



Tribal and Urban  
Indian Leadership  
Recommendations  
September 2022



AMERICAN INDIAN HEALTH COMMISSION  
ADDENDUM TO THE WASHINGTON STATE  
DEPARTMENT OF HEALTH'S  
MATERNAL MORTALITY REVIEW PANEL  
REPORT TO THE LEGISLATURE

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# Stephen Kutz, Chairman of the American Indian Health Commission's letter to Dr. Umair Shah, Secretary of the Department of Health, Washington State



Dr. Umair Shah

Secretary of Health  
Washington State

Re: AIHC Addendum to Washington State Department of Health Maternal Mortality Review Panel Report to the Legislature

Dear Dr. Shah:

The health of our pregnant, birthing, and postpartum people is critically important to the American Indian and Alaska Native (AI/AN) citizens, communities, Tribal and Urban Indian Health Organization (UIHO) leaders, and American Indian Health Commission (AIHC) delegates in Washington State.

The Washington State Department of Health (DOH) reports such as the Maternal Mortality Review Panel's Report to the Legislature 2014-2016, the Infant Mortality Reduction Report and the 2020 Perinatal Indicators Report all reveal alarming disparities in the health and birth outcomes of AI/AN pregnant, birthing, and postpartum people, and infants in our state.

The American Indian Health Commission Executive Committee and delegates are very appreciative of the response to our request for further action and information when presented with the results of the Maternal Mortality Review Panel Report to the Legislature in 2019. The special 1-year funding allowed us to begin the conversations with communities and leadership about concerns regarding the dramatic disparities in the morbidity and mortality of AI/AN pregnant, birthing and postpartum people.

The sacred role of bringing new life to the Tribe has long been acknowledged and supported traditionally by AI/AN communities. The intense trauma, genocide, and ongoing racism and discrimination in the last 500+ years has had profound impacts on the healthy ways and traditional practices of AI/AN people which are manifested as the chronic disease disparities experienced today, including maternal morbidity and mortality. These disparities are of great and ongoing concern to the AIHC and prioritized formally in the 2010 publication of the MIH Strategic Plan.

It is essential to AI/AN healing to rely on Tribal developed and implemented solutions. What the Tribes and UIHO's need is partnership with the state in funding and collaboration. It has been 500+ years of trauma and discrimination; it will take some time to heal. What we have learned in the 10 Conversations with Native Pregnant, Birthing, and Postpartum People Community and Leadership sessions is reflected in the Tribal and Urban Indian Leadership Recommendations listed in the AIHC Addendum to Washington State Department of Health Maternal Mortality Review Panel Report to the Legislature. |

We appreciate the opportunity to share these recommendations and express the need for funding to implement these ideas and solutions. If you have any questions, please contact Vicki Lowe at [vicki.lowe.aihc@outlook.com](mailto:vicki.lowe.aihc@outlook.com) or 360-460-3580.

Respectfully,

Stephen Kutz, BSN, MPH  
Chair, American Indian Health Commission

CC: Tribal Chairs

- Chair
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- Vice-Chair
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- Colville
- Cowlitz
- Jamestown S'Klallam
- Kalispel
- Lower Elwha Klallam
- Lummi
- Makah
- Muckleshoot
- Nisqually
- Nooksack
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- Samish
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- Shoalwater Bay
- Skokomish
- Snoqualmie
- Spokane
- Squaxin Island
- Stillaguamish
- Suquamish
- Swinomish
- Tulalip
- Upper Skagit
- Yakama
  
- Member Organizations:**
- Seattle Indian Health Board
- N.A.T.I.V.E. Project of Spokane
- American Indian Community Center

808 N 5<sup>th</sup> Ave. Sequim, WA 98382 – (360)797-5246 – [www.aihc-wa.com](http://www.aihc-wa.com)



September 2022

## Report and Recommendations from Listening Sessions Held with American Indian and Alaska Native Leaders and Community Members

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## American Indian Health Commission for Washington State

The American Indian Health Commission works on behalf of the 29 Federally Recognized Tribes and two Urban Indian Health Organizations, and one American Indian Community Center in Washington State. It is a Tribal consortium formed in 1994 by leaders from the Washington State Tribes and Urban Indian Health Organizations (UIHOs). The Commission's Mission Is to improve the health of American Indians and Alaska Native people through Tribal-State collaboration on health policies and programs that will eliminate disparities.

