

COVID-19 RESPONSE AND RECOVERY BY TRIBES AND URBAN INDIAN
ORGANIZATIONS IN MONTANA

by

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DEDICATION

This dissertation is dedicated to the ancestors who have been with me as I walked through doors, they opened. My journey began with my first professional position at the Confederated Salish and Kootenai Tribes' Two Eagle River School and every position I have since held. Each has contributed tremendously to this work. I stand on the shoulders of the generations that came before me with lessons of survival and resilience. They are my great grandmother Lydia, my grandmother Mabel, my mother Ruth, and my sisters Rhonda, Cheryl, Terry, and Lesa. And for those to follow Gena, Katy, Esther, and Jonathan.

It is further dedicated to those that left us too soon for so many reasons. Your stories are reflected in this writing. Your grace and presence are remembered. Our tragedies weave us together, whether it is from addiction, cancer, suicide, accidents, or COVID-19. Healing from the trauma, through relationship and as community provides a sense of belonging. We are stronger because you were here in our hearts and won't be forgotten for time immemorial.

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With everyone's support, my dream of a PhD comes true, and I am grateful.

AMERICAN INDIAN HERITAGE

I am an Indigenous, Salish woman. While my father's family immigrated from Wales, my mother's family are enrolled members of the Confederated Salish and Kootenai Tribes (CSKT) of the Flathead Nation, where I am an enrolled member, as are my husband and children. My worldview is through an Indigenous lens in relationships with family community, and Tribe, my connection to land, Salish beliefs and values, and the work I do.

Coming from a mixed family, conflict between my dad's Welsh and my mother's Salish ways might have occurred. It did not. My father accepted and believed in her Indigenous values, rituals, and customs. At dad's funeral, a tribal leader remarked how Dad was a tribal elder because of his acceptance of mom's family, their acceptance of him, and his appropriate involvement in our tribal ways. My mother and her extended family fostered my sense of belonging to the Tribe, beginning at my birth and it continues today. Mom was extremely proud of our connection to the McDonald family and diligently worked to instruct her daughters about being Indigenous in a modern world. She loved Flathead Lake, the Mission Mountains, the Bison Range, and the view at the crest of Ravalli Hill. She would say: "This is home." Her death at age 57, forced me to step into her role to keep our family connected and engaged in our tribal ways.

As I have grown older, I have gained a deep understanding of her words. I have lived within the exterior boundaries of the Flathead Nation since I graduated from college. Even when I had jobs that took me to Washington D.C., Helena, or Billings, MT, I never gave up my reservation residence and traveled home most weekends. Being present at family and tribal events kept me grounded to the land and connected to who I am. In all of my positions, I kept tribal issues in the forefront, and I educate non-Indians about tribal rights, even when the audience was not interested or even a little annoyed at my insistence to include an Indigenous perspective in all areas. Throughout my work, I might have been the only Indigenous person at the table where important decisions were being made. I had to choose, could a bigger impact made staying in meetings or leave when it was clear the outcome would not move the Indian agenda forward. I know I fumbled and took missteps, but I forged this path without a roadmap.

It is connections to significant family members that have directed my life. There was my great uncle Charlie McDonald. I remember sitting on his front porch as he shared stories of his experiences on the first CSKT tribal council and his visits with Chief Joseph. It was my uncle, in an Indian way, Bearhead Swaney, who taught me about tribal sovereignty and kept me humble. I trust my lifelong partner and husband as he teaches me lessons, protects me, and guides me. It is my daughters, Gena, and Katy that I see the traits taught me by Charlie, Bearhead, Gene, and mom and now in my yayas (Salish for my maternal grandchildren) Esther and Jonathan.

It is with all of their imprint that I have chosen my life's work: To improve the health status of American Indians in Montana. I stay focused on this in all that I do. I am their voice. I am their advocate. I hear their stories, in their entirety and with the spirit they are told.

It is in my heart, and deep in my soul. It is who I am.

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GLOSSARY OF ACRONYMS

American Indians and Alaska Native (AIAN)

American Rescue Plan (ARPA)

Department of Interior Bureau of Indian Affairs (BIA)

Coronavirus Aid, Relief, and Economic Security Act (CARES)

Community-based Participatory Research (CBPR)

Center for Disease Control and Prevention (CDC)

Confederated Salish and Kootenai Tribes (CSKT)

General Accounting Office (GAO)

Helena Indian Alliance (HIA).

Indian Health Service (IHS)

Indian Health Service, Tribal, and Urban Indian Health system (I/T/U)

Information Technology (IT)

IHS Programs, functions, services, and activities (PFSAs)

Indigenous Determinants of Health in the 2030 Agenda for Sustainable Development Report
(UN E/C Report)

Indigenous Knowledge (IK)

Institutional Review Boards (IRB)

Montana (MT)

Montana Department of Public Health and Human Services (DPHHS)

Montana Healthcare Foundation (MHCF)

Montana State University (MSU)

GLOSSARY OF ACRONYMS CONTINUED

Public Health Emergency Preparedness (PHEP)

Public Law 93-638 the Indian Self-Determination and Education Assistance Act, as amended.

(P.L. 93-638 ISDEAA).

Sandy Recovery Improvement Act (SRIA)

Salish Kootenai College (SKC)

SARS-CoV-2 variant (COVID-19)

Social Determinants of Health (SDOH)

United Nations (UN)

United Nations Human Settlements Programme (UN-HABITAT)

US Department of Health and Human Services (HHS)

US Department of Homeland Security (DHS)

DHS Federal Emergency Management Agency (FEMA)

Urban Indian Organization (UIO)

ABSTRACT

Research shows American Indians and Alaska Natives' resilience when they are connected to cultural lifeways, beliefs, and in relationship with families, their communities, and Tribes. It aids in traumatic times. This was true during the COVID-19 pandemic. Yet, it still disproportionately affected AIANs in the number of cases, hospitalizations, stays in intensive care units, deaths, and at younger ages than non-Hispanic Whites. This unequal impact of COVID-19 may be explained using the Center for Disease Control and Prevention's social determinants of health, but also raises doubt on the accuracy and thoroughness of data collected for AIANs. Additionally, when Tribes and urban Indian organizations responded to meet the needs of their members and communities, there were positive outcomes. This dissertation shows lessons learned in the response and recovery led by Tribes and Urban Indian Organizations, while successful, may have been improved if their actions were guided by a Tribal or UIO specific, comprehensive emergency preparedness plan. The literature review is a comprehensive examination of available reports, newspaper stories, and journal articles. It found there are gaps in available data that is tribal or UIO specific that has confidence of accuracy and cultural appropriateness as determined by Indigenous researchers. The co-authored manuscript focuses on the social, mental, physical, and spiritual impact COVID-19 had on one Native American and one Hispanic community. While the findings of the study revealed the challenges of COVID-19 pandemic on each of these qualities, there were positive realization about resilience and adaptability. The third dissertation product builds on the findings of the first two products and interviews from two Tribes and one UIO to create an Indigenous strategic planning process for Tribes and UIOs to use when they develop their own emergency preparedness plan to guide their response to the next emergency, crisis, or pandemic. These plans must be written by the Tribe or UIO and incorporate tribal lifeways, beliefs, and values, and shared with key stakeholders. Collectively, the three dissertation products affirm Indigenous leadership is fully capable of directing Tribes and UIOs recovery from the COVID-19 pandemic and set plans to prepare for the next emergent event.

CHAPTER ONE

INTRODUCTION

Across generations, American Indians Alaska Natives (AIANs) have been disproportionately impacted by diseases that has resulted in significant health disparities when compared to non-Hispanic Whites. This was particularly evident during the first year of the COVID-19 pandemic, when AIANs in the US accounted for a disproportionate number of cases and death. The United States (US). Department of Health and Human Services (HHS) Center for Disease Control and Prevention (CDC) reported, according to data collected as of December 2, 2020, that laboratory confirmed COVID-19 cases for AIANs were 3.5 times higher than for Whites. (Arrazola, 2020; Hatcher, 2020) In 14 states with significant AIAN populations, the death rate from COVID-19 was 1.8 percent higher for AIANs when compared to Whites. (Arrazola, 2020). In Montana, the disparity was larger. “Between March and October 2020, AIAN residents accounted for 19 percent of COVID-19 cases and 32 percent associated deaths.” (DPHHS Office of Epidemiology and Scientific Support, 2020) In addition, the same report concluded AIAN residents were almost 3 times more likely to acquire COVID-19 and twelve-times more likely to die when compared to other Montanans. The impact of past pandemics on AIANs, such as the 1918 Flu and the H1N1 pandemic, was similar. There will be pandemics in the future. Without deliberate action taken by all stakeholders, the unequal impact on AIANs will occur.

The purpose of this dissertation is to describe the historic impact infectious diseases have had on Indigenous populations since the arrival of Europeans, with particular attention on the COVID-19 pandemic. It explores the social determinates of health, including Indigenous

determinants of health, which contribute to the diseases' disproportion impacts. Throughout the dissertation, research is presented about the need for quality data specific for AIANs and the engagement of AIANs across all stages of the research. Finally, through extensive examination of available literature, lessons learned by tribal governments, urban Indian organizations, and perspectives from Indigenous people, an Indigenous strategic planning process for future emergencies, crises, and pandemics is created that may result in emergency preparedness plans.

Research Objectives

The following are the objectives of the dissertation:

1. Examine, at minimum 75 citations, on American Indians and COVID-19 to determine key findings, gaps, and challenges in available research. Product #1: COVID-19 Response and Recovery by Tribes and Urban Indian Organizations in Montana: What's Next? Literature Review meets this dissertation purpose and this objective.
2. Recommend research methods to engage tribal communities and academic scholars to honor tribal sovereignty on topics to be researched to prepare for future emergent events. Product #1: COVID-19 Response and Recovery by Tribes and Urban Indian Organizations in Montana: What's Next? Literature Review meets this dissertation purpose and this objective.
3. Understand the social, mental, physical, and spiritual impacts on Native Americans during the COVID-19 pandemic from key informant interviews and focus groups from community members on the Flathead Reservation to apply in the future for emergent planning efforts by Tribes and Urban Indian

Organizations. Product #2: Perceptions and Impact of the COVID-19 Pandemic on Social, Mental, Physical, and Spiritual Health of Rural Western Native American and Hispanic Communities meets this dissertation purpose and this objective.

4. Develop an Indigenous strategic planning process to be used by Tribes and Urban Indian Organizations when a decision is made to create emergency preparedness plans. Product #3: COVID-19 Response and Recovery by Tribes and Urban Indian Organizations in Montana: Indigenous Strategic Planning Process to Create Emergency Preparedness Plans meets this dissertation purpose and this objective.

CHAPTER TWO

RESPONSE AND RECOVERY BY TRIBES AND URBAN
INDIAN ORGANIZATIONS IN MONTANA: WHAT'S NEXT?
LITERATURE REVIEWAbstract

While research details American Indians and Alaska Natives' resiliency as Indigenous people when connected to cultural lifeways, beliefs, and relationship with families, their communities, and Tribes, AIANs were disproportionately affected by the COVID-19 pandemic in the number of cases, hospitalizations and stays in intensive care units, deaths and at younger ages than White non-Hispanics. This disproportionality for AIANs is similar to the impact from previous pandemics, including 1918-1919 Flu and 2009 Influenza A H1N1. This literature review examines public information, government reports, and academic research to form the foundation for this longstanding disparity that impacts the life expectancy and well-being of AIANs. Sources were searched using key words and names of Indigenous scholars. Themes were outlined from the references, which include the impact of previous pandemics and infectious diseases on AIANs and social determinants of health, how governments responded to the COVID-19 pandemic, COVID-19 disease's impact on AIANs, tribal and urban Indian organizations lessons learned from their COVID-19 response and recovery with focus on Tribes and UIOs in Montana. The review begins with challenges on the collection and analysis of Indigenous data. It continues with the validation of an Indigenous framework based on the Indigenous icon, the medicine wheel. The literature review results in the documentation of the

disparate impact with an explanation of social determinants of health that may contribute to this health disparity. The research showed tribal responses met the needs of their members and communities. It concludes, based on the lessons learned, responses and recovery by Tribes and UIOs, while successful, their actions were developed, implemented, and evaluated, at the height of COVID-19 pandemic and were not guided by emergency preparedness plans. It further concludes tribal/UIO responses may have improved if they had been guided by specific, adopted tribal/UIO emergency preparedness plans that included community partners and resources, and that staff were trained and ready to implement once the authorized governing body declared an emergent situation. The emergency preparedness plans written by and for each tribe/UIO would incorporate tribal lifeways, beliefs, and values, and will be shared with key stakeholders. The Plans must support traditional Indigenous knowledge, use tribal expertise that is shared in tribal ways and facilitated by Indigenous people.

Key Words

Key words search using Google, Google scholar, ProQuest

American Indians and COVID-19, Tribes and COVID-19, Tribes and lessons learned COVID-19, Native Americans and Lesson learned in COVID-19, Indigenous, Urban Indian Health and COVID-19

Indigenous Scholars Represented in Literature Review

Dr. Deana Around Him, Dr. Joe Gone, Dr. Spero Manson, Dr. Desi Rodriguez-Lone Bear, Dr. Don Warne, Dr. Robin Wall Kimmerer, Dr. Abigail Echo-Hawk

Introduction

On March 11, 2020, the World Health Organization declared coronavirus disease 2019 (COVID-19) a pandemic. (Katella, 2021) Within one year, the United States experienced 24 million confirmed cases and over 400,000 deaths. (Biden, Joseph, 2021) The United States (US) population is four percent of the world's total population but accounted for 25 percent of the total COVID-19 cases and 20 percent of the death. By early 2023, US reported 101 million cases and more than 1 million deaths. (Onion et al., 2021)

American Indians/Alaska Natives (AIANs) in the US accounted for a disproportionate share of COVID-19 cases and death. The US Department of Health and Human Services (HHS) Center for Disease Control and Prevention (CDC) reported, according to data collected as of December 2, 2020, that laboratory confirmed COVID-19 cases for AIANs were 3.5 times higher than for Whites. (Arrazola, 2020; Hatcher, 2020) In 14 states with significant AIAN populations, the death rate from COVID-19 was 1.8 percent higher for AIANs when compared to Whites. (Arrazola, 2020)

According to the 2020 US Census, the Montana population is 1,084,225, with 67,612 identifying as AIAN, which represents 6.2 percent of the total population. (*Montana - Census Bureau Profile*, 2020) AIANs in Montana COVID-19 incidence and death rates when compared with non-Hispanic Whites were dreadful. "Between March and October 2020, AIAN residents accounted for 19 percent of COVID-19 cases and 32 percent associated deaths." (DPHHS Office of Epidemiology and Scientific Support, 2020) In addition, the same report concluded AIAN residents were almost 3 times more likely to acquire COVID-19 and twelve-times more likely to die when compared to other Montanans. A Brookings Institute's report using CDC data reported,

“in Montana 3.8 percent of all American Indians 75-84 and 4.6 percent of those 85 and older have died of COVID-19.” (Akee & Reber, 2021)

Research further shows the disproportionate COVID-19 impact on AIANs diminished once the vaccine became available. “Throughout the pandemic, American Indians and Alaska Natives have had some of the highest COVID-19 vaccination rates across the country.” (Christensen, Lorretta, 2022) While AIANs reported hesitancy to get vaccinated due to mistrust tied to past epidemics and fear of being used as medical test subjects, (Ignacio et al., 2023) many got vaccinated to protect their families, elders, those with compromised immune systems, and for their community.

Purpose

This literature review provides an understanding of lessons learned from the COVID-19 pandemic by Tribes and Urban Indian Organizations (UIOs) to prepare for future pandemics. Section 3 explores issues with data collection for Indigenous people across Indian Country in the US, with an emphasis on finding research methods that are consistent with the tribal community. Section 4 moves to the examination of the past impact of past infectious diseases and pandemics on Indigenous people to emphasize the important need to act, following the COVID-19 pandemic. Section 5 describes the social and Indigenous determinants of health that put AIANs at greater risk during a pandemic. Federal, state, local, and Tribal government responses are examined in Section 6, with review of their impact on AIANs in Section 7. Lessons learned by Tribes and UIOs are identified in Section 8, with gaps in information for future emergency preparedness explored. The next section, Section 9, analyzes the information provided to identify research needs for Tribes and UIOs to create effective emergency preparedness plans. Particular

focus, across this literature review, was placed on Tribes and UIOs in Montana. Based on the available information about COVID-19 and AIANs, it is imperative before the next pandemic, to analyze the available data specific for Tribes and UIOs. They need access to Indigenous-specific data for comprehensive emergency preparedness planning that includes comprehensive training strategies, for immediate and effective implementation when the next emergency, crisis, or pandemic is declared by the appropriate governing agency.

There is a historic tendency in research to only examine the negative impacts events have had on AIANs. COVID-19 will have lifelong impacts on AIAN communities, as the loss of life was overwhelming and the impact of isolation and separation from loved ones, it left. To leave its impact at the negative outcomes is a tremendous disservice and not accurate. Indigenous healing practices and traditions were mobilized in response to the COVID-19 pandemic. (Manson & Buchwald, 2021) Collective values and Indigenous leadership approaches were put into place, with tribal based policies and public health responses supported by tribal sovereignty, which is the inherent right for Tribes to govern themselves. (O’Keefe & Walls, 2021) These attributes are reinforced in this Indigenous specific COVID-19 pandemic literature review with information generated using methods that honors tribal knowledge and methodologies, are highlighted in Section 3.

Indigenous Framework Methodology

“My grandfather reminded me of the importance of combining traditional ancestor ways with modern knowledge to heal. Each morning, we need to begin our days with a prayer and begin that prayer for our health. Without health, nothing else is possible.”

-Dr. Vernon Finley, Director
CSKT Kootenai Culture Committee (Finley, Vernon, 2023)

This literature review acknowledges the importance of using methods that support Indigenous framework and provides an example of one possible option. Indigenous research methods are not linear (Simpson, Brian W, 2023) but circular. There is not a beginning and an end but opportunities for ongoing learning as situations change, and knowledge is generated. These processes are based on relationships, with researcher accountability to those in the community involved. The research is shaped by the life experiences and interpreted on beliefs, values, and customs, which is different from the researcher that comes from outside the community to study Indigenous problems. (Wilson, Shawn, 2008) One example of a research methodology that respects Indigenous ways is community-based participatory research (CBPR). It requires a balance between the community's interests and the rigors of scientific practices to demonstrate outcome successes for the Indigenous community and the academic infrastructure. (Rink, 2020) It is built on a partnership between the academic researchers and the Indigenous community. It takes time to build longstanding relationships and must be based on trust (Rink, 2020)

Indigenous people have been over-researched and inappropriately researched. (Walker et al., 2014) There is a body of research that documents the problems attributed to research directed on/with/for Indigenous people. These can be categorized as gross underrepresentation, poor data quality, racial misrepresentation (Dellinger & Poupart, 2021), lack of reliable data, lack of Indigenous scholars to participate across all components of the research (Stanton, 2014), and combining Indigenous groups with others such as Native Hawaiians or worse, grouping AIANs, as others. There is a need for inclusion of diverse populations in clinical trials, which was exposed in the COVID-19 pandemic and had not been included in past pandemic research.

(Hammitt et al., 2021) In the search for a COVID-19 vaccine, it was essential to include AIANs to ensure its effectiveness with this population. Their inclusion requires authorization from tribal governments as the tribal government's governing bodies, have the right to determine whether to provide opportunities for their members to participate in clinical research. (Hammitt et al., 2021)

The inaccuracy or lack of AIAN COVID-19 data collected is harmful, with possible long-term impacts. Abigail Echo-Hawk, co-author *Data Genocide of American Indians and Alaska Natives in COVID-19 Data* said, "As our relatives continue to die at disproportionate rates from COVID-19, they are not given the dignity of telling their final story as they are eliminated in the data." (Erickson et al., 2021) The report reiterated the poor data collection has created substantial gaps in understanding the impact of COVID-19, specifically with AIANs. The lack of true data creates a void of information needed by federal, states, local, and tribal governments to make data-driven decisions for equitable policy and adequate resource allocation.

Indigenous leaders across California, with particular concerns for AIAN urban Indians, expressed fear during COVID-19 as there is a long history of undercounting Native Americans. Although California has the largest number of AIANs in the US, including the largest number living in urban areas, they are often declared white by hospital workers or listed as others. (Cimini, 2021) It was such a concern for some AIANs, they insisted on completing the death certificates themselves to ensure the loved one's race was accurately reflected.

It is paramount to find ways to improve AIAN data. This includes methodologies that meet or exceed other academic strategies. Indigenous scholars are calling for Indigenized research methodologies with the same rigor found in Western approaches that respect Tribal data

sovereignty and empowers Tribes to engage in research efforts. (Yellow Horse & Huyser, 2022)

Developing ethical and meaningful research partnerships with AIAN communities requires researchers to understand and commit to an ongoing process of authentic and deliberate relationship-building, cross cultural learning, open communication, trust, and reciprocity.

(National Congress of American Indians & Montana State University, 2012) It is important to acknowledge Indigenous values. This includes:

1. Indigenous knowledge is valid and valued.
2. Culture is always a part of research and thus research cannot be culturally neutral.
3. Responsible stewardship includes the task of learning how to interpret and understand data and research.
4. Tribes must exercise sovereignty when conducting research and managing data.
5. Research must benefit Native people.” (National Congress of American Indians & Montana State University, 2012)

CBPR is one example of a research methodology, with acceptance from the academic community, which through its most basic principles is adaptable to fit Indigenous communities and their research needs. The use of the CBPR methodology fundamentally changes the way research is conducted, to ensure the community is engaged at every stage of the effort. The steps in CBPR requires many steps that builds on Indigenous ways of knowing.

The following is a list that supports tribal engagement:

- Develop a partnership between the community and the academic scholars to determine a topic to research
- Find meaningful ways to include community knowledge

- Share all resources with the community and ensure the community has the time, capacity, and resources to participate actively and equitably
- Gathers data and information and analyze, interpret based on community knowledge and ensure that it is embedded in all aspects
- Safeguard lessons learned by the academic scholars are available to other academics, share and teach community leaders, politicians, and policy makers to find effective ways to change policy
- Communicate to begin the next project and repeat the steps in a circular approach

The CBPR methodology is one methodology to decolonize research in Indigenous communities. CBPR is further refined in the article by John Hallet et.al., What touched your heart? Collaborative story analysis emerging from an Apsáalooke cultural context. They recognize specific engagement activities to be taken to make certain the research is conducted honoring Indigenous knowledge and involvement. The following highlights their findings:

- Partner with the Tribes/UIOs at all stages of the project.
- Analyze data from participants, with community experts, to confirm consistency with community values.
- Recognize the participant may share information through storytelling and preserve their complete story in the analysis and make sure it is not broken into pieces to protect the overall meaning of the story and that it stays intact,
- Preserve the individual integrity of each participant's story.
- Respect Tribal values surrounding community and individual gathering, while seeking the information required, with an effort to listen carefully.

- Conduct participant interviews in a comfortable setting and with adherence to their customs and traditions. (Hallett et al., 2017a)

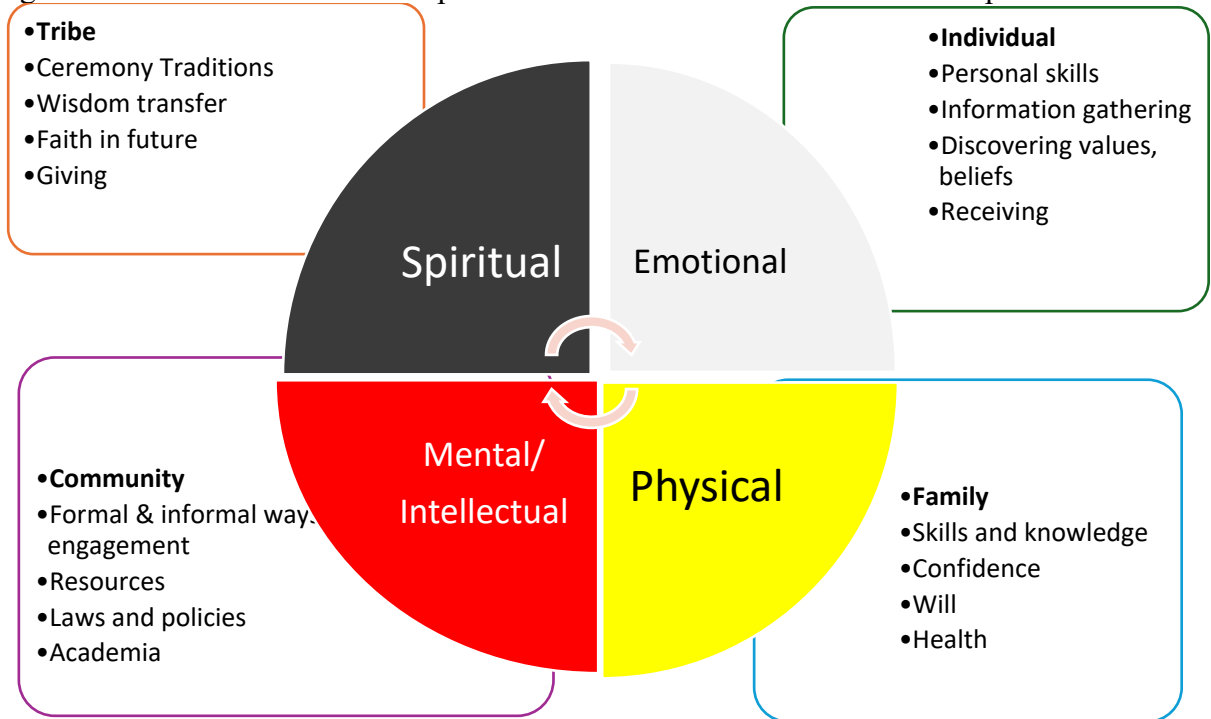
One example of an Indigenous research framework is the medicine wheel. (Coyhis, 1988; Travers, 2021; Twigg & Hengen, 2009) The origins of the medicine wheel have been orally, handed down from one generation to another. It tells a unique story for each tribe but with fundamental core principles representing the four directions (east, south, west, north), four seasons (spring, summer, fall, winter), four universal elements (air, water, fire, land), and generations (infant, adolescent, adult, and elder). It is a method to explain complex situations with “the basic configuration, a circle divided into equal quadrants, can then be used to depict many other relationships, always in sets of four,” (Montour, 2000) It is adaptable to community-based research projects, while placing the Indigenous knowledge in the center. It is important to note, there has been a shift in some research, which examines Indigenous “resiliency and the role of culture in responding to the pandemic.” (Around Him & Elliot, 2022)

Munson and Pedro in their research to validate tribal-specific methodologies, described the medicine wheel as follows: “To ensure educational opportunities are available that address all aspects of a person's being – physical, emotional, intellectual, and spiritual – and further ensure strength in identity, life ways, and contribution, success, and leadership within our communities, the state, the nation, and even the world.” (Munson, Michael & San Pedro, Timothy, 2019)

The following diagram displays the Indigenous worldview using the medicine wheel to show connectedness, balance, belonging, and relationships. It was developed, by the researcher,

for this literature review to displays a framework methodology that incorporates Indigenous knowledge.

