

The Formation of the Indian Health Board: Culturally Sustaining Healthcare in the Phillips Neighborhood of Minneapolis, 1971-present



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Table of Contents

Acknowledgements.....3

A Note on Language.....4

A Note on Methodology.....6

Introduction.....9

Part I
Co-evolution of Federal Indian Policy and the Indian Health Service: Phases of Federally Funded Genocide, Containment, and Assimilation.....16

Part II
Native Activism and Community Building: Relocation and the Formation of the Indian Health Board.....29

Part III
Culturally Sustaining Healthcare at the Indian Health Board.....45

Conclusion
Ensuring the Health & Wellness of Our People for Seven Generations to Come.....60

Appendix.....65

Bibliography.....73

Bibliographic Essay.....81

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Note on Language

The terms *American Indian*, *Native American*, and *Native* refer to groups of people who are indigenous to an area within the noncontiguous United States prior to European contact. The term *American Indian*, reminiscent of Columbus's misconception that he had landed on the coast of South Asia, has been used over 200 years in government documents and holds a specific legal definition under the branch of Federal Indian Law. The fourth term, *Indigenous peoples*, refers to people who lived as a community prior to contact with settler populations, in or outside of the United States, and continue today. Preference varies across families, communities, countries, and persons: in a 2018 *Indian Country Today* article, Amanda Blackhorse interviewed Native people and gained consensus that "whenever possible, Native people prefer to be called by their specific tribal name."¹

Mni Sota Makoce (Dakota language for *Land Where the Waters Reflect the Clouds* – Minnesota) is the homeland of the Dakota people. Through the Indian Removal Act of 1863, the federal government forcibly removed Dakota people from Minneapolis, Minnesota and exiled them reservations on leftover land in the west.² Today there are 11 reservations in Minnesota: four Dakota reservations in the southern portion of the state and seven Ojibwe reservations in the north.³ Comprising the main nations in the Twin Cities, the tribal affiliations of Ojibwe and Dakota, along with their specific band names whenever possible, will appear throughout this paper.

Each of the terms outlined here will appear throughout this paper, but it is my intention to follow this guideline:

- ❖ *American Indian* or *Indian* is used only when necessary for historic documents or items pertaining to Indian Federal Law.
- ❖ Whenever possible, groups or individuals will be identified by their specific tribal names.

¹ Amanda Blackhorse, "Native American vs. Indian," *Indian Country Today*. September 13, 2018, <https://ictnews.org/archive/native-american-vs-indian>.

² For a more in-depth Dakota history of Minnesota, see Gwen Westerman et al.'s *Mni Sota Makoce: The Land of the Dakota People*, which captures the true devastation of Indian removal while still celebrating the Dakota people and their undisputed connection to Minnesota. Additionally, the Bdote Memory Map (<http://bdotememorymap.org/>) weaves together oral histories on the importance of urban areas in the Twin Cities for the Dakota people.

³ A succinct list of the Minnesota tribes and information on their reservations can be accessed through the Minnesota Tribal-State Government to Government Relations training cite, here <https://www.dot.state.mn.us/tribaltraining/tribe-map.html>. For a larger undertaking of the current presence of Ojibwe and Dakota peoples in Minnesota, see Anton Treuer's *Ojibwe in Minnesota*.

- ❖ *Native* and *Indigenous* will be used most often, interchangeably, to discuss groups or communities of people in historic and present contexts.
- ❖ All interviewees will be referred to as they requested or self-identify within the interview.
- ❖ All quotes and names of movements, organizations, and programs retain their original terminology.

Note on Methodology

Auntie Denise impressed upon me a philosophical understanding of beadwork, that beads have a mind of their own, and it is simply the beader's job to follow those pathways. Beads are our ancestors, memories guiding next generations. Together, hunched over leather, we worked together, coating thread in beeswax and running it through the history of our ancestors.

Research, my auntie Heid tells me, is like beading stories.

Stories, my auntie Louise smiles, are the heart of our people.

And our people, Mom says, each have a special role in our community.



Figure 1. My grandmother Rita and great-auntie Dolores with my great-great-great grandmother Eliza's beadwork: a symbol of the persistence and survival of a woman who made a living hitching on trains to peddle her beadwork. These three matriarchs have taught me to tell our stories through our art.

My role, as a beadworker and historian, is to tell our peoples' stories intertwined with our voices and our arts. In resistance to cultural genocide, Native peoples developed survival strategies, like oral histories and beadwork, that we continue to adapt in response to our community's needs. These strategies are Indigenous methodologies of survival, and by extension, the methodologies of reclaiming our health.

For thousands of years, Native people across the Northern Plains painted beautiful hides, fashioned birchbark into elegant and useful containers, shaped porcupine quills into patterns on leather, wove grass and fibers into intricate baskets, and handcrafted beads from stones, bones, shells, rocks, and clay among other items of the earth.⁴ During the mid 1700s into the late 1800s, Italian families produced thousands of glass beads for European merchants, sending them on ships to the New World where they reached Native hands through the fur trade.⁵ Upon contact with Europeans and the new technologies introduced in the fur trade, early Native art forms adapted, incorporating the new materials in the flourishing production of traditional designs.⁶ Beads that formerly took days to hand shape were now available in vials of hundreds and sinew that took weeks to harvest, shred, and dry could suddenly be pulled as cotton thread from a spool.

Contemporary Anishinaabe beadwork comes from the fusion of art forms to create traditional Anishinaabe designs with materials that came from colonization. Beadwork reflects the important work of Indigenous ancestors who incorporated knowledge gained through trade and the Indigenous diaspora as a means of economic and cultural survival. Like beadwork, the history of Native healthcare in the United States is wrought with the complications of colonization and made better by the ingenuity and survivance of Native peoples.

Though treaty-mandated to protect Native peoples, government run Native healthcare simultaneously operated as a force of genocide – under the guise of keeping peace through removal, containment on reservations, and later through assimilation and termination – until the 1970s, when years of Native activism returned agency over our own welfare through self-determination policy and the formation of urban Native health clinics. Urban Native health initiatives surpassed self-determination and evolved into a form of culturally tailored healthcare that fosters Indigenous resiliency, tradition, and community within cities.

Western worldviews are not used to integrating art into other aspects of life. But in Native ways of knowing, we are all connected; art is tied to health – art saves lives. In this paper,

⁴ Edna J. Garte, "Living tradition in Ojibwa beadwork and quillwork," *Algonquian Papers-Archive* (U of Minnesota 1985).

⁵ Marcia G. Anderson, *A Bag Worth Pony: The Art of the Ojibwe Bandolier Bag*, Minnesota Historical Society Press, 2017.

⁶ Lois S. Dublin, *Floral Journey: Native North American Beadwork*, University of Washington Press, 2014.

I integrate beadwork imagery to challenge readers to use their visual senses to enhance their experience of this work. Beadwork and culturally tailored urban Native healthcare are intertwined by their ability to transform communities through reclamation of Indigenous traditions of art, wellness, and being. In this project, beads will guide us through the history of the Indian Health Board (IHB) in Phillips Neighborhood of Minneapolis, one of the first urban Native clinics in the United States. Each section of this paper begins with a visual pause; a reflection on a beadwork piece by a Native to engage in the adaptation and resilience among Native people that is exemplified at IHB.

One of my beadwork teachers, Miskwa Mukwa Desjarlait (Red Lake Ojibwe), told me that what we did as Native people, “in our resilience – in the ability to adapt to our surroundings, our environments – is we took what was supposed to destroy us, and we made beautiful things from it.”⁷ This sense of transformation, of unyielding survival, is alive throughout this work. Beads guide us through IHB’s journey to balance Western and traditional medicine in Minneapolis, ensuring that future generations can continue the ways of our ancestors.

Ambe biskaabiiyang – Come, we’re on a return trip. We are going back home.

⁷ Miskwa Mukwa Desjarlait (Ojibwe beadworker), interview by Hema Patel, October 10th, 2022.

Introduction



Figure 2. *A Dance with Florals* by self-taught beadwork artist Jessica Gokey, La Courte Oreilles Band of Lake Superior Chippewa. “Painted” floral images sewn with Czech seed beads and brass sequin accents on black wool trade cloth. Gokey believes her beadwork skill has been handed down throughout her generations, and she shares her knowledge of traditional Ojibwe beadwork and beaded florals to preserve the art form for future Native artists. This piece features native flowers from the Minnesota and Wisconsin area, invoking the deep call of home.

The Indian Health Board of Minneapolis was founded in direct response to the death of one woman. In the early 1970s, an Ojibwe woman named Gloria Curtis died unnecessarily after seeking medical assistance in two Minneapolis facilities and receiving inadequate care. Though Curtis’s death certificate states that she died due to hepatitis, the root cause of death was discriminatory healthcare in Minneapolis; after the first clinic she sought denied her, Curtis’s condition worsened and she approached another medical facility, which again, denied her care.

Curtis told her social workers that the hospital “wouldn’t touch her” and “looked at her like she was poison.”⁸

According to fellow community member Norby Blake (Ojibwe), Curtis’s experience was typical of many people in the Minneapolis Native community at that time.⁹ In 1951, the Bureau of Indian Affairs (BIA) funded nationwide Relocation Programs, known as Public Law 959, aimed to recruit and relocate Native people from their community reservations into major urban areas to acquire vocational skills, to assimilate into the general population, and to “improve their standard of living.”¹⁰ Between 1951 and 1973, BIA relocation counselors facilitated over 100,000 Native peoples’ transitions to urban life by providing one-way transportation off the reservation into a major city and paying for the first month of rent, clothing, groceries, and expenses incurred traveling to and from work.¹¹ The Minnesota Indian Affairs Commission estimated 6,500 Native people lived in Minneapolis in 1970, and 4,300 in St. Paul across the river.¹² However, despite the growing number of rural Native people moving to the metro area, there were few Native services, especially those staffed by Native professionals, in Minneapolis. Furthermore, in the early 1970s, the city lacked Native schools, affordable housing, cultural centers, childcare options, career and job advice, and accessible healthcare away from the

⁸ *Indian Health Board of Minneapolis 40th Anniversary Video*, edited by Carmella M. Rodriguez (2012; National Council of Urban Indian Health: Vimeo), <https://vimeo.com/40529684>.

⁹ Kenneth Philip’s “Stride toward Freedom: The Relocation Indians to Cities, 1952-1960” describes the bleak reservation climate that encouraged the 75,000 Native people living in the Upper Midwest, to move into cities to escape poverty and racial discrimination. Urban life represented hope, as opposed to rural Upper Midwestern living, which, though rich in culture, represented only limitation and desperation. However, like Gloria’s family, Native relocatees were supported by the BIA for only a few short weeks and then left to navigate the unfamiliar, unwelcoming city alone. Thus, the relocation promises of dependable healthcare, housing, and job security often went unfulfilled.

¹⁰ Donald Lee Fixico, *The Urban Indian Experience in America* (Albuquerque: University of New Mexico Press, 2000), 10.

¹¹ Max Nesterak, “Uprooted: the 1950s plan to erase Indian country,” *APMreports*. November 2019, <https://www.apmreports.org/episode/2019/11/01/uprooted-the-1950s-plan-to-erase-indian-country>.

¹² Etta Lou Wilkinson, “Bridging the Gap: The Twin Cities Native American Community,” *A report by the Minnesota Advisory Committee to the U.S. Commission on Human Rights* (1975), 12.

reservation. Without access to these resources, relocation programs did not improve Native peoples' quality of life, but instead introduced a host of financial, social, and health issues.

Unlike on reservations, where the United States government has provided federally mandated healthcare via the Indian Health Services (IHS) to all Native people since 1787 as a treaty-owed right, options for healthcare in urban areas were largely inaccessible and often racially hostile.¹³

Despite leaving her home in search of a better life, as promised by relocation, Curtis “began to die the moment she left the reservation.”¹⁴

Curtis's spiral of disease and discrimination is emblematic of hundreds of relocation healthcare complications spanning the United States during the 1970s. The relationship between the federal Indian Health Service (IHS) – an assimilation tactic, like relocation, meant to both improve Native life while simultaneously tying Native existence to government aid – and Native communities varies across a spectrum of IHS stewardship and mirrors the historically complicated relationship between the federal government and Native people.¹⁵ IHS clinics serve

¹³A fact sheet published by National Indian Health Board 2015 traces the government's promise of healthcare to several legal documents: Article I, Section 8 of the Constitution grants Congress the power to regulate commerce with Native tribes, Article II, Section 2 confirms the President's ability to make treaties, and Article IV, Section 3 strengthens the United States' control over the welfare of the country's territory and property. These Congressional promises have since been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive orders. Treaties created a trustee-beneficiary relationship between the federal government and tribal nations through a set of uniform promises: Native nations would cede their land in exchange for federally funded benefits, including healthcare, and the right to occupy remaining (or substitute) lands. Native people secured the right to healthcare 1787 but have since faced innumerable obstacles preventing the health and wellness of their communities.

¹⁴ *Indian Health Board of Minneapolis 40th Anniversary Video*, <https://vimeo.com/40529684>.

¹⁵ Though the Indian Health Service provides vital care in rural areas, the system is rooted in assimilationist philosophies and the degradation and subjection of Native peoples. Many Native people are forced to rely on IHS for healthcare despite their distrust of the institution either from family history or personal experience. Countless Native people have lost their lives to needless errors made within IHS clinics across the country; these clinics, and their patients, suffer from chronic mismanagement, limited access to primary care providers, discriminatory staff and lack of cultural competency, long wait times for basic medical treatments, underfunding, and other inconsistencies and inconveniences (Ferguson, 2018). As a result, many Native people today experience extreme discomfort in and fear of medical

mainly rural Native communities, and the historic relocation of Native people into urban areas has necessitated urban Indian health care. In leaving their reservations, urban Natives rarely escaped the conditions that made life difficult for many tribal communities: poverty, inadequate education, alcoholism, and discrimination. These conditions are “acutely felt in cities as the loss of cultural identity, family support, and social contact, combined with the pressures of money, jobs, crowding, competition” situate urban Natives at great physical and emotional risk for health problems.¹⁶

The fight for urban Native healthcare clinics reflects Native peoples’ *survivance* – a term created by White Earth Anishinaabe cultural theorist Gerald Vizenor to encapsulate the active survival of Native communities.¹⁷ *Survivance* highlights the fact that Native communities have not only survived the genocidal ambitions of colonization, but continue, like our ancestors, to adapt our ways of being so that future generations may be immersed in their cultural identities. Urban Native Minneapolis represents a unique case of survivance as the home of the first Congressionally funded urban Native health clinic created for and by Native people in the United States: the Minneapolis Indian Health Board (IHB). Founded in 1971, IHB developed in direct response to Curtis’s death, subsequent nationwide Native and ally advocacy for treaty-owed healthcare rights, and the presidential acknowledgement of failed prior federal Indian policy.¹⁸

establishments, even as Native advocates and allies are working within IHS to contend this history and improve their standard of care.

¹⁶ Ralph Forquera, “Urban Indian Health,” (Washington: *Seattle Indian Health Board*, November 2001), 15, <https://www.kff.org/wp-content/uploads/2001/10/6326urbanindianhealth.pdf>.

¹⁷ G. Robert Vizenor, *Survivance: Narratives of Native Presence*, (Lincoln: University of Nebraska Press, 2008).

¹⁸ In July 1970, President Richard Nixon condemned the 1950s federal Indian policy of termination (which aimed to release the federal government of its treaty obligations) and redirected Indian policy towards Indian self-determination to strengthen Native autonomy. Throughout his final presidential term, Nixon transferred an enormous amount of power from the federal government to Native nations through various acts of self-determination. His nation-wide declaration renewed the collaboration between Native

The formation and evolution of IHB, located near the American Indian Cultural Corridor in the heart of the Phillips neighborhood of Minneapolis, is a story of Native adaptation and resiliency that exemplifies healthcare as central to community-building.¹⁹ IHB has become a model of integrated care that values both the social and physical determinants of health; holistic Native healthcare incorporates traditions, good housing, accessible education, a solid support system, an understanding of Native values, and other services.²⁰ Dr. Angela Erdrich, Turtle Mountain Ojibwe and current IHB pediatrician, emphasized the need for patient-oriented care in a documentary celebrating 50 years of IHB service in Minneapolis. She explains, “You’re not just taking care of their illness. You know, you really have to figure out root causes and address their social needs. Even more than offering just a listening ear sometimes, go make some phone calls and find out what could help them.”²¹

For over 50 years, the Minneapolis Indian Health Board has demonstrated holistic patient care by providing access to primary mental health, dental, and medical services alongside social and cultural services. I consider this holistic healthcare in the framework of Django Paris’

people and the federal government and combined with the persistence of grassroots Native activism, formed the basis for urban Native healthcare. Nixon’s speech, pulled from the Public Papers of the Presidents of the United States archive, can be read here: https://www.ncai.org/attachments/Consultation_IJaOfGZqlYSuxpPUqoSSWIaNTkEJEPXxKLzLcaOikifwWhGOLSA_12%20Nixon%20Self%20Determination%20Policy.pdf. For an excellent summary of see Ned Blackhawk’s book *The Rediscovery of America*, particularly pages 436-440 of Chapter 12 “From Termination to Self-Determination.”

¹⁹ The name and conceptual identity of the *American Indian Cultural Corridor*, developed by Minneapolis-based Native American Community Development Institute, aims to highlight the Phillips Neighborhood of Minneapolis as a place where Native communities can live, work, and access cultural-specific services through a variety of different resources.

²⁰ According to their website, the Indian Health Board’s vision is as follows: “IHB patients reach the highest level of health and wellness available, incorporating cultural health and wellness with the best available scientific medical knowledge.” In particular, the clinic is centered around Mino-Inawendiwin (Ojibwe)/Da Ya Unk Unpi (Dakota), or Good Relationships in English. The clinic promotes three major values within Good Relationships: respect for culture, excellence in service and community, and ethical leadership.

