



USET

SOVEREIGNTY PROTECTION FUND

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Transmitted Electronically

September 4, 2020

Drs. William H. Foege and Helene D. Gayle
Co-Chairs
Committee on Equitable Allocation of Vaccine for the Novel Coronavirus
The National Academies of Science, Engineering, and Medicine
500 Fifth St., N.W.
Washington, D.C. 20001

Dear Drs. Foege and Gayle,

On behalf of the United South and Eastern Tribes Sovereignty Protection Fund (USET SPF), we write to provide comment to the National Academies of Sciences, Engineering, and Medicine Committee on Equitable Allocation of Vaccine for the Novel Coronavirus on its Discussion Draft of the *Preliminary Framework for Equitable Allocation of COVID-19 Vaccine* ("Framework"). As viable COVID-19 vaccines are developed and deployed, it is critical that Indian Country is prioritized for distribution, given the federal trust obligation and the high rate of the disease in our communities. However, any vaccine or therapeutic must receive appropriately thorough and scientifically rigorous vetting and clinical trials prior to reaching Tribal Nations and the general public. As the Department of Health and Human Services (HHS) and the Trump Administration continue to pursue emerging options, Tribal Nations must be consulted on all deployment strategies and guidelines, as well as fully briefed on the results of clinical trials and other testing.

USET SPF is a non-profit, inter-tribal organization advocating on behalf of 30 federally recognized Tribal Nations from the Northeastern Woodlands to the Everglades and across the Gulf of Mexico¹. Both individually, as well as collectively through USET SPF, our member Tribal Nations work to improve health care services for American Indians. Our member Tribal Nations operate in the Nashville Area of the Indian Health Service, which contains 36 IHS and Tribal health care facilities. Our patients receive health care services both directly at IHS facilities, as well as in Tribally-operated facilities under contracts with IHS pursuant to the Indian Self-Determination and Education Assistance Act (ISDEAA), P.L. 93-638.

COVID-19's Impact on Indian Country and the USET SPF Region

Indian Country continues to face disproportionately high rates of COVID-19 infection, even as rates are declining for other populations. At the same time, the historically and chronically under-resourced Indian

¹ USET SPF member Tribal Nations include: Alabama-Coushatta Tribe of Texas (TX), Aroostook Band of Micmac Indians (ME), Catawba Indian Nation (SC), Cayuga Nation (NY), Chickahominy Indian Tribe (VA), Chickahominy Indian Tribe—Eastern Division (VA), Chitimacha Tribe of Louisiana (LA), Coushatta Tribe of Louisiana (LA), Eastern Band of Cherokee Indians (NC), Houlton Band of Maliseet Indians (ME), Jena Band of Choctaw Indians (LA), Mashantucket Pequot Indian Tribe (CT), Mashpee Wampanoag Tribe (MA), Miccosukee Tribe of Indians of Florida (FL), Mississippi Band of Choctaw Indians (MS), Mohegan Tribe of Indians of Connecticut (CT), Narragansett Indian Tribe (RI), Oneida Indian Nation (NY), Pamunkey Indian Tribe (VA), Passamaquoddy Tribe at Indian Township (ME), Passamaquoddy Tribe at Pleasant Point (ME), Penobscot Indian Nation (ME), Poarch Band of Creek Indians (AL), Rappahannock Tribe (VA), Saint Regis Mohawk Tribe (NY), Seminole Tribe of Florida (FL), Seneca Nation of Indians (NY), Shinnecock Indian Nation (NY), Tunica-Biloxi Tribe of Louisiana (LA), and the Wampanoag Tribe of Gay Head (Aquinnah) (MA).

Because there is strength in Unity

Health System is also now facing steep declines in revenue, increases in COVID-19 response expenses, and is not well-equipped to treat the disease. Our region, the Nashville Area of the Indian Health Service (IHS), for example, is one of the hardest hit. Despite the incomplete picture painted by the partial data available to Tribal Nations and Tribal Epidemiology Centers (TECs), as of September 2, 2020, the Nashville Area has the fifth-highest rate of positive cases in Indian Country at 7.88%.

The current state of the Indian Healthcare System is the result of decades of unfunded trust obligations, which has left Indian Country severely under-resourced and at extreme risk during this COVID-19 crisis. The federal government's historic and ongoing failure to live up to its promises, along with centuries of generational trauma, has caused extremely high rates of chronic disease in our communities, including diabetes, heart disease, obesity, cancer, and kidney disease, all of which are risk factors for COVID-19.

