CULTURAL SAFETY PRACTICES FOR WORKING WITH INDIGENOUS BIRTH GIVERS IN MONTANA

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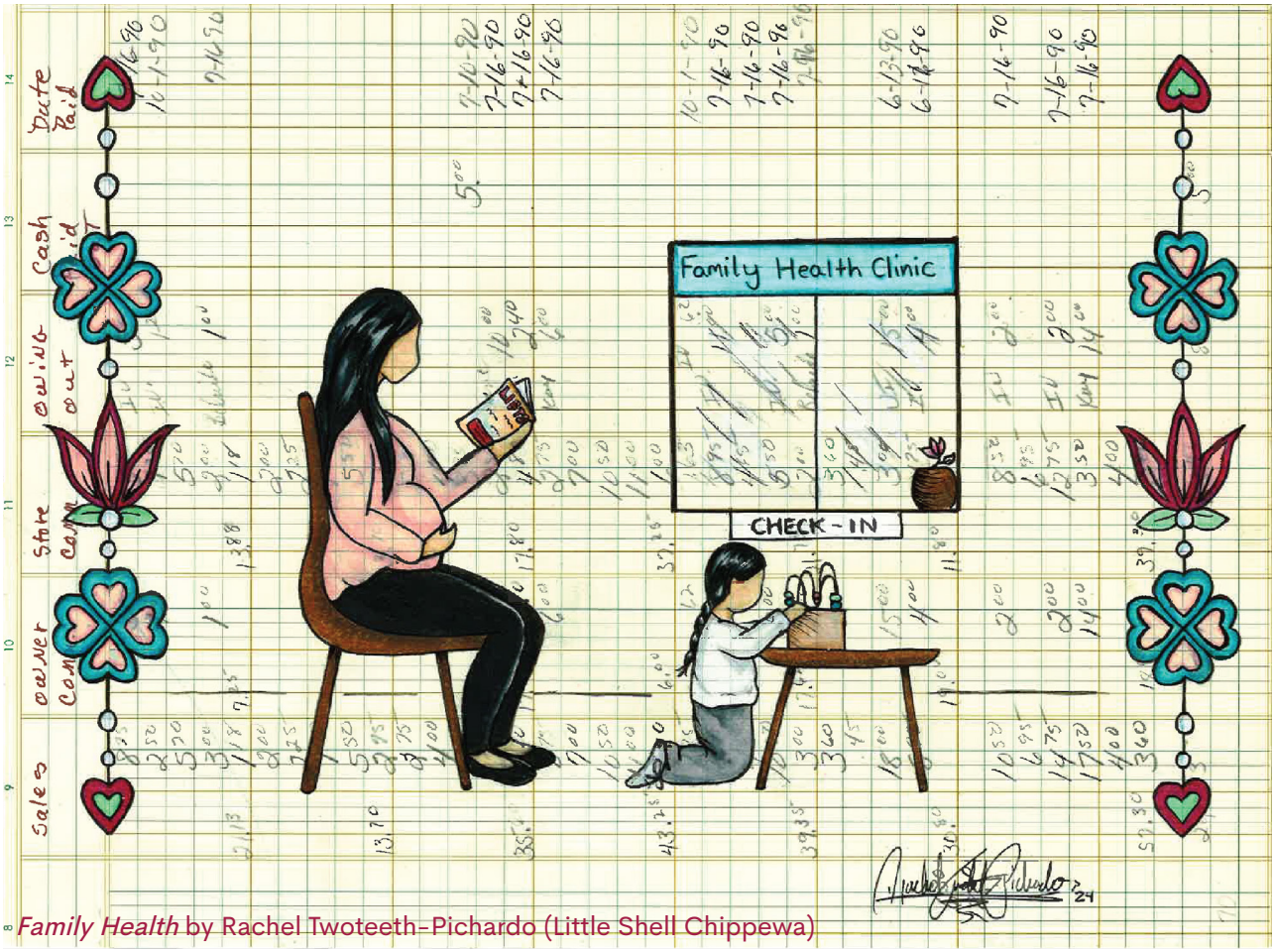

Family Health by Rachel Twoteeth-Pichardo (Little Shell Chippewa)

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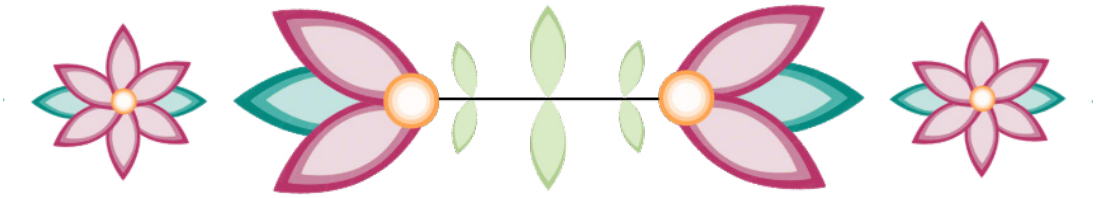
TABLE OF CONTENTS



POSITIONALITY

Naha (hello)! My name is Amy Stiffarm and I am Aaniiih (Whiteclay) from the Fort Belknap Indian Community in north central Montana. I am also Chippewa Cree and Blackfeet. This toolkit was created as part of my dissertation in practice for the University of North Dakota Indigenous Health PhD Program.

When I first began working on my PhD, I had no intention of creating such a resource. However, as I moved on in my studies and began working more with perinatal organizations in Montana it became apparent that more information on cultural safety was needed and wanted! The topic of my dissertation is perinatal mental health for Indigenous women and birthing people. Cultural safety is important for perinatal mental health as it creates an avenue for non-Indigenous providers and western practitioners to better understand the Indigenous people they serve and rebuild trusting relationships with their patients. When trusting relationships exist, Indigenous women and birthing people will feel safe to discuss their history and symptoms of mental health during the perinatal period.

I chose to focus on perinatal mental health because of my personal experience. I suffered from prenatal depression when I was pregnant with my second daughter, and experienced both depression and anxiety postpartum. I was too afraid to be honest with my providers about my history and experiences, even though they were kind people. I didn't disclose my history of depression and I didn't realize how it would impact me during my pregnancy and parenthood. I also felt like I suffered so much in isolation due to stigma, shame, and fear of judgment. This severely impeded me from accessing help. I chose to study the Indigenous experience of perinatal mental health with the hope that I could make a difference and improve the outcomes and experiences for other Indigenous women and birthing people.

When completing this toolkit, I received a small grant from the University of North Dakota Graduate School to solicit feedback on the content. I am grateful to those who took time to read the drafts and provide me with guidance on how to improve the toolkit.

I hope that this toolkit provides you with the information necessary to better serve Indigenous women and birthing people during the perinatal period. Ginehayan (thank you).

-Amy Stiffarm, PhD, MPH
Director of Native American Initiatives

FUNDING DISCLOSURES

I was able to finalize this toolkit while working as the Director of Native American Initiatives at Healthy Mothers, Healthy Babies- the Montana Coalition (HMHB). HMHB allocated funding from the following sources in order to support this work. As the author, I retain all rights related to intellectual property.

This toolkit was sponsored in part by Billings Clinic through a contract with the Montana Department of Public Health & Human Services. The contents are those of the authors and do not necessarily represent the official views of, nor an endorsement by HRSA, HHS, the US Government, or the State Government of Montana. This project is supported by HRSA of the US Department of HHS State Maternal Health Innovation Program (U7AMC33718) as part of an award totaling $9.6 million designed to improve maternal health outcomes, with 0% financed with non-governmental sources.

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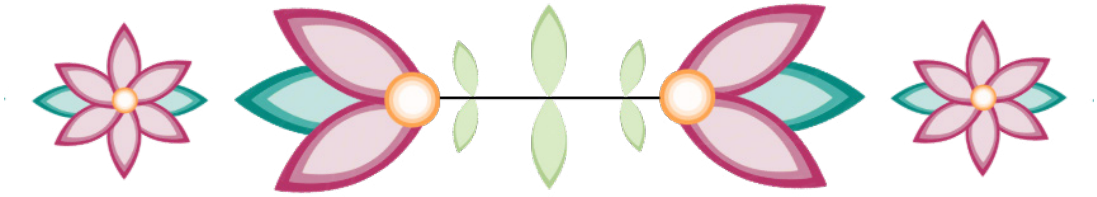


PART 1: OVERVIEW

WHO WILL BENEFIT FROM THIS TOOLKIT?

This toolkit was inspired by a request from the Montana Obstetrics Maternal Support Program which was funded by the Health Resources and Services Administration (HRSA) Maternal Health Innovation Program. While presenting to their leadership council on topics relevant to Indigenous maternal health, cultural safety was mentioned as a means to strengthen support for Indigenous Peoples seeking perinatal health care, or care during pregnancy, birth, and the postpartum period. The Montana Obstetrics Maternal Support Program wanted to learn more about cultural safety and how it could help Indigenous Peoples in Montana. Since then, more research has been carried out and requests continue to be made by other providers and organizations wishing to learn more about cultural safety. This toolkit is designed for all providers that serve Indigenous birthing people during the perinatal period. Most of the examples, exercises, and resources are relevant to Montana, but the toolkit may also be helpful for out of state groups looking for a place to start. If you, your clinic or organization are currently providing care or services to Indigenous women and birthing people in Montana, this toolkit is for you. Examples of providers this toolkit may benefit include: Family Practitioners, Nurses, OBGYNs, Therapists, WIC Counselors, Home Visitors, Lactation Consultants, Midwives, Doulas, Social Workers, and other individuals that seek to broaden their understanding of cultural safety to help better serve Indigenous Peoples.

WHAT YOU WILL LEARN?

The overall goal of creating this toolkit is to better inform providers on how to implement culturally safe care to Indigenous patients and clients during the perinatal period. Due to systematic education issues that fail to properly acknowledge non-dominant cultures, many people lack foundational knowledge about the Indigenous populations in Montana. We cannot address perinatal health issues until we are fully informed on the circumstances that created the environment for significant health inequities to occur. Even more important for Indigenous perinatal health is the cultural knowledge and strengths that are relevant to pregnancy, birth, and the postpartum period. We need to understand historical contexts to truly understand the power dynamics at play when Indigenous birth givers come to our clinics and offices. We will also learn more about data collection with Indigenous communities and considerations for planning a project that includes data or research. Later in the toolkit we will dive deeper into the principles of cultural safety and outline steps we can take to implement culturally safe care. Lastly, we will learn about ways to systematically incorporate cultural safety tenets into our organizations. Exercises are provided for most of the topics discussed in the toolkit. The exercises and other resources listed are by no means exclusive and are meant to get you started on exploring the basics of cultural safety in Indigenous perinatal health. The resources can also be useful in taking a deeper dive into subjects of interest.

WHAT IS CULTURAL SAFETY?

Cultural safety seeks to achieve better care through improving the awareness of power relationships, implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe (Curtis, 2019).

Continuous critical reflection and commitment to addressing power imblances experienced by oppressed people are ways to promote cultural safety (Hall et al., 2023). Cultural safety is an expansion of cultural competence (see definition in Table 1). However, "cultural competence" has been increasingly scrutinized due to the risk of advancing the false idea that someone could ever truly become "competent" in someone else's culture thereby reducing understandings of Indigenous culture to merely sets of skills and behaviors (Curtis, 2019). Cultural safety acknowledges power dynamics that are crucial to understand in order to provide equitable and quality care. Table 1 provides the definitions of other terms that are sometimes used in varied forms of professional training to help better serve Indigenous Peoples. While cultural humility and cultural safety both acknowledge power dynamics, cultural safety will be the term used for the purpose of this toolkit. The goal with the toolkit is to ensure that Indigenous women and people who give birth feel safe in their interactions with providers.

TERMINOLOGY & LANGUAGE

Language is powerful and important for patient and client care. Many Indigenous cultures recognize that there is power in the words that we use. Because of the power of language, it is important to practice using accurate and respectful terminology when engaging with patients and clients. Terminology can be complex and difficult to make changes to. We recognize these challenges but urge you to practice the terminologies and language examples described below.

Indigenous:

A study from the United Nations defined Indigenous Peoples by stating the following: Indigenous communities, peoples and nations are those which, having a historical continuity with pre-invasion and pre-colonial societies that developed on their territories, consider themselves distinct from other sectors of the societies now prevailing on those territories, or parts of them. They form at present non-

TABLE 1: Definitions Relevant to Cultural Safety

TERM	DEFINITION
Cultural Awareness	Acknowledgement of differences in cultures.
Cultural Sensitivity	Builds off cultural awareness by adding the importance of respecting other cultures.
Cultural Competence	Fusion of both cultural awareness and sensitivity while adding behaviors, attitudes, and policies that support working with diverse populations. (Darroch et al., 2017).
Cultural Humility	A lifelong commitment to self-evaluation and critique, to redressing power imbalances...and to develop beneficial and non-paternalistic partnerships (Tervalon & Murray-Garcia, 1998).
Cultural Safety	Having awareness of power relationships and addressing them by implementing reflective practice, and by allowing the patient to determine whether a clinical encounter is safe (Curtis, 2019).

dominant sectors of society and are determined to preserve, develop and transmit to future generations their ancestral territories, and their ethnic identity, as the basis of their continued existence as peoples, in accordance with their own cultural patterns, social institutions and legal system (Martinez Cobo 1983).

There are over 476 million Indigenous Peoples globally, spanning across 90 countries (United Nations, n.d.). In the United States alone, there are over 9.7 million people who self-identified as American Indian or Alaska Native alone or in combination with other races in the 2020 census (US Census Bureau, 2022). Indigenous Peoples account for 2.9% of the population in the United States (US) (US Census Bureau, 2022). As of 2020 there are currently 574 federally recognized Tribes in thirty-five states in the US (National Congress of American Indians (NCAI), 2020). Tribal Nations that are not federally recognized sometimes will get recognized by the state. There are currently sixty Tribal Nations in the US that have state recognition (NCAI, 2020). State recognition is usually achieved through legislative action, as a way of building state-Tribal collaborations and acknowledging historical and cultural contributions. State-recognized Tribes do not have the same federal rights as federally recognized Tribes. Specific to Montana, the Little Shell Tribe of Chippewa Indians received state-recognition from Montana in 2000 and gained federal recognition in 2019 via the National Defense Authorization Act (Montana Little Shell Tribe, n.d.). Their Tribal headquarters is in Great Falls, MT. Nationally, federally, and state-recognized Tribes encompass 334 reservations (NCAI, 2020). However, it is important to note that not all Tribal Nations have formal recognition by the respective state or the US government. All of these noted groups of Indigenous Peoples (recognized or unrecognized) have cultures that are specific and unique to their respective nation, community, family, etc. so it is important to recognize the variability among Indigenous cultures.

