Culture as a Social Determinant of Health:
Examples from Native Communities

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Abstract

Native American populations in the United States are subject to the longstanding effects of historical subjugation. The consequences of colonization, forced migration from their land, and oppression include poor health conditions, high mortality rates when compared with the majority white population, and disproportionately high rates of diseases such as diabetes, alcoholism, and tuberculosis. The extreme levels of poverty among Native American populations mean lower education attainment, economic adversity, social dysfunction, and little or no access to high-quality health care.

Additionally, because the standard biomedical approach focuses primarily on disease progression and treatment, traditional indigenous healing practices and other cultural complexities often have not been taken into account in the design of programs to change health behaviors and improve health outcomes in indigenous communities. The purpose of this project, then, is to describe the role of culture in health promotion and disease prevention for Native American communities.

Culture as a Social Determinant of Health

For a majority of the history of modern medical science, health was viewed primarily as the absence of disease or defect. It was a state of being in which all of the systems that make up the individual were operating "normally." A continuous battle was begun with ill health, and the weapons in this battle were better understanding of the mechanisms of disease and better understanding of the structures and processes of the human body. While this viewpoint achieved many victories and some spectacular successes, its weaknesses have become more and more apparent.

Chief among these limitations is that while there have been staggering developments in medicines and technologies currently available, there is an equally staggering cost for their use. Prescription drugs are the primary cost driver in the modern health system, and these costs have been growing exponentially in the past few decades with no expectation that this trend will slow in the future. The development of increasingly complex and specialized treatment and diagnostic technologies results in the allocation of significant resources to technological marvels that will only affect a comparatively small portion of the population. With the development of each new wonder drug or miracle machine, the system reinforces the idea that for complete health, society needs the newest, the best, and the most advanced treatments. The belief that diseases must be eradicated at all costs results in a system that misallocates resources.

A second limitation of the medical materialist approach is also, paradoxically, one of its greatest strengths. In dealing with individuals in a mechanistic way—that is, as a collection of parts working as a very complex machine—science and medicine have made great strides in our understanding of human biology and the biology of disease. In practice, however, this viewpoint results in a piecemeal and symptomatic approach to disease and ill health. Symptoms are "fixed" with a specific treatment or cure without, in many cases, dealing with the individual as a whole or the underlying causes for those symptoms.

Another limitation is the reliance on, and belief in, the scientific method as the sole source of information and the directing force for innovation. By focusing only on those aspects or facets of individuals and diseases that can be measured, observed, or reproduced in a laboratory, a large blind spot emerges in which the medical model has nothing, or little, to contribute when considering the individual as anything other than a collection of parts. Treating individuals as human beings with minds, emotions, and spirits is not something this approach

does well, and this can result in the denigration of systems or viewpoints that attempt to address these facets. This can be seen in the manner in which the medical and scientific establishments have looked down upon treatments and technologies not developed by their methods. For example, in both Canada and the United States, traditional Healers and Elders have been prevented from providing ceremonies and other healing interventions—in some cases through punitive and legislative methods—and as a result, medicines and treatments developed over the centuries have been dismissed as superstition and quackery.

Recently, however, there is a growing recognition of what has been called a "population health" or a "health determinants" approach in which health is viewed as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity."[1]

In this view, nonmedical determinants of health are considered when analyzing the health of individuals and populations. In these models, other forces and factors in the lives and environments of individuals may have as much or more impact on their health than access to, or provision of, medical services. These include determinants such as socioeconomic status, education level, geography, cultural identity, social inclusion and integration, community, and infrastructure. A significant number of correlations can be made between this approach and what is considered a more indigenous or Native American viewpoint on health. In attempting to be more holistic and comprehensive in dealing with more aspects of an individual or community's life, there are many ways in which this viewpoint intersects with and complements indigenous worldviews and value systems.

Social Determinants

"Every disease has two causes. The first is pathophysiological; the second, political."

The recognition and further refinement of the idea that while biology is obviously

important, there are also nonmedical and nonphysiological aspects to the health of individuals,

communities, and populations has come to be called the "social determinants approach." This

approach recognizes that there are a great number of inputs to both individuals' health and the

systems (environments, families, communities, nations, etc.) to which they belong. Some of the

factors that have come to be recognized as having a direct impact on health at the individual

level are as follows:

- income,
- social support networks,
- education,
- employment,
- social environments,
- physical environments,
- coping skills and resilience,
- childhood development,
- biology,
- health services, and
- gender.

