

## **American Indians and Alaska Natives and Cardiovascular Disease**

Heart disease is the leading cause of death for all people in the US, and stroke is the third leading cause of death. Heart disease and stroke are also major causes of disability and significant contributors to rising health care costs in the US. The mortality rate for cardiovascular disease (heart disease, stroke, and chronic obstructive pulmonary disease) is greater than the combined rates for all other leading causes of death (cancer, unintentional injuries, pneumonia/influenza, diabetes, suicide, kidney disease, chronic liver disease and cirrhosis). (US DHHS, 2000). The major risk factors for cardiovascular disease are hypertension, smoking, hypercholesterolemia, high alcohol consumption, and lack of physical activity. (Tamir and Cachola, 1994).

Cardiovascular disease (CVD) refers to a wide variety of heart and blood vessel diseases and conditions, including coronary heart disease (CHD), stroke, high blood pressure, and high blood cholesterol. CHD accounts for the largest proportion of heart disease. (US DHHS, 2000). Medical research continually contributes to a body of data that confirms that certain populations are disproportionately affected by diabetes and CVD. (US DHHS, 2003).

As recently as 40 years ago, the rates of CVD in American Indians and Alaska Natives were exceedingly low, due to a history of few cardiovascular risk factors such as diabetes, hypertension, and hypercholesterolemia. However, over the past several decades, the incidence and prevalence of these risk factors have risen significantly. The development of a diabetes epidemic and higher rates of other cardiovascular risk factors have resulted in a marked increase in the incidence and prevalence of CVD in American Indian and Alaska Native people. (Indian Health Service, 2001a).

Largely as a result of the Strong Heart Study, conducted in 13 American Indian tribes in three geographically diverse areas, the general assumption that American Indians have a lower risk of developing CVD compared with the general population has been proved wrong. (National Heart, Lung, and Blood Institute, 2001).

This section provides information on the incidence, health practices and beliefs, health challenges, and adherence factors related to CVD and stroke for American Indians and Alaska Natives.

- **Incidence and Mortality**
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## **Incidence and Mortality**

### *Mortality Rates from CVD*

- **Approximately 30% of American Indian deaths for all ages are associated with heart disease**, and the number of American Indians aged 45 years and older dying of heart disease exceeds the number of those succumbing to the next three leading causes of death (cancer, diabetes, and unintentional injuries) combined. (National Heart, Lung, and Blood Institute, 2001).
- **Heart disease and stroke**, the principal causes of CVD, **are the first and fifth leading causes of death**, respectively, among American Indians and Alaska Natives. (CDC, 2000).
- **Cardiovascular disease has emerged as the most common cause of death and a major source of disability**, hospitalization, and inpatient and outpatient procedures for American Indians. (Indian Health Service, 2003). CVD is also the leading cause of death among Alaska Natives. Mortality from CVD among Indian people has now surpassed that of the general population. (Indian Health Service, 2001a).

### *Stroke*

- Among American Indians aged 65 to 74 years, **the annual rates (per 1,000) of new and recurrent strokes are 15.2 for men and 7.9 for women**. The corresponding rates for new and recurrent heart attacks are 25.1 for men and 9.1 for women. (US DHHS, 2000).
- Little information is available on stroke rates in American Indians and Alaska Natives. The incidence of **stroke in Alaska Natives is greatest among Eskimos, followed by Aleuts and Indians**. The overall incidence of stroke in Eskimo women is higher than in any other group studied. (National Diabetes Information Clearinghouse, 2002).

