American Indians and Alaska Natives: Health Disparities Overview

The phrase *American Indian and Alaska Native* refers to people descended from any of the original peoples of North and South America (including Central America) and who maintain tribal affiliation or community attachment. (US Bureau of the Census, 2002a).

The American Indian and Alaska Native population is diverse, geographically dispersed, and economically disadvantaged. Disease patterns among American Indians and Alaska Natives are strongly associated with the adverse consequences of poverty, limited access to health services, and cultural dislocation. Inadequate education, high rates of unemployment, discrimination, and cultural differences all contribute to unhealthy lifestyles and disparities in access to health care for many American Indian and Alaska Native people.

Compared with other Americans, Indians experience disproportionately high mortality from alcoholism, tuberculosis, diabetes, injuries, suicide, and homicide. Tribal leaders report that diabetes, unintentional injuries, alcoholism, and substance abuse are rising to crisis proportions in American Indian and Alaska Native communities. (Indian Health Service, 2001e).

### Underlying Causes of Health Disparities: Income and Education

Inequalities in income and education underlie many health disparities in the US. Income and education are intrinsically related and often serve as proxy measures for each other. In general, population groups that suffer the worst health status are also those that have the highest poverty rates and the least education. Disparities in income and education levels are associated with differences in the occurrence of death and illness, including heart disease, diabetes, obesity, elevated blood lead level, and low birth weight. Higher incomes permit increased access to medical care, enable people to afford better housing and live in safer neighborhoods, and increase the opportunity to engage in health-promoting behaviors. (US DHHS, 2000).

Health disparities are believed to be the result of the complex interaction among genetic variations, environmental factors, and specific health behaviors. (US DHHS, 2000). This section highlights the health disparities among American Indians and Alaska Natives.

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History

- **The conventional theory of the beginning of human life in the Americas** was that the first people arrived in North America between 20,000 and 50,000 years ago from Asia, crossing a land bridge where the Bering Strait now exists and spreading throughout North, Central, and South America thereafter. (Kittler and Sucher, 1998). These first inhabitants were called the Clovis people, named after the town in New Mexico where their fluted spear points were first found in 1932. (Smithsonian Institution, 1999).

- **American Indian and Alaska Native oral traditions.** Many American Indians and Alaska Natives do not agree with the conventional theory of the arrival of the first Americans. Their oral traditions teach that American Indians and Alaska Natives have always been present in the Americas. Some American Indian and Alaska Native peoples find the conventional theory offensive. (Robinson, 2002).

- **Recent discoveries** in New World archaeology, along with new scientific methods of analyzing data, have led to new ideas regarding the origin of the first peoples to inhabit the Americas and the time of their arrival. There is now convincing evidence of human habitation sites that predate the Clovis culture, including sites in South America. (Smithsonian Institution, 1999).

Who Is an American Indian?
No single criterion exists for determining who is an American Indian. Each Indian nation sets its own criteria for membership. Some nations require that a person document a certain percentage of Native American heritage to be considered a member. This criterion is referred to as blood quantum. Some nations require that ancestry be traced to someone who was on a tribal census in a particular year. Other nations trace descent only through the mother or only through the father. Criteria for citizenship in Indian nations may or may not be directly linked to biological heritage or cultural identification. Only the nations themselves are capable of setting standards for citizenship, and these standards are subject to change, just like any other policy. (Weaver, 1998).

Diversity in Language and Culture

- **Diversity in language.** Studies of the Native languages of the Americas have shown them to be extremely diverse, representing nearly 200 distinct families, some consisting of a single isolated language. This degree of diversity is thought to have required tens of millennia to develop through a combination of immigration to the New World and the accumulation of normal linguistic changes over time. Newer proposals have explored deep structural affinities between American Indian languages and circum-Pacific Old World languages. (Smithsonian Institution, 1999).

- **Tribal diversity.** There are 562 federally recognized tribes in the US, including 223 village groups in Alaska; about 100 other tribes are recognized by individual states. There are also tribes that have existed since this country was formed but do not have federal or state recognition. (Department of the Interior, 2002; Bureau of Indian Affairs, 2002).
- Diversity exists in all aspects of American Indian and Alaska Native culture, language, belief systems, relationships with other tribes, and so on. (Indian Health Service, 2001e).

Sociocultural Experience
- Ninety percent of the Native population was eliminated within 200 years of European settlers’ arrival. It is estimated that before contact with European settlers, there were approximately 2.5 million Native peoples in the area that is now the US. By the late 19th century, only about 250,000 remained—10% of the original number. (Orlandi, 1995).
- Shared experience. The poor health experience that is common to American Indians and Alaska Natives, while obscuring their diversity, highlights their shared sociocultural experience, which includes, but is not limited to:
  √ The rapid and forced change from a cooperative, clan-based society to a capitalistic and nuclear family–based system.
  √ The outlawing of language and spiritual practices (reminiscent of the black slavery experience).
  √ The death of generations of elders due to infectious disease or war.
  √ The loss of the ability to use the land walked by their ancestors for thousands of years. (Office of Research on Women’s Health, 1998).
- Alaska Natives today suffer deeply from the undermining or disappearance of many traditional activities and beliefs, the disruption of family and community, and the loss of self-esteem that accompanies social disruption. In modern times, chronic despair combined with unhealthful behaviors (brought about by changes in culture, work, housing, diet, and modes of transportation) is proving almost as destructive as the infectious diseases introduced more than a century ago. (Glanz, 2003).

Cultural Identity
“American Indians may identify themselves according to their particular nation rather than as members of a broad category such as American Indian. For some people, membership in a band or a clan may be equally or more important than membership in a nation as a primary source of identity. Bands or clans are groups of extended family networks, often labeled with the name of an animal like eel or hawk. In some cases a sense of commonality and pan-Indian identification has developed. This form of identification may be particularly common in urban areas where people from various nations have come into contact with each other.” (Weaver, 1998).

Demographics
Size and Location of Population
- In Census 2000, 4.1 million people (1.5% of the total US population) identified themselves as American Indian or Alaska Native—either alone or in combination with one or more other races. Between 1990 and 2000, the “American Indian alone” population increased by 26%. This reflects the new census category that allows people to select “American Indian alone or in combination,” a population that increased by 110% between 1990 and 2000. People of mixed ethnicities can now identify themselves as being American
Indian and Alaska Native alone or in combination with one or more races. (US Bureau of the Census, 2002a).

- It is projected that by 2030, the American Indian and Alaska Native population will grow by 44% to 2.9 million persons. (Maldonado, 1999).

- **Location.** According to Census 2000, of all respondents who identified themselves as American Indian or Alaska Native, 43% lived in the West, 31% lived in the South, 17% lived in the Midwest, and 9% lived in the Northeast. (US Bureau of the Census, 2002a).

- The **ten states with the largest American Indian and Alaska Native populations in 2000,** in descending order, were California, Oklahoma, Arizona, Texas, New Mexico, New York, Washington, North Carolina, Michigan, and Alaska. (US Bureau of the Census, 2002a).

