American Indian Elders: need for Cultural Sensitivity in Health Care and Services

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The American Indian Public Health and Wellness System

We acknowledge that we are located on Dakota land. We recognize the vast amount of indigenous knowledge that this land has seen, and encourage everyone to be respectful of the distinctive and permanent relationship that exist between the Dakota people and their traditional territories. We would also like to pay respect to the elders, both present and past to allow us to be here today.

As sovereign nations, American Indian/Alaska Tribes (AI/AN) are responsible for the overall health and well-being of their members along with the land and environment of each of their respective tribes. Tribes are becoming increasingly involved in more public health activities and regulations. They currently deliver public health and wellness services through various funding sources including: grants, contracts, and collaborations with other tribes, federal, state and local governments.

This presentation is designed to help understand the American Indian Elders need for Cultural Sensitivity and Cultural Humility in service provisions. The lack of adequate health care and services that has resulted in a disproportionate burden of disease and social suffering on the population. History indicates that time and again health inequities are directly and indirectly associated with colonization, social support, hope, general resilient coping abilities, traditional cultural and spiritual practices, ethnic pride/enculturation, community mastery, and political inequities. And most importantly there is a **lack of humility** towards American Indian Elders and our Indigenous knowledge.

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Overview of Presentation

It is vitally import to know the true history of American Indians and Alaska Natives Elders - FIRST – to provide a platform for success into the future.

- Various definitions of culture
- Discussion of cultural humility
- General cultural implications for health service provision
- Importance of understanding historical factors and legal status about American Indians and Alaska Natives for health and wellness services
- Service suggestions for the aging AI/ANs patients/clients for the future

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Historical Health Inequities

MUST:

Understand historical injustices and longstanding structural inequities:

- Understand structural racism & the unique status of AI/AN as a **"political group", we should never be grouped with racial groups (e.g. BIPOC, POC)**
- Stop discrimination of AI/AN peoples, identities, and histories
- Stop disconnection of AI/ANs from community, identity, and culture
- Stop discrimination in opportunities, like education, jobs, and healthcare
- Stop devaluing of Indigenous ways of knowing (knowledge)
- Stop undercutting of Tribal sovereignty and respect of Tribal governments
- Stop distrust and broken relationships between Tribal nations and federal and state governments

* National Indian Health Board. (Feb. 2023). Health Equity in Indian Country: Rethinking How the Centers for Medicare and Medicaid Services Approaches Health Equity for American Indians and Alaska Natives.

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Understanding American Indian/Alaska Native Basis for Experiences with Health Services: Brief History

- When Columbus arrived it is estimated there where 10 million American Indian/Alaska Native (AI/AN) people in America.
- By 1850 the population decreased to 250,000.
- The three primary causes for decline:
  - Foreign Diseases
  - Starvation
  - Extermination
- Current populations estimates there are presently 3 million AI/AN growing to 4.3 million by 2050.
- AI/ANs have become one of the fastest growing segments of the American population.

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Tribal Governance – Cultural Changes

- Currently, there are 574 federally and 74 state recognized tribal governments.
- There remain many tribal communities that are still seeking recognition by the federal government.
- Historically before colonization overran Indian territories, there were multitudes of governance models:
  - matriarchal
  - patriarchal
  - spiritual
  - warrior
  - inherited
  - conquered
- So could one say that the current tribal governance structure is based on the "colonized/western" model?
- Basically millennia of cultural practices were discarded!

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Tribal Governance (cont.)

- Today the 574 federally recognized tribal governments all have *Constitutions*:
  - Each and every tribe has their OWN *Constitution*
- Elections are held to elect tribal leadership
  - Election governance is guided by EACH tribe's *Constitution*
    - Some elect every year
    - Some have staggered terms
- Each tribal government is directly responsive to their individual members.

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Tribal Governance (cont.)

- Tribal governments have a direct government to government relationship with the federal government.
- American Indians and Alaska Natives are identified as a **Political Group** - NOT a racial group.
- Tribal governments are not governed by states.
  - In fact some reservations have physical boundaries that cross state boundaries.
  - Others may have historical populations that now are divided by international boundaries – Canada & Mexico.
- **Some federal funding is only accessible through a state, e.g. Medicaid, various Block Grants.**

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Legal Foundation

- *Treaty of Hopwell* actually preceded the *Constitution* for dealing with the Cherokee Nation
- U.S. Constitution
- 1849 – War Department (Bureau of Indian Affairs) began providing health services
- 1921 – Snyder Act
- 1955 – Transfer Act (from War Dept. to HHS)
- 1975 – Indian Self-Determination & Education Assistance Act (P.L. 93-638)
- 1976 – Indian Health Care Improvement Act (P.L. 94-347)
- 2010 – Affordable Care Act, permanently reauthorized Indian Health Care Improvement Act

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Cornerstones of Federal Indian Policy

U.S. Constitution

• The initial court case that challenged the federal trust responsibility was: Cherokee Nation v. Georgia (1831). Note that in the *Treaty of Hopwell* actually preceded the *Constitution* for dealing with the Cherokee Nation. The court ruling further identified tribes with the unique designation of **"domestic dependent nations"**.