Diagram 1: Medicine Wheel: A comprehensive worldview based on relationships and balance



On December 1, 2022, the White House released the Indigenous Knowledge Guidance for Federal Agencies to formally recognize “Indigenous Knowledge (IK) as one of the many important bodies of knowledge that contributes to the scientific, technical, social, and economic advancements of the United States and our collective understanding of the natural world.” (White House Releases First-of-a-Kind Indigenous Knowledge Guidance for Federal Agencies, 2022) It defines IK as a “body of observations, oral and written knowledge, innovations, practices, and beliefs developed by Tribes and Indigenous Peoples through interaction and experience with the environment.” It calls for federal agencies to understand IK, grow, and

maintain relationships with Tribal Nations to include IK, consider IK in federal research, policies, management, and decision making. A leading Indigenous scholar Robin Wall Zimmerer called this a time to celebrate, while calling for institutions to join with AIAN communities to listen, learn, and only contribute their expertise when asked. There is a need to support Indigenous-led research by addressing barriers to allow for full participation and increased visibility of Indigenous worldviews. (Kimmerer & Artelle, 2024)

Background with Indigenous People and Infectious Disease

Infectious Disease during Colonial Times

Indigenous people in the US have consistently been disproportionately impacted by disease since the beginning of colonization. Disparities have existed throughout the 500 years since European arrival in the Americas. While there is evidence ill health existed prior to their arrival, “colonization made matters worse.” (Jones, 2006) Examples of diseases are smallpox, measles, influenza, and malaria that spread across North America during the 18th and 19th centuries, with death rates in some Indigenous populations as high as 90 percent during the first century after European contact. (Jones, 2006)

One example of the decimation of Indigenous people from disease is in 1633, when an outbreak of smallpox hit in New England, where the Mohegan and Pequot tribal population was reduced from a combined total of 16,000 to just 3,000 individuals. (Ostler, 2020) Ann F. Ramenofsky et.al in the article Native American disease history: Past, present, and future directions concluded that there is no question that Native Americans died in significant numbers following European contact. (Ramenofsky et al., 2003) There was no uniform effect across Indigenous people in different areas across the US. Additionally, the article expressed that

research is needed to understand the current AIAN mortality rates from viral and bacterial infections such as influenza and tuberculosis. The Indian Health Service (IHS) reports their impact continues at almost twice the rate of other populations. (Ramenofsky et al., 2003)

The devastation from disease has had multi-generational impacts, especially when coupled with the “social and cultural dislocation, historical trauma, and population migration” occurring in the 1960s. (Manson & Buchwald, 2021) It can be attributed to the inequalities in AIAN life expectancy, where in some states like Montana, can be as high as a 17-year difference between AIANs and Whites.

In Montana, the Blackfeet Nation experienced three smallpox outbreaks in 1781-1782, 1837-1838, and 1870-1871, with devastating outcomes. It is reported that the last outbreak resulted in the death of 70 percent of their total population. The mass graves for the victims remain a part of the history and culture of the Blackfeet Nation. (Connolly et al., 2021) This tragic chapter in their history was on the minds of the Blackfeet community when the COVID-19 outbreak occurred.

“Infectious diseases remain some of the most enduring,” among the many disparities affecting AIAN communities. (Cheek et al., 2014) In the 1970s, it was predicted that by 2000, their impact would be minimal with significant declines in death from these illnesses. Yet, infectious diseases suddenly reappeared across the general population and with disparate impact on vulnerable populations, including AIANs. As of 2014, there were no national studies focused on AIAN infectious disease mortality. (Cheek et al., 2014)

1918-1919 Flu Pandemic

The 1918-1919 Flu pandemic was the deadliest in world history, with over 500 million individuals infected and nearly 50 million deaths across the world. In the US, it is reported that there were 675,000 deaths. The flu was caused by a new variant of influenza virus and was spread globally because of World War I. There was no vaccine. It is reported to have ended in early 1920. (Onion et al., 2023) (Jester et al., 2018) Like COVID-19, there was no national strategy to respond to the severity of the pandemic. Communities took charge and enacted safety protocols such as school closures, banned public gatherings, and isolation or quarantine orders.

Over the next 100 years, efforts were made to learn lessons in preparation for the next influenza pandemic. This included improved surveillance, testing to detect influenza virus infections in the respiratory tract, and prevention, and treatment strategies, while recognizing rapid response with available treatments, clinical support, and vaccines were vital. Despite this knowledge, in 2018 it was acknowledged “governments and care systems remain inadequately prepared for the impact of a 1918-like severe influenza pandemic.” (Jester et al., 2018)

Steve Helgerson in his novel portrayed the impact of the 1918-1919 Flu pandemic in Montana. While his writing was depicted in novel-like format, the events and facts presented are “consistent with actual events in 1917—1918 in two counties in Montana”. He reflects on the lack of contemporary medical treatments in rural and reservation areas, coupled with fear, anxiety, and beliefs sometimes associated with racist stereotypes about AIANs held in the early twentieth century.” (Helgerson, 2017)

The 1918-1919 flu pandemic struck AIAN at a particularly difficult time in their history. Following centuries of war, removal from homelands, and starvation caused by the near extinction of the bison, their population dwindled from nearly 12 million to a reported 237,000 in

1890. AIAN mortality data was not collected for the 1918-1919 Flu pandemic. (Hedgeth, 2020) However, information is available showing that nearly 12 percent of the Navajo Nation, the largest Tribe in the US, died. In some remote villages in Alaska, it is reported that 70 to 85 percent of their total population died. (Connolly et al., 2021)

The Mille Lacs Band of Ojibwe Tribe in the Great Lakes region of the US and Canada recall through oral storytelling of the impact of the 1918-1919 Flu pandemic. They tell of a young girl sick with what was, most likely, the flu. A medicine man's granddaughter became sick. As he slept, his spirit guides came to him in a dream. They told him to make a dress made of metal cones for her and have her dance. The dress was made. At first, the child was too sick to dance by herself, so the community carried her to dance. Eventually, she was able to dance alone, and she was healed. The dance, now known as the Jingle Dance, is prominent across all Indian Country and important part of the healing that comes with pow wow dancing. (Gowder, 2022)

2009 Pandemic Influenza A H1N1

Influenza A, commonly referred to as H1N1 in 2009, was first detected in mid- April 2009. (Centers for Disease Control and Prevention, 2009) On June 11, 2009, the World Health Organization declared the H1N1 flu, a pandemic. It is estimated by CDC that between April and June 2009, one million people were infected. CDC discontinued collecting H1N1 flu pandemic data in July 2009.

H1N1 was spread from person-to-person, in the same manner as seasonal flu. (Centers for Disease Control and Prevention, 2010) Indigenous populations in Australia, Canada, and New Zealand were reported to have a three to eight times higher rate of hospitalization and death

from H1N1. (Castrodale et al., 2009) Disproportionate rates, of death for AIANs, were reported by CDC for the US. In November 2009, CDC invited all states to provide data on influenza-related deaths from their residents. Twelve states, representing 50 percent of the AIAN population in the US, joined, and reported 426 H1N1 deaths with 42 individuals identified as AIAN or 9.9 percent of the total. In the twelve states, the mortality rate for AIAN was four times higher as compared to all other racial/ethnic groups. “In all age groups, the AIAN death rate was higher than the rate for all other racial/ethnic populations combined.” (Castrodale et al., 2009)

In Canada, it was reported during the H1N1 pandemic, First Nations were excluded from data collection resulting in data being non-existent or that data collected was done without community input. The result was, data used, “perpetuated racial stereotypes and inequities.” (Hayward et al., 2021) One such misuse was the failure to send H1N1 sanitizer gel to First Nation communities as it was thought the “gel may be ingested by individuals,” (Hayward et al., 2021) although there was no empirical data on substance abuse to warrant such decision-making.

In the years following the H1N1 pandemic, researchers examined actions to be taken to reduce the disparate impact from future pandemics on AIAN communities. It was found that there were lessons to be learned for the US, such as the need to create a shared picture of the pandemic based on standardized data and information from all levels of government and build trust in vaccines. (Fraser & Blumenstock, 2021) There were specific lessons for Indian Country. One important lesson was the creation of partnerships with Tribes and IHS, as demonstrated at the start of the H1N1 pandemic when Tribes were not eligible for key funding and it delayed responses. (Center for Disease Control and Prevention, 2009) Additionally, it was documented

that improved quality data was needed as effective health responses depend on quality data and can improve AIAN awareness.

Social and Indigenous Determinants of Health

Social determinants of health (SDOH). SDOH is defined as “the nonmedical factors that influence health outcome. They are the conditions in which people are born, grow, work, live, and age and the wider set of forces and systems shaping the conditions of daily life. These forces and systems include economic policies and systems, development agendas, social norms, social policies, racism, climate change, and political systems.” (CDC, 2022) SDOH is a priority area for HHS Healthy People 2030. It sets the foundation for its effort, especially as it considers health equity (*About - Healthy People 2030*, 2020). In 2023, The United Nations issued a report on the distinct Indigenous Determinant of Health that reframes the accepted SDOH contexts to fit AIANs perspectives. This section is divided into three areas as follows:

- A. Historical SDOH on AIAN Health Status
- B. Indigenous Determinants of Health
- C. AIAN Health Status Indicators

Historical SDOH on AIAN Health Status

History demonstrates the uneven impact of infectious diseases and pandemics on AIANs. To prepare for future emergent events, it is important to understand the cause of it, which can be done through the examination of SDOH. To add to the past devastation during colonial times, AIANs were forced to abide by laws that made it illegal to practice traditions and ceremonies, which could have assisted in dealing with the trauma. (Kelliher, 2023) Research by Mary-Ellen

Kehn reported in her book *Colonizing bodies: Aboriginal health and healing in British Columbia* examined the relationship between religions and the government and its long-term impact on the health of Indigenous people. While her study focused on the control churches had on residential schools and them being used as tools for assimilation, she found a correlation between churches that were assigned to provide Indigenous healthcare. She writes “the prevailing belief that health could only be guaranteed through the assimilation meant that Indigenous bodies became sites of colonization by missionary doctors.” (Kelm, 1998) The practice of religions being assigned to reservations across the US created a lasting and adverse impact on Indigenous trust in the health care delivery that continues today.

It has been reported the “root of all these vulnerabilities are the broken promises that the federal government made to Tribes in the constitutional process of signing treaties to acquire land.” (Doshi, Sahir & Kelly, Kate, 2020) In exchange for land, the US agreed to protect Tribes as sovereign entities with the right to self-governance based on a government-to-government relationship founded on political status, not racial identification. Treaties created a recognized trust responsibility embodied in the US Constitution and federal statutes. With the US failing to uphold its treaty obligations, there has been significant economic, ecological, infrastructural, and humanitarian fallout that are apparent across many aspects of Indian Country.

Indigenous Determinants of Health

On January 31, 2023, the United Nations Economic and Social Council’s Permanent Forum on Indigenous Issues distributed the Indigenous Determinants of Health in the 2030 Agenda for Sustainable Development Report (UN E/C Report) after 20 years of examination. (Denetclaw, 2023) This historic, first-of-its-kind, report explores the unique determinants that

apply to Indigenous people worldwide. It concludes that there is an Indigenous peoples' common approach, which is "all things that exist are interconnected". (Condo Riveros et al., 2023) This leads to a unique Indigenous understanding, which is different from non-Indigenous peoples and separates Indigenous people from other general minority and diverse population approaches. The UN E/C Report will "serve as a foundational framework for United Nations Member States and United Nations-related Agencies to guide their endeavors on Indigenous issues and strengthen the current work to achieve". (Condo Riveros et al., 2023)

The UN E/C Report findings were accentuated during the COVID-19 pandemic. It found that there were inequities in all the status categories examined and there was "severe lack of cultural competence, which negatively impacted Indigenous Peoples' health". (Condo Riveros et al., 2023) State and federal governmental agencies and academic scholars document similar findings: The COVID-19 pandemic disparately affected racial and ethnic minority groups in the United States, including AIANs. The UN E/C Report's overarching assumptions, explaining Indigenous determinants of health, are timely. (Lee, 2023)

The UN E/C Report acknowledges the limited availability of rigorous research across Indian Country. This is a similar finding from academic researchers. For example, in the article "Yarning" as a method for community-based health research with Indigenous women: The Indigenous women's wellness research programs, the authors found "Indigenous people globally have been over-researched and inappropriately researched." (Walker et al., 2014) The article further states, "despite the ever-increasing volume of Indigenous health research, there remains little change in the health disparities". The UN E/C Report offers, "there does exist enough information to establish the connection between colonial practices and institutional rules and

practices, used across multiple generations, to assimilate or marginalized Indigenous Peoples, has resulted in physical, mental, emotional, and spiritual trauma that has caused ‘havoc’ in the soul and life of Indigenous Peoples and communities.” (Condo Riveros et al., 2023) These actions are described in a variety of ways including forced evictions from homeland and placement on desolate lands, stolen children, persecution on community members for protecting or practicing Indigenous lifeways, exploitation of traditional knowledge, limited education, destroyed sacred sites, use of violence such as rape and murder against those who resist, and continuous racism and marginalization. To understand the impact of these atrocities, the UN E/C Report calls for the use of Indigenous knowledge, which is vital to everyone’s well-being not just Indigenous Peoples, and Mother Earth.

The approach to Indigenous health and well-being must consider three factors: 1) the strength and wisdom inherent to Indigenous identities and its connection to everything that exists, 2) collective care must begin with Indigenous principles, values, and traditional knowledge; and 3) current health status is tied to past, present, and future generations. The result is a unique set of “determinants of health to Indigenous Peoples, their cultures, histories, political status, gender, and current experiences.” (Condo Riveros et al., 2023) It identifies two overarching assumptions: Indigenous communities, worldwide, struggle for their bare essential needs and human rights. The second overarching assumption is that being Indigenous is a determinant of health. (Condo Riveros et al., 2023)

Stacy Bohlen, Chief Executive Officer, National Indian Health Board shared that one document cannot express all Indigenous people’s needs and truth but this report has led “us to common grounds of cultural erasure, intergenerational trauma, and loss of language and culture,

all supported by policies designed specifically for those things.” (D. Thompson, 2023) Don Warne, Co-Director for the Center for Indigenous Health at Johns Hopkins University, and a contributor to the UN E/C Report, clearly states in the same article that the UN E/C Report highlights that determinants of health contribute to disparities, and they support or protect, positive health outcomes, such as connectedness to language, culture, and ceremony that “we have some very unique strengths.” Across generations and throughout history, AIANs have faced social injustice and economic challenges but theirs is a “story of resilience and perseverance.” (Mineo, Liz, 2020) Additional AIAN strengths include connection to extended families, some members with strong cultural identities, traditions, spiritual practices, and childrearing beliefs used by families and across generations. (Davis et al., 2020)

AIAN Health Status Indicators

Research documents the AIAN health indicators that begin to explain the disparate health status, all associated with SDOH, and were brought to the forefront during the COVID-19 pandemic. The list is expansive. It is widely accepted that the high poverty rates experienced by AIANs is conducive to disease transmission such as crowded living conditions and for some, lack of running water and indoor plumbing. (Humeyestewa et al., 2021) The list includes low access to quality healthcare and the long distances to travel to access when it is available, and unreliable transportation and in rural reservation areas no public transportation. Reservations have been identified as food deserts, which are defined as lack of access to healthy food. (Haroz et al., 2022) If healthcare is available, there are cultural and language barriers including the use of language where words have different meanings. (Lopez & Wu, 2022) For multiple reasons AIANs engage in detrimental health behaviors such as smoking, drinking, and drug use at high

rates. (Goldman & Andrasfay, 2022) Racism and discrimination by health providers and health systems contribute to lack of healthcare provided to AIANs, many of whom who do not have health insurance and depend on IHS, which is historically underfunded. In 2018, 22 percent of AIANs nonelderly people had the highest rates of being non-insured than all other racial and ethnic groups in the US. (Artiga, 2020) These issues contributed to many AIANs, when they are sick, to “tough it out at home”, with devastating consequences. (Lopez & Wu, 2022) Earlier research affirmed this perspective when it was found that “many forgo medical and diagnostic care because of the mistrust they harbor for the scientific and medical fields.” (Pacheco et al., 2013)

AIANs are underserved in the US healthcare system. There are fewer physicians, nurses, and therapists, less medical technology used for early intervention and diagnosis for ultrasounds and magnetic resonance imaging (MRIs). There is less funding, which equates to less primary care and more emergency room care. IHS, the US federal agency with the primary responsibility to provide healthcare to AIANs is significantly underfunded. “The IHS budgets provide \$4,078 per person/year health care spending, less than half of what is spent for federal beneficiaries in the general population and covers just 16 percent of the estimated funding needed to fully fund all IHS federally operated, tribal operated, and urban Indian operated facilities.” (Manson & Buchwald, 2021) In addition, the vacancy rate for IHS healthcare providers is at 25 percent and higher at some facilities.

AIANs are more likely to have underlying health conditions, such as cardiovascular disease, diabetes, asthma, and obesity. (Artiga, 2020; Ellenwood et al., 2023) This is particularly important to understand as it increased AIANs susceptibility to COVID-19. It is known AIANs

have disproportionate rates of underlying medical conditions when compared to non-Hispanic Whites. (Indian Health Service, 2019)

The health status indicators are further described in research interpreting the impact COVID-19 pandemic had on the decline of life expectancy for AIANs. While high poverty is considered one of the leading health indicators, others were identified or clarified. One such health indicator is high unemployment with many of those employed in seasonal jobs such as wildland firefighting, agricultural positions, or frontline workers that had to report to work during the COVID-19 pandemic. (Gregor et al., 2022; Kelliher, 2023) Tribes lost key sources of revenue and individuals' jobs, during the initial COVID-19 outbreak, when they closed businesses and stopped services, in response to governmental social distancing and essential services directives.

Historical trauma must be weaved into the SDOH discussion including the adverse childhood experience index, social marginalization, and toxic relentless stress related to disease, colonial war, and starvation. AIANs encounter infrastructure inequities such as substandard housing, clean water (Sbicca et al., 2020), plumbing, electricity, poor indoor air quality (Haroz et al., 2022) and live in crowded living arrangements with multi-generational family members that placed older individuals at risk of COVID-19. (Artiga, 2020; Ellenwood et al., 2023) The lack of internet access across rural reservation areas was identified. (Haroz et al., 2022)

Some SDOHs may have a higher prevalence for AIANs residing on reservation rather than in urban areas. The HHS in 2018 reported, "almost four-fifths of American Indians live off-reservation, largely in metropolitan areas." (Leggat-Barr et al., 2021) Most of the SDOH

identified risk factors are more prevalent in individuals residing on reservations. It appears reservation life increases the risk to COVID-19 mortality. (Leggat-Barr et al., 2021)

Governments Response to the COVID-19 Pandemic across Indian Country

The first COVID-19 case, in the US, was confirmed on January 20, 2020, in Washington state, with the first death reported on February 29, 2020. (Onion et al., 2021) By November 2020, the US led the world in confirmed cases and deaths. (Alexander et al., 2021) Immediately upon the confirmation of the first COVID-19 case in the US, the White House established the Coronavirus Task Force, the HHS declared a public health emergency and began screening passengers at certain airports and asked those returning from areas with high rates of COVID-19 disease to self-isolate. (Alexander et al., 2021) Research showed that “racial and ethnic minorities and the poor disproportionately had higher rates of infection, hospitalizations and deaths”, and those with poorer SDOH increased vulnerability and poorer outcomes to COVID-19 infection. (Alexander et al., 2021) The Coronavirus Preparedness and Response Supplemental Appropriations Act, 2020 and Coronavirus Aid, Relief, and Economic Security Act (CARES) were enacted. As the US responded, Tribes, UIOs, and Indigenous people were involved in multiple levels of governmental responses.

Federal Government Response to COVID-19 Pandemic Across Indian Country

Tribes were included in most federal government responses, based on the federal emergency declaration. This action provided opportunities for Tribes to participate in a number of federal programs. (*Coronavirus (COVID-19)*, 2020)

The following are a few of the significant federal programs Tribes became eligible or increased eligibility for participation:

- US Treasury Department – With the enactment of CARES and the American Rescue Plan (ARPA) to respond, recover from the COVID-19 pandemic and emerge strong, Tribes received the “largest infusion” of federal funding in the history of the US. (Henson et al., 2021) APRA acknowledged Tribes make better-informed decisions for their members as they can match the services with their specific needs and values. It is important to note that this substantial funding does not remedy the “the history of gross underfunding” that has ignored promises made in treaties and other executive orders. (Henson et al., 2021) Additionally, there have been significant delays in getting the funding out to Tribes in a timely manner to address the devastation occurring during the COVID-19 pandemic.
- Department of Homeland Security Federal Emergency Management Agency (FEMA) – Tribes became eligible for FEMA public assistance, without declaring an emergency. They could decide to receive services directly from FEMA or through the state where they are located. Whether Tribes decided to work directly with FEMA or to work with the state, they became eligible for FEMA Public Assistance grants. In addition, under certain circumstances, Tribes may have been eligible for reimbursement of COVID-19 related costs. (*Coronavirus (COVID-19)*, 2020) FEMA put in place a comprehensive strategy to collaborate with the 574 federally recognized Tribes to reduce the challenges experienced in the past, especially to ease the burden of disasters due to climate change such as floods and wildland fires and in response to the COVID-19 pandemic. (Tang, 2022)

- Department of Health and Human Services – Centers for Disease Control and Prevention (CDC) – Tribes have long-partnered with CDC. (Centers for Disease Control and Prevention, 2023) During the COVID-19 pandemic, CDC strengthened their partnership with Tribes to plan, prepare, and respond. This included technical assistance, for contact tracing, epidemiology and surveillance support, vaccine uptake, and response management. The Tribes partnered with CDC to create plans tailored to tribal-specific communities, to link to other federal resources, receive training, and health communication. CDC provided protocol reviews for incident command structure, case management, contact tracing, reopening, and recovery. The CDC Foundation was assigned to find ways to better ways to engage with Tribes, as the COVID-19 pandemic raged on. They responded by providing a limited grant funding to a limited number of Tribes.
- Department of Health and Human Services – Indian Health Service (IHS) – With the mission “to raise the physical, mental, social, and spiritual health of American Indians and Alaska Natives to the highest level” (*IHS Agency Overview*, n.d.), IHS worked closely with Tribes and UIOs. IHS received a historic amount of funding of more than \$9 billion to provide resources to IHS health care entities, tribal health departments, and UIOs. (IHS, 2020) As a critical public health effort for AIANs, IHS created the E3 strategy: 1. Every patient at 2. Every encounter should be offered 3) Every recommended vaccine, when appropriate. (Christensen, Lorretta, 2022) This strategy, in partnership with Tribes and UIOs, was essential to amplify vaccine access and resulted in some of the highest COVID-19 vaccine rates in the US. “IHS received \$9 billion in federal COVID-

19 relief funds to address immediate and longstanding health care and public health needs.” (General Accounting Office, 2022)

While CARES, ARPA and other COVID-19 enacted funding was made available to Tribes through IHS, the US General Accounting Organization (GAO) found a number of challenges they faced, especially with IHS hospitals. Some examples include staff shortages, providing general and specialty care for patients with and those without COVID-19, testing supplies and administration for COVID-19, supply shortages, physical infrastructure limitations due to size, age and design of facilities. IHS prioritized telehealth but there were limitations with broadband and internet access. GAO further reported challenges long identified with the IHS healthcare system such as lack of necessary equipment, patient concerns about privacy and quality of care provided. (General Accounting Office, 2022)

Montana State Government Response to COVID-19 Pandemic Across Indian Country

Governor Steve Bullock issued an executive order declaring a “state of emergency” in Montana related to COVID-19 on March 12, 2020. (Bullock, Steve, 2020c) The executive order acknowledged the need for a proactive response since no cases of COVID-19 had been diagnosed in Montana, but CDC had identified the high public health threat. He created a Multi-Agency Executive Task Force to prepare the state. On March 13, 2020, Governor Bullock issued another executive order that Montana’s state of emergency would run concurrently with the federal public health emergency declared by President Donald Trump. (Bullock, Steve, 2020b). In a directive implementing the two executive orders, he described actions to be taken by schools, nursing homes, guidelines for social distancing, specifics for transportation, and

activated the Montana national guard to assist with implementation. (Bullock, Steve, March 15, 2020) By April 2020, Montana had developed a phased approach to mitigate risk and protect the vulnerable citizens for implementation statewide including Tribes and counties, with the ability to adjust based on up-to-date data. (Bullock, Steve, 2020a)

DPHHS Montana Crisis Recovery Program was created with federal funding from FEMA and the US Department of Health and Human Services Substance Abuse and Mental Health Services Administration (SAMHSA) to provide outreach to Montana communities impacted by COVID-19 pandemic. They realized there was a disparate impact on Indigenous reservation and urban communities and contracted with Kauffman and Associates, Incorporated, an Indigenous woman owned company to provide outreach to the eight tribal governments and five UIOs. (Kauffman & Associates, Inc, 2021) It conducted a needs assessment to gain an understanding of the impact of COVID-19 on Indigenous people in Montana. It found that overall 75 percent of those surveyed thought that COVID-19 had a moderate to extreme impact on their well-being. This was caused by the top five issues identified as anxiety, stress, depression, loneliness, and grief. The near 75 percent of themselves or family members suffering for depression, anxiety, and stress was validated by a Robert Wood Johnson Foundation and the Harvard T.H. Chan School of Public Health study. (Chatterjee, Rhitu, 2021)

In a follow up activity to the needs assessment, Kauffman & Associates, Inc. conducted a Montana Crisis Recovery Tribal/Urban Tour and traveled for onsite visits with the eight Tribes, Montana Wyoming Tribal Leaders Council, Billings Area Indian Health Service, and five UIOs. The recommendations from the tour included support to sustain the program beyond the FEMA/SAMHSA grant funding, need for a resource guide of all available state resources,

sharing of successful and culturally appropriate COVID-19 pandemic responses by Tribes and UIOs, training through Tribal colleges, and gathering Tribes and UIO staff involved in COVID-19 response and recovery efforts to share and debrief as a self-care exercise. (Kauffman & Associates, Inc, 2021a) One participant shared, “There is fear with this generation, distrust of information, and broken trust between the government and Indians.” To support the need for self-care, a participant stated, “Remember, if I am struggling, how do I help others?”

