



Healthy Generations

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Disparity and Dispossession, Hope and Healing: Health in American Indian Communities

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*"In my mind, disparity and dispossession go hand in hand. The massive dispossession that removed native people from their ancestral lands – not to mention the genocide and cultural eradication that followed– can hardly be imagined by most people...wherever there has been dispossession we see in the dispossessed populations significant damage in health, in educational levels, and in social wellbeing."*¹

There are over 400 separate American Indian tribes in the United States, including 336 federally-recognized tribes in the contiguous 48 states. Tribal groups differ widely in culture and language, and each tribe has its own criteria for tribal membership.² This means that broad generalizations about health practices and beliefs must be made with caution. However, most American Indian cultures have a broader understanding of "health" than is common among the majority white culture. As Michael Bird, past President of the American Public Health Association notes, indigenous peoples have much to offer, including an understanding of the role of spirituality in health, the concept of the well-being of all vs. the few, the value of family and family wellness, and the importance of balance in one's life and life choices. "Together, we are strong and capable. We are not the sum of our disparities."¹



Photo by Dr. Lana White-King

There are over 4 million people in the United States who identify as American Indian, or about 1.5% of the total US population.⁴ This number grew by 255% since 1960, due to more people choosing to identify as American Indian, combined with relatively high fertility and improving survival.⁴ Overall, the American Indian and Alaskan Native population in the US is younger than the population overall – 33% are under age 18 compared to 26% of the total population.

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This issue of Healthy Generations takes up the topic of health in American Indian communities. While many public health professionals are aware of the great health disparities between American Indians and whites, this issue attempts to also address related factors such as the history of American Indian people in North America, historical trauma, community empowerment, and the role of researchers. Hopefully, it will encourage readers to learn and investigate further, and to not allow another 500 years of health disparities to continue.

For their help in conceptualizing this issue, I would especially like to thank Valerie Larson and Sharon Smith, Minnesota Department of Health; Jennifer Irving, American Indian Family Center; Allison LaPoint, Great Lakes EpiCenter; and Kris Rhodes, Division of Epidemiology and Community Health at the University of Minnesota.

Our next issue of Healthy Generations will focus on the topic of public health and war. If you have comments or questions, please let us know. We like to hear from you!

Diane Benjamin, MPH

Continued from front page

More also live below the poverty line. Twenty-six percent of American Indians are poor, according to the Census Bureau, compared to 12% of the overall population. For some tribes, the percentage is as high as 39%. The majority of American Indians today do not live on reservations; 64% live outside of reservations and other tribal areas, although many retain ties to reservations.⁵ Federal policies in the mid-20th century encouraged relocation to urban areas, and economic opportunities on many reservations are extremely limited, which also encourages migration to urban areas.

Health Disparities

The issue of health disparities for American Indian communities is not new, as David Jones notes in a recent article: “During the past 50 years, the IHS [Indian Health Service] has improved health conditions dramatically, but disparities persist. American Indians continue to experience some of the worst health conditions in the United States. Although this persistence is striking, it is even more striking that the disparities have existed not for 50 years but for 500 years. From the earliest years of colonization, American Indians have suffered more severely whether the prevailing diseases were smallpox, tuberculosis, alcoholism or other chronic afflictions of modern society.”⁶

While estimates vary greatly, the size of the American Indian population in North America before European contact was 2-12 million. Epidemics, war, and US government policies diminished the population to a few hundred thousand people by 1900. Smallpox killed more American Indians in the early centuries after colonization than any other disease or conflict. It was not unusual for entire tribes to die. It is even arguable that colonization would not have succeeded if tribes had not been first weakened by smallpox and other infectious diseases to which they had no immunity.⁷

This history of disparities has lessened but not ended, beginning with smallpox and other infectious diseases, continuing on to deadly tuberculosis epidemics in the 1920s to current disparities in almost all of the leading causes of mortality in the general population.

Health officials and politicians alike have advanced many explanations for these disparities, usually to serve the political interests of the time. These explanations often held American Indians themselves responsible for their own poor health or attributed disparities to genetic differences or even God’s will. However, as David Jones notes, “The existence of disparities regardless of the underlying disease environment is actually a powerful argument against the belief that disparities reflect inherent susceptibilities of American Indian populations. Instead, the disparities in health status could arise from the disparities in wealth and power that have endured since colonization.”⁶

Specific data about maternal and child health disparities in the Upper Midwest shows significant and persistent disparities across a range of indicators. Rates of infant mortality, prenatal care, smoking during pregnancy, and overweight among WIC-enrolled children are all worse for American Indians in Minnesota, Wisconsin and Michigan than for the overall population.⁸ Additional data for Minnesota shows that

American Indian communities experience more births to teens, higher rates of unintentional injuries and violent injuries, higher rates of breast and cervical cancer, and lower immunization rates for children.⁹