This historic and ongoing underfunding also leaves Indian Country without much of the health care infrastructure available to the rest of America. While there are 605 health facilities serving 574 federally recognized Tribal Nations and our citizens across the country, just 46 of those facilities are hospitals, with 13 meeting the criteria to be designated as Critical Access Hospitals. A scant 46 facilities have emergency rooms, while 20 have operating rooms and non offer tertiary care such as open heart surgery or neonatal intensive care. The entire Indian Health System has just 37 ICU beds, 1,257 hospital beds, and 81 ventilators, with few personnel trained in their operation. The Nashville Area has just two Tribal hospitals, with a majority of our citizens served by Tribal health clinics, which lack the capacity to treat all but the mildest COVID-19 cases.

In addition to the neglected Indian Healthcare System, the federal underinvestment in Indian Country's housing infrastructure is also contributing to the spread of COVID-19 in many Tribal Nations. The ongoing lack of affordable housing has led to overcrowded conditions, with multi-family and multi-generational households common. Homelessness is also a problem, with citizens of some USET SPF member Tribal Nations without a permanent address, shuttling between the houses of friends and relatives. Both scenarios facilitate further COVID-19 infection, as those who are positive are unable to isolate themselves from other residents in the case of overcrowded conditions and homeless individuals are potentially infecting multiple households as they seek temporary lodging. Both allow the disease to have a greater reach into Tribal communities than it has in many non-Native communities.

The federal government's chronic failure to uphold its fiduciary trust and treaty obligations to Tribal Nations has exacerbated the COVID-19 public health emergency in Indian Country. As we are collectively focused on eradicating the virus across the nation, it is critical that Tribal Nations and our communities be high on the priority list for the deployment of proven vaccines and therapeutics. A failure to do so would violate the United States' trust obligation to Tribal Nations and result in an incomplete response to this crisis.

Indian Country Must Receive Priority

USET SPF appreciates the Framework's principled focus on health equity and assertion that historically underserved communities should be prioritized, as they are likely to be at greater risk. Indian Country certainly meets the variety of criteria outlined and considered in the Framework's principles and phased allocation methodology, including the criteria for the earliest phases of distribution. Notably, as we discuss above, the citizens of Tribal Nations are likely to have significant comorbid conditions, as well as a lack of access to necessary health care infrastructure or the opportunity to isolate. In addition, like other governments, Tribal Nations employ "frontline" health care workers, as well as first responders and other essential personnel, who continue to find themselves in harm's way as we seek to respond to and mitigate the effects of the pandemic.

However, unlike other underserved communities and other units of government, the federal government has unique trust and treaty obligations to Tribal Nations and Native people, including the obligation to provide health care. We further note that after centuries of policies designed to eradicate our people, traditions, and

our governments, the federal government has an obligation to preserve and rebuild our nations. This sacred responsibility exists in perpetuity and sets Tribal Nations apart from all other individuals included in the Framework. For many Tribal Nations, COVID-19 represents an existential threat to the very survival of our cultures, languages, and spirituality, as our elders are of the highest risk for mortality from the illness. Without their traditional knowledge, the languages, spiritual practices, history, and other irreplaceable heritage of our Tribal Nations risks being lost forever, as it has amid previous pandemics. In accordance with its obligations, today's federal government must make every effort to ensure that the cultural devastation of the past is not repeated.

While we understand and respect the federal government's broader priorities for vaccine allocation, we insist that, because of both the trust obligation and our high risk status, Indian Country be prioritized in Phase 1 of allocation, and every phase thereafter, if necessary. In order to facilitate a transparent and fair allocation of vaccine to Indian Country, we recommend that there be substantial Tribal set asides made in each phase of allocation until all residing and working in our communities have been vaccinated. This will provide an equitable strategy for upholding the federal government's obligation to Tribal Nations, while also acknowledging the importance of vaccinating other populations in the United States.

Vaccines Deployed in Indian Country Must be Thoroughly Vetted

While Indian Country must receive some of the very first doses of vaccine as they become available, any vaccine or therapeutic must only be approved after scientifically rigorous vetting and clinical trials. With this week's announcement from the Centers for Disease Control and Prevention that state and local governments should prepare for vaccine distribution in early November 2020, we are deeply concerned that in an effort to speed the deployment of viable vaccines, research supporting their safety and efficacy may be insufficient. Tribal Nations and Native people continue to face negative impacts from past unethical research practices. With this and the federal trust obligation in mind, Indian Country must not be a proving ground for any vaccine or therapeutic. Prior to deployment in Indian Country, Tribal Nations must be assured that approved vaccines are safe and effective through the transparent sharing of results of clinical trials and other testing.

