



A Publication of the National Indian Health Board

Public Health Digest

SPRING 2016

Mission of the National Indian Health Board

One Voice affirming and empowering American Indian and Alaska Native peoples to protect and improve health and reduce health disparities.

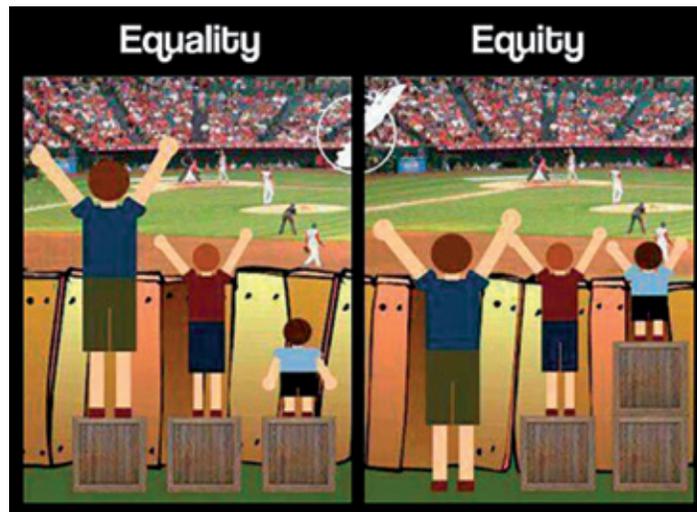
This Publication

The National Indian Health Board (NIHB) invites you to learn more about the latest developments in Tribal public health, including updates on NIHB's current projects. We also invite you to share your news items, comments, or questions.

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Our Path Towards Health Equity



- **Reciprocity:** the mutual respect for all things
- **Redistribution:** re-balancing relationships and sharing knowledge, wealth, time and energy with others

How do we, as nations achieve this complete state of well-being with a respect for all? This involves valuing everyone equally with focused and ongoing societal efforts to address *avoidable* inequalities and injustices. It includes living sustainably, the way that our ancestors did.

To achieve equity, there is a need to address inequality. How is that different than equity? Equality aims to ensure that everyone gets the same things, regardless of their need. The term equality comes

with an assumption that everyone is starting at from same place, therefore has the same needs. Equity, in contrast, focuses on giving people the resources needed to reach a complete state of health and well-being.

It is crucial to have a collective understanding amongst colleagues of health equity and the social determinants of health, as well as an understanding of the impact that social, economic and environmental factors have on them. These factors touch every part of Indian Country, especially public health programs, policies and the interventions to improve the well-being. **Below are some common social determinants of health.**

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WHAT IS HEALTH EQUITY?

Health equity, social determinants of health, health disparities....buzzwords that are seemingly unavoidable in the health field - but what do they really mean? Crucial to understanding these terms and their importance is knowing that health is the complete state of physical, mental, spiritual and emotional well-being. Health equity involves living holistically and embodies an intrinsic value the four Rs – relationship, responsibility, reciprocity and redistribution.

- **Relationship:** the inclusion of everyone
- **Responsibility:** the understanding that we are accountable to everything in our ecological system, including plants, animals and the environment

Social	Economic	Environmental	Structural
<ul style="list-style-type: none"> • Gender • Race • Sexual Orientation 	<ul style="list-style-type: none"> • Employment • Education 	<ul style="list-style-type: none"> • Geography • Living Conditions • Water and Sanitation • Work Environment 	<ul style="list-style-type: none"> • Health Care Services • Economic Systems and Policies • Governing Systems and Policies

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Sex and Salads?

MEET THE PUBLIC HEALTH POLICY AND PROGRAMS DEPARTMENT

While it may be perceived that public health professionals are always talking about condom use (sex) and healthy eating (salads), staff in the Public Health Policy and Programs Department (PHPP) at the National Indian Health Board (NIHB) can also be found working on issues such as assisting Tribes increase their public health capacity, researching agricultural policy as it relates to obesity, and facilitating processes that elevate the voices of Tribal leaders, members and youth to advance health equity for Native people.

While an established presence for years at NIHB, the Public Health Policy and Programs Department has grown in size and scope over the past few years. The Department employs five full time staff (including a director, a program manager, and three project coordinators) and hosts a full-time Public Health Associate from the Centers for Disease Control and Prevention (CDC). Plans to hire more staff for the department will launch later this summer.