This list is far from exhaustive, but it gives us a glimpse of the complexities that arise

when considering the deceptively simple question of why particular individuals or groups of

individuals (i.e., minorities, immigrants, Native American communities, etc.) are less likely to be

healthy than others in society. In considering these issues, the World Health Organization stated:

> Social justice is a matter of life and death. It affects the way people live, their consequent
> chance of illness, and their risk of premature death. Within countries there are dramatic
> differences in health that are closely linked with degrees of social disadvantage.
> Differences of this magnitude, within and between countries, simply should never
> happen. (2008)[3]

Broader Determinants of Health

Along with the above individually-based determinants, there are some more broadly-based determinants that act at the community, population, and/or national levels. These broader determinants of health have only recently begun to be examined for their impacts on the health of specific groups within societies. The following are of particular importance when considering the health of Native American individuals, communities, and populations:

- culture and cultural continuity,
- access to services and supports,
- colonization,
- globalization,
- migration,
- poverty,
- self-determination, and
- territory.[4]

In this paper, I will further examine the role of culture as a determinant of health, particularly with respect to the health of Native American populations.

Why Culture Matters in Addressing Health Inequalities

Two fundamental values that are shared by many indigenous peoples are *balance* and *respect*. These values form the cornerstones of worldviews in which the individual is not the *raison d'etre* for the universe. Instead, the individual is a vital and valued part of the dynamic systems that make up our world, and, as a part of these systems, must respect them enough to ensure that their balance is neither upset nor destroyed. Promoting or protecting the balance found in these systems does not mean keeping them stagnant or unchanged. Dynamic systems are under constant change, but if they are balanced, this change will be incorporated without detriment to the system or the individual. In viewing health from this vantage point, I will focus

on the different aspects of a health delivery system that provides the services, programs, and organization necessary to promoting healthy lives.

Under the social determinants approach, health, like all other aspects of an individual's life, is not seen as a separate and distinct entity. Health is connected with, and dependent on, larger systems such as the individual, the family, the community, and the environment. Ailments, diseases, and conditions are seen as the result of imbalances in these systems. Treatments and interventions attempt to restore an individual's health through analysis of the disturbances in these systems and the restoration of the balance inherent to them. This analysis takes into account the fact that a person is not comprised of his or her physical being alone. Individuals have emotional, mental, and spiritual aspects that need to be considered. Methods used to perform this analysis, and the treatments required, will vary according to the healer, community, or culture under consideration. These methods may include nonmedical interventions such as healing circles, storytelling, prayer, song, and ceremony, as well as more "medically-based" traditional medicines and practices.

This approach is not to be offered in a manner that rejects biomedical interventions altogether in an either/or proposition. Both systems have their strengths and both have their weaknesses. This approach is offered in the hope that by recognizing the strengths and limitations of each system, a better path can be discovered that will lead to the improvement of health for many of the most underserved participants of current services and systems. Culturally competent and culturally safe care will need to recognize that one of the main causes of ill health in indigenous communities and nations has been the almost complete disregard for and denigration of cultural conceptions of health and healing not found in the biomedical or medical materialist model of health.

In order for any intervention, treatment, or healing to take effect, the principle of *respect* must be fostered. For changes to take place in an individual's health, the individual must have respect for him- or herself and his or her position in all of the systems mentioned above. This respect will form the foundation of all interactions and will direct or guide efforts to improve health.

> The native concept of health . . . is said to be holistic because it integrates and gives equal emphasis to the physical, spiritual, mental, and emotional aspects of the person. The circle is used to represent the inseparability of the individual, family, community and world. . . The circle (or wheel) embodies the notion of health as harmony or balance in all aspects of one's life.[5]

From this brief comparison of views on health, it is clear why culture matters in addressing health inequalities. Culture dictates the language used to define issues, the identification of problems, the framing of those problems, the manner in which solutions are sought, and the methods for defining and measuring success.

