

Maternal Mortality and Health Disparities of American Indian Women in South Dakota



A Report of the
South Dakota Advisory Committee to the
U.S. Commission on Civil Rights

July 2021

Advisory Committees to the U.S. Commission on Civil Rights

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**South Dakota Advisory Committee to the
U.S. Commission on Civil Rights**

The South Dakota Advisory Committee to the U.S. Commission on Civil Rights submits this report regarding the civil rights implications related to the maternal health disparities experienced by American Indian women in South Dakota. The Committee submits this report as part of its responsibility to study and report on civil rights issues in the state of South Dakota. The contents of this report are primarily based on testimony the Committee heard during four web-based hearings held on July 14, 2020; September 16, 2020; November 18, 2020; and December 16, 2020; as well as written testimony.

This report details civil rights concerns raised by panelists with respect to maternal health disparities of American Indian women throughout the state of South Dakota. It discusses the roles of discrimination, institutional racism, trauma as well as inadequate infrastructure, transportation, and comprehensive supportive services. From these findings, the Committee offers to the Commission recommendations for addressing this problem of national importance.

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U.S. Commission on Civil Rights**

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I. EXECUTIVE SUMMARY

On October 23, 2019, the South Dakota Advisory Committee (Committee) to the U.S. Commission on Civil Rights voted unanimously to take up a proposal to study maternal mortality of Native American women in South Dakota. To reflect current terminology used in public health settings and data collection,¹ the Committee chose to use the term “American Indian” rather than “Native American.” The Committee’s study focused on understanding the factors that may contribute to American Indian maternal mortality, and includes findings related to maternal health. This report is informed by virtual public briefings held on July 14, 2020; September 16, 2020; November 18, 2020; a virtual public community forum on December 16, 2020; and written testimony from American Indian women, researchers, advocates, and other related stakeholders. As part of this study, the Committee also asked briefing participants a voluntary briefing follow-up question around what was working well that could potentially be improved but received no responses to this question.²

Significant concerns raised in the report include a lack of consistent funding for efforts to track and address issues that contribute to disproportionately high American Indian maternal mortality rates, a lack of support for traditional birth practices to support maternal health of American Indian women, and ongoing and pervasive neglect in addressing living conditions and standards of care for American Indians that collectively contribute to maternal mortality rates. In response to these concerns, the Committee urges policy makers and relevant stakeholders to fund and develop health care programs and resources that (a) are informed by a comprehensive understanding of living conditions and resources for American Indians through ongoing consultation with Tribal members, (b) incorporate traditional birth practices and cultural competency in health care settings and health care provision, and (c) ensure health care standards and resources for American Indians are aligned with national standards. A full list of the Committee’s findings and recommendations from this study follows. This report and the recommendations included within it were adopted by a vote of 7 to 0 by the Committee on May 19, 2021.

1. Findings Maternal Mortality and Health Disparities

- a. Maternal mortality is defined as a death related to pregnancy, which can be caused by infection, heart disease, pulmonary embolism, and postpartum

¹ Indian Health Service, *About IHS*, (n.d.), <https://www.ihs.gov/aboutihs/> (accessed May 12, 2021); Centers for Disease Control and Prevention, *Health Disparities*, (December 21, 2018), <https://www.cdc.gov/Tribal/data-resources/health-disparities/index.html> (accessed May 12, 2021).

² Follow-up Question to Briefing Speakers, February 2021.

hemorrhage.³ Maternal morbidity is defined as any physical illness or disability that is directly linked to childbirth and/or pregnancy.⁴

- b. Sixty percent of maternal deaths are preventable.⁵ Preventive efforts include researching and responding to factors that contribute to disproportionate maternal mortality rates of American Indian mothers, including social determinants of health, social injustice, and structural racism.⁶
- c. There are substantial maternal health disparities between American Indian, Alaska Native, and White mothers.⁷ The national maternal mortality and maternal morbidity rates of American Indian and Alaska Native women are double that of White women.⁸
- d. Comprehensive data to determine maternal mortality rates for small populations across different states is challenging to access.⁹ The Centers for Disease Control's state maternal mortality tables do not include maternal mortality rates for South Dakota because the population size is small,¹⁰ which makes it difficult to easily assess the severity of the issue.
- e. Using the number of maternal deaths to calculate the maternal mortality rates for South Dakota, a panelist shared that American Indian women in South Dakota

³ Stephanie Big Crow, MD, Written Statement for the *December Briefing before the South Dakota Advisory Committee to the U.S. Commission on Civil Rights*, Dec. 16, 2020, at 2 (hereinafter Big Crow Statement).

⁴ Ibid.

⁵ Big Crow Statement, at 4; See also Centers for Disease Control, *Pregnancy Mortality Surveillance System*, Centers for Disease Control and Prevention, <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> (accessed May 10, 2021).

⁶ Big Crow Statement, at 4.

⁷ Linda Littlefield, testimony, *Briefing Before the South Dakota Advisory Committee to the U.S. Commission on Civil Rights*, Sep 16, 2020, transcript, p. 13 (hereinafter *September Briefing*), Ms. Littlefield noted that comprehensive data for maternal mortality rates across states can be challenging to access, is not consistently collected, and has limits due to the small population sizes of those studied. Data shared at the time of the briefing was calculated based on data compiled through a data request submitted previously for births by race to the South Dakota Department of Vital Records alongside 2010-2018 data from the South Dakota Department of Health regarding pregnancy related deaths; See also South Dakota Department of Health, *Maternal Mortality*, (n.d.), <https://doh.sd.gov/statistics/maternalmortality.aspx?>;Centers for Disease Control, *Maternal Mortality*, (n.d.), <https://www.cdc.gov/nchs/maternal-mortality/index.htm>.

⁸ Big Crow Statement at 1; Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, (n.d.), <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> (accessed May 10, 2021).

⁹ Centers for Disease Control, *Maternal Mortality by State, 2018*, (2018), <https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf> (accessed May 12, 2021).

¹⁰ Centers for Disease Control, *Maternal Mortality by State, 2018*, (2018), <https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf> (accessed May 12, 2021).

have a mortality rate of 121.77 maternal deaths per 100,000 births, which is nearly seven times the 2018 national maternal mortality rate (17.9 maternal deaths per 100,000 births), and is also far greater than the state's maternal mortality rate (59 maternal deaths per 100,000 births), and the maternal mortality rate for White women in South Dakota (44 maternal deaths per 100,000 births).¹¹ This is especially concerning considering that American Indian women make up only 18% of births within the state, while White women make up 75% of births in South Dakota.¹²

- f. Access to prenatal care is essential to the health of American Indian mothers. Counties which have reservations within their boundaries or which overlap with Tribal lands experience disparities regarding access to prenatal care.¹³ According to the CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) data, 27% of American Indian mothers reported not having access to transportation needed for pre-natal appointments, 27.5% of American Indian mothers were unable to access prenatal care due to lack of access to childcare, and 19.1% of American Indian mothers reported being unable to get an appointment with their healthcare provider.¹⁴
- g. Disparities regarding access to prenatal care are especially prominent for American Indian mothers between the ages of 15-19.¹⁵ American Indian teens experience a disproportionate lack of prenatal care compared to their White counterparts in the same age bracket.¹⁶ Within this age group, 55.4% of American Indian mothers received late or no prenatal care compared to 21.8% of White teen mothers.¹⁷

2. Lack of Comprehensive Data on Maternal Health Disparities

¹¹ Littlefield Testimony, *September Briefing*, p. 13, Ms. Littlefield noted that comprehensive data for maternal mortality rates across states can be challenging to access, is not consistently collected, and has limits due to the small population sizes of those studied. Data shared at the time of the briefing was calculated based on data compiled through a data request submitted previously for births by race to the South Dakota Department of Vital Records alongside 2010-2018 data from the South Dakota Department of Health regarding pregnancy related deaths; *See also* South Dakota Department of Health, *Maternal Mortality*, (n.d.), <https://doh.sd.gov/statistics/maternalmortality.aspx?>; Centers for Disease Control, *Maternal Mortality*, (n.d.), <https://www.cdc.gov/nchs/maternal-mortality/index.htm>.

¹² *Ibid.*

¹³ McKay Testimony, *September Briefing*, pp. 2-3.

¹⁴ Littlefield Testimony, *September Briefing*, p. 14.

¹⁵ *Ibid.*

¹⁶ *Ibid.*

¹⁷ *Ibid.*

- a. There is a lack of consistent, comprehensive data available regarding the maternal health of American Indian populations in South Dakota.¹⁸ This lack of data makes it difficult to develop explanations for the present maternal health disparities within the state.
- b. Historically, the maternal and child health of American Indians in South Dakota was largely uninvestigated. It was not until the 1990s that the Centers for Disease Control began to study the infant mortality and maternal health rates of American Indians in South Dakota.¹⁹
- c. There needs to be a concerted effort to include Tribal Nation representation on a South Dakota Maternal Mortality Review Committee to ensure that Tribal Nations have state-level support to collect and analyze data specific to the maternal health within their communities.²⁰
- d. National and South Dakota data indicate that American Indian mothers experience maternal health issues at a higher rate than White mothers, despite the fact that they make up a lower percentage of the population.²¹ However, despite current data revealing these disparities, a comprehensive, research-based explanation as to why these disparities exist in South Dakota has yet to be developed.
- e. As a result, the lack of a clear explanation for these disparities makes it difficult for South Dakota Tribal Nations to take the necessary steps to address the disparities experienced by American Indian women in their communities.²²

3. Barriers to Accessibility

- a. Pregnant American Indian women, especially those living in rural areas, experience a multitude of compounding barriers that make it difficult to receive pre-natal and routine maternal health care. There is a need to establish better

¹⁸ Big Crow Statement, at 2.

¹⁹ Amy Elliott, testimony, *Briefing Before the South Dakota Advisory Committee to the U.S. Commission on Civil Rights*, Nov. 18, 2020, transcript, pp. 3-4 (hereinafter *November Briefing*).

²⁰ Littlefield Testimony, *September Briefing*, p. 18; Steffens Testimony, *September Briefing*, p. 17; Sandra Wilcox, testimony, *Briefing Before the South Dakota Advisory Committee to the U.S. Commission on Civil Rights*, July 14, 2020, transcript, p. 10 (hereinafter *July Briefing*).

²¹ Big Crow Statement at 2; Elliott Testimony, *November Briefing*, pp. 3-4; Littlefield Testimony, *September Briefing*, pp. 12-13; “South Dakota Population 2021.” World Population Review. <https://worldpopulationreview.com/states/south-dakota-population> (accessed March 3, 2020).

²² Littlefield Testimony, *September Briefing*, p. 18; Steffens Testimony, *September Briefing*, p. 17; Wilcox Testimony, *July Briefing*, p. 10.

health care, transportation services, housing, employment opportunities, food access and education on American Indian reservations.²³

- b. Many American Indian women living on reservations in rural South Dakota lack access to water, sewage, housing, employment, and technology.²⁴ This lack of technological access includes the unavailability of phones, internet, and computers.²⁵ These aspects make it especially difficult for pregnant American Indian women to schedule appointments, contact medical providers and sign-up for Medicaid.²⁶
 - i. Access to Medicaid was highlighted as a barrier for American Indian women living in rural South Dakota.²⁷
 - ii. In order to apply for and access to Medicaid, American Indian women usually need to have access to a phone, car, and internet service.²⁸
- c. American Indian women also lack access to reliable and consistent forms of transportation (both personal vehicles and public transit) as well as access to roads.²⁹ The lack of transportation makes it difficult for American Indian women to travel to maternal health appointments and their deliveries.³⁰
- d. The locations of birthing centers require American Indian women to travel long distances from their homes on reservations.³¹ These women often have to travel anywhere from one to four hours in order to get to their appointments and to give birth.³²

²³ Steffens Testimony, *September Briefing*, p. 17.

²⁴ Antoine Testimony, *July Briefing*, p. 6-13; Big Crow Statement at 2; Wilcox Testimony, *July Briefing*, pp.9-10.

²⁵ Wilcox Testimony, *July Briefing*, p. 9.

²⁶ McKay Testimony, *September Briefing*, p. 4.; Wilcox Testimony, *July Briefing*, p. 9.

²⁷ McKay Testimony, *September Briefing*, p. 4.

²⁸ Ibid.

²⁹ Antoine Testimony, *July Briefing*, p. 12; Arielle Deutsch, testimony, *Briefing Before the South Dakota Advisory Committee to the U.S. Commission on Civil Rights*, Dec. 16, 2020, transcript, p. 16 (hereinafter *December Briefing*); McKay Testimony, *September Briefing*, p. 14; Wilcox Testimony, *July Briefing*, p. 9.

³⁰ Deutsch Testimony, *December Briefing*, p. 16; McKay Testimony, *September Briefing*, p. 14; Wilcox Testimony, *July Briefing*, p. 9.

³¹ Antoine Testimony, *July Briefing*, p. 7; Kingman Testimony, *December Briefing*, p. 23; Locke Testimony, *December Briefing*, pp. 5-7; Wilcox Testimony, *July Briefing*, p. 9-11.

³² Antoine Testimony, *July Briefing*, p. 7.; Locke Testimony, *December Briefing*, pp. 5-6.; Wilcox Testimony, *July Briefing*, p. 9.

- e. These infrastructural barriers impact American Indian women’s social determinants of health, which are defined as the environmental conditions in which individuals are born, work, and live.³³ Access to early and routine pre-natal care is the main factor which lowers the risk of maternal morbidity and maternal mortality.³⁴ Each of these barriers compounds upon the other, creating enormous challenges for American Indian women to overcome in order to gain access to pre-natal and routine maternal health services.³⁵

4. Traditional Birthing Practices

- a. Regardless of the location or mode of birthing, American Indian mothers need to have access to traditional practices before and during birth.³⁶ Birth and the birthing process is a sacred event where cultural teachings and ceremonies take place.³⁷ American Indian women need the opportunity to participate in these practices, which include having family members present during birth.³⁸ Due to the distance of birthing centers, and a lack of transportation access on reservations, it is difficult for family members to be present during the time of birth, which results in American Indian mothers giving birth alone and missing out on traditional practices.³⁹
- b. The testimony received indicated that European maternal health practices were forced upon Native people during colonization.⁴⁰ These practices do not align with the traditional beliefs and practices of American Indian people.⁴¹ Pre-colonization, American Indian tribes invested in maternal health because it was a pillar of health and success for their communities.⁴² Even today, Lakota tradition holds women to the highest respect by supporting a mother’s decisions about her

³³ Big Crow Statement at 2.

³⁴ *Ibid.*, 3.

³⁵ McKay Testimony, *September Briefing*, pp. 2-3.

³⁶ Antoine Testimony, *July Briefing*, p. 7; Big Crow Statement, at 3; Wilcox Testimony, *July Briefing*, pp. 9-11; Locke Testimony, *December Briefing*, p. 6.

³⁷ Big Crow Statement, at 4; Wilcox Testimony, *July Briefing*, p. 9.

³⁸ *Ibid.*

³⁹ Wilcox Testimony, *July Briefing*, pp. 9-11.

⁴⁰ Big Crow Statement, at 4; Wilcox Testimony, *July Briefing*, p. 9.

⁴¹ *Ibid.*

⁴² Jennifer Giroux, MD, MPH, Written Statement for the *September Briefing before the South Dakota Advisory Committee to the U.S. Commission on Civil Rights*, Sep. 16, 2020, at 2 (hereinafter Giroux Statement). Opinions expressed are those of Dr. Giroux and do not necessarily reflect the views of the Indian Health Service.

baby and her body.⁴³ The Lakota tradition includes honoring fathers within the birthing process and not immediately cutting the umbilical cord post-birth, indicating that fathers should be considered as part of comprehensive efforts to address maternal health.⁴⁴

5. Cultural Competency

- a. American Indian women need access to culturally competent services. Cultural competence is defined as the incorporation and transference of knowledge about persons and groups of people into particular policies, attitudes, standards, and practices used to increase the quality and outcomes of services for all groups and peoples.⁴⁵
- b. The Committee heard testimony that health care providers, institutions and practices do not reflect the values of American Indian women.⁴⁶ The testimony reflected that many hospitals in the state do not allow American Indian women to participate in traditional birthing ceremonies.⁴⁷ This lack of cultural freedom is associated with spiritual harm towards the baby and the family.⁴⁸
- c. Within the testimony, panelists shared that the health care institutions are informed by western ideals that are connected to the infringement of American Indian cultural traditions.⁴⁹ These healthcare institutions were referenced as “culturally-biased” systems that do not recognize the cultural framework of American Indian women.⁵⁰ This lack of recognition was linked to the systemic oppression, structural racism and cultural erasure of American Indian people.⁵¹
- d. There is a dislocation between institutional maternal health and traditional healing practices.⁵² Institutional rules and guidelines pre-natal care and maternal health

⁴³ Locke Testimony, *December Briefing*, p. 8.

⁴⁴ Ibid.

⁴⁵ Centers for Disease Control and Prevention, *Cultural Competence in Health and Human Services*, (n.d.), <https://npin.cdc.gov/pages/cultural-competence#what> (accessed May 10, 2021).

⁴⁶ Deutsch Testimony, *December Briefing*, p. 16.

⁴⁷ Big Crow Statement, at 4.

⁴⁸ Ibid.

⁴⁹ Ibid.

⁵⁰ Ibid.

⁵¹ Big Crow Statement, at 4.

⁵² New Holy Testimony, *December Briefing*, pp. 18-19.

restrict the ways in which American Indian women can experience their traditional modes of healing.⁵³

- e. American Indian women can feel stigmatized, stereotyped, and dismissed by the current medical system, which can deter them from seeking maternal health services.⁵⁴ This lack of cultural understanding, specifically within health institutions, could potentially be a barrier for American Indian women seeking healthcare.⁵⁵ This is especially true if American Indian women are receiving care from a primarily White health institution that does not support or enforce cultural competency efforts.⁵⁶

6. Birthing Centers, Home Births and Traditional Practices

- a. American Indian women need access to healthcare that supports their right to choose the maternal health services that best fit their individual needs. This includes access to reservation-based birthing centers, home births and traditional birthing practices.
- b. There is a lack of accessible birthing centers for American Indian women living on South Dakota reservations.⁵⁷ The Committee heard testimony which highlighted the suggestion that reservation-based birthing centers could act as a solution to accessibility barriers.⁵⁸ American Indian women are in need of reservation-based birthing centers to alleviate transportation barriers and exercise their traditional practices.⁵⁹
- c. Home births are another alternative to institutionalized health care for American Indian women.⁶⁰ This type of birth allows for American Indian women to avoid transportation barriers and experience an empowering, alternative mode of healing.⁶¹

⁵³ Ibid.

⁵⁴ Deutsch Testimony, *December Briefing*, p. 16.

⁵⁵ Ibid.

⁵⁶ Ibid.

⁵⁷ Antoine Testimony, *July Briefing*, p. 7.; Kingman Testimony, *December Briefing*, p. 23.; Locke Testimony, *December Briefing*, pp. 5-7.; Wilcox Testimony, *July Briefing*, p. 9-11.

⁵⁸ Ibid.

⁵⁹ Antoine Testimony, *July Briefing*, p. 7.; Wilcox Testimony, *July Briefing*, p. 9.

⁶⁰ Locke Testimony, *December Briefing*, pp. 5-8.

⁶¹ Ibid.

7. Institutional Racism

- a. Institutional racism is defined as structural policies, practices, and laws that create differential access to resources, goods, services and opportunities for individuals and groups of people based on race.⁶²
- b. Institutionalized racism is often evident as inaction in the face of need.⁶³ Institutional racism is structurally embedded within society, institutions and laws which makes it difficult to identify one single cause for its existence.⁶⁴ Despite the difficulty in identifying a single cause of institutional racism, institutional racism was suggested as directly, negatively impacting the health disparities experienced by American Indian women in South Dakota.⁶⁵
- c. Prejudice, discrimination, and racism are associated with institutional racism.⁶⁶ These factors associated with institutional racism increase the levels of anxiety experienced by American Indian and Alaska Native people because they are associated with colonization, forced migration, genocide, cultural erasure and forced boarding schools.⁶⁷
- d. Institutional racism creates a traumatic environment for American Indian women, which negatively impacts their human development.⁶⁸ Institutional racism can cause intergenerational trauma, adverse childhood experiences, and toxic stress.⁶⁹ These factors can compound with the lack of available resources caused by institutional racism and create health implications for American Indian women in the state of South Dakota.⁷⁰

8. Mandated Reporting and Drug Testing

⁶² Littlefield Testimony, *September Briefing*, p.11.

⁶³ Steffens Testimony, *September Briefing*, p. 11.

⁶⁴ Ibid.

⁶⁵ Giroux Statement, at 3-5.

⁶⁶ Big Crow Statement, at 3; Littlefield Testimony, *September Briefing*, p.11.

⁶⁷ Big Crow Statement, at 3.

⁶⁸ Littlefield Testimony, *September Briefing*, p.11; Giroux Statement at 6-7.; Steffens Testimony, *September Briefing*, p. 11; Giroux Statement, at 3-5.

⁶⁹ Giroux Statement at 6-7.

⁷⁰ Ibid.

- a. More White women drink during pregnancy than American Indian women, but when American Indian women drink during pregnancy, they are more likely to binge drink.⁷¹
- b. American Indian mothers experience more trauma and adverse childhood experiences than White mothers in the state.⁷² These factors can increase their likelihood of developing substance use disorder.⁷³ As compared to White women in the state, American Indian women in South Dakota are disproportionately affected by substance use as well as preconceptions around substance use.⁷⁴
- c. In South Dakota law, health care staff who suspect drug use can order a drug test.⁷⁵ This suspicion is a barrier for American Indian women seeking prenatal care because they can fear being stereotyped and drug tested by healthcare staff who bring their stereotypes into their medical practice.⁷⁶ The Committee heard testimony that American Indian women are often drug screened randomly because of perceptions about their lifestyle based on the color of their skin.⁷⁷
- d. American Indian mothers in South Dakota can also be drug tested for “non-compliance” if they sign up for Medicaid later into their pregnancy.⁷⁸ American Indian women face barriers in applying for Medicaid [phone, transportation, internet services], which may influence the date in which they can apply.⁷⁹ This late uptake of Medicaid can be perceived as a risk for maternal drug use by medical professionals.⁸⁰
- e. Mandated reporting law in South Dakota requires that pregnant mothers be reported for drug use.⁸¹ For American Indian mothers dealing with substance use,

⁷¹ Elliott Testimony, *November Briefing*, p. 6.

⁷² Steffens Testimony, *September Briefing*, p. 15.

⁷³ *Ibid.*

⁷⁴ *Ibid.*

⁷⁵ McKay Testimony, *September Briefing*, p. 4; See S.D. Codified Laws § 26-8A-2(9) (classifying abusive prenatal drug or alcohol use as child abuse); S.D. Codified Laws § 26-8A-3 (2021) (mandatory reporting of suspected child abuse by physicians).

⁷⁶ *Ibid.*, 4-8.

⁷⁷ *Ibid.*, 7-8.

⁷⁸ *Ibid.*, 4.

⁷⁹ *Ibid.*

⁸⁰ *Ibid.*

⁸¹ Giroux Statement, at 6; See S.D. Codified Laws § 26-8A-2(9) (classifying abusive prenatal drug or alcohol use as child abuse); S.D. Codified Laws § 26-8A-3 (2021) (mandatory reporting of suspected child abuse by physicians);

this law can be a barrier to their pre-natal care because there is fear of the legal repercussions connected to this law.⁸²

- f. There is a lack of supportive services for American Indian mothers experiencing substance use.⁸³ Specifically on the Rosebud Reservation, there is only one substance use treatment center, but it has a long waiting list of clients.⁸⁴
- g. Access to substance use treatment programs via telemedicine is important to provide, especially during COVID-19.⁸⁵
- h. Without access to supportive services for substance use treatment, American Indian mothers are more likely to become involved with the judicial system.⁸⁶
- i. The Committee heard testimony that that harsh laws surrounding pregnant substance use further alienates American Indian mothers in need of supportive services and pushes them into the hands of the state's judicial system.⁸⁷

9. Maternal Healthcare for Incarcerated Native Women

- a. In 2020, 52% of women incarcerated in South Dakota were American Indian, however American Indian women only account for about 8% of the state's population.⁸⁸
- b. American Indian women in prison do not receive adequate maternal healthcare which can affect the maternal and child health rates for this population.⁸⁹

see also S.D. Codified Laws § 34-20A-63(3) (permitting involuntary civil commitments of intoxicated mothers who are "pregnant and abusing alcohol or drugs").

⁸² Deutsch Testimony, *December Briefing*, p. 16.

⁸³ McKay Testimony, *September Briefing*, p. 4.; Wilcox Testimony, *July Briefing*, p. 10; Elliott Testimony, *November Briefing*, p. 5.

⁸⁴ Wilcox Testimony, *July Briefing*, p. 10.

⁸⁵ Elliott Testimony, *November Briefing*, p. 7.

⁸⁶ Steffens Testimony, *September Briefing*, p. 15.

⁸⁷ Giroux Statement, at 6.

⁸⁸ *Ibid.*

⁸⁹ Labonte Testimony, *December Briefing*, p.14.

- c. Incarcerated mothers are not allowed visitors during their birth, which is obstructive to the traditional practices of American Indian mothers.⁹⁰ These practices are vital to the cultural well-being of American Indian mothers.⁹¹
- d. The Committee heard testimony that unlike in Alabama, Tennessee and Florida, incarcerated women are not allowed a bonding period with their child post-birth.⁹² This time is essential for mother-child bonding and for mothers to provide necessary anti-bodies to their babies via breastfeeding.⁹³

10. The Impacts of COVID-19

- a. American Indians living in South Dakota are disproportionately impacted by the COVID-19 pandemic.⁹⁴ American Indians in the state have higher rates of positive COVID-19 tests, hospitalization, and death as compared to White individuals.⁹⁵

⁹⁰ Big Crow Statement, at 4; Locke Testimony, *December Briefing*, pp. 14-15; Wilcox Testimony, *July Briefing*, p. 9.

⁹¹ Antoine Testimony, *July Briefing*, p. 7; Big Crow Statement, at 3; Wilcox Testimony, *July Briefing*, pp. 9-11; Locke Testimony, *December Briefing*, p. 6.

⁹² Locke Testimony, *December Briefing*, pp. 14-15; Alysia Santo, “For Most Women who Give Birth in Prison, ‘The Separation’ Soon Follows,” PBS Frontline, <https://www.pbs.org/wgbh/frontline/article/for-most-women-who-give-birth-in-prison-the-separation-soon-follows/> (accessed May 13, 2021); *See also*: In South Dakota, women who are pregnant when they enter the prison system and give birth while incarcerated may be eligible to have their newborn child stay in their care for up to 30 days through the Mother-Infant Program. Mother Infant Programs, SD DEPT. OF CORR.’S, <https://doc.sd.gov/adult/facilities/wp/mip.aspx> (last visited May 12, 2021). Although the exact requirements to be eligible are unspecified, at a minimum the pregnant inmate must complete a parenting class prior to giving birth. *Ibid*. Pregnant women incarcerated in Florida or Tennessee may be eligible for a furlough to bond with their child for a period of time postpartum. *See* Fla. Admin. Code Ann. r. 33-601.603(7)(a) (stating pregnant inmates who meet certain criteria may be eligible for a furlough of up to one week beyond a satisfactory six-week postpartum examination); Tenn. Code Ann. § 41-21-227(h)(1) (stating pregnant inmates who meet certain eligibility criteria may be eligible for a furlough for up to 6 months postpartum). However, depending on the type of delivery, according to a PBS documentary, Alabama inmates who give birth are required to return to prison without their newborn child within twenty-four or forty-eight hours. For Most Women Who Give Birth in Prison, ‘The Separation’ Soon Follows, PBS, <https://www.pbs.org/wgbh/frontline/article/for-most-women-who-give-birth-in-prison-the-separation-soon-follows/> (last visited May 12, 2021). Although South Dakota does not grant furloughs to inmates who have given birth while incarcerated like Florida and Tennessee, South Dakota does allow a bonding period of up to thirty days for inmates who are part of the Mother-Infant Program. The thirty-day period is more generous than what is allowed in Alabama, where the inmates are required to return to prison without the child within twenty-four or forty-eight hours after giving birth. The Parents and Children Together (PACT) Program also provides opportunities for visits between mothers and children, South Dakota Department of Corrections, *South Dakota Women’s Prison*, <https://doc.sd.gov/adult/facilities/wp/mip.aspx#:~:text=program%20is%20to%20enable%20the,The%20P.A.C.T.&text=A%20maximum%20of%20two%20children%20per%20weekend%20is%20allowed.>

⁹³ Roach Testimony, *December Briefing*, p. 14.