• Commerce Clause (Article I, Section 8, Clause 3) authorizes Congress to regulate commerce "with foreign Nations, and among the several States, and with Indian Tribes."

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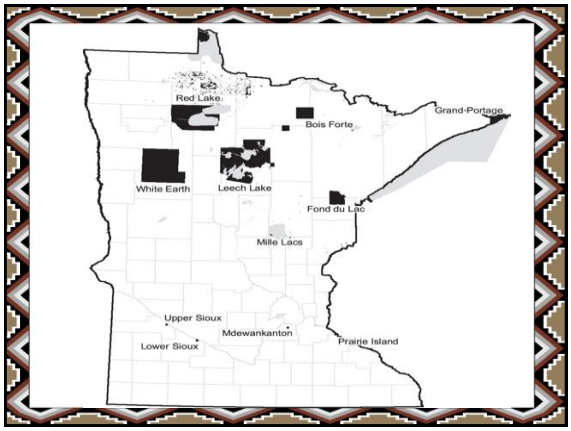

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The Indian Health System

- The Indian health system includes the Indian Health Service/Tribal /Urban. system commonly referred to as: **I/T/Us**
- The Omnibus Reconciliation Act (OBRA) of 1993, added tribal 638, and Title V, urban programs were added to the list of specific programs automatically eligible for FQHC designation

- **Indian Health Service (IHS) federal agency, established in 1955**
- **Federally Recognized Tribes and Tribal Organizations (P.L. 93-638 - compacts and contracts)**
- **Urban Indian Health Programs (UIHP) consist of 35 non-profit 501(3) (c) programs nationwide.**

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The Indian Health System - IHS

- **Federal** Indian Health Service (IHS) established in 1955
  - Divided into 12 administrative "Areas"
  - 31 Hospitals (Service Units)
  - 83 Health Centers (satellite clinics)
  - 2 School health centers
  - 35 Urban Indian Health programs
- Health facilities are located in 34 states
- The Indian health system is referred to as the Indian Health Service/Tribal//Urban system commonly referred to as: **I/T/Us.**

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The Indian Health System - Tribal

Tribes and Tribal Organizations (compacts and contracts)

- P.L. 93-638
- 15 Hospitals (Service Units)
- 538 Health Centers (satellite clinics)
  - Including 166 Alaska Native village clinics
- 9 School health centers
- 10 Regional Youth Substance Abuse Treatment Centers (both IHS and tribal)
- The Omnibus Reconciliation Act (OBRA) of 1993, added tribal 638, and Title V, urban programs were added to the list of specific programs automatically eligible for FQHC designation. (look alikes)

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The Indian Health System - Urban

Urban Indian programs

- Urban Indian Health Programs (UIHP) consist of 35 non-profit 501(3) (c) programs nationwide.
- Programs are funded through grants and contracts from the IHS, under *Title V* of the *Indian Health Care Improvement Act.*
- Approximately 45% of the UIHPs receive Medicaid reimbursement as Federally Qualified Health Centers (FQHC) and others receive fees for service under Medicaid for allowable services.

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Health Equity Practice

Condition	Disparity	vs	Asset
•Lower health status	unhealthy diet	vs	traditional food
•Shorter life expectancy	lack of physical activity	vs	cultural activities
•Disproportionate rates of disease	poor services	vs	community efforts
•Behavior or lifestyle choices	low self esteem	vs	pride in traditions/roots
•Racial & ethnic bias/discrimination	self persecution	vs	ancestor survival
•Health behavior	learned dependence	vs	revert to historical independence
•Environmental factors	toxins	vs	use traditional customs to protect (clan)
•Language	loss of identity	vs	use ancestors to identify, learn, grow
•Health literacy	the "western world"	vs	use inherent ability to adapt
•Disproportionate poverty & poor education	relocation	vs	traditional survival

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What is Culture?

- Is it race?
- Is it ethnicity?
- Is it geographical?
- Does it relate to spirituality/religion?
- Does it have familial ties/history?
- Are there different levels of culture?
- Is it possible to be multicultural?
- Can culture be open or closed? Both?
- Is there more than one culture that governs/guides an individual? e.g. "sub-cultures

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Why is Culture Important for Patient Services?