KAI’s final report to DPHHS on their work with the Montana Crisis Recovery Program reported lessons learned. These included the importance of hiring Indigenous staff when working with the Tribes and UIOs, outreach material that is cultural and tribal specific, finding ways to engage face-to-face to build and retain key relationships, and regardless of location, each community needs their own plan. (Kauffman & Associates, Inc, 2022)

Tribal Government Response to COVID-19 Pandemic

While there was not one COVID-19 Tribal government response across the 574 federally recognized Tribes in the US, there were some consistent actions taken, which were made available because of Tribe’s sovereignty, providing them authority to act for their members and on their land. Tribes could act quickly in ways tailored to their communities and needs. (Florey, 2021) Responding to the COVID-19 pandemic was a “means to exercise sovereignty.” (Saul et al., 2020) While there were distinct challenges for Tribal governments, they had the ability to exercise their governmental powers in ways consistent with their own values and beliefs, unlike other governments that have been addressing Indigenous needs. During the COVID-19 pandemic response tribal governance “saved lives in Indian Country.” (Florey, 2021) Tribes were able to react quickly and effectively. (Saul et al., 2020)

Tribes were able to find creative ways to test, conduct contact tracing, and found “relevant modes of delivery of supplies.” (Saul et al., 2020) This effort was enhanced as Tribal health departments had relationships with the tribal members they serve. This contact became very important as other needs and concerns were found and were able to be addressed. Some Tribes had higher testing rates than surrounding counties, which could be because they were able to offer free testing and could test asymptomatic people.

Tribes were able to institute strong guidelines, quickly, including shelter in place orders, curfews, mask wearing, and social distancing, which were communicated in public education campaigns with tribal trusted messengers, culturally appropriate messages, and often in their Native language. The communication channels were specific to their tribal area. Tribes closed their businesses, and some were able to continue to pay employees. One communication strategy shared was about a Tribe that created a video of their sacred sites, allowing members to visit the sites virtually when ceremonies and other spiritual rituals were stopped. Virtual “pow wow” sites were created.

Tribes closed their tribal casinos and used it as a place to quarantine individuals exposed to COVID-19 or those who were diagnosed with it and needed a place to isolate to protect others living in their place of residence or were homeless. Schools and community centers were cited as being “repurposed” to deliver clothes, food, medical supplies, and additional housing.

One tribal response was to require vaccination, when the vaccine became available, and they found creative ways to get tribal members, non-indigenous family members, and closely connected community members vaccinated. In Alaska, planes, sleds, and water taxis were used to achieve vaccine rates. (Florey, 2021) Tribes that controlled the vaccination adopted their own

priorities to receive vaccination early on. One tribe prioritized native language speakers. Another shared that a tribe asked the federal and state government to step aside and provide them the vaccine, which resulted in 80 to 90 % vaccination rates.

Tribes were able to provide additional services and focus their efforts on targeted populations such as elders and youth. One Tribe created a “per capita” loan program. Many Tribes provided food assistance. The Navajo and Hopi Nations provided food, water, and what were called “kinship kits”, containing other supplies. (Saul et al., 2020)

Tribes put up checkpoints on roads entering the reservations and to control outsiders’ access to tribal land. (Clapsaddle, Annette Saunooke, 2020) In some locations, the tribal checkpoints were used for rapid COVID-19 testing. Tribal examples include instituting emergency laws and creating emergency response teams and incident management authorities.

The Navajo Nation, located in three US states, was identified by the national news early on as one of the areas most impacted by the COVID-19 pandemic in the US and then for the Tribal government’s serious response. (Becenti, 2022) The President of the Nation clearly stated that with all the uncertainty and misinformation, he needed to surround himself with public health experts. Their response included mask wearing, a series of 57-hour weekend lockdowns, curfews, stay-at-home orders, and checkpoints. Some of these directives continued for over two years. One response area the Navajo Nations focused on was keeping their people informed, including weekly town hall online sessions. When one non-profit organization helped, they were assigned to assist those individuals in the most rural area of the Nation, the elders. They delivered wood and other needed supplies. This relationship continues. (Becenti, 2022)

The North Dakota Indian Affairs Commission and the American Indian Public Health Resource Center reached out to the Tribes. They worked together to create the Tribal Response Plan COVID-19 State of North Dakota. It was created on April 24, 2020. The Plan was designed to assist tribal governments with testing, screening, assessing healthcare, restricting access to tribal land, and working with state departments and agencies. (North Dakota Indian Affairs and American Indian Public Health Resource Center, 2020)

Tribal Governments and Urban Indian Organizations
in Montana Response to COVID-19 Pandemic

According to Lesa Evers, Tribal Relations Director DPHHS reported a number of actions Tribal Governments in Montana took. (Evers, 2022) They began by recognizing the risk COVID-19 had on their membership and those in their communities. They exercised their tribal sovereignty, very early in the pandemic, by taking the following actions:

- Creating incident command centers
- Closing public offices, clinics, and tribal programs
- Issuing stay at home orders
- Setting up checkpoints
- Instituting mask requirements
- Restricting travel on and off reservations
- Reporting COVID impact numbers locally instead of by reservation or county
- Conducted mass testing events

CDC published a Morbidity and Mortality Weekly Report dated April 2021 that highlighted actions the Blackfeet Nation, including IHS and the Blackfeet Tribal Health

Department, took to reduce the risk of COVID-19 infections during the first year of the pandemic. They strictly enforced a stay-at-home order, social distancing, instituted remote learning through the fall semester, and adopted a mask use resolution. Other actions taken included closing the east gate to Glacier National Park, located on the Reservation. During the holiday season, the Blackfeet Tribal Business Council provided Thanksgiving dinners to every household to reduce trips to the grocery stores. (Pratt et al., 2021) When restrictions were lifted in August 2020, the number of cases increased following the Northwest Montana Fair and Rodeo in Kalispell, MT, and the Labor Day weekend. The Tribal Council reissued the stay-at-home order, with strict enforcement and substantial fines for violation, resulting in a decrease in cases. CDC concluded “the enforcement of stay-at-home orders, coupled with mandate for mask use in public, likely contributed to the reduction in COVID-19 incidence, potentially helping control the pandemic on the Blackfeet Tribal Reservation.” (Pratt et al., 2021)

The Northern Cheyenne Tribe, located in southeastern Montana reached out to CDC for assistance with data management, epidemiological investigations, and surveillance as a part of their COVID-19 pandemic response. CDC responded by sending two CDC staff members. More than 20 tribal staff were trained in data entry and flow, with some tasks being automated. Data was reviewed for accuracy and completeness, resulting in duplicate data being removed and some entries revised or updated. CDC staff created Northern Cheyenne specific dashboards. The dashboards help visualize for tribal leaders the disproportionate affect the COVID-19 pandemic was having on elders and to assist on creating messages to protect the people most at risk. (Kaur et al., 2022)

COVID – 19 Pandemic Impact on AIANs

Throughout the COVID-19 pandemic, “Indigenous communities’ demonstrations of strength offered inspiration for creative, value-driven public health responses.” (O’Keefe & Walls, 2021) In some of the most difficult times, Tribal governments, UIOs, and Indigenous people found ways to honor their cultural and lifeways under the extreme circumstances. Many set aside their own beliefs, fear, and hesitancy to protect the greater tribal/community good. This is exemplified by the high vaccination rates, which include those individuals that got vaccinated, to protect youth, elders, and those with compromised immune systems and pre-existing conditions, even when they held distrust in the government and research community. When they chose to not get vaccinated, some still protected those most vulnerable by honoring social distancing protocols and not attending family/community gatherings.

The most striking impact of the COVID-19 pandemic for AIANs is on overall life expectancy. Until the COVID-19 pandemic, there were consistent gains in Indigenous life expectancy. CDC reported in September 2022 that between 2019 and 2020 AIAN life expectancy fell from 71.8 years to 65.2. The decline represents the removal of the “equivalent of more than four decades” of life expectancy gains. The result is the average AIAN in 2020 can expect to live as long as the average American did in 1944. (Arias et al., 2022) This reduction in life expectancy “exceeded all other major racial/ethnic groups during 2020-2021.” (Goldman et al., 2023)

In Montana, a 2024 report was released by the Department of Public Health and Human Services Office of American Indian Health. It revealed similar disparities. Between 2017 and 2021, there were 4,119 AIAN deaths. The median age at death was 60 for AIAN men, which is

15 years younger than White men. For AIAN women, the median age at death was 64, which is 17 years younger than for White women. (DPHHS Office of American Indian Health, 2024) The leading causes of death for AIANs in Montana between the ages of 0 to 24 is unintentional injury followed by suicide, perinatal conditions, birth defects, homicide, and other causes. For AIANs between 25 to 44 the leading cause of death was unintentional injury, followed by liver disease, suicide, heart disease, homicide, and other causes. In the ages 45 to 64, COVID-19 was the fourth most common cause of death and for ages over 65, it was the third most common cause of death. (DPHHS Office of American Indian Health, 2024)

The long-term impact of the COVID-19 pandemic is still left to be determined. The significant number of elders lost to COVID-19, often the culture keepers, fluent Indigenous language speakers, storytellers and keepers, and matriarchs/patriarchs of families, will not be known for generations. (O’Keefe & Walls, 2021) The unresolved grief held by those that lost loved ones, some losing entire family units or multiple members. (Evers, 2022) The inability to participate in grieving rituals and ceremonies practiced for generations at times of death has plunged many into hopelessness and helplessness. (Mays et al., 2022)

As discussed in the Indigenous Framework Methodology section, data collection regarding AIANs, “the COVID-19 pandemic highlighted the pervasive exclusion of Native Americans people from public health databases and analyses.” (Friedman et al., 2023) It became clear that it would not be possible to fully understand the impact of the COVID-19 pandemic on AIANs, as primary sources of data that would be used either did not publish information on race or ethnicity or omitted AIANs. With the attention to the impact the COVID-19 pandemic was having on AIANs through media sources (Leggat-Barr et al., 2021), public pressure, and lawsuits

forced a shift in data collection. CDC quickly modified their reporting to reflect data equity by publishing race-specific indicators. (Friedman et al., 2023) The availability of accurate and timely data is needed to justify tribal-specific interventions and resources to address the disparities identified in the initial phases of the COVID-19 pandemic. (Hurwitz et al., 2023) While CDC quickly modified AIAN data collection, there continues to exist “an excessive absence of public health data.” (Hatcher, 2020) This is particularly true for the CDC voluntary case surveillance system resulting in missing data for symptoms, underlying health conditions, hospitalizations, intensive care unit admissions, and deaths. This missing data impacts state, local, and tribal governments’ ability to analyze it and then use it to guide successful responses.

The COVID-19 pandemic exposed discriminatory policies. (Furlow, Bryant, 2020) In areas across the US with significant AIAN populations, they were targeted with practices being implemented to stop the spread of COVID-19. For example, a hospital in New Mexico separated AIAN mothers from the newborn babies, depriving them immediate contact, in what appeared to be “racial profiling”. (Furlow, Bryant, 2020) When AIAN mothers presented for services, they were screened for COVID-19, and additional steps were implemented if their addresses matched reservation areas identified on the “Pueblos List” and included all 19 Pueblos located in New Mexico, Mescalero Apache, and area Navajo Nation areas. It was not consistent with any CDC guidelines for screening for COVID-19. It was reported as a standard only applying to AIANs. When the policy was exposed, no justification was available other than living in Indian Country in New Mexico.

While there is significant impact from the COVID-19 pandemic, there was increased risk of abuse, neglect, domestic violence, mental health difficulties, and substance use. (Davis et al.,

2020) “As social distancing drags on, fatality numbers climb and the economic impacts of the pandemic start to take hold of families and expects to see more suicide attempts.” (Reardon, Sara, 2020) The pandemic has opened wounds. In addition, some Tribes experienced an explosion of drug overdose deaths. (Clapsaddle, Annette Saunooke, 2020)

Tribal and UIOs Lessons Learned in Response to COVID-19 Pandemic Literature

With 574 federally recognized Tribes, the response to COVID-19 varied greatly. It is difficult to generalize. Yet, it is essential to gain an understanding of lessons learned to prepare for future emergencies, crises, and pandemics, which will arrive.

Research takes time. It will be some time in the future before there is an academic understanding of the COVID-19 pandemic’s impact on Indigenous communities across the country. In addition, there will be impacts on future generations that cannot be identified now.

Tribes are the best situated to address emergent situations with their members and on their land. Tribal sovereignty allows Tribes to take immediate actions that are in the best interest of their members. Emergency plans need to be adopted by Tribes, which tribal employees and key partners such as counties and states can be engaged and trained for immediate implementation in the time of crisis. During COVID-19, waiting for outside help was a death sentence. (Clapsaddle, Annette Saunooke, 2020)

An important lesson learned for Indian Country going forward is the important of accurate and timely data collection specific for AIANs. It is vital, data reported at national and state levels, and specifically reflect data for AIANs and no other or other categories used in the past. (Friedman et al., 2023) There must be caution that data collected is accurate, to eliminate

possible misrepresentations. Also, the results must be tangible and usable to support improvement in health conditions by tribal communities. It is imperative Indigenous people are engaged throughout the data collection processes to ensure their priorities for data are included and the data is collected in a meaningful manner with respect to tribal data sovereignty.

COVID-19 amplified social and health inequalities for racial and ethnic groups through the disproportionate prevalence, hospitalization, and death they experienced throughout the pandemic. (Ignacio et al., 2023). As the vaccine became available, AIANs expressed hesitancy due to past experience with historical and contemporary research abuses. There was fear of being used as medical test subjects, as was remembered from previous studies and a general mistrust of the medical system that has not served them well in the past. COVID-19 pandemic provided lessons to counter these past exploitations and to recognize and benefit from understanding AIANs gained during the pandemic such as their willingness to get vaccinated, to protect vulnerable family and community members including youth, elders, and those with compromised immune systems, and to fulfill a widespread cultural value to be a good member of the community. To initiate this finding, it is important communication is delivered by trusted messengers including tribal leaders, local health care professionals, respected elders, religious leaders, cultural leaders, and family and friends with a trusted reputation in the health field. As Dr. Don Warne states, “the messenger matters”. (Simpson, Brian W, 2023)

While reservation living by AIANs may have increased the risk for COVID-19 based on many health indicators, it was learned during the pandemic response and recovery there are health-related benefits. These include a strong sense of community and with where there is a strong connection to tribal culture it provides a social supports and ways to reduce psychological

distress. (Leggat-Barr et al., 2021) Dr. Spero Manson articulates in Bringing light to the darkness: COVID-19 and Survivance of American Indians and Alaska Natives article that while there are challenges prevalent for AIANs, there are also “intrinsic strengths and resilience” (Manson & Buchwald, 2021) that are fundamental to resolve public health issues.

An important lesson was learned when COVID-19 AIANs hospitalizations were examined. When a cross-sectional study of US adults was conducted, AIANs were admitted to the hospital at younger ages, died younger, and were more likely to die in the hospital than adults in all other races, regardless of comorbidity burden. There were important public health findings for future pandemics. First, prevention and treatment strategies should be culturally specific. Second, policy changes are needed to address the pervasive and systemic inequalities that permeate the health care system for AIANs. Finally, the AIAN populations must be included in public health reports, data collection, and have access to evidence-based treatments. (Musshafen et al., 2022) These efforts must be prioritized across the federal and state governments to improve health outcomes as COVID-19 recovery continues and for future pandemics. One report recommends the U.S. government take urgent action on seven areas of high priority: (Doshi, Sahir & Kelly, Kate, 2020)

1. Ensure the inclusion of AIAN people in COVID-19 data
2. Develop executive branch infrastructure to address bureaucratic barriers
3. Support the development of tribal economies
4. Address the chronic underfunding of the Indian Health Service system
5. Support the development of Indian Country’s critical infrastructure
6. Support vulnerable populations by funding tribal public safety and justice needs

7. Restore tribal homelands and support tribal ecocultural resource management

It is important to look for strength-based approaches to data collection and identify what are the factors that are promoting health, not just what are the factors leading to disparities. This includes language preservation, cultural connectedness, and participation in ceremonies.

(Simpson, Brian W, 2023)

Stories are told by Indigenous people that must be understood in their entirety. (Hallett et al., 2017a) Storytelling is part of Indian culture and an important part of connecting and building Indigenous relationships. Data tells the story and must be collected respectfully but collected to improve the health and wellbeing of tribal and urban Indian communities and people. This includes mandates for the collection and reporting of information for AIANs by federal and state government agencies, with enforcement incentives and penalties. Modernize the overall public health surveillance system based on lessons from the COVID-19 pandemic. Standardize data collection according to established Office of Management and Budget 1997 standards, which eliminates other or multiracial categories. (Erickson et al., 2021)

There were specific lessons learned regarding the home testing for COVID-19 disease. Home based testing requires some proficiency in information technology and in English. The individuals must have access to internet. In addition, testing instructions and delivery must consider cultural and demographic differences in their development and implementation. (Gregor et al., 2022)

The Confederated Salish and Kootenai Tribes on the Flathead Reservation agreed to participate in a study funded by the National institute of General Medicine. It found most participants desired to protect family members, including youth, elders, and others in their

communities with compromised immune systems. The tribal members interviewed wanted to be good role models. They expressed a sense of responsibility to the community and the Tribe. This included adherence to COVID-19 pandemic protocols such as social distancing, mask wearing, and quarantine and isolation when exposed or diagnosed with COVID-19. (Van Rensburg et al., 2023) Interviews with community advisory board members, associated with this study reiterated the importance of the partnership between the Tribes, county health, and private healthcare providers. While the relationships built were vital in the response, one person said it was “like building a plane, while flying it.” Comprehensive planning prior to an emergency is vitally important.

Based on CDC research at the Blackfeet Nation in Montana, mitigation strategies such as case investigation, contact tracing, enforced stay-at-home orders, and mask use, “likely helped to reduce some of the associated health disparities experienced across Indigenous communities. (Pratt et al., 2021)

Research Needs for Future Preparedness Planning

This literature review revealed gaps in information for future preparedness planning. Foremost, it identified the lack of tribal-specific planning to identify resources accessible to the Tribe. While for some Tribes, a single plan may be adequate but large Tribes may need to have an overall plan, with sections to address specific tribal communities located within the Tribal Nations. Planning will require further refinement to identify resources and key partners for each reservation communities, especially for the large land-based Tribes covering millions of acres, mainly west of the Mississippi River that have many communities located on their reservations, with distinct community values and resources.

The literature review identified the need for key partners in the development of an emergency preparedness plan. While some states drafted Tribal/ state coordination response plans at the onset of the COVID-19 pandemic, each Tribal response plan ought to include details of resources, staff, and expertise that will need to be made available to Tribes and UIOs during an emergency, crisis, or pandemic. The planning must occur before the emergency, crisis, or pandemic begins. The same level of planning and coordination should begin with Tribes and UIOs with the county, city public health systems, private healthcare resources, and non-profits engaged in healthcare where the Tribe or UIO are located.

Another key partner for Tribes and UIOs is IHS since it is the federal agency in HHS to fulfill the US trust responsibility to provide healthcare services to AIANs. Tribes engage with IHS in one of three ways. First, AIANs through their Tribes' decision, receive healthcare directly provided by IHS. The second option is when Tribes' exercise opportunities provided to federally recognized Tribes authorized in Public Law 93-638 Indian Self-Determination and Education Assistance Act, as amended, to contract for services previously provided by IHS. Finally, Tribes have the opportunity to enter into a third type of agreement with IHS, called Self-Governance, where a Tribe enters into a negotiated agreement called a compact with an annual funding agreement with reporting and audit requirement set by the Tribes. Tribes can exercise a combination of all three options, based on their determination of what works best for their members and in affirmation of their tribal sovereignty. Regardless of the mechanism Tribes and IHS engage for healthcare delivery, IHS is a key partner with Tribes for emergency preparedness planning. Additionally, IHS provides the foundational funding for UIOs. IHS must be a key partner in each tribal/UIO emergency preparedness plan.

There are gaps in the literature about the ways Indigenous people will recover from the COVID-19 pandemic. This literature review showed there is extensive information about the devastation the COVID-19 pandemic inflicted on Indigenous people, with documentation about how experiences with past infectious diseases and the SDOH contributed to the overall impact. There is information on how not focusing on healing from past historic events contributes to the ongoing AIAN health inequities. There is very little information about how individuals, families, communities, and Tribes will recover. This is of particular concern for the frontline responders that dealt daily with COVID-19 cases, hospitalizations, and deaths. There is a need for research on Indigenous grief and bereavement, similar to research conducted about Hispanic communities. For example, one study on this topic concluded the need for “research to identify Latino/a groups’ mental health, cultural , social and family needs and how fulfillment of mourning rituals and other cultural factors may promote or impede bereavement adjustment.” (Falzarano et al., 2022) The same is needed for Indigenous communities.

The utilization of CBPR has begun across Indian Country. There is a gap in its utilization and can create challenges and conflicts, especially with the tribal and other institutional review boards. (McCracken, 2020) There continues to be a tremendous need for Indigenous involvement in all research projects concerning AIANs, with navigation through Tribe’s data sovereignty rights and responsibilities, which are as diverse as each Tribe.

This literature review showed the need for research topics identified by Tribes, based on their priorities and needs. It is vitally important to have Indigenous people, familiar with the specific Tribe, to be engaged from the identification of the research topic, throughout the effort, and the analysis of the collected data integrating traditional knowledge, cultural perspectives, and

understandings. These research projects must focus on the five “Rs” that are defined as respect, relevance, reciprocity, responsibility, and relationship. (Hayward et al., 2021) In addition, there is a gap in capacity-building solutions, which can be built into research efforts. (Hayward et al., 2021)

As illustrated in this review of the research literature, there is a critical need for accurate and timely data collection for AIANs. Research further defines the reasons for the current underrepresentation and inaccuracies in data collection for AIANs. The need for information was reinforced during the COVID-19 pandemic and now for recovery. However, solutions to remedy this longstanding need are not available in existing research. Research, using Indigenous methodologies such as the medicine wheel and in conjunction with Tribes and UIOs, should commence.