⁹⁴ Specker Testimony, *November Briefing*, p. 8.

⁹⁵ *Ibid*.

- b. COVID-19 has worsened issues that were already impacting reservations in the state of South Dakota.⁹⁶ The pandemic has compounded unemployment, overcrowding in homes, inaccessible healthcare, and a lack of resources.⁹⁷ This additional barrier makes it harder for Tribal Nations to work towards healthier communities.⁹⁸
- c. The pandemic has also made it difficult for maternal healthcare providers to deliver services to American Indian women.⁹⁹ During the time in which testimony was received, the U.S. Department of Health and Human Services' Maternal and Child Health Project Launch Program had to suspend home visits and transportation for their American Indian clients.¹⁰⁰ Without these services, it is harder for American Indian women in the program to travel to maternal health appointments and to receive maternal health education.¹⁰¹
- d. Telemedicine appointments are a potential solution for maternal health care providers who cannot see patients in person.¹⁰² Telemedicine appointments are conducted via computer, webcam, smartphone or tablet and allow patients to virtually speak with their healthcare provider.¹⁰³ These appointments could help provide necessary pre-natal education and could help healthcare providers keep track of their patient's health.¹⁰⁴ However, American Indian women often do not have access to the technology necessary for these appointments.¹⁰⁵

11. Indian Health Service – Standards of Care

- a. The Committee heard testimony that Indian Health Service hospitals do not provide a standard of care that is equal to other national-level healthcare systems, due to the underfunding.¹⁰⁶ The underfunding of Indian Health Service hospitals

⁹⁶ Antoine Testimony, *July Briefing*, pp. 6-8.

⁹⁷ Ibid.

⁹⁸ Antoine Testimony, *July Briefing*, pp. 7-8.

⁹⁹ Wilcox Testimony, *July Briefing*, p. 18.

¹⁰⁰ Ibid., 8-9.

¹⁰¹ Ibid., 8-10.

¹⁰² Elliott Testimony, *November Briefing*, pp. 6-7.

¹⁰³ "For Patients: What is Telemedicine?" U Health. <https://healthcare.utah.edu/telehealth/patients.php#:~:text=A%20telemedicine%20appointment%20is%20just,are%20also%20called%20virtual%20visits> (accessed March 3, 2021).

¹⁰⁴ Elliott Testimony, *November Briefing*, pp. 6-7.

¹⁰⁵ Wilcox Testimony, *July Briefing*, p. 9.

¹⁰⁶ Big Crow Statement at 3.

was linked to a lack of adequate maternal care, poor quality equipment, low staffing levels, and outdated medical facilities.¹⁰⁷

- b. Based on panelist testimony, the low standards of care provided by Indian Health Service are not sufficient for an American Indian mother to experience a healthy birth.¹⁰⁸
- c. The lack of quality health care provided by Indian Health Service hospitals was connected to the anxiety experienced by American Indian and Alaska Native women receiving care at these facilities.¹⁰⁹

12. Trauma

- a. American Indian mothers experience a disproportionate amount of trauma, which impacts the health of their babies and can lead to intergenerational trauma.¹¹⁰ Trauma impacts the brain development of a fetus and has an effect on a genetic level.¹¹¹ Trauma is a root cause of issues with the pregnancy such as premature births, morbidity and mortality.¹¹²
- b. American Indian women in South Dakota experience trauma resulting from racism, poverty, discrimination, and prejudice within their lived environment.¹¹³ The trauma related to these factors has serious implications on the health and wellness of this population.¹¹⁴
- c. Historical trauma caused by institutional racism continues to impact the health of American Indian women today.¹¹⁵ Panelists identified the Family Planning Services and Population Research Act of 1970 and the construction of the Keystone XL pipeline as examples of institutional racism that historically and currently impacts the health of American Indians.¹¹⁶

¹⁰⁷ Ibid.

¹⁰⁸ Ibid.

¹⁰⁹ Ibid.

¹¹⁰ Deutsch Testimony, *December Briefing*, p. 16.; Steffens Testimony, *September Briefing*, p. 10.

¹¹¹ Ibid.

¹¹² Steffens Testimony, *September Briefing*, p. 10.

¹¹³ Big Crow Statement, at 3; Giroux Statement at 3-7; Littlefield Testimony, *September Briefing*, p.11.

¹¹⁴ Big Crow Statement, at 3; Giroux Statement at 3-7; Littlefield Testimony, *September Briefing*, p.11; Steffens Testimony, *September Briefing*, p. 11.

¹¹⁵ New Holy Testimony, *December Briefing*, p. 18.

¹¹⁶ Ibid.

- d. The Committee heard testimony that many hospitals in South Dakota do not foster or encourage the traditional birthing practices of American Indian women, which is associated with the historical trauma related to the cultural destruction of Native cultural and traditions.¹¹⁷

Recommendations

1. The U.S. Commission on Civil Rights should send this report to the U.S. Congress and issue recommendations for it to:
 - a. Provide increased and appropriate funding to the U.S. Department of Health and Human Services Indian Health Service so that it can ensure a standard of care that is equivalent to other national healthcare systems in order to guarantee that American Indian mothers experience a healthy birth. This funding should include:
 - i. Allocations to improve maternal health care by implementing high-quality medical equipment, adequate staffing levels, and updated medical facilities.
 - ii. A data research program focused on the maternal health of American Indian women. This program should ensure that data related to the maternal health of American Indian women is reported on a consistent basis in order to investigate and address barriers to maternal health care as well as any preventative measures for maternal morbidity and maternal mortality.
 - iii. Evaluative tools to track and improve the standard of care for maternal health services at Indian Health Service hospitals specifically, as well as state and private hospitals and clinics to ensure parity with national health systems. Such data will provide insight as to whether maternal mortality issues are universal regardless of the facility, or whether medical practices, cultural training, or billing practices affect maternal mortality statistics.
 - b. Ensure that services provided through Indian Health Service facilities are developed in coordination with Tribal members and promote and respect the cultural and spiritual practices of American Indian women. It is essential that American Indian women have autonomy over the type of maternal health services that they receive through Indian Health Service facilities, which includes choosing how and where they would like to give birth.

¹¹⁷ Big Crow Statement, at 4.

- c. Provide increased and appropriate funding to the U.S. Department of Health and Human Services, Center for Disease Control's Office of Tribal Affairs and Strategic Alliances, Indian Health Service, the Indian Health Service Division of Facilities Operations, and the Office of Minority Health. These agencies should collaborate, in coordination with South Dakota Tribal members, to construct and develop American Indian reservation-based birthing centers for each of the American Indian reservations in South Dakota to ensure that American Indian mothers living on reservations have access to birthing centers that are easily accessible for pre-natal care and delivery. This funding should support:
 - i. Adequate staffing levels, high-quality medical equipment, appropriate sanitation services, and funds for continued proper maintenance and updates to facilities.
 - ii. Cultural competency training for all staff in order to ensure that they are properly educated in working with American Indian populations.
 - iii. Policies that ensure that American Indian mothers have access to pre-natal care and birthing practices that meet their health, spiritual, and cultural needs, as well as specific resources to help birthing center staff members gain access to the resources necessary to meet these needs.
 - iv. Transportation services for American Indian women living on reservations to ensure that American Indian mothers have access to birthing centers during scheduled appointments and during the birthing process.
- d. Provide increased and appropriate funding to the U.S. Department of Health and Human Services, Indian Health Service Division of Behavioral Health to develop a program dedicated to mental health and substance use services for American Indian mothers in consultation with South Dakota Tribal members in order to remedy the lack of mental health and substance use services available to these mothers on South Dakota reservations. This may include collaboration with the U.S. Department of Health and Human Services Office of Minority Health, which offers free e-learning programs for maternal health care providers with cultural and linguistically appropriate services which could be a model for further distribution in coordination with South Dakota's Tribal members. This funding should support:
 - i. Accessible mental health centers on every American Indian reservation in the state of South Dakota.
 - ii. Adequate staffing levels, high-quality medical equipment, appropriate sanitation services and funds for proper building maintenance and updates.

- iii. Cultural competency training for all staff in order to ensure that they are properly educated in working with American Indian populations.
 - iv. Transportation services for American Indian women living on reservations to ensure that American Indian mothers have access to mental health services.
- e. Supply and dedicate funding to the U.S. Department of Health and Human Services, Center for Disease Control's Office of Tribal Affairs and Strategic Alliance, Indian Health Service, the Indian Health Service Division of Behavioral Health, and the U.S. Department of the Interior Indian Affairs Division of Economic Development's National Tribal Broadband Grant program specifically in order to support telemedicine services for maternal health and mental health appointments. Telemedicine appointments are essential to ensuring that American Indian mothers have access to essential health services despite transportation and COVID-19 barriers.
 - f. Revise Medicaid reimbursement eligibility standards to include all healthcare provision settings in the state to reimburse a maternal health case manager who should have appropriate qualifications. Training for case managers should be developed consultation with Tribal members.
 - g. Revise Medicaid access eligibility to include more American Indian mothers. Provide funding for developing best practices to revise and expand Medicaid eligibility to include more American Indian mothers in consultation with Tribal members.
 - h. Provide funding to the U.S. Department of Health and Human Services National Institute on Minority Health and Health Disparities in order to further the research of maternal health disparities experienced by American Indian women in South Dakota. This research is needed to gather further data that can be used to support and strengthen local efforts to reduce maternal mortality and maternal morbidity.
 - i. Consider establishing a joint task force between the U.S. Department of Health and Human Services, Indian Health Service, U.S. Department of Health and Human Services Office of Minority Health, and the U.S. Department of the Interior Indian Affairs Division of Economic Development and Housing Improvement Programs in order to address the intersections between health, housing and employment needs among American Indian populations in South Dakota.
 - j. Review the Maternal Health Quality Improvement Act of 2020 alongside the recommendations in this report and consider drafting new legislation to ensure

that American Indian mothers receive the appropriate healthcare resources to reduce concerning health disparities between Indian Americans and other populations across the United States.

2. The U.S. Commission on Civil Rights should send this report to the U.S. Department of Health and Human Services Indian Health Service and its Division of Behavioral Health and Division of Facilities Operations, U.S. Department of Health and Human Services' Office of Minority Health and the Centers for Disease Control and Prevention's Office of Tribal Affairs and Strategic Alliances, and issue recommendations for these agencies to:
 - a. Collaborate to ensure a standard of care that is equivalent to other national healthcare systems in order to guarantee that American Indian mothers experience a healthy birth. This effort should include programs and monitoring that include:
 - i. Programs to improve maternal health care by implementing high-quality medical equipment, adequate staffing levels, and updated medical facilities.
 - ii. A data research program focused on the maternal health of American Indian women. This program should ensure that data related to the maternal health of American Indian women is reported on a consistent basis in order to investigate and address barriers to maternal health care as well as any preventative measures for maternal morbidity and maternal mortality.
 - iii. Evaluative tools to track and improve the standard of care for maternal health services at Indian Health Service hospitals specifically, as well as state and private hospitals and clinics to ensure parity with national health systems. Such data will provide insight as to whether maternal mortality issues are universal regardless of the facility, or whether medical practices, cultural training, or billing practices affect maternal mortality statistics.
 - b. Ensure that services provided through Indian Health Service facilities are developed in coordination with Tribal members and promote and respect the cultural and spiritual practices of American Indian women. It is essential that American Indian women have autonomy over the type of maternal health services that they receive through Indian Health Service facilities, which includes choosing how and where they would like to give birth (including home births).
 - c. The U.S. Department of Health and Human Services, Center for Disease Control's Office of Tribal Affairs and Strategic Alliances, Indian Health Service, the Indian Health Service's Division of Facilities Operations, and the Office of Minority Health should collaborate, in coordination with South Dakota Tribal

members, to construct and develop American Indian reservation-based birthing centers for each of the American Indian reservations in South Dakota to ensure that American Indian mothers living on reservations have access to birthing centers that are easily accessible for pre-natal care and delivery. These programs should support:

- i. Adequate staffing levels, high-quality medical equipment, appropriate sanitation services, and funds for continued proper maintenance and updates to facilities.
 - ii. Cultural competency training for all staff in order to ensure that they are properly educated in working with American Indian populations.
 - iii. Policies that ensure that American Indian mothers have access to pre-natal care and birthing practices that meet their health, spiritual, and cultural needs, as well as specific resources to help birthing center staff members gain access to the resources necessary to meet these needs.
 - iv. Transportation services for American Indian women living on reservations to ensure that American Indian mothers have access to birthing centers during scheduled appointments and during the birthing process.
- d. Develop programs dedicated to mental health and substance use services for American Indian mothers in consultation with South Dakota Tribal members in order to remedy the lack of mental health and substance use services available to these mothers on South Dakota reservations. This may include leveraging the U.S. Department of Health and Human Services Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) programming that offers free e-learning programs for maternal health care providers as a model for further distribution in coordination with South Dakota's Tribal members. This may also include collaborating with the CDC's Maternal Mortality Review Committees (MMRCS) to reduce disparities in maternal mortality. These efforts should support:
- i. Accessible mental health centers on each American Indian reservation in the state of South Dakota.
 - ii. Adequate staffing levels, high-quality medical equipment, appropriate sanitation services and funds for proper building maintenance and updates.
 - iii. Cultural competency training for all staff in order to ensure that they are properly educated in working with American Indian populations.

- iv. Transportation services for American Indian women living on reservations to ensure that American Indian mothers have access to mental health services.
- e. Collaboration between the U.S. Department of Health and Human Services, Center for Disease Control's Office of Tribal Affairs and Strategic Alliance, Indian Health Service, the Indian Health Service Division of Behavioral Health, and the U.S. Department of the Interior Indian Affairs Division of Economic Development's National Tribal Broadband Grant program specifically in order to support telemedicine services for maternal health and mental health appointments. Telemedicine appointments are essential to ensuring that American Indian mothers have access to essential health services despite transportation and COVID-19 barriers.
- f. Review Medicaid reimbursement eligibility standards to include all healthcare provision settings in the state to reimburse a maternal health case manager who should have appropriate qualifications. Training for case managers should be developed consultation with Tribal members.
- g. Review Medicaid access eligibility to include more American Indian mothers and develop best practices to expand Medicaid eligibility to include more American Indian mothers in consultation with Tribal members. Best practices for expanding eligibility should be conducted in consultation with Tribal members.
- h. Develop programming with the U.S. Department of Health and Human Services National Institute on Minority Health and Health Disparities in order to further the research of maternal health disparities experienced by American Indian women in South Dakota. This research is needed to gather further data that can be used to support and strengthen local efforts to reduce maternal mortality and maternal morbidity.
- i. Develop a joint task force between the U.S. Department of Health and Human Services, Indian Health Service, U.S. Department of Health and Human Services Office of Minority Health, and the U.S. Department of the Interior Indian Affairs Division of Economic Development and Housing Improvement Programs in order to address the intersections between health, housing and employment needs among American Indian populations in South Dakota.
- j. Review the Maternal Health Quality Improvement Act of 2020 alongside the recommendations in this report and consider developing programs to ensure that American Indian mothers receive the appropriate healthcare resources to reduce concerning health disparities between Indian Americans and other populations across the United States.

3. The U.S. Commission on Civil Rights should send this report to the U.S. Department of Transportation Federal Highway Administration's Federal Lands Highway Office and the U.S. Department of the Interior Indian Affairs Division of Transportation and issue recommendations for it to:
 - a. Collaborate in providing funds from the Tribal Transportation Program to the Great Plains Regional Division so that the Division may increase funding for road building and maintenance to the nine American Indian reservations in the state of South Dakota in order to improve transportation conditions that prevent American Indian mothers from receiving timely maternal health care.
4. The U.S. Commission on Civil Rights should send this report to the South Dakota Legislature and issue recommendations for it to:
 - a. Allocate state funding to the Great Plains Tribal Chairmen's Health Board, the South Dakota Department of Social Services Division of Child Protective Services and South Dakota State Agencies who monitor licensing requirements for healthcare professionals in order to develop and implement cultural competency training. This funding should be utilized as follows:
 - i. To supply funding to the Great Plains Tribal Chairmen's Health Board for the purpose of researching and developing cultural competency training for South Dakota healthcare professionals.
 - ii. To supply funding to the South Dakota Department of Social Services Division of Child Protective Services so that it can provide cultural competency training, that is developed by the Great Plains Tribal Chairmen's Health Board, for case workers who provide services to American Indian mothers.
 - iii. To supply state funding to South Dakota State Agencies who monitor licensing requirements for healthcare professionals to implement cultural competency training that is developed by the Great Plains Tribal Chairmen's Health Board.
 - b. Provide increased and appropriate funding for the South Dakota Department of Social Services Division of Child Protective Services so that it can provide American Indian mothers with the option to meet with advocates, aside from their case workers, who can help them maintain custody of their children by advocating for their rights and connecting them with resources. Advocates should receive cultural competency training informed by Tribal members.

- c. Provide and allocate funding for the South Dakota Department of Social Services to further research resources and safety measures for homebirths in consultation with South Dakota Tribal members to support American Indian birth preferences and connect American Indian mothers with resources that will support healthy at-home births that meet their cultural needs. These resources and safety measures should address the benefits and risks of home births for healthy and high-risk pregnancies.
 - d. Research and consider the maternal health benefits and fiscal impacts of paid maternity leave models for mothers, fathers, and same-sex couples in order to promote the health of American Indian parents and infants.
5. The U.S. Commission on Civil Rights should send this report to the South Dakota Board of Medical Examiners, SD Board of Nursing, SD Association of Healthcare Organizations, the SD State Medical Association, and the South Dakota Perinatal Quality Collaborative and issue recommendations for each entity to:
 - i. Establish relationships with American Indians living in South Dakota who are experts on birthing practices.
 - ii. Develop and implement cultural competency training to all healthcare professionals involved in maternal health regarding American Indian birthing practices.
 - iii. Develop criteria to include American Indian cultural competency in South Dakota Healthcare Professional licensing requirements.
 - iv. Monitor the implementation of cultural competency trainings and impact on American Indian maternal mortality.
6. The U.S. Commission on Civil Rights should send this report to the South Dakota Department of Health and issue recommendations for it to:
 - a. Reimburse maternal health case managers who would provide social services and address social issues for pregnant women and new mothers in order to, for example, facilitate needs such as travel to and from appointments and food or shelter insecurity.
 - b. Enforce the inclusion and participation of representatives from the Great Plains Tribal Chairmen's Health Board and from each of the nine American Indian Tribes within the state of South Dakota [Cheyenne River Sioux Tribe, Crow Creek Sioux Tribe, Flandreau Santee Sioux Tribe, Lower Brule Sioux Tribe, Oglala Sioux Tribe, Rosebud Sioux Tribe, Sisseton Wahpeton Oyate, Standing Rock Sioux Tribe, Yankton Sioux Tribe] on the South Dakota Maternal Mortality

Review Committee. This inclusion and participation is essential in ensuring that Tribal concerns and needs are met through the work of this Committee.

- c. Provide funding to the South Dakota Maternal Mortality Review Committee so that it can ensure that Tribal representatives have adequate access to technological tools (such as internet services) as well as data and subject matter expertise related to the maternal health issues faced by their communities so that these representatives can fully participate in Committee procedures.
 - d. Establish a sub-committee specifically for American Indian Tribal representatives on the South Dakota Maternal Mortality Review Committee to ensure that Tribal representatives on the Committee have adequate time and resources to meet separately from the larger Committee to discuss Tribal-specific concerns related to maternal mortality. This development is essential to make certain that Tribal representatives have the opportunity to organize and prepare Tribal-related concerns for the larger Committee.
 - e. Provide funding to the South Dakota Maternal Mortality Review Committee that can be allocated towards efforts to communicate the public health recommendations and findings of the Committee to American Indian populations. Communication processes should be created in consultation with South Dakota Tribal members to ensure that the findings and recommendations of the Committee are appropriately shared with populations most affected by maternal mortality issues.
7. The U.S. Commission on Civil Rights should send this report to the Congressional Leadership Conference for The American College of Obstetricians and Gynecologists and issue recommendations for it to:
- a. Use this report to provide further evidence for the need for Congress to pass the Maternal Health Quality Improvement Act, which confronts racism and bias in healthcare through implicit bias training programs and provides funding.
8. The U.S. Commission on Civil Rights should send this report to the National Alaska Native American Indian Nurses Association and issue recommendations for it to:
- a. Develop American Indian maternal healthcare trainings (pre-natal, birthing, and post-natal) for healthcare professionals across the United States and work directly with the Great Plains Tribal Chairmen's Health Board and state-led agencies who license and monitor healthcare professionals.

9. The U.S. Commission on Civil Rights should send this report to South Dakota's Tribal presidents and Tribal health directors for their awareness of the findings and recommendations raised in this report.

II. INTRODUCTION AND BACKGROUND

The U.S. Commission on Civil Rights (Commission) is an independent, bipartisan agency established by Congress and directed to study and collect information relating to discrimination or a denial of equal protection of the laws under the Constitution because of race, color, religion, sex, age, disability, national origin, or in the administration of justice. The Commission has established advisory committees in each of the 50 states and the District of Columbia. These Advisory Committees advise the Commission of civil rights issues in their states that are within the Commission's jurisdiction.

On October 23, 2019, the South Dakota Advisory Committee (Committee) to the U.S. Commission on Civil Rights voted unanimously to take up a proposal to examine the disparities in the maternal mortality rates experienced by American Indian women in South Dakota. American Indian women in South Dakota receive health care from a variety of sources, including the Indian Health Service, which is a federal agency within the Department of Health and Human Services; Urban Indian Organizations, which receive contracts under Title V of the Indian Health Care Improvement Act,¹¹⁸ and other health care organizations that receive Title X and Medicaid funding. With this in mind, pursuant to 42 U.S.C. § 1975(a) this topic falls under the Commission and Committee's jurisdiction to study discrimination based on the denial of equal protection under the law, as well as its authority to review a federal agency's enforcement of civil rights law.. *See* 45 C.F.R. § 703.3 (noting that the "[s]cope of the subject matter to be dealt with by Advisory Committees shall be those subjects of inquiry or study with which the Commission itself is authorized to investigate, pursuant to 42 U.S.C. 1975(a).") The Committee also sought to understand the work of state and local agencies that work to support American Indian health.

An area of growing concern among policy makers is the maternal mortality rate experienced by women of color around the country. According to data collected by the Centers for Disease Prevention and Control between 2011 and 2015, pregnant Black women had the highest pregnancy-related mortality ratio in the United States with a rate of 42.8 deaths per 100,000 women.¹¹⁹ However, American Indian and Alaska Native women had the second-highest rate at 32.5 deaths per 100,000 women.¹²⁰ This rate is 2.5 times the rate that White women experience.¹²¹ According to a United Health Foundation Report in in 2018, South Dakota had one of the highest

¹¹⁸ 25 USC § 1601 et seq.

¹¹⁹ *Vital Signs: Pregnancy-Related Deaths, United States, 2011–2015, and Strategies for Prevention, 13 States, 2013–2017* (May 2019), https://www.cdc.gov/mmwr/volumes/68/wr/mm6818e1.htm?s_cid=mm6818e1_w. (showing that the pregnancy-related mortality ratio for White women is 13 out of 100,000 deaths).

¹²⁰ *Ibid.*

¹²¹ *Ibid.*

maternal mortality rates in the nation – 28 per 100,000 pregnancies.¹²² The concern about racial disparities in South Dakota generally largely reduces to a focus on the mortality rate experienced by American Indian women in South Dakota. Statistics show that in South Dakota, from 2010-2018, White women experienced 55.4% of pregnancy-associated deaths and make up 85% of state's female population.¹²³ However, American Indian women experienced 36.9% pregnancy-related deaths while making up approximately 8% of state's female population.¹²⁴ The maternal death rate for American Indian women in South Dakota is grossly disproportionate to their population numbers.

It is not immediately clear why this discrepancy exists, in part because of the limited nature of the information that is currently available. Data reveals specific *causes* of death, but it typically does not speak comprehensively to the underlying, systemic forces that might contribute to the problem. Examples of these forces might include poverty, the difficulties attendant upon rurality (especially in light of the wide swathe of maternal health deserts that exists across the state), and/or health inequities that have a uniquely pernicious effect on Native women. The establishment of a state-level Maternal Mortality Review Committee (or, perhaps, one housed somewhere else, e.g., in a university) has the potential to explore and identify some of these possibilities.

Recent examples of pregnant women of color who died or had near-death experiences in childbirth, like the story reported by professional tennis legend Serena Williams, have drawn attention to disparities in treatment for pregnant Black women, even across lines of education and class. The call to investigate this issue, however, has not focused on the experiences of American Indian women in a meaningful way.

It appears that there is only limited sustained attention to this issue in South Dakota. Between 2016 and 2018, the CDC provided funding to state¹²⁵ and local¹²⁶ organizations to conduct the Pregnancy Risk Assessment Monitoring (PRAMS) Surveys, and in 2019, the state received a grant from the Centers for Disease Control and Prevention to implement a South Dakota Violent Death

¹²² America's Health Rankings, United Health Foundation, *2018 Health of Women and Children Report* at 43 (2018), <https://www.americashealthrankings.org/learn/reports/2018-health-of-women-and-children-report/state-summaries-south-dakota>. Maternal mortality was not a measure that was reported in the United Health Foundation's 2020 Health of Women and Children Report: America's Health Rankings, United Health Foundation, *2020 Health of Women and Children Report* at 43 (2020). https://assets.americashealthrankings.org/app/uploads/hwc20_state_summaries.pdf.

¹²³ South Dakota Department of Health, *Maternal Mortality*, <https://doh.sd.gov/statistics/maternalmortality.aspx>; "South Dakota Population 2021." World Population Review. <https://worldpopulationreview.com/states/south-dakota-population> (accessed March 3, 2021).

¹²⁴ Ibid.

¹²⁵ "PRAMS (PREGNANCY RISK ASSESSMENT MONITORING SYSTEM)." South Dakota Department of Health. <https://doh.sd.gov/statistics/PRAMS.aspx> (accessed March 29, 2021).

¹²⁶ "GPTCHB Receives 2016 South Dakota Tribal Pregnancy Risk Assessment Monitoring System." Great Plains Tribal Chairmen's Health Board. <https://gptchb.org/news/sd-tprams/> (accessed March 29, 2021).

Reporting System.¹²⁷ As this data becomes available, it may help provide more insight into understanding what is contributing to maternal death rates.

As foundational to its study, the South Dakota Advisory Committee to the U.S. Commission on Civil Rights recognizes the sovereignty of Indian Tribes and the unique government-to-government relationship South Dakota's Indian nations and tribes have with the United States. Indian Tribes are prior sovereigns and Federally Recognized Indian Tribes reserved their inherent right to self-government in treaties with the United States. Tribal Governments are the governing bodies of Federally Recognized Indian tribes.

