AAMC Maternal Health Equity Series Part Two

AAMC
Tomorrow's Doctors, Tomorrow's Cures

Learn
Serve
Lead

Bridging the Urban-Rural Divide: Maternal Health Across Appalachia and Indian Country

May 14, 2020

Association of
American Medical Colleges

AAMC
CHARGE
Collaborative for Health Equity: Act, Research, Generate Evidence

What is AAMC CHARGE?

AAMC CHARGE is a forum for investigators, clinicians, and community partners who design and implement research that eliminates health and health care inequities.

What does AAMC CHARGE do?

- Share accomplishments and crowdsource opportunities for professional achievement.
- Facilitate innovative multi-sector partnerships, collaborations, and research that contribute to the evidence base for solutions to health and health care inequities.
- Collaborate on policy work that impacts health equity at institutional, local, state, and federal levels.

How can I get involved?

Email healthequityresearch@aamc.org to join!

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AAMC.ORG/CHARGE

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American Medical Colleges

Inequities in Infant & Maternal Health in West Virginia: A Set of Recommendations

Lauri Andress, PhD, JD, MPH

Assistant Dean for Public Health Practice and Workforce Development & Assistant Professor in the Department of Health Policy, Management and Leadership

West Virginia University School of Public Health

AAMC

Not Just Surviving, But Thriving: Cultural Practices that Promote Positive Maternal Health Outcomes in Native Women and Families

Hannabah Blue, MS

Consultant, John Snow, Inc.

Vanessa Tibbitts, MA

Program Leader, American Indian Public Health Resource Center, North Dakota State University

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Inequities in Infant & Maternal Health West Virginia

A Set of Recommendations

Lauri Andress, MPH, J.D., Ph.D.
May 2020

"I suppose it is tempting, if the only tool you have is a hammer, to treat everything as if it were a nail."

Abraham H. Maslow (1966). The Psychology of Science. p. 15. ISBN 9780976040231.

Authenticity

Reflexive Auto-ethnography and Positionality

As health clinicians, researchers we must address not just the 'what' of our research questions and design; but also the 'how' of what we do, i.e., how our identities intersect with the research.

How do experiences of social-cultural identities and training express themselves within our efforts and impact our capacity to see and confront inequities?

Muhammad, M., et al. (2015). "Reflections on Researcher Identity and Power: The Impact of Positionality on Community Based Participatory Research (CBPR) Processes and Outcomes." Critical Sociology 41(7-8): 1045-1063.

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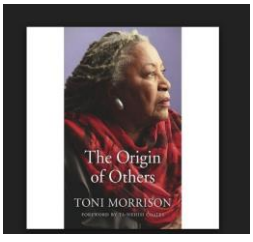
Before

September 2017
Interaction WV Director Office of Maternal, Child and Family Health

October 2017
The Origin of Others by Toni Morrison



December 2017
Begin to draft *Appalachian Narrative*

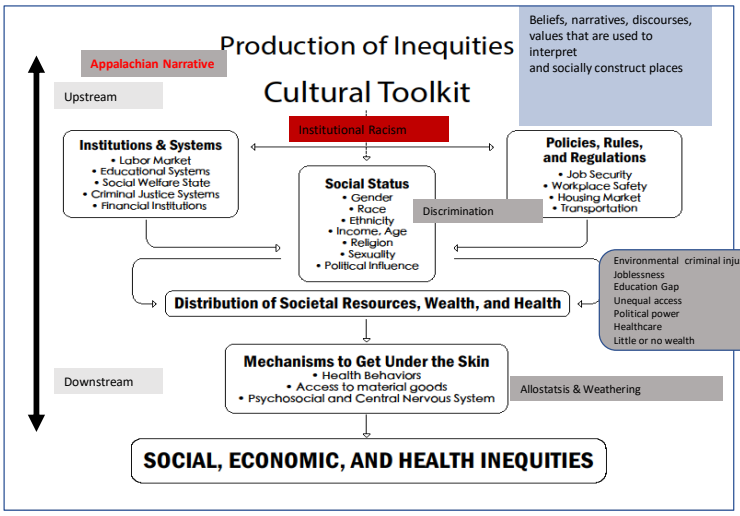
February 2018 WVU Law School Presentation
https://www.youtube.com/watch?v=bZHuNsFxmUk&fbclid=IwAR0s4PWx4U8phYMalW8uf5j0h2-tt-LeSPwVYAoHk8EaYew3jHkj8Rjo4ig

December 1, 2018
Charleston Gazette-Mail
WVU professor's research reveals disparity in infant mortality rates
By Rebecca Carballo Staff writer
https://www.wvgazettemail.com/news/health/wvu-professors-research-reveals-disparity-in-infant-mortality-rates/article_4c2a0356-edca-5607-9981-0a4e736d93a3.html#comments

July 17, 2018
Presentation Joan C Edwards School of Medicine, Marshall University

June 2019
Funded by Joan C Edwards School of Medicine, Marshall University

West Virginia University.



Andress, L. and M. P. Purtill (2020). "Shifting the gaze of the physician from the body to the body in a place: A qualitative analysis of a community-based photovoice approach to teaching place-health concepts to medical students." PLoS One 15(2): e0228640.

POLL

Where Do you Do Most of Your Work?

- Downstream
  - Clinical or behavioral changes
- Midstream
  - Distribution of determinants of health
- Upstream
  - Changing the cultural toolkit
- Not sure

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West Virginia Demographics

Race and Ethnicity

- White: 93.0%
- Black: 3.8%
- Asian: 0.7%
- Two or more races: 1.9%
- Other: 0.5%
- Hispanic or Latino: 1.4%

Income

- Per capita income: $26,179
- Mean household income: $61,707
- Median household income: $44,097

Educational attainment (population 25 years and older)

- Less than high school: 12.2%
- High school or equivalent: 39.7%
- Some college: 19.2%
- Associate's degree: 7.5%
- Bachelor's degree: 12.8%
- Graduate or professional degree: 8.5%

Source: U.S. Census Bureau, 2018 American Community Survey, 1 year estimates

WEST VIRGINIA CENTER ON BUDGET & POLICY

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Appalachia


WISCONSIN
MICHIGAN
NEW YORK
PENNSYLVANIA
ILLINOIS
INDIANA
OHIO
MARYLAND
NEW JERSEY
WEST VIRGINIA
KENTUCKY
VIRGINIA
TENNESSEE
NORTH CAROLINA
SOUTH CAROLINA
MISSISSIPPI
GEORGIA
ALABAMA
October 8, 2008