Amanda Lott (Aaniiih and Nakoda) and Brayden Oats (Chippewa-Cree) with infant Takoa Oats

There are many different terms you may have heard or come across that describe Indigenous Peoples in the US. *Indigenous* is a term used to describe people who are original inhabitants of the land. This is the case for Tribal Nations in the US. *American Indian* and *Alaska Native* are the legal terms that are used in Federal Indian policies and law, and in many health data sets and is abbreviated as *AIAN*. However, some Indigenous Peoples may disagree with the term *American Indian* because it can be seen as being politically incorrect by the fact that the Indigenous Peoples that lived in what would become America were termed *Indians* because

Christopher Columbus thought he landed in India (US National Park Service, 2022). European contact by Columbus and other explorers like him had devastating impacts to Indigenous Peoples, so some Indigenous Peoples prefer not to be called *Indian*. Additionally, it is recommended to not celebrate Columbus and other explorers like him as celebrating exploration that resulted in colonialism, dismisses the immense losses experienced by Indigenous Peoples. Instead, opt for celebrating Indigenous Peoples' Day (The Smithsonian, 2023). *Native American* is also a term commonly used. Some Indigenous Peoples may take issue with the fact that American is used at all as America is named after the Italian explorer Amerigo Vespucci, who was said to be the first to "discover" the New World (Library of Congress, 2003).

Additionally, you may hear the term *Turtle Island* commonly used by some Indigenous Peoples to describe what is now known as North America. *Indian County* is also a common term used to describe anywhere, rural or urban, where Indigenous Peoples live. Furthermore, recognizing that Indigenous Peoples existed prior to America, many people prefer the term *Indigenous*, and this term is becoming much more common. The terms *American Indian, Indian, Native, Native American* and *Indigenous* are all generally acceptable, but people often prefer to be called by their specific Tribal name. More information on specific Tribal names for the Tribal Nations in Montana will be provided later in the toolkit. It's important to recognize that each Tribe has its own unique name. We'll learn later that an important part of cultural safety is to learn how your patients and clients choose to identify. It could be different than the federally recognized name of your patient's or client's Tribe. Some communities have preferred terms for their Tribal Nation, it is important to know your patient's or client's preference for the term to use when acknowledging their nation.

When using terminology for Indigenous Peoples in written form, it's important to also consider capitalization. *Elements of Indigenous Style* is a writing guide by and about Indigenous Peoples and asserts clearly that any term relating to Indigenous identity, institutions, or rights should likely be capitalized (Younging, 2018). Capitalization recommendations from Younging's (2018) style guide state that:

- The term Indigenous should always be capitalized;
- When referencing multiple Tribal Nations use the term Indigenous Peoples;
- When referencing a distinct Tribal Nation, Idigenous People should be used;
- Indigenous people refers to people who identify with a Tribal Nation but is used in a context where their specific affiliation or identity is not an issue (Younging, 2018).

Gender Inclusive Language:

Before the US was colonized, Indigenous communities recognized that many genders existed on this land. Eurocentric worldviews are based on physical traits that reflect a rigid dichotomy of boy or girl. An Indigenous worldview of gender is not dichotomous but more fluid. Instead, gender is based on a person's spirit or gift. Two-spirit is often used to describe someone with both masculine and feminine spirits. When discussing people who give birth, the terms *birthing people* or *birth givers* can be

used to be inclusive of all genders that give birth. Using inclusive language is crucial when working with Indigenous communities especially when discussing sensitive topics such as perinatal mental health. Words have power, therefore we must be careful with how we use language and make sure our words do not cause harm. Not being inclusive of all people that give birth can cause additional harm to people that are already marginalized by health systems (Re:searching for LGTBQ2S+ Health, n.d.). The terms *birth giver* or *birthing person* recognizes the person's sacred ability to give birth and bring life into this world.

Based on Strengths:

Much of the past research and work relevant to Indigenous Health in the US is deficit based, where an emphasis is put on poorer health outcomes in one group as compared to another group (Hyett et al., 2019). Deficit-based narratives are harmful because they can perpetuate negative stereotypes. When we only talk about, write about, and hear about negative qualities from a group of people, it's easy to believe that only negative traits exist among that group. There are many strengths within Indigenous communities. Indigenous cultures have enabled Indigenous Peoples to survive through much adversity despite negative policies by the federal government and other impacts of colonization that will be discussed later in this toolkit. Camie Goldhammer (Sisseton-Wahpeton Oyate), founder and director of Hummingbird Family Services and a leading voice for Indigenous maternal health often says, "There's nothing wrong with Native Women. We are perfect the way we are and like all mothers, we want the best for our babies. It's the system that is failing *US* [Native Women]" (Goldhammer, 2022). When we stop placing blame on communities for disparate situations and hold space for communities to determine their own solutions, we will find knowledge and resources that may have been overlooked by western research and medicine.

We know there are disparities that exist and these need to be clearly acknowledged and addressed, however, we must be careful when talking about and discussing disparities to avoid placing blame on individuals and communities. The continued focus only on deficits in research with Indigenous Peoples is problematic as it makes it appear as though being Indigenous automatically puts you at risk for poor outcomes while minimizing the inherent strengths that Indigenous Peoples have. We must move beyond only identifying individual risks and instead seek to better understand why various risks exist collectively amongst Indigenous Peoples and communities.

LEARNING EXERCISES

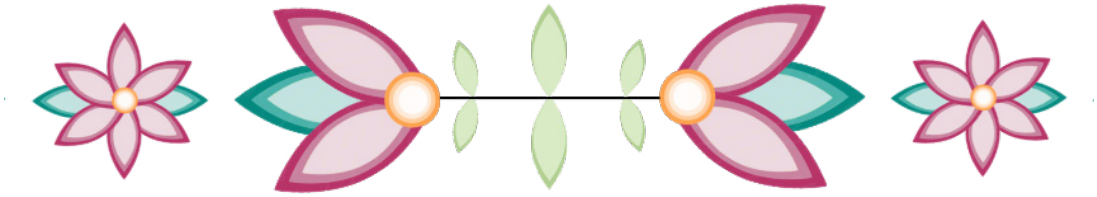
1. Follow the link below to learn about the Indigenous Milk Medicine Collective and their use of inclusive language: https://lllusa.org/an-update-on-indigenous-milk-medicine-week/

2. Please follow the link of at least one of the resources listed below to learn more about inclusive language and proper terminology use:

RESOURCES FOR LEARNING MORE

TRIBAL NATIONS AND USING RESPECTFUL LANGUAGE

1. To learn more about Tribal Nations in the US please see "Tribal Nations and the United States: an introduction" created by the National Congress of American Indians: https://www.ncai.org/tribalnations/introduction/Indian_Country_101_Updated_February_2019.pdf
2. The Smithsonian's Native Knowledge 360° Education Initiative has additional resources to learn new perspectives on Native American history and cultures. They also have a helpful FAQ section: https://americanindian.si.edu/nk360/about/native-knowledge-360
3. For tips on using appropriate terminology for Indigenous Peoples, please see this resource from The Smithsonian: https://americanindian.si.edu/nk360/informational/impact-words-tips#:~:text=American%20Indian%20or%20Native%20American,would%20like%20to%20be%20addressed
4. News Article on the Historical Federal Recognition of the Little Shell Tribe of Chippewa Indians: https://www.greatfallstribune.com/story/news/2019/12/20/montana-little-shell-tribe-chippewa-indians-federal-recognition/2439763001/
5. Mental Health Technology Transfer Center (MHTTC) Recovery-Oriented Language Toolkit: https://mhttcnetwork.org/sites/mhttc/files/2020-08/Final%20Peer%20Language%20Toolkit.pdf
6. Mental Health Technology Transfer Center (MHTTC) Racial Equity and Cultural Diversity Toolkit: https://mhttcnetwork.org/centers/global-mhttc/racial-equity-and-cultural-diversity-toolkits.
7. Elements of Indigenous Style Guide:
   Younging, G. (2018). *Elements of indigenous style a guide for writing by and about indigenous peoples*. Edmonton, Alberta: Brush Education.
8. CDC Health Equity Guiding Principles for Inclusive Communication:
   https://www.cdc.gov/healthcommunication/Health_Equity.html
9. Re:Searching for LGTBQ2S+ Health:
   "Two-Spirit Community." Re:searching for LGBTQ2S+ Health.https://lgbtqhealth.ca/community/two-spirit.php



PART 2: HISTORICAL CONTEXT


Bear Star Photography

Racial health equity is defined by the Centers for Disease Control and Prevention (CDC) as the state in which everyone has a fair and just opportunity to attain their highest level of health (Centers for Disease Control Health Equity Office, 2022). The CDC also acknowledges that to achieve health equity, systems and policies that have created injustices resulting in racial and ethnic health disparities must be addressed. We often hear of racial disparities regarding the health of Indigenous Peoples, but we don't always get the full picture of why these disparities exist. Racial disparities for Indigenous Peoples in the US are rooted within various historical impacts that will be discussed in this section of the toolkit. In this section you will learn crucial parts of history that many of us were not taught in school. Learning these contexts will allow us to better understand beliefs and behaviors that Indigenous patients and clients might have that impact the care they access or receive. There is much to learn about the systems that have created an environment that lacks trustworthiness from Indigenous Peoples. We will walk through each of the various eras of Federal Indian Policy and learn specific examples of how these polices impact perinatal health. Please note that the exact dates and years of the various Federal Indian Law periods or eras vary among the literature. For the purpose of this toolkit, we will abide by the periods and dates provided by the Montana Office of Public Instruction's Indian Education for All curriculum and honor the expertise of the curators of the educational materials (MT Office of Public Instruction (MT OPI), 2019).

DOCTRINE OF DISCOVERY & COLONIZATION PERIOD (1492-1800S)

The Doctrine of Discovery was the basis for land acquisition of Turtle Island including

what is now known as the US. The Doctrine of Discovery was used to justify the colonizing and the taking of lands that were not inhabited by Christians and was first issued via decrees from Popes' from 1452-1493 (Chappell, 2023). The decrees authorized Spain and Portugal to seize lands and dominate people in the lands of Africa and Turtle Island. Colonialism is different than settler-colonialism in that while colonialism seeks to acquire control over other's lands, settler-colonialism's goal is to remove Indigenous Peoples from the land so that settlers can occupy the land instead (Morris, 2019). When settler-colonialism is viewed as the practice of non-Indigenous people living on appropriated land we can recognize that settler-colonization isn't just history but is actually an ongoing practice occurring today (Morris, 2019). In 1823, the Doctrine of Discovery was invoked in a US Supreme Court ruling that Indigenous Peoples only had rights to occupy the land, not own it (Miller, 2005; Frichner, 2010). The Supreme Court ruling opened the land that Indigenous Peoples have long lived in relationship with to settlers to own. The sacred relationships between Indigenous Peoples and specific land is noted in many Tribes' creation stories as they include specific landmarks across Turtle Island. It is important to note that many Indigenous cultures value land, not by which to take ownership of it, but by having a sacred relationship with it (Kimmerer, 2015).

The colonizing of the US and other settler-colonial state lands was done through war tactics aimed at Indigenous birthing people. *Reproduction on the Reservation*, gives historical accounts of Unites States war officers explaining their practice of killing Indigenous women and children as a means to exterminate the Indigenous populations as a whole (Theobald, 2019). Therefore, violence on Indigenous women's and birthing people's bodies was seen as a necessity to establishing the US. Colonial violence was the beginning of the Missing and Murdered Indigenous Women (MMIW) epidemic. Today, it is estimated that four of five Indigenous women or girls will be a victim of violence in their lifetime in the US (National Indigenous Women's Resource Center, 2022). Equally alarming, is the lack of federal help to locate missing Indigenous women and girls. In 2016, the National Crime Center reported that there were over 5,700 reports of Indigenous women and girls missing in the US but only 116 cases in the Department of Justice's federal missing person database (Native Hope, n.d.). MMIW is an epidemic that many Indigenous birthing people are well aware of and many live in fear for themselves and their children. Montana has the 5th highest missing and murdered girls and women in the country (Lucchesi, A. & Echo-Hawk, A., 2018). Making the effort to learn about the current issues faced by Indigenous women and girls is imperative to better serving Indigenous birthing people.

Baby Moccasins
Photo submitted by Shawnalea Chief Goes Out (Aaniiih, Chippewa-Cree, Western Shoshone)

OUR CRADLEBOARD

Miquela Perez (Nakoda)

I based this off the cradleboard my grandma made for me when I was born. All three of my siblings slept in it and our three daughters all slept in it. That's my daughter in the drawing.

It was not until 2023 that the Vatican rebutted this justification to colonialism, stating, "The Catholic Church therefore repudiates those concepts that fail to recognize the inherent human rights of Indigenous peoples, including what has become known as the legal and political 'doctrine of discovery.' " A quote from the Pope's visit to Canadian residential schools was also cited in the repudiation, "Never again can the Christian community allow itself to be infected by the idea that one culture is superior to others, or that it is legitimate to employ ways of coercing others" (Chappell, 2023).

White Supremacy and racism are the foundations of colonization. The historical process and ideas behind initially colonizing Indigenous Peoples is rooted in the belief that western, Eurocentric ways of being are superior or normal and that anything else is inferior or alternative. Colonization is still a contemporary issue as racism continues to impact health. Redvers et al. (2020) describes Eurocentrism as a worldview that is centered on Western civilization and points out how many health and educational institutions are rooted in Eurocentrism. Eurocentrism in health practice creates circumstances where medicine and research are often conducted in a western way that only recognizes Eurocentric ideals. While the Doctrine of Discovery has officially been denounced, its impact on Indigenous knowledge systems is felt today, especially in the ways that perinatal health is commonly approached.

LEARNING EXERCISES

1. Read this article about the Doctrine of Discovery: https://www.npr.org/2023/03/30/1167056438/vatican-doctrine-of-discovery-colonialism-indigenous

2. Follow this link to learn more about Missing and Murdered Indigenous Women: https://www.nativehope.org/missing-and-murdered-indigenous-women-mmiw

TREATY-MAKING AND REMOVAL PERIODS (1778 - 1871)

Treaties were made to end violence and cede land from Indigenous Peoples. Within these treaties were promises of health care among other promises such as education, hunting rights, etc. These promises for health care didn't become formalized until the passing of the Snyder Act in 1921 (National Indian Health Board, n.d.). This legislation solidified the US trust responsibility to provide health care to federally enrolled Indigenous Peoples in the US and the Indian Health Service (IHS) was created to facilitate this obligation. During the Treaty-Making and Removal time periods, 367 treaties were ratified (Prucha, 1994). The treaties were created between the US government and distinct, sovereign Tribal Nations. The recognition of tribal sovereignty asserts that treaty law is the supreme Law of the Land and situates the treaties with Tribal Nations above the laws and jurisdiction of states. Treaties that affect Montana Tribal lands are shown in Table 2.

TABLE 2: Treaties and Tribes in Present-day Montana (Montana Office of Public Instruction (MT OPI), 2019)

TREATY	MONTANA TRIBES
Fort Laramie Treaty of 1851	Dakota, Cheyenne, Assiniboine and Crow
Hellgate Treaty of 1855	Salish, Kootenai, Pend Oreille
Lame Bull Treaty of 1855	Blackfeet
Fort Belknap Treaty of 1866	Aaniiih (Gros Ventre) and Nakoda (Assiniboine)
1868 Agreement with the Gros Ventres	Aaniiih (Gros Ventre)

Land Acknowledgments

The map depicted in Figure 1 illustrates the original Tribal territories and the current reservations in Montana. This map and other similar maps are often used when creating land acknowledgments. Land acknowledgments are meant to be thought provoking exercises for folks whose ancestors are not the original habitants of specific lands and places. The act of acknowledging Indigenous land is the very least we can do. Many institutions and organizations in Montana have made statements to acknowledge land. Please note that it is not appropriate to ask Indigenous Peoples to publicly acknowledge their own homelands. Instead, effort should be made by non-Indigenous people and organizations to do the work of gathering the information and creating an appropriate land acknowledgment. Asking Indigenous Peoples to do the work of creating land acknowledgment statements or reusing blanket land acknowledgments can cause harm. Use the opportunity to learn about the land being acknowledged and which people had to sacrifice and endure hardships so an organization, a building, a town, etc. could occupy the land.

