THE SECRETARY'S ADVISORY COMMITTEE ON

INFANT AND MATERNAL MORTALITY

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES

VIRTUAL MEETING

Day 2, June 15, 2022

12:00 p.m. - 5:30 p.m.

COMMITTEE MEMBERS

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C O N T E N T S

P R O C E E D I N G S

CALL TO ORDER AND REVIEW OF DAY 1

CHAIRMAN EHLINGER: Thank you. Now we are officially started on our second day of our Secretary's Advisory Committee on Infant and Maternal Mortality. It's great. We had a great day yesterday, and I hope to have another set of good topics to discuss and good conversations, and I hope all of you got rested last night. I know Jeanne Conry got up really early in her day to join us today, so we'll get to her introduction in just a second.

But yesterday, we filled in a couple of gaps on two issues that we knew were important that we hadn't looked at related to the birth outcomes for First Nations and Indigenous individuals. We looked at SIDS, SUID, and we talked about the IHS, and I thought both of those were really helpful conversations to fill in some of those gaps.

Today we're going to look at a couple

of other gaps, you know, particularly the issues related the incarceration of pregnant First Nation and Indigenous individuals, and then murdered and missing Indigenous women and girls. So, we have two sessions related to that. And then we'll get some public comments, and then have one more chance to collectively review our draft recommendations before we set off on some work over the summer in preparation for our September meeting.

Now, I started off the meeting yesterday with a quote from Julia Lathrop, the first Chief of the Children's Bureau, and I have to admit that I did that with a bit of fear and trepidation, because I know it used the word handicap, which is usually used in a pejorative sense. And to be honest, I actually was using it in a pejorative sense expressing contempt and disapproval, but not focused on individuals or groups, but on our overall societal policies and systems. You know, so, you know, I was trying to flip things a little bit. I also used that

reframing of that word to underscore that our focus on improving the health and outcomes of a population that we collectively disadvantage actually benefits everyone else.

So, to highlight that point, I'm going to start today with three quotes that I often use in my presentations. One is from Michael Harrington, the author of The Other America. He said, "One cannot raise the bottom of society without benefiting everyone above; that we are in this together. We will raise their -- it's not a zero-sum game." And that's why I used the quote from Senator Paul Wellstone who was from Minnesota. He said, "We all do better when we all do better." And lastly, I always use Doctor Martin Luther King Junior's quote, "Injustice anywhere is a threat to justice everywhere." Whatever affects one directly affects all indirectly. And so, I think our work here related to the needs of First Nations and Indigenous individuals really will benefit everyone, and that's why our work is so important.

Now, I know we have two folks that have joined us today that were not here yesterday. And, Tara, could you introduce yourself?

TARA LEE: Absolutely. My name is Tara Sandra Lee. I am a PhD-trained scientist, and I'm also involved in science policy. For over 20 years, I directed research lab and clinical lab studying the health aspects of pediatric disease, and I'm involved in the science policy behind that. And I am a Senior Fellow and Director of Life Sciences at the Charlotte Lozier Institute, which is located just outside Washington DC.

CHAIRMAN EHLINGER: And, Jeanne Conry, could you introduce yourself?

And can we just give a gallery view? There you go. Thanks.

JEANNE CONRY: Thanks so much, Ed. I'm glad to be here today. Sorry I had to miss yesterday with several conflicting meetings. I'm Jeanne Conry. I am an obstetrician gynecologist. I have a degree in medicine in obstetrics and gynecology, and a PhD in biology. I practiced

with Kaiser Permanente for over 30 years, and oversaw many different aspects of maternal health, pediatric health, neonatal intensive care and a number of other departments. I was President of the American College of Obstetricians and Gynecologists where I introduced the National Maternal Health Initiative. And with ACOG, I currently Chair the Women's Preventive Services Initiative that looks at women's health across their lifespan from adolescence through maturity, and it's something that I'm very proud of what we're accomplishing with HRSA collaboration, really, truly a collaboration with HRSA and all the people there, and through all the providers of women's health across the United States. And I'm currently President of the International Federation of Gynecology and Obstetrics.

CHAIRMAN EHLINGER: I know, Jeanne, this is your last meeting with us, and I want you to know that your work has been fabulous on this committee on a whole variety of areas. You have been an active participant in all our discussions

and some of the workgroups. You really made a huge impact in raising the whole issue of environmental contaminants and its impact on birth outcomes, which we would not have done without your advocacy. And you've been just really challenging us appropriately, getting the right kind of information, linking us with all sorts of partners that we needed to know. Your contributions have been just outstanding. So, thank you for your work, and really appreciate it.

JEANNE CONRY: Thank you. So happy to be part of this and delighted to see the EPA yesterday said they're going to look at perfluoroalkyl, alkaloid, fluorooctanoic acid and PFS in our drinking supplies, and that was something that we brought up last year. Very good to see.

CHAIRMAN EHLINGER: And for the new members, I want Jeanne to be sort of a model for you, because her advocacy brought that issue forward. And so, if there are issues that you are passionate about that want to do some work on and

have some connections and expertise on, I'm sure -- feel free to bring those forward. And so, as your team moves forward over the next four years, that is how you get things done with the work that individuals do, and Jeanne was a really good role model for that, so thank you for that.

One thing before we get into our main content for today, I asked you yesterday to send me whatever kind of work task group that you were interested in. Many of you sent me an e-mail. But if not, if you haven't sent me an e-mail, in the private chat let me know if you want to be in the workgroup related to Indian Health Service, or data, or violence, or care delivery and workforce, and then we'll talk about that at the end of the session. So, just put it into a private chat so I'll be able to know that.

And so, now we're going to get into a couple of content areas that I think are of incredible importance to Native folks and Indigenous individuals, and that's the whole area of violence and incarceration, and murdered and

missing Indigenous women and girls. And so, the first session is going to really be looking at the incarceration, because American Indian and Indigenous women get incarcerated at higher rates than the general population. I think they're the highest incarcerated racial group, at least in Minnesota and how they're treated when they're pregnant is a huge issue, so we're going to focus on that in this first session.

And it's really interesting, for me, you know, a couple of our presenters, you know, I've just -- Rebecca Shlafer was actually -- you probably don't know it. I had a TV show here for 35 years talking about public health, and Rebecca was on it talking about the Prison Doula Project, and that was my first introduction to her. And following her and seeing the work that she's done has just been really impressive. And then last week, I went down to Wichita to give a talk, and I ran into Juliet Swedlund, and she talked about her being a doula and working in prisons, and birth outcomes related to that. So that was a nice

connection. And then Diane Bohn, who will be the third presenter, had worked with Jackie Christensen, who talked about violence at our last meeting and really highlighted her. So, we're going to have three really good presentations.

So, let me just introduce all three of them right now, and then we'll start with Rebecca. Rebecca is a Research Director, Director of the Prison Doula Project. She's an Associate Professor in the Department of Pediatrics at the University of Minnesota School of Medicine. Juliet Swedlund is Program Manager for the Community Health Worker Section of the Kansas Department of Health and Environment. And Diane Bohn is retired from the School of Nursing at the University of Minnesota and is an honorary member of the Ojibwe Tribe and provided midwifery care through the Indian Health Service in Minnesota, and has done, as we heard at our March meeting, research on intimate partner violence among Native American women.

So, let's start with Rebecca. Welcome,

Rebecca, and appreciate you being here with us.

INCARCERATION OF PREGNANT AND POSTPARTUM INDIGENOUS WOMEN

REBECCA SHLAFER: Thanks so much and thank you for the invitation to be here today. I really appreciate the opportunity to share this program of research with you, and really an introduction, I suspect, for many folks on this call to maternal care in the context of incarceration.

Next slide. So, I just want to begin with acknowledging that I have been asked to present today, but this is really collaborative work with a tremendous team of people. The image here is a group of some of our board members and staff from the Minnesota Prison Doula Project and the Alabama Prison Birth Project, colleagues and, frankly, friends at this point after 12 years of doing work in this space with them who are incredible allies and advocates and birth workers in this space, and, of course, countless graduate

and undergraduate students who have contributed to this program of research. I have a current five-year RO1 from NIH that is looking at implementation of prison doula programs in six state prisons, and so I just want to acknowledge the support that I've gotten for this work from NIH.

Next slide. By way of introduction, I just want to give a quick overview to what we know about women in prison. There has been a nearly 700 percent increase in the number of women incarcerated in this country since 1980. We know that most of the women who are coming into prisons and jails are of childbearing age, somewhere between 18 and 44 years, and they have high rates of chronic health conditions and mental health problems that precede periods of incarceration but are also exacerbated by the carceral context. We know that incarcerated women broadly are disproportionately women of color, and I'll share more about that in a minute.

I want to acknowledge that we have very

little data about the reproductive health and pregnancy, in particular, among incarcerated women. The data that are at the bottom of this slide are from my colleague Carolyn Sufrin's Pregnancy in Prison Statistics Study. And Carolyn back in 2016 attempted to survey state prisons, US jails and the Bureau of Prisons, which runs our federal prisons. So, what Carolyn found during this period of time was that there were approximately 3,000 admissions of pregnant people to US prisons each year, and about four percent of females entering state prisons were pregnant, some of whom in the prison setting will be in prison for the duration of their pregnancy and will give birth in custody, very different from the jail setting. And we can talk more about some of the challenges here in working with these populations, because the prison and jail populations are quite different in this respect. Far more admissions to jails and prisons with rapid turnover and very little opportunity for health intervention, frankly. But a very high-risk population in terms

of folks that are coming in with health needs, often ongoing substance abuse issues that have brought them into jail in the first place. So, in that year, there were 55,000 admissions roughly of pregnant people to US jails, as they extrapolated, and about three percent of females entering jails were estimated to be pregnant. So, this gives us the context for which we're going to sort of lay out the rest of our time today.

Next slide, please. I want to emphasize that the criminal-legal system is, frankly, an inherently racist system. We know that there are racial disparities from arrest to reentry, and that black and Indigenous women are disproportionately represented in both the criminal-legal and child protection systems, and this is particularly true for Indigenous women. In Minneapolis, there was a study not that long ago that showed that, actually, arrest rates among Indigenous women were higher than black men in the city of Minneapolis. And I think this is a staggering statistic when we consider just what

Indigenous women are getting arrested for, often sort of public nuisance crimes that are bringing them into jail, right, substance use that is visible, sleeping on the street, those sorts of things that are really generally low-level crimes that are having Indigenous women cycle through the criminal-legal system with collateral consequences for their health, for those who are pregnant certainly their fetal health and then children because many of them are already mothers with minor children.

At our Minnesota Correctional Facility in Shakopee, Minnesota, 20 percent of women in prison identify as American Indian or Alaskan Native and 18 percent of them identify as black, despite much lower rates across the state in terms of population. But, notably, among pregnant people in our women's prison, 35 percent of them identify as American Indian or Indigenous, 12 percent identified as black. And so, I always want to emphasize the point here that when we think about pregnant people in prison, they are

even more racially and ethnically diverse than their nonpregnant peers in prison. They are also younger on average than their nonpregnant peers in prison, and they also have fewer years of education. And so, when we think about who is coming into prison pregnant, they really have this constellation of risk factors that increase their risk for adverse birth outcomes.

Next slide. I want to give a bit of a background on the care and treatment of pregnant and postpartum people in prison, in particular. And, in doing so, I'm going to sort of walk-through care and treatment of this population from prenatal to postpartum giving you, really, a high-level overview. I'm happy to answer more questions on this or give additional resources, but I suspect some of this will be new content for folks thinking about pregnant people in this space.

Next slide. Fundamentally, I want folks to walk away from this conversation recognizing that pregnancy in jail or prison is

characterized by a lack of supportive policies and practices.

Next slide. We know that most jails are not systematically screening for pregnancy. This is something that we've done a lot of advocacy around in our state, trying to balance personal privacy with opportunities for early intervention. Prisons, unlike jails, do routinely screen for pregnancy, but it's important to remember that many people will sit in county jails for long periods of time before they're processed to prison, and may not realize that they're pregnant and have essentially foregone care during that period of time. Across the country, there is no mandatory standard for pregnancy-related care in prisons, and this leads to tremendous variability from prison to prison in what pregnant people receive for prenatal care. Across the board, pregnancy-related care has been consistently described as poor. We know that there are major issues here. We know that most states do not ensure simple things like adequate

prenatal diets. You know, the discussion about sort of exposures to toxins is always something interesting to me. I've always wondered about just the water quality in prisons and what our pregnant patients have access to in this space. They don't have control of their meals. They don't have control of when they eat. And nutrition in this space is really abysmal. And then we know that, despite clinical best practice and clear guidelines here, that detoxing pregnant people with opioid use disorder is common. And this is one space where we see this intersection with substance use disorder in pregnancy in the carceral space.

Next slide. Probably the topic that's gotten the most attention around pregnant women in prison is this use of restraints, and we know broadly that there are risks associated with the use of restraints during pregnancy, labor and childbirth that are very well documented. And more than a dozen states still do not have laws that prohibit the use of restraints or shackles on

pregnant people. And even in states where there are laws like in Minnesota, we know that compliance with these laws is an ongoing concern. We just had a case very recently in Hennepin County, Minnesota where Minneapolis is where, despite, you know, the law being on our books here for many years, we still had a person who was physically restrained in active labor during her transport from the Hennepin County Jail to the Hennepin County Medical Center. And these are really egregious cases, and they still happen, even in states like ours where there is a law, where there is a requirement for reporting to the Department of Corrections and up to the legislature, still an ongoing concern.

Next slide. When we think about labor and delivery support, generally what happens is a pregnant patient is transported to a local hospital for labor and delivery. Policies don't permit patients to know when they will be transported. So, if there is, for example, a scheduled C-section, that patient can't know when

she will be transferred to the local hospital, which you can imagine yields a lot of anxiety and uncertainty for the pregnant patient. Most policies across the country prohibit any contact with family members during that hospital stay. And so, save for the handful of states across the country like ours that have a prison doula program, most individuals will labor and give birth alone, with the exception of the hospital nursing staff that are there and the two guards that will be there throughout the entire labor and delivery. So, not an optimal environment to be giving birth for sure.

Next slide. We know, as I said earlier, very little, actually, about the pregnancy outcomes of this population. Again, data here from Carolyn Sufrin's study in the PIPS Project, on the left you can see pregnancy outcomes for US prisons and on the right for jails. You can see that a majority of these are live births, but 46 of those total in prisons were reported as miscarriage. I think we have so much

more work to do about better understanding the timing of miscarriage, miscarriages that are not reported and real challenges in this space in terms of data collection that's not typically happening.

Next slide. And in the postpartum period, what we know is that across the country nearly all infants will be separated from their biological mothers at the time that the biological mothers are discharged from the hospital, typically within 48 to 72 hours. Unclothed body and cavity searches are common, meaning that when individuals are discharged from the hospital they are often strip searched at the hospital, transported in a Department of Corrections vehicle, and then strip searched again as soon as they return to the prison facility. The trauma associated with this in the postpartum period is hard to describe. Layered on for a population that has very high rates of sexual trauma and having just the physical trauma of just having given birth, for some this is a really, frankly, awful,

and inhumane practice. We know that postpartum screening for this population is nonexistent or highly inconsistent. And, of course, this has really important implications for maternal mental health upon reentry into community. And few facilities have written policies about breastfeeding or lactation.

Next slide. We get this question a lot, so I kept this slide in from a paper that we recently published on the placement of infants born to the moms at Shakopee. What you can see here is about 33 percent of the time those babies are placed with a grandparent, most often a maternal relative. 17 percent are involved with County Human Services or child protection, and we don't -- at that time we're not able to retrospectively determine where those babies were placed. But, given our state statutes and federal laws, the likelihood that those babies were attempted to be placed with relative caregivers is pretty high. And then you can see the other half of this pie chart here really reflects a

smattering of a variety of care environments. And we know that these care environments in infancy are not stable in that babies may start with maternal grandmother, and then go with an aunt, and then go back to grandmother. And while there are lots of strengths to family systems with multiple caregivers, also challenges for bonding and attachment in those early months and years. And, of course, real challenges for biological moms who will be out of prison and resume caregiving roles, most of them. And in Minnesota prior to COVID, the majority of mothers who gave birth in custody were going to be released back into the community within the first year of their baby's life. So, these are moms who are getting out and resuming a caregiving role, often with a really disrupted attachment relationships.

Next slide. Very briefly want to tell you about what our Prison Doula Project does to address these health disparities and the really complex needs of pregnant and postpartum people in prison. So, Ostara Initiative is our 501c3 that

houses the two projects, the Minnesota Prison Doula Project and the Alabama Prison Birth Project. We had the privilege of going to the Tutwiler Women's Prison back in 2014 and meeting with some community doulas at that point. And the Alabama Department of Corrections was very motivated to start a doula program there and have had just a wonderful partnership since that time and are now housed under the same 501c3. Ostara Initiative exists to collectively transform systems by reimagining justice, advancing health, and reclaiming dignity in our policies and practices for all pregnant and parenting people really with the ultimate goal of ending prison birth in America.

