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Bobanne G. Roush
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A POLITICAL ECONOMY APPROACH TO HEALTH CARE
AMONG AMERICAN INDIAN POPULATIONS IN CENTRAL OKLAHOMA

A Dissertation APPROVED FOR THE
DEPARTMENT OF ANTHROPOLOGY

BY

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Abstract

The health care system in America is in crisis. Costs of health services and nutritious foods are increasing dramatically every year for everyone. For American Indians it becomes a test of endurance and creativity to be able to access quality, affordable health care. A commonly held belief that Indians get free health care is misguided. Health care services are not free. They are expensive. They are a provision of many treaties that were negotiated between tribes/nations and the federal government. Thus, Native peoples are entitled to health care services but access is complex and comes at a price.

Like a spider s web, health care and nutrition services are linked to identity, kinship, membership, and social networks which are dependent on the world economy. Tribal economic development is an avenue tribes are taking to be able to provide these services for its members. Economic development also decreases tribal dependence on the Federal dollar.

The research addresses political economy issues in a world economic system as it relates to tribal sovereignty, kinship, identity and health care. An overview of the origins of health care for Indians and its effects over time is provided for clarity and understanding. Tribal governments and Native people often use strategies to maximize what services they have at their disposal. Narratives illustrate trials and tribulations Native individuals have endured just to make ends meet and stay healthy. The study focuses on health care access for American Indian populations living in the Indian communities serviced by the Iowa Tribe of Oklahoma.

Part I

Introduction

Chapter One

American Indian Health Within a World-Economy

In those days and in those places, Joe lived on the southern plains with his family and an assortment of local flora and fauna. His shelter was made of brush, rocks, animal skins, and cedar trees. Not far away was an underground spring with fresh water. He and his animal buddies used this water year round. There was plenty for everyone. When he needed food or clothing, he hunted wild animals. He only took what he needed and he offered thanks and apologies to the animal that was hunted. He and his wife fashioned clothing, utensils, and hunting equipment from various parts of the animal. It was a hard life, but it was good. What he could not eat he preserved. There was usually plenty to share with neighbors who also lived on the plains. He considered himself and his family pretty healthy. Except for a few injuries from time to time, they seemed to rarely be ill.

One day he saw a large object looming on the horizon. It got closer and closer. It dug into the earth and tore it up. It didn t affect him or his family or lifestyle, so he didn t give it much thought. Time passed and soon he saw things that looked like odd-shaped boxes. They were all different sizes. Not only that but the land around it was green and at night he could hear rain. He knew it was rain because it fell from the sky and was wet. In time, he ventured closer and saw there were people, lots of people. They were different from him and they were moving around in machines on narrow strips of black ground. The machines made noise, and were brightly lit. When they stopped people got out and did strange things. This worried him.

One day, months later, he noticed the animals didn t come around anymore and his underground water was not as plentiful as he remembered. It took him longer to find food to hunt and his children were beginning to get thin and cry. His neighbors began to move away and complained of being ill. Soon, the odd-shaped boxes, the black strips, and the moving machines got closer and closer to his home. His children were coughing all the time now and his wife complained they had nothing to eat, and they were so thirsty. Joe couldn t find medicines any more. Where did they all go? The weather hadn t bothered them before but now the sun seemed hotter and the winters seemed colder. He thought of moving, and they began to pack. When they were ready to leave, they looked around. There was nowhere to go. They called this progress.

That was a long time ago when life was simpler, even though harsh. Times change and people change, so do governments. Political economic opportunities tend to be inexorably linked to capitalism. Capital expenditure is considered progress, but progress is not necessarily linked to accessible, affordable, quality health care. The story of Joe is based on fact and illustrates the motivating factors of today s tribal governments to provide services to their people. Many Native peoples today have difficulty participating in quality, affordable health care.

Health and illness needs are tied to a politically motivated world economy which influences health care policies (Federal and otherwise). Environmental factors also contribute to overall health conditions stemming directly from these policies. Depending on which objective is desired (political, economical, or personal), these policies can help or hinder access to and participation in health care programs. Ultimately, such influences

affect any population s access to health care.

Health, especially good health, is a general concern of all people. Even the earliest hunter-gatherers took an interest in their own well-being although they may not have been as aware of it in the same manner as modern day people. Today, good health and good nutrition are, by far, major concerns and quests of most Americans.

Health is a concept of an individual s physical and mental well-being. Its status can be good or bad. In our common sense notion of health, it has no boundaries, no ethnic discrimination, no class distinction. Its only economic basis is cost. Cost has everything to do with the status of one s health. Cost even affects the quality of nutrition, the quantity of prescription drugs, and access to physicians services. HMOs (Health Maintenance Organizations) and PPOs (Preferred Provider Organizations) may help defray the cost of expensive health services but only if one is able to access and participate in these pre-paid insurance programs. Maintaining good health, free from illness and disease, is desirable. However, by present day standards, more often than not the general health status of many people is far below that standard.

Within any American Indian population, the status of health and nutrition can be a result of internal political and economic organization. This includes policies regarding the work environment, living conditions, residence locations, and the availability of transportation. A Native population s health status can also reflect external political and economic pressures. These pressures influence where a person lives, what type of work he/she can obtain, and the distances he/she must travel to receive health care services. Furthermore, some health care access hinges on ethnic identity as well. For example,

there was a time when non-Indian spouses were eligible to receive health care from the Indian Health Service. Today, only American Indians are eligible to access Indian Health Service programs. Eligibility is a reflection of the concept of identity, a very complex issue for non-Indians to understand.

Participation in federally sponsored and tribal administered health care services and nutrition programs is often determined by tribal members proximity to clinics. Although living within a tribe s jurisdiction is optional for tribal members, participation in programs and services often follows set tribal guidelines making it difficult for members to participate when they reside outside their tribe s jurisdictional boundaries. This is especially so in the area of health care.

For example, in terms of spatial proximity and social distance, middle class, specialized hospitals tend to be located in low-income neighborhoods in urban areas for economic and political reasons, because zoning regulations often place low-income housing next to commercial or service enterprises. These hospitals are usually unavailable to low income and minority populations because of cost and discriminatory practices. Thus, urban minorities must travel long distances to receive non-emergency medical care from hospitals they can afford. By contrast, hospitals on Indian reservations are often more centrally located to the main tribal complex and are more easily available to Native peoples although distances from work or home still create hardships.

Since Indian health clinics and hospitals are typically located in or near tribal complexes or small towns, they are close to their original reservation locations, although public transportation is not always available and oftentimes non-existent. Many Native

people must rely on relatives for transportation or else they do not go. Some tribal administrations are attempting to correct this by providing their members with transportation to the health clinic, the doctor s office, and the medical center. However, if a Native person lives outside their tribe s service area, tribal transportation may not be available and the person needing assistance will not be able to access health services or the nutrition programs that their tribe offers. As a consequence, the health status of many Native peoples could be at risk.

My Perspective on the Topic

I became interested in this research topic because of my close association with Native peoples in the Perkins Indian community over the past fifteen years. I was also perplexed over their seeming lack of participation in federally sponsored and tribal administered health care and nutrition programs and services. It seemed to me that since Native peoples were entitled to health care through treaty agreements, they would actively participate in the programs and services provided. Although many Native peoples have participated, there are many more who have not.

My interests lie in the area of health care my own and those of Native peoples in Central Oklahoma. Technology, life expectancy, and the quality of patient care have improved over the years. Even so, inconsistencies still exist. Technology has increased but not everyone has access to it. Although life expectancy has increased, discrepancies still exist among other racial/ethnic groups. Despite the fact that the quality of patient

care has increased, it is still unequally distributed. Naturally, what follows are increases in the overall cost of health care. With such rising costs of medical care, prescriptions, and health insurance, people are faced with a dilemma of either paying exorbitant prices or neglecting their health. Today, health insurance companies are increasingly able to dictate to doctors what procedures they can perform and how long patients can stay in hospitals. Thus, hospital stays and medical procedures are based somewhat on what insurance companies are willing to pay and not on the needs of the patient. This practice has very little to do with illness or injury, or even personal choice, but everything to do with economics and profitability in other words, capitalism.

On the one hand, increased technology and medical breakthroughs seem to be a favorable trend; on the other, more and more members of the population are being denied access to these services because they cannot afford them. Do we, as individuals, have a choice in the matter? How do we, as a society, weigh which things are more important? Thus, today, people are facing economic challenges by having to choose between which bills to pay all because of increases in health insurance often without the benefit of accessible, quality health care. This concerns me. I am concerned because people are being priced out of the health care market.

What I did not know (and what this dissertation addresses) is that (1) only so much federal money is allocated to tribes for medical care. Thus, health care is delivered on a first come, first served basis; (2) the choice of a specialist is determined by an Indian Health Service physician, where an appointment may take months; (3) contract doctors change often, so it is nearly impossible for patient-physician bonding to occur; (4) the time

and distance involved when going to the Indian Health service sponsored clinic is usually lengthy; and (5) many times prescription drugs are unavailable or inappropriate. Thus, my interest was peaked and these issues became something I wished to investigate.

According to demographic data, American Indians are one of the poorest populations in the United States. How do they cope with rising health care costs? Do Native peoples find alternative medical care, or do without? While these questions are perhaps broader than the scope of my dissertation research, they are, nevertheless, within the purview of my interests.

Literature Review

Within the recent past, concerns about health care have steadily increased and have been a primary focus of many Indian and non-Indian health care professionals as well as tribal councils and individual families nationwide. This concern is especially noticeable among the poorer populations in America. Contemporary American Indian populations are concerned as well about having qualified, competent, and accessible health care simply through necessity. This concern is evident and reflected in the literature reviewed for this study (Harwood 1981; Phillips and Rathwell 1986; Adams and Knox 1988, etc.). Most of the authors reviewed for this dissertation are applied anthropologists. Applied anthropology provides a practical, hands-on approach to solving health care problems. The articles indicate ongoing concern over rising costs of health care and increases in the prevalence of certain medical conditions, such as diabetes mellitus, tuberculosis,

hypertension, pneumonia, and drug and alcohol abuse among minority and ethnic groups.

The variety of available literature on the subject of health care is voluminous, particularly in areas of medical practices, diseases, and environmental influences. For example, Campbell (1989) introduces a concise historical overview of diseases and ill-health related to American Indian populations since European contact. Kunitz and Levy (1981) provide a case study and historical overview focusing on major causes of death and disease among the Navajo people; Naranjo and Swentzell (1989) present a case study of the Tewa in which they state:

> health is not merely the absence of illness; it is a social construct which is tied to the structure of society. If intervention and prevention strategies are to be successful, the health care policy must not conflict with but must support the prevailing cultural paradigm of health, disease, and healing (1989:16).

Aside from literature dealing with medical practices, there is also literature concerning health care programs for American Indians, such as the Indian Health Service. The Indian Health Service provides a comprehensive health services delivery system for American Indians and Alaska Natives with the opportunity for maximum tribal involvement in developing and managing programs to meet their health needs (IHS n.d.) The Indian Health Service functions to assist American Indian tribes in developing their health programs . . . . [and] provides comprehensive health care services (IHS n.d.).

In the literature on Indian Health Service programs, Brod and LaDue (1989) and Joe and Miller (1989) provide information and statistics on recent studies of Indian Health Service participants and their relevant service areas. Their studies focus on the mobilization of reservation health services and funding of urban health programs.

However, they do not address issues of access to health care services by eligible recipients in rural or remote areas. Given the dispersed distinct Indian communities in Oklahoma it is difficult to centralize services for the various tribes.

From another perspective, Taylor (1989) provides a statistical analysis and other useful data on the urban Indian health clinic in Oklahoma City. However, he only addresses issues of limited accessibility in the metropolitan setting. Taylor s purpose was to survey the urban Indian population and provide the results to the Oklahoma City urban health clinic. He hoped that additional and specific market information [would] allow [the clinic] to successfully carry out its original mission, and to expand its user population to include a greater mix of paying users (1989:228). The article included results of a study from the Indian Health Care Improvement Act of 1976 stating:

> Urban American Indians were a population group that continued to lag behind others in access to primary health care. Access, Congress found, was severely curtailed by a lack of knowledge or understanding of available medical services in most urban areas, and a lack of income or health insurance to pay for medical care (Taylor 1989:215).

The article included data from the Office of Technology Assessment (1986) concluding that the quantity and type of health care utilized, according to population characteristics, is conspicuously unavailable (1989:216). Taylor s data is relevant in that it identifies Native peoples who have health insurance and those who do not have health insurance or any other means to pay for health care. This is the primary motivation for American Indian participation in Indian Health Service programs within Oklahoma City.

Red Horse, Johnson, and Weiner (1989) outline several concerns of Native people who attended the Indian Health Service research planning meeting held in September

1988. They expressed concern that most research failed to focus on the relationship between cultural factors and health care access. Cultural factors include traits that mold and hold a society together such as world views, morals, language, customs, concepts of wellness, and health and illness beliefs. These will be discussed in Chapters Seven and Eight. Other American Indian attendees pointed out that existing research is guided by disease models that draw upon clinical populations. . . . [which] lends only limited insight into health behavior (1989:268) among Native peoples. Such concerns are a motivating factor for increasing interest in research specifically directed at culturally-oriented health care among American Indian populations.

Adams and Knox (1988) also view cultural beliefs as an important factor in medical treatment. They provide a compelling argument about the complexity of combining traditional concepts and western concepts of health care practices. They suggest that a person s reactions to health, illness, changes in lifestyle and the various caring and treatment practices are linked to his or her cultural beliefs (Adams and Knox 1988:134). Those cultural beliefs are determined by how that society defines health and illness. Western society emphasizes curative functions based on scientific methods more than on preventative methods predicated on an individual s culture. Traditional societies emphasize holistic healing, i.e., a blending of physical and spiritual conditions within the total environment (Adams and Knox 1988) often involving the extended family.

Research Goals and Methods

The Research Design. A study of this nature requires multiple research techniques and necessitates a diverse research design. It needs to be a design that enables the researcher the greatest amount of flexibility, reliability, variability, and allows for entrance into the research site. The holistic approach meets this criteria and forms the basis of the research design for this dissertation. A holistic approach is the doctrine that societies should be seen as wholes, or systems of interacting parts (Abercrombie 1994:201). Holistic research relies heavily on the utilization of multiple techniques including participant observation, ethnographic accounts, interviews, and firsthand exposure. This approach was used as the primary method of data collection and was a contributing factor in the success of the research. Firsthand exposure to tribal operations, employment, and residence within the Perkins Indian community provided empirical knowledge. Thus, it is from an insider, or Indian perspective that this dissertation is written.

Of no less importance to the research design, but contributory to it, is the use of fieldwork and ancillary research methods. The methods are archival data collection, historical, literature, and document searches, and use of the internet for background data. Fieldwork was necessary for travel to distant health care facilities to collect essential data, but minimal, overall ,since the research site was home.

The Question. There are three research questions concerning Indian health care that are addressed in the dissertation research: (1) How is participation in and access to tribal administered health care determined?; (2) What is the impact of residence location to health care facilities?; (3) How are tribal and federal health care resources allocated?

_____The Goals. Specific goals for the study are: (1) to determine which Indian-related health care services are used or not used by tribal members living within or near the Iowa Tribe s jurisdiction and reasons why; (2) to investigate health and nutrition options offered by the Iowa Tribe to participants living within the Perkins and Tryon Indian communities; (3) to collect narratives about problems with and strategies for access to health care and nutrition related services; and (4) to consider how receipt of health care programs and services are related to defining Indian.

_____The Setting. The research project focused on two Indian communities closely associated with the Iowa Tribe of Oklahoma. These Indian communities are located in north-central Oklahoma: Perkins in Payne County and Tryon in Lincoln County. The communities are located approximately five miles, respectively, from the Iowa tribal complex. The land area includes Iowa and non-Iowa jurisdictional boundaries in loosely structured checkerboard style segments. Checkerboard areas can be explained in the following manner. When segments of Indian land alternate with non-Indian land the concept of a checkerboard area is created, much like a game of checkers. This means police, fire, and health care services are allocated according to who has what jurisdiction.

When the Iowa Tribe was removed to Oklahoma in the late 1800s, they were assigned a land mass in north central Oklahoma of approximately 400 square miles. Over time, the land was allotted to tribal members in 160 acre plots and the balance of the reservation was opened for non-Indian settlement. Although the original boundaries remain intact, tribal jurisdiction is limited to tribal lands and allotments. Figure 1 is an example of the Iowa Tribe s jurisdictional boundaries for fire and police protection. It is

also its health and human services area. Yellow areas are tribal lands and original allotments. The rest is privately owned former allotments.

