American Indian Infant Mortality in Minnesota – Gaps in Services for Mothers and Provider Training Needs

A Study Conducted for Twin Cities Healthy Start

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We dedicate this report to our colleague and friend Ron Mortenson, who passed away unexpectedly in December 2014. Ron conducted all of the provider interviews for this study. He was committed to and highly skilled at gathering information in respectful ways that ultimately ensures the community's true voice and story can be told.

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Executive summary

American Indian infant mortality rates are substantially higher than among other racial groups. The causes of this disparity are largely preventable.

Wilder Research was contracted by the City of Minneapolis Department of Public Health, as a part of their Twin Cities Healthy Start initiative, to increase understanding of the training needs of service providers, including health care and public health providers, child protection, law enforcement, and social services. We conducted 44 interviews with Native and non-Native providers who serve the American Indian community, plus two focus groups with American Indian mothers, and we also completed a literature review about infant mortality and about provider training best-practices. The results of this study will inform the development of future training opportunities for providers.

This study indicates that **historical trauma is the underlying factor contributing to the high infant mortality rate among American Indians**, in several specific ways:

- Mistrust of the system and un/under-insurance results in lack of prenatal care that would provide identification of and treatment for conditions that result in infant death
- Higher rates of pre- and post-natal exposure to tobacco smoke, alcohol, and drugs, and increased rates of maternal health problems such as diabetes that cause infant health risks
- Poverty, substance abuse, lack of caregiver knowledge, and cultural factors that lead to unsafe sleeping arrangements that result in SIDS and sleep-related infant death

Results indicate that **many health care and social service providers have gaps in terms of their ability to serve American Indian mothers directly**, including especially stereotyping American Indians as drunks and drug users, as well as having a general lack of knowledge about the history and culture of American Indian peoples, including lacking an understanding of historical trauma that many American Indian people experience. Many providers also lack the ability to modify their service delivery to be responsive to patients/clients who have experienced trauma. Providers also lack awareness of and access to community resources and culturally-specific services.

The following are recommendations for how to address the gaps in provider knowledge and skill:

- Consider ways of providing hands-on, experiential training rather than (or in addition to) classroom-style training

- Build on and use existing materials and resources
- Incorporate relevant information and resources coming out of the "trauma-informed" services and organizations movement, and other approaches that demonstrate how historic trauma should inform practice
- Find ways to teach providers effective and respectful ways to address alcohol and drug use with American Indian patients/clients, especially pregnant women, including being aware of potential hypersensitivity and fear of child protection
- Train providers how to build strong relationships with their patients/clients, using creative approaches within existing systems and bureaucracies to provide genuine care and empathy to their patients/clients
- Approach the issue from a strengths-based perspective; teach providers about American Indian cultural practices, both in terms of general health and well-being, and also in terms of pregnancy, childbirth, and infant care
- Educate providers about community assets, including local programs that use culturally responsive approaches, and help them build relationships in the American Indian community
- Support providers in engaging with American Indian elders and extended family members in program design, service delivery, and decision-making processes to honor the American Indian cultural value of interdependence
- Training should increase providers' awareness of organizations, programs, and resources that could be helpful for their clients/patients who are experiencing poverty – housing, transportation, baby supplies, and in particular free portable playpens/cribs, which several of the mothers in this study noted was the most helpful thing they had received in order to keep their baby safe

In addition to provider training, ongoing assessment of providers' approach with American Indian mothers should be implemented to demand provider accountability for providing high quality care/services to all patients/clients regardless of their race, socioeconomic status, insurance status, or previous behavior. Also, consider ways of distributing information directly to the American Indian community about causes and prevention of infant mortality. Finally, any efforts to increase the availability of resources to address poverty in the American Indian community would also help to prevent infant mortality.

Introduction

American Indian infant mortality rates in the U.S. are consistently higher than infant mortality rates among the general population, and the disparity between American Indians and the general population is even greater in Minnesota than nationally (Child Health USA, 2013; Mathews & MacDorman, 2013; Wilder Research, 2012; Minnesota Department of Health 2011; Urban Indian Health Institute, 2011; Minnesota Department of Health, 2009; Minnesota Department of Health, 2009 [2]).

Infant mortality rates per 1,000 live births for the general population and American Indian population (2000-2010)

United States		Minnesota	
General population	American Indian/ Alaska Native	General population	American Indian/ Alaska Native
6.14	8.28	5.03	8.60

Source: *Center for Disease Control and Prevention. Infant Mortality Statistics from the 2010 Period Linked Birth/Infant Death Data Set*

Research questions

The Minneapolis Health Department, through its Twin Cities Healthy Start grant, contracted with Wilder Research to conduct a study to increase understanding about gaps in the system with regard to prevention of infant mortality among American Indians in Minnesota, and specifically **to better understand the gaps in knowledge and skills and training needs of service providers, including health care and public health providers, child protection, law enforcement, social services, and other providers who often interact with American Indian mothers who are pregnant or who have recently given birth**.

