health and substance use issues, trafficking and missing and murdered indigenous relatives.

COVID has had a deep impact on tribal communities and indigenous people. Rates of domestic violence and child abuse and the housing crisis have all been brought to the forefront during the epidemic, yet we know that safe, adequate housing is one of the strongest mitigating factors in responding to COVID.

Preventative work is work that centers our elders, our youth, incarcerated and formally incarcerated relatives, people with mental health and substance use issues, people with disabilities, death, hard of hearing, climate change and the changing world in which we have created, public health, for our two spirit, LGBTQ relatives, domestic violence, and sexual violence, stalking, traffic -- trafficking, dating violence, and missing and murdered indigenous relatives, and maternal and child health.

We received ARP funding from FVPSA and

are using it to support off-reservation tribal programs and tribes that do not receive FVPSA fund. This funding has been instrumental in helping programs provide hotel vouchers, application fees, emergency rental assistance, transportation, PPE, air filtrations, COVID test kits, and transportation to and from test sites and vaccine sites.

Next slide, please. The movement to end attention and -- I'm sorry. The movement to bring attention and awareness to the issue of MMIW, missing and murdered indigenous women or MMIR, missing and murdered indigenous relatives, has been over a century or two long. It's been driven by indigenous families and communities. There are reports of missing indigenous people that we have been able to document from the 1800s. This movement has been snowballing over the years, slowly in the beginning but faster now, and today, we are seeing and hearing more about it.

There are significant changes in funding, programs, and services, public

awareness, prevention, strategies, policy, judicial systems, attitudes, and most importantly, I think technology's played a huge role in all of this.

Currently, there are fewer than a dozen states that have developed work groups or task forces to address human trafficking and missing and murdered re- -- relatives and who have developed reports on their findings to date.

Next slide, please. The scope of the problem is huge and has gone unresolved and unrecognized for decades. It is our intention at STTARS to encourage all the states that have task forces and work groups to include housing as a preventative and mitigating factor to address missing and murdered indigenous relatives. In a report by the Urban Indian Health Institute, they indicated that 53 percent of native women surveyed lacked permanent housing. Housing is identified here in this chart on public health implications -- I think that's the next slide, the public health implications, along with access to a SART and -- and --

SART -- I'm getting a tongue twister. SART is SANE forensics, gun violence prevention, mental and behavioral health, access to justice and interactions with law enforcement and the law enforcement response, gender-based violence, and access -- or an access to or lack of access to resources, programs, and services.

We go to the next slide, please. As indigenous people, we live within complex jurisdictional issues. We experience inadequate or total lack of resources for direct services, substandard and crowded housing, high rates of poverty and unemployment and a mult- -- for a multitude of reasons, poor law enforcement response. And sometimes there's just not enough law enforcement on some of our tribal communities to be able to respond. Their transportation and geography and climate issues that also impact the response on the part of the law enforcement.

Next slide, please. There's a lack of resources for health care, mental health, and substance use programs, and all

services. And I think it's important to note that all these issues are connected, and it's important that we take a holistic approach to doing this work.

Next slide, please. Violence against Indian women is rooted in colonization. Indian women are murdered at a rate ten times higher than the national average. Homicide is the third leading cause of death for native women. 75 percent of Indian women murdered were killed by an intimate partner, and as Indian women, we live our lives in the dangerous intersection of gender and race.

Next slide, please. It's not surprising that we experience such high rates of violence because we have limited resources and access to services as difficult and often unavailable or nonexistent. Many tribes have domestic violence programs, but they are limited in the services they can provide, such as legal assistance, shelter, counseling, transitional housing or permanent housing, or work -- or to respond to workforce

issues. Although funding for tribal domestic and sexual violence programs has continued to increase over the years, it is still woefully inadequate to address the need -- the needs of our people.

Next slide, please. And so this is a -- and these photos like this kind of are plastered all over Indian country of our missing and murdered primarily indigenous women but we have a lot of children, LGBTQ, and also male victims of -- who are also missing and murdered.

The housing needs for American Indian and Alaskan Natives have never been fully addressed. Funding for housing continues to be inadequate, and many of our communities continue to experience lack of infrastructure, substandard and unsafe housing, overcrowding, and lack of economic development activities or initiatives.

And I think if we can go ahead to slide 13. Next one. Yeah. There you go. Back one. There you go. Thank you.

The Violence Against Women Act was enacted in 1994 and has been reauthorized in

2000, 2005, 2013, and just recently this year in 2022. So hurray -- hurray for that. And many of the tribal provisions were added in the -- in 2005 and forward. And also some of the things that happened during that is that now there was a Oliphant-fix that expanded the jurisdiction for our tribes so that they could prosecute non-natives for certain crimes that are committed within tribal communities. But there's still a long way to go in having the legal protections in place to protect our women and children in our communities.

Next slide, please. These kind of deal with firearms. And with regard to firearms, I would stress the following: That domestic violence and firearms are a deadly combination, and women who are in abusive relationships are five times more likely to be killed by their partner if their abusive partner owns a firearm. Firearms are a critical item on the Danger Assessment Tool that was created by Dr. Campbell. And the presence of a firearm in an intimate partner violence situation increases the risk of

homicide by at least 500 percent.

So all of this speaks to the data that was presented around the violence that our women face and experience. Firearms laws have -- have the potential to protect domestic victims and their children from lethal violence by limiting an abuser's access to firearms. And, of course, we know in Indian country, there's culture reasons why there are weapons in the homes. There's subsistence hunting, and, you know, there's a lot of other reasons that the fire -- there's legitimate reasons that firearms can be used, and so it's always important to take all these things into context.

