# Adapting the Sessions for American Indian/ Alaska Native Women

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*Margaret Anne YellowKidney, Chair*
*Denise Aragon*
*Carol Arnold*
*Angela Broncheau*
*Joy Culbreath*
*Theresa Dyess*
*Leatha Merculieff*
*Louise Shabi-Ashkie*
*Sherrie Perry*
*Janet Shephard, March of Dimes staff*
*Donna Smallwood*

## Introduction

Today, the United States is a tapestry of cultural and ethnic differences. These differences provide a multitude of customs, beliefs and traditions with which we interact daily at work, at play and even through the foods we eat. However, these differences can cause challenges in providing health care and education. This is especially true if one misinterprets or stereotypes an encounter with someone from another culture.

Many Americans know little about American Indian/Alaska Native (AI/AN) people and rely on incorrect stereotypes of AI/ANs found in history, literature and the media. Approximately one-third of AI/AN people live in geographic areas formally designated by the U.S. government as American Indian Areas or Alaska Native Villages (Indian Health Service [IHS], 2009a). These small, rural communities (often called reservations, pueblos, rancherias or villages, depending on their location) have customs, cultural beliefs and traditions that are not totally open to outsiders. This lack of information does not accurately tell the long and proud heritage of the AI/AN people.

AI/ANs have a rich treasure of customs, beliefs, traditions and languages that often conflict with Western culture. Health care providers who work with or want to work with AI/AN populations should become aware of the culture and history of their local AI/AN community. Many AI/AN communities have awareness and education opportunities for those who wish to learn about the culture.

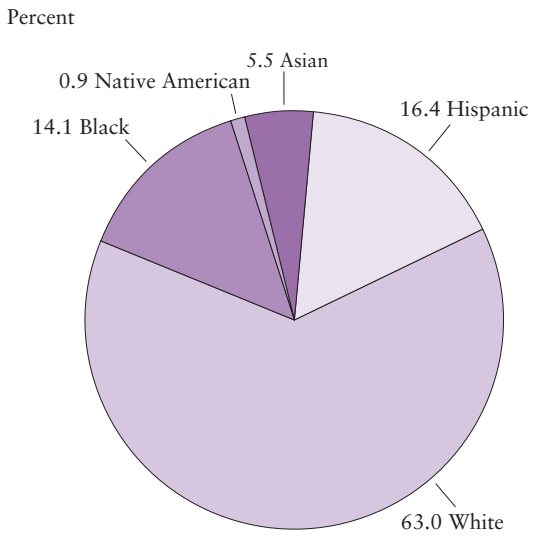
## Demographics

In the 2000 U.S. Census, 4.1 million people identified themselves as either American Indian or American Indian in combination with another racial group (U.S. Census Bureau, 2002). More than 2.5 million individuals identified themselves only as AI/AN (about 1 percent of the U.S. population) (U.S. Census Bureau, 2006). The U.S. government recognizes 569 AI/AN tribes, with many other tribes not federally recognized; each tribe has its own language, philosophy, customs, government and degree of acculturation (Indian Health Service [IHS], 2009b; Lowe & Struthers, 2001).

AI/AN women of childbearing age represent just under 1 percent of the U.S. population (Figure 1). AI/AN births account for about 1 percent of annual U.S. births (Figure 2).

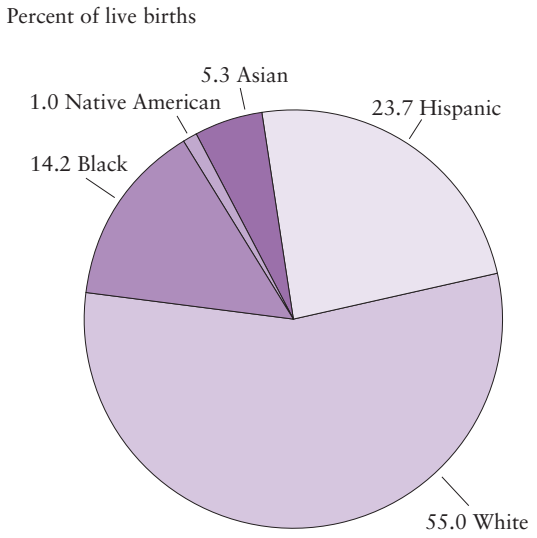
According to the U.S. Census Bureau (2006), the median age of the AI/AN population is 28.5 years, about 7 years younger than the general U.S. median age of 35.4 years. About 33 percent of the AI/AN population is under the age of 18, compared to 26 percent of the total

**Figure 1. Population of women 15 to 44 years by race/ethnicity, United States, 2006**




March of Dimes, 2009e

**Figure 2. Percentage of births by race/ethnicity, United States, 2004 to 2006 average**




March of Dimes, 2009c

U.S. population. The life expectancy of AI/AN people is 4.6 years less than the general U.S. population (IHS, 2009a).