Several research questions guided this study:

1. What are the experiences of American Indian mothers and other caregivers with providers that help or hinder prevention of infant mortality?

2. What are the specific causes of disparities in infant mortality between American Indians and other racial/ethnic groups?

3. What are the gaps in provider skills or knowledge that hinders prevention of infant mortality among American Indians?

4. What are best practices for training non-Native providers how to work with American Indian mothers and families, either generally or specifically related to infant mortality?

5. What specific solutions or issues should providers address to help reduce infant mortality among American Indians?

Sources of information

As a part of this study, we reviewed 24 publications that focused on American Indian infant mortality in the U.S. and Minnesota, as well as on best practices and other recommendations for helping providers work effectively with American Indians regarding sexual health, pregnancy, and infant health. See the attached list of references.

We also conducted two focus groups with American Indian mothers – one group was with eight mothers at American Indian Family Center in Saint Paul and the other group was with four mothers at the Division of Indian Work in Minneapolis. Most of the focus group participants were new mothers and/or expecting mothers. Several were teen moms. Based on their comments made during the focus group, it appears that the majority of these mothers are on public health insurance (Medical Assistance). This is important to note because some of their self-reported negative health care experiences may be related to their status as having public insurance.

Finally, we conducted 44 interviews with Native and non-Native providers throughout Minnesota who serve the American Indian community, including directors, managers and front-line staff from nonprofit community-based organizations, tribal staff, health care providers, and other professionals who serve American Indian mothers and their families. These providers were asked about their perceptions about the key causes of the disparity in infant mortality rates for American Indians, as well as gaps in provider skills and knowledge. We also asked these providers about the types of training that has been beneficial for them in developing their skills for serving Native patients/clients. Quotes from providers and American Indian mothers who participated in this study are used throughout this report to illustrate key findings.

How this information will be used

The results of this study will be used to inform the development of (and to seek resources for) training opportunities to help health care and social service providers better serve American Indian mothers, their infants, and their families, to ultimately reduce the incidence of infant mortality in the American Indian community.

Historical trauma is a key factor in American Indian infant mortality

The causes of higher than average infant mortality rates among American Indians are largely preventable: poor or no prenatal and postnatal care, unsafe sleeping arrangements (which may often be related to unsafe/unstable housing), mothers' substance abuse, and prenatal and postnatal exposure to commercial tobacco smoke (Minnesota Department of Health, 2014; Urban Child Health USA, 2013; Mathews & MacDorman, 2013; Wilder Research, 2012; Indian Health Institute, 2011; National Institutes of Health, 2010; Minnesota Department of Health, 2009; Urban Indian Health Institute, 2009).

The providers we interviewed for this study universally believe that **historical trauma is the primary factor contributing to the high infant mortality rate among American Indians from these largely preventable causes**. In fact, the author of this report has never led a study where the evidence from a variety of sources and large number of respondents so overwhelmingly identifies a single root cause for a serious social problem.

According to the providers we interviewed, there are several specific ways in which historical trauma results in preventable infant deaths:

- Mistrust in providers plus lack of adequate health insurance results in lack of prenatal care that would provide identification of and treatment for conditions that cause infant death
- Higher rates of pre- and post-natal exposure to tobacco smoke, alcohol, and drugs, and increased rates of maternal health problems such as diabetes create increase health problems and risk of death for infants
- Poverty, substance abuse, lack of caregiver knowledge, and cultural factors that lead to unsafe sleeping arrangements that result in SIDS and sleep-related infant death

> *"Our community is caught up in all those cycles, the cycle of poverty, of survival, of mental health, of domestic violence. They are all entrenched in that." – a provider*
>
> *"A lot of moms, who have had some experience in foster care or whatever, have a hard time parenting, because they weren't shown good parenting themselves." – a provider*

Prenatal care

Inadequate or no prenatal care is a risk factor for infant death. Adequate prenatal care identifies and helps to ameliorate negative infant outcomes associated with mothers' health issues such as obesity and diabetes. Prenatal care can also help to address and help mothers and health care providers be prepared for necessary neonatal care for congenital birth defects, which are more common among American Indians than other racial and ethnic groups (Minnesota Department of Health, 2014; Mathews & MacDorman, 2013; Wilder Research, 2012; Urban Indian Health Institute, 2011; Minnesota Department of Health, 2009; Urban Indian Health Institute, 2009).