- **Cities.** In Census 2000, more than 87,000 people in New York City reported being American Indian or Alaska Native alone or in combination with one or more other races. Los Angeles had the second largest number, with 53,092; Phoenix was third, with 35,093. (US Bureau of the Census, 2002a).

- **A minority of American Indians lives on reservations.** Indian reservations are home to only a minority of American Indians (as little as 30%). The majority of the population currently lives in urban or other nonreservation areas. (Smedley et al., 2003).

- **Alaska Natives account for just over 15% of Alaska’s general population, or about 106,000 people.** It is a relatively young population, most of which lives in rural villages with as few as 25 residents. Many Native villages are isolated from the outside world by both distance and, for much of the year, extreme weather conditions. (Glanz, 2003).

- **Alaska Native tribes.** The largest group of Alaska Natives is Eskimos, who can be roughly divided into three linguistic and geographic subgroups: the Inupiat (northern), Yup’ik (southern), and Pacific (along the northern Gulf of Alaska). Southeast coastal Indians, Athabascans, Eskimos, and Aleuts inhabit Alaska’s arctic, interior, and coastal regions. Tlingit, Haida, and Tsimshian Indians occupy the islands and mainland of southeast Alaska. (Glanz, 2003).

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**Alaska Native Tribal Groups**

The population defined as “Alaska Native” includes three distinct ethnic and linguistic groups: Indians, Eskimos, and Aleuts. Indians can be further divided into 3 southeast coast tribes (Haida, Tlingit, and Tsimshian) and 11 Athabascan groups scattered across the state’s interior. All Indian groups share many cultural traits, but significant differences have developed over years of geographic separation. (Glanz, 2003).

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**Size of Tribal or Nation Groups**

- According to Census 2000, the **American Indian tribal groups** with 100,000 or more people or responses were Cherokee, Navajo, Latin American Indian, Choctaw, Sioux, and Chippewa. These six tribal groups accounted for 42% of all responses. Eskimo was the
largest Alaska Native tribal group alone or in any combination, followed by Tlingit-Haida, Alaska Athabascan, and Aleut. These four tribal groupings accounted for 2.7% of all American Indian and Alaska Native tribal responses. (US Bureau of the Census, 2002a).

**Education**

- **College degrees or higher.** Among people aged 25 and older who said that American Indian and Alaska Native was their only race, 11% had a bachelor’s degree or higher at the time of Census 2000, compared with 26.7% of all people aged 25 and older. (US Bureau of the Census, 2002c, 2003b).

- **High school diploma or higher.** Among people aged 25 and older who said that American Indian and Alaska Native was their only race, 71% had at least a high school diploma at the time of Census 2000. (US Bureau of the Census, 2002c). In comparison, 84.1% of all people in Census 2000 had completed high school or better. (US Bureau of the Census, 2003b).

**Income and Employment**


- Unemployment is 2.5 times higher among American Indians and Alaska Natives than for the rest of the US population. (Indian Health Service, 2001e).

**Poverty**

- The poverty rate for American Indians and Alaska Natives in 1999 was 25.7%, compared with 24.9% for African Americans, 22.6% for Hispanics, and 8.1% for non-Hispanic whites. (US Bureau of the Census, 2003a).

- The 1997–1999 Current Population Survey reveals that the Indian population has larger families, lacks health insurance, and has lower household median incomes. (Indian Health Service, 2001i).

**Health Status**

**Infants, Children, and Youth**

- American Indian and Alaska Native children and youth are more than twice as likely to die in the first four years of life as is the general population, and they are twice as likely to die through the age of 24. (American Academy of Pediatrics, 2002).

- **Infant deaths.** American Indians and Alaska Natives have the second highest number of infant deaths in the US. (National Women’s Health Information Center, 2003).

- American Indian and Alaska Native infants die at a rate of 8.9 per 1,000 live births, compared with 7.2 per 1,000 for the US all-races population. (Indian Health Service, 2002b).
• American Indian and Alaska Native children have higher morbidity and mortality from acute respiratory infections than other US children do. Moreover, the mortality from pneumonia for American Indian and Alaska Native infants is twice that of infants in the general US population. (CDC, 2001e).

• The American Indian and Alaska Native youth suicide rate is twice as great among 14- to 24-year-olds and three times as great among 5- to 10-year-olds compared to the US general population. (American Academy of Pediatrics, 2002).

• American Indian and Alaska Native children experience the highest rates of mortality and morbidity due to injury of all US ethnic groups. Death rates for American Indian and Alaska Native children as a result of pedestrian–motor vehicle collisions are nearly four times greater than the rate for all US races combined. (American Academy of Pediatrics, 2002).

• The prevalence of type 2 diabetes among American Indian and Alaska Native children is higher than that of any other ethnic group. Of particular concern, Indian Health Service data indicate that the prevalence of diagnosed diabetes (all types) among youth 15 to 19 years old has increased 54% since 1996. (American Academy of Pediatrics, 2002).

**Life Expectancy**

• American Indians and Alaska Natives born today have a life expectancy that is almost six years less than that of the US all-races population. (Indian Health Service, 2002b).

**Mortality**

• The top five leading causes of death of American Indians and Alaska Natives in 1999 were coronary artery disease, cancer, accidents and unintentional injuries, diabetes mellitus, and cerebrovascular disease. (CDC, 2001f).

• The American Indian and Alaska Native population is younger than the general US population and simultaneously has a lower life expectancy. (Oropeza, 2002).

• American Indian and Alaska Native age-adjusted death rates are greater than for the general US population for:
  ✓ Alcoholism—740% higher.
  ✓ Tuberculosis—500% higher.
  ✓ Diabetes—390% higher.
  ✓ Injuries—340% higher.
  ✓ Suicide—190% higher.
  ✓ Homicide—180% higher. (Indian Health Service, 2001e).

**Recommendation**

Be aware of underlying morbidity and mortality trends in the community, how these affect American Indian and Alaska Native patient perceptions and expectations, and how they might impact a service delivery system. (Oropeza, 2002).
Men’s Health

- Nearly one-fourth (23.3%) of American Indian and Alaska Native male deaths occur by age 34 years, compared with only 15.9% of American Indian and Alaska Native female deaths. (Rhoades, 2003).

- The leading cause of death for American Indian and Alaska Native men is coronary heart disease, followed by accidents, chronic liver disease, suicide, diabetes mellitus, cerebrovascular disease, and pneumonia/influenza. (Rhoades, 2003). American Indian and Alaska Native men are also less likely to seek medical help and more likely to pursue risk-taking behaviors such as binge drinking and failure to use seat belts. (Ham, 2003).

- Ill health and risk-taking behaviors are not evenly distributed among the American Indian and Alaska Native population. With few exceptions, risk-taking is much higher among American Indians of the Northern Plains states, especially compared with American Indians of the Southwest. (Rhoades, 2003).

Women’s Health

- Health issues of concern for Indian women include the increasing incidence and prevalence of cardiovascular disease, accidents, diabetes, and cancer. Cervical cancer rates in some regions are above the rate in the US general population. (Indian Health Service, 2001j).

