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Promoting Cultural Capital in a Medical Camp for American Indian Youth with Diabetes

Jennie R. Joe

CHILDHOOD DIABETES

As noted by many of the contributors in this volume, there are three main types of diabetes, including Type 1, Type 2, and gestational. Gestational diabetes is a special risk factor for childhood diabetes, a form of type 2 diabetes that occurs for certain women during times of pregnancy. The symptoms of gestational diabetes, however, subside after delivery but the gestational diabetic experience places both mother and child at high risk for developing type 2 diabetes. The onset of diabetes for these children and others varies but the Centers for Disease Control reports that most children and adolescents diagnosed with type 2 diabetes are between the ages of 10 and 19 years, although the condition can occur at an earlier age.¹

Type 2 diabetes is the most common type of diabetes found among American Indians. In fact, just being an American Indian places individuals at risk for developing type 2 diabetes. For example, the American Diabetes Association (ADA) includes “American Indian” in its list of risk factors.² Diabetes, however, is an international public health problem. For example, the International Diabetes Foundation (IDF) indicates that 90 percent of the

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diabetes worldwide is type 2 diabetes and the present number of 300 million diagnosed will increase to approximately 500 million within the next generation. IDF also notes that diabetes affects 80 percent of the world's low and middle-income populations.³ In 2000 the United Nations passed a resolution calling for a concerted international effort to prevent childhood obesity.⁴

The connection between poverty and risk for developing diabetes is prevalent in developed countries such as the United States. Using data from 2007, the Centers for Disease Control reported that approximately one-third of US children ages two to four years lived in low-income households (incomes below the federal poverty level of \$20,650 for a family of four), and these children were most likely to be overweight or obese.⁵ Other health statistics also highlight the growing problem of childhood obesity in the United States. For example, the Institute of Medicine reports that obesity among preschoolers has tripled in the last twenty years.⁶ Other data also indicate that diabetes is more prevalent in girls; girls are 1.7 times more likely than boys to develop type 2 diabetes.⁷ Similar types of advocacy have helped initiate childhood obesity prevention programs in the United States. Because these national and local programs are relatively new, the impacts of these interventions on the population are still being collected and evaluated. In the meantime, the rates of diabetes and obesity remain a problem in many communities, including in American Indian communities.⁸

The economic consequences and healthcare costs are critical for those who already live in poverty. Family economic circumstances are impacted when complications of diabetes increase the rates of disability and unemployment.⁹ In the United States, ADA places the cost of diabetes at \$248 billion in 2012, including \$176 billion in direct medical care costs and another \$69 billion in loss of productivity.¹⁰ Thus far, the future economic impact associated with childhood diabetes generally is not analyzed, but one would expect this cost will continue to be a major factor, especially if the number of children with diabetes continues to increase and the incidence of severe diabetic complications occurs earlier.

Scientific information on the different types of diabetes continues to increase worldwide as new information is gained about the process of the disease, its prevention, treatment, and promising clues about a potential cure. At the service and programmatic end, the focus is on early detection in order to begin early treatment to stop the disease and to help delay diabetic-related complications. The risks for developing childhood diabetes include: low or high birth weight; obesity (with a body mass index [BMI] above the 95th percentile); a strong history of diabetes in the family; children born to mothers with gestational diabetes; the presence of key biological markers such as impaired glucose (test results that indicate insulin resistance); and symptoms

associated with metabolic syndrome.¹¹ Other associated health problems for these youth may include hyperlipidemia (elevated levels of lipids in the blood), hypertension, and/or polycystic ovarian dysfunction in girls.¹² The problem of obesity may also bring on other health problems such as asthma, sleep apnea, and depression.¹³ Any one of these comorbidity issues increases the burden of living with diabetes and is another reason for the need for ongoing medical supervision.

CULTURE AND HEALTH

Today, there is a growing recognition that culture is one of the important determinants of health, especially since society in the United States has and continues to become more multicultural, a population trend that creates a greater need for culturally appropriate interventions to improve health.¹⁴ Although there are many definitions of culture, the most common theme includes a recognition that it represents integrated patterns of human behavior that are expressed through language, thoughts, communications, customs, beliefs, values, race, and ethnicity.¹⁵ The repository of these human behaviors and values is a part of individual or group-shared cultural capital. Shared cultural capital includes a shared recognition of the individual's as well as the group's cultural identity, as in the example of an individual who is a member of a specific tribal group.