Furthermore, a land acknowledgement should also be carried out with an act of reciprocity to the Indigenous Peoples of the land you're occupying. An act of reciprocity can be done through gift giving (i.e., donating money to local Indigenous-led organizations or offering discounts/scholarships to Indigenous Peoples who wish to attend your event). Below is an example from the Montana Non-Profit Association's (MNA's) Fundraising Summit. They worked with ACLU Montana to draft a statement that is kept on their website (MNA, 2022). MNA opened the summit with this land acknowledgement, and they also took action by partnering with a local organization to share a call to action on voting efforts for Tribal communities. MNA also made a donation to a

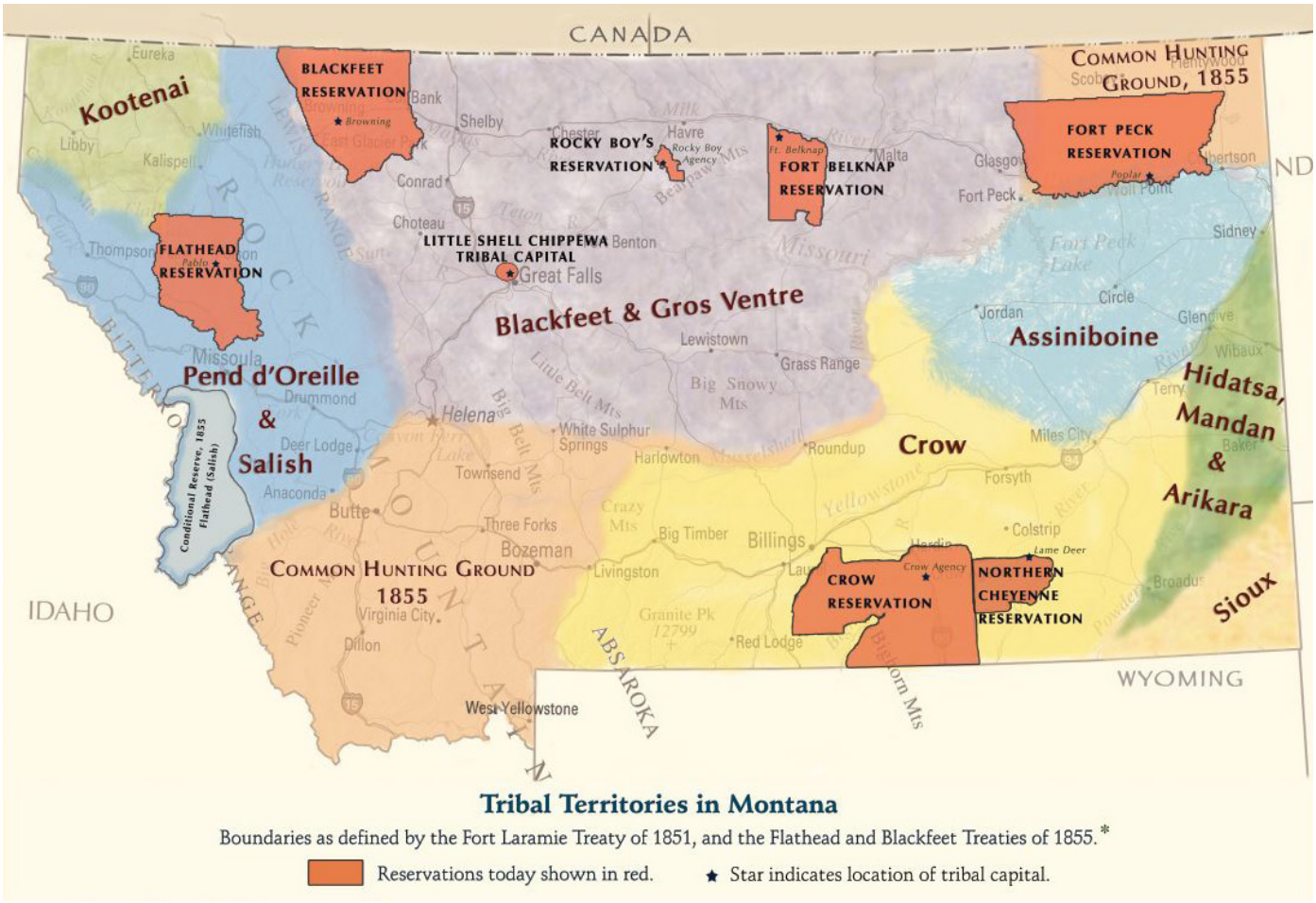


FIGURE 1: Map of Tribal Territories in Montana from the MT Office of Public Instruction (MT OPI, 2019)

local, Indigenous-led non-profit. Take note of how the land acknowledgment was created not only for the location of the summit, but also for the purpose of the summit. MNA also included information on how others can learn more and take action as well.

Montana is the traditional homeland and common hunting grounds of several tribes, including the Assiniboine, Blackfeet, Chippewa Cree, Crow, Gros-Ventre, Kootenai, Little Shell, Northern Cheyenne, Pend d'Oreille, Plains Cree, Salish, Sioux, Hidatasa, Mandan, and Arikara. Today this land is home to twelve sovereign tribes with over 67,000 enrolled members.

We are currently on the ancestral lands of the Salish and Blackfeet tribes, founded as a gold mining town, and named Helena. Land acknowledgments cannot repair inequity or return stolen land. No one entity can fix these issues, it will take a community guided by duty, responsibility, reciprocity with care for each other and the land.

As we gather to learn about fundraising best practices, it is important to recognize only 0.4% of philanthropic funding by large US Foundations is directed towards Native communities. We incite you to learn more about disparities in funding and opportunity, and how to embody the generosity and collaboration of Community-Centric Fundraising Principles at nativephilanthropy.candid.org and communitycentricfundraising.org (MNA, 2023).

INÁ

Taeshon Mirage Scheaffer
(Nakoda and Aaniiih)

I made this piece to portray what Natural Beauty is to me. Motherhood is the purest form of love being unconditional and limitless, I put the mother and baby in traditional regalia to represent the idea that no matter the past or present a mothers love is timeless.

Removal Era Events

One well known event within the Removal Era is the Cherokee Trail of Tears. In the 1930s the Cherokee Tribe was removed from Georgia and thousands of Cherokee People, including Elders and children died on their way to Oklahoma (Cherokee Historical Association, n.d.). Forty years later, within the Reservation and Allotment Eras, the Bitterroot Salish experienced something similar, though not as long a distance. From 1873 – 1891, the Bitterroot Salish were forcibly removed from the Bitterroot Valley in what is now present-day Stevensville, MT. The last to leave were Chief Charlo and a band of around 300 others. In the month of October 1891, Elders and children traveled for 2 nights and 3 days to the Jocko Church on the Flathead Indian Reservation, covering a span of 51 miles (Kidston, 2022). Confederated Salish and Kootenai Tribal (CSKT) member Anna Whiting-Sorrell was quoted during the "Return to Homeland" walk to honor the historical event. To think about how old people, and young people, and mammas with babies did this walk, ...and it was the start of the winter season. So, when you think about that, emotionally I think that's as hard as it is physically. (Grant, 2016).

The impact on Indigenous Peoples during the removal period, wasn't so much the issue of losing ownership of land. As stated earlier, Indigenous Peoples are in relationship with land. Relevant to perinatal health was the consequences of removing people from homelands which resulted in losing access to familiar, nutritious foods and plant medicines as well as historic sites relevant to praying and other ceremonies, including those pertinent to birth.

LEARNING EXERCISES

1. See if your place of work has done a formal land acknowledgement, if not take the time to create one. Use these resources to assist you in creating one or editing your current version if needed:
   - Native Governance Center's Guide to Indigenous land Acknowledgment: https://nativegov.org/news/a-guide-to-indigenous-land-acknowledgment/
   - Native Governance Center's Beyond Land Acknowledgment series: https://nativegov.org/news/a-self-assessment/
   - Montana University System's Land Acknowledgment States Resources: https://mus.edu/AIMA/land-acknowledgement-resources.html

2. Learn more about the Removal of the Selis people by visiting at least one of the links below.
   - https://www.mtpr.org/montana-news/2016-10-13/salish-walkers-retrace-exodus-from-the-bitterroot
   - https://bitterrootstar.com/2016/10/salish-retrace-trail-of-tears/
   - https://montanawomenshistory.org/mary-ann-pierre-topsseh-coombs-and-the-bitterroot-salish/
   - http://www.csktsalish.org/index.php/history

RESERVATION PERIOD - ALLOTMENT AND ASSIMILATION (1887 - 1934)

Following the removal of Indigenous Peoples from their homelands, Tribal members were confined to reservations by the federal government. Reservations are lands that have been reserved by or for the Tribes for their exclusive use as permanent homelands. Some reservations were established through treaties, while others were created by statutes and executive orders. Some reservations are a part of the traditional land base of the Tribe, but not all. Some Tribes were forced to share reservations with other Tribes. Establishing reservations was an effort to "Americanize" Indigenous Peoples by forcing cultural changes onto the population. The intentional disruption in culture is evident in the Second Annual Report of the Indian Rights Association where it is stated, "the Indian as a savage member of a tribal organization cannot survive, ought not to survive, the aggressions of civilization, but his individual redemption from heathenism and ignorance, his transformation to that of an industrious American citizen, is abundantly possible" (Campbell, n.d.; Indian Rights Association, 1885). Today in the US there are 326 reservations, including the seven in Montana (Table 3).

TABLE 3: Montana Reservations and Tribe(s) (MT OPI, 2019)

RESERVATION	TRIBE(S)
Blackfeet	Amskapi Pikuni (Blackfeet)
Crow	Apsaalooke (Crow)
Flathead	Selis (Bitteroot Salish), Ksanka (Kootenai), and Qlispe (Pend d'Oreille)
Fort Belknap	Aaniiih (Whiteclay or Gros Ventre) and Nakoda (Assiniboine)
Fort Peck	Nakoda, Lakota, Dakota (Assiniboine & Sioux)
Northern Cheyenne	Tsististas & Suhtaio (Northern Cheyenne)
Rocky Boy's	Anishinaabe & Nehiyawk (Chippewa Cree)
Little Shell (Landholdings in Great Falls, MT)	Anishinaabe, Metis (Little Shell Chippewa)

Confining once nomadic Tribes to reservations had devastating health results. Not only did removal prevent access to traditional foods, but it also completely disrupted the once active lifestyle of Indigenous Peoples. Many scholars point to the lack of nutritious foods and ability to hunt wild game as the beginnings of many chronic disease epidemics including higher rates of obesity, diabetes, and heart disease (Warne & Lajimodiere, 2015).

The Reservation Era also introduced the foreign concept of blood quantum as a way to limit rights of Indigenous Peoples. The idea of blood quantum was first applied in the colonial periods but more formally utilized in 1884 as the Bureau of Indian Affairs (BIA) assigned blood quantum amounts through Census rolls (Native Governance Center, 2022). This quantum is what is used to determinate who is eligible to be enrolled in a Tribal Nation. Scholars suggest that this imposes on the reproductive autonomy of Indigenous birth givers (Kozhimannil et al., 2022). Pre-colonization Tribal Nations used lineage to determine membership and granted citizenship through adoption and marriage (Native Governance Center, 2022). Now Indigenous birth givers are forced to calculate blood quantum to see if a child with a potential partner will be eligible for enrollment. Blood quantum restricts choices of partners and puts additional burden on birth givers to ensure adequate numbers of membership necessary for things like federal funding for the Tribe that is based on the population of enrolled Tribal members.

The Reservation Era also greatly impacted traditional cultural activities, including the practice of Traditional Medicine (Redvers et al., 2020). On May 7, 1880, the US government outlawed all Indigenous ceremonies that were deemed "uncivilized." Making ceremonies illegal meant that healers and Medicine People would be arrested and prosecuted for practicing traditional ways, including those relevant to pregnancy and birth. The outlawing of ceremonies wasn't reversed until 1978 with the passing of the American Indian Religious Freedom Act (Vile, 2009). The nearly 200-year ban on traditional ways interfered with knowledge sharing and stripped away important and sacred knowledge and practices. In explaining these breaks in knowledge transmission, we must be careful not to use words like *lost*. Traditional Knowledge wasn't misplaced or uncared for, this knowledge was taken by acts of colonialism and white supremacy. The ban on ceremonies also caused many Medicine People and ceremonial practices to be removed from public spaces to be hidden or gone 'underground' in an effort to continue these practices. Unfortunately, the need to hide ceremonies cultivated fear about practicing certain parts of Indigenous culture and healing creating an environment where practices were done in a secretive way. The need to practice culture in secret impacts access to cultural knowledge to this day. Major efforts to revitalize culture continue. Some of these cultural traditions can be seen today being utilized during birth, pregnancy, and parenting by Indigenous Peoples in Montana.

LEARNING EXERCISES

1. To learn more about how blood quantum impacts reproductive choices please read the following photo essay by Tailyr Irvine that was published by the Smithsonian: https://americanindian.si.edu/developingstories/irvine.html

2. Learn more about treaties and the reservations in Montana by following the link below to access "Montana Indians Their History and Location" from the MT OPI IEFA Program. Choose to learn about at least one reservation, preferably one closest to the area you currently serve. https://opi.mt.gov/Portals/182/Page%20Files/Indian%20Education/Indian%20Education%20101/Montana%20Indians%20Their%20History%20and%20Location.pdf

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EASY PAYMENTS

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FINE LANDS IN THE WEST

IRRIGATED
IRRIGABLE

GRAZING

AGRICULTURAL
DRY FARMING

IN 1910 THE DEPARTMENT OF THE INTERIOR SOLD UNDER SEALED BIDS ALLOTTED INDIAN LAND AS FOLLOWS:

Location.	Acres.	Average Price per Acre.	Location.	Acres.	Average Price per Acre.
Colorado	5,211.21	$7.27	Oklahoma	34,664.00	$19.14
Idaho	17,013.00	24.85	Oregon	1,020.00	15.43
Kansas	1,684.50	33.45	South Dakota	120,445.00	16.53
Montana	11,034.00	9.86	Washington	4,879.00	41.37
Nebraska	5,641.00	36.65	Wisconsin	1,069.00	17.00
North Dakota	22,610.70	9.93	Wyoming	865.00	20.64

FIGURE 2: Flyer Advertising Indian Land. Image acquired from the Bill of Rights Institute (Bill of Rights Institute, n.d.)