Castagne, Shervin Aazami

THE STAFF

The staff come from all parts of the country and have diverse educational backgrounds and experiences. One thing all the staff in the department share is a passion for primary prevention, whether that be preventing illness (such as diabetes, sexually transmitted infections, mental illness, or cancer) to creating social and physical environments where all people across the lifespan are able to thrive and live to their fullest health potential. This may involve work related to policy, the environment, addressing economic and social circumstances, or promoting cultural solutions to health inequities.

- **Karrie Joseph** serves as a Public Health Programs Manager and manages the Tribal Accreditation Support Initiative (ASI). The Tribal ASI supports Tribes in the form of small grants to accomplish projects related to public health accreditation. “When one of our Tribal partners says ‘thank you for connecting me with this resource’ or ‘your monthly calls really helped us stay on track’, I know I am doing my job. When I see Tribes accomplish their goals and complete community health assessments or workforce development plans, for example, I know our program is making

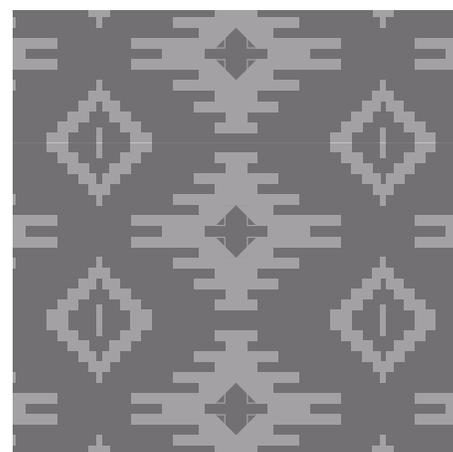
an impact. I hear over and over from Tribes how these accomplishments have increased the quality of public health services in their communities.”

- **Jacquelynn Engbretson** (Ahtna Athabascan, Gulkana Village) is a Public Health Project Coordinator and works with the Methamphetamine and Suicide Prevention Initiative (MSPI). Jackie states that the best part of her work is “assisting Tribes in strengthening policy and programming to more effectively serve Tribal members. Tribes are doing so much amazing and innovative work – it’s an honor to help by providing tools and resources. If I had one public health wish for all Tribes, that wish would be the reduction of stigma overall, whether it be stigma related to mental health issues, obesity, or certain communicable diseases. Stigma prevents individuals and society as a whole from receiving adequate healthcare.”
- **Jamie Ishcomer** (Choctaw Nation of Oklahoma) is also a Public Health Project Coordinator and works with several projects that support Tribes in increasing their public health capacity. One of her projects is leading the development of a Public Health in Indian Country Capacity Survey (PHICCS). “Data on the capacity of the public health infrastructure and workforce in Indian Country has not been collected since 2009. Having this data will help national and federal agencies prioritize what is truly needed amongst this population,” states Jamie.
- **Michelle Castagne** (Sault Ste. Marie Tribe of Chippewa Indians) is a Public Health Project Coordinator and in addition to working with the Tribal Leaders Diabetes Committee, also works with other national organizations on the First Kids 1st initiative that aims to impact the systems that most contribute to good health for youth and their families – their Tribal governments, education, welfare systems, and healthcare and public health services. “One of the most impactful moments for me in the past year with NIHB, was watching a former NIHB Native Youth Health Summit attendee, at 15 years old, stand in front of hundreds of people to tell her story about the health and resilience of her family and, furthermore, the solutions

and policy recommendations that she herself generated and wants to see enacted to improve conditions for her peers and community. It was a great reminder that there is such great work happening in communities across Indian Country and we, here at NIHB, need to continue elevating the programs and voices of those who know them best.”

- **Shervin Aazami** is a Public Health Associate from the Centers for Disease Control and Prevention and will be working with NIHB until October 2017. He is focused on developing a comprehensive report on the state of obesity in Indian Country, and ultimately creating a culturally-relevant intervention. This report includes everything from a literature review to a surveillance and federal, state and Tribal policy scan, a compendium of previous obesity intervention initiatives, and best-practice based recommendations. “If I had one public health wish for all Tribes, that wish would be to establish complete and universal food sovereignty across all of Indian Country.” ■

Robert Foley served as the Director of Public Health Policy and Programs since September 2015 and the Acting Director prior to that. He is now in a new position at NIHB as the Chief Program Officer. When asked about his transition, Robert stated that “While I am sad to be leaving the daily activities of some of the public health projects, I am looking forward to being able to provide vision and direction for our projects and work in a different manner.”