Webpage: <https://aihc-wa.com/>

Facebook: <https://www.facebook.com/pullingtogetherforwellness/>

## Acknowledgements

The American Indian Health Commission acknowledges the Tribal and American Indian and Alaska Native community members, American Indian Health Commission Delegates, Tribal Leaders, staff from Tribes, Urban Indian health programs, and Tribal organizations for sharing so generously about their experiences, wisdom, and love for working to improve the health and experience of Pregnant, Birthing and Postpartum People and improve the health status of American Indians and Alaska Natives in Washington for our current and future generations.

AIHC would like to thank the state agency staff from the Department of Health for their dedication to public service, improving the health of the population of the state, and response to the AIHC's request to provide a strategy to identify issues related to Native maternal mortality and morbidity to inform recommendations for inclusion in the 2023 Maternal Mortality Review Panel Report to the Legislature.



Prepared by:

Cindy Gamble, MPH; JanMarie Ward, MPA; and Ashley Olmstead



# Report and Recommendations from Listening Sessions Held with American Indian and Alaska Native Leaders and Community Members

## Executive Summary

Recently, there has been increased concern about maternal mortality and high levels of disparities among American Indian/Alaska Native and Black populations in Washington State and nationally. Due to these significant disparities among AI/AN people, AIHC has been engaged with the work at the state and federal levels and monitoring the issue closely. AIHC has been working for 14+ years to decrease maternal and infant health disparities with a vision of eliminating inequities. In 2010, the AIHC published the “Healthy Communities: A Maternal and Infant Health Strategic Plan.” This plan serves as a foundational document for the public health work of the Commission. A report on the status of maternal mortality for American Indian/Alaska Native people raised high concern by the Tribal and urban Indian Health Leaders in the state. In response, Washington State Department of Health, provided \$30,000 to AIHC to support a special project to convene one maternal mortality listening session with American Indian and Alaska Native people. AIHC consultants convened five Tribal and AI/AN community conversations to hear concerns about the health of Native pregnant, birthing, and postpartum people and provide learnings to Tribal and Urban Indian Health leaders for their review and recommendations. Five sessions were convened to inform and get input from Tribal and Urban Indian Health Leaders to inform recommendations. Based upon those convenings, AIHC consultants have developed the final recommendations for AIHC leadership approval and have submitted the approved Report and Recommendations to the Washington State Department of Health. Approved recommendations consist of two categories:

- Seven Recommendations to Department of Health and to the Legislature
- Four Recommendations and Support for AIHC Priority List

## Background

On November 19, 2019, when the Washington State Department of Health (DOH) released the Maternal Mortality Review Panel Report, it revealed that ... “American Indian/Alaska Native women had higher maternal mortality ratios than any other race/ethnic group.” The report also stated another remarkable statistic: that the Maternal Mortality Review Panel (MMRP) had determined that 60% of the pregnancy-related deaths were preventable.

Following the release of the report, the Maternal Mortality Review Panel manager and staff presented the report to the delegates and other Tribal and Urban Indian Health leaders at the annual American Indian Health Commission (AIHC) Delegate meeting in December 2019.

AIHC Chair Steve Kutz reflected the concern and interest of the delegates by asking that the MMRP staff engage with AIHC staff and consultants to discuss an appropriate activity and/or strategy to address the alarming maternal mortality disparity of AI/AN people in Washington State. The DOH responded with a one-year project, Sept. 2021 - Sept. 2022, “To hold one or more listening session(s) focused on maternal mortality with the American Indian/Alaska Native community and Tribal health partners.”

Maternal mortality has been identified as a special concern due to persistent disparities for AI/AN people in Washington State and nationally. The MIH challenges include persistent, dramatic disparities, known in our communities, and documented in State of Washington reports, including:

- American Indian/Alaska Native people have the highest ratio of maternal mortality than any other racial/ethnic group in Washington State
- Babies who are Non-Hispanic (NH) American Indian/Alaska Native are twice as likely to die before their first birthday as NH White and NH Asian babies
- NH American Indian/Alaska Natives have the highest post-neonatal infant mortality IM rate (4.1 per 1,000), nearly three times the rate for NH Whites
- The 2020 Perinatal Indicators Report states: “Many Indicators showed stark racial and ethnic disparities, especially among Native American.....women and children.”