²¹ *Indian Health Board of Minneapolis 40th Anniversary Video*, <https://vimeo.com/40529684>.

culturally sustaining pedagogy (CSP), proposed in 2017, that calls for schooling to be a revolutionary site for sustaining the cultural ways of people of color.²² CSP empowers schools to sustain – to continue rather than acknowledge – the cultural ways of being in communities of color.²³ Transferring educational pedagogy into the medical field, culturally sustaining healthcare positions clinics and hospitals as sites for sustaining cultures and sustaining the bodies – the lives – of the people who cherish and practice them.²⁴ IHB is an intergenerational practice in culturally sustaining healthcare, where Native identity is not only accepted, affirmed, and made relevant, but is built into the clinic's very foundation. IHB exemplifies how Native people are actively surviving and adapting institutions like the Indian Health Service to better serve and empower our communities. At the core of this survivance, Native people transform Westernized interpretations of healthcare into community-led, culturally sustaining spaces of care.²⁵

Gloria's story invites us to consider the complicated relationship between the history of federal Indian policy, IHS, and the emergence of urban Native health care organizations like IHB. This paper demonstrates that despite over one hundred years of the federal government waging a multifaceted legal, political, social, and biological battle against Native communities,

²² CSP builds upon Ladson-Billings' culturally relevant pedagogy, which focuses on accepting and affirming students of color, and Hammond's culturally responsive pedagogy, which centers connection to students' cultural knowledge and prior experiences (Ladson-Billings 2014 and Hammond 2014).

²³ Alison Cook Sather, and Praise Agu, "16: Student consultants of color and faculty members working together toward culturally sustaining pedagogy," *To Improve the Academy* 32, 2013, 275.

²⁴ Django Paris and H. Samy Alim, *Culturally Sustaining Pedagogies: Teaching and Learning for Justice in a Changing World*, (New York: Teachers College Press, 2017), 9.

²⁵ Holistic healthcare seeks to treat both the causes and symptoms of a disease; according to the Pacific College of Health and Medicine, holistic medicine is defined as a whole-person approach to care and wellness that addresses the emotional, mental, and spiritual aspects of physical wellbeing. This closely aligns with traditional Indigenous conceptions of health which focus on interconnectivity. The National Library of Medicine crafted a virtual exhibition, "Caring for the Invisible Tribe," that explores the interaction between traditional healing and Western medicine in urban areas (accessible [here](#)). The exhibit posits that Indigenous holistic health in urban areas empowers all Native people to good wellness through ancestral knowledge, holistic medical phenomenology, culturally tailored biomedical interventions, cultural wellness practices, representation among medical providers, increased patient-provider understandings, and effective medical care.

Native people managed to innovate and triumph by creating a culturally sustaining care model that started as a building with meager federal funding and evolved into a place of belonging and wellness for the urban Indian community. As mentioned earlier, images of beadwork head each part of the paper, encouraging readers to unlock deeper historical understanding through their visual senses. Part I documents the U.S. government's approaches to and motivations for providing treaty-owed Native healthcare. Part II discusses urban relocation policies of the 1950s and Indigenous activism which led to the formation of IHB in 1971. Part III examines IHB's intertwined medical and cultural care, through interviews with current doctors, service providers, community members, and clinicians to explore the clinic's culturally sustaining healthcare pedagogy. Finally, I conclude with a discussion of Native Minneapolis today, an ongoing space of survivance – a city of cultural healing, growth, and connection for hundreds of Native people.

Research on the history of Native health care delivery, Indigenous healthcare disparities, Native medical professionals, and non-IHS funded Native health care facilities is underrepresented in academia and medical school curricula. By adopting a methodological approach that brings together traditional textual sources, beadwork, and oral histories, it is my hope that this research can contribute to the gap in literature on these important topics and offer a comprehensive Indigenous perspective on Native community-building and holistic evolution of healthcare delivery in Minneapolis. Through a case study examination of the Indian Health Board (founded in 1971), I will demonstrate how healthcare workers, clinic staff, and community interweave Indigenous and Western epistemologies to Indigenize healthcare in the Phillips Neighborhood of Minneapolis, Minnesota.²⁶

²⁶ To Indigenize is to bring Indigenous ways of knowing, being, and doing into spaces that are not designed for those ways.

Part I

Co-evolution of Federal Indian Policy and the Indian Health Service: Phases of Federally Funded Genocide, Containment, and Assimilation



Figure 3. *Sterilization* by 3rd-year medical school student and Metis artist Jamie Thompson.

Made for an exhibit on Indigenous experiences of discrimination in healthcare, Thompson depicts a uterus that underwent a tubal ligation, with the cross and handcuffs between the gaps representing the ongoing legacy of religion, colonization, and the penal "justice" system in the forced and coerced sterilization of Indigenous women.

In a Tweet on January 22nd, 2019, Dr. Twyla Baker (Mandan/Hidatsa/Arikara), president of the Nueta Hidatsa Sahnish College in North Dakota, introduced her theory of translation exhaustion:

The idea that Indigenous people (or any marginalized person/group) engaging with the larger population on a given subject or topic related to bias, must first set the stage in terms of historical context all the way to current day state of affairs, before even addressing said topic of bias... due to the lack of education/background [of the listener].

A direct impact of erasure of true Indigenous history beyond the cursory mention in our school systems.²⁷

I preface my exploration of urban Native health care in Baker's theory of translation exhaustion by providing an overview of over 200 years of federal Indian policy, the laws establishing the legal relationship between the United States government and Native Nations. As Baker writes, conversations on current Indigenous issues that communicate substantial gravity and significance are difficult to explain properly without historical understanding. The labor of translation within this section only begins to cover the years of policies and mistreatment targeting Native people for generations. Federal Indian law was a targeted, comprehensive, and intentionally devastating tactic of genocide that is not easily encompassed by any academic theory.²⁸ I cohere health care and genocide in this section to grapple with the tensions of the Indian Health Service as perpetrator of harm and institution of healing.²⁹

No sooner had European ships landed on the shores of this continent, then did the colonizers set out to enslave, conquer, exterminate, starve, remove, and corral Indigenous people. Despite settler reliance on Native knowledge for their survival, the formative years before the implementation of intensive federal Indian law were marked by violence and the immediate

²⁷ Twyla Baker. Twitter Post. January 22, 2019, 12:24pm.
<https://twitter.com/Indigenia/status/1087762882983538689>.

²⁸ Several scholars divide the history of federal Indian policy into six phases: the formative years (1749–1828), removal and reservations (1829–1886), allotment and assimilation (1887–1932), reorganization (1932–1945), termination and relocation (1946–1960), and self-determination (1961–1985). The division of dates, though the phases are not mutually exclusive, are based on significant treaties, laws, wars, and other historical moments (Lobo 2009 and Wilkins 2016). In this section, I follow the framework of the phases but rather than divide strictly by dates, I group policies around significant themes affecting the health and wellness of Native peoples. A timeline major legislative and historical events of can be viewed in Appendix A.

²⁹ As this section will detail, the Indian Health Service originally served and protected white people by controlling the health of Native populations. After years of Native advocacy, the organization evolved, and by the latter half of the 20th century at least maintained purer intentions. It is important to note that today, many Native people value IHS services and even dedicate their lives to working for and within the organization. However, many others refuse to seek care in the institution due to its history. Positive or negative perspectives on IHS are not a monolith within the Native community.

subjugation of Native peoples.³⁰ Beginning in the late 15th century, European settlers introduced devastating epidemics of smallpox, measles, typhus, and pneumonia that swept across Native nations; in the 17th century, some New England tribes, lacking immunity to these diseases, lost up to 95% of their members within a few years.³¹ In the late 1770s, as the United States' fledgling democracy manifested a destiny of expansion, conflict between Indigenous peoples and settlers increased. Early Congressional policies focused on the regulation of trade and commerce between groups, the establishment of territorial boundaries, and the long-term scheme to gradually remove all Native claims to the land, which was codified into law in the 1823 Supreme Court ruling on *Johnson v. McIntosh*.³² However, it is often overlooked that during this time colonists depended heavily on Native communities for their knowledge about the natural landscape and understanding of geography; settlers manipulated the generosity of Native wisdom-keepers to extract these resources while simultaneously plotting a genocide.³³ The

³⁰ In their book *Native American Representations*, authors Bataille et al. describes the various images of “the Indian” constructed by white settlers; from Columbus’s infantilization of the Taino people to modern-day mascot controversies. The book reviews centuries of misrepresentation, mythologization, objectification, and degrading imagery that greatly impacted Native health and wellness. I offer this source to demonstrate that the construction of “the Indian Problem” (viewing the Indian as Other) caused not only psychological harm, but directly contributed to decades of genocidal policy (Bataille et al. 2001).

³¹ Kelly Wisecup, *Medical Encounters: Knowledge and Identity in Early American Literatures*, (University of Massachusetts, 2013), 66.

³² In 1823, the Supreme Court ruled on *Johnson v. McIntosh*, setting a new tone in federal Indian policy. This landmark decision declared that based on the doctrine of discovery, Europe (and the United States as their successor), “secured legal title to all Indian lands” (Smalley, 2014, 58). A significant moment in the history of federal Indian policy, this decision formed the basis for the next century of land theft, attempted cultural decimation, and coerced reliance on the federal government.

³³ Indigenous botanical knowledge greatly influenced American medicine in the 17th century; as formally trained European physicians were rare in early colonial America, the more common apothecaries and commoners often turned to Indigenous people to understand the medical botanicals in their surroundings. For an overview of Indigenous botanical contributions to medicine, see Martha Robinson’s “New Worlds, New Medicines: Indian Remedies and English Medicine in Early America” which examines the extractive relationship between colonists and Native physicians and the rise of cross-cultural medical exchange into the 19th century. Additionally, Paul Kopperman’s “The attitude of Benjamin Rush (1746-1813) towards Native American Medicine” illuminates one physician’s characterization of and curiosity towards “Indian medicine” and its impact on American medicine’s new reliance on natural remedies.

combined toll of uncurbed infectious diseases, effects of war, expulsion of Native people from their homelands, and the systematic suppression of Native ways of life effectively decimated Native self-governance structures.³⁴ Consequently, Native people became dependent on the federal government for the provision of healthcare.³⁵

At the turn of the 19th century, federal Indian health policy focused on the military containment of Native people.³⁶ Due to European contagious diseases, overwhelming epidemics of smallpox, measles, cholera, and tuberculosis threatened the survival of Native communities across the United States.³⁷ Fearing that sick Natives living on reservations might infect surrounding white communities, the US Department of War established federal health services for Native people in 1824.³⁸ Early implementation of healthcare for Native peoples was not an act of goodwill or a declaration of healthcare as a human right, but was instead an act of self-interest that focused on removing Native people from fertile lands and surveying reservations to estimate survival numbers among Native populations. In a report to the Secretary of War, Henry Rowe Schoolcraft documented the rapid spread of smallpox originating from a steamboat that docked in a Mandan village and then spread across tribes. The report does not request aid for the sick, but rather tracks the numbers decimated in the affected tribal lands: “The Mandans, among

Finally, Londa Schiebinger’s book, *Secret Cures of Slaves*, synthesizes the intersections of African Indigenous, North American Native Indigenous, and European medicinal knowledge in the 18th century.³⁴ The phrase “effectively decimated” is used here to demonstrate that though Native culture, traditions, and forms of governance are not fundamentally crushed, most do not exist in their original condition. At the core of this paper, Vizenor’s concept of survivance captures the methods of survival employed by Indigenous peoples to adapt traditional ways to modern contexts as a form of both innovation and preservation.

³⁵ US Commission on Civil Rights, *Broken promises: Evaluating the Native American health care system*, Office of the General Counsel, 2004.

³⁶ Robert A. Trennert, *White man's medicine: government doctors and the Navajo, 1863-1955*, University of New Mexico Press, 1998.

³⁷ Felix Cohen, "Handbook of Federal Indian Law," 1982, 246-48.

³⁸ Abraham B. Bergman et al., "A political history of the Indian Health Service." *The Milbank Quarterly* 77, 1999.

whom the pestilence commenced, are stated to have been reduced from an estimated population of 1600 souls to 125... The Assinaboins, a people roughly estimated at 9000, were swept off by hundreds.”³⁹

The fear of infection via proximity motivated the US military to roll out a large-scale smallpox vaccination in Native communities in 1832.⁴⁰ As Office of Indian Affairs (OIA) Commissioner Francis Leupp stated, “the infected Indian community becomes a peril to every white community near it.”⁴¹ In the years following, vaccine rollouts, and much later campaigns to mitigate afflictions like trachoma and tuberculosis, became more common.⁴² Ironically, the organization founded by those who had brought the disease possibly saved Native people from complete genocide. By February 1833, the military had vaccinated 10,000 Native people against smallpox.⁴³ The military continued to control the Bureau of Indian Affairs and healthcare until 1849, when administration shifted to civilians under the newly created Department of the Interior.⁴⁴ Eradication and removal dominated US interactions with Native nations; the BIA

³⁹ Henry Rowe Schoolcraft. *History of the Indian tribes of the United States*. Vol. 6. Reprint by Historical American Indian Press, 1857. Report of smallpox in 1937, 487.

⁴⁰ William P. Quigley, "The Earliest Years of Federal Social Welfare Legislation: Federal Poor Relief Prior to the Civil War," *U. Det. Mercy L. Rev.* 79, 2001, 175.

⁴¹ Todd Benson, "Blinded with science: American Indians, the Office of Indian Affairs, and the federal campaign against trachoma, 1924-1927," *American Indian Culture and Research Journal* 23, no. 3 (1999), 120-124.

⁴² The 1928 Meriam Report found that Native people suffered many more instances of trachoma and tuberculosis than found in the general US population, attributed the high rates of disease to poor hygiene on reservations and in boarding schools. To read more on federal trachoma interventions, see Roberts Trennert's "Indian Sore Eyes: The Federal Campaign to Control Trachoma in the Southwest, 1910-40." Trennert documents both the raging wake trachoma left on reservations and in boarding schools and the difficulties IHS providers faced in improving Native healthcare during the first half of the twentieth century, offering a multi-perspective analysis of trachoma's impact on Native health policy. To read more on tuberculosis, see H. L. Reider's 1989 Public Health Report which states that by 1900, tuberculosis became one of the most serious health problems facing Native peoples and continued its devastation until the 1950s.

⁴³ David H. DeJong, *Plagues, politics, and policy: A chronicle of the Indian Health Service, 1955-2008*. (Lexington Books, 2011): 8.

⁴⁴ Bergman et al., "A political history of the Indian Health Service.

established a medical and educational division in attempt to expand services but was woefully inadequate.⁴⁵

Under the Department of the Interior, Native healthcare became linked to assimilation and cultural genocide. Captain Richard H. Pratt, founder of the Carlisle Indian Industrial boarding school, infamously captured the brutality of assimilationist philosophy: “all the Indian there is in the race should be dead. Kill the Indian in him and save the man.”⁴⁶ The goals of assimilation – to educate and civilize – took a range of violent forms during the late 19th and early 20th centuries.⁴⁷ Communal lifeways fractured under the Dawes Act of 1887, which distributed reservation land among Native people, aiming to create responsible “Indian farmers” in the white man’s image through land ownership and individualism.⁴⁸ In operation from 1869 to the 1960s across the country, federal boarding schools stole children from their families, and from steady healthcare, in order to decimate life-giving sources of wellness.⁴⁹ Boarding schools prohibited anything considered “Indian” (dress, hairstyle, language, religious practices, traditional medicine) through violent methods and forced children to live in unsanitary over-

⁴⁵ Cohen, "Handbook of Federal Indian Law."

⁴⁶ Richard H. Pratt, "35. The Advantages of Mingling Indians with Whites". *Americanizing the American Indian: Writings by the "Friends of the Indian" 1880-1900*, edited by Francis Paul Prucha, Cambridge, MA and London, England: Harvard University Press, 1973, pp. 260-271. <https://doi.org/10.4159/harvard.9780674435056.c39>.

⁴⁷ This period of federal Indian policy, commonly referred to as the assimilation and allotment era, caused a significant shift in IHS administration. Solving the “Indian problem,” that is, Native people asserting their rights or leaving the reservation in any way, remained a priority for federal Indian law policy makers who argued that poor Native health impeded assimilation. The reign of ongoing violence caused by assimilation can be further examined in Katherine Ellinghaus’s *Blood Will Tell*, which discusses the simultaneous presence and absence of blood quantum in assimilation policy, and the subsequent controversy over what makes an individual “Indian.” This question of identity, rooted in assimilation, significantly impacts the delivery of federally mandated healthcare in rural and urban areas and the management of the Indian Health Services.

⁴⁸ Leonard A. Carlson, "The Dawes Act and the decline of Indian farming," *The Journal of Economic History* 38 (1978): 275.

⁴⁹ David R. Wrono, *Indian Treaties and the Democratic Idea*. Electronic reproduction by Wisconsin Historical Society, 2007.

crowded areas where diseases like tuberculosis spread rapidly.⁵⁰ The negative health effects of boarding schools continue today; boarding school experiences are linked to higher rates of alcoholism, depression, suicide, and domestic abuse.⁵¹

As illustrated in Figure 3, the Office of Indian Affairs blamed Native people, and their traditions, for their own illnesses, elucidating the assimilative philosophy of government healthcare provision.

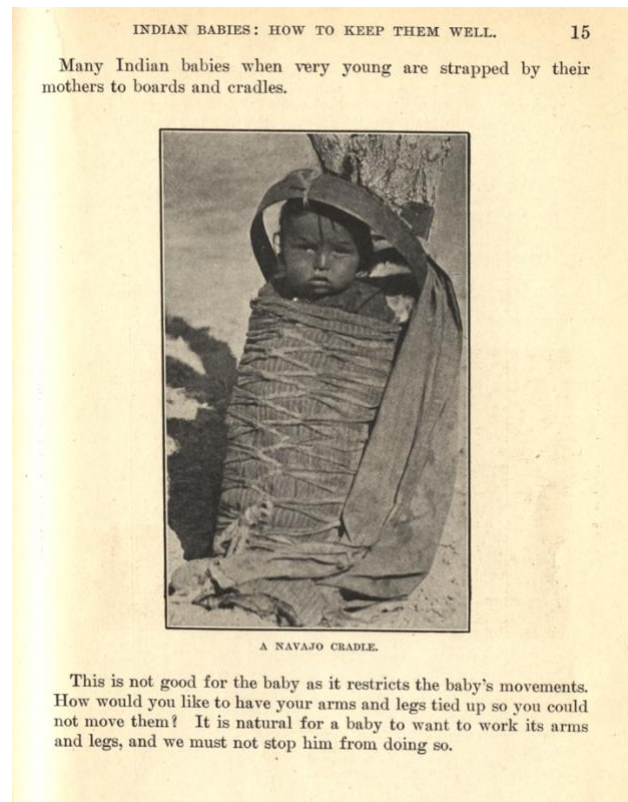


Figure 4. Office of Indian Affairs pamphlet, 1916.