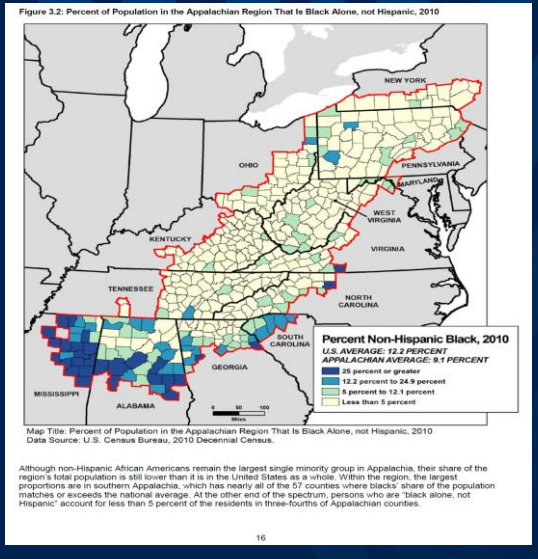
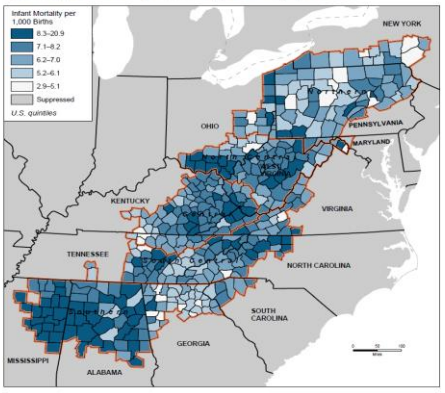


Figure 3.2: Percent of Population in the Appalachian Region That Is Black Alone, not Hispanic, 2010
NEW YORK
OHIO
PENNSYLVANIA
MARYLAND
WEST VIRGINIA
KENTUCKY
VIRGINIA
TENNESSEE
NORTH CAROLINA
SOUTH CAROLINA
GEORGIA
MISSISSIPPI
ALABAMA
Percent Non-Hispanic Black, 2010
U.S. AVERAGE: 12.2 PERCENT
APPALACHIAN AVERAGE: 9.1 PERCENT
25 percent or greater
12.2 percent to 24.9 percent
5 percent to 12.1 percent
Less than 5 percent
Miles
Map Title: Percent of Population in the Appalachian Region That Is Black Alone, not Hispanic, 2010
Data Source: U.S. Census Bureau, 2010 Decennial Census.
Although non-Hispanic African Americans remain the largest single minority group in Appalachia, their share of the region's total population is still lower than it is in the United States as a whole. Within the region, the largest proportions are in southern Appalachia, which has nearly all of the 57 counties where blacks' share of the population matches or exceeds the national average. At the other end of the spectrum, persons who are "black alone, not Hispanic" account for less than 5 percent of the residents in three-fourths of Appalachian counties.
16

Figure 77: Map of Infant Mortality Rates in the Appalachian Region, 2008–2014



Data source: National Center for Health Statistics. Compressed Mortality File, 1999–2014 (machine-readable data file and documentation, CD ROM Series 20, No. 2T) as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program. Hyattsville, Maryland. 2015. http://www.cdc.gov/nchs/data_access/cmf.htm

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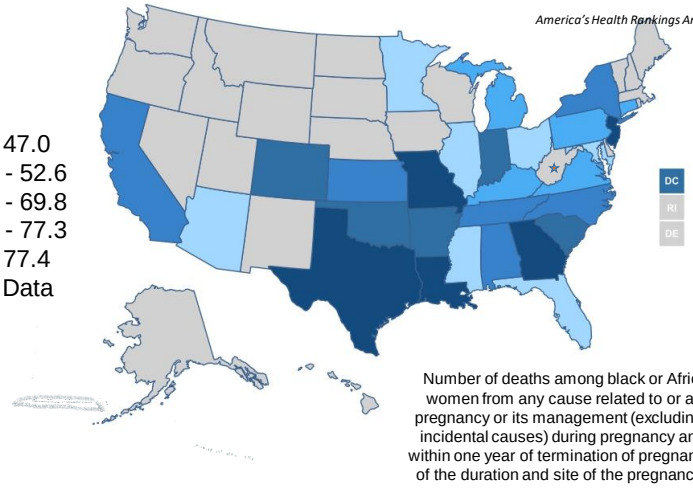
America's Health Rankings Annual Report 2019

<= 47.0
47.1 - 52.6
52.7 - 69.8
69.9 - 77.3
>= 77.4
No Data



Number of deaths among black or African American women from any cause related to or aggravated by pregnancy or its management (excluding accidental or incidental causes) during pregnancy and childbirth or within one year of termination of pregnancy, irrespective of the duration and site of the pregnancy, per 100,000 births

Source:
•CDC WONDER Online Database, Mortality files

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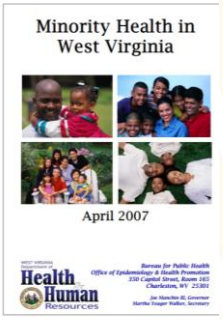

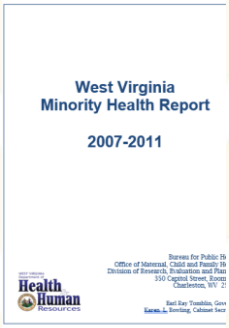

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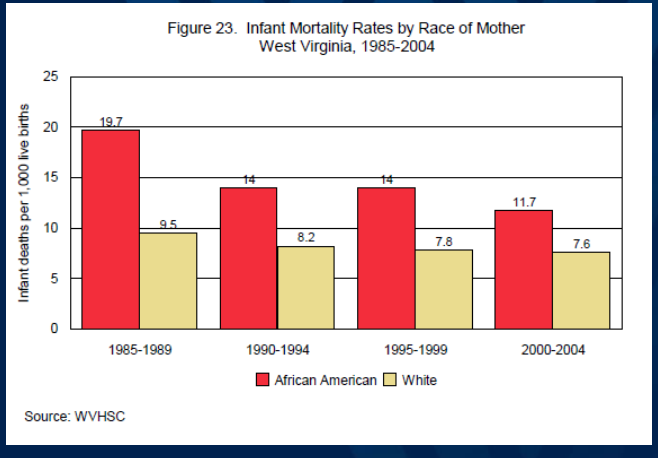

Racial Disparities in Infant Mortality in West Virginia 2006

Minority Health in West Virginia April 2007

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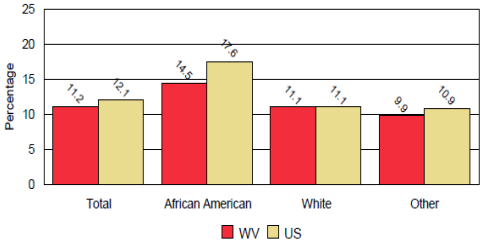
Figure 12. Percentage of Premature* Births
By Maternal Race
West Virginia and United States, 1999-2003



*Gestational age <37 weeks
Source: WVHSC

Racial Disparities in Infant Mortality in West Virginia 2006
Minority Health in West Virginia April 2007

West Virginia University.

