



Initiating Indigenous Cancer Health Equity

Office of Community Outreach & Engagement
2023



CANCER CONSORTIUM
FRED HUTCH • UNIVERSITY OF WASHINGTON • SEATTLE CHILDREN'S

"The said tribes and bands of Indians hereby cede, relinquish, and convey to the United States, all their interest in and to the lands and country occupied by them... the United States... agree to employ a physician... who shall furnish medicine and advice to their sick, and shall vaccinate them; the expenses of the said... medical attendance, to be defrayed by the United States..." (GOIA, n.d.)

Treaty of Medicine Creek, 1854	Treaty of Point No Point, 1855
Treaty of Neah Bay, 1855	Treaty of Point Elliott, 1855
Treaty with the Yakama, 1855	Treaty with Walla Walla, 1855
Quinault Treaty, 1856	

Executive Summary

"If we are ever going to get to health equity, we have to walk through truth. Even when it is unpleasant and even when it makes us uncomfortable."

- Donald Warne, MD MPH (Oglala Lakota)

American Indian and Alaska Native (AI/AN)* populations continue to have a high burden of cancer incidence and mortality in the United States (US) compared to other populations. By identifying and underscoring these inequities among AI/AN populations within Washington state (WA), it is imperative that the Fred Hutch/University of Washington/Seattle Children's Cancer Consortium (Cancer Consortium), the only NCI-designated comprehensive cancer center in WA, continues to improve its existing approaches to support AI/AN populations in addressing cancer inequities.

On May 19, 2022, the Cancer Consortium's Office of Community Outreach and Engagement (OCOGE) held its annual Pathways to Equity Symposium (Symposium) and gathered Indigenous clinicians, researchers, and public health leaders to share space and knowledge about unique approaches and opportunities to address cancer health inequities among Indigenous populations through systems level change. Within his keynote address, Dr. Donald Warne (Oglala Lakota), Co-Director of the Johns Hopkins Center for Indigenous Health, described how primary prevention strategies among Indigenous populations can and must be informed by the historical knowledge of Indigenous health policy derived from the inherent right to health care through US treaty and policy obligations. Drs. Bonnie Duran (Opelousas/Coushatta Descendant), University of Washington, Allison Kelliher (Koyukon Athabaskan), University of North Dakota, and Rosalina James (Lummi), Urban Indian Health Institute, focused their panel discussion on ways to conduct science while respecting Tribal Sovereignty. They highlighted the

need for collaborative approaches between the Cancer Consortium, Indigenous organizations, and Indigenous communities to inform research practices being designed to address health disparities.

Following the Symposium, on May 20, 2022, Cancer Consortium researchers and staff, community partners, leaders, and students gathered for a special session to exchange ideas and strategies for initiating efforts toward Indigenous cancer health equity across the Cancer Consortium. The following priority areas were established:

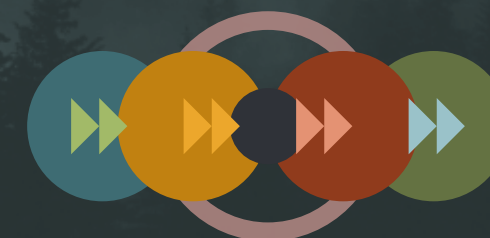
- **Build research capacity** among Cancer Consortium faculty, scientists, clinicians and staff to cultivate Tribal, Academic, and Research partnerships with tribes, the Indian Health Service (IHS) System, and Urban Indian Organizations (UIOs).
- Increase advocacy for Indigenous cancer health equity **to improve systems level coordination of care.**
- **Implement an annual tribal cancer health summit** for WA tribes and UIOs.
- **Initiate workforce development** efforts with Indigenous students and community members .

The Indigenous Cancer Health Equity Initiative (ICHE-i) was created and embedded within the OCOGE to act on these priority areas in November of 2022. Encompassing Tribal Sovereignty, the ICHE-i integrated relationality, sustainability, and holistic Indigenous values to inform its approaches to engaging Indigenous communities in bidirectional relationships and collaborations for cancer patient advocacy and research.

* Throughout this document we use the terms "Indigenous," "American Indian and Alaska Native," or "AI/AN," synonymously, to refer to the enrolled members of the 574 federally-recognized tribes within the US, which includes the 29 federally-recognized tribes in WA.

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▶▶ How Stinging Nettle Saved the People

"Stories remind us of who we are and of our belonging. Stories hold within them knowledge while simultaneously signifying relationships. They are active agents within a relational world, pivotal in gaining insight into a phenomenon. Oral stories are born of connections within the world, and are thus recounted relationally. They tie us with our past and provide a basis for continuity within future generations" (Kovach, 2009).

"How Stinging Nettle Saved the People" was shared by Roger Fernandes (Lower Elwha S'Klallam) to open the Pathways to Equity Symposium on May 19, 2022. We share this gift because of its context and significance in creating space to share knowledge.



A long time ago, the People of the Puget Sound were frightened. They were afraid of the Northern Men with the big canoes who came to attack, steal, burn villages, kill people, and take people back to the North to be slaves. The People never knew when the Northern Men would come. There was a young woman among one of the villages of the People and saw that they were afraid. "This is not right—my people should not be afraid," she said. That night she prayed to the ancestors and the spirits for guidance to help her people. While she was asleep, the Stinging

Nettle plant came to her in her dreams and said to the woman, "I want you to tell your people to gather my leaves in the Spring time when my leaves are growing. Gather my leaves, dry them, and make them into a tea. I want all the People to drink this tea together, and as they drink the tea, I want them to say these words: "We will be strong for our Ancestors. We will be strong for the People. We will be strong for the ones to come." The Woman woke up and she told the People about the dream, and the People followed the dream. They gathered the nettle plant leaves, dried them, made the tea, and drank the tea while they said together, "We will be strong for our Ancestors. We will be strong for the People. We will be strong for the ones to come." And the People felt a little stronger.