Health Care Access

Beginning in 1955, the federal government established the Indian Health Service (IHS), a system of hospitals and clinics on or near reservations and some urban areas to meet the health care needs of American Indians. However, IHS only serves 1.5 million out of approximately 4 million self-identified American Indians. Some people are not eligible for IHS services because they are not members of federally recognized tribes; others do not live in areas where IHS services are available. A survey in the late 1990s found that American Indians overall had less insurance coverage and worse access and utilization of health care services than whites. In addition, over half of low-income uninsured American Indians did not have access to the IHS.¹⁰ Adding to this situation is the chronic under-funding of IHS. Per capita expenditures for Indian health care were about one third as much as for individuals in the general US population in 2001. A final important trend in the IHS system is a move to tribal management of health programs, which now accounts for about half of the IHS budget.¹¹ There is some evidence to suggest that tribes that manage their own health programs are able to provide more new health programs, build more new facilities and collect more third-party reimbursements.¹²

Improving Health and Eliminating Disparities

Along with significant challenges to health, American Indian communities possess many strengths and assets on which to build, and there seems to be some agreement on changes that would improve the health and well-being of Indian people. One article on developing a holistic approach to resolving American Indian/Alaska Native health care disparities delineates three strategies: culturally appropriate health education; promotion of educational opportunities for American Indian health care workers, especially nurses; and mentoring of students and new health professionals.¹³

However, moving beyond improvements to health education and training more American Indian health professionals, others advocate for more comprehensive change by developing community capacity. These frameworks and strategies include indigenous approaches to knowledge and community values and indigenous perspectives not typically included in Western models of capacity building. This capacity building also must acknowledge and heal the wounds caused by racism, colonization, and health disparities. As a recent article on this topic notes, “An indigenous model must reflect indigenous reality. It must integrate the past, the present, and the people’s vision for the future.”¹⁴

Special thanks to Dr. Lana White-King and Ricky White for allowing us to include a photo of their daughter, Memengwa, in this story.

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Web-Based Resources on American Indian Health

American Academy of Pediatrics - Native American Child Health www.aap.org/nach This link has information specifically about the health of Native American children.

American Indian Policy Center www.airpi.org/ Provides information about the legal and political history of American Indian nations, and the contemporary situation for American Indians. Site contains research reports and publications from the Center.

Association of American Indian Physicians www.aaip.org/indian_health/indian_health.htm Contains an extensive set of health links along with information on the Association's programs.

CDC Office of Minority Health - American Indian/Alaska Native Populations www.cdc.gov/omh/Populations/AIAN/AIAN.htm Contains background and census data, information on various health disparities, and links to national organizations committed to addressing these disparities.

Indian Health Service (IHS) www.ihs.gov A federal agency responsible for providing health services to American Indians and Alaska Natives. Contains a comprehensive list of health related programs, services, and resources.

MedlinePlus: Native American Health www.nlm.nih.gov/medlineplus/nativeamericanhealth.html A comprehensive list of trusted links and resources on Native American health, including statistics, research, directories, organizations, and information on prevention/screening, nutrition and specific conditions.

NLM American Indian Health <http://americanindianhealth.nlm.nih.gov/intro.html> A web resource that brings together health and medical resources related to the American Indian population. Site includes policies, consumer health information, research and links to a variety of documents, web sites, databases, and other resources.

NARCH - Native American Research Center for Health www.glitc.org/narch/index.html This collaboration between the Great Lakes Inter-Tribal Council, Wisconsin Tribes, Wisconsin Universities and others provides a cooperative structure for the development and implementation of high quality, culturally sensitive and community supported research linked to health disparity issues. Site contains overviews of current projects.

National Center for American Indian and Alaska Native Mental Health Research www.uchsc.edu/ai/ncaianmhr/ncaianmhr_index.htm One of four minority mental health research centers in the country, focusing specifically on American Indian and Alaska Native populations. Site includes research projects, articles, and various publications on mental health.

National Congress of American Indians (NCAI) www.ncai.org Serves as the major national tribal government organization in this country. Site contains information on issues relevant to American Indians and Alaskan Native populations, including health care.

National Indian Health Board www.nihb.org A non-profit that advocates on behalf of all tribal governments and American Indian/Alaska Natives in their efforts to provide quality health care. Site contains health policy, information on various health topics, and other health resources.

Historical Trauma: American Indians Recovering From Abuses of the Past

Tina Deschenie

Natural disasters and terrorism have raised national awareness of major human trauma. In fall 2005, Hurricanes Katrina and Rita forced hundreds of thousands of people to evacuate from their homes.

Among American Indian people, these times bring to mind the trauma suffered by our ancestors: The Trail of Tears during the 1830s removed 18,000 Cherokee, Muscogee, and hundreds of other Indians from the Southeast to Oklahoma. (Over 4,000 Cherokee died, either in stockades where they were imprisoned before removal, or along the way.) In 1863 on the Long Walk, over 8,000 Diné and Apache were herded to incarceration at Fort Sumner, NM. (About 2,000 died.) In 1890, hundreds of Lakota were killed at Wounded Knee, SD.

Another wave of forcible removal during the early 20th century wrenched Indian children from their homes and placed them in boarding schools, separating them from their families and communities and sometimes subjecting them to physical and sexual abuse. Each removal left Indian people in the most destitute of circumstances, forced to rebuild their lives without resources.

Most never returned to their homelands, and their communities were forever shattered. There were no Red Cross or crisis response teams to deal with the aftermath of Indian genocide (the specific intent to destroy a national, ethnic, or religious group). Removal of Indians from their homelands was the United States' government policy for many years.

