Cultural Competence: What Is Needed in Working With Native Americans With HIV/AIDS?

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American Indian and Alaskan Native (AI/AN) people have a unique culture that is misunderstood by many health care professionals. There are nearly 2.5 million AI/ANs living in the United States in 300 different tribal or language groups and governed by 569 different tribal governments (U.S. Census Bureau, 2002). The myriad of ethnicities within the population labeled AI/AN or Native American makes it difficult to identify the scope of the HIV/AIDS problem under today's system of classification. Throughout the evolution of the health care system, AI/AN populations have experienced, as have other minorities, less than adequate attention with regard to specific and culturally appropriate treatment and prevention programs (Dickey, Tafoya, & Wirth, 2003). Perhaps nowhere is this more evident than in the area of HIV/AIDS prevention and treatment.

In 2000, then-U.S. Surgeon General David Satcher issued a call for action on the HIV/AIDS crisis in AI/AN communities. He stated an urgent need among Native communities as well as federal and state organizations and community health care providers to work together in an effort to fight the HIV/AIDS epidemic and to bring awareness to community members (Satcher, 2000). According to the Centers for Disease Control and Prevention (CDC, 2002), as of December 2002, there were 2,875 AIDS cases among AI/ANs. However, although the actual number of reported HIV/AIDS cases among Native Americans is relatively low, in this small population, the number is alarming. The number of AIDS cases has doubled among this population within the last 5 years (CDC). In the period from 1996 to 2002, AIDS incidence decreased markedly among Whites, Blacks, Hispanics, and Asian/Pacific Islanders but increased among AI/ANs (CDC). During that same time period, the number of deaths from AIDS also declined among all racial groups except AI/ANs (CDC).

Many health professionals estimate the number of AIDS cases among AI/ANs to be much higher than what statistics are currently reporting and that the number of HIV cases could be as much as 10-times greater (Satcher, 2002). For example, a study of drug treatment patients conducted from 1991 to 1994 in New York City showed that the number of Native Americans testing positive for HIV was comparable to that of African Americans (Walters, Simoni, & Harris, 2000). This may indicate higher rates of HIV among AI/ANs within certain geographical populations.

As with other minority populations, there is still a great stigma associated with HIV/AIDS within AI/AN communities. Among AI/ANs, concerns over confidentiality are evident because of the close-knit communities in which they live and the tremendous

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stigma of homosexuality. Many AI/ANs are not seeking testing for HIV because of this concern. As a result, underreporting of HIV among this community remains high. In addition, many Native Americans are misclassified by health care providers as Hispanic, Caucasian, African American, or Asian. During data reporting, this misclassification skews the statistics of the AI/AN population, resulting in underreporting of HIV/AIDS cases.

Risk Factors

Despite reporting inconsistencies, it is important to recognize that HIV/AIDS is a significant burden among the AI/AN population. In addressing this burden, it is important that health care providers understand the unique risk factors and barriers affecting this population and develop the ability to overcome any obstacles in the process.

The AI/AN population is disproportionately affected by many of the social and behavioral factors associated with increased risk of HIV infection. Weaver (1999) notes that high rates of sexually transmitted diseases among Native Americans may serve as an indirect measure of high-risk sexual activity. In 2001, rates of gonorrhea were 3.9 times higher in the AI/AN population than in Whites (CDC, 2002). In fact, in 2001, rates of gonorrhea among AI/ANs increased another 5.2; Hispanics were the only ethnicity who had a more significant increase. The percentage of women 15 to 30 years of age screened at clinics of the Indian Health Service testing positive for chlamydia ranged from 3.1% to 10% that same year.

According to statistics compiled by the National Campaign to Prevent Teen Pregnancy (2004), AI/AN high school students are more likely to have had sexual intercourse and have higher teen birth rates than the national average, and AI/AN female students were less likely to have used condoms during their last sexual encounter. Each of these factors makes this population more at risk for contracting HIV.

Domestic violence also raises concern within the AI/AN culture. Various health agencies working with AI/AN girls and women report rates from 46% of their clients having been physically abused to 60% of their pregnant clients currently being with an abusive partner. One agency working with an Apache reservation reported that up to 75% of its clients had been abused (Hamby, 2000). Each of these circumstances places women in a situation in which they are powerless to demand protective contraception during intercourse, thus placing them at risk of exposure.