How do we do this? Next slide. We started the Minnesota Prison Doula Project. We had our first birth back in 2010, and really began with just offering group-based support with an opportunity to have pregnant and parenting people come to the same space in the prison, right? They were housed all across the prison, not a lot of

opportunity for peer support and learning. And so, this really started with group-based support, but has evolved over the time to offer one-on-one birth support. So, we provide pregnancy support with highly specialized prison doulas who have had training, additional training in trauma and reentry and carceral settings. We provide in-person support during labor, birth, and the separation. So, in sort of the core model for our patients, our pregnant clients who are in prison, we will meet with them at least twice during prenatal period in addition to their group-based support that they're getting. And this is all, of course, pre COVID. We can talk about how COVID has shifted this. We are called -- the doulas are called to the local hospital when the pregnant patient goes into labor, or when there is a scheduled C-section and is there to support the birth and then goes back at the period of hospital discharge and provides support during that critical period, what we call the separation visits, when moms will be returned to prison and

babies will go with elected caregivers in the community. As I said, we offer parenting education groups. We've expanded services over the years to meet folks, both moms and dads, in jails across the state, and have expanded services at the request of some of our corrections partners around supportive visitation for incarcerated parents, particularly in Ramsey County, Minnesota. We are continuing to do a lot of reentry support for parents who are returning home from jail or prison, and last year passed the Healthy Start Act in our state here in Minnesota, which permits the commissioner of corrections to release pregnant and postpartum people into community-based alternatives to incarceration for up to one year. And so, really what that looks like now for our clients who are released under the Healthy Start Act is more or less community-based reentry navigation and support at all levels, whether that is helping them identify a culturally-specific program to be involved within the community, whether it is substance abuse treatment, whether

it is mental health counseling that they need, and really serving as community navigators to help them be out of prison and safely parent their children and have their pregnancy needs met.

We are providing a lot of training and consultation for new prison doulas and programs in other states, and we'll be offering a training for formerly incarcerated folks to join in November of this year, and then my role really, which has been the privilege of researching the effects of incarceration in our programming.

Next slide. I want to talk about -- I mean I mentioned at the beginning the disparities in terms of the racial disparities from arrest to reentry, but really want to hone in on this as it relates to work with Indigenous clients. I am not an Indigenous person, but we have a number of Indigenous doulas on our team, and that is very important. And, I think, bringing their expertise into this presentation today and thinking about what were some of the common themes that our doulas talked about, our Indigenous doulas but

also our doulas of other backgrounds, about their work with Indigenous clients. And some of the themes of this work are really the critical importance of treating all of our clients with respect, compassion and bringing in this role of cultural understanding, and recognizing that the client is the expert of their own experience and really focusing here on the importance of self-direction and advocacy for their health needs, a critical understanding of Indigenous clients' pathways to prison, right? I talked about these disparities in arrest, but thinking about what is bringing Indigenous women into prison in the first place, long histories of trauma, substance abuse that is untreated in the community, and how this impacts their access to prenatal care, right, real concerns about accessing prenatal care and having more control over their lives in terms of fear of having their babies taken from them, and real and understandable mistrust in our traditional healthcare systems, and then thinking about ways in which we can support our Indigenous clients and

cultural birthing practices, and, again, a focus on recognizing the generational trauma for Indigenous clients in the forced separation of Indigenous mothers and children. Many of our clients who were separated from their birth mothers, right, with long histories of their own trauma in childhood and what this means for them as mothers giving birth in custody and, again, being separated from their babies without a lot of formal supports for reentry and reconnection and having that be a part of their culture and family values.

I want to close with where I started. So, next slide. I realize I moved through this very quickly. I started by saying that pregnancy in jail or prison is characterized by a lack of supportive policies and practice -- next slide -- and I want to emphasize that incarceration causes harm, perpetuates health inequities, and threatens maternal and infant health.

I'm going to stop there, and I will be happy to take any questions, or I'll turn it back

over to you Commissioner Ehlinger.

CHAIRMAN EHLINGER: Thank you, Rebecca. Startling, startling stuff. So, we're going to save questions until the end, and we'll have a general conversation.

So, let's now go to Juliet. Juliet Swedlund. Thank you for being here.

JULIET SWEDLUND: Thank you for having me. First, I want to say wow, Rebecca, I've been a fan and follower of the Minnesota Prison Doula Project for a long time. I had the fortunate opportunity to attend the Minnesota Prison Doula Training back in 2018, I believe.

So, a little bit of history about myself -- thank you for having me -- I'm here to speak a little bit about my direct experience as a birth doula in the prison system here in Kansas. So, my degree is in finance, and I worked in health and wellness for 15 years, but the transformational part of becoming a mother is what led me to doula work. I got trained as a doula from the Sunken Center for Allied Birth in

Seattle, Washington, and returned there for my Childbirth Education Training, as well as the When Survivors Give Birth Facilitator Training. That's understanding and healing the effects of childhood trauma on the childbearing person. So, the opportunity to go through that time, in Seattle there's a nonprofit called the Open Arms Perinatal Institute, and they provided doula support to folks who are underserved, underserved populations throughout Seattle. And I knew the Minnesota Prison Doula Project were providing those doula services to folks who are incarcerated. So, when I moved to Kansas in 2014 as a brand-new doula, I provided doula services at a sliding scale to my community, and over a couple of years decided that I really wanted to make a bigger impact on the state of Kansas and chose to develop a 501c3 inspired by the Minnesota Prison Doula Project and Open Arms Perinatal work called the Topeka Doula Project. So, we provided doula services for low-income families throughout Shawnee County and adolescents and incarcerated folks at the Topeka

Correctional Facility. It was a very small grassroots organization. It still is to this day. But that's a little bit about how I got involved in this work. And we started that nonprofit in 2017, and it is still an operation now. I just started a job with the Kansas Department of Health and Environment in our Community Health Worker Section, and I'm sure you can imagine there's a lot of overlap in the work of community health workers and doulas, specifically doulas who are serving underserved populations and in the prison system. So, I'll speak a little bit about that at the end.

But I also want to share that I am also non-Native American. When Ed -- I just happened to meet him last week. I talked about my work in the prison system, and so I'm very fortunate to be speaking with you all today about those experiences and sharing some stories of the people that I've worked with. But I do want to -- if you haven't been connected with Camie Jaye Goldhammer yet, I was fortunate enough to -- we had our

children around the same time in Seattle, and we lived in the same neighborhood, and we're part of a neighborhood support group. So, I've kind of been following her work as well. Licensed Clinical Social Worker, IBCLC, Founder and Chair of the Native American Breastfeeding Coalition of Washington, she helped launch Hummingbird Indigenous Doula Services in that area, and she's President Elect of the National Association for Professional and Peer Lactation Supporters of Color. So, if you're not connected with Camie Jaye Goldhammer, I certainly encourage you to reach out to her and get her expertise and experience in this work as well.

So, starting in 2017, I started the Doula Project. We had our first prison client. I say we a lot. So, for the first three years, it was just me. Topeka's a very small community. There were not a lot of -- I think there were three doulas serving a 50-mile radius when I moved here. And then in 2019, we brought a donor doula trainer to Topeka and trained 17 doulas, offered

scholarships. We gave nine scholarships to people of color, formerly incarcerated folks, or Spanish-speaking people. So, that's kind of the expansion of that work.

Once I started my job at KDHE, I passed the torch on to the folks who are leading the Black Breastfeeding Coalition of Topeka, so Abriona Markham is now the leader of the Topeka Doula Project, and I can't wait to see what she does with that. I do still volunteer in a doula capacity specifically for the prison system with that, so currently have one client.

We were fortunate enough when we partnered with the Topeka Correctional Facility that they had a really great women and child program that they had developed starting in the mid Eighties with the United Methodist Health Commission here in Kansas. So, they had a mother-infant bonding program where after the person gives birth their infant can visit for, I believe, it's up to six weeks every day, instead of the standard weekly visitation. Now, this is one

prison for the entire state. So, you may have folks coming from two or three hours away, or even four or five hours away, where the logistics of actually having that infant bonding time really doesn't play out for most people. But they had individual rooms. They were painted in this really fun kind of nursery motif with semiprivate areas where they could bond with their baby and toys and movies for their other kids. So, there was that opportunity there. They also have a navigator who helps them through their pregnancy process and was my partner in linking people up with a doula, kind of sharing the services that we provided. So, that was kind of advantageous on our part, and I know that a lot of systems are not built that way.

So, to give a little bit of context of what that support looked like, Rebecca laid it out for you and it's pretty similar to that. So, for me, I was contacted by their family navigator and connected with the families there. I would meet one-on-one with folks and share a little bit about what a doula is and how I support them there and

start that prenatal process of exploring -- I like to say, like, help people plan for the birth they hope to have and prepare for the unexpected. So, we went through that process. Providing the support, we were fortunate enough that the hospital that we contract with provides a midwife who comes into the prison system weekly for visits for anybody who's pregnant. So, those visits are really advantageous. I have a great working relationship with the midwife, so we work hand in hand with a lot of clients together. They don't have the midwife when they are transferred to the hospital. They are working with whoever is on call at that point. But they are permitted to have visitors as long as they're -- they have the same kind of visitor rules in the hospital that they would have in the facility, and they're limited to two visitors. So, in our case, if somebody was cleared to be a visitor at the facility, they were cleared to be a visitor in the hospital. However, as I said before, this is one facility for the entire state. So, what that

looked like practically didn't always work out. Somebody might have had folks that they wanted to attend their birth, and those people were not -- didn't have the capacity to actually travel, or commit to being there, or take off work, or find a vehicle to actually support their folks. Almost all of the pregnancies are scheduled inductions in our state at 39 weeks. So, we've had a few clients who have been first-time mothers that we've been able to push that scheduled induction back to 40 weeks when they've desired, and there's a little bit of ambivalence about that. So, I think so much is out of control of the folks that I've worked with that having that kind of known factor can sometimes be comforting, especially if they are hoping to have family come and visit. So, they're trying to make these healthcare choices based on these factors that are really out of their control and have a real impact on their birth experience. So that's something to keep in mind. Depending on their security status, they'll have anywhere between zero to two guards. Most

times they'll try to pick female guards, if that's what's desired, but that's not always the case. I've been fortunate enough to work with some great nurses who try to help provide increased security and ask folks to step out of the room. But in working with trauma survivors, and I would argue that anybody who's incarcerated is a trauma survivor, so it is important to make sure we're being sensitive to what's going to make them the most comfortable during the birth process.

The Topeka Correctional Facility had a great breastfeeding program already set up where they were permitted certainly during the visitation to breastfeed their babies, but also had a pumping station even before I arrived. So that was already in place. Through COVID, they have implemented shipping of the breast milk too, so folks can pump and ship their breast milk as well. So, that's a little bit of like context around the way in which I've served clients.

I want to share with you a few short kind of clips. It's really interesting in doing

this work because it's -- it's easy -- I've served over 40 clients in the last five years-ish, and the stories all kind of blend together. We -- not only in the birth setting, but also, we implemented a support group so anybody who was pregnant or who had had a baby in the last two years was a part of that support group. That's since gone away with COVID. We've not been permitted back into the facility yet, but we are providing still those services, virtually, the birth support services virtually where I can do those prenatal appointments on Zoom, and then join them when they go into the hospital.

So, probably the most striking quote, early on in my work there somebody said, "It'll be better with you there; I won't be alone." And there's nothing that really sums up the work more. Birth is already a time that's filled with fear and anxiety even with the best support systems in place. I'm sure you can imagine how much worse that could be when you would be alone and without any additional support. I've been in birth

settings with women who have had seizures and disassociated during their labor, told me about the brain trauma that they suffered as a result of their ex-husband's abuse. I've been in birth settings with mothers who have been in that situation because they were raped by somebody who held them against their will, forced and threatened them into that setting. I've been in births with somebody who's pregnant with their eighth child at 37 years old, had her first child at the age of 12 after her dad raped her. I've been in birth settings with people whose parents left them alone for days at a time in charge of her toddler sibling when she was six years old. I've been in birth settings with people who are incarcerated for weed and gave birth to their baby and was without their baby for over a year. I've been in birth settings with first-time mothers whose family were too far away to be there and had a 24-hour labor, that ultimately ended in a cesarean. And I also work with the Kansas Juvenile Correctional Complex, and I've been in

birth settings with 15-year-olds, now currently have a 14-year-old client. The 15-year-old I worked with was incarcerated essentially for homelessness, truancy, didn't get to school enough. Her mother was trying to make it to the birth in time, had no transportation and could not be there.

Having these support systems in place for the people we serve is vital. And not only is it vital to provide doula services, but it's important that the doulas that we train and have working in this setting have specialized training in trauma-informed care and reflect the communities that they serve. In my current role as a community health worker program manager, the value and importance of having people there to connect -- and, Rebecca, you talked about that reintegration piece. Community health workers can serve that role, but it's important that the people that are in that position are reflective of the communities that they serve.

So, that's a little bit about my

experience, and I'm happy to answer any questions or give any additional details.

CHAIRMAN EHLINGER: Thank you, Juliet. That was powerful. And I liked the point that you make, you know, that the healthcare team really does need those community health workers, including doulas, which are the community health worker type, and that's how we get into the communities, we hear the voices of the communities, we get the support. So, thank you very much.

And now let's go to Diane, Diane Bohn. Glad you're here, Diane.

DIANE BOHN: Okay. I think I've got it now. Yes?

CHAIRMAN EHLINGER: There you go.

DIANE BOHN: Can you hear me? Okay. Very good. I'm very delighted to be here, and I was very impressed by the work of Rebecca and Juliet who are a part of this group that's doing this presentation.

I do want to make some clarifications.

Ed, I'm sure you got this information from my dear friend and colleague Jackie Campbell. I am not an honorary member of a tribe. I was adopted by a tribal member who wanted to make sure I got my Indigenous or my Anishinaabeg name, which is Wawishkemiezeque (phonetic). And this was done in a ceremony, but it was not an official -- an elder conducted the ceremony, but I am not an honorary member, per se.

Also, I did teach at the University of Minnesota for a time but had been gone from there for 20 years. I'm a certified nurse midwife who's been in clinical practice for 30 plus years, and I've also for that amount of time been involved in violence against women, and children, and elders and in many capacities, and I am a forensic nurse. And so, that's kind of the perspective that I'm bringing to this presentation.

What I wanted to talk about was kind of the intersection between the things that I know well, which are trauma and maternal mortality, and I have learned through the process of preparing

for this presentation that incarceration, of course, is also one of the connecting dots.

Next slide, please. We know that in terms of on a national level that one in four women experienced intimate partner violence, one in five experienced rape in their lifetime, third to half experienced some form of abuse in their lifetime and that multiple victimizations are common among women. We know that people who are victimized as children are at increased risk of being revictimized as adolescents and adults. We know that on a national level that three women are murdered by an intimate partner on a daily basis in this country, and that adverse childhood experiences are quite common with 40 percent of those included in the ACEs study experiencing two or more ACEs in their lifetime. We also know that rates of abuse are higher among American Indian, Alaska Native women, and that includes intimate partner violence, sexual assault, and stalking. And I would argue that in some areas these rates may be much higher. I have worked as a midwife in

Milwaukee for the Indian Health Board Clinic there. I conducted my dissertation study at the Indian Health Board Clinic in Minneapolis and have spent the last 15 years working at the Indian Health Service facility on the Leech Lake reservation in Cass Lake. And I have routinely throughout my career conducted lifetime abuse assessments with the women that I serve. And in my dissertation study, I found that 87 percent of the pregnant women who are in my study had experienced intimate partner violence, child abuse and or child sexual assaults. And I have to say, as I was analyzing that data way back then, I was so taken aback I thought maybe I just had an aberrant population. So, I went around and met with a number of abuse advocates that work with Indigenous communities, and they basically looked at one another and said, you know, I don't know any Indigenous woman who has not been abused; do you, and the other person would say no. And so, I also had found in the routine assessments that I do in the clinical setting that it's about two

thirds of the women that I have worked with throughout my career have experienced some form of violence, and, again, often multiple types of violence.

Next slide, please. Because I am not an expert in incarceration, I did spend some time researching this and I found the ACLU had quite a bit of useful information.

Rebecca and Juliet, please feel free to interject any insights or knowledge that you have on this area.

But according to the ACLU, women are the fastest growing segment within the prison population. Two thirds are women of color. The majority are mothers, and most are there for nonviolent crimes, such as drugs and prostitution. The vast majority have been victimized, and many come into the jail and prison setting with mental and chemical health issues.

Next slide. And this is where we begin to intersect with intimate partner violence is that women who are arrested are often arrested for

acts that are coerced or controlled by male partners in response to violence. This includes trafficking, drug sales, drug use and sales and transportation, fraud, or they may be present during a violent crime committed by their partner and incarcerated as a result. And also, many are incarcerated for responding to abuse. 90 percent of the women who are incarcerated for killing a man had been abused by him previously. We also know that women receive harsher sentences for killing their male partner than men who kill female partners, and that many experienced abuse in prison. Some of you may be familiar with the case of Marissa Alexander from Jacksonville, Florida. This is back like 12 years ago. She was in a very abusive relationship and was being threatened with being killed, and she had a permitted gun that she retrieved from her car, brought it back into the house, again was threatened with being killed. She fired one shot into the ceiling, causing no injury to anybody. And she was sentenced for 20 years in prison after

12 minutes of jury debate. And these are the kinds of things that have -- she has since been released before that 20 years was up. But, again, this just speaks to the intersections that we see between incarceration and abuse.

