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NATIVE AMERICAN WOMEN'S HEALTH CARE CONCERNS
IN COMPARISON TO HEALTH CARE PROVIDERS

by

Cheryl Regan Hefta

Bachelor of Science, University of North Dakota, 1980

A Thesis

Submitted to the Graduate Faculty

of the

University of North Dakota

in partial fulfillment of the requirements

for the degree of

Master of Science

Grand Forks, North Dakota

May

1988

This thesis, submitted by Cheryl Regan Hefta in partial fulfillment of the requirements for the Degree of Master of Science from the University of North Dakota has been read by the Faculty Advisory Committee under whom the work has been done, and is hereby approved.

Chairperson

This thesis meets the standards for appearance and conforms to the style and format requirements of the Graduate School of the University of North Dakota, and is hereby approved.

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Dean of the Graduate School

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6

Permission

Title Native American Women's Health Care Concerns in Comparison to Health Care Providers

Department College of Nursing

Degree Master of Science

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Signature Cheryl Hefta

Date April 22, 1988

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ABSTRACT

This investigation sought to determine if differences exist between Native American women and health care provider's perceptions of Native American women's health care concerns. Understanding of this culture's concerns may enhance future care and treatment of Native American women and help in the development of culturally based health care.

A convenience sample of 36 Native American women and 32 health care providers, age 21-81, was obtained from an upper midwestern Indian reservation and the surrounding communities. Informed consents were obtained. A self-administered three-part questionnaire was given to each participant to complete on perceptions of health care concerns for Native American women and their cultural values.

Parts I and II, demographic data and a scale for health care concerns was developed by the researcher. Part III was a scale on cultural values originally developed by G.W. Renwick and S. H. Rhinesmith and adapted by the researcher for the purpose of this study.

MANOVA results revealed no statistical significance for health care concerns between the two groups. Mean scores showed that both groups believed diabetes, alcohol abuse, and abuse/violence are top priority concerns. When cultural values group differences were assessed to determine differences between groups, MANOVA resuts were significant (Wilks' criterion =.69; $F(9,55) = 2.79$; $p \leq .01$). Further t-test analysis showed that Native American women believe the needs of the family come before individual needs, whereas health care providers felt the needs of the individual come before the needs of the family.

The largest difference existed in the issue of eye contact, the mean for Native American women being M=2.31 and health care provider's mean being M=1.44. Comments from both groups indicated the need for more heath education, better doctors, and more effective communication to help improve health care.

Areas of concern, conflicting perspectives, and agreement were indentified. This information could be valuable in planning culturally based health education and care. Implications for further research include replicating this study using a larger random sample from different Indian reservations, determining if health care providers who have more contact with Native American women have greater understanding of their health concerns, and investigating whether health care perceptions and cultural values are influenced by gender.

CHAPTER I

INTRODUCTION

The need for culturally sensitive care is particulary acute with Native American women. These women are at risk for many health complications because of the socio-economic status, living conditions, and background. Assessment of what Native American women females perceive as their major health care concerns is of importance if health providers want to improve future health and outcomes of Native American women (Burke and Maloney, 1986).

Historically, nursing practice related to women's health has been primarily linked to reproductive health (Webster et al., 1986; Abrum, 1986). However, women's health encompasses more than prenatal care or an annual gynecological exam. It means redefining the nature of health care so that "physical and psychological" well being are always presumed to be intertwined as well as determined by interpersonal, socioeconomic, political, and environmental contexts in which the individual operates (McBride & McBride, 1981). This implies concern about the overall experience of women, not just their diseases or childbearing functions (Stevenson, 1979). The emerging practice in women's health care provides comprehensive attention to women from birth through old age with an emphasis on illness prevention and health promotion. The provision of health care is needed from a variety of perspectives, with professionals working collaboratively to provide comprehensive care (Webster et al., 1986).

The expanded view of women's health has led nurses to become concerned about matters previously not deemed worthy of serious consideration (Vance, Talbott, McBride & Mason, 1985). In the health

care of women, the provider and the clients enter into an egalitarian and collaborative relationship. The provider brings scientific knowledge and the clients bring knowledge of their own bodies, minds, spirits, and experiences. The women's perceptions play an important role in their needs or health care directions. Women make health related decisions and identify health goals consistent with their behavior (Webster et al., 1986).

Further, the social roles of women have been undergoing dramatic changes in the occupational realm and in the home. Both have far reaching consequences for women's health (Leslie & Swider, 1986). Likewise, women's health risk factors have changed. Only by understanding risk factors unique to women can nurses begin to develop and test nursing interventions to promote health and prevent illness (Leslie & Swider, 1986). The United States Public Health Service Task Force on women's issues identifies three of the most important social changes effecting the current health status of women: (a) the increasing number of women living in poverty: (b) the unprecedented increases in the number of women entering the paid workforce, and (c) the increasing lifespan of women (Public Health Report, 1985).

In the United States, studies regarding perception of health have concentrated on the mainstream population (Sobralske, 1985). Additional research is needed relative to women and their perceptions about health. Most theories, definitions, and research studies of ethnic groups of color and cultural diversity effecting the meaning of health are ignored. Sobralske (1985) speculates that the perception of health of ethnic groups of color is different from the mainstream societies perception of health.

Native American women, being a minority and in a low socioeconomic group, most likely have different health care needs than the general population. The health care providers working with this group need to be facilitating the meeting of these needs.

