BACKGROUND

HEALTH EQUITY AND PUBLIC HEALTH WITHIN NATIVE AMERICAN AND ALAKSA NATIVE COMMUNITIES

Native Americans and Alaska Natives (NA/AN) maintain deep and vital connections to community and culture in the face of centuries of historic and ongoing colonial violence and dispossession. Native Americans and Alaska Natives continue to revitalize, reclaim and restore traditional practices, ways of being, and languages, in turn improving the health and wellbeing of NA/AN community members.

Native Americans and Alaska Natives constitute a vast and diverse population of close to one thousand indigenous Nations and tribes. There are 574 federally recognized tribes and several hundred more that either do not seek or receive federal recognition (~400). Diverse cultural practices, governance structures, values, languages, social norms, relationships and kinship structures, health practices, food systems, spirituality and more represent the diversity of Nations and tribes in the contemporary United States. At the same time, similarities in values, traditions, and histories reflect shared experiences and community.

INDIGENOUS SOCIAL DETERMINANTS OF HEALTH

Indigenous populations across the globe face health inequities related to the historic and ongoing impacts of colonization and imperialism. Indigenous determinants of health (IDH or ISDoH) represent an approach to understanding and addressing social drivers of health through an indigenous perspective, oriented around indigenous knowledge systems and values, and accounting for factors that disproportionately impact indigenous communities. ISDoH include the same SDoH that impact all peoples such as housing and cost of living, but expand to also include indigenous values and practices, connection to community and culture, and more.[1] Domains of ISDoH include indigenous knowledge, identity, land, kinship, language sovereignty, governance.[2] Some examples of ISDoH include sustainable and sovereign indigenous food systems, land and water protections, cultural connectedness, connection to shared geography and community, Tribal sovereignty, and protection of traditional medicines.[2]

> ***"Our Indigenous understandings, practices, and beliefs have been retained through hard fought efforts to maintain languages, preserve cultural and community connections, sustain relationships and supports, and protect and sustain our connections to our lands and other living beings that are part of our shared environments"*** [2]

CHRs AND CHWs

Community Health Representatives (CHRs) are part of the CHW workforce, but CHR describes a specific role serving Native American and Alaska Native communities through the Indian Health Service (IHS). One of the oldest community health workforces in the country, the CHR program was established in 1968 by Congress. More than 1600 CHRs worked in the U.S. as of 2019. [3]

CHRs serve NA/AN communities in twelve designated IHS areas, on the lands of federally recognized tribes and native nations. (For purposes of this toolkit, native refers to Native American and Alaska Native). CHRs have delineated scopes of work, training and oversight, funding mechanisms, and communities served. CHRs engage in

EXAMPLES OF INDIGENOUS SOCIAL DETERMINANTS OF HEALTH

community health education, screenings, home safety assessments, connect people with healthcare, housing, and other resources. [4]

Indian Health Service (IHS) serves as the mandated federal system for providing healthcare to NA/AN communities. IHS services are only available to federally recognized tribes and continues to be vastly underfunded compared to other government payment systems (e.g., VA, Medicaid, Medicare).[5]

Tribes operate under Self-Determination contracts under the PL 93-638, Title 1 or Title 5 contracts to implement and fund most CHR programs. CHR programs near cities with large NA/AN populations are often consulted to coordinate and navigate care for non-reservation living tribal members.

Community Health Workers (CHWs) may also work in federally recognized tribal lands, but their scope of work may be different than a CHR, based on the needs of the community.

