www.menshealthlibrary.com

A Vision for Wellness and Health Equity for American Indian and Alaska Native Boys and Men

Stakeholders dedicated to raising awareness on health disparities among American Indian and Alaska Native (AI/AN) males have collaborated with Men's Health Network (MHN) and the Office of Minority Health to develop this brief report which outlines a growing effort to increase awareness of AI/AN male health disparities, including stakeholders from Capitol Hill to those in the most remote AI/AN communities. In cooperation with the Indian Health Service, a series of educational and awareness-building Webinars are in process and directed at public health professionals and community leaders. These webinars address the challenges presented by the defined disparities but with attention to emerging evidence-based and promising approaches underway in diverse native settings.

We need your help to spread the word to interested health professionals, community organizers, those involved in public policy…anyone who might be willing to step forward with this effort. We include among our supporters Mr. Billy Mills, 1964 Tokyo Olympics gold medalist and life-long advocate for Native American health. The goal is to harness the power of media to function as a catalyst for coordinating the diverse interests and concerns of AI/AN stakeholders – male and female – into a concrete plan of action for securing support for the research and pilot testing of interventions needed to realize health equity for AI/AN males and their families.

Contact: Men's Health Network, Native Male Health Coalition, *Warrior's Path to Wellness*
Leo Nolan 240.441.3978 leojnolan3@hotmail.com
Ric Bothwell 301.943.4507 rbothwell@menshealthnetwork.net
Ana Fadich, MPH, CHES 202.543.6461 x 101 Ana@menshealthnetwork.org

1. Background and Problem

The health of American boys and men, particularly those of color, is among the most significant, yet unrecognized, long-standing public health problems still lacking a systematic and well-coordinated national effort. No other health problem affecting so many people has endured benign neglect as much or for longer than has male health disparities. The disparities in health and wellness among American Indian and Alaska Native (AI/AN) men compared to women and all other U.S. racial and ethnic groups are extreme and the evidence suggests the gap is worsening. The Centers for Disease Prevention and Control (CDC) reports that more than half of American men's premature deaths are preventable and, even excluding pregnancy-related office visits, American women make twice as many preventive care visits as men. For AI/AN males, the statistics are even more daunting.

Based on this awareness, a growing group of interested stakeholders from all levels of American society coordinated by the *Men's Health Network* is embracing the notion that solving the health disparities among males demands a concerted effort. Doing so now is even more urgent in light of the health reform spawned by the Affordable Care Act and a recent national study of minority men's health. Dr. David Gremillion of the Men's Health Network describes the current situation:

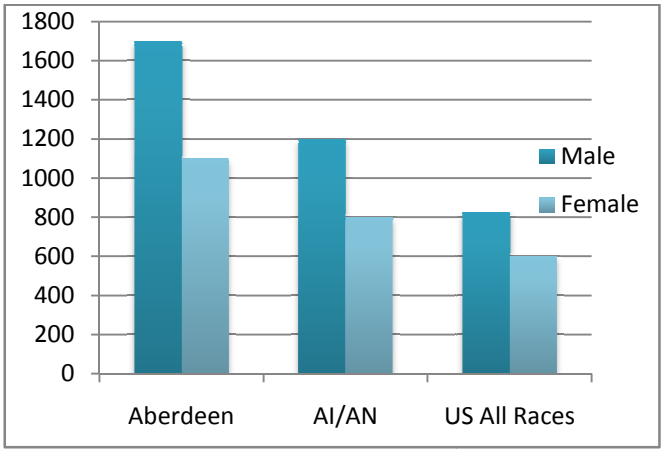
> *There is a silent health crisis in America…. It's a fact that on average, American men live sicker and die younger than American women.*

AI/AN Males Live Shorter Lives

Based on 2003-2005 Indian Health Service (IHS) service population data [i], life expectancy for AI/AN males was 69.4 years compared to 75.8 years for AI/AN females -- about an eight percent difference. Even more compelling, the gap between AI/AN males and females actually widened in regions where health status is lowest. In the Aberdeen area (one of the 12 IHS regions that encompasses North Dakota, South Dakota, Iowa, and Nebraska), which had the lowest AI/AN life expectancy, males on average live nearly eight fewer years than females (63.0 vs. 70.6 years) -- about an 11 percent gender difference. By comparison, the life expectancy gap between the U.S. All-Races population of men and women is less than six years (74.1 years for males and 79.5 years for females), approximately a seven percent gender difference.[ii]

Even larger gender differences were evident in overall mortality rates within the entire IHS service population during 2004-2006. Comparing the Aberdeen area, which had the highest overall death rates among IHS areas, the male death rate was 55 percent greater than the female death rate. Worse yet, compared to the U.S. All-Races males, the Aberdeen AI/AN male rate was 83 percent greater, while Aberdeen AI/AN women had a 66 percent greater death rate than their U.S. All-Races counterparts.[iii]

Figure 1. Overall Mortality per 100,000 Among AI/ANs and U.S. All Races for Males and Females, 2004-2006.