Today, the pain has not diminished among the descendants. While they have survived, Indian people continue to exhibit the aftereffects, as evidenced by high rates of alcohol and substance abuse, suicide, broken families, poverty, and related mental health issues.

Maria Yellow Horse Brave Heart, PhD, explains that Indian people suffer from historical trauma. "Historical trauma is cumulative psychological and emotional wounding across generations," she says, "including one's own life span, and comes from massive group traumatic events and experiences." Brave Heart (Hunkpapa Lakota and Oglala Lakota) recently discussed historical trauma with Tribal College Journal.

TCJ: What are symptoms of historical trauma?

Brave Heart: Historical trauma response includes survivor guilt, trauma, anger, depression, and sadness. It also involves self-destructive behavior with alcohol and substance abuse, suicidal thoughts and gestures, anxiety, low self-esteem, difficulty recognizing and expressing emotions, somatic (physical) symptoms, and high mortality rates.

TCJ: How did you become interested in historical trauma work?

Brave Heart: I was influenced by Indian activism, which brought attention to broken treaties and past massacres in the late 1970s. Around that time, I was home looking at historical photos and became overwhelmed with grief. I started sobbing and realized I was carrying something that was bigger than me,



bigger than my own family and community. I became aware of carrying the grief and trauma of our ancestors. Some repetitive childhood dreams began to make sense and I later discovered my spiritual and professional path - to help our people heal from this trauma that we carry.

TCJ: Tell us about your professional training.

Brave Heart: When I was 14 years old and a Head Start volunteer, I worked with a little girl who would not eat, nap, or talk. I talked to her daily until she joined the other kids. I knew then I could work with people and maybe help them. So, I got a bachelor's degree in psychology, a master's degree in social work, and a PhD in clinical social work. I also took psychoanalytic training courses. My work has been mostly reservation-based, but I have worked with urban American Indians in Denver and in New York. Currently I am director of the Takini Network, an affiliate of the University of Denver Graduate School of Social Work, and also serve on the faculty at the university.

TCJ: Tell us about the Takini Network.

Brave Heart: In 1992, a core group of facilitators formed the Takini Network. Takini is a Lakota word that means survivor or "to come back to life." Through presentations, healing events, and parent training, we seek to restore our communities and move beyond survival to empowering our people. We have conducted more than 100 workshops on historical trauma. Our team has extensive experience in providing and evaluating substance abuse treatment, prevention, and related mental health and human service programs. As a Native-based organization, we are grounded in Lakota and other Native philosophy and values, and we use these as the core organizing principles of our work and our worldview.

TCJ: How did you build your knowledge base in historical trauma?

Brave Heart: I learned traditional Lakota ways through ceremonies and from talking with healers and elders. I also read, researched, and connected with other massively traumatized groups. Dr. Eva Fogelman, a Jewish Holocaust therapist in New York City, shared what she did with children of Holocaust survivors and how she trained providers. She validated that our work was on target. Dr. Donna Nagata and Dr. Rita Takahashi also shared their work with Japanese American World War II internment camp survivors and descendants. I also used my connections with indigenous peoples from other parts of the Americas.

TCJ: How do people overcome historical trauma?

Brave Heart: I prefer to say healing rather than overcoming. The healing is like a wound that leaves a scar - it hurts less and shrinks over time, but it remains. Like grief literature says, we cannot grieve alone. Mourning is a communal experience. So, I think that our historical trauma intervention is the most effective thing we have at this time—it is a beginning, it gets us started down that healing path and can be followed up by some individual work.

We began with the Lakota but work now with many different tribes. Each group adapts the intervention to fit its tribal culture. We start by conducting an orientation and overview and a community presentation. Next we plan the 4-day event and adapt it to fit the tribal culture, and then we deliver the training over four days, ideally. We also do follow up when requested.

TCJ: Is it difficult for people to revisit trauma?

Brave Heart: Our method of having people revisit trauma is paced so that we limit feelings of being overwhelmed. We recommend holding interventions in a safe, retreat-like setting where people feel nurtured. We structure the intervention to build on peoples' strengths while they also face their trauma and grief. By focusing on our common histories, people find the courage to face their pain as a communal pain.

TCJ: What is involved in the parent training?

Brave Heart: We offer emotional support to parents to help them see how their own lifetime trauma, including negative boarding school experiences, affects their relationships with their children and how it impacts their parenting skills. We help parents to understand how trauma across generations has also affected their own experience as children.

TCJ: How do you deal with people who deny historic trauma affects them today?

Brave Heart: We let those in denial know that we carry this trauma, even if it is not conscious. It affects our health, our emotions, our behavior, our relationships, and our children. We remind people that we have a responsibility to our ancestors, our children, and the next seven generations to heal from this. We respect each person's place and their right to follow their own spiritual path. However, in the Takini Network, we feel that our spiritual and cultural traditions are extremely helpful in healing and transcending the trauma.

TCJ: Do you also work with Christian church groups?