Next slide, please. And I think this is one I had already talked about too, so we go to the next one.

Okay. Access to services sums up much of the items mentioned in this presentation and identifies many of the key barriers or challenges we face. It's important to always remember that we are not a monolithic nation of people and that working with and within tribal nations can be -- look very

different. There's many barriers that we have here in Indian country. There are a lot of tribes that don't have access to 9 -- 9-1-1. There's a lot of -- tribes don't have access to N -- NCIC. I know I'm getting my acronyms mixed up here, but into -- to enforce orders of protection. I mean, all of these are very, very important law enforcement tools that a lot of our tribal communities do not have access to. And there's a lot of work being done to -- to change that. I -- I don't want to leave that hanging out there, you know, without saying that there -- there is work being done to -- to change those. And change is happening, and it's -- feels like it's always moving a little too slow, but it is changing.

I want to talk a little bit more about housing, if you want to move into the next slide, please. When it comes to housing and shelter access for American Indian and Alaskan Native relatives, we see that there's a lack of shelter options. Some tribal communities are -- are located hours

away from the nearest shelter, and so transportation can be a problem. There's virtually no housing inventory in a lot of our tribal communities. And -- and that's been the case for decades. There are spaces that are unsafe and are not trauma informed.

Housing, there's housing available or there's housing, but it's not habitable. However, even then, you find people living in -- in -- in unsafe housing, spaces that are not culturally rooted. There's little or no transitional housing available. And housing and shelter programs are not sustainable due to lack of resources and funding. And there are problematic mindsets around who should have and who should not have access to housing and shelter.

Next slide please. With regard to domestic violence shelters, it's important to know that nationally, there are over 1500 -- actually, there's actually over 2,000 domestic violence shelters in the U.S., and yet, there are fewer than 50 tribal domestic violence shelters. And when we think about that 50 in terms of the 50 states or in

terms of the 574 federally-recognized tribes, you really get a good sense of the disparity.

There are 260 tribal domestic violence programs that are funded by the FVPSA office, again, the Family Violence Prevention Services Administration. And it's important to note that FVPSA, since its enactment, really has been the bread and butter for tribes to respond to domestic violence, and we are hoping to also increase the number of tribes that receive FVPSA funding and to also help them build their capacity to house their unsheltered and, you know, indigenous people experience housing insecurity.

Next slide, please. There's a severe housing crisis in this country, period, and yet, some of the hardest impacts have been felt by American Indian and Alaskan Native people, and I know this slide kind of represents a lot of the things I previously mentioned. But I think since COVID hit, we've seen major, major changes in housing. We've seen large investment companies come

in and buy up housing, private homes, apartment complexes, trailer parks, turning them around, doubling the price, and people don't have a place to go. They're -- they're doubling up. They're tripling up. There -- you know, there's -- there's -- I was just talking with some young people the other day, and they were talking about how there's four or five people living in a -- a -- like, a studio apartment, really not even a bedroom, just a living room, kitchenette, and bathroom. You know, they're -- this housing crisis is severe in this country, and we really need to do a lot of work to address how we can change that picture.

Next slide, please. Homelessness is also a rapidly growing situation in every part of this country. Even in our most remote tribal communities and villages, there are homeless and unsheltered relatives. And I've been to some tribal communities that are, you know, three or four hours away from a town or, you know, just someplace. And when I ask them about homelessness, they say, "Oh, yeah they're --

they're living out there in those wrecked cars, or they're -- they're living over there in a cave." And even here in -- I live in New Mexico. I live in Albuquerque. Even here in Albuquerque there was a story of a family that was living underground. They kind of just dug -- made their own little dugout and kept digging and digging and digging and created a little dugout shelter for themselves.

So it -- you know, and the other thing, too, is like, popping up all over Indian country are homeless shelters and -- and there -- there's so many tribes now that are looking to open a homeless shelter. And that was really unheard of as little as ten years ago so, the -- the problem of homelessness is really -- is really getting bigger and bigger every day.

Next slide, please. And so these are some of the things -- these are some reports that we've -- that have been issued over the years that really talk about our high rates of poverty about, you know, the needs of Indian country, the systems deficiency. And

again, COVID brought out all of this; plumbing heating, kitchen, and electrical, structural deficiencies, places without windows or even a roof, overcrowding, often times 20, 20 people or more in, like, a 2-bedroom house, huge, huge problem in Indian country and -- and becoming a big problem in this country too. So it's something that's -- that we're all clearly impacted by.

Next slide, please. And then with regard to gender-based violence and housing insecurity, it's important to note that 92 percent of unhoused women have experienced severe physical or sexual abuse at some point in their lives and that 63 percent have become -- have been victims of domestic violence.

The other thing I just want to mention here is that the safe -- the streets are not safe for anybody and that homeless shelters are really not the best place for victims or survivors of domestic violence and their children, that there have been women who have been sexually assaulted in homeless

shelters. And with tiny home villages, the same way, where they have to have communal showers and kitchen -- shared kitchen space and toilets or bathrooms where those spaces are all shared, they're not a safe place for victim survivors of domestic violence.

Next slide, please. And I just want to say too that, you know, homeless -- in working with homeless people and homeless populations, it's important to remember that homelessness is not the problem but, rather, it's a result of the problem. And so that's -- at STTARS is what we'd like to look into is all those things that kind of brought us to where we are now and how can we change that to create more housing options for -- for victim survivors of domestic violence, safe housing, safe, affordable, and accessible housing options for victim survivors of domestic violence.