The greatest concentrations of AI/AN people are in the west, southwest and midwest. There are more than 300 reservations in 35 states; about 43 percent of the AI/AN population lives in rural, isolated areas (IHS, 2009b; U.S. Census Bureau, 2002). Reservations and pueblos are not tracts of land that were given to AI/ANs by the United States; instead, they are lands that AI/ANs never ceded to the United States, and AI/AN people have always retained ownership of the land. The 57 percent of AI/AN people who live off the reservations reside in large metropolitan cities (IHS, 2009b; U.S. Census Bureau, 2002). The AI/AN living in urban areas may be disconnected from family, culture, beliefs and support structures that are vital to health and well-being. Even though urban areas often provide access to economic stability, most AI/ANs maintain their tribal identity.

## Economic status

More than 25 percent of AI/ANs live below the poverty level, and higher education remains elusive for AI/ANs living on reservations (U.S. Census Bureau, 2006). AI/ANs are less likely to be employed than other Americans; their unemployment rate is 3 times higher than that of the non-Hispanic white population (National Center for Education Statistics, 2005). Though measures taken to reduce poverty and increase education for underserved populations fall outside of the realm of health care, poverty and education do contribute to health status (Bierman, Haffer & Hwang, 2001; Moss, 2000) and place AI/ANs at risk for health disparities targeted for elimination in Healthy People 2010 (U.S. Department of Health and Human Services [DHHS], 2000b).

## Access to health care

Although the health status of the AI/AN people has greatly improved since 1955 (when the Division of Indian Health/U.S. Public Health Service began keeping records), injuries, chronic disease and behavioral-related diseases are major health concerns (IHS, 2009b; National Diabetes Information Clearinghouse, 2002). AI/AN people experience significant disparities in health status compared to the general U.S. population (Bird, 2002; IHS, 2009a; Katz, 2004). Their health needs rank higher than those of all other U.S. races in diabetes, obesity, hypertension and the prevalence of multiple social pathologies, such as alcoholism, violence and unintended injuries (Bird, 2002; IHS, 2009b). Lower life expectancy and disproportionate health burdens exist, in part, due to cultural differences, inadequate education, disproportionate poverty and discrimination in health service delivery (U.S. Census Bureau, 2006).

Disparities in health insurance coverage and health care utilization leave AI/ANs at a disadvantage in the U.S. health system. Nearly one-third of all AI/ANs are uninsured (Henry J. Kaiser Family Foundation, 2004). IHS provides health care as part of the U.S. treaty obligation to approximately 1.5 million AI/ANs (IHS, 2009a). Although many believe IHS providers are available to virtually all AI/ANs, IHS is the only source of health care coverage for only 55 percent of AI/ANs (IHS, 2009a). IHS provides services free of charge regardless of the ability to pay; however, benefits are not guaranteed entitlements. For example, there may be limited or no access to IHS services for the AI/AN who does not live on a reservation (Centers for Disease Control and Prevention Office of Minority Health and Health Disparities, 2009).

Many tribal communities have recognized problems encountered by their populations and have started wellness programs to address them. All of these programs strive to improve health and wellness opportunities for AI/AN people. Examples are:

- The South Piegan Diabetes Program on the Blackfeet Reservation in Montana
- The 100-percent tobacco-free workplace policy for the Cherokee Nation in Oklahoma
- The E'mah-kit's-nu-aah (take care of yourself) wellness program on the Nez Perce Reservation in Idaho
- The Navajo Nation Special Diabetes Program
- Dena A Coy (the people's grandchildren) in Alaska, a comprehensive, individualized addiction and mental-health treatment program for pregnant, parenting and nonpregnant women in Alaska

## Specific health care needs

**Diabetes —** AI/ANs are 2.3 times more likely than non-Hispanic whites to develop diabetes (National Diabetes Information Clearinghouse, 2004). With recent increases in incidence and prevalence, diabetes is an epidemic among AI/AN people, especially among full-blooded AI/ANs; the diabetes rate is 189 percent higher in AI/ANs than in any other U.S. racial group (Kelly et al., 2002; Reid, 2002; Roubideaux, 2002). Diabetes has become so prevalent that, in some AI/AN communities, 40 percent to 50 percent of adults are diabetic; diagnosis of diabetes in the young also is increasing (Action et al., 2002; Roubideaux, 2002). Diabetes among AI/ANs is linked to poor diet, lack of physical exercise and a genetic marker for insulin resistance. The Pima Indians of Arizona have the highest recorded prevalence of diabetes in the world, with 1 in every 2 people having a diagnosis of diabetes (Kelly et al., 2002).