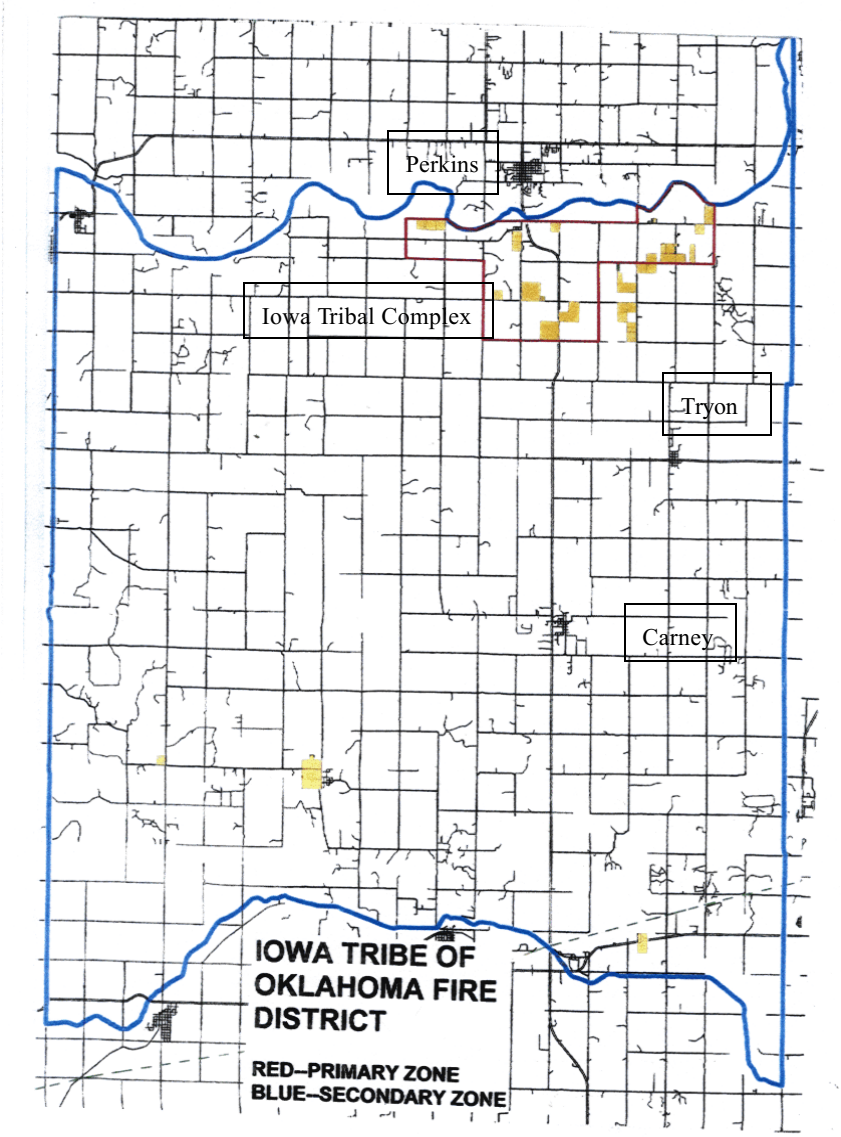


Figure 1

A glimpse into the land area and population size of the city of Perkins and township of Tryon in 2000 should provide the reader with some background data.

Demographic Profile	Perkins	Tryon
Land area: square miles	2.2	2.3
Population	2,272	448
Male	1,086	223
Female	1,186	225
White	1,924	366
Indian	230	72
Mixed-blood	109	11
Other	82	14
Median resident age:	34.7	38.1
Median household income:	$30,030	$21,696
Median house value:	$57,000	$37,500

(www.city-data.com/city).

_____The Population. The sample population was chosen on the basis of the following criteria: (1) individuals who are card-carrying (CDIB, Certificate Degree of Indian Blood) members of a tribe; (2) individuals who self-identify as Indian by blood degree, and (3) individuals who would be eligible for membership in one or more other tribes, if legally allowed. Some non-Iowa tribal members could be eligible for Iowa tribal membership if certain federal acts and tribal guidelines for membership were different. Strategies tribal members use when choosing tribal affiliation and residence location may actually determine participation in and access to tribal health care programs and services, see further discussion in Chapter Six.

Data Collection Methods.

Record Keeping. Handwritten notes and tape recordings, when allowed, provided the means of data collection. Narratives were tape recorded whenever possible and always supplemented by note taking. Personal information was coded and cross-

referenced using initials, pseudonyms, color, *italics*, and/or **bold** type. This made it easier to find information later. Notes and recordings were transcribed to a computer, saved to disks, and stored for safekeeping. All information was kept confidential and accessible only to the researcher and will be destroyed once the study is completed.

_____Participant Observation. Observations were of a participatory nature, and combined obtrusive (open) and unobtrusive (covert) techniques. The participant observation technique, as defined by social scientists, stipulates the researcher to observe a social collectivity of which he or she is a member (Abercrombie 1994:305). Membership within a group, being accepted by a group as one of them, allows unobtrusive data gathering without the subject being aware of the observation. In short, it is a way to get other information without affecting people s behavior. This technique served a useful purpose from time to time especially during my employment with the tribe. The open approach to participant observation is the format used for the greater part of this study. Participants were always informed of the reasons for the interviews.

Since I live in the Perkins Indian community and am acquainted with many of the research participants personally, there was a distinct advantage in being able to observe their day to day behavior. Interactions were frequent with most of the research participants, as well as others in the community. Employment as a Security Officer at the Iowa Tribe s Bingo-Casino also placed me in a favorable position to interact and observe the many local residents Indian and non-Indian. It also allowed entrance into the Indian communities and the tribal complex to visit with Iowa tribal administrators and staff.

_____Ethnographic Accounts. Ethnographic data were collected from primary research

participants on individual identity, accessibility, eligibility, and participation or non-participation in health care services and nutrition programs. Narratives and personal accounts provided dual systems of access for the pooling of resources on health and nutrition which were relevant to Indian identity and tribal membership. They were the major sources of data for this study. Preferences for participation in federally sponsored and/or tribally administered health care services and nutrition programs were sought for Iowa and non-Iowa tribal members living within the two communities. Also of major importance was how Indian identity influenced their decisions.

Some federal and tribal resource requirements define Indian differently, thus, data were collected to determine if anyone was denied access to services and programs because of conflicting criteria. Generally, health care services are defined within the context of federal guidelines and are therefore uniform (see appendix C).

_____Interviews. Structured and unstructured interviews were included as part of the data collection process. Interviews presented scheduling problems and were solved only by patience and persistence. The average interview time with each participant was one to two hours on initial contact. In one instance, we were interrupted and I had to return at a later time to complete the initial interview. Upon completion of the initial formal interview, informal conversations took place at various times throughout the six year study. Sometimes, chance meetings spontaneously took place as we encountered each other in various settings, such as the Perkins Market, Wal-Mart, even during the annual Iowa tribal pow-wow the third weekend in June. Concluding interviews of thirty to sixty minutes duration took place during the final year of study in the summer of 2003, although

informal conversations continued throughout 2004 and even into early 2005.

Formal and informal interviews with medical personnel were also sought from six Indian health facilities. Overall, there were two to three visits to each facility during the course of the study. The clinics were always quite busy and in two instances visits had to be postponed for another time. Although visits to the clinics were time consuming, averaging two to three hours each visit, the actual interview process only lasted 15-20 minutes per person. Nevertheless, it was enough time to gather the needed data. Arranging interviews with physicians, nurses, and other medical staff were more difficult than expected due to limited available staff. Interviews were gathered for one physician, three Physician s Assistants, four nurses, and six pharmacists or their assistants.

Reasons for the lack of personal interviews with physicians were due to the paucity of physicians at each clinic. The smaller clinics, such as the Kickapoo, Ponca, Absentee Shawnee, even the Iowa clinic, did not have full time physicians. They were staffed primarily with physician s assistants or nurse practitioners, and receptionists. Thus, when the physicians were at the clinics they were quite busy. The one physician interviewed was available only because of a cancelled appointment. The other physicians could not be bothered or were simply too busy. Nurses, Physician s Assistants, and receptionists were interviewed as time permitted, in between patient visits. The six clinics visited were:

1. The Perkins Health Clinic, owned and operated by the Iowa Tribe.
   general medicine
2. The White Eagle Health Center operated by the Ponca Tribe.
   diabetes clinic; dental clinic; optician clinic; pharmacy.
3. The Pawnee Indian Health Center is an IHS health facility.
   full service including ex-ray and lab.
4. The Black Hawk Health Clinic operated by the Kickapoo Tribe.

medical clinics; pharmacy

5. The Citizen Potawatomie Nation Health Services in Shawnee.
   dental services; behavioral and substance abuse services
   public health services
6. Absentee Shawnee Tribal Health Care Programs in Shawnee.
   health services: contract, home, community, and behavioral
   nutritionist; pharmacy
   this facility services only Absentee Shawnee tribal members .

Additional information on Indian health care can be found in Chapter Seven.

Interviews were also conducted with several Iowa tribal administrators in the Health and Human Services department. Access to the health director, nutritionist, and other staff was much more successful than with the medical facility personnel. There was one initial visit with the health director lasting one hour, and two additional followup visits at 20 minutes each. Thereafter occasional conversations took place when necessary. Visits with other tribal personnel occurred at various times and lasted as long as needed. At least two informal conversations took place with the Iowa tribe Vice-Chairman for the purpose of obtaining permission for the research.

The interview process was challenging at times due to time limits and interview scheduling. To maintain continuity, questions were asked (see appendix A) of each research participant from a prepared questionnaire. The medical health care staff that agreed to answer questions (see appendix B and C) were also asked questions from a different prepared questionnaire. Often because of interruptions and the limited time available for filling out a complete questionnaire, some of the questions were combined with others for expediency. In two instances informal interviews were determined to be the best method for gathering the data.

_____Archival Data. Archival resources, such as document and literature searches were time consuming but beneficial. Archival data collection included census reports and maps of Perkins and Tryon townships, Payne and Lincoln Counties, and the state of Oklahoma showing statistics, demographics, and the distribution of Native populations. Historical searches were made from tribal libraries (Iowa, and Sac and Fox), including tribal newspapers (Iowa, Pawnee, and Sac and Fox) regarding membership, identity, nutrition and health care. Other data concerning tribal membership requirements and guidelines for health care and nutrition programs were collected from tribal documents.

On a broader scale, historical data concerning federal health care programs and services were collected from various federal agencies, including, but not limited to, the Bureau of Indian Affairs regional and area offices in Anadarko. Federal policies, acts, and legal cases concerning tribal membership, identity, health care and nutrition programs and services were also collected from various non-tribal libraries, such as, the University of Oklahoma Main and Law libraries, the University of Oklahoma Health Science Center, the Western History Collection, the Oklahoma Historical Society, Oklahoma State University, the Perkins Library, and the official internet websites, as needed.

Limitations. Always there are limitations. Within any research context, there are limitations. For example, the Perkins and Tryon communities are not representative of all Indian communities in Oklahoma, and, certainly, they are not representative of American Indian reservations throughout the United States. This is because Oklahoma has a different political structure and economic basis for reservation status which is explained in depth in Chapter Three.

Limitations may also occur with the participants own stories and life histories. Although individual perceptions are important to the research, what participants say is happening may or may not be what is actually happening. They may simply be telling the researcher what they believe to be true, or may say what they think the researcher wants to hear. This is nevertheless an interesting part of the research process. People may vent their frustrations during interviews because they believe they are eligible for health care services and nutrition programs in which they cannot participate because they live in the wrong place. This could make it difficult to obtain unbiased or objective data. However, these limitations are more of a challenge than a hindrance and can be minimized by asking the participant the same question at a later time and comparing answers or by asking others if the same circumstances have occurred to them.

The Study Population. The total number of individual study participants were twenty-eight. This represented twenty households. Participants were contacted either at their homes or places of employment. Sometimes, conversations took place at both locations. There were eight families with children still at home; one family with no children at home; four extended families with children plus one or more grandparent or other relative in residence; and two single parent households, both with relatives living nearby. The ages of the adult family members ranged from 22 to 65. Single households included two students between the ages of 20 - 24 (one male and one female) and one older male (34) living alone. There were two widowed women in their mid-70s living alone with relatives nearby. Most of the research participants preferred to remain anonymous. Thus, names used in various stories and examples throughout the dissertation

have been altered to preserve their anonymity.

All study participants are either members of the Iowa Tribe or members of one of the neighboring tribes (i.e., Sac and Fox, Otoe-Missouria, Ponca, Pawnee, and Shawnee) and, thus, are eligible for health care services under federal guidelines. Investigating tribal affiliation proved to be both surprising and interesting. All of the study participants households had tribal representation from at least two or more tribes, most often Iowa and Otoe. Other households were represented by Sac and Fox, Ponca, Pawnee, and Shawnee. Three households had non-Indians in residence who had either married a tribal member or were mixed-blood with Indian, white, or Mexican descent. The individuals with mixed-blood and identified more with their Indian side, were unwilling to admit or recognize the non-Indian part of their heritage. No respondents indicated Afro-American descent.

Participants were either employed by the Iowa Tribe or in the nearby city of Stillwater. Tribal employees represented a variety of professions, supervisory, agricultural, administrative, housekeeping, law enforcement, cashiering, and accounting. Other participants worked in the public domain in areas of manufacturing, food service, construction, automotive, and retail sales. The students worked part time at the casino.

Since the beginning of this research project during the summer of 1999, ethnographic data has also been gathered formally and informally from more than sixty-five individuals who were knowledgeable about health care, nutrition and tribal programs and services. They included tribal health directors, medical professionals, health clinic personnel, city and tribal law enforcement personnel, and Indian and non-Indian citizens of the Perkins community.

Indians and Fieldwork

Fieldwork within American Indian communities requires sensitivity, patience and a desire to listen and learn. In truth, these qualities are inter-cultural requirements which help researchers anywhere gain access to a field site. There is a false impression that researchers are always welcome in Indian communities. Native reluctance to accept outsiders is often due to certain offensive behavior the latter exhibit. Most often researchers are not welcome simply because in the past too many researchers have exercised disrespect and unbecoming behavior in the field.

Achieving entrance into this field setting takes time and patience, especially when dealing with such sensitive issues as health care and nutrition practices. Without skill, sensitivity, and a working knowledge of certain aspects of Native behavior, their acceptance would be very difficult, if not impossible. Once in the field, it is important to be aware that Native peoples response to researchers when first meeting may be quite different than expected. It may take months before a person gets to know the researcher and what his or her motives are before an interview can be arranged.

For example, within the Indian environment, one s interest and attention are expressed passively by quiet watchfulness; whereas, appropriate mainstream behavior places emphasis on assertive questioning. Many researchers when visiting with Native people chatter or ask lots of questions. This is usually interpreted by traditional people as a short attention span or disinterest. Many times questions are answered simply by being silent and observant. Giving Native people an opportunity to ask the researcher questions and become comfortable within an interview setting modifies a dominant/ subordinate

relationship. Other areas of proper fieldwork etiquette include knowledge of differing views/practices of eye contact, handshake, and a working understanding of a unique communication style known as a non-interference ethic. Simply put, one does not interfere in the business of others unless privileged.

_____Before beginning fieldwork within any Indian community, permission must be granted not just from the academic arena but from the tribal authority as well. It is critical to obtain permission from the tribal council before conducting any fieldwork.
Most tribes have two councils, a traditional council and a political (or business) council. Both of these councils need to be considered when conducting research. The traditional council deals with cultural matters, such as customs, world views, and so on. The business council deals with contemporary matters of everyday living which includes tribal programs and services. Within the business council, there is usually a department that administers tribal human services. It is this department that manages delivery of health care services and nutrition programs to participating tribal members.

The Iowa Tribe has only a Business council. Cultural matters are not dealt with as a matter of tribal policy. A visit with the Vice-Chairman and a letter to the Business Council resulted in permission being granted for the study.

Tribe or Nation?

There are two terms commonly used by governments, individuals, scholars, and even American Indians. Their usage can be confusing. These terms are *tribe* and *nation*. In a political sense, they are used to describe American Indian governments. Upon further investigation, this practice appears to be partly a matter of semantics. Similarities and overlaps of meaning appear in both terms. As to the accuracy of the term according to scholars, it seems dependent on which school of thought or discipline one subscribes to. The following are quotes from *The American Heritage Dictionary* and illustrate the differences and similarities between the two terms. Tribe is defined as:

> 1. Any of various systems of social organization comprising several local villages, bands, districts, lineages, or other groups and sharing a common ancestry, language, culture, and name. 2. A political, ethnic, or ancestral division of ancient states and cultures . . . (Berube 1982:1992).

Nation is defined as:

> 1. A people who share common customs, origins, history, and frequently language; nationality. 2. A relatively large group of people organized under a single, usually independent government; country. 3. The government of a sovereign state. 4. a. A federation or tribe, esp. one composed of North American Indians. b. The territory occupied by such a federation or tribe (Berube 1982:831).

Confusion over which term to use is understandable. These definitions have much in common and often lead to the stereotyping of Native peoples. Scholars continue to create romantic stereotypes of American Indians. Writers of history often depend on stereotyped images to sell books. Governments tend to maintain stereotyped images through policymaking. Each entity applies whichever term suits *its* needs. Native people

use the terms interchangeably, whichever term is convenient, appropriate, or applicable, depending on what suits *their* needs. Historically, the Ioways were never concerned about which term to use. They simply called themselves, the People.

Over time as the federal government became stronger and Indian nations became politically weaker, the term *tribe* was substituted for the term *nation*. As interactions with the federal government increased, the term *tribe* became a more accepted term by all (Deloria 1983). Presently, the trend by many Indian nations is to revert to again using the term *nation*, such as, the Sac and Fox Tribe now, the Sac and Fox Nation; the Pawnee Tribe now the Pawnee Nation. As of this writing, the Iowa Tribe still refers to itself as the Iowa Tribe of Oklahoma, although their internet website is *iowanation.org*.

In some instances, perceptions of tribe or nation seem to depend on the Native group s recorded history, population, land base, political structure and/or economic development. Economic stability often implies a perception of *nation*, meaning an ability to provide funding for membership programs and a measure of independence accomplished through business enterprising. Whereas, individual members tend to perceive themselves as a *tribe* meaning a more personalized relationship. In this context, they receive personalized assistance when needed, such as, payment for utility bills. Sometimes, the terms are applied interchangeably for various reasons, such as, custom, familiarity, personal preference, and so on.

A former OU anthropology professor, Dr. John H. Moore, has combined the terms *tribe* and *nation*. He uses the term *tribal nation* to define certain tribal groups. Most often he uses the term in reference to the Cheyenne. In his book, *The Cheyenne Nation*,

he believes the concept of tribal nation is very useful. It is his desire to amalgamate theories of tribes with theories of nationhood (Moore 1987:8). He provides a definition from *From Empire to Nation* (Emerson 1960) which he merges with his own. Emerson defines nation as a body of people who feel they are a nation. Moore continues with

> The ideal model of the nation . . . is a single people, traditionally fixed onto a well-defined territory, speaking the same language and preferably a language all its own, possessing a distinctive culture, and shaped to a common mold by many generations of shared historical experience. . . . [A] tribal nation writes its own charter, both in mythical or symbolic terms and in all kinds of practical and explicit ways. The tribal nation defines its rules of citizenship and duties of its citizens. It creates special roles by sex, age, rank, and status and defines citizenship by participation in and respect for those roles (Moore 1987:10).

How these terms are used and what is meant by them is an integral part of understanding American Indian political motivations. Thus, the terms *tribe* and *nation*, can and will reflect certain images. Effectively, social scientists may unwittingly assign certain stereotypes by their choice of words. If they are not aware of such effects, the terms may be used interchangeably. For example, the term *tribe* often connotes primitive and uncivilized and the term *nation* portrays quite an opposite image, that of an entity having sovereignty, strength, and independence possessing a geographical area or land base.

