



**A Cultural Competency Model for
American Indians, Alaska Natives, and
Native Hawaiians**

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It's through their artistic expression in tribal art that different cultures are united. From the sacred Turtle of the Hawaiians and the tattoo designs of the Mauri and Plains Indians, the tribal patterns of the Alaskan Natives and the counting techniques of the Aztec Indians there are over 10 regions represented on the cover. The artist, Jolene Nenibah Yazzie, is a Dine' woman from the Navajo Reservation. Her goal in designing the cover was to represent all Indigenous cultures in a way that the differences and similarities between them are portrayed as clearly and accurately as possible.

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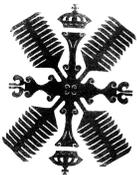
Preface

What is it like treating a patient infected with the Human Immunodeficiency Virus (HIV) who does not have a word for this virus or to explain the etiology of this virus in their language? How does one do it well for the American Indian, the Alaska Native and the Native Hawaiian (AI/AN/NH)?

AI/AN/NH Indigenous people have been and continue to be impacted with health and social well-being challenges. The information in this manual includes cultural beliefs and values that affect how these populations respond to traditional Western health care, their forms of communication, and overall their response to non-Indigenous providers. Most people don't know what these impacts are nor do they know the answer to the previous questions. To successfully service these Indigenous populations, a health care provider must make a diligent effort to learn about the cultural beliefs and values of the populations being served.

This paradoxical concept has been presented to the National Minority AIDS Education and Training Center (NMAETC), which has taken the lead through the BE SAFE Model to help health care providers become comfortable in treating and improving the health outcomes of AI/AN/NH. This program supports the training of physicians, physician assistants, nurses, nurse practitioners, dentists, clinical pharmacists, Indigenous healers, spiritual healers and other health care providers in the treatment and management of HIV/AIDS.

The NMAETC is a collaborative network of experts funded by the Health Resources and Services Administration (HRSA) to provide HIV and AIDS education and training to health care providers that treat minority patients throughout the United States, including Alaska and Hawaii. This manual serves to provide health care providers with information that includes cultural beliefs and values that affect how these populations respond to non-Indigenous providers and non-Indigenous health care practices.



Acknowledgements

We dedicate this manual to our brothers and sisters who have bravely crossed over and we will continue to commit our dedication through the work of this manual as a reminder to others that we will never concede to 'the enemy' - HIV or AIDS.

Our ideas about the principles and practice of Western medicine have been greatly influenced by many cultures, teachers, colleagues, and spiritual and traditional people. We feel privileged to have been inspired and nurtured by many outstanding mentors, including Wesley Thomas, John Lowe, Betty E.S. Duran, Gloria Zuniga, Cissy Elm, Melvin Harrison, Laura Orapeza, Joe Cantil, Carol Makanai Carol Kualii'i and Yvonne Davis. We are pleased to help educate our health care providers in their current practices and for future generations of health care providers toward effective and cultural appropriate treatment for American Indians, Alaska Natives and Native Hawaiians infected and affected by HIV.

We thank our contributors for graciously reading drafts of this manual in their spare time and for contributing many valuable suggestions toward culturally appropriate treatment modalities.

We hope that this manual will serve as a useful reference to health care professionals, both those who currently work and those who have never worked with AI/AN/NH people, as they embark on productive careers in providing culturally appropriate health care.

The National Minority AIDS Education and Training Center thanks our colleagues for their contribution and support of this project.

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American Indians, Alaska Natives, and Native Hawaiians are the Indigenous populations of the United States. The cultural diversity among these groups is extensive, which is further compounded by diagnoses of HIV/AIDS. The information in this chapter is intended to provide health care workers with knowledge about the three Indigenous groups that will enhance workers' cultural competence when working with these populations. The information provided is broad and general, therefore, providers are encouraged to further their knowledge by learning more about specific client villages, tribes or communities in their service areas. References are provided at the end of each chapter for further reading.

Introduction

BE SAFE MODEL FOR AMERICAN INDIANS, ALASKA NATIVES, AND NATIVE HAWAIIANS

American Indians, Alaska Natives, and Native Hawaiians are the Indigenous populations of the United States.

Population Demographics

The three broad categories of Indigenous populations of the United States are American Indian, Alaska Natives and Native Hawaiians (henceforth referred to as Indigenous people or AI/AN/NH). The 2000 U.S. Census reported that 4.3 million people (1.5% of the U.S. population) identified themselves as being of American Indian or Alaska Native ancestry. Of this group, 3.1 million claimed membership in a specific American Indian and Alaska Native tribe (0.9%). Census 2000 reported a population of 475,579 individuals claiming Native Hawaiian ancestry alone or in combination with another race (0.3% of the U.S. population). The Hawaii Department of Health, Bureau of Vital Statistics reported in the Hawaii Health Survey 2003 a resident Native Hawaiian population of 258,489 living in the State of Hawaii (<http://www.hawaii.gov/doh/>).

Currently, there are approximately 700 American Indian tribes and Alaska Native corporations (henceforth referred to as “tribes”) in the United States, with 569 tribes holding a special trust relationship with the United States Government. In the state of Alaska, there are 229 federally recognized Alaska Native tribes. Native Hawaiians originate from the state of Hawaii and are reported to reside throughout the continental United States. For American Indians, there are over 150 different language groups, as well as a diversity of cultures among American Indian and Alaska Native tribes. There are 20 distinct Alaska Native languages among the cultural groups most commonly referred to as Aleut, Alutiiq, Athabascan, Eyak, Yup’ik, Inupiat, Tlingit, Haida, and Tsimshian (<http://www.uaf.edu/anlc/languages.html>). Native Hawaiians have only one language for their population.

Federal Trust Relationship

American Indian and Alaska Native: There are 556 federally recognized tribes in the United States. These tribes hold a special legal relationship with the U.S. Government. The Supreme Court first recognized the existence of federal-Indian trust relationships in its early cases interpreting Indian treaties. Between 1787 and 1871, the United States entered into nearly four hundred treaties with Indian tribes. In these treaties, the United States obtained the land it wanted from the tribes, and in return guaranteed that the federal government would respect “the sovereignty of the tribes” and would “protect the tribes” and would provide food, clothing, and services to the tribes.” The promises were made in exchange for millions of acres of tribal lands and imposed on the federal government “moral obligations of the highest responsibility and trust.” This principle - that the government has a duty to keep its word and fulfill its responsibility - is known as the *doctrine of trust responsibility* (Pevar, 2002, p. 32).

The relationship between *Alaska Natives* and the United States government began with the Treaty of Cession of 1867, wherein Russia transferred to the United States its interest in the scattered settlements along the Aleutian Islands, the Gulf of Alaska, and Southeast Alaska in exchange for \$7.2 million. The treaty linked the treatment of Alaska Natives with that of American Indians by specifying that the “uncivilized tribes” of Alaska were to be “subject to such laws and regulations as the United States may, from time to time, adopt in regard to aboriginal tribes of that country” (Cordes, 1990).

In 1905 the Nelson Act authorized federal appropriations for education and support of Alaska Natives. This was the first of a number of statutes acknowledging federal responsibility for services specifically for Alaska Natives. Over the next twenty-five years, congressional appropriations to the Bureau of Education enabled the operation of health facilities either built or converted from school buildings at 11 village sites (Cordes, 1990).

The Snyder Act of 1921, a general assistance act for Indians, charged the Bureau of Indian Affairs (BIA) to direct, supervise, and expend congressional appropriations for “relief of distress and conservation of health” of American Indians. It charged the BIA to employ physicians for that purpose. Lacking BIA offices in Alaska,

the act did not apply to Alaska Natives until 1931 when administration of Alaska Native affairs was transferred to the BIA from the Bureau of Education. From then, health and welfare services were provided to Alaska Natives on the same basis as American Indians elsewhere (Cordes, 1990).

The next significant legislation concerning the federal-Native relationship was the Alaska Native Claims Settlement Act of 1971. Alaska Native aboriginal land claims date back to 1867 when the Tlingits of Southeast Alaska protested the sale from Russia to America of the land they occupied. Tanana Athabascans asserted their claim to lands in interior Alaska in 1912. In 1959 the Tlingit and Haida won compensation for lands taken from them. The judgment of the U.S. Court of Claims declared that the 1867 Treaty of Cession did not extinguish aboriginal title. Nor did the Statehood Act of 1958, which granted the state of Alaska almost 104 million acres, settle the question of Native land rights. Section 4 of the Statehood Act disclaimed all rights in "any lands or other property, the right or title to which may be held by Indians, Eskimos or Aleuts...or is held by the United States in Trust for said Natives (Cordes, 1990).

A statewide organization of Natives, the Alaska Federation of Natives was established in 1966. Their first joint effort was to request the Department of Interior to enjoin all disposals of federal land pending congressional settlement of Native claims. Secretary of Interior Stewart Udall imposed a land freeze in 1966, suspending patenting or approval of selection of public lands pending settlement of Native claims. By the terms of the Alaska Native Claims Settlement Act signed into law December 18, 1971, Alaska Natives agreed to select forty-four million acres to be selected from federal public lands and \$962.5 million in exchange for extinguishment of all Native claims based on aboriginal right, title, use or occupancy of the land in Alaska. The ownership and management of the land is controlled by twelve regional corporations representing different geographic regions and over 200 village corporations (Cordes, 1990).

Statutory enactments subsequent to the Alaska Native Claims Settlement Act have specifically included Alaska Natives in legislation benefiting American Indians. This legislation includes: the Indian Financing Act (1974); the Indian Self-Determination and Education Assistance Act (1975); the Indian Health Care Improvement Act (1976); and the Indian Child Welfare Act (1978).

The Indian Self-Determination Act (section 4) defines the persons to whom the act pertains as follows:

- (a) “Indian” means a person who is a member of an Indian tribe;
- (b) “Indian tribe” means any Indian tribe, band, nation, or other organized group or community, including any Alaska Native village or regional or village corporation as defined in or established pursuant to the Alaska Native Claims Settlement Act (85 Stat. 688), which is recognized as eligible for the special program and services provided by the United States to Indians because of their status as Indians.

Congress acknowledged the unique character of its relationship with Indian tribes when it charged the secretary of the interior with compiling a published list of tribes with whom the U.S. government maintained a formal relationship. As a preamble to this statute, the Federally Recognized Indian Tribe List Act of 1994, Congress noted among its findings that “the United States has a trust responsibility with those tribes, and recognizes the sovereignty of those tribes.” The resulting dualities in tribal status of dependence under the trust relationship and political independence as governments are often in conflict. Additional information is provided in the section titled “Tribal Sovereignty.”

A number of Indian tribes in the U.S. do not have a federally recognized status, but are state recognized. This means they have no direct government-to-government relationship with the U.S. government. The status and relationship between a state and tribal entity is determined by state statutes and may vary from state to state. Many state recognized tribes currently have petitions pending before the United State Congress for reinstatement or establishment of federal recognition. Additionally, there are a significant number of Indigenous groups who identify as American Indian who do not have either federal or state recognition but continue to maintain a tribal form of government and practice their cultural heritage.

Native Hawaiians have a very different status than (federally recognized) American Indians or Alaska Native tribes. Like all American Indian and Alaska Native nations, the Kingdom of Hawaii was a sovereign nation. After the illegal overthrow in 1893 by the United States, Hawaii became a territory, and eventually a State in 1959. In 1991, the Hawaii Advisory Committee to the U.S.

Commission on Civil Rights issued a report documenting 73 years of civil rights' violations against Native Hawaiians. In 1993, the U.S. Congress passed Public Law 1003-150, the "Apology Bill", which officially apologized to the Native Hawaiian people for the illegal overthrow in 1893. While the "Apology Bill" was not "intended to serve as settlement of any claims against the United States", it did acknowledge the right of Native Hawaiians to self-determination. The "Apology Bill" paved the way for the pending Federal Recognition of Native Hawaiians. If this bill passes, Native Hawaiians will have similar political status as American Indians and Alaska Natives (<http://www.oha.org/databook/>).

The following paragraph is derived in its entirety from the report by the Department of the Interior and the Department of Justice (p. 56-57), which describes the federal relationship with Native Hawaiians.

From 1974 to 1998, Congress enacted approximately fifty (50) pieces of legislation treating Native Hawaiians in the same manner as American Indians and Alaska Natives, and, importantly, in 1974, began using a very broad definition of Native Hawaiians: anyone descended from the aboriginal people who occupied Hawaii before 1778. In the Native Hawaiian Health Care Act, Congress specifically recognized some form of a trust relationship with Native Hawaiians by declaring that "[i]n furtherance of the trust responsibility for the betterment of the condition of Native Hawaiians, the United States has established a program for the provision of the comprehensive health promotion and disease prevention services to maintain and improve the health status of the Hawaiian people" (42 U.S.C. 11701). Congress also passed legislation that required the Administration for Native Americans to provide funds to the Office of Hawaiian Affairs to issue economic development grants to Native Hawaiians (43 U.S.C. § 2991b-1). Some additional examples of legislation treating Native Hawaiians in the same manner as other Native peoples include: The Native American Programs Act of 1974, Public Law No. 93-644 § 801, 88 Stat. 2291, 2324 (1975) (promoting Native Hawaiian, American Indian, and Alaska Native economic and social self-sufficiency through financial assistance to agencies serving these groups); Joint Resolution on American Indian Religious Freedom, Public

Law No. 95-341, 92 Stat. 469 (1978) (recognizing the rights of American Indians, Eskimos, Aleuts and Native Hawaiians to practice their traditional religions); National Science Foundation University Infrastructure Act of 1988, Public Law No. 100-418, 102 Stat. 1107 (1988) (reserving a percentage of appropriations for institutions of higher learning that service Native Americans, including Native Hawaiians); and the Native American Graves Protection and Repatriation Act, 25 U.S.C. § 3001 et seq. (1998). These laws include Native Hawaiians in their scope because they are an Indigenous people with whom the United States has recognized a special relationship and because Native Hawaiians face many of the same challenges that are common to all Native people of the United States.

Reservations

As part of the Federal Trust Relationship, the U.S. Government has reserved lands for federally recognized tribes. Approximately 56.2 million acres of land are held in trust by the United States for various Indian tribes and individuals. These lands are referred to as reservations (also recognized as pueblos, rancherias, tribal communities, villages, and so forth). The largest is the Navajo Reservation of some 16 million acres of land in Arizona, New Mexico, and Utah. Many of the smaller reservations are less than 1,000 acres with the smallest less than 100 acres. On each reservation, the local governing authority is the tribal government. Alaska Native communities are not a part of a reservation with, the exception of Metlakatla on Annette Island in southeast Alaska.

States have limited powers over the tribes that reside within their boundaries. These powers are defined by federal law. On some reservations, however, a high percentage of the land is owned and occupied by non-Indians. This was the result of non-Indians homesteading on tribal lands that were deeded to the non-Indians under the Indian Land Claims Act of 1924. These reservations are often referred to as checker-boarded reservations.

Native Hawaiians do not have reservations or lands specifically allocated to their sole use. Public lands in the State of Hawaii are referred to as “ceded land.” The “ceded lands” are 1.8 million

acres of public land owned by the government of Hawaii that, upon annexation in 1898, were 'ceded' to the United States with the requirement that all revenues or proceeds of the lands, except for those used for civil, military or naval purposes of the United States or assigned for the use of the local government, "shall be used solely for the benefit of the inhabitants of the Hawaiian Islands for educational and other public purposes" (Annexation Act, 30 Stat. 750 (1898)).

In 1959, when Hawaii became a state, the United States transferred title to these lands, less those parts retained by the United States for national parks, military bases and other public purposes, to Hawaii, with the requirement in the Admission Act that the state hold them "as a public trust" for one or more of five purposes: "for support of public schools and other public educational institutions;" "for the betterment of the conditions of Native Hawaiians as defined in the Hawaiian Homes Commission Act," i.e., fifty percent or more blood quantum; "for the development of farm and home ownership;" "for the making of public improvements;" and "for the provision of lands for public use." Until 1978, no receipts from the ceded lands were directly made available to Native Hawaiians (Office of Hawaiian Affairs -1998).

In 1978, Hawaii's Constitution was amended to create the Office of Hawaiian Affairs (OHA). Payments of the income from the ceded lands to the Departments of Education ceased.

In 1980, the Hawaii Legislature, by Act 273, provided that twenty percent of all funds derived from the public land trust would be expended by OHA as outlined:

1. Betterment of the conditions of Native Hawaiians;
2. Betterment of the conditions of Hawaiians;
3. Serving as the single public agency in this state responsible for the performance, development, and coordination of program and activities relating to Native Hawaiians and Hawaiians, except that the Hawaiians Home Commissions Act, 1920, as amended, shall be administered by the Hawaiian homes commission;
4. Assessing the policies and practices of other agencies impacting on Native Hawaiians and Hawaiians, and conducting advocacy efforts for Native Hawaiians and Hawaiians;
5. Applying, receiving, and disbursing grants and donations

- from all sources for Native Hawaiians and Hawaiian programs and services, and;
6. Serving as a receptacle for reparations.

Taxes

American Indians/Alaska Natives/Native Hawaiians pay the same taxes as other citizens. The following exceptions apply to American Indians and Alaska Natives: federal income taxes are not levied on income from trust lands held for them by the United States; state income taxes are not paid on income earned on an American Indian and Alaska Native reservation; states sales taxes are not paid by American Indian and Alaska Natives on transactions made on a reservation; and local property taxes are not paid on reservations or trust lands.

Laws

As U.S. citizens, American Indians, Alaska Natives and Native Hawaiians are generally subject to federal, state and local laws. On American Indian reservations and Alaska Native communities, however, only federal and tribal laws apply to members of the tribe unless Congress provides otherwise. In federal law, the Assimilative Crimes Act makes any violation of state criminal law a federal offense on reservations. Most tribes now maintain tribal court systems and facilities to detain tribal members convicted of certain offenses within the boundaries of the reservation. American Indian and Alaska Natives residing off the reservation are subject to all state and local laws unless they commit a crime within the boundaries of the reservation (<http://www.factmonster.com/ipka/A0192524.html>).

Social and Economic Status

In contrast to the general U.S. population, the American Indian and Alaska Native population contains a greater proportion of young and smaller proportion of elderly persons. It is estimated that 33 percent of American Indian and Alaska Natives are younger than 15 years of age compared to 22 percent for the general U.S. population. Conversely, only 6 percent of American Indian and Alaska Natives are 64 years old or older, compared to 13 percent for the general

It is estimated that 33 % of American Indian and Alaska Natives are younger than 15 years of age

U.S. population. However, the age distribution of the Indian population is gradually beginning to resemble that of the general population (Snipp 2000).

The Office of Hawaiian Affairs reports that 39 percent of Native Hawaiians are under the age of 17, compared to 25.3 percent for the state's general population. Native Hawaiians age 55-74 years make-up 10.5 percent, compared to 16.7 percent for the state's general population, thereby indicating a youthful Native Hawaiian population with a longer life expectancy.

It is estimated that more than half (60%) of American Indian/Alaska Native populations reside in urban areas, with all others residing on reservations or historical sites (Ho, 1987).

About three-fourths of the Indian population is concentrated in the Midwest and Western United States. Fewer American Indians reside in New England and Southeastern states. The small number of American Indians in the New England region is attributed to the result of disease and warfare with colonial settlers. American Indians in the South and Ohio River valley were relocated by the federal government in the 19th century and resettled on reservations or in the Indian Territory of what is now Oklahoma (Thornton, 1987). As recently as 1930, only about 10 percent of the Indian population lived in urban areas, while by 1990 nearly 50 percent of the Indian population lived in urban (Snipp, 2000).

More than any other ethnic group, American Indians continue to be concentrated in the West and in rural areas. The removal of Indian tribes and the creation of reservations generally placed American Indians in sites distant from mainstream American society.

Two events were responsible for the rapid urbanization of American Indian and Alaska Natives. The first was World War II, in which more than 25,000 American Indian and Alaska Natives served in the armed forces, while another 50,000 worked in munitions plants, shipyards, and other war-related industries. Military enlistment was an opportunity for American Indian and Alaska Natives to become immersed in non-Indian culture and to adapt to the demands of a new social environment. For some, military service and the resulting benefits of the GI Bill provided job skills that aided in securing subsequent employment (Bernstein, 1991). Many chose to remain in urban labor markets instead of returning to the poverty and joblessness of reservation life.

After World War II, a series of federal policies known as Termination and Relocation Act assisted American Indian and Alaska Natives to move to selected urban areas, where it was assumed they would become trained, employed, and assimilate into mainstream American society (Fixico, 1986). During the period of 1952 to 1972, an estimated 100,000 American Indian and Alaska Natives were relocated to such cities as Los Angeles, San Francisco, Dallas, and Chicago (Sorkin, 1978). Needless to say, not all of these urban immigrants remained in cities. A substantial number returned to their reservation homes (O'Brien 1989). Today, there is considerable movement between urban and reservation communities.

American Indians and Alaska Natives have consistently been one of the poorest groups in American society. This was first systematically documented by the Merriam Report (Institute for Government Research, 1928), which demonstrated that American Indian and Alaska Natives were plagued by a host of social and economic ills, including illiteracy, ill health, joblessness, substandard housing, and poverty. Although the economic status of American Indian and Alaska Natives has improved over the past half century as a result of multiple federal programs and Indian policies, as well as the successful economic development initiated by tribes on reservations, American Indian and Alaska Natives still remain the most economically disadvantaged group in the United States (Snipp, 2000).

The average medium income for American Indians/Alaska Natives reported by the U.S. Census for the period of 2002-2003 was \$35,441, compared to \$43,349 for the US general population. The U.S. Census reported for the same period, the annual income for Asians, Native Hawaiians, and other Pacific Islanders was \$54,314, compared to \$43,349 for the U.S. general population. Poverty levels reported by the U.S. Census for 2002-2003 were 12.5 percent for the general U.S. population, 19.1 percent for American Indians/Alaska Native and 11.1 percent for Asians, Native Hawaiians, and other Pacific Islanders (U.S. Census Bureau, 2004). It is important to note that the cost of living index for the state of Hawaii is higher than most of the states in the continental United States.