TRIBAL EPIDEMIOLOGY CENTER SPOTLIGHT:

Rocky Mountain Tribal Epidemiology Center



Rocky Mountain Tribal Epidemiology Staff (L-R) Mike Andreini, Deidhra Hill, Pharah Morgan, Jordan Vandjelovic, Nell Eby, Helen Tesfai, and Julie Not Afraid.

The Rocky Mountain Tribal Epidemiology Center (RMTEC) is the designated Tribal epidemiology center serving Tribes in Montana and Wyoming. In total, the RMTEC serves ten Tribes on eight reservations, or approximately 70,000 American Indians. The RMTEC seeks to empower American Indian Tribes in Montana and Wyoming to develop public health services and systems to have resources and express their authority in response to public health concerns. The RMTEC is a Tribally-centered organization that believes in the sovereignty of Tribal nations, deferring to Tribal public health priorities in the development of all projects, open and honest communication that fosters an environment of respect and trust, and encouraging an environment that nurtures ideas, beliefs, perspectives, and cultures.

In 2005, the Rocky Mountain Tribal Leaders Council (formerly the Montana Wyoming Tribal Leaders Council) collaborated with Tribal members, the Billings Area Office Indian Health Service (BAO-IHS), state officials, and county officials to plan and develop the RMTEC. The collaborative effort involved using community-based participatory research methods to meet with Tribal health directors from each of the Tribes in Montana and Wyoming to identify three health priorities for their communities. From these efforts the RMTEC developed a project proposal to address the concerns identified and subsequently submitted the proposal to

the Indian Health Service (IHS). In 2006 the RMTEC came to fruition with an award from IHS.

Projects at the RMTEC are based off of the Healthy People 2020 model, a 10-year agenda for improving health in the United States. RMTEC established five primary goals:

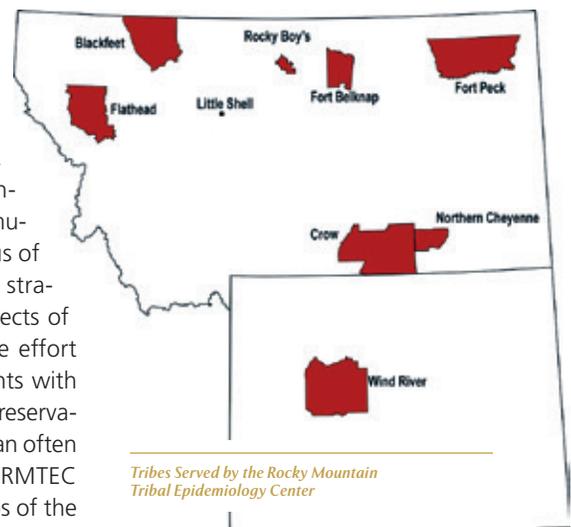
- Capacity building
- Infection/chronic disease and public health ethics
- Healthy lifestyles
- Environmental health and disease prevention
- Community health profiles

One of the current projects RMTEC is working on is their Injury and Violence Prevention Surveillance, Strategic Planning, and Intervention Project. The RMTEC collects, analyzes, and reports intentional and unintentional injury data to help Tribal communities understand the injury status of their community and to develop a strategic plan to reduce the adverse effects of injury. This project is a collaborative effort that requires data sharing agreements with states and the counties close to the reservations (since bordering communities can often be inhabited by Tribal members). RMTEC partners with stakeholders in all steps of the

process, including the BAO-IHS. The end goal is to intervene and reduce injury by seeking intervention funds.

The RMTEC has two projects that focus on youth health. The first project, Child Health Measures (CHM), seeks to inform participating Tribes on the health measures associated with the risks for childhood obesity, diabetes, and heart disease among participating Tribes' children. Trained Tribal field workers volunteer to help with the projects by screening youth ranging from kindergarten to high school. Volunteers measure blood pressure, pulse, weight, height, waist circumference, hip circumference, and acanthosis presence. These measurements are taken yearly and are analyzed and reported. The second project, the Montana Wyoming Native Child and Youth Project (CYP), promotes the body, mind, and spiritual well-being of American Indian youth, ages 5 to 19 year by refurbishing safe and accessible play places for children in reservation communities, while encouraging healthy traditional foods and culturally appropriate emotional well-being and social skills development. The RMTEC seeks to accomplish this by mobilizing the community to assist in refurbishing already existing reservation recreational facilities (making them child friendly and safe for play), assisting with salary funds, trainings and certification of nominated Tribal Staff Recreation Guides/Aids, and assisting with accessing and promoting age-appropriate healthy traditional foods.