Brave Heart: I have conducted some historical trauma workshops for Indian church groups with much success. We only blame individuals at fault—not entire institutions. People are free to choose their own spiritual path, and we respect that, although some church officials may feel threatened. I even presented several years ago at a mission boarding school, at their invitation. I think there are many people who have a higher self that wants to heal, hear the truth, and rectify the wrongs.

TCJ: What has been a challenge for you recently?

Brave Heart: The most challenging thing for me has been lack of funding to do the work that needs to be done. I am not giving up! Calls from tribes keep coming in.

TCJ: Who are your heroes? What are your thoughts about contemporary heroes?

Brave Heart: My foremost hero is Sitting Bull because he devoted his life to protecting the people, especially women and children. Although misrepresented in history books, he was a very spiritual person dedicated to preserving the Lakota way of life.

About contemporary heroes, it is unfair to expect our modern healers and leaders to be superhuman. We have a teaching among the Lakota that our healers are *ikce wicasa* (common people), just human beings that the spirits talk to and through. They are not *wakan* (sacred); we all deserve respect. We each have potential to connect directly with spirits ourselves, which we need to remember and nurture in ourselves.

I know none of the heroes I name here are perfect, and I have many more, but here are a few. Dan Crazy Thunder and others who went to Ground Zero in New York City are modern *akicita* (warriors who kept order in the camp) and are heroes to me. My brother Virgil Kills Straight had the vision for the Big Foot Memorial Ride, sacrificed years to helping our people, and was instrumental in starting Oglala Lakota College.

The counselors who work for little pay or support are my heroes. I think we need to treat everyone in our lives as heroes in their own way.

Tina Deschenie, a member of the Diné Tribe, is a language activist and a poet who lives in Farmington, NM with her family. She is a frequent contributor to Tribal College Journal. Deschenie serves on the board of FIVE, Inc. (Fostering Indigenous Values in Education).

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The Challenge of Infant Mortality

See Moua and Diane Benjamin, MPH

Infant mortality is an important marker of the overall health of a community, since the health of communities can be measured by the health of its youngest members. It is often the “tip of the iceberg,” reflecting the host of complex and interacting factors that affect the health of American Indian communities. Some of these factors include socioeconomic conditions, the health status of the mother (before and during pregnancy), lack of health insurance coverage, unmet needs such as preventive care and accessibility of care to the mother and infant, racism and chronic stress, and the absence of social support networks. Thanks to a variety of advances, the infant mortality rate among American Indians is no longer as high as it used to be. However, American Indians still experience disproportionately higher infant mortality rates than either whites or Asians.

Rates of Infant Mortality in American Indian Communities

During the period 1995 to 2002, 2,915 American Indian infant deaths were reported in the United States. The infant mortality rate (per 1,000 live births) was 9.1. This compared to rates of 13.9 for African Americans, 5.9 for whites, 5.8 for Hispanics, and 5.0 for Asians/Pacific Islanders.¹ From 1989-1991 to 1998-2000, the infant mortality rate declined among American Indians by 33%.² Although disparities still exist, the infant mortality rate for all racial groups has decreased due to a number of factors: vaccinations for childhood diseases, antibiotics for bacterial infections, supine rather than prone sleep position to prevent Sudden Infant Death Syndrome (SIDS), and advances in neonatology for preterm babies.³

Factors Associated with Infant Mortality

According to National Center for Health Statistics, in 2003 leading causes of infant deaths include congenital abnormalities, preterm/low birth weight, sudden infant death, and problems related to complications of pregnancy.⁴ A recent analysis shows that babies born to American Indians suffer from higher rates of infant mortality due to increased incidence of conditions that occur **after** birth. Most of the disparity in rates occurs because of deaths from sudden infant death syndrome, injuries, and pneumonia and influenza.²

Sudden Infant Death Syndrome (SIDS) American Indian infants have higher SIDS rates than white infants. SIDS deaths among American Indian infants are 2.5 times the rate for white infants.² In-

fant exposure to environmental tobacco smoke has been associated with increased rates of SIDS and hospitalizations for lower respiratory infections. Since smoking rates among pregnant American Indian women are quite high, interventions to reduce parental smoking and environmental tobacco smoke may also help reduce deaths from SIDS as well as decrease deaths from respiratory infections.⁵

A case-control study conducted among Northern Plains Indians identified lack of public health nurse visits, maternal alcohol use prior to pregnancy and binge drinking during the first trimester, and two or more layers of clothing worn by the sleeping infant as important risk factors for SIDS. Rates of maternal smoking and prone sleep position did not vary significantly between SIDS babies and the control group.⁶

Intentional and Unintentional Injuries. (Unintentional injuries include motor vehicle crashes, suffocation, falls, and drowning.) A study of unintentional injury and homicide deaths during the first year of life using linked birth and death data found that American Indian infants were at a higher risk than any other racial or ethnic group for unintentional injuries.⁷ Factors related to this disparity may include alcohol use, more driving and lower use of child safety seats, and unsafe housing.⁸

Strategies to Improve Infant Survival

Because the causes of infant mortality are complex and involve biology, behavior, and the environment,⁷ public health workers and others must continue to expand from a focus on prenatal care to more broadly address the health needs of women before and after pregnancy. “It just not about their physical health, but also their spiritual, emotional, and mental health too,” notes Jennifer Irving, Women’s Health Program Manager at the American Indian Center in St. Paul, Minnesota. Some strategies focus on individual-level interventions, including access to family planning services, good maternal nutrition, smoking cessation, and better sleep positions for infants. Additional systems-level interventions include fetal and infant mortality review (FIMR)

of individual infant deaths to identify community strengths and weaknesses as well as the health and social issues that result in those deaths. The FIMR team is made up of leaders from across disciplines and organizations, with the goal of improving community resources and the health care system.⁹

Prevention of post-neonatal deaths can be aided through home visits.