Purpose of the study

The purpose of this study was to determine if differences exist between Native American women's health concerns and perceptions of their needs by health providers who care for them. This information is useful because it will increase health providers knowledge of current health care concerns, identify areas of conflicting perspectives, and highlight areas of agreement. Health providers may use this information in planning culturally based health care interventions. Areas of divergence will assist in alerting health care providers and clients of issues that must be more carefully planned to move toward acceptable health care practices and outcomes for all parties involved (Burke & Maloney, 1986). Adequate assessment of Native American women's major health care concerns are essential to improving their health care and health outcomes.

Research Question

Is there a difference between Native American women and health care providers' perceptions of Native American women's health care concerns?

Theoretical Framework

Caring a transcultural nursing theory proposed by Leininger provides the framework for this study. In the development of the model, Leininger posits the discipline of nursing's central focus is upon caring behaviors, processes and intervention modalities (1979).

Caring is the central unifying concept and is considered to be the essence of nursing. Caring makes nursing unique in that it can be differentiated from other disciplines such as medicine, whose central interest is upon curing. Caring guides nurses professional thinking and action patterns, and it should guide the discipline of nursing to become a fully scientific and humanistic discipline.

Leininger differentiates between the concepts of transcultural ethnonursing. Transcultural nursing refers to a learned subfield or branch of nursing which focuses upon the comparitive study and analysis of beliefs and values. Meaningful and efficacious nursing care, based on cultural values and a health illness context should be provided. More specifically, the goal of transcultural nursing is to identify, study, test, and apply a body of nursing care knowledge and health practices which are culturally derived, understood and closely related to the needs of a culture (Leininger, 1975).

The central part of the model provides ethnonursing care constructs. Ethnonursing refers to the study of nursing care beliefs, values and practices as cognitively perceived and known by a designated culture through their direct experiences, beliefs and value system (Leininger, 1969). The goal of ethnonursing is to obtain the people's local viewpoints, beliefs and usages about nursing and caring behaviors and processes. Ethnoscience is built upon the premise that cultures can know and define the ways in they experience and perceive ir nursing care world and in relation to their general health beliefs and practices (Leininger, 1969).

From an ethnonursing perspective, Leininger contends the local people can define and communicate their nursing care needs and their

health world to an active listener and analyst. The professional nurse then develops appropriate nursing care plans on the basis of these cultural insights. Essentially, the goal is to work with cultural groups and learn their health-illness care behaviors and to adjust professional skill and knowledge to local cultural ways (Leininger, 1979).

Nurses need to step out of their own cultural value orientations and be willing to learn about the cultural values of stranger groups. In light of today's societal trends, the nursing profession and other health professions must move rapidly toward understanding diverse cultural practices in the world. Nursing care should be derived and developed from cultural context, the setting or environment in which an individual or groups health is maintained (Leininger, 1979) The cultural context has many symbolic meanings, referents and beliefs which help professionals understand people's needs and health concerns. The real challenge and goal of transcultural nursing is how to make professional practices more flexible in considering the cultural context of health illness behaviors. One must also try to integrate traditional and current lifestyles of cultures according to people's wishes and needs. Nursing care behaviors should be studied systematically with an emphasis on dominant behavioral themes. Appropriate nursing care interventions which fit the behavior patterns and cultural lifestyle can then be determined.

The Leininger model can be viewed as a structural-functional culture based model. It includes the major social and cultural factors to be examined as well as the social usages and functions of persons in health care roles. The four level model depicts the major

variables to be studied thereby fostering a comparative analysis of several cultures (Leininger, 1976).

Level I, the social structure domain is the broadest and most comprehensive level of analysis to be undertaken. The level of analysis focuses upon the social structure of a culture. Ascertaining the dominant features of the political, economic, social, cultural, educational and technological systems is essential in order to determine their relationship to health care systems features (Leininger, 1976). The health care system of the Native American population is linked to the federal government under the Public Health Service/Indian Health Service. Considerable influence exists at the local tribal levels on the reservations as to who will serve their clinic and/or hospitals. Therefore, congressmen, legislators, and tribal council members at local, state, and federal levels have strong political influence on the health care delivery system.

Level II is concerned with cultural values and health care. At this level, common and recurrent health values of a culture are carefully assessed by observing and listening to the people regarding what they desire in living, doing, and supporting their daily life activities (Leininger, 1976). The wellness or illness cultural patterns over an extended period of time and lifestyles are important sources of information about the culture.

Level III is entitled health care system and taxonomic possibilities. The nature and kind of health care systems of different cultures are surveyed at this level of analysis. Since one of the major purposes of any transcultural analysis is to determine the universality or particularity of trends in health care, this level

of study can be enormously valuable in comprehending health care systems (Leininger, 1976).

Level IV includes the roles and functions of health professionals with focus on the direct and indirect roles and activities of health personnel involved in different health services. The role behaviors and patterns of operation are also considered with respect to different situations or contexts, settings with their special norm expectations influence role-taking, and role enactments with their variabilities. It is also extremely important to document change in role function over short and long periods. Role function changes are indications of societal changes and different expectation of health providers (Leininger, 1976).

Definition of Terms

For the purpose of this study, the following definitions will be used:

Native American Women: females having one-eighth quantum Indian blood, listed on a tribal role and who, on the basis of cultural heritage, consider themselves to be Indian. The females must be living on or near an Indian reservation and receive care at the Indian Health Service clinic or nearby hospital or clinic.

Health Care Providers: those involved with the health care of Native American women. Examples include: registered nurses, licensed practical nurses, nurse practitioners, physician assistants, or midwives working on or off the Indian reservation.

