

Health Disparities: Indigenous: Native American

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The term health disparities: Indigenous: Native American refers to the disproportionate prevalence of diseases, lower life expectancies, and inequities in access to health messaging and healthcare experienced by Indigenous peoples. Differences in care among marginalized groups, particularly Indigenous communities in the US, are attributed to socioeconomic conditions, geographical situatedness, cultural identity factors, and systemic prejudice/malintent. Diverse citizens of 574 federally recognized Indigenous nations designated as “domestic dependent nations” and non-federally recognized nations, a small percentage of whom live on reservations, and urban Indigenous populations make up between 1% and 2% of the total US population. Yet, they experience a disproportionate array of health issues including instances of diabetes, cirrhosis, chronic liver disease, and tuberculosis. Compared to White women, Indigenous women experience twice the incidence of cervical cancer. There are also higher instances of substance abuse disorders, mental illnesses, and more than double the rate of suicide than the rest of the United States. Statistics themselves, however, can be dehumanizing. As such, research on Indigenous health communication and disparities can be problematic in framing communities as diseased or pathologized. Thus, discussion of disparities should be contextualized and communicate correctives, resiliency, and visions for a more equitable future.

Health communication scholars have taken up a variety of studies that discuss colonialism as an underlying contributor of health disparities but are varied in their topical and methodological approaches. Research is attentive to several non-mutually exclusive areas, including (i) economics, behavioral risk factors, environmental exposures, education, and resource access for populations; (ii) digital and infrastructural divides; (iii) inadequate cultural responsiveness and protocols communicated by clinicians and organizations; and, most prevalently, (iv) how Indigenous health disparities are communicated interpersonally and through mass media.

Contemporary Indigenous health disparities, including those associated with mental illness, are tied to legacies of colonialism and paternalism of the US government (Oetzel et al., 2007). The United States committed acts of genocide including, but not limited to, viral biological warfare, food and resource deprivation, and military action beginning in the eighteenth century, as well as forcibly removing Indigenous peoples to reservations or mandating mass assimilation. Currently, they maintain policies that tend to keep reservations socioeconomically disadvantaged and have yet to reconcile for mental and physical health ramifications caused by ongoing colonialism. The federal

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government has attempted to fulfill its treaty obligations to provide healthcare through the Indian Health Service (IHS), founded in 1955; however, the care provided is deemed inadequate.

Indigenous peoples experience poverty at a significantly higher rate than the rest of the United States and access to basic necessities of food, water, housing, education, and the ability to avoid environmental hazards are health challenges. These are well noted by communication practitioners such as journalists and health communication scholars who must contextualize their projects with structural inequalities (Hinnant et al., 2019). For example, contextual information regarding how a high percentage of Indigenous peoples experience food insecurity or live in “food deserts,” without access to fresh fruits and vegetables, is needed in discussion of the prevalence of obesity and diabetes. In the case of COVID-19, Navajo, Hopi, and numerous other nations have warned that their lack of access to safe running water prevents them from washing their hands frequently, per CDC guidelines, during the pandemic. The results of lack of resources and additional comorbidities have had a staggering effect. Indigenous peoples in New Mexico, for example, accounted for over 50% of COVID-19-related deaths despite the fact that they comprise about 10% of the population of the state in a period during 2020.

Further, disparities related to geographic situatedness and financial limitations have resulted in limited access to health facilities and challenges in attracting high-quality clinicians in often remote, rural places. Members of federally recognized Tribal nations can access IHS of the Department of Health and Human Services, but funding has been historically low. Services are limited and specialists and updated equipment are difficult to access. Potential remedies in access to care, such as telehealth, often prove challenging for many Indigenous peoples living on reservations who lack Internet in their homes or urban Indigenous peoples who experience financial and technological barriers to implementation (i.e., digital and infrastructural divides).

