

Summer 2016

# Rural, Cultural & Global Health: As Seen Through the Eyes of Doctoral Students at the University of New Mexico

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## Recommended Citation

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**Rural, Cultural & Global Health:  
As Seen Through the Eyes of Doctoral Students at the University of New Mexico**

**N611 – Rural & Cultural Health – Summer, 2016**



**Rural, Cultural & Global Health:  
As Seen Through the Eyes of  
Doctoral Students at the University of  
New Mexico**

**N611--Rural & Cultural Health--Summer 2016**

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## Introduction

When our early UNM College of Nursing PhD students wrote Volumes 1-3 of this compilation a decade ago, our program was new and growing, and most of the students lived here in New Mexico or in neighboring states. Much has changed since the initial volumes emerged from our course entitled Rural and Cultural Health (Nursing 611), a graduate elective. The world has embraced enormous linkages through technology. Refugee and migration patterns the world over have more people displaced and seeking a permanent home than ever before. International, national, regional and local contexts, conflicts, politics, health-related policies, economic struggles, racial/ethnic diversity, other kinds of human diversity, and all dimensions of health care have undergone tremendous change and continue to do so at a rapid pace. Students from our own and other universities now take this course online and contribute their insights and experience. Nursing 611 has evolved into an 8-week summer elective offered in even-numbered years, focused on three components of health care: global health, cultural health, and rural health. The students, who represent diversity in heritage, geographic location, and clinical/research interests, were asked to produce 3 briefs, or short papers (each 3-4 pages long), on the three components (global, cultural, and rural health). They were encouraged to write in an engaging style, even resembling the tone of a Ted Talk, to interest readers. This collection represents their focused writing in the three areas. Students were asked to prepare the briefs using the following major headings: *topic; background, relevant evidence; link to international/national health-related goals; proposed action or approach to topic resolution; and summary, with a minimum of 10 references per brief.*

To provide readers of our collection a context, the abbreviated content outline used in N 611 this summer was as follows:

### **Unit 1: Foundations for Rural and Cultural Health [6/6-6/13/16]**

*Introduction*, overview of course, assignments, syllabus, grading

*Philosophical foundations*: biosocial approach to global health, public health, critical social theory, complexity theory, multiple ways of knowing/working

*Perspectives*: general, national, regional, global for each of the following content areas:

Demographic trends, migration patterns

Dilemmas: competing agendas, theories, politics

Addressing the WHO Sustainable Development Goals [SDG's] for health worldwide:

<http://www.un.org/sustainabledevelopment/sustainable-development-goals/>

### **Unit 2: Analysis of Culture [6/14-6/22/16]**

What is culture, how is it expressed, how does it work?

The role of language, literacy and voice

Cultural humility, congruence, and literacy

Respecting diversity and multicultural communities

Health disparities and health equity

### **Unit 3: Analysis of Rurality [6/23-7/5/16]**

Definitions of rurality

History of rural public health in the US and elsewhere

Rural health deficits, assets, challenges

Rural health values

Rural public health systems

Models of care

### **Unit 4: Strategies for Engagement and Intervention [7/6-7/20/16]**

Revising, scaling up effective care delivery worldwide, nationally, locally

Partnership models and action plans

Multiple methods for research: epidemiology, measurements/metrics, assessments, collaborative and qualitative methods, use of technology

Inviting voice, listening actively, sharing the effort

Leveraging existing strengths/assets to address gaps, inequities

Suggested toolkit for health activists

The importance of networks [all kinds]

We believe that the state of New Mexico holds unique cultures, characteristics, and problems, yet the health disparities, inequities, population trends, migration patterns, and general state of rural/cultural health the world over are more similar than different. Whatever your own disciplinary connections, we invite you to explore the critical issues presented in the following collection of short essays. In this class, we have defined both *culture* and *rurality* broadly and in multiple contexts. Much remains to be done, both locally and globally, to improve the health status of our varied populations and communities. Please join us in the analysis and resolution of the health challenges, inequities, and unresolved needs that characterize many rural and cultural settings.

Sincerely,

[Jennifer B. Averill, RN, PhD](#)

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Originator and Instructor for Nursing 611

Rural Health Researcher

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# Global Health

## **Global Diabetes**

**Priscella Correa**  
**University of New Mexico**  
**06-17-16**

### **Topic**

As distance in the world continues to diminish with our ability to communicate with someone across the world by use of Facebook, Twitter and many other forms of social media, awareness of serious health conditions around the world becomes increasingly evident. We are more aware of social, economic and healthcare issues that previously were not considerations in our everyday life. As we have often heard and said, “out of sight out of mind”, but now the ability to witness firsthand the inequalities present in our world has encouraged many of us to take action. As we strive to improve healthcare we must expand our perception of what efforts are important when treating diabetes, a disease that is seriously challenging our healthcare system. Healthcare systems now more than ever are dependent on global economies and are heavily interconnected, and international policy makers and health care providers must now look with a wider lens for effective approaches to diabetes treatment.

### **Background, Evidence, Description**

Diabetes continues to be a chronic illness that affects many people in the United States (U.S.), but has also become problematic around the world. Healthy People 2020 (2016) acknowledged that as the diabetes incidence rate in the U.S. increased, it also increased worldwide. The concern that accompanies this reality is that diabetes as a chronic illness, found to lower life expectancy by up to 15 years, increase two-four times the risk of heart disease and is the leading cause of kidney failure, adult blindness, and lower limb amputations (Healthy People 2020, 2016). The International Diabetes Federation (2016) estimates that one in ten adults will have diabetes by the year 2040. The World Health Organization (2016) reports that delay of serious complications can be achieved by effective use of medication and regular screening of glucose levels. Wild et al. (2004) suggest that diabetes would continue as an epidemic if obesity rates remained the same, although we know that this has continued to rise as well. The time has come to reduce the healthcare inequality related to income levels to ensure these basic treatment options for all people. As a global society are we saying that one’s quality of life depends on socioeconomic status?

The American Diabetes Association (2014) estimates that the average medical expenditure is \$13,700 a year for someone with diabetes compared to \$7,900 for one without the disease. The International Diabetes Federation (IDF, 2011) found that global expenditures for diabetes treatment totaled \$465 billion in 2011, with the prediction that this will rise to \$595 billion by the year 2030. The rising costs will have a

dramatic impact on the global economy. How is it ethically and economically possible that the cost of diabetes treatment is so expensive that individuals from lower socioeconomic status or developing countries cannot obtain or sustain the treatments?

### **Link UN Millennial Goals/HP 2020**

The International Diabetes Federation (2016) recognized that diabetes is “a chronic, debilitating and costly disease associated with severe complications, which poses severe risks for families, Member States and around the world” (para. 4). World Diabetes Day has become popular as awareness is raised about the significant threat this disease poses to our world. The United Nations (UN) (2012) recognized that diabetes disproportionately affects families that are poor, and treatment of the disease further magnifies their poverty. The call to action by the UN (2012) is for companies to develop affordable medicine and technologies to provide the availability to monitor blood sugar levels.

As nurse scientists we must align ourselves with global, national and local healthcare goals. It is evident that nurse researchers can become active leaders in areas of health care reform. We must position our profession in such a manner that we are active and influential advocates and agents for activating affordable medications and testing supplies for people around the globe with diabetes. Such action rests on the American Nurses Association (ANA)(2010) Social Policy Statement.

### **Proposed Idea for Action**

As healthcare scientists we have an obligation to mobilize and activate basic care initiatives, provide education to individuals with diabetes and their families, and push for the reduction of costs for medications and technologies that are needed to manage the disease. We have an array of devices to help mitigate poor outcomes, but we also have the obligation to make these resources available to all individuals. We are currently limiting the basic treatment only to residents in higher-earning socio-economic groups.

Cost containment must be a priority in the turbulent global health arena. The startling facts about diabetes should activate measures of aggressive advocacy for patients who face the harsh reality of cost and inability to maintain adequate diabetes control. Advocacy is an important part of the nursing profession and nurses are potential leaders to change policy to reduce health inequality at the global level. Nurses often have personal, first-hand knowledge about individuals with poor health due to inequality of access to measures that could turn poor outcomes to more favorable indicators. As nurse researchers, we can tell the human stories to encourage all at the policy formation table to take positive action and reduce health inequality around the world. This the human dimension of evidence generation.

### **Take-Home Points**

A need exists to reduce health care inequality as addressed by Goal 3.8 of the UN Millennium goals that aim to provide quality essential health-care services to all

people (United Nations, General Assembly, 2015). This will require an active approach by all stakeholders in healthcare. The rise and cost of diabetes and its serious health complications in our global society should motivate us to take an active role in reducing health care inequality. WHO (2016, Global Report on Diabetes) has called to action all governments to ensure that health systems deliver effective care and treatment for diabetes. We can collaborate at all levels to eliminate health inequality in countries that are poverty stricken and affected by war. The WHO shares the story of Hammad Faleh, a Syrian refugee who was forced to leave his native nation and now is in a foreign land and unable to obtain the medication that will keep him alive (WHO, 2016). How is it possible that someone can survive war, yet still be facing death in a safe country because of a disease that can be out of reach of control due to limited financial resources? This brief calls to action the commitment to make diabetes control available to all people regardless of their financial status. A healthier population is more productive and engaged in solving the problems attached to their communities.

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# **Physical Inactivity: An International Health Concern**

**Kimberly R. Hartson**

**N 611**

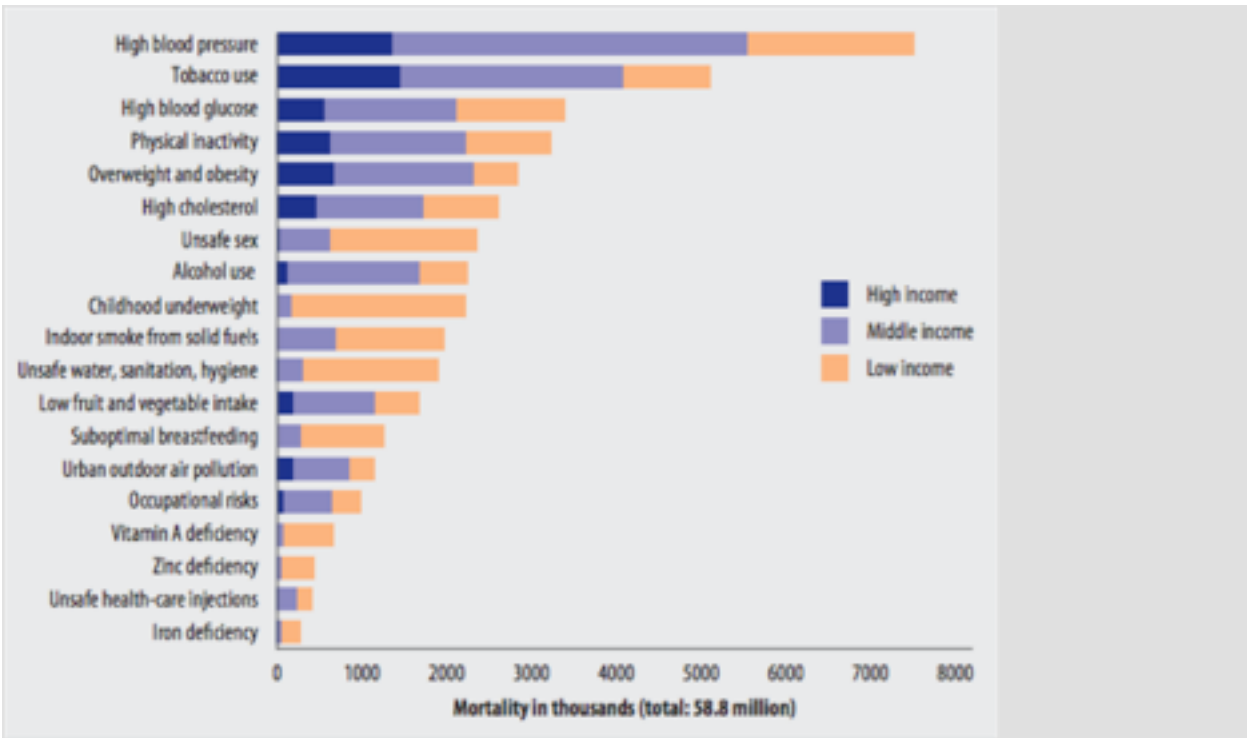
**June 27, 2016**

Insufficient physical activity is an international health concern with potentially devastating effects. Physical activity can be defined as purposeful bodily movement requiring the use of energy, including bodily movement during exercise and daily activities such as transportation, cleaning, playing, etc. (World Health Organization [WHO], 2016). Internationally, 1 in 4 adults and 3 in 4 adolescents do not spend enough time being physically active (WHO, 2015). This is extremely concerning as physical inactivity (PI), the lack of adequate physical activity, and sedentary lifestyles contribute to the detrimental effects of non-communicable diseases. PI is a major risk factor for cardiovascular disease, cancers, and type II diabetes, all of which are among the leading causes of death globally (WHO, 2009; WHO, 2014). In fact, about one fourth to one third of the disease burden from breast and colon cancers, diabetes, and ischemic heart disease is attributed to PI (WHO, 2016). Consequently, eliminating PI could save over 5 million people worldwide each year (Lee et al., 2012).

## **Background and Evidence**

The World Health Organization (2010) recommends that adolescents participate in at least 60 minutes of moderately intense activity every day while incorporating vigorous activity and strength training three times per week. Adults should participate in at least 150 minutes of moderate activity or 75 minutes of vigorous activity per week. Recommendations are intended to be adapted for personal preferences and context (WHO, 2010). The benefits of physical activity include decreased risk of chronic illness, stronger bone structure, healthier body weight, improved mood and mental health, decreased risk of falls as an older adult, increased physical functioning, and increased chances of living a longer, healthier life (Centers for Disease Control and Prevention, 2015; Meisner, Dogra, Logan, Baker, & Weir, 2010).

Physical inactivity was once thought of as a concern for the wealthy and while PI often correlates with higher gross national product, it is no longer a problem solely for higher-income nations, as shown in Figure 1 (WHO, 2009; WHO, 2015).



**Figure 1. Deaths attributed to 19 leading risk factors by country income level in 2004 (Reprinted from “Global Health Risks: Mortality and burden of disease attributable to selected major risks,” by the WHO, 2009, p. 10).**

Physical inactivity is among the top risk factors that increase risk of death, regardless of national income status. Nations are experiencing a transition from struggling with health risks for infectious diseases to fighting modern health risks that increase non-communicable disease. Lower income nations are making the transition more slowly due to health risks associated with poverty (WHO, 2009; WHO, 2015). Even so, 12% of men and 24% of women in low-income countries are not adequately physically active (WHO, 2015). Reasons for the increase in PI and sedentary lifestyles include urbanization characteristics such as fear of violence or crime, low air quality, and lack of safe parks, sidewalks, and recreational facilities. Additional reasons include increasingly sedentary jobs, passive transportation methods, use of technology during leisure time (e.g., electronic games, cell phones), and sedentary entertainment (e.g., watching movies or other entertainment on electronic devices) (Bauman, Finegood, & Matsudo, 2009; WHO, 2015).

**Physical Activity and the United Nations Sustainable Development Goals**

The United Nations has created sustainable development goals to improve the lives of the global community. Improving levels of physical activity is a part of *Goal 3: Ensure healthy lives and promote well-being for all at all ages*. Specifically,



increasing physical activity is imperative in order to attain the 2030 target of reducing premature mortality from non-communicable diseases by one third and promoting mental health and well-being (United Nations, 2015).

### **Proposed Approach for Action**

Physical activity is a universal human need regardless of physical and mental abilities, age, gender, race, or ethnicity; however, as with any health improvement initiative, a blanket or single approach will not be appropriate for every context. Successful health initiatives need to be multidimensional, specific to the context, and be a part of a comprehensive wellness package. Interventions should include multidimensional programs targeted towards the individual, community, national, and international levels. Communication and collaboration among these initiatives with government and local residents are essential to the overall success of increasing physical activity and creating a supportive environment that encourages people to make healthier decisions (Bauman et al., 2009). Addressing PI at multiple levels will decrease barriers to physical activity by strengthening the infrastructure of wellness resources in the area.

Secondly, people and their environments are interconnected in dynamic, complex, and irreducible relationships that must be considered when attempting to influence behavior (Smith, 2011). As a result of this fact, evidence based interventions should be adapted to match the context. The WHO has created health action plans and strategies for decreasing PI that are intended to be adapted for specific environments. For example, strategies may need to be modified based on availability of healthcare resources, social norms, geographic location, safety and poverty level (WHO, 2010; WHO, 2013). Another effective strategy is to involve community members in the planning processes and as specially trained community health workers. Individuals who are engrained in the community can better identify the beliefs and priorities that influence health behaviors in their community. They can also help implement interventions at the individual and community levels while providing familiar, supportive relationships for the participants (Drobac, Basilico, Messac, Walton, & Farmer, 2013).

Lastly, the services provided should be comprehensive, incorporating physical, social, mental, safety and environmental needs into a wellness package. In other words, a program for increasing physical activity should also provide services to assist with barriers to physical activity and general wellness. This may include food services, transportation, or psychological services. These services help participants break out of habitual cycles and structural oppression (e.g., no safe access to walking or recreation areas beyond their dwellings) that may be preventing them from successfully increasing physical activity (Drobac et al., 2013).

### **Summary**

In conclusion, adequate physical activity is a universal need that is imperative to the health of the global community. Unfortunately, a large proportion of the

global community is not participating in enough physical activity to be healthy and it is contributing to the international burden and cost of non-communicable diseases. Successful interventions to decrease PI must be multidimensional, adapted for context, and provide comprehensive health services. Through collaborative and coordinated efforts to improve health through physical activity, the potential exists to improve the health of the global community and save millions of people from poor health outcomes or premature death.

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## **Postpartum Depression: Is it a Social Justice Issue?**

**Jennifer L. Heck, MS, RNC-NIC, CNE  
N 611 – Rural and Cultural Health  
June 17, 2016**

Postpartum Depression: Is it simply a social justice issue? Considering the disproportionate burden of disease carried by millions of people, research in the areas of health disparities, health equity, and social justice are national and international public health priorities (CDC, 2013; U.S. DHHS, 2016; WHO, 2015). Improving health equity and social justice have been major goals of the World Health Organization (WHO), which continues to be committed to the “Health for All” movement (2010). This disproportionate burden of disease carried by numerous marginalized people worldwide manifests as health disparities in diseases and injuries such as diabetes (Borschuk & Everhart, 2015), heart disease (Holly & Sharp, 2012; McNeill, Hayes, & Harley, 2015), and life expectancy (Bor et al., 2015; Chiavegatto Filho, Beltrán-Sánchez, & Kawachi, 2014; Saabneh, 2016; Sasson, 2016).

Postpartum depression (PPD) is no different as a disparity. It is a mental illness that is experienced universally across population groups (Goldbort, 2006), and manifests discrepancies – in prevalence rates, in access to and use of healthcare services, and in its associated maternal/infant health outcomes (Baker et al., 2005; Klainin & Arthur, 2009; O’Campo & Uriquia, 2012; Wei et al., 2008). This brief will introduce the background and evidence of PPD within a global health disparities context. Further, this brief will link PPD to the United Nations’ millennial goals and the Healthy People 2020 goals, and lastly a proposed approach for action will be delineated.

### **Background, Evidence, Description**

Postpartum depression is a wide-reaching mental illness. It is the most common complication following childbirth (Beck, 2008), and can adversely affect maternal, infant/child, and family health outcomes (Horowitz, Briggs-Gowan, Storfer-

Isser, & Carter, 2007; Miklush & Connelly, 2013). In addition, the increased use of health care resources related to PPD indirectly impacts global society (Agency for Healthcare Research & Quality, 2013).

Discrimination, marginalization, and social injustice continue to affect populations worldwide, leading to a widening gap in health status between those who are marginalized (with limited access) and those who are privileged (with fewer limits to access), thus propagating increased health disparities and inequities (Giddings, 2005). While health is influenced by multiple factors, Woolf and Braveman (2011) argue that social determinants of health are the root causes of health disparities. For example, several social determinants influence health, such as education, income, social class, and access to “modern health services” (Farmer, Kim, Kleinman, & Basilico, 2013, p. 5). While attention is needed at the policy level, change is also needed at the individual level, as personal behaviors also influence health disparities.

As with many other diseases, some social determinants of health are major factors in PPD. The relationship between socioeconomic status and PPD is inverse: At high levels, socioeconomic status acts as a protective factor against PPD, yet at low levels, it is a risk factor (Beck, 2001; Dolbier et al., 2013; O’Campo & Urquia, 2012). For example, a woman with low socioeconomic status is at increased risk for PPD, whereas a woman with average to high socioeconomic status is at lower risk. More specifically, there is a moderate to strong relationship between low household income and PPD (O’Campo & Urquia, 2012).

### **Link to United Nations Millennium Development Goals and Healthy People 2020 Goals**

Healthy People 2020 recently added an objective specific to PPD that aims to reduce the proportion of women having given live birth who experience postpartum depressive symptoms (U.S. DHHS, 2016). In addition, there are other Healthy People 2020 objectives in place that indirectly impact postpartum depression. For example, “access to health services” is an objective aimed toward improving access to comprehensive, quality health care services (U.S. DHHS, 2016). With improved access to care, some marginalized people may overcome barriers and thus experience improved and timely screening, diagnosis, and treatment of PPD. This will ultimately improve maternal health outcomes.

Further, the United Nations (UN) has a goal of “improv[ing] maternal health,” (UN, 2016) which addresses postpartum depression generally and globally. More specifically, the UN has a goal to “eradicate extreme poverty and hunger” (UN, 2016). Addressing poverty and improving the socioeconomic status and/or income of marginalized people worldwide will positively impact PPD, as they are inversely related (Beck, 2001; Dolbier et al., 2013; O’Campo & Urquia, 2012). This will also improve maternal health outcomes and the health of families.