Many Native peoples use the term *nation* as a way to avoid the negative connotation of the term *tribe*. Some Native people, as well as tribal officials, use both terms interchangeably often for different reasons. They may refer to themselves as a tribe in certain contexts, such as in conversations with others, in newsletters, and so on. The

Iowa Tribe is such an example. Even official legal titles, logos, and letterhead stationary may indicate tribal status. In a business context, when dealing with federal or state officials, the Bureau of Indian Affairs, and in other legal matters, a tribe may refer to itself as a nation believing its status is elevated. Whether it does or does not effectively alter the status of the group is not the issue.

If the concept of *nation* is used as a measure of economic strength, then it is necessary to indicate which perspective is used, the scientific method or informal observation. Assessing tribal economic strength is not an easy matter. There are many variables. Without a formal analysis, results would be scientifically unreliable. Instead, informal observations were used to designate an order of strength. The criteria used were the age of the equipment and the type of facility. The measure was applied to various tribal businesses, such as medical, law enforcement, fire protection, and others of a peripheral nature (child care, trucking, etc.). Results of this informal assessment were determined and the tribes were ranked. The Iowa Tribe placed third when compared with its five closest neighbors: the Sac and Fox, Ponca, Kickapoo, Pawnee, and Otoe-Missouria. Although the decision is arbitrary it is an indicator of how tribes view themselves in terms of what they feel are important to them.

For example, the Ioways have their own brand new Fire and Police departments complete with jail facilities and new equipment, a 911 Emergency Service contract, an interstate trucking industry, and a new health clinic, gym, and day care center. Whereas, the Pawnee have focused more on health care by providing a brand new hospital with federal financial assistance instead of focusing on a goal of economic independence, i.e.,

their police and fire department is housed in old buildings with used equipment. Simply put, their priorities are different. It is a difficult assessment since each tribe has certain attributes and economic goals unique only to them which makes a comparison difficult.

Once again the terms *tribe* and *nation*, can explain this view. From personal experience some Native people simply prefer to use *tribe* and some prefer *nation*. In conversations, they say it depends on the circumstances and whichever term they are accustomed to using. Much of this is simply based on emic and etic perceptions. That is, how you perceive yourself from within your own social, economic, and political structure and its representation to others (outsiders), and how others (outsiders) perceive you from within the context of their own social, economic, and political structure. So, which term is correct? There are no fixed patterns or standards to follow. Apparently it is left up to the scholars, individuals, or tribes/nations to define. All three terms (tribe, nation, and tribal nation) are used when applicable and appropriate.

Maintaining Identity Despite Government Interference

Individual participation in health care programs and services often involve tribal membership. Tribal membership criteria are indicators of a particular status of Indian identity and are used as proof of Indianness. Proof of this sort can only be accomplished through affiliation with an American Indian tribe/nation. In this manner, Indian identity and health care are connected. Guidelines for tribal membership are historically derived and also involve definitions of Indian which tend to generally rely on

blood degree levels as a basis for eligibility. Defining who an Indian is using federal and tribal guidelines typically varies by tribe. It usually includes proving what degree of Indian blood a prospective member should have, and/or the links back to an ancestor who was an original allottee or tribal member listed on a tribal roll during the allotment period.

Throughout the years, as interactions increased with white bureaucratic entities, the federal government thought it necessary to establish certain guidelines in order to identify qualified members of American Indian tribes and nations. Those who satisfy these and other criteria are granted tribal membership cards and Certificate Degree of Indian Blood (CDIB) cards issued by the Bureau of Indian Affairs. This pressured adaptation to federal norms allowed indigenous nations to maintain many cultural traditions. However, these adaptations were often a contradiction in traditional beliefs which focused more on cultural behavior than on blood degree or how much blood you got. From the onset of federal regulatory acts, tribal governments were increasingly pressured to define their membership criteria using federal statutes.

Participation in health care services and programs also involves definitions of Indian that rely on blood degree levels as a basis for tribal membership. Tribal affiliation is an important aspect of health care access as most health care and nutrition programs are allocated to tribal members first, other tribes members second, Indian elders, handicapped, etcetera, third, and other Indians fourth. American Indians are the only ethnic group in America who must provide proof of their heritage before participating in federally sponsored programs including health care services.

American Indian people face endless challenges to their identity. They respond to

political and cultural intrusions into their daily lives in various ways, such as, passive resistance, cultural traditionalism, and so forth, in order to maintain control of their land and to preserve political and cultural autonomy (Champagne 1989). Outside pressures to change their world views, social behavior, and political structures are ongoing. It has been suggested that all this is because Eurocentric philosophies were opposite and prevailed over Native philosophies.

Euro-American perspectives on business and politics were to dominate, subdue and exploit American Indians in the name of progress, profit, and individuality. Traditional Native beliefs, however, are just the opposite. Human beings are a part of nature and both entities deserve respect. For example, American Indians have (1) a traditional nonlinear cultural world view, (2) a unique non-exploitative relationship to the environment nature, and (3) a group-oriented perspective on resource development. Thus, certain value systems of one segment (American Indians) are in direct conflict with those in the other segment (the dominant American society). Identity misconceptions, the political economy, and self-perpetuated ignorance are several reasons why non-Indians have difficulty understanding Native peoples. A byproduct constantly encountered by this federal direction are complexities concerning definitions of the term Indian. There is no single definition. There are many. When the term Indian is placed in certain contexts, such as cultural, legal, or biological, the definition becomes dependent on how and why the term is applied. Although originally an imposition of the federal government a positive side effect has emerged. Regulations have provided a means for tribes to maintain their distinct cultural identity, tribal cohesion, and a certain degree of autonomy.

So, What s In This Study?

This study is based on the following themes: American Indian identity concepts; theoretical and historical overviews; health and nutrition concerns; issues of political economy; and the dynamics of ethnographic field research. Chapter One introduces the study. It provides research objectives and methods, thesis and purpose statements, and justification for the study. Chapter Two focuses on tribal sovereignty and historical aspects of tribal governments and federal policies having an impact on health care. Chapter Three explains the relationship between tribal governments located in Oklahoma and the state of Oklahoma in general. The chapter includes insights into justifications for tribal economic development and why they can do what they do without state interference. Chapter Four offers theoretical motivations and explanations of the research from within the larger context of a world system and political economy of health perspectives.

Chapter Five presents concepts of kinship connections and social networks within the context of traditional Native teachings. Chapter Six addresses identity issues regarding Indianness; including the concept and origin of blood degree, and who says what about how Indians are defined from federal, state, tribe, and individual perspectives. Chapter Seven addresses areas specifically directed at health care policies and investigates economics in terms of health care. A brief historical overview of the Indian Health Service is included at this point. Chapter Eight discusses food and nutrition programs related to health care and how these impact Native lifestyles. Chapter Nine summarizes the research and presents results of the study in the two Indian communities.

Part II

The Political Economy of Tribal Government

Segregation of Indian health care in a broad perspective (chapter 2)
Focus on Oklahoma (chapter 3)
Native American internal perspectives (chapter 4)

Chapter Two

Tribal Sovereignty and Its Historical Roots

Tribal sovereignty has taken a beating for the past 200 years of American political and legal history. American Indian tribes/nations believe they still possess specific inherent rights to regulate their internal affairs, at least to the extent of their territorial boundaries. If they did not believe this, no tribal services or programs (such as, health care, economic development, law enforcement, medical facilities) would be possible.

Historically, Indian nations governed themselves according to custom. Prior to contact with the European newcomers, they dealt with outsiders as needed and regulated internal affairs in traditional ways. Some tribes had loosely structured governing bodies while other tribes were more stringent.

The essence of this chapter is to provide a brief overview of tribal sovereignty through time focusing on the origins of federal policy which were the beginnings of health care and nutrition programs for Native peoples. The chapter begins when the local people encountered foreigners, continues with varied and controversial policies, and ends with tribal nations reasserting its sovereign authority.

At contact, Europeans were confronted by large organized groups of Native peoples living on the eastern seaboard. In order to establish themselves in this hemisphere, they chose to deal with Native peoples on a nation to nation basis. By doing so, they set a precedence which had lasting effects. The foreigners first established working relationships with indigenous nations by treaties. Later, references to Indians in the United States Constitution, in various acts and policies, and in many Supreme Court

decisions reaffirmed this special relationship Indian nations had and still have with the United States government. Everything considered, Indian nations were autonomous groups with power to determine their own fate.

Tribal Sovereignty: What Is It?

The notion of sovereignty is a difficult concept to comprehend for most people. It can be ambiguous, and is, extremely complex especially so when it pertains to American Indian nations. Felix S. Cohen, in *Federal Indian Law*, defines sovereignty as

> those powers which are lawfully vested in an Indian tribe [and] are not, in general, delegated powers granted by express acts of Congress, but rather inherent powers of a limited sovereignty which have never been extinguished. [*U. S. vs. Wheeler*] the Supreme Court has held that Indian tribes still posses those aspects of sovereignty not withdrawn by treaty or statute, or by implication as a necessary result of their dependent status. [*Oliphant vs. Suquamish*] (Cohen 1982:231-232).

A permanent foothold was established in federal courts that mandated American Indian tribes/nations would be dealt with on a government-to-government basis. Keep in mind, the federal government is simply recognizing powers that already existed prior to contact. They were not authorizing such powers.

Deloria (1989) points out in his essay Laws Founded in Justice and Humanity that some people believe Indian Sovereignty somehow has come to mean a delegated sovereignty. This is an erroneous assumption. He critiques the legal interpretations of three authors, Felix Cohen, David H. Getches, and Charles F. Wilkinson. These authors stress that the present nature of sovereignty examines the scope of jurisdiction for what s

left over after Congress has taken away certain powers. Their interpretations only help to complicate matters more.

Through time, tribal sovereignty has been eroded by Congressional acts and legal opinions. What s left over legal scholars have labeled limited or retained sovereignty. Such limitations should not be construed to mean tribal governments have little or no authority, or worse yet, no powers at all. Tribes retain powers *not expressly terminated* by Congress. In effect, it means Congress must state *which* powers are to be terminated. There are no assumptions or reading between the lines, so to speak. At this time, tribes were described as having opposing dual roles, (1) as wards of the government and (2) as sovereign entities with limited powers. Getches, Wilkinson, and Williams report Indian tribes still retain sovereign, though diminished inherent powers over their internal affairs and reservation territory; and that the United States possesses a trust responsibility toward Indian tribes (Getches, et al. 1993:84).

Deloria agrees with Getches, et al. who emphasizes the nature and character of Indian sovereignty predates the U. S. Constitution. Tribal sovereignty, then, is (and has always been) autonomous. At contact, American Indian governments already had established foreign policies, structured internal affairs, self-regulating methods, and developed military forces to protect their domain and people. In any event, a fact remains Indians pre-existed the United States government and so did their laws, customs, status, and inalienable rights. Deloria put it this way. Tribal rights of self-government predate the Constitution and derive not from the American people or from the Constitution but from the inherent sovereignty of a given tribe (Deloria and DeMallie 1999:70).

Three Supreme Court Cases That Made A Difference

The federal perspective of American Indian sovereignty primarily stems from official recognition of tribes/nations as government entities according to the U. S. Constitution and three major court cases, *Johnson vs. McIntosh* (1823), *Cherokee vs. Georgia* (1831), and *Worcester vs. Georgia* (1832). Frequently referred to as the Marshall Trilogy, these three cases established, as far as U. S. Courts were concerned, that Indian nations were in fact distinct political units. Although not *foreign* nations in the sense of international law, Marshall s opinion determined that tribes maintained a status as *domestic dependent* nations. Nevertheless, precedence was established.

Chief Justice Marshall sidestepped ruling that Indian nations were distinct political entities having the same powers as other foreign nations. Although Marshall s opinions had detrimental effects later on (i.e., tribes would no longer possess criminal jurisdiction powers), positive ones were also realized (i.e., tribes continue to possess limited civil jurisdiction authority and powers of internal regulation). These limiting powers included tribal authority to determine its own administrative guidelines and eligibility requirements for tribal membership, and the ability to provide services and programs to its members.

These early court cases had a profound effect on delineating the sovereign status of Indian nations and have become the foundation of federal Indian law that we use today. Getches, Wilkinson, and Williams (1993) quote Colins article, Indian Consent to American Government.

> The broad principles derived from the Marshall trilogy . . . are: that Congress exercises plenary power over Indian affairs; that Indian tribes

> still retain their sovereign, though diminished inherent powers over their internal affairs and reservation territory; and that the United States possesses a trust responsibility toward Indian tribes (Getches, et al. 1993:84).

Later, a second line of cases and opinions established the ward/trustee relationship between the federal government and Indian tribes. These cases, *Kagama vs. United States* (1886), *Ex Parte Crow Dog* (1883), *Lone Wolf vs. Hitchcock* (1903), and *United States vs. Sandoval* (1913) were no longer concerned with the sphere of tribal sovereignty. Instead, they established that Indian tribes/nations were now dependent upon the whims of Congressional rulings. Other parallel cases also acted to diminish sovereign authority, i.e., *Williams vs. Lee* (1959) and *McClanahan vs. Arizona Tax Commission* (1973). The lasting effects of these legal opinions further eroded the sovereign powers that tribes/nations enjoyed prior to contact. However, erosion does not mean eradication. It can mean interpretation.

Through time tribal sovereignty has been interpreted and reinterpreted from case law, circumstance, and necessity. As long as tribal governments relied on paternalism, sovereignty was frequently interpreted in terms of federal grants. Now that tribes are doing business for themselves, many tribes have reinterpreted sovereignty out of necessity. Defining sovereignty is a test of the ability of a tribe to be able to care for itself. Different times call for different interpretations. This means that tribes will redefine, reassess, and reinterpret themselves depending on the situation and era at hand, i.e., Sac and Fox issuing tribal tags, Indian casinos opening statewide, and the terminated Delaware maintaining cultural identity.

The plenary power era which extended federal power over reservations and Indian Country began with the Marshall trilogy. This extension continued through the allotment, reservation, and assimilation eras including everything before the Indian Reorganization Act of 1934. It ended in 1934 with a policy for reorganization of tribal governments.

As the Road Turns, So Goes Federal Policy: Allotment and Assimilation Era, 1871-1928

Federal origins of the sovereignty concept for tribal governments became underdeveloped after disastrous effects of certain federal policies. As far as tribal governments were concerned, sovereignty was not an issue. It did not become an issue until confronted with federal concepts of power and authority. Such confrontation challenged tribal rights to govern themselves as they always had prior to European contact.

Federal Indian policy development, in a sense, resembles a turning, winding road. As the road winds from era to era, so goes the trends of federal policy makers from positive tribal reorganization to negative termination and relocation, turning again to positive tribal re-organization and self-governance. These are all efforts by the federal government to break up tribal governments and extricate itself from administering Indian business for which it has a fiduciary responsibility. It seems to have difficulty accepting this. Each Presidential administration has tried to deal with the Indian problem in its own way. They have not been entirely successful.

Several policies reveal interesting trends in the federal government s trust relationship with Indian tribes. Primarily these shifts reveal a dichotomy between recognition of tribes as inherent sovereign entities. This was established over two hundred years ago through policy (Indian Commerce Clause) and case law (Marshall trilogy), on the one hand, and to completely abolish its trust relationship, on the other hand.

Federal policy phases involved all out assimilation efforts beginning with allotment and assimilation (1871-1928), reorganization (1928-1945), termination (1945-1961), relocation (1961-1975), self-determination (1975-1988), and self-governance (1988-present) eras (Getches, et al. 1993). Federal intentions were to further the civilization process of American Indian people. However, some sources suggested the real reason was to obtain the last vestiges of remaining Indian land and to decrease the numbers of Indians they were responsible for (Deloria 1988).

> Those friendly to the Indians recognized that the tribal economies were frequently a shambles, that individual Indians were living in hopeless poverty, and that no progress was being made toward overcoming either of these conditions. Others not so friendly resented large tracts of land being excluded from white settlement. The combination of these two sentiments produced the most disastrous piece of Indian legislation in United States history: the General Allotment Act of 1887 also known as the Dawes Act (Canby 1988:19).

Part of the underdevelopment process included allotment of Indian lands to Native families. Allotment legislation appointed specific Indian individuals (for example, heads-of-households) as recipients of private land in an attempt to destroy tribal governments and cultural structures. More important, the Dawes Act broke up and opened communally-owned reservation lands to non-Indians. The federal government believed if

Indians were to learn the benefits of private property ownership this act would hasten their assimilation into mainstream society. It was presumed the greater good would be achieved for everyone concerned if American Indians knew the value of owning private property, were educated, and resided according to mainstream norms. Individual allotments were disastrous to Indian people and the policy was eventually scrapped. Allotment and other assimilationist programs devastated the Indian land base, weakened their cultures, sapped the vitality of tribal legislative and judicial processes, and opened most Indian reservations for settlement by non-Indians (Wilkinson 1987:19).

In short, this policy effectively disrupted traditional Indian life through federal efforts to force a foreign concept of private property ownership. The policy made it easier for non-Indians to more easily obtain Indian land through various so-called legal maneuvers. Land seizures occurred through (1) an inability of many Indian allottees to pay taxes, (2) non-Indian fraudulent practices, (3) court orders falsely declaring American Indians incompetent, and (4) a manipulation of loan defaults (Deloria 1983). Ironically, lands taken over by farmers who planted crops would eventually be subjected to federal plans to subsidize them for their surplus grains. The purchased surplus would be processed and issued to Native families as commodities. The irony comes full circle.

Now, It s Legal To Be Indian
Reorganization Era, 1928-1945

During the late 1920s and early 1930s the federal government changed its thinking and now believed that Indian tribes/nations should be reorganized and began to sanction cultural renewal. The allotment policy was a disaster and Commissioner of Indian Affairs Collier had what he considered a solution, a vision, of a pluralistic society where tribes and mainstream society could exist side by side. However, a pluralistic society was not what the American people wanted, understood, nor would accept. Such recognition resulted in passage of the Indian Reorganization Act of 1934. Prior to this effort everything Indian was discouraged and illegal. Now, it was legal to be Indian, and everything Indian was encouraged.

