Health education and the American Indian

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Introduction

For the sake of uniformity, those native and/or Indigenous people being spoken of in this paper are referred to simply as Indians or American Indians. The term "American Indian" can apply to all native peoples throughout the Americas except, perhaps, select Alaskan natives (namely the Eskimos, Aleuts, and Inuits). The term generally applies to people living in Canada and the United States. Native people in the rest of the hemisphere favor the term Indian by itself (http://www.answers.com/topic/american-indian). Many Native people living in the United States prefer being known by their tribe; “I am Sioux; I am Chippewa; I am Seneca; I am Choctaw.”

Among the events of the Age of Discovery (sometimes referred to as the Age of Exploration) was the landing of European ships on the shores of North America. Since that time, affairs have never been the same, at least for Native inhabitants of the continent. This period extended roughly from early 15th century through early 17th century with adventurers seeking new trade routes as well as precious commodities such as gold, silver, and spices. Some fortune-seekers sought in vain, the mythical “Fountain of Youth,” thought to be somewhere on the North American continent. Still others sought after the “Seven Cities of Gold.” One thing was certain: the newcomers began to settle and make homes for themselves in the “New World” the lives of the Indigenous people would never be the same.

The Europeans quickly wanted to both educate and Christianize the populace on the North American continent. As a result, methodically and systematically laws and policies were put into place to colonize the Native people to the European way of life. Among the policies set down by the United States government to deal with the “Indian problem” was to “remove” them from their original homeland and relocate them to areas west of the Mississippi River (Deloria, 1985).

When Indian Territory was established, thousands of Indians were re-located along the “trail of tears” as it became known, tearful because people and families were uprooted and moved to lands far from their homes. Once relocated, eventually, Indian children were sent to boarding schools, many times far away from their parents and their homes. As an educational tool, the boarding school era in the United States has been met with intensive scrutiny since the time when such practices were commonplace. Many Indian participants were bewildered and knew nothing of what transpired while they were in such schools (Fixico, 2003). The boarding school era has been labeled “controversial” at the very least. Suffice it to say that it is believed that more than 100,000 Native Americans were forced by the U.S. government to attend Christian schools (Deloria, 1999). The effectiveness of the education that took place at these schools is dubious at best. At worst damage, physical, mental, and spiritual, likely occurred (Fixico, 2003).

Health status and colonization

Worthy of note is the following, all of which relate directly to health status and the disparities among the races: (1) only 66% of Indian people are high school graduates and American Indian or Alaskan Natives are twice as likely to be unemployed than whites; (2) 15% of the general population in the United States are not covered with health insurance – among Indians, the rate is 24%; (3) tribal people are the most likely subgroup to be victims of a violent crime (124 out of 1,000 or 2½ times the prevalence for all other races); and (4) the rate of alcoholism among American Indians ranges between 500% and 625% that of all other races (Stone, 2005). The disparities continue to mount.

The figures related to health problems are staggering, given the once proud nature and state of health of the American Indian. The situation today finds widespread feelings of misery, helplessness, hopelessness, and despair among American Indians. It has been reported by Lavalle who cites the work of Wesley-Esquimaux and Smolenski that Indian people have experienced an unequal share of, as well as relentless, pain and distress as a result of the colonization process (Lavalle, 2007).

In addition, Lavalle cites Chansonneauve’s work and states that the

“...effects and trauma of the colonization process in the United States are ubiquitous and can sometimes include: (1) physical disconnection with children, many of whom were forcibly removed from family and community; (2) mental disconnection with this forced assimilation; (3) practice and policy of disallowing the use of Native languages; (4) perhaps forced changes in political and social structures; (5) emotional disconnection by enforcement of the stereotypical view of “savage Indians” which needs assimilation; (6) and spiritual disconnection by the banning of Indigenous cultural ceremonies.” (Lavalle, 2007).