Health Care Concerns: the extent to which the respondent is worried about or interested in her state of health.

Health Care Perceptions: beliefs about health care concerns.

CHAPTER II

LITERATURE REVIEW

This study deals with Native American women's health concerns in comparison with the health care professionals who serve them. In this chapter a review of pertinent literature will be presented. Studies which focus on other ethnic groups will be discussed initially followed by studies related specifically to Native Americans of different tribes.

Selected Ethnic Groups

According to Madeline Leininger (1978), findings about cross culture care reveal more differences than similarities among cultures. Leininger (1985), studied Southern rural black and white Americans lifeways which focused on care and health promotion. A ten month field study using interview, participant observation, and other techniques was used to identify cultural similarities and variabilities. The study pointed to the need to base health care practices upon the clients perceptions, cognition, and experiences rather than impose health professional practices and ideologies. As a result meaningful and satisfying health services could be realized.

Branch and Paxton (1976), stress two steps that must be taken if a health care system is to obtain maximum health for all members of society: (a) re-evaluation of the impact and importance of traditional health practices and systems and (b) development of new models for those of the health field. Therefore, it is of importance that health care professionals look into traditional beliefs and practices of the people they serve. They also need to develop health models that utilize some of the traditions, so the people they serve will use the health services more effectively.

In a study across cultures of educational level and family planning among Chinese in Pennsylvannia and Tawain, an interview survey revealed that cultural differences effected individuals fertility behavior (Wang, 1979). Nurse researchers must become familiar with the culture so they can identify the values, norms, and health practices of the cultural group they are studying.

Native American Tribes

Although a number of studies concerning Native American cultures have been conducted, none pertain directly to the phenomenon of health care concerns of Native American women in comparison to health care providers. Specifically, there are studies that have been conducted in relation to Native Americans and alcoholism, diabetes, health surveys, childbearing, pregnancy, and studies comparing the different tribes of Indians

Cultural influences result in differences in values. In a study of transcultural nursing and childbearing of the Muckleshoot Indian people, Horn (1976), proposed three suggestions. One, there will be better utilization of health care services if nursing care plans are derived from knowledge of the growth and developmental processes of children which Native American persons are most concerned about. Two, if nursing care plans for Native American children and parents take into consideration crises of daily living that effect both groups, there will be increased utilization of the plan. Three, if the health-illness continuum, as perceived by a specific group, is incorporated into nursing care plans, there will be increased utilization of professional health care. In another field study about Native American women during pregnancy, an essential requirement for a

health care person was to be a helping caring individual (Horn, 1975). This requirement may also be found to be essential for Native American women throughout their adult lives.

Using interviews and the effect of experiences on traditions of pregnancy which infuence maternity care of Navajo people in Arizona and based on published and unpublished literature concerning Navajo cultures, Sevcovic (1979) concludes that nurses who work with the Navajo should first learn about tribal customs and beliefs. Attempts can then be made to investigate the congruency between customs and practices. She also states the beliefs and practices of Navajo's like those of other cultures should be regarded as part of a continuum rather than absolutes. Sevcovic recognized that professionals who were willing to risk their own tradition by obtaining and utilizing transcultural and multicultural advances in health care might make real contributions to the body of medical knowledge and obtain a degree of satisfaction with their own work.

The cultural differences between Indians and mainstream American society and the wide cultural variations among over 300 tribes have complicated the planning of large scale health prevention efforts, according to May (1986). Great diversity among American Indian tribes have significant implications for health restoration, promotion, and maintenance efforts on the part of nurses.

In a descriptive study of interactions between western and traditional medicine demonstrated by an urban Indian population (McKenna, 1979), the informants varied in their perceptions of symptoms and treatment from almost total adherence to traditional beliefs, to total acceptance of dominant society practices. This

range of actions highlights the fact that Indian patients come from a variety of tribal background and generalizations about behavior are difficult to make. McKenna indicates that nursing care should be modeled in constructs of transcultural nursing including compassion and empathy toward the Indian patient's previous experiences with medical care. "The nurses knowledge of the reason for the Indian choice in care has practical value for improving local health care and also contributes to a general understanding of illness behavior in relation to cultural changes incurred by a population." (McKenna, 1979, p.714).

In a Rokeach Value survey of a large southwestern Indian Reservation done by Flores (1985), evidence suggested that Native American values are measurable and distinctly different from Anglo values. Many of the health care professionals serving the Native American are of Anglo descent. If this survey done by Flores is also true for the Native American women of the reservation used in this study, better care and understanding might be given to the women.

A descriptive study by Bushnell (1981), designed to obtain current information on beliefs of pregnancy and childbirth of Northwest Indian women revealed young Indian women are becoming less dependent on their families. However, they are more likely to need extra family support when they are pregnant. Additionally, the role of the health provider caring for the pregnant women may change.

In a prospective study of social and cultural factors in pregnancy complications among 968 Navajo women from two Indian Health Service clinics in New Mexico, social and cultural processes were noted to be salient factors in the development of disease,

particularly in populations experiencing major cultural change (Boyce et al., 1986). For a Navajo Health Consumer Survey done with 309 families on the Navajo Indian reservation, an interview instrument was patterned after the Health Interview Survey of 1973 and the Indian Health Survey of 1955-56. The interview respondents were either heads of households or spouses of heads of households. Each family respondent was requested to provide data for all children younger than 16 residing in the home and for any absent adult. All available adults were requested to respond to the individual question regarding their health behavior. Stewart, May, and Muneta (1980), finding's suggest considerations are often either ignored or accepted as truisms in delivering care.