## Proposed Approach for Action

The Commission on Social Determinants of Health (CSDH) is part of the WHO and was charged with examining how societies are impacting the health of the population (WHO, 2010). They developed an action-oriented conceptual framework (see Figure 1) to guide the government and public health sectors in improving health equity and social justice (WHO, 2010).

Figure 5. Final form of the CSDH conceptual framework

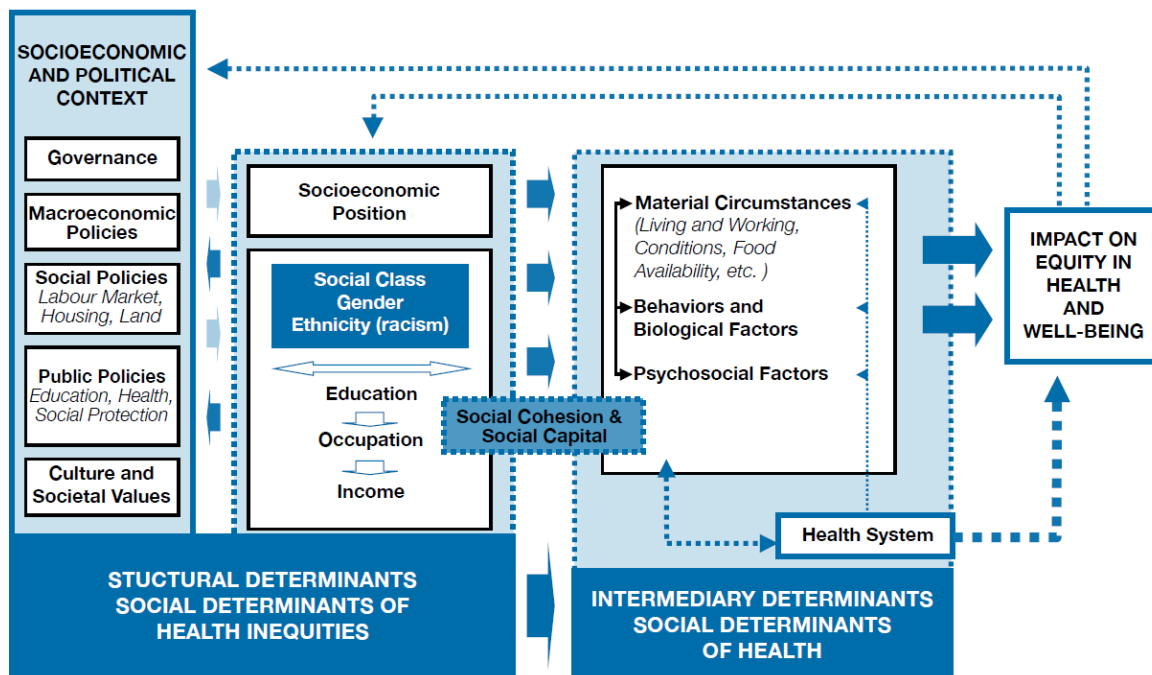


Figure 1. The CSDH Conceptual Framework, Solar & Irwin (2010).

While the framework is complex, it is applicable to postpartum depression. A clear link between social determinants of health, postpartum depression, and resultant maternal health outcomes is established and emphasizes the importance of the need for change. Considering that health disparities are often socially created (WHO, 2015) as a result of laws and policies at the government level (Hofrichter, 2003), it follows that improvements need to begin at the policy level. The CSDH framework should be used as a guide for key decision makers to improve social conditions through policy action. Without action, PPD disparities will not improve, which is why the CSDH framework is so relevant.

Though social policy change is essential, distrust may cause some communities to be hesitant about leaving their health in the hands of policy makers. The distrust is sometimes the result of historical exploitation and marginalization for selected communities. The day policy changes reach the individual's level and accomplish a

reduction in PPD disparities may seem years away, which, to the general population, may seem as though nothing is being done. However, some rewards of policy-driven public health efforts are already apparent in the United States, such as the recent decrease in smoking rates among American Indian/Alaska Native young adults (CDC, 2013). While this is not specific to postpartum depression, it gives us an example worth following. To successfully eliminate disparities in PPD, we need joint efforts at many levels, including the individual level. Joint efforts will best address the gap in this area of maternal health.

## **Conclusion**

This brief highlights the connection among social justice, health equity, health disparities, social determinants of health, and postpartum depression within a global context. These are important linkages to make, as postpartum depression is universally experienced (Goldbort, 2006) and can have detrimental effects (AHRQ, 2013; Horowitz et al., 2007; Miklush & Connelly, 2013).

Health care and other professionals need to be aware of social justice as a core value. According to Boutain (2012), social justice awareness involves a person critically considering his or her beliefs about how and why others are seen as advantaged or disadvantaged. As a discipline, nursing is well positioned to combat social injustice, as it has paved the way for cross-cultural and transcultural awareness (Giddings, 2005). Furthermore, acknowledging the influences of the social determinants of health is a significant undertaking for all people, not only health care professionals, and represents a first step toward reducing PPD disparities.

If change does not occur at the policy level, improvement in disparities will likely remain insignificant (Woolf & Braveman, 2011). Realizing the impact of policies in healthcare, for example, is a first step in addressing PPD disparities and their related social determinants of health (Woolf & Braveman, 2011) and can potentially lower health care costs by improving PPD disparities and thus maternal and family health outcomes.

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# **Female Genital Mutilation: A Global Issue**

**Elizabeth Holguin**

**N611**

**June 16, 2016**

## **Female Genital Mutilation**

Female genital mutilation (FGM) is a non-therapeutic surgical intervention (Yirga et al., 2012) that involves ritual cutting and alteration of the genitalia of female infants, children, and adolescents (Sauer & Neubauer, 2013). The World Health Organization (WHO) holds that “FGM does not have any health benefits and harms girls and women in many ways by removing and damaging health and normal female genital tissue and interfering with the normal function of girls’ and women’s bodies” (WHO, 2016). In addition, it limits sexual freedom and violates human dignity (Nussbaum, 1999 in Farmer et al., 2013). There are four major classifications of FGM: (1) clitoridectomy, (2) excision, (3) infibulation, and (4) all other harmful procedures to the female genitalia for non-medical purposes (WHO, 2016) (Appendix A).

The World Health Organization estimates that over 200 million girls and women currently live with the consequences of FGM in 30 countries (WHO, 2016); practiced throughout Africa, the Middle East, and some parts of Asia (Yirga et al., 2012; Sauer & Neubauer, 2013) with some country level prevalence rates greater than 70% (Yirga et al., 2012). Immigration has brought FGM to Europe, Australia, New Zealand, Canada, and the United States as well (Yirga et al., 2012).

### **Background**

Girls are subjected to FGM mainly due to tradition in settings where they live; other reasons include cultural-group identity, perceived cleanliness and health, preservation of virginity, enhancement of sexual pleasure for men (Sauer & Neubauer, 2013), prevention of female promiscuity (Yirga et al., 2012), and religion (Berg & Denison, 2013). FGM is usually performed by traditional healers with varying levels of surgical experience, while other countries utilize doctors, nurses, and certified midwives to perform the procedures (Yirga et al., 2012). FGM has no known health benefits; immediate consequences include pain, septic shock, hemorrhage, tetanus, urinary retention issues, and open genital sores (Sauer & Neubauer, 2013). Long-term sequelae include urinary tract infections, dysmenorrhea, sexual difficulties, infertility, and birth complications (Sauer & Neubauer, 2013).

Despite all risks involved, findings demonstrate that girls or women who have undergone FGM earn social approval, respectability, and honor for themselves and their families (Khaja, 2004; Vissandjée et al., 2003 in Berg & Denison, 2013). Those who do not participate in FGM are at risk for social insults, teasing, social

unacceptance, and may be rejected as marriage partners (Berg & Denison, 2013); in most societies that practice FGM, becoming a wife and mother is paramount (Johnsdotter, 2002; Lightfoot-Klein, 1989; Nkrumah, 1999 in Berg & Denison, 2013). However, in contrast to some literature in existence (Khalifa, 1994), popular belief, and female perception (Johnsdotter, 2002), many men view FGM as a means to preserve morality and honor, not as a means to increase their sexual enjoyment. In fact, some men expressed interpersonal concerns regarding their wives' suffering during intercourse (Berg & Denison, 2013).

It is paramount that outsiders understand cultural nuances and rationale for some forms of FGM; many comparisons have been drawn to male circumcision, which can also be extremely unsafe and result in loss of life (Earp, 2015). In both circumstances, certain methods can be performed safely and carry perceived benefit (e.g., ...). It may be possible to shift cultural perceptions about GM in order to reduce any further unnecessary stigma related to FGM (Farmer et al., 2013). Work is needed to build open networks of communication with groups who practice GM. The work of Earp (2015) outlines an ethical framework for genital alteration that is grounded in "considerations of bodily autonomy and informed consent, rather than sex or gender" (p. 89).

### **Link to Sustainable Development Goals**

Sauer and Neubauer (2013) note that FGM should be regarded as a "manifestation of sexual inequality, a form of gender-based violence, and child abuse" (p. 2). Due to the Universal Declaration of Human Rights, several international rights treaties uphold the rights of physical integrity and freedom "from all forms of torture, inhumane, degrading treatment and discrimination" now recognize FGM as a direct violation of human rights (Muthumbi et al., 2015).

The Millennium Development Goals (MDGs), ending in 2015, sustained political support for health development with clear objectives and measurable targets (White, 2015). Subsequently, the creation and endorsement of the Sustainable Development Goals (SDGs) by the UN officially occurred on September 25, 2015 (White, 2013). The SDGs are comprised of 17 main items with several sub-goals and accompanying indicators and metrics. The SDGs encompass all countries, rich and poor alike, to make strides towards improved global health. With 30 practicing countries, immigration, and migration, FGM has become a global issue. FGM most closely aligns with SDG 3, Good Health and Well-Being. However, other goals that represent social determinants that impact FGM victims include SDG 1, No Poverty, SDG 4, Quality Education, SDG 5, Gender Equality, and SDG 17, Partnerships for the Goals. The latter refers to the global community partnering to prevent or accelerate abandonment of the practice.

### **Proposed Approach**

The solution to FGM cessation is multi-faceted. Increased progress on the SDGs will contribute to capacity building in communities and law enforcement authorities to include stronger monitoring systems at the local level. Underlying social norms impacting root causes must be addressed including conversations with people in

affected communities, solutions for stigma, dishonor, and shame. Comprehensive legislation is needed at the international, national, and local levels. In changing longstanding practices of FGM, health policy modification should include severe consequences for medical providers that perform FGM (Muthumbi et al., 2015).

Societal support for FGM still remains an issue due to existing mild penalties and low fines (Muthumbi et al., 2015). Social Convention Theory has also been applied to the issue to understand the impact of the desire to achieve social norms along with underlying inequalities such as gender and class (Brown et al., 2013). Brown et al., (2013) state that a “critical mass of families within a community must publically renounce the practice; as it is only when communities desist that, individual families will believe it is acceptable and not detrimental to their status not to cut their daughters” (p. 5).

Diop et al. (2008) note that there is evidence to demonstrate the impact of FGM legislation on prevention and abandonment strategies (Muthumbi et al., 2015). Legislation has become the main intervention tool among Western governments to inhibit FGM practices. National plans have been developed by several African countries aimed at prevention or acceleration of FGM abandonment in addition to integration of care and prevention models into health policies and programs (Muthumbi et al., 2015). Various mandates exist at the national level to accomplish these goals and to oversee prevention at the local level, to conduct research, and advocate for the prevention of FGM (Muthumbi et al., 2015). Strict monitoring by law enforcement, incident reporting, and prosecution of FGM practitioners have ensured compliance in countries who have implemented these tactics (Muthumbi et al., 2015); political support plays a key role in enforcement.

## **Summary**

FGM is a harmful practice without health benefits, although it may still be a preferred practice in some cultures, with the possibility of safe implementation of certain methods. Capacity building is essential to create the necessary frameworks and infrastructure in which to address this multi-faceted issue and to implement key health and public policies. Addressing social norms in a culturally sensitive manner (Farmer et al., 2013) will be key for stigma reduction, social acceptance, FGM abandonment and prevention, or safer practices surrounding FGM. Work is needed from the community level to policy level to sustain this change.

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## APPENDIX A

### WHO Classification of FGM Types

#### Procedures

Female genital mutilation is classified into 4 major types.

**Type 1:** Often referred to as clitoridectomy, this is the partial or total removal of the clitoris (a small, sensitive and erectile part of the female genitals), and in very rare cases, only the prepuce (the fold of skin surrounding the clitoris).

**Type 2:** Often referred to as excision, this is the partial or total removal of the clitoris and the labia minora (the inner folds of the vulva), with or without excision of the labia majora (the outer folds of skin of the vulva ).

**Type 3:** Often referred to as infibulation, this is the narrowing of the vaginal opening through the creation of a covering seal. The seal is formed by cutting and repositioning the labia minora, or labia majora, sometimes through stitching, with or without removal of the clitoris (clitoridectomy).

**Type 4:** This includes all other harmful procedures to the female genitalia for non-medical purposes, e.g. pricking, piercing, incising, scraping and cauterizing the genital area.

**Deinfibulation** refers to the practice of cutting open the sealed vaginal opening in a woman who has been infibulated, which is often necessary for improving health and well-being as well as to allow intercourse or to facilitate childbirth.

Source: World Health Organization (WHO). (Feb 2016). Female genital mutilation. Retrieved from [www.who.int/mediacentre/factsheets/fs241/en/](http://www.who.int/mediacentre/factsheets/fs241/en/)



# **Global Engagement in Nursing Education**

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**N611**

**July 24, 2016**

The borders around global health issues are closing in and disappearing between countries and continents. Globalization of illness and disease examples include the rapid spread and deadly dissemination of the HIV virus in the 1980s, the SARS epidemic in 2003, H1N1 influenza in 2009, and now most recently the 2014 Ebola Virus outbreak along with the spread of the Zika virus. Global health needs to begin in the education of healthcare providers such as physicians and nurses in order to be prepared for what/who may cross our borders at any time. Unfortunately, the concept of global health is not always a consistent part of the health care education in the United States. Nursing education needs to be especially concerned as nurses are a significant part of the primary healthcare workforce in the trenches of global health. In order for education to help drive the solutions around globalization issues, there is a need for radical transformation to nursing education curricula to foster engaged global citizenship (Hanson, 2010). Without implementation of the needed educational reform, nurses will not be adequately prepared for the potential international spread of disease and will be ill-equipped to protect the health of the U.S. population.

## **Background**

Farmer, Kim, Kleinman, and Basilico published their book on global health because of a lack of available resources on the topic for students taking their course at Harvard College in 2008 (Farmer, Kim, Kleinman, & Basilico, 2013). I was persuaded in reading this book that there is indeed a void in healthcare education on global health. As a nurse educator, I can attest to the lack of global health in the New Mexico statewide prelicensure nursing curriculum. Some schools may have the topic as an elective, but excluding it should not be an option. Global health is too important to not include in required coursework. Farmer, Kim, Kleinman, and Basilico contend that proper global health education is important because biological and clinical processes are influenced by society, political economy, culture and historical knowledge. There have been unanticipated consequences from purposive action such as the systematic slaughter of refugees in camps that were created to help and protect along the border between Rwanda and the Democratic Republic of the Congo. Boundaries across the world are shrinking as evidenced by the current migration patterns brought on by disease, climate change, and natural disasters (International Organization for Migration, 2014). With global health needs expanding rapidly, a new generation is now needed to be systems-based in order to improve health care by adopting core global health competencies to apply to emerging global issues (Frenk et al., 2010). Integrating global health into nursing education is proving to be one method in the systems-based approach that is needed to handle the challenges of globalization. This approach to including global health into nursing education is supported by the ANA Social Policy

Statement on the essence of the nursing profession (American Nurses Association, 2010).

### **Link to Healthy People 2020**

The need for global health education is linked to the Healthy People 2020 objectives, which includes some new topics to keep up with the changing needs and demands of worldwide health (U.S. Department of Health & Human Services, 2014). Global health has now been added as a Healthy People 2020 objective. The goals for this new objective are to “improve public health and strengthen U. S. national security through global disease detection, response, prevention, and control strategies”. U.S. health must now be viewed through a global lens and context. In order to work towards this goal, the next generation of nurses must be educated to think and act globally while being trained locally (Turale, 2015).

### **Proposed Approach**

When nursing education curriculum includes global health, students are more likely to develop global attitudes and world perspectives that develop critical thinking that will encompass a broader world view (Riner, 2011). Research is beginning to report data that culturally sensitive nursing care can help to reduce health disparities, increase patient satisfaction and improve treatment outcomes (Agency for Healthcare Research and Quality, 2012). The attainment of culturally sensitive caregiving begins in nursing education as evidenced by the data that nursing students develop an increased appreciation of the world through classroom and clinical global experiences (Riner, 2013). One approach to ensuring the inclusion of global health in nursing education curriculum would be to use a concept-based system. Giddens offers a solution in the inclusion of professional nursing healthcare concepts that include health care economics, health care law and health care organization along with health and illness, and healthcare recipient concepts (Giddens, 2013). This concept-based approach uses the term “population health” to encompass global health issues and topics. In suggesting a four-semester curriculum sample for a concept-based curriculum, Giddens includes a course in semester four on global health (Giddens, Caputi, & Rodgers, 2015). Nursing programs must begin to consistently embrace the idea of a mandated global health course or of global health objectives being incorporated into existing core courses. Nursing education must address the necessary transformation that needs to occur in order to properly educate and prepare future nurses to address global issues that are already in our neighbor’s yard or at our doorstep.

### **Summary**

The concept of global health is now an objective for Healthy People 2020. Health issues in other countries and continents are no longer considered geographically isolated. International outbreaks and epidemics such as the spread of HIV and AIDS,

Ebola, Zika and flu have proven that illness and disease can quickly become a local issue. Healthcare providers including nurses need to be prepared for what is coming through the front door as migration patterns shift and dissolve boundaries. Our country cannot wait for the next outbreak or epidemic to pass through the border without proper preparedness. We must prepare our nurses now while they are in training for what challenges wait for them that are unknown. By mandating the inclusion of global health in nursing education, our next generation of nurses can be prepared with historical, economic, collaborative and political knowledge to use as ammunition to tackle all global health care issues that are beyond or may cross our borders at anytime. Nurses by profession are global citizens so it is time to include global health in their training.

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## **The Global Issue of HIV/AIDS**

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July 25, 2016**

### **Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)**

What do Rock Hudson (Actor), Freddie Mercury (Musician), Anthony Perkins (Actor), Arthur Ashe (Athlete), Perry Ellis (Clothing Designer), and Ryan White (United States Citizen) have in common? They all died from HIV/AIDS. This list is just a few of the millions around the globe who have died from HIV/AIDS. In order to examine the global issue of HIV/AIDS, we must first examine the history of HIV/AIDS, what the historical response to HIV/AIDS has been, what the current global initiatives are, and what I propose for future global initiatives for prevention and treatment of HIV/AIDS.

#### **Historical Background of HIV/AIDS**

According to AIDS (2016) HIV/AIDS was initially thought of as a disease among gay men then transformed to be a disease affecting men, women, and children. In its initial stages, HIV/AIDS was a terminal illness and people with HIV/AIDS died relatively soon after being diagnosed. However, with development of new treatment regimens, HIV/AIDS is now considered a chronic illness requiring lifelong treatment, and people diagnosed with HIV/AIDS live much longer than before. According to Avert (2016), by 1980, there were an estimated 100,000 to 300,000 people in North America, South America, Europe, Africa, and Australia diagnosed with HIV/AIDS. In the 1980s, the number of people worldwide diagnosed with HIV/AIDS steadily increased and by the end of 1985, every region in the world had reported at least one case of HIV/AIDS (AIDS, 2016). In 1985, the World Health Organization (WHO) and the United States Department of Health and Human Services (HHS) convened for the first HIV/AIDS conference. In 1987, HIV/AIDS became the first disease to be discussed in the United Nations (UN) General Assembly (Avert, 2016). During this time, the number of people worldwide diagnosed with HIV/AIDS continued to increase, and as of 2015, globally, there were 36.7 million people diagnosed with HIV/AIDS and approximately 2.1 million people becoming HIV-infected in 2015, globally (WHO, 2016).

Among all the HIV/AIDS cases in the world, the sub-Saharan African region has been the hardest hit. According to the WHO (2016) the Sub-Saharan African region has the highest HIV incidence, with 25.8 million people diagnosed with HIV/AIDS. Furthermore, the sub-Saharan African region accounts for almost 70% of the global total of new HIV infections (WHO, 2016). Also, according to the WHO's Global Health Sector Response Report (2015), African women comprise 60% of people worldwide diagnosed with HIV. While the data may not look promising for people in the

sub-Saharan African region, there has been a global response to the HIV/AIDS crisis with organizations such as the UN, WHO, and the US Centers for Disease Control and Prevention (CDC) collaborating with countries to further address the prevention and treatment of HIV/AIDS worldwide. For the purpose of this brief, I will mainly focus on the sub-Saharan African region.

### **Global Link to UN Millennial Goals**

According to Messac and Prabhu (2013), the early global response to AIDS included the US President's Emergency Plan for AIDS Relief (PEPFAR), the Bill and Melinda Gates Foundation, and the Global Fund to Fight AIDS. These organizations worked to ensure that people had access to HIV/AIDS treatment. Building upon these efforts, there are several initiatives and collaborations globally for current and future response to the prevention and treatment of HIV/AIDS. The Millennium Development Goals Collaboration Council (2016) continues to work on the prevention and treatment of HIV/AIDS by recommending strategies such as expanding care, services and research, advancing prevention, and developing the scope of health efforts to improve access to healthcare services. In 2000, the UN convened to establish the 2015 Millennium Development Goals to address HIV/AIDS. The purpose of the Millennium Development Goals project was to develop goals to address HIV/AIDS globally, with special attention to the sub-Saharan African region, as that area had the highest incidence of HIV/AIDS. In 2010, the Global Health Initiative (GHI) Strategy was tasked by President Obama to formulate a comprehensive government approach to shape US investments in global health (GHI, 2011). In addition, in 2010, the US government teamed with the South African government to formulate goals to improve and enhance the health status of the entire South African population (GHI, 2011). This collaboration allotted \$548.7 million in funding, with the goal that HIV infections should be reduced by 50% by 2014 (GHI, 2011). With these initiatives and collaborations, has there been an impact on the incidence of HIV/AIDS and have the above-mentioned collaborations and initiatives met their stated goals?