Next slide, please. When we look at the intersection again between maternal mortality IPB we know that women of childbearing age are the most likely to experience partner violence, and that abuse may begin or escalate during pregnancy or the postpartum period. And there are IPV-associated risk factors for poor infant and maternal outcomes, including late and inadequate care, often because she is not allowed to access medical care. She may include poor weight gain. I actually worked with a patient many years ago whose husband allowed her one meal a day. The rest of the day she could have water and crackers because he didn't want her to get too fat. Substance abuse is definitely associated with history or current trauma. And then injuries that can occur from intimate partner violence during

pregnancy, particularly close to the abdomen, can result in ruptured membranes, preterm birth and abruption. And women experienced a whole host of injuries during pregnancy from their intimate partners from bruises to strangulation, and or homicide.

Next slide, please. So, if we look at maternal mortality, we know that if we're looking at pregnancy-associated maternal mortality, which unfortunately does not get very much attention really in the literature and in the research, we're very focused in on pregnancy related maternal mortality, but if we look at associated mortality, the most common causes include suicide, homicide, and drug overdoses. And all of these things are known to have intersections with intimate partner violence, and all are more common among Indigenous women. I have to say -- and this was addressed yesterday, and I'm so grateful that they are finally starting to tease out data about Indigenous women from this new multi-race category, because it is really difficult to tease

this information out. Oftentimes, also, because of the low numbers of American Indian and Alaskan Native women, they are categorized as other. So, it's really can be really difficult to tease all of this out. We know in general that a third to two thirds of femicides are associated with intimate partner violence, where a woman is killed by a previous or current partner. This varies widely from state to state and from year to year. We know that pregnant and recently pregnant women are at increased risk of intimate partner violence and homicide compared to nonpregnant women. Some of the state-level data that I have looked at in terms of maternal mortality have attributed up to 13 percent of all deaths -- and this last bullet point on this slide is incorrect. I apologize. We know that 10 percent of maternal deaths in Minnesota and Washington State are attributed to homicide. It's like a third of the deaths in those states were attributed to injury. And in both of those states, American Indians and Alaska Natives actually have a higher rate of overall

maternal mortality than any other racial or ethnic group.

Next slide, please. The other area that I have spent a lot of time working in is trauma-informed care and the physiologic effects of trauma. And when we look at maternal mortality, we definitely have to look at racism as a cause of the inequities that we see. And this intersects, of course, with trauma in terms of child sexual abuse and intimate partner violence as well. The violence against American Indian Alaskan Native women are often committed by non-Indians, and this is particularly true of sexual assault. We know that on a daily basis many Indigenous people experience micro and macro aggressions and institutional racism.

And this is a very knowledgeable group I have learned as I have listened to those of you who are participating in this committee for the last day and a half. So, you probably know all of this, but historic trauma is very important in terms of affecting the health, the housing and

food insecurity, etcetera that negatively affects health and health behaviors in Indigenous populations.

I'm so sorry. There was call coming in on the other line.

One of the other theories that has been postulated to account for higher rates of maternal mortality in Indigenous and other populations, black and brown populations, is the weathering hypotheses that it states that women experienced premature biologic aging and increased preexisting risk conditions because of historic and current trauma. And this theory was initially used to explain increases in negative maternal and child outcomes among black women. And the bottom of this slide are the references for that.

Next slide, please. So, in terms of the physiologic response to chronic stress, I'm not going to go through all of this, but we know that chronic stress which can be from being an intimate, partner violence relationship or being a black or brown person in our society can result in

excessive activation of the HPA axis in the sympathetic nervous system, which ultimately can raise blood sugar, cause immunosuppression, increased blood pressure, etcetera, which can lead to disease. So, in fact, this is the pathway by which the weathering hypotheses really make sense.

Next slide, please. Many of you, I'm sure, are familiar with epigenetics, which postulates that trauma, including ACES and abuse and racism, can actually produce alterations in the epigenome via methylation, and that the stressors that can cause this type of trauma can be nutritional, psychological, or environmental toxins. And the changes that occur in the epigenome do not change the genomic sequence itself, it just alters the phenotypic outcomes by altering its cell differentiation and cell expression. So, for example, it can lock genes into the off position such as tumor suppressing genes. It can also increase the risk of diseases such as diabetes, cardiovascular disease, and hypertension. And another thing that we see very

often when we work with trauma survivors is the alteration in genes that affect the stress response. We have all worked with traumatized people who have a stress response that is much more active than others. My friend talks about having her amygdala being overly active, which is exactly what can happen with chronic stress, including racism. We know that chronic stress can also affect embryonic development, and that intergenerational transmission of these alterations occurs. There is also argument that alterations are reversible if people are able to receive assistance in dealing with their lifetime trauma.

Next slide, please. So, the effects on maternal mortality of stress and trauma are that women do often enter pregnancy with preexisting conditions such as diabetes, hypertension, cardiovascular disease. They enter pregnancy with higher rates of risk behaviors such as substance abuse from smoking to alcohol to drug use. They have decreased access to quality healthcare. They

are less likely, if they are a brown or black person, to have a provider of the same race, which we know can have an effect on outcomes. And they're at increased risk of poverty, including food and housing insecurity and living in neighborhoods where violence occurs on a regular basis.

Next slide, please. So, the takeaway from this is that if we are to address maternal mortality, it is really, really important, that we pay attention to the presence and effects of lifetime abuse and racism, and, you know, that we screen for abuse with our pregnant patients and make sure that we get them connected to any kind of assistance that they might need.

And I just -- in closing I just want to also say that in the work that I've done with maternal mortality, we really need to be increasing our role in supporting the role of midwives. In maternal mortality, you know, there is some really good international and national modeling, that indicates increased use of midwives

would drastically decrease maternal mortality.

And I believe I sent in an article. There was an issue of the Journal of Women's Health in 2020 that was focused on maternal mortality, and I was coauthor of an article in there on maternal mortality among American Indian and Alaska Native women. In that article in the discussion, it does speak to the use of midwives in reducing maternal mortality. And I thank you very much for your time, and I look forward to any questions.

CHAIRMAN EHLINGER: All right. Diane, thank you very much. Important information, and actually is a nice lead into our next session, which we will get to in about 10 minutes or so. But let's now open it up to questions that people might have. So, if you can, raise your hand, and I'll call on you as best I can.

Belinda?

BELINDA PETTIFORD: Thank you, Ed, and thank you all so much for this wonderful presentation. It is definitely needed to make

sure we're all educated even more so than what we thought we were. Now, my question is to Rebecca. In the work you're doing with the Doula Project -- or you can open it up to anyone -- is there any conversation around having -- making sure women maybe can breastfeed for awhile while they're incarcerated, if they can express the milk and still have it available for their children? It's one of the conversations we've had in our state. We haven't figured it out, mind you. But I was just wondering is that any of the efforts that you all are looking at?

REBECCA SHLAFER: Yes. This is where there's such tremendous unevenness in the implementation of these support programs across states. So, while we've had a really robust doula program for more than a decade now, lactation support has been something that our state has challenged with. And we had very early conversations about, you know, the breast milk will be safe, right, really stigmatizing problematic conversations around how would we test

the breast milk so that moms aren't poisoning their babies; we can't have a refrigerator or freezer, that's not logistically possible; how are we -- you know, all of the barriers that DOCs can put up. And I will say that we've made some progress, and in the last six months have been able to have two clients who have pumped, stored, frozen their breast milk and have volunteers picking it up from the prison and delivering it to caregivers in the community. In other states -- so in Alabama they have had a robust lactation program with a beautiful lactation space that volunteers have helped create in the prison. They have been storing, freezing, and shipping breast milk overnight to caregivers in the community. These are happening on small scale. The logistics, I think, are complicated and the long-term sustainability, right, of having a volunteer drive to the prison and drive and drop off breast milk somewhere else is challenging. I think that this is going to be a place where we see considerable movement in the next five years, and

especially around onsite for babies and moms that are geographically proximal to one another are not necessarily co-residents, but, you know, if a mom and a baby -- if baby lives in a community 10 miles down the road and caregiver could bring baby, their right-now policies prohibit their ability to nurse during visits. So, again, there are opportunities both for milk storage, getting it to baby, but also opportunities for nursing on site. But there's a lot more work to do in that space. Great question.

CHAIRMAN EHLINGER: Juliet, do you have anything to add to that? I know --

JULIET SWEDLUND: Yeah. I mean I spoke to it a little bit. But, in our experience, the Topeka Correctional Facility for the State of Kansas has been very pro-breastfeeding and pro-pumping. The challenges that Rebecca mentioned are absolutely true for our space as well. So, I have personally delivered breast milk to the NICU for a mother who was incarcerated. And COVID extends those challenges because the caregivers

who have baby aren't able to be in the facility at the moment. So, the logistics of shipping it out and getting breast milk for the baby -- but I have had somewhere upwards of five to 10 mothers who have successfully pumped and breastfed their babies while incarcerated, including a 15-year-old who was incarcerated for a year.

CHAIRMAN EHLINGER: Jeanne Conry?

JEANNE CONRY: Thank you to everybody for a phenomenal set of talks that really complement one another very, very well and point out huge holes in our caregiving ability.

One comment I have about the intimate partner violence is we screen for diabetes in pregnancy where we look at about one in 10 women with diabetes, and yet we don't screen for -- across the board -- we did at Kaiser, but not at most other facilities -- we don't screen for inter-partner violence where it's one in three. So, we've got some deficits there about what are the best screening options for women.

My question for everybody is, we've got

different types of prison systems, you know, the federal system, the state system, and I'm sure local incarceration, how do we share best practices and really move what's going on. I mean these were phenomenal examples. How do you encourage other systems to change? How do you work at the federal level for -- you know, I live close to Folsom Prison. So, how do you change the federal prison system and the state prison system so they're more empathetic and understanding of the needs of moms?

CHAIRMAN EHLINGER: Who's going to take that one on? Big job.

REBECCA SHLAFER: I can take it on, and I'll put in the chat a paper that my colleagues and I just published on some reactions to the Federal Maternal Omnibus, the Black Maternal Omnibus on sort of reflections at the federal level. A lot of work needs to be done. You're right. Each of these prisons is sort of their own challenge to operate. I think we have done it in a very grassroots way, frankly, over the last

decade plus, and that is a lot of sharing of resources, inviting folks like Juliet to join national sort of conversations that we've hosted in Minnesota really trying to share data collection tools, programming guides, even, you know, our system for invoicing for doulas, right. Anything that we can share, we've really tried to do so, recognizing that if the vision is to end prison birth, it's not just end prison birth in Minnesota, it's across the country.

I do think we are going to continue to see a recognition of how ignored this population has been. And I think, frankly, by design, right, we've all been told that the system has been developed to lock up the bad people to keep the rest of us safe, and I think the more and more people get into this, recognize what a lie we have been told and how our communities are not safer by locking up, you know, millions of people, and moms and babies aren't healthier by putting them in prison and not giving them access to adequate nutrition and prenatal care. So, I think there's

a lot of work to be done.

We always tell people when they want to start in their state have those local conversations and be willing to adapt sort of these foundational programs to the needs of the clients in that facility. You know, every state is doing it a little bit differently. So, some states will have pregnant folks in one facility and then move them to another facility in the postpartum period. That is critically important information to know in terms of programming, right? So, some of the aspects of program implementation need to be site-specific, and we've always -- we started in Alabama by having talking circles, going in and having conversations with pregnant and postpartum clients before we did anything with the Department of Corrections, right, hearing directly from them what do they need, where are there gaps, where they're concerned. And while we heard considerable overlap in the concerns from moms in Alabama and moms in Minnesota, there were also some unique

challenges there that were really important for us to consider in sort of the local piece of implementing new programming there. So, I think it will look a little bit different. I think as this spreads across the country, we'll see more resource sharing, more investment in states.

And, frankly, this is a place where there just has to be cross-agency, cross-government solutions. This is where I have to push my department of health colleagues to think about what are you doing around maternal and child health in prisons, right? It can't be stay in your own lane. This is a place where there is inherent intersection, and we just haven't done a great job to date, and DOCs, the Department of Corrections, haven't done a great job of letting in, right? So, we have to figure out a way. I feel thankful now that we have a Department of Corrections Commissioner who gets it, and really truly does see the intersection and recognizes that corrections is not in the business initially of maternal and child health but these are all

interconnected issues that require collaborative interagency responses.

CHAIRMAN EHLINGER: Rebecca, keep going, man. Keep going.

MAGDA PECK: Remarkable presentations. Thank you for shedding even greater light.

Two quick questions. One has to do with building on Jeanne's question. With the increased privatization in the incarceration business and the ownership, if you will, of prisons by private companies, to what degree is this both a risk and an opportunity for being able to have impact? Have you experienced a difference? Kansas has one facility. But as we go out and see that this is an economic engine for rural communities, how can we be aware from the economic development and the business perspectives that are going on in both opportunity and risk for women?

That's one, and I'm going to ask the second one now because you can respond to either. The second has to do with we heard yesterday about extraordinary, expanded investment in federal

funding and MCH home visitation. What is the connection between home visiting with incarcerated women? Is there any intersectionality in how Title V dollars are being spent or could be spent creatively in redefining what is home visitation in the context of a jailed or incarcerated woman or person who is birthing?

REBECCA SHLAFER: I love this question. Can I take it? Juliet, is that okay if I jump in?

Okay. Thank you. I'm going to take the second question first, and then I'll pass off the first one. I have long wondered about this intersection in part because when I was doing my public health sort of field experience I asked if I could go sit in our local jail for a month, and that was my field experience, and I watched our health services at that county jail at the time was being administered by local public health. Now, this actually ties into your first question because most correctional health services has been privatized. And in the state of Minnesota, only a handful of correctional health services are still

actually administered by local public health. I have to say that in those counties where local public health is doing health services in the jails, there is some sweet spot there between those local public health nurses who get the upstream prevention, they get the intersections with substance use, they get the intersections with mental health, and that seems to be lost on the private companies that are coming in trying to slim down, do the most -- you know, do what they can with a limited amount of resources. And of course, jails, right, want to spend less and less and less on health services because it's a cost, right? So, I am -- on the home visiting side, I have long wondered since this field experience, because what I was seeing was public health nurses who do home visiting services coming into the jail and offering the parenting classes, and I thought, where have we missed this opportunity for intersection. And, of course, when we go back and look at the early literature on nurse-family partnership and other home visiting models, there

was long this conversation about the opportunities for family home visiting to prevent maternal engagement in the criminal justice system, and longitudinal outcomes for their children, right, their adolescent. We are working on a scoping review right now to get a sense of where the literature intersects on this, because we look at the MIECHV programs, right, the evidence-based home-visiting programs, and they talk about reductions in this broad category of crime and violence, but I actually think we know very little about how family home visiting can be a crime prevention strategy. And I say that boldly because I do think, right, these broad investments in children and families and upstream prevention does have implications for families' involvement in the criminal-legal system. So, I think there are lots of opportunities there at a macro level.

And at a micro level, we've been working with jails in Minnesota to do a better system of referral. We found in one jail study, that 10 percent of men who are coming into prison

-- or excuse me, 10 percent of men who are coming into jail, have pregnant partners in the community. One in 10 men coming into jail have a partner that is currently pregnant. Why aren't we doing referrals to those families in the community? Why aren't there warm handoffs? Why aren't there opportunities for early prevention? And I get it, this comes that we have to make sure we're very cautious about, you know, privacy and intervention in families, and the long risk of getting families mixed up in the child welfare system. But I think we have to start getting creative about where can we think about family home visitors who come into the prison, who do resources with alternative caregivers in the community who then help moms reenter into that family system, who work through all of the sort of dynamics of families changing when moms come home. I think that the opportunities there are endless, and I'd love to see more of that thinking and thinking about how to use the Title V dollars in that creative way.

CHAIRMAN EHLINGER: So, I'm going to jump in here for a second. We're going to eat into our break time -- for the people in the next session, we have a half-hour break scheduled, but we're going to eat into that. So, I'm going to take two more -- three more questions. I know Charlene had a question, Yanique (phonetic) had a question and Sherri had a question. So, we'll go with those three before we take a break. So, Charlene?

CHARLENE COLLIER: Yanique can go. I put my hand down. She covered my question.

CHAIRMAN EHLINGER: Okay. Yanique?

YANIQUE: Thank you, Charlene, for deferring. My question -- can everyone hear me? Because I'm having kind of internet issues. My question, I think you touched a little bit on it, Rebecca, is regarding the funding. So, I'm going to be very narrow. One of the issues that I know kind of years ago did some work around incarcerated pregnant women, and at that time was looking at visiting for pregnant women. And one

of the restrictions that I think continues is kind of funding restrictions regarding what kind of either federal funding when it comes to these different programs can be provided for pregnant women, whether it's related to home visiting in nontraditional spaces -- so when we talk about visiting, it's not necessarily within kind of the domestic home, but going to where women are, right, so wherever they are, whether it's in shelters, whether it is in facilities that there is someone that's going in to provide that support, but the funding restrictions that limit them, that funding to go there and CHW. So how do we think about creative ways of ensuring that these funding restrictions are either lifted or modified so that then we can provide these kinds of services to pregnant women within facilities and has that been part of the dialogue for this. So, whether we think of natural supports that go into facilities for women, whether we think of home visiting, whether we think of community health workers, how do we address kind of the

payment models or funding restrictions?