The Indian Reorganization Act was an effort (although a weak one) to recognize the inherent sovereign rights of indigenous nations. It was based on federal assumptions that Indian tribes would not become extinct and would continue to exist, and now they were officially sanctioned (Getches, et al. 1993; Wilkinson 1987; Deloria and Lytle 1983). Ultimately, the act was implemented to protect what was left of the tribal land base and to encourage economic development among tribal governments.

The effects of Collier s positive exposure to Pueblo tribes in the Southwest led him to pursue this policy of tribal reorganization. Under his policy, tribes who agreed could reorganize under charters and write their own constitutions. The act also authorized the repurchase of Indian lands for tribes not already allotted. Many tribes took advantage of this act. However, it was not a panacea for complete tribal independence from the federal

government.

There was a negative side to the Indian Reorganization Act as well. Tribes had very little, if any, input into expenditures or programs. More significantly in order to take part in the I.R.A. program tribes were required to pattern their constitutions after a model provided to them by the Bureau of Indian Affairs. It was thought that tribal organization along federal guidelines would assist in the assimilation process. Thus, tribal constitutions were predominantly generic documents, patterned after model constitutions drafted by officials in the U.S. Department of Interior, to help implement the landmark Indian Reorganization Act (Lemont). Sadly, the constitutional model provided to Indian nations did not reflect Native traditions, cultures, or values, but were a reflection of mainstream society s traditions, culture, and values which often conflicted. Again, the federal government thought it had another solution to the Indian problem by providing federal examples.

Indian nations were not required to adopt the bureau s model but were highly encouraged to do so. Since tribal constitutions were not mandatory, some tribes and nations opted to use ordinances or treaties instead as the basis of their governments.

> These powers of self-government are normally exercised by tribal governments pursuant to tribal constitutions or other governing documents and a tribal code setting forth the legislative enactments of the tribe in furtherance of these powers. In other words, tribal governments having authority over certain subject matter may enact tribal ordinances and promulgate tribal regulations to implement the substance of that power (Pipestem 1978:271).

In addition this act did not extend reorganization policies to Alaska Natives or tribes in Oklahoma. This occurred with the passage of other acts discussed later.

Another positive reinforcement of tribal cohesion came from the Johnson O Malley Act (also passed in 1934). This policy provided funding for education, medical services, and distress relief for American Indians. The reorganization policy era had a positive effect on tribal governments, but it still did not get the federal government out of the Indian business. The reorganization era lasted well into the 1940s until WWII caused budget cuts to tribal governments in essence termination by congressional budget cuts.

Let s Get Out of the Indian Business
Termination Era, 1945-1961

The idea of abolishing Indian governments once again surfaced. It was the beginning of policy shifts away from positive tribal reinforcement to negative termination and relocation policies. Since money was needed for the war effort, many Congressmen and Senators needed some way to support the war industry. One way was to terminate the status of tribes and relocate its members to large cities. This time terminating the trust relationship was thought to solve the ongoing federal dilemma what to do with Indian tribes.

The termination theme was a serious attempt to fully integrate and assimilate American Indians into becoming tax-paying citizens. Again, congressional activities attempted to dispose of Indian land and culture by legal means. For example, four Oklahoma tribes were terminated: the Modoc in 1954, and the Wyandot, Peoria, and Ottowa in 1956. They were later reinstated in 1978. Reinstatement was a result of

congressional awareness of the devastating effects of the terminated Menominee Tribe of Wisconsin in 1954 (Arrow 1994).

The Menominee had had a thriving profitable tribal timber enterprise. The timber enterprise collapsed after the tribe was terminated and the company became a corporation subject to state taxes, which it could not pay. After termination and state acquisition, that county and its people became the poorest in the state. The state complained about having to support that district and the Native people living there. Tribal status was eventually restored in the late 1970s. It was believed that benefits from termination practices were rare or non-existent (Arrow 1994).

During this same era the federal government was ready to allow states to deal with Indian business and in 1953 enacted Public Law 280. This public law would extend state civil and criminal laws over tribal governments. Five states were included in this law: California, Oregon, Minnesota, Nebraska, and Wisconsin. The state of Oklahoma was also scheduled to be included in this policy, but denied the offer claiming they already had this authority.

> When Oklahoma became a state, all tribal governments within its boundaries became merged in the state and the tribal codes under which the tribes were governed prior to statehood were abandoned and all Indian tribes, with respect to civil and criminal causes, came under state jurisdiction. [Governor Johnston Murray, 1953] (Arrow 1994:xxx).

Later, P. L. 90-284 (1968) added a requirement that after 1968 states could assume jurisdiction over tribal governments *only* with consent of the tribe occupying the particular Indian country or part thereof which would be affected . . . (Arrow 1994:xxx).

Because no tribes consented, state control over Oklahoma tribal lands was effectively curtailed much to the embarrassment of Oklahoma state officials. What control they thought they had, they did not have. Thus, Oklahoma tribal governments continued to maintain powers of self-government.

Termination policies had even more disastrous effects on the terminated tribes and nations than did the allotment policy. The first group to be terminated were the Uintah and Ouray Ute mixed-bloods of Utah, followed by the Paiute, the Menominee, the Klamath from Oregon, and others from California, Texas, and Oklahoma (Gibson 1980; Metcalf 2002). Thus between 1954 and 1962 Congress stripped 61 tribes, groups, bands, and communities and rancherias of federal services and protection (Gibson 1980). States were now required to pay for services previously provided for by the federal government which they had not fully realized. This maneuver cost states more than they had bargained for or were willing to spend. Congress finally accepted that termination was detrimental to all involved. Termination was not a policy, but, a decree.

I m Goin to Dallas. Where You Goin ?
Relocation Era, 1961-1975

Relocation provided technical assistance, limited training, and a stipend to encourage Native people to relocate in certain cities. The cities with relocation centers were Seattle, Los Angeles, Dallas, Denver, Phoenix, Chicago, and Salt Lake City. Many Native people took advantage of this hoping to find wage work and a way to support their

families. This is exactly what the federal government had intended this policy to do. As relocatees found themselves in the middle of large unfamiliar cities, apart from relatives, other Indians, and familiar Indian surroundings, and with very little government help finding homes or jobs (as promised), many returned home. Some even requested to be sent to another city to try again. Eventually the government relocated Native people in their own communities within large cities where at least they would not feel so isolated. These communities became distinctively Indian and residents began to take renewed interest in their ethnic heritage blending what they knew about their own Indianness with what others knew about theirs. Thus, we see the beginnings of the urban pan-Indian movement. According to some Native participants, it was a great way to see other parts of the United States at government expense, no less.

As the 1960s progressed and the country became embroiled in civil unrest with segregation/integration issues and marches, the police-action/war in Vietnam, college students rebelling against the establishment, the Black Panther Movement, feminist demands for equality, and Indian activism by the American Indian Movement (AIM). President Johnson s War on Poverty policy addressed some of these issues by establishing a Federal Agency called the Office of Economic Opportunity which provided funding at the local level for development in poverty-strickened neighborhoods. It turned out to be quite unsuccessful in poor urban neighborhoods but was surprisingly successful in Indian communities and reservations. The primary reason for this success was because funding passed through fewer hands on reservations or distinct Indian communities than was the case in urban poor neighborhoods.

Positive Effects of Tribal Self-Determination: 1975-1988

Once again a shift toward positive tribal governments was on the horizon. During the Nixon administration federal recognition of tribal governments as viable sovereign entities surfaced. These entities were deserving of continuing federal recognition with policies that positively reinforced tribal administrative organization. President Nixon enacted the Self-Determination and Education Assistance Act in 1975. The policy s purpose was to strengthen tribal autonomy and provide funds to tribes for education and operation of tribal programs. The act provided a means for tribes to operate authorized services and programs. The Bureau of Indian Affairs still controlled the budget, but now tribal governments could operate their own programs.

Other significant acts also had influence and positive effects on tribal governments. The Indian Child Welfare Act (1978) was a much needed policy directly affecting Indian children. This act provided a way for Indian children to be placed in Indian homes. The preference was to place Indian children in homes within their tribal affiliation. Ideally, Indian children placed with an extended family member would reinforce their cultural heritage. Prior to this policy most, if not all, Indian children were placed in non-Indian homes. This often led to undermining any traditional cultural teachings. The act supported ways to maintain Indian children in an atmosphere conducive to their tribal identity and extended family, if at all possible (Arrow 1994; Getches, et al. 1993; Deloria and Lytle 1983).

At this time, the Indian Health Service Act moved the Indian Health Service

operation from management by the Bureau of Indian Affairs and Interior Department to the Public Health Service operated by the Department of Health, Education and Welfare (HEW). This battery of acts was an improvement over the previous administration s policies, but it still limited tribal governmental abilities to determine internal services and programs. Further discussion of Indian health and the Indian Health Service is provided in Chapter Seven.

Religion did not escape federal policy either during the 1970s. The American Indian Religious Freedom Act (AIRFA) of 1978 was passed allowing individual American Indians freedom of worship without interference from tribal, federal, or state authority. This act primarily concerned peyote use and the Native American Church. The Self-Determination Act ultimately allowed tribes to determine what programs or services they wanted but not how much money to allocate for each program. This did not occur until 1988 with tribal self-governance.

Tribal Sovereignty at its Best: Self-Governance Era, 1988-present

Tribal Self-Governance allowed tribal governments more authority. Indian nations could now reallocate funds and rewrite regulations to better fit their needs. They could also determine where and how to spend the Bureau of Indian Affairs budget allocations. However, this is not automatic. Tribes must apply and be approved for the program. Approval stems from their ability to demonstrate stability and financial responsibility.

Only recently has the Iowa Tribe (2002) completed the planning requirements in order to participate in the tribal self-governance program. The Iowa Tribe certifies it has performed the legal and budgetary research and organizational preparation relative to participation in the self-governance program and has demonstrated financial stability and financial management and capability necessary to participate in the self-governance program [Resolution I-04-15] (Modlin 2004:6). Until approval by the Department of the Interior, the Iowa Tribe continues to operate under the Self-Determination guidelines mentioned earlier.

Policies in this era have had a profound effect on tribal economic development. One policy in particular is the Indian Gaming Regulatory Act (IGRA) passed in 1988. Indian gaming is fast becoming an economic boon to tribes in Oklahoma. IGRA allows tribes to operate Class I, II, and III gaming events. States are not allowed to interfere with class I (low stakes bingo and traditional Indian games) or Class II (games of skill) gaming events; but Class III (high stakes games of chance) gaming requires tribes to negotiate with the state before operating such events. There are gray areas in interpretation of the rules and tribes have had to be creative in what they present to customers. Tribes may have to fight these issues in court. The State of Oklahoma has fought Class III gaming for years. Ironic as it supports horse racing which is a Class III event.

It is only a matter of time before tribes/nations in Oklahoma will be able to offer games of chance to increase revenue to fund their programs. In fact, the time has arrived. The Education Lottery Act and the Tribal State Compact Bill (allowing Class III gaming)

passed in November, 2004. Now, tribes who sign the tribal state compact will be allowed to offer high stakes card games and machines. Major tribes who signed the compact were the Chickasaw, Cherokee, Choctaw, and Absentee Shawnee. Other tribes are expected to sign and have already begun planning to build larger more sophisticated casinos including the Sac and Fox, Kickapoo, Pawnee, and Iowa. Some of the profits from these ventures have been designated for education. Time will tell if this proves to be a positive economic venture for tribes or simply another method of exploitation at tribal expense.

The Power To Tax

> The power to tax is an essential attribute of Indian sovereignty because it is a necessary instrument of self-government and territorial management. This power enables a tribal government to raise revenues for its essential services. The power . . . derives from the tribe s general authority, as sovereign to control economic activity within its jurisdiction, and to defray costs of providing governmental services . . . within that jurisdiction. [*Merrion vs. Jicarilla Apache Tribe*] (Spaeth 1993:303).

The entire scope of taxation as it relates to federal, state, and tribal governments is a complicated and broad area and, as such, is not included in depth in this discussion. This section provides a limited discussion of tribal taxing powers as it pertains to a specific tribal service the ability of tribes to legally assess fees and taxes to individuals who are members of a tribe for the purpose of providing services. An example is tribal license plates. By what authority do American Indian governments provide and charge for tribal license plates? In general, Indian tribes and nations have always been able to tax certain business activities and individuals on tribal lands. However, not until recently have they

exercised this power. Additionally, the ability of tribes to tax and apply certain fees when necessary is not dependent on what states will allow. It is based on what power Congress and the federal courts do not explicitly take away. The following story will illustrate this concept.

> The first Sac and Fox Nation license plate, number SF-49, was issued on August 5, 1983 to then Principal Chief, John R. Thorpe. Rumor was that Department of Public Safety officials in concert with the City Police of Prague, Oklahoma, planned to stop and make an example of any vehicle with non-approved state plates. Knowing this Chief Thorpe and then tribal tax Commission Director Truman Carter set out one evening to see if the rumor was true. . . . One carefully chosen Friday night the two men drove to the small town of Prague for dinner. After dinner they drove around awhile and as expected in less than two hours they were stopped by Prague city police (Roush 1995:81).

Chief Thorpe and Commissioner Carter were arrested and cited for Failure to pay taxes due to State and improper display of license (Soliday 1994:np). The case eventually went to the U. S. Supreme Court and the judge ruled against the state of Oklahoma. Truman Carter had this to say about state taxing authority.

> This ruling is especially important to persons who live and work on the Indian reservations in Oklahoma since these persons derive little or no benefit from paying state taxes. State programs and services do not reach these people. The responsibility to provide public programs and services is shared between the federal and tribal governments [not states] (Carter 1991).

Tribal license plate programs have been successful and effective for many Oklahoma tribes. For Indian tribes/nations, license plate programs generate much needed revenue. The Sac & Fox Nation reports Motor Vehicle Tax income of $3,636.25 for the four week period of June 19, 2001 through July 27, 2001. This is an increase of $1,819.00 over the Motor Tax Revenue reported for the previous month which was $1,817.25 (Soliday

2001). The Iowa Tribe s Annual Treasurer s Report (2001) listed its motor vehicle tax as tribal taxes which was combined with other funds in the General Fund. For FY2001 these funds totaled $170,865 (Roubidoux 2002:2). For some tribal members, license plate programs generate revenue to offer additional employment opportunities, provide needed services (including health care), and assist with living expenses.

The Tie That Binds: Treaties

Treaties became the civilizing instruments intended by the federal government to move the Indians from their aboriginal cultural patterns to the agricultural existence that was deemed necessary for the Indians (Prucha 1988:16). It would appear Native peoples were Indians when it suited governmental purposes. Such purposes varied considerably. Treaties were the means to reach those purposes. Euro-Americans imposed various treaties on Native peoples. Treaties in the European sense were formal, legal, written documents which set out to cover specific provisions. Indian nations had no need for such formal treaties. To them, treaties were a foreign concept. Indians had their own form of diplomatic relations.

> There has always been a question whether treaty making was a process familiar to Indian tribes or whether it was newly introduced by Europeans and inadequately understood by the Indians. As far back as we can trace the practice we find that Indians were quite familiar with diplomatic negotiations and had their own forms for making agreements (Deloria and Wilkins 1999:6).

When necessary, Indian nations negotiated with others as circumstance dictated,

such as, for making peace. In fact, results of such negotiations required certain actions that far surpassed what was expected of European treaties. For example, some members of the Sioux tribe had stolen the sacred corn of the Ree tribe. As a result, the two tribes went to war. Later, both sides got together and negotiated a peace settlement.

> The Indian attitude . . . shows a fundamental difference from that of traditional Western political negotiations. [Native] People believed that peace was a distinct state of being something much different from a lack of conflict. It required the best efforts of the parties to ensure that a good relationship was made and continued to exist. Therefore peace required a positive assumption of moral duties in order to prosper. It was not merely a cession of hostilities as it is for western European peoples. When we compare these procedures for making peace, and the moral pledge that Indian diplomacy involved, with the legalese of the European written document, the European treaty pales and appears for what it truly is a business transaction rather than a diplomatic act (Deloria and Wilkins 1999:7-8).

To Europeans, treaty-making was a logical and legal method of legitimizing ways in dealing with sovereign nations. In the case of land dealings with American Indians, treaties were considered a legal means for taking land without fair compensation. Divesting American Indians of land (as well as traditions, lifeways, and identity) is evidenced in the myriad of broken treaties. Fortunately, the federal government has not been entirely successful. Although altered to a great degree, Native peoples still have their land, still have their traditions, still maintain their lifeways, and continue to have a unique identity.

Officially, the treaty era began with the Delaware Nation in 1778. In actuality, there were at least seven treaties made prior to this one. The earliest mention of treaties was in June of 1775. This was prior to the colonies declaring their independence from

Great Britain on July 4, 1776.

> Since the rebellion [from the British] was successful, it can be assumed that actions having an aspect of legality, such as land warrants issued during the war, would have been recognized as among the political acts of the new nation upon its securing independence. Hence councils, treaties, and agreements made with Indian nations shortly after hostilities began in the American Revolution and continuing until independence should be understood as having validity (Deloria and Wilkins 1999:4).

Since the Delaware Treaty, there have been 523 officially recorded treaties with Indian nations. There were more treaties made and signed by various Indian leaders but, due to incomplete and fragmented records they are not included in the more common studies (Prucha 1994). A treaty, as a negotiating instrument, is defined by Prucha in *American Indian Treaties* as a formal agreement between two or more fully sovereign and recognized states operating in an international forum, negotiated by officially designated commissioners and ratified by the governments of the signatory powers (Prucha 1994:2). Prucha continues stating that American Indian treaties were viewed differently from international treaties.

> [They] exhibited irregular, incongruous, or even contradictory elements and did not follow the general rule of international treaties. . . . Indian treaties had certain characteristics or elements that, although appearing paradoxical or even incompatible, did not cancel each other out but existed together in an anomalous whole (Prucha 1994:2).

