The United States Commission on Civil Rights
Virtual Briefing on Racial Disparities in Maternal Health Outcomes
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Good afternoon distinguished members of the United States Commission on Civil Rights. Thank you for this opportunity to provide testimony on the state of maternal healthy disparities in the United States, as it pertains to Native American women. My name is Nicolle L Gonzales, I am Dine' from the Navajo Nation, in New Mexico. I am a Certified Nurse-Midwife, Founder and Medical Director at Changing Woman Initiative (CWI), a non-profit made up of indigenous leaders and community healers, who are centering our families and communities, by transforming the cultural narrative and setting in motion policy changes. CWI's mission is to support our diverse indigenous communities, to renew cultural birth, and the fundamental indigenous human right to reproductive health, dignity and justice.

I have been a registered nurse for over 19 years and have been practicing full-scope nurse-midwifery for the last 9 years. I am one of only 20 Native American Nurse-Midwives practicing in the United States today. I chose to become a Nurse-Midwife following my own birthing experiences as a Native American mother birthing in a hospital and also from witnessing the mistreatment of Native American women, while working as a nurse at the Santa Fe Indian Hospital, in Santa Fe, New Mexico.

During the 2 years I spent working at the Santa Fe Indian Hospital, I myself experienced lateral violence by white higher- ranking nurses overseeing my employment there. I witnessed unnecessary placement of 16 gage IV's in Native American women by white nurses who used "fear" as their primary motive for excessive medical use of abnormally large IV needles, that were not backed by current hospital polices. The "harm" done to Native American women was unconsented and not informed care, with the excessive use of a medical devices like the IV needle, resulting in increased pain with placement.

While most of my time was working night shift in the small hospital, the nights would get cold in the winter, to the point where I had to were long-johns under my scrubs. One of the

first pregnant women I took care of on the OB floor was someone from the community. There was a lot of concern by the other nurses regarding this patient, because the story was that her baby had died in childbirth at that hospital last year, and here she was again having another child there again. Because this woman was from my community, I went in and asked her why she came back to have another baby there, knowing what happened the year before. She said " I didn't feel like I could go anywhere else."

On another occasion, I overheard the white nurse-midwives be proud of a recent birth they had attended of a woman who was from my community and was there patient. The conversation from the midwives was related to how the Native patient was so stoic in her birth and didn't need pain medication. When I spoke to this community member about her birth experience, she said to me "I wanted pain medicine and I asked for it, but the midwives just told me to go walk instead."

The columniation of these experiences and feeling helpless to really advocate for my community while working primarily as a nurse is what pushed me to return to school to get my Master's Degree in Nurse-Midwifery. While getting my degree at the University of New Mexico and attending conferences specific to Native American women's health, I continued to hear two conversations happening around the care of Native American women. I sat next to doctors and midwives who "loved" working with Native American women because they appeared stoic and never asked questions. When I would return to my community to talk to women who had their babies in the Indian Health Hospital, they spoke of their requests not being honored. They spoke of medical procedures being done to them they didn't really understand or even felt like they had enough information about. Some questioned the care they received, but felt helpless in pursuing anything legal or didn't feel confident it would go anywhere.

Historically we know that Native American women in the United States were sterilized against their consent in the 1970s at Indian Health Hospitals across the nations, but today in 2020, Native American women still receive high rates of unconsented care where they are not adequately educated on ALL of their options and due to government restrictions and funding, are denied the "choice" to have all of their options available to them. Presently I spend much of my time educating legislators and policy makers on the workings of Native communities- while there is little to no Native American representation in policy informing bodies like this commission. If that is not a clear example of how little control or advocacy Native women have around their own bodies, then let me be clear, Native American women are directly impacted by any and all decisions made around funding or underfunding needed healthcare services.

Today, sovereign, equitable, thoughtful and culturally relevant women's reproductive health care for Native American women in the United States is rare to impossible. As the Commission is aware, the United States has extensive treaty obligations to tribal nations to provide benefits and services, including health care for Native Americans. These promises made to tribal nations as an exchange for land and resources have never been kept. The Commission's 2018 report, Broken Promises, highlights

the inability of the Indian Health Service (IHS) to provide comprehensive health care for Native Americans due to chronic underfunding.

With regard to maternal health care, IHS does not consistently provide reproductive healthcare for Native American women. For example, in 2009, the Santa Fe IHS facility closed its doors, no longer providing prenatal care after 30 weeks or birth services for Native women. Instead these women were asked to sign up for Medicaid and transfer care to a private health care provider to deliver at one of the three surrounding hospitals. This has created financial and logistical strife when 33.6% of Native American women in New Mexico live below the Federal Poverty Line (American Community Survey 2018, Table S1701), and non-native facilities lack cultural sensitivity or discriminate, adding stressors to an already stressful situation and/or causing the mother to avoid or discontinue her prenatal care (Truschel and Novoa, 2018). Similarly, at the end of August this year, the Phoenix Indian Medical Center closed its obstetrics unit leaving dozens of expectant mothers without birthing services. IHS has said that this closure is temporary but has not provided a reopening date. This sudden closure signals a lack of care for expectant mothers and the problem of where Native American patients can seek alternate health care, in particular birthing services, if not from IHS facilities.

Historically and currently, Native American women's access to indigenous birthing knowledge has been severely impacted by the interplay of colonization, poverty, discrimination, geography, patriarchy and racism (Truschel and Novoa, 2018).

According to the 2013 Health Equity Report on Racial and Ethnic Health Disparities, 44% of Native American mothers receive no prenatal care or initiate prenatal care after the first trimester. According to a recent report from the World Health Organization, the United States is one of only two countries worldwide where the rate of pregnancy-related death is definitively rising. In New Mexico, the rate of such deaths – 29.5 per 100,000 live births over 2014-2017 – is higher than the national average. According to the March of Dimes 2015-2017 report, the rate of infant mortality in New Mexico is 6.6% in the Native American community. These disparities are not typically caused by biological or genetic factors; they point to a health care system that has failed to address the needs of our most vulnerable communities. American Indians and Alaska Natives rate the second highest in infant death rate in the US. Native infants suffer from having the highest rates of SIDS and are 30% more likely than non-Hispanic White babies to die due to circumstances related to low birth weight or birth defects (Office on Women's Health, US Department of Health & Human Services, 2016).

Not only do Native American women experience disproportionately higher maternal mortality rates then white or Hispanic women, they are portrayed in the data like it is there fault for not accessing prenatal care in the first trimester, or that they have higher rates of obesity and diabetes –when needed services, education, access to clean water, healthy foods, and adequately funded services are lacking, across the nations. Our maternal health crises is not just a single issue problem, it is intersectional and multigenerational.

As a Nurse-Midwife who has worked in 2 different hospitals in urban and rural New Mexico communities, I am fully aware of the structural racism Native American women experience having to navigate healthcare facilities outside of their communities. It is for this reason I founded Changing Woman Initiative, to address the lack of dignified care that Native

American women were experiencing in the hospital systems. I believe- to birth with dignity, is to birth in a ceremonial way while being supported by traditional healers, midwives and birth attendants. My work with CWI is not only to create a healing and supportive birthing space for Native American families, but to also advocate and protect the birthing rights of Indigenous people. Further, to educate and share stories from the communities I serve. I believe our greatest hope for the future is to protect and support birthing families across the country, but through providing adequate funding to grassroots organizations who are filling the gaps in care through the services they are providing by and for their own communities. Beyond this I ask that you see beyond the statistics around your health and wellbeing as Native people and remember the stories I have shared today. Thank you again for this opportunity to share my experiences, wisdom, and knowledge.