The Young Woman had another dream and Stinging Nettle came to her and said, "I want you to tell your strongest men and women warriors to take my whole body – my stalk, branches, and leaves- and to whip themselves with me. When they feel the pain and the power entering their body, I want them to say, 'We will be strong for our Ancestors. We will be strong for the People. We will be strong for the ones to come.'" The Woman woke up and told the warriors about the dream, and the warriors followed the dream- they took the nettle plant, whipped themselves with it, and they felt the power enter their bodies while they repeated, "We will be strong for the People. We will be strong for the ones to come." And the people felt a little stronger.

One day, word came to the People that the Northern Men with the big canoes were coming again into the Puget Sound. They were coming to attack, steal, burn the villages, and kill the people. Instead of running and hiding, as they did so many times before, the men, women, children, and the elders walked down to the beach and gathered in one long line. As the Northern Men were getting closer to the beach, the People began to chant in one loud voice, "We will be strong for our Ancestors. We will be strong for the People. We will be strong for the ones to come." They shouted these words over and over again, and their voices carried over the waters. The Northern Men heard the People shouting in one loud voice, and they realized that the People were not afraid and that they could not be defeated. The Northern People turned their canoes around and returned back to the North, leaving the villages safe and the People unharmed.

Story by:



Roger Fernandes, MA
Lower Elwha S'Klallam

Mr. Fernandes is a Native American storyteller, artist, and educator whose work centers on the Coast Salish tribes of western Washington. He is an enrolled member of the Lower Elwha S'Klallam Tribe, and has B.A. in Native American Studies and Masters degree in Whole Systems Design. He uses story, art, and education to share old systems of teaching and learning.





Pathways to Equity Symposium 2022 | Main Takeaways

Donald Warne, MD, MPH
Oglala Lakota
Co-Director, Center for Indigenous Health
Johns Hopkins University

Allison Kelliher, MD
Koyukon Athabascan
Director, American Indian Collaborative Research Network
University of North Dakota

Rosalina James, PhD
Lummi/Duwamish
Director, Evaluation & Research
Urban Indian Health Institute

Bonnie Duran, DrPH
Opelousas/Coushatta Descendant
Director, IWRI Center for Indigenous Health Research
University of Washington

Background

The Office of Community Outreach and Engagement (OCO) established the Pathways to Equity Symposium in alignment with its vision to promote health equity by sharing innovative approaches that encourage collaboration between the Fred Hutch/University of Washington/Seattle Children's Cancer Consortium (Cancer Consortium) and community champions across Washington state (WA). In 2022, the Cancer Consortium hosted Drs. Donald Warne (Oglala Lakota), Allison Kelliher (Koyukon Athabascan), Bonnie Duran (Opelousas/Coushatta Descendant), and Rose James (Lummi) to share strategies and solutions that address cancer inequities among American Indian and Alaska Native (Indigenous) communities. The following are main takeaways from this inspiring event.

History Informs Approaches to Health Equity

In his keynote address, Dr. Warne encouraged attendees to rethink how we view public health to approach health inequities by "walking upstream and seeing the root of the problem." In other words, focus our collective efforts on primary prevention strategies. Traditional public health illustrates primary prevention as intervening before health effects occur through different measures such as vaccinations, altering risky behaviors, etc. Dr. Warne underscored that primary prevention strategies among Indigenous populations must be informed by historical knowledge of Indigenous health policy in the US, which includes the legal basis of Indigenous people's right to adequate health care services in exchange for the land and resources signed away under treaty and executive order. By understanding the circumstances that created Indigenous health policy, we realize the historical basis for the overwhelming health inequities faced by Indigenous populations. Acknowledging the history of Indigenous populations supports the validation of adverse experiences across multiple generations. It is imperative that this history informs systemic interventions aimed to achieve health equity.

"A lot of our history is difficult and challenging to think and talk about. We need to understand the truth of history, even when it makes us uncomfortable. We will never get to equity unless we walk through truth"

- Donald Warne, MD, MPH

Methods to Improve Collaboration & Partnership

The "Tools to Engage Indigenous Populations for Systems Change" session focused on methods to support collaborative approaches between the Cancer Consortium and Indigenous communities in order to address health disparities and inform research practices. Drs. Duran and James illustrated ways in which Tribal Sovereignty and decolonization methods inform bidirectional approaches to public health interventions



and systems change. Recognizing rigorous efforts by tribal leaders to strengthen Tribal Sovereignty, tribal-autonomy, and self-determination provides opportunity for researchers and community to evaluate their bidirectional relationship and partnership. Recognizing and understanding the Tribal Sovereignty framework enables the Cancer Consortium to analyze its institutional policies and procedures and how they can align with tribal and urban Indian health systems that are subject to federal and tribal laws and policies.

Improving Tribal Sovereignty competency among the Cancer Consortium's faculty, clinicians, and staff ensures data collection and ownership, along with dissemination of research findings is in accordance with tribal nations' and Urban Indian Organizations' (UIOs) laws, policies, and processes.