2011 West Virginia and United States
Infant Mortality by Race of Infant
(Number and Rate per 1,000 Live Births)

Race of Infant	West Virginia		United States*	
	Number	Rate	Number	Rate
All Races	141	6.8	23,907	6.0
White	128	6.5	15,451	5.1
Black	12	16.8	7,221	11.4
Other	1	2.9	1,235	4.0

*Source: http://www.cdc.gov/nchs/data/nvsr/nvsr61/nvsr61_06.pdf

Approximately one out of six (17.0%) infant deaths in 2011 were due to SIDS (sudden infant death syndrome). Approximately one in four (23.4%) was the result of congenital malformations, while 40.4% were due to certain conditions originating in the perinatal period, including disorders relating to short gestation and unspecified low birthweight (12.1%).

West Virginia Vital Statistics 2011

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Infant Mortality Deaths in West Virginia 2018 Analysis

Analyzed by Carol Gilbert, CityMatCH www.citymatch.org Presented 7/17/2018

United States Department of Health and Human Services (US DHHS), Centers of Disease Control and Prevention (CDC), National Center for Health Statistics (NCHS), Division of Vital Statistics (DVS). Linked Birth / Infant Death Records 2007-2015, as compiled from data provided by the 57 vital statistics jurisdictions through the Vital Statistics Cooperative Program, on CDC WONDER On-line Database. Accessed at http://wonder.cdc.gov/lbd-current.html on Feb 16, 2018 2:56:15 PM

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Infant Mortality Deaths in West Virginia 2018

BLACKS ACCOUNT FOR 3.7 PERCENT OF BIRTHS BUT 5.8% OF DEATHS AND 8.6 PERCENT OF EXCESS (PREVENTABLE) DEATHS ---

THE BLACK IMR IS HIGHER THAN THE IMR OF ANY OTHER RISK GROUP

- HIGH SCHOOL EDUCATION
- TEEN
- UNMARRIED WOMEN AND
- LATE OR NO PRENATAL CARE

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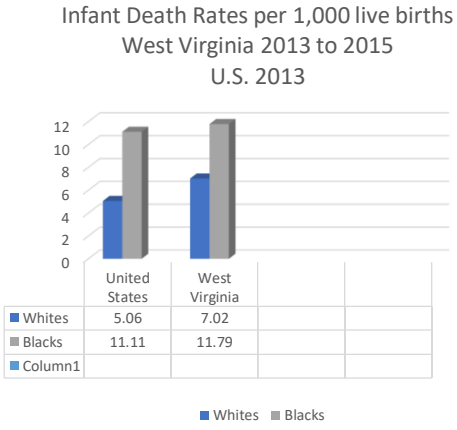
Analyzed by Carol Gilbert, CityMatCH www.citymatch.org Presented 7/17/2018

United States 2013

White infant death rate 5.06/1000

Black infant death rate 11.11/1000

- **West Virginia 2013-2015**
- Black infant death rate was 11.79
- White infant death rate was 7.02
- Ratio between these two rates is 1.7
-
- The chance that a black infant will die in the first year of life is 1.7% times greater than the chances that a white infant will die



Dilemma

How Do you Work on an Invisible Problem?

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Recommendations

Build Capacity, develop common language and narrative

- Community –based Online Learning Group

Overhaul the WV Fetal Infant & Maternal Death Review Panel

- Chapter 61 of the criminal code -Article 12A Fatality and Mortality Review Panel
- Create Community –based Action Team on Infant Mortality Disparities
- Maternal Interviews

National Center for Fatality Review and Prevention (NCFRP)

The National Center for the Review and Prevention of Child Deaths is funded by the Health Resources and Services Administration of the Maternal and Child Health Bureau (MCHB) as a resource and data center for state and local Child Death Review (CDR) and Fetal and Infant Mortality (FIMR) programs around the country.

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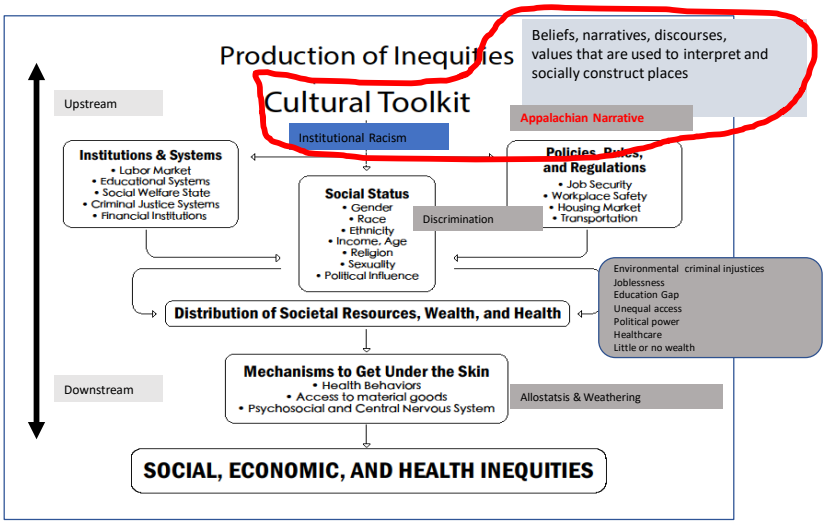
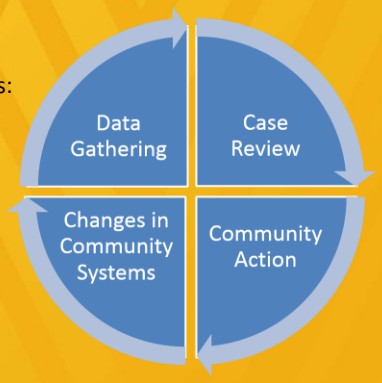


Fetal & Infant Mortality Review (FIMR) is:

A **multidisciplinary, community** team that examines a fetal or infant death case that is:

- Comprehensive
- De-identified
- Confidential
- Giving voice to mothers' experiences
- Engenders Dialogue



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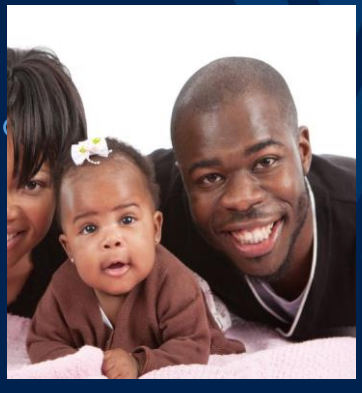
FIMR Interviews plus Community Panel– Why?