Indian nations and tribes are the original American sovereigns. For thousands of years prior to the formation of the United States, Indian nations were independent sovereign nations, and Indian nations, spread across what is now the United States, had inherent sovereignty over their lands and their peoples, and practiced full self-governance. Under the Articles of Confederation,¹²⁸ for example, the United States entered into 16 treaties, 9 treaties with Indian nations and 7 treaties with foreign nations.

Pertinent to this Committee's Report, the tribes in the western half of what is now South Dakota entered into the 1868 Ft. Laramie Treaty¹²⁹ with the United States Government. This Treaty sought to end warfare with the signatories by promising many things in exchange, including a permanent land base and various resources and health care.

Importantly, United States District Judge Roberto Lange, in the District of South Dakota, recently found that:

The United States does owe the Tribe some duty to provide health care to its members, even if the fiduciary duty judicially enforceable is just competent physician-led health care based on the construction of the 1868 Treaty of Fort Laramie.¹³⁰

Judge Lange went on to hold that “[b]ecause the 1868 Treaty of Fort Laramie specifically addressed health care for the Tribe including “that such appropriations shall be made from time to time... as will be sufficient to employ such persons,” the money allocated to Rosebud IHS Hospital represents, at least in some measure, the performance of a treaty obligation, and therefore a trust duty attaches.¹³¹

The determinations of our Tribal governments concerning the relationship between public health and safety, economic relief, and Tribal general welfare are entitled to deference under prevailing Federal law and policy and should be respected. *See*, 26 U.S.C. § 139E note (Statutory

¹²⁷ South Dakota Department of Health, *South Dakota Preventable Death Committee*, <https://doh.sd.gov/statistics/PreventableDeath.aspx>.

¹²⁸ Art. Of Confederation, 1 Stat. 4 (1778).

¹²⁹ Laramie Treaty, 15 Stat. 635 (1868).

¹³⁰ *Rosebud Sioux Tribe v. United States*, 450 F. Supp. 3d 986, 1001 (D.S.D. 2020).

¹³¹ *Id.*, at 1001; *Quick Bear v. Leupp*, 210 U.S. 50, 66 (1908).

construction. Act Sept. 26, 2014, Pub. L. No. 113-168, § 2(c), 128 Stat. 1884) (providing that, under the Tribal General Welfare Exclusion Act, “deference shall be given to Indian Tribal governments for the programs administered and authorized by the tribe to benefit the general welfare of the Tribal community”).

President Biden has said that, “it is a priority of my Administration to make respect for Tribal sovereignty and self-governance, commitment to fulfilling Federal trust and treaty responsibilities to Tribal Nations, and regular, meaningful, and robust consultation with Tribal Nations cornerstones of Federal Indian policy.”¹³²

Reflecting on these treaty obligations, the Committee draws attention to Article XIII of the Fort Laramie Treaty, which states: “The United States hereby agrees to furnish annually to the Indians the physician, teachers, carpenter, miller, engineer, farmer, and blacksmiths, as herein contemplated, and that such appropriations shall be made from time to time, on the estimate of the Secretary of the Interior, as will be sufficient to employ such persons.”¹³³ This article outlines the obligations of the federal government to provide sufficient individuals to support the infrastructure of American Indian reservations. Another article of interest is Article II, which designates American Indians to rural locations to live on reservations.¹³⁴

Despite the language in the Fort Laramie treaty, the U.S. Commission on Civil Rights, *Broken Promises* report found that the federal government had not been fulfilling its treaty obligations towards the health care of American Indians.¹³⁵ According to this report, the federal government has failed their treaty obligations by not providing sufficient health care funding to Tribal Nations, which was directly linked to the health disparities between American Indians and other groups, including American Indian infant mortality rates.¹³⁶ In this report, funding for the Indian Health Service was found to be inequitable and unequal, as its budget has not kept pace with inflation, or its backlog of maintenance for facilities.¹³⁷ It was also found that the rural location of American

¹³² *Presidential Memorandum on Tribal Consultation and Strengthening Nation-to-Nation Relationships* (Jan. 26, 2021).

¹³³ Laramie Treaty, 15 Stat. 635 (1868); *See also*: Yale Law School, *Fort Laramie Treaty, 1868*, https://avalon.law.yale.edu/19th_century/nt001.asp. It should also be noted that the United States District Court for the District of South Dakota held in 2020, regarding this provision of the 1868 Ft. Laramie Treaty, that “[b]ecause the 1868 Treaty of Fort Laramie specifically addressed health care for the [Rosebud Sioux] Tribe including “that such appropriations shall be made from time to time... as will be sufficient to employ such persons,” the money allocated to Rosebud IHS Hospital represents, at least in some measure, the performance of a treaty obligation, and therefore a trust duty attaches. *Rosebud Sioux Tribe*, 450 F. Supp. 3d at 996 (2020).

¹³⁴ Laramie Treaty, 15 Stat. 635 (1868).

¹³⁵ U.S. Commission on Civil Rights, Briefing Before The United States Commission on Civil Rights Held in Washington, *Broken Promises: Continuing Federal Funding Shortfall for Native Americans*, 2018, pp. 208-209 (hereinafter cited as Briefing Before The United States Commission on Civil Rights Held in Washington, *Broken Promises*)

¹³⁶ Briefing Before the United States Commission on Civil Rights Held in Washington, *Broken Promises*, p. 206.

¹³⁷ Briefing Before the United States Commission on Civil Rights Held in Washington, *Broken Promises*, p. 209.

Indian reservations impacted their infrastructural issues, including the functioning of Indian Health Service hospitals.¹³⁸ The federal government's lack of treaty fulfillment was also linked to a deficiency in housing, economic development, criminal justice, and Tribal sovereignty.¹³⁹

The Committee undertook its study with a goal to understand the broad factors contributing to maternal deaths of pregnant American Indian women in South Dakota specifically, and also heard testimony that included the deaths of infants that might be related to poor maternal health over the course of its briefings. To help guide its findings and recommendations to the Commission, this report includes a summary of the testimony heard during its briefings on July 14, 2020; September 16, 2020; November 18, 2020; and a public community forum on December 16, 2020. The Committee also received written testimony as part of its study, which has been included in the summary of testimony as well. As part of their study, the Committee also asked speakers a voluntary follow-up question to ask if they could highlight what was working well that could potentially be improved upon, but received no responses to this question.¹⁴⁰ The findings presented in this report highlight the themes in the testimony the Committee received, and the recommendations seek to address the issues the Committee sought to undertake as part of its project.

It should be recognized that the COVID-19 pandemic began as this Committee was beginning to plan its briefings on this topic, which impacted the Committee's original intended goal of hearing testimony in-person to support the inclusion of American Indian voices. Committee members worked hard to share the Committee's study and include voices from individuals impacted by this issue in its virtual briefings. It is important to consider this study in the context that American Indian communities in South Dakota have been particularly affected by COVID-19 due to the longstanding issues related to adequate healthcare, access to health resources, and access to virtual platforms, particularly by those who live in reservations within South Dakota.¹⁴¹ In this context, the Committee submits its report on maternal mortality and health disparities of Native American women to the U.S. Commission on Civil Rights.

III. SUMMARY OF PANEL TESTIMONY

The virtual public meetings (briefings) held on July 14, 2020; September 16, 2020; November 18, 2020; and December 16, 2020 included testimony from American Indian women, researchers,

¹³⁸ Briefing Before the United States Commission on Civil Rights Held in Washington, *Broken Promises*, pp. 69-176.

¹³⁹ Briefing Before the United States Commission on Civil Rights Held in Washington, *Broken Promises*, pp. 206-213.

¹⁴⁰ Follow-up to Briefing Speakers, February 2021.

¹⁴¹ Indian Health Service, *Coronavirus (COVID-19)*, (May 11, 2021), <https://www.ihs.gov/coronavirus/> (accessed May 12, 2021).

advocates, and other relevant stakeholders. Written testimony provided in connection with the Committee's briefings has also been included within the Committee's summary of testimony.

A. Historical Background

Captain Jennifer Giroux, MD, MPH, medical epidemiologist, employed by the U.S. Department of Health and Human Services Indian Health Service and assigned to the Great Plains Tribal Chairmen's Health Board to provide public health expertise and leadership, drew attention to the historical importance of the 1868 Treaty of Fort Laramie (Sioux Treaty).¹⁴² According to Dr. Giroux, this treaty represents, "the beginning of the United States breaking treaties and promises with on-going attacks on the indigenous people and their way of life in the northern plains."¹⁴³ This treaty designated the western part of South Dakota as Sioux Country, however, this did not last.¹⁴⁴ As pointed out by Dr. Giroux, "the US Army launched a campaign to slaughter the bison, the primary food source of many northern plain tribes."¹⁴⁵ Dr. Giroux drew attention to the fact that after 1872, it was estimated that over 30 million bison were killed.¹⁴⁶ In 1874, gold was discovered in the Black Hills, which led to further violations of the 1868 treaty.¹⁴⁷ Dr. Stephanie Big Crow, a Lakota woman who studies epigenetics, pointed out that American Indians received no monetary gains from the excavation of the natural resources on their reservations due to the mismanagement of American Indian finances by the Bureau of Land Management.¹⁴⁸ During 1879, five years after gold was discovered in the Black Hills, the federal government funded the Carlisle Boarding School whose slogan was, "Kill the Indian, Save the Man."¹⁴⁹ This boarding school assimilated indigenous tribes, stripping them of their social customs, norms and cultural parenting practices.¹⁵⁰ In a written statement to the Committee, Dr. Giroux shared, "This loss [of culture] can be associated with loss of health in American Indian communities today."¹⁵¹

The 1980 U.S. Supreme Court case, *United States vs. the Sioux Nation of Indians*, recognized that the 1868 Treaty of Fort Laramie was broken by the United States and found that the involved tribes

¹⁴² Giroux Statement, at 1.

¹⁴³ Giroux Statement, at 1.

¹⁴⁴ *Ibid.*

¹⁴⁵ *Ibid.*

¹⁴⁶ *Ibid.*

¹⁴⁷ *Ibid.*

¹⁴⁸ Big Crow Statement, at 3.

¹⁴⁹ Giroux Statement, at 1.

¹⁵⁰ *Ibid.*

¹⁵¹ *Ibid.*

should be compensated.¹⁵² American Indian tribes have not accepted this compensation and have instead requested a return of their land, which, according to Dr. Giroux, has not been granted to this day.¹⁵³

Dr. Giroux called on the 2018 report by the U.S. Commission on Civil Rights titled *Broken Promises*.¹⁵⁴ She included an excerpt from the recommendations of this report which suggested that the United States should live up to their treaty expectations, and that Congress should pass a spending packages to address the unmet needs of American Indian tribes including infrastructural needs such as electricity, water, telecommunications, and roads.¹⁵⁵

1. Pre-Colonial, American Indian Maternal Health

In the words of Dr. Giroux, “Pre-colonized tribes in the northern plains highly valued and invested in maternal childhood development.”¹⁵⁶ Dr. Giroux explained that the Lakota people had “winulas,” midwives, that helped deliver American Indian children.¹⁵⁷ To demonstrate this, Dr. Giroux shared an excerpt from Luther Standing Bear’s *Land of Spotted Eagle*.¹⁵⁸ In this excerpt, Luther Standing Bear, a Sicangu and Oglala Lakota chief and author, described that the Lakota people considered a weak or sick baby to be evidence that a mother was not giving their baby proper attention and not fulfilling her duty to the tribe.¹⁵⁹ Moreover, this was evidence that the mother was not using her social supports or following the tribe’s traditions.¹⁶⁰ Dr. Giroux shared that, according to Lakota traditions, a child will have six years of un-restricted attention from their mother, and that no other child be born to that mother within those six years.¹⁶¹ Any mother who broke this law, would lose the respect of her tribe for both herself and the child’s father.¹⁶²

Dr. Giroux utilized this example to show that, for American Indians in South Dakota, an early attention to maternal and child health as well as early childhood development made up the

¹⁵² *Ibid.*, 2; *See also*: *Sioux Nations of Indians v. U.S.*, 220 Ct.Cl. 442 (1979) and *Laramie Treaty*, 15 Stat. 635 (1868).

¹⁵³ *Ibid.*

¹⁵⁴ Giroux Statement, at 2; Briefing before the United States Commission on Civil Rights Held in Washington, *Broken Promises*.

¹⁵⁵ Giroux Statement, at 2.

¹⁵⁶ *Ibid.*

¹⁵⁷ *Ibid.*

¹⁵⁸ *Ibid.*

¹⁵⁹ *Ibid.*

¹⁶⁰ *Ibid.*

¹⁶¹ *Ibid.*

¹⁶² *Ibid.*

foundation for healthy Tribal members.¹⁶³ She stated, “If this traditional wisdom was re-implemented, we contend that in 1-2 generations, American Indians could regain healthier life spans.”¹⁶⁴

Waniya Locke, a member of the public and a doula from Standing Rock Reservation, expanded on the Lakota perspective of maternal and child health.¹⁶⁵ Ms. Locke shared her understanding that the Lakota tradition holds women to the highest respect by supporting the mother’s decisions about their body and their baby.¹⁶⁶ Ms. Locke added that prior to the colonization, Lakota fathers were upheld in the same way as mothers and a large part of the birthing and bonding process.¹⁶⁷ Ms. Locke stated that “...compared to European concepts that have been forced upon us...We value the women so much and their choices, understanding that they're the backbone of the people.”¹⁶⁸

The focus on bonding is, in the words of Ms. Locke, “...something that is really important to the Lakota people.”¹⁶⁹ According to the Lakota tradition, the umbilical cord is not immediately cut from the placenta in order to give the baby extra nutrients.¹⁷⁰ This practice also allows for bonding between the mother and child, as it allows them to be connected outside of the body; acknowledging the baby as an individual.¹⁷¹

A. Disparities Between White and Native Mothers

1. Historical Health Disparities for Native Populations

The U.S. Department of Health and Humans Services Centers for Disease Control and Prevention (CDC), which was created in the 1950s, provides states and communities with funding, as well as disease surveillance; however, according to Dr. Giroux, American Indian tribes were not included in this public health system.¹⁷² Due to this, there is not a systematic process for tribes to receive categorical funding and shared resources.¹⁷³ Dr. Giroux pointed out that American Indian tribes received categorical funding from the CDC, in the 1990s for Tribal Breast and Cervical Cancer

¹⁶³ Ibid.

¹⁶⁴ Ibid.

¹⁶⁵ Locke Testimony, *December Briefing*, p. 8.

¹⁶⁶ Locke Testimony, *December Briefing*, p. 8.

¹⁶⁷ Ibid.

¹⁶⁸ Ibid.

¹⁶⁹ Ibid.

¹⁷⁰ Ibid.

¹⁷¹ Ibid.

¹⁷² Giroux Statement, at 5.

¹⁷³ Ibid.

Early Detection programs, however, much of the public health efforts for American Indian tribes varies largely from state to state; with some developing “subcontracts” with tribes, some paying contractors to work with tribes and some doing nothing in their state.¹⁷⁴

Ten years ago, the Great Plains Tribal Epidemiology Center investigated the mortality rates for each Tribal reservation in the regions of South Dakota, North Dakota, Nebraska and Iowa.¹⁷⁵ According to Ms. Steffens, this was the first time that each tribe had data on their communities’ own leading causes of death and cancer rates.¹⁷⁶ This data was tallied and compared to White individuals in the same counties and it was found that within a thirteen year period, “heart disease mortality ranged from 1.3 to 2.5 times higher for American Indian, cancers were 1.3 to 2.1 times higher, and diabetes with 3.1 to 9.1 times higher.”¹⁷⁷ The term “White” also refers to “Caucasian” in this report. The Tribal Health Directors and the Tribal Epidemiology Center conducted meetings with American Indian tribes, their respective state health department, and experts to evaluate the risk factors that were associated with the leading causes of death found in the study.¹⁷⁸ As Ms. Steffens pointed out, as a result of these meetings, it was found that risk factors such as, “smoking, poor nutrition lack of exercise and obesity,” did not account for the magnitude of racial health disparities.

Ms. Steffens shared Matthew Christiansen and Lon Kightlinger’s research that represented the difference in mortality patterns between white and American Indian populations [see Figure 1].¹⁷⁹ She and Dr. Giroux both highlighted that based off of their research, they found that compared to other ethnic and racial groups, American Indian individuals living in South Dakota had the highest “pre-mature mortality” rates in the country.¹⁸⁰ Additionally, it was found that the high mortality rates exist across all ages of American Indian individuals.¹⁸¹ Ms. Steffens emphasized that according to a summary of the findings, “70% of American Indians die before the age of 70 years of age versus 70% of White[s] die after the age of 70 years.”¹⁸²

¹⁷⁴ Ibid.

¹⁷⁵ Steffens Testimony, *September Briefing*, p. 9.

¹⁷⁶ Ibid.

¹⁷⁷ Ibid.

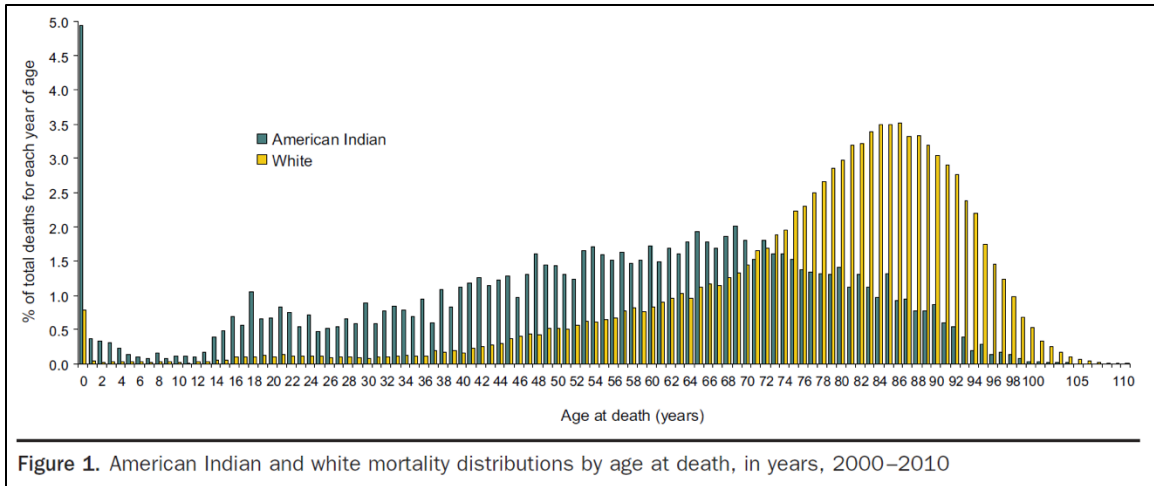
¹⁷⁸ Ibid., 9-10.

¹⁷⁹ Steffens Testimony, *September Briefing*, p. 10.; Giroux Statement at 2; Christensen, Mathew, & Kightlinger, Lon. “Premature mortality patterns among American Indians in South Dakota, 2000-2010.” *Am J Prev Med*, (2013): 465-471. <https://pubmed.ncbi.nlm.nih.gov/23597809/>.

¹⁸⁰ Steffens Testimony, *September Briefing*, p. 10.

¹⁸¹ Ibid.

¹⁸² Ibid.



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Source: Christensen and Kightlinger, *Premature Mortality Patterns Among American Indians in South Dakota, 2000-2010*

Figure 1

2. *Health Disparities for American Indian Infants and Mothers*

a) *Infant Mortality*

Ms. Littlefield outlined the disparities in infant mortality rates between White and American Indian infants and discussed the implications that these rates have on Native communities. Ms. Littlefield drew data from the CDC, stating that between 2005 and 2014, it was found that the infant mortality rate had declined for every single race except for American Indian women. According to Ms. Littlefield, an indicator for the overall health of a community is their rates of infant mortality.¹⁸⁴ In 2018, the national infant mortality rate was 5.66 per 1,000 live births, as found by Ms. Littlefield's research.¹⁸⁵ Based off of South Dakota's records from 2010 to 2018, the infant mortality rate was found to be higher overall compared to the national average.¹⁸⁶ Specifically, the infant mortality rate for White women was 5.4, however, the rate for American Indian women was 11.4, which is two times the rate of the nation and South Dakota.¹⁸⁷ From Ms. Littlefield's professional experience, she has found that the infant mortality rate for American Indian women

¹⁸³ Giroux Statement, at 3; Christensen, Mathew, & Kightlinger, Lon. "Premature mortality patterns among American Indians in South Dakota, 2000-2010." *Am J Prev Med*, (2013): 465-471. <https://pubmed.ncbi.nlm.nih.gov/23597809/>.

¹⁸⁴ Littlefield Testimony, *September Briefing*, p. 12.

¹⁸⁵ *Ibid.*

¹⁸⁶ *Ibid.*

¹⁸⁷ *Ibid.*

is even higher than this within some communities.¹⁸⁸ She has found that some communities have experienced, “an infant mortality rate of 17 or more.”¹⁸⁹

Dr. Amy Elliott, Chief Clinical Research Officer for Avera McKennan Hospital, also discussed the historical disparities in infant mortality between American Indian and White mothers.¹⁹⁰ In the 90s, American Indian babies experienced an infant mortality rate that was two and a half times that of White babies in South Dakota [as seen in Figure Two].¹⁹¹ This disparity was so pronounced that American Indian tribes approached the CDC and the National Institutes of Health and asked for their help to understand why such a disparity existed.¹⁹² The Aberdeen Area Infant Mortality study was born from this collaboration and they found that half of the deaths that occurred in the tribes were considered Sudden Infant Death Syndrome (SIDS).¹⁹³ With further research, they discovered that if a woman drank three months before to three months after conception (also known as the periconception period), it increases a babies chances of dying from SIDS by eightfold.¹⁹⁴ According to Dr. Elliott, this discovery was new to researchers and it hadn’t been previously reported in scientific literature.¹⁹⁵ Following this research, the NIH formed the PASS Network (prenatal, alcohol, SIDS, and stillbirth), who spent the next 14 years developing and conducting a study on these phenomenon.¹⁹⁶

¹⁸⁸ Littlefield Testimony, *September Briefing*, p. 12.

¹⁸⁹ *Ibid.*

¹⁹⁰ Elliott Testimony, *November Briefing*, pp. 3-4.

¹⁹¹ Elliott Testimony, *November Briefing*, pp. 3-4.

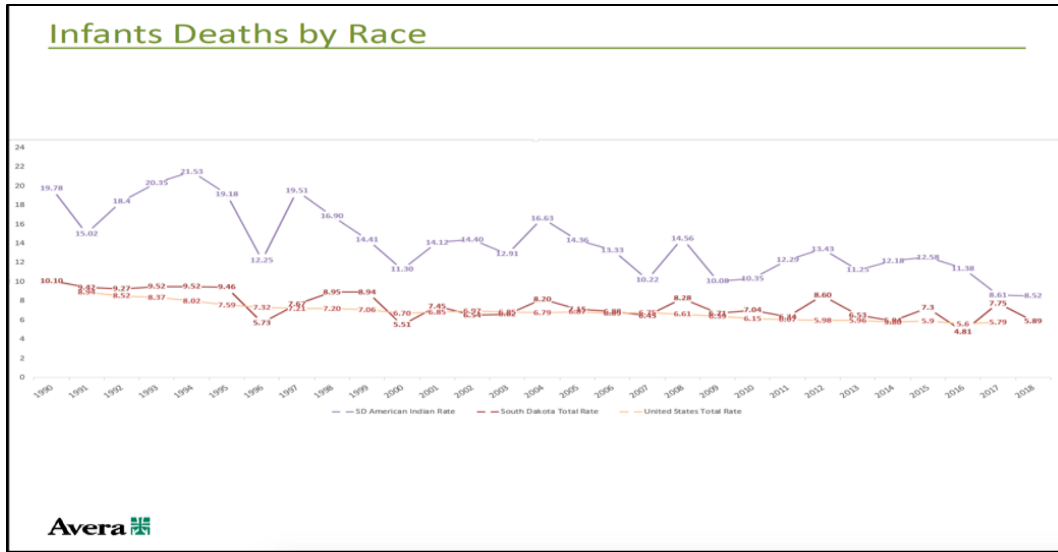
¹⁹² *Ibid.*, 4.

¹⁹³ *Ibid.*

¹⁹⁴ *Ibid.*

¹⁹⁵ *Ibid.*

¹⁹⁶ U.S. Department of Health and Human Services National Institutes of Health, *Prenatal Alcohol and SIDS and Stillbirth (PASS) Network*, (n.d.), <https://www.nichd.nih.gov/research/supported/pass>.



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Source: Safe Passage Study Report - Prenatal Alcohol, Smoking and Adverse Outcomes

Figure 2

Within the PASS Network study, over 12,000 baby-mom pairs were enrolled from all around the world.¹⁹⁸ The women were put into groups based on if and when they had smoke or drank during the first, second or third trimester of their pregnancy.¹⁹⁹ They found that there was a synergistic effect between smoking and drinking.²⁰⁰ Specifically, when the two substances are used together beyond the first trimester, there is greater risk of SIDS than when one substance is used alone.²⁰¹ If a woman drank only beyond the first trimester, the risk of her baby dying due to SIDS increased fourfold.²⁰² If a woman smoked only at a point beyond the first trimester, the risk was raised up to just under fivefold.²⁰³ However, when a woman both drank and smoked beyond the first trimester, the risk of the baby dying due to SIDS was raised twelvefold.²⁰⁴

¹⁹⁷ November 2020 Web Hearing Panelist Presentations, p. 6; Elliott, Amy, et al. “Concurrent prenatal drinking and smoking increases risk for SIDS: Safe Passage Study report.” *EClinicalMedicine* 19, (2020). <https://www.sciencedirect.com/science/article/pii/S2589537019302561>.

¹⁹⁸ Elliott Testimony, *November Briefing*, p. 4.

¹⁹⁹ Ibid.

²⁰⁰ Ibid.

²⁰¹ Ibid.

²⁰² Ibid.

²⁰³ Ibid.

²⁰⁴ Ibid.

Researchers, including Dr. Elliott, were able to compare the experiences of 2,124 American Indian women to 2,753 White women in the study.²⁰⁵ They found that prenatal exposure to alcohol use differs across race.²⁰⁶ According to her research, using a wide sample, Dr. Elliot found that more White women drink during pregnancy than American Indian women,²⁰⁷ but that of the American Indian women that do drink during pregnancy, they are more likely to binge drink.²⁰⁸

Dr. Elliott stressed that there are still a lot of misconceptions surrounding the alcohol use of American Indian women, making the finding that White women drink more during pregnancy an underappreciated fact.²⁰⁹ She shared that these gaps have been improving over the last few years, due to efforts on the part of American Indian tribes.²¹⁰ Within the last few years, the gap between the rates of infant deaths for White and American Indian babies has started to get smaller.²¹¹ However, Dr. Elliott warns that these improvements in maternal health does not indicate that supports that have been put into place need to be removed.²¹² She warns that if these supports were removed, due to perceived improvements, infant mortality rates could end up going back to where they were before efforts were made.²¹³

b) Maternal Morbidity and Maternal Mortality

Dr. Big Crow pointed out that the maternal morbidity and maternal mortality rates of American Indian and Alaska Native women are double that of White women.²¹⁴ She explained that the poorer health status and pre-existing conditions experienced by pregnant American Indian and Native Alaska women make them vulnerable to pregnancy-related health issues.²¹⁵

Maternal morbidity, according to Dr. Big Crow, is a term referring to any disability or physical illness that is directly linked to childbirth and/or pregnancy.²¹⁶ These are non-life-threatening

²⁰⁵ *Ibid.*, 6.

²⁰⁶ *Ibid.*

²⁰⁷ *Ibid.*

²⁰⁸ *Ibid.*

²⁰⁹ *Ibid.*

²¹⁰ *Ibid.*, 3-4.

²¹¹ *Ibid.*

²¹² *Ibid.*, 11.

²¹³ *Ibid.*

²¹⁴ Big Crow Statement at 2.