Diabetes and obesity are related. Both affect pregnancy and can be linked to prematurity and an increase in cesarean delivery in the United States (March of Dimes, 2009d). According to IHS (2009), 62 percent of all American Indian women living on reservations are obese.

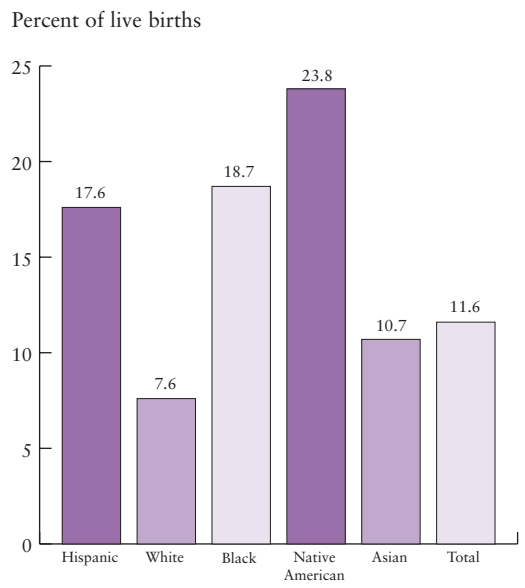
**Smoking and drinking alcohol —** The prevalence of smoking among AI/ANs is twice the rate of the general population, with 2 of every 5 Indian deaths attributed to diseases related to this behavior (Mathews, 1998; U.S. DHHS, 2000a). Alcohol use and alcohol-related death rates are 5 times greater for AI/ANs than for other ethnic groups in the United States; alcohol abuse is a major health problem among AI/AN people (IHS, 2009a; U.S. DHHS, 1998). AI/AN women have higher rates of smoking and drinking than other populations in the United States (American Lung Association, 2008; U.S. DHHS, 2003). Smoking and alcohol abuse are risk factors for premature birth, and alcohol use in pregnancy, particularly binge drinking, can cause birth defects and mental retardation (March of Dimes, 2009d).

## Health disparities

**Prenatal care —** AI/AN people have strong family and community bonds. They have a deep and profound respect for life, women and children. They consider pregnant women special and to be cared for by their family. Despite these beliefs, disparities remain in health status between AI/ANs and non-Hispanic whites (U.S. DHHS, 2006). These health concerns extend to pregnancy and prenatal care.

AI/AN women in the United States have the highest rate of late or no prenatal care compared to all other races (National Center for Health Statistics, final natality data, 2009). They have the highest rates of inadequate prenatal care compared to other groups in the United States (Figure 3). They are less likely than other women in the United States to receive early prenatal care (National Center for Health Statistics, final natality data, 2009). Barriers to prenatal care for the AI/AN woman include: access to care, poverty, family violence, fear of the health care system, transportation, a belief system that may clash with Western health beliefs, and perceived and real cultural insensitivities on the behalf of health care providers (Roubideaux, 2002; U.S. DHHS, 2003).

**Figure 3. Inadequate prenatal care by race/ethnicity, United States, 2000 to 2002 average**

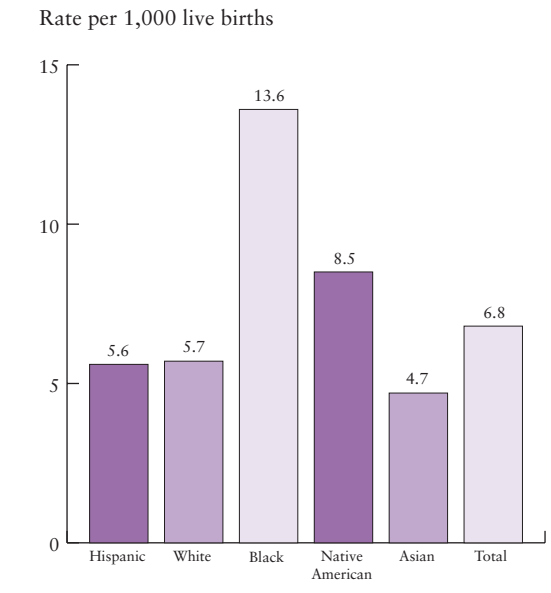



March of Dimes, 2009a

**Infant mortality —** Infant mortality is death before the age of 1. It is related to the underlying health of the mother and the availability of and her use of prenatal care services. The leading causes of infant death are birth defects, premature birth, sudden infant death syndrome, maternal complications and respiratory distress syndrome (March of Dimes, 2009d). The infant mortality rate for AI/AN infants is 8.5 per 1,000 births, the second highest rate in the United States (Figure 4).