Despite the enormous economic impact of Alaska Native corporations, an estimated 21.5 percent of Alaska Native families have incomes below the federal poverty level, compared with 6.8 per-

cent for all Alaska families. The unemployment rate for Alaska Native men is 27.3 percent and 16 percent for Alaska Native women. Due to the lack of jobs in rural areas, unemployment rates in villages are staggering. In one out of every eight villages, unemployment among Native men is in excess of 50%; in 1/3 of all Native villages, male unemployment (32%) nearly quadruples statewide average unemployment rates.

The OHA Native Hawaiian Data Book of 1998 shows that incomes in the Native Hawaiian community are lower than the statewide average. In 1989, 19 percent of Native Hawaiians were in the lowest tenth percentile income bracket (less than \$15,000) and unemployment among Native Hawaiians was 1.5 times higher than the unemployment rate statewide. In 1990, 7 percent of the state's population was below the poverty level, but the rate was 14 percent in the Native Hawaiian community, double the statewide rate of poverty. In 1997, of the 84,000 inhabitants of the islands that were receiving financial assistance, 23,000 (over 25%) of them were Native Hawaiians.

A daunting 49% of Native Hawaiians experience housing problems. A recent study by the U.S. Department of Housing and Urban Development concluded that Native Hawaiians had "the highest rate of housing problems in the nation, exceeding Native Americans and Alaska Natives (44%), and almost double the rate of all U.S. households (27%)." (U.S. Dept. of Interior and U.S. Dept. of Justice, 2000, p. 48)

Educational Attainment

Compared to other groups, American Indian and Alaska Natives have a significant deficit of human capital. The educational attainment of American Indian and Alaska Natives in relation to that of blacks and whites is displayed in the following table. American Indian and Alaska Natives have an excess of poorly educated persons (most likely older individuals) and a shortage of adults who are highly educated. The most significant finding concerns the disparity between college attendance and graduation.

Postsecondary education is not an unfamiliar experience for many American Indian and Alaska Natives. In fact, well over one-third (37%) of the Indian adult population aged 25 and over have attended college, but only 9.3 percent having obtained a bac-

calaureate or higher degree (U.S. Commission on Civil Rights, 2004).

Distribution of education attainment by American Indians and Alaska Natives, Blacks, and Whites, aged 25 and over – 1990

PERCENTAGE			
Completed Schooling	American Indians/ Alaska Natives	Blacks	Whites
Less than ninth grade	14.0	13.8	8.9
9-11 years	20.5	23.2	13.1
High School Diploma	29.1	27.9	31.0
Some College	27.2	23.8	25.4
Baccalaureate and Higher	9.3	11.4	21.5

Native Hawaiians: Statistics show that, Native Hawaiian children ranked in the tenth percentile on the Peabody Picture Vocabulary Test-Revised, a language assessment instrument used to assess readiness for elementary school instruction. These results compare unfavorably with the statewide total of 15 percent and the rates for Caucasian and Japanese children of 36 percent and 42 percent, respectively. In 1990, Native Hawaiians completed high school at a higher rate (50.7%) than the statewide average (43.7%). However, these trends did not continue into higher education, where 27.53 percent of Native Hawaiians completed Associate's degrees, compared to 37.97 percent statewide, and only 2.13 percent completed a Bachelor's degree or higher, compared to 5.37 percent statewide (The Department of the Interior and The Department of Justice, 2000).

Health Status

American Indians/Alaska Natives have higher mortality rates than whites at each stage of the life span. Some chronic conditions are also particularly high among American Indian and Alaska Natives - for example, the highest prevalence of diabetes in the world is found among the Pima Indians of Arizona. American Indian and Alaska Natives poor health indices are related, in part, to their higher poverty rates than whites. However, limited access to high quality health care is also a factor (<http://www.kff.org/minorityhealth/> Fact Sheet: American Indians and Alaska Natives: Health Coverage and Access to Care).

During the past 30 to 40 years, the health status of American Indians has generally improved, sometimes profoundly. However, current data show that American Indian and Alaska Natives still experience an excess burden of illness. Responding to effective prevention and treatment, infectious diseases (e.g., tuberculosis, pneumonia, and influenza) have significantly diminished in importance. Health conditions associated with poverty and harmful lifestyle practices (e.g., heart disease, diabetes, and cirrhosis) now dominate the health care needs of American Indians and Alaska Natives (Brenneman, et. al., 2000).

The proportion of American Indians and Alaska Natives who die in certain age and gender groups differs considerably from that for the general U.S. population. During 1992-94, 31 percent of American Indian and Alaska Native deaths occurred in persons under 45 years of age, compared with 11 percent of those among the general U.S. population. Conversely, the proportion of the latter who died after age 65 was 73 percent, compared to only 45 percent for American Indian and Alaska Natives. Variations in death rates of American Indian and Alaska Natives according to gender also differ significantly. The proportion of male to female deaths is equal among Indians under 5 years of age; from 5 to 64 years of age, death of males predominate; and after age 65, deaths among females predominate (Brenneman, et. al., 2000).

The profile of leading causes of Indian deaths also differs from that of the general population. The five leading causes of death, in decreasing order, for American Indians and Alaska Natives in 1992-94 were diseases of the heart, malignancies, unintentional injuries, diabetes mellitus, and chronic liver diseases/cirrhosis, whereas for all races during 1993, the top five were diseases of the heart, malignancies, cerebrovascular diseases, chronic obstructive pulmonary disease, and unintentional injuries. The fact that diabetes mellitus, chronic liver disease and cirrhosis are among the five leading causes of American Indian and Alaska Native mortality and not among the top five for races in the U.S., indicates the importance of certain lifestyle behaviors and nutrition in the health status of American Indian and Alaska Natives (Brenneman, et. al., 2000).

Following are the mortality percentages for American Indians and Alaska Natives for specific health conditions that dominate among this population: 770% more likely to die from alcoholism, 650% more likely to die from tuberculosis, 420% likely to die from diabetes, 280% more likely to die from accidents, and 52%

more likely to die from pneumonia or influenza than the U.S. general population (U.S. Commission on Civil Rights, 2004 draft). As a result of these increased mortality rates, the life expectancy for American Indians is 71 years of age, nearly five years less than that of the U.S. general population.

Following are brief highlights of leading health concerns for American Indian and Alaska Natives.

Alcohol abuse is widespread in American Indian and Alaska Native communities. These groups use and abuse alcohol and other drugs at younger ages, and at higher rates, than all other ethnic groups. The age-adjusted alcohol related mortality rate is 5.3 times greater than that of the general population (DHHS, 1999). Alcohol is a contributing factor in cases of unintentional injuries, episodes of violence, and suicides within Indian communities.

Tuberculosis rates among American Indians and Alaska Natives is declining, yet it continues to disproportionately affect this population in the number of cases and the severity of disease. American Indians are reported to have a rate of 12.6 cases per 100,000 persons, a rate that is more than five times the rate reported for non-Hispanic whites (Butler, et al., 2001). The Centers for Disease Control and Prevention reports that the incidence rate had dropped to 7 cases per 100,000 by 2002, which was approximately twice that of the U.S. general population, although mortality rates remain six times higher (CDC, 2002).

Diabetes: American Indians and Alaska Natives have some of the highest rates of diabetes in the world, with more than half of the adult population in some communities having the disease (Roubideaux, 2004). Type II diabetes dominates among American Indian and Alaska Native tribes; in fact this population is reported to have the highest prevalence of Type II diabetes in the world (U.S. Commission on Civil Rights, 2004).

Unintentional Injuries: The definition of *unintentional injuries* is injuries caused without intent of harm and are typically described as accidents. Unintentional injuries are a major public health concern in the U.S., particularly in low-income areas. Therefore, it is not surprising that injury is a major cause of premature death and disability among American Indians and Alaska Natives. The importance of unintentional injury as a cause of death among American Indians and Alaska Natives is reflected in the fact that it is the leading cause of death of American Indians and Alaska Natives aged 1 to 44, years and not less than the fourth leading

cause of death in any pre-retirement age group. Almost 60% of deaths of American Indians and Alaska Natives 1 to 24 years of age are due to unintentional injury. While the rank of injury as a cause of death in each age group is similar to that of the total U.S. population, the injury mortality rates among Indians are substantially higher than those of the general population (Smith, et al., 2002).

Mental Health: American Indians and Alaska Natives are at higher risk for mental health disorder than other racial and ethnic groups in the United States (Nelson, et al, 1992). The most significant mental health concerns are high prevalence of substance abuse, depression, anxiety, violence, and suicide. Substance abuse, most notably alcoholism, has been the most visible health disorder crisis. These two illnesses are commonly attributed to isolation, pervasive poverty, hopelessness, and intergenerational trauma, including the “historical attempts by the federal government to forcibly assimilate tribes. (U.S. Commission on Civil Rights, 2004).

Depression is the most serious emerging mental health disorder among the American Indian and Alaska Native population. This is largely reflected in suicide rates. The suicide rate for American Indians and Alaska Natives continues to increase and is 190% of the rate of the U.S. general population. The highest suicide rate among American Indians and Alaska Natives is found in the 15 - 34 year old age range. Suicide is also the second leading cause of death for American Indian and Alaska Natives 15 - 24 years old and the third leading cause of death for children 5 - 14 years old, (IHS Trends,1998-99).

The *Native Hawaiian Health Care Act of 1988* (Public Law 100-579) authorized the establishment of health promotion, disease prevention and primary care services for Native Hawaiians or persons of Hawaiian ancestry. Organizing activities within Papa Ola Lokahi, the coordinating agency, began in September 1989 and continued throughout 1990. Service delivery grants to the five Native Hawaiian organizations, which serve nine islands, were awarded in fiscal year 1992. The Law was amended in 1992 under Public Law 102-396. The services made available for Native Hawaiians is insufficient and were accessed by a limited number of eligible persons.

Native Hawaiians have a shorter average life span and the majority of Native Hawaiians have at least one high risk factor, including a sedentary life style, obesity, hypertension, smoking, or acute drinking (OHA Native Hawaiian Data Book, 1998). Statistics

include a heart disease mortality rate that is 66% higher than for the entire state of Hawaii. In addition, the cancer mortality rate is 45% higher than that in the overall state population and the mortality rate due to diabetes is 130% higher. The Hawaii state average for access to medical care was 77.6%, compared to 70.8% for Native Hawaiians. The major factor cited for impeding access was associated costs.

U.S. Public Health Service - Indian Health Service

Members of federally recognized American Indian tribes and Alaska Native corporations are eligible for services provided by the Indian Health Service (IHS). The IHS is an agency within the Department of Health and Human Services that operates a comprehensive health service delivery system for approximately 1.6 million of the nation's total American Indian/Alaska Native population. Its annual appropriation is approximately 4 billion dollars. It is estimated that the IHS budget only meets approximately 55 percent of the health care needs of Indian people. The IHS strives for maximum tribal involvement in meeting the needs of its service population. Federal policy mandates that the Indian Health Service is the provider of last resort for medical care for American Indians and Alaska Natives.

Preventive measures involving environmental, educational, and outreach activities are combined with therapeutic measures into a single national health system. Within these broad categories are special initiatives in traditional medicine, elder care, women's health, children and adolescents, injury prevention, domestic violence and child abuse, health care financing, state health care, sanitation facilities, and oral health. Most IHS funds are appropriated for American Indians/Alaska Natives who live on or near reservations. Congress also has authorized programs that provide some access to care for Indians who live in urban areas. In 1976, Congress authorized IHS to receive reimbursement from Medicare and Medicaid for services provided to eligible American Indians and Alaska Natives by IHS facilities (Cordes, 1990).

Indian Health Services are provided directly and through tribally contracted and operated health programs. Health services also include health care purchased from more than 9,000 private providers annually. The federal system consists of 36 hospitals, 61

A serious and chronic challenge to most tribal and urban facilities is turnover in professional staff such as physicians and nurses.

health centers, 49 health stations, and 5 residential treatment centers. In addition, 34 urban Indian health projects provide a variety of health and referral services.

Through P.L. 93-638 self-determination contracts, American Indian tribes and Alaska Native corporations administer 13 hospitals, 158 health centers, 28 residential treatment centers, and 76 health stations. (<http://www.ihs.gov>)

The Alaska Area Native Health Service works in conjunction with nine tribally operated service areas to provide health services to 120,000 Alaska Natives. Alaska tribes administer 99% of the Indian Health Service funds earmarked for Alaska. Tribal hospitals are located in the communities of Anchorage, Barrow, Bethel, Dillingham, Kotzebue, Nome and Sitka. There are 25 tribal health centers and 176 tribal community health aide clinics operated throughout the State. The Alaska Native Medical Center in Anchorage serves as the Area's referral center and gatekeeper for specialty care (www.ihs.gov/FacilitiesServices/AreaOffices/Alaska/).

Alaska Natives in rural Alaska are confronted with serious geographical challenges in accessing health care that may indirectly affect the seriousness of health conditions. Alaska's immense geographic area, sparse population, and extreme weather conditions, make delivery of acute medical care an expensive and difficult endeavor. Nonetheless, the Alaska Tribal Health System is designed to maximize health care delivery even in the most remote locations. The Alaska Tribal Health System (ATHS) is a statewide network of thirty-nine tribal healthcare providers that serve the 125,000 Alaska Natives/American Indians in Alaska. Participants in the ATHS are individual, autonomous tribal health organizations that vary in both size (some serve the needs of individual tribes of less than 150 beneficiaries while others are consortia of tribes serving up to 20,000 beneficiaries) and capacity, but which collectively operate a large network of village-based clinics, regional hospitals, sub-regional clinics, and a large tertiary care facility (the Alaska Native Medical Center or ANMC). Primary care is provided at the village, regional, and sub-regional levels. In remote villages, care is delivered by Community Health Aides (local person trained to provide basic health care) practicing under the supervision of a physician. Village residents who are thought to have a serious condition are airlifted to the nearest ATHS hospital or clinic. For women residing in a village, childbirth requires transport to the regional hospital usually a month before due date. Women with high-risk pregnancies are flown to Anchorage for delivery.

A serious and chronic challenge to most tribal and urban facilities is turnover in professional staff, such as physicians and nurses. The limited health staff often needs to address problems such as family violence, unintended pregnancy, and communicable and sexually transmitted disease prevention. Isolation, high risk behaviors, and lack of access to overall medical care all contribute to problems, such as high teen pregnancy rates, increased rates of intentional and unintentional injury and other serious health problems.

Tribal Sovereignty: The following are taken from S. L. Pevar (2002) book, “The Rights of Indians and Tribes” (p. 86-88).

American Indian and Alaska Natives tribes were self-governing centuries before Europeans arrived on this continent, and they still exercise the powers of a sovereign government. Indian tribes, the Supreme Court has recognized, “exercise inherent sovereign authority over their tribal members and territories.”

The Supreme Court discussed the inherent right of tribal sovereignty in 1983 in *Worcester v. Georgia*. The issue of *Worcester* was whether the state of Georgia could impose its laws on the Cherokee Indian Reservation located within the state. In holding that Georgia could not extend its laws within the reservation, the Court stated:

Indian nations [are] distinct political communities, having territorial boundaries, within which their authority is exclusive, and having a right to all the lands within those boundaries, which is not only acknowledged, but guaranteed by the United States . . . Indian nations had always been considered as distinct, independent political communities, retaining their original rights, as the undisputed possessors of the soil from time . . . The Cherokee nation, then, is a distinct community, occupying its own territory, with boundaries accurately described, in which the laws of Georgia can have no force, and the citizens of Georgia have no right to enter, but with the assent of the Cherokee themselves, or in conformity with treaties, and with the acts of Congress.”

The *Worcester* doctrine of inherent tribal sovereignty has undergone some modification over the years, but its basic premises remain the same. American Indian and Alaska Natives have the inherent right of self-determination and self-government. Congress has the authority to limit or abolish these powers, but the powers

that tribes possess are not delegations of authority from the United States or from any other government; rather, tribes possess them as a consequence of their historic status as independent nations.

The source of an Indian tribe's power is its people. As a federal appellate court stated in 2002: "Indian tribes are neither states, nor part of the federal government, or subdivision of either. Rather, they are sovereign political entities possessed of sovereign authority not derived from the United States, which they predate. Indian tribes are qualified to exercise powers of self-government by reason of their original tribal sovereignty."

The Supreme Court has consistently held that although Indian tribes have inherent sovereign powers, "Congress has plenary authority to limit, modify or eliminate the powers of local self-government that the tribes otherwise possess." The federal government has the physical power to limit the activities of Indian tribes and to abolish their governments. Over the years, Congress has abolished many tribal governments and has limited the authority of the rest. The exercise of this power has been extensively criticized on both legal and moral grounds.

Indian tribes have two types of limitations on their governmental powers: *express* and *implied*. Congress has expressly prohibited tribes from exercising certain powers, such as selling tribal land without the federal government's permission and incarcerating someone in tribal jail for more than a year for any one offense . . . In addition to the express limits on tribal power, "Indian tribes have lost many of the attributes of sovereignty" by implication, the Supreme Court has held, due to their "dependent status," that is, by virtue of their "incorporation into the United States." For instance, Indian tribes may no longer declare war on a foreign government or exercise certain powers over non-Indians: they have implicitly lost those powers due to their subordinate position as "conquered" nations under the control of the federal government. However, those powers not expressly removed by Congress or lost by implication are retained (reserved) by the tribe.

Tribal governments have the same powers as the federal and state governments to regulate their internal affairs, with a few notable exceptions. The most important areas of tribal authority are: (1) the right to form a government; (2) the right to determine tribal membership; (3) the right to regulate tribal lands; (4) the right to regulate individually-owned land; (5) the right to tax; (6) the right to maintain law and order; (7) the right to regulate the con-

duct of non-members (within reservation boundaries); (8) the right to regulate domestic relations; and (9) the right to engage in and regulate commerce and trade.

Cultural Beliefs and Values

American Indians today remain the most culturally diverse of the ethnic groups in the United States. Family life, cultural and religious practices, value systems, language, and dress vary greatly between Indian groups that have lived on the same continent for centuries (Drews, et, al., 1982). American Indians and Alaska Natives are racially as differentiated as the Europeans and far more diverse culturally and linguistically (Ho, 1987).

Historically, American Indians developed societies with well-defined roles, responsibilities, government and economic systems, recreational, leisure styles, religious rites and ceremonies, and social behavior in which group involvement, support, and consensus played major roles. Their social, economic, and political traditions reflect a strong emphasis on group involvement and decision making (Edwards, 1980).

American Indian culture emphasizes harmony with nature, endurance of suffering, respect and non-interference toward others, and a strong belief that an individual is inherently good and should be respected for his/her decisions. Such traits make a family and/or individual in difficulty very reluctant to seek help. Fear and mistrust toward non-Indians caused by past oppression and discrimination add to the barriers in asking for help from a non-Indian provider (Ho, 1987).

American Indian values lean toward a cosmic identity, a harmony of the individual with the tribe, the tribe with the land, and the land with the spirit of the universe. Central to this quest for harmony is a sense of constancy - the timelessness and predictability of nature as the foundation of existence. This cycle symbolizes eternity, one reality, and it transcends everything in its absoluteness, giving respect to everything (Herring, 1989).

The family is a recognized cornerstone of American Indian society. It serves as a repository for value orientations that guide human behavior, as a transactional milieu for life span socialization, and as a basic catalyst for cultural revitalization (Red Horse, 1980). The traditional Indian family is the extended family. Child rearing is shared by blood-relatives and clan members. Tribal eld-

ers teach tribal legends, history and traditions, thereby attaining a position of tremendous respect within the family and community (HeavyRunner, et al, Spring, 1997).

Indian values are interwoven throughout their culture, lifestyle, religion, and daily activities. Many values are reinforced through the use of ceremonies (Edwards, 1980). Additionally, the value systems of American Indian groups are as diverse as their lifestyles. However, there are some values that appear to be generic and shared by most American Indian groups. Herring (1989, p. 7) compares differences in American Indian and Anglo values:

ANGLO AMERICAN	AMERICAN INDIAN
Success	Happiness
Ownership	Sharing
"Number One"	Tribe and extended family first, before self
Youth Oriented	Honor your Elders
Learning is found in school	Learning is through legends
Look to the future	Look to traditions
Work for retirement	Work for purpose
Be structured & aware of time	Time is only relative
Oriented to house, job, etc.	Oriented to land
Look ahead, not to the past	Cherish the memories of youth
A critic is a good analyst	Don't criticize your people
"What are you – some kind of animal"	Live like the animals; they are your brothers & sisters
This is America, speak English	Cherish your language
I'll raise my own, you do the same	Children are gift of the Great Spirit to be shared with others
The law is the law!	Consider the relative nature of a crime, the personality of the individual, and the conditions of the offense
Have a rule for contingency	Few rules are best – loose and flexible
Religion is for the individual	Religion (spirituality) is the universe

Communication with American Indians may be complicated because of language differences. There is no universal, traditional Indian language and American Indians differ in their abilities to use the English language. Other differences in communicating styles include minimal eye contact. To many traditional Indians, direct eye contact is considered disrespectful, so one must not engage in

it or expect it. Avoidance of eye contact, in turn, is a gesture of respect. Social mores regarding touching may also vary. American Indian culture views the firm handshake as aggressive and very disrespectful. These differences may also be transferred to touching in general by strangers who have not yet developed a rapport with the client. Touching may be interpreted by an Indian person as inappropriate, aggressive, and disrespectful (Everett, et al, 1983). Additionally, direct questioning may be perceived as rude and reduces the client's self-disclosure.

Alaska Natives

Alaska is home to a diverse population of aboriginal people. The major cultural groups of Alaska's Indigenous, collectively called Alaska Natives, are Aleuts, Alutiiq, Yup'ik, Inupiat, Athabaskans, Eyak, Tlingit, Haida, and Tsimshian. Traditionally, social structure, adaptation to varied environments, and cultural practices differed considerably from group to group, but some broad similarities can be drawn. The following information is drawn from Alaska Federation of Natives Web site. <http://www.nativefederation.org/>

A cultural value shared by all Alaska Native peoples is the importance of the family. The Alaska Native concept of family is very different than the Western concept. The Alaska Native family in villages was traditionally close knit, depending on one another for food and shelter. Families and village members took care of each other; they looked after each other. The health of the family was of paramount importance to the others. Families hunted together, camped together, and celebrated together. The importance of the extended family stems from the subsistence way of life. Before the arrival of retail stores, people hunted and gathered their food, requiring the participation of everyone in the village. Food was shared with everyone in the village with special attention paid to the elders.