A 1916 Office of Indian Affairs pamphlet, *Indian Babies: How to Keep Them Well*, discouraged Native people from wrapping their children in traditional cradle boards, though lacking scientific

⁵⁰ Brenda J. Child, "Indian boarding schools," *Journal of Curriculum and Pedagogy* 13, (2016): 15-32.

⁵¹ Morton Beiser, "A hazard to mental health: Indian boarding schools," *American Journal of Psychiatry* 131 (1974): 67.

medical evidence to justify this warning.⁵² Though the pamphlet posits the cradleboard as unnatural for a baby's movement, Native people have used cradleboard for hundreds of years to keep their babies safe during seasonal travel, to protect fragile heads and bones, and to establish strong posture in young children.⁵³ The government held Native traditions in contempt as they enforced assimilation, and sought to heal Native people only so that they could become assimilated. OIA Commissioner William Jones stated in 1904, "the physical welfare of the Indian is, and always must be, the fundamental consideration in the scheme to educate or civilize him. It is impossible to develop his mental and moral capabilities without healthy material to work on."⁵⁴ Several treaties throughout the 1880-90s further reinforced the connections between medical care and assimilation and established funds for medical purposes like hiring physicians and housing them on reservations (near military forts, Indian agencies, and outposts) and creating hospitals on reservations to deflect from allegations of alarming health conditions of boarding schools.⁵⁵ By 1880, the Department of Interior supported four hospitals across Indian Country, employing over 75 physicians.⁵⁶

As Native people endured forced assimilation in boarding schools and survived on inadequate care at sparse hospitals, they asserted their rights within the U.S. government system, garnered U.S. citizenship under the Indian Citizenship Act of 1924, and determined, under the Snyder Act of 1921, that all Native people, regardless of physical location (such as Natives

⁵² "If you knew the conditions... Health Care to Native Americans," *US National Library of Medicine*, accessed March 16th, 2023, https://www.nlm.nih.gov/exhibition/if_you_knew/ifyouknew_06.html.

⁵³ HealthyMothersHealthyBabies, "Safe Sleep for Baby - Cradle Board," YouTube Video, 36:16, December 29, 2020, <https://www.youtube.com/watch?v=WRI7cxxQbWE>.

⁵⁴ Todd Benson, "Blinded with science," 1999, 120.

⁵⁵ Everett R. Rhoades et al., "The Organization of Health Services for Indian People," *Public Health Reports* (1987): 352–56. <https://www.jstor.org/stable/4628164>.

⁵⁶ Judith Thierry et al., "History, law, and policy as a foundation for health care delivery for American Indian and Alaska Native children," *Pediatric Clinics* 56, no. 6 (2009): 1547.

residing in metropolitan areas) were eligible for federal health services.⁵⁷ Key pieces of legislation amplified Native health needs across reservations and cities. Several reports detailed horrendous health conditions for Native people on reservations and within boarding schools, including poverty, high infant mortality rates, inadequate education, poor housing, and other adverse health determinants.⁵⁸ Most prominently, the 1928 Meriam Report, “The Problem of Indian Administration,” exposed the devastation caused by allotment, the failure of boarding school education, and the dismal state of Native health. The report stated that federal Indian policy should be reorganized to positively develop, rather than crush, Native culture.⁵⁹

In reaction to reports detailing the appalling conditions of boarding schools and reservations, Congress passed The Indian Reorganization Act (IRA) of 1934 as part of the Indian New Deal, a well-intentioned, ground-breaking yet inadequate plan to protect and support Native art, culture, and public and social organization. The act functioned as a government policy of organization that allowed tribes to adopt constitutions which provided terms for managing their own affairs.⁶⁰ But as Graham Taylor concludes in his book *The New Deal and American Indian Tribalism: The Administration of the Indian Organization, 1934-45*, the Indian New Deal and IRA promised positive change but failed because they were “clearly not Indian ideas.”⁶¹ As a product of white bureaucracy, the IRA was another elaborate political proposal that failed to

⁵⁷ Donald Warne & Linda Bane Frizzell, “American Indian Health Policy: Historical Trends and Contemporary Issues,” *American Journal of Public Health* 104, no. Suppl 3 (June 2014). <https://doi.org/10.2105/AJPH.2013.301682>.

⁵⁸ Celia Haig-Brown, *Resistance and renewal: Surviving the Indian residential school*, Arsenal pulp press, 1988.

⁵⁹ Lewis Meriam, “The Problem of Indian Administration. Report of a Survey Made at the Request of Honorable Hubert Work, Secretary of the Interior, and Submitted to Him, February 21, 1928.” (1928).

⁶⁰ Paul Carrick Rosier, “*The old system is no success: The Indian Reorganization Act and the political economy of “self-support” on the Blackfeet Reservation, 1912-1954*,” University of Rochester, 1998.

⁶¹ Graham D. Taylor, *The New Deal and American Indian Tribalism: The Administration of the Indian Reorganization Act, 1934-45*, U of Nebraska Press, 1980, 27.

provide tangible solutions to the issues facing Native people.⁶² Though the IRA effectively ended land allotment, Native farmers struggled financially from loss of land and revenue; by 1945, 51% of Native families living on reservations had a net income of \$501 or below.⁶³ The desperate economic crisis and exposure of the state of health conditions on reservations in the 1930s pushed the government to expand Native healthcare resources.

After nearly 200 years of systematic and government-funded attacks on the cultural and physical wellness of Native people, the need for a directed Indian healthcare service was undeniable; in 1955 the life expectancy of Native people was a full nine years lower than the rest of the population.⁶⁴ And while Native people persisted through countless phases of genocidal strategies aimed to either avoid, undermine, or determine Native health, healthcare guaranteed by treaty rights on reservations remained limited. Native healthcare facilities existed in a perpetual state of crisis-oriented intervention, forced to treat critical patients while severely underfunded and understaffed rather than focus on preventative care that might improve long-term health and return agency to Native individuals.⁶⁵ Despite significant organizational shifts in IHS management and policies, adequate healthcare, basic sanitation, and culturally appropriate

⁶² As the six eras of federal Indian policy demonstrate, the US government has spent decades creating inefficient and mismanaged policies in their lackluster efforts to restore treaty rights. To read more about the failure of the US government to uphold treaty promises and the dozens of ineffective laws they constructed to mitigate this failure since, see Roxane Dunbar-Ortiz's *An Indigenous Peoples' History of the United States*.

⁶³ William Zimmerman, "Economic Status of Indians in the United States," *Journal of Religious Thoughts*, (1950): 309.

⁶⁴ Bergman et al., "A political history of the Indian Health Service," 1999.

⁶⁵ Throughout history, the federal government has promised repeatedly a desire to improve Native health services, yet the results have been disappointing and have shown a lack of follow through. In the late 1890s, the BIA acknowledged for the first time that physicians needed to provide preventative services in addition to directly caring for the sick – doctors would be expected to “do more than sit in an office dispensing pills” (Trennert 1998, 77). However, half a century later, IHS remained stuck in a pattern of providing only crisis-oriented care focused on mitigating life-threatening illness. In many ways, urban Native clinics were the first substantive movement towards not only curing illness but working to solve social health detriments and provide education-based preventative services to improve Native health, breaking the cycle of crisis-oriented care.

treatment remained elusive. Though the federal government deemed healthcare readily available on or near reservations across the nation, it was not uncommon for Native patients to travel ninety miles to the IHS clinics only to “find 200 to 300 people in line ahead of them, and leave at the end of the day without seeing a doctor.”⁶⁶ Throughout the early 1950s, constant turnover, staff shortages due to unappealing housing conditions, cultural differences, poor sanitation, lack of record keeping, and service mismanagement plagued the Indian Health Services.⁶⁷ Coupled with the continuing disparity in Native life expectancy, the Bureau of Indian Affairs grew frustrated with the poor state of Native reservations and searched for a way to divest from the responsibility of care they had promised.

Beginning in the 1940s, the federal government charged the Central Intelligence Agency with the task of determining which tribal nations had been sufficiently acculturated into white society and no longer needed the government to act as their trustee.⁶⁸ Termination Resolution 108, adopted in 1953, codified this task into law; a tribe could be legally terminated once determined acculturated. The government proceeded to authorize 109 cases of termination, “affecting a minimum of 1,362,455 acres and 11,466 individuals.”⁶⁹ Tribal termination policy consisted of the immediate withdrawal of all federal aid services and protections – essentially, the abrogation of treaty rights and end of reservations. In short, the era of termination signaled

⁶⁶ Edgar S. Cahn and David W. Hearne, "Our Brother's Keeper: The Indian in White America," New York: World Publishing Co., (1969): 59-63.

⁶⁷ In *American Indian Health & Nursing*, Margaret Moss writes that the way IHS is funded and managed puts “the service and health status for all served at risk,” (4). The chronic misalignment of IHS with the federal budgeting system has caused historic difficulties in the provision of healthcare for Native peoples despite treaty obligations. *American Indian Health & Nursing* is the first book to examine Native health disparities and impact of IHS through a nursing lens; the expert nurse authors of this book shed light on the intricacies of IHS management that are obscured in other texts.

⁶⁸ Samuel H. Herley, *“The coming tide”: Viewpoints on the formation of US federal Indian termination policy, 1945–1954*, The University of Nebraska-Lincoln, 2010.

⁶⁹ Susan Lobo et al., *Native American voices*, Routledge, 2016, 110.

congressional intent of terminating federal responsibility for Indians, which marked a radical restructuring of the relationship between Native people and the US government.⁷⁰ The Transfer Act of 1954 moved responsibility for Native health unto the Dept of Health, Education and Welfare, where IHS became established as an agency of the Public Health Service in 1955.⁷¹ Though this transfer improved healthcare provisions, adverse health effects from termination persisted.⁷² Under the euphemistic pretense of liberating Native people from federal control, termination separated Native people from federal resources they desperately needed: healthcare, subsidized food, and the tight-knit community reservation life. Without governmental resources, and suffering from economic turmoil, Native communities were forced to move away from their land, and consequently, away from a secure source of health care. The final piece of this resolution, The Indian Relocation Act of 1956, or Public Law 959, aimed to relocate Native people from rural and reservation areas to urban “relocation centers” in a coercive attempt to destroy tribal communalism.⁷³ In the 1950s, the proportion of Native people living in what the US Census Bureau defines as “urbanized areas” grew from 45 percent to 56 percent; at this point over 160,000 Native people moved from their reservations into cities in search of a better life

⁷⁰ Freedom from Federal supervision. Pub. L. No. 280, Stat. 67.

<https://www.govinfo.gov/content/pkg/STATUTE-67/pdf/STATUTE-67-PgB132-2.pdf>.

⁷¹ Brett Lee Shelton, *Legal and historical roots of health care for American Indians and Alaska Natives in the United States*, Issue Brief, (Menlo Park, CA: Henry J. Kaiser Family Foundation 2004).

⁷² Scholars suggest that the establishment of IHS within the Public Health Service is one of the few termination era actions that was actually helpful to Native people as it led to the creation of more hospitals and opportunities for care on reservations. A 1987 report by Everett Rhoades details that between 1955 and 1985, hospital admissions increased by 117%, outpatient medical visits by 870%, and dental services by 964% (Rhoades, 1987, 354).

⁷³ Additionally, as Ned Blackhawk writes in *The Rediscovery of North America*, termination and relocation benefitted white communities “materially, emotionally, and ideologically” (427). By relocating Native people into cities, the government could seize and sell their land to white communities. Termination allowed the government to shirk any responsibility for these actions and further, released the government from any obligations of support. Termination strategically targeted weakened tribes on resource filled lands. For a specific example, see Nicholas C. Perhoff’s *Menominee drums: Tribal termination and restoration, 1954-1974* which chronicles the government’s use of racial logic in this era and explains the evolution of termination policy as it affected the Menominee nation.

and in effect, to assimilate into the United States workforce.⁷⁴ With this influx of Native people in metro populations, desperate for housing, secure work, and a safe place for their families, the already urgent need for urban Indian health care grew even more pressing.

⁷⁴ Forquera, "Urban Indian Health," 3.

Part II

Native Activism and Community Building: Relocation and the Formation of the Indian

Health Board



Figure 5. Cityscape inspired earrings, *Tulsa's Beloved Buildings*, by Jae Anthony Wilson (Cherokee). Wilson shared that she strives to become an honest representation of a direct descendent of the Trail of Tears: “my family and I have our trials and tribulations from relocation, but one thing that can never be taken away from us, is our resilience and ability to honor and love the world around us, even if it is different than what our ancestors hoped it would be.”⁷⁵

Unofficial relocation of Native people off reservations and into cities began as early as 1930, when the Office of Indian Affairs established an employment placement program offering

⁷⁵ Jae Anthony Wilson (Cherokee beadworker), interview by Hema Patel, March 9th, 2023.

job placement in cities like Chicago, Los Angeles, and Minneapolis.⁷⁶ By 1940, more than 1 in 10 (13.4%) of Native people lived in cities, having left their homes in search of suitable housing, job openings, and better opportunities for their children.⁷⁷ City-dwelling Native populations continued to grow such that in 1951, Bureau of Indian Affairs Director Dillon Myer urged an expansion of unofficial relocation programs to create a relocation branch. Myers wielded the same logic of termination policy to push forward the relocation agenda: relocation, like termination, benefited Native people by encouraging them to “live like other Americans without federal trust restrictions.”⁷⁸ The language surrounding relocation is eerily congruent with early assimilation era narratives of “kill the Indian, save the man.” Within the operation of relocation, “killing the Indian” manifested in the separation of Native people from the reservation-based government resources they had become forced to rely on. What Myers considered “federal trust restrictions” consisted of legal rights, the valuable necessities Native people received on reservations: treaty-mandated healthcare, commodity foods, money allocations, and other social services. Relocation policy aimed to reduce the United States economic support to reservations by assimilating Native people into the workforce.⁷⁹

Modeled after Myer’s previous War Relocation Authority program, which facilitated the relocation of Japanese Americans from internment camps after World War II, Native relocation programs sought to provide basic financial aid and early training and placement assistance for

⁷⁶ La Verne Madigan. *The American Indian Relocation Program*. A report by the Association of Indian Affairs, 1956.

⁷⁷ Douglas K. Miller, "Willing workers: Urban relocation and American Indian initiative, 1940s–1960s." *Ethnohistory* 60, no. 1 (2013): 51-76.

⁷⁸ Donald Lee Fixico, *The urban Indian experience in America*, UNM Press, 2000, 8-21.

⁷⁹ Charles F. Wilkinson, *Blood struggle: The rise of modern Indian nations*, (WW Norton & Company, 2005).

Native people to enter cities.⁸⁰ Advertisements at this time, see Figure 5, emphasized that tribal termination and subsequent relocation would improve the health and financial status for Native peoples; urban cities would welcome Native people into the civilized workforce.⁸¹



Figure 6. A Bureau of Indian Affairs Relocation field office poster advertising jobs in Chicago for Natives who join the relocation program.

In a 1950 speech to the National Congress of the American Indians, Myer summed up the true purpose of relocation programming, which was “to provide the institutionalized Indian youngsters with the kinds of home and community life they need if they are to grow up as self-reliant and civic-minded American citizens.”⁸² Under the guise of advancing Native social mobility and welfare, relocation programs instead worked in conjunction with termination

⁸⁰ Larry W. Burt, "Roots of the Native American urban experience: Relocation policy in the 1950s." *American Indian Quarterly*, (1986): 89.

⁸¹ Chicago Field Office Employment Assistance Case Files, 1952-1960, Record Group 75, Records of the Bureau of Indian Affairs.

⁸² Statement of Commissioner of Indian Affairs Dillon S. Myer before the National Congress of American Indians, Bellingham, WA, August 29, 1950.

policies to dissolve reservations and tribes so that Native people would become isolated from their cultures and homes and the federal government could relinquish their responsibility to provide mandated health services on reservations. Myers' influence at the BIA closed 8 Native hospitals between 1951-1955, enforcing a policy of operating facilities only when Native people could not receive care anywhere else, or could not receive care without being segregated.⁸³ In the cities, isolated from their homeland communities and reservation-based government resources, Native people struggled to find accessible, accommodating healthcare.

Gloria Curtis's story is representative of many Native families who bore the brunt of the political, economic, and social effects of relocation.⁸⁴ Born in 1945 on the Red Lake Reservation of Minnesota, Gloria followed her family to Minneapolis as they searched for the promised relocation dream: better housing, education, and jobs. Details of Gloria's life and death are obscured; she worked as a nurse's aide, lived in a condemned building near Franklin Avenue in South Minneapolis, and she passed away at the age of 27 with a death certificate citing hepatitis as the cause of death, an unmarked grave (later identified by close family), and no obituary.⁸⁵ She is survived by 5 children and her legacy: the Indian Health Board, a turning point for Native healthcare in Minneapolis.⁸⁶

In 1973, American journalist and former White House Press Secretary Bill Moyers became aware of Gloria's story. In a 30-minute documentary titled *Why Gloria Died*, Moyers

⁸³ DeJong, *Plagues, politics, and policy*, 30-31.

⁸⁴ In his 2005 book *Relocation and Urbanization* John Laukaitis documents a parallel history of Indian relocation in Chicago. By 1960, nearly 4,000 Native people relocated to Chicago, and though they were offered steady jobs, improved education, and abundant job opportunities, Laukaitis writes that the relocation program's promise of a better life never materialized. His discussion of the harsh education and healthcare realities experienced by Chicago relocates maps onto those of Minneapolis between 1952 and the late 1970s.

⁸⁵ Cynthia Kayan (prod.), *Why Gloria Died*, directed by Bill Moyers, (New York; WNET, 1973), documentary viewed at the Minnesota Historical Society.

⁸⁶ *Indian Health Board of Minneapolis 40th Anniversary Video*, <https://vimeo.com/40529684>.

calls attention to what he calls “the plight of urban Indians... the plight of aliens in a foreign land.”⁸⁷ According to Moyers, by 1970, over 10,000 Native people relocated from rural reservations to Minneapolis, leaving behind their families and homes to culture shock in urban areas.⁸⁸ Transitions to city life consisted of not only difficulties in adjusting to modern technologies – telephones, supermarkets, fast-paced street life – but also housing and employment discrimination.⁸⁹ This documentary – apart from any surviving members of Gloria’s close friends, community members, and family – is the sole record of her story and of the significant role her death played in forming IHB.

