

**U.S. Department of Health and Human Services  
13<sup>th</sup> Annual National HHS Tribal Budget and Policy Consultation Session**

**Testimony Presented by Chairman Chester Antone, Tohono O'odham Nation  
To the National Institute of Health**

I want to thank the National Institute of Health, Tribal leaders, and those present here today who have dedicated their lives to improving the health and wellness of Indian Country. I am honored to be able to speak today on behalf of over 4 million American Indian and Alaska Native (AI/AN) people on the topic of research in Indian Country.

Indigenous societies across the world have always been researchers through systematic observation over centuries. Many of our indigenous findings served as the foundation for modern medicine and continue to provide important health care treatment for AI/AN people through our Traditional ways of healing. Historically; laws, policies, and research in the United States led AI/AN communities to suppress, to practice in secrecy, and even to guard Tribal healing methods and Indigenous medicine as they were generally outlawed until only 33 years ago.<sup>1</sup> The impact of unethical and destructive research *on and not with* AI/AN people in the United States has created mistrust and an overall lack of respect<sup>2</sup>. The fear and stigma of scientific evaluation has only been compounded by the recent disregard for personal stories, family lineage, and Tribal Sovereignty in the name of science<sup>3</sup>. Addressing the fear and stigma around research in Indian Country will be one of our greatest challenges in moving forward toward addressing the needs to combat the health disparities we are facing.

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<sup>1</sup> The American Indian Religious Freedom Act, Public Law No. 95-341, 92 Stat.469

<sup>2</sup> Davis, J.D., Erikson, J.S., Johnson, S.R., Marshall, C.A., Running Wolf, P., Santiago, R.L. (2002). Workgroup on American Indian Research and Program Evaluation Methodology: Lifespan Issues Related to American Indians/Alaska Natives with Disabilities. Flagstaff: Northern Arizona University, Institute for Human Development, Arizona University Center on Disabilities, American Indian Rehabilitation and Training Center.

<sup>3</sup> Havasupai Tribe v. Arizona Board of Regents

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Within the last 10 years there has been a conscious thought within NIH toward reducing health disparities and increasing the number of AI/AN scientists. The NARCH program provides great opportunities for Tribes to take leadership in developing equal partnerships in research and is a program that should be continued and expanded. The NIH has also been working toward increasing in ethnic minority scientist, including our AI/AN Tribal citizens. The Office of Equal Opportunity and Diversity Management at the National Institutes of Health completed a report examining data between 2008 and 2009, finding that NIH had funded over 1,200 doctoral level health scientists, 70% of whom were ethnic minorities. However, in a recent address at the Urban Indian Health Summit held in Washington DC, Dr. John Ruffin from the National Center of Minority Health and Health Disparities shed some light on how this program was supporting Indian Country<sup>4</sup>. Dr. Ruffin reported that since the NIH loan repayment program began in 2001 there have been a total of 2300 recipients. Only 70 of these were American Indian or Alaska Native. This means that in the last 10 years, NIH has supported an average of 7 Native scientists a year to meet the research needs of 565 federally recognized Tribes, more than 220 Alaska Native villages and well over 2 million AI/AN people living in cities across the US. The Center for Disease Control and Prevention just released a report highlighting the health disparities and inequities in health care within this country<sup>5</sup>. The data indicated that AI/AN people had some of the poorest outcomes within the social determinants of health; had the highest rates of death to motor vehicle accidents than any other ethnic group; have seen increased HIV infection among

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<sup>4</sup> Transcript from the proceedings of the Urban Indian Health Summit sponsored by Robert Wood Johnson Foundation with partnership between the Urban Indian Health Institute and the National Council of Urban Indian Health, January 13, 2011: Washington, DC.

<sup>5</sup> Center for Disease Control and Prevention (Jan 14, 2011). CDC Health Disparities and Inequalities Report- United States, 2011, Morbidity and Mortality Weekly Report, 60. Retrieved on February 2, 2011 from <http://www.cdc.gov/mmwr/pdf/other/su6001.pdf>

our AI/AN men; and have demonstrated the most intense binge drinking of any other ethnic group. Of all racial/ethnic groups, AI/AN had the highest rates of suicide (2 times greater than all races/ethnicities) and the highest age-specific rates with AI/AN adolescents and young adults more likely to commit. The disparity around suicide in Indian Country has now been documented in the scientific literature for over 30 years<sup>6</sup> and the overall health disparities of the AI/AN population has been documented since 1928<sup>7</sup>. Although steps are being taken to attempt to address the health disparities, there is still much work to do.