Another contributing risk factor for HIV infection is alcohol and substance abuse. LaBrie and Earleywine (2000) reported that an initial review of studies attempting to correlate alcohol use and risky sexual behavior were mixed. However, their study involving 346 college students (using a survey instrument that does not require participants to answer sensitive questions directly) reported that indeed alcohol consumption had a clear impact on risky sexual behavior. Additionally, Kalichman, Weinhardt, DiFonzo, and Austin (2002) further reported alcohol use outcome expectancies, and alcohol used in sexual contexts was closely associated with unprotected sexual intercourse. Alcohol and substance abuse have long been challenges for AI/AN populations. According to Hanson and Venturelli (1998), in a 1995 study of college students and drinking, Native American students had the highest frequency of drinking episodes, binge drinking, and memory loss related to alcohol. Shaughnessy (2003) noted in a study of AI/AN students who attended schools funded by the Bureau of Indian Affairs that 80.7% of the students reported lifetime alcohol use, 48.8% reported current use, and 38.4% reported episodic heavy drinking.

Socioeconomic factors also play a role in health status for this population. According to the Population Resource Center (2003), only 538,300 AI/ANs live on reservations or land trusts. Of all races, the lowest percentage of AI/ANs, approximately 66%, live in metropolitan areas. As such, many live in rural areas where access to health care services is often limited. The poverty rate for AI/ANs between 1998 and 2000 was 26% higher than all other racial or ethnic groups (Population Resource Center). This also corresponds to health care access in that transportation issues may make it difficult to access whatever health care resources are available. Poverty rates also affect nutritional status, not only in the potential availability of food products but also in the types selected. For example, fresh fruit, which is high in nutritional value but also higher in price, may not be an option on a limited income.

Nationally, 83% of the population at large have received a high school diploma and 26% have attained a bachelor's degree. Among the AI/AI population, those numbers are 71% and 14%, respectively (Population Resource Center, 2003). Education levels affect job opportunities and earning potential. Because the AI/AN population has a much lower level of education, the cycle of poverty issues is perpetuated.

Barriers

Cultural barriers, both within the AI/AN population and the general public, prevent effective dissemination of information on the topic of HIV/AIDS and the risk factors associated with its transmission (Dickey et al., 2003). Historical context is important in understanding the reticence expressed by many AI/AN people in accessing any government health care system or program offering assistance or education. Just as the Tuskegee Experiment led to distrust of health care providers and government officials among members of the African American community, history depicts how U. S. government policy has affected the trust of Native American communities by explicitly and implicitly depriving AI/AN people of their rich culture, traditions, language, spirituality, and extended family and social systems (Vernon, 2001). The suppression of AI/AN religion by the government led to the loss of valuable traditional knowledge including medical and healing practices. It was once illegal for Native Americans to even practice their traditional religion, and those who did were fined or jailed. The ban on American Indian religion was not officially lifted until the American Indian Religious Freedom Act of 1978.

In 1886, a U.S. government commission mandated the formation of boarding schools for AI/AN children under the direction of the Bureau of Indian Affairs. Additionally, during this time many Christian boarding schools for Native American children were also developed. Many of these children were forcibly removed from their families and placed in schools in which they were often forbidden to speak their native language. The children lost their freedom, their families, and their culture. Tribal lands were confiscated, and many tribes were exploited for their various skills. As a result, a foundation of trust continues to be a tremendous obstacle for many in the AI/AN community (Vernon, 2001). Because of this history of neglect and deception, AI/ANs may be hesitant to seek health services from non-Native providers. In addition, the patient-provider relationship, effective communication, and treatment adherence may also be compromised, affecting the quality of care received by AI/AN patients. If the patient does not trust the provider based on the previous cultural history discussed, then the relationship between the two parties is compromised. Whatever treatment protocols or directives for adherence the provider is recommending may be looked at with skepticism and mistrust.

What Can Be Done?

Providing health care professionals with avenues to achieve culturally competent health care practices is especially vital amid the current effort to eliminate health disparities. Among the AI/AN population, these disparities are because of (a) the lack of culturally specific training of health care professionals and health administrators serving these populations, and (b) the lack of funding provided for program development, data determination, and research (Dickey et al., 2003).

Many people, including health professionals, believe that most AI/ANs live on reservations. As stated previously, health care providers need to be aware that today, approximately two-thirds of the 2.5 million AI/ANs live in urban areas and receive health care in urban clinics/hospitals and other urban health service organizations (U.S. Census Bureau, 2002). Although the degree to which all of those individuals maintain the practices of their Native American culture is unknown, it is safe to assume that most, if not all, would take note of a provider's cultural sensitivity with respect to care and treatment.

Approximately half of AI/ANs live in the eastern United States. Many have no choice but to receive care from non-Native health care providers because of the lack of Native Americans working in the health care field. With the immense confidentiality issues present on reservations and in tribal clinics, many Native Americans choose to travel off the reservation for HIV testing and care.