MAGDA PECK: Helpful. Thank you.

CHAIRMAN EHLINGER: Juliet or Rebecca? While you think, Sherri, why don't you raise your question too.

SHERRI ALDERMAN: Thank you very much. This has been a really very, very provocative conversation and presentations. I'm very grateful for that. Mine is more of a comment than a question. In Oregon we have done preliminary work to bring home visiting in quotation marks into the women's prison, recognizing that we need to go beyond that, of course, and include fathers. But in the meantime, we're starting there. And it has been a whole handful of getting exceptions at every step of the way. Healthy Families, it went all the way to the national level. Because of the definition of home, we needed to we get an exception, and we did, and, actually, they very eagerly granted us that exception to be able to do home visiting in our women's prison here in Oregon. We went with Healthy Families because

Healthy Families is statewide. Nurse Family Partnership, another wonderful home visiting program, is not statewide. And we were looking ahead at the point of mothers being released and being able to have either the same home visitor if she stays within the county, or a warm handoff to another home visiting visitor somewhere else in the state. We had to get an exception within the prison, as already mentioned, a limitation the number of people who can visit at any one time in order that we could have mom, the home visitor, the adult accompanying the baby or young child, and the baby or young child there. We were successful at doing that under our legislated Bill of Rights for Children of Incarcerated Parents. COVID, as it did with so many things, put a screeching halt to any advancement in that. But that is the way that we're approaching it. And we have much more to do, much more to learn. I'm very open to others who have experiences that relate to this as well.

CHAIRMAN EHLINGER: Thank you, Sherri,

for that comment, and thanks to our three presenters. This was just really eye-opening presentations, and really helpful in our thinking about the recommendations that we have to move forward in this issue and others. The link with interpersonal violence and incarceration and health outcomes is really, really crucial. So, thank you for your contributions.

And I will now turn it over to Janelle. And, as I said, you know, we can eat into the break time a little bit. So, take it away from here. Thank you.

MURDERED AND MISSING INDIGENOUS WOMEN AND GIRLS

JANELLE PALACIOS: Okay. Thank you. In preparation for today, I just have a few little things that I would like to share with you all, the first being that in the chat box I have placed a number for everyone to text if they want to take the time and just share which ancestral lands you're standing upon. So, I'm speaking to you today from Northern California. I'm standing upon

Pomo and Coast Miwok or Wappo land, and that's where I'm joining you today from.

So, we have three panel speakers. It's my pleasure to introduce the next panel of speakers. We have experts joining us today who will help frame our understanding of the urgency surrounding women and violence, so a nice segue from the incarcerated talk that we've had because this work continues.

Our first speaker will be Doctor Annie Belcourt. Doctor Belcourt, Otter Woman, is an American Indian Professor in the College of Health at the University of Montana School of Public and Community Health Sciences Department. She is an enrolled tribal member of the three Affiliated Tribes Blackfeet, Chippewa, Mandan, and Hidatsa. She was raised on the Blackfeet Reservation. Her doctorate is in clinical psychology research, and her research interests include mental health disparities, environmental health, trauma, posttraumatic stress reactions, risk, resiliency, psychiatric disorder, and public health

intervention within the cultural context of American Indian families and communities.

Following Doctor Belcourt, we will have Michelle Sauve. Ms. Sauve is an enrolled member of the St. Regis Mohawk Tribe, and serves as the Executive Director of the Interdepartmental Council for Native American Affairs, the IC and AA at AHS. As the Executive Director for the ICNAA, she provides coordination across HHS and supports ANA leadership on the council and cross-program collaborations and coordination and policy impacting Native Americans within HHS. Ms. Sauve is also the Intergovernmental Affairs Specialist at ANA. Her work includes providing policy and program advice across a variety of issues that impact tribes, and she helps ANA collaborate across federal agencies via participation on various work groups and interagency initiatives.

Finally, we will conclude our panel with Stephen Hayes. Mr. Hayes is a Public Health Analyst in the HRSA Office of Women's Health, where his portfolio includes violence prevention,

and response, behavioral health, and American Indian Alaskan Native Health. He currently coordinates OWH activities in support of the development of a new agency-wide strategy to address intimate partner violence, and recently led an effort to develop a toolkit, which I will include, for HRSA, supported providers and their organizations to help them better meet the needs of women with opioid use disorder. He represents OWH on numerous workgroups, including the Interagency Council on Native American Affairs, MMIP Health Group, the VA's Intimate Partner Violence Advocate Program, Expert Workgroup, and the HHS Substance Exposed Pregnancies Workgroup.

We will hold all questions until the end of the panel member speaking. So, Doctor Belcourt will be joining us from rural Montana. And while she is speaking, I will be sharing slides that I've created based upon the Urban Indian Health Institute's Missing Murdered Indigenous Women and Girls Report.

Welcome, Doctor Belcourt. You are

welcome start.

ANNIE BELCOURT: Okay.

(Speaking in Siksika.)

My name is Annie Belcourt, or Otter Woman, and I'm speaking to actually from my ancestral homeland on the Blackfeet Reservation in northern Montana. And I am speaking from my vehicle because I'm here at the International Blackfoot Conference on Health and Wellness. And it's a once in a lifetime opportunity, actually, for our tribal community to have folks who are both from Canada and the United States come together and discuss wellness, language, culture, and the intersection of healing. And so, this is, you know, inclusive of folks who are from the arts, from the sciences, from, you know, traditional medicine, and all of the folks who, you know, are really invested in the very questions that all of us are discussing today. So, I wanted to first express my gratitude to everybody on the call, and to all the organizers on this important topic.

I am a tribal member. I grew up on the Blackfeet Reservation, but I'm also enrolled at the three affiliated tribes in North Dakota. And so, I, as part of my background, I chose to become a clinical psychologist in the western training world and a researcher, and so I'm happy to share some research articles, and statistics, and those kinds of aspects. I included in the chat an article I wrote last year that's about this very topic about the intersectionality of trauma, violence and social aspects, especially now following or kind of as we go, you know, the pandemic and the aftereffects of that, which, you know, honestly, as a public health scientist, you know, I know that has differentially impacted people like me, and Indian people, people who are people of color, people who are from our LGBTQ communities, and people have, have suffered greatly the last couple of years. However, you know, we have to always sort of stand in recognition of the fact that these have been planned disparities that have really impacted

communities of color differentially. And so, you know, I greatly appreciate the fact that there's a space to discuss advocacy, science and policy and practice in ways that could help American Indian communities.

And so, I, myself wear different hats. I am a professor, and I will be chairing our Native American Studies Department at the University of Montana as well. So, I wear many different hats, but I also wear the hat of a community member, and so somebody who has lost a family member to murder actually. And my sister was murdered in 2001 when I was a graduate student, and it was really -- you know, prior to there being a lot of sort of public knowledge about the epidemic around violence with regard to American Indian women. And so, you know, that experience was a really profoundly traumatic experience, not only for myself and my family, but for our entire community, for a community to experience, you know, such a constellation of causal factors that led to the loss of my sister.

And so, unfortunately, there are so many families who share that same history and that same story. I don't, you know, pretend to be unique in that. And, unfortunately, it's very much intertwined with maternal health, child health, early adult, you know, that has this cascade effect developmentally to lead to a lot of the disparities that we see.

And so, instead of having, you know, a lot of, you know, data that I was going to, you know, hit you with this afternoon, I really wanted to, instead, talk from first-person experience about what it's like to be a scholar who's trying to write in advocacy informed science around the space of violence and how it's impacted our communities, but then also as a community member and how it is to be a part of a community with so much depth and richness in terms of our culture, our knowledge, our history, our language and, you know, also, you know, be faced with the realities that we see so many forms of violence within our communities. We see lateral violence. We see,

you know, direct discrimination from outside groups, and also from within, you know, and between our communities. So, unpacking all of that has been something that I've really focused on in my research.

But, you know, one of the things that has been really important to me has been to ask difficult questions, and questions that are not always questions that are welcome. Because, you know, when we think about the issue of violence within any community, you really have to think about people, right? And so, I work with a lot of epidemiologists, and they want to do studies that are looking at tree cover and how that corresponds to COVID mortality or things of that nature. You know, the truth is it's important to talk to people and to hear their stories. And I know each of you know that. But as we think about -- even being here this morning, we had some of our relatives from Canada speaking, and it was a residential school survivor who's 79 years old, and, you know, the entire room of Blackfeet

people, you know, was, you know, in just silent awe to think about the resilience. We have a term that's called ika'kimaat, and that means to try hard, and that sort of encapsulates some of what we think about when we think about resiliency. And so, to think about this, you know, elder, and her generosity of spirit and how, you know, she brought back immersion teaching of our language and culture to children who were in, you know, kindergarten up to high school age, and, you know, just the care and kindness that it takes to repair violence. And that's the thing that I think that has been really, you know, hopeful to me and also helpful is to think about how much, as Native people, as many of our communities are kind of informed by compassion and love, and those are things that really sort of mitigate, if not undo, the harms of violence. And that's such an important factor for all of us to sort of recognize within our lives.

And so, something that I share with my students when I teach is how we can kind of see

the best within each other, and how do we think about compassion informing our work and informing the numbers that we see. You know, we see, you know, terrible losses from violence within our communities. And, you know, it's really hard to confront that when you have a system that has, you know, for known human history, postcolonial history, you know, a system that doesn't really care about our lives.

And so, when you think about the cities that are shown here, top cities who have high numbers of missing and murdered Indigenous people, women, and girls, you see places that our people were relocated to. You see places that there were folks who were forcibly removed and placed into boarding schools and had to find a place to recreate their families in their lives. And that level of, you know, intentional violence that happened structurally within this country has led to structural outcomes of inequality. And that's the key takeaway from any discussion I would have is that, you know, we think about those sources of

inequality and how -- how do we unpack that; we do that intentionally as well. And we have to think about ways that we can create and produce structures and policies that are informed, not only by survivors and families, but also, you know, the entirety of a community. So, what leads to people, you know, who are making decisions to be violent to other humans, what is what does that look like, how do we, you know, unpack that, how do we understand that better so that we can make apply changes to change that. So, that's a lot of what we're kind of thinking about from a public health perspective in Montana and part of why I mentioned this conference. It's so important, because, you know, over the pandemic we've had, of course, a lot of challenges, but we've also had our communities coming together in different ways and in ways that have enriched our culture, our heritage, our language and we've had people really sort of leaning into the positive factors that increase and promote resiliency, not only resiliency for individuals, but for communities as

a whole. And so you see, you know, the grandmothers and our elders teaching the language, teaching the culture, and so many of our words in our Blackfeet language and for many, many Native communities are based on things like compassion and love, and when you think about that, you know, that -- that is the kind of key that we need to kind of think about for any community.

And, as a psychologist, you know, I know the importance of development and how, you know, the environment and the things that we experienced from an early age really has a lasting impact on how we as individuals' function. And so, the more that we can kind of infuse that process with some of the kind of, you know, amazing ways that our communities have always prospered and succeeded and done well are ways that are really hopeful.

And so, you know, for example, this is something that comes up frequently for the Blackfeet people. So, most of us have heard of the Maslow's hierarchy of needs. And so, that

hierarchy talks about the foundation being, you know, having basic needs met, and then over time and over kind of a cumulative process you can eventually have self-actualization, and you can have self-esteem, and you can have these kinds of really wonderful things in your life and feel good and feel secure, and all these kinds of healthy emotional factors. So, he actually developed that theory by living with the Blackfeet, and so he lived here in Northwestern Montana with the Blackfeet, I think for a summer, and developed this theory based on his interviews of elders, and they told him about some of the importance of these emotional factors for development. And so, he built that pyramid that was based upon his interpretation of those teachings, right? Now, fast forward, you know, we hear and learn about Maslow's hierarchy of needs as Native people when we go to college and things, and it came back eventually to the Blackfeet people. And the take home from that was that he misinterpreted what they were saying, you know. What they were

actually saying was that if you have the emotional needs met, if the community can kind of value folks in a generous way that is honoring kind of our spirits and is having a solid foundational life based on meaning and hope and many different factors, humor and things that we hold to be very valuable, then you will have, you know, sort of so-called success; you know, then you will have what you need, you will have everything that -- you will live sort of in a bountiful kind of way. And so, it sort of really like inverts the triangle that or the pyramid that he described in theory. And so, I think that's a really powerful message for us to think about is to consider how many of the solutions for Native people are already residing within our culture, within our language. We have words for these things. We have words for caring. We have words for love. We have words for -- in Blackfeet we often don't say goodbye. We say, you know, I'll see you later.

And that's part of it is we live in relationship with not only our land -- and this

sometimes is kind of, I think, romanticized in different ways, but truly we belong to the land. And that was a presentation that happened yesterday is, you know, land doesn't belong to us. We belong to the land. And so, that idea of relationally is such an important factor for our communities, and to the extent too that our ancestors really help us to solidify who we are as people and our development as human beings. And so, those are really important factors.

And I think that as we think about some of the recommendations that like places like the Urban Indian Health Institute, have put forward, those are exactly right. You know, we do want to support law enforcement. We do want to improve law enforcement accountability towards people who perpetrate crimes. You know, being violent and abusing others is not part of our culture, and it's not something that was like historically accepted. So, we think about holding people accountable here in Montana, you know, for doing a partnership -- or partner violence, it's actually

more sort of punished, if you will, to harm property, to have graffiti than it is to harm another human being, especially for a partner or a child. So those things can change. Those are changeable things. We can improve things like misclassifications, so we have better data around MMIW. We can look at investing in our sovereignty of our communities so that they can help to notify when deaths occur. And then, of course, we can fund research that is working with communities, not in communities, in terms of extractive science, but really with communities and partnerships to begin to kind of deconstruct the things that have built violence within our communities and to extract that.

So, that's what I kind of want to just leave you with is just there are many ways, and many of our youth are really creative folks who can really help lead the way. Some of the things we've invested in have been film, looking at documentary film, looking at -- my daughter's a screenwriter, and so she writes for television and

media, and we work together as -- I view us as both public health practitioners, because we're helping people be invited into spaces that really are required for folks to see and witness to help to begin to decrease the impact of violence within our communities, which is, you know, something that we all want, and it's a shared value and a shared hope that we all have. And I know I'm short on time, so I think that might -- I think I might be at time, so I just want to welcome questions at the end of the presentation, and just again express my gratitude for everybody to take on these really difficult topics in ways that are, you know, required. Like, you know, the level of granularity is really important as we think about deconstructing these issues. So, thank you.

JANELLE PALACIOS: Thank you, Doctor Belcourt.

We will now invite Ms. Michelle Suave. Welcome.

MICHELLE SAUVE: (Speaking in Native American language.)

I am joining you today from the ancestral lands of the Nakochick Anacostans and Piscataway Peoples, otherwise known as Washington DC. Thank you for putting the slides up. I'll let you know when it's time for the next slide. I want to thank the Advisory Committee on Infant and Maternal Mortality for inviting me to join you today for this discussion on missing or murdered Indigenous women. I appreciate the very important role of this advisory committee for caring for our sacred ones, the future generations, and the life-bearers, the women who are their first home.

I'm honored to be participating with my fellow panelists, and to share how HHS and the Administration for Native Americans is addressing the issue of missing or murdered Indigenous people. This is not an issue that's going to impress you by the statistics, although I think my fellow panelists had some very good statistics that point out a lot of the gaps in the data that we have. But I do also have a couple of statistics that I'll share with you today. And,

maybe because of this data invisibility, this has largely been an invisible crisis, except within Native American communities. Annie shared her personal story about how this impacted her, and not just her and her immediate family, but, you know, the whole community. And so, raising awareness on this issue, as with any other public health response, is the first step in creating that momentum for change. So again, thank you for hosting this panel.

I also want to talk to you about some of the federal efforts underway, but I do want to state right up front that this is an issue that needs a collective action approach from all levels, federal, tribal, state, private sector, and all the way down to individual actions. And I think, Annie, you spoke to that really beautifully around, you know, needing to get back to traditional values and treating each other as relatives and really addressing violence before it starts.

So, in our traditional greeting, when I

said (Speaks in Native American language) that means do we still share the great law of peace amongst us, and that's how we greet each other. You can see there's an emphasis on living in peace with each other that we're checking in if that's still how we are with each other as an initial greeting.

So, before I talk to you about MMIW, I just want to let you know a little bit about ANA, so if you could go to the next slide. So, ANA was authorized by Congress in 1974 under the Native American Programs Act, and it was an extension both of the war on poverty as well as the era of self-determination for tribes. ANA is situated within the Administration for Children and Families within the Department of Health and Human Services. We have a broad service population defined by Congress, which includes federally recognized tribes and also non federally recognized tribes, Native-controlled nonprofits including urban Indian organizations and nonprofit agencies serving Native Hawaiians and Pacific

Indigenous populations of the US territories.