Dr. James emphasized that tribes and UIOs are "stewards of their own data, including the processes that surround the application of research and data to implement culturally grounded and rigorous interventions – health equity will only be achievable when tribes or Urban Indian Organizations are involved in every step of those processes; we are asking the questions that matter to our communities." Ensuring alignment with these processes provide further opportunities to engage in decolonization strategies that evaluate the Cancer Consortium's and the National Institutes of Health's commitment to addressing chronic issues of misrepresentation of Indigenous people in national, regional, and local datasets that lead to Indigenous populations being undercounted, often resulting in a decreased number of resources distributed to Indigenous communities through state and federal policies.

"Health equity will only be achievable when Tribes or Urban Indian organizations are involved in every step of those processes; we are asking the questions that matter to our communities."

- Rose James, PhD

Exploring upstream solutions to support AI/AN populations' efforts toward increasing AI/AN representation in leadership positions and workforce development within the Cancer Consortium requires unique approaches. Dr. Kelliher suggested instituting intergenerational and holistic approaches that involve students, families, and elders of the community to develop pathway programs further upstream at stages as early as middle school. In academia, "research that engages and addresses the needs of AI/AN populations needs Native researchers, however, not being able to identify 'qualifying' Native people is an ongoing barrier."

Dr. James suggested that addressing underrepresentation of AI/AN populations in academic and research leadership roles does not have to look like Western practices of workforce development, rather it can follow examples of success, "Urban Indian Health Institute hires Native people, develops their skills, and provides necessary training in ways that do not always follow Western ways of knowing."



Initial Recommendations for Indigenous Cancer Health Equity

Background Symposium Special Session

Several key takeaways and themes emerged from presentations and discussions led by Drs. Rose James, Bonnie Duran, Allison Kelliher, and Donald Warne about how the Cancer Consortium can lead efforts to support Indigenous cancer health equity. Tribal and data sovereignty were common themes throughout the Symposium; they encouraged the Cancer Consortium to acknowledge and be informed about Tribal Sovereignty in their academic, research, and clinical programming. By doing so, tribes are provided an opportunity to assert their sovereignty and practice their self-determination as tribal governing bodies when engaging with the Cancer Consortium.

To continue the conversation on these important topics, Cancer Consortium researchers and staff, community partners, leaders, and students gathered for a special session. Discussion centered on how to initiate efforts to work toward Indigenous cancer health equity across the Cancer Consortium in partnership with communities.



- Tribal Sovereignty means that tribes have the inherent authority to govern themselves and therefore the ability to determine their own research agendas.
- Develop Tribal-Academic-Research partnership with the Indian Health Service (IHS), tribes, UIOs, and communities.
- Increase strength-based approaches to cancer prevention and control interventions. Current practices tend to look at deficits and assume Indigenous communities need help or fixing.
- Research efforts need to be bidirectional and based on the perspectives of tribes; current models primarily focus on the perspectives of researchers.
- Institutional Review Board and research processes need to recognize Tribal Sovereignty in the data ownership and decision-making provisions/plans.

A number of recommendations were made to begin addressing these topics. They were categorized into four priority areas for the Indigenous Cancer Health Equity Initiative:

1 Build research capacity among Cancer Consortium faculty, scientists, clinicians and staff to cultivate Tribal, Academic, and Research partnerships with tribes, the IHS system, and UIOs.

Recommendation	Guiding Question
Recommit and increase training on Tribal Sovereignty among the Cancer Consortium.	How does Tribal Sovereignty enhance cancer care research across the Cancer Consortium?
Collaborate with tribes in WA to develop tribal research agendas.	What are the benefits to tribes when their research agendas are prioritized?
Outline & standardize IRB data ownership processes to include tribal- or co-ownership of research data.	Are tribes identified and included in the decision-making process regarding data ownership in research?
Develop research ethics training for researchers and staff working with Indigenous populations.	Does current research ethics training curriculum include tribal topics such as Tribal Sovereignty?

2 Increase advocacy for Indigenous cancer health equity to improve systems level coordination of care.

Recommendation	Guiding Question
Define "Indigenous Cancer Health Equity."	Who defines "Indigenous Cancer Health Equity?" Does a current definition exist?
Outline processes to accessing cancer & supportive care at the Cancer Consortium (adult & pediatric oncology).	Are these processes accessible to IHS, tribal, or urban Indian (I/T/U) health clinics and programs within WA?
Increase advocacy for better access to cancer prevention and screening at the Cancer Consortium.	What gaps exist in accessing better cancer prevention and screening services for I/T/U health clinics?
Develop Indigenous patient resources for accessing care within the Cancer Consortium.	What current resources exist for patients at I/T/U clinics in accessing care within Cancer Consortium?

3 Implement an annual tribal cancer health summit for WA tribes and UIOs to discuss cancer priorities and collaborative actions to address cancer inequities among Indigenous populations.

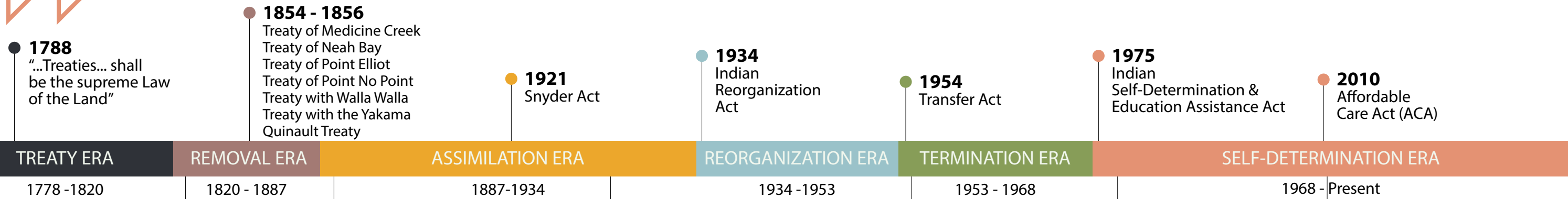
4 Initiate workforce development efforts to increase representation of Indigenous students and community members.