- How do you communicate with Patients or Clients?
  - Verbal
  - Visual
  - Body language
  - Face to Face
  - Gestures
  - Physical contact (e.g. shaking hands, holding hand…)
- How do you listen? What importance is **"listening"**?
- Does **YOUR** culture have any affect on communication?
- Do you believe that **EVERY** patient/client has their own unique culture?

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Why is it important to have Cultural Humility?

- Does culture affect the quality and effectiveness of services?
- Does culture affect understanding of signs and symptoms?
- Are there some questions/topics that are not parts of various cultures?
- Are there some questions/topics that cultural customs prohibit from being asked?
- Should there be traditions that culture protects?
- Can one become culturally aware, sensitive, respectful?
- Can one become culturally competent?

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How do you become Culturally Sensitive or Practice Humility?

- Cultural sensitivity is a life long pursuit.
- Cultures are continuously changing - by way of their own acceptable guides to **SURVIVE**.
- Members of cultural groups have a responsibility to be gate keepers, change agents, mentors, and willing to evolve to protect their cultural practices and populations.
- Individuals can learn to be culturally sensitive by first being respectful of their own cultures, and be humbled in other cultures (**NOT** condescending).
- It is important to never assume facts (may be myths) or assume to understand the actions of other cultures.
- When in doubt ask for advise.

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Cultural Considerations

- Consider historical issues of "trust" of health services providers.
- Consider the individual's perceptions of "normal aging" (e.g. it is "normal to lose memory").
- Does the individual's culture have "stigma" in regard to memory loss? The "A" word or dementia "demented"
- What is the individual's choice of family involvement?
  - what are the cultural expectations
  - family's responsibility to care for individual
  - does/will the family experience "shame" from others
- Are there cultural impacts for choices of ethical issues, artificial nutrition, life support, autopsies?

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Cultural Considerations (Cont.)

- Consider linguistic, economic and social experiences of the individual:
  - What is the choice of communication (self, or family member, advocate)?
  - Are there barriers to access services (including access to culturally sensitive providers)?
  - Do not place all of the family in a single culture or ethnic group.
  - Respect individual choice of:
    - Physical distance
    - Physical contact
    - Tone of voice
    - Eye contact

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Cultural Considerations for AI/ANs with Memory Impairments

- Consider each person as an individual:
  - Member of a family
  - A dual citizen
  - With tribal affiliation (if willing to share)
  - Choice of spirituality (Western or Traditional or both)
  - Language preference
  - Historical trauma (100% of all AI/ANs have a history)
- Understand that some elders have histories of horrific racial experiences:
  - Genocide (bounty on dead Indians).
  - Forced assimilation (boarding schools, harsh punishments of using Native language, clothing).

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Domestic Violence Against Older Women

- There needs to be an increase in knowledge and understanding regarding domestic violence against older women.
- Allow older women themselves to speak about how they define domestic violence:
  - their views about causes
  - reporting, interventions, and consequences for perpetrators
- What are the factors that deter or prevent help-seeking from the justice system and community agencies?
- What are the elements of outreach and intervention strategies they (elders) see as acceptable and/or desirable?

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Facts on Violence Against American Indian/Alaska Native Women

- American Indian women residing on Indian reservations suffer domestic violence and physical assault at rates far exceeding women of other ethnicities and locations.
- A 2004 Department of Justice report estimates these assault rates to be as much as 50% higher than the next most victimized demographic.
- These very disturbing findings have been common over the years. And worse in Canada.
- In a 2008 CDC study, 39% of Native women surveyed identified as victims of intimate partner violence in their lifetime, a rate higher than any other race or ethnicity surveyed.

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Develop Policies

- Central to policy development is cultural understanding, respect of traditional customs and inclusion of local leadership that is ***meaningful*** (e.g. formal consultation)
- A sense of ownership must be nourished to be inclusive of local needs
- Should advocate for equitable distribution of resources
- There should be strategies and policy developed that addresses quality assurances, evaluation, research, surveillance systems, and identified areas of concern
- Target giving people the information they need to make healthy choices
- Engage the community to identify and solve health problems
- Develop health policies and plans that include public health

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Outcome Possibilities for AI/AN Elders

- The use of culturally sensitive health service providers, who have abilities to respect individuals and collaborate with families in a "holistic" approach that had been used for centuries by indigenous peoples, are needed to provide the highest quality and effective services possible.
- Make the time to listen!!!
- It is imperative that health service providers understand the basic historical and governmental influences experienced by AI/ANs. This knowledge is a critical basis for improved understanding of cultural diversity and cultural traditions to reduce unknowing cultural oppression, subconscious racism, and dominant culture practices and policies of colonization that effect how health services are often provided today.

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Lastly, it is fundamentally necessary to understand that the Indian health system is unlike any other. It serves the poorest, sickest and most remote populations in the United States. Each tribe's culture under-grids and guides their elected leadership to meet their respective unique needs in this complex environment.

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