Next slide. So, ANA, our mission is to promote self-sufficiency for Native Americans by providing discretionary grant funding for communities, and for those to be community-based projects. We provide training and technical assistance to eligible tribes and Native organizations and provide advocacy and policy development in partnership with Native Americans and tribal governments. The commissioner for ANA serves as Chair of the Interdepartmental Council for Native American Affairs at HHS, and the Indian Health Service Director is the Vice Chair of that HHS Council.

Next slide. Great. And I did last minute of it, so I have to tell you a few more things before I read that slide. So, we have three broad funding areas in ANA. Its social and economic development strategies, Native language preservation and Environmental Regulatory Enhancement, and I wanted to mention that because one of the policy initiatives that ANA took on was

to add bonus points to our SEDS funding to address missing and murdered Indigenous people. And last year, with those bonus points, we were able to fund two projects intended to address MMIP, and one of those projects is that I Will See You Project developed by Riverside San Bernardino County Indian Health. And they incorporate trauma-informed healthy relationship education, whole family cultural connections and awareness raising of MMIP to the broader community.

So, I want to share a bit more about how ANA and ACF has become involved in this issue. The ANA commissioner who chairs the ICNA also has the role of Deputy Assistant Secretary for Native American Affairs at the Administration for Children and Families. And in this role, they work across ACF and with external partners to identify and address policy issues impacting Native Americans.

Next slide. So, we have a tribal Advisory Committee. It's modeled after the Secretary's tribal Advisory Committee. It has 13

delegates and alternates from across the IHS regions, and they meet regularly with ACF leadership. And they'll actually be meeting next week at HHS headquarters for their first in-person meeting since February of 2020. So, before the pandemic, the ACF tribal Advisory Committee identified MMIP as an issue of concern for the commissioner to address in her roles at ACF and HHS. And, despite and throughout the pandemic, the ACF has continued to stay engaged on a number of issues with ACF, including MMIP, and this slide shows you the current priorities for the ACF TAC and their priority four is addressing missing or murdered Indigenous persons.

Next slide. So, the last administration established an executive order to address MMIP, and that mobilized federal agencies to act more decisively on this issue. This executive order was in effect under two administrations. So, it was issued and effective from November 2019 through November 2021. And so, since that time, the Department of Health and

Human Services, Department of Justice and Interior have worked more closely to achieve the reality envisioned under that executive order. The task force held a dozen tribal consultations, which were all virtual, numerous listening sessions with organizations like the National Congress of American Indians Violence Against Women Task Force and, of course, the ACF tribal Advisory Committee. And tribal engagement has continued. And, similarly, we have sought input that would help inform HHS actions through various means, including discussion with HHS, Tribal Advisory Groups, regional consultations, ACF annual consultations and various panels like this one throughout the last several years.

So, I'm mentioning all of this because I think it's very important to engage at all levels, as I've mentioned, and to continuously receive those with lived experience, their feedback, tribal leaders, what their struggles are. And, you know, as public servants, we really have to commit to working in partnership with

tribal communities, and non-tribal communities to end this crisis of missing or murdered Native Americans by strengthening and empowering our populations that may be especially vulnerable.

So, next slide. I mentioned that for many years this crisis of missing or murdered Indigenous women and girls in the United States was invisible to the general public, even though it was a known issue to many Native Peoples. And slowly through the years of grassroots activism, organizations like Urban Indian Health Institute and others, advocates and communities began to unify around this issue and bring it to light. There was a belief that the issue of missing and murdered women and girls, as well as gender diverse people, was being underreported. I think we most recently saw this with the high media attention given to Gabby Petito, while there were several Native women who had been missing from the same area, and they did not get the same media attention. So, the first step in addressing any problem, right, is first admitting that there's a

problem.

Next slide. So, in November 2021, the previous federal interagency task force sunset, and President Biden issued a new executive order on this issue. Both executive orders share a focus on better coordination by law enforcement, and understanding the data, as well as the limitations of the data. But there are specific actions for HHS to take under this new executive order, which is to evaluate the adequacy of research and data in accurately measuring the prevalence and effects of violence, and to develop a comprehensive plan to support prevention efforts that reduce factors for victimization and increase protective factors. That is not a small task whatsoever.

So, I want to share some information recently published by the CDC on this topic, as well as how ACF and HHS are working towards this comprehensive plan to support prevention efforts.

So next slide.

In November of 2021, the CDC published

homicides of American Indians Alaska Natives National Violent Death Reporting System US data 2003 through 2018 in the Morbidity and Mortality Weekly Report. So, the National Violent Death Reporting System or NVDRS collected data on 2,226 homicides of American Indian Alaskan Natives in 34 states and the District of Columbia from those years of 2003 through 2018, and the age-adjusted AIA and homicide rate was eight per 100,000 population. And it's important to note that this is not all of the states, because not all of the states were initially required to report into NVDRS, and so only slowly over time have we had more information from more states on AI/AN homicides. But the bottom line of the report by the CDC is that homicide is a leading cause of death for American Indian and Alaska Natives, and that intimate partner violence contributes to many homicides, particularly among American Indian Alaskan Native females. So, you can see in the slide here that, while there is an issue with American Indian Alaskan Native deaths, you can see

that the male victim homicide rate was three times higher than the female victims, and that also on one two victims were living in metropolitan areas, so we're really grateful for Urban Indian Health Institute, you know, looking into what's going on in urban areas. And then a firearm was used in one in two homicides.

So, next slide. The CDC also provided some data on suspects of who may have perpetrated these homicides. And eight in 10 of the suspects were male. One in three of the suspects were American Indian or Alaska Native. And four in 10 of the suspects were current or former intimate partners of the female victims. And I pulled out just a little bit more data that you might be interested in in this report, but I encourage you to read the full report. So, within there, I checked for maternal and infant homicide data, and so 343 of the homicide victims were females of reproductive age, but you can see that they only knew the pregnancy status for 88 of those victims. And among those, 14.8 percent were pregnant or

within six weeks postpartum. And you can see here they have a chart broken down that the under one age group of victims of homicide -- and, again, this is from 2003 through 2018, and you can see those numbers there. And then the next group is ages one to nine.

And, while these numbers are important to note, MMIP impacts pregnant and postpartum mothers and their infants. When relatives go missing or murdered, the spiritual, mental, and potential economic trauma is data I don't have to share with you today, but it's very real and also needs to be part of how we're thinking about addressing this issue.

Next slide. So, at HHS, we recognize that this crisis has long been viewed as law enforcement and justice problems. However, violence is not just a crime, it's a public health problem that results in physical and emotional wounds, and American Indian and Alaskan Natives suffer disproportionately from domestic violence, sexual assault, psychological aggression, child

abuse and neglect, among other forms of violence.

And from the request from Tribes across the nation, Department of Health and Human Services has been working diligently to identify ways we can support wraparound services and support from the public health perspective, and we mean working on primary prevention to address the underlying factors that make individuals more susceptible to different types of violence like trafficking, domestic violence, or going missing or being murdered. And these prevention efforts occur at the local level but can be supported through technical assistance and resources from county state and national levels, particularly when they target populations in vulnerable circumstances.

So, the next slide. So, the populations of focus are probably not very surprising. Native women, girls, men and boys and elders exposed to trauma, children in the child welfare system, runaway and homeless youth, LGBTQ and two-spirit individuals, individuals with

physical and intellectual disabilities, and individuals with mental and or substance use disorders and victims of violence are all populations of concern and focus for our efforts.

Next slide. With the input that we've received from tribal leaders, tribal program directors, first responders, educators, Native youth and elders, the Administration for Children and Families published a public health framework for action, and this framework is a culturally informed, multifaceted approach to strengthening our vulnerable and high-risk populations. I hope you all received kind of that summary of that framework.

Next slide. I just want to quickly say that it has four pillars. Culture, language, and traditional practices supporting those within communities is sort of a primary factor we're looking at towards building resiliency and serving as the protective factor, economic mobility, prevention and addressing the social determinants of health. And ACF, given our role with

supporting programs like Head Start, Tribal Home Visiting, the Family Violence Prevention and Services Program and others, you know, really is focused on identifying ways to support families. And I wanted to point out that, under the American Rescue Plan, the Family and Services Bureau received nearly $237 million that includes grants to tribes to provide temporary housing assistance and supportive services to victims of family, domestic and dating violence, the Strong Hearts Native Helpline, the National Indian Resource Center, Addressing Violence Against Indian Women, Alaska Native Tribal Resource Center on Domestic Violence, specialized services for abused parents and their children and new grants to assist rape crisis centers and transitioning to virtual services and meeting the emergency needs of survivors.

So, next slide. I'm going to try to make up some time. Our implementation strategy, the handout we provided has sort of the protective factors that we are focused on. It describes what

we mean by that, and some actions that ACF will be taking. But we're sort of focused on these four actions around communicating, around the resources and technical assistance we have available, working collaboratively and creating new partnerships to advance the strategic actions, capacity building both internally for ACF to engage in this work, but also with our partners that receive our funding and continuous community engagement.

So, the next slide. So, just to sum up, we really need to make sure everyone is aware that this is an issue that needs resources targeted to address it. And, the second thing, especially from the federal government perspective, is to take a collaborative approach to addressing violence. We've learned from listening that this has to be addressed at all levels. It's at the individual, the family, the community level as well. And third, at the national level we can help with identifying and amplifying what's working. But ultimately, it's a

combined effort that's going to make a difference in this issue. As Indigenous Peoples, we've listed much adversity overcoming many challenges, and we remain determined. So, thank you for your time today, and I look forward to listening to Stephen provide his remarks and take any questions.

JANELLE PALACIOS: Thank you very much, Michelle.

We will move on to Stephen, and then we will have questions. Stephen, welcome.

STEPHEN HAYES: Thanks so much, Janelle. And thank you, Michelle. Thank you, Doctor Belcourt. Thanks for this opportunity to speak with the committee. My name is Stephen Hayes. I'm with the HRSA Office of Women's Health, and I really hope the information we provide can be helpful to the committee and all those attending today as you consider some of these pressing issues that we're talking about today. I come to you also from Washington, DC, the ancestral lands of the Nacotchtank and Piscataway Peoples. And I want to also before I

get started recognizing the work of very many people within HRSA and beyond who contributed to a lot of what I'll be sharing today, too many to name. HRSA truly has had an all-hands-on-deck approach to IPB. As a result of some of the work we'll be describing here, I'm excited to share some of the potential implications of that. I'm coming from more of a federal perspective certainly, so apologize that this will be more of a zoom out to systems but want to hopefully be able to frame those in the context of how these systems can be leveraged to address a crisis like this one. I also want to acknowledge that we're talking about sensitive issues, obviously, and that many of us have experience with them. And so please be gentle with yourself and step away or mute this meeting as necessary, so that you can have the time and grace you need. And I appreciate this opportunity again.

So, we can go to the next slide. Thanks.

So, just as a roadmap for what we're

covering today, we'll give you a super quick touch on OWH and where we sit, but we think it's relevant for some of our comments today. We're also going to talk about the process that went into and the data that was formative for the HRSA's first agency-wide approach to intimate partner violence, and then we'll talk about some of the resulting work and its implications for some potential extensions in addressing missing and murdered Indigenous women and girls.

And I want to just sort of emphasize now in the event that they get lost as we go through some of the important themes for us as we discuss this issue that apply, certainly, to this population in question but broadly as well. The importance of meeting individuals' and families' social needs that contribute to preventing violence and other negative health outcomes, I think we've been encouraged to hear that across the presentations both days in this committee meeting. Also, the expanding the understanding to focus on upstream violence prevention is possible

to help us encourage other positive health outcomes, in addition to violence prevention, and also the importance and utility of an organization approach like the one we hope to describe to you in the strategy as being one that's practical and effective, and how those lessons might be applicable outside of the federal space as well.

Next slide, please. So, briefly, where we sit within the Office of the Administrator here at HRSA, and so OWH provides leadership on women's health and sex and gender-specific issues. We work within and outside of the US Department of Health and Human Services to really help improve health, wellness, and safety for women across the lifespan. We accomplish that through the core functions listed here, but I want to emphasize how they kind of fit into some of the discussion we're having today, especially the importance of us being able to articulate what we hear from the field. So that's subject matter expertise that we bring to the administrator and our HRSA partners across the 16 bureaus and offices and beyond HRSA

as well. It comes very directly from, as much as we can, service providers and patients in the field, as well as other subject matter experts through our consultation process and ongoing on several competing public health priorities. But there's always an enduring commitment in our office to addressing violence, as well as addressing sort of the important intersections that it has.

Next slide, please. So, starting sort of where a lot of this work really did have its origin, many of us are familiar with CDC's National Intimate Partner and Sexual Violence Survey, or NISVS, and that's what the graphic on the left comes from. In 2016, so taking a few steps back, OWH took that most recent update from 2015 data and really used that as we engaged with our partners across the agency to highlight the disproportionate impact that IPV has on women and girls. Today, especially, we've already heard some of the particularly important updates to that data and kind of granularity of some of the data

regarding the populations that we're talking about today, and so that emphasizes the disproportionate impact. And that's something that we use as a starting point for conversations when maybe there wasn't engagement already. But on the right side here, you'll see the graphic that sort of results from the really intensive work that went into that process from a lot of HRSA partners and beyond to develop an agency-wide strategy, which is illustrated here in these four priorities.

And before we hop to the strategy, the last data point in the next slide I want to point to is some compelling work that came to us around that same time about the importance of leveraging healthcare provider settings, but beyond as well to engage in discussions about the importance of preventing and screening for IPV.

So, can we just hop to the next slide? Thank you.

So, when we found it -- sorry. I should say that this research comes from our partners in the Futures Without Violence. But in

their work, it became apparent that women who talked with their healthcare provider about experiencing violence were more than four times more likely to use an intervention to address that. But, also, as we all understand and was illustrated to us consistently in our consultations with folks in the public and providers, folks who have experienced violence might not be able to discuss that experience with their healthcare providers for a lot of different reasons, and those include shame and fear of retaliation, especially salient to this group's discussion, the fear of their children being taken away, concerns that other sort of judicial involvement might further jeopardize their safety. And those are particularly important in sort of geographically secluded locations, but also looking at particular subpopulations or other groups, and that applies in our discussion today, obviously. We also know that a lot of healthcare providers have cited several factors for not screening, and screening is not the only

objective, obviously, but looking at this data sort of as a starting point for those conversations, one of the ones that is enduring and we hear consistently and continue to try to address and hopefully can talk about a little bit today as well is the importance of having something to do if we do screen and do identify an incidence of violence and sort of following the patient's -- what would be sort of the best possible outcome based on resources available and ensuring that there are those partnerships necessary to make those resources available in wraparound services.

But hopping to the next slide is when we can kind of describe some of the work that happened between January 2017 and December of 2020 under the auspices of the first strategy to address intimate partner violence, so the four priority areas are listed across the top. And, just speaking from sort of the process-tracking metrics that we use, the strategy had identified 27 key activities for the 16 bureaus and offices

at HRSA to undertake which existed on these four priority areas. By December of 2020, all 27 had been completed. But, critically for us, many of them had recurred already, and also several that were not expressly delineated in the strategy had been undertaken. And the importance of that to us and what we hope it might demonstrate also as sort of a building block for some next steps is that that sort of success in uptake when at the starting point before the strategy's implementation there were only two pilot programs across the HRSA portfolio that expressly focused on IPV. Certainly, there was work in that space, but not specifically. That success really reflects that an agency-wide approach like this one is possible, practical, and effective even in an organization like HRSA, which has more than 2,000 employees and a budget in the billions of dollars. So, that sort of also suggested to us that an expanded focus on violence prevention response is important and possible, and that the success has some implications beyond federal

settings as well, potentially. And a final comment on here as we think about some of the other opportunities is we continue to serve people in the context of the pandemic and sort of the stages that we move through, there are a lot of opportunities that can rise around addressing intimate partner violence and missing and murdered that can also support our work in other areas. And so, as an example of that, as we know, violence and trauma -- the cycles of violence and trauma present a lot of opportunities to disrupt the cycles and use sort of and leverage our prevention response to have lasting impacts on those we serve within their lives in their lifetimes, but, critically, as we've heard across the two days, but especially in our last two presentations, the lasting impacts that exist for folks networks as well, so their families and beyond, and really seizing those opportunities are things that are of interest to us.

On the next slide we'll pull out some of kind of the bigger implications from us from a

federal perspective, and we'll try to synthesize that into some other takeaways potentially and ways that we can continue to move and make progress in this area. Critically, we see in terms of practical implications at the HRSA level HRSA staff broadly and programs, in particular, are beginning to be recognized or -- not beginning -- continuing to recognize IPV's far-reaching impacts on health, and also our position to prevent and respond to it. It's also helped us to consider how other forms of violence impact those that we serve, but also an important layer, especially in the context of the pandemic, our workforce. As we mentioned, HRSA has a diversity of programs which include the National Health Service Corps, so a workforce-oriented program, as well as the Community Health Center Program many of you may be familiar with from our Bureau of Primary Health Care. So, we have the service provision angle as well as the workforce side, and both of those settings, obviously, can be impacted by violence. And to pull out some of kind of the

examples of the wins that came out of this strategy, our wonderful colleagues in the Maternal and Child Health Bureau, their Maternal Infant and Early Childhood Home Visiting MICECHV Program, many of the sites were able to exceed their ambitious IPV screening rates of upwards of 80 percent, and are already thinking about the implications and sort of the next steps of what they can do with that progress. The IPV Health Provider Toolkit, which I think we have a link to as well, is a regularly included resource across HRSA-supported settings and continues to be updated. And also, critically from a federal-funding perspective, the language about the importance of accounting for and addressing intimate partner violence and other forms of violence has been included in standard HRSA Notice of Funding Opportunity templates, and it's been taken up by most of our bureaus and offices pretty consistently as well. And that illustrates, again, another way for us to have that touch point of consistently shining the light on how this is a

very prevalent issue, obviously, in many settings, but also how we're in a unique position as an organization like HRSA and those that we partner with to identify opportunities for prevention and response.