²¹⁵ *Ibid.*

²¹⁶ *Ibid.*

conditions that have a significant impact on a mother's quality of life.²¹⁷ Maternal morbidity conditions include hysterectomy, postpartum hemorrhage, onset of diabetes and/or hypertension, pre-eclampsia, and pre-term labor.²¹⁸ Dr. Big Crow explained that, "Because of the overall poorer health status of expectant AI/AN women, they are more prone to subsequent physical illness or disability as a result of their pregnancy."²¹⁹

Maternal mortality, on the other hand, is a death related to pregnancy, which can be caused by pulmonary embolism, infection, heart disease, and postpartum hemorrhage.²²⁰ Dr. Big Crow shared that maternal mortality has more than doubled over the past 30 years, yet the cause of this increase is still not clear, according to a report from the Center for Disease Control.²²¹ Similar to maternal morbidity, Dr. Big Crow attributed the poor health status of mothers as a factor in the rates of maternal mortality.²²² Chronic diseases that contribute to the mortality of American Indians and Alaska Native include heart disease, obesity, hypertension, and diabetes.²²³ These are many of the health issues that American Indian women experience within South Dakota.²²⁴

Ms. Littlefield highlighted that there are significant maternal mortality disparities between White and American Indian mothers in South Dakota.²²⁵ The Centers for Disease Control's state maternal mortality tables do not include maternal mortality rates for South Dakota because the population size is small,²²⁶ which makes it difficult to easily assess the severity of the issue. Using the number of maternal deaths to calculate the maternal mortality rates for South Dakota, Ms. Littlefield shared that American Indian women in South Dakota have a mortality rate of 121.77 maternal deaths per 100,000 births, which is far greater than the 2018 national maternal mortality rate (17.9 maternal deaths per 100,000 births), the state's maternal mortality rate (59 maternal deaths per 100,000 births), and the maternal mortality rate for White women in South Dakota (44 maternal deaths per

²¹⁷ Ibid.

²¹⁸ Ibid.

²¹⁹ Ibid.

²²⁰ Ibid.

²²¹ Big Crow Statement at 2. Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, (n.d.), <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> (accessed May 10, 2021).

²²² Big Crow Statement at 2.

²²³ Ibid.

²²⁴ Ibid.

²²⁵ Littlefield Testimony, *September Briefing*, p. 13.

²²⁶ Centers for Disease Control, *Maternal Mortality by State, 2018*, (2018), <https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf> (accessed May 12, 2021).

100,000 births).²²⁷ She noted the majority of births in South Dakota are White and American Indian, at approximately 75% and 18% of births, respectively.²²⁸ South Dakota's state maternal mortality rate and the maternal mortality rate for White mothers in South Dakota are both far higher than the national maternal mortality rate, but the maternal mortality rate for American Indian women in South Dakota is nearly seven times the national maternal mortality rate.²²⁹

Dr. Big Crow emphasized that the CDC notes "as many as 60% of maternal deaths are preventable,"²³⁰ noting that factors such as social determinants of health, social injustice, and structural racism must be considered in order to prevent these deaths.²³¹ Additionally, the lack of data that is available regarding this issue contributes to the high rates of maternal health disparities for American Indian and Native Alaska people in South Dakota.²³²

B. Indian Health Service

Dr. Big Crow emphasized that, "Social injustice among [pregnant American Indian and Native Alaska women] ...comes in the form of...[the] underfunded Indian Health Service."²³³ Indian Health Service is a system of health care organized by the federal government. Social injustice, as defined by Dr. Big Crow, is, unjustified actions against individuals in a protected group or the lack of protection for individuals who are the most vulnerable.²³⁴ In the eyes of Dr. Big Crow, Indian Health Service has not been providing a standard of care equal to other health care systems on a national level, due to underfunding.²³⁵ Dr. Big Crow connects this underfunding to the low staffing levels, lack of adequate maternal care, poor quality equipment, and outdated medical facilities

²²⁷ Littlefield Testimony, *September Briefing*, p. 13, Ms. Littlefield noted that comprehensive data for maternal mortality rates across states can be challenging to access, is not consistently collected, and has limits due to the small population sizes of those studied. Data shared at the time of the briefing was calculated based on data compiled through a data request submitted previously for births by race to the South Dakota Department of Vital Records alongside 2010-2018 data from the South Dakota Department of Health regarding pregnancy related deaths; *See also* South Dakota Department of Health, *Maternal Mortality*, (n.d.), <https://doh.sd.gov/statistics/maternalmortality.aspx?> and Centers for Disease Control, *Maternal Mortality*, (n.d.), <https://www.cdc.gov/nchs/maternal-mortality/index.htm>.

²²⁸ *Ibid.*

²²⁹ *Ibid.*

²³⁰ Big Crow Statement, at 4, Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, (n.d.), <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> (accessed May 10, 2021).

²³¹ *Ibid.*

²³² *Ibid.*

²³³ *Ibid.*, 3.

²³⁴ *Ibid.*

²³⁵ *Ibid.*

experienced by the Indian Health Service.²³⁶ Dr. Big Crow shared that the low standards of care provided by the Indian Health Service are not adequate enough to provide the quality of care needed for a Native mother to experience a healthy birth.²³⁷

Dr. Big Crow connects this lack of quality to the reasons why American Indian and Alaska Native mothers experience anxiety when receiving services at Indian Health Service facilities.²³⁸ She pointed out that this anxiety comes from a lack of trust towards western systems of healthcare which stems from a history of unethical research practices utilized on American Indian and Alaska Native people.²³⁹

C. Infrastructure

The lack of infrastructure and its effect on Tribal wellness was a recurring theme within the testimony the Committee received.²⁴⁰ Committee member Paula Antoine, a Sicangu, Lakota woman and member of the Oceti Sakowin tribe, drew attention to the fact that many American Indians living on Rosebud reservation do not have access to water, sewage services, electricity, or adequate healthcare.²⁴¹ Within Rosebud, residents live within a “food desert,” with some people living as far as two to two and a half hours away from a grocery store.²⁴² As highlighted by Ms. Antoine, the lack of infrastructure experienced by American Indians does little to support their communities’ traditional, self-sustaining way of life.²⁴³ Dr. Big Crow explained that American Indians in South Dakota also face high rates of unemployment.²⁴⁴ She shared that the unemployment rate on the Pine Ridge Indian Reservation is around 89%.²⁴⁵ These factors combined with a lack of Tribal resources make it difficult for American Indians to gain access to necessary resources for their health and wellness.²⁴⁶

²³⁶ Ibid.

²³⁷ Ibid.

²³⁸ Ibid.

²³⁹ Ibid.

²⁴⁰ Big Crow Statement at 2; Antoine Testimony, *July Briefing*, p. 6, 13.

²⁴¹ Antoine Testimony, *July Briefing*, p. 6-13.

²⁴² Ibid., 6.

²⁴³ Ibid., 12.

²⁴⁴ Big Crow Statement at 3.

²⁴⁵ Ibid.

²⁴⁶ Antoine Testimony, *July Briefing*, p. 13.

Dr. Big Crow connected infrastructural issues to lower education levels and poverty, stating that these factors are social determinants of health.²⁴⁷ She shared that the Office of Disease Prevention and Health Promotion defines social determinants of health as the environmental conditions where individuals are born, work, live, learn and play.²⁴⁸ These conditions compound upon each other and impact the attitudes and behaviors of the individuals that live in a certain environment, which has an effect on people's access to healthcare services.²⁴⁹ Dr. Big Crow explained that early prenatal and routine care are the main factors which lower risks for maternal morbidity and mortality.²⁵⁰ However, American Indians and Alaska Natives face challenges involved with receiving this care due to the social determinants of health within their communities.²⁵¹

1. Housing

Several panelists highlighted that housing was an essential area where there were infrastructural concerns.²⁵² Sandra Wilcox, a Licensed Practical Nurse and director of the Maternal and Child Health Project Launch Program for the Rosebud Sioux Tribe, presented testimony to the South Dakota Committee. The Maternal and Child Health Project Launch Program, a grant-based program, funded by the U.S. Department of Health and Human services, supports the development and wellness of children within the Rosebud Sioux tribe from the time they are born until they are eight years old.²⁵³ The program addresses social, physical and emotional cognitive and behavioral development.²⁵⁴ Ms. Wilcox stated that at times, two or three generations of families live within the same home, leading to overcrowding.²⁵⁵ Ms. Antoine referenced statistical data that found approximately 1,000 homes were available to 35,000 members living on Rosebud reservation.²⁵⁶ Ms. Wilcox noted that the lack of available housing leads to many families not having a comfortable or safe place to raise their children.²⁵⁷

²⁴⁷ Big Crow Statement at 2.

²⁴⁸ *Ibid.*, 2.

²⁴⁹ *Ibid.*, 2.

²⁵⁰ *Ibid.*, 3.

²⁵¹ *Ibid.*, 3.

²⁵² Antoine Testimony, *July Briefing*, p. 8.; Wilcox Testimony, *July Briefing*, pp. 9-10.

²⁵³ Great Plains Tribal Chairmen's Health Board, *GPTCHB/Rosebud Sioux Tribe Project Indigenous Linking Actions in Unmet Needs Children's Health (ILAUNCH)*, (n.d.), <https://mch.gptchb.org/programs/ilaunch/>.

²⁵⁴ *Ibid.*

²⁵⁵ Wilcox Testimony, *July Briefing*, p. 10.

²⁵⁶ Antoine Testimony, *July Briefing*, p. 8.

²⁵⁷ Wilcox Testimony, *July Briefing*, p. 10.

2. Technology and Roads

The Committee heard testimony regarding the lack of access to technological services and roads among American Indian communities.²⁵⁸ Ms. Wilcox stated that many of the women in the Maternal and Child Health Project Launch Program do not have access to telephone or internet services.²⁵⁹ As Ms. Wilcox points out, many women do not have the monetary funds to afford such services, which leaves them in a vulnerable position of not being able to communicate with the Maternal and Child Health Project Launch Program.²⁶⁰ As a result, many soon-to-be mothers could possibly be missing out on education programs that assist them with having a healthy pregnancy.²⁶¹

Access to roads also creates a barrier to services for pregnant Native women. Ms. Antoine explained that some homes do not have access to roads for transpiration.²⁶² Ms. Antoine stated that a proportion of American Indians on the Rosebud Reservation have to drive across fields to get from house to house.²⁶³ She points out that transportation within these conditions are worsened by weather events.²⁶⁴

D. Barriers to Prenatal Care

Panelists pointed to transportation as a barrier to American Indian mothers' access to reproductive care.²⁶⁵ Dr. Kimberly McKay, Clinical Vice President of the OB Service Line at Avera Health, presented data from the Pregnancy Risk Assessment and Monitoring System (PRAMS).²⁶⁶ Avera Health is a, "faith-based healthcare" provider that offers a variety of health services, including maternal care, in Sioux Falls, South Dakota.²⁶⁷ The Pregnancy Risk Assessment and Monitoring System allocates vital statistics collected by the South Dakota Department of health.²⁶⁸ Dr. McKay

²⁵⁸ Antoine Testimony, *July Briefing*, p. 12.; Wilcox Testimony, *July Briefing*, p. 9.

²⁵⁹ Wilcox Testimony, *July Briefing*, p. 9.

²⁶⁰ *Ibid.*, 9.

²⁶¹ *Ibid.*, 9.

²⁶² Antoine Testimony, *July Briefing*, p. 12.

²⁶³ *Ibid.*, 12.

²⁶⁴ *Ibid.*, 12.

²⁶⁵ Deutsch Testimony, *December Briefing*, p. 16; Antoine Testimony, *July Briefing*, p. 7; Kingman Testimony, p. 23 (hereinafter *December Briefing*); McKay Testimony, *September Briefing*, pp. 2-14; Locke Testimony, *December Briefing*, pp. 5-7; Wilcox Testimony, *July Briefing*, pp. 9-11.

²⁶⁶ McKay Testimony, *September Briefing*, p. 2; Great Plains Tribal Chairmen's Health Board Maternal and Child Health Department, Great Plains Tribal Epidemiology Center, *2017 South Dakota Tribal Pregnancy Risk Assessment Monitoring System Surveillance Report*, Rapid City, SD: 2017. <https://mch.gptchb.org/wp-content/uploads/2020/04/FINAL-SD-Tribal-PRAMS-Aggregate-Final-with-IRB-11-22-19.pdf>

²⁶⁷ "About Avera Health." Avera. <https://www.avera.org/about/> (accessed March 3, 2021).

²⁶⁸ McKay Testimony, *September Briefing*, p. 2.

pointed out that areas where pregnancy outcomes tend to be the poorest are located rurally, have lower household income and contain the largest populations of American Indians in South Dakota.²⁶⁹ Ms. Littlefield pointed out that according to 2017 PRAMS data, 51.5% of American Indian moms surveyed reported an income of \$16,000 or less a year.²⁷⁰ Dr. McKay explained that counties which contain American Indian reservations (Dewey County, Stanley County, Oglala County) experience great disparities in terms of access to prenatal care.²⁷¹ According to PRAMS data, 27.5% of American Indian mothers were unable to access prenatal care due to lack of access to childcare.²⁷² Another 19.1% of American Indian mothers reported being unable to get an appointment with their healthcare provider.²⁷³ Without access to prenatal care, there are consequences to the mother's state of health which can determine when the baby will be delivered.²⁷⁴

Based on South Dakota Vital Records on Maternal and Child Health between 2010-2018, Ms. Littlefield emphasized the connection between teenage pregnancy among American Indian women and a lack of access to essential prenatal care.²⁷⁵ Within South Dakota, 13.4% of American Indian women were teenage mothers.²⁷⁶ According to South Dakota Vital Records from 2010 to 2018, 55.4% of American Indian mothers, ages 15 to 19, received late or no prenatal compared to 21.8% of White mothers in the same age group.²⁷⁷ Within this percentage, 13.4% of teenage American Indian mothers received no prenatal care during their pregnancy and 30.3% of teenage American Indian mothers did not receive prenatal care until the second trimester.²⁷⁸ Ms. Littlefield pointed out that this data draws attention to the fact that teenage American Indian mothers are especially vulnerable to missing out on essential prenatal care.²⁷⁹

²⁶⁹ Ibid.

²⁷⁰ Littlefield Testimony, *September Briefing*, p. 14, In 2017, the national poverty guideline for households with one individual was \$12,060. The poverty guideline for households with two individuals was \$16,240 and the poverty guideline for households with three individuals was \$20,420.

"2017 Poverty Guidelines." ASPE. <https://aspe.hhs.gov/2017-poverty-guidelines> (accessed March 3, 2021).

²⁷¹ McKay Testimony, *September Briefing*, p. 2.

²⁷² Littlefield Testimony, *September Briefing*, p. 14.

²⁷³ Ibid.

²⁷⁴ McKay Testimony, *September Briefing*, p. 3.

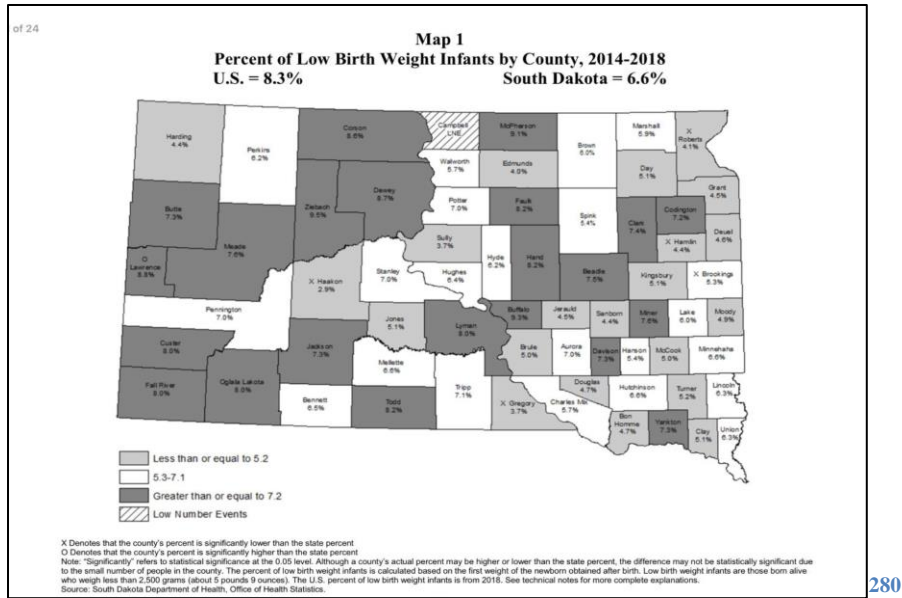
²⁷⁵ Littlefield Testimony, *September Briefing*, p. 14.

²⁷⁶ Ibid.

²⁷⁷ Ibid.

²⁷⁸ Ibid.

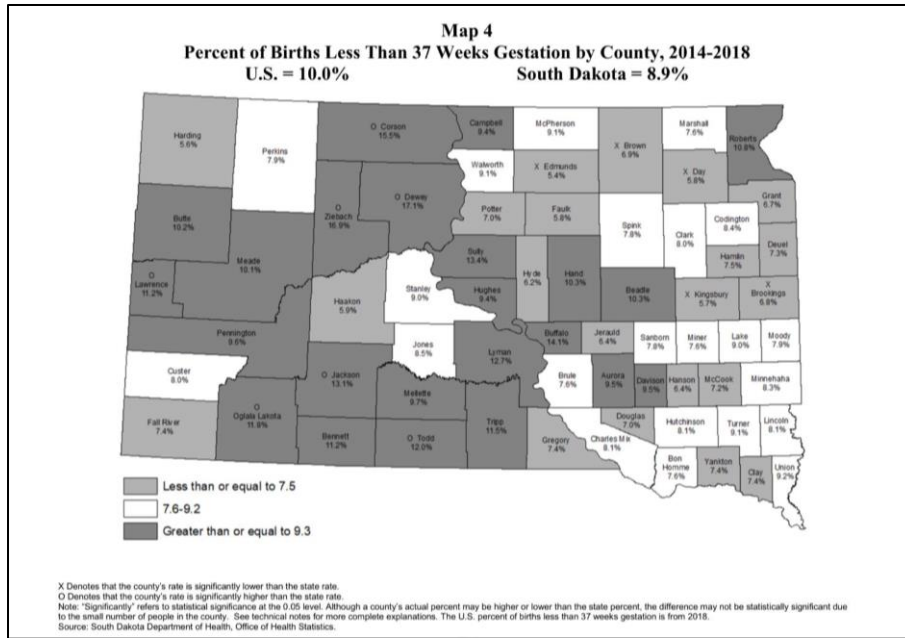
²⁷⁹ Ibid.



Source: 2018 South Dakota Vital Statistics Report – A State and County Comparison of Leading Health Indicators

Figure 3

²⁸⁰ September 2020 Web Hearing Panelist Presentations, p. 7, 2018 South Dakota Vital Statistics Report – A State and County Comparison of Leading Health Indicators <https://doh.sd.gov/statistics/2018VitalMortality.pdf> (accessed May 10, 2021).



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Source: 2018 South Dakota Vital Statistics Report – A State and County Comparison of Leading Health Indicators

Figure 5

I. Access to Transportation

The Committee received testimony stating that the rurality of reservations combined with a lack of access to transportation has negative impacts for American Indian mothers.²⁸³ According to Pregnancy Risk Assessment and Monitoring System data, 27% of American Indian mothers reported not having access to transportation needed for pre-natal appointments.²⁸⁴ Ms. Wilcox stated that many women in the U.S. Department of Health and Human Services Maternal and Child Health Project Launch Program had no access to reliable transportation for medical appointments; an essential component to having a healthy delivery and baby.²⁸⁵ Arielle Deutsch, PhD, a member of the public and a research scientist who works with American Indian women, pointed out that in the state of South Dakota, there is a lack of public transportation services available for Native women to get to their medical appointments.²⁸⁶ Dr. McKay also addressed this issue, stating that, according to the Pregnancy Risk Assessment and Monitoring System data, 27% of Native women

²⁸² September 2020 Web Hearing Panelist Presentations, p. 6.

²⁸³ Deutsch Testimony, *December Briefing*, p. 16; McKay Testimony, *September Briefing*, p. 14; Wilcox Testimony, *July Briefing*, p. 9.

²⁸⁴ Littlefield Testimony, *September Briefing*, p. 14.

²⁸⁵ Wilcox Testimony, *July Briefing*, p. 9.

²⁸⁶ Deutsch Testimony, *December Briefing*, p. 16.

in South Dakota reported having no transportation to get to prenatal care.²⁸⁷ In Dr. McKay's experience, some American Indian women who come to Avera Health travel up to 100 miles to deliver their babies, making transportation a vital factor in addressing prenatal care.²⁸⁸

2. *Location of Birth Centers*

The location of birthing centers was a major concern within the testimony that the Committee received.²⁸⁹ The Rosebud Reservation is about one million acres, taking four hours to completely drive across.²⁹⁰ Native women living on the Rosebud Reservation receive maternal care from a Indian Health Services facility on the Rosebud Reservation and a health facility in Sioux Falls, SD.²⁹¹ It can take some women an hour to an hour and a half to reach the location on Rosebud Reservation.²⁹² Additionally, the Sioux Falls location is a four-and-a-half hour drive from where most women live on Rosebud Reservation.²⁹³ [see Figure 6]²⁹⁴

However, deliveries no longer take place in the Indian Health Services facility on Rosebud, and women are instead transferred to a location about forty-five minutes away in Winner, SD, a location thirty-five minutes away in Valentine, Nebraska, or to a health facility four-and-a-half-hours away in Sioux Falls, SD.²⁹⁵ For the employees of the U.S. Department of Health and Human Services' Maternal and Child Health Project Launch Program, providing transportation of Native mothers on Rosebud can be a 130–140-mile round trip to help mothers gain access to prenatal care.²⁹⁶ The below maps include the locations of health facilities mentioned by panelists that address American Indian maternal care. However, these maps do not represent the exact location of these health facilities. Instead, they represent the exact location of the cities and towns in which the health facilities were mentioned as residing [see Figure 6].²⁹⁷

²⁸⁷ McKay Testimony, *September Briefing*, p. 14.

²⁸⁸ *Ibid.*

²⁸⁹ Antoine Testimony, *July Briefing*, p. 7; Kingman Testimony, *December Briefing*, p. 23; Locke Testimony, *December Briefing*, pp. 5-7; Wilcox Testimony, *July Briefing*, p. 9-11.

²⁹⁰ Antoine Testimony, *July Briefing*, p. 7.

²⁹¹ Wilcox Testimony, *July Briefing*, p. 9; Antoine Testimony, *July Briefing*, p. 7.

²⁹² Antoine Testimony, *July Briefing*, p. 7.

²⁹³ Wilcox Testimony, *July Briefing*, p. 9

²⁹⁴ Maps of South Dakota Cities Where Birthing Centers Are Located, at 1.

²⁹⁵ Wilcox Testimony, *July Briefing*, p. 9; Antoine Testimony, *July Briefing*, p. 7.

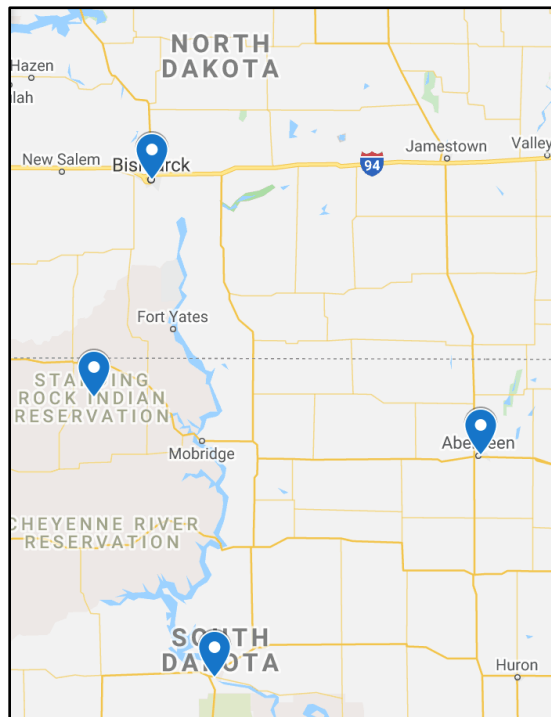
²⁹⁶ Wilcox Testimony, *July Briefing*, p. 11.

²⁹⁷ Maps of South Dakota Cities Where Birthing Centers Are Located, at 1.



Source: Google Maps – Rosebud Reservation Birthing Centers

Figure 6



Source: Google Maps – Standing Rock Birthing Center Locations

Figure 7

Ms. Locke pointed out that there are no birthing centers or hospitals located on the South Dakota side of the Standing Rock Reservation.²⁹⁸ Native Women living on the South Dakota end of Standing Rock have to drive one-hundred miles to get to each of the nearest hospitals, which are located in Bismarck, North Dakota, Pierre, South Dakota and Aberdeen, South Dakota.²⁹⁹ [see Figure 7].³⁰⁰

Birthing centers were highlighted as a possible solution for the maternal health issues faced by American Indian women. Ms. Antoine pointed out that without access to a communal birthing center, American Indian mothers are often overwhelmed by the health issues surrounding pregnancy.³⁰¹ Ms. Wilcox shared in Ms. Antoine's focus on a reservation based birthing center.³⁰² Ms. Wilcox explained that a goal of the Maternal and Child Health Project is to establish a birthing center on Rosebud Reservation.³⁰³ This would give the American Indian women on Rosebud Reservation a culturally appropriate place to deliver, where their family is present during and after the birth.³⁰⁴ In the opinion of Ms. Wilcox, establishing a birthing center would have a positive influence on the mother of the baby, mother, father and extended family.³⁰⁵ A birthing center would help to foster traditional ways of birthing that have gone on for generations.³⁰⁶

Ms. Locke brought up the fact that there has only been one independent, American Indian reservation-based birthing center within the United States.³⁰⁷ It was located in Arizona but was shut down due to lack of funding and because it was located in an asbestos building.³⁰⁸ Committee member Arlouiine Gay Kingman, who is also a member of the Cheyenne River Sioux tribe, mentioned that the South Dakota based Cheyenne River Sioux tribe had a birthing center within their hospital.³⁰⁹ However, it was excluded from Indian Health Service funding and the women of the tribe had to receive services in Pierre, South Dakota.³¹⁰

²⁹⁸ Locke Testimony, *December Briefing*, pp. 5-6.

²⁹⁹ *Ibid.*, 6.

³⁰⁰ Maps of South Dakota Cities Where Birthing Centers Are Located, at 1.

³⁰¹ Antoine Testimony, *July Briefing*, p. 7.

³⁰² Wilcox Testimony, *July Briefing*, p. 9.

³⁰³ *Ibid.*

³⁰⁴ *Ibid.*

³⁰⁵ *Ibid.*

³⁰⁶ *Ibid.*

³⁰⁷ Locke Testimony, *December Briefing*, p. 7.

³⁰⁸ *Ibid.*

³⁰⁹ Kingman Testimony, *December Briefing*, p. 23.