Culture is learned, is never static, and is constantly evolving, shaped and reshaped by maturation as well as by reactions to a variety of daily experiences.¹⁶ That which is accumulated or discarded from one's cultural capital repository is therefore influenced by these experiences, as well as by the environmental context in which such experiences or learning might take place. Certain elements in one's cultural capital can serve as a source of strength or can have a negative impact on health. Thomas Abel argues that individual health behaviors are deeply rooted in one's cultural value system.¹⁷

Today the recognition of culture as one of the important determinants of health has called for a greater national emphasis on increasing the cultural competency of health care providers and others working with groups in multicultural settings, promoting education and skill-building to increase cultural competency, especially for those health care workers engaged in addressing some of the nation's persistent health disparities, disparities that are most common among ethnic and racial minority populations.¹⁸ Given the growing complexity and fluidity of inter- and intracultural differences at all levels of a society, the national goal to achieve cultural competency among health care workers is challenging.¹⁹ In addition to providing cultural competency training,

other efforts also call for increasing the racial and ethnic diversity of the presence of a diverse racial and ethnic health workforce, a resource intended to help improve the quality of care and to provide health care services that are more culturally relevant.

It should be noted that long before culture was identified as one of the determinants of health, the notion of culture has always been a recurrent theme in most descriptions of programs developed for American Indians. Internally, most tribes also maintain that culture is a central part of their tribal identity, a perception that has always viewed culture as a positive attribute. For example, most individuals who identify themselves as American Indians view their identity and their culture as one and the same. In most instances, this tribal identity is also reinforced by geographical location, that is, a specific tribal environment such as a reservation or rancheria. Within this space and place, the tribal environment provides cultural safety, a place where one's tribal identity is usually never questioned.

While tribes view culture as a positive part of their identity, non-Indians do not always share this view. In fact, certain aspects of culture are viewed as a barrier to progress or barrier to assimilation into the majority culture. When the cultural barriers are listed, the list invariably includes language, illiteracy, non-western health beliefs, utilization of traditional tribal healers or healing ceremonies, plus other social issues that are seen as unhealthy lifestyle behaviors.

The camp intervention discussed here does not focus on cultural barriers, but focuses on leveraging cultural strengths to help promote wellness and knowledge that would help accentuate the children's self-esteem, identity, and skills in diabetes self-management. In this way, the health care delivery and message to the youth during camp is based on an appreciation and utilization of culturally relevant tribal and intertribal cultural capital.

ADDRESSING OBESITY AND DIABETES IN TRIBAL COMMUNITIES

Obesity is a health problem in most tribal communities, a problem that has been attributed to increased sedentary lifestyle and unhealthy food patterns. Obesity is relatively a new problem for American Indians. Prior to the 1950s, modernization had little impact on the lives of American Indians residing on reservations, where most of the activities of daily living were labor intensive, requiring considerable energy expenditure. One only has to look at photographs of American Indians before this era to note that obesity was not a problem.

To address the problem of obesity and diabetes, many tribal communities are now providing opportunities for increasing physical activity for all age groups as part of their community-based health promotion programs. As these programs progress, they are also giving more attention to collecting and analyzing data on obesity, information that previously was not usually collected, except for information recorded on individual health records during clinic or hospital visits. However one study conducted with the Pima Indian community found that tribal members who did not have diabetes reported higher levels of physical activity over their lifetimes than those who had developed diabetes.²⁰ This and other studies confirm that maintaining an active lifestyle helps prevent the development of diabetes in several ways: First, a single bout of prolonged physical activity enhances glucose uptake at the cellular level, an effect that lasts for up to twenty-four hours.²¹ Second, physical activity improves abnormal glucose tolerance in insulin-resistant individuals.²² Third, physical activity can reduce or prevent the deposit of intra-abdominal fat, which is related to insulin resistance. According to Jean-Jacques Grimm, long-term interventions that include physical activity can reduce by one-third the number of individuals with laboratory test results that show impaired glucose tolerance (IGT).²³

As the contributors to this collection indicate, most tribal health agencies are now targeting children in their obesity and diabetes prevention programs, citing examples where these programs are incorporating or reintroducing some element of the tribe's cultural capital. Community-oriented programs that promote physical activity have also increased and involve all age groups. Physical fitness or exercise programs in the schools have been added or have been expanded. Increasing numbers of tribal groups are also building community fitness centers. In some places, physicians are routinely prescribing physical activity and recommending the patients to avail themselves of the fitness facilities. Other community activities that are helping to improve the public health of the tribal communities include health fairs, health conferences or symposiums, competitive community runs, and walking groups.²⁴