For more information about the Rocky Mountain Tribal Epidemiology Center, please visit their website: www.rmtec.org/. ■



Tribes Served by the Rocky Mountain Tribal Epidemiology Center

SDPI SPOTLIGHT:

Pokagon Band of Potawatomi Indians

The Pokagon Band of Potawatomi Indians, located in Dowagiac, Michigan, is one of over 300 diabetes treatment and prevention programs in Indian Country funded by the Special Diabetes Program for Indians (SDPI). Like many counties in or surrounding Tribal communities, Cass County, where the Tribe is based, experiences Type II diabetes at a disproportionate rate of 14.6% of the county's population having a Type II diagnosis, compared to only 11.7% in the state of Michigan.

The Pokagon Band of Potawatomi began their SDPI program in 1998, at the beginning of the grant program that was funded by Congress to combat the epidemic levels of diabetes in American Indian and Alaska Native communities. Before SDPI, there were few staff members, no health education services, and diabetes screenings were not performed regularly at the Pokagon Health Services (PHS).

Today, the Pokagon Band has their very own clinic, where many of the providers are Tribal citizens. Ms. Rebecca Price, former Community Health Nurse at the Tribe's health clinic and now Tribal Council Member, provided the following insight on the innovative public health programming being done through the Pokagon Band of Potawatomi SDPI program.

HAS SDPI CONTRIBUTED TO COST-SAVINGS FOR YOUR HEALTH PROGRAM?

"Cost saving is always a major goal in Indian Country. We have been able to supply many things for our patients at the PHS, including glucometers, medications, podiatry care and treatments. We have been able to prevent costly amputations due to the services provided at the podiatry clinics and the therapeutic shoe program ensures each diabetes patient has a well-fitted shoe or orthotic to prevent wounds and skin break down. We also offer more exercise activities

focused on youth and have created programs geared toward prevention – starting with pregnant and new mothers with infants. Our breast feeding program has gained much attention and we've been able to put together a lactation room within the clinic for mothers to use when they visit."

WHAT ARE THE TRIBE'S PLANS TO SUSTAIN THE WORK BEING DONE THROUGH THE SDPI PROGRAM?

"We are in the process of enhancing our billing program, so we can bill for specialty treatments and procedures. Also, we rely more now on non-medical based treatment and prevention activities such as lactation education, our registered dietitians prescribe fitness activities rather than medication, and we are able to provide one-on-one diabetes education to pre-diabetics. Many services we provide can be billed, but we are just not billing for them yet. Once this third-party revenue starts coming in, it will go back into serving our diabetic patients.

In November 2014, we opened our first new clinic building. We now supply many services in our clinic that any American Indian or Alaska Native is eligible to receive. We have much to offer our Tribal community thanks, in part, to the continued funding of the Special Diabetes Program for Indians."

For more information about SDPI, please visit www.nihb.org/sdpi. ■



Upcoming Events

- **8th Annual Tribal Public Health Conference "Create, Inspire, and Empower Healthy Native Communities"**
April 20-21, 2016 in Shawnee, OK
- **Fertile Ground II: Growing the Seeds for Native American Health**
May 2-4, 2016 in Minneapolis, Minnesota
- **Providers Best Practices and GPRA Measures Continuing Medical Ed.**
May 9 - 11, 2016 in Sacramento, CA
- **NCUIH Annual Leadership Conference**
May 12-13, 2016 in San Diego, CA
- **NNPHI Annual Conference**
May 17-19 in New Orleans, Louisiana
- **World Indigenous Suicide Prevention Conference 2016**
June 1-3, 2016 in Rotorua, New Zealand
- **Public Health Improvement Training (PHIT)**
June 15-17 in Baltimore, MD
- **Indian Health Service Behavioral Health Conference**
August 9-11 in Portland, OR
- **American Indian and Alaska Native Suicide Awareness (Hope For Life) Day**
September 10, 2016 in communities across the U.S.
- **NIHB Annual Consumer Conference**
September 19-22 in Phoenix, AZ

Partnership Between IHS and BIA to Reduce Opioid Overdoses

A partnership between the Indian Health Service (IHS) and Bureau of Indian Affairs (BIA) was announced in December 2015. The initiative equips BIA law enforcement officers with naloxone for responding to overdoses in Tribal communities. Naloxone is a medication that can reverse the effects of a prescription opioid or heroin overdose, saving lives.