(It is important to interject here and note that the 2014-2020 report reveals no significant improvement in AI/AN maternal mortality disparities since 2014-2016. This is a grave situation.)

*(Infant Mortality Reduction Report (wa.gov), Washington State Maternal Mortality Review Panel: Maternal Deaths 2014-2016 and 2014-2020, 2020 Perinatal Indicators Report for Washington State). See charts that follow:*



Image 1. (Figure 7) Demographics, Maternal Mortality Ratios (deaths per 100,000 live births) and Counts for **Pregnancy-Related Deaths** (N=30), Washington State 2014–2016. Washington State Department of Health

*Figure 7: Demographics, Maternal Mortality Ratios (deaths per 100,000 live births) and Counts for Pregnancy-Related Deaths (N=30), Washington State, 2014-2016*

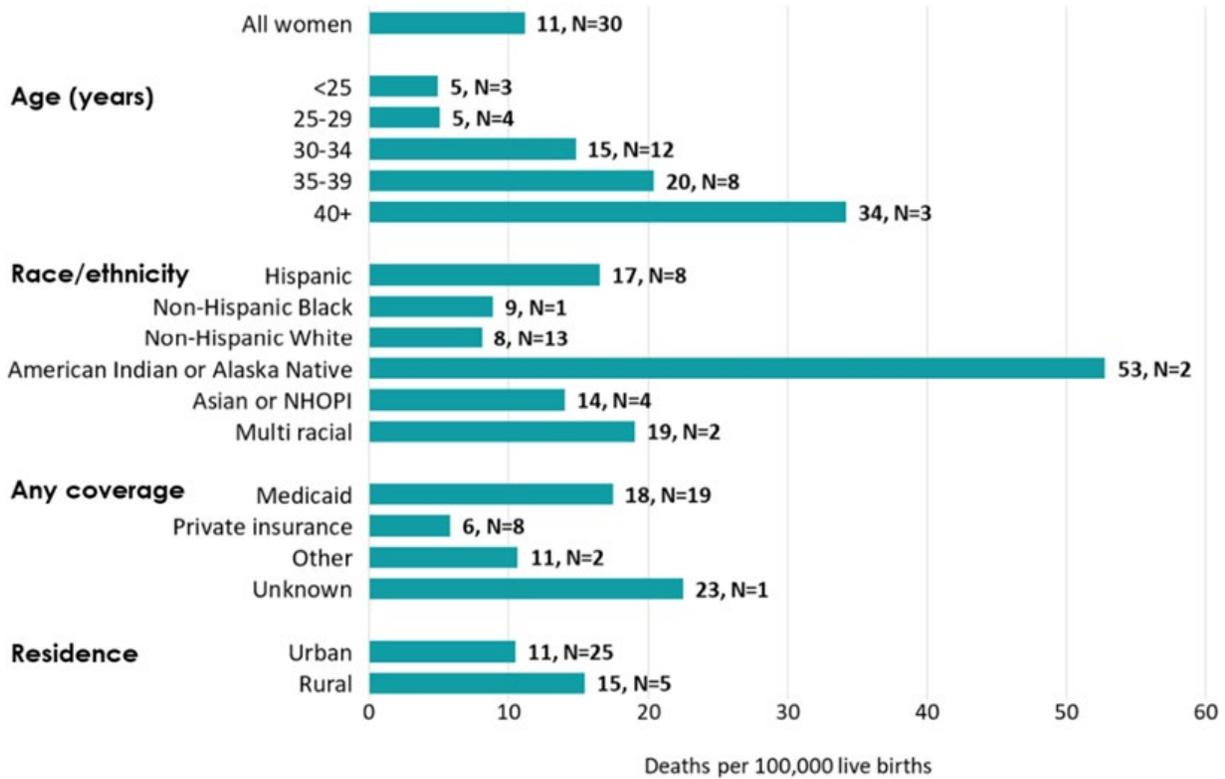
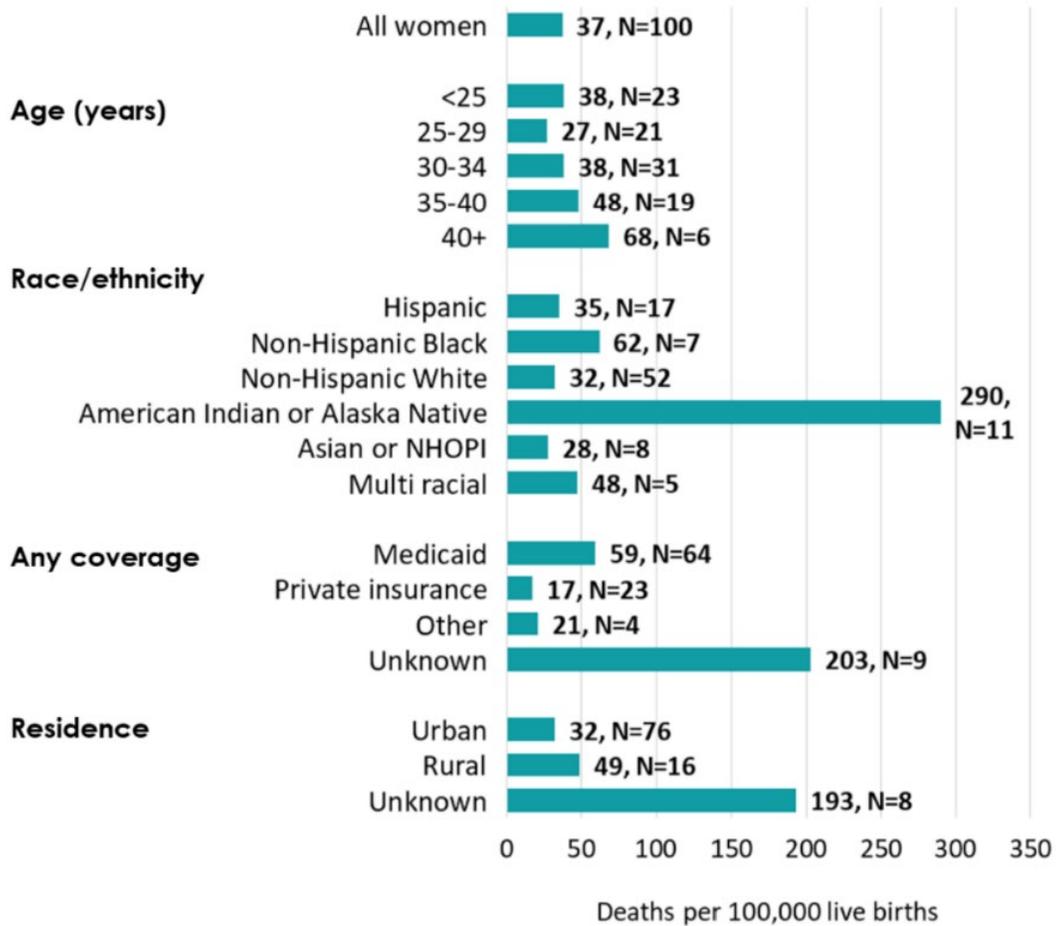


Image 2. (Figure 4) Demographics, Maternal Mortality Ratios (deaths per 100,000 live births) and Counts for **Pregnancy-Associated Deaths** (N=30), Washington State 2014–2016. Washington State Department of Health

Figure 4: Demographics, Maternal Mortality Ratios (deaths per 100,000 live births) and Counts for Pregnancy-Associated Deaths (N=100), Washington State, 2014-2016



## Maternal Mortality Listening Session-Special Funded Project

The Department of Health provided \$30,000 to fund a special project with a one-year contract to: “hold one or more listening session(s) focused on maternal mortality with the American Indian/Alaska Native community and Tribal health partners.” In 2022, the American Indian Health Commission (AIHC) convened a series of listening sessions to address American Indian/Alaska Native (AI/AN) maternal mortality disparities in the State of Washington.