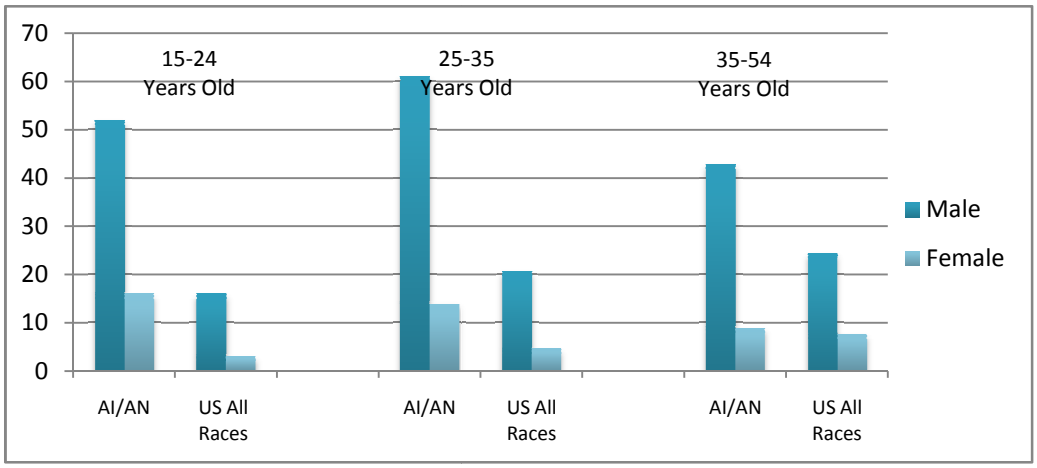
Source: Indian Health Service, Office of Public Health Support, Division of Program Statistics: Unpublished Data, 2011.

Several specific causes of death contribute to the higher mortality rates of AI/AN males compared to AI/AN females. The following are noteworthy among the AI/AN population for some age groups:[iv]

- AI/AN males experience death rates two to five times greater than AI/AN females for suicide, HIV/AIDS, homicide, unintentional injuries, diabetes, firearm injury, and alcohol-related deaths;
- AI/AN males experience death rates 10 to 50 percent higher than AI/AN females for cancer, heart disease, and liver disease.

Perhaps the most tragic and disturbing of all disparities are the extremely high rates of suicide among AI/AN males for the age groups ranging from adolescents to middle age.

Figure 2. Suicide Death Rates of AI/ANs and U.S. All Races/100,000 by Gender, 2004-2006



Source ***Trends In Indian Health 2002-2003 Edition****: American Indians and Alaska Natives, IHS Service Areas, 2002-2004 and US All-Races 2003 (Rate per 100,000 Population). Adjusted to compensate for misreporting of AI/AN race on state death certificates.*

Psychological Stress and Hopelessness is Rampant Among AI/AN Men

These gender and overall disparities among AI/ANs and other racial groups were further documented in CDC's National Health Statistic Reports (Number 20, March 9, 2010) titled *Health Characteristics of the American Indian or Alaska Native Adult Population: United States, 2004-2008.*[v] The findings further documented that, overall, AI/AN males experienced greater disparities in health status and general well-being than ANY group defined by the combination of race and gender.

Several of the CDC gender-specific analyses were particularly revealing. AI/AN are the only ethnic group where males experience higher psychological distress than females based on responses to six questions. Most striking were the responses of AI/AN males to the two questions relating to how frequently they felt "hopeless" and "worthless".