Gloria lived in a small apartment in the Phillips neighborhood of South Minneapolis, which Bill Moyers refers to as “the Indian ghetto.”⁹⁰ Though she still occupied this apartment in 1971, the city had condemned Gloria’s building in 1969; water dripped from the upstairs apartment into her kitchen, cockroaches infested the rooms, and despite calling the power company several times, the power had been shut off. According to her two social workers, Gloria frequently expressed distress over her children’s well-being; they needed dental work, had been struggling in school, and she couldn’t care for them during the day while she worked. Her social

⁸⁷ Kayan (prod.), *Why Gloria Died*, directed by Bill Moyers, (1973).

⁸⁸ In her article “American Indian Relocation: Problems of Dependency and Management in the City,” Joan Ablon details varying Native relocation experiences. Her investigation of Native attitudes towards relocation in the 1960s found that though Native peoples appreciated many of the conveniences of urban life, if there were solid job opportunities back home, more than 75% of relocates would choose to return to reservations as soon as possible (Ablon, 1965, p. 365).

⁸⁹ In his article, “Roots of the Native American Urban Experience: Relocation Policy in the 1950s,” Larry Burt describes the social obstacles and cultural dislocation Native people faced during transitions to city life. One relocation officer describes the insurmountable challenge facing relocatees: “the Indian has never been permanently employed, has never looked at a clock, and is expected within a week’s counseling... to go out and face the world” (Burt, 1986, 91). In my research, literature often focused on Native peoples’ unfamiliarity with modern day technology as the source of their difficulties, rather than the institutional discrimination they experienced as they searched for jobs, housing, and social support. The combined toll of these obstacles, and the lack of support systems for them to return home, forced Native people to become “part of America’s inner-city underclass” – struggling constantly with poverty, cultural alienation, and run ins with the law (Burt, 1986, 92).

⁹⁰ Kayan (prod.), *Why Gloria Died*, directed by Bill Moyers, (1973).

workers described her as depressed and stressed.⁹¹ Gloria's welfare grant, through the Aid to Families with Dependent Children, only stipulated \$8 a month per child.⁹² In the bitter Minnesota winter, she could not afford warm clothes for herself and her children. Despite the severity of her situation, Gloria did not accept her circumstances and worked to find better housing for her family. She made several attempts to negotiate with landlords, but according to her social workers, they would "talk real nice on the phone and tell her to come out and look at the apartment. But, when she'd get out to look at it, they'd say it's rented."⁹³

Gloria's declining health during these years demonstrate the severe generational impacts of relocation. In a 2012 study, "The Intergenerational Effects of Relocation Policies on Indigenous Families," Walls and Whitebeck found that relocation policies affected the psychological welfare of several generations with Indigenous families; grandparent generation relocation experiences directly related to the next generations' substance use-related problems and long term mental health struggles.⁹⁴ Gloria's story represents the ripple effect of relocation's social inequalities across generations, as future Native people in Minneapolis continued to adjust to city life, further necessitating a culturally informed urban clinic.

⁹¹ Psychiatric epidemiological surveys report that since the late 1930s, low-income communities have reported high rates of mental illness; poverty is linked to economic stressors such as unemployment and lack of affordable housing (Kuruville, 2007, 273). Minneapolis lacked both physical and mental health services for Native peoples at this time; Gloria's mental health suffered greatly from her economic status which further impacted the physical wellbeing of her children.

⁹² Aid to Families with Dependent Children (AFDC) is a public assistance program formed in 1935, originally to support female heads of household, who were likely to be much poorer than husband-wife headed households. Gloria usually served as a single mother; according to her social workers, her husband was unreliable during this time. Robert Stein describes the financial climate for single mothers in his article "The Economic Status for Families Headed by Women," and discusses the main critique of AFDC's main critique: that their payment levels are too low to provide proper economic security for single mothers (Stein, 1970, 2).

⁹³ Kayan (prod.), *Why Gloria Died*, directed by Bill Moyers, (1973).

⁹⁴ Melissa L. Walls and Les B. Whitbeck, "The intergenerational effects of relocation policies on indigenous families," *Journal of family issues* 33, no. 9 (2012): 1272-1293.

Due to her difficult living situation and need to care for her children, Gloria avoided seeking medical help until her symptoms, consistent with those of hepatitis, were unbearable.⁹⁵ Finally, one hospital admitted Gloria – though she left a few days later and refused to ever return. Gloria’s social workers recount her experience at this first hospital:

She said they treated her horribly. One morning she asked the nurse for toilet tissue. They brought it to her that night. When she was leaving, one of the nurses called at her and said “we didn’t want you in this hospital anyway and we hope you didn't come back. Now I hope you never come back here again.”⁹⁶

Faced with such discrimination, Gloria left this hospital, and two days later, requested care at another institution. Though Gloria required immediate admittance, her former doctor failed to make the transition arrangements and the new hospital staff berated Gloria for infringing upon their lunch hour. The social workers again recount Gloria’s situation:

Her body was so full of infectious hepatitis. Her coloring was just awful, and she was limp you know, like all her energy had been drained out. She was really, really sick.⁹⁷

Mentally and physically exhausted, Gloria then returned to the original hospital – the same one that she swore never to set foot in again. Within two days of reentering the hospital, Gloria went into a coma. Three days later, she passed away at age 27.

⁹⁵ Due to discrimination within urban health facilities, avoiding healthcare until the situation became dire was frequent among urban Native people in the 1900s. In 1996, Dr. Angela Erdrich conducted interviews with Emory Johnson, former director of the Indian Health Service. She shared with me notes from the interview, in which Johnson, born and raised in Minnesota, expressed undeniable need for directed Indian health services in urban areas. During the late 50s, Johnson worked in a rural clinic in Ponsford, Minnesota where he recalled a “convulsing preeclamptic” Native woman who had traveled nearly four hours from the city to receive necessary care that should have been made available in an urban emergency room. The woman was seizing violently and in desperate need of care. “People were being sent from Minneapolis, said Johnson, “the system in Minneapolis was excluding them.”

⁹⁶ Kayan (prod.), *Why Gloria Died*, directed by Bill Moyers, (1973).

⁹⁷ Kayan (prod.), *Why Gloria Died*, directed by Bill Moyers, (1973).

Gloria’s reluctance to seek hospitalization mirrored a widespread fear among Native people in the 1950’s-70s.⁹⁸ In the early 1970s, IHB interviewed 700 Native households in Minneapolis and reported that 28% of these households identified that a hospital emergency room was their only source of medical care. Nearly 40% could not identify a source of primary medical or dental care.⁹⁹ Though the participants are anonymous, these interviews may easily have featured Gloria’s household.

Current IHB employee Katie Turner (White Earth Ojibwe) moved with her family to Minneapolis in 1954, finding home in the Phillips Neighborhood just as Gloria’s family did. Turner and her siblings watched the Minneapolis Native community growing throughout the ‘50s and into the ‘70s. In our interview, Turner recalled the same scarcity of medical options during her childhood: “we never had routine medical or dental care. As we were growing up, there weren't clinics around to get any kind of medical care.”¹⁰⁰ When she was four years old, Turner fell out of a second story window, breaking her leg and jaw. She remembers waiting in the emergency room for care and watching her mother, knowing their family did not possess insurance, “begging for services from the county and being rejected.”¹⁰¹ Like Gloria, Turner and her mother battled discrimination across the city: “[My mom] always kept us really well

⁹⁸ Data exploring the trust between healthcare providers and vulnerable populations is critical in forming interventions, yet most research fails to document Native American experiences. Studies generally show that people of color have historically tenuous relationships with Western medical systems. The mistrust of the healthcare system is most thoroughly investigated as a barrier for African American patients (Corbie-Smith 2002; Casagrande 2007; LaViest 2000). Buchwald et al., provides evidence that Native people feel mistrust of healthcare providers and dissatisfaction with their healthcare experiences (Buchwald 2006). Those these studies are recent; my interviews corroborate that their conclusions existed in the 1960s.

⁹⁹ Ron Zellar, “Indian Clinic Gives Care with Dignity,” *Minneapolis Star Tribune*, 29 April 1974, ProQuest, https://www.proquest.com/publication/publications_2043506?accountid=15172.

¹⁰⁰ Katie Turner (employee at the Indian Health Board), interview by Hema Patel, February 12th, 2023.

¹⁰¹ Katie Turner, February 12th, 2023.

dressed... she didn't want us to be called "Dirty Indians." And that that's kind of the treatment that you know, her and my dad were receiving back then."¹⁰²

Turner's intimate knowledge of Minneapolis in the '50-70s is reflected in her life-long career journey dedicated to the urban Native community.¹⁰³ Her life experience uniquely showcases what it was like to work for and with Native people in the Phillips Neighborhood during a critical era of activism. In our interview, Turner realized her early proximity to IHB's planning stages. She recalls working for a Family Health program at age 16 with IHB founders Charles Deegan, Norby Blake, and Peggy Green:

Charlie Deegan and Norby Blake, you know, they might have been discussing how to start IHB at that time. I mean, just realizing how close I was to being involved in that part of it, you know... there were these older adults that were talking in that family health office, and yeah, I might have been just around the corner when all that was going on.¹⁰⁴

Turner not only worked closely with IHB's founders, but also witnessed and participated in the birth of the American Indian Movement (AIM) in Minneapolis, July 1968, a grassroots organization advocating for a reclamation of land and improved situations for urban Indians.¹⁰⁵

AIM members aligned closely with the original board of IHB; activism in the Phillips

Neighborhood focused on community-building and sharing resources. Interviewee Reid

¹⁰² Katie Turner, February 12th, 2023.

¹⁰³ Some of Katie Turner's employments include: the American Indian Movement office, the Red Schoolhouse (Native Alternative education program), a part time secretary turned administrative assistant and eventual Mental Health Social Worker at the Indian Health Board, court advocacy for the Minnesota Chippewa Tribe Adoption Agency, the Minneapolis Indian Senate Indian Child Welfare Program, and current supervisor of Registration & Transportation at IHB, where she has worked for the last 17 years and plans to retire within.

¹⁰⁴ Katie Turner, February 12th, 2023.

¹⁰⁵ Among many significant turning points for Indigenous rights, AIM is credited with takeovers of federal buildings and the Winter Dam in Wisconsin, founding survival schools in the Twin Cities, the Wounded Knee trials, international conferences for Indigenous rights, the Trail of Broken Treaties Caravan and the Longest Walk for Survival, powwows, camps, and United Nations actions. For more on AIM, see early AIM co-founder Dennis Banks's book *Ojibwa Warrior*, which is an autobiographical style retelling of the many protests leading to the rise of AIM. To read about AIM's specific influence on the formation of the Twin Cities in the 1960s, see Bruce D'Arcus's article "The Urban Geography of Red Power."

Raymond (Rosebud Sioux), a college student interning in Native public health policy during this time, describes founder Charles Deegan as “in with everybody in a totally tight community. He was kind of like the health guy for AIM.”¹⁰⁶ AIM’s mission, influenced by Deegan’s persistence, spurred a demand for community control of the Indian Health Services, which resulted in an increased hiring of Native medical professions, the creation of community health boards, and the beginnings of decentralizing the Native healthcare system.¹⁰⁷

Inspired by the Civil Rights Movement and movements abroad, Native people won several important political, legal, and cultural victories to regain self-determination after the government had attempted to terminate and separate their tribes: activists organized an American Indian Chicago conference in 1961, demonstrators led the “Trail of Broken Treaties” caravan to DC, held a protest at Wounded Knee in 1973, among countless other untold marches, demonstrations, and boycotts.¹⁰⁸ As President Richard Nixon renewed the government’s commitment to supporting Native self-governance in his special message on Indian Affairs in 1970, AIM led the movement for self-determination on the ground.¹⁰⁹ Native Nations Institute for Leadership authors Stephen Cornell and Joseph Kalt call self-determination “the only policy

¹⁰⁶ Reid Raymond (lawyer), interview by Hema Patel, February 18th, 2023.

¹⁰⁷ Stephen J. Kunitz, "The history and politics of US health care policy for American Indians and Alaskan Natives," *American Journal of Public Health* (1996).

¹⁰⁸ See Dick Bancroft et al.’s *We Are Still Here*, for a photographic history of the AIM written by journalists, activists, and photographers actively following AIM in the 60s. The book also includes many rare interviews with surviving AIM members.

¹⁰⁹ Lina Mann’s mini documentary on Nixon’s speech published by the White House Historical Association calls Nixon “A Champion for American Indians.” The video documents his specific impact on Native affairs in the 70s: restoring land for the Taos Pueblo Native peoples in 1970, the 1971 Alaska Native Claims Settlement Act (ANSCA), and his refusal to reverse self-determination policy despite the political turbulence of the Alcatraz occupation and Wounded Knee takeover. Accessible here: <https://www.whitehousehistory.org/self-determination-without-termination#:~:text=By%20arguing%20for%20self%2Ddetermination,administer%20federal%20programs%20on%20reservations.>

that has worked to make significant progress in reversing the otherwise distressing social, cultural, and economic conditions in Native communities.”¹¹⁰

Turner muses that young Native people across Minneapolis were especially fueled by the strength of AIM’s demonstrations and took every chance to shape their own futures: “I don’t know how many times it was that... Just on a whim, we’d just pack up and go. It’s been a ride. Yeah, we went out to Alcatraz. We went out to the BIA building when they took it over. Yeah, I’ve had my times!”¹¹¹ Turner is referring to the 1969 Occupation of Alcatraz and large-scale takeover of the Bureau of Indian Affairs building in Washington DC in 1972 – two landmark protests that set the precedent for Native activism in the ‘70s.¹¹² Urban Native people, specifically youth like Turner, poured energy, resources, and time into opportunities to create change in the Native community, unrelenting in their goal to improve the quality of rural and urban Native life.¹¹³

Though city life brought forth challenges of discrimination, navigating modern technologies, and separation from homelands, assimilation was not an inevitable consequence, and Native people formed strong communities and gathered resources together as soon as they arrived in Minneapolis. In our interviews, Raymond and Turner painted a picture of Native Minneapolis during this time: a tight-knit group of intergenerational individuals, from many

¹¹⁰ Stephen Cornell, and Joseph P. Kalt, "American Indian self-determination," *Joint Occasional Papers on Native Affairs. Working Paper 1* (2010): 2117090916-1577391906.

¹¹¹ Katie Turner, February 12th, 2023.

¹¹² For a larger overview of Indigenous activism, see Daniel Cobb’s book *Say We Are Nations*, which provides a wide-ranging curated anthology of Native grassroots movements since 1887. Cobb’s retelling is rich with essays, letters, interviews, speeches, government documents, and other testimonies to demonstrate the long-standing demands for Indigenous sovereignty led by Native leaders, intellectuals, and activists.

¹¹³ Bradley Shreve’s book, *Red Power Rising*, illustrates how urban Native youth activism in the city of Gallup, New Mexico in the 1960s launched the Red Power movement for the advancement of Native rights and directly inspired many of AIM’s political actions. Shreve highlights the direct power of Native youth in actively challenge injustices and shaping society, which is exemplified in Turner’s early activism in Minneapolis.

different tribes, playing crucial roles in the future of the Phillips Neighborhood. During this time, every Native person's choice to speak out, from college student Raymond's public health internship to young rebel Turner's lifelong service to her community, directly impacted the future of Native Minneapolis.¹¹⁴ According to Turner, "the community back then was mostly Native, you know, in the Phillips neighborhood. And it's kind of like we all just kind of started gravitating to each other."¹¹⁵ Despite finding themselves miles from home in a neighborhood rife with poverty and discrimination, Native communities thrived. Urban activism, and urban Native organizations like IHB, blossomed in major cities with some irony; as Bruce E. Johansen writes in the foreword of *Urban American Indians: Reclaiming Native Space*, the "federal-government policy sent Native people to cities to assimilate, forgetting that the influence of culture goes both ways."¹¹⁶ Though relocation programs aimed to assimilate Native people once removing them from reservations where healthcare was supposedly more accessible, Native people engaged in survivance, transforming urban areas into spaces of cultural learning, safety, and growth.

Grassroot protests following Nixon's 1970 Indian self-determination policy extended directly into Indian Health Services, as the increasing number of urban Native peoples advocated their right to accessible urban health services. Outraged by Gloria's death, and cognizant that it was symbolic of countless untold experiences, Minneapolis Native community members organized in grassroots fashion and founded an urban Indian clinic in Gloria's honor. Ellie Webster, non-Native ally, AIM member, and early administrator for IHB, notes that Charles

¹¹⁴ Though focused on the history of Native education activism, Julie L. Davis's *Survival Schools* highlights the vigorous and wide-ranging intergenerational activism in the Twin Cities throughout the 1960s. Davis's book offers a closer look at the links between activist agendas and groups within Minneapolis, demonstrating that the growth and success of urban Native Minneapolis came advocates and allies from all walks of life.

¹¹⁵ Katie Turner, February 12th, 2023.

¹¹⁶ Bruce E. Johansen, introduction to *Urban American Indians Reclaiming Native Space* (California: Praeger, 2016), ix.

Deegan led these efforts. As Webster recalled in our interview, Deegan strategized with local hospitals, Hennepin County Medical Center and Lutheran Deaconess, to convince key healthcare leaders of the importance of a Native focused clinic. Webster attended these early meetings, serving as a note-taker and authoring the original bylaws and article of incorporation for the clinic. Webster described that in Minneapolis in the late 1960s, there were clinics focused on Swedish and Jewish populations and so she and Deegan argued that “instead of being an arm of one of the other health facilities,” Native people should start up their own clinic.¹¹⁷ Deegan recognized the importance of working closely with local hospitals to provide evidence-based reasoning for the clinic and partnering with then US House of Representatives Donald Fraser to fund their clinic. According to Webster, Deegan “was the voice of the Indian Health Board, he had the dream of the Indian Health Board, and he really worked to find people who would support that and work with him to get it done.”¹¹⁸ To garner Congressional support, Fraser advised Deegan and Webster to propose that IHB could function as an expansion of Indian Health Services – a satellite access clinic.¹¹⁹ The clinic could then become eligible for Congressional funds, in addition to private donations, foundation grants, and grants from the US Dept. of Health, Education, and Welfare.¹²⁰

Before receiving Congressional funds, IHB founders garnered enough money to kickstart the clinic but lacked funds for construction. So, they built the interior walls and doors of IHB's original location with their own hands.¹²¹ They furnished the building with equipment donated or

¹¹⁷ Ellie Webster (founding member of the Indian Health Board), interview by Hema Patel, February 20th, 2023.