“Increasing home visits, particularly local tribal home visits, can be one of the best strategies to reducing infant mortality,” says Cheryl Fogarty, Infant Mortality Consultant at the Minnesota Department of Health. She notes that American Indian communities have many strengths and traditions to draw upon. “Families and the whole community go through an extremely difficult time when a baby dies,” says Fogarty. “We must work together to change social environments and systems of health. We must work together to bring more support to what has already been proven to be effective.”

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See Moua is an MPH student in the MCH Program

U of MN Center of American Indian and Minority Health

The University of Minnesota Center of American Indian and Minority Health (CAIMH) strives to raise the health status of the Native American population by educating Native American students in the field of health care and Indian Health. CAIMH provides support to Native American students to attain their medical degree, with many returning to their own communities to deliver culturally sensitive health care to their own people.

The Indian Health Pathway was developed by CAIMH to support American Indian pre-health professions students and medical school students throughout all stages of their education and stresses the importance of allowing each American Indian student to retain unique qualities and belief systems that are the essence of being American Indian while progressing through the educational system.

CAIMH works with medical school applicants for both the Medical School Duluth and the Medical School Twin Cities campuses. More information can be found at: www.caimh.org/home.

MCH MPH Online Degree Program Now Enrolling Students

The Maternal and Child Health Program (www.epi.umn.edu/mch) at the University of Minnesota’s School of Public Health is offering a distance learning Master of Public Health (MPH) degree for MCH professionals.

Who should apply: The program is designed for working professionals whose goal is to advance to leadership roles in Maternal and Child Health:

- Individuals with an advanced degree (e.g., MD, MSW, MSN, MS, PhD, DrPH) and 5 or more years of work experience in MCH OR
- Individuals without an advanced degree who have 8-10 years of work experience in MCH.

Focus of the program: The program focuses on the principles of social justice and concern for vulnerable populations. Graduates of the 42-credit program will develop expertise in evidence-based advocacy, rigorous public health assessment, accessible and appropriate health education, and effective and innovative programs that promote the health and well-being of infants, children, youth, families, and women.

Program delivery: The training is delivered through a combination of online courses and short intensive courses offered during a 3-week Public Health Institute held each spring at the University of Minnesota’s Twin Cities campus.

Tuition: Irrespective of residency, all students will be charged in-state tuition.

Deadlines: Application deadlines are Feb 15 (for May admission), April 15 (for fall admission) and Sept 15 (for spring admission).

For more information: Visit our website at www.epi.umn.edu/mch, or contact the MCH Online Program Director, Joan Patterson at (612) 624-1394 or joan.patterson@epi.umn.edu or the MCH Major Chair, Charles Oberg at (612) 625-6616 or oberg@epi.umn.edu.

Diane Benjamin, MPH

American Indian communities have a long and often problematic relationship with health researchers. In the past, most health research was conducted by researchers who were neither members of the community nor culturally aware. Community members often did not benefit from the research and they were often treated as subjects rather than partners.¹

Donald Warne, writing in the *Journal of Transcultural Nursing*, has developed a series of questions raised by conducting health research in American Indian communities. Some of these questions are:

1. Can the community members trust that the research team will conduct research in an appropriate manner with respect to issues like ownership of data and samples?
2. In terms of data ownership, who will house the data set?
3. Will the community be involved in authorship and publication?
4. Will the research result in benefit to the community?

He further notes that the benefits of American Indian communities becoming partners and co-researchers in the research process include improved trust by providing communities a voice in research agenda setting and design; increased benefit by involving the community in linking results to application through program and policy development; greater understanding in the research and academic communities of cultural factors and other issues that lead to health disparities in the population; and improved cultural appropriateness of research design, implementation, and characterization of results.²

Community-based participatory research has emerged as a more acceptable form of research with American Indian communities. To support this type of research, the Native Research Network began in 1997 to “establish and maintain a proactive research network of indigenous people of the Americas and to promote research among indigenous populations that is conducted in a culturally sensitive and respectful manner.” It provides opportunities for networking and mentoring, sponsors events and conferences, and provides assistance to communities and tribes. Non-indigenous researchers are welcome, but they are non-voting members and must be sponsored by an indigenous member as well as have a letter of support from the American Indian community in which they have worked.³

The University of Minnesota has many research projects with American Indian communities that demonstrate the effectiveness of community involvement in research. A few of them are highlighted here.