Framework to Implement Recommendations:





An Overview of Health Policy Impacting AI/AN in the US



1788
“...Treaties... shall be the supreme Law of the Land”

1832
Worcester v. Georgia
Federal Government assumes Trust Responsibility of tribes

1854 - 1856
Treaty of Medicine Creek
Treaty of Neah Bay
Treaty of Point Elliot
Treaty of Point No Point
Treaty with Walla Walla
Treaty with the Yakama
Quinault Treaty

1921
Snyder Act

1934
Indian Reorganization Act

1954
Transfer Act

1975
Indian Self-Determination & Education Assistance Act

2010
Affordable Care Act (ACA)

Background
To understand the context of cancer and its prevalence in AI/AN populations, it is vital to acknowledge how the overwhelming health issues among AI/AN populations are fabricated by genocide and US federal policies. The interaction of these colonial systems with Indigenous peoples have constructed the foundation for the AI/AN healthcare systems and barriers experienced today.

Inherent Right to Health Care
As members of federally-recognized tribes, AI/AN are born with the inherent legal right to health care services within the US. Through treaties, the US Government agreed to provide social services (housing, education, health care, fishing, and hunting rights, etc.) to tribes for the exchange of land and natural resources (Warne & Frizzell, 2014). The US Constitution defines treaties as “binding agreements between nations and becoming international law” (U.S. Const. art II, § 2) and establishes treaties as “the supreme Law of the Land” (U.S. Const. art VI). These binding agreements, or treaties, between tribes and the federal government, establish a trust responsibility or legal obligation, on behalf of the federal government, to uphold its

promises by defending tribal treaty rights, lands, assets, and resources, including providing adequate health care to tribes. Tribes suffered detrimental losses to traditional food supplies, experienced famine, faced US military pressure, and exposure to widespread diseases. To sustain their communities, tribes were forced to sign treaties. Between 1778 and 1868, at least 367 treaties with tribes were ratified, most of which guaranteed the provision of adequate funding and delivery of health care services (Warne & Frizzell, 2014). Seven of those 367 treaties included agreements between the US government and Washington state tribes, promising adequate health care in exchange for their land and its natural resources:

“The said tribes and bands of Indians hereby cede, relinquish, and convey to the United States, all their interest in and to the lands and country occupied by them... the United States... agree to employ a physician... who shall furnish medicine and advice to their sick, and shall vaccinate them; the expenses of the said... medical attendance, to be defrayed by the United States...”

- Treaty of Medicine Creek, 1854

- Treaty of Neah Bay, 1855
- Treaty of Point Elliott, 1855
- Treaty of Point No Point, 1855
- Treaty with Walla Walla, 1855
- Treaty with the Yakama, 1855
- Quinault Treaty, 1856

Beginning in the late nineteenth century, the US government began shifting its policy agenda with AI/AN populations from war and treaty development to assimilation approaches (Kruse et al., 2022). Through its brutal assimilation policies, the US government removed thousands of AI/AN children from their families, communities, and homelands and placed them in federally run boarding schools (also referred as residential schools). After a law passed by Congress in 1891 mandating school attendance for AI/AN children, parents and guardians who objected to sending their children to school were denied rations, annuities, and other dependent services (Warne & Lajimodiere, 2015). In addition, due to the severe economic conditions brought on by the Great Depression, the 1930s were a time when most boarding schools

“Bad policy kills people and cancer is a really amazing framework to understand that.”
- Donald Warne, MD

had their largest enrollments of AI/AN children (Warne and Lajimodiere, 2015). Included in these policies, the Courts of Indian Offenses established statutes prohibiting AI/AN from practicing traditional ceremonies, and if ignored, detained traditional healers indefinitely (Shelton, 2004).

Stricken with assimilation policies, AI/AN people faced increased disparities in infectious disease mortality and malnutrition throughout the Assimilation Era (1887-1934). The US government moved slowly to establish policies in response to the growing health disparities and increasing infectious disease-related mortality rates. In 1921, the US government passed the Snyder Act, which authorized Congress to establish a health division within the Bureau of Indian Affairs (BIA), providing the first formal authority for federal provision of health care services to AI/AN. Despite the Snyder Act of 1921, studies from the US government, such as the Meriam Report in 1928, continued to describe substantial morbidity and mortality and insufficient health services to adequately address the horrific

health conditions of AI/AN populations. The US government began to shift its policies to include Tribal Sovereignty as a viable way to address the varied health needs unique to hundreds of tribes (Kruse, 2022). Tribal Sovereignty, self-determination, and economic independence were underscored within the Indian Reorganization Act of 1934, which established, for the first time, a federal trust responsibility of the US government to invest at the community level of tribes to support their sovereignty, unique political status, and diversity of cultures, languages, and geographic regions (Kruse et al., 2022). In 1954, the US government passed the Transfer Act, which conveyed the provisional responsibility of AI/AN health from the BIA to the US Public Health Service (USPHS), leading to the establishment of the Indian Health Service (IHS) in 1955.