¹¹⁸ Ellie Webster, February 20th, 2023.

¹¹⁹ Ellie Webster, February 20th, 2023.

¹²⁰ Wilkinson, "Bridging the Gap: The Twin Cities Native American Community," 1975, 12.

¹²¹ *Indian Health Board of Minneapolis 40th Anniversary Video*, <https://vimeo.com/40529684>.

offered at a reduced rate by retiring doctors and dentists around the city.¹²² In 1971, the Indian Health Board opened its doors in the Phillips Neighborhood of South Minneapolis, as one of the first community-oriented Native clinics in the country.¹²³ In 1972, the clinic continued work backed by Congressional financial support.

Deegan, a leader in forging connections for Native people, encouraged Reid Raymond to apply for an internship with Representative Fraser to continue the strong relationship between IHB and Congress. Through the vital combination of Deegan's leadership, Webster's administration, Fraser's support, and Raymond's advocacy, the federal government allocated \$1.1 million for urban Indian healthcare through an Interior Appropriations bill in 1972.¹²⁴ As Webster recalled, "that [money] didn't all come to Minneapolis, because the idea behind this was to set up other clinics across the country, we weren't just pushing this just for Minneapolis, but this is where it was initiated."¹²⁵ Deegan, a visionary, sought to found IHB as a model for other cities to improve national urban Native health through the implementation of culturally tailored healthcare initiatives. As IHB generated success in Minneapolis, Deegan and Webster served as a national unofficial advisory board, offering phone call consultations for prospective urban Native clinics and driving to areas like Chicago, Compton, and Detroit to share resources about the clinic implementation.¹²⁶

The work of these Native activists, among others in Minneapolis and across the country, provided the foundation for the Indian Health Care Improvement Act (IHCA) of 1976, a major

¹²² Zellar, Ron. "Indian Clinic Gives Care with Dignity." *Minneapolis Star Tribune*, 29 April 1974. ProQuest, https://www.proquest.com/publication/publications_2043506?accountid=15172 (accessed November 1st, 2022).

¹²³ "Who We Are," *Indian Health Board*, accessed November 18th, 2023 <https://www.indianhealthboard.com/who-we-are/>.

¹²⁴ Wilkinson, "Bridging the Gap: The Twin Cities Native American Community," 1975, 20.

¹²⁵ Ellie Webster, February 20th, 2023.

¹²⁶ Ellie Webster, February 20th, 2023.

political act of Native self-determination, which returned healthcare and welfare agency to Native peoples – the government’s concession to unyielding Native activist protest and advocacy. Though Congress passed IHCA to address unmet needs of Native people in both urban areas and on reservations, Title V of the act specifically established Urban Indian Health Programs (UIHP) to provide outreach, referral services, and direct health care services in urban spaces. According to an investigation report authored by the Department of Health and Human Services in 1988, UIHP predated the title V of IHCA; “UIHP began in the late 1960s as a grassroots effort by Indian community leaders in response to the growing health programs of urban Indians.”¹²⁷ The government’s acknowledgement of urban Native activism during this time is a product of the era of self-determination; federal legislation to improve healthcare in the 1970s simply gave form to existing Native self-governance, community advocacy, decision-making.

As the foundation for future IHCA policies, IHB began unofficially in 1971, received Congressional funding in 1972, and officially started as a UIHP in 1973. Moving from its temporary, hand-built location into a federally funded locale in the Indian-developed non-profit housing project in South Minneapolis, the clinic was directly accessible to those living in Little Earth.¹²⁸ The Indian Health Board transformed healthcare services in Minneapolis. In addition to

¹²⁷ Richard P. Kusserow, “The Urban Indian Health Program: A Bridge to Mainstream Health Care Delivery,” *Report from the Office of Inspector General to the Department of Health & Human Services*, July 1988, <https://oig.hhs.gov/oei/reports/oai-09-87-00027.pdf>.

¹²⁸ The formation of the Little Earth Housing and Urban Development complex is tied to the Indian Health Board; both were founded in grass roots response to issues of relocation and both model self-determination for Native peoples. According to interviewee Reid Raymond, the Indian Health Board operated out of the first floor of the Little Earth apartment building between 1975-76. Little Earth, founded in 1973, is the only Indigenous preference project-based Section 8 assistance community in the United States. The complex seeks to “provide residents with the skills and experience to assist on their journeys toward economic stability and self-determination.” More information on Little Earth can be found here: <https://www.littleearth.org/about>.

offering culturally sustaining care, the implementation of IHB is an act of survivance simply through its community-based formation. Truly unique, IHB's 21 leadership members all identified as Native.¹²⁹ Deegan, Webster, Turner, Raymond, and other countless Native and non-Native supporters survived a long, politically confusing road to implementation. IHB's Native leaders hoped to challenge the narrative of fear surrounding Westernized medicine in which, as Deegan told the Minneapolis *Star Tribune*, "Indians do not utilize existing health services except in emergency situations," by providing culturally tailored, community-led healthcare.¹³⁰ Deegan's words here recall the circumstances of Gloria's death – the vulnerability in her search for a willing hospital and her return to a discriminatory hospital only when she was near death. As Deegan told Bill Moyers: "I don't think it was so much the hepatitis that killed her... the unwillingness of the hospital to admit their deficiency in dealing in cross-cultural areas. That's what killed her... She was a victim of racism."¹³¹ Deegan's words are especially poignant, calling out the inability of rural Indian Health Services and Minneapolis's general healthcare scene to provide culturally inclusive care and failure to treat Native people as human beings.

¹²⁹ Sam Newlund, "New health clinic in city a first for urban Indians," *Minneapolis Star Tribune*, 2 August 1973. Minnesota Historical Society Archives.

¹³⁰ Today, the Indian Health Board of Minneapolis is a non-profit 501(c)3 organization, a Joint Commission accredited facility, and a Federal Tort Claims Act (FTCA) deemed community health center, staffed by a combination of Native and non-Native physicians, administrators, elders, and care givers. Considered a "free" clinic, the Indian Health Board does not require payment from patients – however, these services are treaty-owed, prepaid by Native ancestors who worked tirelessly for over 200 years to provide a better future for the generations to come.

¹³¹ Kayan (prod.), *Why Gloria Died*, directed by Bill Moyers, (1973).

Part III

Culturally Sustaining Healthcare at the Indian Health Board



Figure 7. On the left, an image of the pearly everlasting. On the right, an inhaler resting on a pile of dyed porcupine quills. Miskwa Mukwa Desjarlait quilled this case for his wife who has asthma. His relatives told him stories about a flower, the pearly everlasting, which they used for respiratory medicine. Miskwa translated this story into a quilled floral adorning a modern day respiratory medical device, fusing Ojibwe traditions with technologies of the present.

While traditional Native healing often occurs outside of formal healthcare settings, incorporating traditional customs into clinics strengthens cultural identity, builds community, and is empowering.¹³² From its inception, the Indian Health Board has cultivated culturally sustaining healthcare, fusing Western conceptions of medicine with Indigenous methods to

¹³² Teresa D. LaFromboise et al., "Counseling intervention and American Indian tradition: An integrative approach," *The Counseling Psychologist* (1990), 628-654.

provide relevant, holistic medical care for all patients. Upon first opening its doors, IHB operated from 9:30-4:30pm, Monday through Friday, serving 12-15 dental patients and 7-10 medical patients per day.¹³³ Today, IHB serves over 4,800 patients each year, providing dental, medical, and mental health care as well as substance abuse counseling integrated within a traditional framework, and partners with other Native social services across the Phillips Neighborhood.¹³⁴ In our interview, postdoctoral fellow on IHB's Integrated Behavioral Health team, Dr. Micah Prairie Chicken (Oglala Lakota Oyate/Mdewakanton Dakota/Sicangu Lakota), described IHB as an "anchor in the community."¹³⁵

IHB provides services with dignity, but also with the intent to uplift and empower Native communities so that they may feel comfortable accessing and receiving healthcare.¹³⁶ In Dr. Prairie Chicken's words, the care offered by IHB is a steadfast pillar within the Native community; young Native people in Minneapolis embrace IHB with familiarity, knowing that their family has long trusted the clinic. Interviewee Katie Turner shared that before she began working for the IHB in 1976, she couldn't find reliable healthcare for her son. She explained, "I was very lucky to have Indian Health Board formed not long after I had my son... the Indian Health Board has been his clinic as well as mine, you know, ever since then. And I think that's the reason why we get regular care. Now my granddaughter and my great granddaughter, they get regular care here too."¹³⁷ By offering dependable, quality care, IHB sustains Native culture

¹³³ Zellar, "Indian Clinic Gives Care with Dignity."

¹³⁴ "Who We Are," *Indian Health Board*, accessed November 18th, 2023, <https://www.indianhealthboard.com/who-we-are/>.

¹³⁵ Micah Prairie Chicken (Indian Health Board psychologist), interview by Hema Patel, December 2nd, 2021.

¹³⁶ Zellar, "Indian Clinic Gives Care with Dignity."

¹³⁷ Katie Turner, February 12th, 2023.

not only through medical practice, but by developing an intergenerational sense of community belonging in Minneapolis.¹³⁸

Though the history of earlier cultural services is somewhat opaque, the Indian Health Board has long exemplified their current mission to incorporate cultural health and wellness with the best available scientific medical knowledge.¹³⁹ Examples of culturally tailored care initiated by or embraced by IHB include disease prevention strategies for heart disease, cancers, diabetes as well as efforts to promote Native traditions. Beginning in the late 1960s and early 70s, for example, cardiovascular disease grew as the leading cause of death among Minnesota Native peoples in both rural and urban areas.¹⁴⁰ A 1984 study on cardiovascular risk in Indian communities specifically found that 70% of Native people living in Minneapolis were cigarette smokers.¹⁴¹ The study indicated that many of the smokers who struggled to quit also reported using tobacco for cultural purposes, as it is a spiritual, traditional symbol for many Native people. Tobacco is often placed in a small pile near a tree, sprinkled in a river to give thanks, bundled with other sacred medicines, burned for prayer, or gifted to an elder, among many other uses specific to different nations, bands, and families.¹⁴² As early as the 1930s, relocation into cities caused poverty and crowded living conditions that created social pressures and increased

¹³⁸ In Native cultures, elders are valued as protectors, mentors, teachers, keepers of wisdom, and intergenerational transmitters of cultural knowledge (Whitewater et al., 2016, 3). In addition to offering both age-specific and intergenerational programming, the Indian Health Board retains an on-site elder, Richard Wright, open to guiding and collaborating with all patients (see Appendix D).

¹³⁹ "Who We Are," *Indian Health Board*, accessed November 18th, 2023.

¹⁴⁰ Allen Short's 1992 article "The smoke that kills: programs help Indian fight scourge caused by cigarettes," published in the *Ojibwe News* (a Native operated newspaper founded in Minnesota in 1988) highlights one of the Indian Health Board's education-focused, community-tailored medical interventions – Giving American Indians No-Smoking Strategies (GAINS) programming. A valuable primary source, Short's article is one of the earliest published reviews of IHB's culturally sustaining programming.

¹⁴¹ Richard Frank Gillum et al., "Cardiovascular risk factors among urban American Indians: blood pressure, serum lipids, smoking, diabetes, health knowledge, and behavior," (*American Heart Journal*, 1984).

¹⁴² Joseph C. Winter, *Tobacco use by Native North Americans: Sacred smoke and silent killer*, (University of Oklahoma Press, 2000), 17.

exposures to cigarette smoking, resulting in a complicated relationship between Native people and tobacco. In response, IHB implemented a program focusing on tobacco education as a tool of empowerment.¹⁴³

In January 1992, IHB implemented a Giving American Indians No-Smoking Strategies (GAINS) program which “provides Native smokers with culturally relevant anti-smoking materials and enlists physicians and other professionals at Indian health clinics to deliver the message repeatedly to their patients.”¹⁴⁴ GAINS programming differs from other programs by focusing on education – welcoming and empowering smokers to learn how they can alter their own habits, and why this matters not just for the individual, but for the community.¹⁴⁵ Original IHB member and medical provider Carol Krush explained to the Minneapolis *Star Tribune* newspaper that the clinic is “trying to spend more time explaining just what is happening inside the body and why it's important to follow up on it.”¹⁴⁶ Scholars agree that clinician-patient communication, especially when working with marginalized populations, has proven effective in improving health outcomes, access to care, community support, and patient understanding and comfortability.¹⁴⁷ Rather than stigmatizing Native people for their use of tobacco, whether

¹⁴³ See Appendix B for an example of current tobacco-use and cardiovascular health posters and programming at the Indian Health Board.

¹⁴⁴ Allen Short, “The smoke that kills: Programs help Indian fight scourge by cigarettes,” *The Native American Press & Ojibwe News*, 24 January 1992. Minnesota Historical Society, <https://newspapers.mnhs.org/jsp/PsBrowse.jsp> (accessed November 4th, 2022).

¹⁴⁵ Jacqueline F. Moghaddam et al., Sandra L. "Crystalizing the role of traditional healing in an urban Native American health center." *Community mental health journal* 51 (2015): 310.

¹⁴⁶ Zellar, “Indian Clinic Gives Care with Dignity.”

¹⁴⁷ Various authors offer significant evidence of the benefits of clinician-patient communication in health outcomes (Street et al. 2009; Carroll 2007; Lin 2016; Stewart 1995).

through smoking or cultural practices, the educational program instead establishes healthy alternatives to smoking in the community.¹⁴⁸

Today, the IHB's culturally sustaining offerings expand across medical and dental care, substance abuse counseling, and mental health services. In the clinic's atrium, a poster advertises "Your Wellness is our Greatest Success" – listing available services such as community elder visits, naming ceremonies, Ojibwe cultural heritage, Indigenous healing practices, traditional family help (Skaube'), wake services, and neonatal tribal practices.¹⁴⁹ In our interview, Community Health Educator & Cultural Navigator Nell Barri (Red Cliff Band of Lake Superior Ojibwe), walked me through a typical calendar year of integrative cultural programming:

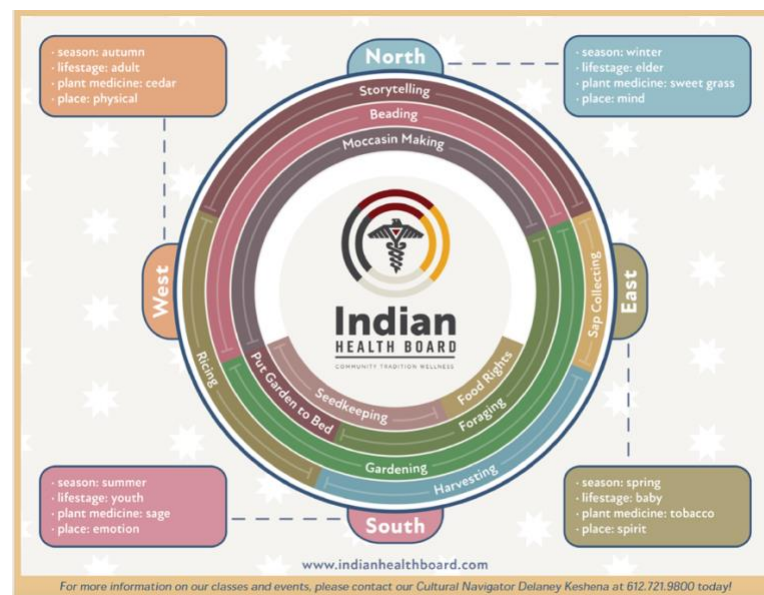


Figure 8. IHB's Indigenous Services calendar poster created in 2020.¹⁵⁰

¹⁴⁸ In the Canadian Journal of Neurological Sciences, Suzanna M. Kurz states that better physician communication skills improve patient satisfaction and clinical outcomes. The key piece of patient-physician communication, Richard Street concurs in a journal on patient education, is ensuring that the patient is offered full explanation of their illness or medical need, and that they are given the tools to further their wellness in and outside of the clinic. By breaking down the complexities of tobacco-use on the body, IHB demonstrates efficient and empowering patient-physician communication.

¹⁴⁹ See Appendix C.

¹⁵⁰ Nell Barri (Community Health Educator & Cultural Navigator at the Indian Health Board), interview by Hema Patel, February 16th, 2023.

Based on the medicine wheel, the calendar incorporates cultural traditions categorized by the sacred number four: the four directions, seasons, and sacred medicines. Though the significance and use of medicine wheels are culture-specific, the symbol generally represents interconnectivity between all aspects of one's being and awareness of one's physical, emotional, mental, and spiritual realities.¹⁵¹ In their article "Incorporating traditional healing into an urban American Indian health organization: a case study of community member perspectives," authors Hartmann and Gone found that across each of their surveyed urban Native health clinics, relearning traditional knowledges and participating in traditional activities was considered an essential part of healing.¹⁵² This calendar, crafted by IHB's Indigenous Services team, is a pedagogical form of culturally sustaining care; traditional services are tied with the seasons and life stages to provide year round support systems for Native people that improve all aspects of their health.

Barri explained that before this calendar was released in 2020, the clinic used to focus on crafting events year-round, like beading groups and moccasin making, often accompanied by traditional storytelling, as forms of cultural wellness.¹⁵³ A 2010 Aboriginal Healing Foundation study links creative arts, culture, and healing to therapeutic success; the restoration of language, culture, and spiritual tradition positively impacts health by decreasing isolation and depression, revitalizing the role of community elders, fostering shared experience of overcoming colonial

¹⁵¹ Bob Joseph, "What is an Indigenous Medicine Wheel," *Indigenous Corporate Training INC.*, May 24 2020, <https://www.ictinc.ca/blog/what-is-an-indigenous-medicine-wheel>.

¹⁵² William E. Hartmann and Joseph P. Gone, "Incorporating traditional healing into an urban American Indian health organization: a case study of community member perspectives." *Journal of counseling psychology* (2012), 542.