- Gallstones. Because of high levels of cholesterol in their bile, more American Indian women have gallstones than do other women in the US. Among the Pima Indians of Arizona, 70% of women have gallstones by age 30. (National Women’s Health Information Center, 2003).

Specific Concerns for Alaska Natives

- *Helicobacter pylori*. Alaska Natives have high rates of acute and chronic gastritis and gastric cancer rates that are twice those found in non-Natives, resulting in illness, death, and high costs for both inpatient and outpatient medical care. Recently, collaborative studies by the Centers for Disease Control and Prevention (CDC), the Indian Health Service, the Native Health Corporation, and the Mayo Clinic found that 90% of the Native American adults with chronic gastrointestinal bleeding have chronic gastritis that may be related to *H. pylori* infection. Chronic gastrointestinal bleeding in this population may cause the high rates of iron-deficiency anemia now well documented among Alaska Natives of all age groups. (CDC, 2001c).

- *Haemophilus influenzae*. Although the Native population represented only 16% of the total population in Alaska in 1980, it experienced 51% of all invasive *Haemophilus influenzae* type b (Hib) disease. The rate of invasive Hib disease in Alaska Native infants in the Yukon-Kuskokwim Delta region was 10 times that of non-Natives in Alaska and in the rest of the US. Early and intense exposure to Hib increases the risk of Hib disease in the Alaska Native population, and breastfeeding offers protection. The disease was more likely to occur in younger infants, with 25% of all Hib disease and 35% of meningitis occurring before 6 months of age, compared with 15% and 17%, respectively, in Alaska non-Natives. Alaska Native children also suffered greater neurological morbidity as a result of Hib meningitis than did non-Native children. (CDC, 2001b).
• **Overall cancer rates** have generally been similar to those in the US, but rates of specific cancers have sometimes differed dramatically. During the period 1969 to 1983, elevated rates among Alaska Natives of one or both sexes, relative to the US population, were seen for cancers of the salivary gland, nasopharynx, esophagus, stomach, colon, rectum, liver, gallbladder, lung, cervix, and kidney. For the same period, lower rates were seen for cancers of the larynx, breast, prostate, uterus, bladder, eye, and brain and for forms of melanoma, lymphoma, and leukemia. (CDC, 2001a).

• High **liver cancer** rates have been described in the Alaska Native population, and an association between infection with hepatitis B virus (HBV) and the development of primary liver cancer has been observed. (CDC, 2001d). When hepatitis B vaccine became available in the early 1980s, a program was started to vaccinate all Alaska Native newborns and as many older children as possible. Since that time, few Alaska Natives have been infected with HBV. A new generation of Alaska Native children has grown up without having to worry about HBV infection and its consequences. (CDC, 2001g).

• The prevalence of cervical infection with human papillomavirus and an increased risk of cervical cancer morbidity have been documented in the Alaska Native population. One recent study of Alaska Native women with invasive cervical cancer found that more than 50% had had a negative Pap smear within the last three years. (CDC, 2001a).

• **Respiratory syncytial virus (RSV) infection** is a major cause of hospitalization in Alaska Native infants. RSV infection was the cause of one-third of all hospitalizations in children younger than 3 years of age between 1993 and 1996. The peak age of hospitalization in this population was very young—0 to 2 months old. Children hospitalized with RSV infection were at high risk for other respiratory illnesses—19% of hospitalized children were readmitted with another RSV infection, and 34% were rehospitalized with another acute respiratory infection within one year of the first RSV hospitalization. Rural Alaska Native children are at high risk of chronic lung disease, including bronchiectasis. (CDC, 2001e).

### Traditional Health Beliefs and Practices

• **Enduring spirit.** The impact and durability of the practice of prevention and intervention for thousands of years should engender respect for American Indians’ enduring spirit. They are stubborn in holding on to what they believe is important, and they discard what they do not feel they need—often with community consensus. There is no argument that Indian Native peoples have survived for thousands of years under all kinds of conditions and circumstances. (Sage, 2001).

• **Holistic approach to life.** Concepts that are key to the cultural context, identity, adaptability, and perseverance of American Indians and Alaska Natives include a holistic approach to life, a desire to promote the well-being of the group, an enduring spirit, and a respect for all ways of healing. (MSH, 2003a).
• **Communal ceremonies.** There are many systems of healing among American Indians and Alaska Natives. Nearly all of them share the belief that large, communal ceremonies promote the well-being of the entire tribal group. (Sage, 2001).

• **Role of elders as advisers.** In many tribes, extended families (and particularly elders) are very important to the lives of individual members and will be part of a patient’s medical experience. (MSH, 2003).

Religion, Philosophy, and Spirituality

• **Spiritual belief** is a pervasive aspect of Indian culture, although belief systems vary widely among tribes or nations and among geographic areas. Most Indians teach that the interconnectedness of all things leads to a relationship among man, Creator/God, fellow man, and nature. In many Indian traditions, healing, spiritual belief or power, and community are not separated, and often the entire community is involved in healing ceremonies and in maintaining the power of Indian “medicine.” (Hendrix, 2002).

• **Healing is considered sacred work** and in many Indian traditions cannot be effective without considering the spiritual aspect of the individual. Many contemporary Indians use “white man’s medicine” to treat “white man’s diseases” (e.g., diabetes, cancer, gallbladder disease) and use Indian medicine to treat Indian problems (e.g., pain, disturbed family relationships resulting in physical symptoms, sicknesses of the spirit). (Hendrix, 2002).

• **Religion permeates all aspects of life** and is an integral part of the American Indian and Alaska Native holistic worldview. Religious concepts influence both the physical and the emotional well-being of the individual. (Kittler and Sucher, 1998).

• **Duality.** Spiritually, American Indians and Alaska Natives may be Christian and at the same time follow traditional spiritual practices and beliefs.

• **Illness means imbalance.** In American Indian and Alaska Native culture, health reflects a person’s relationship to nature, broadly defined as the family, the community, and the environment. Every illness is due to an imbalance, with supernatural, spiritual, or social implications. Treatment focuses on the cause of the imbalance, not just the symptoms, and is holistic in approach. Traditional American Indian medicine is concerned with physical, mental, and spiritual renewal through health maintenance, prevention of illness, and restoration of health.

• **Shared beliefs.** In spite of the enormous diversity in tribal cultures, languages, and religious beliefs among American Indian and Alaska Native tribes, they share some fundamental beliefs related to health, illness, and prevention.
  √ All healing begins with the Great Spirit (or Supreme Creator). Illness is an opportunity to purify one’s soul.
  √ Humanity is made up of body, mind, and spirit, and health is maintained by preserving harmony among the body, heart, mind, and soul. Illness affects the mind and spirit as well as the body. Spirituality and emotions are just as important as the body and the mind are.
Plants and animals, as well as humans, are part of the spirit world that exists alongside, and is intermingled with, the physical world.

Death is not an enemy but a natural phenomenon of life. The spirit existed before it came into a physical body and will exist after the body dies.