Following the transfer of IHS from the BIA to USPHS, the US government continued to pass federal policies that impacted how health care was delivered to AI/AN populations. Such policies include the Indian Self-Determination and Education Assistance Act of 1975 and the Indian Health Improvement Act of 1976, which,

combined, increased annual funding of IHS; however, despite these increases, the chronic underfunding of IHS still exists today compared to other federal programs (Kruse et al., 2022). The US government's funding mechanism for IHS does not uphold its treaty obligations, and in essence, actively becomes in violation of its contract with tribes:

“Federal trust obligations to fund healthcare and public health in Indian Country cannot, and must not, be achieved through the competitive grant mechanism. By their very design, competitive grants create an inequitable system of winners and losers. The federal obligation to fully fund health services in Indian Country was never meant to be contingent upon a Tribe’s ability to produce a grant application – yet that is the construct under which the federal government has forced Tribes to operate. That is unacceptable and goes against the principle of a government-to-government relationship.”

- The National Budget Formulation Workgroup's Recommendations on the Indian Health Service Fiscal Year 2024 Budget



Indian Health Service Overview

“We need to have good coordination across multiple systems to have effective care. The Cancer Consortium and the OCOE can make that happen by coordinating policy to streamline services because it should not be up to the patient to navigate this.” - Donald Warne, MD, MPH

Background

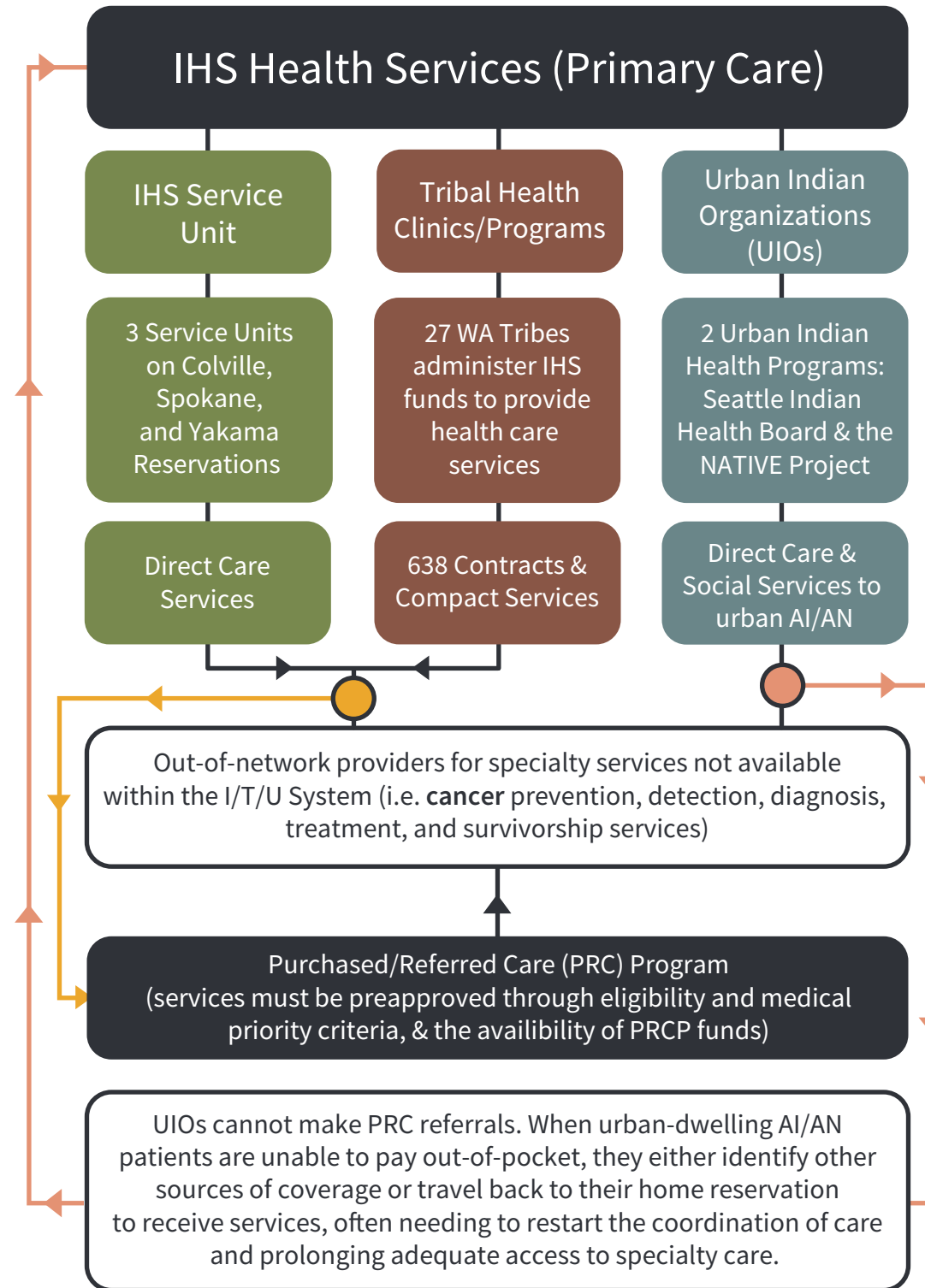
IHS is a federal program that provides direct health care services to AI/AN populations and mostly operates as a rural outpatient system focused on primary care with five types of facilities: hospitals, health centers, health stations, Alaska village clinics, and youth regional treatment centers (CRS, 2016). This health care delivery system is often referred to as the I/T/U system in which “I” represents IHS, “T” represents Tribal 638 programs, and “U” represents urban health centers (Warne & Frizzell, 2018).