All over the country, physicians, nurses, social workers, and community leaders are confronting situations in which cultural backgrounds are influencing health care, and often in a negative way, particularly with respect to HIV care. Cultural differences affect who participates in health care and the quality of that health care as well as adherence to medications and patient satisfaction. All of these factors indicate a need for effective risk reduction strategies, especially HIV prevention strategies (Dickey et al., 2003). Complicating such efforts with regard to AI/AN, many providers may not know that they are providing care to Native Americans simply because they do not ask the ethnicity or cultural background of their patients/clients. Knowing the racial or ethnic background of patients/clients is not only important for understanding cultural characteristics but is also imperative for providing the highest quality of care.

Program Design

For any AI/AN health care program to be successful, it should be designed not only from the basis of Native American teachings but also from the basis of specific community culture, being certain to involve those communities, groups, or organizations in the planning and design of the program. Because of the existing stigma of HIV/AIDS and issues of confidentiality within Native American communities, it can be useful to incorporate HIV/AIDS education with other training programs to increase the dissemination of this important material (e.g., collaborating with diabetes education, alcohol and substance abuse programs, prenatal classes).

It is important for health care professionals to adopt culturally competent approaches to care in an effort to increase the quality of care received by AI/AN patients. A range of skills is involved in effective cross-cultural care giving, including developing alliances with patients, gathering of cultural information, discussing culturally sensitive issues, and negotiating a culturally appropriate intervention/treatment care plan. When health care professionals lack these skills, service becomes less than adequate. Clients in crisis from the stress of medical illness often fall back on culturally defined modes of coping with illness and cultural conflicts.

Although customs may vary by tribe, some suggestions for enhancing care and treatment services for Native Americans include:

- Increase awareness among health care providers regarding the importance and impact history has had on the Native American culture and how that negative influence has created barriers to health care and services.
- Encourage health care professionals to be respectful of traditional approaches to healing and to refrain from judgment about traditional ceremonies and medicines.
- Allow the client to determine how much to share about his or her traditional practices.
- Communicate support and acknowledge traditional approaches and teachings that the patient/client values (e.g., smudging ceremonies that seek to cleanse negativity from the physical and spiritual body) and discuss ways to integrate traditional approaches or teachings into treatment services and action plans.
- Become familiar with communication styles of AI/AN people (e.g., eye contact, direct vs. indirect questions, conversation vs. talking to patients) and how differences in communication styles, if not fully understood, may lead to misinterpretation.
- Identify an AI/AN community member who is willing to serve as a cultural consultant for your organization.
- Attend or request AI/AN cultural training for your staff. Depending on the area of the country, training may be available through local tribal communities; the American Red Cross, which has a specific HIV training program for working with Native Communities; or the National AI/AN Provider Training Initiative, which is a part of the Department of Health and Human Services.

Available Resources

Recognizing the need for further training and education regarding cultural practices when working with AI/AN clients is the first task. The next is to seek expertise in the subject. Depending on the area of the country in which health care providers are located, the opportunity for locating trainers in the area may be limited.

A curriculum entitled, *Changing Directions: Strengthening the Shield of Knowledge* (Dickey et al., 2003), is designed to empower non-Native providers and educators with information and support that builds respect and appreciation for Native people, as well as a deeper understanding. In this way, non-Native professionals can enhance the delivery of culturally competent healthcare including HIV services. This curriculum explores Native American culture in such a way that non-Native HIV providers and educators will come to understand how the experience of being Native American influences and shapes Native people's ability, desire, and comfort level in accessing and using HIV services in particular.

The goal of the curriculum is to provide health care professionals with information and opportunities for skill development in an effort to increase the quality and effectiveness of HIV/AIDS prevention, care, services, and treatment received by Native American people. Additionally, the curriculum is designed to increase providers' understanding and knowledge of Native American people and culture and to explore attitudes, approaches, and skills that foster the development and delivery of culturally competent HIV/AIDS care in both Native American communities and urban centers around the country. By varying the approach, interventions, and/or programs to incorporate Native teachings, health care professionals can increase both the number of Native Americans they serve and the effectiveness of their effort.

The Next Step

Acknowledging the issues surrounding HIV/AIDS care and treatment for AI/AN is only the first step toward improving the care received by this population. Working to eliminate the health disparities of AI/AN people requires understanding, education, and training. Additionally, it requires caregivers and practitioners to look beyond the physical ailments of their patients. It requires knowing how a patient's culture or background impacts his or her adherence and attitude. A holistic approach to health care is essential in providing the highest quality of health care to AI/ANs. It is beneficial for nurses, who are often the frontline practitioners, to understand the importance of developing a trusting relationship with AI/AN patients and to identify needed differences in their approach to this population. These aspects of care are often the foundation for improving health outcomes among this population. Health professionals from all disciplines should be making concerted efforts to address cultural differences that often impede the progress of improved health care among the AI/AN population.

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