In the 2016 Millennium Development Goals Report (MDGR) it was reported that new HIV infections decreased approximately 40% between 2000 and 2013, and in addition, "by June 2014, 13.6 million people with HIV were receiving antiretroviral therapy globally" (MDGR, 2016). The WHO (2015) reported that while "the number of people newly infected with HIV dropped 33% from 2001-2012" there are still 2.3 million people newly diagnosed with HIV annually, and of those, 1.6 million are in the sub-Saharan African region. The WHO (2015) also reported that worldwide, 9.7 million people with HIV received treatment in 2012, compared to 2011 when only 8.1 million people received treatment. In addition, the WHO (2012) reported that more Ethiopian HIV-positive mothers receiving treatment delivered babies who were HIV-negative and in Zambia, 400,000 HIV-positive people were receiving free HIV treatment consisting of antiretroviral therapy (ART), considered the standard of care by WHO (2016).

The Report of the Commission on Women's Health in the African Region (2012) recommended a widespread, multi-sectoral response, increasing the funding for health systems, with a focus on primary care. United Nations AIDS (UNAIDS) (2015) and its partners have endorsed global targets and initiatives to guide and accelerate the AIDS response. This includes the "90-90-90" treatment target for 2020 in which 90% of the population that are HIV positive will know their HIV status, 90% of the population that are HIV positive will access HIV treatment, and 90% of the population that are HIV positive will have suppressed viral loads. Additionally, UNAIDS has a goal to eradicate the AIDS epidemic in selected cities by 2030. Of these cities, the majority of them are in the sub-Saharan African region. In addition, the US National Institutes of Health (NIH, 2016) announced that an HIV vaccine trial will begin in November 2016 in South Africa. This trial obtained approval based on a 2009 study demonstrating how a vaccine might protect people from HIV infection (NIH, 2016). This upcoming double-blind study will administer five vaccine injections to the study participants over the span of one year. The researchers believe the vaccine shows promise in protecting people from HIV.

### **Proposed Approach for Future Action on the Global Incidence of HIV/AIDS and Summary**

As noted above, active collaborations exist that are working to prevent and treat HIV/AIDS on a global level, particularly in the sub-Saharan African region. I recommend that the above-mentioned collaborations continue, certainly, complete with sustainable funding to reduce HIV infections. I also recommend that all people with HIV receive antiretroviral therapy, a strategy that has economic and policy implications. In addition, I suggest that we expand research efforts and advance prevention of HIV/AIDS. Future work may involve the promising treatment in the NIH vaccine trial that is slated to begin in November 2016 in South Africa. Finally, I believe it is vitally important to support the UNAIDS target goals to Fast-Track the AIDS response by following the "90-90-90" treatment targets.

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# **Slow-Roasted Humans: A Global Recipe**

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**June 16, 2016**

To make slow-roasted humans, start by locating a vulnerable population where climate change has already heated the environment 0.6 to 0.9 degrees Celsius above its normal temperature (NASA, 2016). Wait for a system of high atmospheric pressure to move into the area causing upper level air to be pulled towards the ground, producing heated compressed air (Meehl & Tebaldi, 2004). As the temperature rises a heat wave will occur and some individuals may try to escape the hostile climate. Mix together inadequate policies, procedures, and resources to ensure this does not occur. Within one week you will have hundreds to thousands of slow-roasted humans to select from. For additional servings, simply do not change any current policies or procedures.

Heat waves are responsible for cooking hundreds of people alive annually across the globe (Patz, Campbell-Lendrum, Holloway, & Foley, 2005). Ignoring this problem would be similar to ignoring a person trapped in a hot car during summer. Even though turning our backs to them as they struggle for air, lose consciousness, and have their brain cooked like an egg in boiling water is much easier than helping; this action is unethical. With our current technological advances and political partnerships no one should have to die this way. Progression has been made to address the issue at the local levels, but the mortality rates suggest it is a global problem (Kalkstein & Sheridan, 2007). The inevitable climate change, insufficient resources, and inadequate solutions are all contributing factors that need to be taken into account when formulating solutions.

## **Background, Evidence, Description**

According to the National Aeronautics and Space Administration, between 1906 and 2005 the Earth's average surface temperature has risen between 0.6 and 0.9 degrees Celsius and is expected to continually rise (NASA, 2016). Although it is likely both natural and human factors contribute to climate change, the need exists regardless to address and respond to it effectively (United States Environmental Protection Agency, 2016). The Paris Climate Agreement, signed by multiple countries, was one solution proposed to reduce global warming with a goal of maintaining the global temperature rise below 2 degrees Celsius (Jacobs, 2016). Unfortunately, it has been projected the climate changes over the next 30 to 40 years have already been determined by past emissions (Hulme et al., 2002). Essentially, climate change is inevitable despite the action we take.

Numerous studies have shown an increase in temperature is significantly associated with mortality (Basu & Samet, 2002). With each incremental increase in global temperature follows an increased probability of heat wave occurrences leading to heat exposure, heat stroke, and death. The United States, England, Germany,

Australia, India, Greece, Russia, and France have all reported increases in mortality rates associated with heat-related fatalities (Kalkstein & Sheridan, 2007; Brucker 2005). Heat exposure is now the leading cause of weather related deaths in both the United States and India however it is not recognized as a natural disaster (Sheridan & Kalkstein, 2004). In the United States, heat exposure contributes to over 400 deaths annually and it was estimated the 2003 European heat wave contributed to 50,000 deaths (Kalkstein & Sheridan, 2007; Brucker 2005). In 2015, a heat wave was responsible for over 2,500 deaths in India which was followed by over 300 deaths the following year as temperatures rose 20 to 30 degrees above normal (Think Progress, 2016).

### **Link to Healthy People 2020**

Acknowledging our inevitable climate change and the increasing occurrence of heat related deaths gives us the ability to move forward and prepare for future incidents. If we stand by and do nothing history will repeat and thousands of people across the globe will continue to die annually. Preparedness has become a necessary plan of action to reverse this course. Healthy People 2020 recognizes the importance of preparedness and its necessary commitments. To achieve the goal of preparedness multiple entities must work together to prevent, prepare for, respond to, and recover from heat related deaths (Healthy People 2020, 2016).

### **Proposed Idea for Action**

The first step we must take is to recognize and acknowledge heat waves as a natural disaster. This would place it on the same level of importance as hurricanes, tornadoes, earthquakes, and tsunamis. By showing the public heat waves are considered natural disasters they may begin to comprehend the seriousness of the issue. Once heat waves are categorized appropriately global education must ensue. Often times people are unaware they are facing or are at risk for a natural disaster due to lack of education (O’Riordan, 1986). Providing education on heat waves, heat strokes, and resources available will save hundreds of lives.

Training must also be conducted with local health providers regarding the signs and symptoms of heat stroke along with treatment options. They need to recognize the elderly, infants, and those with low socioeconomic status are at higher risk for health related issues (Farmer, Kim, Kleinman, Basilico, 2013). Assisting the community in locating these individuals is a key that can unlock prevention. Additionally, we must ensure health providers are well prepared to handle the disaster when it occurs. An evaluation of their infrastructure should be conducted and a plan must be in place to provide them with lifesaving equipment as quickly as possible.

Both a universal and community specific warning systems must be developed. Not all communities have television, radio, Internet, and social media readily available. An analysis must be conducted in high risk areas to determine what resources are available and preferable. Different social factors all provide a pivotal role in determining

if people will respond to a warning or not (Kalkstein & Sheridan, 2007). It would be wasteful to create a costly warning system within a community that places more trust in family and friends as opposed to governing bodies (Kalkstein & Sheridan, 2007). When applicable, a follow-up plan should also be conducted to evaluate the effectiveness of those warnings systems so improvements can be made.

## Summary

Unlike earthquakes and tsunamis, heat waves do not produce collapsed buildings or washed away homes for the media to capture. Heat waves produce a loss of life so graphic in nature, mainstream media is compelled to omit it (Campbell, 2004). We have no problem rushing in with aid when buildings crumble on the evening news but do not appreciate the devastating human cookout that occurs annually. How many more must die before we take this seriously? Is it really necessary to provide photos of hundreds of slow-roasted people prior to considering any action? I am confident that as progressive thinkers, our logic has exceeded that.

Without question, it is time to recognize heat waves as a global natural disaster. Given the inevitable climate change it would be a mistake for us to consider this only a phase. Thankfully, addressing this issue would not be a new exploration for us. Several preparation models are already in place from other natural disaster plans such as tsunamis and earthquakes (World Health Organization, 2016). Components of these existing models can be adopted for heat waves and instituted globally. Once these basic steps have been completed we can build upon our knowledge for future improvements and help reverse this trend.

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# **Killing People to Save Money: Microeconomic Analysis of Poor World Nations and The Equality of Access to Quality Health Care**

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**June 17, 2016**

## **Are We Killing People to Save Money?**

Economic practices around the globe are killing people to save money. Hidden under the guise of tax revenue shortfalls, many poor nations are depriving their populations of equal access to quality health care simply by the misappropriation of monies. These monies could be easily directed into infrastructure that supports development and delivery of health care to those citizens who may be economically disadvantaged (Gaddah, Munro, & Quartey, 2015).

## **Background**

There has been a longstanding debate on the inclusion of economic analysis and economic practices in the structuring of a country's provision of access to quality health care. Across the globe, there is a large variation that exists in healthcare expenditures (Jan, et al. 2016). Expenditures are often seen as a percentage of a county's gross domestic product (GDP) (Ahmadu, et al. 2014). Many poorer nations look for help from larger, more economically advantaged nations. Many of these larger nations do not appreciate the economic shortfalls that these nations are experiencing and look at delivery of health care as a supply and demand issue rather than something that is ethically imperative (Habicht, Habicht, & van Ginneken, 2015). All too often, the dominant use of microeconomic analysis of these nations' leads to overreach of economists into policy that directly influences health care delivery and quality (Chinitz & Rodwin, 2014). Frequently financial incentives are tied into providing quality delivery (Chinitz & Rodwin, 2014). Microeconomics is defined as the focus on the behavior of small economic units like individual consumers or households (<http://www.investorwords.com/3051/microeconomics.html>) The results are often disastrous, as large corporations reap the benefit and leave socio-economically disadvantaged individuals without equal access to quality care or voice to effectively communicate their plight.

## **United Nations Millennial Goals**

As part of the United Nation's Millennial Goals: 1) good health and well-being; and 2) reducing inequalities, have been identified. All people should be given equal access to quality health care. Health promotion and care for humans should not be relegated only to those who exist in higher socioeconomic classes. Unfortunately, low-income individuals are frequently found to have decreased access to care and as a result experience more serious health conditions (Fujita, et al. 2016). Impoverished children frequently require larger costs of care and larger needs for specialist due to

disease processes easily prevented by access to care (Maharaj, Rahman, & Adamson, 2014). Lack of access to care or quality care can stem from substantial travel distances and high out of pocket expenses (Hernandez & Rossel, 2015; Salti, Chaaban, & Raad, 2010). Geographic features and variation also plays a huge role in delivery (Sheiner, 2014).

### **Proposed Approach**

The use of microeconomics can display the negative impacts that poor delivery and lack of quality health care can have on the economies of poorer nations (Ahmadu, et al. 2014). Human capital has been recognized as being instrumental in reducing poverty levels (Gaddah, Munro, & Quartey, 2015). Instead of attempting to recognize economic gains based off of increasing GDP, countries should focus on maximizing health gains (Pinho, 2014). Advisors, sent from larger, economically advantaged nations, should focus on the reduction of fiscal waste as a result of inefficient public health expenditures (Salti, Chaaban, & Raad, 2012). These monies should be refocused on improving the quality of care. For example, money could be directed at reducing the amount of out-of-pocket expenditures individuals have. Strengthening the provision of health insurance could be key (Ahmadu, et al. 2014). Rationing of health care should no longer be an accepted practice. Human life should not be treated as a simple equation of supply and demand. Disparities must be individually addressed and compensated for.

Corporations and governments assisting countries at a disadvantage should encourage corporate social responsibility to encourage socio-economic development (Memon, Wei, Robson, & Khattak, 2014). Instead of reaping large earnings, control should be redistributed to the socio-economic deprived (McKague & Oliver, 2012). In doing so, these countries can develop capabilities to provide quality levels of health care to those who once would have never received that care. These corporations could essentially create a human capital and realize gains not from the health industry and delivery, but instead from the increase in economic development these healthy populations are able to enrich. Governments of advantaged nations such as the United States (US), Germany, Canada, and Japan should not only encourage corporate social responsibility, they should mandate it through the use of tighter regulations in regards delivery of care to impoverished nations.

### **Take Home Points**

The world is actively globalizing. This brief argues that each person, corporation, and government is socially and ethically responsible for the well-being of all persons. In the rush towards globalization, socio-economically disadvantaged countries and persons around the world should be given equal access to quality health care. We must quit treating the delivery of quality health care impersonally as a supply and demand issue. Instead, through corporate social responsibility and the proper use of microeconomic analysis, we can create a human capital capable of surpassing corporate greed and major economic barriers, to the benefit of the world and all of its citizens. Quality health care should be provided to every human on the planet regardless of socio-economic status or locale.

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Pictures obtained from: [www.who.int](http://www.who.int), [www.hopemusic.net](http://www.hopemusic.net)



# **Mitigating the Global Burden of Hepatitis C in Intravenous Drug Users**

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**June 17, 2016**

The global pandemic of hepatitis C has created major public health, economic and social crises worldwide. Hepatitis C, which afflicts more than 185 million people globally (Doyle et al., 2015), is a prevalent chronic liver infection caused by the blood-borne hepatitis C virus (HCV). Given the asymptomatic nature of the disease during its early stages, most individuals are unaware of their infection until end stage disease (Centers for Disease Control and Prevention, 2016). The morbidity and mortality attributable to chronic HCV infection continues to increase globally, with roughly 700,000 annual deaths from complications of the disease, which include cirrhosis of the liver and hepatocellular carcinomas (World Health Organization, 2016). Given that HCV is highly infectious and the nature of transmission is via blood contact, people who inject drugs (PWID) are disproportionately affected. Specifically, of the 16 million PWID around the globe, it is estimated that 10 million are infected with HCV (Global Commission on Drug Policy, 2013). The historical approach to confronting drug use worldwide, which has involved criminalization and strict law enforcement, has negatively impacted public health; in countries with the harshest drug policies, 90 percent of PWID are infected with HCV (Global Commission on Drug Policy, 2013). Thus, novel strategies are needed to address the global HCV health problem in the PWID population.

## **Background, Evidence, and Description**

Over the past century, opposing perceptions about the nature of drug addiction have persisted. The underlying debate centers around addiction as a medical illness versus a moral problem (Kaye, 2012; Netherland, 2012). This ambiguity in how we understand and define addiction has resulted in global governmental policies that criminalize drug use resulting in mass incarceration of PWID particularly. Paradoxically, this approach to drug policy has not only been ineffective in tackling the 'war on drugs', it has inadvertently exacerbated the spread of HCV and other diseases among PWID through concentration of afflicted individuals in prisons (Global Commission on Drug Policy, 2013). Additionally, approaches to drug policy that focus solely on criminalization have undermined access to necessary harm-reduction and treatment services for these individuals, which has ultimately triggered greater public health harms and increased societal costs (Miron, 2011; Miron & Waldoock, 2010).

## **Link to United Nations Sustainable Development Goals**

The 2016 United Nations (UN) Sustainable Development Goals mandate that governments ensure health and promote well-being for all individuals; by definition this includes PWID. Additionally, this mandate calls for an end to the epidemic of viral hepatitis by 2030 ("UN Sustainable Development Goals," 2016). The World Health Organization (WHO) has also outlined a global vision for halting transmission of HCV and increasing access to safe, affordable and effective treatment to all infected individuals (World Health Organization, 2015). The WHO aims to achieve an 80% reduction in HCV incidence and a 65% reduction in HCV-related deaths by 2030 (Scott, McBryde, Thompson, Doyle, & Hellard, 2016). However, while the UN and WHO offer strategies for HCV detection and treatment, they do not provide specific solutions for targeting the PWID population by failing to consider the the impact of governmental drug policies and the economic realities that impede progress.

The Global Commission on Drug Policy is urging countries to embrace a public health approach to managing HCV. This includes maximizing prevention and treatment rather than enhancing punitive drug policies, shifting away from mass incarceration and drug surveillance which have adversely impacted the spread of HCV (Global Commission on Drug Policy, 2013). Globally, substantial financial resources are currently committed to support the 'war on drugs'; for example, in the US alone the cost has exceeded one trillion since 1971, with greater than 30 billion dollars committed for fiscal year 2016 (Executive Office of the President, 2016). These financial resources could be reallocated toward primary and secondary HCV prevention. This shift would prevent new infections and enhance diagnosis and treatment of existing infections.

## **Proposed Approach for Action**

To tackle the disproportionate rates of HCV in PWID, this brief proposes a three stage plan of action, starting with drug policy change, followed by implementation of primary and secondary prevention strategies. First, as discussed above and in accordance with strategies drafted by the Global Commission on Drug Policy, countries will be urged to shift resources from supporting punitive drug policies toward a harm-reduction model. This paradigm shift is a necessary starting point to prompt the restructuring of financial resources while simultaneously alleviating the social marginalization and stigma that PWID face.

The second component of the overarching plan dovetails with UN and WHO guidelines by focusing on primary prevention. Funding of primary prevention and early diagnosis would expand HCV education and enhance access to sterile needles and syringes. HCV is more than three times more prevalent in PWID than HIV (Global Commission on Drug Policy, 2013), yet harm-reduction messages world-wide have centered on HIV prevention with less concern for HCV (Whiteley, Elliott, Cunningham-Burley, & Whittaker, 2015), keeping HCV awareness on the fringe. Based on our experience with HIV, it is well-documented that awareness and knowledge promote

positive behaviors, minimize new infections and mobilize individuals to demand access to interventions that promote health (Ford et al., 2015).

The third component of the overarching plan focuses on secondary prevention measures, which include enhanced access of PWID to HCV diagnosis and treatment. It is essential that countries implement strategies to diagnose individuals that are infected with HCV in the early phases of the illness, before advanced liver fibrosis occurs, to both promote health-related quality of life and alleviate the long-term financial burden associated with HCV morbidity and mortality. Regarding diagnostic surveillance, HCV testing rates are lowest in countries with more repressive drug laws (Global Commission on Drug Policy, 2013); thus, lack of testing availability has remained a barrier. The proposed shifts in drug policy, coupled with the widespread availability of simplified diagnostic methods, would effectively mitigate this gap. Regarding treatment, new direct-acting antiviral (DAA) medications have transformed HCV treatment (Edwards, Coppens, Prasad, Rook, & Iyer, 2015). Unlike older generation interferon-based treatments, DAAs are manufactured at a much lower cost and are available at discounted prices (Andrieux-Meyer, Cohn, de Araujo, & Hamid, 2015; Jayasekera, Arora, & Ahmed, 2016). DAAs are safe and easy to administer in any clinical setting by non-specialized healthcare workers (Global Commission on Drug Policy, 2013), cause fewer serious adverse events and require less patient monitoring (Ford et al., 2015). DAAs also have shorter treatment duration and are curative in 90% of HCV-infected individuals (Edwards et al., 2015).

## **Summary**

Advances in the treatment of HCV have made eradication a realistic global health goal. To ensure attaining this goal, a three stage plan of action is proposed that 1) urges redirection of squandered financial resources from the 'war on drugs' to support primary and secondary prevention, 2) formalizes educational programming and access to sterile needles and syringes, and 3) provides access to state of the art and cost-effective diagnostic and treatment strategies. Implementing these strategies will improve the health of at-risk and infected PWID individuals while serving the broader goal of ending the global HCV epidemic.

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## **Cultural Health**

# **Cultural Care in an Era of Technology**

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**June 26, 2016**

Social media and its widespread use has fostered a need for constant connection. People have become preoccupied with being noticed for various achievements. Significant value has been placed on how many views or likes can be accumulated on an individual's post. It is in this same environment that being admired as an individual has become very important. Although individuals strive to entertain the idea that there are differences in each person, by human nature individuals try to fit in to the surrounding environment and be accepted, like a chameleon and assimilate to our environment.

The latest technological advances and constant flow of new electronic gadgets have contributed to the technological culture that is being experienced in the United States (U.S.). As with any innovation there are also some negative, possibly unanticipated accompanying effects. Currently, this media-driven culture of technology has contributed to the growing sedentary behavior of all people and is affecting the health and wellbeing of American citizens. Healthy People 2020 (2016) recognizes that environmental factors play a role in physical activity among all age levels. This electronic culture has been linked to the reduction of physical activity to unwanted low levels and unfortunately the outcome is poor health. It is a health concern that needs to be addressed.

Perez & Luquis (2014) explain that culture is a multi-faceted term with multiple definitions. Culture provides an individual with a lens through which the world around them is seen. Cultural differences are valued as people strive to be unique in their environments: professional, home, and social. However, with the continued rise in obesity rates at a national level, healthcare providers must look at approaches that will change the current health behavior modification strategies and assist individuals to establish healthy habits that will positively improve their health.