Shah and Farkas (1985) believe low socioeconomic status, cultural differences and descrimination found in cities are primary blocks to good health care for Indians. Young (1982) did a community health survey using interviews and clinical examination among Indian residents in Northwest Ontario of 1,055 people. He found different socio-cultural background between health care providers and consumers further contributes to divergent concepts of health and disease.

In an article on the health status of Native Americans in New York, May (1986) concluded further research is needed concerning the health status of Native Americans. She suggested numerous Native Americans in the state continue to maintain traditional cultural beliefs and practices including those involving disease. Therefore, health care efforts should be culturally sensitive to those beliefs.

Summary

Health care providers should present modern health care designed

to minimize conflict with traditional beliefs. To achieve cultural sensitivity, practitioners need to study the cultural belief system of the people with whom they are working and should treat that belief system with respect. Even those Native Americans firmly committed to maintaining traditional values and ways of life as much as possible will be more likely to accept modern health care if it does not threaten those traditional ways.

CHAPTER III

METHODOLOGY

Chapter III contains the methodology of this descriptive study. The following are included in the chapter: selection of subjects, setting, procedures, instruments, and statistical treatment of the data collected.

Sample

Two different groups consisting of 36 Native American women ranging in age from 21 to 81 years, and 32 health care professionals were drawn from a convenience sample. The Native American women were assessed from an upper midwest Indian reservation. The health care providers were employed at the Indian reservation and/or the surrounding communities, not more than thirty miles away. The health care providers regularly provided health care for Native Americans.

Recruitment of the subjects was done in person by the researcher at the community center on the reservation, the community college on the reservation, and local gathering places in the different districts on the reservation. Health care providers were recruited by the researcher at the health care clinic on the reservation, community health and home health agencies who serve Native Americans, and a local hospital.

Data Collection Procedure

The self-administered questionnaire was given to subjects who freely chose to participate in this study after permission was received from the University of North Dakota Institutional Review Board. Thirty-eight Native American women were invited to complete the questionnaire with 36 being returned, yielding a response rate of

94.74%. The Native American women who participated in this study were given the questionnaire in a setting of convenience such as the researcher's office, clinic screening rooom or waiting room. The proposal was presented to health care providers at their place of employment in a setting of convenience such as the nurses station or nursing office, thereby enabling the researcher to answer any questions or concerns from potential participants. Thirty-five questionnaires were distributed to health care providers with a response rate of 32 or 91.42%. See Tables I and II for characteristics of the two groups of participants.

Research Instrument

The research instrument utilized in this study was designed by the researcher and consisted of three parts. See appendix A for a copy of the questionnaire. Part I was demographic data. Health care providers and Native American women who participated in the study were given different categories to address. For example Native American females were asked to respond to the following categories: age, education, tribal affiliation, excetera. Health care providers were asked questions pertaining to age, gender, education, primary place of employment years of experience, and experience in providing health care to Native Americans.

Part II of the questionnaire was a six item survey regarding beliefs about Native American female's health care concerns. The questions pertaining to part II were based on ideas from the literature review and professional work experience. Both subject groups completed the same questions for Part II.

Part III of the research instrument was a nine item tool

TABLE I

Profile of Native American Women

Characteristics	N
Marital Status	36
Single	12
Married	17
Separated	1
Divorced	5
Widow	1
Tribal Affiliation	35
Sioux	30
Three Affiliated Tribes	4
Chippewea	1
Education	36
9th Grade	1
10th Grade	2
11th Grade	4
12th Grade	4
13th Grade	3
14th Grade	13
15th Grade	4
16th Grade	3
Graduate School	2
Employment Status	36
Employed	32
Unemployed	4
Types of Employment	28
Clerical	12
Health related	9
Teaching related	3
Retired	1
Student	1
Planner/Grants Writer	2

Characteristics	MEAN	SD	Range	N
Age	[illegible]	12.43	21-81	34

TABLE II

Profile of Health Care Providers

Characteristics	N
Sex	32
Male	2
Female	30
Education	32
Associate Degree	2
Diploma	10
BSN	9
LPN	9
Nurse Practitioner	1
Physicians Assistant	1
Place of Employment	32
Clinic	6
Hospital	23
Community Health	1
Home Health	2

Characteristics	MEAN	SD	Range	N
Age	37.45	9.70	24-57	31
Years of Exp.	13.90	7.42	2-34	32
Exp. with N. Am.	9.47	7.37	0-34	32

originally designed by G.W. Renwick and S.H. Rhinesmith. This tool was modified by Sondra Thiederman and then by this author. Because of the various education levels of participants in the study, changes were made in the vocabulary in order to be more comprehensible. Other changes included shortening the statements to include only one major concept.

Reliability of Parts II and III was determined using alpha coefficents. Tool reliability for the original tool of Part III (designed by G.W. Renwick and S. H. Rhinesmith) was not reported.

Alpha coefficients for this study were .84 (N=36) for the health concerns scale and .38 (N=33) for the cultural values scale for Native American women. The alpha coefficients of the health concerns scale and cultural values scale for health care providers was .86 (N=31) and .55 (N=32) respectively. Face or content validity was established by having other graduate students and nursing faculty members who have expertise in transcultural nursing review the instrument for clarity, ambiguity, and accuracy of content.