The Importance of Culture in Patient-Centered Care

There is growing recognition of the need for culturally safe, patient-centered care in improving the health outcomes of minority populations, particularly Native American populations. The health status of indigenous populations is well below the national average both in Canada and the United States.[6] The experience of many indigenous populations in the mainstream health care system has been negative, often due to cultural differences. Frequently, cultural differences and the inability of health care providers to appropriately address these differences have contributed to high rates of noncompliance, reluctance to visit mainstream health facilities, and feelings of fear, disrespect, and alienation.[7]

Cultural misunderstandings can affect the ability of health professionals to assist their clients or patients in achieving optimal health. For example, health professionals may view clients or patients who are culturally different from themselves as unintelligent or of differing intelligence, irresponsible, or disinterested in their health.[8] This can result in poor health status, marginalization within the health care system, increased risk, and experiences of racism for the Native American patient. In turn, the health care system may operate inefficiently, staff morale may be affected, health care costs may rise as patients return with progressed illness, wait times may increase, health centers may be overburdened, and the overall ethical standard of care may be diminished.[9]

For many indigenous people, the almost complete lack of recognition of culture as a determinant of health and the lack of access to culturally competent care results in an alienating and disheartening experience.

> Commonly, people from a *nehiyawak* [People of the Four Direction; Plains Cree] community in northeastern Alberta would recall their experiences of accessing health care in the area by saying, "They only go there [a hospital] to die, not to get better."[10]

Adopting a culturally safe approach to patient-centered care can benefit individuals, providers, institutions, and health care systems. When culturally appropriate care is provided, patients' response to care is improved, compliance increases, and engagement with the health system is more likely at earlier and potentially less-complicated and less-expensive points in disease progression.

A commitment to acquire the skills needed to provide culturally safe care will also benefit health care providers. It can lead to increased confidence on the job through the ability to address the needs of various groups within their clientele and society at large. The resulting increase in job satisfaction may help to increase retention rates in "high-turnover" facilities and communities

9

(e.g., inner-city, rural, or remote communities). Currently, the dominant discourse on cultural awareness, cultural sensitivity, cultural competence, and cultural safety can be viewed as a continuum that measures the congruence of a person's culture and his or her experience in the health system. This concept largely focuses on increasing health providers' knowledge of various cultural beliefs or trends.[11] While cultural awareness is an important part of cultural safety, it should be emphasized that awareness is only the *starting point* of the learning continuum and that cultural safety is near the endpoint of this continuum. It is therefore important to note the distinctions between cultural awareness, cultural sensitivity, cultural competence, and cultural safety. The provision of *culturally safe* care involves lifelong learning and continuous development and refinement of competence based on awareness of the cultures of their clients and sensitivity to how culture mediates determinants of health, as well as their clients' experience with and beliefs about the health care system. Cultural safety is the outcome of culturally competent care.

> Arriving at an understanding of the concept of cultural safety is a journey of self-awareness on this continuum. According to Irihapeti Ramsden, the Maori nurse and educator who developed the concept in her doctoral thesis in 2002, cultural safety is the ultimate goal in a learning process, starting with cultural awareness of a patient's ethnicity and, in culturally safe practice, growing concerns with "social justice ... and nurses' power, prejudice and attitude" ... In other words, Ramsden turns the focus of cultural safety away from the cultural understanding and knowledge of the health care worker and onto the power inherent in their professional position. She seeks to redefine cultural safety from a transformative point of view of the Aboriginal person receiving care; the determination of success is by the recipient, who defines the care received as culturally safe, or not.[12]

Cultural Competence Continuum (Adopted from the National Center for Cultural Competence)

- **Cultural destructiveness:** The imposition of foreign and damaging systems, actions, and policies (e.g., reservations, industrial schools, etc.) with the intended outcome of disruption or destruction of existing cultures and structures.

- **Cultural incapacity:** The ongoing withholding of recognition and/or respect for the cultural structures of the client or the client's community or population.

- **Cultural blindness:** The deliberate act of development and delivery of programs and services in a manner that pretends that "culture does not matter" or that seeks to treat all clients "equally."

- **Cultural pre-competence/cross-cultural care:** The recognition that culture does matter and that the culture of a particular client or community may be different from that of the service provider.

- **Cultural competence:** Awareness of one's own culture and the culture of clients and communities, and how these will impact the health and healing relationship being developed. Culturally competent care will be as congruent as possible with the culture of the client under consideration.

- **Cultural safety:** Complete congruency between the culture of the person seeking services and the services provided. This would be seen as a goal for all health systems and all clients but, for the most part would be a continuous and iterative process to be striven toward and not necessarily an end result in and of itself.