Preplanning for future emergencies is a need identified throughout this literature review. It begins with rebuilding confidence in the US public health system and highlighting the Tribal and UIOs efforts were identified in research. In a study focused on factors influencing AIANs COVID-19 testing, it was concluded that social, health, and contextual factors were critical in successful prevention strategies, such as testing. There was mistrust in the tests and other aspects of the COVID-19 pandemic. (Van Rensburg et al., 2023) It affirms the gap in information about rebuilding confidence in the US public health system across all segments such as federal and states. While the aforementioned study reported high confidence in local healthcare providers and public health systems, research is needed for planning for future pandemics or other emergencies, whether that is to support testing, vaccines, or other traditional public health functions.

Conclusion

“Our people have been through hardships and they’re still here, and they’ll still be here after this one as well.” Don Wetzel, tribal liaison for the Montana Office of Public Instruction and member of the Blackfeet Tribe, referring to suicide increases after COVID-19. (Reardon, Sara, 2020) “I think if you want to look at resiliency in this country, you look to our Native Americans.”

The COVID-19 brought attention to Indian Country across the US. It showed positive actions and struggles faced by Indigenous people living on reservations and in urban areas. It provides an opportunity for systemic change through the engagement of federal, state, and local partners to move forward. It is an important time to fully examine the lessons learned in the COVID-19 pandemic and plan for the future. If not, history will repeat itself.

This literature review concludes the necessity for systemic changes as a result of the SDOHs and begin to look at ways to evaluate and make change. While improved emergency preparedness plan may improve outcomes in future, change that aligns SDOHs closer to others in the US is required. Following the United Nations acceptance of Indigenous determinants of health to address the unique understanding of Indigenous as a strength, they can guide the recovery from the COVID-19 pandemic and serve as the foundation for planning to respond to future emergencies, crises, and pandemics. It will use Indigenous knowledge, cultural practices, and lifeways and create lasting, long-term change for AIANs in the US.

*There is spirit in your actions.
Language is the distinction.
Elders and youth are all connected.
It is who we are.
It is a way of life.*

*We need to build a bridge of understanding.
It has a spirit.*

*Kevin Kicking Woman
Blackfeet Tribal Member
Missoula, Montana
November 2023*

CHAPTER THREE

PERCEPTIONS AND IMPACT OF THE COVID-19 PANDEMIC
ON SOCIAL, MENTAL, PHYSICAL AND SPIRITUAL
HEALTH OF RURAL WESTERN NATIVE AMERICAN AND
LATINO COMMUNITIES

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Frontiers

Abstract

Objective: To examine social, mental, physical, and spiritual factors influencing decisions to test for COVID-19 among Native Americans on the Flathead Reservation in Montana and the Hispanic community in the Lower Yakima Valley of Washington state.

Methods: We conducted 28 key informant interviews with community and tribal health leaders and 6 focus groups to examine the effects of the onset of the COVID-19 pandemic on well-being in an American Indian and a Hispanic community in rural Montana and Washington state.

Results: As part of the Protect Our Community study, three major themes were identified that were consistent for both communities: (1) The COVID-19 pandemic had significant social, mental, physical, and spiritual impacts on the Native American and the Hispanic individuals, families, and communities involved in our research. It was significant for all ages, especially children and elders. (2) Public health strategies to reduce the spread of COVID-19 disease contributed to sense of isolation, fear, and inability to grieve in accordance with cultural practices; and (3) in a positive sense, highlighted the protective benefit of belonging to a community and adaptability of cultural to respond in a pandemic.

Conclusion: Social, mental, physical, and spiritual factors influence decisions of Native American and Hispanic communities, families, and individual. Understanding these components and incorporating them into future response efforts is vital. COVID-19 pandemic, Native Americans and COVID-19 pandemic, American Indians and COVID-19, Indigenous people and COVID-19 pandemic, Hispanic populations and COVID-19, Hispanic populations, and COVID-19 pandemic

Introduction

In the United States (US), the impact of the COVID-19 pandemic and SARS-CoV-2 infection has disproportionately impacted racial and ethnic minority groups, including high rates of mortality in Native American and Latino communities.(Tai et al., 2021) A cross-sectional study in the US revealed that for young adults into midlife, the Hispanic, non-Hispanic Black, American Indian, or Alaska Native populations had a much higher risk of death from COVID-19 than non-Hispanic Whites.(Bassett et al., 2020) Also in the US, Native American and Hispanic/Latino communities have an estimated 1.6 and 2.0 times higher rate of SARS-CoV-2 infection, and a morbidity rate 2.4 and 2.3 times higher than that of non-Hispanic Whites, respectively. (National Center for Immunization and Respiratory Diseases (U.S.) & United States. Advisory Committee on Immunization Practices., 2021) Similar trends were found at the state level. For example, in Montana (MT) Native Americans represent about 6.2% of the total population,(US Census, 2020b) and accounted for just under 15% of all COVID-19 cases in the state during March through November 2020,(Williamson et al., 2021) while in Washington state (WA) the Hispanic population account for about 13% of the total population,(US Census, 2020c) but represented 29% of all COVID-19 cases as of June 2021.(Latino Center For Health, 2021) In addition to morbidity, the COVID-19 pandemic (herein pandemic) led to many social and economic disruptions nationally, with significant negative impacts on several domains of the social determinants of health.(Abrams & Szeffler, 2020)

COVID-19 impacted numerous factors of health including social, mental, physical, and spiritual. Short-term and prolonged mental health consequences many experienced during the pandemic include panic, anxiety, depression, post-traumatic stress disorders, or disrupted

sleep.(Jakovljevic et al., 2020) Further, existing mental health problems were exacerbated by the pandemic, and many experienced a relapse in disordered eating, substance abuse, or other addictive behaviors.(Nutley et al., 2021; Tsamakis et al., 2021)

Individual case counts of COVID-19 and comorbidities are often incomplete based on race and ethnicity, and Native American and Hispanic communities in particular.(Douglas et al., 2021; Jim et al., 2014; Velasco-Mondragon et al., 2016) In addition to the lack of complete quantitative data, there is inadequate knowledge on *how* these populations were affected and to what extent. There is an urgent need to enhance health equity among Native Americans and Hispanic populations. Understanding people’s lived experiences can inform development of interventions to address COVID-19 sequelae. The purpose of the study was to explore the impact of the COVID-19 pandemic on social, mental, physical, and spiritual health among Native American and Hispanic rural communities to identify culturally grounded strategies to inform current and future preventative health efforts.

Methods

Overview of the Design

This study was part of a larger community-academic partnership study—Protecting Our Communities—that focused on promoting home-based COVID-19 testing in underserved populations.(M. J. Thompson et al., 2022; van Rensburg et al., 2023) The research team was a multi-institutional collaboration and included local community members from each research site in Montana and Washington as co-investigators, project managers, and community health workers (CHWs). All levels of the local community research team provided input and review of the study design and focus group moderator and interview guides. The CHWs conducted key

informant interviews with community leaders and focus groups with community members to understand the impact of the pandemic on social, mental, physical, and spiritual issues in both communities. The research team was engaged with a community advisory board (CAB) in each community that provided guidance for the project. The CAB for the Flathead Reservation consisted of a tribal council member, Salish and Pend d'Oreille and Kootenai Culture Committee leaders, Salish Kootenai College emergency preparedness professional, and health professionals at the tribal, county, and private clinics and hospitals. The Lower Yakima Valley CAB was composed of representatives from community organizations, local health departments, community health centers, and schools.

The Montana State University Institutional Review Board (IRB), University of Washington IRB, and the Salish Kootenai College IRB approved this study prior to implementation. Written informed consent was administered in English or Spanish prior to the focus group or interview. All focus groups and interviews lasted 45-60 minutes, were audio-recorded, and transcribed. Each participant from the key informant interviews and focus groups received a \$25 gift card for their participation. The Salish Kootenai College IRB approved the publication of this manuscript prior to manuscript submission.

Setting

This study was completed in two rural communities: (1) the Flathead Indian Reservation in Montana (herein FR) and (2) the Lower Yakima Valley (herein LYV) in Washington. The two sites were selected due to ongoing partnerships with the study team in addition to their demographic vulnerabilities. Other preliminary research that had been completed at the onset of the pandemic indicated there was a connection between the two communities, with migrant

workers moving back and forth throughout the growing season. Further, there were concerns in both communities regarding the need for culturally responsive and place-based COVID-19 education and testing strategies for Native American and Hispanic populations.(M. J. Thompson et al., 2022)

The FR, located in northwest Montana, is home to three Tribes, the Bitterroot Salish, the Upper Pend d'Oreille, and the Kootenai Tribes. The reservation boundary includes land in four counties, and about 1.3 million acres (526,000 hectares) of forest and woodland systems, grassland systems, alpine systems, and human land-use systems including agriculture(CSKT, 2013; Montana Natural Heritage Program, n.d.). The FR also includes a swath of the Rocky Mountains, the southern half of Flathead Lake, with streams, rivers, lakes and numerous species of fish, wildlife and wild plants.(CSKT, 2013; Smith et al., 2019) The FR community is primarily rural with a population estimated at 30,849.(US Census, 2020a) While FR is a federally recognized reservation, the population is largely non-native (about 75%), reflected in the population statistics in Table 1.(US Census, 2020a)

The LYV is comprised of over 175,000 acres(Department of Ecology, n.d.) and includes Sunnyside, Grandview, Prosser, Granger, Outlook, and Mabton, among other smaller agricultural communities.(Greater Yakima Chamber of Commerce, n.d.) Many Hispanics in the area work in the agricultural industry, including farm work, packing warehouses, and other related work.(CITE) Some migrant workers move frequently between the LYV and the FR to harvest crops seasonally.

Table 1. Demographic characteristics of each site area. (Source: US Census)

Demographic estimates	Flathead Reservation	Lower Yakima Valley*
Population	30,849	39,509
American Indian and Alaska Native, alone	25%	0.5%
Hispanic or Latino (of any race)	4%	82.7%
Median household income	\$50,352	\$50,600
Poverty rate	20.2%	17.1%
Without Healthcare coverage	14.5%	17.6%

*Lower Yakima Valley includes a summary of population statistics from Sunnyside, Grandview, Prosser, Granger, Outlook, and Mabton, WA.

Participants

We used purposive sampling to recruit key informants and focus group participants. Detailed descriptions of the recruitment, retention, and interview process are documented in a coinciding published manuscript.(van Rensburg et al., 2023) Key informant interviews were conducted with trusted members of the community and public health professionals with a total of 28 t interviews analyzed; 13 from the FR community and 15 from the LYV community. Focus group participants comprised community members who lived and/or worked in one of the two rural communities. Six focus groups were convened (three from the FR and three from the LYV community) moderated by the local research team. In the FR community, 21 participants completed one of the three focus group discussions. In the LYV, 19 participants completed one of the three focus groups; eight participated in one focus group conducted in English, and eight and five participants, respectively, participated in the other two focus groups conducted in Spanish.

Data Analysis: Key Informant Interview and Focus Group Data

The interview and focus group moderator guides were designed to understand the consequences of the pandemic on social, mental, physical, and spiritual health. Two theoretical

frameworks informed development of the guides and include Social Cognitive Theory(Bandura, 2002) and Socio-Context Framework.(Burke et al., 2009; Pasick et al., 2009) The local research team at each site reviewed questions and revised the guide as appropriate. A more detailed description can be found in van Rensburg et al (2023).(van Rensburg et al., 2023) The three primary open-ended questions were asked in both the key informant interviews and focus group discussions: (1) “How has COVID-19 affected your family’s dynamics (adult to adult and adult and children)?”; (2) “How has COVID-19 affected your family’s ability to get food, your finances, and your ability to secure housing?”; and (3) “How has social isolation and community containment affected your family’s mental and physical well-being? What about your children?”.

Our analysis team included multiple members of the research team. First, two research team members (LKK and JW) created a tentative codebook using the interview and focus group guide. The codebook was used by three data analysts (JW, TQ, HYC) to conduct deductive coding to tentatively identify codes, followed by an inductive, constant comparison approach, where concepts and major themes were identified from interview and focus group data.(Miles et al., 2019) For more details describing this iterative process, please see van Rensburg et al (2023).(van Rensburg et al., 2023) The data was coded using the coding software ‘Dedoose’ version 9.0.62. Following the identification of major themes, findings were presented to members of the LYV and FR CABs for validation of concepts. Next, a member of the local research community reviewed the key informant and focus group excerpts for additional thematic analysis through an indigenous lens to further investigate and discover culturally-grounded interpretations and sub-themes from a place-based context.(Braun & Clarke, 2021; Hallett et al., 2017b) Using the two-phase process, we began to explore the social, mental,

physical, and spiritual impact on the health as portrayed by the participants in the key informant interviews and focus groups. We reviewed the key informant interviews and focus group responses to find culturally grounded approaches in which the individuals provided in their answers to the questions posed by the CHWs. Themes were presented to the FR and LYV CABs to validate final themes and findings.

Results

Summary

As a whole, the majority of focus group and key informant participants were female (~75%) and just under one-quarter identified as White. Demographic statistics are reported in Table 1 of van Rensburg et al (2023).(van Rensburg et al., 2023) Eight themes were identified which applied to the FR and the LYV. A brief description of each theme, key findings, and FR and LYV participant quotes are provided in Table 2. When aspects of the theme applied to one community, we relate specific aspects of the theme as it pertains to each respective community. Participants shared positive outcomes to the COVID-19 pandemic, in addition to some challenges which are presented under each theme when reported by participants.

Theme 1 – Reaction to Governments Responses

Participants commented on the federal, state, local, and tribal governments responses to the COVID-19 pandemic. The FR and the LYV participants shared there were mixed, and sometimes conflicting, messages provided around COVID-19 testing and vaccination by governmental entities. Participants in both communities expressed these contradictions contributed to their existing mistrust and fear of government officials. However, both

communities' expressed confidence in local and tribal health officials. This trust extended to health care providers when they had established relationships with the participants. LYV participants shared this trust crossed over to school districts that had built trusting relationships with LYV parents. Several participants mentioned that tribal and local governments had effectively collaborated to protect the community and distribute COVID-19 vaccines and expressed gratitude to Confederated Salish and Kootenai Tribal government (FR community) for the efficient operation of vaccine clinics.

Theme 2 – Connection to Land

Participants reflected on the value of being outdoors in response to the COVID-19 shelter-at-home and quarantine requirements. FR and LYV community members handled their feelings of isolation and anxiety by getting out of the house, safely connecting with others, taking walks around the neighborhood, or finding places to hike. While many of the participants responses reflected negative impacts of the COVID-19 pandemic, the acknowledgement of being outdoors and connecting to significant sites is noted as a positive reaction to COVID-19 pandemic. Being outdoors restored a connection to land, where it was safe to gather. A FR participant expressed the importance of finding time and ways to get to Flathead Lake and Mission Mountain trails, key FR natural landmarks with relationship to the FR residents' connection to the reservation land. This sentiment is a commonly shared and significant cultural value among many indigenous cultures.(Mussi, 2023)

Theme 3 – Connection to Family and Community

Most participants from both communities conveyed changes in their daily lives and lessons learned about their relationship to their extended family and larger community. They

acknowledged strong ties to their families and the larger community, and the harmful impacts of being separated from them during the COVID-19 pandemic. Many reported the challenges of coping with cancelled family gatherings, lost opportunities to celebrate, and not seeing loved ones in person for extended periods of time. They acknowledged these changes in day-to-day routines related to social distancing, virtual learning, and work-from-home policies resulted in newfound stress and heightened tension between family members. This newfound stress and tension stretched to those with very different levels of risk aversion and COVID-19 safety adherence or with family members who worked in high-exposure settings such as hospitals, grocery stores, and other essential work. Some participants described the creation of new, positive family routines, like game nights or video calls to stay in touch with loved ones.

Theme 4 – Impact on Youth

Participants noticed changes in their children's mental health and emotional wellbeing. Parents reported academic struggles that had not existed before the pandemic. One participant, who works at a local school, said that they had observed increasing anxiety among school children. Other participants noted that the pandemic illustrated the importance of their children's social development and the connection between socializing, mental health, and day-to-day positive outlook.

The LYV community reported limited childcare for essential workers. They expressed worry about children being left alone when school transitioned to home schooling and parents were required to report to work. The FR expressed concern about youth not being at school and kids wanting social interaction. Parents worried about the untold future consequences they faced

and how it would affect the rest of their lives. Participants expressed concern about the struggle children experienced when they returned to school after home schooling.

Theme 5 – Cultural Impact

Participants from both communities emphasized the impact of the COVID-19 pandemic had on Native American and Hispanic cultural ways and practices. While their cultural practices are unique, the lack of opportunity for participants to attend cultural events was similar for FR and LYV. Several participants discussed how COVID-19 had disrupted in-person cultural practices, gatherings, community events or activities, religious or spiritual events, and schooling, which are key for participants' well-being. These themes were further elaborated on during validation by the LYV CAB members who described the tremendous loss of not being able to attend church regularly or during times of significance in their religious practice and key to their culture. FR participants shared about the interruption and disruption of cultural events as they were cancelled. They specifically stated the loss was felt with the cancellation of cultural winter dances. They also shared the loss was felt not being able to participate in traditional stick games, dancing at celebrations/pow wows, or collecting culturally significant foods together.

Perhaps the most significant expression shared by participants was the sadness felt by individuals, family members, and the overall community when someone they loved was diagnosed with the COVID-19 virus and had to be left, alone, at hospitals. They shared the loss they felt when they could not sit and hold someone's hand when they were dying. Ultimately, they shared they continue to have extended grief since traditional and cultural ways of dealing with death were canceled, postponed, or changed to keep others safe from contracting the virus.

Theme 6 – Food Security

Participants feared not having enough food and other home necessities. They shared the need for increased food as children remained at home without access to school breakfast and lunch programs. They shared the fear of going to the grocery store and contacting COVID-19. They also shared that fear occurred when grocery shelves were empty, which led to over purchasing to ensure food and other supplies were available when needed. The increased cost of food was a major contributor to increased food insecurity. In addition to the availability of food products, having COVID-19-safe transportation and grocery stores observing COVID-19 safety protocols for all consumers were expressed as concerns by participants.

A positive aspect of food security shared by participants was the generosity of community members or community-based organizations who mobilized to support local families or tribal elders, with needed food, other resources, and necessary services. Some stated that food donations and deliveries to families were quite common in their community, suggesting that these efforts gave them pride in their community and hoped this spirit of togetherness continued after the pandemic. FR participants expressed pride in belonging to the Tribe.

Theme 7 – Financial Impact

Participants reported intensified stress for employment, increased living expenses, and other financial obligations. The LYV CAB reported tremendous impact on essential workers, who were worried about getting COVID-19, forcing them to miss work and possibly being fired. This concern was said to have been exacerbated since some could not “affirm their immigration status with different employers” which could have a long-term impact on their future employment. They also reported other employees would “belittle” and accuse others of “fibbing”

if they reported testing positive with the COVID-19 virus. They reported essential workers were told to “man up” if they reported being sick. Another area of concern expressed by LYV CAB members was the previous federal administration’s position on immigration reinforced reluctance to seek medical assistance for COVID-19 illness. It also unfairly blamed immigrants for bringing the virus from other countries.

Participants described the COVID-19 pandemic programs that had positively impacted their finances. These programs were administered across multiple government agencies, including the federal, state, local, tribal, and public and tribal health offices. Participants spoke favorably of increased SNAP benefits such as ‘PEBT’ and other government benefits throughout the pandemic, and some suggested their financial situations were better during the COVID-19 pandemic than before it.

Theme 8 – Mental Health Challenges

The participants reported that existing mental health challenges were exacerbated by the pandemic. Several participants described experiencing increased feelings of isolation, anxiety, and depression as they tried to remain safe during the COVID-19 pandemic. Participants described experiencing heightened levels of stress. One notable stressor was concern about older or more vulnerable family members having to work in unsafe conditions to provide for the household.

Participants focused their discussions on the Pandemic’s impact on their mental and emotional well-being, the social and psychological challenges, and the negative impact on their physical health. Pandemic-induced lifestyle changes such as working from home, staying at home more, and increased reliance on technology, were reported to impact participant activity

levels and physical health. However, positively participants mentioned that the pandemic had compelled them to seek out physical activity and exercise more often as a tool for coping. In addition, participants found different ways to connect to support systems and medical professionals, including virtual options.

Table 2. Key Themes

Key findings	Quote
Theme 1: Reaction to governments responses Messages about COVID-19 testing and vaccination from federal, state, local, and tribal governments were mixed and sometimes conflicting.	
a. Governmental contradictions contributed to their existing mistrust and fear of government officials b. Communication about the COVID-19 pandemic became a controversial, political issue at the federal and state government level, which diminished the opportunity for dialogue and increased isolation and separation c. Confidence existed for local or tribal health officials and health care providers when they have an established relationship with the participants d. LYV participants trusted school districts officials that had built trusting relationships with LYV parents e. FR participants shared tribal and local governments had effectively collaborated to protect the community and distribute COVID-19 vaccines	<i>“One group has half the people thinking federal government last year was handling things just fine, the state should stay out of their business. And then half the group was like the state is doing great and the federal government is killing everybody.... And it seems to be creating some tension between people who view the response from two different camps.” LYV</i>
Theme 2: Connection to land Value identified for being outdoors in response to the COVID-19 shelter-at-home and quarantine requirements	
a. Being outdoors restored a connection to land, where it was safe to be together. b. Relief from the heightened family tensions of being together inside came from being outside c. Relief for feeling isolated from others, was a coping mechanism d. Getting outside provided a way to safely connect with others by taking walks around the neighborhood	<i>“... But if I could take her to the playground and there were two or three children there, she would be just enraptured, looking at other children” LYV</i> <i>“Uh, when it was like spring time we went outside. I took them to the river. I took them to the park. Different places where it was secure to – safe to go without being in a risk of, um, getting the COVID-19.” LYV</i> <i>“And so the feelings of exclusion is a side side effect of of covid and having restrictions on our community to socialize with our people, especially around those things, like I talked about earlier, you know, digging and berry picking, getting medicinal plants and those kinds of things. And some of those some of those things are are meant to be done, a lot of them, with your fellow people. When I think about camas and the camas making, camas take, that's a that's a a role for women. It's a time for women to be together. [interruption] But I just feel like it's it's it's an impact for sure. And it it does take it does impact our wellbeing and our our mental health, our spiritual health and our physicality.” FR</i>

Table 2 Continued

Key findings	Quote
Theme 3: Connection to family and community Significant impact the COVID-19 pandemic had on their connection to family and community as a result of the shelter in place, numbers allowed to gather, and social distancing requirements.	
a. Participants affirmed the important connections they had to their extended families, communities, and for the FR participants, the Tribes. b. Participants reported emotional challenges from the cancellation of events such as graduations, birthday parties, and family dinners c. Gathering with family for long periods of time, such as dinners d. Participants described creating new family routines for spending time together like game nights or using video calls to stay in touch with loved ones. e. Acknowledged changes in day-to-day routines related to social distancing, virtual learning, and work-from-home policies resulted in newfound stress and heightened tension between family members.	<i>"I don't think we understood the importance of interaction until COVID hit."</i> FR <i>"This isn't who we are. We aren't people who stay at home and keep to ourselves. My kids dance at pow wows and play stick game. It is hard to not be together."</i> FR <i>"Everyone spent the holidays at their own house with their own families.... we're a really close family."</i> LYV <i>"We missed hosting quinceañera (a Hispanic/Latino tradition to recognize a girl's fifteenth birthday and change in their status with their family and larger community) a culturally important event for our families and communities."</i> LYV CAB
Theme 4: Impact on youth Participants noticed changes in their children's mental health, emotional wellbeing, and academic struggles	
a. One participant, who works at a local school, suggested that they had observed more and more anxiety among school children. b. Other participants noted that the pandemic had illustrated the importance of their children's social development and the connection between socializing, mental health, and day-to-day positive outlook c. The LYV community reported limited childcare for essential workers. They expressed worry about children being left alone when school transitioned to home and parents were required to report to work d. Worried about the untold future consequences	<i>"I would say for me, it affected my children by not having that interaction with other kids, but other than that, our physical well-being. It just kind of made us start working out more, doing more physical activities."</i> FR <i>"Um, you know, I had a niece that she was really good in school and having good grades. But as soon as COVID hit where she had to do everything online, her grades started deteriorating and going down. And, you know, she just shared her frustration of, you know, always playing catch-up to complete her work, where they didn't have a teacher that was, you know, with their – before, they were going to school and they had a teacher. This time, it was a teacher would basically just be available by email. But they were just basically given packets to do. So, in a way, they felt that they were learning on their own, um, and not have the, the tools and the instruction that they needed to be successful."</i> LYV