And so with that, I'll -- I'll conclude, but I want to thank you for the opportunity to share some of the important work of the STTARS Indigenous Safe Housing Center with you today. Thank you very much.

ED EHLINGER: Gwen?

GWENDOLYN PACKARD: Yes.

ED EHLINGER: Gwendolyn, thank you very much. Will you be able to stay on the Zoom for a little while?

GWENDOLYN PACKARD: Yes.

ED EHLINGER: Okay. Because we have some public comments that we have to get as part of our agenda.

GWENDOLYN PACKARD: Okay.

ED EHLINGER: And I'd like to get to those before we move on. So if you could just hang for a while, we'll --

GWENDOLYN PACKER: Okay. Sure.

ED EHLINGER: -- get back to some questions. So hang in there.

GWENDOLYN PACKARD: Great. I will. Thank you.

LEE WILSON: So good afternoon, folks. Can you all hear me? As I mentioned earlier, this is a public meeting of the advisory committee, and so we have provided an opportunity for individuals to register with us to make public comment both today and tomorrow.

Given that we are a little bit behind time, I'm not going to open it up for those who may have ad hoc comments, but I will recognize the individuals who raised questions with us for public comment in advance and give them three to five minutes to make a presentation, and then -- then if there is a question or so for each of those commenters, we'll provide an opportunity for that.

So in light of that, I would like to recognize Ingrid Skop from the Charlotte Lozier Institute, if Dr. Skop is still available, and provide her an opportunity to address the advisory committee. Thank you. Dr. Skop?

INGRID SKOP: Thank you for this opportunity. Can you hear me okay?

LEE WILSON: Yes, we can.

INGRID SKOP: Okay. Excellent. I -- I'd like to thank the brave panelists earlier. Some of these stories have been heartbreaking, and it's -- there's so much work to be done.

I'd like to address this issue from a

slightly different angle. As a board-certified OB-GYN in Texas, I've delivered over 5,000 babies in the last 30 years. Fortunately, I've never lost a mother in childbirth, but I have cared for two women who died following legal induced abortion.

The U.S. investigation of maternal morality is compromised, as we all know, due to many data deficiencies. We are unable to calculate a denominator of at-risk individuals because we do not require reporting of miscarriages and induced abortions nor do we mandate reporting of their complications and deaths.

The national vital statistics system requires an IPDO code to document a maternal death, but O codes only exist for abortion-related deaths from infection, hemorrhage, and embolism.

Records linkage studies tell us that a woman is two to four times as likely to die in the year following an abortion than following child birth, six times as likely to commit suicide, five times as likely to

die in accident, and ten times as likely to be killed. Aren't we interested in finding about -- find out about these women's deaths?

These studies also document that less than a quarter of abortion-related deaths are documented as such on death certificates. Many of these deaths are never known by the CDC. The pregnancy mortality surveillance system relies on pregnancy check boxes, but these have been documented in Texas to be falsely positive over half of the time. Or could those be real deaths related to early pregnancy events, like induced abortion whose records can't be easily obtained?

In today's politically polarized climate, it has been alleged that restricting abortion will increase maternal mortality, yet abortion restrictions in other countries have not been shown to increase their maternal mortality.

All states with restrictions have exemptions allowing medical intervention for life threatening emergencies. Restricting

later abortions will protect women because abortion-related mortality increases by 38 percent weekly exceeding the risk of death from childbirth when performed after viability.

Restrictions will prevent some future pregnancy complications caused by abortion-related uterine damage such as preterm labor and abnormal placental attachment.

And finally, restrictions will prevent mental health disorders of anxiety, substance abuse, self harm, and suicide in some vulnerable women.

It is essential to improve maternal mortality detection and data analysis by recording and investigating deaths related to all pregnancy outcomes. The CDC collects private data concerning sexually-transmitted infections and other sensitive health issues, so this data can be obtained to help us if we truly want to learn all the reasons that women are dying.

Thank you for your time.

LEE WILSON: Thank you, Dr. Skop. I

want to provide an opportunity for any questions or additional comments to Dr. Skop's comments.

All right. Thank you. Next, I'd like to move on to Candi Cornelius who is with the Oneida Comprehensive Health Division. Ms. Cornelius, are you available?

CANDI CORNELIUS: Yes, I am. Thank you for having me. I am Candi Cornelius from the Oneida Nation and Menominee Nations here in Wisconsin, and I work for the Oneida Community Health Division near Green Bay, Wisconsin.

Recently, I had the opportunity to work with a native medical student, and -- regarding some concerns we had regarding method of delivery. And I just want all the committee members to be aware that little, obviously, or no research is done among Native American women due to population size. However, the data that she gathered was pretty astounding, and I've been working there since 2011, so 11 years, and noticed a huge change in method of -- of delivery just by the patients that I serve. But she has

found there was a relation to increase, and we looked at nationally the rates of cesarean delivery are pretty stagnant for all races, no increase, no decrease.

However, when asked about VBACs, vagina birth after, which are associated with lower maternal morbidity and risk of complications, yet the increase -- there was no increase among American Indian/Alaskan Native before or after 2010 while nonnative women rates increase 1.8.

Brown County, which is the county that I reside in, most of the patients that I take care of, VBAC rates remain stable but increase for all races. So for some reason, we thought maybe the disparity were possibly amongst all, you know, brown and black women, but this specifically stated, it was native American women where Hispanic, black and Asian rates of VBACs increased and ours did not.