On the next slide, I'll just sort of share some of our last impressions here about some of the work that's gone into that 2017 and 2020 iteration. Of particular note, we think that the crisis we're discussing today has a real strong reflection on the need for increased efforts on preventing violence. But as we've heard again across sessions, meeting the social need that exacerbates it if it's not met, and really emphasizing the importance of bringing public health into other services. Given the experiences of the American Indian, Alaskan Native Peoples in particular that we're trying to help in some of our discussions today, it calls for really respectful patient-centered services, which recognize that there's strength and knowledge and understanding in all the folks that we work with,

and that's especially true in these populations, and how we can use that and really work to partner and understand that our goal needs to be sort of a compassionate and responsive care, because we understand also that with providers and the amount of time that many have to sort of dedicate to the different and competing interests, especially in the context of the pandemic, there are a lot of opportunities for us to, in a sense, alleviate that burden for providers by taking it on in other innovative approaches that we've heard examples of as well today that have always been in place in some form or other, but it's sort of an advocacy model in certain settings or community health workers, etcetera, as other ways for us to champion and really work on these priority areas. But in terms of the first theme here on this slide for prevention, you know, as Michelle was just describing the ACF Public Health Framework For Action on Missing and Murdered, there's a particularly salient just sort of line in there that I think sort of summarizes this point here of

the review of the issues related to violence -- this is from the framework -- reveal a range of problems that require a multisystem response. The data show these individuals may have faced Health and Human Services concerns that increase their vulnerability to negative outcomes, and that multiple opportunities to prevent and or intervene may have been missed. And, because of the relationship of these factors, it's really important to collaborate on actions that more comprehensively respond to the problem and think that that's sort of what we strive for with all the agency approach at HRSA, but also something that is reflective of how we think about prevention in terms of identifying and meeting social need at an earlier point. It's really difficult for us to look at the instances of missing and murdered in this context and not see how easier access to more supportive services could have at least helped to prevent some of those negative outcomes. And then we also know that we have the tools to disrupt many of these

cycles of trauma and violence. It's a matter of resourcing them and leveraging them as possible. In terms of multisectoral engagement, we all have a role to play in violence prevention, as we do in most of our public health priorities, but collaboration is especially key to ensure that those who don't screen learn to, that those who do screen have the partnerships that they need to refer, and that the organizations and their staff also recognize that every patient interaction is an opportunity for prevention and response, not just to violence, but other needs as well. And, finally, when speaking about patient-centered care, it's especially important that we normalize listening to the strengths and needs of those that we're working with.

The last two slides that I have here just have other HRSA resources, and I'll kind of zoom through those, as I know we're close to time is --

I'm sorry. I'm skipping one of the biggest points. I apologize. The last thing I'll

actually touch on in some detail here is the current work that we're undertaking as an office. So, we're in the midst of the development of the next iteration of the HRSA strategy to address intimate partner violence. That next iteration is going to build upon the gains we were just summarizing here, and we expect that to come through in early 2023, hopefully. HRSA has engaged throughout this development process with subject-matter experts from academia, national organizations, including those representing American Indian Alaskan Native constituencies, and HRSA-supported settings of care as well to really identify emerging priorities and practices, some of the challenges that are there and opportunities as well as we continue to work through the impacts of the pandemic. And the updated strategy should also reflect HRSA's commitment to health equity, which we think is a theme that's especially salient in the conversations we're having today and yesterday. But, again, bringing us back into our understanding of prevention and patient-

centered care, I saw a comment in the chat in the last couple of presentations that kind of comes to mind in that context as well is we just pointed to data that we used in the 2017 context to really catalyze those discussions, and that was obviously national survey data. But there's an opportunity also, we think, to us to kind of encourage identifying areas where there's existing data that might not be in sort of the quantitative context that can inform this process in really elevating that, especially, you know, in settings where maybe it's more difficult for us to identify what might be considered a critical mass for some studies, etcetera, but we know that the need is there and we also know that there are opportunities there.

So, the next slide is just an example of one of the resources included in the virtual toolkit. This one actually comes from our partners in ACF.

And then the last slide here is going to be just mentioning -- on the next slide.

Sorry. Our HRSA partners in the Bureau of Primary Healthcare, their National Training and Technical Assistance Partnership, which is a TA Center available to all HRSA-supported community health centers to access information about specifically focusing on IPV and exploitation which encompasses human trafficking and other intersecting issues here.

So, thanks very much for the time, and I appreciate and welcome any sort of additional engagement beyond today as well. So, thank you.

JANELLE PALACIOS: Thank you, Mr. Hayes. Thank you to our panel members. And I would like to open up the panel to questions. Would anyone like to ask a question? Magda, are you trying to --

MAGDA PECK: No, I'm good. I'm digesting. It was a huge amount of information. So, maybe if we could all just take a breath and express our gratitude to the array that went from the heart to the mind, if you will, from the micro to the macro. So, I'm just going to take a

breather for a second before I charge in with a question and listen to my other colleagues on SACIMM if they'd like to go first.

JANELLE PALACIOS: This is just a comment, but it's pulling in a little bit from yesterday's introductions where a few of us panel members, committee members introduced ourselves. We spoke about what it would take, and what would it take to improve whatever. And a few of us independently came up with the same general take, and it was we have to see each other as humans. And that work that HRSA's trying to do, you know, all the arms -- HRSA's like this big octopus with so many arms, and the way that we're trying to finally come together and incorporate all the different offices together, but then also branching out and asking Department of Justice, asking other institutions to come together and do the same work, or work together really brings to mind that we are -- in many Native languages, we are one tribe. We are one family. We are one fire. That's what it is in Salish, that we are one

fire. So, what I see is that we are -- western world view is slowly shifting to acknowledge the importance of what many Indigenous people have known is that we have to work together. We are one people.

Does anyone have any other comment?

CHAIRMAN EHLINGER: Well, I want to comment on the fact that you said we have to treat everybody as -- look at everybody as human, we're all human in this together. And certainly, the whole issue of data has come up frequently, and I think part of that is your western view of the objective data. And when we hear, start hearing the stories and the qualitative, that brings out the humanity in all of us, so we really need to -- and we've heard in all of these presentations the lack of data. It's not just the numbers, but it's the stories. We have to figure out some way to really capture that and use those data in a powerful way. So, thanks.

JANELLE PALACIOS: Sherri, I see your hand.

SHERRI ALDERMAN: Yes. Thank you so much for saying that. That is so important. And one thing that troubles me that is it can be flipped to be an incredible opportunity is when we as an American society of all types and colors come together and recognize that infants and children also are human beings and, therefore, are entitled to human rights. And, because of their particular vulnerabilities, special rights for children is so important. And being the only country in the United Nations that has not ratified the Convention on the Rights of the Child, is an atrocity. And when we begin to recognize infants and children as human beings, with special rights entitled to them and operationalize that in all of our policies and projects and programs, we will come closer to assuring that disparities are addressed and that children are honored in their childhood for the contributions that they make to society.

JANELLE PALACIOS: Thank you.

ANNIE BELCOURT: And if I could add to

that, I mean, I think one of the things that would be helpful in terms of like advocacy reform are things like crime victims' compensation programs and having, you know, more coverage for family therapy, as well as for children to have access to therapy. One of the things that we see in rural states, in particular is that, you know, there is a very, very marked inability to access psychotherapy or counseling, especially when we talk about inpatient psychiatric care. And for children who either have experienced crime or violence are things, you know, if they're not in the system, per se, they can really fall between, you know, the cracks so to speak. That's something that's, again, actionable. You know, these are things that we can, you know, find ways to, you know, definitely -- I completely agree. Children are, you know, really a sacred part of our culture and our heritage and our, you know, future, of course, but we're not acting in accordance to that, especially in the ways that we structure our systems to provide care. And so,

some of the times what we've had to do here in our rural communities is to embed some of that curriculum into the educational system, because that's a touch point. But more could be done to help make sure that people have adequate care. And medical care includes psychiatric care and counseling. I used the example earlier of the elder who spoke this morning. She mentioned how it's taken her 79 years to cope with it. You know, and she's done that through traditional healing and methods. But maybe supporting some of those things, like supporting traditional healing methods and practitioners, and some of the ways that we as communities already have built to take care of folks with regard to the psychiatric consequences of violence. And so, those are some things I think that we could support in effective ways.

JANELLE PALACIOS: Thank you, Doctor Belcourt. That was something that was discussed a little bit yesterday in terms of like how to enfold traditional practices as healing and

reimburse those.

I see, Doctor Peck, your hand is up?

MAGDA PECK: Now I'll chime in. First of all, thank you to the range, again, of stories and strategies that have been presented. I've been taking on a lead in SACIMM around the power of data translated to inform action. And we've heard lots of comments about that, so I'd like to see if we could do a once around of our extraordinary speakers today about if there's one thing you feel strongly that if -- if, you know, what would it take, one data wish, if you will, it could be macro, could be micro, it'd be very -- and you can't necessarily -- those who are feds, you can't tell us what to tell you to recommend, but you can suggest. And for those who are more grounded in the field, you can know with your toes, right? So, I'm just wondering what do you wish will change first around having better data, to raise awareness, to shape strategy, to hold folks accountable, to connect. What do you wish for? And if your wish came true, what would be

possible that's not possible now that would compel action? So, I want to know what your wish is, and then what would happen if the dog caught the car, right, if the wish were to come true. And you can go in any of your orders, but I'd love to hear all four voices.

MICHELLE SUAVE: Well, hopefully I won't get in trouble for this.

MAGDA PECK: There's no -- good trouble is welcome, so please bring it. There's nothing out of bounds. I chucked that out when I first came on SACIMM. Nothing's out of bounds.

MICHELLE SUAVE: So, I am going to go with your data theme in a little bit of a tangent way because one of the things that comes up all the time in tribal consultation, right -- so this isn't like my -- I mean it is my wish, but it's not like my wish. This is not like Michelle. This is like what do we hear most often, what keeps getting asked for, and, you know, from a health equity perspective is full funding for the Indian Health Service and that it be mandatory funding,

not discretionary. And the reason why that will help data is, one, we -- there's inequity between, you know, what the urban Indian health organizations get and what goes to the IHS and to the tribes to operate directly. But they're all about integrating behavioral health and mental health services, and thinking about each other as relatives, and providing for the whole person. Like when you visit Native health facilities, that's what they're doing. I just, you know, was listening to what South Central was talking about and how they're providing care up in Alaska. So, to me, that full funding would provide the capacity for better data systems, better data integration. And, because there are these different systems between the tribally operated and the IHS operated, and they can't necessarily, you know, collate and that data can't speak to each other. That's where I'm going to go with my recommendation. I think if we had that, then there could be an improvement, and we just wouldn't -- we wouldn't believe kind of the

difference we could see, and it would be, yeah, I think transformational.

MAGDA PECK: Michelle, that is not anywhere out of left field. That is central to what we heard yesterday. That is already a core recommendation that we as SACIMM are advancing, and we -- I appreciate it. I think we appreciate your underscoring and elevating that there's not a quick fix, and, without the adequacy, that should be defined as generously as possible, then there cannot be the systems that will tell the stories at the numerator, denominator, heart, mind, spirit, and soul. Thank you.

Anybody else have a wish list?

STEPHEN HAYES: To build on that slightly in the data context, it's sort of a -- and I'm going to try to be a little ambitious with it, I guess, in terms of using the framing of definitions. So, data for decision making, lived experience is data. That data can be effective in decision making, especially in the absence of, you know, the preferred controlled trial or something

along those lines, but also there's an extensive amount of qualitative data that we have that paints a story, or tells the story -- paints a picture and tells the story -- I'm mixing metaphors -- that can help us identify some of those priority areas, and even some of the tools to leverage. Sure, we need to be mindful of some limitations in some settings, but the reality is that I think some of our challenges are definitional. So that's the definition there in terms of what is acceptable data. But go a little bit further, the definition of prevention, and it's related to data as well, we struggle sometimes to point to the prevention data. And it's true that we'll often be unable to point to the concrete data points that says that certainly because this person received some sort of economic assistance that's why their health outcomes were better, but we do understand and there's a lot of, you know, more comprehensive out there and data that demonstrates that that does contribute to more positive outcomes in a lot of the areas that

are, you know, our critical priority, health or public health focus areas. So, thinking about data in that way, and then extending it to how we think about prevention seems like that would then get us into a place that might make it a little bit easier to resource or leverage some of the more promising practices or something along those lines. And I know that the work is going in that direction, but in terms of a wish that's sort of one, I guess, from my perspective.

JANELLE PALACIOS: Thank you, Mr. Hayes. I know that we're about to run out of time, but I wanted to give Doctor Belcourt her opportunity to also answer the question before we depart. And there are a number of hands up, so maybe direct message or message to the panelist from our committee would be wonderful. Thank you.

ANNIE BELCOURT: Yeah, just briefly. I mean it's such a wonderful question, and I do wish that there were so -- I agree with everything that was said as far as the other wishes. I also feel really strongly that those who are sometimes like

not served well by IHS as well as data and healthcare are served better. And so, you know, nationally most of our Native people live in urban areas. And the reality is that we are just not built as a system to kind of deconstruct some of the barriers that face our urban, you know, relatives, and that includes my -- like, for example, my children have grown up with, you know, the impact of discrimination on a daily basis, and they don't really receive the benefits of the community. That's why something like -- this is actually an arch-funded conference by IHS and it's helping. You know, this is a great example of investing in the community, reaching people through Zoom or different ways, creative works, things that maybe are more heart-building and helping people create compassionate sort of ways of not only feeling like you understand some of what it is experientially and in terms of the data, but also just, you know, wanting to help change things and being motivated to be sort of like, you know, like you said, you know, the good

trouble. I mean we need that. We need that in our communities, and we need to partner with allies who can help because, you know, the -- the challenges are really profound when you're talking about racism, and the impacts of, you know, a cruel, brutal history for American Indian people. And so, you know, the kind of response to that has to be of equal magnitude, but in a positive direction, right. And so how we can invest in those things, that would be my dream is to have my children have access to things that helped to build their spirit back from things that they have encountered in their lives. And, as a therapist, that's what I'm passionate about is giving people ways to think about how they can live in a more joyful space, which is something that is not guaranteed to everybody. And so, you know, that's, I think, something that we could all strive towards. So, thank you.

JANELLE PALACIOS: Thank you. Thank you, everyone. Thank you to the panel. I know that we would enjoy for you to stay and continue.

We will be having a breakout session. So, following this break there will be a Violence, Incarceration, Substance Abuse. That's room two. We will also have a breakout room number three on Indian Health Service concerns. And breakout room number one is Sudden Unexpected Infant Death. So, if you have time and you are willing, you're welcome to join and listen in and give your two cents as well. Thank you very much. I think that I will allow Ed to kind of lead us onward.

CHAIRMAN EHLINGER: Thank you, Janelle. Thanks to this panel. This was really great. However, there is just -- there is only one set timeline in our meetings, and that is for public comment. So, because we make this public, we have to be back in session by 2:45. So you get a break of about eight minutes. So, we'll see you back here at 2:45 Eastern Daylight Time.

BREAK

(A recess was taken.)

PUBLIC COMMENT

CHAIRMAN EHLINGER: It is 2:45 Eastern Daylight Time, so welcome back. I know that was a short break, but it was needed. We needed that time, and we needed to hear all of those stories and all of the data and all of the information that we had that was the first part of this meeting, so thank you for accommodating that.

I will now turn it over to Lee to run us through the public comment period.

LEE WILSON: Yes. Hi, folks. Lee Wilson here again. This advisory committee is a public committee, and it falls under the requirements of the Federal Advisory Committee Act, which means this meeting is an open meeting for the public, and we provide an opportunity for public comment both in writing and verbally. We received one request this time for public comments from Joy Burkhard, who is with 2020 Mom. We will provide an opportunity for the comment to be provided verbally. If, Doctor Burkhard, you are interested in sharing that comment in writing with

us, we're happy to receive it. If there are any other people who have logged in, and after Ms. Burkhard or Doctor Burkhard, are interested in making their presentation, if you're interested, please send a message through the chat to Ms. Kelly, and we will try to provide an opportunity for you to make a comment as well. Doctor Burkhard.

MS. KELLY: Doctor Burkhard, if you are on, please raise your hand so I can allow you permission to speak.

LEE WILSON: So, while we're waiting, are there any other individuals that would be interested in making a comment to the committee for the record? I'll give about 30 seconds to wait for anyone to identify themselves.

All right. Emma, thank you. Absent any public comments, we will move forward with the meeting.