³¹⁰ *Ibid.*

3. *Lack of Access to Traditional Birthing Practices*

Multiple panelists spoke about the trauma experienced by American Indian mothers as being associated with a dislocation from traditional ways of giving birth.³¹¹ According to Ms. Wilcox, the lack of transportation access and the location of birthing centers makes it difficult for American Indian mothers to know if they will have any family members present during their birth.³¹² According to Ms. Wilcox, it is common for Native mothers enrolled in the Maternal and Child Health Launch Program, a program funded by the Department of Health and Human Services, to give birth alone due to the distant locations of birthing centers in Winner, SD and Sioux Falls, SD, or across the state border in Valentine, NB.³¹³ Ms. Antoine mentioned the potential trauma of Native mothers having to give birth alone due to the lack of support from family members and increased stress experienced by mothers.³¹⁴

Ms. Wilcox stressed that it is culturally important for Native mothers to have their family present during their birth.³¹⁵ As explained by Ms. Locke, “it has been scientifically proven that the more support the mother has, the easier, the less complications [during] birth.”³¹⁶ Traditionally, while family members are present at the time of birth, cultural teachings and ceremonies will take place.³¹⁷ Dr. Big Crow shared that birthing ceremonies are historically held in high honor by indigenous nations.³¹⁸ She emphasized this by adding that, “Each birth considered a sacred event, to bare life, overseen by a sacred ceremony utilizing the natural elements of biodiversity and metaphysical energies by all within the family and tribe.”³¹⁹ Traditionally, midwives would provide spiritual and emotional guidance to the mother as well as the child who has arrived into “Unci Maka (Mother Earth).”³²⁰ According to Ms. Wilcox, these cultural traditions cannot take place, due to the distance of these hospitals from the Rosebud Reservation, which is not conducive to the cultural expression of American Indian mothers.³²¹

³¹¹ Antoine Testimony, *July Briefing*, p. 7; Big Crow Statement, at 3; Wilcox Testimony, *July Briefing*, pp. 9-11; Locke Testimony, *December Briefing*, p. 6.

³¹² Wilcox Testimony, *July Briefing*, p. 11.

³¹³ *Ibid.*, 9.

³¹⁴ Antoine Testimony, *July Briefing*, p. 7.

³¹⁵ Wilcox Testimony, *July Briefing*, p. 9.

³¹⁶ Locke Testimony, *December Briefing*, p. 6.

³¹⁷ Wilcox Testimony, *July Briefing*, p. 9.

³¹⁸ Big Crow Statement, at 4.

³¹⁹ *Ibid.*

³²⁰ *Ibid.*

³²¹ Wilcox Testimony, *July Briefing*, p. 9.

4. *Maternal and Child Health Project Launch Program*

Ms. Wilcox spoke in detail about the work of the U.S. Department of Health and Human Services' Maternal and Child Health Project Launch Program. The Maternal and Child Health Project Launch Program consists of two case managers, one who is a certified nursing assistant and the other who is taking nursing classes.³²² These individuals provide services to high-risk prenatal women, postpartum women, pregnant teenagers, infants and toddlers across three counties (Todd, Mellette, and Tripp) and twenty-two communities within and surrounding the Rosebud Reservation.³²³ The services provided by the Maternal and Child Health Project Launch Program consist of home visits, health education, transportation for medical appointments, and connections to other needed health services.³²⁴

The Maternal and Child Health Project Launch Program is responsible for transporting pregnant American Indian women to and from delivery, which can often take up half of the day.³²⁵ According to Ms. Wilcox, the Maternal and Child Health Project Launch Program is small compared to the number of individuals served, meaning that they must provide transportation across a span of many miles.³²⁶ Ms. Wilcox demonstrated this distance by reflecting on her transportation experiences with American Indian women living in outlying areas of their community.³²⁷ Providers of the Maternal and Child Health Project Launch Program often have to drive one-hundred and thirty to one-hundred and forty miles round-trip to assist women in getting to their maternal health appointments.³²⁸ Ms. Wilcox clarified that this level of distance and transportation is also required when American Indian women deliver their children.³²⁹ As mentioned earlier, the Maternal and Child Health Project Launch Program is currently serving only those clients who are considered high-risk.³³⁰ According to Ms. Wilcox, "I think and I know we should be doing all of our American Indian women a service, so they can get access to healthy prenatal care and healthy babies or deliveries."³³¹

³²² *Ibid.*, 8.

³²³ Wilcox Testimony, *July Briefing*, pp. 8-9; Jennifer Giroux, MD, Response to Draft Report, Mar. 10, 2021, at 3 (hereinafter Giroux Response); Dr Giroux shared that the U.S. Department of Health and Human Services' grant, which helps fund the Maternal and Child Health Project Launch Program, only services one of the nine tribes located in South Dakota.

³²⁴ Wilcox Testimony, *July Briefing*, pp. 8-10.

³²⁵ *Ibid.*, 11.

³²⁶ *Ibid.*, 8-11.

³²⁷ *Ibid.*, 11.

³²⁸ *Ibid.*

³²⁹ *Ibid.*

³³⁰ *Ibid.*

³³¹ *Ibid.*

E. Other Barriers to Care [Both Prenatal and Post-Birth]

1. Insurance

Within the testimony, panelists referenced barriers to care during both the prenatal and perinatal periods of pregnancy.³³² Dr. McKay discussed how insurance coverage, specifically lagging coverage, can lead to postponed prenatal care for women, creating “downstream” effects for patients.³³³ As pointed out earlier, areas within the South Dakota PRAMS database with the lowest healthcare outcomes for pregnant women are also the areas with lower household incomes and the highest populations of American Indians.³³⁴ According to Dr. McKay, these also to be areas with higher Medicaid populations.³³⁵ In order to gain access to Medicaid, Native women will need access to a car, phone, or internet service; all of which are not supported by the general infrastructure discussed previously.³³⁶ When Native mothers gain access to Medicaid later into their pregnancy, their delay in obtaining insurance can be perceived as “non-compliance,” or a perceived risk around drug use by medical professionals.³³⁷

Dr. McKay explained that within the health care field, maternity care is reimbursed in a bundle as a global fee; meaning that health care providers have to take care of their patients with a certain amount of cost savings in mind.³³⁸ As bundled care becomes more popular within the healthcare industry, particularly federally, hospital providers must think about how they are spending, so that they can save money.³³⁹ This is due to the fact that bundled care doesn’t cover high value services and does not encourage coordination between healthcare providers and other entities.³⁴⁰ In the healthcare world, providers of maternal healthcare are poorly reimbursed and are expected to achieve cost savings, which, according to Dr. McKay, can create a “lock leader on the ledger for hospital systems,”³⁴¹ leading to barriers of wraparound services for mothers utilizing Medicaid.³⁴²

³³² Antoine Testimony, *July Briefing*, p. 15-16; Big Crow Statement, at 3; Deutsch Testimony, *December Briefing*, p. 16.; Giroux Statement, at 6; Steffens Testimony, *September Briefing*, p. 15; McKay Testimony, *September Briefing*, p. 4; Steffens Testimony, *September Briefing*, p. 11-15; Wilcox Testimony, *July Briefing*, p. 10.

³³³ McKay Testimony, *September Briefing*, p. 4.

³³⁴ Ibid.

³³⁵ Ibid.

³³⁶ Ibid.

³³⁷ Ibid.

³³⁸ Ibid.

³³⁹ Ibid.

³⁴⁰ Ibid., 4-5.

³⁴¹ Ibid., 4.

³⁴² Ibid., 4-5.

2. *Discrimination and Drug Testing*

a) *Discrimination*

Panelists pointed to drug testing and discrimination as an additional barrier to maternal health care for American Indian mothers.³⁴³ Dr. McKay shared that clinicians can order a drug test based on a suspicion of drug use, and don't necessarily need to get permission to order it.³⁴⁴ Being late to access Medicaid can be cause for a drug test to be ordered on a pregnant, Native woman.³⁴⁵ As stated earlier, many American Indian women in South Dakota do not have access to transportation, phones, or internet service; each of which is usually needed to sign up for Medicaid in a timely manner.³⁴⁶ Dr. McKay mentioned that when women gain access to Medicaid later in their pregnancy, a health provider's perception of that late uptake may come across as "non-compliance" and prompt a drug test to be taken.³⁴⁷

Dr. Big Crow related these barriers to Medicaid to what she called "structural racism," which she defined as ideologies, social forces, systems, and policies that interact to construct and support inequality among racial groups.³⁴⁸ Similar to Dr. McKay, she explained that applying for Medicaid requires Native women to overcome barriers such as understanding a difficult application, traveling long distances to Medicaid offices, and locating complicated financial documents.³⁴⁹ The Medicaid application system interacts with other inequities such as lower education levels, lack of transportation access, financial difficulties and lack of child care.³⁵⁰

Dr. McKay pointed out that American Indian women are often given drug tests because of the harmful stereotypes held about American Indian people.³⁵¹ In Dr. McKay's opinion, "...patients

³⁴³ Antoine Testimony, *July Briefing*, p. 15-16; Big Crow Statement, at 3; Deutsch Testimony, *December Briefing*, p. 16; Giroux Statement, at 6; Steffens Testimony, *September Briefing*, p. 16; McKay Testimony, *September Briefing*, p. 4; Steffens Testimony, *September Briefing*, p. 11-15; Wilcox Testimony, *July Briefing*, p. 10.

³⁴⁴ McKay Testimony, *September Briefing*, p. 4; See S.D. Codified Laws § 26-8A-2(9) (classifying abusive prenatal drug or alcohol use as child abuse); S.D. Codified Laws § 26-8A-3 (mandatory reporting of suspected child abuse by physicians).

³⁴⁵ McKay Testimony, *September Briefing*, p. 4.

³⁴⁶ Ibid.

³⁴⁷ Ibid.

³⁴⁸ Big Crow Statement, at 3.

³⁴⁹ Ibid.

³⁵⁰ Ibid.

³⁵¹ McKay Testimony, *September Briefing*, pp. 4-8.

get drug screened randomly because of the perception of that they're at risk because of where they're from and the color of their skin."³⁵²

The Committee heard testimony raising concerns about the cultural competency of White health care providers.³⁵³ Dr. Deutsch emphasized that the American Indian women she works with often feel stigmatized, stereotyped and dismissed by the medical system, which makes them hesitant towards accessing necessary healthcare.³⁵⁴ According to Dr. Deutsch, "...the health institutions are primarily White and there's very little in terms of any kind of cultural competence or cultural resources, it's an imposing place that you, when you are pregnant and highly vulnerable, do not necessarily want to go to."³⁵⁵

Dr. Big Crow categorized these types of stigmatization based on race as social injustice towards American Indian women.³⁵⁶ American Indian and Alaska Native mothers may avoid seeking maternal healthcare because their healthcare provider holds assumptions about Native people and/or acts in a prejudicial or discriminatory manner.³⁵⁷ Native mothers face health repercussions related to the social injustices they face because these factors cause chronic stress and anxiety.³⁵⁸ Dr. Big Crow points out that these stressors have been shown to, "increase maternal cortisol levels causing preterm labor or also affecting the baby's brain development or immune system."³⁵⁹

b) Mandatory Reporting and Substance Use

Dr. Giroux highlighted that South Dakota has a mandatory reporting law³⁶⁰ that can be used for pregnant moms suspected of substance use.³⁶¹ In Dr. Giroux's opinion, this law is a barrier to prenatal care and substance use services for Native mothers.³⁶² Dr. Deutsch, also expressed concern over mandated reporting, pointing out that it acts as a barrier to Native women receiving

³⁵² Ibid., 7-8.

³⁵³ Deutsch Testimony, *December Briefing*, p. 16.

³⁵⁴ Ibid.

³⁵⁵ Ibid.

³⁵⁶ Big Crow Statement at 3.

³⁵⁷ Ibid.

³⁵⁸ Ibid.

³⁵⁹ Ibid.

³⁶⁰ South Dakota physicians, hospital interns and hospital residents are mandatory reporters of child abuse under South Dakota law. Under South Dakota law, an abused or neglected child is one "Who was subject to prenatal exposure to abusive use of alcohol, marijuana, or any controlled drug or substance not lawfully prescribed by a practitioner." S.D. Codified Laws § 26-8A-2(9(classifying abusive prenatal drug or alcohol use as child abuse); S.D. Codified Laws § 26-8A-3 (mandatory reporting of suspected child abuse by physicians).

³⁶¹ Giroux Statement, at 6; S.D. Codified Laws § 26-8A-8.

³⁶² Giroux Statement, at 6.

healthcare and damages the relationship between healthcare provider and client. Stating that, “there never is...that genuine relationship between somebody who’s using [and their healthcare provider], if they fear that they’re going to be thrown into jail if they actually open up.”³⁶³ Dr. McKay also listed drug testing as a diversion to care, as it detrimental to the mother who may have to navigate the consequences if they receive a positive test.³⁶⁴

As stated by Jennilea Steffens, MPH of the Great Plains Tribal Chairman's Health Board, maternal substance use disorder is a known epidemic within Tribal communities.³⁶⁵ Ms. Steffens compared South Dakota state PRAMS data with South Dakota Tribal PRAMS data to illustrate that illicit drug use before pregnancy, for Native women, is over three times the rate of white women in the state.³⁶⁶ Dr. Giroux pointed out that in 2014, South Dakota tribes anecdotally reported that 50-70% of prenatal Native mothers were using a non-prescribed drug.³⁶⁷ Dr. Giroux shared that in 2014, South Dakota tribes anecdotally reported that 50-70% of prenatal American Indian mothers were using a non-prescribed drug, and a follow-up inquiry by the CDC with local tribes in 2016 confirmed Tribal leader perspectives that 60% of the delivering mothers were using a non-prescribed drug.³⁶⁸

According to Ms. Steffens, contributing factors for drug use are captured by Native women’s Adverse Childhood Experience (ACE) scores.³⁶⁹ Ms. Steffens explained that, “23.2% of White mothers in South Dakota had an ACE score of four or more whereas 39.6% of American Indian mothers in South Dakota had an ACE score of four or more.”³⁷⁰ According to Ms. Steffens, Adverse Childhood Experiences, combined with toxic stress and trauma can lead to the development of substance use disorder.³⁷¹

According to Dr. McKay, there are not a lot of wraparound services for women experiencing drug addiction.³⁷² Specifically, Dr. McKay asserted that there is no “data-driven...objective way to do a risk assessment around any kind of addiction...[or] services to support addiction care so that women can overcome and start to abstain from their addiction.”³⁷³ Ms. Wilcox also pointed to the

³⁶³ Deutsch Testimony, *December Briefing*, p. 16.

³⁶⁴ McKay Testimony, *September Briefing*, p. 4.

³⁶⁵ Steffens Testimony, *September Briefing*, p. 15.

³⁶⁶ Steffens Testimony, *September Briefing*, p. 11.

³⁶⁷ Giroux Statement, at 6.

³⁶⁸ Giroux Statement, at 6; Giroux Response at 3.

³⁶⁹ Steffens Testimony, *September Briefing*, p. 15.

³⁷⁰ *Ibid.*

³⁷¹ *Ibid.*

³⁷² McKay Testimony, *September Briefing*, p. 4.

³⁷³ *Ibid.*

lack of substance use services available to American Indian mothers, stating, that there is only one treatment center on the Rosebud Reservation.³⁷⁴ According to Ms. Wilcox, the treatment center, “has a lot of clients,” as well as a waiting list.³⁷⁵

Furthermore, Ms. Antoine also pointed to the lack of support experienced by Native Mothers who become involved with social services due to substance use, mental health, or economic struggles.³⁷⁶ According to Ms. Antoine, mothers who lose custody of their children will become involved with Department of Social Services.³⁷⁷ During this time, American Indian mothers have access to caseworkers³⁷⁸ however, the case workers lack a cultural understanding of the values and experiences of American Indian women.³⁷⁹ Additionally, Ms. Antoine highlighted that American Indian women lack access to advocates who can help them to acquire the resources necessary to gain back the custody of their children.³⁸⁰ As explained by Ms. Antoine, many Native Mothers are given long lists of tasks and goals by their caseworkers and struggle to complete these tasks due to the lack of resources on the Rosebud Reservation.

According to Ms. Steffens, if a American Indian mother receives no substance use treatment, it can lead to that mother being involved in the judicial system, due to the criminalization of maternal substance use in the state.³⁸¹ Dr. Giroux also spoke of the harsh South Dakota laws surrounding maternal drug use. Dr. Giroux asserted that a mother’s use of drugs while pregnant can “further alienate” Native mothers who are already living in poverty and place these women who need support into the hands of the criminal justice system.³⁸² Dr. Giroux pointed to the fact that in South Dakota, on the 31st of July in 2020, 52% of women in prison were American Indian, although Native women only account for about 8% of the state’s population.³⁸³

³⁷⁴ Wilcox Testimony, *July Briefing*, p. 10.

³⁷⁵ *Ibid.*

³⁷⁶ Antoine Testimony, *July Briefing*, p. 15-16.

³⁷⁷ Antoine Testimony, *July Briefing*, p. 15-16; *See also*: S.D. Codified Laws § 26-8A-21.1, South Dakota law also allows DSS to remove a child from the home, if evidence of abuse or neglect is found. Found at: https://sdlegislature.gov/Statutes/Codified_Laws/2050759.

³⁷⁸ S.D. Codified Laws § 26-8A-21.2; S.D. Codified Laws § 26-8A-1
According to South Dakota state law, DSS must make reasonable efforts to reunify the child with the parent while the child is in temporary custody of DSS. Found at: https://sdlegislature.gov/Statutes/Codified_Laws/2050759.

³⁷⁹ Antoine Testimony, *July Briefing*, pp. 15-16.

³⁸⁰ *Ibid.*, 16.

³⁸¹ Steffens Testimony, *September Briefing*, p. 15.

³⁸² Giroux Statement, at 6.

³⁸³ *Ibid.*

c) *The State of Health Care for Incarcerated Women*

It is important to note that three members of the public pointed out that maternal health care for women within the judicial system is not adequate, which is important to note because this lack of care has impacts on the maternal and child health rates for American Indian women in the state.³⁸⁴ Katherine Labonte, a member of the public with prior experience supporting Native populations, stated that the maternal health support for American Indian women in South Dakota state institutions is “non-existent,” which affects American Indian birth rates and infant mortality.³⁸⁵ Ms. Locke stated that she has witnessed women in prison “get the lowest prenatal care, ” due to lack of emotional support given to incarcerated women.³⁸⁶ Ms. Locke shared, “the baby is immediately removed from the mother’s care,” which draws a stark contrast, in Ms. Locke’s opinion, to states that allow bonding periods, such as Alabama, Tennessee, and Florida.³⁸⁷ Jean Roach, a member of the Cheyenne River Sioux tribe and a grassroots activist from Rapid City, South Dakota, called this kind of treatment, “inhumane,” pointing out that women are treated as “subhuman. ” She explained that Native women in prison need time to not only bond with their child but provide them important anti-bodies from nursing.³⁸⁸ According to Ms. Locke, unlike

³⁸⁴ Roach Testimony, *December Briefing*, pp. 12-15; Labonte Testimony, *December Briefing*, p. 14; Locke Testimony, *December Briefing*, pp. 14-15.

³⁸⁵ Labonte Testimony, *December Briefing*, p.14.

³⁸⁶ Locke Testimony, *December Briefing*, pp. 14-15.

³⁸⁷ Locke Testimony, *December Briefing*, pp. 14-15; Alysia Santo, “For Most Women who Give Birth in Prison, ‘The Separation’ Soon Follows,” PBS Frontline, <https://www.pbs.org/wgbh/frontline/article/for-most-women-who-give-birth-in-prison-the-separation-soon-follows/> (accessed May 13, 2021); *See also*: In South Dakota, women who are pregnant when they enter the prison system and give birth while incarcerated may be eligible to have their newborn child stay in their care for up to 30 days through the Mother-Infant Program. Mother Infant Programs, SD DEPT. OF CORR.’S, <https://doc.sd.gov/adult/facilities/wp/mip.aspx> (last visited May 12, 2021). Although the exact requirements to be eligible are unspecified, at a minimum the pregnant inmate must complete a parenting class prior to giving birth. *Ibid.* Pregnant women incarcerated in Florida or Tennessee may be eligible for a furlough to bond with their child for a period of time postpartum. *See* Fla. Admin. Code Ann. r. 33-601.603(7)(a) (2021) (stating pregnant inmates who meet certain criteria may be eligible for a furlough of up to one week beyond a satisfactory six-week postpartum examination); Tenn. Code Ann. § 41-21-227(h)(1) (2021) (stating pregnant inmates who meet certain eligibility criteria may be eligible for a furlough for up to 6 months postpartum). However, depending on the type of delivery, Alabama inmates who give birth are required to return to prison without their newborn child within twenty-four or forty-eight hours. For Most Women Who Give Birth in Prison, ‘The Separation’ Soon Follows, PBS, <https://www.pbs.org/wgbh/frontline/article/for-most-women-who-give-birth-in-prison-the-separation-soon-follows/> (last visited May 12, 2021). Although South Dakota does not grant furloughs to inmates who have given birth while incarcerated like Florida and Tennessee, South Dakota does allow a bonding period of up to thirty days for inmates who are part of the Mother-Infant Program. The thirty-day period is more generous than what is allowed in Alabama, where the inmates are required to return to prison without the child within twenty-four or forty-eight hours after giving birth. The Parents and Children Together (PACT) Program also provides opportunities for visits between mothers and children, South Dakota Department of Corrections, *South Dakota Women’s Prison*, <https://doc.sd.gov/adult/facilities/wp/mip.aspx#:~:text=program%20is%20to%20enable%20the,The%20P.A.C.T.&text=A%20maximum%20of%20two%20children%20per%20weekend%20is%20allowed.>

³⁸⁸ Roach Testimony, *December Briefing*, p. 14.

other states, South Dakota does not allow any outside individuals to be present during and inmates birth to provide emotional and moral support during birth.³⁸⁹

However, Dr. Giroux clarified that under South Dakota women's prison policy, women who are pregnant upon arriving to prison may be allowed to take part in the Mother-Infant program, which allows the mother to keep her child at a South Dakota Women's prison for up to 30 days.³⁹⁰ In order for a mother to take part in this program, parenting classes must be completed by the mother.³⁹¹

The effects of incarceration on American Indian women can impact their maternal health and wellbeing after being released.³⁹² Ms. Steffens pointed out that even after a mother is relieved from incarceration, she will receive no supportive, wraparound services, such as "medically assisted treatment for her substance abuse disorder, reproductive health education, and treatment for unresolved trauma."³⁹³ This lack of wraparound services, according to Ms. Steffens, can lead to further risk-taking and thus, continued substance use, incarceration and separation from their child.³⁹⁴ Ms. Steffens asserted that this situation becomes cyclical and can happen multiple times to mothers experiencing substance use disorder.³⁹⁵

F. Trauma

1. Intergenerational Trauma

Throughout multiple panels, the discussion of intergenerational trauma was brought to the Committee's attention. According to Ms. Steffens, trauma can stem from the experience of poverty, racism, environmental disasters, family accidents, the sudden death of a loved one and disability.³⁹⁶ Ms. Steffens pointed out that Native people in South Dakota experience a disproportionate amount of trauma and that the trauma experienced by Native mothers can impact

³⁸⁹ Locke Testimony, *December Briefing*, pp. 14-15.

³⁹⁰ Giroux Response at 3; South Dakota Department of Corrections, *South Dakota Women's Prison*, <https://doc.sd.gov/adult/facilities/wp/mip.aspx#:~:text=A%20female%20inmate%20who%20comes,for%20up%20to%2030%20days> (accessed April 2, 2021). Mother Infant Programs, SD DEPT. OF CORR.'S, <https://doc.sd.gov/adult/facilities/wp/mip.aspx> (last visited May 12, 2021).

³⁹¹ South Dakota Department of Corrections, *South Dakota Women's Prison*, <https://doc.sd.gov/adult/facilities/wp/mip.aspx#:~:text=A%20female%20inmate%20who%20comes,for%20up%20to%2030%20days> (accessed April 2, 2021).

³⁹² Steffens Testimony, *September Briefing*, pp. 15-16.

³⁹³ *Ibid.*

³⁹⁴ *Ibid.*

³⁹⁵ *Ibid.*

³⁹⁶ *Ibid.*, 10.

the development of a fetus' brain.³⁹⁷ According to Ms. Steffens' research, babies who are born to mothers who have experienced toxic stress during their pregnancy, can have brains that are a third smaller.³⁹⁸ Ms. Steffens asserted that, "Traumas are the root cause of premature [births] and morbidity and mortality."³⁹⁹ The levels of trauma experienced by American Indian mothers can lead to intergenerational trauma for their child.⁴⁰⁰

Dr. Deutsch also drew attention to the effects of trauma and stress on mother and child stating, "in terms of research...maternal stress is one of the biggest indicators for causes and consequences that facilitates health disparities, lifelong."⁴⁰¹ Dr. Deutsch explained that a mother's stress has consequences at the genetic level, pointing out that stress is, "one of the biggest causes of methylating genes," which determine gene expression.⁴⁰² American Indian women face historical and intergenerational trauma, this combined with a lack of mental health and other health services can lead to issues with pregnancy that are carried on into future generations.⁴⁰³

Dr. Giroux and Dr. Big Crow both explained that intergenerational trauma can impact early childhood development and into adulthood.⁴⁰⁴ Dr. Giroux stressed that the first few years of child's existence, "contribute to about half of the health outcomes," throughout the rest of their life.⁴⁰⁵ Dr. Big Crow described how childhood trauma, resulting from the experience of racism or discrimination, can increase the methylation in genetic variants, which can trigger gene expressions and contribute to disease phenotypes.⁴⁰⁶ According to Dr. Big Crow, this process can have lasting impacts that carry into adulthood.⁴⁰⁷

2. *Effects of Institutionalized Racism*

Multiple panelists brought up the impact that racism-related trauma has on the health of American Indian mothers in South Dakota.⁴⁰⁸ According to Dr. Giroux, "traumatizes

³⁹⁷ Ibid.

³⁹⁸ Ibid.

³⁹⁹ Ibid.

⁴⁰⁰ Ibid.

⁴⁰¹ Deutsch Testimony, *December Briefing*, p. 16.

⁴⁰² Ibid.

⁴⁰³ Ibid.

⁴⁰⁴ Giroux Statement, at 3.

⁴⁰⁵ Ibid.

⁴⁰⁶ Big Crow Statement, at 3.

⁴⁰⁷ Ibid.

⁴⁰⁸ Giroux Statement at 6-7; Littlefield Testimony, *September Briefing*, p. 11; Steffens Testimony, *September Briefing*, p. 11; Giroux Statement, at 3-5.

development...negatively impacts human potential,” and can lead to, “toxic stress, adverse childhood experiences, and intergenerational trauma.”⁴⁰⁹ She expanded on this further, stating that, if trauma is untreated, it can compound up on factors such as a lack of resources during early childhood development, which can affect the health of every U.S. citizen, however, “racism disproportionately disadvantage[s] American Indians.”⁴¹⁰

Ms. Steffens testified that “[r]acism is a fundamental cause of racial and ethnic disparities and health outcomes, such as American Indian maternal mortality. Institutional racism is a system of structuring opportunity and assigned value based on a social interpretation of how one looks.”⁴¹¹

Cynthia New Holy, a member of the public and a long-time educator on several South Dakota reservations, including Rosebud and Pine Ridge, identified historical trauma stemming from institutionalized racism as connected to the health of Native communities today.⁴¹² Ms. New Holy drew attention to the Family Planning Services and Population Research Act from 1970,⁴¹³ which, “took away 25%...of Native women due to sterilization.”⁴¹⁴ According to Ms. New Holy, this was a form of trauma that contributes to the violence and alcoholism experienced by Native people to this day.⁴¹⁵ Ms. New Holy points out that the Keystone XL pipeline is another form of racism that affects American Indian people, as well.⁴¹⁶

Other Panelists also connected the trauma and health concerns that impact American Indian populations to the racism that they experience.⁴¹⁷ In the opinion of Dr. Giroux, American Indians in South Dakota experience both traumatic and racist environments, which contributes more directly to, “morbidity and mortality over a lifetime than access and quality of health care.”⁴¹⁸ Linda Littlefield, MSW, with the Great Plains Tribal Chairman’s Health Board, also spoke to the effects that trauma and racism have on American Indian communities in South Dakota. She called specifically on the work of Dr. Camara Jones, a physician and epidemiologist who specializes in studying the ways in which racism and social inequity affect health.⁴¹⁹ Ms. Littlefield connected

⁴⁰⁹ Giroux Statement at 6-7.