One’s relationships with others and with the earth are essential components of health. Disease is felt not only by the individual but also by the family. (Diversity Resources, Inc., 2001).

Specific Traditional Illness
- **Ghost sickness.** Ghost sickness manifests as a preoccupation with death. Symptoms include weakness, bad dreams, feelings of danger, dizziness, hallucinations, and anxiety. (Mutha et al., 2002).

Traditional Healers
- **Connect culture and context.** Traditional healers do not separate the culture from the context, and they view the connection and dynamic interaction between them as necessary for the healing process. (Sage, 2001).

- The role of the healer, as traditional practitioner, is to reaffirm cultural values, integrate all the pieces into the cultural context, and consider all those involved in the community. (Sage, 2001). In addition to administering cures, medicine men and women are often seen as culture brokers, preserving American Indian and Alaska Native identity in the midst of rapid social change. (Kittler and Sucher, 1998).

- Many American Indian and Alaska Native individuals may have more respect for and rely more on traditional healers than on Western medicine providers.

Specific American Indian and Alaska Native Groups

**Inuit**
- In traditional Inuit (also called Eskimo) culture, an angakut, or shaman, is the spiritual leader of each tribe. He interprets the causes of sickness or hunting failure, determines personal or family responsibility, and isolates the broken taboo. Similar to shamans from other cultures, the angakut goes into a trance so that his soul can leave his body and travel long distances to discover the causes of illness and other community problems. (Robinson, 1995–2002).

**Navajo**
- **Extended family.** Navajo society is matriarchal, built on the belief that a goddess known as First Woman, Spirit Woman, Whiteshell Woman, Thinking Woman, or Changing Woman created the universe. In Navajo society, the extended family, often called a “camp,” generally comprises the senior married couple, their unmarried children, their married daughters, and the daughters’ husbands. (Diversity Resources, Inc., 2001).
• **Leading female elder controls health decision-making.** Traditional Navajos must obtain the permission of the leading female elder before entering a hospital or undergoing surgery. (Diversity Resources, Inc., 2001).

### Risk Factors and Challenges

#### Access to Health Care

- **Health insurance.** Only one in three American Indians and Alaska Natives has private health insurance, compared with approximately one in five in the general population. (Smedley et al., 2003).

- American Indians and Alaska Natives have **less health insurance coverage** than do other Americans, even those with incomes below the poverty level. (Indian Health Service, 2002a).

- For those with access to an Indian Health Service facility, services are provided without cost to the extent funds are available. Sometimes, however, this means that care must be rationed, and patients with less urgent problems often find their **medical care postponed or never provided.** (Indian Health Service, 2002a).

- Forty-four percent of American Indians and Alaska Natives have **no access to Indian Health Service services.** (Indian Health Service, 2002a).

- The **shortage of health care professionals** working in American Indian and Alaska Native communities (fewer than 90 doctors for every 100,000 American Indians and Alaska Natives, compared with 229 per 100,000 nationally) makes health care access a challenging issue for this population. (ICC, 2001).

- **Circular migration.** Many American Indians and Alaska Natives migrate daily, weekly, or several times a year from reservations or rural areas to urban areas. This may either facilitate or impede access to needed preventive care or long-term treatment. It may also mean that disease is carried from urban areas to reservations, possibly contributing to the epidemic proportions of infectious diseases such as HIV/AIDS on reservations. (Oropeza, 2002).

#### Environment

- Of the more than 2 million American Indians and Alaska Natives residing in the US, **1.3 million reside in urban areas** (58%). (Indian Health Service, 2002c).

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<td>Residents in urban settings are at <strong>increased risk for exposure to hazards</strong> that include toxic waste; air pollution; a higher concentration of crime and violence; and older, poorly maintained buildings with inadequate heating, lead paint, and cockroach allergens. Researchers believe that exposure to violence may increase feelings of alienation, powerlessness, and hopelessness. Individuals who live under these conditions may see limited benefit in adopting health-promoting behavioral changes. (HRSA, 2003a).</td>
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- A safe and adequate **water supply and waste disposal facilities are lacking** in approximately 7.5% of American Indian and Alaska Native homes, compared with 1% of homes in the US general population. (Indian Health Service, 2002b).

**Obesity**
- Recent studies confirm **disproportionately high rates of obesity and overweight among American Indian women**, although rates in specific groups vary. A study of American Indian women in urban Phoenix found that 69.6% of those surveyed were overweight, with 41.6% considered obese. The Navajo Health and Nutrition Survey reported that 59% of Navajo women (on reservations) were overweight. A survey of Indian women in California found that 44.5% were overweight. (Glanz, 2003).

**Pharmacological Issues**
- Aldehyde dehydrogenase deficiency results in the **flushing response** in American Indians and Alaska Natives. Flushing response is the name for a reaction to ethanol metabolism that includes, to varying degrees, flushing of the face, neck, and upper chest; tachycardia; hypotension; dizziness; pounding in the head; muscle weakness; sleepiness; and nausea. The biological basis for the flushing response is not entirely clear, but flushers develop a high blood acetaldehyde level after ingesting ethanol. Alcohol is converted to acetaldehyde by the liver. Flushing response appears to be more common among people of Asian and American Indian heritage. (HRSA, 2003d; Prince, 2000).

**Smoking**
- Data from the 1997 National Health Interview Survey show that among the five major racial and ethnic populations, **adult smoking prevalence was highest among American Indians and Alaska Natives** (34.1%), followed by African Americans (26.7%), whites (25.3%), Hispanics (20.4%), and Asian Americans and Pacific Islanders (16.9%). (CDC, 2000). Overall, American Indians and Alaska Natives, blue-collar workers, and military personnel have the highest rates of smoking in adults. (US DHHS, 2000).

- Compared with whites, **American Indians and Alaska Natives smoke fewer cigarettes each day**. In 1994–1995, the percentage of American Indians and Alaska Natives who reported that they were light smokers (fewer than 15 cigarettes per day) was 49.9%, compared with 35.3% for whites. (CDC, 2000).

- **Smoking rates among American Indians and Alaska Natives are highest in Alaska (45.1%) and the North Plains (44.2%) and lowest in the Southwest (17%)**. The prevalence of heavy smoking (25 or more cigarettes per day) is also highest in the North Plains (13.5%). (CDC, 2000).

- Although many tribes consider tobacco a sacred gift and use it during religious ceremonies and as traditional medicine, the tobacco-related health problems they suffer are caused by chronic cigarette smoking and spit tobacco use. Because of the cultural and geographic diversity of American Indians and Alaska Natives, tobacco use often **varies widely by region** or subgroup. (CDC, 2000).
The tobacco industry targets American Indians and Alaska Natives by funding cultural events such as powwows and rodeos. (CDC, 2000).

Teens
- American Indian and Alaska Native lands are sovereign nations and are not subject to state laws prohibiting the sale of tobacco products to minors. As a result, American Indian and Alaska Native youth have access to tobacco products at a very young age. (CDC, 2000).