**Prematurity —** The AI/AN preterm birth rate is 13.8 percent, the second highest rate in the United States (U.S. Census Bureau, 2009). Smoking, drinking alcohol, diabetes and obesity are risk factors for premature birth and low birthweight (March of Dimes, 2009a).

**Figure 4. Infant mortality rates by race/ethnicity, United States, 2003 to 2005 average**




March of Dimes, 2009b

## Cultural considerations

**Historical perspective —** The AI/AN people have a long and turbulent history with the U.S. government and the dominant society. It is a history full of broken promises and treaties, abuse and forced assimilation. AI/AN people were removed from their homelands and forced to live on reservations that generally were in rural and isolated areas with no economic base. In the late 1800s and early 1900s, the U.S. government removed children from their homes and families and sent them to boarding schools in an effort to remake the American Indian. These experiences have led many AI/AN people to mistrust government and the dominant society, including Western medicine and well-meaning interventions of health care providers. Providers who demonstrate a genuine desire to understand AI/AN people within their historical context are more likely than those who do not to be received and trusted by their AI/AN clients.

**World view —** AI/AN people have a circular and holistic world view. The circle represents life. The medicine wheel, or the cycle of life in many native cultures, is a perfect circle without top or bottom, length or width, beginning or ending. The medicine wheel is a symbol of balance and harmony that includes the four cardinal directions of the earth; these directions provide a road map for life in traditional American Indian beliefs. The symbol of the medicine wheel is not familiar to Alaska Natives, but the cycle of life and the connection to the earth is embraced by both American Indians and Alaska Natives.

**Identity —** Identity is a sensitive topic related to the AI/AN history and sense of belonging. AI/ANs cannot be grouped as one homogenous people. Some identify themselves as tribes and some as nations. AI/AN individuals are the only people in the United States who must prove their blood line or inclusion on a tribal role to be enrolled and/or recognized as a tribal member. It is a personal choice by each AI/AN individual to live within or outside of the reservation, pueblo or tribal community. It is acceptable for those outside the community to ask an AI/AN about her affiliation and descent. Individuals should address an AI/AN community by the name of the tribe, reservation or pueblo, and never as "Indian country."

**Family values —** Family has always been an important part of AI/AN life. The AI/AN family structure is extended and may involve multiple households and relatives. Aunts, uncles, cousins and grandparents are all part of the immediate family. They are involved in times of celebration and crisis. Older members may speak on behalf of the young. Because the family is the backbone of the AI/AN sociocultural system, health and healing must include family support. The presence or absence of this support can influence health-seeking behavior and compliance.

**Because many reservations, pueblos and AI/AN** communities are geographically isolated, a pregnant woman may have to go to an urban setting during the last months of pregnancy, leaving her isolated from family and her support circle. For example, high-risk pregnant women in Alaska must go to an urban setting during the last few months of pregnancy, as only a few larger, hub communities have hospital settings to support and care for high-risk pregnancies. These women likely are separated from their traditional circle of support. They may need information about local resources, referrals to social service providers and other support to help them cope with the emotional separation and meet their family's needs.

**Spiritual beliefs — Spiritual traditions are** an important part of AI/AN life. During the resettlement of AI/AN people to reservations, the U.S government allocated the reservations to different Christian religions and missionaries. Today, the AI/AN individual may embrace Christianity or may blend Christianity with traditional practices and beliefs, as does the Native American Church. AI/AN individuals generally feel that everyone is spiritual, but that religion is something to which someone may choose to belong. Opening and closing *Becoming a Mom/Comenzando bien* sessions with a prayer may be an important activity for AI/AN participants.

**Time orientation — The traditional AI/AN** concept of time is casual and present-oriented; life is not dictated by the clock (Duff, Bonino, Gallup & Pontseele, 1994; Spector, 2003; Still & Hodgins, 1998; West, 1993). Most AI/ANs place a greater emphasis on the past than on the future. Planning for the future is not a priority because many believe they can do little to control their destiny (Still & Hodgins, 1998). Therefore, AI/ANs may be less inclined than the general population to arrive punctually or to keep appointments at all, particularly when a friend or family member needs help. Furthermore, traditional AI/AN people may view long-term treatment and planning much differently than providers of Western medicine.