Several studies have found that **American Indian women are less likely than other racial or ethnic groups to receive adequate prenatal care**. Two studies we reviewed from Minnesota noted that American Indian women were less likely than women of other racial and ethnic groups to receive adequate prenatal care, with rates for American Indian women fluctuating between 27 to 51 percent of mothers who are not receiving adequate care. (For comparison, African American women was the group with the next highest percentage of women not receiving adequate care, at 10%.) Further, infant mortality rates are higher for American Indian women who received inadequate prenatal care (Minnesota Department of Health, 2014; Mathews & MacDorman, 2013; Wilder Research, 2012; Minnesota Department of Health, 2009; Urban Indian Health Institute, 2009).

Although most American Indian women view prenatal care as important for infant health, there are several important reasons why American Indian mothers may not receive adequate prenatal care. First, **the care offered by non-Native providers might conflict with cultural beliefs of some American Indians**, particularly the belief that the souls of not-yet-born children hover close to their mothers during pregnancy, and that the Great Spirit decides when a child is born as well as if a child is born successfully. By preparing for and anticipating a successful childbirth – through prenatal care, baby showers, selecting a name for the child before it is born, or other celebratory events – a mother assumes the successful birth of her child, which may conflict with the belief that the Great Spirit makes such a decision at the time of birth (Treuer, 2012; Urban Indian Health Institute, 2011; National Institutes of Health, 2010).

American Indians may also define health more broadly, and in different ways, than health care and social services providers and systems. One study noted that, when asked about infant health, American Indian respondents mentioned spiritual and cultural practices such as dancing, blessings, singing, drumming, placenta/umbilical cord burial, sweats, and sage burning (Urban Indian Health Institute, 2011). These are all practices and traditions that may be important and/or beneficial to the mother but are unlikely to be

recognized or recommended by most health care and social service providers, especially non-Native providers.

Another reason for not getting adequate prenatal care that was mentioned by mothers and providers who participated in this study is that **American Indian mothers exhibit a lack of trust in health care providers and systems**. This lack of trust stems from the fact that so many American Indian families have had their children taken by the U.S. government (or local governments acting on state and federal laws), historically in the name of education (boarding schools) and more recently in the name of Child Protection. Because most health and social service providers are mandated reporters, American Indian women may be reluctant to see these providers, or if they do see them, they may be afraid to open up about their situation, due to the (real or perceived) threat that Child Protection will become involved and their child will be taken from them. **Most of the women who participated in focus groups for this study reported first-hand negative experiences with health care providers** that have contributed to their mistrust and reluctance to fully participate in services or care.

> *"I know of a woman who needed pain medication and had to go to three different places, because she had been viewed as chemically dependent. And I know of a woman who had been physically abused and had been drinking. She needed medical attention, but had been told at a hospital that she needed to be in detox rather than receiving medical care. We need to address stereotyping and the racism that does exist." – a provider*
>
> *"It goes along with respect, knowledge, and understanding. We're not all drunks. We're not all drug addicts. We're not all under the bridge. We're discriminated against a lot." – an American Indian mother*
>
> *"There are large systemic issues and cultural issues. American Indians don't go to their prenatal and well-baby appointments. There is fear to enter into that field. It is associated with Child Protection and social service systems that have interfered with them parenting their children." – a provider*

Finally, **lack of insurance, spotty coverage, and/or poor access to quality providers may also contribute to lack of prenatal care among American Indian women.** Even among focus groups participants with consistent insurance coverage, many experienced problems with the health care system that resulted in them missing appointments.

> *"Sometimes I feel like they care about what insurance you have. If you've got insurance, you get the nicer rooms and the better treatment and you can make your own choices." – an American Indian mother*
>
> *"You have to accept missed appointments and keep trying. In some systems, a couple of missed appointments and you no longer accept the person." – a provider*

Commercial tobacco, alcohol, and drug abuse

American Indians in Minnesota have higher rates of commercial tobacco use as well as higher rates of alcoholism and drug use than the general population (Minnesota Department of Health, 2006).

Alcohol use is a risk factor for infant death (Child Health USA, 2013; Urban Indian Health Institute, 2009). It should be noted, however, that **publications rarely reported findings regarding alcohol use among American Indians during pregnancy, with one study noting a lack of reliable data regarding the subject** (Minnesota Department of Health, 2009).

Alcohol and drug abuse did not come up often during the focus groups, except in the context of "a provider accused me of being drunk/using drugs right away, without even knowing anything about me, and that made me not want to deal with that provider." However, many of the providers we interviewed mentioned alcohol and drug abuse as a contributing factor in the high American Indian infant mortality rate. Several of the providers we interviewed also specifically noted the recent notable increase in heroin and prescription opioid abuse/addiction in the American Indian community and the impact that has on infant and maternal health.

In addition, the providers we interviewed noted that alcohol and drug use of the mother or other caregivers can result in neglect or abuse, as well as accidental infant injury or death. Alcohol and drug use generally contributes to a more volatile, unstable, and violent environment, which can also result in direct harm to the infant. Many of the providers we interviewed view these issues as a direct cause of infant mortality among American Indians.