## **Background, Evidence, Description**

Many terms have been used over the years to describe and discuss culture, cultural awareness, cultural competence, and cultural humility. Perez & Luquis (2013) define cultural awareness as the extent to which an individual is sensitive to beliefs, values, and practices that are specific to that cultural group. They further define cultural competence as the process of values, principles, behaviors attitudes, and policies that allow the nurse to work with multi-cultural groups. Foronda et al. (2016) described cultural humility as a lifelong process of practicing openness, self-awareness, egoless nature, supportive interaction, self-reflection and critique. In reflecting and determining how to be open to new and unique individual attributes, healthcare providers must also try to balance the

ways in which society is evolving in this technological era. Cultural humility is used to describe the individual gaining insight to something or someone who has some type of difference. If healthcare providers look at society in general, nurses try to be accepting of others and yet significant differences in health outcomes are directly related to cultural disparities. These disparities must be addressed in order to achieve the goals of Healthy People 2020 and reduce the deepening health disparities in our society.

In a technological culture, unwanted sedentary life style with its inherently passive connection to others has become an expected norm. The World Health Organization (WHO)(2013) found that reduction in activity has contributed to increasing obesity in this nation and elsewhere. In a multi-cultural society this sedentary life style is adding to a list of pre-existing risk factors among the Hispanic population, a major research focus for this author. The U.S. Department of Health and Human Services Office of Minority Health (2015) found that Hispanics have a higher incidence of obesity than in other groups. The Centers for Disease Control and Prevention (CDC, 2016) recently found in this population that 48.6% of women and 43.5% of men over the age of 20 were obese. This is astonishing, since reducing health disparities has become a national effort to improve health outcomes. The WHO (2003) also found that obesity can further increase the risk of serious chronic disease such as type 2 diabetes, hypertension (HTN), cardiovascular disease and stroke. The U.S. Department of Health and Human Services (2016) noted that the higher the obesity, the greater the probability of early death. These diseases affect the state of health in our country as chronic illness is seen to decrease quality of life in individuals. Furthermore, the Hispanic population is expected to increase by 115 percent by 2060, posing serious implications for chronic illness patterns and challenges (Colby & Ortman, 2015).

### **Link to Healthy People 2020**

Healthy People 2020 (2016) listed national goals to improve the health of the nation by increasing activity. This includes the overarching goals to eliminate disparities and improve the health of all groups. In the Hispanic population in particular, which already has higher rates of diabetes, HTN and other chronic illnesses, adding another devastating factor, caused by this technological cultural increase in sedentary behavior, could be detrimental to this group that already has its unique challenges.

### **Proposed Idea for Action**

Nursing professionals have the opportunity to become active in promoting healthy behaviors in all individuals, regardless of ethnicity/culture, while incorporating the technological culture. Nurses must become active participants in policy change that will promote prevention of chronic illness by incorporating patient education into the technology that is already in place. The WHO (2013) clearly speaks to the fact that partnerships must occur to facilitate effective change. Regarding the use of electronic devices, there are many activity applications (apps) that are used by mobile devices. Why not incorporate an application that the health care provider could use to track an individual's progress, communicate with him/her, and also use it as an educational tool?



The app would be used to educate on the importance of increased activity for wellness and can be used to track individual activity progress. Healthy People 2020 (2016) found that increasing physical activity can lower the risk of the following: falls, depression, type 2 diabetes, high blood pressure, stroke, coronary heart disease, early death, and coronary heart disease. If healthcare professionals are to be proactive in our society they must capitalize on the resources that are currently available and affordable to individuals that may contribute to wellness and health promotion. Just two examples of the many such apps available include “Physical Education (PE) Apps for Teachers” (Spark, 2016) and “PE Central” (PECentral, 2016).

### **Take-Home Points**

The societal norm in the US is to expect instant gratification in all aspects of life and technology has been a key influence for this presumption. Ng & Popkin (2012) predict that a population’s sedentary time will increase and physical activity will decrease as current trends continue and estimate this same trajectory for 2020 and up to 2030. Kline et al. (2016) used technology in combination with entertainment to target Hispanic individuals, in an attempt to promote self-care. They found positive behavior changes related to the technology that was incorporated in the study, suggesting that the incorporation of technology in combination with entertainment, as an intervention can lead to positive outcomes.

Technology has allowed us immediate connection to each other and the world, and information is consistently available from many sources. Nurses can adjust our behavior to be culturally competent in this world of technology and use that technology to meet health goals, educate our clients, and improve health outcomes. Nurses can favorably impact health status by becoming culturally aware of how this technology favorably impacts the type of care that can be given. For all citizens, including growing numbers of Hispanic residents at risk for chronic illness, this use of technology could be very beneficial.

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# The American Diet: In Need of a Cultural Shift

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N 611

June 25, 2016

Dietary practices in America are a part of American culture, but they are in need of substantial change. The definition of culture has evolved from the shared knowledge and learned behaviors of a group to the *translation* of differences between groups, allowing for the understanding of beliefs, knowledge, and behaviors between groups. Consequently, cultures are observable in comparison to other cultures (Agar, 2006). The American diet is a unique conglomerate of items from the many cultures that exist within America's borders. For example, pizza, egg rolls, and burritos are offered as Americanized, high fat, and convenient fast food spinoffs of foods from other cultures (Kulkarni, 2004). Compared to many other countries, in America, portion sizes are often larger, fast food restaurants are more prevalent, and prepackaged meals are more acceptable. Furthermore, the context in which many Americans make food choices encourages poor food selection. For example, commercials encourage unhealthy snacks and the cheapest food options are often prepackaged convenience foods that are filled with hidden sodium, high amounts of sugar, and long lists of chemicals.

## What Americans Eat

The *Western Diet* is used in research to refer to diets high in saturated fats, simple carbohydrates, refined sugar, fast food, or fried foods (Duffey, Steffen, Van Horn, Jacobs, & Popkin, 2012; Kanoski & Davidson, 2011; McCourt et al., 2014). This is not too far from the truth for many Americans. In general, Americans do not eat enough whole fruit, low-fat dairy, whole grains, and vegetables, especially greens and beans. At the same time, they eat exceedingly high levels of saturated fat, sodium, and empty calories. Empty calories are foods that are high in calories, but low in nutritional value. Americans eat plenty of protein and grains, but they are often of low nutritional quality (U. S. Department of Agriculture [USDA], 2013).

## Diet and chronic illness

Dietary patterns consisting of high caloric foods with low nutritional content, such as processed and red meats, sweets, refined grains, and products high in sodium, contribute to chronic illness (USDA, 2015). In fact, unhealthy dietary patterns combined with physical inactivity are the leading risk factors for obesity, high blood pressure, diabetes, cardiovascular disease, osteoporosis, and some cancers (USDA, 2015; World Health Organization, 2004). The American Heart Association (2014) also recommends the consumption of healthy fats for the prevention of cardiovascular disease. Healthy fats refer to monounsaturated and polyunsaturated fats from plant based oils, nuts, seeds, and fish rather than saturated, hydrogenated, or trans fats from animal, dairy, processed, and hydrogenated sources.

## Background and Evidence

**US chronic illness status.** Chronic illnesses are rampant in the US, with almost half (49.8%) of adults having at least one chronic health condition (Ward, Schiller, & Goodman, 2012). Over 70% of adults are overweight or obese, 20% of teenagers are obese, and 17% of children age 6 to 11 are obese (Centers for Disease Control and Prevention [CDC], 2016). Additionally, prevalent chronic illnesses include heart disease, cancers, stroke, and diabetes, which are among the top ten leading causes for death in the US (Heron, 2016).

**Current dietary status.** The dominant dietary pattern has changed little over the past 40 years. In 2010, the average American ate 2,535 calories per day, which was an increase from 2,075 calories per day in 1970. Most of the increased calories were attributed to increased intake of flour, cheese, sugars, and fats (Liebman, 2013). Americans also consume sodium in excess, with an average of 3,400 mg of sodium per day, and 90% of the population consuming more than the recommended daily maximum intake, 2,300 mg (Cogswell et al., 2012; Institute of Medicine, 2013). Also, the average American only eats 1.1 servings of fruit and 1.6 servings of vegetables per day, consuming about half of the recommended amount of fruits and vegetables. Many adults consume fruit and vegetables less than once daily, 37.7% and 22.6% respectively (CDC, 2013).

**Determinants of food choices.** Food choices are influenced by individual, environmental, and social factors. Individual influences include personal characteristics such as nutritional knowledge, resources, attitudes, beliefs, and skills. Environmental factors include the physical location of food decisions (i.e. grocery or convenient store, restaurant, etc.), marketing campaigns, agricultural policies, and access to quality food options. It is currently challenging in many lower income neighborhoods to find fresh, high quality produce that is reasonably priced. Additionally, social influences on food selection can include social support, family roles and obligations, societal norms, and food assistance programs (Haynes-Maslow, Parsons, Wheeler, & Leone, 2013; Office of Disease Prevention and Health Promotion, 2016). Food insecurity currently affects 15% of Americans, forcing many to make decisions between cheap, unhealthy food and other necessities such as housing, utilities, or medications (Feeding America, 2016).

## The American Diet and Healthy People 2020

Improving the dietary patterns of Americans aligns with the *Healthy People 2020* nutrition and weight status objectives, which include the following: (a) improve access to healthy food options in schools and communities; (b) increase proportion of people who are of a healthy weight; (c) increase variety and amount of whole grains, vegetables, and fruits consumed (i.e. dark green, red, and orange vegetables; beans and peas); and (d) reduce intake of solid fats, added sugars, and sodium (Office of Disease Prevention and Health Promotion, 2016).

## Proposed Approach for Action

American dietary guidelines encourage a shift in dietary patterns towards healthier food choices, including a variety of vegetables and whole fruits, whole grains, low fat milk products, lean protein, and healthy oils, while limiting saturated fats, trans fats, added sugars, and sodium. The emphasis is on balancing individual dietary needs and preferences with selecting a variety of healthy foods and adhering to overall calorie guidelines (USDHHS & USDA, 2015).

Interventions to improve American dietary practices should be multidimensional, addressing social, environmental, and individual factors. Social factors are perhaps the most challenging, but they may improve organically as changes in environmental and individual factors become engrained into society. Environmental interventions such as policy changes, public health campaigns, and regulations on the agricultural and media industries, can increase access to healthy food options and encourage healthier food selections in schools, worksites, and communities. Strategies to improve individual factors include interventions affecting nutritional knowledge, motivation, and personal preferences, for example motivational interviewing and education (USDHHS & USDA, 2015). The *Let's Move* initiative has provided a foundation for cultural change by encouraging funding and policy improvements, community gardens, and healthier food choices in schools and the media (Let's Move, 2016). However, this is just one step towards a cultural shift in American dietary patterns. Extensive community involvement and collaboration is still needed to address the many multidimensional influences on food selection.

## Summary

The American diet is a part of American culture and it is in need of drastic change. To improve American dietary patterns, interventions must address social, environmental, and individual influences on food choices. Americans are fighting a losing battle until the context in which they make food choices changes to one that fosters the selection of healthy foods. Only through comprehensive, collaborative efforts will the culture of dietary practices in America change so that healthy food choices and better health outcomes are encouraged in society.

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# **Acculturation in the American Indian Population**

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**N 611**

**June 27, 2016**

An individual's culture is an important factor, influencing all facets of his or her life – knowingly or not. For numerous reasons, an individual, family, or group may experience intercultural contact. For example, families who immigrate from China to the U. S. often come into contact with differing cultures and perspectives as they adjust.

Like many cultures, there are innate values and cultural beliefs that many American Indian groups share (Diaz-Cuellar & Evans, 2014; McIntosh & Eschiti, 2009). However, based on individual and group perception, these inherent philosophies may vary widely from tribe to tribe or person to person (Diaz-Cuellar & Evans, 2014). With colonization, the American Indian population experienced intercultural contact, which has eventually led to varying levels of acculturation among individuals. The extent to which an individual is acculturated also influences his or her cultural practices (Diaz-Cuellar & Evans, 2014). For this brief, acculturation is defined as the degree to which a person ascribes to a new culture, compared to his or her culture of heritage.

This brief will discuss the *acculturation* of the American Indian population in the United States (US), differentiate it from *assimilation*, provide a historical context, and address its impact on health. Further, this brief will describe the link to the Healthy People 2020 objectives and propose action to potentially combat acculturation's negative effects on the American Indian population.

## **Background, Evidence, Description**

The Social Science Research Council (1954) offered a classic description of acculturation as culture change that is initiated by the conjunction of two or more autonomous cultural systems. Acculturative change may be the consequence of direct cultural transmission; it may be derived from non-cultural causes, such as ecological or demographic modifications induced by an impinging culture; it may be delayed, as with internal adjustments following upon the acceptance of alien traits or patterns; or it may be a reactive adaptation of traditional modes of life (p. 974).

To differentiate, assimilation is a process where the merging of the two cultures eventually results in the loss of the first, or native, culture (Facchini, Patacchini, & Steinhardt, 2015). Discussion of the assimilation and acculturation that has occurred and is still occurring in the American Indian population needs to include a historical context.



## **The Historical Underpinnings of American Indian Acculturation**

Historical trauma is considered a significant social determinant of health for the American Indian population (Braun & LaCounte, 2015; Commission on Social Determinants of Health, 2007; Hartmann & Gone, 2014; Jones, 2006; Sotero, 2006). The colonization of America is no doubt the greatest cultural insult to the American Indian population and their health. Colonization introduced harm through loss of land, new forms of warfare, and new diseases to which American Indian people did not have immunity – all resulting in the significant loss of human life and the so-called dwindling of populations (Braun & LaCounte, 2015; Hartmann & Gone, 2014; Jones, 2006; Sotero, 2006). Further, the American Indian population experienced loss of language and culture over their lifespan and across generations via forced attendance at boarding schools aimed at assimilating American Indian children into “mainstream” White American culture, Christianity, and the English language (Braun & LaCounte, 2015; Hartmann & Gone, 2014; Jones, 2006; Sotero, 2006).

These historical events caused traumatic social injustice for the American Indian population, which resulted in the geographic, legal, and cultural marginalization of this group. Further, this historical trauma manifests as persistent intergenerational feelings of guilt, shame, inferiority, and distrust, contributing to racial/ethnic disparities in health seen today (Braun & LaCounte, 2015; Sotero, 2006).

### **Significance to Health Outcomes**

Historical trauma is a social determinant that influences the health of American Indian people through acculturation, and contributes to disparities in various population health indicators, such as suicide (Isaac, 2013). Suicide is a leading cause of death and disability in the U. S., and American Indian people have remarkably higher suicide rates than people in all other racial categories (Centers for Disease Control and Prevention, 2013). Suicide rates among adolescents and young adults are highest for American Indians as well (Centers for Disease Control and Prevention, 2013), substantiating heightened concern for the persistent suicide crisis among American Indian youth.

Studies have investigated the effect of acculturation and related concepts such as cultural or ethnic identity (Albright & LaFromboise, 2010) and cultural continuity, described as factors such as whether an indigenous community had “achieved a measure of self-government; litigated for title to traditional lands; accomplished a measure of local control over health, education and policing services; and had created community facilities for the preservation of culture” (Chandler & Lalonde, 2008, p. 6) on health outcomes. Furthermore, the lack of cultural continuity created by acculturation following historical assimilation and trauma is associated with increased risk for suicide, particularly among youth (Chandler & Lalonde, 2008). Conversely, in communities where there is more cultural continuity, there is little to no youth suicide. Likewise, other reports suggest ethnic/cultural identity acts as a protective factor on the mental health status of ethnically diverse people (Albright & LaFromboise, 2010).

## **Link to Healthy People 2020**

While there are no Healthy People topics or objectives that address acculturation specifically, there are some that address mental health status improvement. Identified as a leading health indicator, reducing the suicide rate by ten percent is an objective of Healthy People 2020 (U. S. D. H. H. S. Office of Disease Prevention & Health Promotion, 2016). In addition, a ten percent reduction in the U. S. suicide attempts by adolescents is another leading health indicator and objective (U. S. D. H. H. S. Office of Disease Prevention & Health Promotion, 2016). These objectives are indirectly related to acculturation and its effects on the health of the American Indian population.

## **Proposed Action**

For American Indian individuals at varying levels of acculturation, comprehensive and quality health services must include culturally congruent factors. By integrating culturally-appropriate modalities such as traditional, cultural healing practices, into health services for American Indian people, ethnic/cultural identity and cultural continuity can be maintained and enhanced. Additionally, efforts to prepare more American Indian health care workers and health care researchers should be enhanced and supported. Further, there is a lack of research concerning the effectiveness of practices that incorporate American Indian values and traditions into Western evidence-based practices (Gray & Rose, 2012). Therefore, the proposed action is to conduct more research on the impact and effectiveness of a bicultural approach to all components of healthcare services for American Indian people, including screening, diagnosis, treatment, and evaluation.

## **Conclusion**

Culture is an important part of an individual, and influences his or her health. By extension, culture also influences patterns of stress response and health-seeking behaviors by groups who share the same ideas. The American Indian population experienced forced assimilation, resulting in historical trauma and acculturation which manifests as persistent health disparities (Braun & LaCounte, 2015; Sotero, 2006). For instance, American Indian adolescents and young adults carry a disproportionate amount of the suicide burden in the U. S. (Centers for Disease Control and Prevention, 2013). Greater emphasis on cultural continuity in American Indian communities may lessen negative impacts of acculturation, possibly improving health outcomes, such as suicide rates. Healthy People 2020 identifies suicide as a leading health indicator for the U. S., substantiating the need for research into the effectiveness of bicultural approaches to healthcare services for American Indians.

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# **The Impact of Culture on Primary Care Access & Quality of Care**

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**N611**

**June 26, 2016**

The United States has more foreign-born residents than any other country. The rise in migration has resulted in an increasingly multicultural country. Cultural minorities often encounter barriers when accessing health care services although providers are seemingly oblivious and often comprise some of the burden of responsibility (Sheppers et al., 2006). Cultural insensitivity in the primary care setting will decrease access, quality of care, and compliance with treatment regimens. In addition, it will likely impact quality of life for new residents, who make up increasing numbers of our citizens.

## **Background**

Primary care service delivery can be problematic; although logistics is often an issue given the sheer number of people that require services and access, patients' health seeking behaviors sometimes hinder or delay access because of culture, social practice, or religious belief (Worthington & Gogne, 2011). In his work *Mirror for Man*, Clyde Kluckhohn defines culture in several ways, including "a way of thinking, feeling, and believing, and "a set of techniques for adjusting to the external environment and to others" (Geertz, 1973, p. 5). Worthington and Gogne (2011) acknowledge that for many, culture and social norms are a stabilizing and positive influence. However, individual autonomy can be directly challenged when personal expectations differ from accepted social norms; norms bound by culture and belief can negatively impact mental and physical well-being (Worthington & Gogne, 2011).

Poor access and subpar performance of the health system within the immigrant population have serious repercussions for their health, their children's health, and the health of the nation (Derose et al, 2007). Ku & Matani (2001) hold that immigration status is a significant component of racial and ethnic disparities in both insurance coverage and access to care. Migration has occurred in the United States for decades, and it is widely recognized that health care is a human right. However, ethnic minorities continue to encounter barriers to health services and access services much less often than non-immigrants (Weijzen & Weide, 1998; Barrett et al., 1998; Flores & Vega, 1998; Garrett et al., 1998; Panos & Panos, 2000 in Scheppers et al, 2011).

Cultural components such as language issues can affect a patient's comprehension of suggested treatments or medication regimens and can inhibit the provider's ability to obtain a complete medical history, or history of present illness (Scheppers et al., 2006). Differing perceptions surrounding symptomatology among ethnic minorities also comprise a perceived barrier due to differing language or terminology [to prevent redundant language from you: descriptors/describe] used to describe what would otherwise be routinely considered to be "classic" symptoms. Such misunderstanding may result in a missed diagnosis; cultural perceptions surrounding

symptoms may make it more difficult to arrive at an appropriate diagnosis for many clinicians (Scheppers et al., 2006).

### **Link to Sustainable Development Goals (SDGs) & Healthy People 2020**

The SDGs build on the Millennium Development Goals, and attempt to increase widespread inclusivity and sustainability for all countries. Decreased access to primary care in this population directly relates to SDG 3, Good Health, and SDG 10, Reduced Inequalities. Currently, the UN estimates that approximately 63% of all deaths worldwide stem from non-communicable diseases such as cardiovascular disease, cancers, chronic respiratory diseases, and diabetes (UNDP, 2016); these conditions are often quite manageable with early detection and continuous care in a primary care setting or with proper referral from primary care providers. SDG 10 calls for “inclusion of all, regardless of sex, race, or ethnicity” (UNDP, 2016).

Regarding the Healthy People 2020 initiative, ‘Access to Health Care Services’ is key. One in four Americans do not have a primary care provider (ODPHP, 2016) and it is noteworthy that “increasing access to both routine medical care and medical insurance are vital steps in improving the health of all Americans” (ODPHP, 2016). Regular and reliable access prevents disease, detects illnesses, increases life quality, and increases life expectancy. Furthermore, establishing regular care with a primary care provider instills greater trust, enhances patient-provider communication, and increases the likelihood that patients will receive appropriate care (ODPHP, 2016).

### **Proposed Approach**

A transition has occurred, causing a shift in focus from disease-oriented etiologies to intermingling factors such as culture, race, ethnicity, policy, and environment. Shi (2012) argues that this transition calls for “person/family focused” and “community-oriented” primary care services to meet population health requirements (p.1). Additionally, the principles of comprehensive care and community orientation have been in place since the 1978 Alma-Ata Declaration (WHO, 2008 in Shi, 2012). Even though most health systems have made the transition in their focus towards culturally competent care, correct implementation and evaluation of such programs is essential and remains poorly developed.