Native Teen Voices. Feelings about Sex, Pregnancy, and Parenting. The Native Teen Voices Survey collected information from urban Native American teens concerning their feelings about sex, teen pregnancy, school, family relationships and their behaviors, such as sex, problem solving, out of school time, and their involvement in Native American cultural and spiritual activities. The survey data were collected in 2004 as part of a

research partnership between the Twin Cities Native community and the University of Minnesota’s School of Public Health. Data collection was Native-led through focus groups and written surveys completed by youth. More information about the study is available at www.ntv.umn.edu or contact Wendy Hellerstedt, hellerstedt@epi.umn.edu

American Indian Community Tobacco Project. The American Indian Community Tobacco Project (AICTP) is a unique partnership between the University of Minnesota School of Public Health and the Twin Cities American Indian Community. The project is addressing tobacco addiction in the American Indian community by designing, conducting, and applying research on the issue. More specifically, it does this by: utilizing research methods that are consistent with American Indian cultural practices and beliefs; identifying the larger social, historical, and policy context within which the urban American Indian population has reached disproportionately higher rates of tobacco misuse; and developing specific intervention strategies that take advantage of the traditional strengths of American Indian people. More information about the project is available at www.epi.umn.edu/research/aictp/index.shtm or contact Kris Rhodes, rhodes@epi.umn.edu

Indian Family Story Project. The goal of the Indian Family Stories Project has been to listen and learn from families who care for American Indian children with special health care needs in order to improve the quality of health care they receive. Based on families’ stories, the project worked in partnership with families, communities, and health care providers to improve care and develop culturally relevant resources for American Indian children and their families. Components include the Indian Family Asthma Project, an assessment of barriers to care for American Indian children with special health care needs, an instructional video to enhance cultural competence of health care professionals, and the Indian Asthma Video Project. www.nursing.umn.edu/IndianFamilyStoriesProject/index.html or contact Ann Garwick, garwi001@umn.edu

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2. Warne D. Research and educational approaches to reducing health disparities among American Indians and Alaska natives. *J Transcult Nurs* 2006;17:266-271.
3. Satter DE. The Native Research Network: promoting culturally sensitive research in indigenous communities. *The IHS Primary Care Provider* 2004;61-2. More information about membership in the Native Research Network is available at <http://www.aaip.org/about/forms.htm>.

Additional resources and information about community-based participatory research are available at the Community-Campus Partnerships for Health website: <http://depts.washington.edu/ccph/commbas.html>.



Diane Benjamin, MPH

In South Minneapolis, the Indian Parents Program is working to help a new generation of children and their parents overcome the difficulties of the past. “For many urban American Indian families, much traditional knowledge—teachings around identity, values, and parenting — have been lost due to historical circumstances,” says Carol Ladd, Program Director at the Division of Indian Work in Minneapolis. Ladd notes that many American Indian families come from a legacy of abusive boarding school experiences, where children were forcibly removed from their parents and communities, forbidden to speak their languages and practice their religion, and sometimes exposed to abuse. This left previous generations with little or no experience of normal family life to pass on to their children. The result of this is that even today, many disconnected families still suffer from trauma, chemical abuse, and mental health challenges.

The Indian Parents Program offers prenatal, parenting and nutrition classes to Indian mothers ages 13 to 22 and 22 and older, resources for Indian fathers to improve their relationship with their children, free and confidential pregnancy testing, a tradition Native doula service to help mothers-to-be with labor and childbirth, and two reduced-rent apartment complexes for young moms who cannot find affordable and safe housing for themselves and their children. Families live at Apa-Waste (“New Beginning”) and Anpa-Waste Numpa (“New Beginning Two”) while the mothers find work or attend school. In 2005, the program served 242 parents and children and 35 healthy babies were born to program participants.

The program is designed to form a continuous path from pre-conception through parenting, thus participants often remain in the program for several years. Ladd reports that program participants are eager to gain cultural knowledge. The program brings in elders who are knowledgeable about traditional parenting practices. They offer lodge-time to all families as well as ceremonies such as baby-naming. Many different Nations are represented by staff members who connect participants with their specific tribal heritage and traditions.

The program also addresses the needs of American Indian fathers. Instead of holding separate programs for fathers, they are invited to join together with the mothers group, which creates a sense of “extended relations” for participants. The program finds that young fathers want to be involved, but they often feel discouraged about stepping up. With advocacy and direction, these fathers can become involved in their families’ lives and “be there” as fathers.

One challenge to sustaining the program financially and programmatically is that the parents it serves face huge barriers and require intensive assistance and intervention to succeed. It takes time and consistency. The program tries to keep a manageable caseload for its social workers and other staff, but it can take several years for a young parent to become self-sufficient. However, the program continues to expand, creating healthier birth outcomes, seeing parents graduate to economic self-sufficiency, and helping children grow up, in the words of the project’s brochure, as “proud and honorable American Indian children.”



Thanks to Carol Ladd, Director, Indian Parents Program, Division of Indian Work, for information used in this article.

For more information: www.gmcc.org/diw/index.html.

Second International Meeting on Indigenous Child Health

The 2nd International Meeting on Indigenous Child Health will be held April 20-22, 2007 at the Fairmont The Queen Elizabeth in Montreal, Quebec. Child health providers and researchers who work with American Indian, Alaska Native, First Nations, Inuit, and Metis children and families are encouraged to attend. The meeting will build upon the successes of the first International Meeting on Inuit and Native American Child Health held on April 29 - May 1, 2005.