AMERICAN INDIAN CHILDHOOD OBESITY AND DIABETES

The prevalence of type 2 diabetes mellitus among American Indian youth has more than doubled from 1994 to 2004; the age-adjusted rates over the ten-year period rose from 8.5/1,000 to 17.1/1,000, with an average annual increase of about 7.7 percent.²⁵ In one study, the Centers for Disease Control reported obesity among children from two to five years of age had increased 35 percent over a ten-year period, predicting that this epidemic would most likely

continue to increase.²⁶ Similar findings were reported from a national BMI survey of 9,464 American Indian children from five to eighteen years of age, in which researchers found that Indian children living on or near reservations had significantly higher BMIs for nearly every age group and for both genders when compared to Hispanic and non-Hispanic white children.²⁷ Another study by Benjamin A. Caballero and colleagues found that the incidence of childhood obesity among seven-year-old American Indian children was nearly twice (30 percent) that of other non-Indian children of the same age.²⁸ The increase in childhood obesity increases the incidence of type 2 diabetes in American Indian children.²⁹

Other studies show that prior to the 1990s, the national incidence rate for pediatric type 2 diabetes was less than 4 percent, but soared to 45 percent in the late 1990s. Together with the Centers for Disease Control, the federal Indian Health Service, which is the key health care provider for American Indians and Alaska Natives, reported that between 1990 and 1998 there was a 54 percent increase in the prevalence of diabetes among Indian youth from fifteen to nineteen years of age.³⁰

ACCEPTING AND LIVING WITH DIABETES

Living with or accepting diabetes in any culture is usually problematic, especially after the initial diagnosis. As noted before, the daily treatment and attention diabetes requires is intrusive, time-consuming, and costly, demanding that one learn and conduct certain medical procedures that are often seen as clinical duties and procedures performed by health professionals, including drawing blood for glucose testing and injecting insulin. In addition, the management of diabetes also requires constant attention to balancing dietary intake and physical activity and frequent visits to the clinic, and in the case of kidney failure, possibly traveling several times a week to a dialysis center.³¹

Because it is not immediately life-threatening, initially an American Indian youth or child may consider the interruption that diabetes brings to be an inconvenience, and their attention to self-care may not be consistent. For example, some youth who attend the camp report that they do not use the glucose monitor given to them to check their blood sugar. They say there is no need because “they feel fine,” or they may say that if they are taking the prescribed medications they do not see the need for testing. Further, most newly diagnosed campers are generally on oral medication, and some therefore perceive the oral medication as the “cure.” Unfortunately, this reliance on the medication to take care of the diabetes problem often means the child does not have an adequate understanding of the disease and its treatment. Such

education would help the youth to know that medication alone will not take care of the problem.³² The misunderstanding about long-term consequences associated with poorly managed diabetes is also evident when children are asked about how diabetic-related complications occur. Those newly diagnosed have especial difficulty connecting diabetes with some of the more common complications. Some of this difficulty is probably because most campers also say that their families do not discuss health problems such as diabetes in the home, even when other family members have diabetes and/or are experiencing diabetic-related complications.

Some young people with diabetes also deny they have diabetes even after they have developed other health problems such as hypertension or depression. Some of the youth who have been living with diabetes for several years explain they have at times stopped taking their medication because the constant attention they must give to managing their diabetes becomes depressing and hopeless. Some add that they also stop taking care of themselves because even if they follow all the prescribed treatment, nothing changes. This sense of hopelessness and depression is more likely to be reported by the youth who are overweight. This is understandable since personal appearance is important to most adolescents, who usually are concerned about their body image. Children and youth who are extremely overweight are often reluctant to be weighed when they come to camp. For them weight loss is as difficult as it is for adults. Some studies indicate that young people are more easily persuaded to make lifestyle changes such as losing weight than older adults with diabetes, but it is not always the case for some young people who are obese and have little or no support in their efforts to lose weight.³³

CHILDHOOD AND CULTURAL CAPITAL

Susan Dumais states that the accumulation of cultural capital begins at childhood.³⁴ Cultural capital deposited during childhood may or may not be maintained throughout adulthood. For example, an adult who maintains a healthy lifestyle will most likely attribute that lifestyle to what he or she has learned and come to value since childhood. Unfortunately, every child's circumstances and family situation are different, and some youth are subject to obesity because they are drawn to activities that do not involve or require extensive physical activity, such as television, video games, and spectator sports.