In the primary care setting, it is essential for providers to be mindful of cultural factors that can negatively impact patient well-being (Worthington & Gogne, 2011). According to Levesque et al. (2012), approachability and acceptability are important considerations. Approachability refers to awareness of services and their accessibility. The ability to perceive a need for care among culturally minority populations is aligned with approachability and is based on health literacy, and knowledge and beliefs regarding health (Levesque et al., 2012). Accessibility encompasses “cultural and social factors determining the possibility for people to accept the aspects of the service” and the “judged appropriateness for the persons to seek care” (Levesque et al., 2012, p. 5).

The National Standards for Culturally and Linguistically Appropriate Services in Health and Health Care (National CLAS Standards) have been a major driver in increasing cultural and linguistic competencies in health care. The principal goal of the CLAS standards is to “provide effective, equitable, understandable, and respectful quality care and services that are responsive to diverse cultural health beliefs and practices, preferred languages, health literacy, and other communication needs (HHS, 2016)”. When these competencies are incorporated, quality of care is improved, health equity is increased, and health disparities are reduced (Barksdale et al., 2015). To ensure that CLAS standards are implemented correctly, I propose adapting the Cultural Competency Assessment Tool for Hospitals (CCATH) for the primary care setting. The CCATH tool assesses adherence to the CLAS standards (Weech-Maldonado et al., 2012). In addition, measuring outcomes such as professional interpreter usage, health service navigation services, social service provision, and provider adherence and respect for traditional health beliefs is key to ensuring the highest quality of care amongst cultural minorities (Ngo-Metzger et al., 2003).

## Summary

Culture and presence or lack of culturally appropriate services directly impact access and quality in the primary care setting. With ever increasing numbers of immigrants in the United States due to global migratory patterns, it is prudent to ensure that primary care clinics are functioning in a culturally sensitive manner. Legislation surrounding requirement of the CLAS standards is variable throughout the nation (Appendix A). Implementation and careful outcome evaluation of evidence-based cultural competency initiatives such as the CLAS standards is imperative for all communities. Doing so will improve quality of care, increase medication and treatment adherence, and decrease disease burden.

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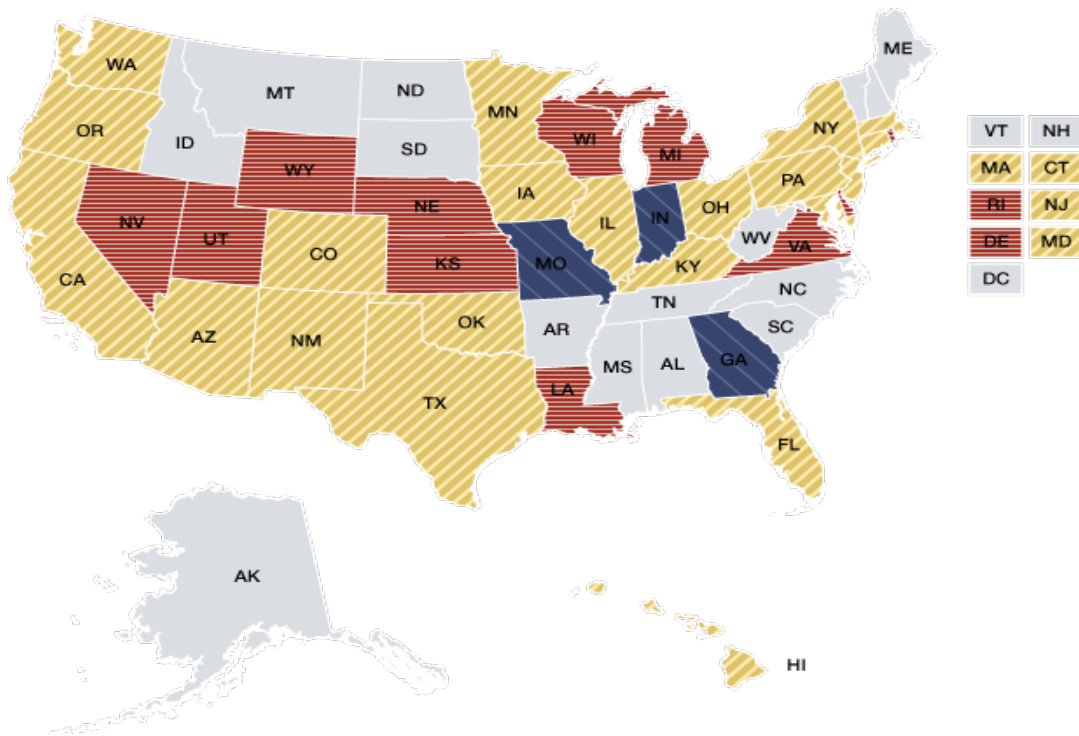
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## Appendix A: National CLAS Legislation



- Only legislative activity on cultural competency training
- Only state-sponsored *National CLAS Standards* implementation activities
- Legislation (either legislative activity or enacted legislation) on cultural competency training and state-sponsored *National CLAS Standards* implementation activities
- Legislation (either legislative activity or enacted legislation) on cultural competency training and state-sponsored *National CLAS Standards* implementation activities were not identified via Internet searches

Source: U.S. Department of Health and Human Services. (2016). Tracking CLAS standards. Retrieved from <https://www.thinkculturalhealth.hhs.gov/Content/LegislatingCLAS.asp>

# **Cultural Competence in Nursing Education**

**Jenny Landen**

**N611**

**June 26, 2016**

Scholars propose that improved health professions education is one the most critical and potentially effective interventions to eliminate health care disparities (Calvillo et al., 2009). Perez & Luquis (2014) argue that skills in cultural competency are needed in health education programs to address health care disparities locally and globally. For this brief, cultural competency is defined as “the capacity to work effectively across racial, ethnic, and linguistically diverse groups” (Luquis, Perez, & Young, 2006). In this context, cultural competency can be an effective strategy to close health gaps and disparities but current health professionals as well as the new generation of healthcare graduates must be properly trained. Standardized cultural competency training needs to be incorporated into pre-licensure nursing education. Appropriate cultural competency training could improve the capacity of nurses in practice to blend cultural considerations into nursing therapeutics. Unfortunately, the current definition of cultural competency is commonly misunderstood so it is imperative for educators to learn and accept the more contemporary understanding of the term (Luquis, Perez, & Young, 2006). The teaching of cultural competency in nursing education can only be effective if consensus is reached in the intended definition of the term.

## **Background**

The Institute of Medicine and the Office of Minority Health have supported the notion of a health care workforce capable of delivering culturally competent services to an increasing diverse population (Perez & Luquis, 2014). National initiatives such as these have created a resurgence of interest in public health. As a result, cultural competence has now become linked increasingly to reducing health disparities among under-served U.S. populations. The American Nurses Association included in their social policy statement the need for linguistic and cultural sensitivity (American Nurses Association, 2010). Cultural competency training is beginning to be reported with increasing frequency but much more work needs to be done regarding best practices in the delivery of cultural competence training (Beach et al., 2011). The American Association of Colleges of Nursing Advisory Committee state that “improved health professions education is one of the critical and potentially most effective interventions to eliminate health care disparities” (Calvillo, E., Clark, L., Ballantyne, J. E., Pacquiao, D., Purnell, L. D., & Villarruel, A. M., 2009). However, one major barrier to achieving an integration of appropriate cultural competency training into nursing education is the lack of consistent standards and competencies for the training across all programs (Ballantyne, 2008).

## **Link to Healthy People 2020**

One of the four overarching goals established by Healthy People 2020 is to “achieve health equity, eliminate disparities, and improve the health of all groups” (Perez & Luquis, 2014, p. 2). The goals for *Healthy People 2020* have expanded to include emerging issues such as genomics, global health, preparedness, and social determinants of health (U.S. Department of Health & Human Services, 2014). Culture is listed as a component of social determinants that must be considered in meeting the goals of Healthy People 2020. Health equity cannot be attained without the consideration and knowledge of culture. Nurses must be educated on the concept of cultural competency in order to address the goals of Healthy People 2020.

## **Proposed Approach**

Currently no standards for essential competencies for cultural competency outcomes exist in pre-licensure nursing education (Calvillo et al., 2009). Although the term is interpreted in various ways, the current definition in nursing is based on a model of culturally competent healthcare: “the ongoing process in which the healthcare provider continuously strives to achieve the ability to effectively work within the cultural context of the client (individual, family, community)” (Campinha-Bacote, 2002, p. 181). Piecemeal information in core courses or optional electives is insufficient in preparing nursing graduates to respond to the demands of the increasing kinds of diversity in the community (Lipson & Desantis, 2007). Nursing schools have begun to address health disparities and related public health issues (Anderson, Calvillo, & Fongwa, 2007) but more work needs to be done to include consistent and accurate content on culture and related topics. Traditional methods of teaching and historical content cannot be expected to meet the global and cultural demands facing nursing graduates today. One extensive review of the literature in nursing education reports that service learning and study abroad opportunities are becoming more popular as part of nursing curricula but further transformation depends on finding a common language in delivering the concept of cultural competence (Kulbok, Mitchell, Glick, & Greiner, 2012). Evidence suggests that nursing education programs should have the concept of cultural competence imbedded throughout the curriculum in at least one course at each level for true integration. Nursing educators need to begin work to fully integrate the concept into the current curricula.

## **Summary**

If the profession of nursing is to have an impact on global and local health disparities, there needs to be a transformation in nursing education. Cultural competency education if done appropriately, is one of the essential keys for nursing education to achieve change and move towards health equity and improved outcomes. Nursing faculty members can become champions in the effort of cultural competency training by educating themselves on the definition and uniting on an approach to integrate the teaching of the concept to their students.

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## **Health Care Disparities Experienced by American Indians (AI's) and Alaska Natives (ANs)**

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N611  
July 25, 2016**

The US government has a trust and treaty obligation to provide health care services to AI's and ANs; however, some of the treaties and obligations have not been honored by the US government. In addition, there have been Acts passed through Congress which have had detrimental effects on the health care for AI's and ANs. For example, Knibb-Lamouche (2012) found that as a result of colonization, forced migration, and oppression, AI's and ANs experience poor health, high mortality, and higher rates of certain diseases such as diabetes. Furthermore, due to extreme levels of poverty among AI and ANs, this population experiences economic adversity, lower education attainment, and limited access to quality health care. As a result, AI's and ANs have experienced disproportionate health care disparities when compared to the general US population. In 2010, the Affordable Care Act (ACA) was passed and signed into law by President Obama.

There were several provisions in the ACA and one such provision is the Indian Health Care Improvement Act (IHCA). The ACA permanently reauthorized the IHCA, which included requirements to improve health care services for AI's and ANs, including adequate appropriation of funding for Indian health care, establishment of behavioral health programs, authorization to allow for collections from third-party insurers, Medicaid, and Medicare; and measures to increase health care providers in Indian Health Services (IHS). With these provisions, one would think that health care services have improved for AI's and ANs. However, numerous studies have shown that AI's and ANs continue to experience severe health care disparities when compared to the general US population, specifically, other minority groups.

### **Historical Background of Treaties and Trusts**

According to the Kaiser Family Foundation (KFF, 2004) as early as 1492, AI/AN tribes were sovereign and practiced traditional health practices. Eventually, treaties began to be established between tribes and the colonizers (KFF, 2004). The Commerce and Treaty Clauses of the Constitution (Article I, § 8, clause 3) "authorizes Congress to regulate commerce with foreign Nations, and among the several states, and with Indian Tribes". Treaty Clause (Article II, § 2, clause 2) "grants to the federal government the exclusive authority to make treaties on behalf of the United States" (KFF, 2004). *Worcester v. Georgia* held "that since the United States chose to relegate tribes to a dependent status in terms of tribal dealing with other nations, the federal government also assumed a trust responsibility towards the tribes and their members" (KFF, 2004). In 1921, the Snyder Act was passed for "providing explicit legislative authorization for

federal health programs for Indians by mandating the expenditure of funds for the relief of distress, conservation of health, and for the employment of physicians for Indian tribes” (Snyder Act of 1921). In 1928, the Meriam Report (also referred to as The Problem of Indian Administration) compared health services of the general US population with Indian health services, and the report revealed subpar education and health status of Indians (Institute for Government Research Studies in Administration, 1928).

The Johnson-O'Malley Act of 1934 “authorized the Secretary of the Interior to contract with states and territories for provisions of services for Indians” (Johnson-O'Malley Act, 1934). The Indian Reorganization Act of 1934 created changes to “encourage economic development and self-determination by tribes” (Indian Reorganization Act, 1934). Indian health care services continued to be inadequate throughout this time, and in 1954, the Transfer Act “moved the responsibility for Indian health to the Public Health Service” (Transfer Act, 1954). In 2010, the ACA was passed and includes provisions for Indian Health Services.

### **Historical Background of Health Care Disparities Experienced by AI's and ANs**

AI's/ANs have a life expectancy that is 4.2 years less than the general US population (IHS, 2016). According to the National Congress of American Indians (NCAI, 2016) AI's'/AN's rate of alcohol-related deaths are 552% higher than the general US population. Their rate of diabetes-related illness is 182% higher than the general US population (NCAI, 2016). AI's'/ANs' rate of death due to homicide is 83% higher than the general US population (NCAI, 2016), and AI's'/ANs' rate of death due to suicide is 74% higher than the general US population (NCAI, 2016). AI's/ANs have a maternal death rate that is 1.4 times higher than the general US population (NCAI, 2016). According to the Centers for Disease Control and Prevention (CDC, 2016), AI's/ANs accounted for 1% of the new HIV diagnoses in 2014. In 2013, the per capita spending for health care of the general US population was \$7,717, while the per capita spending for AI's/NAs was \$2,859 (NCAI, 2016). IHS remains “severely underfunded at only 59% of total need” (NCAI, 2016).

### **National Link to Healthy People and Current Initiatives to Address Health Care Disparities Experienced by AI's and ANs**

In 2010, the US Department of Health and Human Services (USDHHS) “unveiled Healthy People 2020, the nation's new 10 year goals and objectives for health promotion and disease prevention” (USDHHS, 2010). The topic areas for the goals included focusing on disparities for minorities, not only reduce health disparities, but also to eliminate health disparities experienced by minority populations, including AI's and AN's. The factors that influence health are determinants of health, including “genetics, individual behavior, socioeconomic status, physical environment, literacy levels and legislative policies” (Healthy People 2020, 2016). Healthy People 2020 (2016) recommends addressing social determinants of health by utilizing social and

physical environments to promote health by establishing a “place-based organizing framework” to focus on five key determinants, “economic stability, education, social and community context; health and health care, neighborhood and built environment.

### **Proposed Approach for Future Action on the National Incidence of Health Care Disparities Experienced by AI’s and NAs and Summary**

Kegler and Butterfoss (2012) found that rural populations, including many AI/AN communities, are at increased risk for experiencing health care disparities. To address this, coalition building and respectful communication are imperative. I propose that the federal government address health care disparities and social determinants of health and honors its trust and treaty obligations to AI’s and AN’s by fully funding and increasing the federal budget to \$28.7 billion. I also propose that the federal government adhere to the provisions included in the ACA which ensures access to health care, improve health care facilities, and to increase the number of health care professionals to provide care to AI’s and AN’s. As this is my population of interest, I believe it is important to develop coalitions/partnerships, and I propose to work with my state and federal senators and representatives to ensure the government honors its trust and treaty obligations to AI’s and AN’s. I also propose to advocate for AI’s and ANs by placing myself (and encouraging other professional nurses to do so) on governing boards for the health of AI and AN populations in my state.

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# **Oven-Baked Minds with Pharmaceutical Sauce: An American National Culture Recipe**

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**June 27, 2016**

To make oven baked minds with pharmaceutical sauce, start by locating individuals who suffer from any uncomfortable sensation. Back pain, depression, sleepiness, illness, headaches, muscle aches, bloating, nervousness, constipation, and memory loss are all good starting points, but feel free to add or mix and match additional sensations. Once your target population is identified proceed to create a medication that will “stop” those sensations. There is a possibility the medication will not work, work minimally, or cause side effects, but that is not your concern. Hire people who have “taken” the medication and advertise the reduction of their ailments. These advertisements will create the sauce that can be glazed over everyone’s minds slowly, convincing them life can be improved with the medication. Once you have convinced someone they need something they never knew they needed your dish is complete.

Despite having fewer than 5% of the world’s population, United States (U.S.) accounts for 80% of opioid and roughly 40% of global pharmaceutical sales (Manchikanti et al., 2010). Our culture has essentially become a culture of reliance where pills are relied on to take our problems away. Sensations such as depression, back pain, nervousness, bloating, and sleepiness are all natural human states yet we seek medications to eliminate these issues. Are we losing our ability to cope? Are we doing this for convenience? Should it be culturally acceptable to sedate your child rather than console? Perhaps direct-to-consumer pharmaceutical advertising has influenced us. I am in no way implying medications are not beneficial, but am stating that our over consumption and misuse of medications has its consequences. The creation of superbugs and prescription opioid overdoses are proof of this. Ignoring our national culture of dependence would be similar to allowing our minds to bake continually under a pharmaceutical sauce. If not addressed, I hope we have the capacity to digest the dish we have created.

## **Background, Evidence, Description**

Sales of pharmaceuticals are at an all-time high in the U.S., as the market is projected to reach \$548.4 billion by 2020 nationally (Global Data, 2015). In 2015, the industry spent \$5.2 billion on direct-to-consumer (DTC) advertising (ProCon, 2016). These companies are fully aware medications are nine times more likely to be prescribed when DTC advertising is conducted (United States General Accountability Office, 2002). Although studies have shown that DTC advertising is beneficial in providing patients information regarding medical conditions, it has also been shown to misinform and overemphasize medication benefits (Huh, DeLorme, Reid, & Soontae, 2010; Donohue, 2006). Additionally, DTC advertising has been known to stigmatize

normal body conditions and functions, thus creating a desire to eliminate common issues such as back pain and nausea with medication (Wilkes, Bell, & Kravitz, 2000). This criticism of DTC has resulted in all countries with the exception of U.S. and New Zealand to ban this practice (Gilbody, S., Wilson, P., & Watt, I., 2005).

As a result of this, Americans are now faced with the reality of superbugs and increased prescription opioid overdoses. The overreliance on antibiotics has created bacterial strains that are resistant to these medications and the problem is becoming worse (Capriotti, 2006). Despite this trend people continue to request and expect antibiotics to cure common ailments, indicating there is a severe disconnect (Mangione-Smith, 2001). If this trend is allowed to continue, antibiotic therapy will become ineffective against infections resulting in increased mortality rates.

Inappropriate expectations can also be found among pain sufferers. In 2014, nearly two million Americans abused or were dependent on prescription opioids (Substance Abuse and Mental Health Services Administration, 2015). One out of every four individuals prescribed chronic opioids for non-cancer pain now struggle with addiction (Boscarino, 2010). Today, nearly half of all U.S. opioid deaths involve a prescription opioid, which has exceeded heroin and cocaine deaths combined (Centers for Disease Control and Prevention, 2016).

### **Link to Healthy People 2020**

Healthy People 2020 was designed to create social environments to promote good health and strengthen policies with the best available evidence, yet we are not practicing this initiative (Healthy People 2020, 2016). Multiple studies indicate that DTC advertising has a negative impact on our society, but we allow it to continue. The aim of Medical Product Safety for Healthy People 2020 focuses on empowering individuals toward making informed health decisions and appropriate use of products, but the path we have taken indicates otherwise (Healthy People 2020, 2016). Surprisingly, its objectives focus on adverse events and drug overdoses, but do not include public perception or misinformation. DTC advertising contributes to those issues so it must be considered in future HP documents.

### **Proposed Idea for Action**

Acknowledging DTC advertising as a considerable problem would be the first step towards progression. Its exclusion from the Medical Product Safety objectives indicate it is not considered a serious issue: however, its banning from multiple countries proves otherwise. Leaders and consumers must be informed that DTC advertising promotes over-medicating and can increase health care cost (Ventola, 2011; Law, M., Soumerai, S., Adams, A., & Majumdar, S., 2009). Presenting them with this knowledge can be a catalyst towards change. Concerned prescribers, myself included, must also come together to voice their concerns and assist in the development of a position statement regarding inappropriate DTC advertising. As our society evolves we

must evolve and present our leaders with the best available evidence about the impact of DTC advertising on national health.

Consumer education must also be a priority. Oftentimes people are unaware they are making uninformed decisions due to lack of education about pharmaceuticals (O’Riordan, 1986). The public needs to be educated regarding the concerns for pharmaceutical DTC advertising, dangers of over medicating, and inappropriate use of medication. Education regarding the benefits of cognitive-behavioral therapy, family therapy, and preventive therapy as suitable alternatives to pharmaceuticals could improve public awareness. If the public continues to remain unaware they will not be empowered to make an informed decision, which goes directly against the goals of Healthy People 2020. A National education campaign should be conducted similar to the successful anti-smoking campaign. Tobacco, like pharmaceuticals, was once a socially accepted custom that was eventually shown to be harmful. Our leaders came together to fight this issue head-on, saving lives and money in the process (Centers for Disease Control and Prevention, 2016). Using the anti-smoking campaign as a guideline towards consumer education can provide us with a valuable resource.

## **Summary**

In conclusion, there is not a magical pill designed to take all of someone’s problems away. DTC advertising has been successful in convincing us otherwise. This practice will continue for as long as these companies continue to profit more than their lawsuits pay out (Outterson, 2012). Our denial of this contributes to the inappropriate use of medications and superbug creation, as consumer expectation does not match reality. DTC advertising omission from Healthy People 2020 indicates we are indeed denying it. An overhaul of the public’s perception regarding medications is long overdue. A national education campaign similar to the successful anti-smoking movement will help facilitate this. By taking these steps we will better inform the public leading us towards a path of recovery and vitality.

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# **A Culture of Sexual Trauma: How the Culture of the United States Military Creates a Culture That Condones Sexual Misconduct**

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**June 26, 2016**

## **A Culture that Condones Sexual Misconduct**

Military sexual trauma (MST) is described as sexual harassment or sexual assault that occurs during military service (Burns, et al. 2015). MST can occur in both women and men. In the United States (US) military, MST has become a wide spread problem that is going underreported and unprosecuted due to cultural norms that have existed for long periods of time.