⁴¹⁰ Ibid.

⁴¹¹ Steffens, *September Briefing*, at 11.

⁴¹² New Holy Testimony, *December Briefing*, p. 18.

⁴¹³ Family Planning Services and Population Research Act of 1970 42 U.S.C. § 201

⁴¹⁴ New Holy Testimony, *December Briefing*, p. 18.

⁴¹⁵ Ibid.

⁴¹⁶ Ibid.

⁴¹⁷ Littlefield Testimony, *September Briefing*, p.11.; Steffens Testimony, *September Briefing*, p. 11.; Giroux Statement, at 3-5.

⁴¹⁸ Giroux Statement, at 3.

⁴¹⁹ Littlefield Testimony, *September Briefing*, p.11.

the disparities experienced by American Indian people in South Dakota to the presence of institutional racism. She shared the work of Dr. Jones who defines institutional racism as, “the structures, policies, practices and norms resulting in differential access to goods and services and opportunities as a society by race.”⁴²⁰ Specifically, Ms. Littlefield pointed to the lack of opportunities available to American Indian people in South Dakota as being a result of institutional racism.⁴²¹

Ms. Steffens pointed to institutional racism as, “a fundamental cause of racial and ethnic disparities and health outcomes,” including maternal mortality.⁴²² Ms. Steffens emphasized that institutional racism impacts a person’s access to healthcare based on their race, as well as, the quality of that healthcare.⁴²³ It was also pointed out that this type of racism is often structural, meaning it is difficult to identify one culprit who is responsible for institutional racism as a whole.⁴²⁴ Instead, it is a type of racism that is embedded, “into our institutions of custom, practice and law.”⁴²⁵ According to Ms. Steffens, the evidence of institutional racism is often shown through a lack of action, “in the face of need.”⁴²⁶

Dr. Giroux and Dr. Big Crow echoed these sentiments, pointing to the connection between racial health disparities and institutional racism.⁴²⁷ Dr. Big Crow emphasized that prejudice and discrimination increase the levels of anxiety in American Indian and Alaska Native people because they are directly related to colonization, forced migration, genocide, cultural erasure and forced boarding schools.⁴²⁸ Dr. Giroux focused on the work of Dr. Jones, which has highlighted that there is a historical connection between racial injustices faced by certain groups of people and the health disparities that they face, stating that, “There would be no racial health disparities if there was racial equality.”⁴²⁹

⁴²⁰ Ibid.

⁴²¹ Ibid.

⁴²² Steffens Testimony, *September Briefing*, p. 11.

⁴²³ Ibid.

⁴²⁴ Ibid.

⁴²⁵ Ibid.

⁴²⁶ Ibid.

⁴²⁷ Giroux Statement, at 3-5.

⁴²⁸ Big Crow Statement, at 3.

⁴²⁹ Giroux Statement, at 5.

3. *Lack of Access to Comprehensive Health Services*

The Committee received testimony that highlighted the need for maternal health services that honor traditional health practices and support the mother's mental health.⁴³⁰ Dr. Big Crow drew attention to the fact that many hospitals do not allow Native mothers the opportunity to participate in traditional birthing ceremonies, which harms the family because it creates cultural and spiritual harm to the child.⁴³¹ She shared that the western ideals which frame systems of health care stem from the historical infringing of the cultural practices of indigenous women.⁴³² This creates "culturally-biased systems," which do not allow for or understand traditional birthing practices of Native people.⁴³³ As stated by Dr. Big Crow, "...culturally-biased systems that do not understand the ancient birthing practices of indigenous peoples have led to systemic oppression, structural racism, thus, aiding to the cultural demise of first peoples, as the Lakota. It is under these frameworks that we find our indigenous women estranged, cultural vitality stagnant, and a dying way of life, our reality."⁴³⁴

Included in this conversation was the need for culturally relevant healthcare. Maymangwa Flying Eagle, a member of the public and the Standing Rock community, clarified that culturally relevant healthcare includes American Indian women having access to a person that they trust throughout their pregnancy, at the time of birth and post-delivery.⁴³⁵ This person could help protect the health of the mother by ensuring that they have access to the care supports their needs, financial help, and transportation services.⁴³⁶ Ms. Flying Eagle stated that, "I think that would be one of the things that...would be most important in ensuring that a pregnant native woman doesn't die during her pregnancy."⁴³⁷

Ms. Wilcox advocated for American Indian to have a place to deliver that is culturally appropriate and where they can be with their family.⁴³⁸ In her opinion, this could lead to positive outcomes for

⁴³⁰ Big Crow Statement, at 3; Flying Eagle Testimony, *December Briefing*, p. 21; Wilcox Testimony, *July Briefing*, p. 10.

⁴³¹ Big Crow Statement, at 4.

⁴³² Ibid.

⁴³³ Big Crow Statement, at 4.

⁴³⁴ Ibid.

⁴³⁵ Flying Eagle Testimony, *December Briefing*, p. 21.

⁴³⁶ Ibid.

⁴³⁷ Ibid.

⁴³⁸ Wilcox Testimony, *July Briefing*, p. 8.

the baby, mother, father and their extended family.⁴³⁹ Traditional modes of healing have been utilized for generations and Ms. Wilcox asserted that they need to continue into the future.⁴⁴⁰

She also brought up the lack of postpartum mental health services for American Indian women living on the Rosebud Reservation. According to Ms. Wilcox, “Mental health services for...prenatal [and] postpartum women experiencing depression, stress and other issues are...not adequate because mental health services here are so limited.”⁴⁴¹ Ms. Wilcox pointed out the fact that there is one mental health program available on the Rosebud Reservation, however, “their primary focus is suicide.”⁴⁴²

Ms. Locke brought up the need for destigmatizing home births in South Dakota.⁴⁴³ Within her work as a doula, she has witnessed the empowering nature of an American Indian woman giving birth without medications or hospital assistance.⁴⁴⁴ She noted that:

[H]ome births are not illegal, but there is a stigma with it that CPS and other forms of investigation is [*sic*] done upon any family, not just indigenous families. This is including non-indigenous families within the state of South Dakota are immediately investigated upon, with a home birth. That stigma can be really detrimental, to creating a prison pipeline system. That's one thing I really wanted to bring to everyone's knowledge; that we can have home births without stigma, we can have home births that will be quality care, and, another option for women.⁴⁴⁵

G. COVID-19 Impacts

Ms. Antoine spoke to the ways in which the COVID-19 pandemic has compounded issues that were already present on reservations, as well as how it has impacted a key financial source.⁴⁴⁶ She explained that reservations are communities that have historically experienced and continue to experience isolation from access to resources, which leads to high rates of unemployment, limited access to transportation, overcrowded homes and limited access to health care.⁴⁴⁷ These issues have been compounded further by the devastation of the COVID-19 pandemic, making it difficult

⁴³⁹ Ibid.

⁴⁴⁰ Ibid.

⁴⁴¹ Ibid., 10.

⁴⁴² Ibid.

⁴⁴³ Locke Testimony, *December Briefing*, pp. 5-8.

⁴⁴⁴ Ibid., 8.

⁴⁴⁵ Locke Testimony, *December Briefing*, p. 5.

⁴⁴⁶ Antoine Testimony, *July Briefing*, pp. 6-13.

⁴⁴⁷ Ibid., 6-8.

for reservations to work towards a healthier community.⁴⁴⁸ Ms. Antoine also pointed out the effects that the pandemic has had on funding sources such as the reservation's casino.⁴⁴⁹ Revenues from the casino go towards educational development for students who want to seek educational opportunities outside of the reservation, however, the casino is currently close due to the pandemic, meaning a loss in this funding source.⁴⁵⁰

Ms. Wilcox brought up the impacts that the pandemic has had on their organizations and their access to the American Indian mothers that they work with.⁴⁵¹ She spoke specifically about the ways in which the pandemic has impacted the service delivery of the U.S. Department of Health and Human Services' Maternal and Child Health Project Launch Program, which provides services to high risk prenatal and postpartum Native women in twenty-two communities within South Dakota.⁴⁵² Ms. Wilcox emphasized how the presence of the pandemic has made it difficult to do outreach with their clients.⁴⁵³ The Maternal and Child Health Project Launch Program provides home visits and transportation for these women, however both of these services have been suspended do to COVID-19.⁴⁵⁴

Ms. Antoine spoke to the ways in which the pandemic has made it even more difficult for American Indian mothers to work through Child Protective Services requirements.⁴⁵⁵ The barriers that Native mothers face within the Child Protective Services system, such as inexperienced case workers and a lack of support, have been exacerbated by COVID-19.⁴⁵⁶ Specifically, employment requirements have become harder to fulfill, with the pandemic worsening the already sparse employment opportunities for American Indian women living on reservations.⁴⁵⁷ Without access to steady employment, American Indian women are at higher risk for losing custody of their child due to the inability to meet work requirements.⁴⁵⁸

The Committee heard testimony that outlined additional concerns for the impacts that the COVID-19 pandemic has had on incarcerated, American Indian women.⁴⁵⁹ This is a group that may include

⁴⁴⁸ Ibid., 7-8.

⁴⁴⁹ Ibid., 13.

⁴⁵⁰ Ibid.

⁴⁵¹ Wilcox Testimony, *July Briefing*, pp. 8-17; Locke Testimony, *July Briefing*, p. 18.

⁴⁵² Wilcox Testimony, *July Briefing*, pp. 8-9.

⁴⁵³ Ibid., 17.

⁴⁵⁴ Wilcox Testimony, *July Briefing*, pp. 8-9.

⁴⁵⁵ Antoine Testimony, *July Briefing*, p. 16.

⁴⁵⁶ Ibid.

⁴⁵⁷ Ibid.

⁴⁵⁸ Ibid.

⁴⁵⁹ Roach Testimony, *December Briefing*, pp. 11-12.

pregnant American Indian women who need access to health services, outside of COVID services. Ms. Roach shared her frustration that the state has not taken necessary steps to appropriately address the COVID-19 health crisis within prisons, which further exacerbates pre-existing health issues for American Indian women who are pregnant.⁴⁶⁰ She brought up the case of Andrea Circle Bear, a pregnant woman and member of the Cheyenne River Sioux tribe who died from COVID, after contracting it within a South Dakota federal prison.⁴⁶¹

Dr. Bonny Specker, Professor at South Dakota State University, utilized state data⁴⁶² that was collected until November 12th, 2020 to outline the impact that COVID-19 has had on American Indian communities.⁴⁶³ According to Dr. Specker, COVID-19 rates have increasingly gotten worse since the Smithfield outbreak in the spring of 2020 [see Figure 3].⁴⁶⁴ Disparities can be seen between White and American Indian individuals when COVID-19 diagnosis rates are categorized by race and age [see Figure 4].⁴⁶⁵ Among individuals aged less than 30 years, 6.8% of American Indian individuals have tested positive compared to 4.6% of White individuals.⁴⁶⁶ Among individuals between 30 and 59 years of age, 14.5% American Indian have tested positive compared to 6.2% among the White population.⁴⁶⁷ Finally, for individuals 60 years of age and above, 12.5% of American Indian individuals and 5.5% of White individuals have tested positive.⁴⁶⁸

⁴⁶⁰ Ibid., 11.

⁴⁶¹ Gordon, Scott. "Baby Born By C-Section to Inmate Who Died of Coronavirus is 'Doing Great,' Family Says." *5NBCDFW*. May 1, 2020. <https://www.nbcdfw.com/news/coronavirus/baby-born-by-c-section-to-inmate-who-died-of-coronavirus-is-doing-great-family-says/2361690/> (accessed March 3, 2021).

⁴⁶² The Committee noted the following regarding COVID data in South Dakota: Prior to August 5, 2020, South Dakota did not report ethnicity or race data for COVID deaths. "South Dakota: Race & Ethnicity Historical Data." The COVID Tracking Project. <https://covidtracking.com/data/state/south-dakota/race-ethnicity/historical> (accessed March 3, 2021). Prior to May 3rd, 2020, South Dakota did not report ethnicity or race data for COVID cases.

"South Dakota: Race & Ethnicity Historical Data." The COVID Tracking Project. <https://covidtracking.com/data/state/south-dakota/race-ethnicity/historical> (accessed March 3, 2021). As of March 3rd 2021, South Dakota has not report race or ethnicity data for COVID tests.

"South Dakota Assessment." The COVID Tracking Project. <https://covidtracking.com/data/state/south-dakota/assessment#race-ethnicity> (accessed March 3, 2021). In April of 2020, South Dakota Department of Health Secretary, Kim Malsam-Rysdon, stated that there was no presence of racial disparity related to COVID-19. Zions, Arielle. "State health official: No large racial disparities in SD COVID-19 cases." *Rapid City Journal*, April 14, 2020. https://rapidcityjournal.com/news/local/state-health-official-no-large-racial-disparities-in-sd-covid-19-cases/article_4f2b725d-2183-5d53-b3ec-8cb6990f447e.html (accessed March 3, 2021).

⁴⁶³ Specker Testimony, *November Briefing*, p. 7.

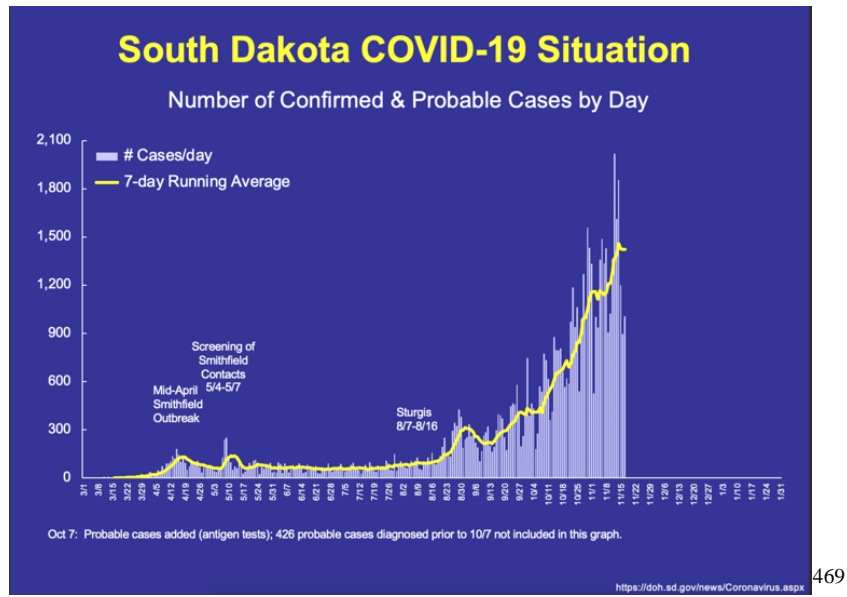
⁴⁶⁴ Specker Testimony, *November Briefing*, p. 7.

⁴⁶⁵ Ibid., 8.

⁴⁶⁶ Ibid.

⁴⁶⁷ Ibid.

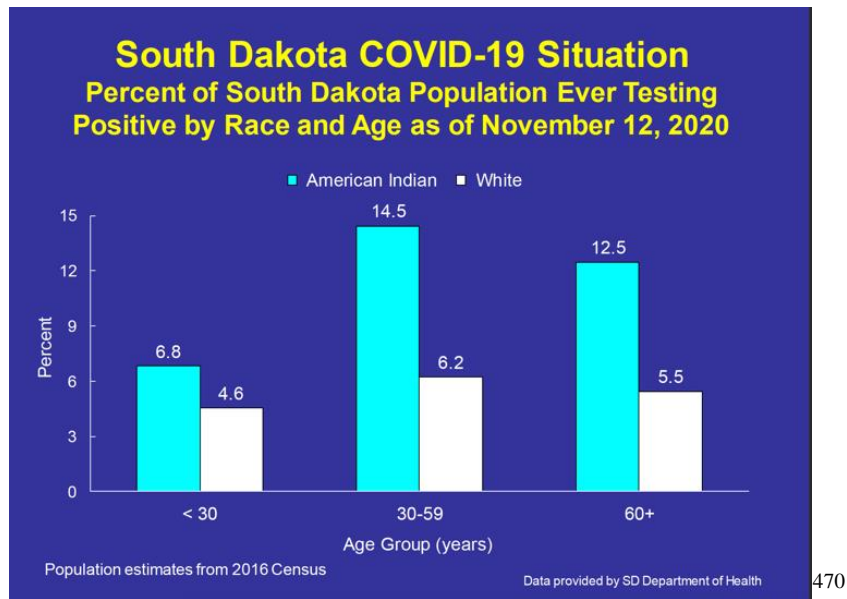
⁴⁶⁸ Ibid.



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Source: South Dakota Department of Health – COVID-19 Trends

Figure 8



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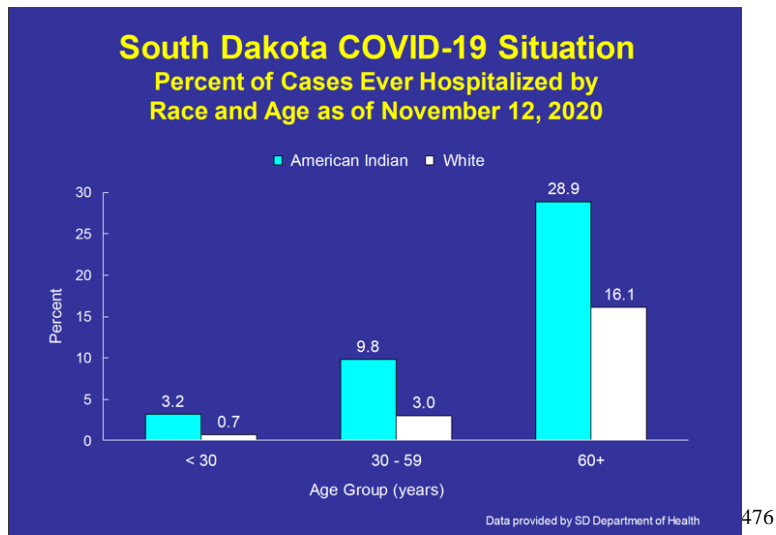
⁴⁶⁹ November 2020 Web Hearing Panelist Presentations, p. 23, South Dakota Department of Health, *South Dakota Covid-19 Dashboard*, (n.d.) <https://doh.sd.gov/COVID/Dashboard.aspx>.

⁴⁷⁰ November 2020 Web Hearing Panelist Presentations, p. 26, South Dakota Department of Health, *South Dakota Covid-19 Dashboard*, (n.d.) <https://doh.sd.gov/COVID/Dashboard.aspx>.

Source: South Dakota Department of Health – COVID-19 Demographics

Figure 9

Rates for American Indian populations were higher regarding hospitalization and death. Dr. Specker reported that after comparing the percentage of COVID-19 cases that experienced hospitalization, it was found that hospitalization rates for all age groups are higher for American Indians as compared to Whites [see Figure 5].⁴⁷¹ According to Dr. Specker, this may indicate that American Indians are experiencing a more severe case of the disease than White populations.⁴⁷² In terms of fatality, or those who have been diagnosed with COVID-19 and die, racial disparities were present [see Figure 6].⁴⁷³ Dr. Specker reported that 0.8% of American Indians have died between the age of 30 and 59 compared to 0.1% of Whites in the same age bracket.⁴⁷⁴ For individuals over 60, 5.7% of American Indians passed from COVID-19 compared to 4% of White individuals.⁴⁷⁵



Source: South Dakota Department of Health – COVID-19 Demographics

⁴⁷¹ Specker Testimony, *November Briefing*, p. 8.

⁴⁷² Ibid.

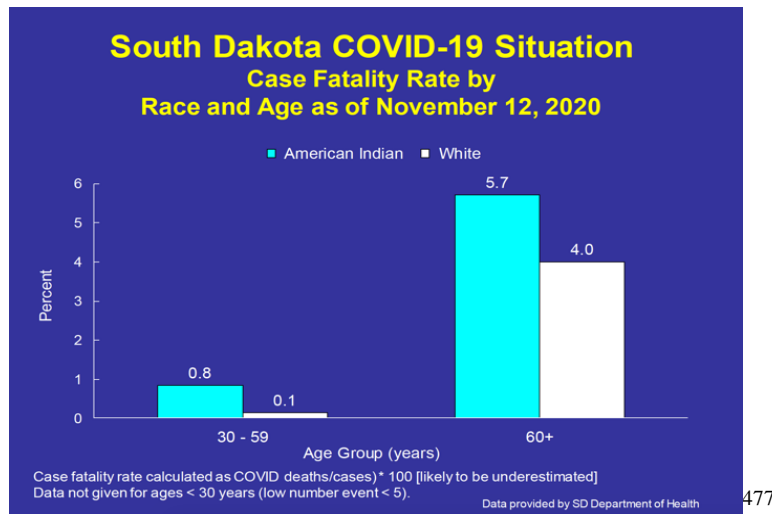
⁴⁷³ Ibid.

⁴⁷⁴ Ibid.

⁴⁷⁵ Ibid.

⁴⁷⁶ November 2020 Web Hearing Panelist Presentations, p. 27, South Dakota Department of Health, *South Dakota Covid-19 Dashboard*, (n.d.) <https://doh.sd.gov/COVID/Dashboard.aspx>.

Figure 10



Source: South Dakota Department of Health – COVID-19 Demographics

Figure 11

H. Recommendations for the Committee’s Consideration

1. *Equity and Supportive Services*

The Committee heard testimony that drew attention to the need to create racial equity and supportive services for American Indian people in South Dakota.⁴⁷⁸ In order to work towards racial equity, Ms. Steffens suggested the need to increase the awareness of institutional racism, decriminalize behavioral health disorders, increase American Indian’s access to the quality health care through supportive services, and improve American Indian’s environmental conditions.⁴⁷⁹ In relation to improving health care through supportive services, Ms. Locke drew attention to the need for economic development and community services on reservations.⁴⁸⁰ Economic development was highlighted as a tool that could help improve American Indian women’s access

⁴⁷⁷ November 2020 Web Hearing Panelist Presentations, p. 28, South Dakota Department of Health, *South Dakota Covid-19 Dashboard*, (n.d.) <https://doh.sd.gov/COVID/Dashboard.aspx>.

⁴⁷⁸ Steffens Testimony, *September Briefing*, pp. 16-17; Locke Testimony, *December Briefing*, pp. 5-6.

⁴⁷⁹ Steffens Testimony, *September Briefing*, p. 16.

⁴⁸⁰ Locke Testimony, *December Briefing*, pp. 5-6.

to gas money and transportation, which in turn would help them get to their maternal health appointments.⁴⁸¹

Ms. Antoine addressed the need for South Dakota Department of Social Services to better train their case workers generally, but especially those individuals working with American Indian mothers who have had their child taken by Child Protective Services.⁴⁸² Additionally, Ms. Antoine brought up the need for American Indian mothers to have advocates in addition to the South Dakota Department of Social Services case workers.⁴⁸³ These advocates should be available to help these mothers gain access to services and supports that will help them gain custody to their children.⁴⁸⁴

Ms. Steffens brought up the need for justice in order to achieve racial equity.⁴⁸⁵ In order to create justice, it was suggested that inequity be monitored in order to expose areas of opportunity as well as areas where disparities exist.⁴⁸⁶ Monitoring inequity would also include the examination of societal structures, policy practices, norms, values, attention to systems of power and interventions on societal structures.⁴⁸⁷ Additionally, it was suggested that American Indian's living in South Dakota should be able to lead and make decisions related to maternal and child health concerns.⁴⁸⁸

On the federal level, Ms. Steffens advocated for coordination with American Indians to establish better housing, food access, health care, transportation, education, and job opportunities.⁴⁸⁹ By doing so, the federal government could help create opportunities for American Indians to overcome equity barriers as well as, "improve the social determinants of health," for American Indian women.⁴⁹⁰

2. *Maternal Mortality Review Board and Access to State-wide Data*

Multiple panelists highlighted the need for a maternal mortality review board and American Indian involvement within current maternal mortality review committees.⁴⁹¹ Ms. Wilcox testified that in order to open up the discussion on maternal mortality, it is necessary to establish a maternal and

⁴⁸¹ Ibid.

⁴⁸² Antoine Testimony, *July Briefing*, p. 16.

⁴⁸³ Ibid.

⁴⁸⁴ Ibid.

⁴⁸⁵ Steffens Testimony, *September Briefing*, p. 16.

⁴⁸⁶ Ibid.

⁴⁸⁷ Ibid.

⁴⁸⁸ Ibid., 17.

⁴⁸⁹ Ibid.

⁴⁹⁰ Ibid.

⁴⁹¹ Littlefield Testimony, *September Briefing*, p. 18.; Steffens Testimony, *September Briefing*, p. 17; Wilcox Testimony, *July Briefing*, p. 10.

infant mortality review board that includes all American Indian tribes in South Dakota, the Indian Health Service, and the South Dakota state government.⁴⁹² This type of collaboration was presented as a way to create preventative measures which could improve the health outcomes for American Indian women and their babies.⁴⁹³

Ms. Steffens brought up the need for American Indian tribes to lead and make their own decisions regarding maternal and child health.⁴⁹⁴ She advocated for the representation of the Great Plains Tribal Chairmen's Health Board and American Indian tribes on the South Dakota Infant and Maternal Mortality Review Committee.⁴⁹⁵ She mentioned that the state of South Dakota should provide technical assistance as well as data and subject matter expertise to help ensure that Tribal leadership is effectively informed about process of the state's maternal mortality review board and their results.⁴⁹⁶ Additionally, it was suggested that data and public health recommendations from the South Dakota Infant and Maternal Mortality Review Committee be communicated to American Indian tribes.⁴⁹⁷ Ms. Littlefield touched on the importance of making sure that American Indian tribes have access to health-related data so that they can make their own decisions regarding the health of their community.⁴⁹⁸ Ms. Littlefield explained that every Tribal community is different, and that the severity of issues faced by American Indians vary across tribes.⁴⁹⁹ It was suggested that if American Indian tribes have access to the data from their respective communities they will have a better opportunity to address the issues facing their community.⁵⁰⁰

3. Birthing Center

Reservation-based birth centers were emphasized as a solution to the Maternal health issues faced by American Indian women.⁵⁰¹ Birthing centers based on reservations could provide culturally appropriate care and allow for family members to be present during and after birth.⁵⁰² Having a reservation-based birthing center would cut down on travel times mentioned by panelists and

⁴⁹² Wilcox Testimony, *July Briefing*, p. 10.

⁴⁹³ Ibid.

⁴⁹⁴ Steffens Testimony, *September Briefing*, p. 17.

⁴⁹⁵ Ibid.

⁴⁹⁶ Ibid.

⁴⁹⁷ Ibid.

⁴⁹⁸ Littlefield Testimony, *September Briefing*, p. 18.

⁴⁹⁹ Ibid.

⁵⁰⁰ Ibid.

⁵⁰¹ Antoine Testimony, *July Briefing*, p. 7; Kingman Testimony, *December Briefing*, p. 23; Locke Testimony, *December Briefing*, p. 7; Wilcox Testimony, *July Briefing*, p. 9.