Regardless of the method of care, issues exist in clinical communication between clinicians and patients, and issues also exist regarding communities’ trust in individuals employed at Tribal health education programs (Clean, 1997). These include high turnover rates of clinicians, which results in less continuity in care, language barriers, and lack of cultural responsiveness. Clinicians trained in Western medicine often designate their methods of diagnosis and care as superior to Indigenous “traditional” medicine and advice of community healers. Such misunderstandings are embedded in dichotomies and discourses in medicine about what is “civilized versus savage” or “archaic versus modern.” These are rooted in colonialism and its attendant form of systemic racism. Patients’ fear of discrimination, being stereotyped, or not being believed for their medical conditions has led to rampant mistrust between Indigenous peoples and settler society’s medical praxis and theory. Additional interpersonal and intercultural communication training is needed as an intervention. Well-intentioned Indigenous doctors who go back to serve their communities are better equipped to communicate interpersonally with their patients and more accurately report data to internal and external entities.

Mass media and messaging is also an important component of Indigenous health disparities in communication research. It has long been known that media conveys and

frames health discourses. Research by Gearhart and Trumbly-Lamsam (2017) notes that Tribal publications (e.g., Tribal newspapers) include health disparities through the use of stories about diseases like kidney disease or cancers that disproportionately afflict Indigenous peoples. However, coverage of disparities is less prominent in Tribal news than coverage of other health topics such as health services or public safety. When health campaigns emerge from a specific Indigenous nation, provide historical information, promote unity over individualism, and focus on the contemporary, adaptive identities of Indigenous peoples, they can effectively combat disparities. Strategically produced and disseminated campaigns about fetal alcohol syndrome (FAS), for example, helped reduce FAS deaths by 19% among Indigenous peoples in the United States (Rentner, Dixon, & Lengel, 2012). The importance of cultural responsiveness and achievement-oriented messages has also been highlighted in a study examining Indigenous cultural adaptations of a youth substance abuse prevention campaign (Stanley et al., 2018). Health campaigns in general US media, however, are frequently produced without considering Indigenous peoples as a target audience or without considering disparities as important to the mainstream health agenda (i.e., agenda-setting issues).

The aforementioned topical areas have been researched by health communication scholars using a variety of qualitative and quantitative methods. However, Smith (2012) and others have critiqued methods regularly used in health communication research that are extractive, exploitative, colonial, or claim objectivity. For example, pharmacogenetic studies using Indigenous samples to analyze diabetes primarily for benefit of White patients, studying maps of Indigenous genomics that misuse or dehumanize genes, or misstating Indigenous identity as tied to DNA or race as opposed to citizenship are problematic. Moreover, research regarding statistics can homogenize Indigenous peoples, failing to distinguish between urban Indigenous populations and those living on reservations in different regions with vastly different living conditions and experiences. The result is misleading data that can make health disparities seem like less strident problems than they are.

Because of a long history of research and reporting problems, strict institutional review board (IRB) protocols are implemented to prevent health abuses and many Indigenous nations now have their own committees and boards serving as gatekeepers. These entities review proposed health communication research projects to ensure they are beneficial to nation(s), that data and tissue samples can be owned by the nation(s) or individuals, and they often provide opportunities for researchers to present their results in communities to foster relationships.

Indigenous scholars, in particular, are prioritizing health communication research through a guiding imperative of survivance (Vizenor, 1994). Survivance regards taking a stance of pride and presence above being victims, which includes facing, discussing, and advocating for better health. Such efforts have been achieved using anti-colonial methods such as autoethnographically oriented Indigenous truth-telling and participatory action research, working collaboratively with communities to benefit and assist them with their own health goals. Survivance-based communication health research ideally also shares successes in Indigenous communities, for example, research detailing how Tribal nations are creating their own improved clinics through grants or

independent economic profits that provide healthcare not only to their peoples, but also to surrounding communities.

Indigenous peoples remain underrepresented in health communication research but reviews of existing bodies of literature addressing health disparities offer fruitful future directions grounded in cultural responsiveness. Boyd and Furgal's (2019) review suggests research on environmental health issues contributing to disparities should be focused on Indigenous subpopulations longitudinally and should advocate for culturally specific and understandable health messaging delivered by trusted spokespeople. Disparities, particularly those due to inequitable colonial conditions, are urgent social justice matters that require intervention regarding dynamics of "researcher and researched." Indigenous peoples and clinicians have their own research agendas and visions for equitable health. Lastly, future research on health disparities and communication should consider Indigenous epistemologies and conceptions of relationality – connections and actions between peoples, nonhuman entities like the environment, histories – and how these impact health.

