NATIONAL DIABETES PREVENTION PROGRAM AUDIENCE PROFILE

AMERICAN INDIANS & ALASKA NATIVES

This profile provides general information and resources for teams working with health promotion and diabetes prevention programs among American Indian and Alaska Native (AI/AN) communities. It highlights information to enhance your understanding of working with AI/AN communities by providing social and health demographics, including diabetes prevalence, and actionable approaches to building relationships. This document is not an in-depth research report or analysis, and it is recommended that you engage members of the AI/AN community and diabetes prevention program managers in your area for guidance and to provide input on specific program efforts.

NATIONAL DIABETES PREVENTION PROGRAM

Overview of AI/AN Communities

There are 574 federally recognized Tribal nations in the United States.[1] Over half of these are Alaska Native Tribes. Additionally, there are about 240 nonfederally recognized Tribal nations.

Sixty percent of AI/AN persons live in metropolitan areas, including Los Angeles, CA; New York City, NY; Phoenix, AZ; Oklahoma City, OK; and Anchorage, AK.[2]

Twenty-two percent of AI/AN persons live on Tribal reservations.[3]

According to the 2016 American Community Survey, 27 percent of AI/AN persons speak a language other than English at home.[4]

As of 2017, the AI/AN population alone or in combination with one or more other races represents 1.7 percent of the overall U.S. population.[3]

Native culture is central to the identity of Tribal nations and Native people. While there is great diversity across and within communities, some similarities exist within regions based on adaptation to ecology, climate and geography, and linguistic and cultural affiliations. Many AI/AN communities place great value in the importance of cultural knowledge, a sense of community, traditional foods, and connection to the land. AI/AN cultural customs include food, dress, dance, ceremony, drumming, song, stories, symbols, and other activities.

Spirituality. A strong respect for spirituality, whether traditional, Christian (as a result of European influence), or a combination of both, is common among AI/AN communities. Some AI/AN populations have a strong church community and organized religion, which is integrated within their culture. Traditional spirituality and organized religions often focus on the community rather than the individual.

SOURCES OF STRENGTH AMONG AI/AN COMMUNITIES:

- Extended family, kinship ties, and support systems
- Laughter and a strong sense of joy as a positive cultural value
- Collective community responsibility and pride
- Physical resources such as traditional foods, plants, and animals
- Indigenous generational knowledge and wisdom
- Tribal sovereignty
- Elders are valued
- Resiliency in the face of multiple challenges
- Traditional language and cultural practices such as storytelling and passing of traditions
- Ability to walk in two worlds (mainstream culture and AI/AN culture)

It is important to keep in mind that specific practices (ceremonies, prayers, religious protocols) will vary among different AI/AN communities, and therefore generalizations should not be made.

Community gatherings. Sharing food and resources is a way of welcoming visitors, similar to offering a handshake in many situations. Local, harvested traditional foods are often offered at community meetings and other gatherings as a way to build relationships.

TRIBAL SOVEREIGNTY

As sovereign nations, Tribes determine their own governance structures; pass and enforce laws; and administer multiple programs and services, including emergency services, social programs, education, workforce development, infrastructure, and energy and land management. Treaties and laws between Tribal nations and the United States create what is known as the Federal Trust Responsibility. This protects Tribal lands and sovereignty, supports Tribal relationships with the federal government, and provides for federal assistance to ensure the success of Tribal communities.[5]

Impact of Colonization on AI/AN Communities

Colonization—the takeover and attempted subjugation of AI/AN communities by European settlers—has had a traumatic impact on AI/AN peoples. Due to forced geographic relocation, many Tribes are currently not living on their ancestral lands. Western colonization and forced assimilation of AI/AN persons resulted in historical trauma, loss of language, geographic isolation, poverty, loss of cultural and foodway traditions, and lack of access to resources that continue to directly affect the health and well-being of these communities. While the impact of colonization varies across AI/AN communities, understanding and considering these dynamics can help you maximize the reach and effectiveness of your program efforts.