### **Background**

The US military is well known for its might around the world. However, a serious flaw in the cultural construct of the US military has recently been uncovered. Recent studies have demonstrated that only 20 percent of sexual misconduct in the US military is actually reported (Vukotich, 2013). In 2013, 57,800 men and 77,000 women veterans demonstrated positive screens for MST (O'Brien, Keith, & Shoemaker, 2015). Unfortunately, certain aspects of longstanding military culture have been identified as being probable causes that promote sexual misconduct in the military: 1) widespread sexism; 2) hyper-masculine environments; 3) abuse of power and authority; and 4) reporting processes (Buchhandler-Raphael, 2014; Burns, et al. 2015). Widespread sexism and hyper-masculine environments are frequently defining cultures in military environments. Hyper-masculine behavior is behavior that promotes what is thought of as stereo-typical masculine behavior. New recruits, E1 through E4 grades, are often subjected to hyper-masculine environments (Buchhandler-Raphael, 2014). Terms such as "pussies" or "sissies" degrade genders and sexual minorities (O'Brien, Keith, & Shoemaker, 2015). In these environments, a culture is created that creates perceptions such as "men don't get raped"; "male rape is about homosexuality"; "they should have escaped"; or "rape victims are not seriously affected" (O'Brien, Keith, & Shoemaker, 2015; Burns, et al. 2014; Voller, Street, & Polusny, 2015). This immersion into a masculine environment is continually reinforced for recruits and others (Weitz, 2015). The complexity of sexual assault and management of it falls to the hands of military leaders (Castro, et al. 2015). Service members often encounter barriers in reporting sexual trauma (Holland, Rabelo, & Cortina, 2016). A victim of sexual trauma may have to remain in a unit with the perpetrator if the unit commander does not escalate or act upon the report. In fact, it has been demonstrated that higher-ranking individuals may use their power to place increased pressure on the victim for accepting the sexual trauma (Buchhandler-Raphael, 2014). There is considerable damage done on the fighting force itself by sexual trauma. Female victims often report higher levels of post-traumatic stress disorder (PTSD), difficulty adjusting to society, eating disorders, and

alcohol abuse (Burns, et al. 2014). Men have demonstrated higher rates of psychiatric hospitalization and symptoms, distress, substance abuse, and self-harming (O'Brien, Keith, & Shoemaker, 2015). After suffering sexual trauma, many of these members are unable to remain an effective part of the fighting force. A need exists to finally confront and resolve this model of human degradation and abuse.

## **Goals**

As part of the Healthy People 2020 goals, health-related quality of life (HRQOL) and well-being has been chosen to represent the victims of sexual trauma in the US Military. The goal of HRQOL is that people will report: 1) self-rated physical and mental health; 2) overall wellbeing; and 3) participation in society. By decreasing and eliminating sexual trauma in the military, we can better serve our military members and veterans and leave them with self-reported quality of life.

## **Proposed Approach**

We must be proactive in addressing the care of our military members and veterans (Biggins, et al. 2013). The age of hyper-masculinity in the military should to come to an end. Terms that are derogatory towards other genders or sexual practice need to be removed from the everyday vocabulary of military members. Training should instead focus on building a force that focuses on the task at hand rather than inappropriate descriptors or disrespectful communication. Recently, the US military has begun a program called Sexual Harassment and Assault Response (SHARP). The program has been tasked with defining cultures that promote sexual trauma in the military (Fromm, 2015). The program should focus on strengthening investigation and prosecution of reported events (Burns, et al. 2014). By demonstrating that the military is willing to address and actively confront sexual trauma, barriers of discomfort with reporting and feared reprisals should diminish and allow for better management and prevention of sexual trauma (Vukotich, 2013). Health care providers need to be specially educated in dealing with issues specific to US military members (Cooper, Andrew, & Fossey, 2015). Resources need to be advanced for these military members to access care and reporting (Kuehner, 2013). Opening these resources could help military members seek out care and report if they have been the victims of sexual trauma. Similar to the civilian world, the military could find great success in training and use of Sexual Assault Nurse Examiners (SANE).

## **Take Home Points**

Current and historical trends in the US military have bred a culture that often supports or hides sexual trauma. Military leaders, as well as health care providers, need to be sensitive to adapting changes to decrease and eliminate the practice of sexual trauma in the US military. By tearing down previously-built reporting behaviors and cultural structures, the US, military can restore a strong fighting force free of sexual trauma, devoted to a shared vision of serving and protecting the citizens. It is long overdue.

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# **Meeting Syrian Refugee Mental Health Needs in the United States**

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**June 27, 2016; Revised July 25, 2016**

Estimates indicate that globally, one in every 122 humans is either a refugee, seeking asylum, or internally displaced within their homeland (United Nations High Commissioner for Refugees, 2015) due to war, violence, lack of food, environmental disasters and oppression. Since 2011, the war in Syria has triggered the highest level of global mass migration ever recorded; Syrians will constitute more than 18% of the total migrant population in 2016 (McNeely & Morland, 2016). In response to this global migration crisis, the US is raising the annual ceiling on total migrant and refugee admissions from 70,000 in 2015 to 100,000 by 2017 (Newland, 2015) with the specific goal of admitting a minimum of 10,000 displaced Syrians per year starting in 2016 (U.S. Department of State, 2016). Among challenges that will be created by this influx of Syrian immigrants, the mental health of these people will need to be a national public health priority (McNeely & Morland, 2016). Thus, there is the need to develop culturally appropriate mental health care interventions for this vulnerable population.

## **Background, Evidence, and Description**

As the war in Syria continues, the number of conflict-affected refugees entering the US will be on the rise. Pre-migration experiences of trauma, persecution and displacement predispose many refugees to symptoms of psychological and social distress. Among other social, economic, and legal stressors associated with post-migration, Syrian refugees have the additional challenge of facing discriminatory attitudes related to post-9/11 terrorist fears (Newland, 2015). While symptoms of emotional distress precipitated by these factors are common, they do not necessarily indicate the presence of a chronic mental disorder (Hassan, Ventevogel, Jefee-Bahloul, Barkil-Oteo, & Kirmayer, 2016). In fact, Syrian refugees are tremendously resilient; many experiencing acute trauma will recover within the first year of exposure if stability and safety are established (Jefee-Bahloul, Barkil-Oteo, Pless-Mullooli, & Fouad, 2015). Thus, culturally appropriate early interventions that foster resiliency are critical.

In the US, refugee mental health interventions have been driven by the medical model of psychological distress. The problem with this approach is that it pathologizes symptoms of trauma (Murray, Davidson, & Schweitzer, 2010), leading to over-diagnosis of illness. This becomes especially problematic when applied to refugee populations who view health from unique cultural perspectives (Szajna & Ward, 2015). In Syrian culture specifically, expression of emotions is socially acceptable and perceived as a routine aspect of life. Thus, the labeling of distress as a psychological problem becomes a source of shame (Hassan et al., 2016). Furthermore, the U.S. model relies on medical jargon which contributes to language barriers and prevents therapeutic

communication. Thus, the U.S. 'standard of care' interventions tend to be culturally insensitive and need to be rethought to address the needs of Syrian refugees.

### **Link to Healthy People 2020**

In the US, the elimination of health disparities is a national priority established by the Health People 2020 initiatives (Zografos & Perez, 2014). Specifically, an overarching goal of Healthy People 2020 is the creation of social and physical environments that promote good health for all by addressing the unique social and cultural determinates of health (U.S. Department of Health and Human Services, 2012); this must include the recognition of migration itself as a distinct social determinant of health. Specifically, the migration process has significant social, economic and health consequences for refugees. These consequences are a result of both pre-migration social determinants, such as poverty and persecution, as well as the migration event itself, which represents a critical social determinant of health in its own right (Castaneda et al., 2015). Examining migration through a social determinants of health lens would reveal how Syrian refugee experiences, challenges and cultural beliefs impact health.

### **Idea for Action**

First, aligning with Healthy People 2020 initiatives, the US must aim to address the social determinants affecting the health of Syrian refugees. To date, the failure to recognize migration itself as both socially determined and a social determinant of health has led to both an incomplete conceptualization of health inequalities (Castaneda et al., 2015) and a disparity in how the renegotiation of cultural identity after migration impacts mental health (Shaw, Dorling, & Smith, 2006). Failure to consider the complex health effects that migration has on Syrian refugees will prohibit creation of effective interventions. To achieve health equity, this must be a priority.

Next, it is necessary to shift from the traditional U.S. medical model, which uses a 'top-down' approach where mental health specialists unilaterally determine strategies for care, toward a community-based, 'ground-up' public health approach that is sensitive to Syrian refugee priorities. This strategy would deconstruct the power differentials in the mental health provider-refugee relationship, fostering therapeutic connection, equitable engagement and social justice. It would also reduce stigma, foster resiliency, ensure cultural salience, and build community capacity. The inside knowledge related to mental health that emerges from engagement with the Syrian refugee community will be valuable for the development of novel and culturally-specific interventions; obtaining indigenous wisdom and personal narratives of adversity is itself an essential component of personal and social healing (Murray et al., 2010). This will strengthen individual, community and cultural resources, promoting mental health (Baarnhielm, 2016).

Finally, steps must be taken to ensure that all Americans are educated about Syrian refugee culture through educational programs in schools and workplaces, facilitating cultural humility and acceptance while minimizing irrational fears. Of

particular importance in this context, mental health providers must be both culturally competent and open to new ways of understanding that transcend the dominant medical model. When cultural considerations are ignored, this adversely impacts refugee mental health (Huang & Zane, 2016). Mental health providers must be able to differentiate between normal stress reactions and mental disorders (Baarnhielm, 2016); this requires sociocultural knowledge and cultural humility. Cultural competency must not be conceptualized as a skillset, but rather as a lifelong process and ongoing commitment to engaging, learning, and mutual respect (Tervalon & Murray-Garcia, 1998). While several factors, including stigma, language barriers, and power dynamics of the therapeutic relationship influence access to mental health services for Syrian refugees (Hassan et al., 2015), these barriers will be mitigated when trust and collaboration are maximized.

## Summary

In response to the global Syrian migration crisis, the U.S. government has committed to accept a large number of Syrian refugees in the coming years. It will be critical to deliver culturally sensitive mental health care to these refugees and the current medical model is not ideal for effectively dealing with this situation. To provide effective and culturally-sensitive mental health care, it is proposed that the US must 1) address the effects of social determinants, including migration, on Syrian refugee health, 2) embrace a community-based public health approach responsive to the unique needs of the Syrian population, and 3) develop educational programs for all Americans, particularly mental health care providers, about the essence of sociocultural knowledge and cultural humility. This three-step social justice approach will foster resiliency, ensure cultural salience, and aim to achieve health equity, important steps to prepare for the imminent influx of Syrian refugees into the US and their unique mental health needs.

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## **Rural Health**

# **Rural Nutrition**

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**N611**

**June 26, 2016**

Nutrition is commonly understood to be a basic necessity for human existence and thriving. The need for nutrition knows no boundaries due to ethnicity, regional location or religious background; it is an essential requirement for the wellbeing of humans and all other living organism. The concept of adequate nutrition is so elemental that the lack of adequate and healthy nutrition in the United States (US) is disconcerting and worrisome. It is further enraging that in a country with as many resources as the US, the communities that are responsible for feeding the nation, such as our rural and farming communities, have citizens who are uncertain whether they will have a meal to eat each day (Feeding America, 2016).

Rural communities in United States are an established and important component of our national identity. The United States Census Bureau (2016) defines urbanized areas as areas that have a population of 50,000 or more people and the land use, commercial or residential, is considered highly developed. Further defined into urban clusters are those areas in which the population is at least 2,500 residents, but fewer than 50,000. Rural areas are classified as the exception to those parameters, or settings that do not meet the above definition of urban or urban clusters. The U.S. Department of Agriculture Economic Research Service (2016) adds that rural locales are areas of open countryside. The lack of concrete, consistent definitions and multiple explanations of rural make research in these areas a challenging endeavor due to multiple interpretations of the terms. Grappling with the many portrayals and definitions of rural complicates the analysis of specific problems and proposed solutions in the current state of healthcare delivery.

## **Background, Evidence, Description**

Rural areas continue to struggle with a variety of health disparities and challenges. Examples of the major issues are the following: continuous population loss (especially of younger residents), the inability to overcome poverty, and barriers to educate the members of the community (United States Department of Agriculture, 2016). Rural West Texas, familiar to this author, is following these same trends and patters that impact the rest of the rural nation. The West Texas region is experiencing slow population growth, but overall population has declined especially in areas not neighboring a metropolitan (urban) area. The area is also changing, as demographic profiles are radically shifting and economic hardships continue to rise (Texas Tech University Health Sciences Center, 2016). Rural Healthy People 2020 identifies that nutrition is a topic in the top 10 concerns for rural populations (Public Health, Texas A&M Health Science Center, n.d.). A growing concern exists as rural communities are facing higher rates of food insecurity than their urban counterparts. It is currently estimated that 17% of households in Texas are faced with food insecurity, higher than



the national average of 14% (Feeding America, 2016). This fact is indeed a cause for concern in West Texas, as the author has seen firsthand.

The Centers for Disease Control and Prevention (2012) defined food desert as an area that has a shortage of affordable foods that make up a nutritious diet. The foods that make up healthy diets are fruits, vegetables, whole grains and other foods that are proven to support health and vitality. Beaulac, Kristjansson and Cummins (2009) found that socioeconomic inequality related to nutrition exists in the US, indicating the need for policy implementation at the federal, state and local level that would address these disparities. The low socioeconomic status that is common in rural areas can directly affect the access to nutritious food and contribute to the existence of food deserts in these locations.

The healthcare system has begun to take a closer look at chronic illnesses in our country due to the increased burden placed on the economic indexes and growth of our country. The injustice of inadequate nutrition is addressed here, as it has been found to increase disease and weaken the immune system (The State of Food and Agriculture, 2013). The ability to produce positive change in this area (e.g., in capacity for healthy engagement in school and the workplace, attainment of life goals and good quality of life) is far more economical than treating the burden of chronic illness and reduced ability to thrive in a difficult environment. This shift will require a change agent, which in this case is proposed to be the nursing profession.

### **Link to Healthy People 2020**

In an effort to reduce health disparities, Healthy People 2020 formulated leading health indicators that will assess challenges the nation faces in an effort to reduce health disparities and inequities (Healthy People 2020, 2016b). Healthy People 2020 (2016) identifies nutrition and the access to nutritious foods as the essential beginning to allow individuals to adhere to a healthy diet and thrive. It also acknowledges that obtaining nutritious foods is currently more difficult in low-income or rural areas. The ability to address the nutritional status of individuals should be a basic assessment by nurses in environments such as schools, health care organizations, and community venues (Healthy People 2020, 2016a).

We understand Maslow's Hierarchy of Needs and the important need for basic needs to be met such as adequate nutrition, critical to insure survival and quality of life (McLeod, 2016). If this basic need is not met then meaningful progress according to Maslow's Hierarchy of Needs in the rural population becomes stagnant. Many nurses in practice consider this topic a societal issue, although the direct impact on wellness and health should have the undivided attention of nurses everywhere in the country, in a variety of practice settings. In a society that is fighting for equality for all, nurses are well positioned to advocate for food security while educating those in their care about adequate nutrition. The nursing profession as a whole is a significant stakeholder in the healthcare system, with approximately 3.1 million RNs, or about 10 nurses per 1,000 persons in the US (The Truth About Nursing, 2009). Professional nurses are direct

providers of care and are often first hand witness to poor outcomes in patients who been denied the equal distribution of healthcare nutrition to meet their basic needs. Therefore, achieving health equity should be a priority for nurses, and this is supported by the American Nurses Association (ANA) in their revised social policy statement (ANA, 2010).

### **Proposed Idea for Action**

In the context that nurses must complete a full head to toe assessment of those patients in their care, an intentional action to address nutrition should also occur. This added appraisal could be done not only for individuals, but also for families and groups within the community. Numerous specific instruments and tools exist to do nutritional assessments. One example is used by the United States Department of Agriculture and may be seen at <http://fnic.nal.usda.gov/dietary-guidance/individual-dietary-assessment>. Nutritional status is usually overlooked and passed on to the dietician, who will possibly be asked to visit with the patient. Follow-up and interaction with nurses is often overlooked. The link between adequate nutrition and health/wellness has been established and nurses must take a proactive approach to educating individuals in their care.

In the community setting nurses, are able to provide education for effective change. Nurses must begin by forming relationships that are founded on trust formation and is necessary as behavior modification is the goal. In an attempt to achieve the goal it is absolutely necessary to establish rapport and partnership to achieve long-term change. If change is necessary for health, nurses must meet individuals where they are on the journey of achieving wellbeing. Nurses should begin by educating, as it is a core function of nursing practice. This action will require nurses to become active members of boards in local communities and at the state level in their practicing states that address rural food insecurity and “food deserts.” Nurses need to become activists to influence policy and nursing practice in rural communities to reduce health disparities.

### **Take-Home Points**

As part of an overall effort to reduce rural health disparities related to food deserts, I propose that a basic nutritional assessment, including the access to nutritional foods be incorporated in the basic nursing assessment done in multiple environments. The assessment can be used in all patient interactions across rural healthcare settings. Although, the notion of a basic nutritional assessment seems elemental, the burden being currently experienced in our healthcare system due to chronic illness in its absence is unsustainable. The nursing profession should align nursing practice to reduce poor health outcomes related to nutritional deficiencies. Patient education and the use of established nutritional assessments should become routine in rural patient care. Nurses have the power to effectively promote and advocate for nursing practice change. Nurses are recognized for the ability to effectively promote and lead the way in innovative approaches to meet the needs of the population being served, it is in the process of innovation that the proposed nutritional assessment should be considered

(The Robert Wood Johnson Foundation, 2011) The inclusion of a nutritional assessment in the rural community is absolutely necessary for nurses to adequately assess and meet the health care needs of the rural population, link residents to food-related resources and improve health outcomes in the rural population.

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# Tobacco Use in Rural New Mexico

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N 611

July 27, 2016

Smoking tobacco has become the leading cause of preventable death in the US and is a major risk factor for morbidity and mortality related to cancers, cardiovascular disease, and respiratory disease (Centers for Disease Control and Prevention, 2015). In spite of unwavering evidence, black box warnings, and public campaigns, 20% of adults in New Mexico (NM) currently smoke tobacco and almost 5% use smokeless tobacco products (New Mexico Department of Health [NMDOH], 2016a; NMDOH, 2016b). Tobacco use is an especially challenging problem for rural communities where smoking and smokeless tobacco products are consistently more prevalent than in urban areas. Based on national survey data, 24% to 28% of rural residents as compared to 21% to 23% of urban dwellers currently smoke cigarettes. Furthermore, smokeless tobacco is twice as prevalent among rural residents as compared to urban residents (American Lung Association, 2012; Roberts et al., 2016). About one third of NM residents live in rural areas (U.S. Department of Agriculture [USDA], 2016), placing them at increased risk for tobacco use. Tobacco use in NM must be addressed with special consideration given to the unique needs of rural populations.

## **New Mexico: Background and Evidence**

*Rural New Mexico:* As shown below, a large portion of land in NM is rural and there are numerous rural counties with higher than average proportions of adult smokers. In addition, males, lower levels of education or income, and being unemployed or uninsured are associated with tobacco use (NMDOH, 2014b). Smokeless tobacco is also a concern; prevalence among rural NM residents (7.3%) doubles that of urban residents (3.3%), and usage continues to increase (NMDOH, 2016b). It is important to acknowledge that 23 Indian tribes live within the state's borders, each with its own government, lifestyles, and culture (New Mexico Indian Affairs Department, n.d.). National surveys are often not created specifically for these cultures; therefore, the data may not be as accurate in these communities.

*Barriers to smoking cessation in rural communities:* Challenges for decreasing tobacco use in rural communities are multifaceted. Rural communities in NM have higher rates of poverty, lower education levels, and higher unemployment rates than the average for rural areas in the US, as well as, urban areas in NM (USDA, 2016). However, the effect of rurality on tobacco use extends beyond that of poverty (Roberts et al., 2016). Poor healthcare infrastructure including access to providers, cessation programs, technology, and reasonably priced medications add to the problem (Crosby, Casey, Wendel, Mills, & Vanderpool, 2012; Geletko & Bellamy, 2015). Additionally, close-knit rural communities can be difficult to infiltrate due to a sense of pride regarding independence and self-reliance. Even when cessation programs are accessible, social oppression, stress, and targeted tobacco marketing campaigns contribute to societal

norms that encourage tobacco use (Crosby et al., 2012; Dino, Pignataro, Horn, & Anesetti-Rothermel, 2012; Tobacco Use Prevention and Control, n.d.).

*Current programs.* The NM Tobacco Use Prevention and Control program includes community-based outreach; however, it encourages the use of phone and web based services, which is not culturally sensitive to rural communities that lack access to technology (Tobacco Use Prevention and Control, n.d.). The NMDOH (2014b) created a health improvement plan that includes rebuilding and engaging community councils; however, more focus needs to be placed on the specific and diverse needs of rural communities. In spite of these programs, NM received a failing grade from the American Lung Association (2016) for cessation efforts, citing low funding, inadequate taxes on tobacco products, and poor access to cessation services.

### **Tobacco Use and Healthy People 2020**

Decreasing the use of tobacco products in rural settings aligns with Rural healthy people 2020 (Geletko & Bellamy, 2015) and the Healthy people 2020 tobacco use objectives, which include: (a) reducing initiation and tobacco use for all ages; (b) increasing screening and counseling in healthcare settings; (c) increasing access to evidence based, sustainable, and comprehensive cessation programs; and (d) using policy to create smoke free environments, increase taxes on tobacco products, reduce illegal sales to minors, and reduce marketing to adolescents (Office of Disease Prevention and Health Promotion, 2016).