Originally, the first Indian treaties consisted of specific items: (1) promises of peace and friendship, (2) protection of the United States, (3) extension of United States jurisdiction over Indians, and (4) establishment of boundaries. Later, additional items were included: (1) removal to or from specific areas, (2) assimilation procedures, (3) land cessions, (4) hunting and fishing rights, and (5) annuities, provisions, and sometimes

grants (Deloria 1989). These were promises made in good faith from one nation to another. However, these good faith treaties were not kept by the federal government. Often these promises were broken. Deloria comments that America has yet to keep one Indian treaty or agreement despite the fact that the United States government signed over four hundred such treaties and agreements with Indian tribes (Deloria 1989:28).

Language barriers also caused treaties to be interpreted in certain ways such that: (1) ambiguous expressions must be resolved in favor of the Indian parties concerned; (2) Indian treaties must be interpreted as American Indians themselves would have understood them; and (3) Indian treaties must be liberally construed in favor of Indian people (Cohen 1982, Getches, et al. 1993). It is now known this interpretation process was not often followed.

The official treaty-making period ended in 1871. Negotiated agreements were substituted and continued until 1911 (Prucha 1994). A sobering reason for discontinuing official treaties appeared to stem from Congressional conflicts. For example, the Senate (with no voice) paid for what the House (with a voice) approved; the Senate decided this would not do. They wanted a voice in what they paid for. Other mitigating factors also influenced Congress decision to ultimately discontinue treaties and agreements.

> Today, tribal governments are able to exercise their powers because of sacrifices made by their forefathers. Foundations were set through treaties and the respective constitutions of each tribe. They were used as a shield to fight for rights such as sovereignty. We have exerted our rights within the court system and won important cases that have benefitted other tribes as well as the Creeks. [Sovereignty Symposium IV.] (Cox 1991:643)

Original Natural Rights of Tribal Self-Governing Authority

> Indian tribes are distinct, independent political communities, retaining their original natural rights in matters of local self-government. The original natural rights of self-government have been described as inherent rights, inherent in the tribal legal status because Indian tribes were possessed of these rights from time immemorial and as such, they are not derived from constitutional or statutory sources (Pipestem 1978:263).

Original natural rights of tribal power and authority are summarized as follows. Tribal governments are empowered (1) to establish and define a form of government, (2) to determine membership criteria, (3) to regulate domestic relations, (4) to administer justice, (5) to exclude nonmembers from their lands, (6) to charter business organizations, (7) to levy taxes, and (8) to govern descent and distribution of property. Tribal governing authority also includes police powers, the power of eminent domain, and sovereign immunity (Pipestem 1978). This authority allows tribal governments to provide education, social programs including health care and nutrition counseling, police and fire protection, and other needed services to enrolled members.

In spite of this apparent unlimited tribal power and authority, limiting factors do exist. Limitations stem from recognition that Congress in its plenary role has the authority to limit, alter, curtail, or *expand* tribal powers of self-government (Pipestem 1978:272). Examples are: (1) certain acts of general application (the Major Crimes Act passed in 1885); (2) federal statutes concerning termination (the Curtis Act of 1868); (3) acts that limit tribal sovereignty (the Indian Civil Rights Act of 1968); and (4) self-enacting restrictions, omissions, or oversights in some constitutions, such as, a tribe or nation not maintaining a judiciary because of a lack of funds (Pipestem 1978).

Inherent sovereignty and powers of self-government are not synonymous. Powers of self-government are delegated powers and inherent sovereignty is an intangible and spiritually derived feeling of oneness. Sovereignty is not something one government can delegate to another (O Brien 1989:64). Each Indian nation derives self-government authority from their inherent sovereign status and deals with the federal government on an individual nation basis. While the courts are responsible for interpreting the broad outlines of the tribal-federal and tribal-state relationships, each tribe maintains its own separate and unique government-to-government relationship with Congress (O Brien 1989:68). Since Congress may at whim choose to divest power and authority from tribes, tribes must be alert to challenge legislation that threatens their existence. However, Congress present policy acknowledges and encourages tribal sovereignty.

Simply A State of Mind

Throughout this chapter insights into the scope and nature of federal policy and its effects on the political economy of tribal governments was discussed. The origins of the federal-Indian relationship was presented with the recognition that in the beginning tribal governments were equal to the new American Nation. As time progressed the equality gap widened and the political powers became unequal. Now tribes found themselves under the power and authority of the federal government. Times change and so do policies. Reflected in the rest of the chapter was a discussion of the positive efforts and economic benefits tribes/nations have made today while taking back its sovereign status.

A question remains. Where does tribal sovereignty stand today? It depends on who you ask. At present, some answers are clear. Tribal sovereignty pre-existed United States formation. Tribal sovereignty is self-regulated under a system of tribally developed codes and laws monitored by federal authorities. Modifications are agreed upon by both parties. Although it sounds like a contradiction, anything not expressly divested by Congress remains with the tribe/nation. Even though limited, a tribe still has inherent authority to determine its own fate. During an interview about the issue of sovereignty, former Sac and Fox Chairman, Jack Thorpe, said it best. Tribal sovereignty is a state of mind. If you think yourself weak; you re weak. If you think yourself strong; you re strong (Thorpe 1994).

Chapter Three

Tribal Governments Within Oklahoma: A Status Higher Than States

This chapter continues the historical overview with tribal sovereignty, but with a focus on tribal governments and their relationship with the State of Oklahoma. Such relationships are explored in depth answering questions about tribal-state jurisdiction boundaries, tribal reservation status versus Indian Country, and confusion over Indian allotments versus Indian land title. The chapter ends with an example of how legal misunderstandings can cause confusion.

Through time, and without fail, states have attempted to exercise complete authority over tribal governments ever since statehood in Oklahoma. In a consistent effort to gain control states have not been entirely successful. The lack of state control over Indian affairs stems from the 1831 *Worcester* court decision that reaffirmed tribal government status as equal to, or higher than, state governments. Claude Cox, Chief of the Creek had this to say at the 1991 Sovereignty Symposium in Oklahoma City.

Throughout the United States the respective states are educating themselves about Indian tribal governments. In the education process each state finds that Indian tribes should be handled on a government-to-government relationship (Cox 1991:643). For example, state governments do not have jurisdiction over crimes committed within tribal boundaries by Indians against each other, or against non-Indians (*Williams vs. U. S.,* 1946; *Williams vs. Lee,* 1959); nor can states interfere with economic development (gaming, taxation) or internal mechanisms aimed at providing quality health care for the welfare of its

members/citizens.

Presently, states maintain civil and criminal jurisdiction within Indian country only between *non-Indian* offenders which was reaffirmed in *U. S. vs. McBratney* (1881), *Draper vs. U. S.* (1896), and *Oliphant vs. Suquamish Indian Tribe* (1978). Outside tribal boundaries, states have jurisdiction over all citizens, including Indian offenders (Canby 1988). As always, state and tribal governments have differing opinions and interpretations concerning who has what power and authority over whom. Infringement of state authority over the sovereign status of tribes has always been complicated and prompted questions. Essentially, [s]tate jurisdiction is pre-empted by the operation of federal law if it interferes or is incompatible with federal and tribal interests reflected in federal law, unless state interests at stake are sufficient to justify the assertion of state authority (Canby 1988:221).

Consolidation and Fragmentation: An Oklahoma Consequence

As early as 1830, Congress believed all tribes and nations should be relocated to the newly created Indian Territory which, at that time, included parts of Oklahoma, Kansas, Nebraska, and Missouri (Gibson 1980, Waldman 1985). By 1866, Indian Territory was diminished to the present-day state of Oklahoma. Congress thought removal would promote tribal consolidation and expedite assimilation. It was an all-out federal effort to centralize tribal governments and Indian people in one place Oklahoma.

It is interesting that in only a few short years the idea of an all-Indian state was abandoned in favor of merging the two (Twin) Territories into one state. It was hoped that within twenty or so years Native peoples would assimilate into mainstream society, lose their tribal identity, and abandon their tribal heritage to become ordinary citizens of the new state of Oklahoma.

This was not the case. Culture, as a lifeway, is strong and traditions die hard. It has now been almost 100 years and tribal governments in Oklahoma are now stronger than ever. If the first governor of Oklahoma, Charles N. Haskell, were alive today, he would be surprised. He predicted there would be no Indians in his state within twenty years believing intermarriage and assimilation would diminish any affiliation and identity with tribal groups. He must have been thinking Native people would willingly abandoned their heritage, their traditional lifestyles, and actively seek a new way of life wanting to identify with the newly formed state. If that was Haskell s state of mind, there would have been no need for reservation status. Such a notion would have been a basis for the ongoing belief there are no reservations in Oklahoma. Culture does not work that way. It is not surprising, though, that Haskell would make such a statement, as his political agenda would have favored a unified body of people.

Over a sixty-three year time span, over sixty tribes were consolidated within the territorial boundaries of Oklahoma. Of those tribes, 37 are federally recognized. The rest are non-federally recognized tribal remnants who still maintain cohesive cultural and political ties. So, what are the effects of removal and consolidation on Native peoples, their land base, and tribal governments today? Not much. The tribes I have become

familiar with still maintain a distinct tribal identity. Some are even increasing their land base by repurchasing their old reservation land. The Iowa Tribe, for example, have repurchased over 288 acres of their original Oklahoma reservation since their removal from Iowa and Nebraska in 1891 (Sanders 1993). They plan to continue additional land purchases.

Tribal governments are thriving in the state of Oklahoma, today, thanks to economic development. They have overcome removal from their native lands and become stronger entities. However, there is a downside to all this. It is the process of fragmentation.

Removal to Indian Territory has resulted in tribes becoming fragmented to a certain extent. Oklahoma is home to tribes who have counterparts on reservations in other states. The Cherokee, Choctaw, and Seminole are three examples. Also, the Sac and Fox have a counterpart (the Mesquakie) who reside in Kansas, as do the Kickapoo, and the Ioway. Another example are the Cheyenne and Arapaho who share a land base in Oklahoma with counterparts in Montana and Wyoming respectively. The Shawnee are represented twice in Oklahoma. These tribes all have counterparts recognized by the federal government as separate entities. But how can that be? Their cultures have not changed, neither have their traditions or world views. The only difference is the federal government recognizes them as separate legal entities. There are others, but these examples will suffice.

Interesting unexpected consequences of federal regulation can also occur, a notable example is the Delaware. They are an especially unusual circumstance. At the

beginning of my study, the Delaware were two separate tribal entities, each with federally recognized status. By the completion of my study, the federal government decided to terminate one group s federal tribal status. At this writing there is only one federally recognized Delaware Tribe located in southwest Oklahoma. I understand the newly terminated Delaware Tribe from northeast Oklahoma are seeking a legal appeal. This could be a modern form of divide and conquer by the federal government.

What are the consequences of this? What I have noticed is Native peoples who live in Oklahoma have greater potential to interact with non-Indians and other tribal members than with their own tribal members. Not that they do, but they are often in close proximity to these other groups. There is also the issue of marriage practices. Although discussion of this issue might be better located in the chapter on kinship and social networks, it is presented here to maintain continuity and will be referred to later.

Fragmentation of tribal groups means there is a risk of loss of tribal enrollment for future generations. If marriage rules require clan exogamy and through attrition there are no eligible marriage partners, then individuals must look outside their tribe for a partner or risk committing incest according to their marriage practices, that is, assuming love and personal choice do not matter. To stay within the bounds of acceptable cultural norms, persons will have to look elsewhere for a marriage partner. Mixed marriages produce mixed blood offspring who often learn multiple cultures, such as, following Christian values which allow marriage outside clan and band affiliation. Eventually, they will have to choose which culture or tribal affiliation to identify with. This could result in identity issues. The risk of pan-Indian identity is ever present as well. Even so, traditions die hard

and it is not all that unusual for a person of multiple heritage to be able to maintain more than one tribal identity. This is what is unique to the tribes in Oklahoma.

Contrast that explanation with the large land mass of the Navajo Nation in Arizona and New Mexico. The land mass is large enough that the potential for Navajo to meet non-Navajo is greatly decreased. Thus, the potential for maintaining the traditional social, economic, and political structure is not as difficult. Traditional marriage practices can be maintained more easily because there are more available marriage partners assuming, of course, compatibility, and personal choice.

Oklahoma Land Status vs. Indian Country

The state of Oklahoma has a unique history in its dealings with Indian tribal nations. By 1880 more than sixty Indian nations and tribes had been relocated to Oklahoma s Indian Country. This broad expanse was now to be their home (Gibson 1991). Prior to statehood, Oklahoma was referred to as Indian Territory, and later as Indian Country. Historically, this region was to be a permanent home for relocated tribes during American westward expansion. Ultimately, the character of the state was determined by the nature of the removals.

Oklahoma was divided into two regions. Originally, there was an informally organized eastern region known as Indian Territory, and a more formally organized western region known as Oklahoma Territory. Indian Territory would be home for the relocated so-called Five Civilized Tribes (the Cherokee, Chickasaw, Choctaw, Creek, and

Seminole), the Osage, and later others (the Quapaw, Miami, Modoc, Seneca, etc.). Oklahoma Territory would be home for what the federal government called hostile or wild tribes, such as, the Iowa, Kiowa, Otoe-Missouria, Comanche, Apache, Ponca, Pawnee, Kickapoo, Cheyenne and Arapahoe, the Sac and Fox, Shawnee, Caddo, Delaware, Wichita, and others (Kickingbird 1994).

Other important reasons for such a division originated from the distinct legal statuses of these regions. Oklahoma Territory (the western region) came into being with the passage of the Oklahoma Organic Act of 1890. The act s purpose was to provide non-Indian settlers with a form of government after the land runs. The land runs assumed two forms: the illegal Boomer runs of 1879-1884, and the legal Sooner runs of 1889-1893 (Gibson 1991). In its origination, the act was not intended to subject tribal governments or Indian individuals to the new territorial government. Indian nations/tribes continued to maintain sovereign powers of self-government subject only to Congress. Eventually, land allotments and land cession agreements diminished tribal land holdings in the western region. However, tribal powers of self-government continued and were not extinguished.

In 1905, Congress considered establishing a separate Indian state the state of Sequoyah from the existing eastern region which was the designated Indian Territory (Kickingbird 1994, Gibson 1991). It did not matter that the relocated tribes had their own distinct cultural traditions that might have been compatible with each other. The idea was later abandoned because of the onslaught of white settlers moving into the area. Racial prejudice and politics were cited as reasons. During this time, the various Indian Territory tribal governments, with federal law enforcement assistance, were the only governing

authority. These tribal governments were left intact for only a short time only until Congress approved several acts which threatened their existence. There were three (1) the 1890 Oklahoma Enabling Act, (2) the 1897 Appropriations Act, and (3) the 1898 Curtis Act. The Appropriations Act drastically infringed on and diminished governing powers of the Five Civilized Tribes. The Curtis Act was enacted to provide for land allotments, establish federal territorial governments, and abolish tribal courts (Kickingbird 1994).

Inevitably, the two territories were destined to become one. Oklahoma s 1906 Enabling Act became the vehicle to accomplish this. It combined both territories into one temporary government, thus, establishing a pre-state Oklahoma Territory (Kickingbird 1994). The act provided the mechanism for authorizing the adoption of a state constitution. However, there were certain stipulations addressing rights of Oklahoma s tribal governments and Indian people. The Enabling Act was clear in its intent.

> *Provided*, That nothing in this act shall be construed to impair any right now pertaining to any Indians or Indian tribe in said Territory under the laws, agreements, and treaties of the United States, or to impair the rights of person or property pertaining to said Indians, or to affect the authority of the United States to make any regulation or to make any law respecting said Indians, their lands, property, or other rights which it would have been competent to make or enact if this act had not been passed (Pipestem 1978:280).

At last, Oklahoma became the 46th state in the Union in November 1907, pledging that it would never interfere with the sovereign rights of Indian tribes or the federal government in carrying out its legal responsibilities to the Indians (Kickingbird 1994:321). This is an interesting comment considering the state did not want reservation status. Upon further investigation such a statement was required before statehood would

be allowed. A disclaimer clause in Oklahoma s constitution was provided to this effect.

> The people inhabiting the State do agree and declare that they forever disclaim all right and title in or to any unappropriated public lands lying within the boundaries thereof, and to all lands lying within said limits owned or held by any Indian, tribe, or nation that until the title to any such public land shall have been extinguished by the United States the same shall be and remain subject to the jurisdiction, disposal and control of the United States. [Article 1, Sec. 3] (Kickingbird 1994:321).

At this point the new state officials arbitrarily dismissed the term reservation and substituted the term Indian Country in an effort to dismiss Oklahoma s reservation and allotment status. However, the federal relationship with tribal governments continued to remain unaffected (Kickingbird 1994; Pipestem 1978).

The 1934 Indian Reorganization Act did not apply to Oklahoma tribes. The Oklahoma Indian Welfare Act of 1936 was passed so Indian Reorganization Act provisions could be extended to Oklahoma tribes/nations. The welfare act provided additional features. These features became the foundation of local Indian cooperatives for credit administration, production marketing, consumer protection, and land management. Tribes were now legal and could (as of 1936) reorganize under the Oklahoma Indian Welfare Act. Most tribes did not. Due to tribal distrust only ten tribes reorganized under this act (Kickingbird 1994; Pipestem 1978). The Iowa Tribe was one of the ten. They reorganized under this statute on February 5, 1938 under a Charter from the Department of the Interior (Wright 1951:158). At that time they also established their constitution and by-laws.

So, what is the present state of affairs affecting the Oklahoma s views of the status of the Indian tribes/nations residing within its borders? The state of Oklahoma has

reaffirmed its willingness to work with these tribes/nations. The State of Oklahoma recognizes the unique status of Indian Tribes within the federal government and shall work in a spirit of cooperation with all federal recognized Indian Tribes in furtherance of federal policy for the benefit of both the State of Oklahoma and Tribal Governments [State Senate Bill 144] (Gourd 1989:7).

Oklahoma officials were not always so cooperative and willing to work with tribal governments, especially concerning health care. Today, state officials now grudgingly honor decisions of tribal governments to provide health care and other services. Only Congress or the tribe can limit the exercise of the tribe s sovereign power. The state has no jurisdiction over tribal governmental matters [*U. S. vs. Pawnee Business Council,* 1974] and in most cases involving internal matters of the tribe, the federal government has chosen not to interfere (Kickingbird 1994:335).