Honor Tribal Sovereignty and Self-Determination in Distribution

There are three sovereigns in the United States: Tribal governments, the federal government, and state governments. The U.S. Constitution recognizes Tribal Nations as distinct political entities, vested with the same powers of self-government as state and federal governments. While Tribal Nations are subject to federal law, states have no authority over Tribal Nations unless expressly authorized by Congress. When it comes to sovereignty, Tribal Nations and states are on equal footing. Accordingly, the federal government must recognize and uphold our sovereign status in all aspects of vaccine allocation and distribution. While we were pleased to see this articulated in the draft Framework, we would like to underscore and expand upon this principle.

First, it cannot be overemphasized that any vaccine supply designated for Indian Country must be allocated directly to Tribal Nations and not any other unit of government. During the 2009 H1N1 influenza pandemic, vaccinations for Indian Country were distributed to state governments, which undermined the sovereignty and self-determination of Tribal Nations, and resulted in an insufficient number of vaccinations for our communities. It would be an affront to our sovereign status and a violation of the federal trust obligation to force Tribal Nations to seek vaccine supply from state or local governments. State and local governments do not have an obligation to Tribal Nations and have proven themselves to be, at best, unreliable in distributing federal supplies or pass-through dollars to neighboring Tribal jurisdictions. In addition, using our experiences accessing personal protective equipment as an example, we stress that Tribal Nations should not have to contend with multiple layers of government bureaucracy to access vaccines, including the Indian Health Service. Our access must be as direct and expeditious as possible. It should also be understood that the cost

of vaccine allocated to Indian Country be borne by the federal government in accordance with the trust obligation.

Second, as allocation strategies are developed at all levels of government, nationally, within Indian Country, and within individual Tribal communities, Tribal sovereignty should be given deference. This means that the strategy for allocation of a Tribal supply of vaccine be developed in consultation with Tribal Nations and that Tribal Nation guidance during any consultation be honored. A within-Indian Country strategy should take into account the diverse circumstances facing Tribal Nations, as well as the prevalence of COVID-19 in our regions and communities. In addition, Tribal Nations themselves should determine how the vaccine will be allocated in Tribal communities. No other unit of government should make this choice. While we welcome the development of a model Tribal vaccine allocation plan, in consultation with Tribal Nations, we should not be required to utilize any particular allocation plan or guideline. Only we can determine how best to utilize a limited supply of vaccine or therapeutic within our communities.

Ongoing Tribal Consultation Required

The public health emergency caused by COVID-19 is likely the greatest national crisis we will face in our lifetimes. Given its gravity and profound impact on Tribal Nations, any federal vaccine allocation framework, guideline, or plan, including the draft Framework, must receive meaningful and ongoing Tribal consultation. The draft Framework promotes a commitment to procedural fairness in vaccine allocation, which necessarily includes robust Tribal consultation. As the HHS Tribal Consultation Policy states, Tribal consultation will occur, “before any action is taken that will significantly affect Indian Tribes.” It is with this in mind that we expect Tribal consultation will occur on this and any other strategy for the deployment of limited supplies of vaccine and therapeutics. We remind the Committee and HHS that a public comment period is not a substitute for formal Tribal consultation. In addition, while we recognize the urgency posed by the pandemic, we are frustrated by the absurdly short public comment period for this draft Framework, and urge that the Tribal consultation period be longer than 72 hours.

Conclusion

All units of government must come together amid the extraordinary circumstances posed by the COVID-19. As we collectively seek to eradicate the disease domestically, once and for all, the equitable and thoughtful allocation of safe and effective vaccines is of paramount importance. In seeking to uphold the draft Framework’s principles of maximization of benefits, equal regard, mitigation of health inequities, and fairness, it is critical that the trust obligation to Tribal Nations and Native people be prioritized as essential to each. While we understand the United States has a duty to each of its citizens, its obligation to Indian Country is unique. A failure to deliver upon this obligation as a vaccine is allocated will be detrimental to Indian Country and the nation as a whole. We encourage you to keep this in mind, as you craft and finalize a federal allocation strategy in the coming months.

Sincerely,



Kirk Francis
President



Kitcki A. Carroll
Executive Director