Analysis of Data

Data were analyzed using descriptive statistics such as means and standard deviations. The research question was answered by using multiple analysis of variance (MANOVA) which related the nominal independent group variable of Native American women and health care providers to the multiple interval level dependent variable of the health care concerns and cultural values scale. The study determined if differences in education, tribal affilation and age effected Native American women's perception of health care concerns. The health care providers place of employment, experience in health care and experience in providing care for Native Americans were also analyzed by using chi-square and analysis of variance to determine differences in group means.

Protection of Subject Rights

This research proposal was submitted to the University of North Dakota Institutional Review Board. The clinical directors and director of nursing at the various facilities were also asked for their approval.

Informed Consent

Subjects were free to choose to participate in this study. The consent form included the following information: (a) the person conducting the research; (b) a brief description of the study; (c) procedures involved; (d) assurance of confidentiality and anonymity; (e) subjects freedom to withdraw from the study at any time; and (f) an invitation to the subjects to ask questions. Subjects were further assured their participation or non-participation in this study would in no way affect their job (for health care providers) or jeopardize the health care they receive (for Native American women). By completing the questionnaire, the subject implied his/her consent. See Appendix B for a copy of the letter of consent.

CHAPTER IV

RESULTS

Introduction

Qualitative and quantitative data from the sample of 36 Native American women and 32 health care providers are presented in this chapter. Statistics were compiled using the IBM Statistical Analysis System (SAS) Program and Statistical Package for the Social Sciences (SPSS-X). Findings relevant to the research question as well as additional findings will be presented.

Examination of the Research Question

Is there a difference bet[illegible] Native American women and health care providers' perceptions of Na[illegible]erican women's health care concerns? Subjects were asked to r[illegible]primary health concerns for Native American women. Multiple analysis of variance (MANOVA) results indicated no significant difference between Native American women and health care providers related to Health Care Concerns (Wilks' criterion = .67; F (14,[illegible])=1.84; p=NS). Because the MANOVA result was not significant, further analysis of variance was not done. In Table III mean score results are presented for each concern included in the health care concern scale.

Diabetes, alcohol abuse, and abuse/violence were perceived as factors holding the greatest concern by both groups of subjects. Native American women perceived alcohol abuse to be of great significance (M=4.75); whereas abuse/violence was of greater importance to the health care providers (M=4.59). Although MANOVA results indicated no significant differences between Native American women and health care providers, observations of the differences in means could suggest physical fitness/exercise, mental illness,

parenting, and stress were perceived differently in terms of priorities by both groups. Both groups found high blood pressure to rank in the middle with the mean for Native American women being M=4.00 and health care provider's mean being M=3.77.

TABLE III

Mean Scores of Health Concerns between Native American Women and Health Care Providers

Concern NA Women	N	MEAN	SD	HCP N	MEAN	SD
Diabetes	36	4.44	0.60	31	4.30	0.64
Alcohol Abuse	36	4.75	0.73	31	4.41	0.89
Heart Disease	36	4.11	0.78	31	3.90	0.94
High Blood Pressure	36	4.00	0.79	31	3.77	1.06
Female Problems	36	3.94	0.83	31	3.58	0.72
Preg. Complications	36	3.92	1.05	32	4.03	0.90
Communicable Diseases	36	3.83	1.08	31	3.90	0.94
Abuse/Violence	36	4.47	0.81	32	4.60	0.56
Poor Nutrition	36	4.0	0.89	31	3.74	1.21
Physical Fitness	36	4.11	0.82	31	3.16	1.27
Mental Illness	36	3.64	1.02	31	2.84	1.00
Parenting Issues	36	4.28	0.88	32	3.72	1.05
Stress	36	4.00	0.99	31	3.42	0.99
Accidents	36	3.75	1.08	32	3.69	0.90

Other concerns mentioned by Native American women included dental care, teenage pregnancies, drug abuse, and reading, writing, and spelling. Health care providers also identified concerns such as planned parenthood, health education, and teenage pregnancies.

Differences were also assessed to determine whether Native American women and health care providers held varing views about illness prevention, acute illness and whether health care providers had different concerns than Native American women. Tables IV and V portray the mean score for Native American women and health care providers.

From the mean scores Native American women and health care

providers had similar beliefs that health care providers should focus on illness prevention. Greater mean score differences were noted in the need for health care providers to focus on health care needs when clients are seriously ill. Of interest is the mean score difference of .59 between Native American women and health care providers score for rating perceptions of health concerns for Native American women. Both groups rated primary care and acute care similarily, yet this summary question would indicate a difference. Even though a marked emphasis in health care delivery currently focuses on prevention, health care providers thought they should have greater emphasis on acute care. This may be explained partly in that the majority, 23 of the 32 health care providers, in this study were employed in a hospital setting.

TABLE IV

Native American Women's Health Care Perceptions

	MEAN	SD	N
Illness prevention	4.61	0.87	36
Acute Needs	4.42	0.97	36
Different Concerns	3.44	0.91	36

TABLE V

Health Care Providers Health Care Perceptions

	MEAN	SD	N
Illness prevention	4.66	0.79	32
Acute Needs	4.16	1.11	32
Different Concerns	4.03	0.93	32

Both groups of participants were also asked to rate their beliefs regarding how sick should you be and how sick are you before seeking

health care attention. Tables VI and VII illustrate the mean scores for Native American Women and health care providers.