Organization

Federal reservations across the US, American Indian communities, as well as Inuit, Yupik, and Aleut communities in Alaska, are all served by the IHS health care delivery system. Twelve area offices, which are further divided into services units, make up the organizational structure of the system. Service units can serve one or more tribes and can have one or more facilities (CRS, 2016). IHS-funded health care is provided in facilities through the twelve area offices and 170 service units. Service units and specific health facilities are operated and managed by either IHS Service Units, or by Tribal Health Clinics/Programs through self-determination contracts (Title I) and self-governance compacts (Title V), as defined within the Indian Self Determination and Education Act of 1976 (ISDEAA). Through Title I, or “638 contract,” tribes or tribal organizations contract with IHS to plan, conduct, and administer one or more individual programs, functions, services, or activities, that IHS would otherwise provide. Through Title V, tribes or tribal organizations compact with IHS to assume full control of programs, functions, services, or activities, that are provided by IHS. With just 1% of its budget, IHS also funds approximately 41 urban Indian organizations (UIOs) in an effort to provide health care services for urban-dwelling AI/AN, representing 70% of AI/AN throughout the US (Khetpal et al., 2022).

Purchased/Referred Care

IHS health services are provided directly by IHS-funded facilities (IHS or tribal facility) when possible, and if services are not available, AI/AN patients are referred to private, or out-of-network, providers for care through the Purchased/Referred Care (PRC) program (CRS, 2016). Through the PRC program, IHS purchases care services by contracting with out-of-network providers, however, these funds are limited due to insufficient budget allocation within the IHS annual appropriation by Congress (Khetpal et al., 2022; CRS, 2016). The chronic underfunding of the PRC program within the IHS budget and eligibility criteria constructs limitations that force IHS-funded facilities to withhold key health care services, except in circumstances in which health services prevent the immediate death of the AI/AN patient (CRS, 2016). For AI/AN patients to receive services that are not otherwise available by IHS or their tribal facility, they must be preapproved to receive those services through the PRC program funding.



Why is this information important for the Cancer Consortium?

Incidence and mortality rates for most cancer types currently reported indicate that AI/AN populations have the highest burden of cancer as compared to non-Hispanic White populations, both nationally and in WA. By identifying and underscoring these disparities among AI/AN populations within WA, it is imperative that the Cancer Consortium continue to improve its existing approaches to support AI/AN populations in addressing cancer inequities.

To advance its mission of “uniting innovative research and compassionate care to prevent and eliminate cancer and related diseases,” the Cancer Consortium has three strategic priorities:

- Lead in scientific discovery and research innovation
- Advance cutting-edge clinical research and care through collaboration with patients and communities
- Strengthen our foundation of inclusive excellence

Such strategic priority areas include initiatives to advance and improve health equity through authentic engagement and innovative research among populations within its catchment area of WA. AI/AN populations are included within this catchment area, and should be distinctly considered by the Cancer Consortium due to their unique and complex relationship with the US government and health care delivery system, and the critical cancer health disparities and inequities members of these communities face.

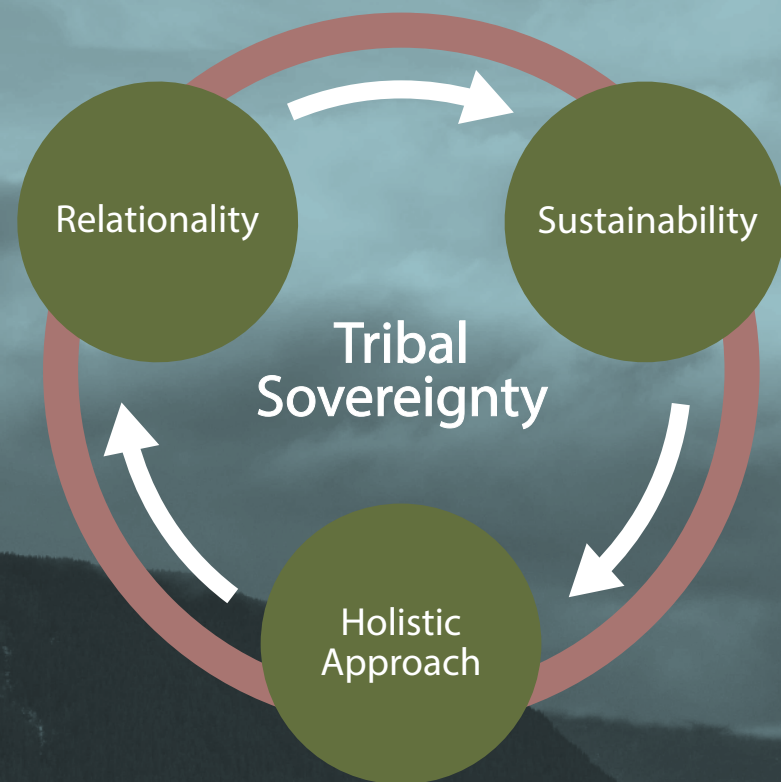
The Cancer Consortium's catchment area includes the land recognized within the following treaties:

- Treaty of Medicine Creek, 1854
- Treaty with Walla Walla, 1855
- Treaty of Neah Bay, 1855
- Treaty with the Yakama, 1855
- Treaty of Point Elliott, 1855
- Quinault Treaty, 1856
- Treaty of Point No Point, 1855

The Cancer Consortium's approaches to advancing and promoting health equity calls for culturally-centered methods to adequately address the burden of cancer among the Indigenous people living on this land. In order to so do, the Cancer Consortium must ask itself the following question to invigorate its relationship and partnership with AI/AN communities:

What is the Cancer Consortium's role to advance and improve Indigenous cancer health equity?