- Aggregated 1990–1994 Monitoring the Future Survey data show that racial or ethnic smoking prevalence is highest among American Indian and Alaska Native high school seniors (males, 41.1%; females, 39.4%), followed by white high school seniors (males, 33.4%; females, 33.1%). (CDC, 2000).

- Girls’ smoking rates are higher at BIA schools. The 1997 Youth Risk Behavior Survey showed that the percentage of girls who had ever smoked a cigarette was substantially higher among those attending schools funded by the Bureau of Indian Affairs (93.5%) than among high school girls overall (69.3%). (Office on Women’s Health, 2001).

Women
- In 1998, smoking prevalence was highest among American Indian and Alaska Native women (34.5%), intermediate among white women (23.5%) and black women (21.9%), and lowest among Hispanic women (13.8%) and Asian or Pacific Islander women (11.2%). (Office on Women’s Health, 2001).


- Reported smoking rates for women vary widely among American Indian tribal affiliations and by geographic location. The type of cigarettes, manner of inhaling, and number of cigarettes smoked also vary widely. Data from 1994–1996 show that smoking prevalence was highest among American Indian and Alaska Native women living in the Northern Plains (43.5%) and Alaska (40.6%), intermediate among women living in the East (33.4%) and on the Pacific coast (30.6%), and lowest among women living in the Southwest (18.6%). (Office on Women’s Health, 2001).

- Variation in women’s smoking by tribe and location. The Navajo Health and Nutrition Survey found that only 4% of Navajo women on reservations were current smokers. A survey of adult Indian women in urban Phoenix found 20.2% to be smokers. A survey of Indian women in California found that 37.2% were current smokers and another 27.1% were former smokers. In the California survey, more than half the smokers smoked 10 or fewer cigarettes per day. (Glanz, 2003).

- Tobacco use during pregnancy by American Indian and Alaska Native mothers was higher than in any other racial or ethnic group, but the prevalence decreased from 23.0% in 1989 to 10.2% in 1998. (Office on Women’s Health, 2001).
**Substance Abuse**

**Alcohol and Ilicit Drug Use**
Alcohol and illicit drug use are associated with many of this country’s most serious problems, including violence, injury, and HIV infection. Alcohol and illicit drug use are also associated with child and spousal abuse, sexually transmitted diseases (including HIV infection), teen pregnancy, school failure, motor vehicle crashes, and homelessness. Long-term heavy drinking can lead to heart disease, cancer, alcohol-related liver disease, and pancreatitis. Alcohol use during pregnancy is known to cause fetal alcohol syndrome, a leading cause of preventable mental retardation. (US DHHS, 2000).

**Historical Trauma and Its Response**
“Historical trauma (HT) is cumulative emotional and psychological wounding over the lifespan and across generations, emanating from massive group trauma experiences; the historical trauma response (HTR) is the constellation of features in reaction to this trauma. The HTR often includes depression, self-destructive behavior, suicidal thoughts and gestures, anxiety, low self-esteem, anger, and difficulty recognizing and expressing emotions. It may include substance abuse, often an attempt to avoid painful feelings through self-medication. Historical unresolved grief is the associated affect that accompanies HTR; this grief may be considered fixated, impaired, delayed, and/or disenfranchised.” (Brave Heart, 2003).

**Pertinent Fact**
Patterns of substance use vary widely from group to group, and research has been conducted with only a limited number of American Indian and Alaska Native nations.

- A study of enrolled members of four tribes (on reservations) in the northern US (Northern Plains and Rocky Mountain states) found that most drinkers are binge drinkers, and on any typical day, abstinence is the modal pattern. Males begin regular drinking at an earlier age than do females (17 versus 18.1 years), and more males than females drink alcohol—in the 12 months prior to the study, 70.7% of males and 60.4% of females had consumed at least one drink. (These percentages are virtually identical to the male and female alcohol consumption rates of the overall US population.) Most participants in the study drink infrequently, and the older population (40+) has a high rate of abstinence. Drinking is primarily a social experience and is rarely done in isolation. (May and Gossage, 2001).
Recommendation
“One useful treatment approach for American Indian and Alaska Native substance abusers may be the Medicine Wheel. The Medicine Wheel model differs from community to community and from family to family, and may be unfamiliar to some American Indian and Alaska Native communities. It is a useful tool that helps address the individual in a holistic manner with a focus on balance of the spiritual, physical, mental/emotional, and social/cultural aspects of the whole person. The Medicine Wheel is a simple, elegant circle with a cross bar in the center and may be enhanced by creative local artists. At each of the four directions—north, south, east, and west—an element of a balanced life is assigned. This differs from community to community, but the variations in assignments of the elements of balance to one of the four directions make no difference. The Medicine Wheel is another creative, rich approach that is the hallmark of a healthy, balanced American Indian and Alaska Native approach to life.” (Gray and Nye, 2001).

To learn more about the Medicine Wheel, go to http://www.uchsc.edu/ai/ncaianmhr/journal/10(2).pdf, pages 77–78.


- The same study (see previous bullet) showed that the number of drinking days per month is 4.7 for males and 2.1 for females. On those days when drinking occurs, males consume an average of 5.7 drinks and females an average of 3.1. Male drinkers in this sample who are under age 40 report consuming an average of 9 to 10 drinks per occasion, whereas female drinkers under 40 report consuming 4.5 to 5.7 drinks. Prevalence and heavy drinking are highest among those under 30 years of age. (May and Gossage, 2001).

No Stereotyping!
Risk factors present in particular individuals, tribes, or regions cannot be generalized to other American Indians and Alaska Natives. For example, southwestern tribes and the Plains tribes of Oklahoma appear to have lower prevalence rates of drinking than do Northern Plains tribes. (May and Gossage, 2001).

- Binge drinking, generally in social groups and gatherings, is common, particularly among Plains Indians. Binges are described as sporadic and heavy drinking events, clustering on weekends and special occasions. (May and Gossage, 2001).

Recommendation
“It is crucial to examine historical experiences of the American Indian and Alaska Native client’s nation, village, and family in order to understand the possible use of substances to self-medicate and soothe psychological pain and grief. All types of traumatic experiences may be related to substance abuse, and trauma and its aftermath (anger, grief, and depression) must be addressed when developing treatment approaches for American Indian and Alaska Native substance abusers. One traditional American Indian and Alaska Native approach [is the Medicine Wheel].” (Gray and Nye, 2001).
• **Death rates among American Indians and Alaska Natives due to alcoholism** are seven times higher than in the general population. Many individuals diagnosed with chemical abuse illness also have an associated mental health diagnosis such as depression. (Indian Health Service, 2001a).

• **Methamphetamine abuse.** In recent years, use of methamphetamines has been on the rise in many American Indian communities. This extremely dangerous behavior is identified primarily in youth and contributes significantly to many violent events. (Indian Health Service, 2001a).

**Urban Life**

• Indians living in urban areas share the same health problems as the general Indian population; in addition, their health problems are exacerbated in terms of mental and physical hardships because of the lack of family and traditional cultural environment. (Indian Health Service, 2001k).