Land Allotment

During the creation of reservations, non-Indian settlers moved across the West, now reaching coast to coast. In order to create room for incoming settlers, the Dawes Act was passed in 1887 (National Archives, 2022). Through the Dawes act, land on the reservations were pieced apart and parcels were given to individual families. The image above, in Figure 2, shows an advertisement from this time period listing over 11,000 acres for sale in Montana for less than $10 an acre (Bill of Rights Institute, n.d.). Allotting segments of land in an effort to promote agriculture, broke up communal lands. The leftover land that was not allotted was made available for sale to non-Indian buyers. This created a "checkerboard" pattern of Indigenous and non-Indigenous land ownership on reservations. The checkerboard pattern of ownership on the Flathead Indian Reservation is a result of the Dawes Act.

Assimilation & Boarding Schools

During this era, US policy was enacted to relocate Indigenous children to boarding schools. This was a shift from promoting Indian massacres, highlighted by the infamous quote from US General Phillip Sheridan, "The only good Indian is a dead one" to attempting to destroy Indigenous cultures highlighted by the quote from US General Richard Henry Pratt who stated, "Kill the Indian in him, and save the man" (The National Native American Boarding School Healing Coalition, n.d.). The schools were either government run or operated through religious groups such as the Catholic Church. Children slept in dormitories similar to military barracks. They were known to be overcrowded and had poor food and hygiene which created illness and death at the schools (Montana State Library, n.d.). Most children were not sent voluntarily. Children as young as 3 years old were forcibly removed from their families. Families were threatened by withholding food rations or jail if they did not send their children.

Mom & Baby Moccasins
Photo submitted by Adriann Ricker
(Fort Peck Assiniboine & Sioux Tribes)

By 1926, 83% of Indigenous school-aged children were in boarding schools (The National Native American Boarding School Healing Coalition, n.d.). At these schools the epistemicide, or destruction of Traditional Knowledge took place. Children were not allowed to speak their Indigenous language and they were not able to participate in Traditional Knowledge translation occurring back home with family and community. Camie Goldhammer (Sisseton-Wahpeton Oyate), the director of Hummingbird Doula Family Services in Washington, pointed to boarding schools as a cause of low chestfeeding/breastfeeding rates among Indigenous Peoples (Goldhammer, 2016). Simply put, children were not around to see how their families traditionally fed babies. This disruption in knowledge transmission for Indigenous Peoples is also true for other practices and knowledge relevant to pregnancy, birth, the postpartum period, and parenting. Furthermore, formal reports have been released, making more people aware of the extensive abuse, including sexual abuse that occurred at these boarding schools. Indian boarding schools are also where many Indigenous Peoples had their first interactions with western health care systems. We must recognize that these were traumatic experiences, and these memories and feelings are passed down to generations by means of historical trauma. In Montana there were 17 boarding schools across the state (The National Native American Boarding School Healing Coalition, n.d.). Many Indigenous birthing people of reproduction age today have parents and/or grandparents that were in boarding schools.

LEARNING EXERCISES

1. Follow the link below to browse the American Indian Board School Healing Coalition. See which boarding schools were in Montana. Were there any near where you currently live and work? https://boardingschoolhealing.org/list/

2. Watch this short video from PBS, Montana Mosaic: *The Indian Boarding School Experience*: https://montana.pbslearningmedia.org/resource/2a54e6dd-d95a-48ff-b9d3-1d08ca2d2b69/montana-mosaic-the-indian-boarding-school-experience/

3. Watch this video by Camie Goldhamer as she explains the impacts of boarding schools on maternal health for AIAN People. It's over an hour long but would be great to watch with a whole department. Keep in mind this was in 2018, before we knew the importance of inclusive language: https://vimeo.com/545996034

TRIBAL REORGANIZATION PERIOD (1934 - 1953)

Assimilation policies were failing and American Indian culture prevailed despite political attempts of cultural genocide. The Reorganization Act of 1934 ended the allotment of Indian Reservations (MT OPI, 2019). Indian allotments were put into permanent trust status, which meant they could not be taxed. This also allowed Tribal Nations to take over governance of their people, subject to the ultimate authority of the Federal Government.

TERMINATION AND RELOCATION PERIODS (1953 - 1968)

During the termination era, numerous acts were passed that terminated the existence of Tribal governments and reservations. A total of 109 tribes were terminated from these Termination Era policies (Mann, 2021). Termination impacted around 2.5 million acres of trust land and over 12,000 Indigenous Peoples (Partnership with Native Americans, n.d.). None of the Montana reservations were affected by termination. However, relocation policies aimed to remove Indigenous Peoples, including those in Montana, from the reservations to bigger cities to find work and become assimilated into American society. Relocation is one of the reasons why there are so many "Urban Indian" communities. In Montana, cities like Missoula, Butte, and Glasgow were designated relocation cities. However, the relocations were not well documented. During relocation there were significant impacts to perinatal health. Firstly, many of the people who moved away from home communities were not offered any assistance in finding jobs, housing, or health care. Many people that relocated were subjected to prejudice and discrimination. Women and birthing people were unable to utilize the traditional, communal, and extended family support systems in place on reservations. Women and birthing people were also unable to access cultural teachings from family and Elders relevant to pregnancy, birth, and postpartum. Discrimination in health care is a phenomenon still experienced by Indigenous Peoples today.

Grandmother & Granddaughter
Photo submitted by Sharen Kickingwoman
(A'aaniii and Blackfeet)

LEARNING EXERCISES

1. Read this article to learn about a modern instance of discrimination in maternal health care against Indigenous birthing people: https://www.propublica.org/article/federal-investigation-finds-hospital-violated-patients-rights-by-profiling-separating-native-mothers-and-newborns

RESOURCES FOR LEARNING MORE

INDIGENOUS EXPERIENCE DURING THE TERMINATION ERA

1. '*There there*' is a book by Indigenous Author, Tommy Orange that is set during the relocation period.
   Orange, T. (2019). *There there*. Vintage.

2. *The Night Watchman* is by Indigenous Author, Louise Erdrich and it takes place during the termination era.
   Erdrich, L. (2020). *The Night Watchman*. HarperCollins.

REPRODUCTIVE INJUSTICES IN THE 60S AND 70S

The Indian Child Welfare Act (ICWA)

In 1958, the US government launched the Indian Adoption Project to help make it easier for Indigenous children to be adopted (US Department of the Interior, 1967). The Indian Adoption Project lasted until 1967 and it's been estimated that over 12,000 children were adopted out of Indigenous communities during this period (Palmiste, 2011). Prior to the passing of the Indian Child Welfare Act (ICWA) of 1978, an estimated 75-80% of Indigenous families in the US had lost at least one child to the foster care system. While Indigenous children only made up 9% of the population, they were overrepresented in foster care at 35% (Bombelles, 2022). In Montana the rate of Indigenous children placed in foster care was 13 times greater than that of whites prior to ICWA (Bual, 2018).

Historically, the child welfare systems in the US were not only ignorant, but indifferent to and insensitive to Indigenous culture. The lack of knowledge and bias by the child welfare systems caused many unwarranted adoption practices to take place. ICWA (25 U.S.C. § 1902) was enacted to "protect the best interests of Indian children and to promote the stability and security of Indian Tribes and families" (House of Representatives, 2009). ICWA set forth the requirement that caseworkers make considerations when dealing with ICWA cases such as: providing active efforts to the family; identifying a placement that fits under the ICWA preference provisions; notifying the child's Tribe and the child's parents of the child custody proceeding; and working actively to involve the child's Tribe and the child's parents in the proceedings. These considerations gave more protections to Indigenous children in the welfare system (i.e., that children be placed within Indigenous foster families so that they are no longer disconnected from their culture.)

Recent reports indicate that the rate of Indigenous children in foster care has declined nationally, but is still four times higher for Indigenous children than the general population (Bombelles, 2022). In Canada, which is another settler-colonial state, evidence exists of illegal adoption practices where Indigenous children were advertised through television commercials and newspaper ads. For Canadian history, this era was coined as "the Sixties Scoop" and many Indigenous Peoples in the US will refer to this time period as so.

Sterilization

Coinciding with the unwarranted removal of Indigenous children from their families was the forced sterilization of Indigenous women and birthing people in the US. Between 1970 and 1976 25-50% of Indigenous women were sterilized (Lawrence, 2000). An atrocious, estimated rate of 1 in 4 Indigenous women were sterilized by the Indian Health Service (IHS) without consent or knowledge (Lawrence, 2000). Eugenic sterilization laws were made legal by the Supreme Court in 1927 during the period where slaves were emancipated (Kozhimmanil et al, 2022). White supremacist thinking was responsible for these eugenic depopulation policies. Scholars have documented racial bias from physicians at that time with beliefs that Indigenous Peoples were morally, mentally, and socially defective. Some IHS physicians didn't

feel that Indigenous women and birthing people were intellectually able to use family planning methods and the Indigenous population needed to be controlled (Lawrence, 2000). The results of these sterilization atrocities are still felt today. The history of forced sterilization are meaningful in regard to perinatal health as these family experiences affect how Indigenous women and birthing people interact with the health care system due to longstanding, justified, fear and mistrust. Unfortunately, we know the mistrust goes both ways. The mistrust is evident in the welfare system's failures to protect Indigenous children and the supremist need to impede on reproductive rights of Indigenous birth givers. Combined with the forced assimilation of Native American children of earlier generations in compulsory boarding schools and modern-day failures of social services to place Native American children in foster care with Native parents in accordance to modern child welfare laws, the forced sterilization of Native American women is another page in the long book of abuse brought upon Native peoples by the United States (Lawrence, 2000).

The Hyde Amendment

In 1976, the Hyde Amendment set the boundaries on what medically necessary abortions would be covered by federal funding such as Medicaid and the Indian Health Service (IHS). In general, it's important to know that IHS does not offer abortion care. Abortion access among Indigenous Peoples is a delicate topic, and care should be used when discussing the topic. The complexity on abortion access is a recurring phenomenon among populations that have survived genocide. Many Indigenous

Aaniiih Mother, Ticia Cliff (Gros Ventre (Aaniiih))

birthing people recognize birth as a resistance to the efforts of genocide and colonization, however Indigenous scholars have also pointed out Traditional Knowledge on plant medicines that were utilized by Indigenous Peoples to prevent unwanted pregnancies. A recently published article spoke to the racial injustices regarding abortion access (Kozhimannil et al., 2022). Important notes in that article include other infringements on reproductive rights for Indigenous Peoples including the topic of blood quantum that was discussed earlier in the Reservation Period section of Part 2 of the toolkit. Additionally, the author states that due to the highly disproportionate rates of death during pregnancy for Indigenous birth givers, abortion may be a safer choice than pregnancy and delivery in certain cases. Limited access to abortion care is another injustice to reproduction faced by many Indigenous birth givers.

Reproductive justice is defined as "the human right to maintain personal bodily autonomy, have children, not have children, and parent the children we have in safe and sustainable communities (SisterSong, n.d.). As

we can see from previous policies listed in this toolkit, reproductive injustices have been forced upon Indigenous birth givers since colonization. Later in the toolkit more information about the devastating perinatal health impacts these historical injustices are currently causing will be presented. In 2007, the United Nation's Declaration on the Rights of Indigenous Peoples (UNDRIP) was adopted by the General Assembly, making the UNDRIP a legally non-binding resolution. The United Nations doesn't explicitly call out reproductive rights in the UNDRIP, however the Articles relevant to the improvement of economic and social conditions, protection against all forms of violence, and access to health services (Articles 21, 22, and 24, respectively) are related to perinatal health (United Nations, 2007). The relevant articles are listed below:

ARTICLE 21

PART 1: Indigenous peoples have the right, without discrimination, to the improvement of their economic and social conditions, including, inter alia, in the areas of education, employment, vocational training and retraining, housing, sanitation, **health** and social security (United Nations, 2007).

PART 2: States shall take effective measures and, where appropriate, special measures to ensure continuing improvement of their economic and social conditions. Particular attention shall be paid to the rights and special needs of indigenous elders, **women**, youth, children and persons with disabilities (United Nations, 2007).

ARTICLE 24

PART 1: Particular attention shall be paid to the rights and special needs of indigenous elders, **women**, youth, children and persons with disabilities in the implementation of this Declaration (United Nations, 2007).

PART 2: States shall take measures, in conjunction with indigenous peoples, to ensure that indigenous women and children **enjoy the full protection and guarantees against all forms of violence and discrimination** (United Nations, 2007).

ARTICLE 22

PART 1: Indigenous peoples have the right to their traditional medicines and to maintain their health practices, including the conservation of their vital medicinal plants, animals and minerals. **Indigenous individuals also have the right to access, without any discrimination, to all social and health services** (United Nations, 2007)**.**

PART 2: Indigenous individuals have an equal right to the enjoyment of the highest attainable standard of physical and mental health. States shall take the necessary steps with a view to achieving progressively the full realization of this right (United Nations, 2007).

LEARNING EXERCISES

1. Follow this link to learn more about the Policy Basics of ICWA from the Montana Budget and Policy Center: https://montanabudget.org/post/policybasics_icwa

2. Or from the Montana Department of Public Health and Human Services: https://dphhs.mt.gov/cfsd/icwa/icwahistory

3. Follow this link to read an article about the Sixties Scoop: https://www.cbc.ca/news/canada/manitoba/sixties-scoop-americans-paid-thousands-indigenous-children-1.3781622

4. Read one or both of the following article on sterilization of Indigenous women and birthing people:
   - https://www.cfp.ca/content/67/7/525
   - https://daily.jstor.org/the-little-known-history-of-the-forced-sterilization-of-native-american-women/

RESOURCES FOR LEARNING MORE

THE LASTING IMPACTS OF ICWA

1. *Daughter of a Lost Bird* is a documentary about an adult Native adoptee reconnecting with her birth family and heritage. It's a great story relevant to ICWA and gives historical context throughout.https://www.daughterofalostbird.com/about-3

2. The second season of This Land Podcast is a great resource to learn more about the current importance of ICWA. https://crooked.com/podcast-series/this-land/

INDIGENOUS SELF-DETERMINATION POLICY ERA (1970S - PRESENT)

During the civil rights movements, much needed attention was drawn to the injustices of Indigenous Peoples in the US. In 1970, President Nixon worked to end termination policies and reinstated the status of some Tribes that were terminated by previous policies (Mann, 2001). Public Law 93-638 is called the Indian Self-Determination and Education Assistance (ISDEA) Act and was passed in 1975, which officially ended the previous termination and relocation policies (IHS, 2017). This act recognizes Tribal Nations in the US as sovereign, domestic dependent nations. The idea behind self-determination was to allow Indigenous Peoples in the US to take responsibility for operating programs and funding that they are most affected by. By Tribes having more local control, the programs that serve AIAN people will be more tailored to the needs of the community and the funding could be more effectively utilized. Other programs such as police enforcement and social services can also be 638 programs. As sovereign nations, Tribes have the right to take over control of their health care and operate their own clinics versus IHS facilities. As stated earlier, during this era is when the Indian Child Welfare Act (ICWA) was passed.