Brown County also, repeat cesareans were done seven more times amongst Native women. And this is the trend that I've been seeing in the women that I work with, which

is prenatal care coordination. I kind of guide and support women through their first pregnancies, often don't follow them the second pregnancy, but just being a small community, I would hear, you know, a normal vaginal, maybe they had a primary -- I'm sorry -- a cesarean and then had repeat.

And so we're going to look further into that, so I'm looking for any additional support and promotion of both methods of delivery, specifically for my population, which is native women and then really looking at is this maternal mortality and maternal morbidity put it partially related to the cesarean delivery due to the medical complications that it kind of comes toward the moms, which is infection, hemorrhage, and difficulties for future pregnancies, so really looking at that component of VBAC.

So once we -- we are almost at the approval point now for the nation, and then we'll be able to go into electronic records and start surveying and find those moms who had cesarean and kind of find the reasoning. Was it patient? Was it provider? Is there

enough education found and given?

I know on a personal level, my sister had a primary due to complications, and I was present. There was no way around it, but she was pretty adamant. She, herself, was a nurse, and said, "I want my second a VBAC." The length of time between pregnancies were good. She was a healthy female. Yet every single visit she walked in, her provider would say, "Are you sure? Let's revisit your birth plan." You know, so I even know from a educated, you know woman's point of view, native point of view, that she's walking in, and, you know, getting type of persuasion. So that was, I guess, my own personal experience.

So much data -- much data has been gathered here in my particular county, but I know more research needs to be done specifically on method of delivery.

The other point that I wanted to express and recommendation to improve maternal child health is, I guess, advocate -- advocating doulas in tribal health facilities. They are titled as non-health

care providers, so it's really hard for a health care facility to wrap around the thought of a nonprofessional going to assist mom during deliveries. So some advocating for doulas to be present. A lot of the American Indian women have little to no support or, you know, a person that can be them -- be there with them during delivery, so -- but if we -- we were unable to hire doulas ourself to do to the administration asked about liability. Do they have medical liability? Well, they're non-health care providers. So just some wording, possibly, or higher up advocates in stating that doulas, the importance of them and how they can fit in a tribal facility.

We are -- our IHS facilities are mainly focused about elders, so we have nurses servicing elders, but there's community health workers, and I've seen that where a community health worker was also a doula. So I see it being doable. It just needs, I guess, a little bit more support in advocacy for doulas to support our moms, definitely, you know, to increase and improve maternal

child health.

So those are my two recommendations. I thank you for your time.

LEE WILSON: Thank you very much, Ms. Cornelius. Are there any comments or questions for Ms. Cornelius from the Oneida Nation?

CHARLENE COLLIER: Thank you, Ms. Cornelius. This is Charlene Collier, and I'm an OB-GYN. And I really appreciate your comments and bringing comments that bringing awareness to specific needs of indigenous women that haven't been voiced here and representing those -- the challenges of increased mortality connection to birth type. And we know racism can affect VBAC because it was imbedded within the VBAC calculator for black women, Hispanic women, and I have no doubt that vicariously that was applied to American Indian and Native American women as well. And even if that calculator is not used, we know people have to have an advocate, they have to be told it's an option, and they have to know very early on in the birth

process if their hospital or their birth location is supportive of VBAC.

So there is a very -- very upstream path that has to happen and -- and unfortunately, many people are not informed that their provider is actually not supportive of VBAC up until it's quite -- too late.

So I thank you for bringing that, and I think it brings recognition that more indigenous advocates -- I think someone said earlier, you don't go into the hospital without an advocate. Well, you don't start prenatal care without one either, unfortunately.

And so I think this just highlights the need for more, you know, imbedding of cultural practices, indigenous birth workers, doulas, advocates, and, again, just calling out that these medical interventions are not applied equally and that there has been bias imbedded within them. So I thank you again for that and appreciate your work and look forward to what you find.

CANDI CORNELIUS: Yeah, definitely.

Thank you.

LEE WILSON: Thank you very much. Before we tran- -- yes. Go ahead, Janelle.

JANELLE PALACIOS: Sorry, Lee. Can I just say, thank you very much also for the comments you shared because this is something we haven't vetted yet, the obstetrical, like in-hospital delivery issues, which are abounding which will be your charge as you go forward.

But speaking as a clinician, I know that we -- even though we have some national standards on the definitions for things like failed induction or, let's see, a -- doing an emergent delivery for a Category 3 tracing, when the water is muddy, it is really hard to have strong definitions that really give us a great idea of what the picture will turn out to be, and I know from clinical practice and from speaking to other people and the research is showing us that black and brown women and birthing people, when they enter the hospital, they already -- they're facing a system that's stacked against them. And so clinicians and

protocols at the hospital are not always working to their favor.

So whether C-sections are happening, a primary C section on a low-risk person is happening, we still have yet to discover that just knowing that -- that the hospital system and the provider system have a lot to learn and unlearn in terms of how to help take care of people better. Thank you.

CANDI CORNELIUS: Thank you.

LEE WILSON: Thank you, Dr. Palacios. Yes. We have another comment.

MAGDA PECK: This is Magda Peck. We received this morning, and you had mentioned another public testimony from Nickolaus D. Lewis at the Northwest Portland area Indian Health Board, and I just want to thank Ms. Cornelius for showing how meaningfully quoting the letter in our packet that just -- we just received, meaningfully involving tribal nations as partners in research. The bottom line is, when it comes from the field, when it comes from your lived experience and what you collect as data in systematic ways, that kind of

community-driven research is what we should be supporting more of. And I just wanted to note the similarity in this example to this very eloquent letter that we got from Mr. Lewis this morning and something that we, under our data and research to action work group and the larger ACIMM or SACIMM should take under advisement. Wonderful example of that in action.