Appropriate role models who are physically fit or who promote physical fitness are not available in most tribal communities. Such role models would be a good resource for many children and youth, since cultural capital is gained by exposure to these types of resources. John Wilson and Marc Musick, for

example, describe values that influence healthy behaviors as a form of “symbolic good,” behaviors that can be adopted by others through role modeling.³⁵

Not all of the cultural capital deposited is acquired willingly. Most people would say that they do not seek or want to accept ill health or a disability as part of their cultural capital. Avoidance is preferred because most chronic diseases are not only burdensome but can negatively impact a desired quality of life. Young adults and youth in particular are more likely to resist a chronic disease such as diabetes because they consider themselves to be invincible.

It goes without saying that a weeklong medical camp is only a brief intervention, but the camp planners place priority on information that will help those children and youth who have difficulties accepting and managing a chronic disease that has suddenly interrupted their lives. In all, the camp has four major aims: (1) to provide an educational intervention that is culturally and age-appropriate; (2) to offer activities that include physical activities that are fun to learn and easy to maintain; (3) to offer kid-friendly and culturally sensitive health education that is individually oriented; and (4) to provide an educational environment that is age-appropriate and culturally safe.

WHY IS THERE A NEED TO ENRICH THE CULTURAL CAPITAL OF INDIAN YOUTH?

Learning or reclaiming the strengths of tribal cultural capital is important for these American Indian children because, historically, government policies and multiple other forces have attacked and devalued so many of the lifeways of American Indians, including numerous policies that pushed for their assimilation into majority culture. Among the losses are not only total destruction of some tribes, but many of the tribes that survived lost their ancestral land and all the speakers of their tribal languages. The prolonged years of colonization also forced change in self-identity by means of government policies that initiated blood quantum as the definition of an Indian. Through all of these devastating events, most tribes resisted giving up their way of life or their culture but many of these policies, as well as other experiences, did change the cultures of most American Indians.

Throughout time, distrust and resistance drove most tribes to avoid various assimilation efforts, an avoidance that followed several decades of mistreatment and large-scale disenfranchisement by the colonial power. Those who managed to survive were often met with other waves of sickness and death. In all, wars and conflict took the lives of many young men while the displacement and epidemics took the lives of women, children, and the aged. The high mortality rates among the elderly left a critical void that was especially devastating to

the cultural capital of the tribes. The deaths often destroyed the keeper of the tribe's repository of cultural knowledge. It was the elders who oftentimes served as teachers and mentors who passed on the important cultural knowledge to the children. Moreover, because many elders were also skilled healers, their decline crippled many tribes' source of health care. Programs intended to help tribes such as the introduction of Western style medical care were resisted initially. Whatever the federal government asked the tribes to adopt was often perceived as another layer to the control and/or increasing dependency on the federal government.

Reservation life did not bring salvation but added more in the way of poverty, sickness, and other forms of misery. Management of the reservations posed difficulties for the tribes as well as for the government. To keep tribes under control, the federal government delegated some of its oversight responsibilities to a cadre of federal agents as well as organized religions. In exchange for gaining access to tribal communities, the missionaries offered to establish churches, schools, and health facilities. The initial agenda of the missionaries was to use these programs to "civilize" and convert the Indians. In the conversion efforts, considerable emphasis was placed on devaluing the religious beliefs and practices of the tribal communities. These early campaigns left deep political and religious divisions among tribal members that continue today.

Most established schools were boarding schools and most did not welcome parents.³⁶ Parents were barred to guard against parental influence that might bring "primitive or uncivilized" teachings and undo the lessons taught to their children. The children's use of tribal language and their participation in any tribal ceremonial activities were forbidden. The strategy to win the minds and the souls of American Indian children as enforced by the schools obviously launched a process that eroded the children's cultural capital by indoctrinating them with primarily non-Indian values.³⁷ These boarding schools were modeled after military schools, so children wore uniforms, marched to all events, and were likely to be assigned a number as a form of identification instead of their name. The assigned number became a new identity and the number was inked onto the child's clothing or other personal possessions.