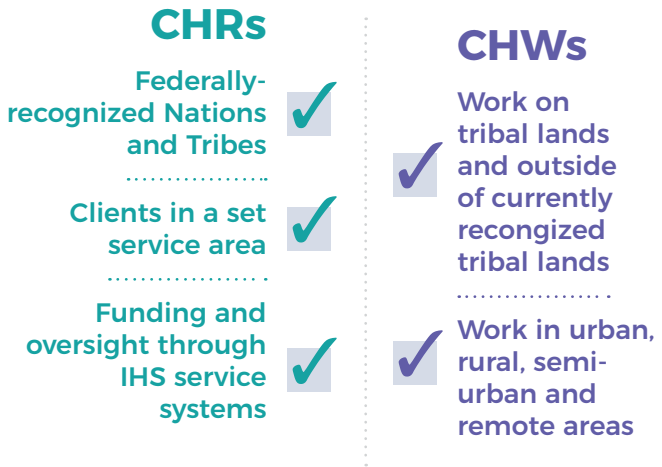
CHWs also serve NA/AN communities that are either not federally recognized (and denied IHS services) or who live outside of tribal lands including but not limited to urban areas. During COVID, tribes that did not have federal recognition (over 200) did not receive any of the federal resources and services through IHS despite experiencing the same challenges and burdens, resulting in added barriers to healthcare, vaccines, and testing or going without needed care. [6]

As trusted partners, CHWs and CHRs (CHW/CHRs) work to break down barriers to health and belonging, bridge gaps between western medical systems and NA/AN communities, by serving as connective tissue within the fractured public health ecosystem. Research evidence demonstrates CHW/CHR effectiveness in improving health outcomes in NA/AN communities. [4]

CHR/CHW ROLES

Common CHR/CHW roles include elder and rural outreach, resource and patient navigation, health education, cultural mediation, and addressing health-related social needs (HRSN) such as housing, shelter, basic needs, and more.CHRs/CHWs work with all age groups. Common CHR activities include addressing health needs and access to healthcare (screening, helping schedule

FIGURE 1.
CHRs and CHWs Overview



and maintain healthcare appointments, and promoting healthy lifestyle behaviors), advocating for clients, and individual and community outreach.[7] Similarly, tribal CHWs engage in cultural mediation, healthcare navigation and addressing HRSN.

CHWs also serve NA/AN who are not enrolled tribal members or do not live on tribal lands. Individuals may not be enrolled for many reasons, including disconnection from tribal nations (e.g., due to displacement), tribal requirements, and lack of access to enrollment. CHWs flexibly meet overlapping health and social needs, address barriers and restrictions to accessing services, and help people to build community and connect with culture.

INDIGENOUS SOCIAL DETERMINANTS OF HEALTH (ISDOH) AND HEALTH-RELATED SOCIAL NEEDS (HRSN)

CURRENT STATE OF HEALTH EQUITY

Native Americans and Alaska Natives (NA/AN) include people living in sovereign tribal nations and tribal lands as well as Native Americans who are displaced from or living away from their tribal lands.

Native Americans and Alaska Natives had established longstanding traditional healing and medical practices and indigenous approaches to health prior to colonization, many of which have been adopted by western medicine without common knowledge.[7] Today, NA/AN are impacted by longstanding health inequities and ISDoH stemming from centuries of colonization and imperialism and ongoing structural violence.[8] Health inequities are seen downstream through health-related social needs (HRSN) (e.g., access to food, housing, income), high rates of chronic health conditions, and a high burden of mental health, suicide and substance use.[9]

Disproportionate burdens of chronic health conditions stem from ISDoH and resulting HRSN. NA/AN communities have the highest rates of diabetes in the country, high rates of other chronic health conditions, dental problems, infant mortality[9], and victimization due to violent crime.[10]

Mental health and substance use: NA/AN communities experience disproportionate mental health burdens including psychological distress, depression and other mental health conditions; self-harm and suicide.[10] Alcohol and substance use disorder rates are higher than that of any other racial/ethnic group.[11] In addition, NA/AN have higher rates of trauma, post-traumatic stress disorder (PTSD), and exposure to violence—including the well-documented ongoing impacts of generational trauma from boarding schools which carried out physical, emotional and sexual abuse, other types of trauma and violence that reverberate across generations, and the crisis of missing and murdered indigenous women and girls (MMIW).[11]

> **Among many needs identified by CHR/CHW survey respondents, substance use was the most frequently identified health challenge facing CHW client populations, followed by mental health and physical health needs.**

Barriers to basic needs in NA/AN communities include utilities (running water, electricity, heat), infrastructure (e.g., lack of roads, bus routes), access to healthy food, mobile phone and broadband service, housing, transportation, clean water, and more. In addition to these material needs, ISDH includes connection to culture and community. NA/AN also experience barriers to accessing services and public benefits to which they are entitled.