While situations are improving and Tribal Nations have more control over how they operate their programs, there are still many improvements to be made. Mistrust is something we often hear about when serving Indigenous patients and clients, but it's important to understand where that mistrust stems from. For the general population much of the information


Chanel Standing Rock (Chippewa Cree Tribe)

presented in this toolkit thus far may be new, or something they have vaguely heard about. For Indigenous Peoples, this mistrust was passed down by generations to try and protect against the injustices that had happened prior. Scholars have demonstrated how these horrible acts have created cycles of historical trauma in Indigenous families. Warne & Lajimodiere (2015) created a framework to show the pathways in which traumas from the past create conditions of Adverse Childhood Experiences (ACEs) and Adult Adverse Experiences (AAEs) which then lead to chronic diseases among AIAN Peoples. Understanding power dynamics is a crucial step in creating culturally safe interactions. When a pregnant, Indigenous birthing person is in your office or comes to your clinic, imagine yourself in their shoes, and wonder how they are feeling. Imagine the strengths it took them to leave their home communities and get to their appointments. Celebrate the resiliency of Indigenous patients and clients and provide them with the best, culturally safe care you can, because Indigenous women and birthing people deserve it.

LEARNING EXERCISES

1. Follow the link below to learn more about Tribal 638 Clinics: https://www.ihs.gov/sites/selfgovernance/themes/responsive2017/display_objects/documents/TitleIandV.pdf

2. Read the following paper to learn more about the pathways between historical trauma and chronic disease among AIAN People: https://doi.org/10.1111/spc3.12198

TREATY OBLIGATIONS FOR HEALTH

The following section will briefly go over how the US tries to fulfill the promise to provide health care to Tribal Nations. We will learn about the Indian Health Service (IHS), Tribal 638 Programs, and Urban Indian Health. This section will explain the systems that Indigenous Peoples are operating in to receive health care. Understanding the lack of adequate funding for IHS by Congress will provide better understanding as to why accessing perinatal and mental health resources is difficult for Indigenous birth givers.

The IHS is the principle federal health care provider for American Indian and Alaska Native (AIAN) People. As mentioned previously, Congress expends funds to IHS by law. It was the Snyder Act of 1921 that authorized Congress to fund American Indian Health care (National Indian Health Board, n.d.). Because of this law, IHS is funded by the federal government. Health Services for American Indians were first established in 1824 through the War Department (US Commission on Civil Rights, 2018). Currently, there are three health programs that provide health care services to federally recognized AIAN People. The Indian Health Service represents the "I", Tribal "638" Programs represents the "T", and Urban Indian Health Centers represent the "U". Each program has a unique legal basis for how they provide health services to AIAN People (IHS, n.d.).

"I" – Indian Health Service

In Montana, each reservation has an IHS Unit except the Crow and Northern Cheyenne Tribes who share one unit. The Little Shell Tribe of Chippewa also has an IHS facility in Great Falls, MT. Of these service units, only the one on the Blackfeet Reservation is currently delivering babies. Both the Flathead and Fort Peck Reservation do have birthing facilities from outside organizations within the boundaries of the reservations. However, most Indigenous birth givers in the state need to travel to neighboring towns for prenatal appointments and labor and delivery services. A recent study conducted in Montana found that on average, Indigenous birth givers must travel 24.2 miles farther for perinatal health care than their white counterparts (Thorsen, 2022).

"T" – Tribal 638 Health Programs

The ISDEA Act serves as the legal basis for Tribes to negotiate establishing Tribal "638" Programs to administer their own health care services delivery programs. Tribal Nations enter into a Self-Governance Compact with the Secretary of Health and Human Services (HHS), allowing the Tribe, instead of IHS, to assume responsibility for all health-related functions, services, and activities (IHS, n.d.). The Tribal Nations currently operating all of the health care services through Tribal 638 Health Programs in Montana include CSKT (Flathead Reservation) and the Chippewa Cree Tribes (Rockyboy).

"U" – Urban Indian Health Centers

Urban Indian Health Centers are crucial for providing health care services for federally recognized AIAN People. As stated previously, the Indian Relocation Act in the 1950s promised a new life for Indigenous Peoples by offering an opportunity to relocate to urban areas from their reservations (National Archives, 2023). Health coverage by IHS does not pertain to AIAN

people living out of an IHS service area and is not a form of "insurance" that AIAN people can take with them when they move away from the reservation. Currently in the US there are now 67% of the AIAN population living in urban areas (US Census, 2010). In 1976, Title V under the Indian Health Care Improvement Act (P.L. 94-437) was passed (US National Library of Medicine, 2021). This $1.6-billion allocation by Congress allowed IHS to contract with urban American Indian non-profit organizations to provide health care to the urban AIAN population (US National Library of Medicine, 2021). The Urban Indian Health Clinics in Montana include: All Nations Health Center in Missoula, Billings Urban Indian Health and Wellness Center, Butte Native Wellness Center, the Indian Family Health Clinic in Great Falls and Lee Pocha Memorial clinic in Helena. These operate as Federally Qualified Health Centers (FQHCs) and can accept insurance and provide care to non-Indigenous people as well. The Bullhook Community Health Center in Havre is a FQHC and serves Urban Indian populations, however it is not operated by an American Indian non-profit.

Budgetary Issues

Currently, the budget used to fund IHS only covers an estimated 60% of the health care needs of eligible AIAN People (US National Library of Medicine, 2021). The extremely underfunded budget is why priority is given to issues where there is a life-threatening illness or injury. Patient referrals can be denied if the medical need isn't great enough for the amount of funding left for the fiscal year. Other health care programs like Medicaid or Medicare are entitlement programs. Access to these programs


Pete James (Aaniiih)

is not an entitlement program but considered a discretionary program, meaning that the IHS and its clients (federally recognized AIAN People) are not entitled to funding and services. IHS funding and its capacity to provide adequate services is at the discretion of Congress and is not guaranteed (Office of Finance and Accounting-Division of Budget Formulation, 2022). The IHS budget is in competition with other Non-Defense Discretionary Programs that provide services such as environmental protection, border security, low-income assistance, and more. All of the funding for these programs are ultimately decided by Congress on an annual basis, whereas entitlement programs like Medicaid are automatically funded every year and the budgets take into account population growth and the rising costs of health care through inflation (Office of Finance and Accounting-Division of Budget Formulation, 2022).

As mentioned earlier, the IHS is significantly underfunded. While there are current advocacy efforts underway to make IHS an entitlement program, there is still proper feasibility analysis needed to determine future implications (IHS, n.d.). In the meantime, we must consider how to provide adequate health care for Indigenous Peoples in the US with the IHS budget currently available. An important way to help AIAN People receive proper health care and stretch the IHS budget is by ensuring that all eligible IHS recipients are signed up for entitlement programs such as Medicaid and Medicare. In 1976, the Indian Health Care Improvement Act allowed the federal government to reimburse for services received through IHS facilities for eligible AIAN Medicaid beneficiaries (IHS, n.d.). Under 42 C.F.R 136.61, IHS is the payer of last resort (Code of Federal Regulations,1999). Being the payor of last resort means that if a person is eligible for both Medicaid and IHS services, then Medicaid must cover the costs of health care before IHS is billed. This billing hierarchy applies to all other alternate resources, meaning any health care resource other than IHS. Alternate health care resources could be private health insurance, state programs, Medicaid, Medicare, etc. Until an amendment is made to the Snyder Act of 1921 declaring IHS an entitlement program, the budget of the IHS and ability to provide adequate health care to AIAN People will be decided annually by Congress.

A report by the Medicaid and CHIP Payment and Access Commission (MACPAC) (2020) found that Medicaid covered 67.3% of births for Indigenous Peoples in the US out of 30,000 births. Medicaid is essential for the health of Indigenous Peoples in the US as the IHS is severely underfunded and recipients of IHS receive far less funding (~$4,000 per person) compared to other government programs like Medicaid (~$8,000 per person) (Centers for Medicare & Medicaid Services, 2020; Indian Health Service, 2020). In Montana, 41.3% of births are paid for by Medicaid and as of January 2021 and over 15,000 of eligible Indigenous People were enrolled in Medicaid in the state (Semmens, 2021).

Sisi Whiteman Runs Him (Bitterroot Salish) and Daughter (Bitterroot Salish and Crow)

LEARNING EXERCISES

1. Read one of the articles below on Montana Medicaid and Indigenous Peoples:

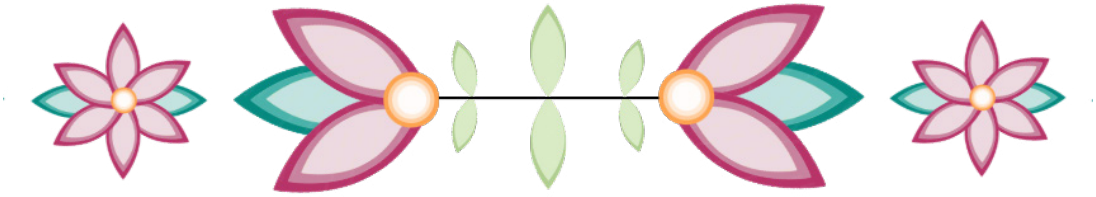
- https://www.macpac.gov/wp-content/uploads/2021/02/Medicaids-Role-in-Health-Care-for-American-Indians-and-Alaska-Natives.pdf
- https://montanabudget.org/report/medicaid-expansion-in-indian-country-improving-the-health-of-individuals-and-communities-2#_edn22

RESOURCES FOR LEARNING MORE

TOPICS DISCUSSED IN PART 2

1. To learn more about Montana Tribal Nations read the Indian Education for All's document on Essential Understandings Regarding Montana Indians through the MT Office of Public Instruction. https://opi.mt.gov/Portals/182/Page%20Files/Indian%20Education/Indian%20Education%20101/essentialunderstandings.pdf

2. To learn more about Missing and Murdered Women and Girls read this report by the Urban Indian Health Institute. https://www.uihi.org/resources/missing-and-murdered-indigenous-women-girls



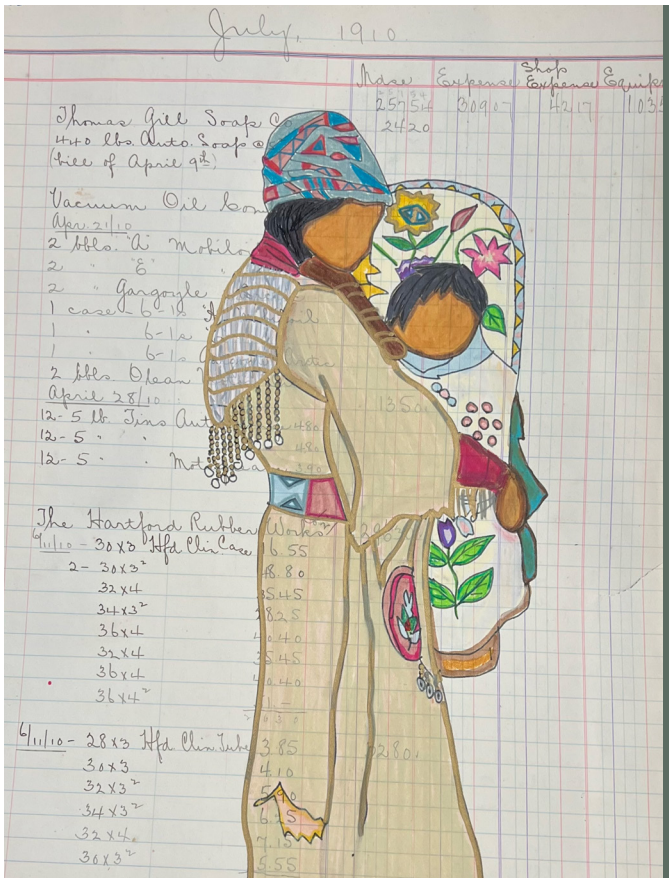
PART 3: INDIGENOUS PERINATAL HEALTH CONSIDERATIONS

The traumatic experiences mentioned during Part 2 continue to impact Indigenous birthing people in negative ways, increasing risk for mental health issues and other pregnancy-related complications. However, there is power and healing in Indigenous culture. While many injustices and hardships were experienced by Indigenous Peoples in the US during the eras discussed previously, Indigenous cultural strengths have persevered. Indigenous culture keeps Indigenous Peoples resilient, or able to survive hardship. Indigenous Traditional Medicine and healing should be considered for health promotion efforts in Indigenous Communities. In a 2020 scoping review on Traditional Medicine, Redvers and Blondin provide a resource tool to better understand Traditional Medicine in North America that could inform policies and health care practices (Redvers & Blondin, 2020). As the literature review mentions, Traditional Medicine within health care settings requires more research, but Traditional Medicine and cultural practices can potentially be useful for preventing health issues, including those relevant to perinatal health.

INDIGENOUS CULTURAL WORLDVIEWS

"Birth is ceremony," is a widely known proverb for Indigenous Peoples as many Indigenous cultures recognize the extreme significance of women and birth givers carrying new life. Many Indigenous cultures hold the belief that women and birthing people are sacred due to the ability to bring life into this world. With that knowledge is also the belief that children are gifts from the Creator, and they travel from the Spirit World to us. The sacredness and ceremonial aspects of birth mean that some Indigenous birth givers will want to bring traditional aspects into the birthing experience. Integrating cultural components during labor and birth could be done in several ways, sometimes praying through songs or smudging. Smudging is when certain plant medicines are lit during prayer. Try to make sure you have policies that can accommodate ways for Indigenous families to incorporate ceremonial aspects into the birthing experience and let Indigenous families know what the policies are in advance. Also within the Traditional Knowledge realm is the fact that pre-colonization Indigenous communities knew how to take care of people in pregnancy, birth, and postpartum. Extended kinship networks were strong, and a birthing person had an abundance of help and support throughout their pregnancy, birth, and postpartum. This support is evident in modern times when you may witness large groups of families waiting for the arrival of the new baby in hospitals and birthing centers. While some policies at clinics and hospitals may put limits on waiting room capacities and who all can be present during labor and delivery, we need to think about how these policies impact Indigenous families. It's important to find alternatives so that Indigenous birthing people can have the support they deserve during the sacred time of birth. For example, maybe the waiting room in the labor and delivery unit is small, tell families where additional waiting rooms are, maybe there are other rooms that can be used.

"Native Culture" has been demonstrated to be a significant protective factor against mental health issues (Morris et al., 2021). Having a strong cultural identity means being connected to traditional language, ceremonies, land, traditional foods, or other powerful healing



HOLDING THE FUTURE

Aspen Decker
(Confederated Salish and Kootenai Tribes)

This artwork captures the essence of heritage and continuity. Rendered on a vintage 11" by 14" ledger paper, this piece is a delicate tribute to Nimiipúu 'Nez Perce' history. Utilizing colored pencil and Artist Loft markers to breathe life into this work, drawing inspiration from timeless black and white photographs depicting a Nimiipúu mother cradling her child from the 1890s. The artwork resonates with the quiet strength of the past, showcasing the enduring connection between generations.

tools. Having a cultural identity also comes with a different way of looking at the world. Indigenous worldviews have different ways of looking at health and related topics. Collective health and healing are aligned with the understandings of Indigenous worldviews. Indigenous worldviews of health are more holistic than western views and include relationships with the environment and even other people. Because of the emphasis of co-relationality within Indigenous worldviews, focusing on improving the health of the collective versus the individual should be considered (Alvarez & Farinde-Wu, 2022).