The idea of family did not necessarily consist of just blood relatives. It included those received through marriage, adoption, naming, and other special relationships between people. Within a given Alaska Native community, individuals can trace the ways in which they are related to one another. Rather than being defined by a mother, father, and children, the family is conceived in terms of the extended family and complex social networks. All members

of society are valued. Every individual is someone's mother, father, sister, brother, aunt, uncle, cousin, and so forth. This viewpoint places importance on all people: children, adults, and elders. A sense of personal responsibility and caring extends to family members within and outside the nuclear family. Family is regarded as the cornerstone of the Alaska Native way of life.

Alaska Native people have a wide variety of spiritual beliefs that make up their world view. The majority of Alaska Natives practice Christianity. However, a great number believe in elements of traditional Native spiritual beliefs, while many practice other faiths such as Bahai or the Native American church. Others are agnostic or atheist. Oftentimes, Christian beliefs are blended with traditional Alaska Native beliefs. In other words, one may be a Christian, but still maintain and practice elements of the traditional Alaska Native worldview. Although many Alaska Natives consider themselves as Christian, the Native world view persists. Respect for the land, elders, family, and community underlies the everyday actions of most Alaska Natives. The Alaska Native viewpoint was and remains quite different from the Western perspective. Maintaining a balance with the land is especially important today as Alaska Natives fight for the right to practice traditional subsistence activities.

Alaska Natives are descended from peoples who believed in a dual existence; the physical and the spiritual. That is, the physical world that they lived and walked in was only one aspect of existence, controlling the physical and giving it "life" and character was its spiritual counterpart. This basic belief was the foundation of all Alaska Native cultures and was their "world view." The expression of this reality - a reality that non-Natives, to this day, do not understand - is the sum total of Native cultures: the arts, ceremonials, songs, feasts, social and political organizations, use and treatment of resources, and ways of passing on the knowledge that enabled a people to survive and co-exist for millennia in a hostile physical environment.

In addition to the spiritual world view that permeated life, Alaska Native spirituality was manifest in many ways. Different stages of life, such as birth, puberty, marriage, and death, were accompanied by ritual rites of passage. Throughout life, people respected taboos. The people believed in important deities or spiritual animals. Stories passed from generation to generation told of mythical and sacred exploits of past humans, animals, and mythi-

cal times. For some Alaska Native groups, shamans assisted with accessing the sacred world and healing the sick. Ceremonies, songs, and dances performed throughout the year ensured community prosperity and maintained the balance between the spirit and the natural worlds.

Some basic concepts common to most Alaska Native peoples' traditional world view are listed as follows:

- Respect and reverence for the land and all its inhabitants;
- Humans have responsibility for maintaining harmonious relationship with the natural world;
- Sharing the gifts of nature;
- Wisdom and ethics are derived from direct experience with the natural world
- Respect for elders;
- Universe is viewed as an ever-changing, holistic, integrative system with a unifying force;
- Belief in life after death;
- Time is circular, with natural cycles that sustain all life.

The entire section on Alaska Native Beliefs and Values may be found at www.nativefederation.org/frames/health.html, Wellness/Cultural Values. See also <http://www.ankn.uaf.edu> for lists of traditional values specific to a number of Alaska Native cultural groups.

Native Hawaiians

Today's *Native Hawaiian* population comes from a mixed heritage and must reconcile their Hawaiian identity with their other cultural backgrounds. In order to sustain their claim to solidarity as an Indigenous people, Hawaiians have advocated a cultural revitalization, including the promotion of language, religious practices, and cultural traditions such as the hula kahi-ka, or ancient dance.

In the Hawaiian cosmology and contemporary Hawaiian ways of thinking, land is fundamental to achieving physical, spiritual, and cultural health. Obstructing access to land through development, high food prices and pollution is the same thing as obstructing the health and vitality of Hawaiians.

Land is not merely a political and economic issue; it is a key to defining a Hawaiian identity and health.

Another important cultural value is restoration of taro gardens. This is significant as taro is not only the cornerstone of the Hawaiian diet; it is also a symbol of family. According to the Hawaiian origin story, taro is considered an elder sibling who cares for you by providing you with food, but you must also care for it. Thus, in restoring the taro gardens and finding traditional Hawaiian fishing techniques creates an opportunity to practice the lifestyles of the “healthy ancestor” (refers to the healthy lifestyle of Native Hawaiians before contact with foreign individuals and the introduction of disease) and more importantly passes onto one’s son the importance of respect and caring for family and land. In obtaining food from the land, just as the “healthy ancestor” did, both Hawaiian health and identity are revitalized (J.M. McMullin).

Native Hawaiians define themselves by their relationships to each other, their ancestors and their land. Without these bonds of interconnectedness, they would be incomplete. Being Hawaiian involves nurturing and honoring these ties. In the Hawaiian society, one is expected to know and understand what it means to be a contributing member of the community. Everyone has a responsibility to use their talents to the benefit of the entire ohana (family).

Ohana is defined as a group of both closely and distantly related people who share nearly everything, from land and food to children and status. Sharing is central to this value since it prevents individual decline. Hawaiians embrace the family as the basic unit of society and the best form of human expression, and readily reject the rugged individualism so highly valued in Euro American societies.

Built upon the foundation of the ohana, the family, Hawaiian culture ensures the health of the community as a whole. The Western concept of “immediate family” is completely alien to Indigenous Hawaiians. The Hawaiian ohana encompasses not only those related by blood, but all who share a common sense of aloha (love and compassion). It is common to hear Native Hawaiians who are meeting for the first time to ask “Who is your family?” and then joke they must be related “because we are all related.” The ties that bind ohana together cannot be broken, even by death. As loved ones pass on, they continue to fulfill their obligations to the rest of the ohana from the next realm. Hawaiians cherish their ancestors, committing to memory generation upon generation of lineage and composing beautiful chants heralding their ancestors’ abilities.

Hawaiians continue to have allegedly “illegitimate” children, to hanai (adopt) both children and adults outside of sanctioned Western legal concepts, to hold and use land and water in a collective form rather than a private property form, and to prescribe to the notion and the value that one person should not strive to surpass and therefore outshine all others.

By fulfilling their duties to the ohana and recognizing the accomplishments of others, Hawaiians increase their mana, or spirituality (www.alternative-hawaii.com/hacul/beliefs.htm).

Traditional Medicine

Literature on the use and access to Indigenous traditional healing is limited. The following information consists of both a literature review and the author’s personal experience and knowledge in working with traditional tribal communities.

Access and use of traditional Indian medicine varies from tribe to tribe and is affected by levels of acculturation. Traditional practices may include ceremonies specifically for the community or the individual and family. Ceremonies may be complex, requiring extensive time commitments by the participants, or simple, only requiring a brief period of time. Traditional medicine has been used to cure multiple types of illness. Some brief examples of illness are: (1) the spirit wherein the person is not in harmony with the universe; (2) mental health, wherein a person is unable to deal with psychological or emotional stresses and requires support and intervention; (3) physical illness which may be associated with general illness such as persistent colds, infections of a wound, issues of cancer, alcoholism, or prayers for a healthy baby; and (4) ceremony for dealing with supernatural illness which may have been caused by violations of tribal teachings or bad will imposed by another person.

Many medical providers have recognized the importance of traditional medicine among American Indians and Alaska Natives. The Indian Health Service has established relationships with tribal community elders, allowing them to come into the local IHS health care facility at the request of tribal members and provide healing services to the patient in the hospital or outpatient clinic setting. Other initiatives include traditional healers

in medical training and social service program classes offered by tribal community colleges.

The understanding of traditional Indian medicine by many scientists, lay persons, and the rapidly increasing number of New Age healers remains meager, fragmented, and often distorted. True traditional medicine is a profound system that is far more deeply rooted and complex than is understood (Adair, Deuschle & Barnett, 1988). Both Western and traditional medicine are vast systems of health maintenance and treatment that operate at several levels: personal care of most common maladies not requiring expertise, “folk” healing by “lay” individuals with special skills, and an elaborate system of practitioners who dedicate a substantial portion of their lives to the “healing arts” (Kleinman, Eisenberg, and Good 1978).

Preminent among characteristics of Indian medicine is the degree to which it includes religion and a realm of spirits capable of doing either good or harm, characterized as a complex “theologico-physical” dualism (Stone, 1932). The titles for traditional healers vary by tribe. These healers are individuals who possess special power to communicate with the spirits, heal the sick, and foretell future events (Eliade, 1972). Such power is often transcendently obtained through a trancelike state, which is facilitated by fasting, meditation, and a certain degree of sensory deprivation, often through the popularly noted vision quest or mind-altering drugs. At other times, power may be obtained from a simple dream. This power is not a personal attribute of the individual but a higher power invoked by the healer, more often described than defined (Basso, 1967).

The critical and often profound differences between traditional healing and Western medicine obviously derive from the underlying cultural percepts of each. A generally accepted Indian concept of health is that it is a tangible reality, not simply the absence of disease. This health, or wellness, is often described as the ability to exist in a harmonious relationship with all other living things, but also with a number of spirits, including a great and all-powerful spirit. The emphasis on the spirit world, supernatural forces, and religion stand in sharp contrast to the secular emphasis on disturbed physiology and purely physical explanations of Western medicine (Rhoades, et. al, 2000).

Use of traditional Indian Medicine by Indigenous people: (Wesley Thomas)

A. Access

Local tribal cultural knowledge and environment dictates what becomes part of the traditional medicinal plants and practices. A very strong Indigenous community tends to have medicine women and men who conduct ceremonies and prescribe herbal remedies. In some cases, they have been apprentices for many years before the community gives its permission for them to be practitioners.

1. Primary Provider

If a community still has access to tribal medicine people, the traditional medicine is viewed as the primary health care outlet. If one is ailing from any form of physical or mental pain, one employs a medicine person. It is a general practice for a traditional medicine person to also refer his/her patient to take advantage of Western medicine while undergoing traditional treatment.

2. Secondary Provider

If the medicine person is not able to relieve an ailment, they will refer the patient to a secondary health facility that prescribes Western medicine (medical doctors and hospitals). Unfortunately, only in very rare cases are Western medical practitioners making referrals for their patients to utilize traditional medicine practitioners. In even fewer cases, traditional medicine people are housed under the same roof as the Western medical practitioners.

B. Frequency

The amount of usage of traditional medicine depends on access.

C. Encourage use of Traditional Medicine.

D. Accessing Traditional Medicine care

Indigenous people do not need encouragement to use traditional medicine. In some individual cases, the person may lack awareness or knowledge of how to access traditional healing and may need assistance from another Indigenous person in accessing the services.

E. Benefits of Traditional Medicine

There are multiple levels of benefit for its usages. For example, its primary use perpetuates its practice, in addition to healing and maintaining wellness. It also helps maintain cultural beliefs and practices intact while providing physical and spiritual healing for the individual and community. Use of traditional medicine encourages elders and medicine persons to maintain and expand traditional medicine and to teach their skills to an apprentice, thereby ensuring the carry over of a tradition that is centuries old. Continued use of traditional medicine offers medicine people a source of financial and spiritual support within the community and encourages the renewal of plants for use in healing practices.

F. Discouragement of Traditional Medicine and Practitioners

For a very long time use of traditional medicine and turning to traditional medicine people for spiritual and physical healing has been discouraged by Western society and persons not familiar with its practices. Until recently, a majority of Western medical practitioners have been the main players in discouraging Indigenous communities from employing their own traditional medicine for any form of healing or wellness maintenance. Others who have discouraged the use of traditional medicine include Indigenous people influenced by Western religion and education, and those less connected to their community and culture.

1. Generalization

Lack of cross-cultural information, ethnocentricity continues to perpetuate the devaluing of Indigenous traditional medicine. Recently cultural sensitivity is being promoted in Western medicinal training, as well as in social services.

2. Regional Differences

Geography determines the difference in what is part of the local traditional medicine. For example, in the Pacific Northwest and in the Northeast regions, seaweeds and forest plants are the basis of medicinal plants. These same items are not available to Indigenous people in Alaska, the Midwest or the Southwest. Each local com-

munity and environment defines and determines what becomes part of the local cultural knowledge on what defines traditional medicine.

Use of Traditional Medicine Among Alaska Natives

“Before contact, the Indigenous people of Alaska depended on knowledge of anatomy, herbal medicine, and other healing practices for health maintenance. Early records indicate that the Alaska Native cultures had a fairly sophisticated medical system in place that included surgery, weapon removal, amputation, ligation, opening of the abdominal cavity, acupuncture, bloodletting, considerable skill in the delivery of malposed fetuses, breech-level deliveries, massage, and the use of herbal medications and hot packs.” Healers also practiced “various forms of energy healing, including the laying on of hands and the directing of spiritually healing force from a practitioner to a client.” (Morgan, n.d.)

For the majority of contemporary Alaska Natives, Western allopathic medicine is the primary source of care for illness and injury. Traditional practices continue in an informal way in some areas and there is a growing interest in establishing formal mechanisms to support traditional healers to practice in conjunction with Western medical providers through Alaska Native tribal health organizations. Morgan describes a model Tribal Doctor program at Southcentral Foundation Health Corporation in Anchorage for incorporating traditional healing practices into conventional health care. He notes, however, that “true traditional health is unlikely to be practiced in an integrative setting because medical liability, insurance and law currently prevent the full practice of traditional healing ways.”

Strengths of Cultural Intervention for American Indians and Alaska Natives

Tribal ritual and ceremonial practices provide a code for ethical behavior and social organization that contribute to a meaning of life. It also provides a means for intervening in individual and social dysfunction. American Indians and Alaska Natives are caught between two cultures, attempting to preserve the best of the old, while adopting the best and necessity of the new. Though there has been significant progress in the control of bio-medical-oriented pathologies, there still exists a high rate of

death attributed to the stress of biculturalism. Much of this high death rate is due to accidents, suicides, substance abuse, and violence, "...expressions of the emotional stress experienced by individuals who have been stripped of their cultural traditions and forced to live a bicultural existence" (Guilmet & Whited, 1987). Racism and oppression, including internalized oppression, are continuous forces that exacerbate these destructive behaviors (Brave Heart & Debruyn, 1998). The chronic depression displayed by many American Indians and Alaska Natives can be linked with such factors as failing to acquire upward mobility in American society, subjective feelings of rejection and discrimination, guilt stemming from collective and personal denial of their heritage, and moral disorientation due to the fragmentation of traditional practices. Guilmet and Whited (1987) report that an increasing body of psychiatric literature suggests that the integration of Indian healing practices along with Western treatment strategies can have a positive impact on Indian depression.

Cultural interventions include ceremonies of name giving, spiritual cleansing of individuals, as well as homes and offices, and education on tribal traditions and practices. Strengthening of ethnic identity results from participation in tribal community activities, tribal language classes, traditional arts and crafts, and teaching of traditional rewards and values as compared with Western society. Tribal members who do not adhere to cultural rules and functions tend to feel isolated, struggle with identity, and may act out frustrations by using alcohol or engaging in other kinds of destructive behavior. Religious observances are particularly important to the integrity of the Indian social/cultural system (Dicharry, 1986). Therefore, health care practitioners need to blend Western strategies along with traditional culture and values when working with American Indian and Alaska Native clients. Key community resource people and elders need to be included in the development of effective cultural programs (Guilmet & Whited, 1987). The Kwawachee Mental Health Counseling Center of the Puyallup Tribe of Indians in Washington State has used this approach with tribal members experiencing a variety of mental health problems, resulting in increased use of mental health services and decreased episodes of treatment for the same patient.

Traditional American Indian and Alaska Native beliefs about health, as well as all aspects of living, evolved from Indian religion.

Health is not just the absence of disease, it is harmony with oneself, including body, mind and spirit, harmony with others, and harmony with one's surroundings and/or environment. Therefore, the concept of spirituality and religion are inseparable from one's health. American Indian culture promotes the spiritual side of wellness and healing, whereas Western medicine focuses primarily on the physical aspects. Traditional Indians believe that there are three kinds of disease: 1) natural (cuts, broken bones, etc.), 2) supernatural (curses), 3) non-Indian illness associated with contact with European culture (Baines, 1992). Baines (1992) identified only three ways of healing illness: illness only traditional healers can treat, illness only Western medicine can treat, and illness both methods can treat comprising the majority of illness.

Westermeyer and Neider (1995) in a study of cultural affiliation in a treatment program of American Indian alcoholics reported that resources supporting American Indian ethnic affiliation may ameliorate the mental health problems in Indian communities. These resources include American Indian community centers, Indian self-help groups, and various American Indian associations and cultural activities within the community. Although these may be viewed as only having cultural enrichment value, they may also have positive effects on enhancing health and reducing social and behavioral problems.

Brave Heart and DeBruyn (1998) present a model for facilitating the resolution of historical unresolved grief through an integration of both clinical and traditional American Indian interventions. They contend that their model is a catalyst for stimulating the process of grieving historical trauma. Through the model, individuals can continue their healing process through individual, group, and family therapy, while attending to their spiritual development. This process can be facilitated by American Indian and Alaska Native tribes including elders in programs to conduct activities with clients such as storytelling, teaching tribal history, and serving to heighten historical awareness. This model emphasizes the importance of extended kin networks, which support identity formation, a sense of belonging, recognition of shared history, and survival as a group. Additionally, the model supports development of cultural competence and self-awareness, as well as grief management.

Stereotypes of American Indians and preconceived notions of Indian needs

Indigenous people must be active in removing the stereotypes and other negativity that are assigned to Indigenous populations of North America.

This idea basically comes from lack of knowledge of and/or from maintaining the classic stereotype of the Indigenous people of the Americas. Not knowing and wanting to know contributes to the development of a preconceived notion of what “those” people are all about. This is blatantly expressed in the United States history books where Indigenous people are discussed and only associated with “Thanksgiving.” There is little discussion or mentioning of Indigenous people before or after that time period. Indigenous people must be active in removing the stereotypes and other negativity that are assigned to Indigenous populations of North America. Some examples of existing stereotypes are:

- **ALL AI/AN/NH receive free health care**
- **Fact:** Health care is primarily provided to residents of federally recognized reservations and in some large urban areas. Less than 55% of American Indians and Alaska Natives receive limited health care from the United States government, either through the Indian Health Service or publicly funded clinics. Native Hawaiians have no designated health care system
- **All AI/AN/NH receive Indian Health Service medical/mental health care**
- **Fact:** - The Indian Health Service is the provider of last resort; meaning that an American Indian or Alaska Native must access and utilize all other public health benefits before utilizing the resources of the Indian Health Service. The Indian Health Services does not provide any medical care for Native Hawaiians
- **All AI/AN/NH receive funds from tribes operating casinos**
- **Fact:** - The operation of casinos on many reservations has increased access to employment and some tribal benefits for tribal members. In the majority of tribal communities with casinos, the tribal membership have chosen to reinvest their profits in additional enterprises, and fund community services such as child care, senior citizens programs, educational scholarships, social services, and community infrastructure such as water and sewer systems

- **All AI/AN/NH do not pay taxes**
- **Fact:** - Individual tribal members must pay employment taxes, sales taxes, and property taxes for deeded property. American Indians and Alaska Natives residing on federal trust land do not have to pay property taxes but must pay employment and sales taxes.

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I. Barriers to Health Care



Overview of HIV/AIDS among American Indians, Alaska Natives, and Native Hawaiians

Declines in overall AIDS mortality in the United States may be generating perceptions that it is under control. The CDC reports that as of December 2002, a total of 886,575 cases of acquired immunodeficiency syndrome (AIDS) had been reported. Of these, 2,875 (3 percent) occurred in American Indians and Alaska Natives. American Indians and Alaska Natives represent less than one percent of the total U.S. population. The Hawaii State Department of Health reported that between 1983 through 2003, reported cases of AIDS among Native Hawaiian/Pacific Islander males was 38 percent of 2,621 AIDS cases and Native Hawaiian/Pacific Islander females was 39% of 205 AIDS cases. Native Hawaiians represent 19.85% of the population of the state of Hawaii.

Native Hawaiians are identified as one of the three Indigenous groups of the United States. Native Hawaiians have become identified as Indigenous people due to their cultural ties to traditional healing, and ancestral ties to the lands of the Hawaiian Islands. Notably, Native Hawaiians also comprise a high-risk population in need of culturally-responsive HIV/AIDS prevention and care services (Aiu & Reinhardt 1998, Aiu, 1996). High rates of poverty, homelessness, substance abuse, teen pregnancy, domestic violence, and sexually transmitted infections contribute to increased risk of HIV transmission and a need for HIV/AIDS prevention and medical treatment for Native Hawaiians (Aiu & Reinhardt, 1998).

Highlights from the CDC *HIV/AIDS among American Indians and Alaskan Natives - United States, 1981 - 1997*, report AIDS cases among American Indians and Alaska Natives of an age greater than or equal to 13 years was 98% of the total number of AIDS cases (1,783). Compared with the total number of persons with reported cases of AIDS in the United States, a higher percentage of AI/ANs with AIDS were aged 20-29 years (23% versus 17%

respectively), and a lower percentage were aged 40-49 years (21% versus 25%). More than half (53%) of AI/ANs with AIDS resided in five states at the time of their AIDS diagnosis: California (25%), Oklahoma (11%), Washington (7%), Arizona (6%), and Alaska (4%). The five metropolitan statistical areas with the highest percentages of AI/AN with AIDS were San Francisco, California (6%); Los Angeles-Long Beach, California (6%); Seattle-Bellevue-Everett, Washington (4%); Tulsa, Oklahoma (4%); and San Diego, California (3%). Compared with all persons who have AIDS, a lower proportion of AI/ANs resided in metropolitan areas with populations greater than 1,000,000 (56% AI/AN, versus 77% general population), and a high proportion resided in rural areas with populations less than 50,000 (19% AI/AN, versus 6%, general population).