⁵⁰² Wilcox Testimony, *July Briefing*, p. 9.

reduce the stress of American Indian mothers facing health issues during their pregnancy.⁵⁰³ In regard to financing this effort, Ms. Kingman recommended that Indian Health Service provide adequate funding for reservation-based birthing centers.⁵⁰⁴

Dr. McKay was hesitant to endorse birthing centers due to the lack of funding given rural hospitals as well as the higher rates of neonatal complications associated with birth centers.⁵⁰⁵ Dr. McKay mentioned the possibility of instead, establishing a birth center model within established hospital systems.⁵⁰⁶

4. Traditional Understanding of Healing and Birthing

Many panelists referred to the need to nourish traditional understandings of healing and birthing within and outside of the health care system. Ms. New Holy addressed that Indian Health Service needs to develop programs that support American Indian women's emotional healing and maternal health outside of the technical, medical view of healing.⁵⁰⁷ She asserted that there must be a connection developed between the traditional and modern views of emotional and maternal health and healing.⁵⁰⁸ The rules and guidelines surrounding prenatal care restrict the ways in which women can experience traditional modes of healthcare and a direct healthcare plan that can address healthcare needs as well as generational trauma is needed.⁵⁰⁹ An important aspect of culturally relevant healthcare would include Native Mothers having access to an advocate that could help provide access to transportation, care supports and financial assistance.⁵¹⁰

Valeriah Big-Eagle, a member of the public from the American Indian Nursing Education Center of South Dakota State University, highlighted that Oyate Health and Monument Health are two examples of hospitals incorporating aspects of traditional healing.⁵¹¹ Oyate Health incorporates traditional healing as a treatment option, while Monument Health has implemented a sage and smudging policy.⁵¹² This incorporation of traditional modalities of healing within the health care

⁵⁰³ Antoine Testimony, *July Briefing*, p. 7.

⁵⁰⁴ Kingman Testimony, *December Briefing*, p. 23.

⁵⁰⁵ McKay Testimony, *September Briefing*, p. 6.

⁵⁰⁶ Ibid.

⁵⁰⁷ New Holy Testimony, *December Briefing*, p.18.

⁵⁰⁸ Ibid., 18-19.

⁵⁰⁹ Ibid., 19.

⁵¹⁰ Flying Eagle Testimony, *December Briefing*, p. 21.

⁵¹¹ Big Eagle Testimony, *December Briefing*, p. 20.

⁵¹² Big Eagle Testimony, *December Briefing*, p. 20.

system are the start of culturally relevant healthcare, but there needs to be more incorporations of this healing across the state of South Dakota.⁵¹³

It was recommended Child Protective Services destigmatize their understandings of home births, by avoiding any stigmatization of mothers who choose this birthing option.⁵¹⁴ Home births offer an opportunity for American Indian mothers to experience the birthing process without hospital assistance or medications.⁵¹⁵ Home births can provide an opportunity for alternative modes of healing, while avoiding the transportation issues mentioned by panelists.⁵¹⁶

5. Mental Health Services

Attention was drawn to the need for improved mental health services access for American Indian women in South Dakota.⁵¹⁷ These services should support American Indian women's pregnancy, while addressing and healing generational trauma.⁵¹⁸ These efforts to improve the effects of generational trauma could have an impact on an epigenetic level and improve the long-term health of American Indian women.⁵¹⁹

6. Insurance Policy

Dr. McKay recommended needed improvements to insurance policy as a way to remove barriers to American Indian women's access to maternal healthcare.⁵²⁰ According to Dr. McKay, "current reimbursement strategies [of insurances companies] do not cover additional net services necessary to create a value-based purchasing model."⁵²¹ In order to cover mother's needs, Dr. McKay suggested that this model needs to be explored further to identify other services needed for mothers and their costs.⁵²² Additionally, it was suggested that insurance payment models investigate the ways in which specialized medical institutions and health systems can support rural hospitals and clinics, Indian Health Service facilities and Federally Qualified Health Centers.⁵²³ Additionally, it

⁵¹³ Ibid.

⁵¹⁴ Locke Testimony, *December Briefing*, pp. 5-8.

⁵¹⁵ Ibid., 8.

⁵¹⁶ Ibid., 5.

⁵¹⁷ Deutsch Testimony, *December Briefing*, p. 17.

⁵¹⁸ Ibid.

⁵¹⁹ Ibid.

⁵²⁰ McKay Testimony, *September Briefing*, pp. 5-6.

⁵²¹ Ibid.

⁵²² Ibid.

⁵²³ Ibid.

is important that insurance policy recognize that a mother is not just a vessel for a child.⁵²⁴ By doing so, health systems could help implement healthy strategies and habits that a woman can sustain throughout her lifetime, such as opportunities to address obesity, healthy eating, exercise, and smoking.⁵²⁵ Dr. McKay asserted that this investment in the health of women over their lifetime is an investment in the health of their children.⁵²⁶

7. *Telemedicine Services*

The need for telemedicine services focused on substance use treatment, prenatal appointments and case management was highlighted.⁵²⁷ There is evidence that drinking, smoking and drug use has increased during the COVID-19 pandemic.⁵²⁸ Telemedicine services could increase the ability for virtual case management and help prenatal clinics keep in contact with women who are missing appointments.⁵²⁹ Dr. Elliott pointed out that prenatal appointments are essential for women to receive education on prenatal health and telemedicine services can increase access to this type of education.⁵³⁰

8. *Maternity/Paternity Leave*

Paid maternity and paternity leave for American Indian parents was recommended to the Committee.⁵³¹ It is important for fathers to be present for the first four weeks of the baby's life without having to worry about financial repercussions of missing work.⁵³² In this way, the baby has a chance to bond with their father, which can help prevent social ideas of toxic masculinity and help solidify the father as a significant role model for the child.⁵³³ Ms. Locke spoke to the need for same-sex parents to have access to maternity or paternity leave to bond with their baby.⁵³⁴ If same-sex parents have adopted a child, it is essential that they receive time to bond with their new child in order to solidify good parenting techniques and a good foundation for their child.⁵³⁵ In the opinion of Ms. Locke, having these services available to all parents will

⁵²⁴ Ibid.

⁵²⁵ Ibid.

⁵²⁶ Ibid.

⁵²⁷ Elliott Testimony, *November Briefing*, pp. 6-7.

⁵²⁸ Ibid.

⁵²⁹ Ibid.

⁵³⁰ Elliott Testimony, *November Briefing*, pp. 6-7.

⁵³¹ Locke Testimony, *December Briefing*, p. 5.

⁵³² Ibid.

⁵³³ Ibid.

⁵³⁴ Ibid.

⁵³⁵ Ibid.

have long term effects, which improve society.⁵³⁶ Dr. Giroux shared she, “...contends that paid maternal leave and an infusion of traditional wisdom and investing heavily in the early childhood development is the single most valuable upstream intervention for American Indians to regain pre-colonized health and to reduce mortality disparities across the life span, including maternal mortality.”⁵³⁷

IV. FINDINGS AND RECOMMENDATIONS

A. Findings

In keeping with their duty to inform the Commission of (1) matters related to discrimination or a denial of equal protection of the laws; and (2) matters of mutual concern in the preparation of reports of the Commission to the President and the Congress,⁵³⁸ the South Dakota Advisory Committee submits the following findings to the Commission regarding maternal health of American Indian women in South Dakota. This report is intended to highlight salient civil rights themes as they emerged in testimony during the Committee’s inquiry. The following findings result directly from the testimony received and reflect the views of the cited panelists. While each assertion has not been independently verified by the Committee, panelists were chosen to testify due to their professional experience, academic credentials, subject expertise, and/or firsthand knowledge of the topics at hand. The complete meeting transcripts are included at the link in the Appendix for further reference.

1. Maternal Mortality and Health Disparities

- a. Maternal mortality is defined as a death related to pregnancy, which can be caused by infection, heart disease, pulmonary embolism, and postpartum hemorrhage.⁵³⁹ Maternal morbidity is defined as any physical illness or disability that is directly linked to childbirth and/or pregnancy.⁵⁴⁰
- b. Sixty percent of maternal deaths are preventable.⁵⁴¹ Preventive efforts include researching and responding to factors that contribute to disproportionate maternal

⁵³⁶ Ibid.

⁵³⁷ Giroux Response at 2.

⁵³⁸ 45 C.F.R. § 703.2.

⁵³⁹ Big Crow Statement at 2.

⁵⁴⁰ Ibid.

⁵⁴¹ Big Crow Statement, at 4. Centers for Disease Control, *Pregnancy Mortality Surveillance System*, Centers for Disease Control and Prevention, <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> (accessed May 10, 2021).

mortality rates of American Indian mothers, including social determinants of health, social injustice, and structural racism.⁵⁴²

- c. There are substantial maternal health disparities between American Indian, Alaska Native, and White mothers.⁵⁴³ The national maternal mortality and maternal morbidity rates of American Indian and Alaska Native women are double that of White women.⁵⁴⁴
- d. Comprehensive data to determine maternal mortality rates for small populations across different states is challenging to access.⁵⁴⁵ The Centers for Disease Control's state maternal mortality tables do not include maternal mortality rates for South Dakota because the population size is small,⁵⁴⁶ which makes it difficult to easily assess the severity of the issue.
- e. Using the number of maternal deaths to calculate the maternal mortality rates for South Dakota, a panelist shared that American Indian women in South Dakota have a mortality rate of 121.77 maternal deaths per 100,000 births, which is nearly seven times the 2018 national maternal mortality rate (17.9 maternal deaths per 100,000 births), and is also far greater than the state's maternal mortality rate (59 maternal deaths per 100,000 births), and the maternal mortality rate for White women in South Dakota (44 maternal deaths per 100,000 births).⁵⁴⁷ This is

⁵⁴² Big Crow Statement, at 4.

⁵⁴³ Littlefield Testimony, September Briefing, p. 13, Ms. Littlefield noted that comprehensive data for maternal mortality rates across states can be challenging to access, is not consistently collected, and has limits due to the small population sizes of those studied. Data shared at the time of the briefing was calculated based on data compiled through a data request submitted previously for births by race to the South Dakota Department of Vital Records alongside 2010-2018 data from the South Dakota Department of Health regarding pregnancy related deaths; See also South Dakota Department of Health, *Maternal Mortality*, (n.d.), <https://doh.sd.gov/statistics/maternalmortality.aspx?> and Centers for Disease Control, *Maternal Mortality*, (n.d.), <https://www.cdc.gov/nchs/maternal-mortality/index.htm>.

⁵⁴⁴ Big Crow Statement at 1; Centers for Disease Control and Prevention, *Pregnancy Mortality Surveillance System*, (n.d.), <https://www.cdc.gov/reproductivehealth/maternal-mortality/pregnancy-mortality-surveillance-system.htm> (accessed May 10, 2021).

⁵⁴⁵ Centers for Disease Control, *Maternal Mortality by State, 2018*, (2018), <https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf> (accessed May 12, 2021).

⁵⁴⁶ Centers for Disease Control, *Maternal Mortality by State, 2018*, (2018), <https://www.cdc.gov/nchs/maternal-mortality/MMR-2018-State-Data-508.pdf> (accessed May 12, 2021).

⁵⁴⁷ Littlefield Testimony, *September Briefing*, p. 13, Ms. Littlefield noted that comprehensive data for maternal mortality rates across states can be challenging to access, is not consistently collected, and has limits due to the small population sizes of those studied. Data shared at the time of the briefing was calculated based on data compiled through a data request submitted previously for births by race to the South Dakota Department of Vital Records alongside 2010-2018 data from the South Dakota Department of Health regarding pregnancy related deaths; See also South Dakota Department of Health, *Maternal Mortality*, (n.d.), <https://doh.sd.gov/statistics/maternalmortality.aspx?> and Centers for Disease Control, *Maternal Mortality*, (n.d.), <https://www.cdc.gov/nchs/maternal-mortality/index.htm>.

especially concerning considering that American Indian women make up only 18% of births within the state, while White women make up 75% of births in South Dakota.⁵⁴⁸

- f. Access to prenatal care is essential to the health of American Indian mothers. Counties which have reservations within their boundaries or which overlap with Tribal lands experience disparities regarding access to prenatal care.⁵⁴⁹ According to the CDC's Pregnancy Risk Assessment Monitoring System (PRAMS) data, 27% of American Indian mothers reported not having access to transportation needed for pre-natal appointments, 27.5% of American Indian mothers were unable to access prenatal care due to lack of access to childcare, and 19.1% of American Indian mothers reported being unable to get an appointment with their healthcare provider.⁵⁵⁰
- g. Disparities regarding access to prenatal care are especially prominent for American Indian mothers between the ages of 15-19.⁵⁵¹ American Indian teens experience a disproportionate lack of prenatal care compared to their White counterparts in the same age bracket.⁵⁵² Within this age group, 55.4% of American Indian mothers received late or no prenatal care compared to 21.8% of White teen mothers.⁵⁵³

2. Lack of Comprehensive Data on Maternal Health Disparities

- a. There is a lack of consistent, comprehensive data available regarding the maternal health of American Indian populations in South Dakota.⁵⁵⁴ This lack of data makes it difficult to develop explanations for the present maternal health disparities within the state.
- b. Historically, the maternal and child health of American Indians in South Dakota was largely uninvestigated. It was not until the 1990s that the Centers for Disease

⁵⁴⁸ Ibid.

⁵⁴⁹ McKay Testimony, *September Briefing*, pp. 2-3.

⁵⁵⁰ Littlefield Testimony, *September Briefing*, p. 14.

⁵⁵¹ Ibid.

⁵⁵² Ibid.

⁵⁵³ Ibid.

⁵⁵⁴ Big Crow Statement, at 2.

Control began to study the infant mortality and maternal health rates of American Indians in South Dakota.⁵⁵⁵

- c. There needs to be a concerted effort to include Tribal Nation representation on a South Dakota Maternal Mortality Review Committee to ensure that Tribal Nations have state-level support to collect and analyze data specific to the maternal health within their communities.⁵⁵⁶
- d. National and South Dakota data indicate that American Indian mothers experience maternal health issues at a higher rate than White mothers, despite the fact that they make up a lower percentage of the population.⁵⁵⁷ However, despite current data revealing these disparities, a comprehensive, research-based explanation as to why these disparities exist in South Dakota has yet to be developed.
- e. As a result, the lack of a clear explanation for these disparities makes it difficult for South Dakota Tribal Nations to take the necessary steps to address the disparities experienced by American Indian women in their communities.⁵⁵⁸

3. Barriers to Accessibility

- a. Pregnant American Indian women, especially those living in rural areas, experience a multitude of compounding barriers that make it difficult to receive pre-natal and routine maternal health care. There is a need to establish better health care, transportation services, housing, employment opportunities, food access and education on American Indian reservations.⁵⁵⁹
- b. Many American Indian women living on reservations in rural South Dakota lack access to water, sewage, housing, employment, and technology.⁵⁶⁰ This lack of technological access includes the unavailability of phones, internet, and computers.⁵⁶¹ These aspects make it especially difficult for pregnant American

⁵⁵⁵ Elliott Testimony, *November Briefing*, pp. 3-4.

⁵⁵⁶ Littlefield Testimony, *September Briefing*, p. 18; Steffens Testimony, *September Briefing*, p. 17; Wilcox Testimony, *July Briefing*, p. 10.

⁵⁵⁷ Big Crow Statement at 2; Elliott Testimony, *November Briefing*, pp. 3-4; Littlefield Testimony, *September Briefing*, pp. 12-13; "South Dakota Population 2021." World Population Review. <https://worldpopulationreview.com/states/south-dakota-population> (accessed March 3, 2020).

⁵⁵⁸ Littlefield Testimony, *September Briefing*, p. 18; Steffens Testimony, *September Briefing*, p. 17; Wilcox Testimony, *July Briefing*, p. 10.

⁵⁵⁹ Steffens Testimony, *September Briefing*, p. 17.

⁵⁶⁰ Antoine Testimony, *July Briefing*, p. 6-13; Big Crow Statement at 2; Wilcox Testimony, *July Briefing*, pp.9-10.

⁵⁶¹ Wilcox Testimony, *July Briefing*, p. 9.

Indian women to schedule appointments, contact medical providers and sign-up for Medicaid.⁵⁶²

- i. Access to Medicaid was highlighted as a barrier for American Indian women living in rural South Dakota.⁵⁶³
 - ii. In order to apply for and access to Medicaid, American Indian women usually need to have access to a phone, car, and internet service.⁵⁶⁴
- c. American Indian women also lack access to reliable and consistent forms of transportation (both personal vehicles and public transit) as well as access to roads.⁵⁶⁵ The lack of transportation makes it difficult for American Indian women to travel to maternal health appointments and their deliveries.⁵⁶⁶
 - d. The locations of birthing centers require American Indian women to travel long distances from their homes on reservations.⁵⁶⁷ These women often have to travel anywhere from one to four hours in order to get to their appointments and to give birth.⁵⁶⁸
 - e. These infrastructural barriers impact American Indian women's social determinants of health, which are defined as the environmental conditions in which individuals are born, work, and live.⁵⁶⁹ Access to early and routine pre-natal care is the main factor which lowers the risk of maternal morbidity and maternal mortality.⁵⁷⁰ Each of these barriers compounds upon the other, creating enormous challenges for American Indian women to overcome in order to gain access to pre-natal and routine maternal health services.⁵⁷¹

⁵⁶² McKay Testimony, *September Briefing*, p. 4.; Wilcox Testimony, *July Briefing*, p. 9.

⁵⁶³ McKay Testimony, *September Briefing*, p. 4.

⁵⁶⁴ Ibid.

⁵⁶⁵ Antoine Testimony, *July Briefing*, p. 12; Deutsch Testimony, *December Briefing*, p. 16; McKay Testimony, *September Briefing*, p. 14; Wilcox Testimony, *July Briefing*, p. 9.

⁵⁶⁶ Deutsch Testimony, *December Briefing*, p. 16; McKay Testimony, *September Briefing*, p. 14; Wilcox Testimony, *July Briefing*, p. 9.

⁵⁶⁷ Antoine Testimony, *July Briefing*, p. 7; Kingman Testimony, *December Briefing*, p. 23; Locke Testimony, *December Briefing*, pp. 5-7; Wilcox Testimony, *July Briefing*, p. 9-11.

⁵⁶⁸ Antoine Testimony, *July Briefing*, p. 7; Locke Testimony, *December Briefing*, pp. 5-6; Wilcox Testimony, *July Briefing*, p. 9.

⁵⁶⁹ Big Crow Statement at 2.

⁵⁷⁰ Ibid., 3.

⁵⁷¹ McKay Testimony, *September Briefing*, pp. 2-3.

4. Traditional Birthing Practices

- a. Regardless of the location or mode of birthing, American Indian mothers need to have access to traditional practices before and during birth.⁵⁷² Birth and the birthing process is a sacred event where cultural teachings and ceremonies take place.⁵⁷³ American Indian women need the opportunity to participate in these practices, which include having family members present during birth.⁵⁷⁴ Due to the distance of birthing centers, and a lack of transportation access on reservations, it is difficult for family members to be present during the time of birth, which results in American Indian mothers giving birth alone and missing out on traditional practices.⁵⁷⁵
- b. The testimony received indicated that European maternal health practices were forced upon Native people during colonization.⁵⁷⁶ These practices do not align with the traditional beliefs and practices of American Indian people.⁵⁷⁷ Pre-colonization, American Indian tribes invested in maternal health because it was a pillar of health and success for their communities.⁵⁷⁸ Even today, Lakota tradition holds women to the highest respect by supporting a mother's decisions about her baby and her body.⁵⁷⁹ The Lakota tradition includes honoring fathers within the birthing process and not immediately cutting the umbilical cord post-birth, indicating that fathers should be considered as part of comprehensive efforts to address maternal health.⁵⁸⁰

5. Cultural Competency

- a. American Indian women need access to culturally competent services. Cultural competence is defined as the incorporation and transference of knowledge about persons and groups of people into particular policies, attitudes, standards, and

⁵⁷² Antoine Testimony, *July Briefing*, p. 7; Big Crow Statement, at 3; Wilcox Testimony, *July Briefing*, pp. 9-11; Locke Testimony, *December Briefing*, p. 6.

⁵⁷³ Big Crow Statement, at 4; Wilcox Testimony, *July Briefing*, p. 9.

⁵⁷⁴ Ibid.

⁵⁷⁵ Wilcox Testimony, *July Briefing*, pp. 9-11.

⁵⁷⁶ Big Crow Statement, at 4; Wilcox Testimony, *July Briefing*, p. 9.

⁵⁷⁷ Ibid.

⁵⁷⁸ Giroux Statement, at 2.

⁵⁷⁹ Locke Testimony, *December Briefing*, p. 8.

⁵⁸⁰ Ibid.

practices used to increase the quality and outcomes of services for all groups and peoples.⁵⁸¹

- b. The Committee heard testimony that health care providers, institutions and practices do not reflect the values of American Indian women.⁵⁸² The testimony reflected that many hospitals in the state do not allow American Indian women to participate in traditional birthing ceremonies.⁵⁸³ This lack of cultural freedom is associated with spiritual harm towards the baby and the family.⁵⁸⁴
- c. Within the testimony, panelists shared that the health care institutions are informed by western ideals that are connected to the infringement of American Indian cultural traditions.⁵⁸⁵ These healthcare institutions were referenced as “culturally-biased” systems that do not recognize the cultural framework of American Indian women.⁵⁸⁶ This lack of recognition was linked to the systemic oppression, structural racism and cultural erasure of American Indian people.⁵⁸⁷
- d. There is a dislocation between institutional maternal health and traditional healing practices.⁵⁸⁸ Institutional rules and guidelines pre-natal care and maternal health restrict the ways in which American Indian women can experience their traditional modes of healing.⁵⁸⁹
- e. American Indian women can feel stigmatized, stereotyped, and dismissed by the current medical system, which can deter them from seeking maternal health services.⁵⁹⁰ This lack of cultural understanding, specifically within health institutions, could potentially be a barrier for American Indian women seeking healthcare.⁵⁹¹ This is especially true if American Indian women are receiving care

⁵⁸¹ Centers for Disease Control and Prevention, *Cultural Competence in Health and Human Services*, (n.d.), <https://npih.cdc.gov/pages/cultural-competence#what> (accessed May 10, 2021).

⁵⁸² Deutsch Testimony, *December Briefing*, p. 16.

⁵⁸³ Big Crow Statement, at 4.

⁵⁸⁴ Ibid.

⁵⁸⁵ Ibid.

⁵⁸⁶ Ibid.

⁵⁸⁷ Big Crow Statement, at 4.

⁵⁸⁸ New Holy Testimony, *December Briefing*, pp. 18-19.

⁵⁸⁹ Ibid.

⁵⁹⁰ Deutsch Testimony, *December Briefing*, p. 16.

⁵⁹¹ Ibid.

from a primarily White health institution that does not support or enforce cultural competency efforts.⁵⁹²

6. Birthing Centers, Home Births and Traditional Practices

- a. American Indian women need access to healthcare that supports their right to choose the maternal health services that best fit their individual needs. This includes access to reservation-based birthing centers, home births and traditional birthing practices.
- b. There is a lack of accessible birthing centers for American Indian women living on South Dakota reservations.⁵⁹³ The Committee heard testimony which highlighted the suggestion that reservation-based birthing centers could act as a solution to accessibility barriers.⁵⁹⁴ American Indian women are in need of reservation-based birthing centers to alleviate transportation barriers and exercise their traditional practices.⁵⁹⁵
- c. Home births are another alternative to institutionalized health care for American Indian women.⁵⁹⁶ This type of birth allows for American Indian women to avoid transportation barriers and experience an empowering, alternative mode of healing.⁵⁹⁷

7. Institutional Racism

- a. Institutional racism is defined as structural policies, practices, and laws that create differential access to resources, goods, services and opportunities for individuals and groups of people based on race.⁵⁹⁸
- b. Institutionalized racism is often evident as inaction in the face of need.⁵⁹⁹ Institutional racism is structurally embedded within society, institutions and laws which makes it difficult to identify one single cause for its existence.⁶⁰⁰ Despite

⁵⁹² Ibid.

⁵⁹³ Antoine Testimony, *July Briefing*, p. 7; Kingman Testimony, *December Briefing*, p. 23; Locke Testimony, *December Briefing*, pp. 5-7; Wilcox Testimony, *July Briefing*, p. 9-11.

⁵⁹⁴ Ibid.

⁵⁹⁵ Antoine Testimony, *July Briefing*, p. 7.; Wilcox Testimony, *July Briefing*, p. 9.

⁵⁹⁶ Locke Testimony, *December Briefing*, pp. 5-8.

⁵⁹⁷ Ibid.

⁵⁹⁸ Littlefield Testimony, *September Briefing*, p.11.

⁵⁹⁹ Steffens Testimony, *September Briefing*, p. 11.

⁶⁰⁰ Ibid.

the difficulty in identifying a single cause of institutional racism, institutional racism was suggested as directly, negatively impacting the health disparities experienced by American Indian women in South Dakota.⁶⁰¹

- c. Prejudice, discrimination, and racism are associated with institutional racism.⁶⁰² These factors associated with institutional racism increase the levels of anxiety experienced by American Indian and Alaska Native people because they are associated with colonization, forced migration, genocide, cultural erasure and forced boarding schools.⁶⁰³
- d. Institutional racism creates a traumatic environment for American Indian women, which negatively impacts their human development.⁶⁰⁴ Institutional racism can cause intergenerational trauma, adverse childhood experiences, and toxic stress.⁶⁰⁵ These factors can compound with the lack of available resources caused by institutional racism and create health implications for American Indian women in the state of South Dakota.⁶⁰⁶

8. Mandated Reporting and Drug Testing

- a. More White women drink during pregnancy than American Indian women, but when American Indian women drink during pregnancy, they are more likely to binge drink.⁶⁰⁷
- b. American Indian mothers experience more trauma and adverse childhood experiences than White mothers in the state.⁶⁰⁸ These factors can increase their likelihood of developing substance use disorder.⁶⁰⁹ As compared to White women in the state, American Indian women in South Dakota are disproportionately affected by substance use as well as preconceptions around substance use.⁶¹⁰

⁶⁰¹ Giroux Statement, at 3-5.

⁶⁰² Big Crow Statement, at 3; Littlefield Testimony, *September Briefing*, p.11.

⁶⁰³ Big Crow Statement, at 3.

⁶⁰⁴ Littlefield Testimony, *September Briefing*, p.11; Giroux Statement at 6-7; Steffens Testimony, *September Briefing*, p. 11; Giroux Statement, at 3-5.

⁶⁰⁵ Giroux Statement at 6-7.

⁶⁰⁶ Ibid.

⁶⁰⁷ Elliott Testimony, *November Briefing*, p. 6.

⁶⁰⁸ Steffens Testimony, *September Briefing*, p. 15.

⁶⁰⁹ Ibid.

⁶¹⁰ Ibid.

- c. In South Dakota law, health care staff who suspect drug use can order a drug test.⁶¹¹ This suspicion is a barrier for American Indian women seeking prenatal care because they can fear being stereotyped and drug tested by healthcare staff who bring their stereotypes into their medical practice.⁶¹² The Committee heard testimony that American Indian women are often drug screened randomly because of perceptions about their lifestyle based on the color of their skin.⁶¹³
- d. American Indian mothers in South Dakota can also be drug tested for “non-compliance” if they sign up for Medicaid later into their pregnancy.⁶¹⁴ American Indian women face barriers in applying for Medicaid [phone, transportation, internet services], which may influence the date in which they can apply.⁶¹⁵ This late uptake of Medicaid can be perceived as a risk for maternal drug use by medical professionals.⁶¹⁶
- e. Mandated reporting law in South Dakota requires that pregnant mothers be reported for drug use.⁶¹⁷ For American Indian mothers dealing with substance use, this law can be a barrier to their pre-natal care because there is fear of the legal repercussions connected to this law.⁶¹⁸
- f. There is a lack of supportive services for American Indian mothers experiencing substance use.⁶¹⁹ Specifically on the Rosebud Reservation, there is only one substance use treatment center, but it has a long waiting list of clients.⁶²⁰
- g. Access to substance use treatment programs via telemedicine is important to provide, especially during COVID-19.⁶²¹

⁶¹¹ McKay Testimony, *September Briefing*, p. 4.

⁶¹² *Ibid.*, 4-8.

⁶¹³ *Ibid.*, 7-8.

⁶¹⁴ *Ibid.*, 4.