Mental health issues during the perinatal period are on the rise, and Indigenous women and birthing people are subject to significant racial disparities within this realm. We will discuss data and statistics later, but it's important to consider how an Indigenous worldview approaches mental health compared to western medicine. Western paradigms view mental health as illness within a person, but Indigenous perspectives view mental illness as something that occurs when the physical, mental, emotional, and spiritual realms are out of balance (Mehl-Madrona, 2009). Healing from mental health issues can be achieved by returning to balance. Many Indigenous groups recognize the power of singing and dancing for healing. Many ceremonies for healing are conducted with family and community members present. Traditionally, healing is not usually something one does on their own, but collectively instead.

LEARNING EXERCISES

1. Review Substance Abuse and Mental Health Services Administration's (SAHMSA's) Culture Card: https://store.samhsa.gov/sites/default/files/sma08-4354.pdf

2. Read this commentary from one physician on their perspective on Indigenous Health from a settler standpoint: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC6104323/

THE RESURGENCE OF INDIGENOUS DOULAS AND OTHER BIRTH WORKERS

There is a growing trend in implementing and advocating for doula care in the US. Doulas are trained to provide non-clinical emotional, physical, and informational support for people throughout their reproductive lifespan, prenatally, during childbirth and postpartum, as well as including all pregnancy outcomes such as abortion, miscarriage, and adoption (Bey et al., 2019). Community-based doulas are birth workers that usually serve families of people of color. Community-based doulas serve within a human rights framework to ensure that all people and families have access to safe, dignified, and culturally relevant care geared toward elevating health equity, reproductive justice, and all stages of perinatal health.

Indigenous doulas are different than mainstream doulas in that Indigenous doulas offer everything doulas do and can be considered community-based, but they may go a step further and often approach their work and care in a sacred way congruent to their culture and the culture of the community they are serving. Indigenous doulas view their patient holistically and can provide care that is in alignment with traditional Indigenous culture. Indigenous doulas have roles that were already well established in Indigenous communities before colonization. Thankfully, the roles of Indigenous doulas and other birth workers are making a comeback and in doing so, improving perinatal health conditions for Indigenous Peoples. Indigenous doulas are also sometimes referred to as *birth workers* or other terms relevant to their specific Tribal community.


Bear Star Photography

Research has shown that doulas are an important factor for helping pregnant people and birth givers during this impactful time of their lives and can aid in positive health outcomes for the mother and child (Gruber et al., 2013). Policies are being pushed by many advocacy groups for PMH to fund doula care for birthing people. Doulas are able to help prepare the birthing person for all aspects of birth, including preparing for managing stress and recognizing signs and symptoms of mental health issues. When Tribal communities offer Indigenous doula care, doulas can help to restore supportive relationships, provide culturally safe care, and reclaim ceremony that combats the loss of Traditional Knowledge (Cidro et al., 2018). Indigenous doulas can be the life force needed to address PMH issues for Indigenous birthing people by guiding families towards healing and restoring the sacred relationships between birthing people and community.

LEARNING EXERCISES

1. Look through these Zoomcasts offered for free by Indigenous Midwifery and choose one to listen to: https://www.indigenous-midwifery.org/podcast

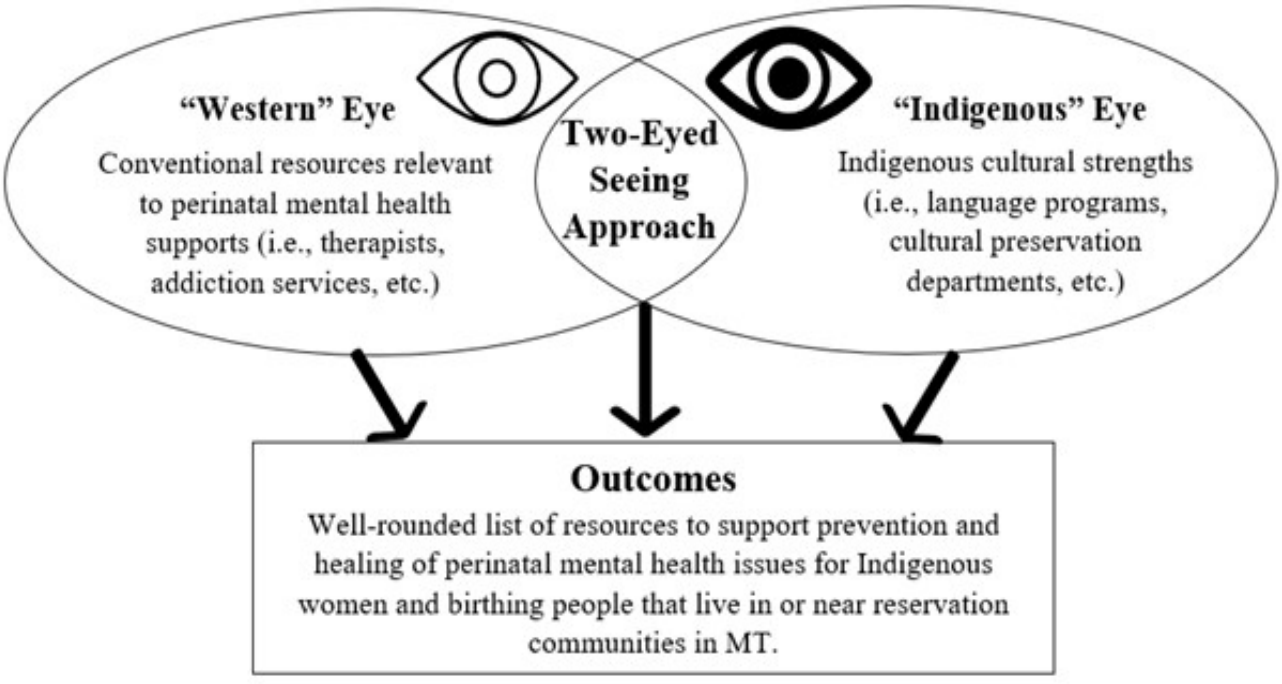
ACCESS TO CULTURE

Indigenous culture, Traditional Knowledge, and Medicine have also been deeply impacted by colonization through ethnocide or the systematic destruction of an ethnic group's culture (Hall & Tandon, 2017). Some scholars suggest that due to residual patriarchal worldviews left over in Indigenous communities from colonization, as well as efforts from various churches, cultural revitalization efforts have been male dominated (McKay, 2015). We've also already learned about the impacts of outlawing Traditional Medicine and ceremonies in 'Part 2: Historical Context.' Nonetheless, cultural revitalization efforts continue. Indigenous cultural knowledge and practices relevant to pregnancy, birth, and the postpartum period are resurging. This resurgence is likely due in part to the growing increase of Indigenous birth work efforts across the nation and internationally such as Indigenous Doula Trainings, Indigenous Midwifery, and Indigenous Lactation Consultant Certification Training. While many cultural components are beneficial to promoting health and wellness, we must remember that culture is not always accessible to everyone. We need to be mindful that not every birthing person will want cultural components present in their health care. However, we need to be sure that when someone does, we do our best to support cultural revitalization efforts by individuals and communities. We need to all reflect on our practices and policies to examine whether we are actually supporting or hindering access to Indigenous cultural strengths.

TWO-EYED SEEING APPROACH

When implementing Indigenous culture in health care practices or public health work, it doesn't need to be western medicine vs. Traditional Medicine. It's not a competition. Both aspects

FIGURE 3: Application of Two-Eyed Seeing for Perinatal Mental Health (Bartlett, Marshall, & Marshall, 2012).

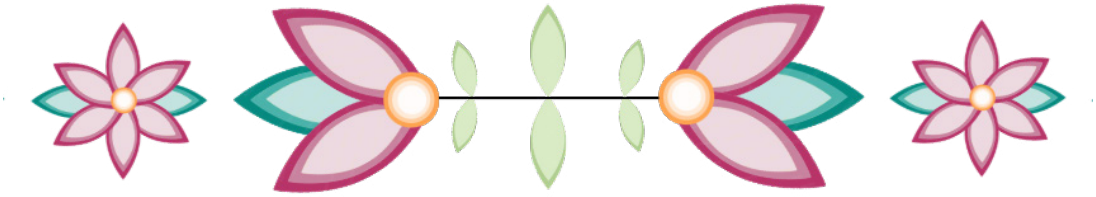



The Kickingwoman-Buckskin Family (Blood tribe, Blackfeet, A'aaniii)

can be beneficial when we use a "Two-Eyed Seeing" approach within health promotion (Hovey et al., 2017). The "Two-Eyed Seeing" approach was coined by Mi'kmaq Elder Albert Marshall and is used to identify and learn from the gift of multiple perspectives by considering both the world views and Traditional Knowledge of Indigenous People in Canada and western science and research knowledge (Bartlett, Marshall, & Marshall, 2012). Using a "Two-Eyed Seeing" approach (Bartlett, Marshall, & Marshall., 2012) acknowledges that there is a sacred space to acknowledge wisdom and practices of both Traditional and western medicine where deeper knowledge and healing can occur. Health and healing does not have to be solely one way or another. The best of both worlds can align to create a bridge to better care for all people. Indigenous birth givers deserve the best care of both worlds. Shared Decision Making (SDM) is one tool that may be helpful in equalizing power dynamics and rebuilding trusting relationships by creating space for Indigenous worldviews within perinatal health care practices (Groot et al., 2020).

LEARNING EXERCISES

1. Read this article on trust and world view in shared decision making with Indigenous patients: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC7154772/



PART 4: DATA & RESEARCH

Indigenous Peoples have always been researchers. Indigenous cultures have knowledge that has been tried and tested throughout time. However, because of Eurocentric thinking and systemic colonization efforts, Indigenous knowledge has not been valued in the same way as western-based knowledge. Even worse, attempts have been made to destroy Indigenous knowledges. The intentional destruction of Indigenous knowledge systems is evident in the various policy eras discussed previously, with a specific highlight on the assimilation policies including the mandatory attendance at boarding schools. Colonization efforts have also utilized data and research to cause harm to Indigenous Peoples. The disregard for Indigenous Traditional Knowledges, unethical research practices, and other historical contexts creates a complex, mistrusting relationship between Tribal Nations and outside researchers or data collection efforts. To better protect Tribal Nations, many Tribes have begun to implement their own research review boards to review and monitor research conducted in their communities. Research review boards review and monitor research projects using different systems with some nations having their own separate committee, some will utilize local Tribal College Universities, and some others will have Tribal Councils oversee the review process entirely. Whether or not a Tribal Nation has a research review board separate from Tribal Council, usually Tribal Council approval is still needed to conduct research projects in the community. Tribal Research Review is a crucial additional step that must be taken by researchers or other programs that wish to conduct research in a Tribal community. In Part 4 we will go over considerations in data collection and research regarding Indigenous birth givers. To better understand data considerations relevant to working with Indigenous Peoples and Tribal communities, see Table 4 below:

TABLE 4: DEFINITIONS RELEVANT TO INDIGENOUS DATA

Indigenous data sovereignty is the right of Indigenous peoples and tribes to govern the collection, ownership, and application of their own data (Rainie et al., 2017).

Indigenous data governance is decision making. It is the power to decide how and when Indigenous data are gathered, analyzed, accessed and used (Walter et al., 2018).

Decolonizing data occurs as Indigenous Nations and other data agents replace external, non-Indigenous norms and priorities with Indigenous systems that define data and inform how it is collected and used (Carroll et al., 2020).

Data genocide is the continued erasure of Indigenous peoples through elimination or lack of inclusion of Indigenous Peoples in data collection and reporting. Examples of how this is done is by racial misclassification or "othering" data relevant to Indigenous Peoples by lumping them into one category" (Wade, 2020; Urban Indian Health Institute, 2021).

PERINATAL HEALTH RACIAL DISPARITIES

Serious racial disparities within perinatal health research exist for Indigenous birth givers in Montana and the US broadly. Indigenous birth givers are three times more likely to experience a severe maternal morbidity event compared to white patients and nationally, are more than twice as likely to die of pregnancy-related deaths than white women (Woo & Glover, 2022; Trost, 2022; Hassanein, 2022). As stated earlier, a recent study also found significant disparities in access for prenatal care and delivery for Indigenous birthing people in Montana (Thorsen, 2022). The study found that Indigenous birth givers were traveling over 20 miles farther for perinatal health care and were 20 times more likely to give birth at a hospital without obstetric services (Thorsen, 2022).

Mental health issues during pregnancy and postpartum are a growing concern in the US. Nationally, suicide and overdose combined are the leading cause of death in the postpartum period (Trost, 2022). PMH issues include depression, anxiety, bipolar disorder, PTSD, substance use disorders (SUDs), and similar issues. Research on the general population has found PMH to be one of the most common complications of maternal health (Mughal et al., 2022).

RESEARCH NEEDS

While research and programs are well established for PMH in the general population, there is hardly any research or information on the unique experiences of Indigenous birth givers regarding PMH (Baker et al., 2005; Heck, 2021). Without accurate data and information, interventions and policies will continue to only focus on

Brandon Fitch, Ezabella Fitch, and Andy Elliot (Turtle Mountain Chippewa)

the general population. However, Indigenous communities have unique circumstances and worldviews that require tailored approaches-from screening up through interventions and prevention work.

Most of what little research exists is conducted from a western perspective, often by non-Indigenous researchers, and without the use of Indigenous research methodologies. Even more concerning is the deficit focused orientation of the research for perinatal health among Indigenous birth givers. For example, there is an overwhelming amount of literature surrounding the topic of substance use among Indigenous birth givers. However, there lacks research on solutions to Indigenous PMH issues. There is immense focus on the occurrence of this one area of perinatal health (i.e., substance use), but not very much literature to investigate the root causes of PMH disparities among Indigenous birthing people.

There is also a lack of perinatal health research that is conducted with Indigenous communities. So far studies often report on the rates and occurrences of perinatal health issues, but space must be created for more community participation in research. Research in partnership with communities could lead to a better understanding of root causes of perinatal health disparities and the potential for healing within Indigenous culture. Perinatal health research with Indigenous communities should be based in local cultural values. Furthermore, to collect accurate data, culturally appropriate methodologies need to be utilized in research projects. One example of a methodology is the importance of storytelling among Indigenous cultures. Local cultural values must be considered when research teams are deciding how to collect data *with,* not *on,* Indigenous communities.

Chelsea Bellon (Yankton Sioux) and Daughter, Laurel (Yankton Sioux and Winnebago)

For Indigenous birth givers, one benefit of Indigenous-led research projects within the community is the possibility of Traditional Knowledge reclamation and/or preservation. While the topic of Traditional Knowledge must be approached respectfully, including creating and following data agreements stating that

AJ LastStar (Aaniiih, Chippewa-Cree, Blackfeet)

all data belongs to the community, there is great potential for reclaiming cultural practices and knowledge relevant to pregnancy, birth, and postpartum care. The specific needs and solutions of Indigenous birth givers can be found by engaging Indigenous communities and sharing power so projects can be driven by the community. Community-based participatory approaches in health practice and research is one pathway for power sharing with Indigenous communities.