Due to the alarming health conditions that are now epidemics in Indian Country the need for local research has never been more important. The partnership between Tribal Nations and NIH is critical to increase the number of Native scientists, to expand opportunities for local research dollars, and to reduce the stigma around research in Indian Country. NIH has an opportunity to provide leadership, create a shift in conscious thinking, and embark on a true partnership with Tribal Nations to not only address the serious health conditions but to assist in the development of healthy productive AI/AN citizens of this global planet.

To accomplish this Tribal Nations and NIH must build a long-term relationship that is based on trust, mutual respect, and an equal partnership. A Tribal Consultation Policy is the foundation for this relationship. Not only does such a policy support the Government to Government relationship between the United States and the Tribal Nations within, but the policy indicates that HHS is invested in partnering with Tribal Nations for the betterment of the first citizens of this country. Since, 2009 the Tohono O’odham Nation has been recommending that

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<sup>6</sup> May, P., & Dizmang, L. (1974). Suicide and the American Indian. *Psychiatric Annals*, 4, 22–28.

<sup>7</sup> Meriam, L. (1928). *The Problem of Indian Administration: Report of a Survey made at the Request of Honorable Hubert Work, Secretary of the Interior, and Submitted to Him, February 21, 1928/ Survey Staff: Lewis Meriam...[et al.]*. Baltimore, MD: Johns Hopkins Press.

that the NIH develop a policy on how the agency will consult with Tribes on research and initiatives that will impact our communities. Today, I want reiterate our recommendation for this policy as it will be the foundation for a long-term relationship that is founded on trust, mutual respect and an equal partnership.

Second, in addition to an NIH-Tribal Consultation Policy I am again recommending the development of an American Indian and Alaska Native Advisory Board, representative of Tribal leaders and Native scientists, to guide the work of NIH. An Advisory Board could provide tremendous support to the NIH in developing research agendas and programs that match the Tribal needs, assisting in the data translation to the community, reducing stigma, and maximizing Tribal participation, including the recruitment of Native scientists.

Finally, we have a desperate need for more Native scientists conducting community-based research in partnership with Tribal communities. Native scientists are critical to develop a common language, to understand and overcome local barriers, and to translate scientific findings into strength-based community practice. To increase Native scientists, I recommend that NIH embark on a multi-prong approach to meet the immediate needs for Native scientists, as well as a long-term approach to grow future scientists in Indian Country. First, I recommend that NIH expand the loan repayment program to include the Indian health providers<sup>8</sup> as placement sites for loan repayment. This could result in an immediate support to tribal communities. Placing Native scientists in local communities conducting community-based participatory research with Tribes would not only allow Tribes to begin addressing immediate needs for research but it could also serve to reduce the stigma of research. Second, I recommend that NIH partner with the Indian Health Service to build upon already existing Health Profession Workforce Programs to train

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<sup>8</sup> Indian health providers include: Indian Health Services, Tribes, and Title V urban Indian Health Programs.

Scientist-Practitioners who can support community based research and move effective services into practice. Such a partnership would create both immediate and intermediate results as the Workforce programs range along the continuum of educational development. Finally, I recommend that NIH partner with the Bureau of Indian Education to develop community-based interactive science training programs to promote youth engagement in local research projects. This strategy would serve to grow a workforce of future Native scientists.

One hundred years ago, the majority of the world depended upon local evaluation for survival. Today, science has moved out of the communities and become centralized in colleges, universities, and research centers. It is critical that AI/AN communities reconnect to science if we are to address the health disparities we are currently facing. The NIH has supported the use of Community-Based-Participatory Research (CBPR) and we are asking for this to be implemented in its truest form. Being community-based is the most necessary criteria for implementing CBPR and should serve as the basis for our work.

I want to thank NIH for their partnership with IHS to support community-based research opportunities in AI/AN communities and want to encourage continued NIH efforts toward reducing health disparities in Indian Country. Developing a strong Tribal consultation policy, creating mechanisms for guidance from AI/AN communities, and implementing strategies to increase our culturally competent scientist workforce will be critical toward our joint efforts to eliminate the burden of disease that we are currently facing. I want to thank NIH, the tribal leaders present, and the communities that spend countless hours supporting healthy communities for the opportunity to present this testimony today.

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