In addition, on-going trauma has produced generations of “post-traumatic effects” demonstrated today in many Indigenous communities. According to Lavelle, the World Health Organization reported that post-traumatic effects among Indigenous communities throughout the entire world. One example is that Indigenous people experience higher rates of illness and death compared with non-Indigenous people (Lavalle, 2007). The generational impact of colonial trauma and forced assimilation has been termed historic trauma transmission (HTT) (Lavalle, 2007). It could be that the ill-health suffered by the American Indian is partially a result of the loss of self-efficacy and self-esteem of an entire people.
Health education, national health education standards, and Indian-specific health education standards

Currently, with thousands of Indian children and adults quarantined on reservations scattered from east coast to west coast and from border to border in the United States, education of the American Indian is not without its problems. With the variety of gadgets, gimmicks, and technological toys available and employed in educational practice, one must realize that first and foremost the most important element brought to any classroom is the teacher himself or herself.

What is one’s philosophy regarding teaching today’s Indian students? Are Indian children different from other students? If so, how might they be different? How might one reach them to have a positive impact upon them with one’s instruction? More questions abound with regards to the education of American Indian youth. One could ask, “What is best for Indian people regarding the education of their children in the twenty first century?” For those assigned to teaching positions involving American Indian children, these are basic questions pre-service and beginning teachers must begin to ask themselves if effective education and interfacing with Indian children and young people is to take place. The pre-service teacher, as well as college and university professors must face these questions and concerns as well if they intend to reach and relate with the American Indian student. It is important to ponder these and other ethical questions as failure to do so might continue practices of ineffective schooling for Indian children. Cultural differences with regard to educational practice must be addressed and adequately corrected. “What is it like being non-Indian teaching Indian students? What is the best way to teach the American Indian student about health and wellness, fitness and wholeness? How might one integrate traditional Indian views on health, healing, and wellness into the curriculum? Would one even want to consider Indian views on health education topics?” If so, what would be the motivation to do so? If not, what would be the motivation to fail to do so? These are questions that may not surface in the schools of education in colleges and universities throughout the United States.

Some believe that Indians see and understand and make sense of their world from a point of view that emphasizes circles and cycles (Cohen, 2003). This comes, perhaps, from their cultural background which has always been one ‘close to the land.’ They developed ways of being in harmony with what was observed in nature, for example, severity of long winters, the freshness and newness of spring and summer, and the seasons which yielded various crops necessary for their survival. Through the process of observing and participating actively in the various cycles of nature, Indian people made sense of their surroundings and their lives. In addition, the circle and story-telling became a large part of their way of life (Mehl-Madrona, 1997). In addition to stories and storytelling, myths arose and became widespread. Such myths and stories served to better communicate views of creation, of life, and of death.

Conversely people of European ancestry view life’s situations and happenings in more linear or logical ways of thinking. Is it possible that these two world views could be in conflict with one another, thereby causing a great deal of confusion and misunderstanding for American Indian children when it comes to their education? Has the outcome of colonization in the United States helped lead to depression, misery, helplessness, and hopelessness in the lives of American Indians? There appears to be a correlation with the negative results of colonization and with psychological self-esteem and lack of self-efficacy of those colonized.

2008 and beyond

Today in the United States, national health education standards have been created and circulated widely in colleges and universities as markers at which to aim regarding instruction in health. Do these standards address the cultural differences and beliefs of the American Indian? One example of a long-held tradition in American Indian culture is that of the medicine wheel, a practice that has long been used by various Indigenous groups and is representative of American Indian spirituality (Cohen, 2003). The medicine wheel symbolically outlines an individual journey one must take to find one’s path in this life. Inclusion of this concept does not appear in the standards for health education in the United States. Should such cultural beliefs and traditions be addressed or even be included when considering national health education standards in the United States?

Today, national health education standards number eight total with benchmarks for achievement aimed at grades Pre-k-grade 2, grades 3-5, grades 6-8, and grades 9-12. Cultural-specific terminology does not appear in these standards with the single exception of standard number two which includes information on how culture (as well as a variety of other variables listed in this standard) might influence one’s health behavior (American Cancer Society, 2007).