Understanding the effects of using alcohol while pregnant is mixed among American Indians. These perceptions are due to inconsistent messages regarding alcohol use during pregnancy from health care providers (such as some providers advising no alcohol use at any point of a pregnancy and others taking a more moderate stance), as well as a lack of adequate explanation from health providers to American Indian mothers about the effects of alcohol use during pregnancy (Wilder Research, 2013; Urban Indian Health Institute, 2011).

Regarding commercial tobacco use while pregnant, one study noted that American Indian mothers were most likely to smoke during the last three months of pregnancy compared with other racial and ethnic groups (26% smoked during this time period compared to 15% of white women, the next highest percentage). Additionally, one study noted that from 2007-2011 in Minnesota more than two-fifths of American Indian women (42%) smoked during their pregnancy, compared to 11 percent of white women, the group with the next highest percentage of women smoking during pregnancy. Further, infant

mortality rates among Minnesota American Indian women who use tobacco during pregnancy are higher than among those who do not use tobacco (Minnesota Department of Health, 2014; Child Health USA, 2013; Minnesota Department of Health, 2009).

Exposure to secondhand and third-hand smoke after birth may also be a contributing factor for high infant mortality rates among American Indians. American Indians in one study we reviewed mentioned the social discomfort of asking family members to refrain from commercial tobacco use in the presence of their infant, and the social isolation that might accompany the request (Urban Indian Health Institute, 2011).

SIDS and sleep disorders

SIDS is defined as the sudden death of an infant younger than one year of age that remains unexplained after a thorough case investigation. Studies found that **SIDS and other sleep disorders were a primary cause of infant death in the American Indian population,** noting that death due to SIDS is more common among American Indian infants as compared with other racial or ethnic groups (Minnesota Department of Health, 2014; Mathews & MacDorman, 2013; Urban Indian Health Institute, 2011; National Institutes of Health, 2010; Minnesota Department of Health, 2009).

A study by National Institutes of Health identifies altering environmental factors as the most effective way to reduce the likelihood of SIDS. The following were identified as environmental risk factors for SIDS:

- Overheating during sleep
- Bed sharing
- Stomach sleeping during naps and at night
- Soft sleeping surfaces and loose, fluffy bedding
- Maternal alcohol use (during pregnancy and after birth of the infant)
- Commercial tobacco use (during pregnancy and in baby's living environment)

Findings from our literature review noted that some **American Indian mothers are taking steps to prevent SIDS in some cases**. One study found that more than three-quarters (77%) of American Indians mothers placed their babies on their backs to sleep, a sleeping position which reduces the risk of SIDS. Another study highlighted generational differences between American Indian elders' approach to infant care and the views and approaches of younger American Indians. (This generational difference was attributed by

the authors of this study to the effectiveness of communication and outreach efforts regarding infant health from health care providers and public health workers.) In particular, **some younger American Indian respondents mentioned elders instructing them to place infants on their stomachs to sleep, which is contrary to safe sleep best practices**. Given the importance placed on elders in many American Indian cultures, rejecting an elder's advice is often a social taboo (Child Health USA, 2013; Urban Indian Health Institute, 2011; National Institutes of Health, 2010).

Regarding sleep-related causes of death, bedsharing is another risk factor for infant mortality. Just over one-quarter (28%) of American Indian mothers shared their bed with their infants always or often, and almost half (46%) shared their bed with their infant sometimes or rarely. (Bedsharing rates were higher among some racial and ethnic groups, such as African American and Asian, and lower among others, such as white and Hispanic.) Both the providers and American Indian mothers who participated in this reviewed study noted that it is common to bedshare with infants and that many American Indian women believe bedsharing is an important aspect of bonding with their baby (Child Health USA, 2013). Providers who were interviewed here also noted the prevalence of co-sleeping.

> *"One big difference I would see [between Native and other groups in terms of causes of infant mortality], co-sleeping has been adopted as a norm in Native country, whereas in other groups, having a nursery and separate crib is something they would do without question. My mother slept with me, I slept with my babies. It wasn't until I was of the reservation that I saw it the other way. I think Natives had always done some co-sleeping. The breastfeeding was always our culture. But we never had that substance abuse, big soft couches, that sort of thing. It was never a concern before." – a provider*

Putting an infant to sleep in a hammock is a cultural practice that was mentioned several times by providers, who recognized this could be an unsafe sleeping arrangement for the infant due to the risk of SIDS/suffocation. (One provider, as illustrated in one of the quotes below, also indicates that there are "safe hammocks.") On the other hand, several of the providers who participated in this study implied that **cradleboards, which are traditional Ojibwe devices used to carry infants and keep them safe and cozy, are considered to be safe for sleeping when used appropriately**. Cradleboards were also noted as safe for infant sleep by published literature (National Institutes of Health, 2010).