- Four corners of the death record cannot tell us everything we need to know about a mother's experiences.
- Pregnancy is about more than the 9 months that a woman is pregnant.
- The Community is where narratives and discourse determine how phenomena are framed, considered,
- The community is where stakeholders have a real stake
- Health care facilities
- Where we work
- Where we go to school
- Where we play

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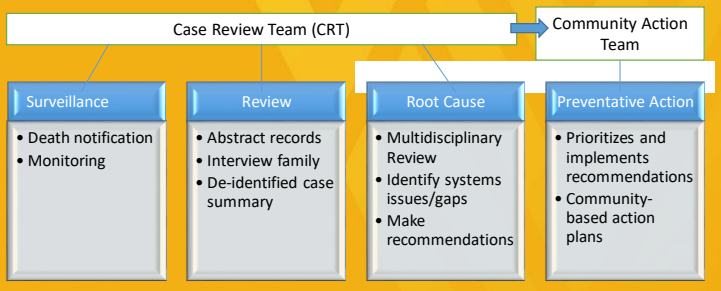
The FIMR process



NATIONAL CFRP Center for Fatality Review & Prevention

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FIMR Focuses on Systems

Each FIMR Case Review provides an opportunity to improve communication among medical, public health and human service providers and to develop strategies to improve services and resources for women, infants, and families

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Fatality & Mortality Review Team
West Virginia

April 2013

Senate Bill 108 passed establishing Chapter 61 of the criminal code - Article 12A

February 2015

Rule 29 : Established procedures for the formation of the Fatality and Mortality Review Team FMRT

Created under the WV Bureau for Public Health.

A multidisciplinary team created to oversee and coordinate the examination, review and assessment of:

- (1) The deaths of all persons in West Virginia who die as a result of unintentional prescription or pharmaceutical drug overdoses;
- (2) The deaths of children under the age of eighteen years;
- (3) The deaths resulting from suspected domestic violence; and
- (4) **The deaths of all infants and all women who die during pregnancy, at the time of birth or within one year of the birth of a child.**

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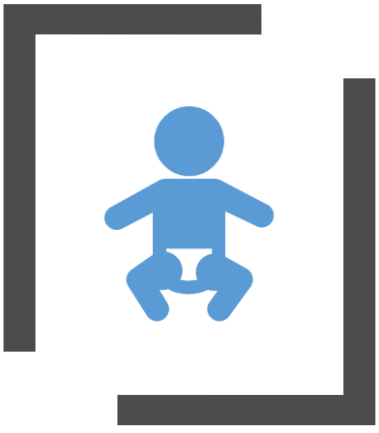

February 2015 Rule 29 West Virginia State Code

Established procedures for the formation of the Fatality and Mortality Review Team FMRT

Rules prohibit family contact which goes against the national recommendations

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TITLE 64
LEGISLATIVE RULE
BUREAU FOR PUBLIC HEALTH

SERIES 29
FATALITY AND MORTALITY REVIEW TEAM

§64-29-1. General.

1.1. Scope - This rule establishes standard procedures for the formation and conduct of the Fatality and Mortality Review Team. The Fatality and Mortality Review Team (FMRT) is a multidisciplinary team created to oversee and coordinate the examination, review and assessment of special cases of death where other than natural causes are suspected. This rule should be read in conjunction with W. Va. Code §61-12A-1, et seq. The W. Va. Code is available in public libraries and on the Legislature's web page, http://www.legis.state.wv.us/ .

1.2. Authority - W. Va. Code §16-1-4 and §61-12A-2(c).

1.3. Filing Date -

1.4. Effective Date -

§64-29-2. Application and Enforcement.

2.1. Application - This rule applies to the Fatality and Mortality Review Team and also to four fatality and mortality Advisory Panels set forth WV Code §61-12A-1, et seq. and described in this rule.

2.2. Enforcement - This rule is enforced by the Commissioner and by the Chief Medical Examiner in the Bureau for Public Health.

§64-29-3. Definitions.

3.1. Bureau – The Bureau for Public Health in the Department of Health and Human Resources.

3.2. Child - A person less than eighteen (18) years of age.

3.3. Child Fatality Review Panel (CFRP) - A multidisciplinary group of professionals including representatives from public health, medicine, law and law enforcement, and child welfare that reviews the circumstances surrounding the deaths of children.

3.4. Commissioner – The Commissioner of the Bureau for Public Health or his or her designee.

3.5. Department - The West Virginia Department of Health and Human Resources.

3.6. Domestic violence fatality - An unnatural death precipitated by events surrounding a relationship among individuals who are family or household members as defined in W. Va. Code §48-27-204.

3.7. Domestic Violence Fatality Review Panel (DVFRP) - A multidisciplinary group of professionals including but not limited to representatives from public health, mental health, medicine, law and law

13.2.c. The Chief Medical Examiner in the Bureau for Public Health or his or her designee;

13.2.d. The Director of the Office of Vital Statistics in the Bureau for Public Health or his or her designee;

13.2.e. Representation from each of the three medical schools in the state;

13.2.f. The Director of Obstetrics, the Director of the Neonatal Intensive Care Unit and the Director of Pediatrics at each of the tertiary care hospitals in the state;

13.2.g. On representative from the West Virginia State Medical Association;

13.2.h. One representative from the West Virginia Nurses Association;

13.2.i. One representative from the West Virginia Society of Osteopathic Medicine;

13.2.j. One representative from the West Virginia Academy of Family Physicians;

13.2.k. One representative from the West Virginia Chapter of the American College of Nurse Midwives;

13.2.l. One representative from the West Virginia Chapter of the American College of Obstetrics and Gynecology;

13.2.m. One representative from the West Virginia Chapter of the American Academy of Pediatrics;

13.2.n. The Chairperson of the Child Fatality Review Panel; and

13.2.o. Any additional person that the chairperson of the IMMRP, or the Chairperson of the FMRT, determines is needed on a particular case under consideration by the panel.

13.3. The current membership of the IMMRP shall remain effective and authorized to carry out the duties described in this rule and the authorizing statute. In the future the FMRT shall appoint members to serve on the IMMRP and shall also appoint persons to fill vacancies on the Infant and Maternal Mortality Review Panel.

13.4. Each member shall serve for a term of five years.

13.5. Members of the Infant and Maternal Mortality Review Panel shall, unless sooner removed, continue to serve until their respective terms expire and until their successors have been appointed and have qualified.