HOUSEHOLD INCOME

THE MEDIAN HOUSEHOLD INCOME FOR AI/AN PERSONS IS **$40,315** COMPARED WITH **$57,652** FOR THE U.S. POPULATION.[1]

UNEMPLOYMENT RATE

SEVEN PERCENT IS THE UNEMPLOYMENT RATE FOR AI/AN PERSONS COMPARED WITH **4 PERCENT** FOR THE U.S. POPULATION.[6]

POVERTY RATE

TWENTY-SEVEN PERCENT OF AI/AN PERSONS LIVE BELOW THE POVERTY LINE COMPARED WITH **15 PERCENT** OF THE U.S. POPULATION.[1]

DISABILITY STATUS

TWENTY-FOUR PERCENT OF AI/AN PERSONS QUALIFY AS HAVING A DISABILITY COMPARED WITH **19 PERCENT** OF THE U.S. POPULATION.[7]

COLLEGE EDUCATION

FIFTEEN PERCENT OF AI/AN PERSONS AGE 25 AND OLDER HAVE A BACHELOR'S DEGREE OR HIGHER COMPARED WITH **32 PERCENT** OF THE U.S. POPULATION.[8]

Lifestyle and diet. Colonization has played a significant role in the lifestyle and health practices of AI/AN communities over the years. Through the 1940s, traditional diets of fish, meat, and foods that were high in fiber and low in carbohydrates were common, and diabetes was rare. Hunting and fishing also supported active lifestyles that helped prevent obesity. However, forced assimilation to Western culture and ways of life, including nutrient-poor food commodities, led to an increase in the rate of disease and health issues. Industrial developments in the mid-1900s (see text box on the right) on some Tribal lands further limited Tribes' abilities to harvest their traditional foods.[9]

Historical trauma. Many research studies discuss the challenges AI/AN communities faced as a result of Western colonization, including economic exploitation, segregation into reservations, forced acculturation through boarding schools that separated families, and violence. In some cases, different AI/AN groups were forced to coexist on reservations, causing repercussions that some communities still experience today. This resource provides more information: Tips for Disaster Responders: Understanding Historical Trauma When Responding to an Event in Indian Country.

Lack of funding. The U.S. Indian Health Service (IHS), which administers health care for AI/AN communities across the country, has faced a chronic funding shortage that has further contributed to health disparities among AI/AN persons.

For centuries, the Pima-Maricopa and Akimel O'odham people channeled the waters of the Gila and Salt rivers in the Sonoran Desert in Arizona through irrigation systems that secured their foods. In the 1950s, the U.S. Army Corps of Engineers diverted the rivers for construction of the Coolidge Dam, which made the land unsuitable for farming. By 2006, 38 percent of adults age 20 years and older in this area had type 2 diabetes.[10]

Prevalence of Diabetes Among AI/AN Communities

While many AI/AN communities experience a high prevalence of diabetes and related risk factors including overweight and obesity, rates vary by gender and age. People who are overweight are more likely to have diabetes, high blood pressure, and high cholesterol, which are all risk factors for heart disease and stroke.[11]

- Fifteen percent of AI/AN persons age 18 and older have diabetes compared with 8 percent of non-Hispanic Whites.[12]
- AI/AN adults are 50 percent more likely to have obesity than non-Hispanic Whites.[11]

MEN

AI/AN men have one of the lowest life expectancies of any demographic group. The gender gap in life expectancy is higher for AI/AN men than women (8 years lower than women for AI/AN men versus 6 years lower for men in other populations).

Fifteen percent of AI/AN men have diabetes.[12]

ELDERS

While only 9 percent of the AI/AN population is over the age of 65 (compared to 14 percent for the U.S. population), AI/AN Elders are more likely to experience barriers to medical care and have more difficulty with daily activities.

Thirty percent of AI/AN people age 65 and older have a diabetes diagnosis.[13]

Health Care Delivery to AI/AN Persons

Indian Health Service. The Indian Health Service (IHS), an agency within the U.S. Department of Health and Human Services, oversees health care delivery for Indian persons through direct IHS, tribally operated, and urban health clinics. The IHS's Division of Diabetes Treatment and Prevention addresses the disproportionate impact of diabetes among AI/AN persons.

Special Diabetes Program for Indians. The Special Diabetes Program for Indians (SDPI) funds 301 community grants in 35 states that implement diabetes prevention and treatment programs. The SDPI Diabetes Prevention Program Toolkit provides keys to success and lessons learned from 38 SDPI diabetes prevention programs throughout Indian Country.

Tribal health care self-governance. Congress recognized the importance of Tribal decision-making and nation-to-nation relationships between the United States and Tribes through the 1975 Indian Self-Determination and Education Assistance Act (ISDEAA) (Public Law 93-638). By 2000, Congress permanently authorized the IHS Tribal Self-Governance Program by creating Title V of ISDEAA through Public Law 106-260.

Urban Indian Health Program. About 7 out of 10 AI/AN persons live in urban areas.[14] IHS addresses the health of urban-based AI/AN persons by funding 41 Urban Indian Health Program (UIHP) sites in U.S. cities, providing comprehensive, culturally appropriate health care, outreach, and referral.