Table 2 Continued

Key findings	Quote
Theme 5: Cultural Impact COVID-19 disrupted in-person socializing and gatherings, community events or activities, religious or spiritual events	
a. Not being to attend church on Sundays was a big loss for the LYV b. The FR participants expressed interruption and disruption of cultural events c. According to FR participants, activities are meant to be done in groups and are times to bring communities together, and this was prohibited d. Ceremonies were put on hold, which are conducted to protect children, elders, and those with compromised immune systems e. CAB members shared the devastating impact on community members not being able to be with family members hospitalized with COVID-19 or when they died f. There are untold consequences in not participating in the burial rituals.	<i>"Our whole culture is based on relationships. During COVID, we missed cultural events like wintertime dances, and we need that time to be in prayer and to set our year straight." FR</i> <i>"our tribal and cultural leaders were super strict allowing only small groups, which made other feel excluded." FR</i> <i>"There is a tradition of going to the hospital with family members and they could not go. We could not do our traditional burials. There is a very deep mental health impact with the loss of a loved one and there was not a time for mourning according to our traditions." LYV CAB</i>
Theme 6: Food security Participants shared the fear of being without enough food and other home necessities.	
a. a. Increased need for food as children since not in school with breakfast and lunch programs b. fear of leaving home to go to grocery stores that might not be practicing COVID-19 safety guidelines c. Grocery shelves were empty, which lead to over purchasing food and other supplies when they were available d. Increased food costs e. Acknowledged the generosity of community members, community-based organizations, and the Tribes to support local families or tribal elders, who needed food, other resources, and necessary services.	<i>"So right before they were considering closing things down I'm like oh we better go get some food 'cause we were out of food. Went to the store and there was nothing. There was like hardly any food on the shelves. There was fresh vegetables but there was no rice. There was no pasta, no cereals, no beans. I mean nothing that was shelf stable whatsoever on the shelves and I'm like are you kidding me?" LYV</i> <i>"It was a beautiful thing the community coming together, including the delivery of food boxes to families and elders." FR</i> <i>"I tell you, we were lucky when it came to that. Um, not really. We were able to go to the store. ... we got groceries here at the food bank. Um, and for the summer, we kind of grow a garden." LYV</i>

Table 2 Continued

Key findings	Quote
Theme 7: Financial Impact Heightened stress due to changing work obligations, financial challenges including employment, housing, food, or household staples, and concurrently some pandemic-focused government programs increased, providing some relief	
a. Essential workers worried about missing work and being terminated from their positions if they tested positive for COVID-19. b. Essential workers needed to maintain their work due to untended consequences based on immigration status, especially in the previous federal administration c. Blame by some that immigrants were bring the virus to the United States d. Positive, unexpected consequences during the pandemic when community members, neighbors, or family shared their resources e. Increased government income-based programs at the federal, state, local, and tribal levels, including SNAP and Medicaid benefits	<i>"The pandemic has cost me extra money because of the cost for wood supplies. We are about out of construction supplies, wood, stuff like this... even electrical, plumbing."</i> FR <i>"I think there were some unsettling times of, you know, we were furloughed a day during the pandemic, beginning of the pandemic, because of our hospital's financial situation. I can't remember what month, but it was maybe three or four, five months that we were furloughed for one day a week, at least in my business."</i> LYV <i>"I live in the [TOWN] community, and I find it very nice because we're very close. Now I'm in a group of strong women supporting women. We've seen that families have become ill and we cooperate. I think we're now around 20. We cooperate with each other carrying rice and beans when the family gets sick. We make a basket and leave it at the door of the house. We just knock on the door, and they look at us through the window, 'Thank you.' We're going to support families that are sick, infected, and unable to leave for about 2 weeks."</i> LYV
Theme 8: Mental Health Impact Increased feelings of depression, lack of motivation because of the pandemic, and typically focused their discussions on the impact of the pandemic on their mental and emotional well-being, social and psychological physical health challenges.	
a. Increased feelings of isolation, anxiety, and depression trying to stay safe b. Heightened levels of stress due to COVID-19 pandemic challenges, such as keeping children and elders safe that may be in the household c. Compelled to seek out physical activity and exercise more often as a tool for coping d. Found different ways to connect to support systems, including virtual options	<i>"COVID will be like how 9/11 impacted our lives. Common but different experiences. It will be interesting to watch over time."</i> FR <i>"Um, so, yeah, I think it is something that, um, especially the – the social distancing, the isolating from other family members and friends, did affect, uh, their mental health a bit. Um, you know, more, um, I'm not sure how to explain this, but there were definitely times where, uh, you know, we – we were tired of quarantining and there was just this, um, annoyance with COVID-19 and not being able to go back to the activities that we enjoyed. Um, so I – I would say that there was definitely an impact on – on their mental health due to the pandemic."</i> LYV

Each of the eight themes is identified, followed by theme description, key findings (left column), and participant quotes (right column) with community site designated as 'FR' for the Flathead Reservation, or 'LYV' for the Lower Yakima Valley community.

Discussion

The COVID-19 pandemic had significant social, mental, physical, and spiritual impacts on the Native American and the Hispanic individuals, families, and communities involved in our research. It was significant for all ages, especially children and elders. COVID-19 resulted in disruption to both communities financially, which was particularly evidenced in the LYV. However, both communities reported increased access and benefits from federal and state government programs, which eased the burden and fear they felt during these extremely uncertain times of COVID-19 illness and death. They also shared an increased sense of belonging as the communities responded to meet the needs of their neighbors and tribal members by sharing food and other resources. The protective benefit of community on well-being is similar to findings from Burnett et al (2022), where community belonging was associated with positive mental health outcomes.(Burnett et al., 2022)

The separation from extended family and the larger community and Tribes for the FR participants was significant, especially when loved ones were hospitalized and family members were not able to be with them as is the tradition for both the FR and LYV. This separation was exacerbated if the loved one died alone. Since traditional grieving rituals were prohibited to comply with COVID-19 safety protocols, participants expressed on-going guilt and unresolved grief.

Participants recognized, because of the COVID-19 pandemic, the importance of gathering with extended families for birthday celebrations and graduations from Head Start to high school and college, and important cultural rituals, and ceremonies. While Native American

and Hispanic families found safe ways to gather and adapt their traditional cultural ways, it was difficult.

With limited exception surrounding essential workers and immigration status, the two communities shared similar experiences across the social, mental, physical, and spiritual characteristics of their well-being and that of their families and communities. These similarities may reflect that both the FR and the LYV are similar as Indigenous people having existed in North American from the earliest of time and before the arrival of the colonists. (Merriam-Webster Inc, n.d.)

Strengths and Limitations

The selection of the FR and the LYV to participate in this research resulted in a primary strength of the overall investigation as the common findings between the two communities were significant and can be used to plan for future emergencies, crises, and pandemics. There is limited knowledge around the similarities between the two populations. Since both communities are in the western United States, the applicability of findings may be limited. Similarly, females were overrepresented in the key informant and focus group interviews and may not reflect Indigenous and Hispanic male perspectives.

Conclusion

As recovery from the COVID-19 pandemic continues, it is vitally important to recognize the devastating and disproportionate impact on Native American and Hispanic people and communities. The overwhelming harm experienced, with the high rates of illness and loss of life, needs to be acknowledged and culturally grounded ways to accommodate grief found. Without

proactive measures, the trauma will linger and manifest in other, destructive ways, such as increased substance abuse, violence, and suicide.

The economic reality for many, in these communities, is a reliance on governmental income-based programs for basic necessities such as food and access to health care. When these programs were expanded to include others during the pandemic, they noticeably improved lives. As these programs scale back, consideration must be made to define basic standards for our children, families, and communities.

While there were many negative consequences of the pandemic there were also positive outcomes including increased ways for families to connect virtually and increased community support for neighbors fostering a shared sense of belonging. The information gained through this research needs to be returned to Indigenous and Hispanic rural communities to be used to prepare for future emergencies, crises, or pandemics. With its use, planning can occur and hopefully limit the devastation that occurred the COVID-19 pandemic. .

Conflict of Interest

The authors declare that the research was conducted in the absence of any commercial or financial relationships that could be construed as a potential conflict of interest.

Author Contributions

AWS, TW, and AA contributed to the data analysis, interpretation of the data, manuscript development, and revision. AA, LG, VD, and PD contributed to the conceptualization and the design of the study. TQ contributed to the data analysis, data interpretation, manuscript development, and revision of the manuscript. LK contributed to the conceptualization and the

design of the study, data analysis data interpretation, manuscript development, and revision. AWS and TW contributed to data interpretation and revision of the manuscript. All authors contributed to critical revision of the manuscript for important intellectual content and have approved the current version.

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CHAPTER FOUR

RESPONSE AND RECOVERY BY TRIBES AND URBAN
INDIAN ORGANIZATIONS IN MONTANA: INDIGENOUS
STRATEGIC PLANNING PROCESS TO CREATE
EMERGENCY PREPAREDNESS PLANS

Abstract

Research shows American Indians and Alaska Natives' resilience, when they are connected to cultural lifeways, beliefs, and in relationship with families, their communities, and their Tribe. This connection is a protective factor in traumatic times. This was true during the COVID-19 pandemic. Yet, it disproportionately affected AIANs in the number of cases, hospitalizations, stays in intensive care units, deaths, and at younger ages than non-Hispanic Whites. This unequal impact of COVID-19 may be explained using the Center for Disease Control and Prevention's social determinants of health, but also raises doubt on the accuracy and thoroughness of data collected for AIANs. Additionally, when Tribes and urban Indian organizations responded to meet the needs of their members and communities, there were positive outcomes. This study shows that the lessons learned from the response and recovery efforts, led by Tribes and Urban Indian Organizations, while successful, may have been improved if their actions were guided by a Tribal and UIO specific comprehensive emergency preparedness plan. These plans must be written by the Tribe or UIO and incorporate tribal lifeways, beliefs, and values, and shared with key stakeholders. While there are templates available to meet federal and state government emergency preparedness plan requirements, it is

equally important for the Tribe or UIO to include their specific resources, based on a cultural foundation. This research makes this shift using an Indigenous strategic planning process each Tribe or UIO may implement to embed their specific information in their emergency preparedness plan for use in future emergencies, crises, and pandemics. It uses an Indigenous icon, the medicine wheel, as a guide. Its use makes sure their plans account for a comprehensive set of characteristics reflective of the whole Tribe, community, family, and individual. It directs a response established and understood by them and those who will benefit from the plan.

Introduction

The COVID-19¹ pandemic is not the first pandemic or disease to have disproportionate impact on American Indians and Alaska Natives (AIANs). “Historians have long noted that Europeans brought smallpox, measles, and other diseases that were previously unknown in the New World.” (Connolly et al., 2021) While Indigenous populations experienced disease prior to the European arrival, “colonization made matters worse.” (Jones, 2006) The devastation endured by Indigenous people at early contact did not end as time passed. The 1918-1919 flu pandemic and the 2009 Flu H1N1 pandemic had disproportionate impact, as did “outbreaks of other diseases including tuberculosis, hantavirus, and even bubonic plague.” (Jones, 2006)

AIANs in the United States (US) accounted for an uneven share of COVID-19 cases and death. The US Department of Health and Human Services (HHS) Center for Disease Control and Prevention (CDC) reported, according to data collected as of December 2, 2020, laboratory

¹ The SARS-CoV-2 variant continuously evolves. Throughout the COVID-19, there were many variants of the SARS-CoV-2 virus, although all variants have been commonly referred to as COVID-19 pandemic. (CDC, 2020)

confirmed COVID-19 cases for AIANs were 3.5 times higher than for Whites. (Arrazola, 2020; Hatcher, 2020) In 14 states with significant AIAN populations, the death rate from COVID-19 was 1.8 percent higher for AIANs when compared to Whites. (Arrazola, 2020)

The uneven impact on AIANs in the US was more evident in Montana. “Between March and October 2020, AIAN residents accounted for 19 percent of COVID-19 cases and 32 percent of associated deaths.” (DPHHS Office of Epidemiology and Scientific Support, 2020) In addition, the same report concluded AIAN residents were almost 3 times more likely to acquire COVID-19 and twelve-times more likely to die when compared to other Montanans. A Brookings Institute’s report using CDC data found, “in Montana 3.8 percent of all American Indians 75-84 and 4.6 percent of those 85 and older have died of COVID-19.” (Akee & Reber, 2021)

While the COVID-19 pandemic took a devastating toll on Tribal communities, there are important lessons to use in preparation and response to future pandemics. The most fundamental of which is that “Tribal sovereignty and cultural and community strength and resiliency play...’a’ positive role.” (Connolly et al., 2021) For example through the exercise of Tribal sovereignty, some of the 574 federally recognized Tribes “were able to react quickly and effectively.” (Saul et al., 2020) This quick action “saved lives in Indian Country.” (Florey, Katherine, 2021) The Tribes in Montana used their Tribal sovereignty to respond early and quickly to COVID-19, when there was not a national response strategy. (Connolly et al., 2021)

Montana is the fourth largest state in the US, with 147,040 square miles. The landscape is diverse with the eastern side of the state characterized by prairies and grasslands, and the western side the most northern sections of the Rocky Mountains and forested land. There are three types

of areas: frontier², rural, and urban areas that influence the type, amount, and access to resources and healthcare. This diversity is reflected in the Tribal homelands.

The Montana Department of Public Health and Human Services (DPHHS) was charged with a key role in Montana's COVID-19 response, including engagement with the Tribes and Urban Indian Organizations (UIOs) in Montana (MT). There are eight tribal governments in Montana. The name of their government and locations are as follows in alphabetical order:

1. Blackfeet Tribal Business Council (located on the Blackfeet Reservation)
2. Chippewa Cree Business Committee (located on the Chippewa Cree Rocky Boy Reservation)
3. Confederated Salish and Kootenai Tribal Council (located on the Flathead Reservation)
4. Crow Executive Branch (located on the Crow Reservation)
5. Fort Belknap Indian Community Council (located on the Fort Belknap Indian Reservation)
6. Fort Peck Assiniboine and Sioux Tribal Executive Board (located on the Fort Peck Reservation)
7. Little Shell Tribe of Chippewa Indians in Montana (no reservation with their headquarters in Great Falls, MT)

² Frontier area are the most remote and sparsely populated places along the rural and urban continuum. In Frontier designated areas it is a long distance to healthcare, schools, grocery stores, and other. (*Health and Healthcare in Frontier Areas Overview: Rural Health Information Hub*, 2023)

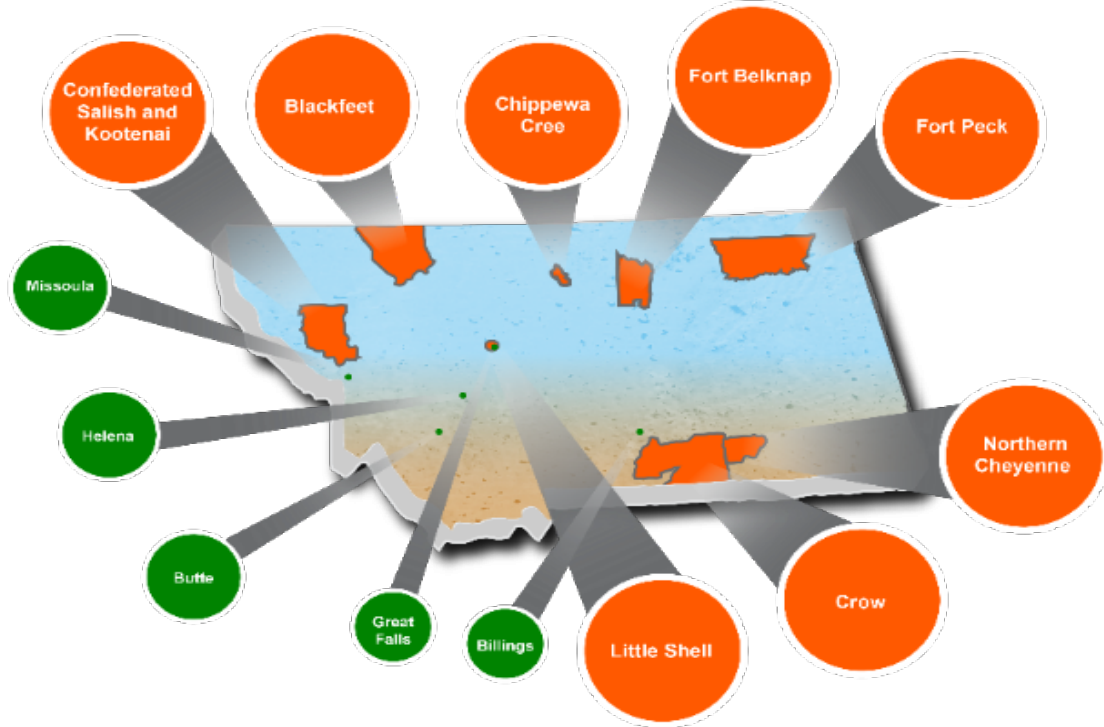
8. Northern Cheyenne Tribal Council (located on the Northern Cheyenne Reservation)

There are five Urban Indian Organizations, as determined by receipt of funding for the IHS authorized in the Indian Health Care Improvement Act – Title V. They are listed below in alphabetical order:

1. All Nations Health Center (located in Missoula, MT)
2. Billings Urban Indian Health and Wellness Center (located in Billings, MT)
3. Butte Native Wellness Center (located in Butte, MT)
4. Great Falls Indian Family Health Clinic (located in Great Falls, MT)
5. Helena Indian Alliance (Helena, MT)

The Figure 1 is a Montana map, created for the Montana Crisis Recovery Program by Kauffman & Associates in 2021.

Figure 1: Tribal Homelands and Urban Indian Organizations in Montana



According to Lesa Evers, DPHHS Tribal Relations Director, tribal governments in Montana took a number of actions during the pandemic. (Evers, 2022) They began by recognizing the risk COVID-19 had on their membership and those in their communities. They exercised their tribal sovereignty, very early in the pandemic, by taking the following actions:

- Creating incident command centers
- Closing public offices, clinics, and tribal programs
- Issuing stay at home orders
- Setting up checkpoints
- Instituting mask requirements
- Restricting travel on and off reservation
- Reporting COVID impact numbers locally instead of by reservation or county

- Conducting mass testing events

As described in the Literature Review, CDC reported on the COVID-19 pandemic response by the Blackfeet and the Northern Cheyenne Nations. CDC described the Blackfeet Nation's response as to strictly enforced stay-at-home orders, social distancing, instituted remote learning in public schools, mask use, and closed the east gate to Glacier National Park, that is located on the Reservation. (Pratt et al., 2021) The Blackfeet Tribal Business Council stayed the course and reissued orders and restrictions when the COVID-19 rate increased at separate times during the pandemic.

CDC responded to a request from the Northern Cheyenne Tribe to assist with data management, epidemiological investigations, and surveillance as a part of their COVID-19 pandemic response. CDC sent staff to train tribal staff on data entry and flow. They reviewed to ensure accuracy and that the data collected was not duplicative. CDC created COVID-19 pandemic dashboards , which demonstrated the disproportionate affect the COVID-19 pandemic was having on elders and to assist in the creation of public awareness messages to protect the people most at risk. (Kaur et al., 2022)

Based on the literature review conducted as another product within this dissertation, there are gaps in the existing research. It concluded there is a need for strength-based research on the resilience of AIANs that have survived, and thrived, through hundreds of years of experiencing health inequities, which results in years younger life expectancy when compared to non-Hispanic Whites. It further concluded that for a true understanding of health equity, there must be improved data collection and analysis conducted by Indigenous scholars. (Kimmerer & Artelle, 2024) Data collection must accurately account for Indigenous populations, regardless of who

collects and the analysis occurring through an Indigenous lens. It further identified the need to relook at the CDC's social determinants of health by including the United Nations (UN) Indigenous health determinants. Finally, Tribes and UIOs are commended for their COVID-19 pandemic responses, future responses could be improved through the creation and implementation of tribal and UIO specific emergency preparedness plans based on their resources and culture.

The literature review identified a clear need for emergency preparedness plans. The plans must be specific for each Tribe or UIO. This becomes particularly important as each Tribe's government authority differs. Factors considered in planning are the size of the Tribe, land base of Tribe, the primary access to health care including the role of Indian Health Service (IHS) and other healthcare providers located within the exterior reservation boundaries, and cultural ways such as language, spiritual opportunities, customs, and practices. The creation of emergency preparedness plans will be essential to rebuild confidence in the public health systems, including those in Indian Country. (Van Rensburg et al., 2023)

It is also clear, there must be concentrated attention to address the tremendous amount of grief in Tribal communities. The grief is on many levels such as individual, across families, multiple tribal communities, and the entire Tribe. It is not exclusively from the loss of life, which would be massive, but is also from the impact of the shutdown of schools, lack of preventive health care when the focus turned to COVID-19 patients, inability to gather for cultural rituals, and so much more.

Purpose

Each Tribe and UIO is different, with unique strengths and challenges. Each entity has distinctive resources, governmental authorities located on their land, funding opportunities, and established relationships with others providing response during emergencies. This research joined with two Tribes and one UIO in Montana to understand the lessons they learned during their COVID-19 pandemic response and through their ongoing recovery. The data collected forms the foundation for the need and creation of Indigenous emergency preparedness plans.

Through interviews with tribal and UIO staff, the researcher asked them to identify successes and challenges during their COVID-19 pandemic response and ongoing recovery. In addition, they were asked to consider if there were different actions they would take, as they look back, what preparation would help them in future emergencies, and who is critical to be involved. Based on these interview findings and other sources, an Indigenous strategic planning process was created for use by Tribes and UIOs to establish their own emergency preparedness plans. Once the plan is drafted, it will require approval by the Tribe's or UIO's governing body.

There is a historical understanding of the need to change the way Tribes and UIOs respond during a pandemic that research confirms. It is clear emergency preparedness plans are vital. In 2022, the DHS Federal Emergency Management Agency (FEMA) acknowledged this need in their comprehensive National Tribal Strategy. The Strategy describes the federal responsibility to federally recognized Tribes. (Tang, 2022) Its purpose is to describe the actions FEMA can take to build, enhance, and sustain its relationships with Tribes. The 2013 Sandy Recovery Improvement Act (SRIA) authorized Tribes to directly request presidential and disaster declarations, instead of through the state. This change required FEMA to build different

relationships with Tribes. Its focus is to guide the FEMA Tribal relationship, which is vitally important and begins the process to “create a FEMA program to build on tribal mitigation planning for all hazards”. (Criswell, 2022)

The Montana DPHHS Public Health and Safety Division Emergency Preparedness Program works with county and tribal health departments to prepare for adverse events and respond and recover when an event occurs. This includes coordination of surveillance and response systems and informing Montana citizens. DPHHS receives federal funds and distributes the majority of the funding to local and tribal partners. (DPHHS Public Health and Safety Division, 2024)

The Confederated Salish and Kootenai Tribes (CSKT) is a DPHHS partner for public health emergency preparedness. It is an example of the partnership built between DPHHS and tribal health departments. CSKT receives a limited amount of funding through a contract for public health emergency preparedness (PHEP). The Tribe appoints a PHEP coordinator, who is charged with the responsibility to oversee the extensive actions required as is defined in a series of documents. (DPHHS Public Health and Safety Division, 2022, 2024; Matt, 2023, 2024b, 2024a) The minimal amount of funding does not cover the cost of the broad and massive requirements DPHHS requires the Tribe complete. Additionally, while the state-required plans may meet the state and federal funding requirements, they may not effectively or efficiently incorporate Indigenous responses or reflect Tribal and UIO available staffing, resources, tribal sovereignty, and cultural practices, particularly in frontier and rural reservation areas.

Some Tribes and UIOs in Montana have diligently worked to comply with the federal and state requirements for emergency preparedness. This includes submission of grant applications at

the federal and state governmental jurisdiction levels. Some Tribes and UIOs have participated in tribal consultations on emergency preparedness. While these efforts are important, they do not provide the Tribes and UIOs with plans specific to guide their own response during an emergency event. This dissertation product provides an Indigenous strategic planning process to guide Tribes and UIOs in the creation and adoption of specific plans to meet their need for plans and can be used to supplement federal and state requirements for funding or other emergency response resources.

In acknowledgment of the need for specific Indigenous emergency preparedness, the Montana Healthcare Foundation (MHCF) funded an invited proposal, Lessons Learned from Tribes and Urban Indian Organization UIO) Response to the COVID-19 Pandemic in Montana. Based on the lessons learned during the COVID-19 pandemic, the strategic planning process is a way Tribes and UIOs can establish their own emergency preparedness plans.

Nine Steps Taken in Preparation to Create an Indigenous Strategic Plan Process

To create an Indigenous strategic planning process for use by Tribes and UIOs in Montana (herein after referred to as Process), it required respectful preparation occur, including mandatory academic approvals, tribal approvals to acquire information, and collection of tribal and UIO lessons learned and experiences from their COVID-19 pandemic response and recovery. Since the creation of the Process is the final outcome of this dissertation product, it had to remain faithful to research methodologies consistent with the collection of data from Indigenous communities and importance of Indigenous traditional knowledge.

Community based participatory research (CBPR) is one “collaborative approach to research that equitably involves all partners in research processes and recognizes the unique strengths each brings”. (Wallerstein et al., 2018) Several CBPR principles form the foundation of this work. For example, it builds on the strengths and resources of the community. It integrates a balance between research and action for the mutual benefit of all partners. It emphasizes a tribal public health problem with local relevance. (Israel et al., 2010; Rink, 2020; Wallerstein et al., 2018) While it was not possible to adhere to all the CBPR principles due to the requirements set forth as a dissertation, the intent and spirit of CBPR held true.