13.6. An appointment of a physician, whether for a full term or to fill a vacancy, is to be made by the FMRT from among three nominees selected by the West Virginia State Medical Association or the organization to be represented on the panel. When an appointment is for a full term, the nomination is to be submitted to the FMRT not later than eight months prior to the date on which the appointment is to become effective. In the case of an appointment to fill a vacancy, the nominations are to be submitted to the FMRT within thirty days after the request for the nomination has been made by the FMRT to the chairperson or president of the organization. When an association fails to submit to the FMRT

nominations for the appointment in accordance with the requirements of this section, the FMRT may make the appointment without nominations.

13.7. Each member of the Infant and Maternal Mortality Review Panel shall serve without additional compensation and may not be reimbursed for any expenses incurred in the discharge of his or her duties under the provisions of this article.

13.8. The Office Director of the Office of Maternal Child and Family Health in the Bureau shall serve as the chairperson of the Infant and Maternal Mortality Review Panel, or his or her designee. The IMMRP shall review death certificates of infants and women sent monthly by the office of vital statistics.

13.9. Each member of the Infant and Maternal Mortality Review Panel shall examine the records of his or her agency to determine if the infant or woman received services at his or her agency, and if necessary, may contact other agencies to complete the review.

13.10. Panel members shall present to the rest of the Infant and Maternal Mortality Review Panel the information obtained from the record reviews, but shall retain the documents in each agency's files.

13.11. All documents regarding a particular case that are reviewed by the Infant and Maternal Mortality Review Panel shall be destroyed by the Panel after the publication of the FMRT annual report in which that case data is included.

13.12. The Infant and Maternal Mortality Review Panel members, in the exercise of their duties as defined in this subsection, may not:

13.12.a. Call witnesses or take testimony from individuals involved in the investigation of an infant or maternal fatality;

13.12.b. Contact a family member of the deceased infant or mother, except if a member of the panel is involved in the investigation of the death and must contact a family member in the course of performing his or her duties outside of the panel; or

13.12.c. Enforce any public health standard or criminal law or otherwise participate in any legal proceeding, except if a member of the panel is involved in the investigation of the death or resulting prosecution and must participate in a legal proceeding in the course of performing in his or her duties outside of his or her affiliation with the panel.

§64-29-14. Recommended Protocols for Panel Reviews.

14.1. The following are recommended protocols to aid in the review of unintentional pharmaceutical drug overdose, child, domestic violence and infant and maternal deaths by all four of the Fatality and Mortality Review Advisory Panels.

14.1.a. All Review Panel members shall sign a sworn statement promising to maintain the confidentiality of information, records, discussions and opinions disclosed during reviews.

14.1.b. The Review Panel may call for an immediate review of medical records requested from physicians and hospitals treating the person whose death is under review to try and determine causes and possible preventative measures related to the death.

Recommendations

- Add **Community Action Team** to the Review Panel like other state level Fetal Infant Mortality Review Panels (FIMRs).
- Add **family interviews** where infants have died as other FIMR's already do this.
- Build capacity, common language and narrative
- Will use the information from the review processes to inform communities on factors that contribute to disparities in infant and child outcomes, and, most importantly, to create tools and best practices to help communities translate those finding into action.
- Design or identify a method to engage in conversations necessary to address inequities created by adverse circumstances (e.g., poverty, racism, historical trauma, socioeconomic biases, etc.).
- Design activities that engage the community and stakeholders authentically (e.g., evening meetings, residents actively involved, etc.).
- Initiate study to explore relationship between adverse events over the life course of women in WV ages 18-45.

What are differences in (adverse) experiences over the life course between Black and White mothers in West Virginia?

Berkeley 21.4/1,000 live births

Cabell 21.1 /1,000 live births

Kanawah 8.8/1,000 live births

Do American-born Black mothers in Berkeley or Cabell county (where the Black IMR is high) and low income, American-born Black mothers in Kanawha county (where the Black IMR is low) experience different kinds of structural, institutional, policy-based or systems problems?

Hypotheses

POLL

Where Do you Do Most of Your Work?

- Downstream
  - Clinical or behavioral changes
- Midstream
  - Distribution of determinants of health
- Upstream
  - Changing the cultural toolkit
- Not sure

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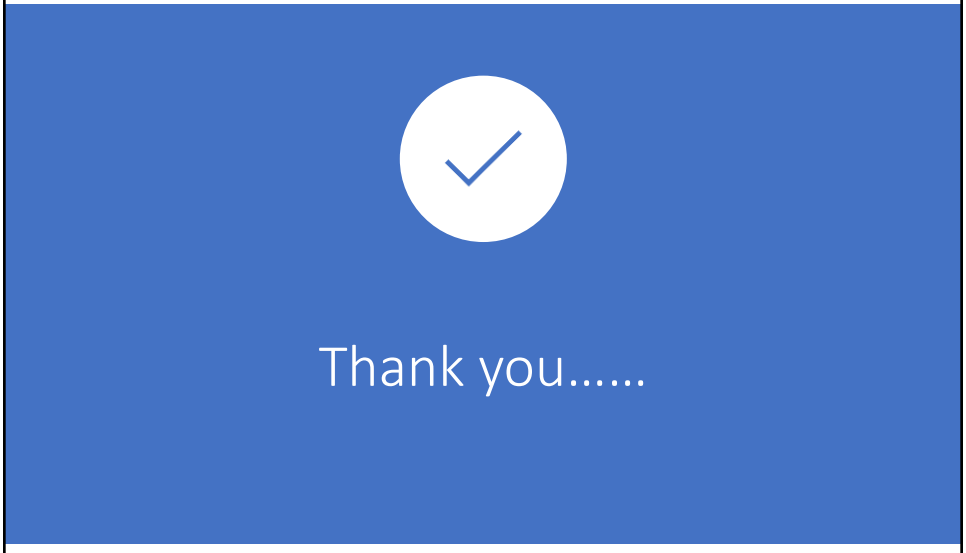
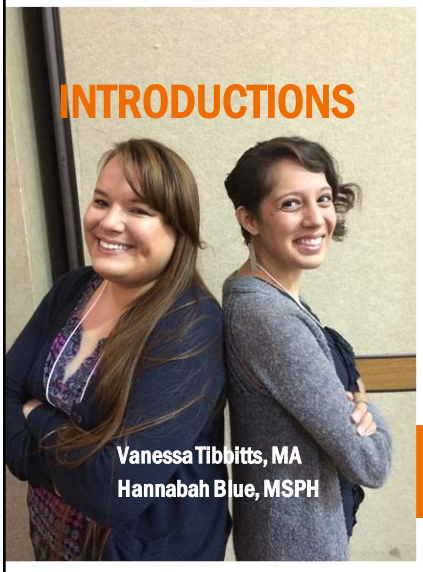