⁶¹⁵ *Ibid.*

⁶¹⁶ *Ibid.*

⁶¹⁷ S.D. Codified Laws § 26-8A-2(9) (classifying abusive prenatal drug or alcohol use as child abuse); S.D. Codified Laws § 26-8A-3 (mandatory reporting of suspected child abuse by physicians); see also S.D. Codified Laws § 34-20A-63(3) (permitting involuntary civil commitments of intoxicated mothers who are “pregnant and abusing alcohol or drugs”); *See also*: Giroux Statement, at 6.

⁶¹⁸ Deutsch Testimony, *December Briefing*, p. 16.

⁶¹⁹ McKay Testimony, *September Briefing*, p. 4; Wilcox Testimony, *July Briefing*, p. 10; Elliott Testimony, *November Briefing*, p. 5.

⁶²⁰ Wilcox Testimony, *July Briefing*, p. 10.

⁶²¹ Elliott Testimony, *November Briefing*, p. 7.

- h. Without access to supportive services for substance use treatment, American Indian mothers are more likely to become involved with the judicial system.⁶²²
- i. The Committee heard testimony that that harsh laws surrounding pregnant substance use further alienates American Indian mothers in need of supportive services and pushes them into the hands of the state's judicial system.⁶²³

9. Maternal Healthcare for Incarcerated Native Women

- a. In 2020, 52% of women incarcerated in South Dakota were American Indian, however American Indian women only account for about 8% of the state's population.⁶²⁴
- b. American Indian women in prison do not receive adequate maternal healthcare which can affect the maternal and child health rates for this population.⁶²⁵
- c. Incarcerated mothers are not allowed visitors during their birth, which is obstructive to the traditional practices of American Indian mothers.⁶²⁶ These practices are vital to the cultural well-being of American Indian mothers.⁶²⁷
- d. The Committee heard testimony that unlike in Alabama, Tennessee and Florida, incarcerated women are not allowed a bonding period with their child post-

⁶²² Steffens Testimony, *September Briefing*, p. 15.

⁶²³ Giroux Statement, at 6.

⁶²⁴ Ibid.

⁶²⁵ Labonte Testimony, *December Briefing*, p.14.

⁶²⁶ Big Crow Statement, at 4; Locke Testimony, *December Briefing*, pp. 14-15; Wilcox Testimony, *July Briefing*, p. 9.

⁶²⁷ Antoine Testimony, *July Briefing*, p. 7; Big Crow Statement, at 3; Wilcox Testimony, *July Briefing*, pp. 9-11; Locke Testimony, *December Briefing*, p. 6.

birth.⁶²⁸ This time is essential for mother-child bonding and for mothers to provide necessary anti-bodies to their babies via breastfeeding.⁶²⁹

10. The Impacts of COVID-19

- a. American Indians living in South Dakota are disproportionately impacted by the COVID-19 pandemic.⁶³⁰ American Indians in the state have higher rates of positive COVID-19 tests, hospitalization, and death as compared to White individuals.⁶³¹
- b. COVID-19 has worsened issues that were already impacting reservations in the state of South Dakota.⁶³² The pandemic has compounded unemployment, overcrowding in homes, inaccessible healthcare, and a lack of resources.⁶³³ This additional barrier makes it harder for Tribal Nations to work towards healthier communities.⁶³⁴

⁶²⁸ Locke Testimony, *December Briefing*, pp. 14-15; Alysia Santo, “For Most Women who Give Birth in Prison, ‘The Separation’ Soon Follows,” PBS Frontline, <https://www.pbs.org/wgbh/frontline/article/for-most-women-who-give-birth-in-prison-the-separation-soon-follows/> (accessed May 13, 2021); *See also*: In South Dakota, women who are pregnant when they enter the prison system and give birth while incarcerated may be eligible to have their newborn child stay in their care for up to 30 days through the Mother-Infant Program. Mother Infant Programs, SD DEPT. OF CORR.’S, <https://doc.sd.gov/adult/facilities/wp/mip.aspx> (last visited May 12, 2021). Although the exact requirements to be eligible are unspecified, at a minimum the pregnant inmate must complete a parenting class prior to giving birth. *Ibid.* Pregnant women incarcerated in Florida or Tennessee may be eligible for a furlough to bond with their child for a period of time postpartum. *See* Fla. Admin. Code Ann. r. 33-601.603(7)(a) (2021) (stating pregnant inmates who meet certain criteria may be eligible for a furlough of up to one week beyond a satisfactory six-week postpartum examination); Tenn. Code Ann. § 41-21-227(h)(1) (2021) (stating pregnant inmates who meet certain eligibility criteria may be eligible for a furlough for up to 6 months postpartum). However, depending on the type of delivery, according to a PBS documentary, Alabama inmates who give birth are required to return to prison without their newborn child within twenty-four or forty-eight hours. For Most Women Who Give Birth in Prison, ‘The Separation’ Soon Follows, PBS, <https://www.pbs.org/wgbh/frontline/article/for-most-women-who-give-birth-in-prison-the-separation-soon-follows/> (last visited May 12, 2021). Although South Dakota does not grant furloughs to inmates who have given birth while incarcerated like Florida and Tennessee, South Dakota does allow a bonding period of up to thirty days for inmates who are part of the Mother-Infant Program. The thirty-day period is more generous than what is allowed in Alabama, where the inmates are required to return to prison without the child within twenty-four or forty-eight hours after giving birth. The Parents and Children Together (PACT) Program also provides opportunities for visits between mothers and children, South Dakota Department of Corrections, *South Dakota Women’s Prison*, <https://doc.sd.gov/adult/facilities/wp/mip.aspx#:~:text=program%20is%20to%20enable%20the,The%20P.A.C.T.&text=A%20maximum%20of%20two%20children%20per%20weekend%20is%20allowed.>

⁶²⁹ Roach Testimony, *December Briefing*, p. 14.

⁶³⁰ Specker Testimony, *November Briefing*, p. 8.

⁶³¹ *Ibid.*

⁶³² Antoine Testimony, *July Briefing*, pp. 6-8.

⁶³³ *Ibid.*

⁶³⁴ Antoine Testimony, *July Briefing*, pp. 7-8.

- c. The pandemic has also made it difficult for maternal healthcare providers to deliver services to American Indian women.⁶³⁵ During the time in which testimony was received, the U.S. Department of Health and Human Services' Maternal and Child Health Project Launch Program had to suspend home visits and transportation for their American Indian clients.⁶³⁶ Without these services, it is harder for American Indian women in the program to travel to maternal health appointments and to receive maternal health education.⁶³⁷
- d. Telemedicine appointments are a potential solution for maternal health care providers who cannot see patients in person.⁶³⁸ Telemedicine appointments are conducted via computer, webcam, smartphone or tablet and allow patients to virtually speak with their healthcare provider.⁶³⁹ These appointments could help provide necessary pre-natal education and could help healthcare providers keep track of their patient's health.⁶⁴⁰ However, American Indian women often do not have access to the technology necessary for these appointments.⁶⁴¹

11. Indian Health Service – Standards of Care

- a. The Committee heard testimony that Indian Health Service hospitals do not provide a standard of care that is equal to other national-level healthcare systems, due to the underfunding.⁶⁴² The underfunding of Indian Health Service hospitals was linked to a lack of adequate maternal care, poor quality equipment, low staffing levels, and outdated medical facilities.⁶⁴³
- b. Based on panelist testimony, the low standards of care provided by Indian Health Service are not sufficient for a American Indian mother to experience a healthy birth.⁶⁴⁴

⁶³⁵ Wilcox Testimony, *July Briefing*, p. 18.

⁶³⁶ *Ibid.*, 8-9.

⁶³⁷ *Ibid.*, 8-10.

⁶³⁸ Elliott Testimony, *November Briefing*, pp. 6-7.

⁶³⁹ "For Patients: What is Telemedicine?" U Health.

<https://healthcare.utah.edu/telehealth/patients.php#:~:text=A%20telemedicine%20appointment%20is%20just,are%20also%20called%20virtual%20visits> (accessed March 3, 2021).

⁶⁴⁰ Elliott Testimony, *November Briefing*, pp. 6-7.

⁶⁴¹ Wilcox Testimony, *July Briefing*, p. 9.

⁶⁴² Big Crow Statement at 3.

⁶⁴³ *Ibid.*

⁶⁴⁴ *Ibid.*

- c. The lack of quality health care provided by Indian Health Service hospitals was connected to the anxiety experienced by American Indian and Alaska Native women receiving care at these facilities.⁶⁴⁵

12. Trauma

- a. American Indian mothers experience a disproportionate amount of trauma, which impacts the health of their babies and can lead to intergenerational trauma.⁶⁴⁶ Trauma impacts the brain development of a fetus and has an effect on a genetic level.⁶⁴⁷ Trauma is a root cause of issues with the pregnancy such as premature births, morbidity and mortality.⁶⁴⁸
- b. American Indian women in South Dakota experience trauma resulting from racism, poverty, discrimination, and prejudice within their lived environment.⁶⁴⁹ The trauma related to these factors has serious implications on the health and wellness of this population.⁶⁵⁰
- c. Historical trauma caused by institutional racism continues to impact the health of American Indian women today.⁶⁵¹ Panelists identified the Family Planning Services and Population Research Act of 1970 and the construction of the Keystone XL pipeline as examples of institutional racism that historically and currently impacts the health of American Indians.⁶⁵²
- d. The Committee heard testimony that many hospitals in South Dakota do not foster or encourage the traditional birthing practices of American Indian women, which is associated with the historical trauma related to the cultural destruction of Native cultural and traditions.⁶⁵³

⁶⁴⁵ Ibid.

⁶⁴⁶ Deutsch Testimony, *December Briefing*, p. 16.; Steffens Testimony, *September Briefing*, p. 10.

⁶⁴⁷ Ibid.

⁶⁴⁸ Steffens Testimony, *September Briefing*, p. 10.

⁶⁴⁹ Big Crow Statement, at 3; Giroux Statement at 3-7; Littlefield Testimony, *September Briefing*, p.11.

⁶⁵⁰ Big Crow Statement, at 3; Giroux Statement at 3-7; Littlefield Testimony, *September Briefing*, p.11; Steffens Testimony, *September Briefing*, p. 11.

⁶⁵¹ New Holy Testimony, *December Briefing*, p. 18.

⁶⁵² Family Planning Services and Population Research Act of 1970 42 U.S.C. § 201; New Holy Testimony, *December Briefing*, p. 18.

⁶⁵³ Big Crow Statement, at 4.

B. Recommendations

Among their duties, advisory committees of the Commission are authorized to advise the Agency (1) concerning matters related to discrimination or a denial of equal protection of the laws under the Constitution and the effect of the laws and policies of the Federal Government with respect to equal protection of the laws, and (2) upon matters of mutual concern in the preparation of reports of the Commission to the President and the Congress.⁶⁵⁴ In keeping with these responsibilities, and in light of the testimony received on this topic, the South Dakota Advisory Committee submits the following recommendations to the Commission.

1. The U.S. Commission on Civil Rights should send this report to the U.S. Congress and issue recommendations for it to:
 - a. Provide increased and appropriate funding to the U.S. Department of Health and Human Services Indian Health Service so that it can ensure a standard of care that is equivalent to other national healthcare systems in order to guarantee that American Indian mothers experience a healthy birth. This funding should include:
 - i. Allocations to improve maternal health care by implementing high-quality medical equipment, adequate staffing levels, and updated medical facilities.
 - ii. A data research program focused on the maternal health of American Indian women. This program should ensure that data related to the maternal health of American Indian women is reported on a consistent basis in order to investigate and address barriers to maternal health care as well as any preventative measures for maternal morbidity and maternal mortality.
 - iii. Evaluative tools to track and improve the standard of care for maternal health services at Indian Health Service hospitals specifically, as well as state and private hospitals and clinics to ensure parity with national health systems. Such data will provide insight as to whether maternal mortality issues are universal regardless of the facility, or whether medical practices, cultural training, or billing practices affect maternal mortality statistics.
 - b. Ensure that services provided through Indian Health Service facilities are developed in coordination with Tribal members and promote and respect the cultural and spiritual practices of American Indian women. It is essential that American Indian women have autonomy over the type of maternal health services

⁶⁵⁴ 45 C.F.R. § 703.2.

that they receive through Indian Health Service facilities, which includes choosing how and where they would like to give birth.

- c. Provide increased and appropriate funding to the U.S. Department of Health and Human Services, Center for Disease Control's Office of Tribal Affairs and Strategic Alliances, Indian Health Service, the Indian Health Service Division of Facilities Operations, and the Office of Minority Health. These agencies should collaborate, in coordination with South Dakota Tribal members, to construct and develop American Indian reservation-based birthing centers for each of the American Indian reservations in South Dakota to ensure that American Indian mothers living on reservations have access to birthing centers that are easily accessible for pre-natal care and delivery. This funding should support:
 - i. Adequate staffing levels, high-quality medical equipment, appropriate sanitation services, and funds for continued proper maintenance and updates to facilities.
 - ii. Cultural competency training for all staff in order to ensure that they are properly educated in working with American Indian populations.
 - iii. Policies that ensure that American Indian mothers have access to pre-natal care and birthing practices that meet their health, spiritual, and cultural needs, as well as specific resources to help birthing center staff members gain access to the resources necessary to meet these needs.
 - iv. Transportation services for American Indian women living on reservations to ensure that American Indian mothers have access to birthing centers during scheduled appointments and during the birthing process.
- d. Provide increased and appropriate funding to the U.S. Department of Health and Human Services, Indian Health Service Division of Behavioral Health to develop a program dedicated to mental health and substance use services for American Indian mothers in consultation with South Dakota Tribal members in order to remedy the lack of mental health and substance use services available to these mothers on South Dakota reservations. This may include collaboration with the U.S. Department of Health and Human Services Office of Minority Health, which offers free e-learning programs for maternal health care providers with cultural and linguistically appropriate services which could be a model for further distribution in coordination with South Dakota's Tribal members. This funding should support:
 - i. Accessible mental health centers on every American Indian reservation in the state of South Dakota.

- ii. Adequate staffing levels, high-quality medical equipment, appropriate sanitation services and funds for proper building maintenance and updates.
 - iii. Cultural competency training for all staff in order to ensure that they are properly educated in working with American Indian populations.
 - iv. Transportation services for American Indian women living on reservations to ensure that American Indian mothers have access to mental health services.
- e. Supply and dedicate funding to the U.S. Department of Health and Human Services, Center for Disease Control's Office of Tribal Affairs and Strategic Alliance, Indian Health Service, the Indian Health Service Division of Behavioral Health, and the U.S. Department of the Interior Indian Affairs Division of Economic Development's National Tribal Broadband Grant program specifically in order to support telemedicine services for maternal health and mental health appointments. Telemedicine appointments are essential to ensuring that American Indian mothers have access to essential health services despite transportation and COVID-19 barriers.
- f. Revise Medicaid reimbursement eligibility standards to include all healthcare provision settings in the state to reimburse a maternal health case manager who should have appropriate qualifications. Training for case managers should be developed consultation with Tribal members.
- g. Revise Medicaid access eligibility to include more American Indian mothers. Provide funding for developing best practices to revise and expand Medicaid eligibility to include more American Indian mothers in consultation with Tribal members.
- h. Provide funding to the U.S. Department of Health and Human Services National Institute on Minority Health and Health Disparities in order to further the research of maternal health disparities experienced by American Indian women in South Dakota. This research is needed to gather further data that can be used to support and strengthen local efforts to reduce maternal mortality and maternal morbidity.
- i. Consider establishing a joint task force between the U.S. Department of Health and Human Services, Indian Health Service, U.S. Department of Health and Human Services Office of Minority Health, and the U.S. Department of the Interior Indian Affairs Division of Economic Development and Housing Improvement Programs in order to address the intersections between health, housing and employment needs among American Indian populations in South Dakota.

- j. Review the Maternal Health Quality Improvement Act of 2020 alongside the recommendations in this report and consider drafting new legislation to ensure that American Indian mothers receive the appropriate healthcare resources to reduce concerning health disparities between Indian Americans and other populations across the United States.
2. The U.S. Commission on Civil Rights should send this report to the U.S. Department of Health and Human Services Indian Health Service and its Division of Behavioral Health and Division of Facilities Operations, U.S. Department of Health and Human Services' Office of Minority Health and the Centers for Disease Control and Prevention's Office of Tribal Affairs and Strategic Alliances, and issue recommendations for these agencies to:
 - a. Collaborate to ensure a standard of care that is equivalent to other national healthcare systems in order to guarantee that American Indian mothers experience a healthy birth. This effort should include programs and monitoring that include:
 - i. Programs to improve maternal health care by implementing high-quality medical equipment, adequate staffing levels, and updated medical facilities.
 - ii. A data research program focused on the maternal health of American Indian women. This program should ensure that data related to the maternal health of American Indian women is reported on a consistent basis in order to investigate and address barriers to maternal health care as well as any preventative measures for maternal morbidity and maternal mortality.
 - iii. Evaluative tools to track and improve the standard of care for maternal health services at Indian Health Service hospitals specifically, as well as state and private hospitals and clinics to ensure parity with national health systems. Such data will provide insight as to whether maternal mortality issues are universal regardless of the facility, or whether medical practices, cultural training, or billing practices affect maternal mortality statistics.
 - b. Ensure that services provided through Indian Health Service facilities are developed in coordination with Tribal members and promote and respect the cultural and spiritual practices of American Indian women. It is essential that American Indian women have autonomy over the type of maternal health services that they receive through Indian Health Service facilities, which includes choosing how and where they would like to give birth (including home births).
 - c. The U.S. Department of Health and Human Services, Center for Disease Control's Office of Tribal Affairs and Strategic Alliances, Indian Health Service,

the Indian Health Service's Division of Facilities Operations, and the Office of Minority Health should collaborate, in coordination with South Dakota Tribal members, to construct and develop American Indian reservation-based birthing centers for each of the American Indian reservations in South Dakota to ensure that American Indian mothers living on reservations have access to birthing centers that are easily accessible for pre-natal care and delivery. These programs should support:

- i. Adequate staffing levels, high-quality medical equipment, appropriate sanitation services, and funds for continued proper maintenance and updates to facilities.
 - ii. Cultural competency training for all staff in order to ensure that they are properly educated in working with American Indian populations.
 - iii. Policies that ensure that American Indian mothers have access to pre-natal care and birthing practices that meet their health, spiritual, and cultural needs, as well as specific resources to help birthing center staff members gain access to the resources necessary to meet these needs.
 - iv. Transportation services for American Indian women living on reservations to ensure that American Indian mothers have access to birthing centers during scheduled appointments and during the birthing process.
- d. Develop programs dedicated to mental health and substance use services for American Indian mothers in consultation with South Dakota Tribal members in order to remedy the lack of mental health and substance use services available to these mothers on South Dakota reservations. This may include leveraging the U.S. Department of Health and Human Services Office of Minority Health's Culturally and Linguistically Appropriate Services (CLAS) programming that offers free e-learning programs for maternal health care providers as a model for further distribution in coordination with South Dakota's Tribal members. This may also include collaborating with the CDC's Maternal Mortality Review Committees (MMRCS) to reduce disparities in maternal mortality. These efforts should support:
- i. Accessible mental health centers on each American Indian reservation in the state of South Dakota.
 - ii. Adequate staffing levels, high-quality medical equipment, appropriate sanitation services and funds for proper building maintenance and updates.

- iii. Cultural competency training for all staff in order to ensure that they are properly educated in working with American Indian populations.
- iv. Transportation services for American Indian women living on reservations to ensure that American Indian mothers have access to mental health services.
- e. Collaboration between the U.S. Department of Health and Human Services, Center for Disease Control's Office of Tribal Affairs and Strategic Alliance, Indian Health Service, the Indian Health Service Division of Behavioral Health, and the U.S. Department of the Interior Indian Affairs Division of Economic Development's National Tribal Broadband Grant program specifically in order to support telemedicine services for maternal health and mental health appointments. Telemedicine appointments are essential to ensuring that American Indian mothers have access to essential health services despite transportation and COVID-19 barriers.
- f. Review Medicaid reimbursement eligibility standards to include all healthcare provision settings in the state to reimburse a maternal health case manager who should have appropriate qualifications. Training for case managers should be developed consultation with Tribal members.
- g. Review Medicaid access eligibility to include more American Indian mothers and develop best practices to expand Medicaid eligibility to include more American Indian mothers in consultation with Tribal members. Best practices for expanding eligibility should be conducted in consultation with Tribal members.
- h. Develop programming with the U.S. Department of Health and Human Services National Institute on Minority Health and Health Disparities in order to further the research of maternal health disparities experienced by American Indian women in South Dakota. This research is needed to gather further data that can be used to support and strengthen local efforts to reduce maternal mortality and maternal morbidity.
- i. Develop a joint task force between the U.S. Department of Health and Human Services, Indian Health Service, U.S. Department of Health and Human Services Office of Minority Health, and the U.S. Department of the Interior Indian Affairs Division of Economic Development and Housing Improvement Programs in order to address the intersections between health, housing and employment needs among American Indian populations in South Dakota.
- j. Review the Maternal Health Quality Improvement Act of 2020 alongside the recommendations in this report and consider developing programs to ensure that

American Indian mothers receive the appropriate healthcare resources to reduce concerning health disparities between Indian Americans and other populations across the United States.

3. The U.S. Commission on Civil Rights should send this report to the U.S. Department of Transportation Federal Highway Administration's Federal Lands Highway Office and the U.S. Department of the Interior Indian Affairs Division of Transportation and issue recommendations for it to:
 - a. Collaborate in providing funds from the Tribal Transportation Program to the Great Plains Regional Division so that the Division may increase funding for road building and maintenance to the nine American Indian reservations in the state of South Dakota in order to improve transportation conditions that prevent American Indian mothers from receiving timely maternal health care.
4. The U.S. Commission on Civil Rights should send this report to the South Dakota Legislature and issue recommendations for it to:
 - a. Allocate state funding to the Great Plains Tribal Chairmen's Health Board, the South Dakota Department of Social Services Division of Child Protective Services and South Dakota State Agencies who monitor licensing requirements for healthcare professionals in order to develop and implement cultural competency training. This funding should be utilized as follows:
 - i. To supply funding to the Great Plains Tribal Chairmen's Health Board for the purpose of researching and developing cultural competency training for South Dakota healthcare professionals.
 - ii. To supply funding to the South Dakota Department of Social Services Division of Child Protective Services so that it can provide cultural competency training, that is developed by the Great Plains Tribal Chairmen's Health Board, for case workers who provide services to American Indian mothers.
 - iii. To supply state funding to South Dakota State Agencies who monitor licensing requirements for healthcare professionals to implement cultural competency training that is developed by the Great Plains Tribal Chairmen's Health Board.
 - b. Provide increased and appropriate funding for the South Dakota Department of Social Services Division of Child Protective Services so that it can provide American Indian mothers with the option to meet with advocates, aside from their case workers, who can help them maintain custody of their children by advocating

for their rights and connecting the with resources. Advocates should receive cultural competency training informed by Tribal members.

- c. Provide and allocate funding for the South Dakota Department of Social Services to further research resources and safety measures for homebirths in consultation with South Dakota Tribal members to support American Indian birth preferences and connect American Indian mothers with resources that will support healthy at-home births that meet their cultural needs. These resources and safety measures should address the benefits and risks of home births for healthy and high-risk pregnancies.
 - d. Research and consider the maternal health benefits and fiscal impacts of paid maternity leave models for mothers, fathers, and same-sex couples in order to promote the health of American Indian parents and infants.
5. The U.S. Commission on Civil Rights should send this report to the South Dakota Board of Medical Examiners, SD Board of Nursing, SD Association of Healthcare Organizations, the SD State Medical Association, and the South Dakota Perinatal Quality Collaborative and issue recommendations for each entity to:
- i. Establish relationships with American Indians living in South Dakota who are experts on birthing practices.
 - ii. Develop and implement cultural competency training to all healthcare professionals involved in maternal health regarding American Indian birthing practices.
 - iii. Develop criteria to include American Indian cultural competency in South Dakota Healthcare Professional licensing requirements.
 - iv. Monitor the implementation of cultural competency trainings and impact on American Indian maternal mortality.
6. The U.S. Commission on Civil Rights should send this report to the South Dakota Department of Health and issue recommendations for it to:
- a. Reimburse maternal health case managers who would provide social services and address social issues for pregnant women and new mothers in order to, for example, facilitate needs such as travel to and from appointments and food or shelter insecurity.
 - b. Enforce the inclusion and participation of representatives from the Great Plains Tribal Chairmen's Health Board and from each of the nine American Indian Tribes within the state of South Dakota [Cheyenne River Sioux Tribe, Crow

Creek Sioux Tribe, Flandreau Santee Sioux Tribe, Lower Brule Sioux Tribe, Oglala Sioux Tribe, Rosebud Sioux Tribe, Sisseton Wahpeton Oyate, Standing Rock Sioux Tribe, Yankton Sioux Tribe] on the South Dakota Maternal Mortality Review Committee. This inclusion and participation is essential in ensuring that Tribal concerns and needs are met through the work of this Committee.

- c. Provide funding to the South Dakota Maternal Mortality Review Committee so that it can ensure that Tribal representatives have adequate access to technological tools (such as internet services) as well as data and subject matter expertise related to the maternal health issues faced by their communities so that these representatives can fully participate in Committee procedures.
 - d. Establish a sub-committee specifically for American Indian Tribal representatives on the South Dakota Maternal Mortality Review Committee to ensure that Tribal representatives on the Committee have adequate time and resources to meet separately from the larger Committee to discuss Tribal-specific concerns related to maternal mortality. This development is essential to make certain that Tribal representatives have the opportunity to organize and prepare Tribal-related concerns for the larger Committee.
 - e. Provide funding to the South Dakota Maternal Mortality Review Committee that can be allocated towards efforts to communicate the public health recommendations and findings of the Committee to American Indian populations. Communication processes should be created in consultation with South Dakota Tribal members to ensure that the findings and recommendations of the Committee are appropriately shared with populations most affected by maternal mortality issues.
7. The U.S. Commission on Civil Rights should send this report to the Congressional Leadership Conference for The American College of Obstetricians and Gynecologists and issue recommendations for it to:
- a. Utilize this report to provide further evidence for the need for Congress to pass the Maternal Health Quality Improvement Act, which confronts racism and bias in healthcare through implicit bias training programs and provides funding.
8. The U.S. Commission on Civil Rights should send this report to the National Alaska Native American Indian Nurses Association and issue recommendations for it to:
- a. Develop American Indian maternal healthcare trainings (pre-natal, birthing, and post-natal) for healthcare professionals across the United States and work directly with the Great Plains Tribal Chairmen's Health Board and state-led agencies who license and monitor healthcare professionals.

9. The U.S. Commission on Civil Rights should send this report to South Dakota's Tribal presidents and Tribal health directors for their awareness of the findings and recommendations raised in this report.

V. APPENDIX

The following materials related to the Committee's project on maternal health disparities of American Indian Women are located at the following link:

https://securisync.intermedia.net/us2/s/folder?public_share=409J0xbKeIQ2vuMJBvQond0011ef58&id=L1NEL05hdG12ZSBBbWVyaWNhbiBNYXRlcm5hbCBIZWFsdGg%3D

7.14.20 Meeting Records: Flyer, Agenda, Minutes, Transcript

9.16.20 Meeting Records: Flyer, Agenda, Minutes, Slides, Transcript

11.18.20 Meeting Records: Flyer, Agenda, Minutes, Slides, Transcript

12.16.20 Meeting Records: Flyer, Press Release, Agenda, Minutes, Transcript

Jennifer Giroux Written Testimony

Jennifer Giroux Response to Report Draft

Stephanie Big Crow Written Testimony

Waniya Locke Written Testimony

Follow-Up Question to Briefing Speakers

South Dakota Cities Where Birthing Centers are Located

**South Dakota Advisory Committee to the
United States Commission on Civil Rights**



U.S. Commission on Civil Rights

Contact: Regional Programs Coordination Unit
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