Although there may be cultural reasons for bedsharing and alternative sleeping arrangements, it is also clear that **poverty leads to housing instability and inability to obtain safe infant beds** (cribs or portable playpens, for example). There are some programs that provide free or low cost infant beds to eligible mothers, but many providers (and the mothers themselves) may not be aware of these resources, and mothers may not be able to access these programs due to lack of transportation. Also, it is likely that there are not

enough of these types of programs to meet the need. Several of the mothers who participated in a focus group for this study had received a portable playpen/infant bed through the program they were participating in at Division of Indian Work, and these mothers said that this was one of the most helpful resources that had been offered to help them keep their infant safe.

> *"I think that [unsafe sleep arrangements] is often associated with unstable, unsafe living environments. There is a lot of couch hopping, or staying in shelters or wherever you can. Moms who are juggling a lot of different things. It is difficult for them to provide adequate and safe conditions. Trying to find housing that is safe becomes a priority. The housing issue is huge." – a provider*
>
> *"Unsafe sleep environments. Bed-sharing, sleeping together on sofas. Makeshift things on the floor, with pillows and blankets, and other people. That is the cause of death. And you look at the larger social determinants. Housing, poverty, health care that people are comfortable with, that they trust. The financial resources to have a place for baby to sleep. Even cradleboards and safe hammocks for those who want to use some of the more traditional approaches." – a provider*

Gaps in providers' knowledge and skills to effectively work within American Indian communities to prevent infant mortality

The interviews with providers and focus groups with mothers revealed several prominent gaps in many providers' ability to effectively work within American Indian communities to prevent infant mortality. These gaps fall into two main categories: providers' ability to work directly with American Indian mothers and other community members, and providers' awareness of resources available in the community to address the needs of American Indian mothers.

Working directly with American Indian mothers and community members

As noted above, **nearly all of the mothers who participated in focus groups, as well as many of the providers who were interviewed, have experienced situations of providers stereotyping American Indians as drunks and drug users**. Similarly, some providers may assume a lack of parenting skills or knowledge among their American Indian patients/ clients. This is an extremely pervasive concern, based on this and previous studies we have conducted with American Indians in the Twin Cities (Minnesota Department of Health, 2012). The vast majority of American Indians who have participated in these studies (who are also mostly poor and on public insurance) describe their experiences, and the degree to which these experiences make them unwilling to deal with or place their trust in the provider, which ultimately results in poorer care/service and outcomes.

> *"When I was pregnant with my little baby girl, when I first went to the doctor, the first thing the doctor said was, 'How many drinks, beer or alcohol, have you had this week?'" – an American Indian mother*
>
> *"The doctor came in and closed the door and he was like, 'I know you just came in for pain medicine. I'm not giving you narcotics.' I had never seen this doctor before." – an American Indian mother*
>
> *"If something is wrong with your baby and you bring them to the emergency room and every time they assume it's something that you did." – an American Indian mother*

American Indians may also have hyper-sensitivity to being accused of using alcohol or drugs, questions about their parenting, and related topics, due to historical trauma and the community's own first-hand experience about how they and others have been consistently treated by providers.

> *"Being sensitive to the historical trauma and distrust of the system. To make an effort to make the patient feel welcome and respected. That is always the biggest thing, because they seem to be expecting not to be." – a provider*
>
> *"It is important to go in and develop a relationship, a connection, so that person will continue to work with them and will follow through. So developing the empathic relationship, meeting them where they are at, with no judgment of their situation or why it has gotten to that situation. Indian people will pick up on that judgment very quickly and shut down the relationship." – a provider*

The specific gap to be aware of here is providers' lack of ability to effectively address alcohol and drug use with American Indian mothers (regardless of the mothers' current use and/or history of use), and how ineffectively addressing this and related topics can result in poor or no prenatal care, and ultimately, harm to the mother and/or infant.

In general, it was clear from this and previous studies we have conducted with American Indian mothers and other American Indian community members (Minnesota Department of Health, 2012) that **many health care and other providers lack the skills or resources necessary to build a positive relationship with their patients/clients**. This includes not taking the time to listen to them, not trusting the patient/client to know themselves or their children and what their needs are/what they are experiencing, and scaring new mothers or pushing them into having various procedures or into taking medications (for themselves or their children) without fully explaining why they needed it or how it would affect them.

