

National Indian Health Board



Submitted via: <http://www.regulations.gov>

September 14, 2016

Akua White
Nutritionist, Nutrition Services and Access Branch USDA,
Food and Nutrition Service, Room 508,
3101 Park Center Drive
Alexandria, VA 22302

**Re: Agency Information Collection Activities: Proposed Collection; Comment Request-
FDPIR Nutrition Paraprofessional Training Assessment for Indian Tribal Organizations**

Dear Akua White:

On behalf of the National Indian Health Board (NIHB), I write to submit comments on the Food and Nutrition Service's proposed information collection plan regarding the introduction of Nutrition Paraprofessional Training under the Food Distribution Program on Indian Reservations (FDPIR).

Established in 1972, the NIHB is an inter-Tribal organization that advocates on behalf of Tribal governments for the provision of quality health care to all American Indians and Alaska Natives (AI/ANs). The NIHB is governed by a Board of Directors consisting of a representative from each of the twelve Indian Health Service (IHS) Areas. Each Area Health Board elects a representative to sit on the NIHB Board of Directors. In areas where there is no Area Health Board, Tribal governments choose a representative who communicates policy information and concerns of the Tribes in that area with the NIHB. Whether Tribes operate their entire health care program through contracts or compacts with IHS under Public Law 93-638, the Indian Self-Determination and Education Assistance Act (ISDEAA), or continue to also rely on IHS for delivery of some, or even most, of their health care — the NIHB is their advocate.

AI/ANs have long experienced lower health status when compared to other Americans and they continue to experience disproportionate health disparities. These health disparities are only partially exemplified by the staggering chronic disease rates that pervade across nearly all AI/AN reservation and Tribal jurisdiction area-based communities in the lower 48 states and Alaska. Statistically, the Indian Health Service in 2011 reported that roughly 80% of AI/AN adults are classified as being either overweight and/or obese, and 1 in 2 youth are slated to develop diabetes in adulthood. In a landmark report released by Peggy Halpern, Ph.D. of the U.S. Department of Health and Human Services, (HHS), the Office of the Assistant Secretary for Planning and Evaluation reported how since 1990, obesity rates have doubled for AI/AN children between the ages of twelve to nineteen, and tripled for youth between the ages of six and eleven. These numbers are exacerbated by the

prevalence of food deserts, exceedingly high rates of poverty, lack of critical infrastructure and a transition from an agrarian to sedentary lifestyle. For instance, the USDA has classified the entire Navajo Nation, which encompasses over 27,000 square miles— a landmass roughly the size of West Virginia—as a food desert with merely 10 fully operable grocery stores. Moreover, it is not uncommon for residents to travel upwards of 240 miles roundtrip to access a supermarket. These factors, amongst many others, have collectively beset Tribal communities with chronic disease rates that are consistently higher than the rest of the US population.

As you know, FDPIR was initially authorized under Section 4(a) of the Agriculture and Consumer Protection Act of 1973, reauthorized under Section 4(b) of the 2008 Food and Nutrition Act and codified in the latest Agricultural Act of 2014, and authorized through 2018. In its original form and purpose, FDPIR was meant to be an additional food source for Tribal residents on or near reservations. However, current statistics place 93,000 participants across 276 Tribes as reliant on FDPIR. Additionally, in the most recent summary of FDPIR participation, USDA reported how 38% of households classify FDPIR as their “...sole or primary source of food” while nearly 10% classify it as their only source of food. FDPIR is not just an ‘additional’ source when such a high percentage of AI/ANs are so heavily reliant on its existence.

Given the exorbitant chronic disease rates pervading Indian Country, lack of nutritional education and lack of access to healthy foods remain key focus areas for organizations such as NIHB working towards improved health outcomes for Tribal communities.

We appreciate FNS’ dedication towards expanding access to nutrition education for ITO staff administering FDPIR, and support the training assessment to ensure that the education is delivered in the most effective and culturally competent manner. However, we posit that FNS needs to be incredibly mindful and pay careful consideration to how this program is implemented. Paraprofessional training programs are not new to Indian Country. The Community Health Aide Program (CHAP), Behavioral Health Aide (BHA) Program, and the Dental Health Aide Program (DHAT) through Indian Health Service (IHS) facilities in Alaska have proven success records that have enhanced the delivery of medical, dental and mental health care to some of the most rural Tribal communities in the country. For example, more than 40,000 Alaska Natives across 81 communities have gained access to dental care through the DHAT model in Alaska, and Alaska Native children are now being seen with no cavities. The DHAT model has also built community health care delivery capacity and created jobs by training community members to become DHATs.