### **Proposed Approach for Action**

The use of *Best Practices for Comprehensive Tobacco Control Program* is recommended to guide the development of a multidimensional state program to reduce tobacco use. The guide includes evidence based strategies to encourage social norm change, decrease tobacco-related disparities, utilize mass campaigns and quit-lines, improve health systems, expand insurance coverage, and evaluate progress (Centers for Disease Control and Prevention, 2014).

However, the success of cessation programs in rural communities is largely dependent upon acceptance by key stakeholders who exhibit influence in the community. These members should be involved in every step of the process so that potential social barriers common in close-knit rural communities such as strong independence, pride, self-reliance, and resiliency can be used as strengths for the initiative. Also, community members should be trained to be tobacco cessation leaders and educators to allow the community to become their own healthcare resource, bridging the infrastructure gap, and creating access to resources greatly needed in rural areas. A sustainable and culturally sensitive cessation program includes close collaboration with the community and is based on respect for local beliefs, values, and priorities, as well as, an understanding of the context including the geographical, social, political, and economic needs of the area (Crosby et al., 2012; Drobac, Basilico, Messac, Walton, & Farmer, 2013).

## Summary

Tobacco use has detrimental effects on health and yet, 20% of NM residents smoke tobacco and almost 5% use smokeless tobacco. Prevalence of tobacco use is higher among rural populations, where it can be challenging to address the problem due to lack of access to health resources and societal norms that encourage tobacco use. Rural populations tend to have a strong sense of community and take pride in their independence and self-reliance. This can be beneficial to cessation initiatives if influential community members are supportive of the program. Specially trained community members can help bridge the infrastructure gap and increase sustainability. Strategies for reducing tobacco use should be community based, culturally respectful, and context specific.

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## **Access to Mental Health Care for the Rural American Indian Population**

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**N 611**

**July 15, 2016**

Access to health services is defined as the “timely use of personal health services to achieve the best possible health outcomes” (Institute of Medicine, 1993, p. 202), encompassing insurance/health coverage, services, timeliness, and workforce (U. S. D. H. H. S. Office of Disease Prevention & Health Promotion, 2016a). Access to health care is a determinant of health for Americans, and as with such other determinants of health, disparities exist (Isaac, 2013; Smedley, Stith, & Nelson, 2003). For instance, American Indian (AI) people have higher uninsured rates when compared to White people, and in addition to other measures, uninsured rates are used to evaluate the degree to which individuals/groups have access to health care (Agency for Healthcare Research and Quality, 2016; Joe, 2003). Further, access to care has been identified as one of eight key factors in rural health (Crosby, Casey, Wendel, Mills, & Vanderpool, 2012). While this disparity exists for AI people residing in both urban and rural communities, those living in rural areas face unique challenges that impede access.

More specifically, access to mental health care is an even greater problem for rural America, where 87% of nonmetropolitan “counties are totally or partly in a mental health care [health professional shortage areas]” (HPSA; Miller, 2009, p. 14). As AI people who reside in rural areas are more likely to receive health insurance coverage through Indian Health Services (IHS) without alternate or additional coverage, they are much less likely to receive needed specialty services such as mental health (Baldwin et al., 2008). For example, it is estimated that one in three rural U. S. counties has no health care professionals prepared to provide mental health care services (McCord, Elliott, Brossart, & Castillo, 2012). Furthermore, social norms and values in the context of rurality can limit access to mental health care due to heightened stigma surrounding mental illness and lesser acceptance of and willingness to seek treatment (Snowden, Masland, Ma, & Ciemens, 2006).

This brief will discuss the issues surrounding access to mental health care experienced by the rural population, and specifically AI people residing in rural communities in the U. S. Further, this brief will describe links to the Healthy People 2020 objectives and the Rural Healthy People 2020 goals and objectives. Lastly, this brief will propose action to improve access to mental health care for the rural AI population.

## **Background, Evidence, Description**

While the majority of AI people reside in urban communities, access to health care for AI people living in rural communities remains an important consideration. Although AI people residing on federal reservations or tribal lands often have better access to healthcare provided by IHS than their urban counterparts (Duran et al., 2005; Zuckerman, Haley, Roubideaux, & Lillie-Blanton, 2004), they nonetheless experience issues with access to care within the context of rurality. For instance, harsh living conditions (e.g. absence of utilities) and geographic isolation have been identified as obstacles to care for rural-residing AI people (Duran et al., 2005).

Furthermore, there are marked disparities in access to and availability of mental health care in rural America (McCord et al., 2012). Compared to their urban counterparts, AI people living in rural areas face unique challenges in accessing mental health care, such as geography, higher poverty rates, and mental health care HPSAs (Crosby et al., 2012). In addition, AI people experience worse outcomes related to the access of mental health care when compared to their White rural counterparts (Agency for Healthcare Research and Quality, 2016; Grandbois, 2005), highlighting another racial/ethnic disparity and necessitating action.

## **Link to Healthy People 2020**

With a focus on expanding treatment, Healthy People 2020 has an objective aimed at increasing the “proportion of primary care facilities that provide mental health treatment onsite or by paid referral” (U. S. D. H. H. S. Office of Disease Prevention & Health Promotion, 2016b). While indirectly, meeting this objective has the potential to improve access to mental health care for rural AI people. Further, there are several objectives specific to access to care, such as increasing the “proportion of persons with health insurance” and increasing the “proportion of persons who have a specific source of ongoing care” (U. S. D. H. H. S. Office of Disease Prevention & Health Promotion, 2016a).

There are no Healthy People 2020 topics or objectives that are specific to rural communities; therefore, Rural Healthy People 2020 was created and is referenced here. In identifying the top 10 priorities for Rural Healthy People 2020, “access to health care” and “mental health and mental disorders” rank numbers one and four, respectively (Bolin, Bellamy, Ferdinand, Kash, & Helduser, 2015). Subareas within the priority issue of access to health care include “rural access to quality health insurance,” “access to primary care in rural areas,” and “rural access to quality emergency services” (Bolin et al., 2015). Lastly, mental health and mental health disorders is ranked as the fourth priority health concern for rural communities (Bolin et al., 2015). There remains a disproportionate burden of mental health illness within rural communities (McCord et al., 2012), rendering it a priority rural health concern.

## **Proposed Action**

For solutions to the unique challenges faced in accessing mental health care by AI people residing in rural communities, thinking must occur “outside the box.” Similar to a framework described by E. Holguin (colleague), one potential solution is to bring mental health services to the rural AI people. Services such as consultation, assessment, counseling, and therapy are well-suited to be administered via a mobile health platform. Also similar to the mobile “meth cooking lab” seen on the popular television series *Breaking Bad*, mental health services could be distributed to rural AI clients via a “mobile mental health dispensary.” Mobile mental health services administered by specialized mental health professionals would address barriers of access to mental health care for AI people living in rural areas, such as lack of providers due to mental health care HPSAs, and some transportation and geography issues. Work will be needed to secure community support and funds to make this happen. In addition, results of this effort will need evaluation to establish evidence of its effectiveness.

## **Conclusion**

Access to care is an important factor in any person’s health and well-being. Barriers of and disparities in access to care impact equity in the use of services and the related health outcomes among groups in the U.S. Rural communities experience higher rates of mental illness than urban communities do (McCord et al., 2012), creating a locale disparity. Complicating matters further, AI people experience higher rates of mental illness such as substance abuse and suicide than other Americans do (Gone & Trimble, 2012), creating a racial disparity.

American Indian people living in rural areas experience unique challenges with access to health care, and access to mental health care services may be even more problematic. For example, geographic isolation is a common barrier among rural, reservation-dwelling AI people that is unique, as AI people residing in urban communities do not have to contend with this issue.

Access to general and mental health care services are priority concerns for rural public health, as demonstrated by numerous Healthy People 2020 and Rural Healthy People 2020 topics and objectives. However, challenges to resolution remain, and disparities in access to care for rural AI people continue. Mobile health may be a viable solution, if support and funding can be secured. Specifically, a mobile mental health dispensary is worth testing to address issues related to access to mental health care for the rural AI population, and to determine its acceptability and effectiveness in this population.

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# **A Nurse-Led Prenatal Mobile Dispensary Unit to Reduce Infant Mortality in Rural U.S. Populations: A Policy Proposal**

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**July 10, 2016**

## **Infant Mortality Rate Reduction in Rural America**

The infant mortality rate (IMR) of a society reflects the socioeconomic well-being, prevailing public health conditions, and overall health status of a population (Miller 2011; Bryant 2009). Relatively speaking, the gap between the United States and nations with the lowest IMRs is widening (MacDorman; Miller 2011). Thirty- three nations have better IMRs than the United States, despite the fact that the U.S. ranks first in health care spending per capita (Miller 2011; Johnson 2014).

It is well known that increased participation in enhanced prenatal care programs reduces infant mortality (Meghea et al., 2015; Partridge et al., 2012; Kassir et al., 2013). However, there is an uneven distribution of hospitals that offer obstetrical care throughout the United States (Kozhimannil et al., 2013). Nonmetropolitan and rural areas are more likely to be medically underserved coupled with poor transportation (Singh & Siahpush, e19); rural women experience higher driving times to access obstetric care (Rayburn et al., 2012 in Kozhimannil et al, 2015). Furthermore, women who travel farther for services have worse birth outcomes including higher infant mortality rates (Kozhimannil et al., 2015).

## **Background**

Within the U.S., we must be concerned about the linkage between socioeconomic status (SES), race/ethnicity, and infant mortality rates. Higher neonatal, postnatal and infant mortality rates are directly associated with preterm births; preterm births are more prevalent in lower SES groups and racial and ethnic subgroups (MacDorman 2011). Rural populations tend to be comprised of minorities who are socially and economically advantaged. The health of our 62 million (NRHA, 2016) rural residents are influenced by geography coupled with SES disparities (Downey, 2013).

Preventing preterm births is paramount for the reduction of the infant mortality rate; preterm babies are more likely than full-term babies to die within the first year of life (MacDorman 2011). Opportunities for linking pregnant women with interventions for their health and well-being and that of their infants are presented frequently in the prenatal period; potential intervention benefits include increased growth, reduced risk of infection, and increased survival for infants (Brown 2008); impoverished mothers are known to have worse birth outcomes (Aizer 2011).

Quality care for infant mortality disparity elimination requires attention at both the individual and societal level (Rowley 2012). The CDC taskforce on preconception health found that many women of childbearing age do not currently access preventive services within their communities and they note that their geographical location and neighborhood may negatively impact their ability to access care and reach “their full potential for health and well-being” (Johnson 2014). At present, clinical care is not considered to be equitable and is believed to be contributing to disparities in care (Rowley 2012); a study performed in New Mexico between 1989 and 1999 found that mothers from low-income areas received lower levels of prenatal care (Schillaci 2010). A policy statement by the American Academy of Pediatrics that endorses equity-based pediatric practice in clinical care recognizes that providers can no longer neglect the importance of effective care specifically intended to reduce disparities in infant mortality (Rowley 2012). In reality, to effect positive systemic change, an alignment must exist between those at the health service level and those in the external policy environment (Wakerman 2011).

### **Proposed Approach**

Bodenheimer (1969) stated that “the fundamental problem of rural health is the extremely low density of health professionals per unit of surface area, resulting in large distance between patient and service” (p. 144). This statement remains true today. Due to the rural nature of much of the United States, I suggest implementation of a mobile dispensary unit to increase access and service availability. A mobile dispensary will allow for visitation and critical assessment of home and social environments (Bryant 2009). In 2008, a Kenyan study demonstrated a positive correlation between number of prenatal visits provided by a mobile dispensary and number of live births and likelihood of having a healthy weight baby (Brown 2008).

### **New Mexico Pilot**

An initial trial with a mobile dispensary unit targeting identified counties in New Mexico could be utilized as a means for preliminary data collection regarding infant mortality rates and their correlation with increasingly regular access to prenatal care. The New Mexico IMR is 6.9, higher than the national average of 6.2. State birth rates and teen birth rates in New Mexico are consistently higher than the national average. More than half (51.9%) of infants were born to single mothers compared to the national average of 40.7% (NM Dept. of Health, 2012).

Several determinants of newborn morbidity and mortality risk were identified by Bhutta et al. (2012). Determinants most pertinent to the state of New Mexico include poverty, poor access to services, sociocultural, and illiteracy or lack of education. The large rural population and significant levels of both poverty and infant mortality make New Mexico a rational starting point for initial implementation and subsequently expanded to other states with stakeholder interest. Preliminary data can then be interpreted and developed into meaningful policy change on health care delivery for rural and underserved populations.



## **Cost-Effectiveness**

A cost-effective and efficient mode of prenatal and postnatal care delivery would be care delivered solely by registered nurses, nurse practitioners, and nurse midwives by way of a mobile dispensary unit. Bauer notes that “overall costs of medical care are held at unnecessarily high levels by policies that prevent substituting nurse practitioners for physicians” (Bauer 2010). Fairman et al. (2011) call for an increase in the scope of nursing practice to treat the influx of patients due to the Affordable Care Act. She states that nurses would be integral members of interdisciplinary teams needed to provide case management to health and illness services. Expanded scope of nursing practice and team-based approaches have been shown to improve quality of care and patient satisfaction, and also demonstrate cost reduction (Fairman 2011).

## **Link to Sustainable Development Goals**

In keeping with the aim of the United Nations that all nations strive toward the sustainable development goals (SDGs) (United Nations Economic and Social Council, 2015), this initiative would address indicator 3.2 and metric 3.2.2 pertaining to the reduction of neonatal mortality rate under SDG 3, Good Health and Well-Being. Regular access to prenatal care will also contribute to indicator 3.1 pertaining to maternal mortality reduction and increased proportion of births attended by skilled health professionals. This initiative also draws on SDG 10, Reduced Inequalities and SDG 17, Partnership for the Goals. SDG 1, No Poverty and SDG 11, Sustainable Cities and Communities will contribute to improved infrastructure for communities in which this initiative may take place.

## **Summary**

Research on mobile dispensaries in the United States used to address health care needs by increasing access are lacking. Potential policy implications exist at the local and state levels and would align U.S. initiative with the SDGs. This model has application to primary care and could fit other disease models (e.g. COPD, CHF) as well. Economic studies are needed to determine efficiency and effectiveness for the model as a whole versus traditional free-standing clinics, and also effectiveness of nurse staffing. Cost-savings determined by decreased intensive care stays should also be calculated in order to have a greater impact on policymakers' decisions. In summary, a nurse-led mobile dispensary for prenatal care will be a cost-effective mechanism for reducing IMR and increasing health care access in rural America. In addition, this initial model will serve as a prototype for rural communities across the United States and can potentially be adapted to treat other disease processes and reduce public health disparities.

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## Appendix A: Figure 1

**Table 1. Determinants of infant morbidity and mortality**

Distal determinant	Proximal determinant	Associated newborn morbidity & risk of mortality
Poverty Low birth weight, SGA, prematurity, IUGR, neonatal infection	Maternal undernutrition  Maternal infections	
Poor access to services IUGR, prematurity, birth asphyxia	Late identification and referral  for high-risk pregnancies	
Sociocultural Mother-to-child transmission  Birth asphyxia	Women's empowerment  Lack of social support system  Cultural taboos Unsafe/unprotected sex Drug abuse Domestic violence	
Illiteracy/lack Mother-to-child transmission of education	Maternal infections	

Source: Adapted from Table 1 in: Bhutta, Z.A., Cabral, S., Chan, C., & Keenan, W.J. (2012). Reducing maternal, newborn, and infant mortality globally: an integrated action agenda. *International Journal of Gynecology & Obstetrics*, 119 (1), S13-S17.

# **Community Health Workers: A Vital Link in Rural Health**

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**July 14, 2016**

While health disparities are a global and national issue, many of the disparities are concentrated in rural settings (Sumaya, 2012). Poorer access to care, lower rates of preventive screening, decreased treatment for chronic diseases and mental health problems, and higher rates of morbidity from acute and chronic conditions are seen more in rural versus urban areas (Crosby, Casey, Wendel, Mills, & Vanderpool, 2012). Rural areas also have more elderly, unemployment, lower economic status, and uninsured than urban areas. A primary challenge to access to care in rural areas is a shortage of healthcare professionals. One solution to dealing with the challenges in rural health is to increase the use of community health workers (CHWs) to supplement and substitute for the lack of nurses and physicians in rural areas. Recent Medicaid changes allow reimbursement for non-licensed providers such as CHWs but the change requires a State Plan Amendment (De Biasis, 2014). This brief proposes that states that have rural areas with a lack of nurses and physicians are in need of such an amendment to deal with the health disparities that exist.

## **Background**

Historically, community health workers have had many titles including village health workers, lay health workers, promotores, and community health representatives (CHRs). They lack professional healthcare certification but they are proving to be instrumental in their ability to reach and connect with community members, and have the potential to greatly impact disease prevention and health promotion efforts (Pallas et al., 2013). They are trusted members of the community that they serve with training to assist the nurses and physicians that may not be connected to the community or are remotely located from the community. CHWs are indigenous public health workers that have the ability to bridge the gap between the community and health care services (Kim et al., 2016). Current research supports the impact that CHWs can have on health promotion and disease prevention or maintenance efforts (Lipp, 2011). There are many examples in the literature on the positive impact that CHWs have had on controlling chronic disease, improving screening rates and diagnosis for cancer, and prevention of illness or disease (National Center for Chronic Disease Prevention and Health Promotion, 2015).

## **Link to HP 2020**

One of the four overarching goals established by Healthy People 2020 is to “achieve health equity, eliminate disparities, and improve the health of all groups” (Healthy People 2020, n.d.). As a result of the disparities that exist in rural areas, Rural Healthy People 2020 was designed to advance the promotion of the health of those living in rural communities (Bolin & Bellamy, 2012). The top priority for Rural Healthy

People 2020 based on survey response was access to quality health services. A recommendation on making an impact on rural health for next steps was identified as considering prevention and care management models in rural areas that take a community-wide focus. The role of the CHW can be a prevention and care management model that rural health is needing in the absence of nurses and physicians.

## **Proposed Approach**

Programs utilizing CHWs have been shown to be effective in addressing health disparities in diverse ethnic and rural communities (Center for Disease Control and Prevention, 2015). There needs to be a concerted effort across the United States to gain reimbursement for non-licensed providers such as CHWs. If CHWs could be reimbursed for their services, more volunteer CHWs could attain employment, which helps the rural economy. Reimbursement would also stimulate the economy as potential employers could create more CHW positions to supplement or replace nurse vacancies that exist in rural settings. The opportunity for reimbursing community prevention and health promotion efforts has come as CHWs are being recognized for their work. Healthcare professionals in each state need to be aware of the process and advocate for CHW reimbursement. Medicaid agencies need to be supported and encouraged to request a State Plan Amendment (SPA). CHW advocates need to meet with local Managed Care Organizations (MCOs) to develop workforce innovation partnerships to hire and support the work of CHWs. By collaborating with state Medicaid agencies to submit and implement SPAs, healthcare professionals and their agencies in each state can play a part in advancing the support that is needed in funding CHW work for rural areas. Some states have paved the way for such innovations, such as Minnesota which enacted CHW payment legislation in 2008 (Association of State and Territorial Health Officials, 2015).

## **Summary**

Research evidence indicates that CHWs can have a positive impact on cancer prevention screening, chronic disease management and health promotion activities in their communities (Wynn & Fouad, 2012). It is time to recognize a profession that serves diverse and rural areas that are underserved by nurses and physicians. Partnerships with public health and other health care delivery systems such as MCOs can support the efforts to Medicaid agencies to submit SPAs that can establish reimbursement for CHW services. Taking action for reimbursement could not only provide a livelihood for someone's work in their community but ultimately save lives and improve the healthcare for those living in rural areas. With the current shortage of healthcare professionals in rural areas, CHWs could be the most vital link to health care for their communities.

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## **Mental Health and Substance Abuse Issue in New Mexico**

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N611  
July 15, 2016**

According to the United States Census Bureau (2015), as of July 1, 2015, the population in NM is estimated to be 2,085,109, and of these residents, 46.4% are Hispanic and 8.7% are American Indian (AI). The New Mexico Department of Health (NMDOH, 2012) posits that NM is one of the most rural states in the country. As a result of being such a rural state, many New Mexico minorities, including many Hispanics and AI's have difficulty accessing health care services, including mental health and substance abuse services. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2015) states that approximately 72,000 NM adults have mental health and/or substance abuse disorders.

Minorities in NM experience increased mental health and substance abuse issues. For example, AI's in NM have a 70% higher rate of alcohol-related deaths when compared to Hispanics and Whites, and AI's in NM have the highest rate of adult suicide (NMDOH, 2014). In addition, AI's in NM have double the US rate of youth suicides. Also, according to the NMDOH (2014), Hispanics in NM have the highest drug overdose death rates when compared to the general population. Alcohol-related deaths, suicide deaths, and drug overdose deaths are indicative of substance abuse and mental health illness. In order to examine the issue of mental health and substance abuse, we must first examine the national history of addressing mental health and substance abuse issues, what the current initiatives are and consistent with the intent of this brief, what I propose for future initiatives for addressing mental health and substance abuse issues in NM.

### **History of Mental Health and Substance Abuse Services**

In 1992, the United States Appropriations Committee requested that the National Advisory Mental Health Council (NAMHC) prepare a report on the cost of mental health parity, and in 1993, the NAMHC presented the Health Care Reform for American's with Severe Mental Illness report (NAMHC, 1993). The report determined that mental illnesses and substance abuse disorders were treatable and could be cost-effective with legislation. The report also revealed that minority people with substance abuse disorders and/or mental health disorders did not have adequate health insurance to ensure access to mental health and substance abuse treatment. As a result of this report, the Mental Health Parity Act of 1996 (MHPA, 1996) was passed. This Act aligned coverage for mental health and substance abuse treatment with that of medical and surgical benefits. However, it only applied to insurance companies that already offered mental health and substance abuse benefits. In 2008, the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (NHPAEA, 2008) was signed into law. This Act was designed to require health care insurance companies to



ensure that mental health benefits would not have financial requirements or treatment limitations.