NOT JUST SURVIVING, BUT THRIVING

Cultural Practices that Promote Positive Maternal Health Outcomes for Native Women and Families

INTRODUCTIONS



Vanessa Tibbitts, MA
Hannabah Blue, MSPH

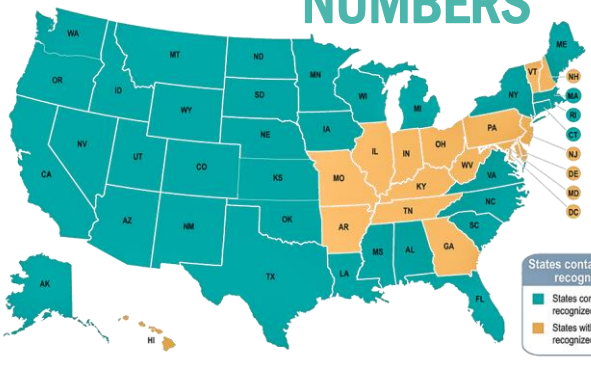
Happy National Women's Health Week!
Happy Mental Health Awareness Month!

9 RESERVATIONS IN THE STATE OF SOUTH DAKOTA


OGLALA LAKOTA COLLEGE
OGLALA LAKOTA COLLEGE
WOOKAHNIGE


BURRITOS
ICE

NATIVE PEOPLE BY THE NUMBERS



5.2 MILLION
NATIVE PEOPLE IN THE US

573
FEDERALLY RECOGNIZED TRIBES

100s
STATE AND UNRECOGNIZED TRIBES

50%
ESTIMATED AI/ANS LIVING IN URBAN AREAS

Federal Native Public Health Agencies

Cabinet-Level Federal Agencies

- Department of the Interior – Bureau of Indian Affairs
- Department of Health & Human Services – Indian Health Service & Administration for Native Americans
- Department of Justice – Tribal Justice and Safety & Office of Tribal Justice
- Environmental Protection Agency – American Indian Environmental Office
- Department of Housing & Urban Development – Office of Native American Programs
- Department of Veterans' Affairs – Office of Tribal Governmental Relations

Independent Regulatory Agencies

- Center for Disease Control and Prevention – Office for State, Tribal, Local and Territorial Support
- Substance Abuse and Mental Health Services Administration – Tribal Affairs, Tribal Technical Advisory Committee and Technology Transfer Centers
- Corporation for National and Community Service – The Strategic Advisor for Native American Affairs
- White House Executive Office of the President – Office of National Drug Control Policy

NATIONAL NATIVE PUBLIC HEALTH ORGANIZATIONS

- National Indian Health Board https://www.nihb.org/
- National Council of Urban Indian Health https://www.ncuih.org/
- National Congress of the American Indian http://www.ncai.org/
- Association of American Indian Physicians https://www.aaip.org/
- Seven Generations: https://www.indigenousphi.org/
- Urban Indian Health Institute https://www.uihi.org/
- Center for Native Youth https://www.cnay.org/
- National Native American AIDS Prevention Center https://www.nnaapc.net/
- National Native HIV Network https://www.hiv.gov/blog/time-commemoration-renewal-and-rebirth
- American Indian Public Health Resource Center https://www.ndsu.edu/centers/american_indian_health/

REGIONAL NATIVE PUBLIC HEALTH SYSTEMS

- Area IHS Offices
- Area Indian Health Boards
- Tribal Epidemiology Centers

Area Indian Health Boards / Tribal Epidemiology Centers

- Alaska Area: Alaska Native Health Board / Alaska Native Tribal Health Consortium Epidemiology Center, Anchorage, AK
- Albuquerque Area: Albuquerque Area Indian Health Board / Albuquerque Area Southwest Tribal Epidemiology Center, Albuquerque, NM
- Bemidji Area: Great Lakes Area Tribal Health Board, Gresham, WI / Great Lakes Inter-Tribal Epidemiology Center, Lac du Flambeau, WI
- Billings Area: Rocky Mountain Tribal Leaders Council / Rocky Mountain Tribal Epidemiology Center, Billings, MT
- California Area: California Rural Indian Health Board, Roseville, CA / California Tribal Epidemiology Center, Sacramento, CA
- Great Plains Area: Great Plains Tribal Chairmen's Health Board / Great Plains Tribal Epidemiology Center, Rapid City, SD
- Nashville Area: United South and Eastern Tribes, Inc. / USET Tribal Epidemiology Center, Nashville, TN
- Navajo Area: Navajo Nation Department of Health / Navajo Epidemiology Center, Window Rock, AZ
- Oklahoma Area: Southern Plains Tribal Health Board / Oklahoma Area Tribal Epidemiology Center, Oklahoma City, OK
- Phoenix Area: Inter Tribal Council of Arizona / Inter Tribal Council of Arizona Tribal Epidemiology Center, Phoenix, AZ
- Portland Area: Northwest Portland Area Indian Health Board / Northwest Tribal Epidemiology Center, Portland, OR
- Urban Indians: Urban Indian Health Institute (Tribal Epidemiology Center), Seattle, WA

STATE AND TRIBAL PUBLIC HEALTH SYSTEMS

- **STATE/LOCAL**
  - Tribal State and/or City Liaisons or Offices
- **TRIBAL JURISDICTIONS & RESERVATIONS**
  - Tribal Departments, Divisions, or Offices of Health
  - Tribal IRBs and Tribal Resolutions
  - Tribal Clinics: Direct Federal Service, Tribal Administration, Purchase and Preferred Care

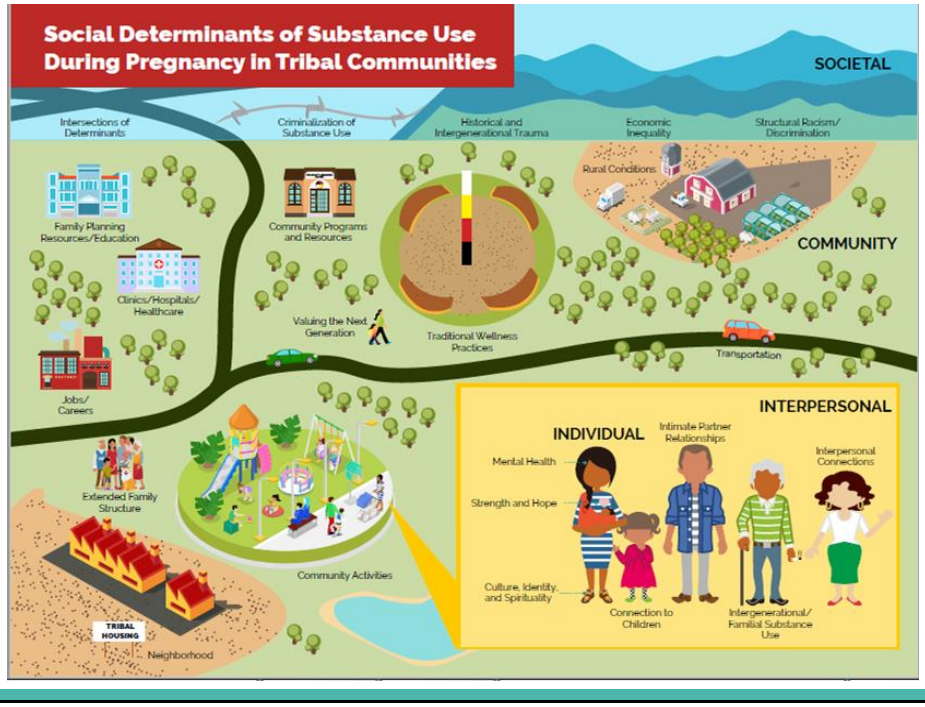
DISCRIMINATION IN AMERICA:
Experiences and Views of Native Americans