¹⁵³ See Appendix E for examples of posters advertising the Indian Health Board's recent cultural programs.

oppression, and increasing self-esteem, and renewing cultural identities.¹⁵⁴ Though community members and patients enjoyed and benefited from these crafting events throughout the year, Barri's team realized that from a traditional standpoint, Native people craft and tell stories mainly in the winter.¹⁵⁵ To truly commit to providing cultural services, IHB's programming expanded to follow seasonal traditions, demonstrating holistic care not only through performing traditional activities, but by restructuring the clinic to mirror traditional ways of being. The detailed culturally informed calendar is not simply a representation of inclusive cultural activities, but an exemplary pedagogy of healthcare that integrates Native knowledge systems alongside traditions.

Combined with Westernized programming, Indigenous Services is geared towards spreading cultural knowledge so that participants may bring these traditions and teachings into their own homes, developing a greater sense of trust with the clinic while strengthening their support systems outside of the Indian Health Board. As spring approaches, Barri is planning a maple syrup harvesting educational event that will eventually lead into a summer focused on the IHB's traditional medicine garden, Mashkiki Gitigaan, which is located right across the street.¹⁵⁶ Importantly, in IHB tradition, cultural events are education focused – Barri explained that when people come to garden harvesting events, it is fruitless to simply distribute produce without

¹⁵⁴ Linda Archibald and Jonathan Dewar, "Creative arts, culture, and healing: Building an evidence base," *Pimatisiwin: A Journal of Aboriginal and Indigenous Community Health* 8, no. 3 (2010).

¹⁵⁵ Dennis Zotigh's Smithsonian Magazine article on seasonal traditions writes that traditional storytelling is reserved for long, dark winter months given the fact that during other seasons, Native people focus on outdoor activities such as growing, hunting, and gathering. Additionally, as IHB acknowledges, Native people perceive the world as interrelated. Many stories contain animal characters and so to be respectful, some Native people believe in waiting for winter hibernation so that the animals do not hear themselves being talked about.

¹⁵⁶ See Goodkind 2015 for a study detailing the importance of land as a therapeutic landscape in Native health. As the study suggests, many Native people view their relationships with land as interpersonal. Opportunities to heal and work with the land, as in the case of Mashkiki Gitigaan, are beneficial to the health of both the communities and landscapes involved.

explaining the significance of traditional Native plants and how to cook and use them.¹⁵⁷

Upcoming events are also interconnected: Barri is currently planning a foraging walk where participants learn to identify edible plants that will lead into a tea-making workshop where elders and leaders walk participants through creating teas from harvest to brewing. IHB's Indigenous Services programming, fortified in culture and education, serves not only patients' most immediate health concerns, but enhances their lifelong cultural wellness and impact in the Phillips neighborhood.¹⁵⁸

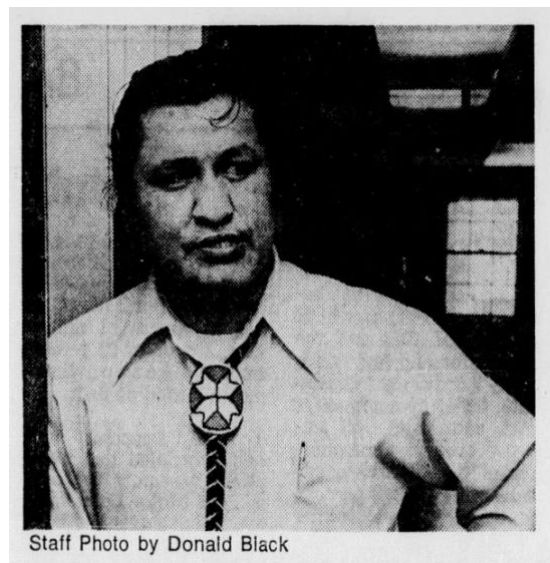


Figure 9. Charles Deegan standing in the clinic in 1974. He wears a beaded bolo tie, likely depicting the four colors of the sacred medicine wheel, an important cultural symbol for many Native people.¹⁵⁹

In addition to Indigenous Services cultural programming, Barri provides sexual health education for the Native community, focusing on common topics like healthy relationships, consent, birth control, STIs, and gender and Two Spirit identities. In her educational sessions on consent, Barri begins from a Western standpoint, providing important information such as no

¹⁵⁷ Nell Barri, February 16th, 2023.

¹⁵⁸ Nell Barri, February 16th, 2023.

¹⁵⁹ Zellar, "Indian Clinic Gives Care with Dignity."

means no, and that a lack of a no does not mean a yes, it must be freely given and can be reversed. After opening the session with the familiar Western conception of consent that many people may have heard in schools or around the clinic, Barri then Indigenizes the conversation and examines what consent means for Native people as a tradition practiced for generations.¹⁶⁰ Consent, says Barri, is something “we've actively taught to our people, we just didn't use the same words that we do now.”¹⁶¹ She offers session participants stories from her own family and community, relatable across Native nations, to demonstrate that consent is a long-standing, traditional practice. For example, when looking for guidance or help, many Native people offer their elders tobacco as a request for their knowledge and an act of thanks. Barri describes consent as an act of ongoing exchange and further connects consent to the earth within an Indigenous framework: “When we are harvesting traditional medicines, or food foraging, or hunting... traditionally we offer our tobacco. We're asking for the consent to take this [resource] and only taking what we need, using all of it, and not being wasteful and not being selfish.”¹⁶² By reframing consent with in a decolonial perspective, IHB tailors sexual health education to Native community members. Often, in a room filled with nervous teens and uncomfortable parents, Barri feels that discussing sexual health with an emphasis on cultural connection calms the room and helps participants focus on learning and sharing rather than on any existing sexual health stigmas. In most cases, Barri expressed that this is the moment in her sessions when the material “just clicks” for participants.¹⁶³ Indigenizing sexual health workshops at the Indian Health Board

¹⁶⁰ In “Decolonizing education in Canadian universities” educator Marie Battiste (Mi'kmaq) posits that we should view Indigenous and Western knowledge systems not as oppositional binaries, but as complementary tools for deeper understanding. As Barri demonstrates, Indigenous knowledge can fill the gaps within Eurocentric teaching models and extend concepts beyond Western limitations.

¹⁶¹ Nell Barri, February 16th, 2023.

¹⁶² Nell Barri, February 16th, 2023.

¹⁶³ Nell Barri, February 16th, 2023.

combats education barriers in understanding health concepts, highlights cultural knowledge over Western perspectives on common health information, and builds critical trust between the medical system and Native community.

Along with Indigenizing wellness programming and health education, IHB offers comprehensive, culturally sustaining mental health care through their Mental Health and Counseling (MHC) program – an important addition to the clinic that has continued to grow since implementation in the 1980s. A few years after solidifying medical and dental care in the Phillips neighborhood, IHB redirected energy to meet a pressing need for mental health services. In the 1970s, Ellie Webster recalls stocking the IHB waiting room with leaflets on anxiety and depression and seeing the material “fly off the walls.”¹⁶⁴ As a result of surviving years of systemic violence, Indigenous communities are plagued by high rates of psychological distress and mental illness; Native people report experience psychological distress at 2.5 times more than the general population.¹⁶⁵ Native youth, in particular, are at an increased risk for substance abuse, clinical depression, and suicide.¹⁶⁶

My interview with Dr. Prairie Chicken illuminates IHB’s current mental health services after decades of dedication to expanding programming from Webster’s days. MHC consists of the standard comprehensive mental and behavioral health services: such as individual counseling, psychological assessments, crisis intervention, psychiatric services, and integrated care and consultation programs. In addition to these Western services, the clinic is deeply “committed to decolonizing our healing work with clients and including traditional and cultural

¹⁶⁴ Ellie Webster, February 20th, 2023.

¹⁶⁵ National Center for Health Statistics. “Health, United States, 2017, with Special Feature on Mortality.” Hyattsville, MD. 2018. <https://www.cdc.gov/nchs/data/abus/abus17.pdf>.

¹⁶⁶ Joseph P. Gone, "Mental Health Services for Native Americans in the 21st Century United States," *Professional Psychology: Research and Practice* 35, no. 1 (2004).

practices in our services.”¹⁶⁷ As of recent years, these services include hand drum groups, beadwork workshops, therapeutic beading support groups, and school-based behavioral health services at the three local Minneapolis schools with large numbers of Native students: Anishinaabe Academy, Sanford Middle School, and Takota Prep. The drum group in particular, Drum Teachings for Success, is an innovative program that promotes early intervention strategies to reduce risk factors in Native youth through making traditional hand drums and singing songs to maintain balance.¹⁶⁸

To Prairie Chicken, IHB is special because physicians provide mainstream services along with traditional ways of medicine. But while IHB provides access to some traditional ways of wellness, they are constrained by their urban location: as Prairie Chicken put it, “there is no access to certain traditional methods. We don’t have sweat lodges outside, and we don’t necessarily have pipe ceremonies.”¹⁶⁹ Though Native patients in cities deserve the same access to tradition they might have on reservations, years of cultural separation, isolation, and decimation contribute to a discrepancy in access to cultural knowledge off reservation. To begin to navigate this challenge, MHC works closely with Indigenous Services, Barri’s area of expertise, to provide traditional medicines for patients and families throughout their clinic visits. Dr. Angela Erdrich (Turtle Mountain Ojibwe), current pediatrician at IHB, informed me that physicians are instructed to provide patients who would benefit from traditional medicines with personal baskets containing individual samples of the four sacred medicines: sage, sweetgrass, kinnikinnick (tobacco), and cedar as well as suggestions for different medicinal uses. The medicines are a gift

¹⁶⁷ “Counseling & Support,” *Indian Health Board*, accessed November 18th, 2023, <https://www.indianhealthboard.com/counseling-support/>.

¹⁶⁸ “Drum Teachings for Success,” *Indian Health Board*, accessed November 18th, 2023, <https://www.indianhealthboard.com/drum-teachings/>.

¹⁶⁹ Nell Barri, February 16th, 2023.

and an invitation to explore traditional healing; patients determine their approach – for example, they can visit with IHB's elder, ask their physician for further guidance, take to YouTube, or simply use the medicines on their own. Dr. Erdrich explained that she sees many patients come to the Indian Health Board “looking to connect to healing in a Native way.”¹⁷⁰ The Indian Health Board empowers Native people to forge and strengthen both culture and community through the reclamation of traditional medicines within a Westernized medical setting.

The realm of “traditional medicine” offers its own complications; Prairie Chicken expressed that providing mental health care for Native people can be a difficult subject because current mainstream treatments are entrenched in Western paradigms and definitions of well-being. According to Prairie Chicken’s experience in pursuing a psychology PhD, mental health norms have been established on the terms of young white people, excluding the wellness needs of Native people. “The development of diagnoses and psychological tests, even modalities is very Western-based,” said Prairie Chicken, “and if not Western-based, then co-opted by [these notions] of Western mental health.”¹⁷¹ As IHB has expanded both their cultural and Western based care, the staff must navigate a difficult question: in Prairie Chicken’s words, “Are we furthering the colonization of Native people by using Western-based treatments with Native people? Are we further indoctrinating our community by using the methods we learned in places like graduate school?”¹⁷² Ultimately or practically speaking, the clinic focuses not on these abstract questions but on how to meet the daily mental health needs of a community who has survived hundreds of years of trauma. The Indian Health Board’s integration of cultural services defies boundaries between Western medicine and tradition; rather than choosing between

¹⁷⁰ Angela Erdrich (pediatrician at the Indian Health Board), interview by Hema Patel, January 9th, 2023.

¹⁷¹ Micah Prairie Chicken, December 2nd, 2021.

¹⁷² Micah Prairie Chicken, December 2nd, 2021.

modern medical technologies or traditional techniques, the clinic succeeds through both ways of knowing.

Redefining healthcare through tradition poses an additional challenge; Native patients from many nations come to IHB with extremely complex mental health needs, and so the clinic works diligently to offer non-generalized services that encompass the increasingly diverse urban Native community in the Phillips neighborhood.¹⁷³ In Prairie Chicken's words, it is "hard to not fall into pan-Indianism... you can't use the same medicine for every tribe, for example."¹⁷⁴ Care providers at IHB struggle to determine a set of traditional services that encompass vast cultures of Indian Country.¹⁷⁵ Hartmann and Gone note that pan-Indianism can separate urban Native people from the traditions of their homelands while also uniting them with the growing movements of pan-Native solidarity; incorporating traditional healing into an urban setting requires the negotiation of traditional healing protocols that also contribute to cross tribal community building.¹⁷⁶ As IHB navigates colonial conceptions of medical care, the clinic tries their best to attend to diverse tribal needs in their overall mission to meet the most pressing

¹⁷³ Eleanor E. Yurkovich et al.'s "'Chaotic soup of politics:' a Native American Indian mental health perspective" offers further insight to the diversity of complex mental health issues affecting tribal nations.

¹⁷⁴ Micah Prairie Chicken, December 2nd, 2021.

¹⁷⁵ Indigenous peoples of the North America are diverse; the US government officially recognizes 574 tribes in the contiguous 48 states who are eligible for funding and services from the BIA. Despite this diversity, Native peoples are typically viewed as a monolith and stereotyped with one generalized culture. Scholars and communities refer to this stereotype as Pan-Indianism/Pan-Indigeneity: the grouping of Native nations into one dominant culture rather than acknowledging individual tribal culture and practices. Throughout history, Native communities both supported pan-Indianism as a space of collective gathering for activism or celebration (for example, a powwow) and rejected the term for its erasure of different tribal needs. To further explore perspectives on Pan-Indianism in the late 1900s, see Robert Thomas's 1965 article "Pan-Indianism." In the context of healthcare, the Indian Health Board works to offer traditional services for a range of Native tribes, ideals, specific cultures, and levels of prior cultural knowledge, but also relies on larger Pan-Indian values. The clinic highlights Pan-Indian values, such as beadwork and gardening, in their programming while making space and providing support for patients to explore their individual tribal teachings.

¹⁷⁶ William E. Hartmann and Joseph P. Gone, "Incorporating traditional healing into an urban American Indian health organization: a case study of community member perspectives."

concerns within the community. To accomplish this, Prairie Chicken described the care offered by IHB as a culturally tailored, individually based treatment service. “For someone who is more traditional and wants to get into cultural activities, we would refer them to the therapeutic beading group,” said Prairie Chicken.¹⁷⁷ Referral to elders and traditional activities like drumming and beading is linked to therapeutic success.¹⁷⁸ But for other patients, the clinic might offer other psychological modalities like narrative therapy or cognitive behavior therapy. As is clear through Prairie Chicken’s description of the services offered at IHB, providing adequate mental health to Native people involves continually assessing the community in terms of types of cultural services they might want; “this is what drives our treatment planning and the ways we approach therapy,” said Prairie Chicken.¹⁷⁹ By recognizing the diversity of patient cultures encompassed in the realm of Indigeneity, the Indian Health Board strives to preserve tradition while embracing all people seeking patient-centered, culturally sensitive healthcare.

Finally, not only does IHB demonstrate a commitment to amplifying Native voices within medical treatments, but the clinic is also dedicated to sharing their resources and knowledge throughout the community. In 2015, IHB earned an accreditation to start Niigimowinmiiwinzha (in English, the Doctoral Internship Program), in which up and coming Native people in the medical field just like Prairie Chicken can begin to serve their communities while training as the next generation of professionals. The Indian Health Board provides culturally sustaining healthcare for a historically traumatized and marginalized people through

¹⁷⁷ Micah Prairie Chicken, December 2nd, 2021.

¹⁷⁸ Ethan Nebelkopf and Mary Phillips, eds. *Healing and mental health for Native Americans: Speaking in red*. Vol. 11. Rowman Altamira, 2004.

¹⁷⁹ Micah Prairie Chicken, December 2nd, 2021.

the integration of traditional healing practices, education-oriented programming, community building.¹⁸⁰

Each of my interviewees expressed that generations of patients and families, community activists, and future medical workers from diverse nations and homelands find a home in the Indian Health Board. Barri, for example, moved to Minneapolis from her reservation as recently as 2020 and already feels accepted and welcomed into the Phillips neighborhood as both a Native community member and an IHB representative. She recently led a workshop on the menstrual cycle at a moon ceremony; though she works at a clinic, she is “asked to speak in sacred spaces as well.”¹⁸¹ This integration of health education within a ceremony, in the middle of a city, exemplifies culturally sustaining healthcare; through the influence of IHB, medical perspectives are welcomed into traditional spaces and have become central to community building in the Phillips neighborhood. As the beaded images of the uterus, city-buildings, and Native plants throughout this paper have demonstrated, traditional ways of healing and Western medicine cohabitate to ensure survivance.

¹⁸⁰ Angela Erdrich, “Indian Health Board of Minneapolis: a 50 Year Vision for the Future,” *MetroDoctors: The Journal of the Twin Cities Medical Society*, Spring 2022, https://issuu.com/metrodoctors/docs/metrodoctors_spring2022.

¹⁸¹ Nell Barri, February 16th, 2023.

Conclusion

Ensuring the Health & Wellness of Our People for Seven Generations to Come



Figure 10. I beaded Ojibwe florals on this blazer in 2018 as a declaration of cultural celebration, revitalization, and dedication. Five years later, I reflect on the inspiration for this piece, the traditional 7th Generation Teaching passed to me by my family; that the choices I make today impact seven generations into the future. Survivance, in these beaded florals, transcends time as I carry my ancestors with me into the modern world.

The grass roots formation of IHB embodies Indigenous resistance against inaccessible and inadequate healthcare, fear of Western medicine and medical services, severe health disparities in comparison to other races, historical and ongoing trauma, and other long persisting aftereffects of colonization that plague Native communities. The Indian Health Board is one of many local Native-led organizations protecting Indigenous futures in the Phillips neighborhood. If Gloria Curtis needed care in Minneapolis today, she would have access to a Native childcare facility and school for her children, traditional one-on-one counseling, traditional medicines and ceremonies, emergency financial and health assistance, job search help, and other social services

stewarded by Native organizations in the same Minneapolis neighborhood. Most significantly, she would have vaccination against two common types of hepatitis, and primary care doctors from not one, but two clinics tailored to Native communities who could urgently refer her to world class specialists for the treatment of hepatitis.