In 2010, the Affordable Care Act (ACA, 2010) was signed into law on the federal level. The purpose of the ACA was to increase health insurance coverage for Americans. There are provisions in the ACA that specifically addresses mental health and substance abuse treatment and coverage for AI's. One provision is the Indian Health Care Improvement Act (IHCIA). The ACA permanently reauthorizes the IHCIA to improve health care services for AI's, including appropriation of funding for Indian Health care and establishment of behavioral (mental) health and substance abuse services. The ACA also built upon the MHPA and MHPAEA by expanding the federal mental health parity requirements and to create mandated health coverage for mental health and substance abuse disorders, to include inpatient and outpatient services, in addition, to ensure that medications to treat mental health and substance abuse disorders must be covered.

### **National Link to Healthy People and Current Initiatives to Address Mental Health and Substance Abuse Disorders**

In 2010, the US Department of Health and Human Services (USDHHS) revealed a new 10-year goal with objectives for health promotion and disease prevention, known as Healthy People 2020. According to Healthy People 2020 (2016) the objectives and recommendations to address mental health and substance abuse disorders includes reducing the suicide rate, increasing the proportion of primary care facilities that provide mental health treatment onsite, increasing depression screening by primary care providers, and increasing the proportion of persons with co-occurring substance abuse and mental disorders who receive treatment for both disorders.

### **Proposed Approach for Future Action to Address Mental Health and Substance Abuse Ideas for Action**

In NM, minorities such as AI's and Hispanics experience increased risk of alcohol-related deaths, suicide deaths, and drug overdose deaths, in comparison to the general population. McCord, Elliott, Brossart, and Castillo (2012) found that living in a rural area can make accessing mental health services especially difficult. One recommendation to combat this problem is for local health care providers to utilize long-distance technology such as telecommunications and consultations which allows expert health care providers at a distance to assess, counsel, and treat patients with mental health or substance abuse disorders. According to Vockley (2015), telemedicine technology is cost-effective and an efficient method for delivery of health care. An Adult Behavioral Health Program Evaluation Report (ABHPER, 2014) suggests that NM's expansion of Medicaid under the ACA is expected to improve behavioral health outcomes, following recommendations from Healthy People 2020. The report recommends increasing the funding for NM behavioral health services to \$538 million for fiscal year 2015. The report also recommends utilizing Assertive Community Treatment Approach (ACTA), supported housing, Cognitive Behavioral Therapies

(CBT), Screening, Brief Intervention and Referral to Treatment (SBIRT), Matrix Model Intensive Output (IOP), and Methadone and Buprenorphine programs. My recommendations are that mental health care providers utilize telecommunications, as noted above, since this is a proven effective tool to provide mental health and substance abuse services to people in rural areas. In addition, I recommend that mental health care providers utilize ACTA, CBT, supported housing, SBIRT, IOP, and Methadone and Buprenorphine programs. By utilizing these programs, mental health care providers can treat patients with mental health or substance abuse disorders. Lastly, I recommend that NM increase its funding for behavioral services and continue its Medicaid expansion to provide mental health care coverage for its residents. This recommendation will require interactions between legislators and rural community representatives, including advocates for this increase in resources for mental and behavioral health.

## Summary

A significant but resolvable problem exists in NM regarding equitable access to mental health and substance abuse services, especially for minority populations. By following the recommendations of Healthy People 2020, adhering to the provisions of the ACA, utilizing the programs recommended by the ABHPER, building responsive community partnerships, and utilizing telecommunication, NM can meet the objectives from Healthy People 2020 to improve behavioral health outcomes for minorities in NM, specifically alcohol-related deaths, suicide, and overdose deaths. All citizens can benefit, but the Hispanic and AI groups stand to benefit the most. Since their rates of tragic outcomes exceed those of the general population, the proposed actions are long overdue.

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## **Young Lost Souls Soup: A Rural Recipe**

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**July 15, 2016**

To make young lost souls soup, start by locating youths in an isolated community with limited resources. I highly recommend rural communities with high unemployment rates and poverty levels as those typically make the perfect base. Sprinkle in highly addictive substances such as alcohol, marijuana, methamphetamines, and opioids. These additives should cause the community to simmer a bit resulting in escape attempts by addicted souls from our soup. To prevent this, ensure there is limited access to substance abuse prevention, treatment, and recovery programs. Doing this will keep the community drug-addicted and escaping will no longer be a concern. Within time, your soup will come to a boil and addiction will be passed down from generation to generation creating the perfect lost souls soup.

Substance abuse prevention and treatment resources typically focus on urban areas; however, approximately 15% of Americans (46.2 million people) reside in rural counties (Kusmin, 2014). Despite the common assumption that rural areas are devoid of urban issues, substance abuse is also a significant problem within rural communities and in some instances worse (Becker, 1994). Rural substance abusers tend to be less ethnically diverse, younger, and unemployed with higher rates of alcohol, opioid, marijuana, and stimulant abuse than compared to their urban counterparts (Substance Abuse and Mental Health Services Administration, 2012). As each generation within these communities suffer from drug addiction they can become desensitized to its effects and addiction may viewed as a normal part of life. Without the proper resources these addicted souls become lost within our society only to be uprooted for statistical data. In order to break this cycle, steps must be taken to empower rural communities to recover these lost souls.

### **Background, Evidence, Description**

Addressing the impact of substance abuse in America carries an estimated cost of more than \$600 billion annually (Substance Abuse and Mental Health Services Administration, 2016). By 2020, it is projected that mental and substance abuse disorders will surpass all physical diseases as a major cause of disability worldwide (Substance Abuse and Mental Health Services Administration, 2016). Additionally, drug and alcohol use has been linked to other diseases such as diabetes and heart disease (Substance Abuse and Mental Health Services Administration, 2016). A survey uncovered substance abuse as a top ten priority in rural communities and coincidentally, so are diabetes and heart disease (Bolin & Bellamy, 2016). In 2000, rural youths were reported to have a higher probability of becoming substance abusers than their urban counterparts (Kraman, 2004). Further studies indicate substance abuse among rural youths is in fact 4% higher than urban youths (Hutchison, 2004).

There is a concern that the lack of educational and recreational resources within rural areas leads to boredom, which drives substance abuse. Community centers, bowling alleys, or arcades are typically non-existent in rural areas, leading youths to seek other options for entertainment which includes drug use (Willging, Quintero, & Lilliott, 2014). Many rural youths state they turn to drugs because they are simply bored and have nothing else to do (Willging, Quintero, & Lilliott, 2014). Despite their admitted drug addictions, many view themselves as “clean” as these practices become a normal part of their daily lives (Willging, Trujillo, & La Luz, 2004).

Rural residents are known to have less access to substance abuse treatment centers related to their geographical locations, less likely to seek out treatment due to associated psychological stigma, and often lack the financial resources necessary for treatment (Sexton et al., 2008). Additionally, rural mental health workers in schools receive less training than those who staff urban schools (Van Gundy, 2006). Adequate services such as counseling, outpatient, inpatient, medication assisted treatment, and recovery support services are often not available to the rural communities due to these barriers.

### **Link to Healthy People 2020**

Healthy People 2020 recognizes that substance abuse problems must be addressed to protect the safety, health, and quality of life for all (Healthy People 2020, 2016). In the past five years, adolescent abuse of prescription drugs has continued to rise and this increase can contribute to higher incidences of crime, teenage pregnancy, sexually transmitted diseases, and homicides (Healthy People 2020, 2016). It is reported that almost 95% of people with substance abuse problems are unaware they have a problem (Healthy People 2020, 2016). These findings are consistent with rural youths who consider themselves “clean” and not addicted due to routine daily drug use (Willging, Trujillo, & La Luz, 2004).

### **Proposed Idea for Action**

A three-step plan consisting of prevention, treatment, and recovery must be implemented to reverse this trend. Prevention will be aimed at educating youths regarding the dangers of substance abuse. Education will focus on alcohol, opioids, marijuana, and stimulants, as those are the most commonly abused drugs in rural areas (Substance Abuse and Mental Health Services Administration, 2012). Youths must realize that any form of substance abuse is indeed abnormal and there is not a “clean” form of substance abuse. The justification of turning to drugs due to boredom may sound reasonable; however, youths nationwide have reported an increase of available non-productive leisure time and yet their substance abuse is less prevalent (Zick, 2010). Rural youths’ economic realities and future possibilities are likely the underlying contributors to their perception of boredom (Jervis, Spicer, & Manson, 2003). To create a positive atmosphere, funding must be identified and provided to the community so that drug free social spaces, educational, and vocational training opportunities can be developed.

To increase treatment and recovery options, states need to require public and private insurers provide coverage for counseling, outpatient, inpatient, medication assisted treatment, and recovery support services. This action involves significant changes to policies and laws. The Mental Health Parity and Addiction Equity Act ensures health insurance plans covering more than 50 employees have this coverage. However, small businesses are not mandated to do so (United States Department of Labor, 2010). Reforming this plan will allow those who work in small businesses to obtain these services. A partnership between crisis hotlines and local services must also be formulated in all rural areas. These hotlines can provide free confidential substance abuse counseling, but must be aware of the available resources within each community. Additional options for access to treatment and recovery experts exist in universities with telehealth or Internet capacity, and should be engaged for rural communities. Coordinated treatment methods such as this have been shown to dramatically increase the use of substance abuse services (National Safety Council, 2016).

## **Summary**

Due to the geographical isolation of rural communities they can often become lost within our larger society. Once the backbone of our country, these areas are now struggling to obtain adequate assistance as America has consolidated its resources into urban areas. Substance abuse is a top ten priority among these rural areas and if not addressed it will lead to chronic health issues causing further demise. Rural youths have increased rates of substance abuse compared to their urban counterparts, and if they are going to be the future leaders for rural communities this trend must be reversed. The three-step plan of prevention, treatment, and recovery will help achieve this, but will require work on the part of the rural communities themselves. Educating the youths and providing them with adequate resources will empower these communities to overcome these dilemmas and secure a safer future and quality of life for America. Ignoring these facts will produce more young lost souls eventually leading to an overflow of our pot. Acknowledging the problem today will prevent this catastrophic spill from ever occurring and will shift our methods towards a reduction. These actions will result in an improved life for all and a reduction in years of young lives lost.

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# **Killing Small Town Kids: A Look at the Lack of Pediatric Critical Care in Rural America**

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## **Background**

Nineteen percent of Americans live in rural areas (Seright & Winters, 2015). With increasing costs of care, many rural communities lack care from practicing physicians. As many as 80% of the small rural hospitals participate in the Critical Access Hospital(CAH) program. Many of these hospitals still struggle with reimbursement and physician and nurse recruitment (Pink, Holmes, Slikfin, & Thompson, 2009). Financial viability of these hospitals is frequently in question (Rosko & Mutter, 2010). If a physician is available, the physician will frequently only have specializations in family medicine. Many nurses in these small facilities report that their hospitals are good for minor injuries or illness, not major problems (Baernholdt, et al. 2014).

Pediatric patients in rural areas are more often likely to come from backgrounds of poverty (Peltz, et al. 2016). These pediatric patients will likely have many unmet medical needs. With reduction of community based medical care, many basic needs of health prevention are unavailable. As a result, the only presentation to care many of these children have is when they are faced with acute critical illness or injury. As a population, pediatric patients have unique needs for care. Many of these unique needs go unmet when they are in need of critical care. Nurses and physicians may lack the frequent exposure and experience needed to practice competently during a pediatric emergency. Pediatric patients in need of increased level of care are forced to travel to tertiary levels of care, which frequently results in increased costs that may not be able to be met by impoverished pediatric patients. As a solution to varied levels of critical care available in rural areas, telemedicine is frequently used as a tool to provide care that could not otherwise be provided. However, the use of telemedicine continues to go largely undeveloped for the pediatric population (Ray, et al. 2016).

## **Goals**

As part of the United Nations Millennium Goals and the WHO Sustainable Development Goals, there has been a call for the reduction of childhood mortality and promotion of childhood well-being (United Nations, 2016; <http://www.un.org/sustainabledevelopment/health/>). Increasing the level of pediatric critical care and critical care access can directly impact addressing this goal in the United States. Decreasing proportions of mortality is feasible (Norheim, et al. 2015). Identifying goals that are achievable could help in the reduction of these avoidable deaths (Nordheim, et al. 2015).

## Proposed Approach

Quality of care is frequently called into question in rural communities for pediatric critical care. In order to assist the local staff in better recognition of critical needs for these critically ill pediatric patients, education needs to be paramount. Appropriate education about pediatric critical care management and referrals can provide and sustain resilience in healthcare professionals (Lee, et al. 2015). Education has been found to promote recognition and early transfer of patients to tertiary care centers (Heath, et al. 2009). This then improves the overall health, well-being and prognosis for rural children. Through this recognition a more efficient use of beds can be recognized and implemented (McWilliams, et al. 2013). One way to provide greater recognition and increased levels of care is to allow nursing and physician staff to have access and participate in high fidelity simulations (Campbell, 2015). High fidelity simulations provide these clinicians with realistic training and preparation for scenarios that could frequent the rural populations. Through frequent practicing these clinicians could be exposed to and experience a comfort level with practicing in critical care.

Measures must be taken to ensure the financial viability and expense of rural hospitals that provide care to these pediatric patients. There is currently great concern over the viability of existing programs (Rosko & Mutter, 2010). Many of these children from impoverished homes only have Medicaid funding. The current levels of prospective payment are not enough to keep these hospitals viable and operational. Those children presenting to a CAH must continue to receive subsidies from the federal government. These programs will worsen the financial distress of rural based care if they become solely centered on receiving prospective payments (Holmes, Pink, & Friedman, 2013).

These financial measures must also include supporting and funding increased technologies in rural areas. Telemedicine is becoming more prevalent in rural emergency departments (Ellenby & Marcin, 2015). Telemedicine is the “use of medical information shared from one site to another” (Burke & Hall, 2015, p. 136). Many of the telemedicine consultations are currently not provided for pediatric care (Ray, et al. 2016). Telemedicine can provide care from researchers actively engaged in frontline care techniques (Burke & Hall, 2015, p.136). It can provide access to pediatric patients who would likely have to go without the care of a pediatric specialist otherwise (Burke & Hall, 2015, p. 136). Funds must be devoted to training health care providers in rural areas to utilize telemedicine effectively. A tool is only as good as its use. Therefore, clinicians who are going to be using telemedicine during critical care should not only have input into the build of the technology, but also the effective use of the technology during critical situations.

## Summary

The level of care in rural areas for pediatric patients in the United States continues to be poor. As these frequently impoverished children grow, they are often deprived of the basic necessities of medical care, including critical care management and intervention. As a result, they frequently present to rural community hospitals critically ill and in need of costly tertiary care. Lack of staff, both nurses and physicians, frequently leads to poor treatment decisions and ultimately higher mortality rates for children in rural America. These needs can be addressed by: 1) promoting increased education; 2) increasing funding to both Critical Access Hospitals and rural community hospitals (implies work with legislators and local advocates); 3) and increasing the availability and efficiency of telemedicine programs. Accomplishment of these goals can better assist the United States in reducing childhood mortality and adhere to the goals defined by the United Nations Millennium Goals and the WHO Sustainable Development Goals.

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# Mitigating the Opioid Epidemic in Rural America

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**July 14, 2016**

Globally, opioid misuse is a significant and growing clinical and economic problem that is associated with a high rate of opioid-related morbidity and mortality. In the US, nearly 2.5 million Americans have a substance use disorder involving opioids (Substance Abuse and Mental Health Services Administration, 2015). Within this group, 1.9 million engage in prescription opioid misuse (POM), while 586,000 abuse heroin (Substance Abuse and Mental Health Services Administration, 2015). As of 2012, drug overdose became the leading cause of accidental death in the US (American Society of Addiction Medicine), with more than half of these fatalities opioid-related (Center for Disease Control and Prevention, 2015). The effect of this opioid epidemic has been most pronounced in rural states, which have experienced the largest increase in frequency of fatal overdose to opiates over the past decade (Hall et al., 2008), mostly attributed to POM (Wang, Becker, & Fiellin, 2013). Given these sobering statistics, there is a critical unmet need to develop approaches to address the opioid epidemic in the rural US.

## **Background, Evidence, and Description**

Over the past 20 years, excessive prescribing and illegal diversion of prescription medications have contributed to the opioid crisis in rural communities. In fact, the origins of the POM epidemic can be traced to rural America (Monnat & Rigg, 2016) where there are higher rates of labor-based jobs, leading to increased numbers of occupational injuries and associated disability due to chronic pain (Florence, Pack, Southerland, & Wykoff, 2012) that is typically treated medically with opioids. Thus, in rural areas, prescription drug use has become embedded in the culture as a means to maintain steady employment (Keyes, Cerda, Brady, Havens, & Galea, 2014). Additionally, rural populations are faced with deteriorating economic conditions, lower income, worse self-reported health status, and greater frequency of emergency department visits, all of which are factors associated with POM (Rigg & Monnat, 2015). Given that prescription opioids are more expensive, less potent, and becoming more difficult to access, many rural prescription opioid users have transitioned to injection heroin use (Cicero & Kuehn, 2014) sparking a dual POM and heroin crisis in rural regions.

Opioid-agonist medication-assisted therapy (MAT) with buprenorphine or methadone is globally accepted as the most effective treatment for opioid dependence, reducing morbidity, mortality and spread of needle-borne infectious disease (Sigmon, 2014). Unfortunately, these therapies remain largely inaccessible in rural areas due to geographic misdistribution of physicians and methadone clinics as well as federal prescriptive restrictions on buprenorphine (O'Connor, 2011). Specifically, greater than 59 million people in the US live in a rural area where only 9% of health care providers

practice (Bolin et al., 2015). This limits access to all services including MAT. Furthermore, only physicians who complete training and obtain a waiver can prescribe buprenorphine, and only 46% of US counties have a physician with this privilege, leaving 30 million rural persons without access to MAT (Rosenblatt, Andrilla, Catlin, & Larson, 2015). Additionally, naloxone, a safe and effective antidote for life-threatening opioid overdose, is administered less commonly in rural areas (Faul et al., 2015). Overall, treatment for substance use disorders is accessed half as frequently in rural versus urban areas, translating into a doubling of the death rate for rural opioid misusers (Hirchak & Murphy, 2016).

In summary, high rates of opioid prescribing and transition from POM to heroin coupled with lack of access to naloxone and MAT have led to the disproportionate rate of opioid-related morbidity and mortality in the rural US. Commitment of federal resources to enable safer prescribing and reduced prescription diversion (Meyer, Patel, Rattana, Quock, & Mody, 2014) has not effectively mitigated the epidemic, which is a bigger problem rurally because prescription diversion occurs mainly via family and social networks, which are larger and stronger in rural settings (Keyes et al., 2014). To confront this problem, there must be simultaneous efforts to stop the diversion of prescription opioids to nonmedical users, to expand opioid treatment access, and to ensure culturally relevant care to rural populations in crisis.

### **Link to Healthy People 2020**

Healthy People 2020 has identified substance abuse prevention and treatment as a national priority; increased access to treatment providers and substance abuse services has been set as a benchmark goal (U.S. Department of Health and Human Services, 2012). Complimenting this, Rural Healthy People 2020 has identified this as a priority as well (Bolin et al., 2015). Currently, given an undersupply of mental health and specialty addiction providers rurally, access to MAT has remained largely unattainable in these regions. For those that can afford treatment in urban areas, in addition to significant travel burden, they must obtain care from providers that have little understanding of rural culture (Oser & Harp, 2015). Thus, to ensure attaining the goals of the Healthy People initiatives, rural access to MAT must be expanded and the unique cultural, familial and social norms specific to the rural US must be understood and integrated into the opioid treatment paradigm to elevate the likelihood of success.

### **Idea for Action**

To tackle the disproportionate rates of opioid-related morbidity and mortality among rural Americans, this brief proposes a two stage plan of action. First, in alignment with Healthy People 2020 goals, efforts must be made to protect rural persons already dependent on opioids from overdose and opioid-related harms by expanding treatment access in rural areas. This includes expanding access to MAT and naloxone. Improved MAT access could be accomplished by expanding prescriptive authority of buprenorphine to Nurse Practitioners who are significantly more likely than physicians to practice in rural, federally designated primary care shortage areas most

impacted by the opioid epidemic (DesRoches et al., 2013). Given that naloxone is life-saving, without serious adverse effects or potential for abuse, and can be administered by anyone, it too must be made widely available to all individuals living in rural communities faced with this problem, not just emergency medical personnel. Second, in addition to federal government efforts to enhance prescription monitoring and to reduce excessive prescribing, there must be specific efforts made to reduce opioid prescription diversion through social networks in rural areas. Given that POM is embedded in rural culture and the main source of opioids in rural areas is through social networks, this will require community-level engagement to promote action-oriented critical dialogue and social analysis of the root causes (Minkler & Wallerstein, 2008) of the opioid problems that are specific to their area. This type of community-level change is more sustainable, impacts infrastructure, and aids in shifting cultural norms (Centers for Disease Control and Prevention, 2010). Thus, a community-based approach would build community capacity to address this problem and reshape cultural perceptions of POM and heroin use in rural areas most impacted by the opioid epidemic.

## Summary

The escalating opioid epidemic is a public health crisis that weighs most heavily in the rural US where morbidity and mortality are the highest. The problem concentrates rurally because of unprecedented rates of opioid prescribing, lack of access to life-saving treatments, and cultural acceptance of opioids as a routine part of life. To address this rural opioid epidemic, it is proposed that access to MAT is enhanced in underserved rural areas, that naloxone be made widely available rurally to prevent death from acute overdose, and that local coalitions be built to drive sustainable community-level change while shifting rural opioid misuse cultural norms.

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