Indigenous Health Equity

Abigail Echo-Hawk, Director of Urban Indian Health Institute

INTRODUCTION

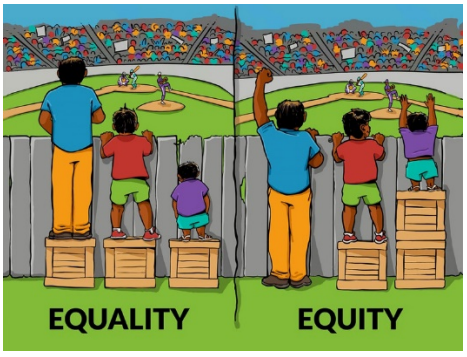
American Indians and Alaska Natives (AI/AN) were once the healthiest people in the Americas as we lived in harmony with each other and the natural resources around us. However, as a direct result of colonization over the last 500 years, AI/AN people suffer from some of the worst health disparities in the United States including infant and maternal mortality, cancer, cardiovascular disease, and depression. For all AI/ANs, there are systemic issues which give rise to health disparities: genocide, uprooting from homelands and tribal community structure, bans on cultural practices and language, racism, poverty, poor education, and limited economic opportunity. In addition, for urban AI/ANs, forced relocation due to 1950s federal relocation and termination policies is another contributing factor. Efforts to address these health disparities are often complicated by culturally inappropriate interventions and an inadequate understanding of the historical and ongoing trauma of AI/AN people, which results in deep health disparities.

The Urban Indian Health Institute (UIHI), a national Tribal Epidemiology Center serving urban AI/ANs, is dedicated to addressing health disparities and reaching health equity in a culturally rigorous way. AI/ANs nationwide are raising their voices and demanding health equity for their people as we know it is our responsibility to reclaim our healthy lifestyles and eliminate health disparities for the future generations. We know we will again be the healthy people our Ancestors were. To reach this goal, we must ground our efforts in cultural and traditional knowledge systems. It is only then that health equity for AI/ANs will be achieved.

DEFINING HEALTH EQUITY

Healthy People 2020 defines health equity as the “attainment of the highest level of health for all people.” Health equity recognizes that not all people have the same opportunity to achieve optimal health outcomes, and this access is deeply influenced by the institutional and structural barriers that were built and are sustained by colonization. The uneven distribution of social determinants of health like education, housing, neighborhood environment, and employment opportunities affect a person’s ability to earn a good living, work in a safe and healthy environment, and effectively use resources (especially health care resources). As a direct result of these barriers, differences in health outcomes among groups of people emerged. These are defined as health inequities and play a big role in creating and maintaining health disparities. When all individuals, regardless of race, ethnicity, social position, gender, religion, sexual identity, or disability have equal opportunities to maintain their health and are afforded all the same resources in a culturally attuned way, health equity is achieved.

When people of different ethnic groups, such as AI/ANs, suffer from these inequities due to public policy, institutional practices, and social and economic structures, it is known as structural racism. A great example of this comes from Camara Jones, MD, MPH, PhD. According to Dr. Jones, racism happens when opportunity is affected by a person’s race. Racism unfairly disadvantages individuals and communities while unfairly advantaging others. Institutionalized racism, or the inability to access certain goods, services, and opportunities because of one’s race, is the main cause of health disparities among ethnic populations.

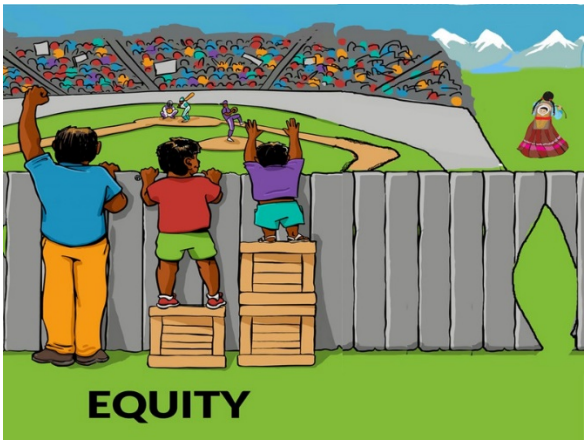


Over the years, numerous efforts have been made to reach health equity for AI/AN people. Many are built on the commonly used model visually represented in the panels to the left. This model uses the metaphor of a “game” to symbolize health, and the fence as limiting the ability of individuals to see and participate in the “game.” It recognizes that because of the institutional and structural barriers, giving equal access does not allow everyone to see the “game,” but instead, to reach equity, we have to give those who need it more boxes (services/resources) to see over the fence. However, in Indian Country, very few of these efforts have seen any success.

DEFINING INDIGENOUS HEALTH EQUITY

At UIHI, we believe the reason we have seen little improvement in our health outcomes is because the movement for health equity has always been based in western cultural norms. And many of these western norms are influenced by the institutional and structural barriers that continue to inhibit our health outcomes. In the graphic above, marginalized populations are always “behind a fence” and never in the grandstands with the rest of the people. Affected communities are often pictured as smaller or less than their counterparts. It assumes that the “fence” is the only barrier, and, if we can see above it, we can “see the game.” It also assumes we are all looking at the same “game” when it comes to health.

UIHI challenges these assumptions, and instead, as seen in the adapted panel below, we believe that health equity will be achieved when our efforts are grounded in our culture and traditional knowledge systems. We need to break down the fence, recognize we are not and should not be looking at the same game (health), and lift our eyes to the land and put our feet in the water and reclaim our health in a culturally rigorous way. In this graphic, the woman has broken through fence, taken the pieces to build a cradleboard (traditional method of infant safe sleep), and is keeping her eyes on culture and tradition to guide the wellness of the next generation.



In taking the pieces of the fence, we recognize that there are great strengths to western science and health equity efforts. We can use it to strengthen our traditional knowledge systems. However, we cannot be grounded in it. Our interventions cannot be based in it. Cultural rigor requires us to first be grounded in our own way of knowing, recognizing that the answers lie within our cultures, and that our resilience is based in taking action to improve the health and well-being of the future generations. That is the self-determination needed for true change.

This is what Urban Indian Health Institute is working toward—health equity for American Indian/Alaska Native populations—by breaking barriers, building beauty, and restoring culture. We believe that data, research, and evaluation are cultural values and ancestral practices, and we are reclaiming them to be used for Indigenous people, by Indigenous people. Tribal communities, both urban and rural, are exercising self-determination and reclaiming their unique cultural knowledge systems for the health of the future generations.

When undertaking any efforts toward achieving health equity among AI/AN people, come to indigenous people because we have the answers, not because you think we have the most problems. The answers to solving health disparities for AI/AN people are within our communities and are carried in our stories, our land, and our DNA. Only when this knowledge is incorporated and valued will we begin to achieve health equity.