The relationship the children had with their boarding school matrons was not culturally friendly. As strict disciplinarians, the matrons failed to provide a nurturing environment, an environment that forced most children to depend on their peers for emotional and social support.³⁸ The lack of a nurturing boarding school environment that was devoid of parental guidance psychologically damaged several generations of American Indians, especially those who were enrolled at an early age and grew up in these institutions. The pressure to prevent parental involvement helped to convince some children that their cultural ways were undesirable and of no value. Today, the era

of boarding schools has all but ended and most American Indian children attend schools in their communities or in nearby communities. The few federal boarding schools that are left have greatly improved and no longer take very young children. Some residual damage left by the prolonged boarding school institutionalization, however, is still associated with poor parenting skills that have been passed from one generation to another in some families. Boarding schools did not equip subsequent generations with ways to prevent their children from adopting unhealthy lifestyles that include substance abuse, family violence, and delinquency. These periods in American Indian history, marked by various forms of cultural deprivation, also robbed the children's ancestors from fulfilling their traditional roles as teachers and mentors.

Another blow to cultural continuity has been a government program that carried out relocation of several hundred American Indians to the cities. This federal program was initiated by the federal government in 1956 under Public Law 959, promising those who volunteered that they would find employment, education, and a better life in the urban environment.³⁹ The urban resettlement pattern, however, selected urban ghettos, and since the plan's intention was to speed up the integration and assimilation of American Indians into mainstream culture, it had a purposeful strategy not to relocate these families or individuals nearby each other. In addition to dealing with the culture shock that came with the new urban environment, many of the relocated individuals and families experienced hardships. In some cases, those who were ill were denied health care under the mistaken assumption that all needs of tribal members are met by the federal government. Others questioned whether they should remain in the cities when they encountered neighbors or service providers who did not believe that American Indians still existed.⁴⁰

Without the nearby support of kin or other familiar resources, many of those who were relocated returned to the reservation, where their circumstances also remained unchanged. Others eventually stayed in the city, and now many of those children born and raised in the cities do not know or speak their tribal language, nor have they participated in their tribal traditions, except perhaps to attend a local powwow periodically. Many of these young people also say they have no desire to move to a reservation and/or see the need of learning their tribal language because it is not spoken in their home or in their urban communities. There are exceptions. For example, American Indian families who live in urban communities close to tribal lands are more likely to be involved in their cultural traditions or to continue them, and have more opportunity to learn or speak their tribal language. These losses of cultural capital have been uneven. Some tribes have lost their language but have maintained some of the cultural traditions. The children who come to the Wellness Camp come from Arizona tribes where the cultural capital is

largely intact, primarily because most of these tribes make an effort to keep these elements of their cultural capital alive. Still, these efforts continue to lose ground with each new generation. For example, more than 50 percent of the children who come to camp indicate they do not speak their tribal language. They say they have a desire to learn, but either the language is not taught in the school or they do not have relatives who have the time to teach them.

THE CAMP INTERVENTION: THE CAMPERS

The camp began in 1991 and thus far, more than five hundred American Indian children and youth between the ages of ten and fifteen years have attended, including a few who ask to return to camp as junior counselors after reaching the age of sixteen. Eligibility for attending the camp is based on priorities established from the first camp in 1991. Priority is given to children between the ages of ten and fifteen years who are newly diagnosed with diabetes and/or have been identified at high risk for developing diabetes. The criteria for high risk include (1) those who are overweight or obese, (2) those with a strong history of diabetes, (3) those born to a mother with gestational diabetes, and (4) those who have clinical indicators such as impaired glucose tolerance or *acanthosis nigricans*, dark velvety skin patches that are commonly found in areas of skin folds such as the neck or armpits.

The profiles of the campers have changed over the years. During the first few years, more females than males attended camp, but the gender distribution now has become more even. The prevalence of obesity has escalated, however, increasing the number of campers with BMIs in the obese range. The average age of the campers, however, has not changed significantly since 1991 and hovers around 12.6 years. Another profile that has not changed significantly is the presence of diabetes in more than one family generation. For example, 68 to 70 percent of campers have a parent or another sibling with diabetes, a percentage that increases to 77 percent when the child's grandparents are added. The number of campers with health problems in addition to diabetes has been increasing. On the average, 30 to 40 percent of the campers who now attend camp each year are taking medications that include oral medication, or insulin, or insulin in combination with oral medication, and a third of these campers are also taking medication for asthma, allergies, hypertension, and/or for developmental problems.