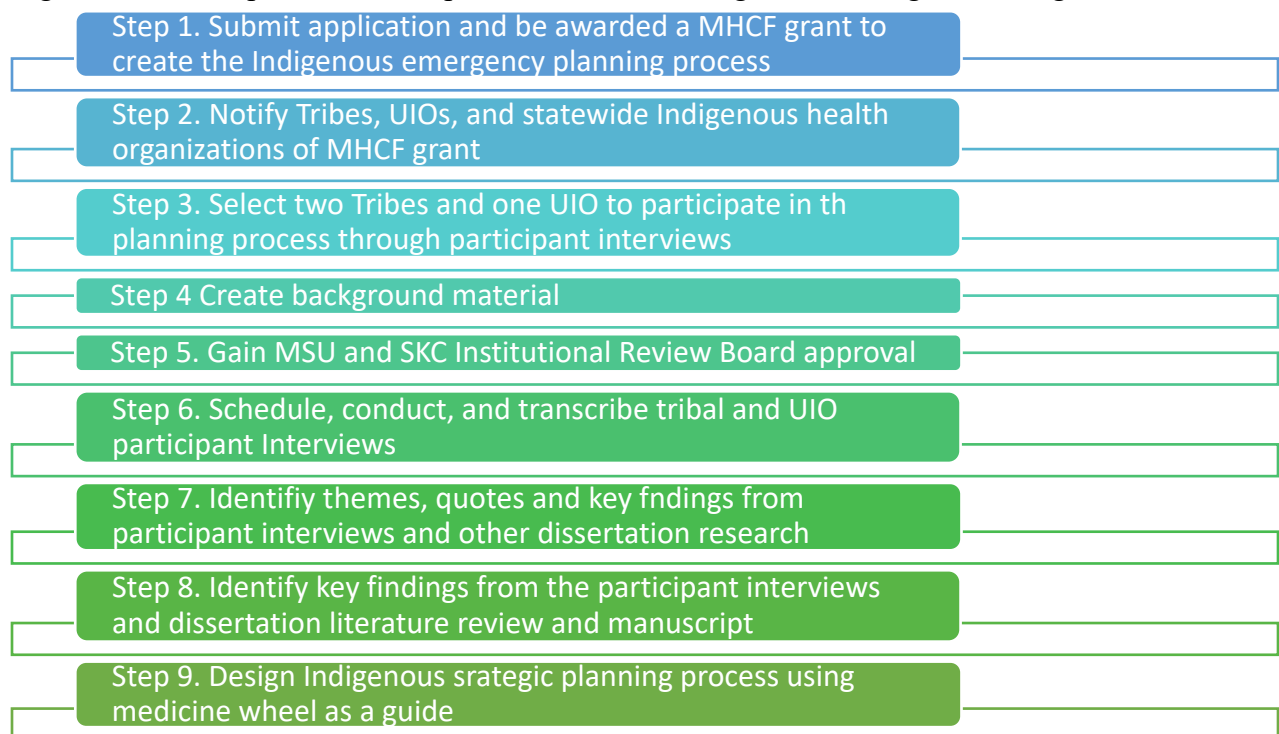
Additionally, the research approach was shaped by notions articulated in the article What touched your heart? Collaborative story analysis emerging from an Apsáalooke cultural context. (Hallett et al., 2017a) Several of their findings were incorporated into this research. For example, the researcher sent the information collected in the participant interviews to the Tribes’ and UIO’s primary contacts for their review and affirmation of themes developed to ensure accuracy and consistency with community values. In the creation of themes and then used throughout the Process, there was an intention to safeguard the stories told by the participants interviewed. It was important their stories remained intact, and their stories retold with integrity. The interviews were conducted in a place the participants felt comfortable, with the offer of food and water, and a token of appreciation shared with each participant to honor their time and to show appreciation for their story. (Hallett et al., 2017a)

The COVID-19 pandemic had devastating consequences across the emotional, mental, physical, and spiritual domains of individuals, families, communities, and the Tribes. A tribal and UIO process is needed. It must be completed with the utmost respect, compassion, hope, and

understanding as the participants' stories shared were heartfelt and compelling, entwined with cultural values and beliefs. It required substantial preparation to hear and record them.

There were nine preparation steps taken to create the Indigenous strategic planning process. The preparation steps are described in Figure 2.

Figure 2: Nine Steps Taken in Preparation to Create Indigenous Strategic Planning Process



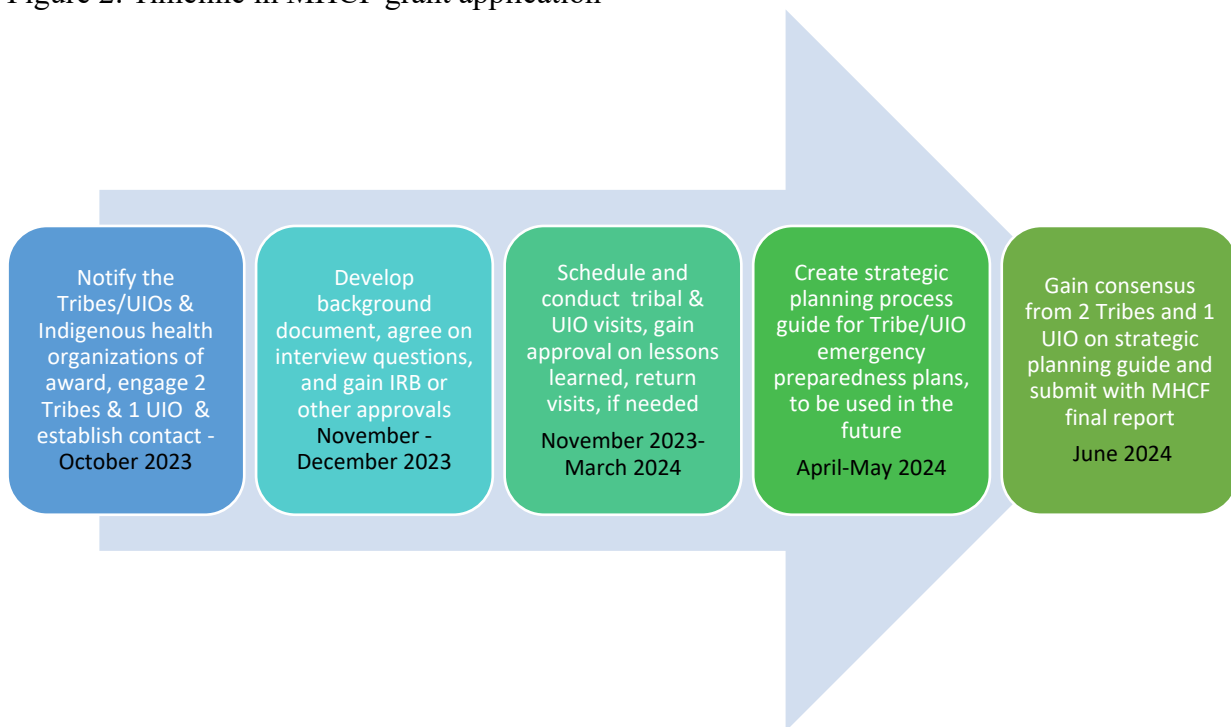
Step 1. Submit Application and Awarded an Invited Montana Healthcare Foundation Grant to Create the Indigenous Emergency Planning Process

History could have predicted the disproportionate impact the COVID-19 pandemic would have on AIANs when compared to non-Hispanic Whites and other races. It is foreseeable, without deliberate attention for a different outcome, the same will happen again. At the invitation of the Montana Healthcare Foundation (MHCF), the researcher applied to develop a research-

based Indigenous planning process for Tribes and UIOs to use in the creation of emergency preparedness plans.

The MHCF approved the application and provided funding. The timeline provided in the application is Figure 3. While there were minor adjustments to the overarching objectives and to the timeline, it remained the high-level guide throughout the research for the Process.

Figure 2: Timeline in MHCF grant application



Step 2. Notify Tribes, UIOs, and Statewide Indigenous Health Organizations of the MHCF Grant

While the project worked with two Tribes and one UIO in Montana, it was important that the eight Tribes and five UIOs were aware of the project. To meet this important responsibility, there are three, statewide Indigenous organizations allied with healthcare in Montana. They are:

1. Rocky Mountain Tribal Leaders Health Subcommittee

2. MHCF American Indian Health Leaders Committee

3. Montana Consortium of Urban Indian Health

At the onset of MHCF grant implementation, each of the three organizations were contacted. A request was made to present at their next scheduled meeting. A PowerPoint explaining the grant's purpose to Indigenize emergency preparedness plans through a strategic planning process was presented. Once the Process is drafted, it will be shared with the three organizations for their advice. The final Process and the background documents will be shared with the Tribes, UIOs and the three statewide Indigenous organizations.

**Step 3. Select Two Tribes and One UIO to Participate in
the Planning Process Through Participant Interviews**

The MHCF proposal proposed to engage two Tribes and one UIO to conduct five participant interviews at each site. The Tribes selected were based on their willingness to participate and to reflect a set of diversity requirements. There is a complex healthcare delivery system for Indigenous people across the US and in Montana. To gain the full understanding of the Tribal COVID-19 response, it was important to examine the actions taken by Tribes that choose to administer healthcare services through different options available in Public Law 93-638 the Indian Self-Determination and Education Assistance Act, as amended. (P.L. 93-638 ISDEAA). Tribes with P.L. 93-638 ISDEAA compacts had a great responsibility in the delivery of healthcare and in their COVID-19 response. Tribes, where IHS directly provides the healthcare, worked together to respond to the COVID-19 pandemic. Examining both options was important in the Process. The UIO selected was based on their willingness to participate and the continuity of their leadership throughout the COVID-19 pandemic response and recovery.

It was important for the three entities selected to represent the access to healthcare available in frontier, rural, and reservation areas, which is different from locations in urban areas. The federal and state governments have required Tribes to agree to emergency preparedness requirements to receive certain grants. The approach to receiving the grants may be characterized as a fragmentary process that is not comprehensive or one that expects continuity across governmental authorities.

The three entities selected are the Confederated Salish and Kootenai Tribes (CSKT), the Crow Tribe, and the Helena Indian Alliance (HIA). Table 1 lists the diverse elements of the Tribes and UIO selected.

Table 1: Diverse Attributes of Selected Tribes and UIO

Attribute	Confederated Salish and Kootenai Tribes	Crow Tribe	Helena Indian Alliance
Tribe or UIO	Tribe	Tribe	UIO
Location in Montana	Western Montana	Eastern MT	Central Montana
Primary funding mechanism	Indian Health Service P.L. 93-638 ISDEAA Self Governance Compact	Indian Health Service Direct Service, with limited healthcare services delivered by the Tribe through a P.L. 93-638 ISDEAA contract	Indian Health Care Improvement Title V
Access to federal FEMA declarations of emergency	X	X	
Access to state PHEP	X	X	
IHS hospital		X	
Access to COVID-19 Vaccine	State	IHS	State
Institutional Review Board Approval	Salish Kootenai College IRB	Montana State University IRB	Montana State University IRB
Submitted letters of support	X	X	X

Step 4. Create Background Material

In addition to this dissertation product, there were two additional dissertation products created as background material. The first dissertation product is the COVID-19 Response and Recovery by Tribes and Urban Indian Organizations in Montana: What's Next? Literature Review. It is a comprehensive review of information from government reports, newspapers, and research articles. It explores the history of past pandemics on Indigenous people, assesses the contribution the SDOH and Indigenous determinants of health had on COVID-19 outcomes, identified data collection and analysis issues, government authority responses, and concluded with Tribes and UIOs lessons learned and gaps in the information available.

The second dissertation product is a co-authored manuscript, Perceptions, and Impact of the COVID-19 Pandemic on the Social, Mental, Physical, and Spiritual Health of Rural Western Native American and Hispanic Communities. This study was part of a larger community-academic partnership —Protecting Our Communities—that focused on understanding and promoting home-based COVID-19 testing in underserved populations. (Gregor et al., 2022; Van Rensburg et al., 2023) It concludes that COVID-19 had significant impact on both the Native American and Hispanic communities involved, and the impact was across the social, mental, physical, and spiritual areas. It also caused significant financial disruption. It concluded initiative-taking measures must be taken to address the “overwhelming harm experienced.” While there were many negative consequences experienced during the COVID-19 pandemic response, it also resulted in positive lessons and changes in tribal communities.

Step 5. Gain Montana State University and Salish Kootenai College Institutional Review Board Approval

To protect the rights, safety and welfare of the individual participants interviewed, the researcher practiced the utmost precaution, including the approval by two institutional review boards (IRB). The Confederated Salish and Kootenai Tribal Council authorized the Salish Kootenai College (SKC) IRB to serve as the appropriate approval entity for research conducted across the Tribes or with tribal members. The Crow Tribe's IRB reviews research conducted by their tribal college, the Little Big Horn College, staff, or students. Other research requires approval from the research entity's IRB, which in this case is the Montana State University IRB. There is no IRB affiliated with the Helena Indian Alliance, requiring MSU IRB approval. The SKC and MSU IRBs approved the research. In addition, they approved an informed consent form and required each participant to sign the form prior to the interviews. The SKC IRB informed consent form is **Appendix A** and MSU IRB informed consent is **Appendix B**.

Step 6. Schedule, Conduct, and Transcribe Participant Interviews

The research did not commence until IRB approval was received. Upon receipt of SKC IRB approval, the researcher contacted the CSKT Tribal Health Department Head for identification of appropriate staff to interview and to schedule the interviews. The researcher followed the same process for the Crow Tribal Health Department and the HIA, when MSU IRB approved. A total of 16 participant interviews were conducted. Table 2 lists the participants interviewed, with additional information.

Table 2: List of Research Interview Participants

Participant Number	Entity	Generic Description of Role	Interview location	Interview Transcribed
1.	Confederated Salish and Kootenai	Tribal Health Administration	St. Ignatius, MT	X
2.	Confederated Salish and Kootenai	Tribal Medical Clinic	Ronan, MT	X
3.	Confederated Salish and Kootenai	Tribal Public Health	Ronan, MT	X
4.	Confederated Salish and Kootenai	Tribal Public Health	Ronan, MT	X
5.	Confederated Salish and Kootenai	Tribal Public Health	Ronan, MT	X
6.	Crow Tribe	Incident Command	Crow Agency, MT	X
7.	Crow Tribe	Community member	Crow Agency, MT	X
8.	Crow Tribe	Private healthcare nurse aide	Crow Agency, MT	X
9.	Crow Tribe	Nursing home administration	Phone interview	Researcher notes transcribed
10.	Crow Tribe	Indian Health Service	Crow Agency, MT	X
11.	Helena Indian Alliance	UIO Medical Clinic	Helena, MT	X
12.	Helena Indian Alliance	UIO Public Health	Helena, MT	X
13.	Helena Indian Alliance	UIO Information Technology	Helena, MT	X
14.	Helena Indian Alliance	UIO Administration	Helena, MT	X
15.	Helena Indian Alliance	UIO Administration	Helena, MT	X
16.	Helena Indian Alliance	DPHHS contact for Tribes/UIOs	Helena, MT	X

The researcher conducted the participant interviews at a time and location decided on by the participant, except for one interview she conducted over the telephone as an emergency required her to be off site and she was comfortable with a telephonic interview. The group of three interview participants were interviewed together, at their request. Each participant received a \$100 gift card or a gift honorarium to honor their time and story . The researcher offered water, snacks, or lunch to express the as the importance of shared food.

The participants agreed to be interviewed by signing the informed consent form. Fifteen of the participant interviews were recorded and electronically transcribed. One participant interview was not recorded, with the researcher notes transcribed.

The participant interviews were guided by sample questions reviewed by the SKC and MSU IRBs. While the sample question guided the interviews, the researcher followed up with additional questions, when additional information to describe an answer would enhance the information provided. The sample questions are **Appendix C**.

Step 7. Identification of Themes and Quotes from Participant Interviews

Step 7 is divided into three sections. Step 7a describes the inclusion of an additional individual to assist with the qualitative data analysis from information collected from the participant interviews. Step 7b identifies themes generated across the participant interviews. Step 7c presents quotes from the participant interviews.

Step 7a. Hire, Train, and Collaborate with Student Scholar: A student scholar was hired to ensure appropriate academic rigor in the verification of the interview transcripts and development of themes presented through the participants interviews. A description of tasks was

submitted to the SKC Internship Office in December 2023. Misty Ostlie, a senior at SKC expressed interest. She was selected and hired by MSU. Ms. Ostlie is a member of the Fort Hall Shoshone Bannack Tribes. She resided on the Flathead Reservation during the COVID-19 pandemic, with her two children. They experienced the COVID-19 pandemic similar to other AIANs across the state and US. Ms. Ostlie signed the Transcriptionist Confidentiality Agreement that was required by the SKC IRB. It is **Appendix D**.

Student Scholar Ostlie was provided with a list of names of the participants interviewed at CSKT, Crow, and HIA in a table to confirm the participant interview was verified with the electronic transcription and themes identified. A second table was provided for the student scholar to combine similar themes from the interviews and name the themes. Finally, the student scholar was tasked with recording quotes from specific interviews that augmented specific themes. At the same time, the researcher identified themes and found compelling quotes associated with the themes.

Step 7b. Themes and Quotes from the Participant Interviews: The researcher and the student scholar reviewed the 15 electronically transcribed recordings or notes taken from the 16 participant interviews and the available handwritten notes the researcher took during the interviews to verify transcription completeness and accuracy. Each transcript was examined for statements for successes and challenges, lessons learned, and what might be done differently in the future. Once this thorough review was completed, highlights were generated across all participant interviews, with similar responses combined and named, which became a theme. When the participant interviewed made a significant statement, the quote was recorded with its connection to the theme.

The theme and quote identification were done independently by the researcher and the student scholar. Once the researcher and student scholar completed this step, they met and discussed themes and quotes. Together, they developed the list of themes and quotes. In addition to honor community participation, the themes and quotes were sent to the two Tribes and one UIO for their review. They responded with their concurrence.

Table 2: Participant Interview Findings and Quotes

Theme 1: Be prepared	
Interview Participant Findings	Interview Participant Quotes
Create plans, teach people, realize people adapt, be courageous, be creative to get solutions, and trust leadership	COVID brought to life our shortcomings and things we need to fix Make sure everyone is trained
Need critical thinking and adaptability to shift the ways services are provided, immediately	March 17, 2020, Saint Patrick's Day was our "D Day", we needed to act immediately
Develop comprehensive, tribal- or UIO-based plans including human needs, based on culture, and specific not only for the Tribe but also for different communities on the reservation.	We had PH plans conducted tabletop exercises prior which helped but needed the human components and inclusion of culture Each of our tribal communities is different and that needs to be reflected in the plans. The plans were very sterile, missing the human component We should have a plan that includes scaling back services It is important to train outsiders who are providing assistance to our community. They must understand historic trauma to prepare for them prior to engagement.
Theme 2: Support Community and Leadership	
Interview Participant Findings	Interview Participant Quotes
Engage leadership across governments including DPHHS, IHS, BIA, FEMA, Tribes, UIOs and counties. Tribes respond differently than IHS, federal, and state agencies and keep them connected throughout the emergency	Adhere to the State of Montana's government-to-government policy, it is important to engage DPHHS and federal agencies leadership to understand Tribal sovereignty, as Tribes make their own decisions
Need a joint or incident command group with boots on the ground	Tribes stayed the course when the county shifted away from CDC protocols

Table 3 Continued

Theme 3: Build Partnerships	
Interview Participant Findings	Interview Participant Quotes
Build partnerships before an emergency with the federal government, state of Montana and DPHHS and counties	There is no way to build a relationship during a crisis The most important thing was relationship in Indian Country Flying the plane without knowing the destination
Fully understand the governmental relationships, authorities and contractual relationships with roles and responsibilities	We felt like we were left on an island, without support from those we thought were our partners
Participants from each location reiterated it was important to serve everyone in the community, including AIANs and not natives, as the pandemic impacted everyone in the community	Everyone in our communities is connected. We are all in this together, whether we Indian or non-Indian.
Theme 4: On-going Communication	
Interview Participant Findings	Interview Participant Quotes
Keep I/T/U informed of federal, DPHHS and with data collected	Communication between the State and I/T/U became more important when people were dying every day, and it was realized AIANs were dying at disproportionate rates. At first there was a little bit of this is some of this death is normal in our communities, I don't know when it became a shocker
Increase community outreach to correct misinformation now. For example, tribal health departments are dealing with misinformation on RSV. Educate patients, family members, friends, and healthcare staff internally and with external partners and inform on changes in response	Everyone in the community must be on the same page

Table 3 Continued

Interview Participant Findings	Interview Participant Quotes
Reduce fear and mistrust in the community through on-going, accurate, and relevant information using trusted messengers to communicate	Get people who are trusted to communicate like tribal leaders, healthcare providers, and those that speak the language Take care of each other. An elder shared, in the old days, when people were sick, they didn't cross the river to be with others. It was almost like quarantine: they stayed to themselves to protect others.
Train everyone included involved in the joint command center making decisions or interacting with community members on the Tribe's culture and historic trauma prior to their engagement with the public.	Outsiders with different values created bad experiences. We need the right people to communicate with, that are trained There was distrust of responders in military uniforms
Theme 5: Stay Patient Focused	
Interview Participant Findings	Interview Participant Quotes
Need flexibility to respond quickly	We converted the gym to a makeshift MASH unit to serve patients and keep them safe We adapted to the best of our ability to deliver services to our people
Understand the unique needs of individuals	We experienced language barrier overlooked.
Find ways to put all patients and community first	Patients were overlooked, like they weren't there. They had no explanation of their diagnoses. No education about co-morbidities. Doctors and nurses would ask questions and patients couldn't answer: They didn't understand: They couldn't ask questions, let alone express themselves to others.
Healthcare shifted to only focus on COVID-19. There were no childhood immunizations, even treatment for cancers and diabetes was stopped	The shift in healthcare to COVID only during the initial phases will have a ripple effect for a long-time to come

Table 3 Continued

Interview Participant Findings	Interview Participant Quotes
Realize the importance of infection control	We were able to hire someone to focus on infection control, purchase additional equipment, and learned how to use it correctly
Theme 6: Know Resources	
Interview Participant Findings	Interview Participant Quotes
Know all available resources and use all of them	Our incident command team had members with experience in emergencies and we learned from them We learned from others such as wildland fire fighters on Reservations, as they have experience that applied to our response to COVID-19 Resources were provided by the federal government including personal protective equipment, medical equipment, information technology items like secure video cameras for telehealth and hotspots, and support from CDC
Share resources across Tribes, health organizations, and other jurisdictions	The Portland Area Indian Health Board, created a forum for physicians to gather with a specialist for difficult cases
Prepare in advance, as much as possible, to secure needed resources, vehicles, IT access, equipment, and personnel, with flexibility to respond quickly, using tribal sovereignty	It was important to be a part of the federal supply chain The van we purchased became a symbol of hope We purchased a jeep so the weather could not keep us from the patients and community members that needed us With the increased resources, we were able to build a new health clinic

Table 3 Continued

Interview Participant Findings	Interview Participant Quotes
Create appropriate human resources acquisitions to hire needed personnel, quickly	There were significant monetary resources provided but we couldn't hire the manpower we needed. It took a long-time and there weren't ways to speed up the hiring process
Theme 7: Honor Our Values	
Interview Participant Findings	Interview Participant Quotes
Exercise authorities provided to Tribes, using tribal sovereignty	We prioritized Native Elders and native language speakers for vaccine and home visits It was a privilege to work with our patients and community members
Ensure the emergency preparedness plan is inclusive of everyone in the community	We are all in this together, whether we Indian or non-Indian Everyone in our communities is connected We tried to not waste one dose of vaccine, as one dose can affect a person, a family, and a community We distributed to everyone, as everyone is part of our communities. It was about belonging.