LEE WILSON: Thank you, Dr. Peck.

CANDI CORNELIUS: Great. Another data collection in Wisconsin, if anybody is familiar with PRAMS, pregnancy risk assessment measurement, they did a over sample of native women for the first time in 2020, so that was also good data that we received and there -- from that, it had, you know, negative experiences into part -- intrapartum, which was not feeling involved in the decision-making and negative experiences in the hospitals.

So yes, definitely, it's -- someone had said, it's, you know, hospital setting where they -- it kind has to be set before they enter a different hospital system and with

that provider also being their advocates.

But the PRAMS, I asked if that could continue because there's hardly any areas of data that are large enough, but they had said due to funding, it was only going to be that single year in 2020, and the findings are going to be coming out soon. A PhD candidate had compiled all of that, and I sat on her committee and things, so I was really grateful for that. But once again, it was, no, we can't do it again as to funding, and I think it was, like, $10,000 to over sample American Indian women.

LEE WILSON: Thank you for those comments.

Before we close out, I'd just like to take the opportunity to recognize a couple individuals for their hard work in this first. There are a number of staff who have been in engaged in pulling this meeting together. A meeting like this does not happen without a great deal of effort. Some of them on the -- are on the line and for various reasons, they were not able to be here with us. Some of them are here. So

I'd like to give a brief recognition to Vanessa Lee, Abigail Dechat Lesjadis (phonetic), Ann Leech, Michelle Lowe, the HRSA Office of Communication, and to Derrick Idios (phonetic) who made the -- all of this work possible on the HRSA end.

I'd also like to recognize Emma and James who are here in the back from LRG who have been providing the technical support and moving chairs around and making sure that the temperature is good and everybody is well cared for, so we appreciate your hard work.

I would like to recognize the tribe for allowing us to be here for this event and being so hospitable with us. We appreciate the -- the -- the welcomes, the good wishes, and the support that you're providing to us and for -- to the individuals that you represent and serve.

Finally, I'd like to take a couple minutes and just recognize Dr. Ehlinger for his really being the fire for this meeting and for so much of the work that this subcommittee has been able to accomplish

over the last few years during his tenure as the acting chair. He has really focused a tremendous amount of energy and personal investment into advancing the agenda for maternal and infant mortality and morbidity prevention and care as well as a specific focus on disparities and racism.

I'd like to recognize Dr. Warren for his commitment and dedication to these activities, for coming out here for this meeting even though it meant that it -- he didn't get here until 3:00 this morning and for just the -- the day in and day out work that he does 7 days a week, and I -- I'm not sure that all of you recognize the commitment that it takes to be an associate administrator in the government.

And to our administrator Carole Johnson for her commitment and dedication to those activities. It is not easy for an administrative who approved the amount of resources that go into making a meeting like this possible at the end of a -- of a pandemic where we're going to be not in the Washington area but someplace else.

So I'd just like to thank all those individuals and congratulate them on their good work and the movement towards success that we are all trying to achieve.

So for those of you who were not able to make a public comment and would like to make a comment, we will be offering another opportunity tomorrow. Hopefully, we will be able not only to take names of those individuals in advance but also have ad hoc presentations or comments be available.

If you would like to make a public comment, please let us know through the SACIMM -- through the ACIMM website, which is posted online and -- and in -- is in the federal register notice or if you're here in the room, you can come up and see me, and I'll take your name. Thank you very much.

ED EHLINGER: And I'm going to -- I'm to take the prerogative of the chair just to rearrange the agenda just a little bit. We're at the end, officially at the end. So we're going to have our closing song, but I would like to then offer people to stick around a little bit longer, and I would

informally call up our previous presenters to have some conversations with them because I think there were lots of questions that -- that were there, but we will -- we'll close our official meeting with -- with the drum and song, and then we will have some conversation for a little while and then we can informally go on till all hours of the evening if you so choose. But let us -- let's have a little music to end here.

(Closing native drum and singing ceremony.)

ED EHLINGER: Thank you again for providing the wonderful beginning and such an ending to our -- today's this meeting. It was beautiful music and it -- it added a lot to the whole event. Thank you. Thank you. Thank you.

And if -- all of the -- the previous speakers who we didn't have a chance to ask questions, if you could come up to the tables on both -- both ends, and we'll see if there's any questions. And Gwendolyn, if you're still there, we can put you on the screen. And it may be hard to remember all

of the questions that we had, but there was -- it was -- it a very intense afternoon of presentations.

LEE WILSON: We have a junior contestant here.

ED EHLINGER: And I had just one quick -- you know, Rebecca, we talked about the doula program. Are there other programs in other states, not necessarily the doula program but -- but programs within the prisons that offer parenting that have remote sites that -- where you can labor and deliver and parent for months outside of the prison as opposed to being in the -- are there model programs anywhere?

REBECCA SHLAFER: Oh, that's a great question. So other states have what we're sort of grouping now as enhanced perinatal programs that offer a variety of pregnancy and postpartum support services that range from group-based education like we provide in Minnesota to doula support as well as some states have robust lactation programs where moms can pump and store their breast milk and ship it to caregivers in the

community.

In terms of the -- the prevention of separation, right, alternative to separating moms and -- and their newborns, so the only other option at this point is prison nursery programs save for what Minnesota passed last year, which is the Healthy Start Act, which aims to prevent the separation of moms and their newborns by offering community-based alternatives to incarceration, so not bringing babies inside the prison, like the eight or so states that have prison nursery programs, but instead, identifying ways to get moms out of prison recognizing that these carceral spaces are -- are not ever equipped to really provide the care and support that postpartum moms and newborns need.