CHAIRMAN EHLINGER: All right. Thank you, Lee. Public comment is always important, particularly when we're dealing with the issues

that we're dealing with today and yesterday. And that's why we're hoping to have at our next meeting, in-person meeting some really extended period of time, like a full day where we can get comments from community members related to the issues that we're addressing.

So, now we're going to go into our breakout sessions, the second breakout sessions that we have scheduled. And over the last two days, we've heard from three particular issues that we hadn't really looked at before, and that was related to the Indian Health Service, the violence, incarceration, murdered and missing women and girls, and then SIDS/SUID. So, since we had not heard about those before, I would like to have you break up into those three groups to see is there anything that we've learned in the last two days that needs to be addressed with those recommendations. Look at the recommendations. I've broken them up in the draft recommendations by those issues for those three groups. So, the SIDS and SUID group, Charlene Collier has agreed

to moderate that discussion. And the Violence, Incarceration and Substance Abuse, Sherri Alderman has agreed to moderate that one. And the Indian Health Service one Joy Neyhart has agreed to moderate that. So, I want you to look at those set of recommendations just like he did yesterday, what's missing, what should we prioritize, what additional information we have, how can we collapse some of those things. That's what I would need some feedback from those groups. So, you have on your agenda, I think, the link. So, I'll turn it over to Emma to make sure that we get into the right groups. And I'm just assuming that again like yesterday they'll break out in pretty evenly matched groups, and then we'll be back in about an hour or so, back at four o'clock to report out on those sessions.

MS. KELLY: So, just like yesterday, please go to our registration website, and then you'll be able to select whichever work group you want to be in.

For our panelists, at about 3:50, I'll

resend you your panelist link to this Zoom webinar. So, it should be right at the top of your inbox. For all of our public attendees, once the breakout is finished, please rejoin this main webinar using the link you used this morning.

If you have any questions, I'll be remaining in this main room and will be accessible via voice and chat.

BREAKOUT SESSIONS

(Breakout sessions.)

REPORT OUT FROM BREAKOUT SESSIONS

CHAIRMAN EHLINGER: All right. I think we're all back. Thank you for your input. I was on one group, and there was some good conversation, but it always comes in at -- you know, everybody's a little hesitant, what is my role, you know, do I have standing to talk. You know, everybody's input is really, really necessary on these calls. So, you know, for the ex-officios and the workgroup members and the

SACIMM members by themselves, we really appreciate everybody's input. And so, like yesterday, we're going to just go down from each of the three workgroups just to find out what you talked about, you know, the input that you have so we can all hear it. And then I'll explain after we're done with all of this conversation what are the next steps in the process.

So, let's take room one, SUID and SIDS, Charlene.

CHARLENE COLLIER: Okay. Thank you. I may need the slides, but I'll try to go through. I'm Charlene Collier. I'm an OB-GYN in Jackson, Mississippi, which is the Native land of the Choctaw and Natchez and the Ugakhpa -- I hope I can say that right -- peoples. I'm happy to be here, very humbled to even lead this conversation and certainly recognizing the importance of this topic. And we had a great conversation. I want to thank Shira Rutman, and ShaRhonda, and Tara Sanders, and Yanique, and Danielle, and particularly Lee Tanner a community member who

joined the call. So, their contributions are very important. If I'm not looking particularly at my slides, I would say that the recommendations were centering upon acknowledging the need for approaches that acknowledge the environmental, social contributions to the disparities in SUID.

We spoke a lot about housing, particularly acknowledging that housing insecurity and the lack of solutions there drives the disparities in SUID. And then, going further, to acknowledge how when we speak of disparities acknowledging where they came from, particularly as it relates to unsafe sleep environments and that speak of SUID and its disparities as a result of the historical trauma, colonization, racism are -- it's a downstream effect of those things when it comes to the disproportionate number particularly of unsafe sleep environment related deaths, and certainly they need to continue to perform research and understand medical conditions that may drive SIDS.

We spoke about not reinventing the

wheel and looking to solutions that have been done successfully like the Healthy Native Babies Project and just bringing more funding and scale to those solutions and to ensure funding for that.

We spoke a lot about prenatal care, and that many of the risk factors are present in the prenatal period and we need to provide resources and education to the prenatal providers to address housing insecurity or tobacco and all those things are not just being addressed after a baby is born, and also acknowledging the need for Indigenous midwifery, doula support, breastfeeding. All of those are important.

We spoke about acknowledging Native traditions, practices, wisdom, and reclaiming and restoring those as fundamental solutions to infant safety and acknowledging that all Native and Indigenous people do not live on reservations or have access to their community and that shared wisdom and knowledge, and so find ways and provide funding so that Native communities can share that wisdom.

We spoke about cradleboarding and how practices like cradleboard classes, talking circles about using them is acknowledged as an infant safety practice, and that there isn't any inconsistencies when there is safe sleep education from either governments or medical providers.

We spoke a lot about funding and how it should be going to Native communities and populations to solve the problems that they identify as driving disparities, as opposed to what we see now, acknowledge when it goes to a medical community it's often driven from a medical lens, and there should be some source of funding there.

So, others who want to share or jump in? Because I know you e-mailed me the notes, but I haven't had time to open them. So, I'm just going off of my memory, but I think, yes, that those are some of the high points of certainly acknowledging that SUID is a downstream effect of all of these experiences that we've been talking about for the last couple of days and that when we

-- when we value Indigenous women and communities and families and provide necessary resources, we will see improvements across infant mortality results.

We spoke also about the potential for creating FIMRs, particularly, owned by within Indigenous and Tribal FIMR programs that use their wisdom, and how data is collected and shared. So, that's what I remember. If there's anything anyone else would like to add, please.

CHAIRMAN EHLINGER: Just for my perspective for them, thank you for sharing that. I love the -- some of the issues you brought up, I think, we may want to bundle into a sort of an assumption that we just expect, these are the things that are assumed to be good and best practice without making necessarily a recommendation, but just assume them to be true, you know, good cultural practices. And so, I'll look at those in that way. So, thank you.

Any other any other questions from anybody to that group?

CHARLENE COLLIER: We also referenced the Broken Promises Report and just completing those recommendations and how that again all ties back into that these are results of those deficiencies has its effect on infant health and safety. So not, again, recreating new recommendations, but completing those as well.

CHAIRMAN EHLINGER: Yeah. That'll be good. Yeah, because we don't want to repeat. If we can say we support the recommendations from so that we at least reference and we know them and that they're there and put them on record as we're being in support of those, so we don't have to repeat them. It's a good idea.

All right. And I know when we -- when we go into little groups during the summer, SIDS is not going to be one that's going to be specific. SIDS/SUID is not going to be specific, but it's going to be -- I'm going to sort of bundle it with the data and with the clinical care, the care and quality and workforce one. So, we'll be able to get at that one again. But I

just wanted to make sure that after having that session yesterday with SIDS/SUID we specifically focused on those recommendations today so we could get in-depth look at that.

All right. So, let's go then to the Violence, Incarceration and Substance Use that Sherri Alderman led.

SHERRI ALDERMAN: Yes, yes. We had a really powerful group. It was such a fabulous diversity of voices and perspectives, and I was -- everyone really chimed in, and we got into a lot of detail on the 20 recommendations.

And I'll stay at a pretty high level to summarize, but I'd like to start with a gap that we found that I think is very valuable, and that is speaking to data and recommending that there be a survey of what data are available on these topics that we're talking about, data banks and how coordinated or not they are, and then consider that also when we look at some of the specific recommendations for specific data to qualify that we would also recommend that they be well-

integrated and interfaced with other data collection. So, that was a high one for us.

We also mentioned multiple times something that was discussed previously, and that is a glossary of terms so that we are all understanding what we intend to be communicating when we use a certain term. And, speaking of terms, we wanted to be sure that at every point possible we be very inclusive, and so really assessing the terms that we use and making sure that we are not unintentionally not including certain segments of the population, certain family configurations, those kinds of issues in the terms that we use so that we are very inclusive.

And we talked also about educating, educating professionals and that it be a very integrated process that is representative of the whole system of care, including bringing, for instance, law enforcement together with medical providers and others to be educated about the issues that we talked about here together.

And then one that came up multiple

times for sure was that the service array be very comprehensive starting with promotion and prevention and harm reduction to assessment, evaluation and treatment and services in ensuring that there's access to all of those components of the system of care.

And I'd open it up then to the group members for additional comments.

CHAIRMAN EHLINGER: Any comments from others? I like that -- I know that the data group will be looking at the sources of data, and they won't just come from HHS sources, they will come from the Department of Justice and the Department of Housing and Urban Development and God knows where else they'll come from. But, you know, I'm sure that's going to be really an issue and it's always going to come up with the interoperability and the data privacy and all those things, but that will be part -- I'm sure will be part of our recommendations.

Any other questions of this group from anybody else? All right. Then let's go to the

Indian Health Service with Janelle. Joy, I mean. Joy. Sorry.

JOY NEYHART: Well, you know, that was probably correct because Janelle did the lion's share of the lifting and helped me.

So, we were fortunate enough to have Doctor Pattara-Lau join us and give us the guidance she was able to, which was really helpful. So basically, we took, looking at the six recommendations in the draft, reworking prioritizing that funding needs to be not dependent each year on changes, but baked in and reliable. And we talked about a lot of other things that I'm totally blanking on now, but I would love if Janelle would jump in.

JANELLE PALACIOS: Sure. I'm happy to help. And I also took notes, so I'm cheating too, Joy. Okay? The overwhelming bit is that for as little as our audience thinks they know about Indian Health Service you know far more than the average person walking down the street. Just know that you are an honorary inductee into an Indian

Health Service professional background understanding, okay, even though that's very little. And that is for me as well. Like I do not have a comprehensive understanding Indian Health Service.

So, we had -- a good portion of our discussion pertained to just the funding issue and the mechanism. So, the overall big priority goal, which is something that we echoed from our last set of recommendations last year was to just fully fund Indian Health Service and make it continued funding, something that is not cut, no funding is sequestered, and look into models as to what the standard should be, not just meeting the bare minimum, but even more.

And then following that, we then had a discussion about certain priorities under the funding, would it fund, you know, comprehensive data collection, and what that would look like; would it fund workforce development and recruiting, retaining and integrating community members into service within the Indian Health

Service.

We also then talked about having a body within HRSA that would be like the Native American, American Indian, Alaskan Native kind of point person, point body that would be able to integrate all the work that HRSA is doing in addition to what IHS is doing in terms of their maternal child and infant health work. So, we have so many hands involved doing different things and measures, but there really is no centralized office that knows what everyone is doing, and that might be helpful.

We talked about, let's see, when it comes to data collection, just supporting efforts to allow comprehensive data collection, whether it's within HRSA, with CDC, with the Indian Health Service, within Tribal Epidemiology Centers, with tribal communities, but just finding methods to really allow comprehensive data collection, because we don't have that. It's fragmented. And we have small population numbers and tribal identities as reasons as to why we don't have this

and also funding, lack of funding. That's a big one.

I think then we also talked a little bit about involving the community in almost every step of the way, basically, so whether it's workforce development, or if it's evaluating Indian Health Services meeting their actual needs. But community voices and representation and integration is needed, in addition to identifying ways to support traditional healers and practices for reimbursement.

And, finally, we discussed a little bit about Indian Health Service and the ACOG contract, their just relationship, having a little bit more background understanding of that. We still don't have much information, and it would be really helpful to understand over the past 50 years what activities have been done, what are the outcomes, have they been measured, and if this relationship is evaluated in any way. And we understand that Indian Health Service has similar contracts with other entities related to healthcare, so it's not

just ACOG. They have other contracts with pediatrics, and possibly injury prevention or mental health. So, there's other contracts as well. It's not just maternal-child initiatives, but this is one that we are interested in understanding.

Are there any questions?

CHAIRMAN EHLINGER: All right. Thank you. It looks like Lee has his hand up.

LEE WILSON: Janelle, thank you. This is Lee. I'm just wondering if you can expound a little bit on what you mean by fully fund the Indian Health Service, because this comment has been repeated a number of times as a recommendation, and it’s very broad recommendation, so I'm just -- I'm just trying to get a sense of what that means.

JANELLE PALACIOS: Sure. Thank you, Lee. Anytime I get a chance to talk. So, a number of reports, GAO reports have commented that IHS has not been adequately funded. But in addition to this, there is a report and I have to find it.

I'm not sure if it's Broken Promises, but there is a report, and I'm going to butcher the name, but there's a -- for the -- it's the funding portion of maybe like Tribal -- I am going to -- budget, Tribal Budget Opportunity, or something. Every year, I understand, there is an entity -- and I'm not sure who it's connected with, because it's -- whether it's National Indian Health Board or some other National Native American organization, but there -- there are actual people who come together that evaluate the current needs for this fiscal year and next fiscal year that Indian Health Service should need, what tribal communities would need. And I believe that where we are sharing -- where we're all citing each other is probably from this tribal arm of organizations and people that have come together that have really evaluated the funding so --

LEE WILSON: I think it would be useful to consider how you reference that. Just given my experience working with some of the budget issues associated with the Indian Health Service, I don't

want to make recommendations for the committee or direct you in a particular way. However, the Indian Health Services not only funds services, but has an enormous construction budget and maintenance budget attached with the hospitals and sewage and all sorts of things, water supply, and there are assumptions that are baked into what the ongoing costs are. And there are, you know, lifespans of various activities, and some of those assumptions are very, very underfunded as well. And so, what might be seen as fully funding would be based on projections that a group like this may or may not agree with. So, I think it's a broad issue. And I think if you were to consider specific areas that you are keenly speaking to, it would go a long way in sort of explaining this as our committee saying these pieces cannot be sacrificed. So that's my recommendation.

CHAIRMAN EHLINGER: This is one of my takes. So, one of the comparisons, we spend $13,000 per person per year on medical care. And for the American Indians, it's probably about

$4,000, you know. We spend so much on public health activities per person per year. It doesn't get related to a similar level on tribal communities. I think we need to start making those kinds of comparisons when we say what's the adequate level of funding.

LEE WILSON: Okay.

JANELLE PALACIOS: We will include that from especially the 2017. And only most recently the 2020 funding that came out for IHS in general included that bump because of COVID. Otherwise, that would not have included that bump that brought them up to where it hadn't been anticipated was needed.

CHAIRMAN EHLINGER: I love this. We've got lots of hands up on this one, so this is good. Joy?

JOY NEYHART: And I'm just wondering where do we get the data on how much Medicaid spends per patient per year, and Medicare, and then what's the base funding that's provided to Alaska Tribal Health Systems versus the base

funding per person for Indian Health Service, and, you know, give those comparisons when we are making the case that I address continues to be historically underfunded.

CHAIRMAN EHLINGER: So, this raises a good point. Of the four little workgroups that we're going to be having, I think the one that will be doing the most work in terms of amount of time spent is going to be the one on Indian Health Service, and that has not gotten any volunteers. So, it'll be Janelle and me working on this, but we would love to have -- because there's going to be some work that needs to be done in the Indian Health Service, because there's so much ground that we have to cover. I think the other workgroups are going to be pretty straightforward, and you'll be able to do that work pretty quickly. So, if anybody really has an interest to dig into this deeply, please let me know. I'd love to add you to that workgroup because we're going to be doing a lot of work over the next month or so. And I think with Doctor Pattara-Lau we've got a

partner to help work through some of that. So let me know.

JOY NEYHART: I will change groups and continue to work with Janelle and you on this.

CHAIRMAN EHLINGER: Okay. That will be helpful. Thank you.

Jeanne?

JEANNE CONRY: I just wanted to speak because I think when we're talking about a contract and all the work that ACOG has put into the Indian Health Service, it's a very robust program with very dedicated physicians and leaders within ACOG. I would never be in a position to suggest the intricacies of the contract or how they engage who they do and what they do. But I think if you're planning on any discussions, I would bring in the ACOG leadership to do a presentation or to be part of this. And I'm not volunteering, because I'm history.

CHAIRMAN EHLINGER: We got that message loud and clear earlier on. We need to have all of the voices at the table.

Magda?

MAGDA PECK: Yeah. I just want to acknowledge that Doctor Pattara-Lau let us know about -- and, Jeanne, you know this -- in the Green Journal of OB-GYN in 2020, there was a significant article that summarized the 50 years, and I don't know if that made it into our briefing book or not. But I think that that's a -- I did not know about that, and so Tina was able to share with us and she's sending us the link to that. So, there's not a formal evaluation, but there was a Green Journal publication. So, Karen, thank you for sending that article to Janelle just now. We really appreciate that. That was one clarification.

And the second clarification, and I'm happy to just end with this piece, is that I think we talked about trying to figure out not only to say adequate, you have to find what that is, fund, what do we mean by fund, Indian Health Service. But we also want to talk about the mechanism. And I think that that was the most -- the thing we

heard consistently over the last two days, which is this notion of mandatory funding to fulfill treaty obligations that were made, and not be at the mercy of appropriations, and so the mechanism of funding, not just the level of funding. So, I think, as we deconstruct adequacy, it should be about continuity and sufficiency. And so, I just want to make sure that that was elevated up in our report.

CHAIRMAN EHLINGER: All right. Thank you. Yeah. I heard that loud and clear multiple times. All right. Any other questions for the Indian Health Service Group?