Located just two blocks from IHB, the Native American Community Clinic (NACC), promotes the health and wellness of mind, body, & spirit in Native American families through similarly integrative traditional healthcare practice.¹⁸² In 2003, former IHB clinicians developed and founded the NACC as an alternative to IHB to further distance Indigenous healthcare from the control of the Indian Health Services.¹⁸³ The federal government's approach towards treaty-owed healthcare, specifically through the Indian Health Service, is tense and ever-evolving. The NACC stands on its own as a historic innovation in the Minneapolis healthcare scene and together with IHB should be part of a larger conversation on survivance – Native peoples' ongoing advocacy for change for seven generations to come. As is evident in the 1990s, while

¹⁸² “Home,” Native American Community Clinic, accessed February 27th, 2023, <https://nacc-healthcare.org/>.

¹⁸³ The NACC creation story is complicated and best told by the individuals involved, though I was able to learn from my interviews with Antony Stately as well as several *Ojibwe News* articles published around the time the clinic emerged, notably from reporters Gary Blair and Clara NiiSka, In the 1990s, five clinicians were suspended from the Indian Health Board for insubordination; they joined a group of AIM protestors picketing the clinic's executive leadership team and IHS's continued involvement in the clinic. Notably, IHB founding member and physicians Dr Carol Krush and longtime family practitioner Dr. Lori Banaszak were fully terminated for signing an open letter to IHB's Board of Directors. The articles reveal conflict between the board and employees who felt that the clinic suffered from employee discrimination, mismanaged funds, and a hostile work environment. Articles cite conflict beginning in the early 1990s, and in 2002, Dr. Carol Krush, Dr. Lydia Caros, and Dr. Lori Banaszak (among others) formed the Native American Community Clinic as an alternative to IHB. Dr. Caros told the *Ojibwe News* in 2002 that she hopes the NACC can “get people to take ownership, and fight for their families... what we do now – or don't do – will impact the next seven generations,” (NiiSka 2002). The formation of the NACC exposes the issues affecting Native healthcare that this paper has interrogated: mismanagement, shirked federal responsibilities, political tension between federal and community run organizations, forced focus on crisis-oriented care, and budgeting issues. And yet also exemplifies urban Native survivance – the ability to work together to overcome hardships in the journey to care for our communities.

IHB transformed resources from the Indian Health Services into culturally sustaining care, the clinic still battled issues of underfunding, IHS restrictions, and mismanagement.¹⁸⁴ The NACC represented a community-led initiative to protest these issues and further reclaim control over urban Native healthcare. Neither clinic posed the perfect solution to navigate the complicated relationship between the federal government and Native nations, but rather together, both built a foundation for change within the Phillips neighborhood.

In our interview, current NACC CEO, Antony Stately (Oneida Nation, Red Lake & White Earth Ojibwe), asked me: “How do we use this moment, right now, to ensure that in seven generations our children’s children’s children are still here?”¹⁸⁵ The history of IHS, IHB, and the NACC prove that Native people are here today because, as the teaching imparts, seven generations ago our ancestors made thoughtful and intentional decisions to secure our futures. Stately told me that it’s our duty to continue this work: “If we follow the process that we’ve been doing since time immemorial, we will still be here. Our food, relatives, medicines, and traditional ways will still be here.”¹⁸⁶ Stately’s words are at the core of culturally sustaining healthcare: Native people are the producers of wellness as well as consumers and are endowed with the health wisdoms to care for our people and the strength to adapt current systems to best serve our communities.

¹⁸⁴ The threat of budget cuts constantly impacts the Indian Health Board. For example, in a 2006 Indian Country Today article, David Melmer discusses the effects of underfunding on the ability of the Indian Health Board to maintain and improve services. Budget cuts are justified by the logic that in place of funding urban health programs, money will be directed into the rural Indian Health Services. Melmer’s interviewee, Dr. Terril Hart (IHB director in 2006), states that this overused logic is “an abdication of the government’s obligations” (3). The financial insecurity and constant threat of budget cuts has contributed to mismanagement within Indian Health Board over the years as directors are forced to focus on financial concerns rather than improving and expanding programming.

¹⁸⁵ Antony Stately (CEO of Native American Community Clinic), interview by Hema Patel, December 9th, 2021.

¹⁸⁶ Antony Stately, December 9th, 2021.

Though these clinics target the same community, their work is not redundant. IHB and the NACC work in tandem to provide accessible, culturally sustaining healthcare for diverse patient needs; as Katie Turner puts it – “we really don't have to compete to serve our people.”¹⁸⁷ If one clinic grows overwhelmed with patients, they often refer incoming families to the other. Patients seek elder wisdom and engage in cultural programming at both clinics.¹⁸⁸ Over COVID, IHB shared their steady supply of PPE from the Indian Health Services with the NACC, and during staff shortages, NACC workers assisted IHB’s drive through testing sites.¹⁸⁹ Though distinct from one another, the clinics serve something larger than their differences: the holistic health of urban Native people in Minneapolis. Along the American Indian Cultural Corridor, a 1.5-mile stretch of south Minneapolis, dozens of Native social services like IHB and the NACC work together to provide healthcare for urban Native peoples that not only saves lives but enriches both culture and community. As Dr. Erdrich writes in her article on 50 years of service at IHB, the Indian Health Board is not alone in their vision for holistic health, but “serves as both a safety net and a vehicle of creative renaissance” in their collaboration with Native-led programs and businesses carrying on Indigenous traditions across the great Native American metro of Minneapolis.¹⁹⁰

Urban Native health care is diverse and vulnerable; laws and regulations that challenge the ability of tribes to receive and to provide health services must be monitored closely, but through organizations like the Indian Health Board, urban Native communities thrive.¹⁹¹ As an Ojibwe

¹⁸⁷ Katie Turner, February 12th, 2023.

¹⁸⁸ Antony Stately, December 9th, 2021.

¹⁸⁹ Katie Turner, February 12th, 2023.

¹⁹⁰ Erdrich, “Indian Health Board of Minneapolis: a 50 Year Vision for the Future.”

¹⁹¹ Finally, I would like to acknowledge that the use of the word “thrive” doesn’t mean that all individuals are thriving. Members of the Phillips community still suffer from insecure housing, poverty, substance abuse and addiction. There is a significant amount pain in the neighborhood primarily due to fentanyl

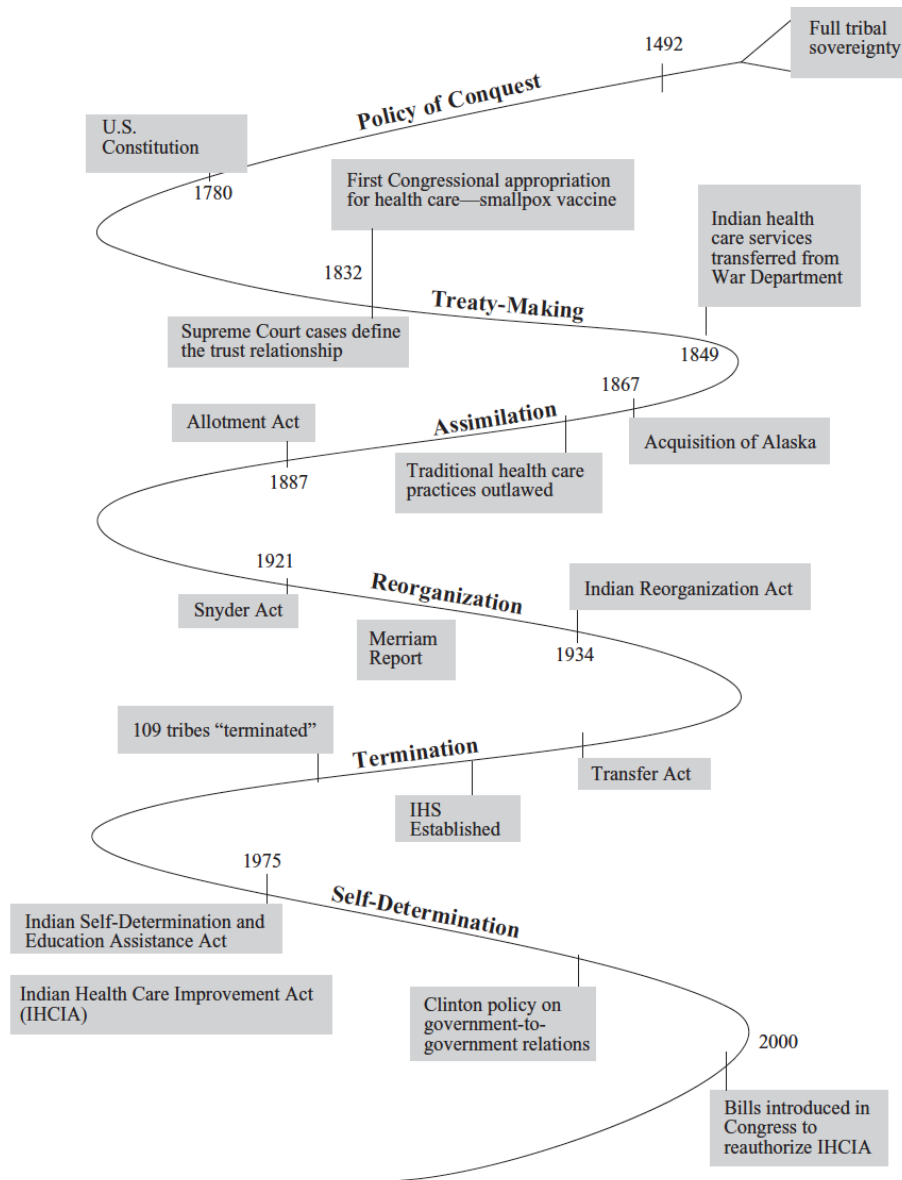
woman growing up in Minneapolis, my ability to write this thesis today is in part due IHB, for the care that supported me throughout my education while ensuring my mental, spiritual, and physical wellbeing. By revitalizing our traditional ways within Westernized systems of care, Native communities strive to demonstrate the importance of our heritage as part of our health. And by reclaiming agency over the systems and resources owed to Native peoples by treaty rights, our communities are continuing the work of our ancestors to pave the way towards a healthier future for seven generations to come.

Word Count: 12, 396

epidemic and unhoused relatives. Closing health disparities in this neighborhood is a great challenge; while this paper celebrates the celebrate successes and achievements of urban Native organizations, I also acknowledge that suffering continues for a significant segment of the Native population. As the work done by Indigenous ancestors exemplifies, Minneapolis benefits from listening and uplifting the Native community as they find solutions to combat this suffering.

Appendix A

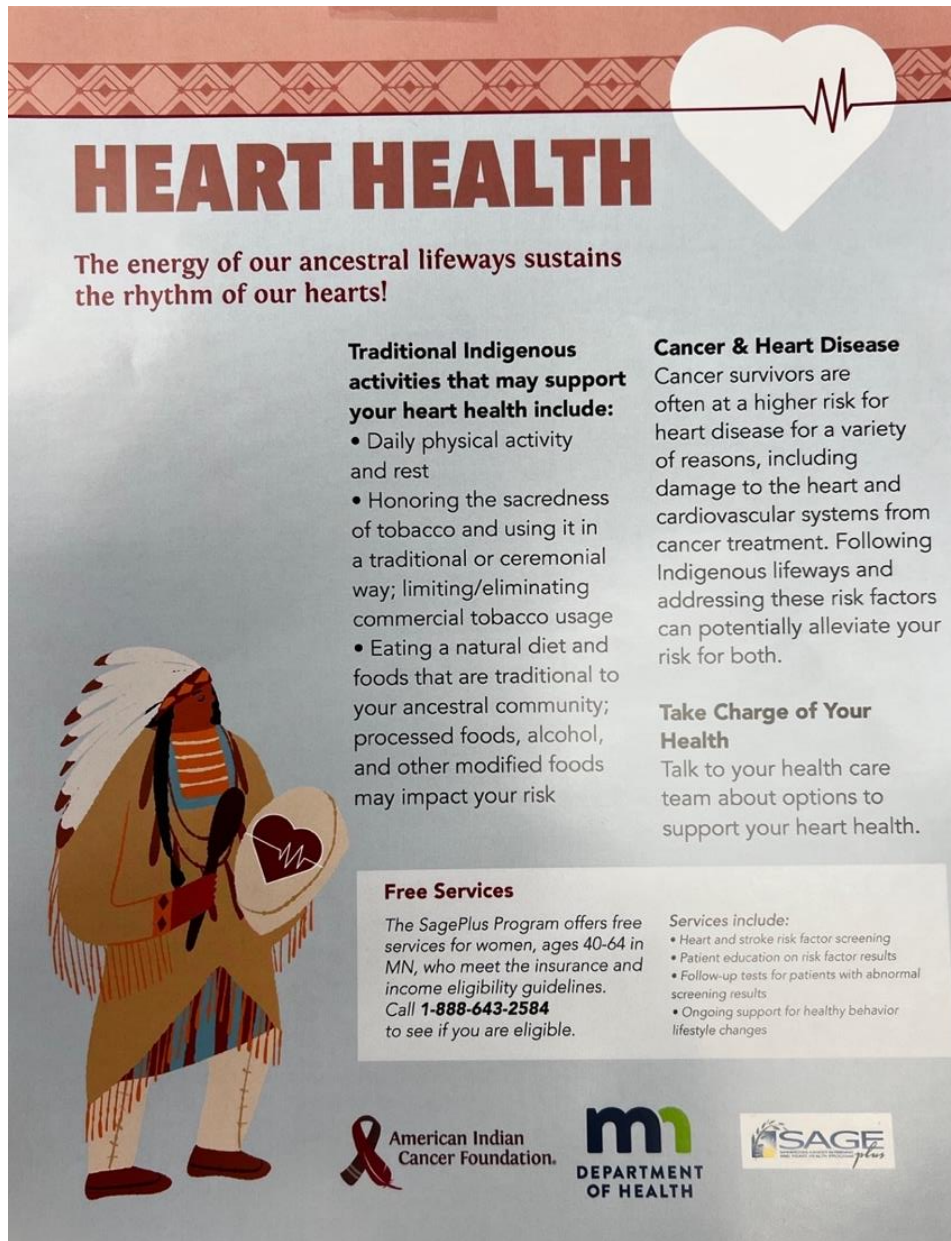
Timeline of Major Legislative and Historical Events in Health Care for American Indian and Alaska Natives



This graphic, published by the Keiser Family Foundation in 2004, provides a visual representation of major acts of federal Indian policy that affect Indigenous health.

Appendix B

“Heart Health” poster at the Indian Health Board



An image of a poster from the Indian Health Board waiting room (taken in January 2023), explaining heart disease and detailing how traditional Native activities might support heart health.

Poster at the Indian Health Board advertising the “American Indian Quitline”

QUITPLAN

**THE
AMERICAN INDIAN
QUITLINE**

CALL 1-888-7AI-QUIT

AIQUIT.COM

**OUR TRADITIONS TO KEEP AND OUR WAY
TO QUIT COMMERCIAL TOBACCO**

Our ways of using sacred tobacco span generations, honoring the Creator through spiritual and ceremonial practices. More than ever, commercial tobacco—such as cigarettes—threatens our way of life with sickness, disease and death. Now we have our way to quit commercial tobacco too: the American Indian Quitline.

ABOUT THE AMERICAN INDIAN QUITLINE

Developed with guidance from the community, the American Indian Quitline from QUITPLAN® Services offers completely free and specially designed support to help you, or someone you know, quit commercial tobacco.

HOW WE CAN HELP

The American Indian Quitline (1-888-7AI-QUIT or 1-888-724-7848) is staffed from 9 a.m. - 9 p.m. CST* (Monday - Friday). Anyone who lives in Minnesota can get the following free help to quit commercial tobacco:

- A dedicated team, including American Indian coaches who understand your culture and respect your traditions.
- Up to seven calls with the coaches, allowing you to get to know them.
- Up to 12 weeks of free lozenges, gum or patches to help you quit the addiction.

*Hours subject to change.

An image of a poster from the Indian Health Board waiting room (taken in January 2023), advertising the American Indian Quitline. The poster reads describes the use of sacred tobacco as a tool to quit commercial tobacco use and continue Native traditions.

Appendix C

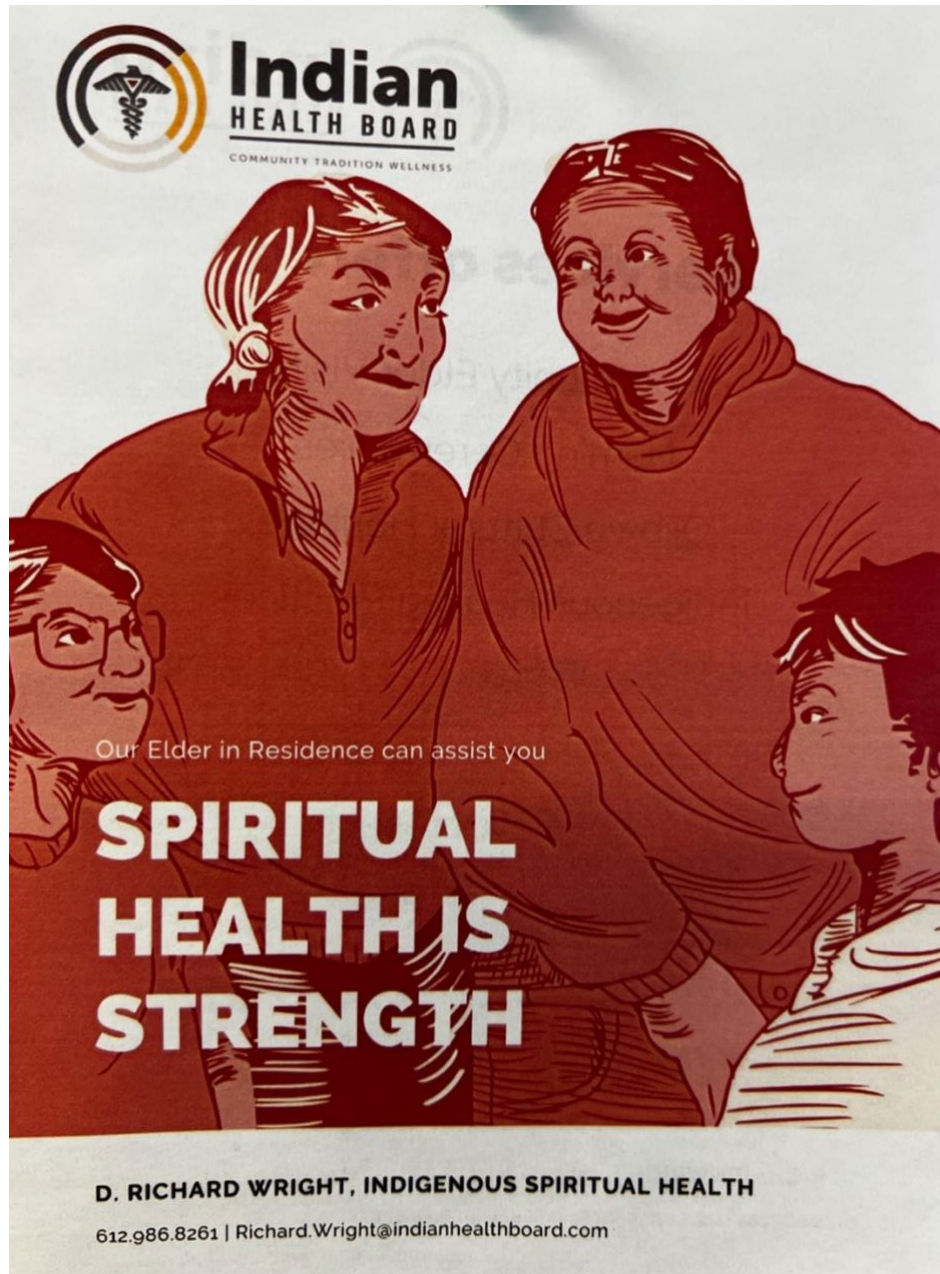
“Services Offered” poster at the Indian Health



An image of a poster from the Indian Health Board waiting room (taken in January 2023), listing available traditional healing services.