> *"They just kept coming in and [saying that I needed a C-section]. Of course I was scared … and so I eventually had a C-section, but I felt more like I was pushed to have the C-section. The doctor said, 'You have 20 seconds to sign this paper.' I was 15, and I was scared." – an American Indian mother*
>
> *"It felt like they didn't want to take the time to talk to me about it. I think if they would take those little steps like that, you know, because there are so many debates now about what that [medication] does to the kids or whatever, but if you would take a few minutes and accurately tell a parent what this is for and why, it would scare people so much less." – an American Indian mother*
>
> *"They treat you kind of like you don't understand things. They talk to you like you're a child." – an American Indian mother*

> *"It takes time to develop relationships within the Native community, and a lot of people don't take that time. Like going on a home visit the first time and sitting down and drilling the case plan right off the bat. It can take more time and more work to build relationships in the Native community." – a provider*

Further, **most non-Native providers lack knowledge of the history and culture of American Indian peoples**, especially factors that contribute to historic trauma, such as boarding schools, removal of children from their families (including historical and contemporary Child Protection processes).

Many providers also do not understand how these traumatic events have contributed to the loss of protective cultural and traditional infant care and related practices. In other words, they **lack awareness of cultural and community strengths**.

> *"A lot of people just don't really know about things like sending kids to boarding schools where they were physically and sexually abused, raised in an institutional culture, with no idea of how to parent and raise kids properly, having not lived with their parents. And that is hard for people to grasp and for some people to see a correlation with that." – a provider*
>
> *"I think a lot of times people who come in from outside really don't understand the unique needs of the complexity of the community. They have the best of intentions, but want to use their way of doing things." – a provider*

Finally, **even if providers have a basic awareness of historical trauma, they often lack the skills and tools needed to modify their service delivery to be responsive to the needs of individuals and communities who have experienced this trauma.** In addition, the health care, social service, and related institutions and systems that providers work within and American Indian mothers interact with, are unresponsive to and unprepared to provide appropriate, trauma-informed services and interventions to prevent infant mortality within the American Indian cultural context.

> *"We go through cultural proficiency training here in [name of organization] each year. It seems the majority of the workers do listen, but they don't know how to take action or they don't have the continuous training." – a provider*

Awareness of and access to community resources and assets

As described above, **poverty is a major social problem that contributes to the high rate of infant mortality among American Indians in Minnesota**. Specifically, poverty is associated with lack of adequate prenatal care, housing instability, inability to provide a safe sleeping arrangement for baby, lack of transportation for medical appointments, poor nutrition, and so on. Although it is unlikely that this study or the resulting training for providers will solve systemic issues like poverty and racial disparities, **the questions**

to specifically consider and address through provider training are: what are the resources available in the community to help American Indian mothers who are experiencing situations of extreme poverty or hardship? And how can we make sure providers who are serving these mothers in health care and social service settings are aware of these resources and are making effective referrals to the mothers, as appropriate? Another question: are the resources available in the community adequate to meet the need? (The answer is probably no, but we won't know until we ask.) And if not, what can or should the role of providers be in making that need known to stakeholders and the public, and identifying resources to meet the need?

Also, **most non-Native providers are not aware of the traditional cultural practices of American Indians and how to integrate these into their care/services.** This could include general spiritual, health, and wellness practices (e.g., sweatlodge), as well as practices related specifically to pregnancy, child birth, and infant care. It is important to approach working with American Indians from a standpoint of honoring their cultural values and traditions. Programming should strive at all times to value the perspectives of American Indian peoples regarding sexual health, pregnancy, and infant health – particularly when those perspectives may differ from, or directly contradict, biomedical understandings of health (Wilder Research, 2013; Treuer, 2012; Urban Indian Health Institute, 2011; Gray & Wolf, 2008; Weaver, 2004; San Diego State University, no date).

Because we are not so naïve as to believe that this study or the resulting training will revolutionize Minnesota's health care and social service systems to provide more culturally responsive care based in traditional and folk knowledge ("Indigenous best practice"), **the issues we recommend for consideration here are: What are some cultural practices that can support good infant and mother health that providers should be aware of? What are the resources in the community that providers can connect to (or refer their patients/clients to) to meet these cultural needs?**

The last question leads directly into the final gap that we identified with regard to providers' awareness of community resources and assets. Several of the providers who were interviewed as a part of this study indicated that **non-Native providers may not be aware of the community-based organizations that provide Native-specific services**. In addition, we assume that most non-Native providers do not have access to an informal network of Native providers and community leaders, elders, healers, etc., who they can call on if they are not able to meet the needs of an American Indian patient/client. One study we reviewed noted that, at the very least, practitioners should make consistent efforts to build relationships in American Indian communities that they serve, and they should seek feedback from their clients regarding perceptions of services received (Wilder Research, 2013).

Recommendations

The purpose of this study was to develop recommendations for training health care and social service providers who serve American Indian mothers and infants, so these providers can better serve their patients/clients to ultimately prevent infant mortality. The following recommendations include things related to the training format and content, specific ideas or resources to consider incorporating, and suggestions of activities in addition to provider training that could help to prevent American Indian infant mortality.