I will say that although we passed the Healthy Start Act in Minnesota last year, the implementation has, perhaps, not been -- it's been slow, and I think that there's a lot to be learned about -- in ineligibility criteria and who is being released and -- and what opportunities there are in the

community to provide basic resources and needs in terms of housing and culturally-specific substance abuse treatment programs, treatment programs where moms and babies can stay together.

So I think we have a long way to go in terms of innovating -- innovative programming in the community for this population, not just in our state but across the country.

ED EHLINGER: Thank you. And Gwendolyn, are you still there?

GWENDOLYN PACKARD: Yes, I am.

ED EHLINGER: All right. I'm wondering about data on murderer and missing individuals, indigenous relatives. Is there a data set that -- because one of our recommendations is to standardize the data and data collection protocols related to MMIWG. Is -- is -- are there some standards or are there some best practices that you could recommend?

GWENDOLYN PACKARD: Yes. You know that this is a -- a -- an issue that's being brought up in state after state after state

as states adopt -- a lot of the -- a lot of this is left up to the discretion of states how they collect the data, who collects it, what questions are asked and so forth. And so it's really kind of jumbled and confusing right now. You'll see different -- different numbers depending on what state you're from. And so yeah. Data is clearly an issue and a challenge that I think we face in -- in really understanding the scope of the problem.

ED EHLINGER: Thank you. Any questions for any of the presenters?

MARISA CUMMINGS: First, I want to thank the young ladies as they're leaving because they really remind me of why we're here, and I hope that when they're older, this isn't relevant anymore, you know, that this won't be something they have to worry about. So thank you to your daughters and to you for bringing them.

I think someone mentioned a couple -- I think it was Jackie, earlier, that systems are people and people are benefitting from almost all of the tragedies that we see

driving these outcomes, the housing crisis, someone is benefitting, the prison crisis someone is benefitting, substance use, someone is benefitting, and even sexual exploitation, someone is benefitting. And they may not care about the stories and what's happening, but they shouldn't have the privilege of the comfort of ignorance about what's happening, and they shouldn't have the comfort of not knowing or hearing the stories, and I feel like at a minimum, we should know who is benefitting and the minimum, they should be accountable to knowing the information we have.

So we've all been preaching to the choir. I think everyone in this room is -- is leaning on the same page, but it's who isn't part of our of choir and who needs to know. Because I hope they just don't know the impact of when you're buying up housing on a reservation or nearby one or when -- when addiction is criminalized, the kind of impact it has on a family. I hope they just don't know and that's why policies like these persistent, and maybe if they know,

these policies can change, but I feel like delivering our report to the Secretary when he is part of our choir is only part of the battle. We have to think about who is actual benefitting from these systems.

So my question to the panelists and those here is, who needs to hear the recommendations that you see are, you know, maybe not part of those advocating for change but possibly benefitting from it or just generally where do you want to see these recommendations go beyond we know we're going to deliver them to the Secretary? We know we have a president and vice -- a vice president who are listening, but we want our findings that hopefully, truly reflect your words and -- and recommendations to get out to those who need to hear it. So I just want to know who you think needs to get these things.

ED EHLINGER: I would particularly like to hear in the -- the panel with Marisa and -- and Joni and Lynn and Heidi and Noya, you know response to that question. Who needs to hear these recommendations? Because you

work in many of these areas in state and local. Any -- any suggestions?

MARISA CUMMINGS: Okay. I really think we need to start developing policy around funding and we need to start funding outside of an IHS model. IHS is underfunded and clearly doesn't work for our people. And so I truly believe that we need to resort to our traditional birth work, our traditional midwives, which do not need to be clinically trained. And I know people don't want to hear that, but we have clinically trained folks with our women all the time, and they're still dying. And so those traditional practices are rooted in something much stronger. It provides women with a sense of identity, a sense of self esteem, self-love that we are not taught. It provides traditional teachings around birthing, around our cradle boards, which our children used to be removed from homes for being on.

All of those concepts of the belly button, burying the placenta, all of these concepts that tie us to creation itself.

And as women, that was taken from us due to patriarchy, due to federal policy like the Dawes Act implementing male head of households on a reservation.

All of those things have had consequences. And it's time we start dismantling it and deconstructing it, and how we do that is by listening to those of us that do the work and know how to do it best and fund us so that we can grow, so that we can prosper and that we can impact the lives of our community and our people.

Because we -- we are one percent of the population. It is likely we won't be here in a hundred years. It is likely. My tribe is 4500 people. You heard people saying a hundred people in their tribe. If we have a 90 percent rate of substance use on our reservations, these are our future leaders. You're talking about killing nations. And so it's time to do something different. Think outside the box, and let us do the work.

ED EHLINGER: Janelle?

JANELLE PALACIOS: Thank you. The --

as one of the speakers shared with us today that when they started this work, the average life expectancy for native people was 44 years of age. And, again, that's the common theme that we're finding now is that it is still that young for our people. We die slowly or we die fast, but we still die.

One of the things that we've heard for the past four years now is how important the home visiting program is. What is that really? It's trying to repair but not explicitly what has been disrupted and taken from our families and from our communities, how to care -- how to demonstrate that you can care for an infant, right? That was all knowledge and stuff that was broken and taken away from our families and our communities.