Without a doubt, nutrition education is a dire need in Indian Country, and we are encouraged to see FNS taking measures to increase access. Based on the guidelines listed in the FNS Federal Register posting, the NIHB has provided recommendations for ensuring that the training assessment program is conducted in a way most mindful of Tribal sovereignty, Executive Order 13175, and in the most culturally competent manner.

Firstly, Executive Order 13175, first authorized by former President Bill Clinton and reauthorized by every incumbent forward, requires all Federal agencies to conduct meaningful and representative consultation sessions with Tribal governments prior to the enactment of any legislation or policy that will impact Indian Country. FDPIR is a Tribal nutrition assistance program, and thus any changes to its functionality, scope, administration or activities will affect residents of Indian Country. As outlined in the Federal Register, FNS has planned to conduct open-ended interviews with FDPIR directors from 23 ITOs, and “...15 key stakeholders considered expert representatives of FDPIR, ITOs, and/or experts in nutrition training.” FNS has intended for this information to gauge and inform:

- interest in the paraprofessional training project
- types of nutrition training topics
- determining the most effective and culturally competent format for training
- determining motivational factors for engaging in nutrition training

Although NIHB is glad that a considerable percentage of ITO agents are included in the scope of the interview process, we propose that this is insufficient to be considered robust, meaningful consultation. Indeed, consultation itself has a unique, specified structure that must be adhered to in order for it to judiciously be classified as such. Furthermore, NIHB recommends that these interviews not only be expanded to include recipients of FDPIR—who would most directly be affected by the inclusion of a paraprofessional training initiative—but also to Tribes themselves. Although no Tribe independently administers FDPIR, this should not exclude them from being able to voice opinions, objections or recommendations for how their Tribal citizens can be best served by the program.

More specifically, FNS needs to consider the burgeoning food sovereignty movement, and how Tribal efforts towards reintroducing traditional foods requires a different approach than the predominately Western model of nutrition education. We ask that FNS take concerted measures to involve traditional Tribal healers, nutritionists, and elders, who are knowledgeable in the various foods consumed by their communities since time immemorial. By doing such, FNS will ensure the cultural competency of the nutrition education training program while also reducing barriers in motivation to participate.

We also ask that Tribes and ITO staff work together to set the standard for how the paraprofessional training program will be delivered. Similar to CHAP and other programs administered by the IHS, such programs best serve Indian Country when they are developed by the community members themselves. Indeed, this has been the cornerstone of the success we have seen with CHA/Ps, DHA/Ts and BHA/Ps. We encourage FNS to consult with the various experts in these programs and seek their recommendations for how best to integrate a community-based, culturally competent and inclusive paraprofessional training program.

We would like to emphasize our recognition and appreciation of FNS' efforts to improve the nutrition education provided by FDPIR staff. We believe that although it is absolutely a step in the right direction, additional measures must be taken to ensure that the program is implemented with the full endorsement and understanding of Tribal leaders, FDPIR recipients, and ITO staff. Therefore, we hope that FNS will consider working with Indian Country and arriving at a mutually equitable solution. Indeed, federal law mandates that FNS engage Tribes in active, meaningful consultation by virtue of Executive Order 13175. This consultation must occur prior to the rulemaking process.

We appreciate the USDA FNS for their continued efforts to engage Tribes and improve the livelihood of Indian Country. Additionally, we encourage the FNS to maintain and build on their relationship with key Tribal stakeholders, and continue striving for better health outcomes. Thank you again for this opportunity to comment. Please contact Devin Delrow, NIHB Federal Relations Director at ddelrow@nihb.org if you have any questions on the concerns raised above.

Sincerely,

A handwritten signature in blue ink, appearing to read 'Lester Secatero', with a long horizontal flourish extending to the right.

Lester Secatero
Chairman, National Indian Health Board