LEARNING EXERCISES

Read the following articles by leading Indigenous Data Experts in the Field:

1. Urban Indian Health Institute's Report Card to learn more about Data Genocide: https://www.uihi.org/projects/data-genocide-of-american-indians-and-alaska-natives-in-covid-19-data/

2. CARE Principles for Indigenous Data Governance: https://datascience.codata.org/articles/10.5334/dsj-2020-043

A NOTE ON ALLYSHIP

Many health workers and researchers hold power, whether they realize it or not. This power comes in the shape of resources, formal western education, funding, and other structural support. When we truly collaborate with communities, we must be willing to share our power and privilege with communities to meet common goals. In addition, caution must be used as we must not approach Indigenous communities as if they are powerless. Power-sharing can be achieved by practicing critical allyship. Where being an ally is suggested as a static state, critical allyship addresses social inequalities as an ongoing practice (Nixon, 2019). Too much harm has been caused by well-intended people working in Indigenous communities. Approaching projects with Indigenous communities with a mindset that we have the solutions they need leaves too much room for the white savior phenomenon. The white savior complex is an idea in which a white person or white culture as a whole feels as though they know what's best for Black, Indigenous and People of Color (BIPOC) and need to rescue or save BIPOC (Healthline, 2021).

People from outside of Indigenous communities must be critical of themselves and be able to recognize if their interest in the project comes from a place of saviorism.

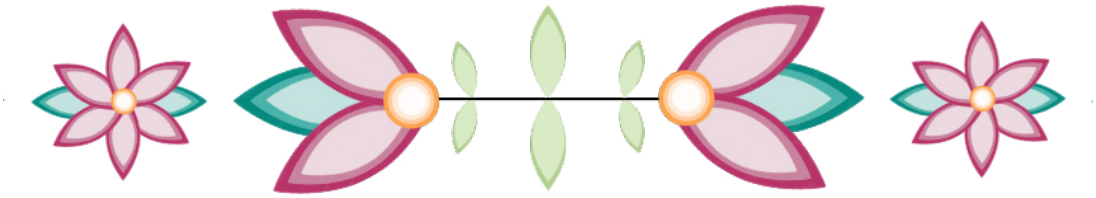
As mentioned previously, Indigenous communities and culture contain great strengths and resiliency. Solutions to social inequalities can be cultivated from within Indigenous communities. However, researchers and organizations outside of Indigenous communities often hold the resources necessary for addressing inequities. True collaboration occurs when outside, privileged organizations and funders give essential resources to community so that the community can address whatever issues they choose, however they choose. Perinatal health issues affecting Indigenous birthing people must be approached with projects led by Indigenous researchers and communities. If we keep utilizing only western worldviews and approaches, we will continue to come to the same conclusions. Uplifting Indigenous narratives on perinatal health will allow for new perspectives in the perinatal health field.

Pregnant Mother with Baby Moccasins
Photo submitted by Chelsea Bellon (Yankton Sioux)

LEARNING EXERCISES

1. Please read this article to learn more about critical allyship: https://www.researchgate.net/publication/337779936_The_coin_model_of_privilege_and_critical_allyship_Implications_for_health

2. Read this article from Healthline to learn more about the White Savior Complex: https://www.healthline.com/health/white-saviorism



PART 5: CULTURAL SAFETY & PRINATAL HEALTH PRACTICES

Cultural safety requires health care professionals and their associated health care organisations to examine themselves and the potential impact of their own culture on clinical interactions and health care service delivery. This requires individual health care professionals and health care organisations to acknowledge and address their own biases,attitudes, assumptions, stereotypes, prejudices, structures and characteristics that may affect the quality of care provided.

In doing so, cultural safety encompasses a critical consciousness where health care professionals and health care organisations engage in ongoing self-reflection and self-awareness and hold themselves accountable for providing culturally safe care, as defined by the patient and their communities, and as measured through progress towards acheiveing health equity. Cultural safety requires health care professionals and their associated health care organisations to influence health care to reduce bias and achieve equity within the workforce and working environment (Curtis et al., 2019).

The concept of cultural safety was created by Maori (the Indigenous Peoples of Australia) nurses to address the inequitable health status of Maori People in Australia (Papps & Ramsden, 1996). Later work on cultural safety was developed in Australia for nurses working with Aboriginal cancer patients by the National Cancer Nursing Education (EdCaN). Aboriginal Peoples are the people Indigenous to Australia and include Maori Peoples. Australia is another settler-colonial state and the work on cultural safety with Aboriginal patients is very relevant to the US. In the education geared toward nurses, EdCaN outlines three steps towards cultural safety: 1. Cultural Consciousness, 2. Cultural Appraisal and 3. Cultural Safety and Communication (National Cancer Nursing Education, 2022). The work from EdCaN will be used as a foundation for Part 5 of the toolkit, and the cultural safety practices relevant to perinatal health will be translated from EdCaN's cancer-focused work. While the steps towards cultural safety are numerical, the process shouldn't be interpreted as linear as much of this work is interconnected.

STEP 1:

Cultural consciousness or awareness of the constructs of one's own culture and recognition of unique and similar qualities of other cultural groups (National Cancer Nursing Education, 2022).

LEARN ABOUT THE PEOPLE YOU SERVE

In general, there is a lack of knowledge about Indigenous Peoples and Indigenous culture. This absence of understanding stems from systematic issues and the lack of required education on the subject. Also, the way health care and many health promotion systems were designed, does not allow much time or space to learn about the specific perspectives, values, and beliefs of the patients served. The first step towards cultural consciousness involves acknowledging that Indigenous Peoples have a different culture and worldview. We must now make an effort to learn about the Indigenous Peoples of Montana. The earlier parts of this toolkit have hopefully given you a better understanding. However, reading the toolkit is just the start. We must make an effort to learn more specifically about the Indigenous birth givers we are serving. Which Tribal Nations(s) are our patients and clients from? What resources do we have to learn more about Tribal Nations in Montana? Please note, making an effort to learn more about the Indigenous Peoples in the state does not mean to make patients and clients educate us about their culture. Making an effort means learning the cultural identification of the population we are serving and take the time to learn more about that Tribe. In general, we should all be trying to learn about the Indigenous Peoples here in Montana. We need to encourage other staff and coworkers to learn and ask that leadership mandate trainings or other educational opportunities that would allow staff to better understand Tribal Nations in Montana in conjunction with cultural safety initiatives.

LEARN HOW YOUR PATIENT OR CLIENT IDENTIFIES

In the "Terminology" Section of this toolkit, we learned about the importance of knowing Indigenous patient's and client's preference for identifying their Tribal Nations. European naming of Indigenous Nations is not always accurate. Additionally, many people recognize the naming of other groups as an act of control with many present-day Indigenous groups starting to protest the names acquired by acts of colonialism. For example, Gros-Ventre is the federally recognized name of one of the Tribes of the Fort Belknap Indian Community. However, the Tribe was given this name due to the incorrect understanding of sign-language by French fur traders. While federally recognized as Gros-Vetnre, this Tribe refers to themselves as Aaniiih, or Whiteclay People. The sign-language to show who the Aaniiih were was to put your hands in front of you and make a motion similar to a waterfall to signify the white clay found below waterfalls, which is part of the Tribe's creation story. French fur traders misinterpreted the hand motion to be relevant to their stomachs and

named the Tribe Gros-Ventre, which translates from French to English as big bellies (Garter Snake, 1980). The misnaming of the Aaniiih People is just one example of the importance of understanding the terminology and names relevant to the people you are serving.

UNDERSTAND THAT THERE IS HETEROGENEITY AMONG INDIGENOUS NATIONS AND CULTURES

As mentioned earlier, there are well over 574 Tribal Nations in the US and over a dozen in Montana. There are also many Urban Indian communities with people from various Tribes. We must also keep in mind that there are many Indigenous Peoples that live in Montana that are not from a Montana Tribe. We cannot assume that every Indigenous group has the same culture. While there may be some common, underlying values (i.e., relationship with land), we must remember that each nation, community, family, and individual are different. We cannot expect that what is true for or relevant to one of our patients or clients of certain Tribal descent will be the same for all other patients or clients from other Tribes. Because of the impacts of colonialism, knowledge of and participation in culture varies greatly. Do not categorize Indigenous Peoples into one homogenous group. Instead, recognize the heterogeneity among Indigenous Peoples and let the patients or client decide which parts of their culture they feel comfortable sharing.

RECOGNIZE AND LEARN ABOUT CULTURAL CONSTRUCTS THAT MAY AFFECT INTERACTIONS WITH HEALTH CARE SYSTEMS

One main construct of Indigenous culture in the US is colonization. It is important to realize that the western health care systems were introduced during very traumatic times for many Indigenous Peoples and may be associated with the intense oppression occurring during colonization efforts. As previously stated, the first interaction with western medicine usually occurred at boarding schools for many Indigenous families. Historical interactions with western systems and potential residual feelings must be considered when recognizing power dynamics with Indigenous birth givers.

REFLECT ON PERSONAL BELIEFS THAT INFLUENCE THE MODE OF PRACTICE AND INTERACTION WITH INDIGENOUS PEOPLES

As stated earlier, most people were not required to learn about Indigenous Peoples and the accurate history of Indigenous Peoples and the US government. Most people's education and what is known about health care is based on Eurocentric thought. Furthermore, due to high volumes of deficit reporting on Indigenous issues along with other issues of white supremacy, many negative stereotypes exist about Indigenous Peoples and especially about Indigenous birthing people. Decolonization refers to the undoing of colonialism. There seem to be varying degrees of a consistent definition, but overall, decolonizing is more than social justice. One article stated the way to decolonizing paradigms is to include Indigenous ways of knowing in academia and research and to value these ways of knowing in the same way as Eurocentric research is valued (Held, 2019). When working with Indigenous birth givers, we must decenter Eurocentric thoughts and beliefs and shift the power back toward our patient or client.

LEARNING EXERCISES

1. Look up information on six well-known Indigenous people from Montana and learn more about what they are known for and their contributions.

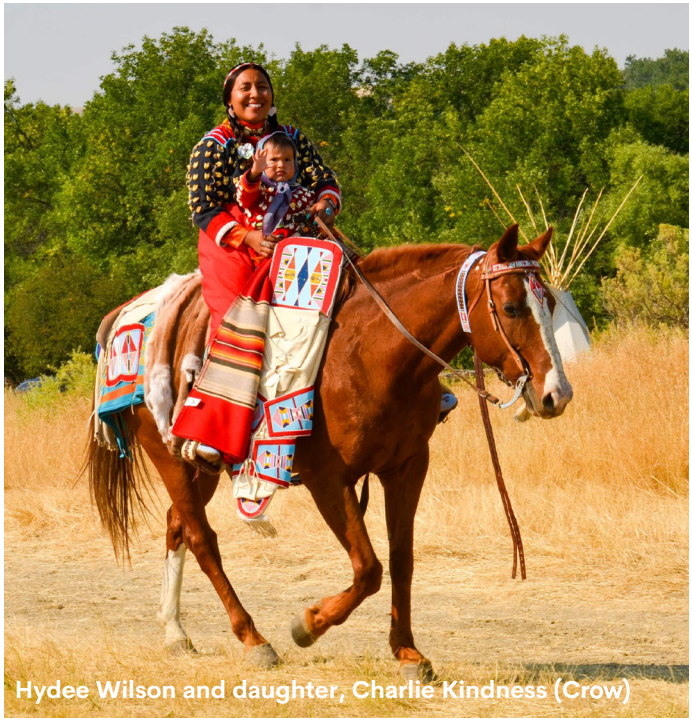
2. Learn more about one of the Tribal Nations in Montana. Learn the accurate name of that tribe. Are there more resources to learn from?

STEP 2:

Cultural appraisal or assessment to identify cultural domains of difference that need to be considered for the [perinatal period] (National Cancer Nursing Education, 2022).

DEVELOP COLLABORATIVE RELATIONSHIPS WITH INDIGENOUS STAKEHOLDERS

We must take a relationship approach to accurately identify the cultural strengths of Indigenous communities. Identifying Indigenous cultural strengths can only occur with Indigenous Peoples. We also cannot better serve Indigenous birth givers, without learning from Indigenous birth givers themselves. We cannot learn about Indigenous communities and culture in an extractive way. We must intentionally engage with and start rebuilding trusting relationships with Indigenous communities. We must approach engaging with Indigenous communities in a power-sharing way. If your organization has the resources, hire Indigenous staff to lead projects. Organizations and clinics can create compensated, Indigenous-led boards to guide these efforts. When beginning to engage Indigenous communities, we need to ensure reciprocity is being considered. What do we have to offer that the community feels is important? Rebuilding trusting relationships will take time and likely additional resources, however, Indigenous birth givers are deserving of this effort.



Hydee Wilson and daughter, Charlie Kindness (Crow)

IDENTIFY AND VALUE DIFFERENCES AS STRENGTHS INSTEAD OF BARRIERS

One example of Indigenous strengths is Indigenous kinship networks and extended family support. An example of differences creating barriers is when an Indigenous patient is at a hospital. Many of the patient's friends and relatives may wish to come to the hospital to see their loved one. However, large volumes of guests don't often align with waiting room or visitor policies. In the moment, hospital staff can feel upset that the patient has too many visitors. Especially during very special and sacred times such as birth, many Indigenous patients may have a high number of guests. From an Indigenous perspective, the birthing person having the support from family and extended kinship networks is a great strength. This is especially true during the postpartum period, when support for parents is of great importance.

LOOKING AFTER OUR LIFE GIVERS

Julianne Beaudin-Herney
(Nehiyaw, Ojibway, Mikmaq)

This artwork captures the essence of heritage In 'Looking After our Lifegivers' by Julianne Beaudin-Herney, I explore the profound bond between Indigenous women as they navigate the sacred journey of perinatal care. This piece celebrates the interconnectedness of community, the resilience of women, and the nurturing spirit that lows through generations. Through intricate symbolism and vibrant imagery, I aim to honor the vital role of Indigenous women in supporting each other during the transformative process of bringing new life into the world. 'Looking After our Lifegivers' is a testament to the strength, wisdom, and unity found within Indigenous communities.

Another example is when Elders accompany birthing people to appointments. Elders are highly valued in Indigenous communities, and they might be the grandmother, aunt, or a respected member of the family or community where there is a relationship built from respect. You may sometimes see that the birthing person will defer to their family and Elder(s) when communicating or making decisions. The birthing person may want to include their family in this process, and you may need to explain information to both the birthing person and their family. Needing to relay information to other people besides the patient or client can be viewed as another inconvenience or more work. However, having Elders or family present during appointments is also a strength and shows the birthing person's value of family and demonstrates that they have support from their family as well.

Situations where differences occur are when we must recognize where our own beliefs and feelings are coming from. We need to be aware of the strengths and the potential benefits relevant to Indigenous women and birthing people. The examples given about families, Elders, and extended kinship networks during hospital visits or appointments might not be relevant to all who are reading this toolkit, however, you should consider other instances that may seem inconvenient and challenge yourself to see the strengths in a given situation.

LEARNING EXERCISES

1. Have you witnessed any Indigenous cultural strengths in your practice? Discuss this with a coworker and practice using language and narratives that highlight Indigenous strengths.

