

## **American Indians and Alaska Natives and Immunizations**

Infectious diseases are still major causes of illness, disability, and death. Moreover, new infectious agents and diseases are being detected, and some diseases that were once considered under control have reemerged in recent years. In addition, antimicrobial resistance is evolving rapidly in a variety of hospital- and community-acquired infections.

Vaccines can prevent the debilitating and in some cases fatal effects of infectious disease. Although vaccines have helped eliminate the illness and disability of polio, measles, and rubella, for example, the organisms that cause these diseases have not disappeared. They have only receded and have the potential to reemerge if vaccination coverage drops. Vaccines protect more than the vaccinated individual—they also protect society.

Historically, childhood vaccination rates have been lower in certain minority populations compared with the majority population. Immunization efforts need to be intensified, particularly to increase vaccination coverage for children living in poverty. Substantial numbers of undervaccinated children remain, particularly in large urban areas with traditionally underserved populations, causing concern about potential outbreaks of disease.

Many adults are also at increased risk for vaccine-preventable diseases. Vaccination coverage against pneumococcal infections and influenza among African Americans and Hispanics, for example, remains substantially below that of the general population. (US DHHS, 2000).

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### **CHILD**

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## ADULT

Recommended immunizations for adults aged 65 and older include a yearly vaccine against influenza and a one-time vaccine against pneumococcal disease. Most of the deaths and serious illnesses caused by influenza and pneumococcal disease occur in older adults and others at increased risk of complications because of other risk factors or medical conditions. (US DHHS, 2000). Vaccination is an effective strategy to reduce illness and death due to pneumococcal disease and influenza.

Immunization coverage levels in adults are not as high as those achieved in children, but the health effects may be just as great. Barriers to adult immunization include not knowing that immunizations are needed, misconceptions about vaccines, and lack of recommendations from health care providers.

Federal initiatives have highlighted the need to focus vaccination resources on adults. Current levels of coverage among adults vary widely among age, risk, and racial and ethnic groups.

Opportunities for vaccination outside of primary care and other traditional health care settings could be increased to reach elderly persons who do not routinely access primary care. For example, more than 90 million emergency department visits are made in the US annually. Emergency department vaccination would likely increase vaccination rates among select populations that are difficult to vaccinate through office-based programs. In any nontraditional site, a method for tracking vaccinations and communicating vaccination information to patients' primary care providers is needed. (US DHHS, 2000).

### **Recommended Adult Immunization Schedule**

The Advisory Committee on Immunization Practices of the Centers for Disease Control and Prevention (CDC) has provided a schedule and guidelines for immunizing adults against tetanus; diphtheria; influenza; pneumococcal disease; hepatitis B; hepatitis A; measles, mumps, and rubella (MMR); varicella (chickenpox); and meningococcal disease. The CDC also provides immunization guidelines for adults with medical conditions such as diabetes, heart disease, leukemia, renal failure, and HIV infection. You can access the Recommended Adult Immunization Schedule, United States, 2002–2003, and the Recommended Immunizations for Adults with Medical Conditions, United States, 2002–2003, at <http://www.cdc.gov/nip/recs/adult-schedule.pdf>. (CDC, 2002b).

### **Incidence of Preventable Diseases**

- In 1997, the **rate of new hepatitis A infections in the American Indian and Alaska Native population was 23.1 per 100,000**, compared with 24.2 in the Hispanic population, 8.1 in the white population, and 6 in the African-American population. (US DHHS, 2000).

## **Immunization Rates**

- **American Indians of all ages in Minnesota are less up-to-date with immunizations than are whites.** Less than 50% of American Indian children were up-to-date with immunizations at 8, 17, and 20 months of age. (Minnesota Department of Health, 2001).

### **No Stereotyping!**

There are more than 560 federally recognized tribes in the US, and about 100 others are recognized by individual states. (Department of the Interior, 2002). Health beliefs, practices, and status may vary greatly among different tribes, among different regions, and, as for members of any population group, among individuals. Each community and its individuals are unique, and it is dangerous to generalize.

- **Less than 50% of American Indian elders in Minnesota have been vaccinated against pneumococcal disease,** one of the leading causes of death in American Indian communities. American Indians are also at higher risk for hepatitis A than are other Minnesotans. In 1992, more than 38% of the 884 cases of hepatitis A in Minnesota were in American Indians. Hepatitis A vaccine can protect American Indian children against infection. (Minnesota Department of Health, 2001).

## **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).

#### **Pertinent Fact**

Residents in urban settings are at **increased risk for exposure to hazards** 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).

- 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).

## **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/>.

### *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).

## **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).

#### *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).

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