Figure 3. "Feel Hopeless" Distress Measure Males and Females by Race/Ethnicity, 2004-2008

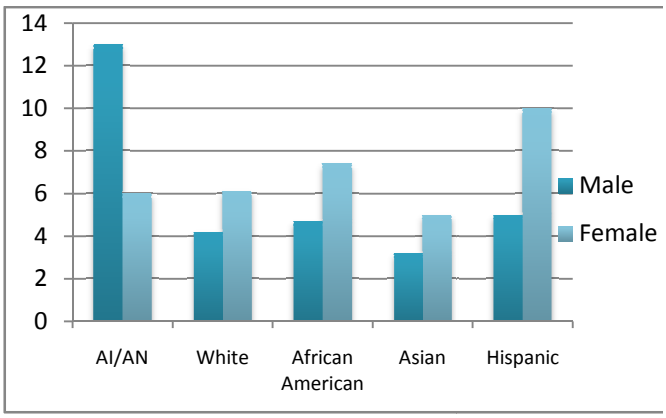
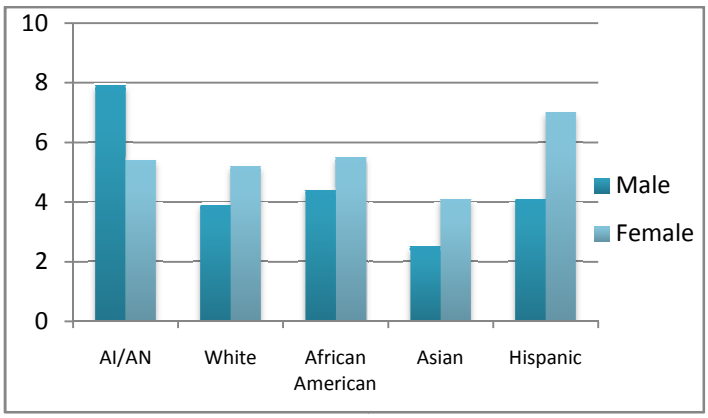


Figure 4. "Feel Worthless" Distress Measure Males and Females by Race/Ethnicity, 2004-2008



Source: Barnes, P., Adams, P., and Powell-Griner, E. Health Characteristics of the American Indian or Alaska Native Adult Population; United States, 2004-2008.National Health Statistics Reports; No 20. National Center for Health Statistics, 2010.

It is tragically evident that when AI/AN males report they feel "hopeless" or "worthless," they mean it at the deepest level, as confirmed by their suicide rates. In the same way, one could argue that the strong association between the greater likelihood of AI/AN males to rate their health as poor and their rates of suffering from multiple causes further underscores this sense of illness and despair. Yet, despite multiple physical and behavioral health problems, AI/AN men utilize health services significantly less frequently than AI/AN women. The reasons for this lack of utilization are complex and likely relate to the lack of support to increase health literacy among AI/AN men, inadequate cultural competence within the health care systems and other factors. One thing is clear – the systems of health care available for AI/AN males are falling short of meeting their needs.

Of great concern, but more difficult to measure, is that before the lives of AI/AN men are taken by alcohol, suicide, injuries and chronic diseases, they suffer from multiple debilitating physical and mental conditions and have experienced high levels of violence and sexual abuse that appear to predispose them to much higher rates as perpetrators of domestic violence and sexual abuse. The resulting suffering and costs to their families and communities are enormous, as are the costs to the Nation's medical and judicial systems, and losses of productivity and quality of life for the many people affected.

II. Emerging Opportunities and the Need for Action

The reasons for the health, well-being, and life expectancy disparities are complex and remain poorly understood. A recent comprehensive review of the literature of programs and intervention studies specifically targeting AI/AN males revealed a virtual absence of data. The research that would lead us to better understand the causes of inequality, and test approaches to address them, has simply not been undertaken. Existing evidence suggests that social determinants such as historical trauma, loss of social roles and cultural connection, poverty, and unemployment may have greater adverse health effects on AI/AN men than women. But to date, no effective, overarching efforts to study the root causes and develop AI/AN male-focused interventions to support better health outcomes have been put forward.

Despite this discouraging history, now is the most opportune time in recent history to address AI/AN male health disparities and break the cycle of suffering, considering:

- The authorization of the Indian Health Care Improvement Act (as part of the Affordable Care Act) has given authority to the IHS to establish an Office of Indian Men's Health along with other provisions for extending services, including behavioral health in community settings;
- A rapidly growing national coalition of stakeholders (including women and women's groups) committed to improving male health with AI/AN representation coordinated by the Men's Health Network has emerged, and their recent release of *A Framework for Advancing the Overall Health and Wellness of America's Boys and Men* highlights male health disparities;
- The recent formation of the Congressional Men's Health Caucus and the American Public Health Association Men's Health Caucus;
- The Kaiser Family Foundation's 2012 publication of *Putting Men's Health Care Disparities on the Map: Examining Racial and Ethnic Disparities at the State Level;*
- The National Partnership for Action to End Health Disparities, coordinated by the HHS Office of Minority Health, is incorporating efforts to address health disparities for males of color;

- There is a growing national awareness and concern related to the preponderance of mentally distressed males as the perpetrators of the most horrific acts of violence;
- The Tribal Law and Order Act and efforts to address and prevent domestic and sexual violence are being implemented;
- There is an emerging group of AI/AN male role models including healers and providers, advocates, and leaders with passion and commitment to health equity for AI/AN males and families.