### Purpose

- 1) To hold gatherings in Tribal and Urban Indian Communities to hear concerns about the health of Native pregnant, birthing, and postpartum people in a safe, non-judgmental, and confidential space, where the words, concerns, fears and hopes of participants are heard and honored.
- 2) To update Tribal and Urban Indian Health leaders on the issues of Native maternal mortality and morbidity including concerns from their communities to inform their recommendations for the 2023 Maternal Mortality Review Panel Report to the Legislature.
- 3) To reduce maternal mortality disparities in American Indian and Alaska Native (AI/AN) people in Washington State until they are eliminated.

### COVID-19 Impact on Project

The COVID-19 Pandemic impacted this project in several ways. First, the project was approved and offered 2 years after the request by Tribal, Urban Indian and AIHC leaders. During that time the Tribal and state priority efforts to manage the impacts of a global pandemic was essential. Second, our initial plans for the listening sessions were based on local or regional in-person listening sessions due to the sensitive nature of the topic. However, after extending our timeline several times, in the hopes that in-person sessions might be possible, we had to concede. We had to accept that our maternal mortality listening sessions had to be virtual.

### Project Strategy

Once the decision was made to hold virtual listening sessions, we revisited our initial plans to ensure our success in inviting and engaging participants. It was important to use a “Seven Generations Principles” approach as we planned our engagement strategy. This meant that we would not only consider how the historical experiences of our ancestors and elders define current Native health status, but also how the decisions made today, how action—or lack of action— will impact the generations following us.

We knew the right approach was to invite the community to engage with us in “Conversations about the Health of Native Pregnant, Birthing and Postpartum People” and address maternal mortality in a broader context of issues and needs and what might contribute to issues of mortality and morbidity. To invite them, we promoted the sessions through AIHC, Tribal and Urban Indian Community channels which included AIHC delegates, Tribal and Urban Indian



Health Organization leaders and the AIHC MIH Work Group. To participate one had to be an American Indian/Alaska Native or a member of an AI/AN family and a resident of Washington State.



**SAVE THE DATE!**

**You Are Invited to a Conversation**

**About the Native Experience of Pregnancy, Birth, and the First 1000 Days of Parenthood.**

**Intended audience: Tribal Leaders, Tribal Health Directors, and AIHC Delegates Residing in Washington State.**

**Advanced Registration is Required.  
This is for Washington State residents ONLY.**

**August 4th: 1:00pm-2:00pm or 5:00pm-6:00pm**

**SCAN QR CODE TO REGISTER**

**1pm-2pm**

**5pm-6pm**

**PULLING TOGETHER FOR WELLNESS**

If you have any questions, please contact Ashley Olmstead - [ashleyolmstead91@gmail.com](mailto:ashleyolmstead91@gmail.com)

### Community and Leadership Conversations

Our plan was to hold several Community Conversation sessions which would inform the Leadership sessions and possibly be reflected in their recommendations. Although the project required holding one listening session, our goal was to hold three Community Conversation sessions, and two leadership sessions. To encourage participation, we scheduled the sessions over a variety of days and times. We developed a list of questions to prompt the conversations, and an agenda to ensure all participants were informed about the goals and background of the listening session project. We emphasized the importance of their participation, and how they were giving voice to many in their communities who for understandable reasons may not feel comfortable or trusting to participate in the Community Conversations.

We signed into our first Community Conversation About the Health of Native Pregnant, Birthing and Postpartum People with some trepidation. Although we did have pre-registered participants, would they show up? If they showed up, would they participate? Or would this be the shortest Zoom meeting ever?



It turns out that our first session had the largest number of participants. Our agenda and questions worked wonderfully; people participated fully, and we had rich and important responses to the questions. The session did not end early. Participants were engaged and stayed on for the full session. Participants could choose to introduce themselves in the chat, but it was not a requirement. Since we wanted to respect their privacy and it was not a requirement of our project, we do not have an exact number of participants.