TABLE VI

Native American Women's Mean Scores in Perceptions of Seeking Health Care

Group	MEAN	SD	N
Should seek	1.72	1.00	36
You seek	2.06	1.04	36

TABLE VII

Health Care Provider's Mean Scores in Perceptions of Seeking Health Care

Group	MEAN	SD	N
Should seek	1.91	0.47	32
You seek	2.53	0.67	32

Similarities were found between the Native American women and health care provider on when someone should seek health care attention. The majority of Native American women felt it was most important to seek health care attention at the first sign of illness, whereas the health care provided felt one should seek health care after home remedies no longer help. Dissimilarities were found as to when the Native American women seek health care versus when health care providers seek health care. This difference may be due to the fact that health care providers are more knowledgeable in treating sickness or illness because it is their profession. The t-test results indicated no significant difference in seeking health care between Native American women and health care providers.

Part three of the questionnaire was to determine if cultural values differed between the Native American women and the health care providers. MANOVA results indicated a significant difference between Native American women and health care providers related to the cultural values scale (Wilks' criterion =.69; $F(9,55) = 2.79$; $p=.01$).

TABLE VIII

T-Test for differences in Cultural Values between Native American Women and Health Care Providers

Concept	N	MEAN	SD	VARIANCES	T	DF	PROB>|T|
Future/Life Course							
NA Women	35	1.54	0.98	Unequal	1.34	65.0	NS
HCP	32	1.28	0.52	-	-	-	-
Answers							
NA Women	35	3.11	1.41	Unequal	0.63	65.0	NS
HCP	32	2.91	1.28	-	-	-	-
Punctuality							
NA Women	35	2.77	1.40	Unequal	1.93	65.0	NS
HCP	32	2.13	1.34	-	-	-	-
Dealing with Pain							
NA Women	35	3.86	1.35	Unequal	0.61	65.0	NS
HCP	32	4.03	0.93	-	-	-	-
Gifts							
NA Women	35	3.74	1.20	Unequal	2.82	65.0	0.01
HCP	32	2.94	1.13	-	-	-	-
Addressing Someone							
NA Women	34	2.15	1.26	Unequal	0.79	64.0	NS
HCP	32	1.94	0.84	-	-	-	-
Direct Questioning							
NA Women	35	1.63	0.81	Unequal	0.34	65.0	NS
HCP	32	1.56	0.76	-	-	-	-
Eye Contact							
NA Women	35	2.31	1.18	Unequal	3.57	65.0	0.001
HCP	32	1.44	0.76	-	-	-	-
Indiv. vs Family							
NA Women	35	3.71	1.25	Unequal	3.69	65.0	0.001
HCP	32	2.69	1.00	-	-	-	0

In Table VIII T-test results are presented for each concept in the Cultural Values Scale.

The greatest difference of the cultural values questionnaire existed in the statement concerning individual versus family needs. The Native American women agreed more with the statement: the needs of the individual are always secondary to the needs of the family. Health care providers agreed more with the statement that ultimately, the independence of the individual must come before the needs of the family. The next largest difference existed in the issue of eye contact, the mean for the Native American women, being 2.31 and the health care provider's mean being 1.44. The statement most similar between the two groups dealt with direct questioning; Native American women means of 1.63 and health care providers' mean of 1.56.

Additional Findings

Additional data analysis was done which included determining if Native American women's perceptions of differences were impacted by age, education, and tribal affiliation. All results were non-significant. Tests of significance (Anova, T-test, and Chi square as appropriate) were used to determine if health care provider's age, level of education, place of employment, years of experience, and experience in providing care to Native American made a difference in health care providers beliefs regarding Native American women's health care concerns. These results were also non-significant.

Comments were sought from both groups regarding how they believed health care could be improved for Native American women. The most frequent comment from both groups was the need for more education, such as health education which focuses on prevention. The second most

common comment from the Native American women was to have more qualified doctors, preferably more Indian doctors. The health care providers also suggested better compliance as an important need to help improve health care delivery to Native American women. Other suggestions included more money, better communication, alcohol counseling, having doctors stay longer, and more health personnel.

CHAPTER V

DISCUSSION AND CONCLUSIONS

This chapter is presented in four sections. The first section will be a summary or overview of the statement of the problem, theorectical framework, review of the literature, design and conduct of the study, and data analysis. The second section provides an interpretation of data followed by a presentation of the conclusions drawn from the study findings. The fourth section discusses resulting implications for practice and research.

Summary

The purpose of this study was to determine if differences exist between Native American women's health concerns and perceptions of their needs by health providers who care for them. The following research question was investigated:

Is there a difference between Native American women and health care providers' perceptions of Native American women's health care concerns?

Madeline Leininger's transcultural nursing model provided the theorectical framework for this study. Investigations examined in the review of the literature pertained to studies of other ethnic groups to studies of Native Americans from various tribes and ways to improve upon cultural differences in order to provide more effective health care.

The research instrument utilized in this study consisted of three parts. Part I dealt with selected demographic data of Native American women and health care providers. Part II was a six-item survey regarding beliefs about Native American female's health concerns. Part III of the research instrument was a nine-item tool on cultural

values.

The sample groups for this study consisted of 36 Native American women and 32 health care providers, located on or near an upper midwestern Indian reservation. The self-administered questionnaire was given to subjects who freely chose to participate in the study.

In the interpretation of the results of this study no differences were found between the two groups in relation to health care concerns. Significant differences were found in the two groups in comparing health care perceptions, when seeking health care and cultural values. Additional findings suggested differences in perceptions were not impacted by age, education, and tribal affiliation with the Native American women. Health care providers were also assessed as to whether age, level of education, place of employment, years of experience and experience in providing health care to Native American women influenced their beliefs regarding health care. No significance was found.