Appendix D

“Elder in Residence” poster at the Indian Health



An image of a poster from the Indian Health Board waiting room (taken in January 2023), advertising the Elder In-Residence services stewarded by Richard Wright.


Appendix E

Umbilical Amulet Project Pamphlet

The Umbilical Amulet Project

What is an umbilical amulet?


An umbilical amulet is a small pouch, usually made of leather and beads, that is crafted with love to preserve a baby's umbilical cord. The umbilical cord is saved by many indigenous people as a symbol of the lifelong connection between mom and baby. Saving the umbilical cord is a sweet tradition that can be shared among cultures.




Re-indigenizing parent-child relationships for a better future

Indian Health Board (IHB) wishes to spread materials and knowledge to more indigenous families in order to make the creation of these amulets more accessible. IHB promotes this healthy way to welcome children into the world. IHB will be hosting a pilot program that will offer free umbilical amulet making kits to any parent or guardian wishing to take part in this tradition.

If you are interested, ask your medical provider for more information and request a kit. Start creating a loving masterpiece for you and your little one.

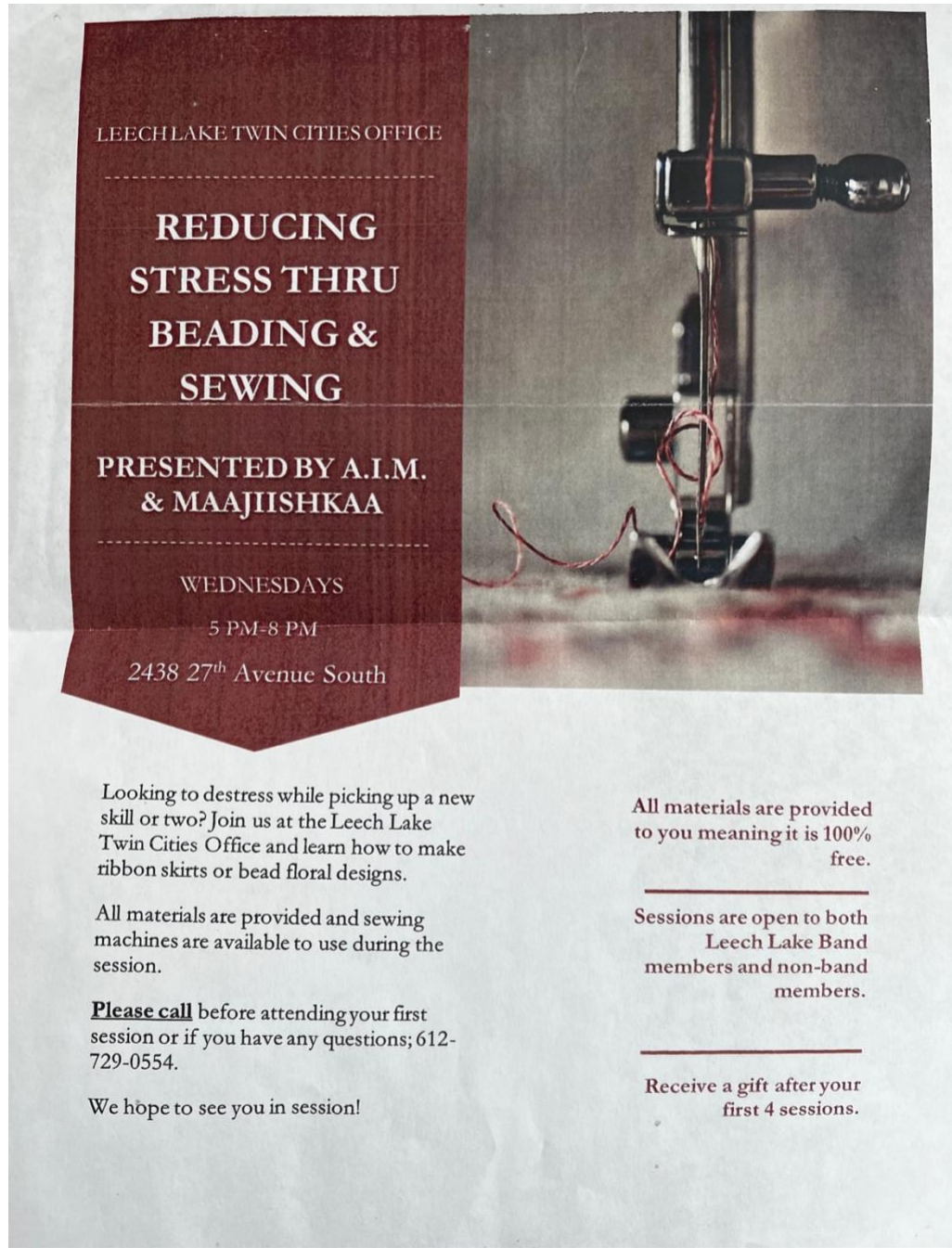


Call us today to make an appointment with your medical provider at 612-721-9800
1315 East 24th Street Minneapolis, MN 55404 | info@ihb-mpls.org | indianhealthboard.com



An image of page one of the Indian Health Board's Umbilical Amulet Project (taken in January 2023). The Umbilical Amulet Project offers patients the opportunity to craft traditional parent-baby keepsakes as part of their birthing plan.

Therapeutic Beading & Sewing Program Poster



LEECHLAKE TWIN CITIES OFFICE

**REDUCING
STRESS THRU
BEADING &
SEWING**

PRESENTED BY A.I.M.
& MAAJIISHKAA

WEDNESDAYS
5 PM-8 PM
2438 27th Avenue South

Looking to destress while picking up a new skill or two? Join us at the Leech Lake Twin Cities Office and learn how to make ribbon skirts or bead floral designs.

All materials are provided and sewing machines are available to use during the session.

Please call before attending your first session or if you have any questions; 612-729-0554.

We hope to see you in session!

All materials are provided to you meaning it is 100% free.

Sessions are open to both Leech Lake Band members and non-band members.

Receive a gift after your first 4 sessions.

An image of a poster from the Indian Health Board waiting room (taken in January 2023), advertising a therapeutic beading group from a neighboring organization, demonstrating IHB's collaboration across the Phillips neighborhood.

Doula Programming Poster

Doula Support for you and your baby



A doula is a trained woman who provides emotional, physical, and spiritual support for women while they are pregnant, during the birth, and after the baby is born, much like how Native aunties traditionally helped bring new life into this world.




The Ninde doulas can...

- ✦ Assist you and your family as you prepare for and give birth
- ✦ Encourage and support you and your loved ones
- ✦ Help you connect with traditional and spiritual practices
- ✦ Create a birthing environment that meets your personal and cultural needs
- ✦ Help you communicate with your loved ones and medical staff
- ✦ Maintain a relationship that lasts after the baby has been born
- ✦ Connect and refer you and your family to resources

For more information, please contact:
 Takayla Lightfield - Ninde Coordinator
 tlightfield@diw-mn.org
 612-279-6347




An image of a poster from the Indian Health Board waiting room (taken in January 2023), listing a Native doula service for use in the clinic.

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Bibliographic Essay

Both my parents worked for the Indian Health Service; I spent my childhood living on different reservations, never farther than one block from an IHS clinic. I moved to Minneapolis when I was 10, and as I adjusted from various reservations to urban life, I found that the Indian Health Board provided a constant – the familiar health and culture of my childhood, even away from my homelands. Despite this personal connection, my academic work didn't engage in Native healthcare histories until Dr. Cutter and Dr. Beitel's class *Native American Health* in Fall 2021. During this class, we engaged with readings on the history of Native healthcare and learned from guest speakers working in Native healthcare systems across the country. This combination of oral and written information inspired my paper: originally an analysis of the six phases of federal Indian healthcare policy and how they formed the basis for a seventh phase of cultural revitalization, exemplified through the Minneapolis Indian Health Board and the Native American Community Clinic. Oral histories comprised the focus of this essay, corroborated and amplified by a wide range of secondary literature.

The history of federal Indian policy is well documented; I found a wealth of material focused specifically on Native health law and policy to craft Part I. However, I struggled to capture the depth of Native healthcare policy without allowing historical context to overwhelm the paper. I remembered Baker's theory of translation exhaustion from Dr. Makomenaw's class on Contemporary Native Education, which I took in Spring 2022. I felt, as Baker's theory supported, that providing a meaningful overview of over 200 years of Indian health policy was a daunting, but essential task. I began by writing Part I structured by the six phases of federal Indian policy (proposed and backed by many scholars, such as Warne, Bane Frizzell, Wilkins, and Thierry) as they related to Native health.¹⁹² I wrote detailed sections on each phase backed by various secondary source materials on key eras and pieces of legislation. My research for Part I came from legal documents (such as treaties and congressional documents) and secondary sources spanning journal and newspaper articles, books, and reports on Native health throughout history. Dejong's *Plague, Politics, and Policy* provided an excellent overview of IHS from which I could gather specific sources to serve my narrative. Additionally, Trennert's *A White Man's Medicine* offered specific examples of IHS's impact on Navajo Nation, modeling the nature of the relationship between the federal government and Native peoples that I could map on to other time periods, locations, and tribes. Because this portion of my project encompassed over 200 years of history, these larger overview texts were critical aids in my search for primary sources as I narrowed my scope on federal Indian policy and its relation to Native health.

As I wrote the historical context for Part I, I felt constrained by creating sections focused on the different phases of policy and pivoted to reorganize by theme/impact rather than specific era, which also influenced my sources. My original thesis proposed a seventh phase of federal

¹⁹² For reference on the six phases: the formative years (1749–1828), removal and reservations (1829–1886), allotment and assimilation (1887–1932), reorganization (1932–1945), termination and relocation (1946–1960), and self-determination (1961–1985).

Indian policy: Reclamation and Revitalization, as exemplified by the Indian Health Board and Native American Community Clinic. However, as I continued to write, I felt compelled to shift into a framework that focused on a local history of the clinic and its impact, rather than on phases of policy. This shift better fit my interest in tracing how the impact of federal Indian relocation policy directly contributed to the Native activism in urban areas, and the subsequent creation of IHB. My vision transformed – I decided to narrow my focus onto the Indian Health Board, untethered from the policy framework, to explore the grassroots origin of the clinic and the culturally tailored care they provide today. I realized that I would not be able to properly document the histories of both clinics, and so chose to preserve my sources on NACC, including an interview with its current CEO, for a future paper.

As I reshaped my work into a local history of urban Native Minneapolis, the story of Gloria Curtis became central to IHB's narrative. With the help of IHB and Melissa Grafe, I tracked down Bill Moyer's documentary, *Why Gloria Died*, at the Minnesota Historical Society (MHS). This documentary provided an invaluable resource, painting a picture of urban Native health in Minneapolis that highlights Gloria's impact on the formation of IHB. There are few other sources on Gloria Curtis – she did not come up in any newspaper, academic journal, or MHS database. So, to corroborate and build upon her story, I relied on secondary source material on relocation policy as well as oral interviews from individuals active in Minneapolis at this time. Fixico's *The Urban Indian Experience*, Miller's "Willing Workers," and Martinez's *Urban American Indians: Reclaiming Native Space* I gathered a collection of sources describing Native experiences relocation experiences from the 1940s-60s. Additionally, Laukaitis writes specifically on relocation experiences in Chicago which I mapped onto Minneapolis. These sources provided an essential basis for understanding the widespread impact of relocation on Native families which I investigated in Part II.

Additionally, I found that IHB director Charles Deegan was heavily featured in Moyer's work. To further my understanding of Gloria and Deegan's impact in this time, I reached out to interview several community members about their experiences and knowledge of the clinic. Katie Turner shared information about her childhood relocation experience, the activist scene for teens in Minneapolis during the 60s, and her lifelong involvement in Native services in the Phillips neighborhood. Reid Raymond described the political and legislative scene in Minneapolis at the time. As a college student, Raymond interned with MN Rep. Donald Fraser worked closely with Deegan to establish IHB, secure Congressional funding, and lay the groundwork for future urban health clinics. This paper provides an overview of that relationship – my interview with Raymond illuminated an extremely compelling, rich sub history on the persistence of Native activists working as liaisons between their urban communities and Congress and another sub history on the creation of the National Council of Urban Indian Health, which originated in Deegan, Raymond, and Webster's work. Raymond referred me to Ellie Webster, the original administrative leader at IHB, and an expert on the technical aspects of the clinic's formation. Though not all her words made it into this paper, Webster helped me visualize the trajectory of IHB from the mid 1960s to the present: what buildings they occupied, their

partnership organizations, the evolution of IHB's services, and the employee experience across the years. Webster provided me with additional contact information for IHB's original nurses, clinicians, technicians, and support systems during the 60-70s.

I only wish that I could have followed up on this information and could have written more on these unique stories – I have over an hour's worth of information for each interview and could easily have written this entire essay on just one of these powerful individuals. The level of detail alone in their memories demonstrates the meaningful journey and formative experience of working for IHB. Turner expressed that she was grateful for the chance to tell this story; until recounting the formation of the clinic, she hadn't fully realized the depth and impact of this work. I feel incredibly lucky to have spoken to these individuals; in part due to poor Native health services in the 50s, few Native people have lived long enough to share these stories – many experiences are recounted from family members. In fact, I learned from an obituary that Charles Deegan passed away just a few years before I began this research. I wonder what he would think of this work, and I wonder if he knew the extent of his impact on urban and rural Native communities across this country. My interviewees inspired me to see the afterlife of this thesis, and I hope to one day develop a book or medical school curriculum on urban Native healthcare in Minneapolis which builds upon these oral histories.

While I believe that oral histories can stand alone as valid academic sources, this project has been an exercise in providing strong historical evidence from additional primary sources as well as secondary sources to bolster the strength of my argument. To navigate this challenge, I collected a wide range of secondary sources and spent hours browsing the Minnesota Historical Society newspaper archives as I searched for written primary source material on the creation of the Indian Health Board. The *Minneapolis Star Tribune* and the *Ojibwe News* offered a collection of important articles that helped me ground the history of the Indian Health Board in perspectives from clinicians, community members, and reporters in the 1960s and 70s. Most articles concerning Native health were written by presumably non-Native white reporters until the *Native American Press/Ojibwe News* was founded in 1991. Throughout this archival work, I was struck by the unimaginable bravery of Minneapolis Natives in the 50-70s and their relentless advocacy for the betterment of our communities.

Searching through archives is an emotional process; I struggled to read through the deeply upsetting physical, mental, and spiritual mistreatment of Native peoples in the 50-70s. Though I key-word searched for terms like "Indian health" and focused on articles concerning the clinic, I felt compelled to read many other articles that seemed unrelated to Native health as they shone a light on the underrepresented stories of what it was like to be Native in Minneapolis during the 50-70s. This exploration of experiences outside of healthcare led me to the realization that the urban Native Minneapolis is rooted in community-building through dozens of Native-led organizations that could each constitute their own historical investigation. Schreve's *Red Power Rising*, Cobb's *Say We Are Nations*, Bancroft's *We Are Still Here*, Vizenor's *Survivance*, and Davis's *Survival Schools* helped me build my research in urban Native activism in Part II.

Finally, Native people are often thought of in past-tense, and so I provided present day examples of IHB's service through oral interviews, backed by posters from the clinic and secondary source material on the importance of traditional healing in Western. My interview with Barri illuminated the important work IHB's Indigenous Services contributes to the clinic and the relationship, or overlap, between, standard clinicians and cultural providers. IHB pediatrician Dr. Erdrich showed me how clinicians utilize Indigenous Services and broaden their medical capacity to care for Native people. IHB psychologist Dr. Chicken taught me about the clinic's mental health services and the struggles the clinic faces today. And CEO Dr. Stately strengthened the connection between IHB and the NACC in my work, providing a foundation for future endeavors to capture their shared impact in Minneapolis. The *Ojibwe News* offered several 1990s articles that discussed culturally competent provisions of care at IHB. As for secondary sources, I found works by Moghaddam et al., LaFromboise et al., and Gone on traditional healing in urban settings crucial to intertwining academic article research with my newspaper archives and oral histories in Part III.

Finally, beadwork methodology found its way into this paper as an extension of my research for an ER&M independent study I developed in Fall 2022 under the guidance of Dr. Makomenaw. I found that stories of beadwork and Native healthcare paralleled, and I spent my senior year exploring the connections between them, as well as applying the pedagogies I had learned through my Education Studies classes. This paper is rooted in the intertwined methodologies of oral history, artwork, archival research, and education pedagogy. Through the research and writing process, I sought to cite books, journals, and documents written by Native people. To the best of my ability within a year of research, I vetted the authors of my major sources, aiming to uplift and continue Indigenous-led research. As this project expands and grows, I hope to continue to feature and learn from Indigenous scholars, community members, healthcare workers, and activists.