The 2nd International Meeting is jointly sponsored by the American Academy of Pediatrics, the Canadian Paediatric Society, the Indian Health Service, and the First Nations Inuit Health Branch, Health Canada. Please note that US attendees will need a passport or other secure, accepted document to enter Canada.

More information is available at: www.aap.org/nach/2InternationalMeeting.htm

Understanding Infant Deaths: The Aberdeen Area Perinatal Infant Mortality Review Committee

Diane Benjamin, MPH

The Aberdeen area of the Indian Health Service (IHS) has the highest infant mortality rate among all IHS service areas. The Aberdeen Area Perinatal Infant Mortality Review (PIMR) committee was developed in the late 1980s and continues to meet twice each year. Its purpose is to improve the classification of the cause and manner of death, to identify preventable causes of infant death, and to report these to tribal leaders, IHS health care providers, and the Aberdeen Area IHS. The Aberdeen Area Office of the IHS in Aberdeen, South Dakota, provides health care to approximately 94,000 Indians on reservations located in North Dakota, South Dakota, Nebraska, and Iowa. The committee is made up of IHS physicians, nurses, staff, Tribal members, Tribal Healthy Start staff, and the Aberdeen Area IHS Women's Health Nurse Consultant, who chairs the group. The committee also includes pathologists, epidemiologists, physicians and nurses with expertise in SIDS from across the US.

Much of the work of the committee is done prior to actual case reviews. This includes identifying infant deaths through multiple methods and extracting data from birth, death, and medical records. Typically, 25 to 30 deaths are reviewed at each meeting. The committee discusses each case to determine the cause and manner of death and to identify preventable factors. When these factors are identified, the PIMR makes recommendations to the local IHS service unit, health care providers, and other appropriate agencies with suggestions for change.

A recent review of infant deaths in the area from 1998 to 2002 found that SIDS accounted for 33% of the deaths. The Aberdeen Area of the IHS has had elevated SIDS rates for many years, but the reasons for this are not clear and there are additional projects underway to address this risk. (One such project is the Healthy Native Babies project, an educational intervention using culturally appropriate materials. More information is available at www.healthynativebabies.org.) Infant mortality was also very recurrent, with 32% of mothers in the case reviews having a previous infant death. This pattern of recurrent mortality supports the importance of careful investigation of all infant deaths, increased support for these mothers during pregnancy, and additional support such as home visiting after births.

Some of the challenges of doing these reviews include the rural nature of the area. Infant deaths may occur 100 miles from a health care facility with expertise in infant mortality or pediatric services, and autopsies might be conducted up to 300 miles from the site of the death. Severe winter weather for up to five months of the year also hinders travel. The PIMR works with 19 individual Tribal Nations spread over four states, with widely differing belief systems about infant deaths.

The PIMR committee has achieved many successes over their years of work. Completeness of local death reviews has improved. A pool of knowledgeable personnel on the reservations has developed. The committee connects parents, childcare workers and others with grief support services. Infant death review is now an expectation and the results are used in developing prevention strategies. Finally, data from the effort has

helped attract additional funding and researchers for prevention and services to high risk infants, families and communities.

As members of the Aberdeen Area PIMR note, "Each infant death is now not just an isolated tragedy, but rather an event requiring careful examination of what happened and an opportunity to improve care for the next infants in these communities...Each one of these deaths has a story to tell. Each story has a lesson. While we still have much to learn, the tragedy of each infant death furthers our education. This knowledge is necessary to give each future baby the opportunity for life."

Information in this article comes from Eaglestaff ML, Klug M and Burd L. Infant mortality reviews in the Aberdeen Area of the Indian Health Service: strategies and outcomes. *Pub Health Rep* 2006;1212:140-148.

U of MN School of Public Health 2007 Summer Public Health Institute May 21 – June 8

This year's Summer Public Health Institute will offer a series of MCH and Nutrition courses designed to strengthen and expand the abilities of health and human service professionals. These graduate-level courses can be taken to fulfill degree or certificate requirements or serve as continuing education units.

Of the nearly 60 courses offered, those specific to MCH are as follows:

Assessment, Prevention and Treatment of Child and Adolescent Obesity; 1 credit; May 29-June 1; Jamie Stang and Melissa Nelson, faculty. An overview of child and adolescent obesity from a public health perspective.

Community-Based Participatory Research; 1 credit, May 29-June 1; Wendy Hellerstedt and Kathleen Call, faculty. Attendees will be exposed to various research designs, ranging from those that emanate from the community, community-academic partnerships, and academic research projects that depend on community participation.

Motivational Interviewing: Strategies to Effect Behavioral Change; 1 credit; May 21-23, May 25; Joan Patterson, faculty. Course is designed as an introduction to the theoretical basis of the MI style. Emphasis will be placed on demonstration and practice of MI skills/strategies.

Women's Mental Health and Reproductive Outcomes; 1 credit; May 29-June 1; Bernard Harlow, faculty. Course will include didactic lectures followed by a seminar format to assess current knowledge regarding the relationship between psychiatric morbidity and adverse reproductive events.