- About a 1/4 of Native respondents reported being discriminated against when visiting the doctor or clinic.
- Fifteen percent reported avoiding visiting the doctor due to fear of discrimination.
- Natives living in majority-Native areas were more than twice likely to report institutional discrimination and avoidance, than those living in non-majority Native areas.

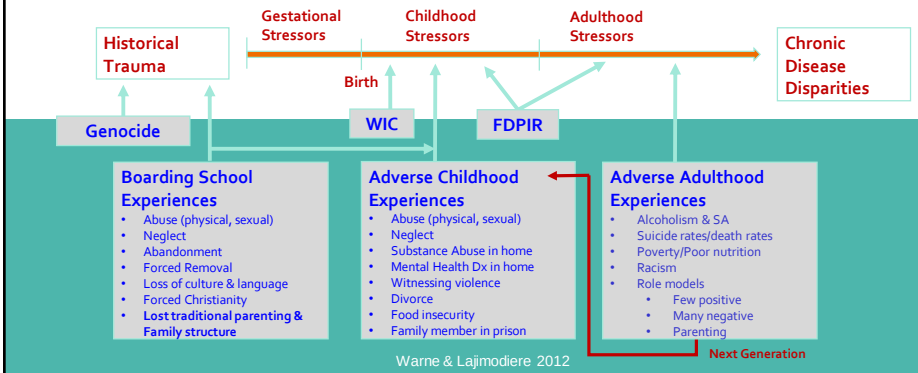
https://theforum.sph.harvard.edu/events/discrimination-in-america-2/
https://www.npr.org/documents/2017/nov/NPR-discrimination-native-americans-final.pdf

MATERNAL, PARENT & CHILD HEALTH DISPARITIES

- Health and birth and death records underreport racial classifications for Natives
- In 2015, Native infant mortality was 8.3 per 1,000 births compared to that of White babies at 4.9 deaths per one thousand births. Infant mortality rates declined for infants of all races except for American Indians.
- Native infants are twice as likely as White infants to die from Sudden Infant Death Syndrome (SIDS), and are 70 percent more likely to die from accidental deaths before the age of 1.
- Maternal mortality rates for Urban Native women was 4.5 times greater than White women.
- Native women are 2.5 times more likely to receive late or no prenatal care compared to white mothers.

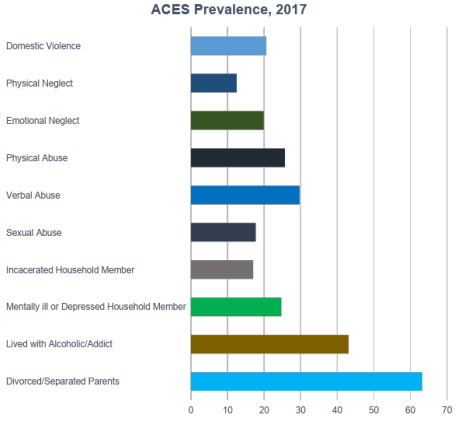


Inter-Generational Basis for Chronic Disease Disparities Among American Indians & Alaska Natives



Warne & Lajmodiere 2012

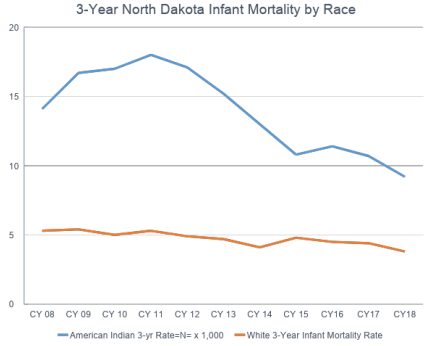
Adverse Childhood Experiences

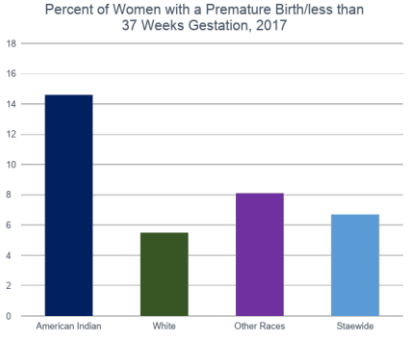


- 31% of American Indian women had an ACE Score of 4 or more
- Divorced or separated parents was the most common ACE at 63%
- Closely followed by living with a person with a substance use disorder at 43%
- Physical and verbal abuse about 28%

North Dakota PRAMS 2019

North Dakota Birth Outcomes





- 7% of all births were premature
- American Indian infant more likely to be born premature than non AI at 14%
- 4 per 1,000 White infant deaths vs. 9 per 1,000 American Indian infant deaths ND Department of Health

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Rewire.News

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ANALYSIS MATERNITY AND BIRTHING

Amid Staggering Maternal and Infant Mortality Rates, Native Communities Revive Traditional Concepts of Support

Jul 9, 2018, 11:05am Mary Annette Pember

"They say that historical trauma is in the DNA of Native peoples, but love is in there too. We need to focus on that and bring it to the surface."

"We stopped keeping statistics on the number of Native moms and babies that are lost in our region; it was just too upsetting," said Millicent Simenson, co-founder of Mewinzha Ondaadiziike Wigaaming.

In light of growing awareness of the negative impact of institutional racism on health for women of color, especially Black women, a new analysis argues the experience of Native American women closely parallels that of African American women. An emerging community-centered and culturally relevant response is offering families hope amid staggering rates of maternal and infant mortality.