• **Indian youth living in urban areas are at greater risk** for serious mental health and substance abuse problems, suicide, gang activity, teen pregnancy, abuse, and neglect. (Indian Health Service, 2001k).

**Strengths and Protective Factors**

**Adaptability**

• **New solutions, ideas, and creativity evolve** within the ceremonial life of the community. (MSH, 2003).

**Community Strength**

• Community organizing, networking, and a sense of tribal purpose and solidarity lead to strong community-level organizations that encourage healthy behaviors and support access to and utilization of preventive, healing, and other health services, as appropriate. (MSH, 2003).
Mobilizing and Building on Community Strengths: The Healthy Nations Initiative

“Since 1993, 14 American Indian and Alaska Native communities have worked diligently to reduce the harm due to substance abuse in their communities. Funded by the Robert Wood Johnson Foundation’s Healthy Nations Initiative I, these communities implemented creative strategies that span the continuum from community-wide prevention, early identification and treatment to aftercare. Drawing upon the unique strengths of their own cultural traditions to find solutions to local substance abuse problems, these efforts have identified important and useful lessons. Characteristics that appear to increase the likelihood of success” include:

- A culture-focused approach. “Culture became ‘the program’ for the most effective grantees instead of culture as an ‘add on.’”
- Community ownership and “buy-in.” “Effective programs stressed that community members should be involved at all levels of the planning and implementation and incorporated the perspective of ‘doing with’ the community instead of ‘doing for’ the community.”
- Effective collaboration. “Programs that established effective collaborative linkages across service organizations and successfully combined resources and talents were more effective.” (Noe et al., 2003).

For more information on this initiative and the programs of the 14 grantees, visit the Healthy Nations Initiative web site at [http://www.uchsc.edu/ai/hni/](http://www.uchsc.edu/ai/hni/).

Connection with the Past

- By revitalizing old practices and making the community aware of them, American Indians and Alaska Natives have established (or reestablished) constructive activities promoting health and healing. (MSH, 2003).

Family and Elders

- Family, including traditional kinship and extended-family structures within the community, is of paramount importance among and within all American Indian and Alaska Native groups. (MSH, 2003).

- The presence of elders is critical to the provision of culturally competent services for American Indians and Alaska Natives. Elders can provide specific advice and emotional support and can guide the approach to counseling or other forms of intervention and prevention from an American Indian and Alaska Native perspective. (MSH, 2003).

Holistic Thinking

- Holistic thinking is a strength of the American Indian and Alaska Native community and should be used to identify effective action. (Office of Minority Health, 2002).

Recommendation

Providers can obtain better results for American Indian and Alaska Native patients by taking a holistic approach to health and addressing physical, emotional, mental, and spiritual needs in the care and treatment plan. (Oropeza, 2002).
Identification with Culture

- **Indian youth who have a greater identification with their Native culture** may demonstrate less drug and alcohol use and other unhealthful behaviors. (MSH, 2003).

Abstinence from Alcohol

- A handful of studies has shown that American Indians, more so than any other ethnic groups in the US, have a **tendency to give up alcohol during the middle years of adulthood.** (May and Gossage, 2001).

<table>
<thead>
<tr>
<th>Abstinence Days Far Outnumber Drinking Days</th>
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<tbody>
<tr>
<td>“An over-emphasis on drinking among American Indians, while ignoring the abstinence measures, has been common in the past among journalists, academics, and others. That is, even though males (and to some extent females) [of Northern Plains and Rocky Mountain tribes] may drink substantial quantities when they do drink, on most days no drinking occurs at all. Similarly, approximately 35% of the adults are complete abstainers. Therefore, abstinence days in each month and year far outnumber drinking days. If the point prevalence of drinking is taken as any day, particularly a weekday, the modal pattern of drinking among American Indians is abstinence. This is not intended to minimize the fact that heavy drinking causes a tremendous number of problems ranging from adverse social consequences, morbidity, and mortality. It is, however, intended to emphasize the clearly documented strengths rather than the weaknesses exhibited in this population. The modal category on most of the frequency of drinking variables is zero drinks for both males and females.” (May and Gossage, 2001).</td>
</tr>
</tbody>
</table>

- Studies of drinking epidemiology among the Navajo have shown that a **low percentage of Navajo adults drink**—only 30% to 52% of the adult population. Further, more males than females drink (64% for males, 40% for females). (May and Gossage, 2001).

- In general, **southwestern tribes and the Plains tribes of Oklahoma appear to have lower prevalence rates of drinking** than do Northern Plains tribes. (May and Gossage, 2001).

Diet

- **Navajos traditionally classify foods into strong and weak foods.** Strong foods such as meat, fried bread, corn, and potatoes are believed to promote health. Milk is a weak food. It is believed that it is all right for the old to drink goats’ milk and for infants to drink mother’s milk, but milk in general is not considered a healthful food. (Diversity Resources, Inc., 2002).

- **Today's food and traditional Northwest Indian foods.** The US Department of Agriculture (USDA) published the Food Guide Pyramid in 1992. The pyramid provides for six food categories and emphasizes eating more breads and cereals and fruits and vegetables. The following box outlines examples of traditional Northwest Indian foods, grouped under the six categories of the USDA Food Pyramid.
**Suggestion:** Consult with your patient and family members to determine culturally appropriate foods that are already part of the household’s diet or would be possible to add to it and can be grouped under the major food categories.

### Traditional Northwest Indian Foods

- **BREAD GROUP:** Traditional Grains
  - Indian biscuits (bannock bread)
  - Dried corn
  - Lukameen
  - Mush
  - Wild oats
  - Wild rice
  - Popcorn

- **VEGETABLE GROUP:** Traditional Vegetables
  - Sprouts or new shoots
  - Peeled stems
  - Spring greens
  - Wild rhubarb
  - Indian celery
  - Wild mushrooms
  - Wild roots, such as bitter root, camas, cattail
  - Seaweed
  - Black tree moss

- **MEAT GROUP:** Traditional Meats, Fish, Birds, Eggs, and Nuts
  - Deer, elk, mountain goat, rabbit, squirrel, beaver
  - Seal or whale
  - Salmon or other fish
  - Oysters, clams, sea urchins, mussels, crabs, squid, octopus
  - Ducks, geese, pheasant, grouse, quail, chuckers
  - Eggs of salmon or birds
  - Acorns, hazelnuts, pine nuts

- **FRUIT GROUP:** Traditional Fruits and Berries
  - Wild berries, such as huckleberries
  - Chokecherries
  - Wild crab apples
  - Wild black cherries

- **DAIRY GROUP:** Traditional Calcium Sources
  - Breast milk for babies
  - Bone soup or broth
  - Fish head soup
√ Canned salmon with the bones  
√ Coush, camas, wild carrots (in large amounts)  
√ Oysters or clams  

• EXTRAS: FATS AND SWEETS: Traditional Fats and Sweets  
  √ Animal fat  
  √ Fish oil  
  √ Honey  

(Association of American Indian Physicians, 2001).