So a home visiting program includes a little bit more than that with assessments and it's a little bit more medicalized, but that's what it is. It's a social program as well. And we -- and it's -- it's thriving because it's needed because it's been -- it's been destructive in a little of black

and brown communities. But the idea of a home visiting program is -- it's ridiculous that it's needed because we are so far away, so out of touch with what it is to have families and healthy families that this is what we're calling upon. And it's a needed program, definitely is a needed program, but it is -- it is -- it is a -- it is what is happening -- what is needed today because of what has happened in our history.

So that is just a little bit of perspective of this novel program and it's not so novel. It's filling the gap that was taken.

MARIE RAMAS: I didn't have the opportunity to say thank you to the panelists, and I -- I want it on the record that the passion and the pain and generational trauma that was demonstrated and bravely shared today was palpable. It was absolutely palpable. And what I hope that the words that we share with the Secretary can translate the palpable fracture and raping of generations of power, self-worth, dignity and humanity that we

have inflicted on these lands, on your lands.

And so I want to thank you all for coming here and, once again, demonstrating a humble disposition and once again opening your arms to -- to people that represent violence.

I was moved by a couple of words, and I want to make sure that we have adequate definitions and that we can, again, translate these very different cultural perspectives into some kind of a semblance into the system that we work within.

So I -- I ask you all, there's a couple things. I heard the word, "system" several times. So if you may, please share with me, what do you mean by, "system"? What does "system" -- what does "systems" represent? So that is one question that I would -- I would like to ask the panelists.

I would like to submit to our committee that absolutely everything that we see and all the disparities that we see here is absolutely -- it could be reversed, and it -- and there is an antidote to it, and it's

absolutely continued on purpose, whether by omission or implicit or -- or -- or -- or just omission of work or active -- active reduction of access and power, but it is absolutely on purpose.

And to Dr. Palacios' point, I, frankly, am beyond discouraged and disappointed. I'm absolutely embarrassed that we have in our midst, just a few miles down the way, third-world conditions in the most powerful country in this world. It's -- it is absolutely intolerable.

So my question is, one, to -- to bring a little bit of -- of a hope to this. Oh, so one, when we say, "system," what do we mean? And part of our recommendations will be a Glossary of Terms, and so this is why I -- I would like for you to explain, what do "systems" mean as -- as we share your story.

And then the other thing is a question of funding. So funding has also been repeated throughout the day. Are there current programs, mitigation strategies? We -- we heard the home visit program as one of them. But do you have any resources that

you can point the committee to that has proven or showed, demonstrated a return on investment? Because our policymakers, at the end of the day, while we are talking about very real well-being implications, our policymakers need to know what's the bottom line. And there are policymakers on both sides of the -- of -- of the aisle that want to do the right thing. They also need to stay in office. The way that they stay in office is by creating a fiscal -- a fiscal no part of that.

And so are there proven or examples, resources that we can be pointed to that can elucidate that, in fact, when we take care and we do what is right, we actually do have a return on investment?

So I will -- I will return my time now.

MARISA CUMMINGS: I -- would like to respond to "the system." I think the system is white supremacy and how it shows up within our judicial system, our law enforcement system, our health care system, our educational systems. These stories of trauma that our people go through are

visible in every one of those systems. And we had our own systems. We have traditional governance. We had food systems that now feeds -- 80 percent of the food that feeds the world comes from us. We were incredibly bright people who had social structures that didn't need prisons. We weren't perfect, but we had our way of life that worked would for us that was intentionally and systematically dismantled and replaced with -- so our seeds end up in museums, and we're given commodity foods, right, and then we wonder why we have obesity rates.

I -- I would like to point out that when we talk about return on investment, I think we need to look at the Mowry as an example of creating a social return in investment. When we talk about these disparities in health and we talk about these social factors that directly impact health, we need to touch each one of those. And a social return on investment shows how housing can impact a woman's sobriety, can impact her child not being removed and put into the foster care system. All of these

things are intersectional, but that's not how it's done. It's piecemealed. We have to take a grant piece here that we can do this with and a piece of a grant here and we have to make it work for us.

And so I think looking at -- at the funding mechanisms and creating a more holistic wrap around approach to creating a support system for women if people are truly intentional about wanting to change it because our grandparents were sitting here. Literally, my great grandfather was the first chairman of our tribe, and he sat in Washington DC for the same things that we have to do right now again today.

So if people are truly intentional about change, that change needs to happen through truly investing in the holistic way of supporting our people. We know how to do it. I can write you a whole report right now. I'll testify for you. I'll find people to testify.

We have the resources. We just need people to listen and stop trying to tell us what's best for us. I hope that answers

some of your questions.

NOYA WOODRICH: I think to answer a few of your questions, I wasn't here to hear what Jackie said this morning, but I'm -- I'm thinking that she was saying that there's people that have power and there's people that don't, and people that have the power are going to do everything they can to keep that because that's just the way things are.

I think -- when I think of systems, I think of people that have the power, and by and large, I would say that's white men, subset white people. They -- these systems, many of which Marisa mentioned are schools, are hospitals, are government systems, are health departments, are police department, are fire departments, those are all systems that are, by and large, run by -- run by, designed by, and operated for not us. And so I think, again, people are going to try to keep that power, and in order to keep that power, they need to keep us down.

So I -- systems, I'm just -- you know, I -- I was trying to come up with a couple

examples, and someone reminded me of this, and I wanted to say it when I was up on -- up front. Healthy Start is a national -- it's not -- not your Healthy Start, a different Healthy Start. Healthy Start was a program out of the Department of Health and Human Services. Here in Minneapolis, we first started in 1999. It was a really clinically-based program. And year after year after year, we would listen to the African American and the Indian American Community in Minneapolis and St. Paul, and, like, we don't need such a clinical system. We need a socially close, we need social -- socioeconomic indicators. We need something that's focused on those social issues, not just the clinic issues. And the Healthy Start folks, sorry. We're a clinical program. Sorry. We're a clinical program. So it's that refusal to listen and just continue to administer something in light of all of this other different information coming at you.