The camp has been sustained by a strong partnership commitment with the Arizona tribes and the University of Arizona.⁴¹ The responsibilities for the camp are shared by the partnership in several ways, including fundraising: the communities obtain funds to cover the camp expenses for the campers, while

the university raises funds to cover per diem for the volunteers. Serving as the camp's administrative agent, the university coordinates the camp, recruits medical staff, and provides orientation and training of volunteers. Tribal partners, most of whom work in their respective tribal community's diabetes prevention programs, recruit volunteers and work with the families to identify youth eligible for camp. The tribal partners assist the families with the registration paperwork, coordinate or schedule physical examinations for the children, and also provide follow-up, continuing to work with the children and their families after camp.

The University of Arizona recruits needed medical staff, a coverage that changes somewhat each year, but typically will include one or two physicians, one of whom is a pediatrician, a registered nurse, and two trained tribal community health representatives (CHRs). For several years, the two CHRs assisting with camp have been individuals who live with type 2 diabetes. Their personal experiences and health education expertise help provide considerable personalized health information for the campers. Their interactions with the campers are from their own experiences and/or lessons they have gained from working with other tribal members who have diabetes. Their interactions with campers and one-on-one teaching is an important source of sharing aspects of their cultural capital, keeping in practice the way young people used to be taught by their elders.

Because the camp planning committee responds to the recommendations of the campers and the volunteers, the camp offering each year is flexible and changes when needed, although much of the health information remains a central piece of the curriculum. And despite the curriculum changes, it keeps an approach that is childhood-friendly and culturally appropriate so that the offering helps strengthen those aspects of their cultural capital that improves their self-esteem, identity, and confidence.

ASSESSMENT

Although the intervention does not emphasize research, certain assessments are made to gauge the education needs of the campers and to obtain some evaluative data that can be provided to the community as well as the referring physicians. All of the campers take a pre-test on arrival at camp and take a post-test at the end. The true-false questionnaire provides some insight as to how much the campers know about diabetes, and the post-test gives them an opportunity to draw what they perceive to cause diabetes. Most of the children's drawings focus on junk food or what they describe as foods not to eat.

In addition to the above information, clinical assessments taken at camp include blood pressure, fasting and non-fasting blood sugar, and BMI. Of all these markers, most campers are especially interested in weight loss, while the community diabetes program staff want and utilize medical information. Any medical information that needs to be reported to a child's physician is sent directly to the clinician; such follow-up alerts the child's physician about the reduction in child's diabetes medicine when the child responds favorably to a proper diet and increased physical exercise.

In general, most campers lose four to six pounds during the week, an important incentive that is usually welcomed by the campers, some indicating that they will continue to work on losing weight. Other welcomed results are decreases in blood sugar levels, as results from fasting and non-fasting glucose readings usually show a significant drop, requiring the medical team to decrease some of the campers' medication dosages. In addition, the campers' scores on *Knowledge about Diabetes* pre- and post-tests routinely demonstrate improvement and some of the comments entered on the post-test indicate that the campers enjoyed the camp and/or specify what health information they have learned. Enjoyment of the camp is also reflected in the increasing number of campers who recommend that camp should go on for more than one week. Overall, the evaluations provided by the volunteers have also been consistently positive. And many of these volunteers return year after year to assist with the camp.

HEALTH EDUCATION: LEVERAGING CULTURAL STRENGTHS

The sessions taught at camp are delivered by health professionals as well as by community consultants. In preparation for these presentations, the faculty members are asked to include specific examples that are familiar to the campers, such as relevant tribal histories or other common intertribal examples. Usually such examples draw from each presenter's personal experiences, such as their work in tribal diabetes programs or their work with Indian youth.

Teaching that occurs is both informal and formal. In addition to adult faculty teaching, story sharing is encouraged among the campers. Such intertribal sharing is encouraged since the camp may be the first opportunity for a child from Pascua Yaqui to share a cabin with a child from White Mountain. To encourage the intertribal sharing, each morning during colors, campers from one tribal community show and discuss the significance of the symbols displayed on their tribal flag. What is displayed on tribal flags often symbolizes the tribes' treasured resources or history. The intertribal sharing also concludes the day during the evening fireside activities when a tribal elder might tell a

story that brings a message about health or the value of engaging in cultural activities like dancing or learning a song. Campers' support for continuing this informal intertribal sharing has remained enthusiastic over the years.