We held the next two scheduled Community Conversations sessions, and the participation was so wonderful, the conversations so rich, wise, heartfelt, and appreciated, we decided we could schedule two more sessions and still meet our timeline. In total, we held five Community Conversations About the Health of Native Pregnant, Birthing and Postpartum People. We had participants from across the state. They ranged in age from teenager to elder, different genders were represented as were the roles of mother, father, grandparent, aunt/uncle, community leaders, and concerned community members. We thanked all the participants who were so generous with their time, their wisdom, and their advocacy for the health of pregnant, birthing and postpartum people in their families, communities and Tribes.

**“Leaders, Tribal leaders, families all need to provide support for expecting moms. Support means more than sending someone off to treatment. It means providing a safe place for the most vulnerable—our unborn”**

*Community Conversation Participant*

Once the Community Conversation sessions were complete, we prepared for the Leadership sessions. This included sending out invitations through the regular AIHC, Tribal and UIHO channels, but also personal invitations. All the Community Conversation responses had to be data entered, analyzed, and categorized to be shared concisely with the AIHC, Tribal, Urban Indian and other community leaders. A succinct agenda designed to give the project overview and goals, share the Community Conversation responses, and elicit recommendations had to be prepared and consistently delivered. Finally, the day of the first of our two scheduled Leadership Recommendation sessions arrived. As with the Community Conversation sessions, the first Leadership Recommendation session exceeded our expectations, and encouraged us to schedule more sessions. In total, we held five Leadership Recommendation sessions. Although our initial plan was for three community and two leadership sessions, in perfect synchronicity, we ended up scheduling five community and five leadership sessions for a total of 10.

## Community Conversations Results

We will not be sharing the Community Conversation participants’ specific responses and concerns in this document; their understanding was that these would be shared with Tribal, UIHO and AIHC leaders. However, we will share some observations and themes.



One persistent theme is that the Community Conversation participants were grateful for the opportunity to discuss these issues. One dad shared with us that his spouse encouraged him to participate as ... “I think you will like it.” There is a high level of concern about the experiences of Native pregnant, birthing, and postpartum people in their communities. There is also clear understanding how their experiences of negative prenatal, birthing, and postpartum care result in AI/AN maternal morbidity and mortality disparities.

Four strong themes emerged regarding needs and issues around: pregnancy and birth experiences, pregnancy, birth and postpartum needs across the continuum, new parent needs and prevention of the systemic issues that contribute to maternal morbidity and mortality.

The need for equitable access for appropriate and culturally relevant resources and care throughout the pregnancy, birthing and postpartum continuum was seen as a critical need. Exposure to stigma, discrimination and racism was a major concern, with an intimate understanding of how these exposures impact physical, mental, and emotional health. Also, there was a feeling that most non-Native people do not fully understand the constant array of macroaggressions and microaggressions that Native people encounter on a regular basis. As one participant stated:

***“Many young women don’t have to advocate to not get murdered.”***

Tribes are insular communities, and the Community Conversation participants are experts in their communities, whether urban or rural. As experts, they know what the challenges and needs are, and they have very informed ideas regarding solutions that will work. A value that many Tribal communities share is “to hold each other up.” These values came through loud and clear in support of the pregnant, birthing, and postpartum person and their family. One participant shared their belief that:

***“Help is not taking the baby from the parents. What we need is laundry cleaned, dishes washed, and some good heartwarming food.”***

Participants emphasized the importance of both community and leadership:

***“True support from Tribal leadership is important for the sustaining of a healthy Native community.”***



## Leadership Considerations

Tribal and UIHO leaders are citizens of their Tribe and community, and experts in the history, battles, needs, challenges, strengths, resources, and wisdom in their communities. Most of them have been immersed in the work of representation, advocacy, and self-determination for their Tribe/community for a very long time. They are familiar and knowledgeable about the issues and concerns of their community. When we shared the results of the Community Conversations, some of the concerns may have been familiar, and ideas from other communities may have been thought provoking.

**“The number one priority is to reduce Native Maternal Mortality until the disparity is eliminated.”**

**“Priority 1–Access to health care through the continuum of pregnancy and postpartum for both mom and dad.”**

There are two top priority recommendations from the Leadership Recommendation sessions. As obvious as it may seem, measurement and initiatives have not necessarily been focused on elimination of disparities. They have only been defined and funded for incremental change at best. It is important to take note of this shift in the language used by leaders to a strategy to “eliminate” that demonstrates the importance of addressing root causes and understanding that to address root causes, we have not yet reached far enough upstream in our systems change and transformation efforts. Nevertheless, it is important to acknowledge this shift as the top priority of the AI/AN Tribal and UIHO leaders.