In 1996, as the result of a grant-sponsored project in the American Southwest, educators and community leaders led a consortium of nineteen Indian communities in the creation and development of American Indian-specific health education standards (American Indian content standards for health education, 1998). Needless to say the standards developed by and for American Indians differed greatly from the aforementioned national health education standards adopted for use by American colleges and universities.

An example of an Indian-specific benchmark for standard one (e.g., the student will comprehend concepts related to health promotion and disease prevention) is, “explain traditional American Indian symbols and concepts (specific to a student’s tribe) related to health promotion and disease prevention for teenagers, such as the Medicine Wheel, the Good Road, Hozho or the Circle” (American Indian content standards for health education, 1998). It is likely that few pre-service teachers have any notion of what the medicine wheel, let alone the Good Road or the Hozho, is or its relationship to health.

Development of Indian-specific health education standards is work that is missing and that is greatly needed. New Indian-specific standards must be included in the education of all pre-service teachers if the goal is that of communication, education, respect, and behavior change. If all those involved in the education of Indian students would
begin to develop and relate to benchmarks and standards from the American Indian’s “cultural eyes” they could begin to integrate new ways of thinking, interacting, and being into their classrooms. By so doing, the Indian child and his non-Indian teacher could likely gain greater understanding of health content and concepts necessary for prevention to take place.

If decision-makers and policy-makers decide to take into account and include American Indian cultural views on health, wellness, and healing, the future could begin to look much brighter for the health of Indian children. If the goal of education is communication, behavior change, and/or prevention, the inclusion of Indian values and practices in the health education standards is imperative. As indicated earlier, Indian ways of seeing the world of health, healing, and wellness differs greatly from that of the dominant culture.

**Action steps**

Veteran teachers and pre-service teachers must come to realize that communication and understanding is imperative if health behaviors are to change. American Indian students could be “lost” when it comes to understanding current concepts and practices relating to health education, therefore a series of actions must be considered and then followed if positive change is to take place, change that will take into consideration and include the heritage-rich history of the American Indian child.

First, all must realize that problems exist with current national health education standards. By excluding or omitting American Indian beliefs and traditions from national health standards, teachers colleges set themselves up to produce generation after generation of teachers ill-equipped to address the health concerns of Indian students in a culturally appropriate manner. Cultural heritage, beliefs, and practices of Indian people need to be included in national standards for health education and teachers must become increasingly aware of their importance.

Next, a list of possible solutions to this problem must be created, a list that will address culture and its place in education. Third, inclusion and implementation of various standards that are appropriate for Indian children must begin to take place. Fourth, evaluation of the progress of such actions or lack of progress must be measured. Fifth, based on evaluation, appropriate revisions to standards and practice must be made as needed. Sixth, repeat this cycle with the idea of appropriate methodology as the guiding principle.

Innovative and caring ways of integrating cultural beliefs, attitudes, and practices into the education of the pre-service teachers and of teachers of the American Indian students must be addressed and thoughtfully implemented over time if the health of these people is ever expected to improve. Arguably, current practice and policy has accomplished little, if any, positive gain with regards to the quality and quantity of life for the American Indian. In the meantime, health disparities continue to increase between the Indian and his/her brothers and sisters of other races in the United States.

Only until Indian’s views of health are taken into account and integrated into the national health education standards imposed by the schools of education and teachers colleges throughout the nation will positive changes begin to be seen in the health status of the American Indian. Time is of the essence. It could take generations before positive changes in the health status of Indian children and Indian people are realized. Positive results after years of neglect and indifference are difficult to accomplish regardless of the issue. The first steps, as previously outlined, could go far in the prevention education for Indian children. We all have the time to see that this is accomplished. We are educators and as benevolent and caring people we all have the charge to do what is outlined herein as well.

**References**