The risk/exposure group characteristics in 2002 of AI/AN/NH (American Indians, Alaska Native, and Native Hawaiians) were similar to those of all persons with AIDS in the United States. The most frequently reported mode of HIV exposure was men who have sex with men (MSM): 47% for AI/AN with AIDS, compared to 69% for U.S. white AIDS patients; 65% for Asian/Pacific Islanders (includes Native Hawaiians); 37% for Hispanics; and 30% for blacks. However, a larger percentage of AIDS cases in AI/AN were associated with MSM who also were injecting-drug users (IDUs) (MSM/IDUs) in comparison with AIDS cases in all U.S. patients (23%, versus 10.4%). The rate of IDUs and MSM/IDUs among Asian/Pacific Islanders was 11%. Among AI/AN/NH women, IDU was the exposure category for 44% of AIDS cases in 2000, higher than for all other races or ethnic groups. Heterosexual contact was the exposure category for 52% of AI/AN/NH women (HRSA 2002). AI/AN/NH individuals diagnosed with AIDS tend to be young, reflecting that this population is younger than the U.S. population at large: 24% of AIDS diagnoses reported among AI/AN through 2000 were in individuals age 29 or younger, compared with 18.3% for all U.S. races.

The AI/AN, as well as the Native Hawaiian population, are disproportionately affected by many of the social and behavioral factors associated with increased risk for HIV infection. These populations are relatively young (median age: 24.2 years) in comparison with the U.S. population (median age: 32.9 years). The AI/AN population is disadvantaged socio-economically: 31.6 percent live below poverty level, compared with 13.1 percent for all races in the United States. Unemployment for AI/AN men is 16.2 percent

The AI/AN, as well as the Native Hawaiian population, are disproportionately affected by many of the social and behavioral factors associated with increased risk for HIV infection.

and 13.4 percent for AI/AN women, compared to 6.4 percent for men and 6.2 percent of women in the total U.S. population. Unemployment for Native Hawaiians was 1.5 times higher than the statewide rate for Hawaii. AI/ANs also have high rates of sexually transmitted diseases. (During 1984-1988, AI/ANs in the 13 states in which the AI/AN population was greater than 20,000 had more than twice the average rate of gonorrhea and syphilis cases compared with non-AI/ANs (Toomey, et. al., 1989).

During 1995-1996, the incidence of AIDS Opportunistic Infections (OIs) leveled among AI/AN. This leveling may reflect: 1) the overall decline in the growth rate of the AIDS epidemic in the United States, which has been attributed to a decline in the rate of new HIV infections, and 2) delays in AIDS OI incidence among HIV-infected AI/ANs who are receiving anti-retroviral therapy and OI prophylaxis (CDC, 1997). AIDS OI incidence also has leveled among other racial/ethnic minorities (i.e., non-Hispanic blacks and Hispanics). To maximize opportunities to benefit from new treatment advances, timely access to HIV counseling and testing and early access to care and treatment services are critical. These surveillance findings suggest that HIV-infected AI/ANs, who disproportionately reside in rural areas including reservations, have reduced access to facilities for HIV diagnosis and treatment, and medical and public health staff in these areas may have less experience with the currently recommended practices for HIV prevention and medical care.

AIDS in the United States remains primarily an epidemic affecting MSM and racial/ethnic minorities. A new generation of MSM has replaced those who benefited from early prevention strategies, and minority MSM have emerged as the population most affected by HIV. Socioeconomic factors (e.g., homophobia, high rates of poverty and unemployment, and lack of access to health care) are associated with high rates of HIV risk behaviors among minority MSM and are barriers to accessing HIV testing, diagnosis, and treatment (CDC, 2000). Minority men may not identify themselves as homosexual or bisexual because of the stigma attached to these activities and may be difficult to reach with HIV prevention messages.

Providing appropriate interventions and therapeutic measures has been hobbled by numerous barriers to care, which is defined as real or perceived gaps to providing quality care. This is compounded by the relationship that HIV has to ethnicity. These barriers

ers include mistrust of government institutions and medical care providers, access to care issues, stigmas surrounding HIV, lack of support systems, and bias in medical decision-making. While not discussed in detail here, researchers also have found an association between education literacy to HIV treatment adherence and barriers to care among racial/ethnic minorities. Those subjects with lower education and/or literacy levels were more likely than participants with higher literacy levels to miss medication schedules because they were confused about dosage amounts.

Mistrust of Medical Care System and Historical Trauma

Though the three Indigenous populations share many experiences with other people of color, they also have many unique experiences as Indigenous groups in the United States. A long history of disenfranchisement; extermination of tradition, language, Tribal members, and land rights; broken treaties, sterilization of Indian women, placement of Indian children in Indian boarding schools, and other experiences of oppression have established deep-rooted intergenerational anger, intergenerational grief, and mistrust of government that persists to this day. Clearly, this mistrust and these feelings of resentment are not unfounded.

Among the American Indian, Alaska Native, and Native Hawaiian populations, disease has functioned both as a significant historical variable and as an occasion for unethical medical treatment policies supported by the federal government. Contact of Western/European settlers with Indigenous populations greatly impacted the well-being of Indigenous communities. Disease and epidemics (small pox, bubonic plague, whooping cough, venereal diseases, mumps, pneumonia and others) introduced by Europeans were the main cause of the genocidal decline of Indigenous people and the main force for colonial expansion. The colonization of America was the “most striking example of the influence of disease upon history...” (Thornton, 1987, p. 47)

The use of disease as a strategy of colonization, a history of unethical research practice and ongoing substandard medical treatment has left many Indigenous people and tribal communities distrustful of government and medical providers (Duran and Walters, 2004). This mistrust extends to public health officials as well, as a result of specific tribal histories of poor health care and

deliberate infection. Most American Indians are familiar with the government's gift of blankets to many tribes, which were infected with small pox; and the sterilization of Indian women without their consent and knowledge, which was still practiced in 1976. This history is well recognized in the Indigenous community, and often translates into a level of mistrust of health care providers in contemporary settings (NNAAPC, 2002).

Several studies have addressed the impact of historical trauma on American Indian and Alaska Native communities, which also affects other Indigenous populations. Duran and Duran (1995) write about the phenomena of cumulative and community level trauma and the pain that American Indian and Alaska Native communities suffer as a direct result of the genocidal effects of colonization. They describe the notion of a "soul wound" that is at the core of much of contemporary suffering of Native people, which they contend must be acknowledged and understood within a historical context. This historical trauma has been described by Brave Heart and DeBruyn (1998) as "historical unresolved grief" that has affected generations of tribal people. This historical grief was bought about from loss of lives, land, and vital aspects of Native culture that resulted directly from colonization. Similar to the trauma experienced by Holocaust survivors and their decedents, the effects of physical and cultural genocide directed at Native people are transferred across generations. Current generations of Native people have faced generations of traumatic losses that are physical, mental, cultural and spiritual in nature. The accumulation of this trauma contributes to the pain, psychological numbing, and destructive coping that are best described as chronic stress disorder at a community level.

Brave Heart and DeBruyn (1998) have presented a model for facilitating the resolution of historical unresolved grief through an integration of both clinical and traditional Native interventions. They contend that their model is a catalyst for stimulating the process through individual, group, and family therapy, while tending to their spiritual development. This process can be facilitated by Indigenous groups and tribes and by including Indigenous elders in programs to conduct activities with clients such as storytelling, teaching tribal history, initiating healing ceremonies, and heightening historical awareness. This model emphasizes the importance of extended kin networks that support identity formation, a sense of belonging, recognition of shared history, and survival of a group. Additionally, the

model supports development of cultural competence and self-awareness, as well as grief management.

The issues of historical mistrust must be considered when serving American Indian, Alaska Native, and Native Hawaiians in order to ensure that the patient is not further alienated from services due to uninformed actions by the agency staff or the medical provider. To achieve this end, it is recommended that the medical provider and staff access and participate in local cultural sensitivity training that will increase their understanding of the cultural issues that impact access to care by Indigenous people.

A survey of tribal employees requesting them to rank a list of 19 factors in selecting a health care provider, found employees ranked tribal language spoken and availability of traditional Indian healers as a low priority in selecting a provider. The prevalent issue for tribal employees in selecting a provider was selecting one who recognized, understood and accepted their culture. A doctor's experience with Indians was considered somewhat important among 52 percent of tribal employees surveyed and 85 percent of Medicaid consumers interviewed (Dixon, Lasky, et al 1997). This study strongly emphasizes the importance of cultural sensitivity and community awareness in working with tribal community members.

Provider Bias

Social and cultural barriers contributing to health disparities include health care providers' bias and stereotyping; misunderstanding of patients culture and language; patients' socioeconomic status, including poverty and educational attainment; and patient health behaviors and lifestyle.

Conscious discrimination is not as common as the unconscious bias frequently displayed by health care providers serving Indigenous communities. Studies have discovered that while unintentional, health care providers make treatment decisions based on the providers' cultural and racial biases and stereotypes. One study concluded that too often, a physician's perception of a patient's race and ethnicity, which is not based on any communication with the patient, is being recorded and used by the health care team to make clinical decisions and medical and social judgments about the patient. This practice perpetuates physician paternalism and racism (US Commission on Civil Rights, 1999).

An independent study by Michelle van Ryn and Steven Fu (2003), published in the *American Journal of Public Health*, found that health providers directly contribute to racial disparities in health care and health outcomes. The research found that providers may intentionally or unintentionally reflect and reinforce societal messages regarding the value, competence, and deservingness of treatment of non-white patients. Providers communicate lower expectations for patients of color and poor patients, including the expectation of medical resources and assistance, expectations of improvement in their medical condition, and views concerning family and social support necessary to aid in or support recovery. On a more basic level, interpersonal behavior is also influenced by the provider's bias and use of stereotypes. In the Ryn and Fu study (2003), it was reported that care providers use "less participatory decision-making style" and communicate information in a highly technical manner with little opportunity for patient input and questions when treating non-white and low-income patients. Because of cultural differences, American Indians, Alaska Native and Native Hawaiians tend not to question physician decisions or speak out against any mistreatment, making them more vulnerable to unfair treatment.

Efforts to enhance cultural sensitivity and incorporation of traditional beliefs and values into the service delivery model must be part of the care provided to Indigenous clients. Relying on a purely Western medical model of care will be ineffective in treating Indigenous clients and reduces the likelihood of adherence to medical care or maintenance of appointments with the provider.

For these Indigenous groups, there is a concern that health care providers' cultural insensitivity and the lack of acceptance of traditional healing practices may create barriers to receiving care. If health services are not offered to the targeted patient population in a culturally and linguistically appropriate manner, treatment will remain ineffective and any effort to eliminate racial and ethnic health care disparities will fail (U.S. Commission on Civil Rights, 1999).

Access to Health Care

Today academic studies find that racial bias significantly contributes to differences in health care provided to American Indians and other people of color (U.S. Commission on Civil Rights, 1999). A recent Institute of Medicine report established that "whites are

Urban Indian Health programs only serve approximately 6% of Indigenous people residing in urban areas, but more than half of Indigenous populations in the United States now reside in urban environments.

more likely to receive more, and more thorough diagnostic work and better treatment and care than people of color - even when controlling for income, education, and insurance (V. Randall, 2002).

Other factors contributing to health disparities include:

- Limited access to appropriate health services and facilities;
- Poor and no access to health insurance, including Medicaid, Medicare, and private insurance;
- Insufficient federal funding;
- Quality of care;
- Availability of culturally competent health services;
- Disproportionate poverty and poor education;
- Behavior or lifestyle choices; and
- Cultural and language barriers.

The Indian Health Services (IHS) provides medical care to American Indians and Alaska Natives who reside on or near reservations of federally recognized tribes, with some financial assistance provided to Indian urban health centers. The budget for IHS is \$3.5 billion for medical and environmental services, which only meets approximately 55 percent of the health care needs of its service population (1.6 of 2.6 million eligible patients) (U.S. Commission on Civil Rights 2004). American Indians and Alaska Natives live in some of the most remote geographic areas and these circumstances result in some of the same access problems that affect other Americans who live in rural areas (Dixon 2001). Residing in rural/isolated areas affects the level and quality of care due to limited numbers of medical providers, lack of specialty medical care, no hospital facilities, stigma of HIV infection, transportation challenges, confidentiality, and lack of ancillary support services.

It is important to note that not all Indigenous people live in rural areas. Urban Indian Health programs only serve approximately 6% of Indigenous people residing in urban areas, but more than half of Indigenous populations in the United States now reside in urban environments. Challenges to medical service access for both rural and urban Indigenous people include socioeconomic issues of poverty, educational attainment, unemployment, lack of medical insurance, language barriers, and historical mistrust.

Native Hawaiians are also confronted with limited access to health care. There are limited health resources available specifically for Native Hawaiians; therefore, they must rely on the same health and social services as the general population in the State of

Hawaii. Issues of poverty and lack of medical insurance pose serious limitations to health care.

HIV specialty health care is typically not available through the regular means of health care received by these three populations. Lack of medical insurance and limited access to health care facilities staffed with internists or HIV specialists pose challenges for Indigenous clients requiring HIV specialty care. Although Title III does provide HIV specialty care in large metropolitan areas, these are often not accessible to rural clients. A serious factor to consider is that Indigenous people often will not seek services or medical care in facilities that are presumed as treating only “whites” or regarded as not being culturally sensitive. The Indian Health Services does provide HIV medical care at many of the larger facilities located near urban centers. On many reservations or rural areas, the IHS clinics are not staffed with specialists or doctors trained in HIV care. In many instances, IHS or tribal clinics do not have HIV medications on their drug formularies, so even if the patient receives HIV medical care, access to HIV medications becomes a challenge due to cost and, in most cases, geographic location. These barriers serve as a hindrance to patients, which leads to poor health outcomes.

Stigma

Obstacles to successful HIV prevention programs continue to be a serious challenge for American Indians, Alaska Natives, and Native Hawaiians. Continuing challenges include lack of awareness of HIV transmission modes, lack of knowledge of individual HIV risk factors, homophobia at all social levels, including tribal communities, and lack of well organized and visible gay Indigenous community programs with resources to advocate for needed services and support for persons living with HIV. The number of Indigenous specific programs is limited, and typically located in urban areas, with many blended into large HIV/AIDS programs with few specific resources for AI/AN/NH.

There has been an effort by the Health Resources and Services Administration (HRSA) (Ryan White Care Act - Special Projects of National Significance) to fund pilot research projects in Native communities, with an emphasis on development of models of service and care that incorporate the cultural beliefs and values of the population served. The National Native American AIDS Prevention Center (NNAAPC) in Oakland, California, was the lead agency in developing

a culturally holistic model that addressed the personal, psychological, medical, and spiritual needs of the AI/AN/NH clients served. Preliminary findings from their study demonstrated that a service program identified as being Native specific, that offered a one-stop approach to services, was staffed by Native professional staff, and incorporated cultural beliefs and values into their core of services, was effective in reducing client risk behaviors, while demonstrating a positive impact on the client's quality of life. Other tribal groups with HRSA support continue to expand this effort in different regions of the United States.

American Indians, Alaska Native, and Native Hawaiians are confronted with accessing services within their communities, which are often agencies staffed by family members and relatives. This raises serious concerns of client confidentiality. A cultural value for these populations is the belief that as members of the community, everything they do reflects on their community. Therefore, they avoid situations in which their sexual preference and HIV status may become known within the tribal community. The fear of exposure also extends to medication treatment. Indigenous clients will not take medications in the presence of family in instances where they have not disclosed their HIV status to family members. If they attempt to take medications secretly, issues of taking medications at the correct times and intervals becomes a serious challenge for the patient, as well as adherence to nutritional requirements.

These behaviors are further compounded by the homophobia that exists among Indigenous people. Historically, persons with sexual identities different from their biological being were accepted within the tribal community. These individuals, along with all tribal members, had a responsibility to be functioning and contributing members of the community and as long as they adhered to the social and religious expectations, they seldom encountered any objection to their sexual identity. Among many tribes there is an acknowledgement that every human being is created with the essence of both male and female, and that during the course of childhood, the person may choose to pursue a different gender identity than their biological sex. Historically, many Indian tribes held individuals who were different in high regard. This was not true only for gays and lesbians, but also for people who were physically different. They were considered to have special spiritual beings protecting them. But today these individuals are often times ostracized from tribal life (Day, 1990).

With exposure to Western culture and Christianity, many American Indians, Alaska Native, and Native Hawaiians have adopted the attitudes of Christians toward homosexuality. The result has been that homosexuals, lesbians, and transgender persons have become culturally invisible in tribal communities.

Unfortunately, homophobia extends beyond the Indigenous community. A survey by the National Native American AIDS Prevention Center assessed knowledge, attitudes and behaviors among clients and counselors of Indian chemical dependency treatment centers. It showed that attitudes expressed by both clients and counselors toward gays and bisexuals were negative: fifty percent of those surveyed believed that homosexual lifestyle should be condemned (Day, 1990). This is further compounded by the fact that many Native people fail to express any alarm or concern about the impact of HIV in the American Indian population (H. Weaver, 1999).

Accurate information about HIV transmission, as well as the reduction of stigmas associated with HIV infection, is a critical measure for prevention. Recent reports from the CDC (2000) and Institute of Medicine (2001) suggest a correlation between HIV knowledge and stigma, with those who have lower levels of HIV-related knowledge more likely to hold biased views regarding people living with HIV/AIDS. Other research has shown that people who fear HIV-related stigma and discrimination are less likely to seek information about prevention, may delay being tested for HIV and implementing treatment, and may be reluctant to discuss their HIV status and thereby preclude starting support networks (Kerek 1998; Chesney and Smith, 1999).

In spite of education and prevention efforts, high-risk behaviors continue among many Indigenous people (DePoy & Bolduc, 1992; Elders 1994). There is a dire need for services and HIV education for persons at risk or infected with HIV. Additionally, there is an immense need for new approaches to HIV and gender diversity education for the AI/AN/NH community at large.

Support Systems

In urban communities with significant populations of persons living with HIV/AIDS, the social networks and community norms that support neighborhood-based public health interventions have been destroyed. The increasing poverty of inner city residents and the corresponding increases in crime, violence, and drug abuse -

and their associated risk behaviors - can only be countered by efforts to stabilize the community and prevent further destruction of its social networks. Wallace, et al., (1995) state, "Because of the interrelated nature of the nexus of behavior leading to substance abuse and associated pathologies - including AIDS - general systemic social interventions will go toward mitigating many of the urban ills of the United States, including a whole host of problems of public health and public order which now overwhelm the nation's criminal justice and health care systems, problems for which substance abuse is a kind of university matrix in which they are embedded and to which they contribute."

In rural communities, where a vast number of AI/AN/NHs reside, there is little, if any, infrastructure to support expanded support services to persons living with HIV. Tribal and Native programs typically are forced to prioritize services within their communities, often focusing on prenatal health, diabetes, cardiovascular disease, adolescent health and health issues affecting the general population. Minimal resources are available for addressing HIV prevention or health care.

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II. Ethics

Introduction

HIV/AIDS is a serious public health problem that will continue to exist for many years to come or until the time an HIV vaccine is developed and made available to the general population. The goal of this chapter is to examine the barriers created by the ethics of HIV/AIDS treatment and care. Ethics within an Indigenous culture can be looked at as an actual reflection of the cultural beliefs and values of an Indigenous society. Culture is often misinterpreted by individuals who lack knowledge about the social and political history of a specific Indigenous group, and how that history affects the group's response to social and medical care. Issues of historical oppression, discrimination and power conflicts also affect the response of Indigenous populations. It is unfortunate in the wake of the HIV/AIDS epidemic that we fail to recognize and understand the value and diversity of culture and how cultural influences can lead to errors in diagnosis and treatment. Such errors can lead from what was initially intended as a helpful situation to one that is destructive and potentially harmful to the patient (Brant C., 1990).

The intent of this chapter is to assist the health care provider in gaining knowledge of the traditional tribal ethics of American Indian/Alaska Native/Native Hawaiian (AI/AN/NH) and how these ethics affect the individual's response to a medical provider's communication and treatment. Additionally, this chapter will address the multiple challenges posed by medical ethics that confront this population in accessing HIV care and support services.

First, we will look at the ethics of health care as defined by Western culture. The majority of Western health ethics were developed by Thomas Percival, an English physician, who published his Code of Medical Ethics in 1803 (AMA, 2002). It is this code of medical ethics that governs the majority of health care in the United States. The aim of this chapter is not to argue that the health community should tackle all instances of power differentials and

conflict generated by these ethics; nor is it the intent of the author to address the challenging and politically unrealistic endeavor of the current flattened social gradient created by foreign standards unfamiliar with the traditional ethics innate within most tribal councils.

The intent of this chapter is to acknowledge that historical traditional beliefs and values that were formed and later classified as tribal ethics continue to govern tribes, villages and individual community members. These original tribal ethics (instructions) have inevitably worked in tandem with wider efforts toward social justice by tribal councils. These traditional tribal ethics include provisions of safety nets; protection against health impoverishment; and the provision of traditional education, environmental risk reduction, efforts to ensure peace, and a political or tribal voice for the tribal community. Traditional ethics have been thought to provide equity as inherently imbedded in a more general pursuit of social justice (Mihesuah DA, 1998).

Issues of historical oppression, discrimination and power conflicts also affect the response of Indigenous populations.

Challenges for Health Care Professionals

Access, financing, and specialized medical care are traditional challenges faced by health care providers serving rural populations in Indian Country. When working with AI/AN/NH, these challenges are exacerbated by issues of sovereignty, geography, cultural diversity, and history (Barney D, 1999). The cultural diversity among AI/AN/NH is extensive. Additionally, the type and level of health services available to each of these Indigenous groups varies. Knowledge of the cultural, social and political issues that affect health care for Indigenous populations is not imparted to most medical students in educational institutions and often is not addressed until the professional is practicing medicine. Additionally, health care providers are unaware of the systems of health care that provide medical care to Indigenous populations in rural and urban areas. The medical care may be the result of direct federal funding to federally administered hospitals and clinics, contracting by tribal governments, or services through an urban Indian community health center. In all instances, health services provided to AI/AN/NH must be prioritized due to the limited resources available within the community. Often this results in limited resources for HIV/AIDS testing, diagnosis, and treatment. The limited funding also affects the ability to recruit and retain spe-

cially medical professionals trained in treating HIV/AIDS. Many health care professionals are also unaware of the complexities associated with contract health care. The process of contracting health care services has changed the dynamics of health delivery in Indian Country by shifting the responsibility from the Indian Health Service, a sister agency of the Centers for Disease Control and Prevention, directly to the tribes (Dixon M, 2001).