For complete course descriptions, schedules and registration information go to www.cpho.sph.umn.edu/institute or call 612-626-4515 to request an Institute catalog.

Interested in making a difference?

Consider a Master's in Public Health (MPH) Degree in Maternal and Child Health (MCH)



Tiffany Beckman, MD, MPH, an enrolled member of the Leech Lake Band of Ojibwe, is a proud graduate of the MCH Program at the University of Minnesota. She is currently an Assistant Professor and Endocrinologist at the University of Minnesota, who also plans on working as a consulting endocrinologist with the Shakopee Mdewakanton Sioux Community and serving in their mobile clinic.

Beckman got her start in the health professions when she entered the MCH program in 1993. Although she had always wanted to become a physician, several mentors suggested that she would benefit from first receiving an MPH degree. Dr. ten Bensel, former chair of the MCH program, encouraged her to enroll and she found that the field of maternal and child health fit with her interests and passions.

During her time in the MCH program, she developed an interest in obesity and diabetes through her course work and research assistantship. Her final project was a review of the literature which focused on gestational diabetes and offspring obesity and diabetes in the Pima Indians. This work deepened her interest on the impact of the intrauterine environment on children.

"The MCH program gave me a more global perspective that many of my medical colleagues don't often share," said Beckman. "Medicine is often fractionated and health care is more expensive than it needs to be. Often times, the focus is not prevention." Using a public health approach, however, "you can intervene more naturally through changes in programs, policies and the community environment, rather than just administering a drug."

Dr. Beckman's current research and clinical practice focuses on obesity and diabetes prevention and treatment, with a special interest in nutrition in Native populations. She feels that her current work is "like coming full circle" leading back to her public health beginning.

What is the Maternal and Child Health Program? An MPH training program promoting and preserving the health of families, women, children, and adolescents. It is in the Division of Epidemiology and Community Health in the School of Public Health at the University of Minnesota.

Who are the faculty? The MCH faculty is multidisciplinary (e.g., epidemiology, medicine, nursing, psychology, sociology, nutrition) and focuses on children with chronic health conditions; reproductive health and family planning; pregnancy outcomes; social inequities in health; women's health; infectious diseases; substance use; and child, adolescent, family, and community health promotion, risk reduction, and resiliency.

Who should apply? People who care about vulnerable populations and want careers in program planning and development, evaluation, surveillance, assessment, teaching, or research. The program offers a special emphasis on MCH epidemiology for interested students.

For further information about the MCH Program call 612-626-8802 or 1-800-774-8636; e-mail gradstudies@epi.umn.edu; or visit www.sph.umn.edu/education/mch/home.html.

Stay in the Know! Join our MCH Leadership Education Center Listserv!

Do you ever have a question that you know someone in your field could answer if you could only connect with him or her? Have you ever had a great success that you know would be helpful for colleagues to hear? Have you ever sponsored a program that you know would attract more people if you only knew how to share the event with others? Would you like to receive announcements, research updates and links to publications via email?

The Maternal and Child Health Program in the Division of Epidemiology and Community Health in the School of Public Health at the University of Minnesota sponsors the cyfhealth listserv to enhance networks between professionals working to improve the health and well-being of children, adolescents and their families.

The listserv can be used to share ideas, new research developments, resources, and event announcements. In addition, the listserv helps inform academicians of the training needs of public health practitioners.

To sign up for the listserv, send an email message to: cyfhealth-request@epi.umn.edu. In the body of the text write: SUBSCRIBE cyfhealth.

If you have problems with the subscription process, you may also send an email to pearson@epi.umn.edu requesting to be subscribed.

Save these dates for upcoming regional conferences ...



May 3-4, 2007: Minnesota Organization on Adolescent Pregnancy, Prevention and Parenting Annual Conference. "Broadening Our Perspective: Refining Our Approach." Earle Brown Heritage Center, Brooklyn Center, MN. Co-sponsored by the Center for Leadership Education in Maternal and Child Public Health. www.moapp.org/conference.html

May 15-16, 2007: 20th Annual National MCH Leadership Conference. Hilton Garden Inn, St. Charles, IL (Close to both O'Hare and Midway Airports.) Sponsored by the University of Illinois at Chicago Maternal and Child Health Program. www.uic.edu/sph/mch/mch_leadership_conference.htm

July 24-25, 2007: MCH Summer Institute on Addressing Health Disparities. "Connecting Communications and Health." HHH Center, University of Minnesota West Bank. Sponsored by the Center for Leadership Education in Maternal and Child Public Health, School of Public Health, University of Minnesota. www.epi.umn.edu/mch

July 25-27, 2007: The 2007 National Maternal Nutrition Intensive Course. HHH Center, University of Minnesota West Bank. Sponsored by the Public Health Nutrition Program, School of Public Health, University of Minnesota. www.publichealthplanet.org

Both July conferences combine for an overlapping day. Highlights include a focus on health communications and health literacy, a sneak preview of an exciting new PBS documentary on health disparities, panel discussions, break-out sessions, and much more. Registration for both conferences opens soon and registration information will be at www.epi.umn.edu/mch.

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