The specific aims of the camp also have not changed since the initiation of the intervention. These aims include the following:

Aim 1: Provide an educational intervention appropriate to age and culture

The teaching methodologies utilized are all sensitive to the age of the audience as well as to the intertribal cultures represented by the campers, who often come from at least six or more different Arizona tribal communities. The teaching methods also build on some of the traditional forms of tribal teaching that incorporate storytelling, illustrations or use of visual aids, games, and more westernized forms of assessment that include games containing questions in order to check what has been learned. The medical information is relayed through personal stories as well as through the use of visual aids. In addition, technical and medical terminologies are presented in a way that can be understood by the campers.

The storytelling approach has been and continues to be one of the traditional ways of teaching in many tribes. Most storytelling delivers a message but in doing so, the story is grounded in what is familiar to the audience. For example, one of the first health education sessions covers the topic of how diabetes came to one tribe in Arizona. The presenter draws these events as the story unfolds. The story begins with some history of the tribe and how the tribal community relied on gardening as well as harvesting and preparing edible plants and other food sources growing in the desert or in the nearby mountains. The story continues to illustrate how modernization such as trading posts arrived with their processed foods and sweets and how tribal farming activities declined when the water source for farming was diverted to non-Indian lands for their large-scale agricultural enterprises. The third focus of the story tells of how changes such as modernization and the arrival of automobiles impacted the health of the tribe, especially in changing levels of physical activity and introduction of fried or processed foods, and how these changes contributed to the increased sedentary lifestyles and the rise in obesity and diabetes.

Within these stories is also an opportunity to discuss some of the unique innovations that Arizona tribes developed prior to these forced changes, such as the expert irrigation systems and the successful ways they managed to produce vegetables, such as dry farming. Because such information is usually not taught in the schools, including these stories is often necessary to help the

campers understand that their ancestors skillfully managed their environment and its resources so that they enjoyed a healthy life.

Visual aids are used to convey some of the more technical information, such as the interactions between glucose and insulin, how this physiological process can result in destroying the function of insulin, and how high levels of sugar in the bloodstream is associated with diabetes. An animated DVD is utilized to illustrate this process and is sometimes followed by a game to further illustrate the role of insulin, glucose, and medication used in treating diabetes. Popular games such as “Diabetes Bingo” and other games played during the camp’s health fair include questions related to these sessions. A dart game, for example, has questions about diabetes or nutrition inserted in each of the inflated balloons that are targeted in the dart game. A successful dart hit gives players an opportunity to win a prize if they supply the correct answer. Another popular game that campers enjoy is guessing each other’s latest blood sugar reading. Games such as these are included not only to help reinforce learning, but also as activities that interest the youth, and they willingly become involved in these friendly contests. These are but a few examples that tell how the health education lessons are sensitive to the culture of childhood, as well as to the tribal cultures of the campers.

Aim 2: Offer fun-to-learn and easy-to-maintain activities, including physical activities

To welcome the campers, in the first evening activity after they arrive at the Whispering Pine Camp in Prescott, Arizona, the youth are taught about and participate in two or more traditional tribal games. A tribal consultant and his or her helpers organize these activities and begin with the history and the meaning of games before the campers are taught a game and allowed to play. The tribal consultant selects the traditional games, which may include stickball, spear throwing, kickball, hoop game, and ring the stick. Most of these traditional games are new to most of the campers so the emphasis includes the games’ significance, usually collaboration, sportsmanship, and humility.

Throughout time, most tribes developed or invented various games to encourage physical fitness and mental acuity, such as guessing the location of the game stick in a shoe game. Some games were strictly competitive and were held at seasonal tribal gatherings, while others, such as running, had a more practical purpose. Runners, for example, held special positions in many tribes because they were the messengers trusted to travel great distances to deliver important messages to other tribes. In teaching the youth about some of these games or physical activities, the focus is on more than just how the game is played, but also why. The why helps them learn that physical fitness has always

been viewed by tribes as a necessary part of keeping healthy: a harmonious state of the body, the mind, and the spiritual.

The camp allocates 30 to 40 percent of the week's activities to some form of physical activity. For example, the first activity of the day begins with each camper joining his or her cabin group in one of three or four physical activities, which might include yoga, hiking and running, or Zumba, a dance that gives participants a good cardiovascular workout. Competitive sports that involve all of the camp participants such as volleyball and basketball are also included. Short physical activity breaks are also scheduled between teaching sessions. Group hikes are included at least twice during the week, as well as a field trip that involves swimming. Other than the introduction to some traditional tribal games, most of the physical activities are those already familiar to most campers. Recreational areas and equipment are available as well. For example, the outdoor basketball court and the Ping-Pong table are highly utilized when other activities are not scheduled.