The AI/AN/NH Be Safe Model is committed to identifying and advocating for solutions that can address public health disparities identified in Indian Country and in rural minorities in the wake of the HIV epidemic. Indigenous people have additional layers of complexity that argues for the development of a service model that is unique to this population. In the preceding chapters, the complex health history experienced by AI/AN/NH and the impact of historical trauma have been addressed, as well as the stigma associated with HIV/AIDS.

How Ethics affects the Epidemiology of HIV/AIDS and how this can affect the care and treatment in American Indians/Alaska Natives and Native Hawaiians

A major concern regarding the epidemiology of HIV/AIDS among AI/AN/NH is the lack of accurate data reporting. Issues of underreporting HIV, racial misclassification, and lack of adequate reporting mechanisms have a detrimental impact on reporting the accuracy of prevalence of HIV/AIDS in AI/AN/NH populations. Without data supported evidence on the HIV trends in Indigenous populations, health disparities in HIV treatment cannot be thoroughly addressed. Currently, we can speculate on the numbers of cases that potentially exist among the federally recognized tribes. Clinical information on the numbers of AI/AN/NH currently in care is often not available for use in calculating the percent of the population who are in care compared to persons who are not in care.

For many tribes and villages, the mere lack of vital statistics and reliable health information about diseases such as HIV represents a de facto statement that the health of its people is not a priority, therefore, producing a vivid reflection that the epidemic is not a problem. The lack of basic mortality and morbidity statistics for HIV infection for the AI/AN/NH population is a clear sign

that their needs are simply not considered in health policy development.

Recent conceptualizations regarding how this epidemic is impacting AI/AN/NH will not be evident until we begin to start collecting empirical data regarding the impact, the characteristics, or the constructs of how this epidemic is impacting AI/AN/NH. Therefore, without data, we are creating barriers that inhibit our ability to ascertain prevalence (Odo C, 2001). Without adequate data, we are not supporting our medical providers who have the compassion and desire to work in rural areas or on reservations or in villages.

Historical research of AI/AN/NH culture and its influence on future data collection

Indigenous people in North America and the world are increasingly rejecting Western colonial frameworks of research and policy development. Instead, they are reclaiming their right to be AI/AN/NH while revitalizing tribal culture through promotion and utilization of Indigenous research methodologies and development of culturally rooted policy. Although response of researchers and policy-makers is not yet known, these developments will continue into the future due to the commitment and work of Indigenous people.

Health care providers who wish to conduct research for AI/AN/NH will need to begin with recognizing and respecting tribal sovereignty, which is the least understood aspect of research in AI/AN/NH communities. Tribal sovereignty means that tribal communities retain sovereign status while there is any interaction with other government entities. Health care providers funded by these entities who wish to conduct research will need to become fluent and understand proper protocols that are unique for each population. Respect and negotiations with tribal, village, or corporate governments can ultimately lead to clarification of the research process on each reservation, village or island.

Most AI/AN/NH communities have not established protocols to conduct research within their community. Ethical access can involve a tribal resolution, which is a document to acknowledge that the tribe, village or island is aware of the proposed activity and approves of the activity. In addition, many AI/AN/NH are estab-

Indigenous people in North America and the world are increasingly rejecting Western colonial frameworks of research and policy development.

lishing their own internal review panels to rule on issues of informed consent and other human subject aspects of the research process. This can add additional levels of scrutiny to the research process. However, it is important for the health care provider to step toward culturally respectful research procedures and to understand that what may appear to be non-intrusive and non-harmful questions to non-AI/AN/NH panels in university and funding agencies may violate norms of propriety and privacy in AI/AN/NH cultures (Brant, 1990).

Historically, non-Indian academics have monopolized the study of American Indians and their cultures (Deloria V, 1999). There is no doubt that American Indians have often been treated as objects in the studies. However, authors in this manual suggest that much of this research and many researchers' cultural interpretations have informed and misinformed both the academic study of American Indians and the body of knowledge used to educate the general population about American Indians (Mihesuah, 1998).

Social Justice

It is commonly observed that increases in social status are paralleled by increases in health status. Similarly, as an individual gains a grade increase in education level or occupation hierarchy, the resulting yields correspond to increased increments in health outcomes. Higher levels of education appear to confer lower risk of ill health or death across a wide variety of causes, including death related to AIDS. However, in AI/AN/NH communities, and among women, higher levels of education appear less effective in protecting against the mortality crisis of HIV. The link between education, employment, and health lies in whether individuals can generate an income sufficient to sustain well-being. In AI/AN/NH, the unemployed have the highest mortality rate in the adult population. In addition, the high job turnover rate is strongly correlated with decreased life expectancy in rural communities.

The conceptualization of social determinants of health is limited but evolving rapidly (Lyme, 2002). Traditionally, social determinants have been identified as a characteristic of the individual, such as a person's social support network and income or employment status. AI/AN/NH populations are not merely collections of individuals but are structured as living communities. Health care professionals need to understand the causes of HIV are clustered in

systematic patterns, and the effects on one individual may depend on the exposure and outcomes for other individuals. Individuals in a tribe or village are defined in part by their relationship to the social context (Duran B, 1995). We refer to the concept of 'social position' to describe a person's 'place' or social standing within the society in which they live. These social positions can evolve by a person's occupation. For example, clanship exists among some tribes to define the independence of individuals and to specify their roles in their respective communities. Other villages, communities or populations rely on other forms of social hierarchy to define specific roles, such as parent, relative, or profession.

Principle of Personal Ethics

Contemporary ethics recognizes that medicine manifests social and cultural values and that the institutions of health cannot be structurally disengaged from the sociopolitical powers that create such values (Van Reijen, 1988). Western medicine and the Western society in general largely reflect modern, Christian, and liberal values that have determined the way we should behave, live, and work, as well as the appropriate manner in which we communicate and the construction and value of our interpersonal relationships and means for understanding the world.

As the world is becoming increasingly complex, and as diverse populations interact more with one another, we see increased population mobility, communication gaps, and international commerce. These three factors are prominent reasons why those in the public health profession, or any other profession, need to develop competence in understanding diverse populations. This begs the question: should the ethics of each paradigm or dimension in each population or culture be the foundation where exchange should originate?

HIV is an epidemic that is constantly evolving, which requires a mutual acceptance of the many auspices of ethics. One of these auspices of ethics is in regards to personal ethics that include individuals who have committed their life to work with those infected and affected by this epidemic. These individuals, for the most part, unknowingly include personal ethics in their many daunting tasks that may be influenced by Western ethical principles without regard to Indigenous culture, tradition, or relevance to improve health. For example, when members of two different societies, or from two different clans within one tribe, come into lasting contact with each other, such as HIV pos-

itive AI/AN/NH and their physicians, almost invariably there is a flow of ideas and objectives between the two groups that requires sensitive interpretation. This interpretation often results in the modification of the culture of one or both of the societies. This sort of cultural exchange also relies on information from both societies and is usually stemming from a personal ethics perspective.

When contact is established between two societies, not all members of both societies have an opportunity to share ideas. In some societies, certain individuals perceived to occupy status within their own society (i.e., physicians, spiritual healers, etc.) will only converse with others like themselves within these societies. These individuals usually keep in contact with each other for the purposes of discussing diagnosis or treatment, and converse using jargon only they can decipher.

The concept of **autonomy**, a root principle of ethics, is one possible way to address the issue of the inability to ascertain the concepts of prevalence. This Western concept provides empowerment to an individual so that they can make decisions based on information received. Often this is influenced by who has been providing the information. For individuals providing information about HIV/AIDS and its related diseases, this information is usually grounded by the three constructs of data, treatment, and research. We need to understand that these constructs of data may be foreign to most individuals. When providing information to an individual, it is important to make sure that language and culture are relevant and translated into these constructs at a level appropriate to the individual.

The concept of autonomy is a familiar concept among many AI/AN/NH, however, the constructs associated are uniquely defined. Over the last decade it has been strongly stressed that the patient has the right to be informed about the risk and benefits of a treatment or intervention. Based on information received the patient will decide to consent, or by not doing so, they practice autonomy. Having affirmed the patient's 'right to know' as a fundamental ethical and legal principle, health care providers now face the apparently opposite demand. This takes place particularly in the area of testing. As the predictive power of HIV testing increases, more and more individuals will come to know that they may be at risk for HIV exposure.

Let's look at one case study to illustrate the problem. (Case Study 1)

- Barbra, a 35-year-old woman and a mother of two children, has a family history rich in practicing Native tradi-

tional ceremony. Her relatives and her boyfriend, who is also the father of her children, are avid ceremony followers as well. One family member is a physician and sometimes returns for occasional ceremony, but stays in touch with the entire family around holidays. One day, Barbra decides to be tested for HIV because she overheard on the radio that AIAN/NH heterosexual women are at increased risk of developing breast cancer than other women of other ethnicities. Without a discussion with her boyfriend or relatives, she takes a test and forgets about returning for the results in two weeks.

- Her aunt works at the clinic as a medical records technician. One day as she is filing lab results into medical records, she comes across Barbra's test result for HIV and is shocked to see that the test was positive. Her immediate response was to go and inform Barbra of the test results, however, through HIPPA training she had received two weeks earlier, she remembered that this would definitely jeopardize her future promotion by violating patient confidentiality.
- Barbra's aunt decides to go to a medicine man, spiritual healer, or spiritual person to discuss this test result. She felt that such a consultation would help her overcome her anxiety and urge to tell Barbra.
- The consultation with the healer is just as she expected. Barbra should not receive these tests because it would be perceived as a 'death sentence' and if the news were given to Barbra from her aunt, then the omen of death would fall back onto her aunt, only because she was the originator of the bad news. Barbra's aunt decides that the healer should provide Barbra with the test results and ceremony thereafter. Barbara's aunt followed traditional protocol in seeking the guidance of a traditional healer. The cultural beliefs and practices of her tribal group conveyed by the healer are tribal ethical mores that a tribal member is expected to adhere to without question. The healer in this case will be responsible for addressing the health issues with Barbara without relaying to her his source of information. Although confidentiality may have been breached by Barbara's aunt, traditional roles and protocols overrode the necessity to pursue the issue based on tribal beliefs and values.

Far from being academic, this scenario can happen in the daily routine of genetic testing and research. It is important to understand that tribal protocols (ethics) often guide the response of tribal members to health issues. This is important to understanding Barbra's aunt's reluctance to have Barbra receive the information directly from the clinic versus receiving it from the healer. The potential consequence of the aunt informing Barbara could result in depression in both women due to the nature of the test result, negatively affected family ties, and violated traditional beliefs and values of their culture. For Indigenous people, the personal diagnoses of a terminal disease that brings unbearable suffering or death, can lead to depression that diminishes their quality of life, personal and family happiness, and the purpose of their lives would literally evaporate (Wachbroit, 2004).

Principles of Professional Ethics

Individuals in a professional capacity generally take on additional burdens of ethical responsibility. One example is how the HIV epidemic is affecting health care professionals in their determination of how to place the patient's best interest first which is the second principle identified-**beneficence**. This principle is frequented and governed by professional associations that have their code of ethics prescribe a required behavior within the context of a professional practice (i.e., medicine, law, and accounting).

"Tribal ethics or original instructions" can be deemed as the principles that govern the ethics of health care for AI/AN/NH. Even when not written into a code, these principles or "original instructions" are usually expected of Native individuals and those living within a traditional society, including healers and spiritual healers. However, without such understanding, health care professionals may misinterpret these original instructions (Colero, 2002).

By not understanding the potential for conflicting cultural concepts of morality, some health care professionals may inadvertently create a hostile or humiliating environment for patients. This behavior, defined as non-maleficence (to avoid causing patients any harm), can be very difficult for health care providers who are not locally acculturated.

For example: (Case Study 2)

A psychiatrist assessing Native children and adolescents in a reservation setting often finds them passive, dif-

difficult to assess, and not forthcoming. A dialog between two colleagues in this field who are unfamiliar with the culture, language, or traditions could describe this type of behavior as actually reflecting the influence of Indigenous culture. In contrast, other clinicians could misinterpret this particular cultural behavior as evidence of passiveness, lack of motivation, or lack of resiliency, especially when unfamiliar with the local cultural beliefs and values. Health care professionals unfamiliar with such cultural influences can increase their potential for misdiagnosis and ineffective treatment (Brant C., 1990).

It is important for health care providers to understand that AI/AN/NH live in two worlds (Western and tribal societies). These individuals live and work in both worlds simultaneously, but typically function under a dominant set of beliefs and values that typically are tribal based. Health care professionals need to also understand that 500 years of oppression and domination pose substantial challenges in delivering health care to Indigenous populations. When and if this is overlooked, it is likely that distrust will escalate, creating significant barriers as in Barbra's situation. Moreover, the increasing access to medical tests leads lawmakers to recognize the necessity to protect confidentiality and individual privacy. The 'right not to know' is one of them. This claim is based on individuals' autonomy and on their interest in not being psychologically harmed by the results of such tests—the principle of non-maleficence. Such a right, as an exception to both the patient's right to know and the clinician's duty to inform, needs to be activated by the explicit will of the patient. According to the literature, this right has dual characteristics: 1) it can only operate in the context of the doctor-patient relationship; 2) it is a relative right, in the sense that it may be restricted when disclosure to the individual is necessary in order to avoid serious harm to third parties, especially family members, which means that some form of prevention or treatment is available (Chadwick, 1997). This tends to conflict with the approach taken by Barbara's aunt.

Due to the cultural cohesiveness of AI/AN/NH communities, it is essential that health care professionals in delivery of culturally sensitive health care to Indigenous populations seek the benefit of making community connections that will inform them of cultural and social issues that affect an individual's response to health care. This does touch on a topic "cultural sensitivity,"

which has yet to be defined; however, the studies refer to this concept as the simple recognition of how cultural differences are viewed. Generally, health care providers must be able to engage the community on their terms and demonstrate acceptance of cultural difference in an open, genuine manner, without condescension.

Justice: The Global principle

Ethical principles can be absolute rules that include universality. Indeed, culture is not static but is constantly being altered. Therefore, culture needs to be viewed as a living and an evolving system. Some traits of culture do change while others do not change and some are discarded. One common, albeit limited, view of cultural evolution is that it does not occur in a void, but evolves along a continuum from “traditional” to “contemporary.” Within this continuum, cultural and ethical values can become factors that can impede communication and service delivery in healthcare and other settings (Hunter, 2001). To approach and attempt to resolve these differences, it helps to acknowledge the fact that I/AN/NH cultures are complex and diverse. Therefore, health professionals should avoid applying a ‘standard’ or monoculture approach to all AI/AN/NH people, and should not expect all interactions to ‘fit’ a particular model. Barbra’s story highlighted some important values and ethical convictions that may be utilized to develop a deeper understanding of how to appreciate AI/AN/NH values or ‘ethics’ in healthcare settings and improve healthcare practice.

Colonization and dispossession have had a dramatic impact on the physical, emotional, and spiritual well-being of the AI/AN/NH. Although some aspects of this history may not be immediately obvious, it is important to note that the impact extends beyond the loss of land to continued racism, exploitation, and economic disadvantage, which forms the basis of distrust, grief and loss felt by AI/AN/NH (Stiffarm LA, 1992). It is critical that the health professional be aware of the history and cultural traditions of AI/AN/NH and their sense of continued loss and hopelessness as a result of historical trauma. Knowing this, development of culturally responsive communication, interventions, and health care will potentially enhance an Indigenous person’s response and adherence to such care.

Conclusion

Co-Existence of Principles

To illustrate an example of how culture continues to evolve between an anthropocentric and an eco-centric perspective can be demonstrated through the conflicts and inadequacies present from the first time that a plant is gathered or how a family can reconnect with self and family through the land, the ocean and the food (Stannard, 1989). These are governed by principles that have been handed down through generations of Indigenous people as proper gathering techniques and offerings. Yet, the actions of individuals, corporations, and governments have influenced us to become dependent on a fabricated medical system that is founded on principles, beliefs, and values that have a foreign or negative impact on those who do not share a common foundation. Today, we experience the difficulties that arise as a result of conflicting ethical principles and values, as well as awareness of how shared values and principles may be expressed differently (Chadwick, 1997).

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III. Sensitivity of the Provider

Introduction: Cultural Competency

The literature is clear that historical and cultural differences between the Indigenous/Native patient and the health care provider create difficulties for Indigenous people when accessing health care services. Culturally competent and responsive medical care requires that health care professionals be trained in methods of culturally competent practices that will enhance client retention and compliance to medical care. Greene and Hucles-Sanchez define cultural competence as:

...a measurable professional standard that evaluates the incorporation of the differential historical, political, socio-economic, psychophysical, spiritual and ecological realities, their interaction, and its impact on individuals or groups. Here culture is used in its broadest sense to include race, ethnicity, gender, and sexual orientation and considers other dimensions of individual or group experiences that are salient to their understanding of the world and of themselves (1994: 8).

There are a number of approaches that contribute to becoming culturally competent, which include: 1. The provider's acknowledgement of diversity within a culture and ethnicity. 2. The provider's awareness of his or her own values beliefs, and willingness to do a self-assessment of their cultural values, beliefs, traditions and its practices. 3. The provider's recognition of the clinical dynamics created by cultural diversity. 4. The provider's knowledge of the patient and their Native community values. 5. The provider's willingness to adapt medical skills to the patient's culture (Hooper & Moore, 2001: 33). Medical professionals may comprehend the medical conditions of a Native client and community, but without an understanding of Native values, the health care provider will lack the theoretical foundation to form appropriate healing strategies and engage the client. McCormick states that, "In order to communicate with First

Nations people, service providers must understand the traditional world view of First Nations people” (1994: 8).

Multicultural Approaches to Service Delivery

Culture teaches people who they are and establishes their values and beliefs. Sue, Arredondo and McDavis point out that before the advent of multicultural awareness, clients from non-Western cultures were often serviced with mono-cultural models that viewed their culture in terms of deviancy, pathology or inferiority (being culturally deprived) (1992: 484). As suggested by Napoleon (1991), it appears to be necessary to have Native cultures die or be ignored so that the Euro-American culture can live.

Pedersen, Draguns, Lonner, and Trimble identify ten negative effects of mono-cultural services that can create difficulties for Native patients.

1. All patients are measured according to the same “normal Western” standard of behavior.
2. Individualism is presumed more important than a collectivist perspective.
3. Professional boundaries and behavior are narrowly defined and interdisciplinary cooperation is discouraged.
4. Psychological health is described in abstraction rather than within a cultural context.
5. Dependency is always considered as an undesirable, even neurotic, condition.
6. A patient’s support system is considered not relevant.
7. Only linear “cause-effect” thinking is accepted.
8. The individual is expected to adjust to fit the Western system.
9. The historical roots of a client’s background are disregarded or minimized.
10. The health care service provider is presumed to be free of racism and cultural bias.

Mono-cultural approaches usually contain faulty assumptions about Indigenous patients, their history and values. First, mono-cultural approaches contain a misconception of what is normal and fail to allow for the variance in behavioral values in Native contexts. Second, mono-cultural approaches emphasize individu-

All Native values define the way in which relationships occur with other people, including the creation of life and what encompasses the universe.

alism and other dominant societies' values, which fail to consider Native sense of orientation to family, community, and traditional values (Ka'ano'i , 2001). Third, mono-cultural approaches are based on compartmentalization that denies the holistic nature of the Native world view. Fourth, mono-cultural approaches do not validate the Native patient's support system or their need for a support (extended family) system, if none exists. Mono-cultural systems are often based on a self-sufficiency model that contradicts tribal values of relationship. Finally, mono-cultural systems often neglect the personal and cultural history of the Native patient (Peavy, 1993).

One specific service model, the circle of care model, provides an innovative approach to direct service delivery for Native patients utilizing a community focus (Freeman, Iron Cloud-Two Dogs, Novins, & LeMaster, 2004). Pedersen, et al. (1996), report that a culturally appropriate approach is now considered essential for accurate assessment, meaningful understanding and appropriate diagnosis, care and treatment.

Native Cultural Diversity

To appropriately provide health services to Native patients, providers need to be knowledgeable of Native cultures and comfortable with the local Native community. Providers may become comfortable with the Native culture and community by:

Immersion in the culture, studying history and culture, participation in cultural activities, developing relationships with cultural members, and learning cultural protocols, rituals, ceremonies, customs and respectful attitudes (Peavy, 1993).

What is not acceptable is for providers who have only superficial knowledge of Native culture or no knowledge at all, to believe themselves to be above the need for acquisition of Native cultural knowledge. Providers must be aware of the diversity within a Native community. Patient variation within the group is determined by their relationship within the culture, their level of acculturation, their living situation, and their personal preferences (Peavy, 1993). Providers must be wary of making assumptions about the cultural orientation of Native patients because of the many variables involved. Palafox, Buenconsejo-Lum, Ka'ano'i, & Yamada (2001) suggest a process for gaining and maintaining cul-

tural competence. This includes becoming more aware of one's own culture, acquiring knowledge about the patient's culture, and developing skills to apply acquired knowledge in clinical settings.

Knowledge of Self

Practitioners must take great pains to develop knowledge of themselves as cultural, ethnic and social beings with a set of values that are based on a specific world view (Duran and Duran, 1995). They need to be aware of their cultural self. Self-awareness is essential in every aspect of the clinical relationship in order to maximize the effectiveness of health care particularly with a patient from a different culture and world view. This self-awareness would include an understanding of the beliefs and attitudes contained in their world views, as well as the philosophical orientation that is the foundation of their values. Practitioners need to be cognizant of how their values are similar to, or in contrast to, Native values.

Self-Assessment

Being a member of the majority European-American population can block the ability of a provider to notice value variation between cultures. Requesting a self-assessment of values can be difficult, with a resulting emotional reaction of disdain and/or avoidance.

"Aren't we all living in America with the same values?"

"Why don't they get with the program and join the rest of us?"

"I'm a doctor (clinical provider) not a social worker."