To say that “The number one priority is to reduce Native Maternal Mortality until the disparity is eliminated”, is a strong statement and differs from mainstream goals such as Healthy People 2030 (HP2030), which acknowledges maternal deaths are “getting worse”. This statement does not give a target number like the HP2030 target of 15.7 per 100,000; our focus is on the elimination of the disparity.

One of the fundamental issues that must be resolved to reduce maternal morbidity and mortality is to improve and increase access to care for Native Pregnant, Birthing and Postpartum people. Tribal and Urban Indian Health Leaders assert that the improved and expanded access must be for culturally relevant services throughout the continuum of pregnancy, birth and postpartum. This must include the will and necessity to address historical inequities and create trust in the health transformation system change through policy, inclusion, and allocation of funds.

**“This is why we do what we do, one child, one family, makes it all worth our time”**  
**Cheryl Sanders**  
**“Takwiltsa”, Lummi Nation**



Culturally relevant services require that the importance of ‘Seven Generation Principles’ are understood and integrated into service planning and delivery. Utilizing ‘Seven Generation Principles’ encompasses the understanding of the adverse impacts of historical and intergenerational trauma and ongoing structural and interpersonal racism. Additionally, the need for trauma-informed care in all aspects of care throughout the continuum, and the Native value of ensuring that decisions made today will have positive consequences for future generations.

Relevant services also include a healing team that is trusted by the Native Pregnant, Birthing and Postpartum People. An example of named members of a trusted team include midwives, doulas, elders, and WIC providers. Access to a trusted team is critical to engage Native pregnant people in early entry and consistent prenatal care. The improved and increased culturally relevant services must also include support and resources for both parents and be open to the fact that extended family are essential support for American Indians/Alaska Native Pregnant, Birthing, and Postpartum People. The roles of grandparents are especially relied on to fill many roles in our communities.

There was a lot of discussion about the need for more American Indian/Alaska Native specific data, not only for Tribal PRAMS, but for other issues that may be pertinent to AI/AN communities, but not recognized or accepted as critical. The Tribal and Urban Indian Health leaders listed a variety of issues observed in their communities and clinics that have adverse effects on Native maternal morbidity and mortality. The critical importance of maintaining the Tribal/UIHO Clinic as the medical home and assuring close and continual contact with their pregnant, birthing, and postpartum people throughout the continuum was also recommended.

There is a high level of concern from both the Community Conversation participants and the Leadership sessions about the discrimination, racism, and stereotyping that the Native Pregnant, Birthing and Postpartum people face, which cause high levels of stress and distrust in providers and the health care system overall. There is significant evidence about the negative effects of stress and toxic stress which pose developmental concerns for the baby, and emotional and physical health issues for parents and families. Racism and discrimination are core elements in the formation of American society based on centuries old policies, structures, and institutions. It will take long term commitment for intentional policy, systems, and societal change by many to cure it. However, a substantive recommendation that can move us in the right direction in the health system would be for the state to analyze and find ways to measure the harms caused by racism in health care systems to create momentum for change. Change that would see funding allocations for Tribal-led workforce development and training to increase the number of AI/AN health providers and educators that are needed to serve their communities. There are many system barriers at this time; funding, focus and prioritization could help us to successfully recruit, train and hire an AI/AN workforce to meet the needs stated by Tribal and AI/AN communities.