Building Relationships With the AI/AN Community

It is important to develop relationships and build trust within AI/AN communities. This includes taking the time to get to know community members, developing trust, and showing respect for the individual. Program officials should reach out to Tribal leaders to identify formal and informal Tribal partners and decision-makers who can help ensure that appropriate Tribal protocols and processes are considered when engaging their communities.

TRUSTED SOURCES AND INFLUENCERS

Tribal Elders. Tribal Elders are culturally important figures across different AI/AN groups, and their endorsement is highly important.[4] In many Tribes, Elders are often asked to offer opening and closing words at meetings or ceremonies and are given a small gift as a sign of respect for sharing this offering.

Healers. Traditional medicine and healers may play both ceremonial and active roles in the AI/AN health care system.[15] Qualitative interviews conducted with AI/AN individuals have found that healers' wisdom and perspectives are highly valued. It is recommended that you work with Tribal leadership, including Elders, to identify whether and how healers may support health education efforts.[16]

When working with AI/AN communities, it is important to practice cultural humility—defined as a lifelong process of self-reflection and self-critique whereby the individual not only learns about another's culture, but one also starts with an examination of her or his own beliefs and cultural identities.

Outreach With AI/AN Communities

Below are strategies for conducting outreach with AI/AN populations.

HEALTH PROMOTION STRATEGIES

AI/AN communities have long-standing traditions around communication that can be real strengths when incorporated by health programs.

Use of storytelling. AI/AN cultures often focus on key stories and narratives that are communicated orally within communities and families and during special events. These stories relay key experiences and help form the core elements of AI/AN identity.[4,17] Successful programs have conducted health promotion by telling stories. For example, a CDC diabetes prevention program used the narrative of a "River of Hope" to document the Native response to diabetes.[18]

Community-driven outreach. Outreach to AI/AN persons should be community-driven and focus on personal relationships, using local sources of information such as community centers and local media. Program officials should keep in mind that internet access and bandwidth are often limited and unreliable, especially in remote and rural communities, which may limit the usability of web-based outreach and initiatives.[19]

HEALTH INFORMATION AND INFORMATION SEEKING

Many AI/AN communities see social and health problems as part of a holistic worldview of the balance between mind, body, spirit, and the environment. As a result, solutions to these challenges may be, at least in part, spiritually based.

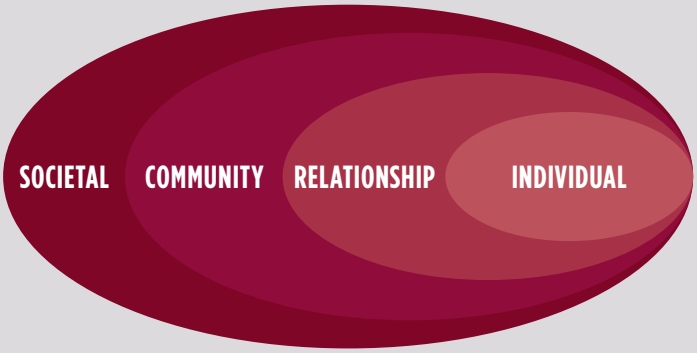
- IHS offers support for programs working with AI/AN communities, including educational materials and training information, on its Division of Diabetes Treatment and Prevention webpage.
- CDC's Native Diabetes Wellness Program honors a balance between cultural practices and Western science in Indian Country to promote health and help prevent type 2 diabetes among AI/AN persons who are at risk.

MEDIA TRENDS

Tribal newspapers and radio are often a good resource for how AI/AN communities access health information.

- The Michigan State Library has a Native American studies research guide that includes a newspaper collection.
- There are nationally organized outlets such as Native Voice One and Native Public Media, as well as stations that serve specific geographical locations. In addition, the National Museum of the American Indian curates a list of Native radio stations.
- Red Nation TV and First Nations Experience (or FNX) are national television and streaming platforms directed to AI/AN audiences, although the national or online nature of these platforms makes them ill-suited for tailored local marketing.
- A recent study of health information among AI/AN persons in Arizona found that 13 percent of individuals most recently received information from a pamphlet and the same amount received information from television.

The socio-ecological model is a prevention framework used to further the understanding of the dynamic interrelations among individual, relationship, community, and societal factors.



Considerations for Messaging

A socio-ecological model of health promotion is helpful in understanding the multifaceted and interactive effects of personal and environmental factors on behavior and can be used to guide and inform marketing and engagement efforts. Messages and approaches to health should be consistent with cultural values and reinforced through storytelling, gratitude for the gifts of the Earth, and generosity in sharing harvested foods throughout communities.