An overarching concept necessary for the creation of cultural safety in health services and systems is the willingness of health care professionals to develop, implement, and internalize the idea of cultural humility, which can be defined as follows:

> Cultural Humility incorporates a lifelong commitment to self-evaluation and critique, to redressing the power imbalances in the physician-patient dynamic, and to developing mutually beneficial and non-paternalistic partnerships with communities on behalf of individuals and defined populations.[13]

Cultural humility can be seen as the driving force in moving health and health care services further toward culturally safe care, and is based on a specific and ongoing commitment of service providers, administrators, policy developers, and decision makers. It relies on recognition of the fundamental inequalities that permeate the "traditional" patient-professional relationship and that these inequalities have a significant impact on the health outcomes of clients and communities.

> The increasing cultural, racial, and ethnic diversity of the United States compels medical educators to train physicians who will skillfully and respectfully negotiate the implications of this diversity in their clinical practice. Simultaneously, increasing

attention is being paid to nonfinancial barriers that operate at the level of the physician/patient dynamic. This dynamic is often compromised by various sociocultural mismatches between patients and providers, including providers' lack of knowledge regarding patients' health beliefs and life experiences, and providers' unintentional and intentional processes of racism, classism, homophobia, and sexism.[14]

Cultural humility is, at its heart, recognition of the failures of past, and many present, service models and relationships in the field of health (i.e., relationships that are external and/or expert-based searches for diagnoses, treatments, and cures driven by the idea that one person or professional will have the answer and that the trick is to find that individual). Cultural humility is a commitment to improving the health of diverse and disparate clients through true partnership at the community level as well as true patient-centered care models.

> It is a process that requires humility in how physicians bring into check the power imbalances that exist in the dynamics of physician-patient communication by using patient-focused interviewing and care. And it is a process that requires humility to develop and maintain mutually respectful and dynamic partnerships with communities on behalf of individual patients and communities in the context of community-based clinical and advocacy training models.[15]

The Role of Community-Based Efforts to Promote Better Health Outcomes

Cultural continuity in a community context is at the heart of promoting better health outcomes in Native American communities. Cultural continuity should not be confused with "authentic," "traditional," or similar labels. Cultures are dynamic systems under continuous internal and external pressure to respond, change, and adapt. The key to continuity is that the persons involved have the ability for self-determination with respect to the systems and structures through which they choose to engage the world. Ideally, the health system that serves them would be located within these systems and structures and not imposed externally. The responses of communities would then be more likely to be culturally-based—and therefore more likely to be culturally competent and culturally safe—even in instances where these responses

include or utilize external service providers or structures. It is important to note that Native American populations differ significantly from other minority groups in their conceptions, relationships, and interactions with lands and territories as well as with the state or states currently occupying their lands or territories. Even for individuals who reside in urban environments, connection to the land is a fundamental aspect of the expression of cultural experience, whether through seasonal or regular migrations, ongoing connections and relationships with "home," or individual expressions of this connection.

Community-based efforts are the best hope for promoting better health outcomes, whether that community is at the Nation or Tribe (i.e., Lakota, Tulalip, Haudenosaunee, etc.), reservation, municipal, or virtual (i.e., groups within an urban milieu) level. Culturally competent and safe health systems and services have never, and will never, exist at the national level. No single system could provide for all the variations in culture, geography, demography, and economics found in Native American communities across the country. A single "one-size-fits-all" design for systems and services has not been successful in the past and will not be successful in the future.

Over the past decade, the United States has spent an average of 16 percent of gross domestic product (GDP) on health expenditures (federal, state, and individual). This is the highest amount spent by any Organisation for Economic Co-operation and Development (OECD) countries. Health expenditures in many other OECD countries (Canada, Australia, Sweden, Japan, and Germany, for example) represent approximately 10 percent or less of GDP. However, by many measures of health outcomes (infant mortality, life expectancy at birth, disease-specific mortality, etc.) the United States achieves significantly lower scores than most.