And I think, by and large, Healthy Start's a great model. Like, there's a lot

of really good things about Healthy Start except for that ex -- exclusive focus on clinical care and not the care of the person as a whole.

And I think of hospital systems. There's a hospital system here in Minnesota where we re -- we routinely hear about native women being treated poorly during pregnancy and labor and delivery. And if not having a physical impact on them, certainly re-traumatizing them and making them not trust that system, not want to go there. Well, we need them to go there. We need them to get their prenatal care. We need them to be seeing practitioners and community health workers and doulas and midwives, whomever it might be. But if they're not trusting that system, they're not going to go get that care that they need.

So just a couple examples of -- and -- and I think it is -- your other question, who needs to hear these recommendations? Those -- those people, the ones in power. Now, are they going to listen? Experience

tells me probably not, but that doesn't mean we can't -- that we stop repeating the message over and over and over.

JONI BUFFALOHEAD: Hi. Okay. Make sure it's on. To define "systems," from my perspective it comes -- the reason why we're here, you know, the colonizers came here for the land, for the minerals, and if you look around today, you know where current situation is, you know, I'm really worried about our sovereignty because of the minerals that are left in the -- just in the United States boundaries itself, the borders.

If we disappear, we don't -- if we lose our language, we lose our culture. We lose our people. We -- we -- the U.S doesn't have to hold onto the promises or the land, and they want the land. They want the minerals.

The systems are funding and the power, just like everyone else is saying here, and when I think about systems, it's -- look at our education system. Look at our government. Have we ever even acknowledged

what they did to the -- to our indigenous people, our ancestors today?

You know, I mean, to this day, I mean, you know, you have some countries, Canada, Australia, that they at least admit what happened. Here, we won't. They will not even admit to it.

The funding, again, it -- it's -- it's the systems that are set up for whoever the person is that's at the receiving end. They don't know how to talk to each other. And so when I think of systems, too, I also think about the interfacing of our technology today, and how many different layers of patches have you put on there? How much money have you thrown into electronic health records? I keep thinking of -- of the docs at the clinic site being frustrated about that.

And, again, you know, the treaties, the treaties that were made a few hundred years ago were to provide health care education forever. They can't uphold on -- they can't keep that promise. Look at how expensive it is today. You know, if you look it the

value of -- of education, of health care, housing. They -- they -- they can't even -- so I think that the government really just would rather have us go away so they don't have to pay this big huge debt that they owe to our families and future generations, to be honest. That's what a system is to me.

UNIDENTIFIED SPEAKER: Can I just -- this will be really quick. Thank you. I think when you mentioned that, you know, policymakers want to also hear what in -- the return on the investment would be. I would just reiterate what you just said, which is that we -- we've already prepaid for health care as indigenous people in this country. So I just want the policymakers to be reminded that we've already prepaid. We've given up our land. We've faced cultural and historical genocide over and over and over again, and those trust and treaty responsibilities are the thing that we need to instill the continuance of because it's already been paid. So we don't need to prove anything.

JANELLE PALACIOS: One last comment

just to con -- piggyback off of everything is that the -- if your -- this has been discussed in various forms, but sometimes we have so much content we forget, but for the committee, again, Native American people in this country are the only group that have to consistently have documents, documentation that says who they are, and it's historical documents. So you have to prove whether it's a degree of bloodline or it is some other nature, but you have to prove that you are of this nation, and it is not necessarily easy. And, again, it was the long game of the government that made every federally-recognized tribe to decide what they were going to use in terms of deciding who was going to be an enrolled member or not. And we see this played out time and time again, and it is -- it was a -- very intentional that the government made native communities do this because eventually, with all the -- the termination, the relocation, all the different acts that were enacted upon our people, this should also have been -- I don't know what this should be called

-- the blood act, but this was intentionally done so that over time we would not be here so that they would not have to continue to provide because we already prepaid.

ED EHLINGER: This -- this has been a very powerful day, lots of incredible testimony and storytelling from across the country and across this state from people at all different levels with different perspectives. It has stimulated, obviously lots of conversation, lots of thought, and it will continue with some additional testimony tomorrow in presentations and -- and learnings. And it is just one step in what's going to be a long, long process, but I harken back to what -- and what particularly what I'm hearing in this conversation right now harkens back to what Secretary Becerra said, those three words, "Never do mild." And then I think our recommendations, as we've drafted them, I don't think main -- have the energy or the -- the urgency or the pain in them. And so we need to have a little bit of un-mild in those recommendations. So I -- I ask the

committee members tonight and tomorrow and tomorrow night, think about how do we take the mild out of the -- the recommendations? Because we don't want to do mild. We want to do effective. We want to do strategic. We want to do bold. We want to do what should have been done long, long time ago but needs to be done now.

So we will end this meeting for today. We adjourn or we pause or whatever it is. We break, take a break until tomorrow. But if anybody would like, there's a nice lounge out there where you can get sodas for free and, you know, you can imbibe in a lovely beverage, and I'm sure that a lot of people would love to chat about what we heard today and -- and what the future might hold for this meeting tomorrow.

So this meeting is adjourned. Thank you for all your input and all your conversation. It has just been very powerful. Thank you.

(The meeting concluded at 4:53 p.m.)