## **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**

- The Strong Heart Study confirmed that **diabetes** is a major risk factor for CVD among American Indians. (National Heart, Lung, and Blood Institute, 2001).
- Results from a national telephone survey by the Centers for Disease Control and Prevention (CDC) showed that **more than 60% of American Indian and Alaska Native men and women reported having one or more of the following risk factors for heart disease and stroke:** high blood pressure, current cigarette smoking, high cholesterol, obesity, diabetes. The number of risk factors increased with age, less education, and unemployment and among those reporting their health status as fair or poor. (CDC, 2000).
- **Having two or more risk factors is common.** More than 25% of American Indian men living in the Midwest had two or more risk factors for heart disease and stroke. About 28% of American Indian women in the Northeast and 20% in the West had two or more risk factors. Regional differences in heart disease and stroke risk factors and death rates may reflect differences in cultural backgrounds, historical circumstances, and socioeconomic conditions. (CDC, 2000).
- Among American Indians aged 45 to 74, **26.8% of men and 27.5% of women have high blood pressure**, defined as definite hypertension: systolic blood pressure of 140 mmHg or higher or diastolic blood pressure of 90 mmHg or higher on one occasion, or those currently taking antihypertensive medication. (Indian Health Service, 2001b).
- **Only 50% of American Indians and Alaska Natives have had their cholesterol checked within the past two years.** (Cohen and Goode, 1999).

### *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).

### *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).
- **Rates higher among Alaska Native women.** Current Population Survey data for 1992–1993 showed a higher smoking prevalence among Alaska Native women (46%) than among American Indian women in the continental US (35%). (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).

### **Strengths and Protective Factors**

#### *Leisure Activities*

- **Physically active leisure pursuits.** The most common leisure activities reported by male participants in the Strong Heart Study were gardening, walking, and hunting, whereas walking, gardening, and dancing were most popular among women. The men in all three areas of the study were at least 50% more active than the women were. Both men and women from the Dakotas were more active than participants from Arizona and Oklahoma. (National Heart, Lung, and Blood Institute, 2001).
- **Relatively less television viewing.** The average number of hours of TV viewing per day for the men and women in each area of the Strong Heart Study was less than that cited by the Nielsen Report on TV watching by people aged 54 and older. (National Heart, Lung, and Blood Institute, 2001).

#### *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/>.

#### *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).

### **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).

## Diet

### **Eating Your Way to a Healthy Heart**

Planning meals aimed at reducing blood cholesterol doesn't have to be complicated. Here are a few suggestions for American Indians and Alaska Natives from the web site of the American Indian Health Council (<http://aihc1998.tripod.com/>):

- Choose fish, poultry, and lean cuts of meat, and remove the fat and skin before eating. Eat no more than about six ounces per day.
- Broil, bake, roast, or poach foods rather than fry them.
- Cut down on high-fat processed meats, including sausage, bacon, and cold cuts such as salami and bologna.
- Limit organ meats such as liver, kidney, and brains.
- Use skim or low-fat milk and cheese and low-fat or nonfat yogurt.
- Instead of butter, use liquid or soft margarine or vegetable oils high in unsaturated fats. Use all fats and oils sparingly.
- Eat egg yolks only in moderation. Egg whites contain no fat or cholesterol and can be eaten often.
- Eat plenty of fruits and vegetables, as well as cereals, breads, rice, and pasta made from enriched or whole grains (e.g., rye bread or whole wheat spaghetti).
- Many packaged and processed foods are high in saturated fats, so get in the habit of reading food labels. Look for the "Nutrition Facts" on the label, and choose products that are low in fat and saturated fat. Also read product labels for cholesterol content.

(American Indian Health Council, 2003).

- **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
  - √ Cough, 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).

## **Service Interventions**

### **Culturally Appropriate Encouragement to Get American Indians to Exercise More**

“Getting started with exercise is much like having a garden. With our gardens, we have a plan and set a goal, to make a garden and have vegetables, even though we may not say I’m planning a garden and my goal is to have vegetables.

“Just like you plan your garden with the goal of having vegetables, you can plan your exercise with the goal of lowering your blood sugar.

“Just like your family and friends help you with your garden, by weeding and watering, family and friends can help you with your exercise goal by exercising with you, watching the children while you go for a job, and walking to the post office with you. What else can you think of?” (Native American Diabetes Project, 2003).

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