Collectively these diverse forces have the potential to support the development of a combination of strategies and activities that can be condensed into two areas of:

1. Increasing access and quality to critical primary health services for prevention and control of chronic diseases;
2. Targeting recognized social determinants of health (positive and negative) and altering their health effects through efforts that address hope, healing, parenthood, and wellness for AI/AN males and their families.

The first step to realizing these outcomes is increasing awareness with stakeholders from Capitol Hill to those in the most remote AI/AN communities who will be needed to make this effort successful. Besides highlighting the magnitude and impact of AI/AN male health disparities, this effort will identify gaps in knowledge, and provide examples of how these disparities are being addressed in AI/AN and other in real world settings. Toward these goals, a two-pronged educational and media approach is being coordinated under the auspices of the *Men's Health Network* beginning with the production of a series of knowledge-building webinars targeting public health professionals and interested stakeholders at all levels. Entitled *Partnering for Wellness: Charting a Course to Hope, Healing, and Health for Native Males and Their Families,* the initial webinar of this series will be presented during Men's Health Month on June 13, and will provide an overview of the magnitude and nature AI/AN male health disparities and there determinants, the social, emotional and economic impact of these disparities on AI/AN families and communities, the need for expanding research and evaluation of best and promising practices, and opportunities for expanding collaboration to address these needs with a new sense of urgency. Follow-up webinars will address specific topic areas relating to the health disparities of Native Males (including Native Hawaiian and Pacific Islanders)in greater detail, outline emerging best practices, identify opportunities to systematically target and test approaches to reach Native males more effectively, and identify needed collaboration. As now planned, the following topics will be included in these webinars:

- Youth/Resilience and Prevention
- Behavioral Health/Substance Abuse/Suicide
- Domestic Violence and Sexual Assault
- Nutrition/Obesity/Diabetes and Chronic Diseases
- Veterans, Incarcerated, and Elderly

The second element of the awareness building media effort is the production and release of a compelling and informative video documentary on AI/AN male health disparities in late 2013 or 2014. The intent of this effort is to reach an even broader group of diverse stakeholders. As now envisioned, the video would be narrated by an AI/AN health professional/healer with support provided by a multi-generational group of recognized AI/AN advocates and role models that will include Billy Mills, Olympic Gold Medal winner. The goal is to harness the power of social media to function as a catalyst for coordinating the diverse interests and concerns of AI/AN stakeholders – male and female – into a concrete plan of action for securing support for the research and pilot testing of interventions needed to realize health equity for AI/AN males and their families.

To make this vision a reality and end the continued benign neglect of AI/AN boys and men will require the effective coordination of a broad range of expertise, funding, and creativity. As Chief Seattle noted so long ago:

> ***Humankind has not woven the web of life. We are but one thread within it. Whatever we do to the web, we do to ourselves. All things are bound together. All things connect.***

If you or your organization is interested in changing how "all things connect," you can help…or someone you know can help … by contributing to this effort with money, time, or with the passion to make a difference, please contact:

Leo Nolan 240.441.3978 leojnolan3@hotmail.com
Ric Bothwell 301.943.4507 rbothwell@menshealthnetwork.net
Ana Fadich, MPH, CHES 202.543.6461 x 101 Ana@menshealthnetwork.org

---

[i]Life Expectancy of American Indians and Alaska Natives, Data Years: 2003-2005. DHHS, Indian Health Service, Released October 2010, Appendix Page A6-7.

[ii] Life Expectancy of American Indians and Alaska Natives, Data Years: 2003-2005. DHHS, Indian Health Service, Released October 2010, Appendix Page A6-7.

[iii]Indian Health Service, Office of Public Health Support, Division of Program Statistics: Unpublished Data. (2011) provided April 1, 2011.

[iv]Indian Health Service.*Trends in Indian Health 2002-2003 Edition*. Released October 2009:73, 77, 81, 85, 93, 96, 101, 125, 129, 142. http://www.ihs.gov/nonmedicalprograms/ihs_stats/files/Trends_02-03_Entire%20Book%20(508).pdf

[v]Barnes P, Adams P, Powell-Griner E. Health characteristics of the American Indian or Alaska Native adult population: United States, 2004-2008. *National Health Statistic Reports*. 2010; 20:1-22.