Indigenous Cancer Health Equity Initiative: *Core Values*



Supporting Tribal Sovereignty through *Relationality, Sustainability, & Holistic Values*

ICHE-i integrates Indigenous relationality, sustainability, and holistic approaches as core values to engage and support the Cancer Consortium's capacity to cultivate Tribal-Academic-Research partnerships, center Tribal Sovereignty, and increase Indigenous patient advocacy for cancer health equity among tribes and UIOs in WA.

Relationality is a foundational and valued component for engaging and collaborating with Indigenous communities - it calls into consideration the shared benefit and accountability of cultivating relationships between the Cancer Consortium and the community to address existing cancer health inequities. In part, relationality is building and strengthening relationships between communities to embody the sustainability of culture, knowledge, language, ideas, and land. While there are several components of relationality, the approaches to building and strengthening relationships need to be contextualized within the perspective of Indigenous communities. Too often are research agendas curated by the researcher and not driven in true partnership with Indigenous communities. Practicing relationality addresses these imbalances by increasing trust and leveling the decision-making power between the community and the Cancer Consortium.

Indigenous communities are not monolithic or static. Understanding an Indigenous community's political, social, economical, and environmental context is critical in conducting research and implementing public health interventions and programming. Integrating this **holistic approach** also includes understanding and acknowledgement of how tribal and UIO health systems operate (varies by tribe and UIO) to inform research and programming to be more effective, relevant, and actionable for Indigenous communities.

Conducting research and implementing public health interventions and programming with Indigenous communities requires sustainable practices that lead to sustainable outcomes. **Sustainability** is an essential component of Indigenous knowledge due to its consideration of preserving knowledge and practices for future generations.

Centering **Tribal Sovereignty** in this work supports the mission and vision of tribes and UIOs in their endeavors toward self-determination and self-governance. There are 29 federally recognized tribes in WA, and each may have their own definition of Tribal Sovereignty. Therefore, it is critical for the Cancer Consortium to understand the local context and definition of each tribal community they engage with. ICHE-i believes that by upholding relationality, sustainability, and holistic approaches as core values, Tribal Sovereignty becomes an integral component to achieving Indigenous cancer health equity.

Indigenous Cancer Health Equity Initiative: *Staff*



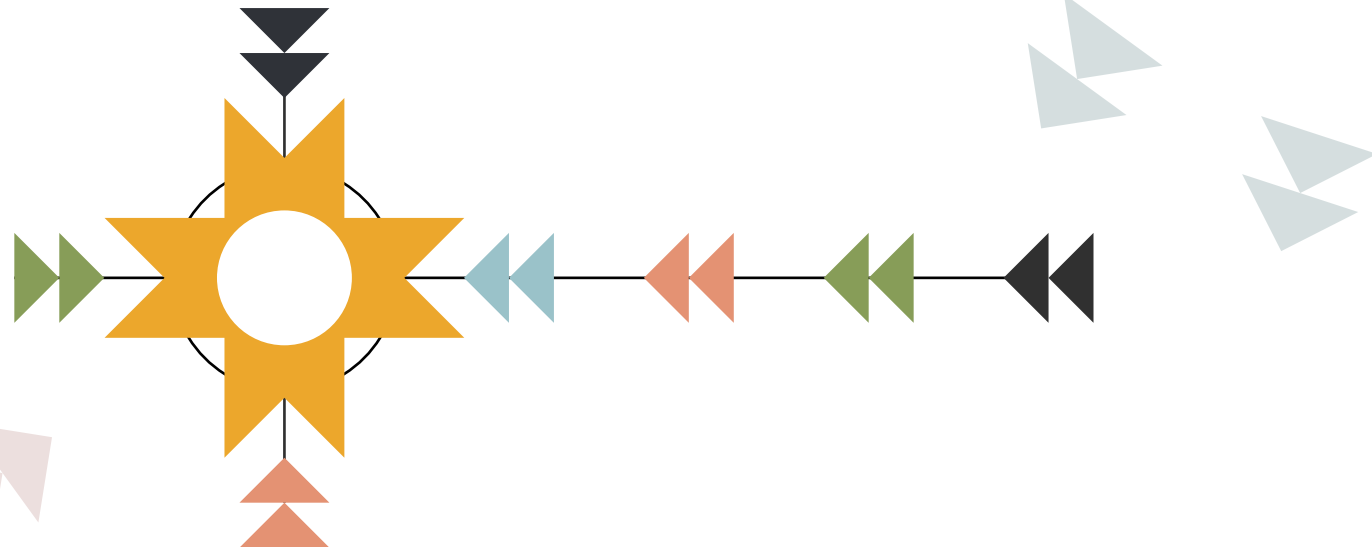
Snowy Johnson, MPH
Apsáalooke, Kainai, & Bitterroot Salish
Community Health Educator



Myra Parker, PhD, JD, MPH
Mandan & Hidatsa
Program Lead



Craig Dee, MPH(c)
Diné
Project Manager



Collaborating Across the Fred Hutchinson Cancer Center (Fred Hutch)