> **CHR/CHW survey respondents identified food insecurity and hunger, poverty and cost of living, housing insecurity and homelessness, and employment and economic opportunity as the most pressing social and resource needs of their client populations.**

Barriers to accessing healthcare services include discrimination by providers, distance to/from

remote locations requiring long-distance travel, access to transportation, lack of culturally and linguistically appropriate services, cost of services, and mistrust due to past negative experiences and historical trauma.[11]

Structural violence, historical trauma and discrimination: NA/AN communities face ongoing threats to sovereignty, land and water rights, as well as language, culture, traditions, and more.[12,13] Historical trauma is widely understood as a driver of ongoing health inequities and burdens,[14] and is accompanied by imposition of western worldviews and dispossession of indigenous traditions.[15] Poverty and economic disenfranchisement is deeply connected to this history and continued marginalization. For example, while one in five Alaskans are Alaska Native, 16–35% of Alaska Natives lived in poverty between 2015–2019 (varying by Tribal health region) compared to 7% of non-Native Alaskans.[9]

CHR/CHW survey respondents identified subgroups that experience additional health barriers including elders and people with disabilities and/or chronic health conditions (including mental health), and people who are isolated or lack transportation.

POLICY AND PRACTICE LANDSCAPE

Inequitable federal response

With over a century of underfunding of IHS, federal funding inequities and continued structural violence and dispossession has resulted in an inequitable public health landscape. Despite federally designated funding mechanisms, tribal members of federally recognized tribes lack sufficient access to healthcare and social resources.[5] For eligible recipients of IHS services, IHS covers only "a fraction of" NA/AN health care needs.[10]

While more than 20 federal agencies serve NA/AN individuals, federal programs designed to support the social and economic wellbeing of Native Americans, including IHS, remain chronically underfunded. In 2016, IHS spent significantly less per capita than other federally funded healthcare systems such as Veterans Health Administration, Medicare, Medicaid and prison-based healthcare.[5,10]

In some high-income countries (e.g., Canada, Australia) robust and well-funded national efforts have sought to remediate the health inequities facing indigenous populations. However a similar large-scale effort has not been attempted in the United States.[15]

Recent Directions

Policy efforts seeking to advance NA/AN health recognize and center NA/AN expertise and promote community-driven and inclusive practices to positively impact ISDoH and build additional tribal public health infrastructure. Calls to integrate NA/AN expertise in addressing ISDoH have not identified CHRs/CHWs as a source of this community health expertise.[15] Two large government public health initiatives aimed at addressing ISDoH and improving NA/AN health include the following:

1. Good Health and Wellness in Indian Country (GHWIC) represents the Centers for Disease Control and Prevention (CDC) National Center for Chronic Disease Prevention and Health Promotion's largest investment to improve NA/AN health. This $100 million initiative focused on health promotion and chronic disease prevention including diabetes and smoking, through "policy, systems, and environmental, changes to create sustainable health improvements while addressing health disparities."[16] GHWIC includes a focus on traditional practices, community-clinical linkages and multidisciplinary care teams
2. Tribal Practices for Wellness in Indian Country (TPWIC)[17] supports Tribal programs to promote cultural connectedness for wellness and chronic disease prevention. GHWIC and TPWIC do not explicitly feature or name CHRs/CHWs or CHR/CHW leadership though grantees may