The physical activities encouraged at camp are focused on enriching the cultural capital of the campers as well as a comfortable childhood environment where such sports as basketball, volleyball, and swimming are available. The other aim is to provide the campers with an opportunity to learn something new; a new dance such as Zumba is a skill that usually most campers are willing to learn.

Aim 3: Offer kid-friendly, culturally sensitive health education that is individually oriented

Children and youth who need improvement in managing their diabetes receive one-on-one attention and education from the medical staff. In these sessions, the medical staff assesses the degree of self-management already performed by these campers, such as blood sugar testing, calculating the amount of insulin that is needed, and awareness of some of the side effects that might occur such as low blood sugar. The medical staff members take the time to review with each camper the purposes of their prescribed medicines, such as the different types and actions of insulin.

Many of the newly diagnosed children are on the oral medication Metformin, one of the few diabetes medications approved for children and youth. Although most of the youth have had some education about these medications, few understand how the medicine works or some of the side effects, and the medical team provides this information during their sessions with the campers.

Depending on the needs of the patient(s), most tribal traditional healing approaches can treat an individual patient, a group of patients or a whole

community. During camp, the medical attention is focused on the individual child while the health education and other teaching activities are group oriented. During individual consultation at camp, special attention is given to the personal concerns of the patient, allowing ample time for discussion, teaching, or demonstration. Most campers say when at home, they do not get this type of personal attention when they go in for their regular medical appointments. They say the doctors generally ignore them but elect to talk to their parents or other adult caretakers. Some campers say that their session with the medical providers at camp is the first time they are able to present their concerns or questions directly.

Aim 4: Provide an educational environment that is age-appropriate and culturally safe

In more ways than one, the camp becomes an extension of most of the children's familiar home environment because it is attended by other children from their own or other tribes and the camp is staffed primarily by American Indians or health care providers who work in tribal communities.

Providing a medical wellness camp that is culturally sensitive, culturally comfortable, and yet fun can help empower children and youth who are having difficulties adjusting to a lifestyle that demands daily attention to self-medication, dietary restrictions, performing blood glucose testing, and finding ways to remain physically active. The camp gives the campers an opportunity to learn they are not alone with this problem and that they are in a safe environment where they can talk about diabetes and other personal concerns that are frequently neglected during their clinical visits at home. Also, most of the tribal communities do not have pediatricians or other specialists in diabetes care.

Staffing the camp with a cadre of American Indian volunteers who are culturally competent and knowledgeable about diabetes is an important component to providing a medically and culturally safe environment. In addition to sharing a common culture, the volunteers from the participating communities not only know the children and their families, but also establish stronger rapport by actively participating with the campers in all of the camp activities. The rustic setting that the camp offers is another source of comfort because it does not look like a clinic or a school. The informal setting is kid-friendly and informal.

CONCLUDING COMMENTS

Diabetes camps are not new, but most have been established for children with type 1 diabetes. Summer recreational camps are also not new. Today,

many tribes sponsor summer camps for youth but do not target children with specific health conditions. The medical camp described here grew out of necessity because in the early 1990s, there was no blueprint for how best to help children who were developing type 2 diabetes. This camp, like many others, is a brief intervention, but it is workable because the community partners continue to work with these children and their families.

One of the lessons learned from doing this intervention over these many years is that to make this type of health education intervention culturally and age-appropriate requires a cadre of willing volunteers, financial resources, and ongoing planning and evaluation.

To make the intervention culturally relevant, attention also has to be given to the history that has destroyed the way of life for many tribes. Despite these losses, there remain elements of cultural capital that can enhance the confidence and self-esteem of the children that aids them in living with diabetes. The children attending camp come from several generations of families that have survived the decades of assimilation attempts and are not familiar with how this history has impacted their health. These children and youth express a desire to learn about their tribal cultures and positive lessons that can be gained from this cultural capital to help them. As noted earlier, cultural capital is held by an individual and shared in common by a family or a community and expressed through language, art, stories, music, and ideas. These shared resources, knowledge, and values provide a place of belonging and an identity.

As the epidemic of childhood diabetes continues, there is a need for developing resources for these children that are sensitive to their medical, social, and cultural needs. A culturally safe environment should be a priority, providing a place where these children and youth not only have access to information about managing the disease but also a place where health care providers can help empower them with knowledge and skill to manage their diabetes. Such a place can be an ideal medical “home” because it is child-friendly and culturally safe.

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