**Common health beliefs and healing practices — Although there is enormous diversity among** tribal cultures, languages and practices, many AI/AN individuals share some fundamental beliefs about health, illness and illness prevention. The circle of life supports the view that health is a balance between the physical, emotional and spiritual worlds within and around an individual. Health and wellness are dependent on a harmonious balance of body, mind, heart and soul. Illness is caused by an imbalance of these integral components, and many believe that the supernatural often is the cause of these imbalances (Huttlinger & Tanner, 1994; Spector, 2003; West, 1993). Many AI/AN people strive to live in harmony with nature and make no distinction between the physical, psychological, social or spiritual being (Huttlinger & Tanner, 1994; Spector, 2003; Weaver, 1999; West, 1993; Williams & Ellison, 1996).

Many AI/AN people hold traditional beliefs about healing and **health practices that come** from tribal beliefs on how individuals fit into the circle of life. Many of these beliefs focus on harmony, as health and healing exist in both the physical and spiritual world (Upvall, 1997). What may seem to be a cure to the Western mind may only be a treatment of a symptom to AI/AN people, who believe illness and disease are caused by an imbalance in the spirit, mind and body (Boyden & Prestrzelski, 1995; Hodge & Fredericks, 1999; Williams & Ellison, 1996). In traditional AI/AN healing, there is no separation of mind, body and spirit; all must be healed together. The use of sweat lodges, talking circles, songs, prayers, **traditional healers and** herbal remedies are regular practices for many **AI/AN people (Hutlinger & Tanner, 1994;**

IHS, 2009b; Hodge, Pasqua, Marquez & Geishirt-Cantrell, 2002; U.S. Census Bureau, 2006). These traditional practices are not just treatment of a symptom, but an overall healing of the person. Although many AI/AN people have access to Western medicine, some may prefer to use a spiritual healer. Reluctance to use Western medicine often is caused by health care providers' negative attitude toward the use of healers (Harris, 2002).

Building trust is important. Health care providers and educators should approach every client with a positive and welcoming attitude. The Western health care system tends to be prescriptive and directive. A collaborative approach works better with AI/ANs. Providers should be supportive of AI/AN strengths, such as strong family bonds, and help women and mothers build a wider circle of support.

**Cultural beliefs about pregnancy and the postpartum period —** Becoming a mother is a sacred event in the life of an AI/AN woman. It is important to prepare spiritually, emotionally, mentally and physically for pregnancy (March of Dimes, 2008). She tries to cleanse her body of impurities by eating healthy foods and not smoking, drinking alcohol or using drugs. It is tradition to protect a woman during the sacred time of pregnancy because her actions reflect her intentions of having a healthy baby. She may use sacred herbs, plants, rituals and ceremonies during pregnancy as she tries to decrease stress, get rest and eat healthy foods. Some traditional teachings caution her to avoid certain activities and ceremonies. She may talk with elders, grandmothers or aunties to help guide her decision-making (March of Dimes, 2008).

The postpartum period is a special time in the lives of women and families. Many tribes, nations and pueblos have special traditions to help the woman recover from pregnancy and childbirth and help families to bond. One common tradition is saving the placenta to plant or bury in a special place at home to help connect the baby to the land and ancestors. Another tradition involves saving part or all of the umbilical cord so that the baby remains connected to the mother, the family and the tribe throughout life. Facilitators should encourage and empower women who embrace these traditions to ask their health care providers to honor their requests. Many IHS medical facilities have staff who do ask women if they want to honor these traditions, but many AI/AN women give birth in health care systems not connected to the IHS.

Some AI/AN women drink special teas to heal and cleanse their bodies after pregnancy. One such tea is cedar tea or "tree water." Some AI/AN mothers have the benefit of older women and traditional healers to advise them about the benefits of waiting at least 2 years before trying to conceive again. (The March of Dimes recommends that a woman wait at least 18 months between pregnancies.) This time gives the body a chance to heal and gain strength, especially for a woman who had pregnancy complications or a difficult birth. These traditions are a part of the holistic AI/AN view of health and the importance of being a mother.

For AI/ANs, breastfeeding is the tradition of their ancestors (March of Dimes, 2008). Breastfeeding can help protect the baby from obesity and diabetes later in life, both serious concerns for AI/ANs. Many WIC (Women, Infant and Children) sites support breastfeeding for AI/AN women. The mother also is encouraged by her circle of support to take care of herself, sleep, eat well and to get to know the baby with her partner.

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## notes

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