A long-standing recommendation when discussing MIH disparities is based on results of centuries of U.S. Indian policies that have resulted in the long-term health consequences of poor nutrition of AI/AN people. From the very beginning of forced relocation, to reservations which changed access to traditional and customary places to hunt, fish and gather, to the intentional underfeeding of the AI/AN children who were forced to live at boarding schools, to the nutrient poor commodity foods given to Tribes in the early days when it was an embarrassment on the world stage that America's first peoples were dying of starvation, generations of AI/AN people have been exposed to the risks of nutrient poor foods and underfeeding. Epigenetics now tell us that these experiences have long lasting effects that can impact AI/AN health to this day. The adverse health impacts of poor nutrition are of great concern to the Tribal/UIHO leaders and there were many nutrition-related concerns that were mentioned during the sessions. Again, Tribal-led solutions such as the Food Sovereignty Movement in Indian Country, need to be funded and supported. Having traditional food options in AI/AN diets is a goal of the Tribal/UIHO leaders. One Tribal/UIHO leader shared that her health advice to people is:

***"No drugs, alcohol, tobacco or junk food."***

***"If buffalo, deer, and salmon are what's best for us, it is what is best for our babies. It makes our brains healthy. It just makes sense."***

The Tribal and Urban Indian Health Organization leaders are very aware of, and invested in, the need to drastically and immediately improve the health of Native Pregnant, Birthing and Postpartum People. As one stated:

***"We have to save our Existence!"***

## Recommendations to Department of Health and to the Legislature

The elimination of Native Maternal Mortality is an urgent priority. The 2019 MMRP Report to the Legislature revealed dramatic and highly disproportionate maternal mortality disparities for AI/AN people in WA State (see Image 1 [Figure 7] and Image 2 [Figure 4], Addendum pages 7 and 8). In the 2023 MMRP Report to the Legislature, the disparities have not improved. (See Figures 4a and 4b, MMRP report pages 25 and 26; and Figures 6a and 6b, MMRP report pages 30 and 31.) This is of great concern and requires immediate attention.

It is essential to AI/AN healing to rely on Tribally developed and implemented solutions. What the Tribes and UIHO's need is partnership with the state in funding and collaboration. It has been 500+ years of trauma and discrimination; it will take some time to heal. What we have learned in the 10 Conversations with Native Pregnant, Birthing and Postpartum People Community and Leadership sessions is reflected in the Tribal and Urban Indian Leadership Recommendations below:

- 1) The number one priority is to reduce Native Maternal Mortality until the disparity is eliminated.
- 2) Culturally appropriate engagement and building trust at the community level is critical to understanding root causes of Native Maternal Mortality and essential to finding appropriate solutions and strategies.
- 3) Tribal-led data needs assessments, planning, administration, and analysis, including Tribal PRAMS, to address root causes of AI/AN maternal morbidity and mortality, substance misuse, and harm reduction strategies.
- 4) Address historical inequities and create trust in health transformation system change through policy, inclusion, and allocation of funds to create and assure culturally relevant services.
- 5) Improved and expanded access for culturally relevant services and resources, utilizing *Seven Generations Principles*, throughout the continuum of pregnancy, birth and postpartum for both parents.
- 6) Funding, focus and prioritization to support Tribal-led Workforce planning and development to successfully recruit, train and hire an AI/AN workforce to support the needs of Native pregnant, birthing, and postpartum people.
- 7) Support and fund Tribal-led nutrition planning and project development initiatives, such as Food Sovereignty and First Foods (breastfeeding) work.

### Ongoing and Current Work of the AIHC

Tribal-led and holistic approaches and continuity of work is very important to Tribal and Urban Indian Health Leaders. When you are continually underfunded and under-resourced, duplicative, and unnecessary rework is not welcome or efficient. In the overview presentation to the Tribal and UIHO leaders, the current and ongoing MIH work and projects were shared. It was agreed that these were important and should be integrated into the recommendations.

### Recommendations and Support for AIHC Priority List

- 1) AIHC will continue to participate in the NW Portland Area Indian Health Board Community Health Aide Program (CHAP) development work to investigate and advocate for the inclusion of a MIH role in support of the AIHC's 2017 resolution in support of a reimbursable provider type to provide MIH services in Tribal/Urban Indian communities.
- 2) AIHC will continue to work with the Foundational Public Health Services (FPHS) Lifecourse sub-committee to look at potential alignment for shared services or projects across sectors based on Tribally established priorities.
- 3) Finalize and administer the AIHC MIH Work Group's baseline survey on providers, programs, and patients. Secure funding to successfully complete all phases of the survey: promotion, administration, analysis, and dissemination of results.
- 4) Update and evaluate the AIHC MIH Strategic Plan to reflect the current landscape of MIH in Indian Country.