Adherence Factors

Questions to Promote Adherence
• Do you have any questions about what I explained?  
• Do you understand what I am recommending?  
• Is there anything that would make it difficult to follow my recommendations?  
• Is there anything that you think should be changed?  
(MSH, 2003b).

Providers should:  
• Acknowledge bias.  
• Value diversity and difference.  
• Look for cultural strengths.  
• Recognize the interaction of race, culture, and gender.  
• Know that culture is important to the clinical encounter.  
(MSH, 2003b).

Communication: Verbal and Nonverbal
• Handshake. A firm handshake in Anglo-American culture is a symbol of strong character, but in some American Indian groups, a limp hand is culturally appropriate and is a symbol of humility and respect. (HRSA, 2003b).

Recommendation
To enhance provider-patient communication, build culturally competent care elements into clinical practice guidelines. For example, use the mnemonics BATHE, ETHNIC, and ADHERE. (HRSA, 2003d).

• English language. More than 1 in 20 American Indians and Alaska Natives lives in a household in which no adolescent or adult speaks English “very well.” (Smedley et al., 2003).

• Some American Indians and Alaska Natives exhibit a style of communication that is reserved and may be interpreted as unfriendly. Many American Indian and Alaska Native people also exercise caution in personal communications with others. Information or problems may not be readily shared.
**Recommendation**
Do not interpret a failure to volunteer information as an indication that nothing is wrong. An American Indian or Alaska Native patient is more likely to share information if you have developed trust. (Oropeza, 2002).

- **Slow down.** American Indian languages have some of the longest pause times compared with other languages, especially English. Silence is valued, and long periods of silence between speakers is common. (Hendrix, 2002).

**Create an Atmosphere of Open Communication**
Perhaps the most important thing a provider can do to ensure that a patient adheres to recommended treatment is to create an atmosphere of open communication. The patient needs to trust that the provider is acting in his or her best interests. The patient needs to understand the purpose of the treatment and be confident that the provider has used good judgment in recommending it. What many providers overlook is that the patient needs to be able to tell the provider when he or she does not understand something about the recommended treatment—most importantly, when the treatment conflicts with the patient’s beliefs or lifestyle. Cultural factors may interfere with the provider’s ability to understand what the patient means or needs. (MSH, 2003b).

**Communicate Effectively**
- Listen to how the client describes his or her condition.
- Learn to ask questions appropriately.
- Learn to observe nonverbal behavior.
- Ask the client for his or her views.
- Know when to involve family members.
- Know when to use interpreters.
(MSH, 2003b).

- **How to refer to American Indians.** Although there is no agreement about appropriate labels, when speaking generally of American Indians rather than of a specific nation, using the word people (Indian people, Native people, indigenous people, First Nation people) may be most appropriate. When speaking of a specific nation such as Lakota, Onondaga, or Nez Perce, use of these specific labels is generally preferable to a broader term. (Weaver, 1998).

**Recommendation**
When working with a specific client, ask about that client’s preferred terms. Doing so communicates respect. (Weaver, 1998).
Keys to Communicating with American Indian Patients

1. **Greet** your patient warmly, smile, shake hands, and be friendly. The return handshake may feel softer or gentler than what you are used to.

2. **Eye contact** is expected at first greeting, but prolonged eye contact may be considered disrespectful.

3. **Do not appear to be in a hurry.** Your patient may have traveled a great distance at great expense to see you. If you spend only a brief amount of time, your patient may get a negative impression of the value of the visit.

4. During the visit, **avoid medical terms that may not be understood.** Do not speak “down” to your patient, however.

5. When you have finished speaking, **give your patient time to reflect** on what you have said. Do not be afraid of silence.

6. Your patient may not understand what you mean if you ask him or her to identify a specific location of pain. Rather than asking, “Where is the pain?” ask the patient to point to the area of most intense pain.

7. Patients may wish to perform certain **tribal healing ceremonies,** such as smudging (see the Complementary and Alternative Medicine section), even in the hospital. Try to accommodate these practices.

8. Great respect is given to the elderly. **Treat the elderly with kindness and respect** and do not appear to criticize or scold them.

9. Poverty, distance from the medical facility, and taboos against dying in the home may put a strain on the family of a patient who needs long-term or terminal care. **Discuss different care options with the family** and decide together what option is most appropriate.

10. The **extended family** plays an important role in health care decision-making. Several family members may accompany a patient when he or she arrives to be admitted to the hospital. Try to make accommodations so that family members can be close to the patient’s room or close to the hospital.

11. Work with your patients and their families to determine how best to remember to **take medications at prescribed times or return for appointments** when needed.

12. Indian culture discourages competitive behavior and encourages giving, sharing, and cooperation. **Generosity and doing things for others** are regarded highly.

(Adapted from Diversity Resources, Inc., 2001).
Communicating with Elders

- **Listening is valued over talking** by most older American Indians. Calmness and humility are valued over speed and self-assertion. (Hendrix, 2002).

- Elders frequently complain that English speakers “talk too fast.” (Hendrix, 2002).

- **Interrupting a person who is speaking is considered extremely rude,** especially if that person is an elder. (Hendrix, 2002).

- **Nonverbal communication.** A distance of several feet is the usual comfort zone. Body movements are minimal. Except for a handshake, touch is not usually acceptable. (Hendrix, 2002).

Suggestions

- Avoid the “invisible elder” syndrome and ask for the elder’s help in understanding the current situation and in planning the components of care to show respect for the elder’s experience.

- Adapt questions to the patient’s age and acculturation level. Slow down when communicating with an Indian elder, especially during initial encounters and when explaining treatments, medications, or health care decisions.

- Frame questions carefully to convey the message of caring rather than idle curiosity about the patient’s culture or cultural practices. (Hendrix, 2002).

Decision-making

**Recommendation**

Address the individual’s health problems in the context of his or her family. In many cultures, an individual’s health problems are considered the family’s problems, and it would be improper and disrespectful to exclude family members from medical interactions. Family members can provide valuable information about the patient’s diet, health behavior, daily activities, and types of alternative medications used. Their involvement in a treatment plan may be vital to the patient’s ability to adhere to the recommended treatment. Families may decide what the patient eats, when he or she takes medication, whether he or she exercises, and when he or she seeks medical attention. (MSH, 2003b).

A culturally competent provider discusses with the patient the patterns of decision-making in his or her family. Understanding and respecting the complex and often delicate interactions that exist between family members enable providers to use the patient’s family as a valuable resource, rather than seeing it as an intrusion into the provider-patient relationship. Working with the family often means working with the extended family (aunts, uncles, grandparents, etc.). (MSH, 2003b).
• **Family often extends** beyond the sphere of the traditional nuclear family. Because health care decision-making may include members of the extended family and the community, providers should consider familial influence on treatment decisions. (HRSA, 2003b).

• **Wisdom of elders.** The presence of elders is critical to the provision of culturally competent services. Elders can provide specific advice and emotional support and can guide the approach to counseling or other forms of intervention and prevention from an American Indian and Alaska Native perspective. (MSH, 2003).