The Indigenous Cancer Health Equity Initiative (ICHE-i) recognizes the need for cross collaboration and strives to engage with other Indigenous programs, initiatives, and researchers at Fred Hutch to align resources toward cancer health equity among tribal and urban Indian communities. Grounded in the core value of relationality, ICHE-i recognizes that by understanding, acknowledging, and collaborating with one another's strengths, we exemplify authentic community engagement within the Cancer Consortium. The following Fred Hutch programs and initiatives are led by Indigenous colleagues for Indigenous community:

həli?il Program

Lung Cancer Screening & Tobacco Cessation

The word, həli?il, means "to become well/heal" and that name was gifted to the Fred Hutchinson Cancer Center's program from a local WA Tribe. The name derives from the Coast Salish territories and comes from the Lushootseed language. Established in 2019, the həli?il Program aims to identify barriers to lung cancer screening in Indigenous communities and to partner with tribal and community leaders to:

- Promote non-ceremonial tobacco cessation among tribes and tribal organizations
- Identify barriers to lung cancer screening among Indigenous populations
- Reaching out to tribal nations and Indigenous communities to promote lung cancer screening



Ursula Tsosie, MS
Diné
Program Manager & Tribal Liaison
həli?il Program

Patient Navigation for Indigenous Populations

Supportive Care Services

The Indigenous patient navigator supports Indigenous patients from arrival at a Fred Hutch clinic through the course of their cancer treatment, all with the goal "to become well/heal". The Indigenous patient navigator guides patients, their families and caregivers through the medical system, and helps them apply for assistance with finances, transportation, housing, and insurance. Services provided include:

- Practical assistance such as transportation, lodging, and social services
- Cultural bridging to help patients communicate with their providers
- Help finding support groups, classes, and other programs
- Resources to work through financial, job-related, and insurance concerns
- Guidance navigating the health care system, and much more



Lenora Starr
Warm Springs
Patient Navigator for Indigenous Patients
Patient Navigation Program

Indigenous Initiatives Program

Diversity, Equity, & Inclusion Core

The Indigenous Initiatives Program within the DEI Core plays a critical role in helping to connect Indigenous knowledge to cancer research and care, nurture decolonizing cultures at Fred Hutch, and engage Indigenous methods in research, education, and care. The broad goals of the program prioritize deepening our connections within Indigenous ecosystems for the Fred Hutch's development of scientific researchers, care providers, students, and patients to advance anti-racist and broader anti-oppressive goals. The Indigenous Initiatives Program works collaboratively in interpreting policy, developing best and promising practices, representing the DEI-Core, and interacting with Fred Hutch staff and outside organizations in the approach to building Indigenous knowledge around research and health.



Joshua Marceau, PhD
Bitterroot Salish
Program Manager, Indigenous Initiatives
Diversity, Equity, & Inclusion Core

Pathways to Equity Symposium Special Session Attendees

May 20, 2022



Back row: Dr. Ulrike "Riki" Peters, Dr. Kris Blair, Dr. Derek Jennings (Quapaw/Sac & Fox), Dr. Wendy Barrington, Dr. Joshua Marceau (Bitterroot Salish/Flathead), Craig Dee (Diné), Dr. Donald Warne (Oglala Lakota), Tia Yazzie (Diné), Kauthar Salum, Karma Kreizenbeck, Dr. Myra Parker (Mandan/Hidatsa), & Dr. Paul Buckley.

Front row: Dr. Hilary Godwin, Dr. Michelle Johnson-Jennings (Choctaw), Hallie Pritchett, Dr. Rachel Ceballos, Kathy Briant, Shauntel Thomas (Diné), Dr. Allison Kelliher (Koyukon Athabaskan), & Angelina Janeway.

Not pictured: Dr. Dornell Pete (Diné), Brandi Reano (Diné), Dr. Jason "Jay" Mendoza, Elizabeth Carosso, Marilyn Drennan, Rebecca Bryant, Judy Nelson, Ursula Tsosie (Diné), Twila Gleason (Diné), Dr. Vida Henderson, & Dr. Karina Walters (Choctaw).

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Donald Warne, MD, MPH
Oglala Lakota
Johns Hopkins University

Allison Kelliher, MD
Koyukon Athabascan
University of North Dakota

Rosalina James, PhD
Lummi Nation
Urban Indian Health Institute

Bonnie Duran, DrPH
Opelousas/Coushatta Descendant
University of Washington

Roger Fernandes, MA
Lower Elwha S'Klallam

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Ahéhee' and ahó (thank you) to the Office of Community Outreach & Engagement (OCOE) leadership for inspiring the ICHE-i team to dream big, and for their unrelenting guidance, leadership, and advocacy toward Indigenous cancer health equity.

Myra Parker, PhD, JD, MPH
Mandan & Hidatsa
University of Washington

Kathy Briant, MPH
Assistant Director
Office of COE

Jason Mendoza, MD, MPH
Director
Office of COE

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"The said tribes and bands of Indians hereby cede, relinquish, and convey to the United States, all their interest in and to the lands and country occupied by them... the United States... agree to employ a physician... who shall furnish medicine and advice to their sick, and shall vaccinate them; the expenses of the said... medical attendance, to be defrayed by the United States..."

Treaty of Medicine Creek, 1854 Treaty with Walla Walla, 1855
Treaty of Neah Bay, 1855 Treaty of Point No Point, 1855
Treaty with the Yakama, 1855 Treaty of Point Elliott, 1855
Quinault Treaty, 1856

Craig Dee, MPH(c)
Diné
Project Manager

Selisha "Snowy" Johnson, MPH
Apsáalooke, Kainai, & Bitterroot Salish
Community Health Educator

Myra Parker, PhD, JD, MPH
Mandan & Hidatsa
Program Lead

Indigenous Cancer Health Equity Initiative
Office of Community Outreach & Engagement



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