Discussion

A synthesis of the results of this study in relation to findings of relevant studies reviewed in the literature and theoretical framework are presented. The theoretical framework of Madeline Leininger differentiates between the concepts of transcultural ethnonursing. This study looked at Native American women's health care concerns in order that health care providers could learn and adjust their skills and knowledge to the local cultural ways. The goal of transcultural nursing and this study was to identify, study, test, and apply a body of nursing care knowledge and health practices which are culturally derived and understood and related to the needs

of the culture. The needs of this culture as identified in this study were more health education, better doctors, better communication, and more health care providers.

The leading causes of death in Native American communities are accidents, heart disease, cirrhosis of the liver, suicide, and homicide (Spector, 1985). In this study the leading concerns for Native American women were alcohol abuse, abuse/violence, diabetes, parenting issues, and heart disease. Although accidents are the leading cause of deaths in Native Americans, the group of Native American women in this study placed accidents second to last in the Health Concerns questionnaire. Accidents were rated tenth by the health care providers. The top five concerns listed by the health care providers were abuse/violence, alcoholism, diabetes, pregnancy complications, and heart disease. According to mean scores, exercise/physical fitness, mental illness, parenting issues, and stress were the health concerns which the two groups rated most differently.

This study also supported the Rokeach Value survey done by Flores (1985) which stated Native American values are measurable and distinctly different from Anglo values. A statistical significance was found between the two groups in the Cutural Values questionnaire (see Table VIII). Health providers who try to understand and learn these difference will probably be better at understanding the nonverbal communication and beliefs of Native American women. With this new knowledge and understanding, health care delivery might improve. The Native American women also indicated in the cultural values questionnaire that family needs are probably of more importance

than individual needs, therefore health care providers should take a look at the whole family as well as the individual when providing health care.

Although similarities are found, improvement needs to be made with better communication between the two groups. Through better communication, health education will become more beneficial to the Native American women, as they and the health care providers come to understand each other more completely.

Conclusions

Although conclusions drawn from this study are only generalizable to Native American women and health care providers of an upper midwestern Indian reservation, study findings hold implications for health care delivery to other Native Americans. Because of the small sample size, results may be most generalizable to the local reservation where data were collected.

The statistical results of the data in this study demonstrated both non-significance and significance in the three part questionnaire. No significant difference was found between the two groups in the area of health concerns. Significance was found in health care perceptions of the Native American women and health care providers. Although the two groups agreed with the first two questions, they differed in views on the third question. This difference may be due to the lack of clear communication between the two groups.

Differences were also found when Native American women and health care providers seek health care. Although they both were in agreement as to when someone should seek health care, they differed as to when

they did seek care. This difference may be because health care providers have more knowledge of illness and health care when compared to the Native American women.

Cultural values also showed much statistical significance. This supports the belief that one needs to understand anothers culture to give more complete health care. Better understanding of that culture will then enhance communication.

As a result of identifying areas of health concerns as well as congruence and incongruence between health care providers and Native American women, health care providers should be able to use this information in planning culturally based health education. Health care providers will be able to have better understanding of Native American women's health concerns, improve communication and therefore meet their needs more completely.

Recommendations

The results of this study suggest four directions for further research. One, replicate this study on a larger scale, using a larger sample size with random sampling on different Indian reservations. This would enhance the generalizability of the study findings. Two, another variable which could be assessed could be that of health care providers who have had transcultural nursing courses in their nursing cirriculum. Does this make a difference in health care concerns and cultural values perceptions regarding Native American women? Three, investigate to determine if a difference exists between health care providers who work in hospitals or clinics on the reservation compared to health care providers who work in hospital or clinic settings off the reservation. Do health care providers who have more consistent

contact with Native American women have greater understanding of Native American women's health care concerns? Four, study the concerns of Native American males and see if their concerns are congruent with Native American women. Health care perceptions and cultural values as influenced by gender have not been emperically studied.

APPENDICES

APPENDIX A

Consent Form (Native American Women)

I am a graduate student currently enrolled at the University of North Dakota. I am presently conducting a study as part of the requirements for a program leading to a Master of Science degree. The purpose of this study is to determine if differences exist between Native American women's health concerns and perceptions of their needs by the health care providers who care for them. You are invited to participate in this study to determine what you believe are important health care needs of Native American women. The information you provide on this questionnaire is useful in increasing health care provider's knowledge of your health care concerns and thereby planning more effective health care interventions. You will be asked to rate a variety of health care concerns to the degree of importance they have for you. You will also be asked questions about your age, tribal affiliation, education, anu employment status. There are no known risks associated with answering this questionnaire. It should take you approximately 10-15 minutes to complete. I will be available to answer any questions you may have.

Your participation in this study is completely voluntary. Your particapation or non-participation in this study will in no way jeopardize the care you receive. You have the right to withdraw your information at any time if you choose. Your anonymity and confidentiality are assured.

Your completion and return of this questionnaire indicates that you have read this consent form, your questions have been answered, and you voluntarily agreed to participate in this study. Should you

desire a summary of the study findings, I will be happy to provide them to you. A separate sheet of paper will be provided for your forwarding address upon your request.

Thank you for your time and assistance.