Table 3 Continued

Interview Participant Findings	Interview Participant Quotes
Find safe and appropriate to incorporate tribal cultural practices into emergency preparedness planning that allows them to continue during the response and recovery.	The effect of loss of life was felt across the Tribes and tribal communities. Our cultural ways, such as the death rituals were interrupted. Our people died alone, by themselves, which wouldn't happen before COVID-19. We weren't allowed to prepare our loved one's bodies, no dressing them, no blankets, and the morgues covered the graves, which traditionally is done by the community. We mourn alone. People are in survival mode, in shock and grief with up to 100 having died from COVID-19 and that doesn't include those that died from car wrecks, heart attacks, cancer...I had 20 of my family die in that time How will Tribal people recover? This is the kind of trauma that will be transferred to future generations if not addressed COVID-19 caused cultural distress, but we found ways to strong. When the Crow Fair was cancelled, we went to the mountains, to our own land for protection. Now trying to find a new way in 2024. We have more to do My family connected to our land for traditional medicines and to be safe. We returned to traditional healing practices for strength
Find tribal and cultural expertise to advocate for those impacted by the event	It really warms my heart knowing that they made it through when they (patients) were so lost and worried and scared and knowing that I was there to comfort during that time, it really makes me feel good. Some of the workers didn't understand why it was important

Table 3 Continued

Interview Participant Findings	Interview Participant Quotes
Find ways to blend western medicine with Indigenous healing and give it equal importance.	There was a lack of acceptance from western medical providers, which led patients to be unsure how to use their cultural beliefs. It made people feel isolated and it was heartbreaking People felt ashamed and embarrassed about being Indian We need advocates to help translate for our Indian people to the western healthcare providers. Tribal members were treated differently than non-members. They were judged and sent away within the same level of care provider to non-Indians.
Theme 8: Self-Care and Wellness	
Interview Participant Findings	Interview Participant Quotes
Find ways to care for staff, including financial incentives and their physical and emotional needs	Provide lunches, snacks, massage chair, and pay incentives to support employees
Find ways to appreciate staff and reduce isolation in non-virtual ways	We need a safe space to share our true feelings without fear of retribution Compassion fatigue lessons did not work. The pandemic didn't stop; it kept coming, so we didn't get to put into practice what we learned to restore ourselves
Keep staff and first responders safe	It was physically, emotionally, socially, and mentally exhausting every day
Staff isolated even when meeting virtually, daily	We are bonded together, core stayed together. Now we are veterans

Table 3 Continued

Interview Participant Findings	Interview Participant Quotes
Ensure all staff, including frontline responders, are working within appropriate work standards and guidelines, and are not overworking	We need to find out where do we go and how do we truly recover, especially for frontline workers I felt like I missed a good portion of my children's life during COVID-19 as I worked trying to take care of things that needed my attention. It was recognized and I was able to hire an assistant I did not set personal boundaries between work and personal responsibilities. I found it hard to share the workload. Working overtime strained my personal relationships with my wife, family, and children
Find ways to help staff, frontline responders, and community members to process their professional experience during and at the conclusion of the event, remembering many have also personally experienced the consequences from the event.	Balance patient care with self-care I want to learn to let go and live in the present There was concern expressed for employees that worked through COVID-19 response and how what they encountered will be addressed going forward, including burnout and stress that continues to linger during the ongoing COVID-19 recovery We are suffering from survivor's guilt." Our death rituals were taken from us during when we needed them the most, with so much death. Life is precious.

Step 8. Identification of Key Findings
from Participant Interviews and Dissertation
Literature Review and Manuscript

Upon the completion of the participant interviews and the identification of themes and quotes, the next step taken was a key findings analysis. It provided an opportunity for the incorporation of knowledge from the two other dissertation products, which are product 1

COVID-19 Response and Recovery by Tribes and Urban Indian Organizations in Montana:

What's Next? Literature Review, product 2 the co-authored manuscript: Perceptions and Impact of the COVID-19 Pandemic on Social, Mental, Physical and Spiritual Health of Rural Western Native American and Hispanic Communities, and the participant interview process. The key findings laid the foundation for the structure of the Indigenous strategic planning process.

Key Finding #1: It is vital to be prepared. This requires the creation of emergency preparedness plans that are specific for the Tribe or UIO. The plan must be culturally grounded and reflective of the Tribe's lifeways, beliefs, history, and resilience. While federal or state governments can set requirements for funding or to meet requirements, the Plans must be directed, owned, and led by the Tribe or UIO. The following are areas of consideration in creating the plans.

- Description of land and geographic landscape.
- Unique communities within the Reservation or specific targeted areas in an urban area.
- Population to be covered.
- Leadership, first with Tribes and UIOs, then engagement with key partner leadership and technical support staff, with recognition that leaders and direction changes over time or throughout the emergency, crisis, or pandemic.
- Resources, including financial assets, from the Tribe or urban area, which are delineated for specific tribal communities and urban areas.

Key Finding #2: The Tribal Health and UIO healthcare delivery system may need to change their focus at the start and throughout the duration of the emergency, crisis, or pandemic.

During the COVID-19 pandemic, there were different phases and each phase required flexibility.

The following are examples of changes that occurred in the initial response by Tribes and UIOs:

- Healthcare services changed from ambulatory care to a greater emphasis on public health and community population healthcare with a focus on testing, contact tracing, and addressing the needs of community members diagnosed with COVID-19.
- There was a widespread effort to educate individuals and families about quarantining when there was exposure to someone with COVID-19 and isolation for those with COVID-19.

“Take care of each other. An elder shared, in the old days, when people were sick, they didn’t cross the river to be with others. It was almost like quarantine: they stayed to themselves to protect others.” - Participant interview quote

- Healthcare staff distributed personal protective equipment (PPE)
- There needs to be advocates, with cultural expertise to support patients.

“It really warms my heart knowing that they made it through when they (patients) were so lost and worried and scared and knowing that I was there to comfort during that time, it really makes me feel good. Some of the workers didn’t understand why it was important.” - Participant interview quote

- Provision of healthcare transitioned from in-person to telehealth.
- There were shifts in staffing across the healthcare system. For example, registration and billing staff had to shift to on-line registration and changes in billable healthcare services.
- Infection control was identified as key to keeping staff and patients safe, in addition to quality care.

- Maintenance and janitorial staff shifted their work to be more focused on infection control.

Key finding #3: The Tribes and UIOs recognized the need for effective coordination and on-going communication strategies across multiple media channels.

- There was a need for coordination across governmental jurisdictions including tribal, federal, state, county, city, and other governmental entities.
- Engagement of leadership across government authorities, healthcare delivery systems including IHS, private providers and non-profits entities was critical.
- Grassroot volunteers, community groups, and entities like Red Cross, while having a vital role, needed to coordinate with incident command or other entities charged with the Tribes' or UIOs' response and be flexible to modify their approach to meet the Tribes or UIOs needs and in a culturally appropriate manner.
- All responders need to be trained on the historical impact and trauma related to past pandemics or crises and modify their outreach efforts to be appropriate.
- Clear communication, across all partners, using multiple channels with trusted messengers, on an on-going and consistent schedule to leadership, responders, staff, and community members.

Key finding #4: Self-care and employee wellness are critical throughout the incident and recovery from its consequences.

- Acknowledgement of importance of self-care for all responders, including leadership

- Employee wellness plans across partners.
- Appreciation for those “boots on the ground” staff engaging in the difficult response and recovery actions that may place themselves at risk and as they and their families may be experiencing the effects of the emergency, crisis, or pandemic.
- Thoughtful attention is needed to recover mentally, emotionally, physically, and spiritually from the lingering effects of the COVID-19 pandemic.

“The effect of loss of life was felt across the Tribes and tribal communities. Our cultural ways, such as the death rituals were interrupted. Our people died alone, by themselves, which wouldn’t happen before COVID-19. We weren’t allowed to prepare our loved one’s bodies, no dressing them, no blankets, and the morgues covered the graves, which traditionally is done by the community. We mourn alone.” - Participant interview quote

The four key findings from the analysis of the participant interviews and the other dissertation products form the basis for the Indigenous strategic planning process. Each finding provides an area for inclusion in the planning process. The four areas, when combined, establish the plan structure.

Step 9. Design Indigenous Strategic Planning Process

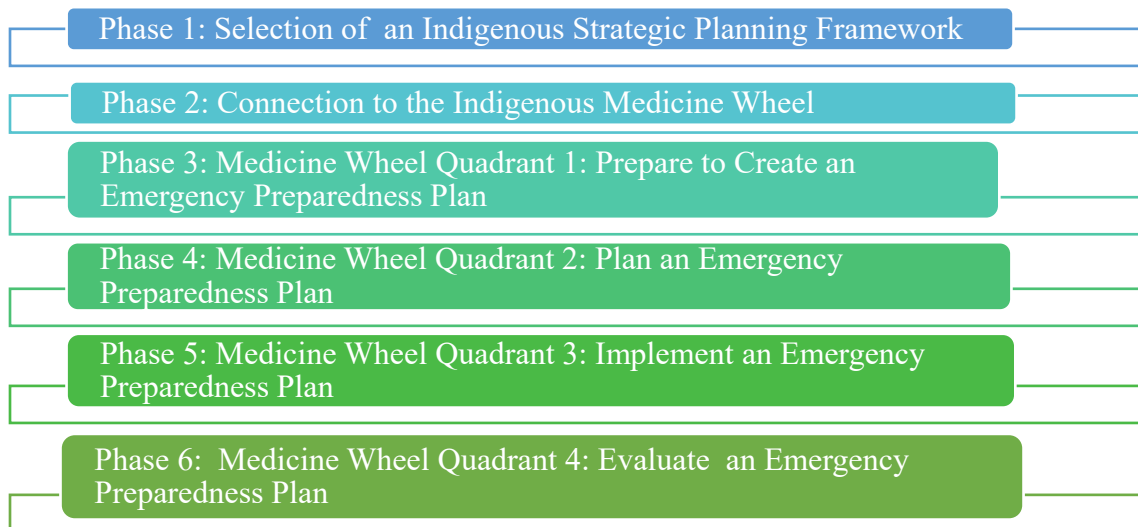
The final preparation step to create the Indigenous Planning Process was the examination of available information. It includes the research conducted for this dissertation and begins the actual creation of the process for tribal and UIOs Plan. The foundation of each Plan must be the Tribe’s history and background in emergency responses, vision, available resources and expertise, and culture. These four elements can be explored independently and then consolidated for the Plan. The Indigenous strategic planning process uses methods to gather information specific to the Tribe or UIO. Once a consensus is reached within the four areas, it will be

combined into the Plan for adoption by the Tribe's or UIO's governing body and distributed to all the partners engaged in the planning process for the execution upon declaration of an emergency, crisis, or pandemic.

Indigenous Strategic Planning Process

This section uses information generated in the nine steps described in Section III. Steps Taken in Preparation to Create an Indigenous Strategic Plan Process as the foundation for this dissertation product. It takes the data gathered and applies it to a research framework to guide the overall process and eventual development of specific emergency preparedness plans for Tribes and UIOs in Montana. The Indigenous Strategic Planning Process is completed in six phases. The six planning phases are detailed in figure 4.

Figure 3: Six Phases of Indigenous Strategic Planning Process



Phase 1. Selection of an Indigenous Strategic Planning Framework

The first phase in the creation of the Indigenous strategic planning process is the selection of a research framework. It guides the overall Process. It is imperative the framework is based in traditional knowledge and affirms Indigenous culture and lifeways. An example of a strategic planning framework is the Promoting Local and Economic Development through Strategic Planning Manual, written by the United Nations Human Settlements Programme (UN-HABITAT). It uses 10 focus areas to answer four questions. It is an inclusive way to set priorities, make choices, allocate resources such as time, funding, and skills to achieve objectives, monitor progress, and adjust as needed based on evaluations. (*Tibaijuka, 2005*) Their Strategic Planning Wheel is figure 5. It was created by the UN-HABITAT.

Figure 4: UN Human Settlement Programme Strategic Planning Wheel



The UN Human Settlement Programme Strategic Planning Wheel identifies ten focus areas divided into four categories. They are as follows:

A. Where are we now?

Focus Area 1: Getting Started

Focus Area 2: Stakeholders and Participation

Focus Area 3: Situation Assessment

B. Where Do We Want to Go?

Focus Area 4: Visioning

Focus Area 5: Issues and Objectives

C. How Do We Get There?

Focus Area 6: Strategy Development

Focus Area 7: Action Planning

Focus Area 8: Organization and Implementation

D. Have We Arrived?

Focus Area 9: Monitoring and Evaluation

Focus Area 10: Adjust and Modify

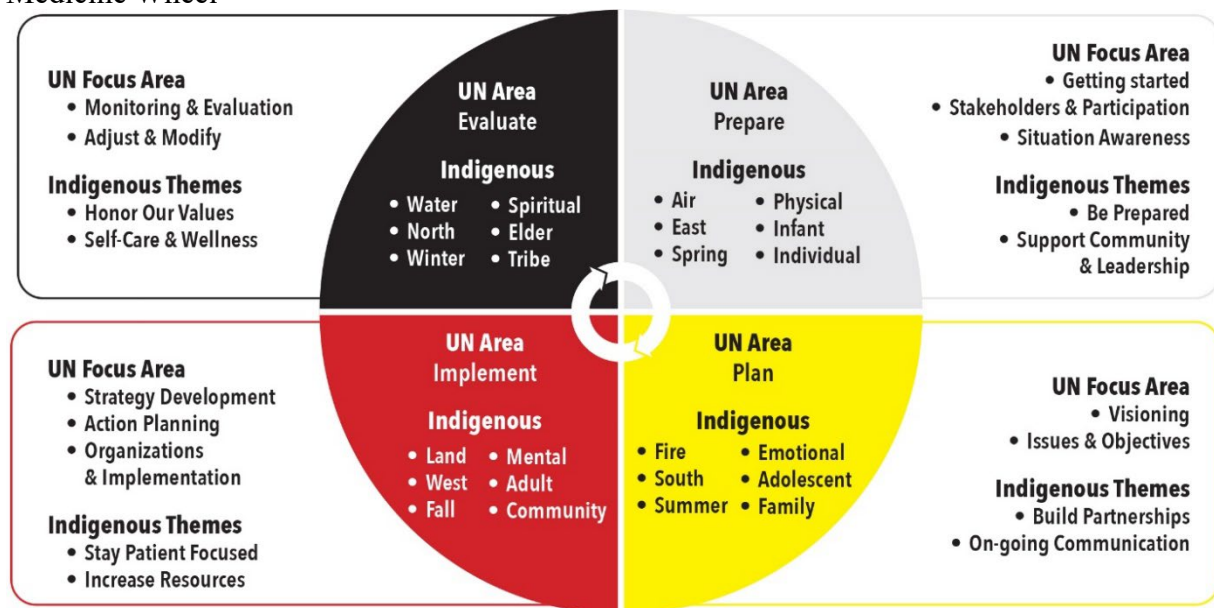
At the core of the UN's Strategic Planning Wheel is the community for which the planning is occurring. It requires cooperation between partners and stakeholders across the communities. It requires a willingness to work together, often with difficult topics. It can be done successfully, with the community's definition of success.

The UN Human Settlement Programme Strategic Planning Wheel transitions to the American Indian icon, the medicine wheel. Once transitioned, the medicine wheel serves as a

framework. (Coyhis, 1988; Travers, 2021; Twigg & Hengen, 2009) It serves as the framework for the Process. The origins of the medicine wheel have been orally handed down from one generation to another. It tells a unique story for each Tribe but with fundamental core principles. It is a method to explain complex situations with “the basic configuration, a circle divided into equal quadrants, can then be used to depict many other relationships, always in sets of four,” (Montour, 2000)

The medicine wheel was be adapted to serve as the framework for the Indigenous strategic planning process, using the questions and focus areas from the UN Human Settlement Programme Strategic Planning Wheel. The transition to a medicine wheel framework is depicted in figure 6, with the medicine wheel content created by the researcher and graphic set by Airam Gessner.

Figure 5: Transition UN Human Settlement Programme Strategic Planning Wheel to Indigenous Medicine Wheel



Phase 2. Connection to the Indigenous Medicine Wheel

The UN Human Settlement Programme Strategic Planning Wheel serves as the foundation for the categories and focus areas to conduct the Indigenous Strategic Planning Process for Tribes and UIOs to create emergency preparedness plans. It is important to note that the UN planning process was designed to be used with Indigenous people across the world. In early 2023, the UN adopted the Indigenous determinants of health. In this landmark document, it reflects that being Indigenous is by itself, a determinant of health and calls for the Indigenization of research approaches and frameworks. (Condo Riveros et al., 2023) The transition of the UN Human Settlement Programme Strategic Planning Wheel to the Native American medicine wheel converts it to an approach familiar to Tribes and UIOs. Like the UN Human Settlement Strategic Planning Wheel, there are fundamental core principles in the Medicine Wheel. It begins with learning is a cycle, with no beginning and no end but rather a constant movement through four quadrants. Once the cycle completes, it starts again based on the lessons learned and wisdom gained.

Further refinement in concepts and language used in the UN Planning Wheel could be conducted but is beyond the scope of this research. However, at the time the Indigenous Strategic Planning Process to create a Tribe's or UIO's emergency preparedness plan is used, it would be important to dedicate time and resources to further adapt it to Tribes and UIOs in Montana.

The next four phases describe how Tribes and UIOs might apply the Indigenous medicine wheel framework in the creation of their emergency preparedness plans, consistent with the UN planning wheel.

Phase 3. Medicine Wheel Quadrant 1: Prepare to Create an Emergency Preparedness Plan

Quadrant 1 of the medicine wheel represents the launch or start of the planning process for Tribes or UIOs to create emergency preparedness plans. The Indigenous features emphasized in the medicine wheel reflect a beginning. Air is the universal element, like the first breath taken after our birth. The sun rises in the east. Spring is the time when the earth is restored; animals give birth; wildflowers bloom. The individual is the focus as an infant, with a focus on their physical well-being.

There are three focus areas identified in the UN Human Settlement Programme Strategic Planning Wheel in the category Prepare. For the Indigenous Medicine Wheel it is a time to prepare. Each of the focus areas are explained below, with the connection to the Indigenous Themes identified through the participant interviews.

Indigenous Theme: Be Prepared; UN Focus Area: Getting Started: The planning process begins when the Tribe or UIO makes the decision to create an emergency preparedness plan. Tribal governments and UIO boards of directors have significant demands on their time and attention. The decision will require formal action and commitment of the Tribes' or UIOs' time and resources. It is essential the decision to create a Plan is based on accurate information and there are clear expectations of its purpose.

As the decision to create a plan is made, it is important there is someone assigned to be the primary point of contact, or as it is referred to as the Plan Champion. This person must have a background in emergency preparedness and the confidence of the governing body and staff and stakeholders key to the creation of the Plan and its long-term sustainability. In addition, the Plan Champion will need to be granted time to focus on this effort.

Once the decision is made to create the Plan, communication across the Tribe or UIO must begin. Sharing information, including the background data, will be key in generating support and on-going involvement in the planning process and the outcomes of the Plan. Communication channels should include internal and external sources. At an appropriate time, patients and community members will need to be involved, for their participation, understanding, and support.

It will be essential the Tribe's or UIO's governing body announce the intent to create the Plan and specifically invite key stakeholders to participate. The invitation should state the Tribe's or UIO's commitment to the planning process and eventually the Plan. The statement should communicate their agreement to appoint appropriate staff, commit required time and resources for their staff's meaningful participation, and ask the invited key stakeholders to do the same.

It is in this phase the Tribe or UIO may consider hiring an outside consultant or entity to facilitate the overall creation of the emergency preparedness plan. It has been determined an independent, neutral facilitator that brings a specific set of skills may assist. It will be key for all stakeholders to build trust with this person, and that they are held accountable to keep the process moving forward to the successful completion of the Plan. (Tibaijuka, 2005)

Indigenous Theme: Support Community and Leadership; UN Focus Area: Stakeholders and Participant Situation Awareness: Participant Interview Quote: *"COVID brought to life our shortcomings and things we need to fix."* The most important group of stakeholders will be the Tribes or UIOs internal staff, across their departments and programs. While the health department will most likely play the key role, other programs have knowledge and expertise in dealing with emergencies such as wildland fires, flooding, oil spills, or accidents on highways or

reservation roads. At the time an emergency, crisis, or pandemic is declared by the governing body, the type of the event will determine the primary point of contact for the specific response.

There is a wide range of other diverse stakeholders required to be involved in the creation and on-going involvement of the Plans for Tribes and UIOs. The first groups to be considered represent governmental jurisdictions including the federal, state, county, and if appropriate, cities. Their involvement and on-going participation will be key to the Plan's success.

Tribes and UIOs will need to include two key partners. First Indian Health Service (IHS) as the federal entity that provides the federal authority to provide healthcare and allocates core funding for Tribes and UIOs. The extent of their involvement for Tribes will be determined by decisions the Tribe has made regarding the delivery of IHS programs, functions, services, and activities (PFSAs), as authorized by P.L. 93-638 ISDEAA. It provides Tribes the opportunity to assume the administration of IHS PFSAs as Tribe determine appropriate, under a Title III Self-Determination contract or a Title V Self-Governance compact. In addition to these mechanisms, Tribes may also decide to have the IHS directly provide the IHS PFSAs to their eligible beneficiaries. UIOs receive the status and funding provided in Title V of the Indian Healthcare Improvement Act. These substantial roles dictate an IHS role in all Tribal or UIO Plans.

The second partner all Tribes and UIOs will need involved is the State of Montana's DPHHS. Much of the federal authority to respond to emergencies is assigned to states, which have the opportunity to design the state's emergency response and complement it with state authorities and resources. DPHHS has charged the Public Health and Safety Division with leading their response. It is important to note that the Governor's office and many other Montana

departments, programs, and agencies also have key responsibilities in emergency responses, which will need to be coordinated by the DPHHS.

County and cities, if located on tribal land, will be key partners. Often, there is concurrent or overlapping jurisdictions between Tribes and counties for almost all services where AIANs reside and so do non-Natives. For UIOs, counties and cities are key partners since they do not have governmental jurisdiction based on Tribal sovereignty, to assert. During the COVID-19 pandemic, coordination between Tribes, UIOs, and counties was crucial. This was especially true with county health departments.

There are statewide Indigenous organizations to engage for purposes of collaboration and coordination. This includes the Rocky Mountain Tribal Leaders Council, specifically their Health Subcommittee, the Montana Consortium of Urban Indian Health, and the Montana Healthcare Foundation, specifically their American Indian Health Leaders Council. The Rocky Mountain Epidemiology Center will be important to engage for national, regional, and state data.

The COVID-19 pandemic demonstrated the importance of the Tribes and UIOs partnership with local, private healthcare providers and hospitals. Access to healthcare is a key element in any event. It must be available when needed.

Non-profit organizations such as the American Red Cross and others respond to emergencies, crises, and during the COVID-19 pandemic. The work they contribute is very important. It needs to be coordinated and delivered in a culturally humble manner. For this to occur during an event, coordination must occur during the preparation phase. Participant Interview Quote: *“Outsiders with different values created bad experiences. We need the right people to communicate with, that are trained.”*

The situation assessment is an examination of the relationships between the Tribe or UIO that are anticipated to be involved in an event response. It includes gathering relevant information about the interactions of the stakeholders and their available resources to respond. It includes the determination of applicable regulations, policies and procedures, and available funding, equipment, and personnel expertise.

It is in this phase of preparation that background information can be shared regarding the Tribe's or UIO's response and recovery during the COVID-19 pandemic, with specific attention to its relationship to the President's public health emergency declaration and the opportunities and challenges it provided. This collection of data will provide a place to gather the actions taken and lessons learned, which can be used to set the foundation for future events. This effort will need to be conducted by an independent, neutral source to ensure the individuals are comfortable and do not fear retribution for exposing challenges they encountered. Participant Interview

Quote: *"We need a safe space to share our true feelings without fear of retribution."*

It is in this phase that a hired facilitator or the person assigned as the Plan Champion gathers the assigned stakeholders and begins a collection and analysis of baseline information. It is at this first meeting a team will begin to be formed. One exercise that might be conducted is the Strengths, Weaknesses, Opportunities, and Threats (SWOT). It helps clarify issues from the past, an understanding of the present, and opportunities for the future. Participant Interview

Quote: *"Tribes stayed the course when the county shifted away from CDC protocols."*

Phase 4. Medicine Wheel Quadrant 2: Plan to Create an Emergency Preparedness Plan

Quadrant 2 of the medicine wheel represents the planning of the Indigenous emergency preparedness plan. The Indigenous features emphasized in the medicine wheel reflect a time of

growing. Fire is the universal element, as the heat and light from it is needed for growth. The sun is high in the sky which is prominent in the south and in summertime. It pertains to the age of adolescence, as they learn their place, emotionally and in their family.

There are two focus areas identified in the UN Human Settlement Programme Strategic Planning Wheel in the category Plan. For the Indigenous Medicine Wheel it is a time to plan. Each of the focus areas are explained below, with the connection to the Indigenous Themes identified through the participant interviews.

Indigenous Theme: Build Partnerships; UN Focus Area: Visioning: A vision is the act of imagining. (*Merriam Webster Dictionary*, 1982) A vision clarifies the final outcome for the Plan. It is a snapshot of what is wanted for the future. It must be based on core values that are held across the stakeholders. This may be a challenge due to the diversity and numbers of stakeholders identified. Yet, it is paramount to come to agreement after everyone has a chance to express their ideas and hopes. The vision will guide the remaining portion of the process. When conflicts arise, the vision will be reflected upon to remind the process members of the important work they are doing.

In this part of the medicine wheel, the focus is on finding support for the plan. It forces a reflection on ones needs and values to discover partners and necessary relationships. It is important all aspects of the community are assessed and not just those that are most similar or likely to be good contributors. In an emergency, partners may come from unanticipated areas.

- Participant Interview Quote: *“The most important thing was relationship in Indian Country.”*

- Participant Interview Quote: *“We felt like we were left on an island, without support from those we thought were our partners.”*

Indigenous Theme: On-going Communication; UN Focus Area: Issues and Objectives:

As the identification of issues and objectives, the results of the SWOT exercise completed in the preparation phase of the process, can be used, as well as others process members may contribute. Issues can be those of one stakeholder group, those of a segment of the stakeholder group, or those for all stakeholders. It is important to provide ample opportunity for process group members to share their issues, as it will allow them to express their concerns and add to their belief and build ownership in the final Plan.