"I don't notice race. We are all the same."

These are some of the comments that can result from the introduction of a self-assessment exercise. It is recommended that this line of thought be reviewed with the provider audience before introducing an exercise.

Self-Assessment Exercise

Each provider has a culture from which his individual values originate. Assessing personal cultural attitudes, values, and beliefs is best facilitated through the use of an experiential exercise.

This exercise includes asking the audience to think about their cultural heritage, including food, celebrations, religious orientations, or family structure. Subsequently, each audience member would be asked to share their thoughts with the larger group or the larger group would be divided into smaller groups and these smaller groups would share their experiences. An exercise like this can be difficult for audience members from the dominant culture who are not often confronted by their differences from and similarities to others in the larger society. If the groups are divided into smaller units, this exercise needs to end by having each smaller group share with the larger group their cultural experiences. Such an exercise would be more functionally beneficial if individuals not of European-American ancestry would be invited to participate in the group exercise. This would allow for discussion on diversity beyond social class, religion, and education. It is recognized that some European-Americans continue to retain some cultural beliefs, values and language of the ancestral homelands.

Aboriginal Values and the Clinical Process

As previously stated, the cultural and value differences of Native patients and the lack of understanding of these differences can create difficulties in a provider/patient relationship. Locust (1985) comments on the importance of understanding Native values such as harmony and its relationship to the Native perspective on health:

Native Americans believe that each individual chooses to make himself well or to make himself unwell. If one stays in harmony, keeps all tribal laws and the sacred laws, one's spirit will be so strong that negativity will be unable to affect it. Once harmony is broken, however, the spiritual self is weakened and one becomes vulnerable to physical illness, mental and/or emotional upsets, and the disharmony projected by others (Trimble, 2002).

Health care delivery must consider the cultural process. Failure to do so can result in greater illness for the patient.

Sioui states that values are a "portrait of a culture" and argues that understanding cultural realities is fundamentally a question of understanding values (1992: 20). Cultural values create the

patient's sense of self. A provider's knowledge and awareness of the cultural differences between the provider and the patient ensures a high degree of cultural competence that will be beneficial in moving the patient toward wellness.

Therefore, when providers are working with Native patients the most critical aspect of helping the relationship is an awareness of the differentiating cultural values that exist in Native communities, families, and patients. Native values have proved to be enduring despite acculturation and assimilation. We will provide a brief overview of these values and discuss areas of concern for the medical setting. However, it should be noted that it is impossible to consider everything there is to know about the cultural values of Indigenous people in one article and therefore we must avoid over generalizing. However, there is agreement that a set of unique values, different from the dominant society, exists among most Native people in North America as well as in the Hawaiian Islands (DuBray, 1985).

The Value of Relationship

Relationship is the primary Native value. The value of the relationship ties together all Native values, including respect, cooperation, harmony, modesty, patience, and spirituality, tolerance/discipline, autonomy/non-interference, placidity/ silence, relative time, present orientation, pragmatism, and observation. All Native values define the way in which relationships occur with other people, including the creation of life and what encompasses the universe. For instance, the value of respect defines the way in which all things are related to and interrelated with one another. The value of harmony dictates that we must be in tune-spiritually, mentally, and physically-within our relationships. The value of spirituality derives from the religiosity of our cultures and it relates to every dimension we have in our relationships with people, animals, and abstract thoughts. McCormick (1994) describes relationship as an interconnectedness that is "the individual's connection to the world" This interconnectedness begins with family and extends beyond to encompass all relationships, including those with human and non-human relatives. Medical care that reflects the relationship that exists in the context of the interconnectedness of all things creates meaning for Native patients and therefore assists the healing process. In short, this cultural philosophy gives the patient a sense of place and belonging. From this place, a patient

is able to relate to their surroundings and (retreat) with ease to a place of healing.

In addition, relationship in the Native view includes all thoughts, feelings, and words that connect a person to the universe and community around them (Swinomish Tribal Mental Health Project, 2002). This contrasts with the Euro-American view that thoughts, feelings, and words are separate and formed apart from creation and spirituality. Since most Natives see themselves as being related to all of creation and all people, the use of thoughts, feelings and words becomes important in defining connection to others during the clinical process.

The Swinomish Tribal Mental Health Project (2002) suggests that the Native sense of empathy and kinship is the extreme opposite of the Euro-American, which is the sense of separateness from and superiority over other forms of life. The Native view that one should be related to and part of the designs of nature conflicts with the Euro-American view, which advocates dissecting, analyzing, and manipulating nature and resources (Swinomish Tribal Mental Health Project, 2002). Providers should be aware that Native patients might be very concerned with achieving balance and harmony with these forces during the healing process. Therefore, negative value judgments directed at any aspect of creation can affect the trust level in the healing relationship.

Kawagley (1999) sums up the difference between Euro-centricity and Native views of the universe as:

The Native creative mythology deals with the whole—the physical, intellectual, emotional, and spiritual, of inner and outer ecologies. The Native person realizes that he/she is a microcosm of the whole, the universe. Therein lies the ultimate difference between the two.

Providers must respect the concept of relationship and be aware that every action they take is connected to a “web of values and behaviors” within the Native community (Kawagley 1999:).

The strong value of relationship may require an extra emphasis on relationship during the clinical appointment. Providers can minimize formality and use a “friendly” approach that will offset power differentials and “official-ness” and thereby create more of a kinship setting in the clinical process. This may require additional time, although development of the relationship and establishment of trust provides an opportunity for the Native patient to fully disclose their health concerns. Providers should be aware

that questions viewed as too personal by a Native patient or asked before a relationship is established, can derail the healing process. Trust in the relationship can be enhanced through “genuine interest,” patience, keeping commitments, and participation in community activities. Personal questions and intake information may need to be postponed until a sense of relationship is established. The Native patient, particularly elders, may need time to determine where the provider fits into their world view.

The Value of Respect

Respect is the most important of the values defining the nature of relationships in Native society. Respect for people and their choices are highly valued. Respect for self is expressed with quiet personal dignity in Native cultures and self-respect extends beyond the person to the elements of creation, as previously mentioned. Riddington (2000) describes the Native view that “each person must be responsible to all sentient beings of the world in which he or she lives.” Native people view the world of “all my relations” as being populated by relatives and must be dealt with respect.

Providers must be careful not to disrespect the Native community or any aspect of their creation of their culture. In addition, providers must refrain from pursuing treatment options that puts the Native patients in a situation that is considered disrespectful to themselves or others in the community. Providers must realize that strictly scientific explanations may be considered incomplete, non-holistic and disrespectful within the context of Native worldviews. Native patients may reject Western scientific explanations because they leave out spiritual considerations and lack understanding of relatedness. Traditional Native philosophies view health and healing as a spiritually based, holistic process in which the protocols of healing may require a reconnection to one’s spiritual world and beliefs.

Another form of respect in Native communities is the high value placed on the wisdom and experiences of age. Providers, by emphasizing attitudes of youthfulness or showing disrespect for elders, may jeopardize the healing relationship for the Native patient. Providers must be aware that it is often essential to learn and follow protocols with patients if the treatment process requires interaction with traditional helpers and/or community leaders. Rattray (n.d.) comments:

Every First Nations community has community protocols and customs that need to be understood if respect, trust and openness are to be realized. Protocols are often dependent upon the local political and social structures within the community.

The Value of Non-interference

One of the most misunderstood values in Native communities is the value of non-interference. In Native communities one does not interfere or give advice unless asked. Riddington (2000), in commenting on non-interference among the Athapaskan Slavey Tribe, said that the Slavey people do not “interfere with someone engaged in a line of thought, a task or endeavor, but allow the person to finish out their intention.” He points out that non-interference extends to the practice of not interrupting a speaker. Brant (1990) writes that the value of non-interference discourages coercion. She states:

The white man who can out advise another is “one up” and the individual over whom he has exerted influence is expected to take it with good grace. In Native society, by contrast, such an attempt to exert pressure by advising, instructing, coercing or persuading is always considered bad form or bad behavior.

A person’s individual autonomy and dignity are valued and the provider may be considered rude if they interrupt patients while they are talking or even while they are taking the time to consider an answer to a question. Interrupting patients may stop them from sharing valuable information regarding their health concerns. Providers must learn how to carefully *listen* in a Native context. This requires allowing the patient to speak, sometimes with long pauses, without interrupting.

The Value of Cooperation

Native people seek cooperation to maintain group harmony and good relationships. Kawagley and Barnhardt (1999) state that the Native value of respect in Native culture is based on the premise that cooperation and inter-dependence will produce learning and harmony. Battiste (2000) writes, “The strength of tribalism lies in our collective values, which must be fostered toward a collective consciousness as opposed to individual gain.” Therefore, in Native communities cooperation is highly valued and competition

within the group or other individuals is rare. In fact, winning or “showing others up” is highly frowned on and would be a source of embarrassment to the winner in Native society. Group concerns are often put first in a context where agreement and consensus are very important.

The value of cooperation often conflicts with the Euro-American value of competition. Providers must realize that Native patients may be reluctant to answer questions that cause other people to “lose face” or that create conflict with others. Providers need to be aware that exalting competition or success during discussion with patients may not be consistent with the value of cooperation.

Harmony is based on caring for others through deep respect and kindness that contributes to tribal survival.

The Value of Harmony

In Native communities emphasis is placed on maintaining group harmony and there is often a striving for personal anonymity. Harmony is based on caring for others through deep respect and kindness that contributes to tribal survival. Orientation to people is stressed over orientation to task when the task will disrupt the personal harmony of individuals in the community. This means that the needs of the group and the need for group harmony are generally placed over the needs of the individual. Garret (1999) writes:

The harmony ethic guides both the beliefs and behaviors of Native American people in the communal spirit of cooperation and contribution as a way of maintaining the natural harmony and balance that exists within oneself and with the world around oneself.

Garret (1999) articulates four tenets of harmony:

1. Non-aggressive and noncompetitive approach to life.
2. The use of intermediaries to minimize face to face hostilities.
3. The practice of generosity and reciprocity.
4. A belief in immanent justice that relieves people from the need to punish, control or interfere with others' behaviors.

Harmony is also encouraged through the value of sharing in Native communities. Ownership of too much material wealth is considered in a negative light. Avarice and greed are discouraged, as are displays of wealth. A Native patient may view their wealth

in terms of the relationships they have, rather than the material property they own. Giving away excess material wealth is often a ceremonial aspect of existence that is encouraged in Native communities. For ceremonial purposes, material wealth can be gathered and given away, but not kept for a long duration, which would be perceived as an act of hoarding and greed.

As with the value of cooperation, the Native value of harmony is often in conflict with the Euro-American value of individualism and individual accomplishment. In Native communities harmony is preferred over domination or hierarchical structure and is accomplished by giving “honor, respect, dignity and reciprocation” (Kawagley, 1999). This value goes hand in hand with cooperation and maintenance of the status quo rather than conflict and competition. Providers may need to be very careful not to put individual needs and the value of competition above the need to maintain harmony in the community. Providers also need to be aware that individual patients may put the value of community harmony above their own individual health concerns.

The value of harmony places a high preference on acceptance without judgment. The Swinomish Tribal Mental Health Project (2002) suggests that in the traditional way, trying to control things or people is considered a waste of energy because it is believed that everything is as it should be at any given point in time. Harmony and the corollary of acceptance create a valuing of humility as a way of maintaining balance and unity with other members of society (Garret, 1999). In fact, Dubray (1985) found that in some Native cultures harmony in interpersonal relationship and within the community was considered to be the goal of helping relationships.

Providers should be aware of their own ego level and that it may be higher than the ego level of Indigenous patients, especially if the health care provider is from any of the European-American cultures. This can lead to humiliating and embarrassing feelings for patients during clinical sessions if the provider is not aware of or cannot lessen their ego level. In other words, the attitude of humility that is practiced in Native culture may be in conflict with the attitude of personal gain or pride in accomplishment that is supported in the dominant culture’s strong ego level. These two attitudes can clash during a clinical session, leaving the Native patient feeling disrespected and misunderstood.

The Value of Spirituality

Native spirituality is contemplative rather than utilitarian and is integrated into all areas of life. Garrett (1999) states that, "it is possible to generalize to some extent about a number of basic beliefs characterizing Native traditionalism and spirituality across tribal nations."

The value of spirituality is closely tied to the values of harmony and balance. Kawagley and Barnhardt (1999) point out that in Native societies, such as the Yupiaq, balance and harmony were the main characteristics of spirituality. There is sometimes an emphasis on the mystical aspects of life.

Deloria (1995) points out that European religious beliefs are temporal and therefore tied to "cultural context, time and place." Native spirituality, however, is "spatial" and is tied to and has meaning in the land and relationship with all life. It is expressed in ceremony that is tied to a specific place. Deloria (1995) says temporal religions become focused on good and evil, whereas Native beliefs are centered on the importance of relationship. The meaning and sacredness of Native space must be understood, acknowledged and respected by physicians and other health care providers. Questions about spiritual beliefs are generally considered extremely personal in Native communities and are avoided to prevent interference and conflict.

Providers need to be aware that Native patients may view the clinical process as incomplete, inadequate and unnatural if spirituality or ceremony is not a part of the process (Lowe, 2002). Since Native spirituality views the universe in a holistic manner physicians must remember that Native patients will not see a problem in isolation, but in relation to a spiritual context. Native individuals and communities may even feel they are being disrespected if their spirituality or dreams are viewed as not being taken seriously or merely dismissed. Depending on the degree of acculturation, some Native people may benefit from the use of ceremonial processes or the use of traditional healers in the clinical process. However, this must be approached carefully because of the personal nature of an individual's spiritual beliefs. As an example, a health care provider could recommend traditional healing in a non-directive way as part of the healing process.

The Value of Modesty

Modesty is a required element of conduct in Native society. It is unacceptable to boast about oneself or personal achievements. Therefore, boasting and loud behavior that attracts attention is discouraged and perceived as embarrassing by Indigenous people. Modesty regarding the physical body is also common (Covone & Hivatsuka, 2003).

Providers need to be aware that Native patients may be reluctant to supply information or display knowledge that requires them to identify themselves in a non-modest manner. This includes undressing for various medical examinations, and can also manifest as difficulty and embarrassment when sharing some types of knowledge. In addition, publicly praising a patient's achievements or commenting on physical characteristics can create embarrassment during the clinical process. Therefore, the provider may need to develop a relationship of trust and understanding before these types of knowledge can be shared by the patient.

The Value of Time

In Native communities, time is viewed as flowing and in a state of process - more as a movie than a picture. Deloria (1994) writes that the Native view of time is "cyclical in nature" (71). The European view of time is linear and is more like a picture than a movie. Native languages reflect this reality by being based on verbs and movement rather than the nouns and things that English is based on.

Deloria (1994) argues that Native communities make decisions that are based on present community realities and not on an orientation to the future (68). Furthermore, the past is addressed as a continuation of the present. Due to this construct, there is no sense of history as defined in Western context. He argues that this can be a source of conflict because European cultures tend to be future oriented. Many Native languages do not contain a future tense and therefore the future can only be spoken of in terms of the present. If the future needs to be addressed, it is done in abstractness and very hypothetically. Ridington (1990) states that in hunting societies discussions occur in time that is meaningful as "real time" or "common time."

Providers must realize that time is flexible and relative to the task at hand for Native patients. Patients may not share the same sense of time as providers. Therefore, the providers may need to adjust their time orientation to fit the patient when working in Native communities. Practitioners must be careful not to misinterpret the Native view of time as being irresponsible or rude. Providers need to be aware that patients may have a different view of time and focusing too much on punctuality or on the future, which can create meaninglessness in the clinical context. Clinical sessions may need to relate discussions, including those of the future, to the present.

The Value of Tolerance

The values of cooperation, respect, non-interference and harmony require a high level of tolerance. Harsh discipline or negative comments, especially with children, are considered demeaning in Native communities. Attitudes that are intolerant bring shame to the person who holds them. Therefore, people strive to be tolerant and understanding of the situation of others.

Providers need to be aware that critical or negative comments, even toward a person not present, can be offensive to the majority of Native patients (Swinomish Tribal Mental Health Project, 2002). Criticism in Native communities is usually communicated indirectly. Practitioners need to develop a listening strategy that notices indirect criticism as a source of the patient's concern. In response, it is best for the health care provider to place criticism on a third-person and consequently provide indirect feedback to the Native patient. Providers may find that Native patients respond negatively to direct criticism. Direct criticism may terminate a conversation between the provider and the patient and it may also preclude future clinical sessions. Direct criticism may also cause patients to withdraw and therefore providers should learn how to avoid direct criticism to prevent negative reactions.

The Value of Silence

Kawagley and Barnhardt (1999) write that the Native self is "grounded in silence," they state that it is through silence that Native development and learning is created through a "drawing force at the center." In this silence, there is belonging and connection to the universe. Relationship is created in the quiet con-

templation of stillness and silence. The silence of the personal self learns from the profound silence of the universe.

Providers need to be aware that the ability to remain quiet and still is valued and has been a practical act of survival. Maintaining silence is acceptable and comfortable. Practitioners may be tested with silence to determine if they can be silent and the degree of self-discipline they have attained. If clinical topics are uncomfortable, Native patients may hide their discomfort by maintaining silence and be hesitant to share information. Providers may need to be able to allow long periods of silence while the patient considers their answer. Providers should be careful to not assume that a patient does not have any knowledge just because they are maintaining silence while considering what to do or say.

In addition, practitioners should be aware that Native patients may sometimes communicate knowledge through non-verbal cues. Culturally competent practitioners must include verbal and non-verbal language that is appropriate to the culture of their patient in their clinical strategy (Pedersen & Ivey, 1993). This requires that they are aware of the meaning of their words and the meaning of non-verbal communication, including modest dress. It also requires that the practitioner needs to be aware of the meaning of the different communication styles of Native patients. It is important to know that silence, avoiding direct eye contact and taking time before answering questions are all non-verbal forms of respect and cooperation. These non-verbal cues are sometimes viewed as being uncooperative, withdrawn, lazy or unassertive by physicians and other health care providers unaware of Native values.

The Value of Patience

Related to the value of silence is the value of patience. Patience and the ability to wait are considered good qualities among Natives.

Providers need to be aware that they cannot pressure Native patients into making rapid responses or decisions and should not become impatient while the Native patient deliberates their response or decides how they will participate or share in clinical sessions.

The Value of Pragmatism

Most Native people converse in concrete rather than in abstract terms. Deloria (1994) argues that spatial thinking and belief require that ethics (and therefore values) be tied to the “physical world and real human situations.” However, Europeans generally have abstracted one set of principles and beliefs that are held to be “valid at all times and under all circumstances.” Native ethics, as well as most Native languages, are contextual rather than universal.

Brown (2004) suggests that the non-Native belief that reason eclipses the natural world and can produce independent thought is in conflict with the Native view that knowledge, wisdom, values and ethics are derived from direct experience and are contextual. Providers need to be aware of how their clinical strategy is relevant to the present real world situation of the patient. Therefore, providers may need to talk about concrete examples that are related to the patient’s life experience.

Stairs (1995) writes of the importance of learning through observation. This value is closely related to non-interference, silence and cooperation. He writes that *Isumagsayuq* is an Inuit observational method of learning from family and relatives embedded in Native social structure. The silent awareness of observational learning transmits material and social knowledge. Most importantly, the value of cooperation and group cohesion is practiced through the technique of observation.

A possible value conflict mentioned by Stairs (1995) is that practitioners may confuse observation strategies of Native patients with learning deficiencies if practitioners are unaware of the social orienting network that is the life reality of Native patients. Practitioners can view the method of learning through observation to be incomplete, inefficient and random. However, and this is extremely important, practitioners may fail to bring meaning into the clinical process for Native patients by failing to understand the “richness of the social, perceptual, and affective elements” of the Native context (145).

Practitioners need to be aware that observation, often practiced with silence, which is considered to be respectful, is a learning style of Native patients.

Conclusion

Values define the way in which patients perceive the boundaries of their world and the way in which they communicate these perceptions. Providers who can understand Native values will be equipped to communicate across these boundaries and connect with the Native patient. This will lessen value difference, reduce conflict, and create cultural competency.

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IV. Assessment

Campinha-Bacote's (1998, 1999) model of cultural competence provides a basis for an appropriate approach to culture based assessments of American Indians, Alaska Natives, and Native Hawaiians. This model assumes that the health care provider strives constantly for cultural competence and the ability to conduct assessments that are culturally sensitive. The health care provider should seek to work in the cultural context of the Native American client when conducting an assessment. Campinha-Bacote's model uses a framework that considers cultural competence as an ongoing process that involves the integration of five constructs - *cultural awareness, cultural knowledge, cultural skills, cultural encounters, and cultural desires*.

Cultural Awareness

Cultural awareness is an intentional, cognitive-learning process in which health care providers become appreciative and sensitive to the values, beliefs, practices, life-ways, and problem-solving strategies of the client's culture. Cultural awareness involves the health care provider first assessing their own cultural and professional beliefs, assumptions, and possible feelings of prejudice toward American Indians, Alaska Natives, and Native Hawaiians. Health care providers who are culturally competent are self-reflective and remain aware of the possibility of cultural imposition during the process of an assessment (Campinha-Bacote, 2002).

Cultural Knowledge

Cultural knowledge is a process of discovering a sound educational grounding concerning the world view of the client's culture. According to Campinha-Bacote (2000), cultural knowledge is the process of making an effort to learn about others by increasing and improving one's own knowledge. When assessing an American Indian, Alaskan Native and/or Native Hawaiian, the health care

Cultural awareness involves the health care provider first assessing their own cultural and professional beliefs, assumptions, and possible feelings of prejudice toward American Indians, Alaska Natives, and Native Hawaiians.

provider should focus on culturally specific knowledge of health-related beliefs and values, disease conditions, and treatment options.