MAGDA PECK: Just a thanks to Joy for doing her first-ever moderation. She's learning. And for Janelle to buddy with her, really appreciated the leadership of this group.

JOY NEYHART: Thank you, Janelle and Magda.

NEXT STEPS AND ASSIGNMENTS, NEXT MEETING

CHAIRMAN EHLINGER: All right. Well,

so what I'm going to do with this, following this meeting I will take the feedback from all of these breakout sessions, and I hope that the moderators of those six sessions could get me something by early next week. It doesn't have to be in great detail, but just whatever I can -- whatever you can get me by early next week.

And then I will work and redraft those recommendations, and then I'll send them back to the forecast groups for one more review. This is going to be your last chance, you know one more time to really review them, and you can review them in any way you want. You can get together as a group and really discuss them, or you can kind of get individual feedback. But try to get this last draft before we make it available, and reminder that it's, you know, one related to the Indian Health Service, one related to data, and Magda wanted to make sure that storytelling is going to be part of that, the Violence, Incarceration, Substance Abuse, Care Delivery and Workforce. And so, like I said, I would then like

to have you do that and have your comments from that next level of review back to me by Friday, July 22.

And then I will then do another draft, and then send it out to outside reviewers. And this is where I would like to also have any suggestions that you have about who we should send this to prior to our September meeting to get some feedback from people who, you know, could give us some help.

And then with their feedback from that group, I will try to get a final draft ready for our September meeting, which is going to be, I hope, in the Shakopee Miwok and Sioux community here in Shakopee, Minnesota between three and four miles from the Shakopee Women's Prison on September 13, 14 and 15 with a travel day on the 12th. And at that meeting, I hope to have one day of testimony where we bring in as many voices as we can both in person and virtually. Again, any recommendations you have about who should be making statements in response to our

recommendations, but also bringing up other issues that we may not have addressed. I would also like to have policymakers engaged in this as much as we can. I would love -- we will be inviting the Secretary of Health and Human Services, will be inviting the Secretary of the Department of Interior. I know that her administrator would love to be there, and I hope that she can. I will be inviting our governor and our lieutenant governor here, who is an American Indian woman, who I think might be able to attend for sure, and certainly our senators. But I'm trying to get this is an opportunity to really get this out as an important issue in front of the policymakers.

And then also at that meeting, you know, then we will finalize our recommendations, and then we will also then have transition of our membership, you know, our one group going off and the others taking full leadership of that.

So that's what we're going to be doing. That's sort of the next steps. So, any questions or comments about that process?

MAGDA PECK: Sounds clear, Ed, and thank you for leading the charge here and keeping us on track. Really appreciate that.

CHAIRMAN EHLINGER: All right.

JOY NEYHART: And I hate to be the calendar clarifier, but it's important, I think, especially for the active clinicians. We've saved 13th and 14th for meeting dates, and travel in the 12th. Are we going to meet also on the 15th now, so extend it to the 15th?

CHAIRMAN EHLINGER: Yes, the Thursday. It's going to be we're going to meet Tuesday, Wednesday and Thursday. Travel on Monday, meet on Tuesday, which is going to be basically a testimony day, and then Wednesday and Thursday will be our full committee meeting like we've done here over the last two days.

MAGDA PECK: And that's parallel to what we were going to do now right, Ed? It's a similar --

CHAIRMAN EHLINGER: That's what we initially had planned for June, but then we moved

the -- you know, sort of just picked it up and moved it to September.

All right. There's a lot of conversation we could have, a lot more things that need to be discussed, so I'm hoping -- but let's take about 15 minutes. I'm not going to go around the circle and ask for each individual person, but I would like to get just some thoughts that people have of what you've learned in brief form, please, so that we don't go until six o'clock Eastern Daylight Time, just some thoughts about the meeting, what did you learn, what's new, what's still missing, what do we have to do.

Charlene?

CHARLENE COLLIER: I just wanted to share how humbled and really almost embarrassed I am by how little I've known about the experiences and conditions of Native Americans and Indigenous people, you know, as an OB-GYN. And we have coupled maternal morbidity, mortality and seeing their elevated rates in black and Indigenous people. And I have a very clear picture of black

maternal mortality disparities because that's the community that I serve and that I've been a part of, but I had not known, and I still have yet to like interact with the community and the population or really do my due diligence in seeking out those voices. And, you know, after all of this I still am very, you know, hungry for more of just hearing directly from this community and population, and hope that we can find ways to elevate those stories. So, the Photo Voice, the documentaries, like I think we need much, much more of that where we can feel that connection, because I still feel very disconnected. It's all things being told to me, and I want to -- I think the space -- and, as we mentioned, kind of like if there's a Hear Her, there needs to be specific space around Indigenous populations and communities. And I just -- I want to hear more directly, and I think many as a State Department of Health just want to do more to reach out and engage. And so, I think I was sad by how much was brand new information to me, and there's a lot of

work we have to do to bring these stories to light. So, thank you for all of those, particularly those of you who have shared, and this is from your personal experience in your lived experience. So that's -- I appreciate that.

CHAIRMAN EHLINGER: And I want to call out and I raised Lee Wilson. I want to thank you, Lee, for being so supportive of us having our meeting on tribal land. This committee has never met outside of Rockville that I'm aware of, and certainly never met on tribal land, and Lee has been very supportive of us doing that. So, this is going to be a unique experience. And I hope it's one, Charlene, that actually allows you to learn a little bit more. That's why I really hope that all of you members can come and be on tribal land and hear directly from individuals who are affected by our society in various ways. So, thanks.

Steve?

STEVE CALVIN: Thanks. I was just going to add that yesterday, I -- well, all

throughout the meeting I've been really impressed by meeting the new members who have joined us, and particularly yesterday ShaRhonda Thompson, I think, really summarized it for us in the Equality and Access discussion where she said, you know, this is a committee that's focusing on, you know, infant and maternal mortality. She said we also shouldn't forget that we should be focusing on maternal and infant vitality, and it just stuck with me overnight and through the day today. So, you know, ShaRhonda, thanks for that and thanks for being part of the committee as well as all the rest of the new people who I'm enjoying getting to know.

CHAIRMAN EHLINGER: Yeah. I'm comfortable with what's going to happen once I leave this -- well, I don't have much -- it's going to be a good group moving us forward without a doubt.

Other comments or reflections on the meeting? Jeanne?

JEANNE CONRY: Yeah. I just wanted to

say and echo what you had said that with Janelle Palacios bringing this forward and opening everybody's eyes in a very eloquent and very powerful way, I think it's helped everybody. I just think the meetings have really developed very strongly, and I very much appreciate, Ed, how you've conducted everything, and then allowing people to be a spokesperson and advocate and show their passion, but then bring in all of the different committees to provide that information I think has been a really wonderful element of the committees. And I too look -- well, I won't be here with all of you, but look forward to the new committee members who are going to be taking over and contributing so well.

CHAIRMAN EHLINGER: Well, then, Jeanne, I do hope you take time to review and stay engaged with our committee, because it's a public meeting, and I will send you some information. So, any feedback you give will always be welcome.

JEANNE CONRY: Thank you.

CHAIRMAN EHLINGER: Magda?

MAGDA PECK: Well, I want to acknowledge just how much work went into making this meeting happen. And I just think that it's because we don't just show up, but that there's a lot of work that each person has done to make today possible. And it will only happen if we take it more than just showing up for a meeting. So, kudos to everyone who prepared, and set the stage, and set the agenda, and created the political will. So, first a thanks for all the things that happened beforehand, because, if it comes off seamlessly, it is because of that investment upfront. And that gives me hope that we'll be able to sustain that investment right through to delivering a potent set of recommendations that will get off the shelf and into action to make a measurable difference. So, kudos for that.

The second that I want to do is just to acknowledge the joy I felt from the new members as well as our presenters who welcome strategic storytelling. You know, as a data maven my whole life and as a scientist, many know that I've

shifted into this world of elevating the power of story, the capacity of story, the readiness for story, the strategy of story as being a missing component in our work. And I said up front that, you know, what will it take to shape and drive more powerful narratives, not just based on sound science, but lived experience. So, to the new members who one said what about the story and story are data, and our speakers as well, I feel like I have a whole lot more company and I'm not out on a limb on that one. It's not soft science. It's the heart and head of the matter that need to go together.

And last, I also said in my what will it take is this notion of collaborative, courageous leadership which will give us the wisdom to make difficult decisions based on incomplete or imperfect data. And so, my observation over the last two days is that we have the capacity to collaborate in SACIMM, SACIM, ACIMM, whatever acronym you want to use, but the reality is it's the persistent and persevering

courage, because it's structural. While we have never been on Indian land, it's structural while this has been insignificant numbers and not talked about, while it's been an initial without a whole lot of depth. And we get to elevate up Indigenous health and First Nations in a way that is long past due, and it should never be an asterisk as insignificant ever again. We changed the rules of how maternal and child health will work. And that to me gives me high hope. What I hope won't happen, and I don't think we will let it happen because of our courageous leadership is that this will become a topic that says, Oh, we covered that, let's move on. May the social DNA of SACIMM, SACIM, ACIMM be altered because of the work we are doing never to regress again into the margin.

A delight and an honor to be here. Thanks so much.

CHAIRMAN EHLINGER: All right. Thank you.

Janelle?

JANELLE PALACIOS: Thank you, Ed. I'm going to try to be very quick, but I want to just let you know that I'm very grateful to you. Since, the very beginning of this first committee meeting when it was restarted almost four years ago, you shared that you wanted people to be brave and courageous, and you wanted us to tackle issues that needed tackling, and you gave us space to be able to be authentic and space for us to really work for the changes that we felt or we see we needed.

In particular, I want to also thank the committee at large for letting us veer off into Indigenous health concerns. And I know that we've spent a few meetings on this topic, and I want you to know that, as I'm departing from the committee after September. It's all in your hands, what happens what actions are taken later. So, I'm here at your service to offer you any thoughts or if you want to discuss anything a little bit more deeply.

I also want to just point you to

September 21. We had an ACIMM meeting, and on day two I gave a brief presentation on Indigenous history and related to maternal child health outcomes, and I included the lived experience of my family in that. It's recorded. You're welcome to review it. But that also serves as a great foundation for understanding how history has affected policies today that affect Indigenous health.

Lastly, I want to just end with centering this back to humanity and recognizing that we need to work as a community to improve life not just for Native women and infants and children or women in general, but for the whole community, for fathers, for grandparents, for everyone, because that's really the work that we're trying to do. Many may not know this. You might be familiar with Centering Pregnancy. It's a group prenatal care model that has been shown to do a number of positive things for pregnant people and postpartum people. It helps them with self-advocacy and health literacy. It helps them have

less stress. It helps them have better maternal infant outcomes. But did you know that Sharon Schindler Rising, the nurse midwife who created this program, this model of care, modeled it after a Native American talking circle? So, we are bringing Indigenous ways, not just Native American ways, but Indigenous ways of knowing -- whether that's in Asia or Africa or in the United States, we're bringing Indigenous ways of knowing into our daily lived experience and health. So, I would continue to advocate for us to look for those places where we can bring that into our lives, into our research, because I think they had something with a talking circle. I think there's something to be said about Maslow's hierarchy that he had it wrong, perhaps, and it was upside down. Right? So, what else have we not listened to appropriately? But we have space to do that here. Thank you.

CHAIRMAN EHLINGER: Thank you, Janelle. Thank you for your leadership on this. And certainly, our efforts looking at Indigenous

health has not been veering one direction or another. It is central, it is core to what we have to do. It would have been, like I say, public health malpractice not to focus on the needs of American Indians and Alaska Natives, because, as Charlene pointed out, we've ignored this group for so long. Just because their numbers are so small, that doesn't mean they are not absolutely essential and core to what we need to do. And, as I tried to point out at the beginning, this is going to impact the health of everybody in this country what we come up with, and so it is essential that we do this. So, thank you for your leadership on this, and look forward to more of that as we move ahead.

Any other comments? Any comments from the new folks that have just recently come on? I would appreciate any kind of thoughts that you might have.

JOY NEYHART: I have my hand up.

CHAIRMAN EHLINGER: Go ahead.

JOY NEYHART: So, I want to thank

everyone for having me be part of this committee. I feel like a small one among giants, but I'm learning. I guess I just realized that Janelle is turning off, and so I hope I can live up to her standard and I hope that she will continue to be a resource for me.

And the comments that Magda made about stories, stories are what brought me to the two-year process of being appointed to this committee, the stories of the moms and the children that I've cared for over the past 20 years, and the good, the bad, and the ugly. But those stories drove me to want to do better for all moms and kids across the country.

And again, I mentioned several times that I'm just recently a part of a Tribal Health Organization as a pediatrician, and I feel like these two things coming together at once, this committee and this job, working together, I think I can do a lot of good things, not just for kids in Alaska, but for kids all over. So, thank you for having me.

CHAIRMAN EHLINGER: Thank you, Joy.

All right. Well, it's been a busy couple of days, and I -- it's really been nice. I've really bonded with this group of SACIMM members, even though I've only met with them in person once. I just bonded with them even just in person once, but I've really bonded. These are now my lifelong friends and colleagues. And I'm also, you know, really pleased with the expertise and involvement of all of the new members, so I really feel good about the direction that SACIMM is going to go once we transition off.

Lee, you had a comment?

LEE WILSON: Yeah, I do. I just have a few items that I wanted to mention as we close out this meeting, if this is a good time to do it.

CHAIRMAN EHLINGER: This would be good, and then I'll have a closing last comment like I usually do.

LEE WILSON: So, first, as a federal representative and as the acting DFO on this, I'm humbled at the opportunity to be able to

participate in an event like this with a group of individuals with the members that are on the committee. In particular, I want to just give my thanks and appreciation both professionally and personally for the opportunity work with Jeanne Conry and to work with Paul Wise, two very, very bright lights in this area. Just the insights that I've been able to glean from the conversations that we've had both in a group and one on one have just been invaluable to me and something that I will remember for a very, very long time. So, thank you for your hard work, and for your openness to engage with me and with us. It's been a remarkable journey, and one that I hope we get to continue through different paths over coming years.

Also, thank you in advance to the committee members who have agreed to extend their terms for the remainder of the year to get us through the discussions that we're going to be having in September around tribal health and the recommendations that you will be making in that

space. We are planning to meet in Minnesota in September, as Ed had given the dates on that Tuesday, Wednesday, and Thursday. Please be on the lookout for information from Michelle Loh on our staff, who will be making the travel arrangements for all of you and making all of this happen. We are set for that meeting. And, you know, I've said that before, and then COVID and other issues have jumped into place. Hopefully that will not happen. We have a great deal of support here, and, you know, transitioning on this topic. And I think we've made some real good bridges with the new people who are at the Indian Health Services. I want to thank them, even though they're not here, but I'm extending on some thanks in writing to Doctor Christiansen to Doctor Pattara-Lau and to Ms. Carr for their willingness to step in, given the very, very busy workloads that they have at IHS, not that we don't all have busy workloads, but they did put forth a great deal of effort for this committee, and I hope to continue that relationship. In fact, it's already

paid off, because we're in negotiations, discussions about information regarding formula and whether or not we can help them out with making some connections that we have in that space. So, I appreciate that, and I appreciate all of your flexibility when it comes to adjusting to meetings being on again, off again, virtual and in person. It is a difficult juggling process for us right now. And I do want to call out again Anne Leitch, Michelle Loh, Abigail Jeudy Duchatelier for their participation and their work in making this committee meeting go, as well as Emma and the LRG team.

Finally, I do want to just recognize all of you, and in particular, Doctor Ehlinger for his dedicated and tireless and persistent work in this space. He does not let anything go. And you get very full rich meetings because he is so persistent and deliberate in his thinking on these activities. So, thank you all. I will turn the closing remarks over to Doctor Ehlinger. But if you have any questions, concerns, comments, or

feedback, please do send them to me directly at lwilson@hrsa.gov. And we will be turning over the DFO role after this meeting back to Vanessa Lee, who handles it so much better than I do. So, thank you.

CHAIRMAN EHLINGER: Thank you, Lee, for all your work.

MAGDA PECK: Thanks, Lee.

CHAIRMAN EHLINGER: It's been a real pleasure working with you.

ADJOURNMENT

CHAIRMAN EHLINGER: So, let me leave you all with this. Today is Magna Carta Day, which you probably didn't recognize. On June 15, 1215, King John signed the Magna Carta at Runnymede. Now, the design and concept of the Magna Carta led to the Declaration of Independence, the United States Constitution, the Bill of Rights, and many of these state's constitutions. They relied on the Magna Carta for guidance. But the reality was back in 1215 that

document was really very limited, very limited to a very specific thing, but it stimulated the imaginations of others that followed. That was the power of the Magna Carta. As limited as it was at the beginning, it stimulated the imagination of the people that followed, and it ultimately formed the foundation of democratic values and principles. So, our document that will be coming may or may not be limited, but I hope it stimulates people's imagination about what could happen and stimulate the action that needs to happen to make that vision come true. So, on Magna Carta Day, go out and change the world because we're on our process of doing this. So, thanks for all your work. Thanks for your involvement. And I will get stuff back to you as soon as I can after I get input from the workgroups. So, enjoy the rest of the day, and the rest of the week, and peace to all of you.

(The meeting adjourned.)