A brainstorming exercise might be useful to generate issues. For this exercise to be effective, all ideas must be collected without judgement or fear of ridicule. (Tibaijuka, 2005) Once all issues are identified, the exercise concludes with process members combining issues into like or similar groupings and then the process of identifying objectives can proceed.

Issues are translated into objectives. Clearly written objectives become the roadmap for the emergency preparedness plans. Because of the significant role the objectives have in the Plans, adequate time must be allocated for their development.

One way to ensure meaningful objectives are crafted is to utilize the SMART objective approach. SMART is an acronym where the S stands for smart, M stands for measurable, A stands for appropriate, R stands for realistic, and T stands for time dated. Adhering to the SMART objective approach ensures a clear direction will be set for the Plan. The table 3 was taken from the Promoting Local Economic Development through Strategic Planning Volume 2: Where do we want to go? to serve as a checklist for each of the objectives within the Tribe's or

UIO's emergency preparedness plan. (Promoting Local Economic Development through Strategic Planning: Where Do We Want to Go?, 2005)

Table 4: Smart Objective Checklist

	Name	Explanation	Complete with a check
S	Specific	Does the objective state precisely in simple terms, what is to be achieved?	
M	Measurable	Does the objective have clear indicators to give it meaning and clarity?	
A	Appropriate	Does the objective fall within the overall vision? Is it an emergency preparedness objective or does it belong in a linked planning process?	
R	Realistic	Given resources and constraints, is the objective achievable?	
T	Time dated	Can a time limit be set for the achievement of the objective by date and duration?	

Objectives serve as the foundation for the implementation of the Plan. They assist in the development of the Plan approach and actions. They will also be key in the evaluation phase.

Participant Interview Quote: *"Everyone in the community must be on the same page."*

Phase 6. Medicine Wheel Quadrant 3: Implement an Emergency Preparedness Plan

Quadrant 3 of the medicine wheel focuses on the implementation of the Indigenous emergency preparedness plan. The Indigenous features emphasized in the medicine wheel is at a time when a person has grown to an adult. They have found their connection to the land. Their role in their families is as parents, with a responsibility to care for adolescents and infants. They are mentors and role models and are mentally focused to be the foundation of their communities.

The sun is moving to the west, as daylight fades. Fall is the time to put into action the preparation and planning that has taken place.

There are three focus areas identified in the UN Human Settlement Programme Strategic Planning Wheel in the category Implementation. For the Indigenous Medicine Wheel it is a time to implement. The focus areas are explained below, with the connection to the Indigenous Themes identified through the participant interviews and participant interview quotes.

Indigenous Theme: Stay Patient Focused; UN Focus Area: Strategy Development: The strategic development phase focuses on transitioning the SMART objectives into action. In this phase, process members generate many ideas. All ideas are considered. Once all ideas are collected, the process members describe the ideas and combine them where appropriate. Next, the group can discuss, negotiate, combine, and agree on action to be taken. While small groups may be used to assess each SMART objective, a consensus of all process members is needed to define the action to be taken. An important consideration for the inclusion of activities is does it bring the Plan closer to fulfilling the vision.

Once the actions have been agreed upon by the process members, the action planning phase begins, with agreement on a description of the action. Next, the person or agency with the primary responsibility is assigned. This is followed by setting timelines and identification of resources including staff, support of process stakeholders, and funding. If all these elements cannot be reached by the process members, the action must be revisited and a determination of how to adapt the action to meet each of the action criteria. Finally, a discussion on the launch details for each of the actions is agreed upon by the process members, and with the way it will be communicated to the process stakeholders, leadership, and community, if appropriate.

- Participant Interview Quote: *“Patients were overlooked, like they weren’t there. They had no explanation of their diagnoses. No education about co-morbidities. Doctors and nurses would ask questions and patients couldn’t answer: They didn’t understand: They couldn’t ask questions, let alone express themselves to others.”*
- Participant Interview Quote: *“We adapted to the best of our ability to deliver services to our people.”*

Indigenous Theme: Increase Resources; UN Focus Area: Action Planning and

Organization and Implementation: Phase five’s final focus area is organizing to implement. This focus area puts the Plan into action. Unlike other strategic plans, the emergency preparedness plan does not have an official start and end date. It is Plan to be implement if an event happens. While one can fully expect the next emergency, crisis, or pandemic, will occur there is not a foreseeable time, which makes maintaining motivation to be ready harder. It may be easier to retain commitment tribal and UIO staff that worked through the COVID-19 pandemic, as they refer to themselves as veterans. However, as new staff join the workforce keeping them committed may be more difficult. Finding ways to connect the “veterans” with the new recruits will need to be a focus for leaders guiding this planning process.

There are specific actions the process members can include in their Plans. This includes training on the Plan, which may occur at different levels such as training for leadership, communication experts, and emergency responders. It is important to conduct tabletop exercises to practice the activities contained in the Plan.

The Plans need to include regularly scheduled check-in meetings with set dates, time, and location set in advance. A set agenda including the introductions of new staff that have joined the

response efforts. The meeting agenda should specify the length of meeting, to be respectful of the commitment the agencies and individuals are making. Ensuring meetings are productive and within a time constraint is important to maintain on-going attendance from individuals and support from the agencies they work for. In addition, orientation of recently hired staff on their responsibilities with the Plan at time of hire will be vital, as will exit interviews of staff when they leave jobs associated with the Plan.

The participants interviewed all stressed the importance of communication. They expressed the need for communication across multiple communication channels. In addition, they expressed the importance of messages being created for presentation by trusted messengers, such as elected leadership, elders, healthcare providers, and spiritual leaders. Participant Interview Quote: *“March 17, 2020, Saint Patrick’s Day was our ‘D Day’, we needed to act immediately.”*

Phase 6. Medicine Wheel Quadrant 4: Evaluate an Emergency Preparedness Plan

Quadrant 4 of the medicine wheel represents the time to assess the overall Plan and its impact. The Indigenous features emphasized in the medicine wheel is a time of reflection. Water is life and prominent in this quadrant. The sun has set, and darkness allows for quiet time within our spiritual prayers. It is a time for the elders to consider what is best for the whole Tribe and teach and share through storytelling. In these stories are the lessons from other quadrants to use, when the cycle repeats, returning to the first quadrant.

There are two focus areas identified in the UN Human Settlement Programme Strategic Planning Wheel in the category evaluate, as it is for the Indigenous Medicine Wheel. Each of the

focus areas are explained below, with the connection to the Indigenous Themes identified through the participant interviews.

Indigenous Theme: Honor Our Values; UN Focus Area: Monitoring and Evaluation:

Phase six is the monitoring and evaluation focus areas of the strategic planning wheel.

Monitoring and evaluation are different. Both are needed for different purposes. Compliance monitoring is the review to determine if agreed upon activities are complete. The second type of monitoring regards the impact of the activities undertaken. Evaluation uses the information generated by the monitoring. Monitoring is conducted internally and is ongoing. Evaluation is, most often, conducted by an independent, outside entity and occurs at a specific timeline of a project. Both are important to the sustainability of the Plan.

Results from the monitoring and evaluation are key to reporting to the governing body of the Tribes and UIOs and key stakeholders' leadership. The outcomes can be considered to be reported to the communities. Success or ways to improve are validated through the evaluation. Participant Interview Quote: *"It was a privilege to work with our patients and community members."*

Indigenous Theme: Self-Care and Wellness; UN Focus Area: Adjust and Modify: The most important function of the evaluation is its utilization to adjust and modify the Plan. As the key stakeholders review the evaluation, it provides an opportunity to improve the Plan. It can guide the revision of actions or suggest new partners or different ways to communicate. While at times evaluation may be seen as negative, it should be framed as a time to get better. It is at this focus area a determination to recommit is foremost.

Included in the Plan is the need for responders to debrief following the events. This includes debriefing regarding the professional response, with a focus on what worked, what did not work, and what can be done better in the next event. Debriefing must also occur on a personal level and assistance should be provided for responders to practice self-care.

Finally, a time to celebrate must be worked into the Plan. It can celebrate small successes, such as hitting certain milestones in the launch strategy or an anniversary of key date. When significant Plan actions are achieved, a time to celebrate and congratulate the Plan members and responders is key to its sustainability. Participant Interview Quote: *“We need to find out where do we go and how do we truly recover, especially for frontline workers.”*

Strengths and Challenges for Tribes and UIOS in the Indigenous Strategic Planning Process

As COVID-19 continues to exist in the US and Indian Country, it is a reminder to Tribes and UIOs to plan for what disaster may happen next. There is a tremendous amount of pride, buried in the heartache from the loss of life, when responders reflect on their response during the initial phase of the COVID-19 pandemic before the vaccine became available. The participants interviewed speak clearly about the importance of the work they did during a time of uncertainty. They reflect on being scared and having tremendous fear. Yet, they went to work, often putting in 12- and 16-hour days. One participant described her work demands as “flying a plane without knowing the destination.” Many spoke about being creative, trying new solutions, and thinking outside the box. As they reflected on their work, often through tears, they wished they could have done more for more community members, and that it was a “privilege” to have served during this difficult time.

While most of them see the value and appreciation of the work they did, there is also the need to move ahead. There are many different priorities surfacing that takes their time and attention. It is hard to find balance. After nearly four years, COVID fatigue has set in and there is no more energy to put towards it. There is an agreement emergency preparedness planning is needed but is there time and energy to do it?

AIANs have been researched for generations. Emergency preparedness planning might be seen as another academic exercise. Just like grants and grant funding comes and goes, so does strategic planning, where the completed plans sit on a shelf, gather dust, and remain unused until the next consultant or governmental programs offers the next version of planning. The challenge as the effort begins to conduct emergency preparedness will be to remind those Tribes, UIOs, and key stakeholders of how being prepared may have changed their initial COVID-19 pandemic responses. Additionally, it is important to remind them of the importance of improved health outcomes.

Conclusion

The COVID-19 pandemic changed the Tribes and UIOs in Montana. While the devastation from losses of lives and impact on the other fundamental Indigenous lifeways and culture of Indigenous people in Montana, the most important action to be taken is to prepare for the future. It is a way to honor those lost and those that will come after. It is essential deliberate actions be taken to heal from COVID-19. Otherwise, the negative effects will be brought forward. Together, across Tribes, UIOs, stakeholders and partners, Indigenous and non-Indigenous communities healing is needed and possible. Most importantly, the seven generations that are to come are counting on us.

CHAPTER FIVE

CONCLUSION

Indigenous people, when guided by their traditional knowledge, culture lifeways, and well-being, are fully capable to address any situation brought to them. This conclusion is established based on the findings from the three dissertation products contained in the dissertation. Upon examination of the response and recovery from the COVID-19 pandemic by Tribes and UIOs in Montana, the resilience and determination demonstrated across Indian Country, in the midst of the devastation occurring from it, was remarkable. The findings included herein must be contemplated, and when possible, followed, to provide the highest probability of different outcomes in future emergencies, crises, and pandemics.

The three dissertation products concluded that comprehensive planning is needed to guide tribal and UIO response and recovery from an emergent event. The plan must be written, implemented, and monitored by the Tribe or UIO, with extensive training of partners and stakeholders. The plan must be flexible in such areas as the way services are delivered, acquiring needed manpower, and utilization of resources to meet the immediate needs of the Tribes or UIOs. Communication, across all media channels and by trusted messengers, with a focus across multiple targeted populations such as leadership, employees of partners and stakeholders, and community members is essential. Communication is key throughout the planning process, beginning when the decision to create a plan is made, during the plan creation, at the time of plan adoption, and on-going to keep the plan in the forefront and readily available for its effectuation at the time an emergent event occurs.

The planning process can be guided by academic research. While there has been an abundance of scholarly investigations about AIANs on a multitude of topics, this dissertation concluded that the studies must engage the tribal communities to generate topics of relevant interest, throughout the entire study period including sharing the resources available from it and allow the Tribes or UIOs to control the dissemination and ownership of the findings.

Additionally, it is imperative scholars indigenize or use Indigenous models and frameworks to conduct the research. As was used throughout this dissertation, the medicine wheel icon can be built upon to guide studies, as it has the confidence of Indigenous populations and research confirms its approach. It is clear tribal communities seek assurance the actions they are taking are making a difference. The information needs to be available in a timely manner and based on quality data, which will deliver improved outcomes.

People were scared. They feared getting sick or getting children, elders, or those with compromised immune systems sick. They feared the long-time impact social distancing, isolation, and quarantine would have on youth. They feared not having enough food, not being able to go to the store to purchase needed items due to supply scarcity. They feared going to doctors and hospital to access healthcare or not having access to healthcare for preventive or chronic health conditions. They feared not being able to go to work or having to go to work, where they would contact COVID-19.

While fear was present, important positive lessons were learned during the COVID-19 pandemic. For Indigenous people, they returned to their connection to land for their individual and family's physical, emotional, mental, and spiritual wellbeing. They found confidence in their local leaders, who worked to build trust when the federal and state government authorities

provided conflicting messages and failed to provide ways to keep individuals, families, and communities, safe. The Tribes, through the execution of their tribal sovereignty, were the best equipped to meet the needs of their tribal and other community members. Tribal cultures were affirmed as life sustaining and necessary to be safe and to heal.

This dissertation found that emergency preparedness planning is important to respond to future emergencies but there are other significant reasons to conduct this work. It is a way to honor those that lost their lives to COVID-19 disease, especially since cultural ways to grieve at the time of their death was prohibited. It is a way to show appreciation for those that responded, at times at risk to their own health and the health of their families. While most shared it was a privilege to have served during the COVID-19 pandemic, there is a tremendous amount of healing that needs to occur and be on-going. Healing enforces the sense of belonging that is needed for all of us.

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APPENDICES

APPENDIX A

SKC INFORMED CONSENT FORM

Informed Consent Form

Project Title: Lessons Learned from Tribes and Urban Indian Organization (UIO) Response to COVID-19 Pandemic in Montana

You are being asked to participate in a voluntary research study. The purpose of this study is to join with two Tribes and one UIO in Montana to understand the lessons you learned during their COVID-19 pandemic response and through the ongoing recovery to understand the successes and challenges you experienced to create an Indigenous strategic planning document for Tribes and UIOs in Montana to create emergency preparedness plans. Participating in this study will involve interviewing high level Crow and Helena Indian Alliance administrators, who were involved in the COVID-19 pandemic response and recovery and your participation will last approximately eight months. Risks related to this research include may include participants to remember difficult issues related to COVID-19; benefits related to this research include the opportunity to engage in a process that will result in Indigenous specific emergency preparedness plan.

Principal Investigator Name and Title: Anna Whiting Sorrell, MSU Indigenous and Rural Health PhD student, graduate research assistant, and principal investigator for Montana Health Care Foundation grant

Contact Information: awsorrell@yahoo.com, telephone: 406.261.5524

Secondary Investigator/Faculty Advisor Name and Title: Dr. Alexandra Adams, Director Department and Institution: Center for American Indian and Rural Health Equity, Montana State University

Contact Information: Alexandra.adams2@montana.edu, telephone: 406-994-6077

Why am I being asked?

You are being asked to be a participant in a research study to assist in the development of an Indigenous strategic planning template, which may be used by Tribes and Urban Indian Organizations to create emergency preparedness plans. The purpose of this research is to assist Tribes and UIOs with a template to develop their own emergency preparedness plan before the next emergency, crises, or pandemic. You have been asked to participate in this research because of your experience and expertise in the COVID-19 response and recovery.

Your participation in this research is voluntary. Your decision whether to participate will not affect your current or future dealings with Salish Kootenai College or the researchers. If you decide to participate in the research, you are free to withdraw at any time without affecting those relationships.

What procedures are involved?

This research will be performed at a location mutually agreed upon by researcher and participant. You will need to meet with the researcher at a minimum of four time and a maximum of seven times over the next eight months. Each of those visits will last a minimum of one hour and maximum of two hours, unless an extension of time is agreed upon by the participant.

What are the potential risks and discomforts?

The interviews may trigger uncomfortable memories or experiences related to the COVID-19 pandemic response and recovery, which may be personal in nature although all questions asked will focus on your professional involvement.

Are there benefits to participating in the research?

The interviews will serve as the foundation of the creation of a tribal-specific emergency preparedness plan, which will guide future emergencies, crises, and pandemics. It is believed tribal preparedness will improve future responses and possibly diminish negatives impacts of the emergency, crisis, or pandemic.

What other options are there?

You have the option to not participate in this study.

Will my study-related information be kept confidential?

We will use all reasonable efforts to keep your personal information confidential, but we cannot guarantee absolute confidentiality. When this research is discussed or published, no one will know that you were in the study. But, when required by law or college policy, identifying information (including your signed consent form) may be seen or copied by: a) The Institutional Review Board that approves research studies; b) auditors responsible for oversight of research; c) or Montana Health Care Foundation, the funder of this research.

Will I be reimbursed for any expenses or paid for my participation in this research?

Gift cards, in the amount \$100 / per interview will be provided for your participation in this research. Breakfast, lunch, or dinner, according to time, of interview will be provided.

Can I withdraw or be removed from the study?

If you decide to participate, you are free to withdraw your consent and discontinue participation at any time. The Obest interests.

Will data collected from me be used for any other research?

Your information will not be used or distributed for future use, even if identifiers are removed.

Who should I contact if I have questions?

Contact the researchers Anna Whiting at 406.261.5524 or awsorrell@yahoo.com if you have any questions about this study or your part in it, or if you have concerns or complaints about the research.

What are my rights as a research subject?

If you have any questions about your rights as a participant in this study, please contact the Montana State University Institutional Review Board.

I have read the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I will be given a copy of this form.

Signature

Date

Printed Name

Signature of Person Obtaining Consent

Date

Printed Name of Person Obtaining Consent

.

APPENDIX B

MSU INFORMED CONSENT FORM

Informed Consent Form

Project Title: Lessons Learned from Tribes and Urban Indian Organization (UIO) Response to COVID-19 Pandemic in Montana]

You are being asked to participate in a voluntary research study. The purpose of this study is to join with two Tribes and one UIO in Montana to understand the lessons learned during their COVID-19 pandemic response and through the ongoing recovery to understand the successes and challenges experienced to create an Indigenous strategic planning document for Tribes and UIOs in Montana to create emergency preparedness plans. Participating in this study will involve interviewing high level tribal and UIO health administrators, who were involved in the COVID-19 pandemic response and recovery and your participation will last approximately eight months. Risks related to this research may foster participants to remember difficult issues related to COVID-19; benefits related to this research include the opportunity to engage in a process that will result in an Indigenous strategic planning template, which may be used to create tribal/UIO specific emergency preparedness plan.

Principal Investigator Name and Title: Dr. Alexandra Adams, Department Director, and
Institution: Center for American Indian and Rural Health Equity, Montana State University
Contact Information: Alexandra.adams2@montana.edu, Telephone: 406-994-6077

Project Manager: Anna Whiting Sorrell, MSU Indigenous and Rural Health PhD student,
graduate research assistant, and program manager for Montana Healthcare Foundation Grant
Contact Information: awsorrell@yahoo.com, Telephone: 406.261.5524

Additional contract information: Montana State University (MSU) Institutional Review Board (IRB) irb@montana.edu Telephone: 406.994.4706

Why am I being asked?

You are being asked to be a participant in a research study to assist in the development of an Indigenous strategic planning template, which may be used by Tribes and Urban Indian Organizations to create emergency preparedness plans. The purpose of this research is to assist Tribes and UIOs create a template to develop their own emergency preparedness plan before the next emergency, crisis, or pandemic. You have been asked to participate in this research because of your experience and expertise in the COVID-19 response and recovery.

What procedures are involved?

This research will be performed at a location mutually agreed upon by researcher and participant. You will need to meet with the researcher several times, over the next eight

months. Each of those visits will last a minimum of one hour and maximum of two hours, unless an extension of time is agreed upon by the participant.

What are the potential risks and discomforts?

The interviews may trigger uncomfortable memories or experiences related to the COVID-19 pandemic response and recovery, which may be personal in nature although all questions asked will focus on your professional involvement.

While extremely minimal, there may be a potential risk to your job, if negative information is shared about the Tribe/UIOs response. Also, there may be damage to the Tribe/UIO reputation if negative information is shared about the Tribe/UIO's handling of the COVID-19 pandemic response and recovery. The PI and PM will do everything in their capacity to ensure these things do not happen. The research questions asked focus on lessons learned and responses will be used in aggregate with the other participants and your information deidentified. Your information will not be used or distributed for future use, without your written permission.

Are there benefits to participating in the research?

The interviews will serve as the foundation of the creation of a tribal-specific emergency preparedness plan, which will guide future emergencies, crises, and pandemics. It is believed tribal/UIO preparedness will improve future responses and possibly diminish negative impacts of future emergencies, crises, or pandemics.

What other options are there?

You have the option to not participate in this study.

Will my study-related information be kept confidential?

The names of the participating Tribes and the UIO will be stated in the final report to the Montana Healthcare Foundation and when the research is presented. However, we will use all reasonable efforts to keep your personal information confidential, but we cannot guarantee absolute confidentiality. When this research is discussed or published, no one will know that you were in the study. But, when required by law or college policy, identifying information (including your signed consent form) may be seen or copied by a) The Institutional Review Board that approves research studies, or auditors responsible for oversight of research.

Will I be reimbursed for any expenses or paid for my participation in this research?

Gift cards, in the amount \$100 / per interview will be provided for your participation in this research. Breakfast, lunch, or dinner, according to time, of interview will be provided.

Can I withdraw or be removed from the study?

If you decide to participate, you are free to withdraw your consent and discontinue participation at any time. The researchers also have the right to stop your participation in this study without your consent if they believe it is in your best interests.

Will data collected from me be used for any other research?

Your information will not be used or distributed for future use, without your written approval.

Who should I contact if I have questions?

Contact the researchers Anna Whiting Sorrell at 406.261.5524 or awsorrell@yahoo.com if you have any questions about this study or your part in it, or if you have concerns or complaints about the research. Contact may also be made to the MSU IRB at 406.944.4706 or irb@montana.edu

What are my rights as a research subject?

Your participation in this research is voluntary. Your decision whether to participate will not affect your current or future dealings with MSU or the researchers. If you decide to participate in the research, you are free to withdraw at any time without affecting those relationships.

If you have any questions about your rights as a participant in this study, please contact the Montana State University Institutional Review Board.

I have read the above information. I have been given an opportunity to ask questions and my questions have been answered to my satisfaction. I agree to participate in this research. I will be given a copy of this form.

Participant Signature

Date

Participant Printed Name

Signature of Person Obtaining Consent

Date

Printed Name of Person Obtaining Consent

APPENDIX C

SAMPLE INTERVIEW QUESTIONS

**Sample Questions for Tribes and Urban Indian Organizations
For Planning for the Next Emergency, Crisis, and Pandemic**

Name of interviewee:

Date:

Position:

Tribe or UIO name:

- 1. Describe your role in the COVID-19 response including as it continues following the end of the United States Emergency, and efforts in recovery.**
- 2. Did the Tribe or UIO have an emergency preparedness plan? Was there an emergency response team? If yes, please provide details.**
- 3. Were additional resources (funding, source of additional funding, staffing, expertise, supplies) provided to Tribes, UIOs, and IHS to respond and recover from the COVID-19 pandemic and currently as COVID-19 continues.**
- 4. What do you think were the most important lessons learned from your Tribes/UIOs COVID-19 responses/recovery**
- 5. What were the most difficult parts of your participation in the COVID-19 pandemic response/recovery?**
- 6. If you were planning for another pandemic or crisis like COVID, what would be most helpful, what decisions would you make differently, etc.**
- 7. Please let me know if I missed anything or what you would add.**

APPENDIX D

TRANSCRIPTIONIST CONFIDENTIALITY AGREEMENT

Transcriptionist Confidentiality Agreement

For: Lessons Learned from Tribes and Urban Indian Organizations (UIO)
Response to COVID-19 Pandemic in Montana

I, _____, transcriptionist, agree to maintain full confidentiality in regard to any and all audio and/or video recordings and documentation received from Anna Whiting Sorrell related to *Lessons Learned from Tribes and Urban Indian Organizations (UIO) Response to COVID-19 Pandemic in Montana* project.

Furthermore, I agree:

To hold in strictest confidence the identification of any individual that may be inadvertently revealed during the transcription of audio and/or video recorded interviews, or in any associated documents;

To not make copies of any audio records of the transcribed interviews, unless specifically requested to do so by Anna Whiting Sorrell.

To store all study-related audio materials in a safe, secure location as long as they are in my possession;

To return all study-related audio materials to Anna Whiting Sorrell in a complete and timely manner.

To delete all electronic files containing project-related documents from my computer hard drive and any backup devices.

I am aware that I can be held legally liable for any breach of this confidentiality agreement, and for any harm incurred by individuals if I disclose identifiable information contained in the audiotapes and/or files to which I will have access.

Transcriber's name (printed)

Transcriber's signature

Date