Culturally specific historical knowledge draws on the lived experience of American Indians, Alaska Natives, and Native Hawaiians. The interplay of race and disease has been significant in the history of both colonization and medicine in the United States (Dean, 1994). Historical cultural knowledge of the use of disease as a strategy of colonization, unethical research practice, and ongoing substandard medical treatment is necessary for both the health care provider and the American Indian, Alaska Native, and Native Hawaiian client. The level of historical connectedness through personal experience may influence the level of trust, sense of identity and willingness of the client to participate in the assessment, follow advice, and accept treatment from the health care provider. Developing this awareness and knowledge by the health care provider may help to put the client's reactions and behaviors in perspective and within a cultural context. Through the assessment, the client can be assisted by identifying fears and behaviors that are a result of the historical trauma experienced by many Indigenous people. The cumulative and intergenerational effects of historical trauma have been characterized as "soul wounding" among Indigenous peoples, which may influence the reactions and behaviors of clients (Duran & Duran, 1995; Duran, Duran, Yellow Horse & Yellow Horse, 1998).

Cultural Skills

Cultural skills refer to the ability to systematically collect relevant data regarding the client's health (Campinha-Bacote, 1999). Cultural skills suggest the ability to assess and collect cultural data that is meaningful and the ability to do a holistic assessment that is cultural in nature. "The Native world view and quality of life is holistic in orientation, which makes it necessary for the health care provider to obtain assessment data that goes beyond the client's physical well-being." The client's belief and value system should also be ascertained by using appropriate skills to ask for information such as the use of traditional healing services.

Other culturally appropriate skills include the ability to listen and observe for information, both verbal and non-verbal. Listening and the use of silence provides the opportunity to assess and per-

ceive the client's level of balance and harmony (Lowe, 2002, 2003).

Kleinman's eight questions for eliciting the client's explanatory model (EM) of his/her illness or condition is a good resource and guide for assessing and obtaining a history of the client (Kleinman, Eisenberg, & Good, 1978).

The questions include:

- (1) What do you call the problem?
- (2) What do you think has caused the problem?
- (3) Why do you think it started when it did?
- (4) What do you think the sickness does? How does it work?
- (5) How severe is the sickness? Will it have a short or long course?
- (6) What kind of treatment do you think the patient should receive?

What are the most important results you hope he/she receives from this treatment?

- (7) What are the chief problems the sickness has caused?
- (8) What do you fear most about the sickness?

These questions can be used as a basis to begin eliciting information. The health-care provider should frame the questions within the context of obtaining the client's "story." Time should be given to listen to the story and the client should not be rushed or hurried. The client may answer the questions in a story-like fashion and may be very circular and non-sequential in giving events. For example, the client may begin talking about his/her HIV/AIDS illness at any particular time period or stage of the illness. The client may not refer to a beginning or end, but rather speak in terms of an on-going process.

Taking a non-dominating and non-controlling approach during assessment will enhance the outcomes of the assessment process. This can be implemented by not asking demanding or threatening questions. Being forceful or demanding answers in a hurried way may result in limited information provided by the client. Among some Native groups, rushed and hurried questioning is an act of dismissal and marginalization. The client's reaction to the approach used during the assessment will heavily influence his/her maintaining future appointments/visits with the health care system.

During a physical exam, efforts should be applied to limit the exposure of the body of the American Indian, Alaska Native, and Native Hawaiian client. Physical health problems may be aggra-

vated by poverty, alcohol, and drug use and should be assessed. Information concerning the income and other economic resources of the client will be essential. Poverty along with alcohol and drug use, combined with HIV/AIDS can also pose barriers to the delivery of appropriate health care for American Indians, Alaska Natives, and Native Hawaiians. Other barriers may include the availability of transportation and the geographic distance that the client may have to travel to receive health care services.

The level of language and health literacy abilities of the client should be assessed. For many American Indians, Alaska Natives, and Native Hawaiians, the predominant language spoken may be their original tribal/traditional language. Therefore, many Western health-related terms and concepts may not have meaning to the client. The health care provider should assess for the appropriateness of the terminology being used when interacting with the client and/or the client's family members. More importantly, learning some of the common words in the local Indigenous language is very important and strongly recommended, if not essential, especially medical-related terms or basic instructions. Reading levels should also be assessed before disseminating health-related literary materials.

MODEL CASE: Transportation issues will vary greatly. A client may not own a vehicle, and will request transportation from family and friends for times when it is convenient for them versus asking them to transport them for a specific appointment. This often results in missed appointments. There will be occasions when the family owns one vehicle with very limited cash for gas and travel expenses, so a doctor's visit will be fitted into a comprehensive family trip in which multiple family issues will be addressed. The family will agree on the importance of each task to be achieved during the trip, typically with grandparents' needs taken care of first, then family survival needs, then medical appointments (particularly in cases where the person is not in critical condition such as severe pain, bleeding, etc.). This situation may place the client's follow-up appointment with medication re-fills at the bottom of the list. In a situation involving language, the client may not attend an appointment until they have a family member who is perceived as being more Western educated and who will be able to translate medical information in their ancestral language. (Or into more colloquial English with less medical jargon!)

Cultural Encounters

A cultural encounter is a process that encourages health care providers to engage directly in cross-cultural interactions with people from culturally diverse backgrounds (Campinha-Bacote, 1999). A cultural encounter with American Indians, Alaska Natives, and Native Hawaiians is the process of being directly involved in experiences that are cross-cultural by design. This would include interactions that would modify and affirm or redirect the health care provider's thinking about American Indians, Alaska Natives, and Native Hawaiians. Also, stereotypes could be dispelled during these encounters. The assessment process can be viewed and considered as a cultural encounter. During the assessment process, the health care provider should use this encounter as an experience to learn about the cultural influences on the health behaviors and beliefs of the client.

The health care provider can use this encounter to become familiar with how connected the client is with his/her family and tribal community. American Indian, Alaskan Native, and Native Hawaiian communities vary in size, economic development and geographic locations, ranging from being very rural to very urban. For example, the client may be living in an urban setting but all of their family members are still living on a rural reservation. Approximately half of all American Indians, Alaska Natives, and Native Hawaiians live in rural areas, with the other half living equally between the central city and suburban areas (Bureau of the Census, 1998).

Residential patterns may be complicated and hard to assess due to frequent migration. Many tribal people commonly migrate between urban areas and reservation/tribal communities on a regular basis. Many clients may live and work in urban areas, but they return to the reservation/tribal community several times a year to visit family and friends and to participate in ceremonies and other traditional activities (Sullivan, 1991). Also, many clients with AIDS may return to the reservation/tribal community toward the end stages of the disease.

Family is the corner stone of American Indian, Alaska Native, and Native Hawaiian life. It is critical that during the initial assessment, the health care provider explore who is considered to be family by the client. These family members may serve as sources of

support and may also take on the responsibility of making treatment decisions. Assessing who the client identifies as his community also may determine the source of where the client will receive care. If the client resides in an urban setting, there may not be Indian Health care facilities or services available. Therefore, health care may be received from private or public systems depending on the type of insurance/benefits available to the client. Becoming aware of traditional beliefs and values adhered to and followed by the client may also determine the level of willingness to follow treatment. Family and community pressures to follow a particular protocol may also influence and determine the client's choices for treatment.

MODEL CASE: A young American Indian adolescent who was experiencing disturbing psychotic symptoms refused to take his prescribed medications because of potential conflict with sacred practices. This occurred despite urging by his parents. However, after a meeting with his medicine man, who prescribed tossing sacred corn toward the rising sun each morning, the young man was willing to take his medications because it was not replacing his religious beliefs.

Cultural Desires

According to Campinha-Bacote (1999), cultural desire is the motivation of health care providers to want to engage in the process of cultural competence. Cultural desire is expressed by the health care provider's eagerness to become culturally aware, knowledgeable, skillful, and engaging in interactions with American Indians, Alaska Natives, and Native Hawaiians through the assessment process. This involves the health care provider's desire to affirm the cultural differences while being respectful of the client's culture during the assessment. The provider's motivation should be based in personal interest to be culturally knowledgeable and not in fulfillment of standards or policies (Campinha-Bacote, 2002).

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When it comes to beliefs, these are rooted and connected to the tribes' environmental surroundings.

V. Facts

Indigenous World View

The Indigenous world consists of multiple worlds and views. One has to take into consideration the geographies, languages, levels of cultural knowledge, connections to communities, generational differences, to mention only a few that create the difference. In that sense, there is no one world view from the Indigenous communities. Each tribal group, pueblo, village, Native community, has its own individualized local perspectives on their Indigenous existence and function. All of the information in this section is based on very broad generalizations.

Beliefs and Values

There are approximately 556 different types of Indigenous groups that are federally recognized by the United States government. They all reside within the confines of U.S. borders. In addition, there are about 350 other Indigenous groups that are not recognized, but are acknowledged as functioning entities in the worldviews of Indigenous peoples.

Each of these individual tribes, Native villages and so forth, has its own cultural constructions that determine their beliefs and values. There are areas where various cultural knowledge overlap - for example, in the understanding of their relationship to the earth, the importance of the water, and the significance of human life. When it comes to beliefs, these are rooted and connected to the tribes' environmental surroundings.

There are sacred sites determined, identified and maintained according to the local Native people. The knowledge and connection to these places are transmitted from one generation to the next. In each transmission, the value of the site is re-confirmed, re-blessed and secured for the next generation. This process establishes a sense of place for the local Native people and thereby gives them a place to belong to.

Each of the Indigenous groups has their ways of worship, conducting rituals and practicing religious ceremonies. In some cases, there is an overlap with neighboring tribes, which provides closer cultural connections and where adaptive practice takes place. Some have branched off from the larger local group in the past due to cultural changes and have created their own specific tribal paths.

Each Indigenous group does connect to each other, similar to a large tree. Though each group branches off on its own like branches of a tree; still they branch off the same large trunk that serves as a place of commonality.

Gender

Today, in Indigenous communities, cultural values and norms regarding gender identity has aligned with Western perspectives. Indigenous people no longer have the constant gender flexibility they had in the past for boys/men and girls/women, especially of those who did not fit into the normative gender identity as a boy/man and/or girl/woman. Currently, Native people discuss third and additional gender identities as being in the “gray area,” which indicated that it is not the norm. In the late 1800s, the additional genders had their own places within their tribal societies. They were additional genders, **not** alternative genders.

Gender is basically defined on the basis of “masculine” and “feminine” in characteristics. In this setting, a masculine male should be a man and a feminine female should be a woman. If a switch took place somewhere along ones’ life, such as a male child growing up with feminine characteristics, then “she” would be a male-bodied woman. She would be defined and understood to be a woman (gender) and **not as** a female (sex). Today this understanding of the third gender makes sense only to the elders in some of our Indigenous communities and the third gender is often ridiculed outside of specific tribal cultural spaces. Though some younger Indigenous people who are heavily vested in their cultural beliefs and values do understand this concept, they are very few in number.

Gender Roles and Duties

Each tribal group has its sets of rules of what defines a boy and girl as they grow into maturity. What a boy and a girl do is based on play/work duties created and assigned to them from the beginning of time within their specific tribal/cultural group. Of course, this has

changed due to the ever-present process of acculturation and assimilation into the dominant Western cultures. Native people have moved away from their traditional Native values and being, and have conformed to the Western construct of what a boy and girl should do and be to establish their gender identities.

In the Indigenous past, boys were taught the various survival skills that started in play activities when they were young children. As they matured, these lessons were embedded in their play and interactions with their peers, some siblings and relatives, and later in life, with other adults in their own communities. The same was true for young girls. Many mimicked their mother's and grandmother's duties, and cultural obligations, and learned their expected roles for their adult lives.

The gender roles of the third, fourth and other genders were eliminated mostly by force, and not necessarily by choice by tribal members, in the second half of the 1800s through the early part of the 1900s. Role models of these additional genders for young children were no longer available from that time period. This aspect of the culture was eliminated due to tribal indoctrinations into various forms of Christianity and through the mandated acquisition of Western education (Jacobs, et al. 1997, Thomas, 2006).

Sex, Sexual and Sexuality

According to *Merriam-Webster's Collegiate Dictionary*, "sex" is the biological term used to define "male" and "female." "Sexual" is "relating or associated with sex or sexes," and "sexuality" is the "quality or state of sexual" or "expression of sex" (1998).

In Native communities, there are now two biological sexes, male and female, similar to the dominant societies. Any additional sex identity is understood to be in the "gray area," such as hermaphrodite or inter-sexed. Due to Natives' disconnection to their own past, they no longer are able to clearly define and understand their cultural constructions of genders and sexualities.

With the elimination of gender variance within Indigenous communities we are left simply with the beatification of man and woman. Sexuality has also been conformed and confined to heterosexuality. Native people now use Western (via the English language) definitions. As they no longer are aware of other sexualities, they have left their cultural teachings. A vast majority of Indigenous people establish their knowledge about gender identities and sexuality through Western education.

It has become a Native norm to view homosexuality as a sexual relationship between two males (sex), not based on two men (gender), which was the case. In Indigenous histories, if a relationship took place between two same-sex people, one had to be feminine and the other masculine. This was viewed, understood and accepted as a hetero-gender relationship. Now in Native communities, gender identity is not important as before nor is it recognized as a critical aspect of a person either, but their sexual identity is currently deemed to be essential as a mean of identification. Before, what you contributed to the community for its survival was more important. Today, reciprocity is no longer the basis of tribal communities nor does it depend on it as it once did. With this perspective, a relationship between two men—one feminine and the other masculine—is viewed as a homosexual relationship as defined in Western cultures.

Spirituality

The sense of and existence of spirituality, as it is understood according to religious beliefs and practices among Native people, is acknowledged from early childhood, when the teaching of Native beliefs begins. And among some Native people, spirituality is recognized and associated with ceremonies.

The majority of “traditionalists” believe the existence of spirituality began alongside evolutions of their Native worlds. It is further understood as an entity that is intertwined in all aspects of life. It becomes part of one’s soul when you first ingest the first breath of air as an infant. In that essence, you are born with it and it is believed that it does not detach itself from you until your physical death. From then on, the spirit moves on into another world.

In some Native communities they believe in reincarnation. This is based on the soul leaving a human body on its death and the energy of the spirit gets embodied in a newborn or another person. With this belief, the spirits of human beings do not necessarily leave the earth, but live on in the next generation.

Although a separate entity, spirituality is believed to be married to religion and its activities. It does come together and merge as one during religious rituals and ceremonies, where spirituality is “reactivated” and/or “reaffirmed.” The concept of spirituality has a life of its own and does not require a religious ritual or art to affirm it.

Religiosity

There are various forms of religion and practices within Indigenous communities. Some are still strongly rooted in their tribal practices that were created for them when their Native worlds were made at the beginning of time. Some practice various forms of Christianity, which has been a part of Indigenous lives since the fourteenth century after the arrival of the “accidental tourist” in 1492. The most recent arrival of a new form of religion is Native American Church (NAC) in many of the Native communities in the United States and Canada, though it has been there much longer with many Indigenous people in Mexico.

There are now new practices where Native traditional ceremonies are meshed in or together, in part with other tribal religious practices. For example, bible use can co-exist in Native American Church rituals; ceremonial pipes are blessed in Christian churches, peyote used in specific traditional tribal diagnostic ceremonies, and so forth. These types of practices are common in all forms of religion worldwide, where some are met with strong resistance but in time are merged as each generation accepts new practices and as their ways of life changed due to acculturation and assimilation.

Place of Residence

Currently, tribal peoples live on reservations, on reserves, in pueblos and villages, and in Native communities constructed by their residents. Some reside in rural areas where there may be limited access to health care services that require dependable transportation. Recently, it has been mentioned that more than half of the American Indian people are now residing in urban environments or in small towns where more access is available to health care facilities and health care providers. Of course, more access does not equate with adequacy of health care.

Types of Health Care

Many Indigenous people and communities have limited access to health care. This limitation includes the lack of funding from the federal government as it has recently been acknowledged that only fifty-five percent is provided to meet the health care needs of American

Indian and Alaska Native populations. The high rate of Native death is due to the lack of adequate and appropriate health care that is needed. This is one of the main reasons why the elders in all Native communities are very small in numbers. Some attribute the larger number of elders in earlier times to local traditional food sources that enhanced health and longevity. Now, we hear of cancer in children, which never existed in significant numbers in tribal histories. Also, many of the threatening health problems are detected and diagnosed in advanced stages. Preventive and interventive health education needs to be constantly promoted in Native communities. Despite the cultural taboos about fatalism, health, life and wellness need to be mainstay messages with Indigenous populations.

Thinking that “at least” we have health care is not enough and should never be for any group of Indigenous people, anywhere. The agreements and treaties between Indigenous Nations and federal governmental agencies has never been fully met to the point that Native peoples lives are at ease and comfortable. With the current state of health care for Indigenous populations, adequate or excellent health care familiar in Western cultures will be always at an arm’s reach, unless one has the necessary funds to access decent and portable health insurance. This option is now being jeopardized because of escalating health care costs in America.

Indigenous Traditional Medicine

In the 21st Century, Indigenous Nations still practice their own traditional ceremonies and practices of medicine. For example, the administration of herbs is still a way of life in many communities. Beliefs of traditional medicinal usages are still valued and appreciated.

When a patient is experiencing sickness of any form, some turn to their traditional medicine practitioners while a handful of these patients seek Western health care, too. Still, there are some people who only use traditional medicine and shun Western medicine for reasons known to them alone. It is suspected that it might be due to their experiences with Western health care.

It has been a common belief that Western medical health care providers viewed themselves to be the only solution to healing a person. This belief should be outdated in the medical field now because of the many proponents of diversity and tolerance. Arrogance, ignorance and ethnocentricity do not belong in a multicultural world, especially in the various Indigenous communities in the United States.

HIV/AIDS Disparities

The introduction of HIV and AIDS to Native people has created variations in confronting and dealing with the illness due to differences in knowledge and awareness of the disease. Some Native communities readily accepted this new form of disease afflicting its population. The acceptance is based on the tribal intellectual knowledge of diseases, which is part of their realities in their creation stories.

In places where people are densely concentrated in one location, such as a village, community or pueblo, the residents tend to seek treatment or testing much later. In some cases, they are tested for HIV only when one of the symptoms shows up and/or when it is “accidentally” discovered during a health care visit for another illness.

Living Conditions

The living environment seems to play a major role in the health of the Native people. There are still some places within Indigenous communities where there is no running water inside the homes, no telephone lines or access, and dirt roads are common place. Substandard housing still exists, and heat is still generated by wood, coal or propane stoves. On the opposite economic spectrum, some Native families own well-maintained modern homes with conventional sanitation, convenient appliances, and computer access- a far cry from the average family in urban or reservation settings.

Transportation

Many Native communities are rural, which affects a person’s ability to access services, especially the specialty services that may only be offered in urban areas. In many cases, these services are hours away. Reliable and affordable transportation is essential to treatment. Access to the Community Health Representative (CHR) program or local transportation services remains limited in some areas.

Additional Contributors to Health-Related Risks

Alcohol Usage

To this day, alcohol consumption continues to take place in the borders of Indigenous communities, to varying degrees, despite the declaration of some reservations as dry communities. It's common knowledge that some Indigenous communities are plagued with abuse brought on by chronic alcohol consumption to the point where it often is not considered an abuse, but rather a form of daily life. Among alcohol users, in particular, drinking has been normalized as a need rather than a form of abuse.

There are multiple layers of problems alcohol creates within a family setting. Alcohol tends to play an active role in the acquisition of HIV in some instances, where transmission took place under the influence of alcohol or other drugs and when the mind had been altered. Alcohol abuse contributes to letting one's guard down and engaging in unsafe sex. There is more sexually transmitted disease associated with drug use than from any other practices.

Diabetes

In more recent times, diabetes has surpassed many of the common ailments of Native people. Its presence is common now to the point that residents of Indigenous communities are either related to or know someone with Diabetes. (State University of New York) If a Native person is HIV positive, it is one more strike against them that they have to deal with, which further creates a conflict in medication usage. If any other illness is present, an HIV patient has to own their own health and illness to ensure that complications are kept to a minimum and to keep any form of opportunistic health problems at bay.

A strict diet needs to be in the peripheral aspect of a person's changed life. If a good diet is compromised, then a domino effect that enhances immune system complications can arise, which is not an ideal situation for a person who is living with HIV.

Sexual Behaviors

It is common practice among Indigenous heterosexual men, for example, to practice unsafe sex when they are not in their own com-

munities. In addition, some men migrated to urban areas for employment, educational opportunities, various types of training, or to attend a conference, where the tendency to practice unsafe sex is common. This is one of the initial reasons why women in Native communities are becoming HIV positive.

If a heterosexual Indigenous man becomes HIV positive as a result of an encounter in an urban area, for example, the encounter was based on his own cultural understanding of gender identities. Many of the Indigenous men have a basic understanding of current and various gender identities. For example, coming from an Indigenous culture where there were additional genders creates a sense of curiosity, especially if one is away from his cultural environment. In these men's minds, the Western construct of "gay," "transgender" or "transsexual" are unconsciously placed into the role of women, as in a "heterosexual role." In the past, the above three identities would have been classified in the "third gender" category. Remnants of this thought still exists in some Native communities and its men, which is the reason why it is "viewed" as OK to have sexual relations with someone who is gay, transgender or transsexual. In this act, many of the Indigenous men are the inserters and the partners are the insertees (Thomas, 2006). In this setting, Indigenous men do not compromise or jeopardize their sexual identity, but reinforce it by being the inserters, which is the role designated for heterosexual masculine men.

Despite the difference in Indigenous gender constructions, we have embraced Western construction and in many cases are only aware of the latter. Due to this recent cultural view, we are now seeing more and more Indigenous gays, lesbians and others having relationships with one another, in the sense of gay/gay relationships, lesbian/lesbian relationships, and so forth. The basic understanding within Native views is that the relationship should be between a masculine and feminine gender and not between two masculine genders or two feminine genders.

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VI. Encounters

Initial health care encounters with Native peoples are different from culture to culture, especially between positive HIV patients versus an individual who is seeking health care for another ailment. This is quite true between male and female, and to a larger degree between older and younger Indigenous people. Differences may also exist according to a person's place of residence, be it reservation, rural or urban environments. From the start, the health care provider has to quickly take into consideration the sex of the person, their self-named rather than culturally imposed gender identity, and their age.

Despite the fact that Indigenous people live their lives within the confines of various Western dominant cultures, they may still maintain their cultural identity and awareness of cultural norms. Six areas common to health encounters are described in detail below.