Another dimension of the problem involves the variation of health care costs across the United States. A recent analysis by the Medicare Payment Advisory Commission found

13

that spending in higher-cost areas of the United States (that is, those in the 90th percentile ranked by cost), even after controlling for various factors, was 30 percent higher than in lower-cost areas (those in the 10th percentile). This substantial variation is undesirable both because the high cost areas unnecessarily drive up total costs and the results are often haphazard for patients. Indeed, higher costs typically do not equal better care—and sometimes they mean the opposite.[16]

Through shared colonial histories, the United States, Canada, Australia, and New Zealand share relatively similar levels of development, economic philosophies, and legislative regimes. Each of these countries also has similar experiences with respect to relations with indigenous populations. In each of these cases, it can be seen that these populations are overrepresented at the higher-cost end of the spectrum with respect to health care. This is not a result of intrinsic poorer health among these populations, but is more likely a measure of the disengagement from the health care system until emergent (i.e., the most expensive) services are required.

For culturally competent care to be effectively developed and delivered, it must be designed, managed, and administered by the community. This requires a level of flexibility and responsiveness not easily attained with current delivery models and paradigms. This also requires a fundamental shift in how health is viewed and defined. As stated previously, a rough definition of health under the biomedical model would be the absence of disease or defect. With this definition, it is easy to see how systems would be developed and reinforced which solely dealt with the treatment and eradication of diseases or conditions. Under a community-developed or culturally safe model, however, health can be defined as a life lived in balance with all the other systems of which an individual is a part. These include systems such as environment, community, and family. In this definition, a health care system and health services developed to provide or promote health would need to be holistic, flexible, and responsive not just to the disease or condition but to the individual and restoring the balance necessary for health. From this perspective, many of the interventions or developments necessary for the improvement of

health outcomes would take place outside of what would be considered "health areas" in a biomedical, policy, or bureaucratic sense.

> A landmark study conducted by Chandler and Lalonde (1998) revealed that among First Nations people in British Columbia, rates of suicide (which are strongly linked to proximal determinants) varied dramatically and were associated with a constellation of characteristics referred to as "cultural continuity"... Cultural continuity might best be described as the degree of social or cultural cohesion within a community. According to Chandler and Lalonde, low rates or a lack of suicide in a community appear to be related to: land title, self-government (particularly involvement of women), control of education, security and cultural facilities, as well as control of the policies and practice of health and social programs. Cultural continuity also involves traditional intergenerational connectedness, which is maintained through intact families and the engagement of elders, who pass traditions to subsequent generations.[17]

Land and Self-Determination

It is important to note that Native American populations differ significantly from other minority groups in their conceptions, relationships, and interactions with lands and territories. There are also distinct and politically charged divergences between the relationships of Native American populations with the land and those of majority populations. In order to understand these divergences and how they impact the development and delivery of care, it is imperative to take into account the connections between land, spirituality, and politics, and to recognize that the Native American relationship with the American state is anchored in land politics. This historical reality has resulted in a number of determinants of ill health that are unique to this group, including

- the destruction of traditional economies through expropriation of traditional lands and resources;
- the undermining of traditional identity, spirituality, language, and culture through missionization and residential or industrial schools;
- the destruction of indigenous forms of governance, community organization, and community cohesion through the imposition of European governmental forms; and
- the breakdown of traditional and healthy patterns of individual, family, and community life.

These attributes of the relationships between indigenous populations and colonial states such as the United States, Canada, New Zealand, and Australia result in the need for the recognition, integration, and support for the revitalization of culture through the restoration of connections to land and territories and the recognition of self-determined forms of governance and decision making at all levels (individual, community, and tribal/national).

The Role of Culture in Health Research and Practice

Indigenous peoples have explored, researched, refined, and perfected healing traditions for millennia. These traditions continue to provide guidance for the protection and promotion of individual and community health throughout their territories and communities. Unfortunately, the process of colonization has resulted in these traditions being devalued, denigrated, and alienated by the mainstream society and health system. Colonization and marginalization have resulted in some of the worst health outcomes in the world for indigenous communities in Canada and the United States. Elders and Healers continue to practice and develop indigenous healing traditions to this day, and continue to call for support for these traditions as part of any response to the dismal determinants of health and poor health outcomes in many indigenous communities and nations.

> Scientists ignore Indian myths and traditions because they have been trained to do so. It is simple racism to believe that people can have been on the planet for 100,000 years or so and not have known or observed anything. (Vine Deloria, Jr., 1969)[18]

Indigenous peoples have always had health knowledge, although many traditional teachings have been lost, underused, or intentionally hidden. However, these communities are experiencing a rebirth of cultural and traditional knowledge as what was almost lost is being reclaimed and applied to meet the needs of contemporary people. Many communities are

combining traditional healing and wellness approaches with the best of Western technology and ideas.