**Diet**

**Encouraging Adherence to Recommended Dietary Changes**

Getting a patient to change his or her diet is difficult under ordinary circumstances, but cultural factors can complicate a patient’s ability to adhere to recommended changes. Diet is so closely related to culture that failure to incorporate a patient’s dietary customs is a recipe for noncompliance. Many cultures follow food guidelines based on religious beliefs. Some cultures have strict beliefs about the kinds of food a woman can eat during pregnancy or after giving birth.

Ask the patient about any dietary restrictions. Get a sense of the patient’s usual diet and the way foods are prepared at home. Show interest, respect, and understanding for the patient as an individual and as part of a cultural tradition, and you will be rewarded with information about dietary beliefs and traditions that will help you find suitable and appropriate ways to get the patient to make the dietary changes you propose. (MSH, 2003b).

**Historical Distrust**

• **Past injustices** may cause American Indian and Alaska Native patients to distrust their providers. (HRSA, 2003b).

• **Suspicion and mistrust** are natural outcomes and important survival skills for people who have experienced genocide. Practitioners and program planners who seek to work with American Indian people must realize that their helping interventions may be viewed in this context. (Weaver, 1998).

**Suggestion**

Patience, perseverance, and working with clients around concrete issues are ways that social workers (and health care providers) can begin to establish trusting relationships with American Indian clients. (Good Tracks, 1973).

**Interpretations of Disease and Disability**

• Physicians have many ideas about disability. For example, most doctors believe that treatment should include intervention and that biological anomalies should be corrected. However, some cultures believe that the "disability" is spiritual rather than physical or that the "disability" itself is a blessing or reward for ancestral tribulations. (HRSA, 2003b).
Western physicians are well indoctrinated about the dangers of “invisible” diseases such as hypertension and high cholesterol, but people in other cultures may not be as willing to intervene when there are no symptoms. (HRSA, 2003b).

**Complementary and Alternative Medicine (CAM)**

**Definition**
The National Center for Complementary and Alternative Medicine (NCCAM) defines CAM as follows:

“CAM covers a broad range of healing philosophies (schools of thought), approaches, and therapies that mainstream Western (conventional) medicine does not commonly use, accept, study, understand, or make available. A few of the many CAM practices include the use of acupuncture, herbs, homeopathy, therapeutic massage, and traditional oriental medicine to promote well-being or treat health conditions.

“People use CAM treatments and therapies in a variety of ways. Therapies may be used alone, as an alternative to conventional therapies, or in addition to conventional, mainstream therapies, in what is referred to as a complementary or an integrative approach.

“Many CAM therapies are called holistic, which generally means they consider the whole person, including physical, mental, emotional, and spiritual aspects.” (HRSA, 2003c).

**Use of traditional medicine and healers.** Many American Indians continue to practice tribal religions and rely on traditional medicine. One study reported that 70% of Navajos living on the reservation used traditional healers, and another found that approximately 28% of Indians living in Milwaukee and the San Francisco Bay area continued to use traditional practitioners. (Diversity Resources, Inc., 2001).

**Suggestion**
Respect traditional health practices and values and integrate them with behavioral health and wellness programs.

**Reticence.** Many Indian people who maintain traditional spiritual and healing practices will not openly discuss these practices because of their private nature, the fear of exploitation and prejudice, and a long history of persecution for their beliefs. (Weaver, 1998).

**Consulting a traditional healer first.** A patient may consult a traditional healer to diagnose or remove the cause of a disease before consulting a Western physician to cure the symptoms. (Diversity Resources, Inc., 2001).

**Home treatment.** Economic factors, knowledge about and access to herbs, and distance from biomedical care often influence the decision to seek home treatment. However, over-the-counter remedies are becoming more popular. (Diversity Resources, Inc., 2001).
• **Drum or sweat lodge.** American Indians may work with the drum or sweat lodge in healing. (HRSA, 2003c).

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**ALIGN: Improving Compliance among Patients Who Use CAM**

**Ask.** It is reasonable to assume that clients may be using one or more CAM products or practices. Research in this area shows that the majority of clients do not mention their use of CAM practices for a variety of reasons. Asking patients about their use of CAM can provide useful information and help build rapport.

**Learn.** Listen to your patients and learn what you can about their alternative approaches to healing, especially their subjective experiences with perceived efficacy. In addition, there are many books, research journals, web sites, and other resources on this topic.

**Integrate.** As appropriate, work with patients to integrate their CAM practices into the treatment plan. This can help increase compliance by working with existing beliefs, motivational tendencies, and cultural traditions.

**Grow.** In many cases, the process of inquiry and integration provides an opportunity for growth for both patients and providers.

**Network.** As knowledge of CAM increases, it may be useful to network with other interested physicians and CAM providers. Learn about the providers and suppliers of CAM services and products used by your patients. Consider the opportunity for cross-referrals, where appropriate, to trusted healers within the community. (HRSA, 2003c).

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**Navajo**

• The following are possible **causes of disease** according to the traditional Navajo belief system:
  √ Soul loss.
  √ Intrusive objects.
  √ Spirit intrusion or possession.
  √ Breach of taboo.
  √ Witchcraft or sorcery. (Diversity Resources, Inc., 2001).

• **Combined use of traditional and modern medicine.** The two approaches to health and illness are viewed as distinct but complementary. It is perfectly acceptable for a person to consult a Navajo diagnostician to identify the cause of a disease and arrange a ceremony to eliminate that cause, as well as to consult a physician to alleviate the symptoms of the disease. (Diversity Resources, Inc., 2001).

• **Navajo language and the classification of illness.** Illnesses are classified by the agents believed to cause them or the ceremonies used to cure them—such as the Wind Way, the Evil Way, the Night Way, the Plume Way, and the Earth and Beauty Way—rather than by the symptoms expressed or the parts of the body affected. The ability to describe the nuances of
pain and symptoms in the Navajo language is highly sophisticated, and patients can be good historians of their illnesses if they understand why the physician needs an accurate history. (Diversity Resources, Inc., 2001).

Specific Practices

- American Indian healers may burn herbs to purify people and places in a ritual called **smudging**. Smudging with sage, cedar, and sweet grass is performed to purify places before sacred events or meditation, before beginning an important meeting, or before offering help or healing. It is also used in health centers to keep the space clear and in places where unpleasant events have occurred (e.g., theft, violence). Traditionally, Native Americans would burn smudge in an abalone shell. In the alchemical process of transformation (in this case, purification), the four elements are represented: the shell for water, the match for fire, the herbs and ashes for earth, and the smoke for air. (Rainbow Nations, 2003).

References and Resources


Department of the Interior. (2002). Indian entities recognized and eligible to receive services from the United States Bureau of Indian affairs; Notice. *Federal Register*, Friday, July 12.


Source for Further Learning
The IHS Primary Care Provider, a journal for health professionals working with American Indians and Alaska Natives, can be obtained free of charge from this address:

US Department of Health and Human Services
Indian Health Service
Clinical Support Center
1616 East Indian School Road, Suite 375
Phoenix, Arizona 85016