VERBAL COMMUNICATION

It is necessary and essential for all non-Natives and tribal people from other communities to know the importance of the various tribes' cultural norms in communication and non-verbal communication in their service area.

From the onset, health care providers need to take the time to learn a portion of the various ways local Indigenous populations behave, and react. This should be done before beginning work as a health care provider in the local area and it is strongly suggested that the provider learn as much as possible from the start.

Clarity only comes with time spent on the process of learning a culture. Stumbling and "falling" along the way takes place in any form of learning, especially in acquiring another culture's practices. Be mindful of the variation even within one Native community or setting. Furthermore, there are generational dif-

ferences in how patients live their culture(s), and there are regional differences in larger Indigenous communities - more so if the community is close to an urban environment.

In some contemporary Indigenous communities, English is the only language. This does not mean that the older people have lost their tribal language. It would be an asset to learn so they could use their “former” tribal greetings, especially with elders, in the tribe.

Here are a set of suggested greeting rules and some “do’s” and “do not’s”:

- Introduce yourself properly
- Greet your patient in his/her tribal language
- Learn how to address an elderly person respectfully in their culture
- Learn from as many different local Indigenous persons, since there are dialect differences even within a small cultural community
- Refrain from using any form of medical jargon with a patient
- Do not intellectually “speak down” to any patient
- Make time to see each patient - each deserve it
- Do not rush your talk. Converse in the same methodical pattern of the community

NON-VERBAL COMMUNICATION

Out of cultural habits in the West (dominant USA and so forth), many health care providers are not aware of cultural differences in non-verbal communication among Indigenous populations. At times this is one of the most dismissed parts of providing health care for a patient. Due to productivity pressures in health settings, patients are at risk of becoming numbers, and their individuality and cultural norms can be compromised. If this occurs, the patient may consider this situation the norm in a patient/health care provider relationship, with future adverse impacts to this relationship and to accessing medical care.

Here are a set of some suggested “do’s” and “do not’s”:

- Enter a patient’s exam room with a positive expression, no matter what the circumstances are, especially with older patients. Being jolly and overly expressive should be reserved for the younger children.

Differences may also exist according to a person's place of residence, be it reservation, rural or urban environments.

- Throughout the exam, do not repeatedly look at your watch. This indicates the current patient is not important.
- Create a practice style where you actually have a time-appropriate encounter with a patient. Many times the diagnosis is determined speedily through reading the assistant's interviews/evaluations. In a handful of Native communities, the patients refer to this as the "doorway diagnosis." In fact, some health centers and health care providers are known as the "doorway" doctors, physician assistants, family nurse practitioners and nurses.

Adopt a communication strategy that can confirm to your satisfaction that the patient did understand your instructions. Leaving it to another person is not appropriate, especially expecting a translator to convey your instructions without your direct input. Local tribal translators may be under the impression that the patient already knows information you are describing on the basis of the frequency of visits to the health center, or because they are related to the patient and have insider knowledge.

Gestures

One main point here is that hand gesturing needs to be acknowledged according to the cultural variation of the multiple Indigenous populations health care providers work with. Especially among the elders within each specific tribal group, finger pointing is not appropriate, even its use as part of giving a direction. It is best to gesture with one's chin and movement of the head in the direction you want the patient to go, for example. Over time, one is able to gesture with the chin or whole head. From a Western perspective, this may seem odd or strange. From a Native perspective, gesturing with one's hand or finger is odd or even insulting and rude.

Touching

It is best to inform the patient when you are touching their body and why you are touching their body. Some tribal members will not let you touch their bodies for various reasons, such as coming directly from a ceremony and their whole body has not yet been cleansed. If so, they will instruct you or if you noticed body paints or objects worn on the body, it is best to ask before touching. Knowing of

Out of cultural habits in the West (dominant USA and so forth), many health care providers are not aware of cultural differences in non-verbal communication among Indigenous populations.

the local Indigenous seasonal ritual cycles would be of much benefit to all health care providers. Being observant plays a crucial and critical role in this particular setting. Some Native people assumed you are aware of their cultural norms, just as health care providers assume that all Native peoples culturally are acculturated and assimilated into Western cultures and have aligned themselves to Western clinical settings.

Eye Contact

There is still belief among quite a few Indigenous groups that one can observe one's inner soul by gazing into the eyes. This is considered an intrusion. In addition, it is considered impolite to look into a Native person's eyes during a conversation. This belief is opposite in the Western world, where one is expected to look into the eyes of the other person during conversation. When this happens, the Native person may become distracted, and want to end the encounter quickly and leave the room.

There is no prohibition in looking if it is for an eye exam. Glancing periodically into their eyes is permissible during any form of communication. Again, this is especially true with the elderly population in most of the tribal groups.

Formal versus Informal

There should be a formal introduction by the health care provider to their elderly patients using titles and last names. The younger ones might be more comfortable with being addressed informally, such as addressing them with their first names.

INDIGENOUS HEALTH CARE WORKERS AND LAY PEOPLE

It is commendable that Native people are in various health care fields and in their home communities. The majority of them are in the health care field out of desire and wanting to "give back" to their communities.

For example, if you are not related to them in any form, you may not automatically be a priority in their work. Work ethics in being a health care professional is altered at this stage and fairness in provid-

ing adequate health care for all patients is not the same and does not exist. It is doubtful that it ever will be.

This is a topic that has never been seriously, if not critically, addressed, nor has it been dealt with adequately since the introduction of Western medical health care in the Indigenous communities. Current and past health care administrators basically set rules on not to discriminate on service provision to clients, but the rules are basically treated as just that—a set of rules which are plastered on a wall or in employees' handbooks. Not one Indigenous health care facility in North America is immune from this. Sadly, it is now a cultural practice within health care settings. This basically goes hand in hand with the lack of confidentiality for patients, again due to relatives, neighbors and so forth, who are employed at Indigenous health care facilities. It has been addressed in various forms, but not adequately enough to meet the needs and expectation of all patients.

INTERPRETERS

For monolingual Native speaking patients, it can be difficult to find medical information materials translated in the local tribal language. Some elderly Natives do understand English basics, but are not able to speak it, despite their outward appearance or contemporary dress.

Translating has always been a critical part of health care for the Indigenous population. There is a huge difference between providing literal translation and spoken language translation. Many translations done in health care centers are peppered with English words, which is a blatant indicator that a “gloss translation” is taking place. Doing a literal translation does take a long time. Because of visit time constraints, it may be easier for some interpreters to conduct all translations quickly, which is “glossing.” Health care and medication intake errors can take place due to misinterpreted information.

In addition, even if patients do not understand the English language, some will gesture with their hands and so forth, indicating that they understand you and acknowledge your words. Nodding of the head is a common practice that should **never** be understood by any health care provider as an acknowledgement of information comprehension.

The elderly may not be the only ones who do not understand or speak English well. There are some who are younger in age, even in their twenties, who do not speak or understand English. This is due to

the high dropout rate among Indigenous secondary school students. Many drop out due to frustration with learning another culture's practice and/or not being able to adapt to Western ideology of education.

This population will not freely admit that they do not understand the English language. They definitely can carry on a basic conversation, but any form of medical terminology will cause challenges. This can lead to misunderstood medical instructions, with adverse impacts on decisions to return for future clinic visits. Due to the above reasons, each medical facility has to have thoroughly trained interpreters. It is an extremely frustrating but common practice to see and hear "trained" interpreters translating in the English language to a patient who does not understand English. A **trained** interpreter should be translating from English into the local Indigenous language and be fully able to handle dialect differences. As a health care provider, **please do not** ask or use relatives to conduct any form of translation, they will not be able to convey the details of the health care provider's instruction, especially if it is sensitive medical information, such as sex related topics like HIV, AIDS, and so forth.

"CURRENT" MEDICAL "HISTORY"

The word "current" should not be dealt with lightly in any setting, medical or otherwise, in a Native community. The Indigenous patient's "current" health problem is not only in term of the time and "now." In many instances, the "current" health problem or issue is well rooted in the past.

In Native communities (State University of New York), the "past" is a continuation of what happened before and is heavily intertwined with the "current." It is of one conglomerate make-up, not of two compartments. It is the same with word "history," which is apart (not "a part") of the current present-day event. What happened to a patient twenty years ago, for example, may have implications for the patient's current health problem or issue. It is best to address what is ailing the patient today, physically and mentally. The spirituality aspect needs to be left to the Indigenous lay people and practitioners of their Native beliefs.

Indigenous health care providers will deal with spiritual, mental and a portion of the physical needs. At times, a well-informed health care provider should feel comfortable enough to suggest to the patient to seek additional healing beliefs within their cultural setting. Ownership of health care is not only in the hands of the Western

worlds, which it has never been. Tolerance and acceptance of additional health care should be considered an asset to Western practitioners, not a threat.

To this day, many Indigenous people seek their own Native health care and at the suggestion of the medicine people, the patients are referred to Western health care providers for additional care. Within this population, their own tribal medicine people are their primary health care providers and Western health care is the **alternative**.

CULTURAL PRACTICES

“Race” as a term in the English language has been normalized as vocabulary over the centuries. “Race” is a word that was initially constructed to mean the difference of the physical human bodies. For the measure size of a European male’s head and that of an Indigenous male’s head. The size difference was the deciding factor of who was intelligent or not. This is an outdated term that should no longer be used, but put in a historical context. When the term “race” is used, 99% of the time it is meant as a replacement for “ethnicity,” cultural differences is being discussed. “Ethnic” encompasses a cultural component of a person; a person’s cultural way of life. When a Native person states his/her Tribal or Indigenous affiliation, he/she is stating her nationalist status, such as “I am Cheyenne” and so forth. Ethnicity outdates “race” as a cultural identifier. “Race” determines the difference between species, not within one species. If it is used currently it implies racism and many do without the intention of being racist.

For too long, Indigenous people have been forced to adapt into fitting the Western world and its models. Due to self-determination among Indigenous populations, they have the means to stop chasing Western standards and norms. Sadly, in some cases the Indigenous models no longer exist and the chase continues.

Euro-centricity has been the norm for too long among the Indigenous population, to the point it has driven many cultures into silence and out of existence. Still today, Indigenous peoples’ lives have a place in their tribal societies, which detects the outcome of their lived lives and clarifies their visions in life. To fulfill these goals, Native individuals have to have access to adequate health care in appropriate cultural settings to accomplish and maintain a decent life as expected for every living human being. This is best accomplished with knowledge on the part of health care providers of the various cultural differences.



VII. Appendix: Case Scenarios

Case 1

A 32-year-old Native woman from a small reservation in Montana presented for care to a large urban clinic in the Northwest. She was married, and had contracted HIV from prior IVDU. Her husband, a Central American immigrant, had been HIV tested and was negative, although the patient admitted they occasionally had unprotected intercourse.

Her medical history was complicated by periodic alcohol and crack binges, and a history of abnormal Pap smears. Her family and social history was notable for childhood physical and sexual abuse, and chemical dependency. The patient was unemployed. Although she had a brother living nearby in the city, she was adamant that he know nothing about her diagnosis or treatment, nor anyone back home in Montana, fearing family revenge and their trying to take her back home- a place she tried to escape from. She was vehement about not wanting to return to the reservation, even after death. Her husband agreed, but stated her family did not like him as ‘an outsider,’ and that they felt marginalized. The brother often called the primary care doctor asking for updates on his sister’s condition. The patient was aware of this, and agreed that he could learn of her diagnosis only after her death. She frequently reminded her physician of her needs for confidentiality and for her own right to choose, even if the choices appeared harmful to others.

She was initially started on antiretroviral therapy, but frequently missed appointments for medical and gynecologic care. She occasionally spoke of wanting to see a medicine person through the clinic, but did not follow through on this because the healer was male, and because she was actively using drugs. Her CD4 counts continued to decline, with rising viral load, and she was admitted to the hospital’s intensive care unit with opportunistic infection and cardiomyopathy. She had previously expressed a strong desire to be a “no code,” but suddenly changed her mind in the ICU just prior to her death.

After her death, her brother and elder aunt demanded to know her diagnosis. They then told her husband that “they were her blood family, and she needed to be buried at home,” regardless of her wishes, and that he had no legal or other rights to make such decisions.

Case 2

A 35-year-old homeless Iroquois man sought care from a large urban clinic in the Pacific Northwest. He was fully aware of his AIDS diagnosis and frank about his desire to continue drinking and to live in the street camps, where he felt he could make an impact among youth to reduce their risk of contracting the illness. He requested the services of a traditional healer, who did see him on a few occasions, and then declined to do so. The healer said it was because the patient was not sober during their visits. The patient strongly denied this and was saddened about it, knowing this was disrespectful behavior. At the clinic, he also requested to see a Native American physician, particularly someone from his own tribe. He was also close to a non-Native nurse who worked at the local shelter and in the clinic who he felt was trustworthy, and often asked to see her on a walk-in basis to talk.

The patient required periodic hospitalizations that were complicated by making care arrangements for his dog, which he considered his main family. He was not in contact with other family members. At times, he would ask his doctor and other clinic staff to help him obtain traditional medicines or objects to use in his medicine bundle to help him cope with his situation.

Case 3

A 26-year-old woman whose ancestry was mixed (African American and multiple Southwestern tribes) presented to a clinic for a same-day appointment with the complaint of sore throat. On exam, she was found to be obese, and to have thrush. Past medical history was positive for her having had thrush once before a year ago. The physician assistant told her of his concern for both diabetes and HIV, and asked her to be tested for both. Because of her ethnicity and family history of diabetes, she agreed. Labs were drawn.

A week later, another physician in the group was asked to see the patient as a walk-in because “someone in clinic contacted her to come in for results.” The original PA who saw her was not working that day. Upon reviewing the chart, the physician could not find a pre-test consent to draw the HIV test, and was uncertain if the patient really had given informed consent. The test was positive.

VIII. Conclusion

American Indian, Alaska Native and Native Hawaiian (AI/AN/NH) people represent a unique population within the US, not only because of the oppression they suffered in the development of this country but also because of their ongoing struggle to gain recognition in the HIV/AIDS epidemic.

The long history of oppression faced by American Indians, Alaskan Natives, and Native Hawaiians has had a devastating effect on the health and well-being of Native Peoples. This history, including colonization, outlawing Native languages and spiritual practices, and centuries of forced relocation, has created justified mistrust of health care programs and institutions. This legacy continues to shape the experience of AI/AN/NH as they are disproportionately impacted by poverty, ill health, family violence and drug and alcohol abuse. All of these factors are associated with HIV risk.

The AI/AN/NH population is very diverse in culture, traditions, language, and geographical origin. Each tribe exists as a sovereign entity with its own culture, language, beliefs, and practices. Native Americans have a holistic view of the world where people, community, nature, and spirituality are interconnected and interrelated.

Effectively treating the American Indian, Alaska Native and Native Hawaiian (AI/AN/NH) populations requires a commitment to culturally competent care. The process of becoming culturally competency is a continuous learning progression. Providers who are committed to providing culturally appropriate care will strive to maintain an open and understanding attitude towards their patients' cultural beliefs, traditions, values, and backgrounds and will make efforts to treat each and every American Indian, Alaska Native, and Native Hawaiian patient with the respect they deserve.

AI/AN/NH communities, although diverse in many ways, share a sense of pride, self-determination, spirituality, and resiliency which have helped them fight HIV infection in their communities. These efforts need to be encouraged to ensure sustained HIV prevention. HIV/AIDS must be made visible in AI/AN/NH communities to prevent the spread of HIV.

Visibility can be increased by collecting reliable HIV/AIDS data, including AI/AN in the design and delivery of HIV prevention programs, addressing AI/AN stigma about homosexuality and drug use, and linking to STD, violence, unintended pregnancy, and alcohol and drug abuse prevention programs.

This book provides information of six culturally relevant elements that effect American Indians, Alaska Natives and Native Hawaiians with HIV/AIDS: Barriers to Care, Ethics, Sensitivity of the Provider, Assessment, Facts, and Encounters. The information provided in this BE SAFE Model can be used as a guide for health care providers who wish to increase their knowledge about the American Indian, Alaska Native and Native Hawaiian culture and issues facing patients with, or affected by HIV/AIDS.

The National Minority Aids Education and training Center welcomes feedback and pertinent comments related to this manuscript and culturally competent strategies to improve HIV/AIDS related health care for American Indians, Alaska Natives, and Native Hawaiians.

X. Glossary

- Acculturation**-*n.* The modification of the culture of a group or individual as a result of contact with a different culture.
- Alaska Native** -*n.* A member of any of the Indigenous tribes in Alaska. The major cultural groups of Alaska's Indigenous population are called Alaska Natives. They are Aleuts, Alutiiq, Yup'ik, Inupiat, Athabascans, Eyak, Tlingit, Haida, and Tsimpshian.
- American Indian**-*n.* A member of any of the peoples I to the Americas, except the Alaskan Natives and Native Hawaiian.
- Anthropocentric**- *adj.* Regarding humans as the central element of the universe.
- Assimilation** - Total identification with mainstream culture.
- Ceremony**- A formal act or set of acts performed as prescribed by ritual or custom. A conventional social gesture or act of courtesy.
- Chief** - (Tribal Leader) In Native Communities, one individual or individuals chosen by that tribe to make decisions based on present community realities and past experiences.
- Colonization**- Extension of political and economic control over an area by a state whose nationals have occupied the area and usually possess organizational or technological superiority over the Native population. It may consist simply in a migration of nationals to the territory, or it may be the formal assumption of control over the territory by military or civil representatives of the dominant power.
- ANCSA Corporation**- Alaska Native Group organized pursuant to the laws of the Alaska Native Claims Settlement Act (ANCSA) or tribal resolution. Under the laws of the State of Alaska, it may function as a business for profit or nonprofit corporation to hold, invest, manage and/or distribute lands, property, funds, and other rights and assets for and on behalf of members of a Native group in accordance with the terms of this Act.
- Cultural Competence**- A set of congruent behaviors and policies that come together in a system, agency, or among professionals that enable effective work in cross-cultural situations.
- Cultural genocide** - A term used to describe the deliberate destruction of the cultural heritage of a people or nation for political or military reasons.
- Culture** - Distinct, preferred (idealized) or performed patterns of behavior (e.g., practices), communication, and cognitions that are held in common and accepted by members of a distinct group of people.
- Ecocentric**- By not focusing solely on human activity, and taking into account physical processes that support life, the aim of an ecocentric outlook is to be more consistent with the reality of life on earth as defined by ecology.
- Environment** - Physically external, objective factors that influence a person's behavior.
- Historical Trauma**- Physical and cultural harms inflicted on Native people during the colonization process.
- Matrilineal**- *adj.* Relating to, based on, or tracing ancestral descent through the maternal line; Mother's side.
- Medicine man/woman**-*n.* Among Native Americans and other traditional Indigenous peoples as far back as Paleolithic times, a person believed to possess extraordinary healing powers.
- MSM**- Men who have sex with men.
- Native Hawaiian**-*n.* A member or descendant of the Indigenous Polynesian people of the Hawaiian Islands.
- Ohana** - A term used among Native Hawaiians to describe a group of both closely and distantly related people who share nearly everything, from land and food to children and status; a family.
- Patrilineal** - *adj.* Relating to, based on, or tracing ancestral descent through the paternal line; Father's side.
- Pow-wow**- A gathering of Native Americans. It

derives from the Narragansett word *powwow*, meaning shaman. Its evolution is also rooted with the Ponca Tribe of southwest Oklahoma. History indicates that both started around the same time, the second half of the 19th Century. An early twenty-first century powwow is a specific type of event held by Native Americans. Typically, a powwow consists of people (Native American and non-Native American alike) meeting in one particular area to dance, sing, socialize, and generally have a good time. Pow-wows can vary in length from a single session of about 5-6 hours to three days with one to three sessions a day. Major pow-wows or pow-wows called for a special occasion can be up to one week long.

Reservation - As part of the Federal Trust Relationship, the U.S. Government has reserved lands for federally recognized tribes (approximately 56.2 million acres).

Rural- *adj.* Of, relating to, or characteristic of the country or the bush; Non urban. Of or relating to people who live in the country or in the bush, relating to farming/agricultural or subsistence activities.

Sexually-transmitted infections (STIs), also known as **sexually-transmitted diseases (STDs)**, are diseases that are commonly transmitted between partners through some form of sexual activity, most commonly vaginal intercourse, oral sex, or anal sex. They were commonly known as **venereal diseases** (VD) until some time around 1990, when public health officials introduced the new term in an effort to improve the clarity of their warnings to the public.

Sovereignty - (Tribal Sovereignty) Indian tribes exercising inherent sovereign authority over their tribal members and territories.

Stereotyping - Generalization of what a person or a group of individuals should look like, act like or be like.

Tradition-*n.* The passing down of elements of a culture from generation to generation, especially by oral communication. A

mode of thought or behavior followed by a people continuously from generation to generation; a custom or usage. A set of such customs and usages viewed as a coherent body of precedents influencing the present: followed family tradition in dress and manners. A body of unwritten religious precepts. A time-honored practice or set of such practices.

Traditional medicine- Traditional medicine refers to health practices, approaches, knowledge and beliefs incorporating plant, animal and mineral based medicines, spiritual therapies, manual techniques and exercises, applied singularly or in combination to diagnose, treat, and prevent illnesses or maintain well-being.

Transgender- Appearing as, wishing to be considered as, or having undergone surgery to become a member of the opposite sex.

Tribe - (Indian Tribe) Any Indian tribe, band, nation, or other organized group or community, including Alaska Native village or Native Hawaiian community.

Two-Spirit- A term for third gender people (for example, woman-living-man) that are among many, if not most, Native American tribes. It usually implies a masculine spirit and a feminine spirit living in the same body. It is also used by gay, lesbian, bisexual, transgender, and intersex Native Americans to describe themselves. There are also Native terms for these individuals in the various Native American languages. The term was coined in urban areas, and therefore may not be acknowledged in traditional terminology or in Alaska.

Urban- *adj.* Of, relating to, or located in a city. Characteristic of the city or city life.

Village- *n.* A small group of dwellings in a rural area, usually ranking in size between a hamlet and a town. A community in Alaska may be rural and remote (off the road system). Many villages in Alaska are federally recognized tribes.



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