2. Think about and discuss with coworkers how you can learn about the cultural strengths of a nearby Indigenous community. Who are some stakeholders you think would be important to assist with this effort?

STEP 3:

Cultural safety skill development of appropriate behaviors, attitudes, and communication strategies that reduce the gap of inequities in [perinatal health] outcomes (National Cancer Nursing Education, 2022).

Communication differences can impede access to care. However, it's important to keep in mind that one communication style is not better than the other- the styles are just different. Differences in styles can create miscommunication or give wrong messaging. We must be mindful of some common tenets among Indigenous cultures that may be relevant to the Indigenous birthing people you serve. However, remember that there is heterogeneity amongst Indigenous Peoples and don't assume you know their preferences. Instead, observe the person you are working with and let their style guide the interaction. Keep in mind that your style of communication can be very different to the patient's or client's and the people your patient or client may be used to communicating with. Recognize that your style could be overwhelming to the patient or client and adjust accordingly.

NON-VERBAL COMMUNICATION

One common non-verbal communication difference you may come across when working with Indigenous birth givers is that regarding eye-contact. Some Indigenous Peoples find it aggressive to look at people in the eyes. Some Indigenous Peoples may have been taught to not stare at people when they talk, especially Elders. If there are Elders accompanying the birthing person this will especially apply to them. To western society not looking at people in the eyes could be viewed as disrespectful, and some might assume that the patient or client is not paying attention. However, for some Indigenous Peoples it is rude to look at people directly when they are speaking, so looking down or away could actually be a way to show respect or at the very least be non-confrontational.

THE USE OF SILENCE

Another communication difference is the use of silence. Indigenous Peoples may use periods of silence when communicating with you. You may notice long pauses after you're done speaking and might worry that the patient or client is not going to answer you back. Allow time and space for moments of silence instead of interjecting with a question or more conversation. This silence is usually just a time of deep listening, where your patient or client is taking the time to understand what you said and wants to be intentional when responding. Indigenous cultures are careful with words because of the power that words can carry. Therefore, some Indigenous birth givers may need a moment of consideration before responding.

DIFFERENCES IN PERCEPTION OF TIME

Time is another common difference that can bring about miscommunications. Indigenous Peoples' cultural worldviews may see time as cyclical rather than the western view of time

being linear. You can often notice this difference in concepts of time as Indigenous Peoples will acknowledge ancestors in the past and also future generations to demonstrate their high regard. Indigenous-based perceptions of time does not mean that Indigenous Peoples don't have clocks or aren't aware of western's society's view on time. You may have heard jokes about "Indian Time" as an excuse for people being late. However, the "Indian Time" joke does not explain the full story and is only a narrow point of view on the concept of time from an Indigenous world view. Things will happen when they need to happen and if someone is late, it is understood that whatever the person is dealing with is more important at that time and had to be done. Do not take it personally if someone is late. Instead think of all the things you learned about in this toolkit that an Indigenous birthing person had to overcome to make it to your office and find ways to be more flexible for situations when patients may be late.

We must remember the importance of health equity. To improve racial inequities in perinatal health in Montana, we have to make system-level changes. Ensure that cultural safety is in your mission statements and strategic plans. Don't limit cultural safety initiatives to perinatal health departments, make them organization-wide, and educate all staff including administrative staff, leaders, and care providers. Promote conversations on cultural safety amongst staff, and discuss strategies to "call each other in" with grace to hold each other accountable to the tenets of culturally safe health care. By creating more opportunities for discussion and accountability, we can think about our own power and privilege and how we can use our voices to speak up when there are issues.

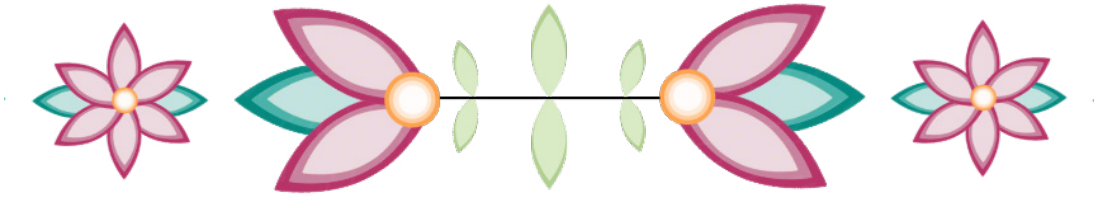

Mesteth Family
(Hunkpa/Oglala Lakota,
Northern Cheyenne, and Kiowa)

Work with Tribal Nations and local Indigenous communities nearby to monitor progress. This can be done through surveys and even focus groups with Indigenous patients/clients as examples. The Canadian Institute for Health Information (CIHI) has designed a framework for measuring cultural safety in health care settings that would be helpful in monitoring progress (Canadian Institute for Health Information, 2021). The National Collaborating Centre for Indigenous Health also has a resource for measuring cultural safety (Johnson & Sutherland, 2022.) The Birth Place Lab has developed evaluation tools to measure respectful care within perinatal services (Birth Place Lab, 2023). The Mothers on Respect index (MOR) assesses respectful patient-provider interactions, and the Mothers autonomy in Decision Making scale (MADM) assesses overall maternal care experiences (Vedam et al., 2017; Vedam et al., 2017). Be transparent about your goals and progress to show Indigenous birthing people that you are invested in providing culturally safe care.

LEARNING EXERCISES

1. Engage with Indigenous stakeholders in the community you serve and discuss ways to respectfully communicate with the Indigenous birth givers in your service area. Remember to do this in a way that shows value (monetary, gifts, or other) for their time and expertise.

2. Does time seem to be an issue when serving Indigenous birthing people? Think about ways to adapt in your scope of work or your organization to accommodate different perceptions of time.



PART 6: SYSTEMIC APPLICATION OF CULTURAL SAFETY

Changing individual providers' beliefs, att tudes, and behaviors can only go so far. In order to make sustainable change, we must use a system-level approach. Curtis et al. made the following considerations for health care organizations and regulators (Curtis et al., 2019):

1. Mandate evidence of engagement and transformation in cultural safety activities as a part of vocational training and professional development;
2. Include evidence of cultural safety (of organizations and practitioners) as a requirement for accreditation and ongoing certification;
3. Ensure that cultural safety is assessed by the systematic monitoring and assessment of inequities (in health workforce and health outcomes);
4. Require cultural safety training and performance monitoring for staff, supervisors and assessors;
5. Acknowledge that cultural safety is an independent requirement that relates to, but is not restricted to, expectations for competency in ethnic or Indigenous Health.

Zael Ricker
(Fort Peck Assiniboine & Sioux Tribes)

The First Nations Health Authority (FNHA) in Canada published their policy statement on cultural safety and humility (FNHA, n.d.). Within this document they list several recommendations around the areas of training, policies, evaluation, and more. A sample of some of the recommendations from the policy statement are listed below (FNHA, n.d.). Please note that First Nations are one of the recognized groups of Indigenous Peoples of Canada:

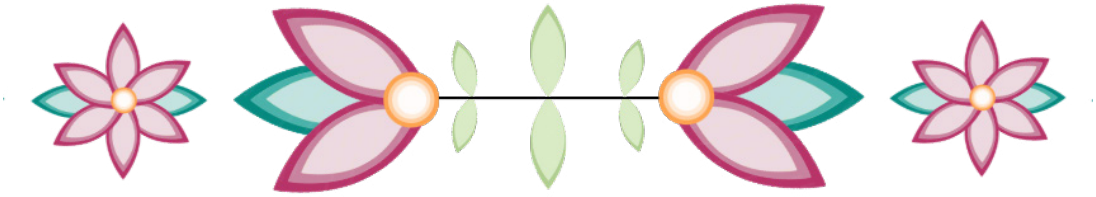
1. Increase opportunities to educate health care professionals, those training to become health professionals, and others working in the health system on the history of First Nations health, as well as the concepts of cultural safety, and cultural humility and the relevance to First Nations health.
    a. Recognizing the First Nations Perspective on Health and Wellness and the role of culture, traditional medicine and healing.
    b. Involving First Nations individuals as the main decision-maker in their health.
2. Identify and address organizational and public policy barriers to creating culturally safe health care environments and health programming, including barriers to integrating First Nations approaches and traditional healing practices in the mainstream health system.
3. Conduct patient journey mapping to support ongoing improvement and learning.
4. Development of measures to assess cultural safety and humility across an organization or program, as a part of quality improvement.
5. Commit to evaluation, publicly reporting, and continuously improving cultural safety within the health system for First Nations.
6. Make specific efforts to ensure a workforce that includes First Nations leadership and staff are visible across all levels of the organization.
    a. Develop initiatives to recruit and retain First Nations health leaders, health care professionals and other employees.
    b. Encourage First Nations students to become health professionals (e.g. offer scholarships, outreach).
7. Create physical environments that are culturally safe for First Nations and that are connected with other services.


Solei Buckskin (Blood tribe, Blackfeet, A'aaniii)

Accountability is an important part of health care systems and personal responsibility is essential so taking the time to learn from this toolkit is a great step in the right direction. We must now make efforts to impact our systems and organizations. An article on accountability in health care recommends formalizing values and vision (in this case, cultural safety); formalizing strategies at every level of the organization; encouraging communication; creating education and training opportunities; and creating measurable goals and monitor progress openly (PowerDMS, 2020).

We must remember the importance of health equity. To improve racial inequities in perinatal health in Montana, we have to make system-level changes. Ensure that cultural safety is in your mission statements and strategic plans. Don't limit cultural safety initiatives to perinatal health departments, make them organization-wide, and educate all staff including administrative staff, leaders, and care providers. Promote conversations on cultural safety amongst staff, and discuss strategies to "call each other in" with grace to hold each other accountable to the tenets of culturally safe health care. By creating more opportunities for discussion and accountability, we can think about our own power and privilege and how we can use our voices to speak up when there are issues.

Work with Tribal Nations and local Indigenous communities nearby to monitor progress. This can be done through surveys and even focus groups with Indigenous patients and clients as examples. The Canadian Institute for Health Information (CIHI) has designed a framework for measuring cultural safety in health care settings that would be helpful in monitoring progress (Canadian Institute for Health Information, 2021). The National Collaborating Centre for Indigenous Health also has a resource for measuring cultural safety (Johnson & Sutherland, 2022.) The Birth Place Lab has developed evaluation tools to measure respectful care within perinatal services (Birth Place Lab, 2023). The Mothers on Respect index (MOR) assesses respectful patient-provider interactions, and the Mothers autonomy in Decision Making scale (MADM) assesses overall maternal care experiences (Vedam et al., 2017; Vedam et al., 2017). Be transparent about your goals and progress to show Indigenous birthing people that you are invested in providing culturally safe care.



CONCLUSION

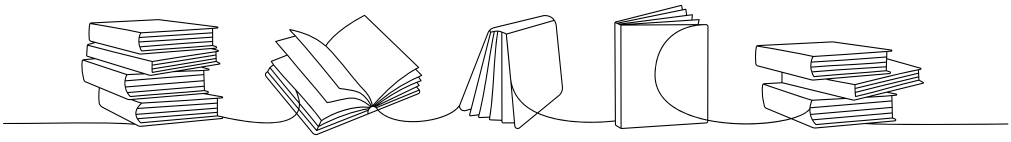
We must shift away from education and training that only address cultural competency. Attempting to learn specifics about Indigenous culture is simply not enough. We must consider the power-dynamics at play, critically reflect, and practice providing care that ensures Indigenous birthing people feel safe to engage in healthcare settings or other offices relevant to perinatal health. Addressing the disparity gap within Indigenous perinatal health demands effort and attention. We must approach closing the perinatal health disparity gap in relationship with Indigenous Peoples and Tribal Nations. Re-forming health organizations and clinics to provide culturally safe care in Montana will take great effort but will have meaningful effects for Indigenous communities in the state. Indigenous women and birthing people in Montana are deserving of safe and effective perinatal health care, and they are deserving of optimal health during the perinatal period.

THANK YOU FOR COMPLETING THIS TOOLKIT!

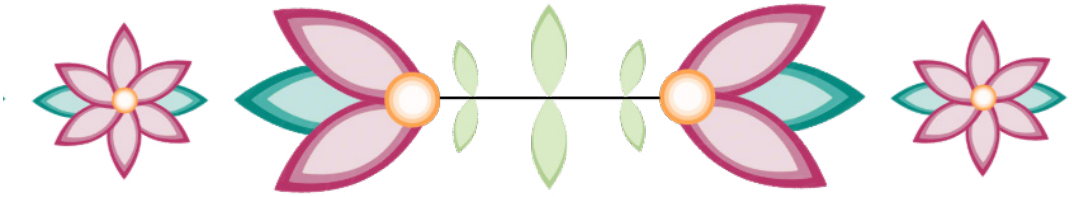
ADDITIONAL CULTURAL SAFETY RESOURCES

1. This literature review is by Curtis et al. (2019) and it outlines why we need to consider power dynamics: https://equityhealthj.biomedcentral.com/articles/10.1186/s12939-019-1082-3
2. This course was created by Education Cancer out of Australia. It was created for nurses who work with Aboriginal cancer patients: https://www.canceraustralia.gov.au/about-us/news/new-guide-deliver-culturally-respectful-indigenous-cancer-care
3. This is a free course on cultural safety from Frontier University designed for nurses: https://frontier.edu/news/new-introduction-to-cultural-safety-course-available-to-all/
4. This is a two-page printable document from Alberta Health Services that discusses cultural safety and lactation with Indigenous women and birthing people: https://www.albertahealthservices.ca/assets/info/hp/hcf/if-hp-hcf-bf-indigenous-mothers-printable.pdf
5. This is a document by First Nations Health Authority on their policy statement on cultural safety and humility: https://www.fnha.ca/documents/fnha-policy-statement-cultural-safety-and-humility.pdf
6. This paper published by the Canadian Institute for Health Information discusses a framework developed by Nohotout Consulting for measuring cultural safety: https://www.cihi.ca/sites/default/files/document/measuring-cultural-safety-in-health-systems-report-en.pdf
7. This document was published by the National Collaborating Centre for Indigenous Health as a resource for measuring cultural safety: https://www.nccih.ca/Publications/Lists/Publications/Attachments/10375/Cultural_Safety_Measurement_EN_Web_2022-06-01.pdf

BOOKS RELEVANT TO INDIGENOUS HEALTH AND RESEARCH



1. Science of The Sacred
   Redvers, N. (2019). *The science of the sacred: Bridging global Indigenous medicine systems and modern scientific principles*. Berkeley, CA: North Atlantic Books.
2. The Seven Circles of Wellness
   Luger, C., & Collins, T. (2022). *The seven circles: Indigenous teachings for living well*. New York, NY: HarperOne, an imprint of HarperCollins Publishers.
3. Conducting Health Research with Native American Communities
   Arambula Soloman, T. G., & Randall, L. L. (2014). *Conducting health research with Native American communities*. Washington, DC: Alpha Press, an imprint of American Public Health Association.
4. Reproduction on the Reservation Theobald, B. (2019). *Reproduction on the Reservation: Pregnancy, childbirth, and colonialism in the long twentieth century (critical Indigeneities*). University of North Carolina Press.



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