Training format

Before we make recommendations for "training," it is important to note that a majority of the providers who we interviewed for this study (some of whom are non-Native but have nonetheless been able to establish their credibility as providers in the Native community) cited their real life experience as the most effective approach to learn about how to best serve American Indian mothers. Therefore, **when designing any future "training" opportunity for providers, strongly consider ways to make it hands-on, experiential training rather than (or in addition to) classroom-style training**. This might include, for example, shadowing experienced providers, attending events or programs in the American Indian community, volunteering for an organization or program that serves American Indians, etc.

Several of the providers we interviewed specifically noted that **any training about how to serve American Indians should be provided by a Native person**. Some respondents also suggested that provider trainings incorporate Native traditional practices (smudging, storytelling, etc.).

> *"I really enjoy when the presenters are from the Native American community. I say that as a non-Native. I think it has more credence. I would not want to be involved in anything that is disrespectful of the Native people and their culture and their stories. I think having as much cultural traditions involved in the training, from smudging to drumming – anything that can be incorporated helps people to understand the role and the respect that is given to that and why." - a provider*

Finally, we recommend that **provider training should use or build on existing materials and resources** (see references, for some examples of resources that could be used for this purpose) rather than using limited resources to create new materials from scratch. For example, the Healthy Native Babies project workbook and toolkit that could be shared with non-Native providers offers in-depth information about SIDS and strategies to prevent SIDS.

Training content

As described extensively above, many providers lack even a basic awareness of history of American Indians in Minnesota or an understanding of how historic trauma plays out in the lives of their patients/clients. Further, even providers who are aware of the history and who acknowledge that historic trauma plays an important role in the high rates of American Indian infant mortality (and other social problems) often lack the skills needed to modify their practice to address this trauma. Therefore, **future provider training should incorporate relevant information and resources from the "trauma-informed" services and organizations movement, and other approaches to understanding how historic trauma should inform practice**. Most importantly, provider training on historic trauma should always be paired with practical training and tips for how to improve practice to better meet the needs of individuals and communities that have experienced trauma.

> *"I already knew the problem, what existed. I was hoping to get out of the training how to work with families, how to work with the community." - a provider*
>
> *"Like, if there is historical trauma training for those who have been to other historical trauma trainings, so it is more advanced – kind of a 'now what?' training, more advanced steps." – a provider*

An important goal of any provider training should be to reduce providers' stereotypes and biases, especially related to alcohol and drug use and parenting skills. At a minimum, the **training should teach providers effective and respectful ways to address alcohol and drug use with American Indian patients/clients, especially pregnant women**. The training should address why American Indians may have hypersensitivity to these types of questions from providers. The training should also teach providers how to both provide information to, and obtain information from, their patients/clients about alcohol and drug use and other sensitive parenting topics in a way that will be most likely to reduce the infant's exposure to harmful environments, and that will maintain the ongoing care/ service relationship with the patient/client.

Many of the American Indian mothers who participated in this study described feeling that providers are too rushed, and that the format in which information about infant care is provided (usually in writing) is not helpful. Several of these **mothers wanted more hands-on experience with infant care** and more support from providers to do this. These **mothers also wanted providers to take more time to explain medications, treatments, and procedures, and to work with them to make the right choices for themselves and their babies**. Moms want providers to listen to them, to trust their knowledge of their children and family, and to be supportive of them regardless of their life circumstances or previous decisions. (And not having providers take the time needed or work with the patient/client to decide on the best treatment option is a very common

experience across multiple studies we have conducted in the American Indian community.) **Training providers on how to build strong relationships with their patients/clients is very important, as is teaching providers how to use creative approaches while working within existing systems and bureaucracies to provide genuine care and empathy to their patients/clients.**

> *"…There needs to be a big shift in how women with substance abuse are being treated. They love their babies and want to help their babies, but they are so afraid of being criminalized and having their children taken. Creating some sort of 'safe harbor' situation where they can come for help." – a provider*

Any training for providers should **approach the issue from a strengths-based perspective**, rather than a deficit-based perspective, such as acknowledging spirituality as a cultural strength (Urban Indian Health Institute, 2011; Gray & Wolf, 2008; Weaver, 2004). A strengths-based perspective reduces barriers to effective service delivery, for example, value judgments associated with "problem-based" programming. One way to support a strengths-based approach is to **teach providers about American Indian cultural practices, both in terms of general spirituality, health, and well-being, and also in terms of pregnancy, childbirth, and infant care**. It is important to note that there are nearly 600 federally recognized American Indian tribes in the United States, and each one has its own culture and traditions, and we acknowledge it is not feasible to provide training in each of these cultures so the recommendation would be to focus on the major tribal groups in Minnesota – Ojibwe, Dakota/Lakota, Ho-Chunk, and so on.