Dr. Charles A. Gourd, former Executive Director of Oklahoma s Indian Affairs, made the following statement about tribal-state relationships.

> Tribal Sovereignty is secured in the U. S. Constitution. The Commerce Clause reserves, to the Federal Government, sole and exclusive jurisdiction to treat with Indian Tribes. State Sovereignty is secured through the Oklahoma Enabling Act and the subsequent, Constitution of the State of Oklahoma. . . . Tribal sovereignty, therefore, is not an Oklahoma specific issue or problem. As in the international community of nations government -to-government agreements are negotiated, so to, in Oklahoma. . . . Senate Bill 144 forms the basis for this future
> (Gourd 1989:1).

It is this justification that tribal governments in Oklahoma base legal authority for providing programs and services for their members. There are limitations though. Tribes are not limited by state regulations for their resources, but they are limited to some degree

to the extent of what they can do. For the most part, tribes are limited in the level of health care they can provide for their members, mostly due to a lack of funds. Thus, tribes must continue to rely on the Indian Health Service for health care for their members. Health related topics are discussed in more detail in Chapter Seven.

Economic development has enabled many tribes to purchase or build their own health care facilities. Today, a major source of revenue is the gaming industry. According to the law, tribal gaming statutes stipulate that tribes must limit its maximum gaming activities to the extent of what the state allows. This means tribes have sole discretion on whether to become involved in Class I and/or II gaming activities without state permission. It is only when tribes desire to offer Class III gaming that limitations may be imposed. Federal statutes require tribes must enter into compacts with the state if they desire to offer Class III gaming. Otherwise they are operating illegally. The recent legislation allowing the lottery and Class III gaming has interesting implications for the tribes. Time will determine if this was a wise move or not. Ideally, tribes should benefit from this action and with the increased revenue, tribal services, including health care, should increase.

So, How Much Land, Ya Got?

Land is a very desirable commodity. We all wish we had some. Europeans placed great value on it at contact. What they failed to see was the value the Native population also placed on it. The inevitable land grab resulted in conflict. Euro-Americans thought land needed to be exploited and used to its fullest capacity. Whereas, the Native population embraced the land, which reflected their world view, and felt blessed to be able to take care of it and assure its perpetual use. These opposing views of land use ultimately led to the allotting of Indian lands.

Land is allotted in a different manner in the state of Oklahoma as compared to other states. Tribal land ownership in Oklahoma has been defined as property in which an Indian tribe has a legally enforceable interest (Maxfield, et al. 1977:125). Indian land is vested or acquired in six ways:(1) treaties, (2) acts of Congress, (3) executive decision, (4) purchase, (5) actions of state or foreign nations, and/or (6) aboriginal possession (Maxfield 1977). Aboriginal possession refers to land occupied by specific Indian nations before white settlement. Prior to 1871, treaty-making was a primary method of confirming American Indian legal land rights. Treaties usually recognized aboriginal rights and included exchanges and/or land cessions to the federal government. Congressional acts also created or confirmed Indian tribal land interests. United States policy has been to recognize property rights created or confirmed under prior sovereigns such as with the Pueblo lands in New Mexico acquired from Spain (Maxfield 1977:130).

Tribal land interests were, and still can be, created by the federal government in several ways: (1) through withdrawal or exchange of public lands, (2) by authorization to

purchase private lands, and (3) through acquisition or withdrawal by executive order. Court decisions also affect the outcome of tribal land interests. Sometimes, the results are positive and sometimes they are not. Tribal governments are also able to purchase or exchange lands, or receive them as a gift. Several variables affect Indian land titles: (1) whether the land is owned by tribe, nation or individual; (2) whether the land is owned by Indian or non-Indian individuals; (3) whether the land ownership is held in trust, fee simple, or restricted status; and (4) location, whether the land in question has reservation or non-reservation status (Maxfield 1977).

Further, the state of Oklahoma has a unique situation regarding the nature of tribal land ownership. The federal treatment of tribes at one time differed by region, such as, between Indian Territory and Oklahoma Territory. Once these regions were merged into one entity known as Indian Country, the state ignored these differences and believed tribal governments had very little, if any, governing authority. What little authority states assumed tribes had was not differentiated between the eastern and western regions as was the case. Another jurisdiction complication is some tribal lands are divided checkerboard style. That is, specific parcels of tribal lands alternate with specific parcels of non-tribal lands into smaller areas with more blurred boundaries. This makes tribal self-governing difficult. The Indian Country distinction has made regulation and self-governance complex.

Oklahoma s unique situation and Indian Country s misunderstood interpretation, when applied to Oklahoma s type of land base, creates confusion for state officials and the general public. The confusion stems from earlier interpretations of various statutes (such

as, the Trade and Intercourse Acts of 1790-1802 and the Trading House laws of 1796-1822). As early as 1763 references to Indian land use the terms Indian territory and Indian country interchangeably. These terms referred to specific boundaries at various points in time depending on westward expansion. Eventually, references such as Indian town, settlement or territory, lands allotted or secured to Indian tribes, and lands to which the Indian title has not been extinguished (Cohen 1982:29) were used to distinguish Indian land from non-Indian land. The Acts, read as a whole, appeared to apply to lands owned and occupied by tribal Indians wherever they were located (Cohen 1982:29).

The nature and character of Indian communities also fell under the Indian Country description. The dependent Indian community designation was reaffirmed in *Sandoval* (1913) whether its original territory or territory subsequently acquired, and whether within or without the limits of a State (Cohen 1982:33). By 1948, the rules changed and Congress intent was clearly to designate Indian Country as

> (a) all land within the limits of any Indian reservation . . . , (b) all dependent Indian communities . . . , and (c) all Indian allotments, the Indian title to which has not been extinguished . . . (Cohen 1982:27).
> . . . . . .
> [Further] all lands set aside by whatever means for the residence of tribal Indians under federal protection, together with trust and restricted Indian allotments [are Indian country]. Congress also specified that fee patented lands within reservations are Indian country (Cohen 1982:34).

Confusion over these assumptions is perpetuated by several myths concerning the status and nature of Oklahoma s Indian land (Kickingbird 1994). Two are presented here. The first myth is the *Reservations have been Disestablished* assumption. This assumption

concerned the General Allotment Act and definitions of Indian Country. It was a popular belief that allotments automatically disestablished reservations and tribes did not have self-governing powers. It was generally accepted that states had complete jurisdiction over land issues (Kickingbird 1994). This is not so.

Tribal governments retain jurisdiction over all trust lands within their original reservation boundaries. This means that land still under trust status (individual allotments and tribally owned lands) falls under the self-governing powers of the tribe. All other non-trust lands within the original boundaries owned by other individuals falls under state jurisdiction. Thus, Oklahoma s checkerboard jurisdiction maize was one reason tribal law enforcement officers have become trained in federal, state, and tribal law enforcement. Because of Oklahoma s unusual reservation/jurisdiction boundary confusion, tribal officers are cross-deputized and are legally able to enforce state, tribal, and federal laws.

The question was, did allotments effectively terminate the reservation status of tribes in Oklahoma or not? According to the Congressional-authorized American Indian Policy Review Commission of 1977; it did not.

> It has long been assumed uncritically by both federal and state authorities that the initial reservation boundaries no longer exist for jurisdictional purposes as a result of the allotment process. As a corollary mis-conception, it has been assumed that Indian tribes within the state possess few, if any, residual powers of self-government. . . . [T]here is a definite need to clarify jurisdictional relationships of the tribes which includes a clear recognition that Oklahoma tribes do enjoy reservation status (Kickingbird 1994:336).

There is no legal basis for the assertion Oklahoma no longer has reservations, only false assumptions. The *Cheyenne-Arapahoe Tribes vs. Oklahoma* court case in 1980

clarified this misconception. Supporting this concept are reports and federal legislation referring to Oklahoma s Indian lands as reservation lands. Evidence of this can be seen throughout Oklahoma by the small green boundary signs along the roadside. The signs indicate the extent of a tribe s jurisdiction area, such as, Entering/ Leaving [*tribe s name*] Tribe Nation/Reservation.

The Supreme Court, in *DeCoteau* (1975), also indicated allotments did not extinguish reservation boundaries. The question of reservation disestablishment must be decided on the basis of careful study of each reservation s surrounding circumstances and legislative history with respect to the intent of Congress to continue reservation status (Kickingbird 1994:337). In February, 1972, the Bureau of Indian Affairs Area Director in Anadarko, Oklahoma further substantiated:

> I hereby certify that all Indian land, individually or tribally owned in the State of Oklahoma for which the U. S. Government, U. S. Department of Interior, Bureau of Indian Affairs, is the trustee. . . does constitute duly established and existing Indian reservations in the State . . . of the respective tribes and . . . said reservations are recognized and substantiated by this office (Kickingbird 1994:337).

The second myth and assumption is *Allotments do not constitute Indian Country.* The State of Oklahoma has used this argument to assume jurisdiction over Indian lands. Because allotments took tribal land out of common ownership and title to lands were held in trust, the state assumed they had legal jurisdiction. Indian land titles are held in trust for 25 years then converted to fee simple titles and made available for sale. Only then would the state have jurisdiction authority but not until the end of the trust period. A careful reading of the Burke Act (1906) and the Allotment Act reveals federal jurisdiction over

allotments would remain as long as trust status and restrictions on alienation remained and *no earlier*. This decision was clarified in a 1915 court case, *United States vs. Nice* (Kickingbird 1994.338).

Indian country still exists in Oklahoma, and state and tribal governments continue to challenge each other. Tribal governments have recently begun to read, research, and interpret legal documents to their advantage. For the most part federal and state courts continue to reaffirm allotments as maintaining the nature and character of Indian country. In *Ahboah vs. Kiowa Housing Authority* (1988) the Oklahoma Supreme Court reaffirmed the status of allotments as Indian country.

> Individual trust allotments have long been recognized as Indian Country, whether within or without continuing reservation boundaries. The test, as articulated by the Supreme Court, is whether the land[s] in question have been validly set apart for the use of the Indians as such, under the superintendence of the Government. . . . Extensive federal regulation of the leasing of allotments, even to non-Indian lessees, shows Congressional intent that the leased allotments remain Indian Country (Kickingbird 1994:339).

As the nature and character of Indian Country s land trust status became more understood, tribal governments sought creative ways to finance their operations. During the mid-1960's, they pursued grants and contracts to finance limited services. By the 1980s, Indian nations were looking to expand their financing abilities to provide even more services and programs, in addition to increasing operating revenues. Some of these services and programs included gaming, issuance of tribal license plates, oil and land leasing, operation of their own gasoline trucks, and retail development (smoke shops, gift shops). These are but a few ways tribal governments (including the Iowa Tribe) express

their sovereignty. And although the state of Oklahoma persistently challenges tribal authority and jurisdiction over trust, allotted, restricted, and tribally owned Indian lands, the United States Supreme Court continually insists that Indian Country is Indian Country regardless of whether it is located on a reservation or on trust lands (Kickingbird 1994:341). The United States Supreme Court contends that it doesn t matter what you call it, these tribal lands and trust allotments are all Indian Country and that all receive the same treatment (Kickingbird 1994:302).

For example, the Iowa Tribe of Oklahoma had twelve acres of trust land and 1,509 acres of allotted lands in 1977. In 1993 the Iowa Tribe increased their land holdings to 208 acres and their allotments declined to 1,334 acres (Sanders 1993; Maxfield 1977). These figures represent changes in trust lands and allotments from purchase, exchange, or gift over a sixteen year period. As of June 2002, the tribe s land ownership totaled 656 acres (IT 2002). Additionally, the figures also do not represent other non-trust, tribally owned real estate property. Revenue to purchase trust land in part comes from economic development administered by the tribes/nations. Clearly Indian nations are exercising their inherent sovereign powers and tribal self-governance and it seems to be working.

During an interview with a Bureau of Indian Affairs employee from the Anadarko Area Office, a comment was made that Indian tribes can purchase available land anywhere in the state of Oklahoma and apply to the federal government for trust status. The only drawback is where the land is located. Location determines the expediency of the trust status request, not whether the land can be placed in trust. If the purchased land is located on a present or former reservation approval is simpler, faster, and more easily

accomplished. Otherwise, if the property is located outside reservation boundaries approval is not impossible but much more complicated (Sanders 1995).

When Misunderstandings Lead to a Conflict of Interest

There is another little known term and legal definition called *near reservation* that addresses jurisdiction issues which became effective July 6, 1979. Essentially, the term designates certain areas close to tribally owned lands as being near reservation locations. Thus, such an area is deemed appropriate for the extension of tribal activities and is conducive to the consolidation of services for Bureau of Indian Affairs financial assistance and/or tribal social services. This term, however, does not take into account tribal membership status or American Indians who are non-tribal members.

The near reservation land base for the Iowa Tribe of Oklahoma was defined as

> All of Payne County north of the Cimarron River except that part which lies within the boundaries of the Pawnee Tribe s former reservation . . . and all the area within a six-mile-wide strip of land in Logan, Oklahoma, and Cleveland Counties beginning where the line intersects with the Cimarron River, then running due south to the South Canadian River [Federal Register No.154 (Seneca 1979 n.p.).

The Iowa Tribe believed they had tribal land which fell into this federal definition. However, the area defined is known as the Unassigned Lands on most topographical maps and in various written Oklahoma histories (Gibson 1991; Morris, et al. 1986). In theory, this method appeared to be a simple solution for providing services to Native people who are members of other tribes who do not live within their own tribe s

boundaries. Realistically, though, it was not that simple. Unknown to the tribe (at that time), the Unassigned Land designation nullified the near reservation concept.

Several situations occurred within the town of Perkins involving the Iowa Tribe and some Indian residents. These centered on public services. What surfaced was the reality of the complex terms near reservation and tribal sovereignty. The following account demonstrates how most legalese in actuality does not consider what some Native people must contend with during their daily living situations.

Three events occurred within the Indian community in the town of Perkins in 1992: (1) an incident involving a handicapped elderly Indian woman, (2) a near break-in of an Indian home, and (3) an alleged physical assault of another Indian female. The events brought emergency requests by the town s Indian citizens for city police assistance. However, city police assistance was denied. This alarmed the Indian community. Further inquiries revealed the Perkins city police had been mis-informed about the legal jurisdiction concerning the Indian housing located within the township. The city police were advised by the city attorney, who was informed by the tribal council that the Indian housing in Perkins was located in Indian Country. Therefore, city law enforcement officials were not legally liable to respond to calls. They believed the Iowa Tribe Police should have answered the calls. At the time, they were answering other calls forty miles away when the above incidents occurred.

The Iowa Tribe based their conclusion on an application sent to the Bureau of Indian Affairs for approval to grant near reservation status to the Indian community. This action designated the Indian community housing as falling under the Iowa Tribe s legal

jurisdiction to provide services. Application of this near reservation concept would qualify the Indian residents for tribal services and programs, such as health care and the purchasing of tribal license plates. As a result, the Indian residents were denied city police protection.

Thus, a dilemma was presented in which the Indian residents remained legally obligated to pay state and county taxes because they owned their homes, but without receiving city or county emergency services. Further investigation revealed the Tribe based its legal jurisdiction on the belief that land north of the tribal boundary had at one time been classified as Indian Country. Tribal officials assumed the area fell under the near reservation concept. Therefore, the tribal government felt it could legally claim and maintain their jurisdiction claim within this area. No official investigation was ever conducted to verify this assumption by city officials. In addition, the Indian residents were never notified they did not have city police, health, or fire protection.

A full investigation began with the cooperation and agreement of the Perkins City Council and the Indian homeowners. Specific questions needed to be answered. What was the status of the land in question and who had legal jurisdiction? Who owned the homes? The first question, concerned jurisdictional authority and land status. To answer this question, research was completed on land ownership dating back to Spanish contact in 1540 (Chapman 1981). A chronology of dates and classification was developed and completed from historical accounts to the present (Morris 1980; Prettyman 1957). This research demonstrated the land in question had in fact been designated Unassigned Lands, and was never designated Indian Country nor connected with any particular tribe

since 1889 prior to Oklahoma statehood (Morris 1980; Prettyman 1957).

The second question involved home ownership. Housing records showed the Indian homes in the community were purchased through the Sac and Fox Nation Indian Housing Authority. When these homes were paid in full, fee simple titles were presented to the families. At that time, the land was taken out of Sac and Fox trust status and placed on the Oklahoma tax rolls. Thus, state and county taxes applied. Paying these taxes (which residents had been paying all along anyway) entitled property owners to state and county emergency services.

After weeks of meetings, the city attorney announced his decision. The residents were, in fact, entitled to full protection and services under the law from city and county agencies. The Indian community won this issue and presently receives city and county services. Ironically, residents who are Iowa tribal members are still eligible to receive programs and services from the Iowa tribe including health care and tribal license plates. Members of other tribes who reside in the Perkins Indian community are also eligible to receive health care services and, due to changes in tribal codes, many have purchased license plates from their own tribes. The only change has been in tribal police protection. Unless operating under the cross-deputization compact, tribal police do not answer calls in the Perkins Indian community.

Today, many of the Iowa tribal police officers are cross-deputized and hold federal commissions. This enables them to assist the Perkins Police Department when necessary. In fact, the Perkins Police Department contracts out their dispatching services (including 911 emergency services) to the Iowa Tribe Police Department. Simply put, this is another

innovative tribal economic development opportunity that produces revenue which defrays costs incurred by the tribal police department.

So you see, there are reservations in Oklahoma. Overall, this chapter has attempted to dispel myths about reservations, explain tribal sovereignty, and clarify jurisdiction over Indian lands with its confusing checkerboard status. Today, tribal governments and the Oklahoma State legislature are working together to reach compatible agreements on jurisdiction, economic development, and law enforcement. It is an interesting time to be living in Indian Country.

Chapter Four

Explanation and Theoretical Motivation: A Basis For Understanding, Under The Sun

Explanations show how and why something to be understood is related to other things in some known way. They rely on associations which are observed relationships between two or more variables. Typically, they are answers to *why* questions. For example, why do Native people appear to get free health care? Why can tribes build casinos? How come tribes do not pay taxes? And, what about all those tribal license plates, anyway? Societies have their own answers for questions like these. It explains how their world works. It may not be the western scientific method of explaining things, but it usually satisfies Native people.