Cheryl Hefta--------------(701) 662-2414

APPENDIX B

Consent Form (Health Care Providers)

I am a graduate student currently enrolled at the University of North Dakota. I am presently conducting a study as part of the requirements for a program leading to a Master of Science degree. The purpose of the study is to determine if differences exist between Native American women's health care concerns and perceptions of their needs by health care providers who care for them. You are invited to participate in this study to determine what you feel are the health care concerns of Native American women. The information you provide on this questionnaire is useful in improving the health care provided to Native American women. You will be asked to rate a variety of health care concerns to the degree of what you feel are important health concerns of Native American women. You will also be asked to provide pertinent demographic information. There are no known risks associated with answering this questionnaire. It should take you approximately 10-15 minutes to complete. I will be available to answ-` ..̦ questions you may have.

Your participation in this study is completely voluntary. Your decision to participate or not participate will in no way affect your employment status or perfomance evaluation. You have the right to withdraw your information at any time if you so choose. This study is about Native American women and Health Care professional's perceptions and is NOT an evaluation of specific individuals or institutions. Your anonymity and confidentiality are assured.

Your completion and return of this questionnaire indicates that you have read this consent form, your questions have been answered,

and you voluntarily agree to participate in this study. Should you desire a summary of the study findings, I will be happy to provide them to you. A separate sheet of paper will be provided for your forwarding address upon your request.

Thank you for your time and assistance.

Cheryl Hefta--------------(701) 662-2414

APPENDIX C

Part I Demographic Data (Native American Women)

1. AGE __________

2. MARITAL STATUS SINGLE____ MARRIED____ SEPARATED____

   DIVORICED_____ WIDOW_____

3. NUMBER OF CHILDREN_______

4. TRIBAL AFFILIATION ________________________________

5. EDUCATION (Highest level completed) ________________

6. EMPLOYED ______ (If so what type of occupation)

7. UNEMPLOYED _________

APPENDIX D

Part I Demographic Data (Health Care Providers)

1. AGE ______
2. SEX ______
3. EDUCATION: RN: AD______ DIPLOMA______ BSN______ LPN______

   NURSE PRACTITIONER______ PHYSICIAN ASSISTANTS______
4. PRIMARY PLACE OF EMPLOYMENT: CLINIC______ HOSPITAL______

   COMMUNITY HEALTH______ HOME HEALTH______ OTHER ______
5. YEARS OF EXPERIENCE__________
6. YEARS OF EXPERIENCE IN PROVIDING HEALTH CARE TO

   NATIVE AMERICANS______

APPENDIX E

Part II Health Concerns Questionnaire

1. What do you believe are the primary concerns for Native American Women?
   Please rate each of the following conditions:
   5 Most Important   3 Undecided   1 Not Important
   4 Important   2 Least Important

   _______ Diabetes
   _______ Alcohol Abuse
   _______ Heart Disease (strokes, heart attacks)
   _______ High Blood Pressure
   _______ Female Problems (Gynecological)
   _______ Pregnancy Complications
   _______ Communicable Diseases (Veneral Disease, Measles, Tuberculosis, Aids)
   _______ Abuse/Violence
   _______ Poor nutrition
   _______ Physical Fitness/Exercise
   _______ Mental Illness
   _______ Parenting Issues
   _______ Stress
   _______ Accidents
   _______ Others, please specify

Please circle: 1 strongly disagree   3 Neutral   5 Strongly Agree
2 disagree   4 Agree

2. Health care professionals should focus on illness prevention:

SD	D	N	A	SA
1	2	3	4	5

3. Health care professionals should focus on health care needs when clients are seriously ill.

SD	D	N	A	SA
1	2	3	4	5

4. Health care professionals have different concerns than do Native American Women regarding health care concerns?

SD	D	N	A	SA
1	2	3	4	5

5. How sick should you be before you seek professional health care attention?

   1 First sign of illness
   2 After home remedies no longer help
   3 When you feel really miserable
   4 When you are too sick to get out of bed

6. How sick are you before you seek professional health care attention?

1 First sign of illness

2 After home redmedies no longer help

3 When you feel really miserable

4 When you are too sick to get out of bed

7. How do you believe health care for Native American Women can be improved?

Directions

Circle 1 - strongly agree with the statement of the left.
Circle 2 - agree with the statement on the left
Circle 3 - are neutral
Circle 4 - agree with the statement on the right
Circle 5 - strongly agree with the statement on the right

1) Preparing for and influencing the future are important parts of being a responsible adult.	1 2 3 4 5	Life follows a set course.The individual should follow that course.
2) Vague and tentative answers are dishonest and confusing.	1 2 3 4 5	Vague answers are sometimes preferred as they avoid embarrassment and confrontation.
3) Punctuality and efficient use of time are reflections of intelligence and concern.	1 2 3 4 5	Punctuality is less important than maintaining a relaxed atmosphere.
4) When in severe pain, it is better and more appropriate to remain stoic.	1 2 3 4 5	When in severe pain it is better to express the discomfort.
5) It is not appropriate to accept a gift from someone you do not know well.	1 2 3 4 5	It is an insult to refuse a gift when it is offered.
6) Addressing someone by their first name shows friendliness.	1 2 3 4 5	Addressing someone by their first name is disrespectful.
7) Direct questions are usually the best way to gain information.	1 2 3 4 5	Direct questioning is rude.
8) Direct eye contact shows interest.	1 2 3 4 5	Direct eye contact is disrespectful.
9) Ultimately, the independence of the individual must come before the needs of the family.	1 2 3 4 5	The needs of the individual are always secondary to the needs of the family.

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