The new agreement formalizes the partnership between IHS and BIA to reduce opioid overdoses among American Indians and Alaska Natives. In 2016, the more than 90 IHS pharmacies will dispense naloxone to as many as 500 BIA Office of Justice Service's officers and will train these first responders to administer emergency treatment to people experiencing opioid overdose. The partnership will be reviewed annually by IHS and BIA and will continue as long as the agencies agree it is delivering the desired results.

IHS data indicate that the rate of drug-related deaths among American Indians and Alaska Native increased from five per 100,000 population (adjusted) in

1989-1992 to 22.7 per 100,000 in 2007-2009. The rate among American Indian and Alaska Native people is almost twice that of the general population; drug-related deaths were 12.6 per 100,000 population for the U.S. all race population in 2007-2009. According to the Centers for Disease Control and Prevention (CDC), the rates of death from prescription opioid overdose among American Indian or Alaska Natives increased almost four-fold from 1.3 per 100,000 in 1999 to 5.1 per 100,000 in 2013.

For more information visit: 1.usa.gov/1RE9m0K

PARTIAL LIFT ON FUNDING BAN FOR SYRINGE EXCHANGE PROGRAMS

Congress passed a measure in the omnibus signed by President Obama in January that effectively ended the funding ban of syringe exchange programs. While federal funds still can't be used to purchase new syringes, programs can now use federal funds to pay for things like staffing, rent, vehicles, counseling, and outreach. Syringe exchange programs provide new needles in exchange for used needles from people who inject drugs intravenously. These harm reduction programs help prevent the spread of hepatitis and HIV. ■



WHY SHOULD I CARE ABOUT HEALTH EQUITY?

Ultimately, everyone deserves a fair shot at a healthy, happy life. As public health practitioners, it is our job to promote health and prevent disease. The unfortunate reality is that dramatic differences exist in the health outcomes of the general U.S. population compared to many American Indian and Alaska Natives. By using a health equity lens in our public health programming and policy work in Tribal communities – one that addresses avoidable inequalities such as poor housing conditions, lack of access to healthcare, and less education opportunities – we can honor and attempt to correct the damage done by the forced and systematic departure from cultures and traditions that is at the root of the unequal resource allocation and health outcomes that exist today.

HOW TO ACHIEVE HEALTH EQUITY

It is unrealistic to believe that 100 percent equity is achievable. Hundreds of years of discriminatory practices have shaped the healthcare system that we currently live in, however there are ways to work towards a more equitable world. **They key to healthier nations start with public health – addressing the population's health, not just individual's.** This includes providing access to a healthier lifestyle for the entire community, establishing cross-sector collaborations and empowering the individuals that make a community by addressing social, economic and environmental injustices.

ACCESS

The most well-known ways to live healthily are to exercise and eat a balanced diet. While these seem simple enough, unfortunately, there are a great deal of barriers that impede thousands of able-bodied individuals from doing so. Exercise, for example isn't as easy as going for a jog. Sure, a gym isn't necessary to get in some cardio. However, a safe place to do so is. Communities often lack sidewalks, streetlights, and green space to safely go for a walk. "An apple a day keeps the doctor away", but what if there aren't any grocery stores with fresh produce for miles around? Without access to spaces to safely be physically active or to purchase raw foods, how can there be an expectation for the community to live healthily? Public health interventions can be geared towards giving

the community, as a whole, a chance to incorporate walking into their daily lives by hosting a walking club or sponsor a 5k. Community gardens with traditional foods offer access to both fresh foods and cultural knowledge.