The chapter presents underlying theoretical motivations for my research. A world systems perspective is used to explain aspects of tribal economic development. Development of an internal colonial model explains economic challenges tribes face when developing health care programs. This discussion is continued in the section on political economy, capitalism, and health in this chapter. Also included in the chapter, is a discussion of the political economy of health from critical and clinical medical concepts and how certain illnesses have become medicalized.

Most theories about indigenous peoples stem from European or Eurocentric scholarship and do not accurately reflect the reality of Native peoples from a neutral perspective. These explanations are of limited help in understanding Native peoples, their governments, their attempts at economic development, their tribal sovereignty, and so on.

Western or Eurocentric theory tends to explain other cultures and peoples in terms of its own norms and values . . . [which] follows a lineal evolutionary approach in which societies develop step by step through predictable successive stages (Pino 1998:np). This approach insinuates that the past is primitive or somewhat inferior and the present is progressive, inevitable and superior (Pino 1998:np).

For Native peoples of North America it is just the opposite. Life interactions operate [in a type of] network. The basis of all interaction is found in a number of constant relationships of everything forming Creation (Pino 1998:np). It is a type of reticulum system with all aspects of life interconnected. It is the relationships between religion, language, culture, politics, kinship, and economics which are all interdependent on each other. It is much like structural-functionalism, which is also balanced. This means that all aspects are related in such a manner that if change occurs in one part, it affects all the other segments. This is the core of a circular approach to life (Pino 1998:np) which is quite different from a western linear approach to life.

Researchers desire a more structured model for their explanations. They use theories as tools in their attempts to explain and understand why people do certain things and what motivates certain actions. One difference between the two ideologies is perspective. Is it scientific or humanistic? By humanistic, I mean it is the quality of being human that is focused on culture (Webster 1998). Otherwise is it not all the same under the sun? After all, they are both explanations for human behavior.

Here is an example. A long time ago before western medicine came to the Otoe and Ioway people, there was a commonly held belief about *strokes*. An elderly Ioway

woman told me it was a bad thing to have enemies because if amends are not made and an enemy should die, they will seek you out. When they find you, they will touch you. At that point, the part of your body that is touched dies. Even today, that belief is not too far from mind. It is not a scientific explanation, but more to the point, it is an explanation that has a deep, humanistic, or cultural, meaning. It was explained that as a matter of social control, people strove to be nice to others or make amends for wrongdoing. Sometimes, just to be on the safe side, apologies would be offered even if it was unknown that an offense had been committed. The belief was that by doing so order was restored or at least maintained.

By contrast, the medical community provides a scientific explanation, or medicalizes, a stroke as a sudden cerebrovascular failure usually caused by arteriosIcerosis, hypertension, embolism, or hemorrhage and resulting variously in impaired vision and speech, coma, paralysis, etc. (Webster 1998). That is a more accurate explanation of what is physically happening to the body, nevertheless, both versions are explanations. It is only the belief and perspective that differs.

Most Native people I have spoken with are not very interested in technical explanations of their behavior. In fact, I have been told they get somewhat tired of hearing how researchers describe their universe in scientific terms. It seems that a humanistic approach is more valid and practical to Native peoples.

The point is there are many approaches to explaining a society and its behavior. Another example of this is a structural-functional approach. This approach attempts to explain the structure of a society and the behavior of its members in terms of how it

functions within that structure. Since the 1930s, many anthropologists were largely concerned with the study of society as an enduring system of groups composed of statuses and roles, supported by values and connected sanctions which operate to maintain the system in equilibrium (Boissevain 1974:4). It is a good theoretical position, however, there is a problem with it. It does not account for change nor does it take into account people who choose actions advantageous to themselves instead of following socially prescribed behavior. Boissevain puts it simply.

> [Certain] influences may range from culturally defined directives for behavior, through the demands made by relations, friends and associates, to the limits imposed by the physical environment. Within the social, cultural and ecological framework so established, people decide their course of action on the basis of what is best for themselves, and not only, . . . on the basis of the accepted and sanctioned norms of behavior. . . . Man is thus also . . . constantly trying to better or maintain his position by choosing between alternative courses of action. But since he is dependent on others, it is impossible for him to achieve his own self-interest unless he takes others into account and can demonstrate that his action in some way benefits or does not harm them (Boissevain 1974:6).

As Boissevain points out, Man chooses those actions that benefit him and his family the most, but only based on whatever resources are available to him. One action is participation in health care services and programs. In the Indian world, kinship relationships, identity factors, and membership status are integral links to effective health care. Health care is also linked to a larger world system which is based on a world economy and capitalist enterprises which, in turn, influences the access and cost of health care at the local level.

It s All About Making Sense of the World Around Us

> While dealing with the proposition of Indigenous self-government and autonomy in the present world-economy, the world-system concept should be taken into account because such self-government will be functioning within the supranatural situation. Native People s [state of affairs] also depends on the social, political and economic conditions in the rest of the world because of the historical unfolding of world capitalism and its movement toward globilization. Nearly all aspects of life today are dictated by this dominant capitalist system. . . [consider Coca-Cola, Walt Disney, and Big Macs] (Pino 1998:np).

World-systems theory is a perspective some scholars use to explain and make sense of how societies function economically. It suggests that socioeconomic differences among various societies are a result of an interlocking global political economy (Scupin and DeCorse 2004:483). As defined by Immanuel Wallerstein, a modern world system is a social system, one that has boundaries, structures, member groups, rules of legitimation, and coherence. Its life is made up of the conflicting forces which hold it together by tension and tear it apart as each group seeks eternally to remold it to its advantage (Wallerstein 1976:229). Indian Country is encapsulated by the U.S. component of the modern world system.

When Wallerstein talks about a social system, he explains that most social systems are not in fact total systems (1976:229) since people do not live in total isolation away from the influence of others. His view of a social system is one in which life within it is largely self-contained (1976:229). He explains that most social systems written about are described as tribes, communities, nation-states, and, so on. These entities are not largely self-contained. They interact with others at some point. He argues the only real social systems are, on the one hand, those relatively small, highly autonomous

subsistence economies not part of some regular tribute-demanding system and, on the other hand, world-systems [which are] relatively large (Wallerstein 1976:229) and are based on extensive labor and include multiple cultures.

Wallerstein uses the term world-economy to mean those systems in which a single political system does not exist over all, or virtually all, space (1976:229). The survival of such a world economy is what Wallerstein calls a political side of the form of economic organization called capitalism. . . . which magnifies and legitimizes the ability of some groups within the system to exploit the labor of others. . . (1976:229-230). He explains that the success of capitalism has been because the world-economy has had within its bounds not one but a multiplicity of political systems (Wallerstein 1976:229). The world-system perspective has been used to explain the spread of capitalism and its effects and power on less developed, interdependent countries. It has also been used to explore economic dependence and exploitation of third world countries and to make sense of early political bureaucratic social structures (Wallerstein 1976).

The world-system is divided into economic zones based on an international division of labor (Lewellen 1992:158). It is interdependent and consists of three zones, (1) core-states, (2) peripheral areas, and (3) semi-peripheral areas. Core-states have a strong state machinery coupled with a national culture, a phenomenon often referred to as integration (Wallerstein 1976:230). By strong machinery Wallerstein is referring to strength vis-a-vis other states within the world-economy . . . and strong vis-a-vis local political units within the boundaries of the state (1976:230). It includes strength vis-a-vis any particular social groups within the state (1976:230).

> A strong state then is a partially autonomous entity in the sense that it has a margin of action available to it wherein it reflects the compromises of multiple interests. . . . To be a partially autonomous entity, there must be a group of people whose direct interests are served by such an entity (Wallerstein 1976:232).

According to Wallerstein peripheral areas cannot be states because they are typically weak, ranging from its nonexistence (that is, a colonial situation) to one with a low degree of autonomy (that is, a neo-colonial situation) (Wallerstein 1976:230). Semi-peripheries are multidimensional and dependent upon (1) how complex the economic activities are, (2) how strong the state machinery is, and (3) cultural integrity, (Wallerstein 1976).

Simply put, the world system is made up of core-states and periphery areas. Economic and political centers are the core of the system. Core-states are economically and politically dominant. Peripheral areas supply raw materials to the core-states. Peripheries are economically dependent on core-states. Semi-peripheral areas are somewhere in between. Semi-peripheral areas combine traits of both core-states and periphery areas and mediate between the two (Lewellen 1992:159). They are a necessary structural element in a world-economy where change is frequent and boundaries are fluid. Put simply, core regions are developed as industrial systems of production. Peripheries provide the raw materials and are dependent on prices which are set at the core regional level. Semi-periphery areas are a combination of social and economic characteristics of both core and periphery areas (Abercrombie 1994).

A good example of this is the relationship between the United States federal government and tribal governments, peripheries within a globally dominant area. In the

beginning, before European contact, many tribal groups were autonomous social systems with subsistence economies capable of self-regulation. From Wallerstein s perspective, they would not have been included as an entity in the then world economy because they were isolated from the dominant world. At that time indigenous tribes/ nations were part of a system of trade networks with varying degrees of social interaction.

Over time, many tribal-nations have survived European colonialism, internal colonialism, ethnocide, and exploitation. Some tribal-nations have emerged as sovereign entities capable of entering the world economy through economic development (such as, building their own health care facilities and providing their own health care services and programs). The Iowa Tribe of Oklahoma is one of several such entities. Today, it has taken control of its own destiny and within a world-system context could be regarded as a peripheral entity. For various reasons, other tribes have also remained at the peripheral level dependent on the dominant political and economic system.

Lewellen explains that a world-system model is fairly stable allowing considerable flexibility within its structure. For example, core-states can become peripheries, peripheral areas can become core-states, and semi-periphery areas can move either way, core or periphery. What is important about this view is that the world economy is seen as a single integrated system [even though] there is no one world political system (Lewellen 1992:159).

An example of how Wallerstein s theory is applied to Native people in North America can be found in K. Pickering s book, *Lakota Culture*, *World Economy* (2000). Pickering applies a world-systems theoretical framework to interpret how Lakota society

functions. She agrees with Wallerstein that certain aspects of social identity, in this case Lakota social identity, are manipulated to regulate economic opportunities and direct the flow of accumulated capital toward the beneficiaries of the world economy (Pickering 2000:xii). Using this theoretical model, her position is that

> Culture and the world economy are inextricably woven into Lakotas lives. Each day, the Lakotas think and do things that make them distinctively Lakota, yet every day they also experience the far-flung effects of a global economic system. . . . Lakotas confront manifestations of the world economy with distinctly cultural responses to production and consumption. Lakota households make decisions about what economic activities to engage in. . . [and] what and how much to consume. . . . (Pickering 2000:xii).

Pickering has proposed that the effects of Lakota economic decisions were tied to influences based on certain cultural and economically defined needs. Since those often vary from individual to individual and from society to society, there may or may not be conflicts between economic values defined in terms of profit, and cultural values defined in terms of shared, learned knowledge. The needs of a world economy also compete and can impose its expectations on the needs of a local economy. The world economy has great power to homogenize and naturalize needs that in reality further the interests of capital, sometimes to the detriment of a local culture whose needs are supposedly being met (Pickering 2000:113).

Health and illness considerations are only one of many needs implicit within a society. On a worldwide scale, participation in health related services becomes less and less an individual or family oriented decision based on cultural factors, but becomes more and more a capitalist enterprise reflecting affordability factors. From this viewpoint, then,

it is not difficult to imagine health and illness needs tied to a politically motivated world economy.

Individual decisions about health care are affected by overall conditions that impact the structure, availability, and accessability of health care. Thus, when health policies are developed by corporations or government agencies, the impact of those policies are felt by individuals, who, in turn must adapt those policies to meet their needs. If the policies meet those needs, the individual participates and the policy is a success.

So, when corporations or governments make policies, there is an affect on the individual and conditions may change. If the policy is appropriate, affordable, and accessible the individual participates, and the change is positive. If the policy does not meet the needs there is an adverse reaction and the individual suffers. Either way, the impact of the policies are felt by the corporate and government entity who stands to make or lose profits. It is the flow of goods (i.e., health services) that moves back and forth between the political/corporate level (who formulate policies), to the individual level (who purchase the goods), and back again (in the form of profit).

Internal Colonialism: An Exercise in Duality

> Economically, internal colonies can be conceptualized as those populations . . . who constitute a market for the products and services of the centres. . . . An internal colony constitutes a society within a society based upon racial, linguistic, and/or marked cultural differences as well as differences of social class. It is subject to political and administrative control by the dominant [society] (Pino 1998:np).

Internal colonialism has much in common with the world system perspective. They both rely on economic dependence and exploitation. Only internal colonialism controls and exploits segments of its own population instead of interacting at the global level. Internal colonialism has been defined and applied to Native peoples as recipients of political destablization, economic exploitation, cultural annihilation, and the destruction of the spirits and persons of the citizens of Indian nations (McKenna 1981:2). Evidence of this position is documented throughout history in Congressional testimony, Federal court decisions, more than 300 treaties . . . and in Indian publications (Mckenna 1981:2). Examples of federal exploitation include poorly negotiated leases of Indian lands, mismanagement of individual Indian funds, poor health resulting from unsafe mining procedures, and elimination of Indian life through involuntary sterilization of Indian women (McKenna 1981:6). Internal colonialism (sometimes used within the context of domestic dependence) has been a tool used by federal authorities to justify actions intended to repress tribal economic development or at the very least to maintain a measure of economic dependence, a type of periphery core relationship.

The concept of internal colonialism is an interesting exercise in duality. For example, if the economic development tribes have succeeded in creating is nothing more than an activity that the federal government allows only to be quashed later at its own discretion, then would the concept of tribal sovereignty even exist? Thus, tribes would be caught up believing some kind of myth. A myth that tribes, as sovereign nations, have powers to exercise internal controls and external economic development. From that standpoint, then, would not the Constitution and treaties also be a myth, since the basis for

federal recognition rests with those documents?

So, if this is accurate, when tribes presume they are sovereign entities and practice economic development, would it not be an exercise in futility? If so, it would suggest that successful tribal enterprising such as gaming, smoke shops, health care facilities, child care facilities, fire and police protection are nothing more than a cog in a wheel of economic exploitation by the federal government. How can it be exploitation if tribes are willingly contributing to the betterment of their society?

Under internal colonialism, tribal economic development is controlled and limited. However, even limited development provides some self-sufficiency. Self-sufficiency is a level of relative autonomy that allows participation as producers in the world-economy. The Sac and Fox Nation is such an example. South of the town of Stroud, Oklahoma there is a sign that says This Project Funded by the Sac and Fox Nation. The Sac and Fox government has provided funding to build and improve some of the primary roads in their county for the benefit of the community. The Iowa Tribe has also provided services to its community through contracting Police, Fire, and Emergency 911 Dispatch and Jail Services to the town and surrounding areas of Perkins. Projects like these stem from economic abilities and sovereign concepts tribes and nations believe is their place in the world. For this reason, they choose to do these things. So, if this is a common practice, then at least some tribal nations have been able to turn potential exploitation around in the name of sovereign economic development, just because they can, and function well within a world economic system at a periphery level. The exercise in duality comes full circle. In the end, there is nothing new under the sun after all.

Political Economy, Capitalism, and Health

A political economy of health approach is an approach that emphasizes how historical and political factors shape contemporary decision making as well as the distribution of present-day health problems (Brown 1998:16). The approach can explain a population s problems and issues, and its conceptual framework provides a means for examining factors that affect a population s access to health care. Two such factors include the social construction of illness and personal risk. Risk is an aspect of life that cannot be ignored when discussing health status and political economy. People take risks every day. They make decisions based on economics and social values exposing them to risk.

The pharmaceutical industry is a good example of this approach using illness and risk. Medications are expensive. They are intended to cure illness and/or maintain wellness. Obtaining helpful, affordable medicine in today s market economy is challenging. With internet pharmacies available at the touch of a button and less expensive than local pharmacies, temptation occasionally overcomes caution. Risk is the result. Strategies for staying healthy involve assessing risk and tolerance levels. How much risk an individual is willing to assume against how much illness an individual believes he/she can tolerate includes risk assessment and personal perceptions of illness.

Circumstance and environmental influences both contribute to specific patterns of health status, that is, the pursuit of an acceptable level of health. Research participants all had concerns about access to and cost of their medications and knew there were risks. The majority of the prescribed medications were for diabetes and hypertension. Others

received additional medications for other maladies. Two research participants were particularly annoyed with what their health care providers offered. They felt it was too expensive for the level of care they received, and it put unnecessary stress on the families.

George (middle-age, Otoe, M, counselor) said the Pawnee Health Center Pharmacy never had what the doctor prescribed, only other brands. That frustrated him and made his decision even more difficult. Should he take the brand the pharmacy had, or go elsewhere and pay the higher price for the one prescribed by the doctor? In either event, he was worried about side effects if he took any pills and just as worried about health risks of not taking any pills.

Sarah (young, Ioway, F, cashier) has health insurance through her employer. This past year the co-pay amount for her prescriptions went from $20 to $50 per month for each brand-name prescription. She takes three. She has decided to take her medications every other day or cut them in half in an effort to balance cost with risk. At least, it is a strategy.

Capitalism is also a factor in the political economic arena. It is clearly related to ecological considerations which are reinforced by distances to health care facilities, available transportation, and environmental factors. A population s health status can be influenced by where someone lives and works, their living conditions, child care options, belief systems, and so on. When this is combined with political maneuvers that influence where one lives, works, and socializes, a population becomes structured and controlled by the economic agenda outside the community.

For example, housing is often more affordable at remote locations or near areas

with industrial, mining, and landfill activities which coincidentally are often located near or on Indian lands. In the northeast sector of Ottawa County, Oklahoma, there is an abandoned mining area known as Tar Creek. Lead and zinc were mined extensively from the 1920s through the 1970s. One of the products, bullets made of lead, was considered an important part of the national security. Thus, lead was a much sought after raw material (Newcomb 2005). Unknown to the public, the aquifer and ground water were becoming contaminated from the mining with iron sulfate, lead, zinc, arsenic, and cadmium.

The site covered forty square miles and included five mining communities and ten tribes/nations (Searfoss 2004). Eighty percent of the Tar Creek site was tribal property held in trust by the BIA. The rest, 20 percent, was private property leased by corporations for mining purposes.