The need for knowledge has never been greater. Indigenous communities are facing rapid change and daunting symptoms of ill health, such as community and family violence, suicide, high levels of infectious and chronic diseases, and tragic levels of childhood deaths, youth injuries, and adult disabilities. However, there is great opportunity for change as indigenous communities gain more control over their present and their future. Knowledge is essential to positive change.

Conducting and using research are integral to the worldview of indigenous peoples. Research, in its purest sense, is about both gathering and sharing knowledge. Indigenous peoples have been in this business for thousands of years and have developed extensive and diverse systems for both the collection and dissemination of knowledge. Therefore, in order to have an effective discussion with respect to an indigenous definition and understanding of research, indigenous epistemological and pedagogical methods and systems need to be given the same weight as biomedical methods and systems. This needs to be more than just lip service to "ethical" treatment within what for all intents and purposes is a foreign system. A system used for guidance or direction in activities (ethics) that is not respectful of indigenous worldviews or perspectives will be inherently unethical and likely damaging, regardless of the character or the intent of that system or the professionals and researchers within that system. The fundamental assumptions of biomedical research, i.e., that the research is inherently good, for the greater good, and necessary for the expansion of knowledge, have all in one form or another been used to direct or justify some particularly odious ethical practices. The ideas and assumptions that drive research in its current form must be examined and reframed to be more inclusive of

indigenous insights and perspectives if that research truly seeks to be reflective of, or useful to, indigenous peoples, communities, and individuals.

With respect to indigenous definitions or understanding of research, it is important to note that indigenous communities are not, for the most part, against the acquisition of knowledge or information that results from research. The issues that are repeatedly raised are not, as some assume, a romanticization of the past or a fear of the new. They are a reaction to what has been, for the most part, a severely unbalanced and unhealthy relationship with the health system for indigenous individuals, communities, and peoples. For this relationship to become more balanced and, hopefully, more healthy, the value and usefulness of indigenous knowledge must be fully recognized, not in the sense of what it brings to "scientific" thought or how it can be subsumed into that body of knowledge, but as a source of knowledge in and of itself.

> A body of knowledge differs when it is viewed from different perspectives. Interpretations of Indigenous knowledge depend on researchers' attitudes, capabilities, and experiences, and on their understanding of Indigenous consciousness, language, and order.[19]

Research is a systematic way of building knowledge that can be as simple as observing the world, drawing conclusions from what is seen, testing those conclusions, and confirming what is learned. More sophisticated research involves developing a sound method, collecting accurate information in a variety of ways, analyzing what is collected (often using elaborate theories and technologies), interpreting the results (understanding what the information means), and communicating the results to others.

Unfortunately, many indigenous communities have been the victims of research that was badly designed, failed to collect accurate information or understand information in context, and did not communicate its findings well. Indigenous peoples and communities have cooperated with—and sometimes have been forced to engage with—research they had little say in or control

18

over that was used to further misinformation and negative stereotypes. Much needs to be done to restore indigenous peoples' trust in academic and scientific research. Some critical issues to address include the need to embrace "different ways of knowing" based on traditional and cultural knowledge; development of true partnerships among researchers and those researched; greater ownership and control by indigenous people over research; and research ethics, priorities, and principles that reflect the values and beliefs of participants and participating communities and institutions.

For research to be relevant to the needs of indigenous people, it is important that indigenous people develop and promote culture-based principles to guide this research.

Just as research continues to evolve with every scientific advance, research principles are intended to be dynamic and adaptable to change as we learn better ways of working toward meaningful research agendas and outcomes. Below are some key guiding principles to inform the development of research activities. These are

- Research is focused on community priorities, needs, and realities.
- Methodologies are culturally appropriate and respectful.
- The research process is open and inclusive.
- Research designs are credible and of high quality.
- Due consideration is given to ownership, control, access, and possession of data and research outcomes.

Just as the concept of cultural humility is useful in guiding the development of culturally safe health care, it can be utilized by researchers in understanding the historical and cultural contexts of research, and it can help guide them in making conscious commitments to the development of research that is a joint activity in conjunction with, and for the betterment of, indigenous peoples, communities, and individuals. The goal is to move the locus of control and

efficacy from something that is done *to* indigenous communities and institutions to something that is done *with* indigenous communities and institutions.