COLLABORATION

While health departments play a central role in creating healthy communities, they cannot do it alone. Communication across sectors must be ongoing to achieve equitable policies and programs that provide opportunity for all community members to lead healthy lifestyles. For example, transportation departments play a major role in improving the sidewalks, adding streetlights, and establishing bike lanes to create safe spaces for physical activity. Additionally, police departments are responsible for ensuring the overall safety of a community and, by increasing the law enforcement presence in an area, could give residents the assurance that it is safe to walk around the block. Creating and maintaining a healthy community is a shared responsibility of the entire community, including the private sector, governments, schools, and families. Collaboration of these different entities is key in creating an environment that promotes physical, emotional, social, and spiritual well-being for all.

EMPOWERMENT

Finally, empower your community to live healthier lives. Give them a voice and arm them with the knowledge and resources they need to focus on their mental, physical, spiritual, and social well-being. Incorporate the four R's into every programmatic and policy intervention so our communities can be healthy for the next seven generations. ■

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Navajo Nation Takes a Policy Stance on Junk Food

The Healthy Diné Nation Act (HDNA), signed into law in November 2014 by former President Ben Shelly of the Navajo Nation, is the first legislation of its kind in Indian Country, wherein a tax was imposed on certain foods deemed to be low in nutritional value. Although 20 states currently tax sugary sweetened beverages (SSBs) at a higher rate than other food items, this is the first precedent in Indian Country and is more extensive given its coverage of chips, cookies, and other foods historically known as 'junk' foods in addition to SSBs. This tax has been heralded by activists and health professionals for signaling a new approach to combatting chronic disease, and opposed by some political and economic pundits who claim it may stifle small businesses and expressed concerns about how it will be regulated. Proponents of the new law have pointed towards the expected \$1-2 million in revenue it will generate per year which will be utilized to fund new farmer's markets, greenhouses, traditional cooking classes, and wellness programs.

Rising levels of chronic disease remain a key issue in Tribal communities nationwide, and Navajo representatives are hopeful that this tax will convey the urgency with which their government is tackling this concern, while also promoting awareness within the community. The bill was authored and promoted by the Diné Community Advocacy Alliance (DCAA), a local community organization that hopes that the new law will eventually decrease the inventory of unhealthy foods while increasing the demand for and availability of healthy foods through education and investments in local farming.

Although colloquially dubbed as the "junk food tax", many claim this label to be trivializing and misleading, as an amendment only a few months prior to the passage of HDNA removed a 5% tax on fruits and vegetables. This tax reduction on fruits and vegetables extended also to traditional Navajo foods: such as corn, squash, beans and others. Essentially, the goal was to increase the affordability of healthy, traditionally appropriate foods while decreasing the affordability of calorically dense, innutritious foods.

Scientifically speaking, there seems to be evidence that such taxes are an effective deterrent for unhealthy behavior. According to a report released in October 2012 by the Rudd Center for Food Policy and Obesity, "A 10% increase in price is estimated to result in an 8% to 12.6% decrease in consumption." In addition, citing a 2011 study on SSB taxes in Illinois, researchers "... estimated that a penny-per-ounce excise tax would reduce the number of obese youth by 9.3%, and obese adults by 5.2%; diabetes incidence by more than 3,400 cases; diabetes-related health care costs by \$20.7 million; and obesity-related health care costs by \$150.8 million." Although these are predominately long-term benefits, representatives of the bill have no illusion that this legislation is only the first step towards improving health and wellness in Navajo Nation. There seems to be agreement that this new law harbors symbolic significance in addition to tangible benefits, as according to Denisa Livingston, a constituent of DCAA, "Healthy food is not just our tradition, it's our identity. This is the start of a return to food sovereignty."

The Healthy Diné Nation Act is set to expire in 2020. Although some are hoping that this new tax will inspire enough awareness, community support and investment in healthy farming so as to render renewal of the tax unnecessary, negotiations over reauthorization are not off the table. At this point, only time will tell. HDNA went into full effect in April 2015, and Tribal administrators are currently in the process of reviewing year-one revenue totals and statistics.

The National Indian Health Board is in the middle of policy scan examining Tribal and federal policies impacting obesity prevention. The hope is to publish this compendium later in 2016 as a resource for all Tribes seeking varied approaches to combatting this epidemic in Indian Country. The scan will also inform a training on obesity prevention that will tap into best and wise practices for nutrition and physical activity. Please reach out to Shervin Aazami, saa-zami@nihb.org, for more information on the obesity prevention program at NIHB. ■

How Health Inequities Drive HIV in American Indians/Alaska Native Communities

American Indian/Alaska Native (AI/AN) people have limited access to HIV prevention services and treatment services in rural, reservation-based communities. Unfortunately, limited access to health care in rural communities is interrelated with AI/AN poor health status and elevated disease risk factors. AI/AN communities are disproportionately affected by poverty, chronic disease, substance abuse, alcohol use and unemployment. All of these factors offer some explanation for the lower health status of AI/AN people when compared to other races and ethnicities.