> *"The one thing for me, I always want my room smudged and I know in a hospital it's not always easy to do that but as soon as I found out that I was going to have the baby, like before the operation or anything because I had a C-section, that's what I wanted and they were really understand and really helpful." – an American Indian mother*
>
> *"If you go back to the traditional teachings in the community, there is a lot of this information already available in those teachings. People are hungry to reach back to the traditions, like the teachings of the cradleboard." – a provider*
>
> *"It is important to know our traditional ways. To know them and understand how they can be used as a protective factor, using culture and understanding. Being trained to go into our community, understanding birthing and other practices and how to incorporate some of those traditional ways into our work." – a provider*
>
> *"It is having the confidence and the competence to ask questions, to recognize that you don't know, don't understand. Having the curiosity to ask." – a provider*

In the same vein, **provider training should increase the awareness of providers about community assets, and help them build relationships in the American Indian community**, so that they can refer their American Indian clients/patients to these resources, as appropriate.

> *"They should recognize that the reservations have these services and skills and capabilities, that we can address these referrals and these clients. Clients do not want to be serviced by the county due to the whole historical trauma issue, and they are more willing to take services from their own tribe." - a provider*

Providers may also consider including American Indian elders, parents, and others in decision-making processes, and they may need training or support to do this effectively. Such a practice acknowledges American Indians as the experts regarding their own well-being, contributes to more effective services/care, and combats perceptions of paternalism. Published literature mentioned a number of program examples in which tribal elders and other American Indian leaders have been engaged in this way (Wilder Research, 2013; Urban Indian Health Institute, 2009; Gray & Wolf, 2008; Weaver, 2004).

Multiple publications reviewed here noted the importance of community in American Indian views of health, advising practitioners to emphasize the community value of interdependence, and to focus on the benefits of engaging with and supporting family and community members. Two studies we reviewed also mentioned the importance of a female community for American Indian women who are pregnant or who are new mothers, for the purposes of exchanging knowledge and resources as well as social support. Other publications noted the importance of fathers for infant health and development, advising practitioners to offer programming specifically for fathers. Since elders are also influential advisers to young mothers, the education and collaboration of elders in supporting efforts to prevent infant mortality in the American Indian community is critical (Urban Indian Health Institute, 2011; Urban Indian Health Institute, 2009; Gray & Wolf, 2008; Great Lakes Inter-tribal Council, no date).

Future trainings for providers to prevent American Indian infant mortality should also introduce providers to local programs that are using culturally responsive models, for example, the parenting classes that are provided by American Indian Family Center and Division of Indian Work, from which the mothers who participated in this study were recruited, or the Family Education Diabetes Series program run by the Saint Paul Council of Churches Division of Indian Work in partnership with the University of Minnesota Department of Family Social Science.

And finally, the **training should increase providers' awareness of organizations, programs, and resources that could be helpful for their clients/patients who are experiencing poverty** –housing, transportation, baby supplies, and in particular free portable playpens/cribs, which several of the mothers in this study noted was the most helpful thing they had received in order to keep their baby safe. In addition to provider training, a referral network or directory could also be useful for this purpose.

> *"Look at the community and the individual in a more holistic way. Really take into account socioeconomic status, tapping into more than just a hospital visit or your well-being check-ups. It is mental health, health care, education. It is more than just going to your appointments." - a provider*

Other recommendations

In addition to provider training, there are several other recommendations. First, **methods of assessing providers' approach with American Indian mothers should be used to demand provider accountability for providing high quality care/services** to all patients/clients regardless of their race, socioeconomic status, insurance status, or previous behavior. This would preferably be done in partnership with the health and social service systems that employ these providers, but could also be completed with the help of outside advocates. A "secret shopper" type of model could be used to assess providers' response to a new patient/client who is an American Indian mother or pregnant. (In this author's opinion, a brighter light needs to be shone on the issue of American Indians not being able to access quality health care due to provider bias and ineffective ways of addressing American Indian patients/clients.)

Second, **we should consider ways of distributing information directly to the American Indian community about causes and prevention of infant mortality**, and possibly also about pregnancy prevention for teens, since several of the providers we interviewed specifically mentioned pregnancy prevention and teen pregnancy as issues that contribute to the high American Indian infant mortality rate. This effort could be modeled after the African American Babies Project[1] or other efforts. In addition to public health campaigns, community-based group formats are also recommended, as many of the mothers who participated in this study indicated their preference for receiving information about keeping their babies healthy in a culturally-based, "community of women/mothers" format.

Finally, any **efforts to increase the availability of resources to address poverty in the American Indian community would also help to prevent infant mortality**. Specifically, efforts to ensure that pregnant and new mothers have access to safe, stable housing and safe sleeping arrangements for their baby, plus transportation, nutrition, and access to prenatal and postnatal care and support services, legal services, and addiction and mental health treatment, will help to prevent infant mortality.

[1] https://www.wilder.org/Community-Leadership/Community-Initiatives/Pages/African-American-Babies-Coalition.aspx

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