Recommendations and Considerations

The following are a number of recommendations and concepts for the consideration of health professionals, administrators, policy decision makers, community members, and researchers. They are offered in the hope that they can assist in guiding discussion and thought around the recognition of culture as a determinant of health as well as in working toward culturally safe care and services for Native American nations, communities, and individuals.

- Healing is a central concept for many indigenous cultures and should be distinguished from treatment and/or curative processes in a biomedical context. For many indigenous peoples and communities, healing includes an active process of recovery from the social impacts of colonization that have had adverse affects on the lives and health of indigenous peoples for generations.[20]
- Wellness refers to the maintenance and enhancement of health and well-being for individuals, families, communities, and nations through the restoration of balance at each of these levels. This restoration, sought by many indigenous peoples, is based on a return to traditional spiritual values, indigenous knowledge, and culture.
- The focus should be on training current health care providers to be culturally competent in the short term while working toward the goal that all service providers share the cultural background of the clients they serve. Within Native American communities and institutions that serve a large Native American population, the demographic makeup of service providers should at the very least match the demographic makeup of the community and clientele. On an individual or personal level, professionals should continuously be vigilant for opportunities to be role models and mentors for promising youth, in the hope of being succeeded by them.
- Educational programming in the health sciences for those likely to work in or with Native American communities must include Native American history, culture, conceptions of health, and principles of self-determination and management. This programming would likely be of benefit to all professional programs at some point and should be undertaken in conjunction with Native American institutions and educational structures (i.e., not anthropological study of Native Americans, but educational engagement and opportunities for cross-cultural exchange.)
- Pursuit of equity in access to culturally competent health care and healing services must be an overarching goal of any strategy for the amelioration of negative health outcomes.

Proximity to services is not equity of access. In order for best results to be attained, services need to be accessible physically, emotionally, mentally, and spiritually. The concept of equity also needs to be reframed as equity of opportunity or equity of outcome rather than a focus on equity of investment or equity of service. Equal services do not necessarily deliver equal outcomes.

- The pursuit of holism is important in approaches to problems, their treatment, and their prevention. Multifactoral analysis of dynamic systems is the essence of consideration of broader determinants of health. Health care providers, administrators, and policy decision makers need to open their minds to factors that are not "traditionally" considered health-related in the bureaucratic or service sense. For example, it is a widely held belief in many indigenous communities that youth interventions that focus on language and culture will enhance the health of communities. Unfortunately, these interventions are often "unfundable" through most health program jurisdictions.

- Indigenous and community authority over health systems, facilities, and services need to be fostered and supported where they currently exist, and mechanisms to support this authority need to be developed in those areas where they do not currently exist.

- Diversity in the design of systems and services should accommodate diversity in communities, cultural groups, and nations or tribes. There are fundamental differences between indigenous and biomedical approaches to health and healing. There are also differences among and within indigenous cultures and communities themselves. Any approach or system that fails to recognize this diversity cannot hope to be fully effective. Culturally appropriate program design and delivery are not frills to be tacked on to health care services or programs; they must be at the heart of generating health and healing in any community. When this is the case, culturally competent care will flow directly from the service delivery model and not exist as a separate goal in and of itself.

- For research to be useful, it needs to be practical and directly applicable to the needs of indigenous communities. Research conducted solely to benefit a clinical or biomedical approach will contribute little to the creation of knowledge that can be used to improve health status. As a guiding principle, it is important that health research priorities be based on population and community needs. Good research involving indigenous peoples
  - considers the root causes of ill health and the requirements for optimal health that are particular to the experiences and histories of indigenous peoples;
  - respects the worldviews of indigenous peoples on connectedness, respect, balance, and the equal importance of physical, emotional, social, mental, and spiritual health;
  - provides insight into key health issues, and offers the potential to improve promotion, prevention, treatment, rehabilitation, and family and community support; and
  - addresses particular issues within the context of the long-term aspirations of indigenous communities to be self-sustaining, healthy, and prosperous.

- The importance of the relationship of Native Americans to their lands and territories cannot be overstated. Indigenous cultures are the manifestation of a deep and spiritual connection to the land. One of the primary determinants of poor health outcomes in indigenous communities is their dispossession and disconnection from the land. The best hope for improvement on these outcomes is the reestablishment of this connection through culturally competent care.

[1] World Health Organization, *Preamble to the Constitution of the World Health Organization.* 1948.

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