Gender roles. Gender roles can vary significantly among different AI/AN communities. Each community may have gender-specific protocols related to, for example, eye contact, style of dress, physical touch, personal space, decision-making, and the influence of male and female Elders.

Representation. It is important to engage with members of the AI/AN community when representing AI/AN groups in the media as part of outreach efforts. This includes traditional medicine healers. As discussed above, traditional healers are critical to the Native American health care system and should be engaged in the development and distribution of outreach materials.[20]

Community gatherings. An important facet of AI/AN culture is the occurrence of frequent cultural events and gatherings. These are great opportunities for health promotion programming, as they emphasize health-positive cultural elements like traditional dances and food. They are also opportunities to market your program through partnerships and vendor opportunities.

Community driven. Community-driven health promotion and education efforts are a critical first step to program development. Advisory boards, community needs assessments, and engagement with Native American Tribal liaisons are good ways to learn from AI/AN community members about their needs and approaches for addressing those needs. Focus groups, interviews, and surveys can also support understanding of community perceptions. Engaging local artists and storytellers to highlight cultural variations and meanings will be beneficial. Translating program materials into Native languages will help people to understand the messaging and the program.

FOR ADDITIONAL INFORMATION ABOUT WORKING WITH AI/AN COMMUNITIES, PLEASE ACCESS THE RESOURCES HIGHLIGHTED BELOW:

American Indian/Alaska Native Culture

A Giant Step to Joy: Understanding Historical Grief and Trauma

American Indian and Alaska Native Culture Card

"Walk softly and listen carefully": Building Research Relationships With Tribal Communities

Diabetes Prevention for American Indian/ Alaska Native Communities

Living a Balanced Life With Diabetes

Native Wellness Diabetes Program

Special Diabetes Program for Indians Diabetes Prevention Program Toolkit

The Art of Storytelling and Use of Culturally-Adapted Tools to Educate on Diabetes Prevention

Keys to Success: How to Enroll and Retain American Indian Participants for Your Type 2 Diabetes Prevention Lifestyle Change Program

QUESTIONS TO HELP GUIDE AND INFORM AI/AN DIABETES PREVENTION PROGRAM EFFORTS

COMMUNITY BACKGROUND

- ❑ What is the demographic background of the AI/AN population in your region? (e.g., population percentage, age, gender, country of origin, language, economic status).
- ❑ What percentage of AI/AN individuals have diabetes or prediabetes?
- ❑ What are the cultural backgrounds and language differences among the local AI/AN community?
- ❑ Within your community, are there groups that represent AI/AN persons?

HEALTH CARE AND HEALTH INFORMATION SEEKING BEHAVIORS

- ❑ Where specifically does the local AI/AN population go for health care services?
- ❑ How accessible is health care within the community, especially for AI/AN persons?
- ❑ Are the health information seeking behaviors the same or different for AI/AN persons when compared with other populations within the community? If they are different, how?
- ❑ Who are the trusted sources for health information in the local AI/AN population? Are health sources different or the same as other trusted sources?

TRUSTED SOURCES

- ❑ Who are the trusted thought leaders in your local community—specific to the AI/AN community (i.e., Elders, spiritual leaders) or in general?
  - Community based organizations? Faith communities? Health care providers? Vocal advocates?
- ❑ Who are the leaders and champions or gatekeepers for these groups? With whom do you need to collaborate?
- ❑ How can you use these trusted sources to help you with marketing and promoting your lifestyle change program?

MEDIA HABITS

- ❑ Which media channels—including social and digital media—are most popular or preferred among AI/AN persons in your community?
- ❑ What relationships do you have with these media outlets? Who do you need to reach out to?
- ❑ What infrastructure does your organization have to use popular social and digital channels? What media channels do you need to strengthen?

MESSAGES

- ❑ Are your messages culturally sensitive? Do they reflect cultural humility?
- ❑ Do you have images that will resonate with the local AI/AN population?
- ❑ Are you working with community organizations or groups that will be able to assist with message development for your marketing materials?

BARRIERS AND BENEFITS TO THE NATIONAL DIABETES PREVENTION PROGRAM

- ❑ What are the specific barriers to promoting the lifestyle change program in your community?
- ❑ How will you work to mitigate these barriers?
- ❑ What lifestyle change program benefits are meaningful to your audience? How can you work these benefits into your marketing materials?
- ❑ What does your lifestyle change program offer the community that other disease prevention programs or events do not—or can't—offer?

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