According to 2014 statistics, the number of AI/AN people newly diagnosed with HIV between 2010 and 2014 increased by 25.4% (Centers for Disease Control and Prevention, 2015). And based upon survival data, 2005-2010, only 88% of AI/AN live longer than three years after being diagnosed with HIV, which is the lowest percentage of survivors when compared to other races (CDC, 2015). Furthermore, many AI/AN live on rural reservation lands where high unemployment, high substance abuse, and limited opportunities for career advancement are common. Approximately 26% of AI/AN reported living in poverty in 2012, and AI/AN had the second highest (11%) high school dropout rate when compared to other races and ethnicities.

The World Health Organization defines social determinants of health as conditions in which persons are born, grow, work, live, and age, and the wider set of forces and systems shaping the conditions of daily life (World Health Organization, 2016). These include economic policies and systems, social norms and policies, political systems, as well as socioeconomic status, race, gender, and geography. These social determinants drive health inequities. Health inequities are the unfair differences in health status between different groups of people – in this case between American Indian/Alaska Native and non-Native populations. Social determinants of health are key drivers of the HIV epidemic as the disease is driven by social behavior and controlling the disease requires consistent access to medical services.

The disproportionately high rates of poverty, substance abuse, and unemployment in AI/AN communities severely undermine HIV prevention efforts and complicate access to the needed health resources. For example, AI/AN people living with HIV who are not able to secure a living wage as a result of living in a remote area may be less likely to adhere to a daily medication regimen and receive regular check-ups from an infectious disease specialist. Identifying these inequities in health outcomes is essential towards restoring balance, but is also just the first step. To address health inequities, a broader, more long-range strategy is needed.

HIV is a manageable, chronic disease that is preventable when resources are plentiful. Simple strategies like improving access to free condoms and clean syringes in rural areas can be a key strategy to reducing the inequity. Early detection through screening is important, so Native communities may explore outreach testing as opposed to only offering testing in clinical settings as a method to combat the challenges of geography and community-based stigma. AI/AN Tribes have led the way in innovative economic development strategies and they could take a large progressive step by just examining how the economic development can support individual health. Making that link will be an important connection. Employment may provide additional health insurance coverage benefits, but it also provides a sense of stability. These are important factors for people who are fighting a chronic disease. So having that sense of security will allow AI/AN people to stop worrying about battling for the most basic needs and focus on other priorities – like their controlling their HIV disease. ■

CITATIONS

Centers for Disease Control and Prevention. (November 2015). HIV Surveillance Report, 2014; vol. 26. Retrieved from www.cdc.gov/hiv/library/reports/surveillance/

World Health Organization. (2016). Social Determinants of Health. Retrieved from www.who.int/social_determinants/en/

JOIN THE TRIBAL ACCREDITATION LEARNING COMMUNITY

NIHB has been convening the Tribal Accreditation Learning Community (TALC) via webinar the 2nd Friday of every month to learn and discuss issues related to Tribal public health accreditation. Some of the presentations that have been hosted are Engaging Your Tribal Community, Strategic Planning for Health Equity and Impressions of the Site Visit Process. TALC has hosted presenters from the University of New Mexico's Center for Participatory Research, public health staff from NIHB and a trained Public Health Accreditation Board site visitor. Each month, one of the Tribal Accreditation Support Initiative awardees presents their Tribe's journey to accreditation from planning community health assessments to engaging staff and collecting and tracking documentation. So far this year, we have heard from the Oneida Tribe of Indians of Wisconsin, Forest County Potawatomi Community, Notawaseppi Huron Band of Potawatomi, Ho-chunk Nation, and the Pascua Yaqui Tribe.

TALC is open to anyone who is interested in learning and sharing about public health accreditation in Tribal communities.

More information and past presentations can be found in pdf format on the NIHB TALC website www.nihb.org/tribalasi/tribal_asi_talc.php

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