SEE ALSO: Food Insecurity; Health Campaigns: Underserved/Vulnerable Populations; Indigenous Research Methods; Postcolonialism; Race and Clinician–Patient Communication.

References

- Boyd, A., & Furgal, C. M. (2019). Communication health risks with Indigenous populations: A systemic literature review of current research and recommendations for future studies. *Health Communication, 34*(13), 1564–1574. <https://doi.org/10.1080/10410236.2018.1507658>
- Clean, S. M. (1997). A communication analysis of community mobilization on the Warm Springs Indian Reservation. *Journal of Health Communication, 2*(2), 113–125. <https://doi.org/10.1080/108107397127824>
- Gearhart, S., & Trumbly-Lamsam, T. (2017). The scoop on health: How Native American newspapers frame and report health news. *Health Communication, 32*(6), 695–702. <https://doi.org/10.1080/10410236.2016.1168001>
- Hinnant, A., Subramanian, R., Ashley, R. R., Perreault, M., Young, R., & Thomas, R. J. (2019). How journalists characterize health inequalities and redefine solutions for Native American audiences. *Health Communication, 34*(4), 383–391. <https://doi.org/10.1080/10410236.2017.1405482>
- Oetzel, J., Duran, B., Jiang, Y., & Lucero, J. (2007). Social support and social undermining as correlates for alcohol, drug, and mental disorders in American Indian women presenting for primary care at an Indian Health Service hospital. *Journal of Health Communication, 12*(2), 187–206. <https://doi.org/10.1080/10810730601152771>
- Rentner, T. L., Dixon, L. D., & Lengel, L. (2012). Critiquing fetal alcohol syndrome health communication campaigns targeted to American Indians. *Journal of Health Communication, 17*(1), 6–21. <https://doi.org/10.1080/10810730.2011.585692>
- Smith, L. T. (2012). *Decolonizing methodologies: Research and Indigenous peoples* (2nd ed.). London: Zed Books.
- Stanley, L. R., Kelly, K. J., Swaim, R. C., & Jackman, D. (2018). Cultural adaptation of the be under your own influence media campaign for middle-school American Indian youth. *Journal of Health Communication, 23*(12), 1017–1025. <https://doi.org/10.1080/10810730.2018.1536730>

Vizenor, G. R. (1994). *Manifest manners: Postindian warriors of survivance*. Middleton, CT: Wesleyan University Press.

Further reading

- Anastario, M., FireMoon, P., Ricker, A., Holder, S., & Rink, E. (2020). Self-reported exposure to sexual and reproductive health information among American Indian youth: Implications for technology based intervention. *Journal of Health Communication*, 25(5), 412–420. <https://doi.org/10.1080/10810730.2020.1777599>
- Indian Health Services. (2019). Disparities. [Fact sheet]. <https://www.ihs.gov/newsroom/factsheets/disparities>
- LaVallie, D. L., Wolf, F. M., Jacobsen, C., Sprague, D., & Buchwald, D. S. (2012). Health numeracy and understanding of risk among older American Indians and Alaska Natives. *Journal of Health Communication*, 17(3), 294–302. <https://doi.org/10.1080/10810730.2011.626497>
- Sequist, T. D. (2017). Urgent action needed on health inequalities among American Indians and Alaska Natives. *The Lancet*, 389(10077), 1378–1379. [https://doi.org/10.1016/S0140-6736\(17\)30883-8](https://doi.org/10.1016/S0140-6736(17)30883-8)
- Simonds, V. W., Rudd, R. E., Sequist, T. D., & Colditz, G. (2011). An assessment of printed diabetes-prevention materials available to a Northern Plains Tribe. *Journal of Health Communication*, 16(4), 431–447. <https://doi.org/10.1080/10810730.2010.546482>