Mewinzha is a Native American holistic care center for pregnant, birthing moms and their families in Bemidji, Minnesota. Simenson, of the Mandan Hidatsa and Arikara tribes, and her partner at Mewinzha, Roberta Decker of the Leech

Jayceanna Charnoski, 3 weeks, tries her new cradleboard on for size at the Welcoming Baby Ceremony on the Leech Lake Reservation in Minnesota. Parents and Leech Lake tribal members Geraldine Fairbanks and John Charnoski won the cradleboard made by elder Mike Smith during the Welcoming Baby Ceremony.
Mary Pember

https://rewire.news/article/2018/07/09/amid-staggering-maternal-infant-mortality-rates-native-communities-revive-traditional-concepts-support/

- Cradle Boards
- Spirituality and Cultural Practices
- Ceremonies
  - Baby's First Laugh (Dine')
  - Welcoming Baby (Ojibwe)
- Breastfeeding as Food Sovereignty and First Food
- Matriarchal and Matrilineal
- Multigenerational Households

PUBLIC HEALTH

Combating "Maternal Health Mysticism" in Native American Communities

OCTOBER 17, 2019 • NICOLLE L. GONZALES, CNM

As a Navajo Nurse-Midwife, when I attend seminars and conferences I can count on being asked a particular question in each and every setting, and it sounds something like this:

"What traditional birthing practices do Native women have?" It almost feels like they expect me to reach into a pouch and pull out a handful of herbs or a vial of potions, or perhaps utter some incantation in my tribal language.

https://www.aspeninstitute.org/blog-posts/combating-maternal-health-mysticism-in-native-american-communities/

"What traditional birthing practices do Native women have?" It almost feels like they expect me to reach into a pouch and pull out a handful of herbs or a vial of potions, or perhaps utter some incantation in my tribal language.

Sitting Bull Tribal College
Lakota Language Immersion Nest
https://sittingbull.edu/immersion-nest/

https://www.mewinzha.com/

- Doulas and Midwives
- Language
- Value of Elders and Youth
- Storytelling, Art and Creative Expression

Many Other Successful Programs

TEWA WOMEN UNITED
Indigenous Women United in Heart, Mind and Spirit

TRIBAL HOME VISITING

STRATEGIES TO ENGAGE & SUPPORT NATIVE PEOPLE

- Seek to ensure mutually beneficial partnerships through relationship building
- Beyond trauma-informed care, promote Native strengths
- Honor Tribal sovereignty and systems
- Seek to understand and acknowledge history, lands and context of Native people
- Combat stereotypes, while honoring Native diversity

LEARN MORE!

- **REPORTS AND RESOURCES**
  - NCAI 2020 State of Indian Nations
  - NIHB Listservs and Newsletters
  - 2019 State of Native Youth Count Report
  - ACOG Health Care for Urban AI/AN Women
  - National Tribal Behavioral Health Agenda
  - 'Celebrating our Magic' Native LGBTQ2S
  - CDC Racial and Ethnic Disparities Continue in Pregnancy-Related Deaths
  - Tapping Tribal Wisdom: Providing Collaborative Care for Native Pregnant Women With Substance Use Disorders and Their Infants
- **WEBSITES**
  - Area IHS offices
  - Area Indian Health Boards
  - Tribal Epidemiology Centers
  - State-Tribal Liaisons and Departments
  - Tribal IRBs, if needed
  - IHS Maternal Morbidity and Mortality
  - Healthy Native Youth
  - We R Native
  - Find IHS Clinics (including Behavioral Health Services)
  - Strategies for Effectively Working with American Indian and Alaskan Native (AI/AN) Communities
  - Best Practices in American Indian & Alaska Native Public Health
  - Healthy Native Babies Project
  - Association for American Indian Physicians

PILAMAYAYÉ

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www.ndsu.edu/centers/american_indian_health/

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AAMC Health Equity Research and Policy

AAMC Maternal Health Equity Webinar Series

Part One: Context Past & Present
Thursday, May 14, 2020
1:30-2:30 p.m. ET
WATCH THE RECORDING
bit.ly/3bsCHrw

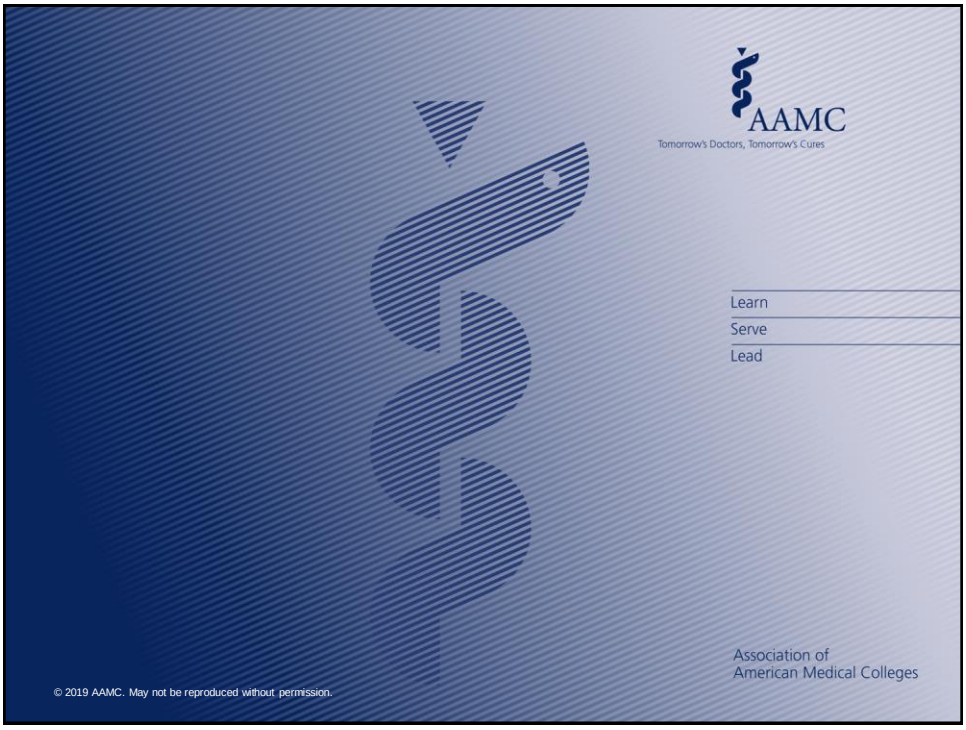
Part Three: Immigrant Maternal Health Equity
Wednesday, June 24, 2020
1:30-2:30 p.m. ET
REGISTRATION COMING SOON

This series highlights the unique role of academic medicine in the fight for maternal health justice and features physicians, community leaders, and researchers who are committed to eliminating inequities.

LEARN MORE

Thank you

healthequityresearch@aamc.org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