Tailings once believed to be harmless were available for sale at a low cost. It was a convenient way of getting rid of the chat (mining waste) and making some money. Leasing corporations sold the chat mined on the private sector leased lands to the local community. The community used it as sand and gravel to fill playgrounds, school yards, ball fields, and private homes for yards and driveways, and on roadways (Montgomery 2005: n.p.). The chat located on Indian lands were never available for sale because the BIA disallowed it. Reasons why are vague (Montgomery 2005; Newcomb 2005).

During the early 1980s, reports indicated that lead and cadmium contamination was beyond acceptable standards. The US Public Health Service s Indian Health Service recently reported to EPA Region VI that 34% of the 192 Native American children tested

had blood lead levels higher than the 10 æg/dl standard (Montgomery 2005). Since eighty percent of the mining took place on Indian lands and the waste was never removed, it is not surprising Native peoples got sick and children were the most vulnerable. It is yet another example of health risks tied to economics and the environment. Sadly, Tar Creek is one of twenty-six hazardous waste sites in Oklahoma and most of them are located on or near Indian lands.

Overall, many things contribute to an individual s health status, this section has touched on only a few. The example of Tar Creek fits within the scope of the political economy approach because it combines capitalism (mining for profit), ecological considerations (hazardous waste) with a disregard for personal health and safety (high lead levels and contamination). The Tar Creek mine site is now being cleaned up but serves as an example of how illness and risk factors are tied to the greater political economy.

George and Sarah were a good example of factors that shaped contemporary decision making and distribution of health care. Both individuals were concerned about the status of their health and applied strategies to maintain it. George knew the difference between various medications and was wary of taking just any ol pill. Sarah used strategies by obtaining double strength prescriptions that she could cut in half in order to extend the them for a two month period. It was how they balanced cost with health risk.

Medicalization of Illness:
Clinical and Critical Medical Concepts

A political economy of health approach can also be explained using critical and clinical medical concepts. The first, clinical medical anthropology, focuses primarily on the biomedical field within the clinic or hospital setting. Brown explains, Clinically applied anthropology focuses on health care within biomedical settings and analyzes the effects of cultural and socioeconomic factors on doctor-patient interaction, adherence to treatment, and the experience of healing (Brown 1998:16). I could not help but wonder how clinical medical anthropologists would explain the story in Chapter Five about the Creek woman who would not take her hypertension pills because they were red. Red is the color of death in Creek society. Would they have a solution to this dilemma?

The clinically applied medical approach deals with policymaking in public health, the development of programs, and health care intervention. It is in this arena that clinically applied medical anthropologists, in Brown s view, are consulting with domestic and international health agencies in order to develop health programs that are culturally sensitive, applicable to local needs, and effective in obtaining community support (Brown 1998:17).

The second, the critical medical approach, has been defined as a theoretical and practical effort to understand and respond to issues and problems of health, illness, and treatment from perspectives of interaction between political economy, class structure, the institutional level, the community level of folk beliefs and actions, the illness experience, personal behavior, and environmental factors (Singer, et al. 1998:225).

The critical medical approach looks at health issues from a global perspective which views an individual s illness or disease within the context of a political and economic domain. It is a more sophisticated health and illness focused world systems approach. Turner suggests.

> There is a clear tendency to see illness in individualistic terms rather than in terms of environmental and social causes. Illness is seen to be the personal problem of the worker, often resulting from his or her moral failing. Illness is seen to be in individualistic terms the consequence of a failure to abide by appropriate diets, exercise and personal hygiene; the structural and environmental causes of illness are obscured by this individualistic approach, reflecting the individualism of capitalist society (Turner 1995:168).

This critical medical view does not mean that cultural behavior or an individual s social or cultural setting is ignored (which is what advocates of the clinical approach would suggest), but simply that ill-health may stem from other influences. The following is an example of how over-consumption of alcohol is viewed as a disease and treatment should reflect that viewpoint. The case study of Juan Garcia is an interesting account of alcoholism from a critical medical viewpoint. It is presented here because over-consumption of alcohol is an issue that faces many Native American communities.

Juan Garcia was born in Puerto Rico and was always a heavy drinker. After a troubled childhood he met and married a cousin. Unemployment, fears of witchcraft for marrying a close relative, and the recommendations of a healer, the couple moved to New York City. Juan, mono-lingual in Spanish and uneducated, found a job in the unskilled labor market. Through the patient teaching of another worker, he moved up the employment ladder from janitor to draftsman in an appliance factory. All went well in his

household until Juan lost his job when the factory relocated to another state. When unemployment insurance ran out, he was forced onto welfare and began to drink even more than before. He became abusive to his family and eventually left them. Juan soon died of alcohol-related causes, a broken man, impoverished, friendless, and isolated from his family (Singer, et al. 1998:289-290).

As Singer, Valentin, Baer, and Jia (1998) explain, it would be easy to say Juan s drinking problem was an individual problem. It also makes sense to assume that Juan suffered from a behavioral disorder characterized by a preoccupation with alcohol to the detriment of physical and mental health, by a loss of control over drinking, and by a self-destructive attitude in dealing with personal relationships and life situations . . . (Singer, et al. 1998:290). In this context, contrary to the critical medical approach, those in the clinical medical field would separate Juan from the wider historical, political-economic context and place him in a biomedical setting.

However, in the past, drinking in Puerto Rico had always provided reward and respite for low wage workers whose jobs were unfulfilling. Alcohol became socially-constructed as a man s reward for labor (Singer, et al. 1998:291). Besides, it was cheap and available. Singer added that the consumption of alcohol is a culturally entrenched and emotionally charged symbol of manhood itself, [which included] what it meant to be a man in terms of sole responsibility for the economic well being of one s family (Singer, et al. 1998:292).

Historically, with the transference of Puerto Rico to the U. S. War Department, and the added taxes on rum, many government owned manufacturing plants were sold to

local capitalists. As a result, the plantation based sugar economy was transformed into an industrialized economy displacing many low wage agricultural workers. The displaced agricultural workers quickly came to be defined as both an undesired surplus population and a *cause* of Puerto Rico s economic underdevelopment (Singer, et al. 1998:292). This precipitated, Juan and his wife s moved to New York. There is more to the story, but more to the point is how Juan s behavior was contextualized and interpreted from the critical medical approach.

> The goal of critical medical anthropology is not to obliterate the individual nor the poignant and personal expressions produced by the loss and struggle to regain well-being. Nor does this perspective seek to eliminate psychology, culture, the environment, or biology from a holistic medical anthropology. Instead, . . . we attempt to unmask the ways in which suffering, as well as curing, illness behavior, provider-patient interactions, etc., have levels of meaning and cause beyond the narrow confines of immediate experience (Singer, et al. 1998:298).

What is apparent in Juan s story is an example of a medicalization of problem drinking. At one time, alcoholism or problem drinking was thought to be behaviorally induced. Therefore, it became the problem of the individual to take care of, not the state. Alcoholism was a social problem, not a medical one. Over time, alcoholism has become medicalized and more respectable than street drugs. That is to say, alcoholism is now considered a disease (where once it was not) and is supposed to be treated as such by the medical profession. The National Council on Alcoholism states, The main task of those working to combat alcoholism . . . is to remove the stigma from this disease and make it as respectable as other major diseases such as cancer and tuberculosis . . . (Singer, et al. 1998:288). This is one illustration of how unproductive or socially unacceptable

behaviors eventually becomes acceptable in terms of labeling it as a medical problem.

Further, the American Hospital Association proposed that the primary attack on alcoholism should be through the general hospital (Singer, et al. 1998:288). Also the World Health Organization listed alcoholism in its International Classification of Diseases. Later, in 1956, the American Medical Association declared alcoholism to be an officially recognized disease in U.S. biomedicine (Singer, et al. 1998:288). Singer also states that from the perspective of critical medical anthropology, the conventional disease model of alcoholism must be understood as an ideological construct compre-hensible only in terms of the historical and political-economic contexts of its origin . . . (Singer, et al. 1998:289). Their points are if you understand how an illness or disease is socially or biologically constructed in terms of what is taking place, it can be treated.

When alcohol related activities were discussed with the some of the research participants, drinking was nothing more than a choice people made, not an addiction, not a disease. Although not a very scientific explanation, they believed that if excessive drinkers wanted to stop drinking, they could. Most of the Native individuals I have spoken with believed excessive drinking was a social problem of too much time and too little meaningful activity. They felt those who drank excessively should go out and find a job. The idea Indians could not handle alcohol, or it was some kind of pre-disposed disease that grabbed Indians and didn t let go, was not an option.

Another social practice that has become medicalized over the years is tobacco use. At one time, smoking was an accepted and popular social activity. It was considered glamorous and fashionable. People smoked because they wanted to. They still do.

Native people smoke too. In fact, they have used tobacco for centuries. Tobacco is still an integral part of their society and serves a purpose. Tobacco usage has been so incorporated into the daily lives of some traditional Native peoples that the reasons for its use are not given much thought. It becomes second nature to them. When someone wants information from an elder, tobacco is used. A cigarette is used today instead of the more traditional pipe. It is more convenient. Tobacco was rolled into a cigarette and given to the elder who would smoke it. The conversation would proceed from there. There was not much to it. Both parties understood the significance and purpose behind the action.

In the old days, Native peoples would gather and mix their own tobacco. It was fresh and suited their needs no additives were used. For Native people, tobacco use was not that much different than a gardener gathering fresh carrots from the garden. The same perceptions were used. Carrots gathered from a garden were fresh and natural. Their use was significant to sustain life. Tobacco grew naturally and was gathered fresh. Its use was significant to maintain life. Both had value and meaning. They each served a purpose.

Today, medical research has determined smoking causes or contributes to lung cancer, emphysema, and other diseases. As a result of this research, smokers are increasingly ostracized in public places, and laws have been passed to make sure no one smokes where they are not supposed to. The focus is on helping the smoker quit for health s sake. The political and medical community are doing their part as well. Doctors prescribe medication and treat for addiction. Taxes have been increased on tobacco

products as an incentive for quitting. Advertisers market products to help smokers quit for their health, they say. Smoking has become a medical problem in western society. It has become a disease that can be treated with pills. It has even become an economic enterprise.

So, what if tobacco had curative properties? Would that make a difference? Would it be more acceptable if tobacco was used for medicinal purposes, such as marijuana is in California? Maybe a doctor s prescription would give it value. As it so happens, tobacco can be used as a healing agent.

> When my granddaughter got a bee sting the other day I remembered what my old grandma used to do. She d get some tobacco, chew it, and take a big wad of it and put it on the bee sting. Works great for drawin out the poisons. It takes away the sting, and itch, and all. Even the swelling goes down. Don t know what doctors think about it, but it works. I use it. Comes in handy, cause I smoke, then I have a remedy right close by. Don t got to go lookin for somethin . I don t pay no attention to those doctors who say smokin is bad for you. After all, Endns used tobacco long before the Surgeon General said it was bad for you (Fields 2002).

Summary: Connecting the Points

A brief summary of the major points in this chapter is presented here for clarification. The primary objective of the chapter is to explain the theoretical motivations for this study. It begins with an overview of the world system perspective with insights into where tribes fit within a global niche and the conditions surrounding their status. It is a foundation for explaining social, economic, and political conditions of tribes as dependent nations and their abilities to provide economic development.

A brief comment on internal colonialism follows. Its significance is its link with the world systems view. Both promote exploitation, dependence, and controls on economic development. Differences are that internal colonialism is an inward focus compared with an outward, global focus.

The pursuit of acceptable health care requires understanding the influences a population is exposed to and what choices they have. A political economy of health perspective is such an approach. It can be used to explain why people do what they do when faced with limited choices. This model explains medical concepts from two viewpoints, within biomedical settings (the clinical approach), or by defining disease and illness from within the context of a global economy (the critical approach). Individual perceptions of disease and illness are socially constructed and embedded within the larger economic and political domain.

An important thing to keep in mind is what was stated at the beginning of this chapter, explaining motivations using connections. While the topics in this chapter appear to be disjointed, they are not. All these topics are connected much like a spider s web where a world system perspective is connected to colonialism, politics, and economics in more than one way. Disease and illness, and the medications to cure or maintain good health is linked to a global economy. Economic policy filters down to the consumer who purchases what he/she can afford. Profits are returned back to the corporate/political level. A reticulum approach considers all the links connecting one to the other in terms of participation, access to, and distribution of health care. This is what I have attempted to explain.

Part III

Kinship and Identity

The utilization of Social Networks for health care and other social needs (chapter 5).
Who one is and what one gets (chapter 6).

Chapter Five

Kinship and Friendship and the Use of Network Analysis

This chapter focuses on kin and non-kin relationships from a perspective of kinship and network analysis. Kinships and friendships are the most important types of relationships people can have, if for no other reason than it provides a pool of potential resources who can be called upon in times of need. Social network analysis explains the links between family and friends and how these links facilitate support for others when situations arise. Structural and interactional characteristics of network analysis are also presented in later sections and explains the various types of connections people have to one another. As in other chapters, participant examples give insights into the importance of kinship connections for healing and other health related issues.

> The importance of kinship is threefold. First, kin are especially likely to know one another, so that the kinship region of the network is likely to be more close-knit than other sectors. Second, relationships with and among close kin are relatively permanent. Third, kin play an important double role, not only supporting but also dividing the marriages of the families in the network (Bott 1971:295).

Ultimately, people are connected to one another through various linkages. These linkages can be complex or simple, large or small. Simply stated, connections to many people are possible; conversely, connections to few people may have the same effect if one considers the potential multiplicity of roles. Most societies have networks of kin and others they can rely on in times of need or for help. Native peoples are no different. It is only in the way they interpret and view their networks of relationships that differences are apparent. Among native societies, kinship connections play an important role in

establishing linkage with others. Choices people make about participating in health care services often involve kinship relations. Being able to rely on family is very important, especially with regard to health care.

> Grandma was sick a few years ago and needed home care. She lives alone so she wasn t able to stay home by herself. We live just down the street, so my wife and I brought her to our house for a few days. It s not huge but it s big enough. Besides, I ve always believed where there s room in the heart, there s room in the home. . . even if you gotta sleep on the floor, which I often do anyway. Don t know why my brother didn t come get her. He s retired and home all the time, but he said he was busy and it was too far to drive. No matter. We can handle it. I was raised to believe that s what families do help each other. My wife works, I work, so no one would be with her during the day. But my daughters were close by and they said they d come by and check on her. It worked out just fine (Middle-age, Pawnee, M, management).

An extended family network links individuals to others (kin and non-kin) who are able to provide help when needed, such as when someone needs medical attention or child care or transportation to a health facility, even home care. Thus, a network of kinship and friendship relations among native people is quite extensive and is often called upon in times of need.

Social Networks and Network Analysis

> The network of friends, relatives and workmates; the visiting, bargaining, gossiping and maneuvering that goes on between them; the impact on these of promotion, ideology, and conflict; . . . These are processes and situations with which we are all involved and they are the basic stuff of social life (Boissevain 1974:4).

Social networks are defined by a method called network analysis. Network

analysis attempts to analyze choices people make as a means to achieve certain ends based on the types of connections they have to others, such as kinship ties, group membership, friendships, and identity. Schweitzer and White state that social network analysis "focuses on social relations and the flow of resources within networks of actors and investigates the emerging social order of patterns generated over time by networked activities" (Schweitzer and White 1998:i).

Bott states, "the focus of interest is on the ways in which social networks link and divide individuals and groups within the local group or social category" (Bott 1971:325). Much like the case study in Chapter Eight of Sam's experience in trying to obtain food commodities from his tribe. Sam thought he would be successful. He was not. He thought his son, the linking relative, would authorize the commodity item. He did not. So, either the family connection was not as solid as Sam thought or the son followed federal regulations to the letter. In either event the son's behavior was not characteristic of traditional kinship behavior.

Bott suggests that network analysis is not an entirely new approach. Previously, it had been used to examine social linkages, to study environmental relationships, and to analyze "social process and social forms" (Bott 1971:324). Bott humorously notes that along with such interests in network studies comes numerous and often confusing terminology.

> [T]he concept of network has thus been used in several types of empirical studies, and the definitions used and emphases given vary considerably from one study to another. When one contemplates the language "total network, personal network, ego-centric network, set, action-set, reticulum, quasi-group, field, star, zone, personal community, ambience, social circle,

> faction, party, clique, grouping, group, and corporate group one feels oneself teetering on the brink of terminological if not conceptual disaster (Bott 1971:318-319).

Mitchell echoes Bott, when he states that the characteristics of social networks vary with definition and use by scholars when interpreting field data. However, he refers to linkages in a metaphorical sense which is then used to represent a complex set of interrelationships in a social system (Mitchell 1969:1). This view of social behavior is very different from the notion of social networks as a specific set of linkages among a defined set of persons . . .[which] may be used to interpret the social behavior of the persons involved (Mitchell 1969:1-2).

Furthermore, newer concepts have emerged to include ideas about structure and change through time and the role of the individual. The idea is that because people and circumstances change through time, so do the relationships, even among kin. Thus, new approaches to explain these processes were needed. Today, scholars of social network analysis argue that the content and meaning of social relations are related to the contexts of transaction and exchange in social networks and should be considered in studies of kinship analysis (Schweizer and White 1998:5).

By contrast, Cochran quotes Bronfenbrenner who presented another view of network analysis. He calls it a *mesosystem* and defines it as a set of interrelations between two or more *settings* in which the developing person becomes an active participant (Cochran 1989:4). This view has a more geographic focus on characteristics between two or more settings as opposed to links between two or more *individuals* as Mitchell (1969) presents.

Cochran (1989) asserts individual linkages are viewed as being determined by friendship, kinship, and neighborhood. He takes this concept one step further by emphasizing that linkages between individuals are *personal* networks anchored by a specific individual. He argues that settings in and of themselves are not enough to establish a personal network. Therefore, the emphasis should not be on the individual in the setting but on the quality of the relationship. Unlike the mesosytem, the individual s mere participation in two settings is not enough to establish a personal network. For that to occur, the person must develop relationships with one or more persons in each of the settings (Cochran 1989:4-5). Cochran continues to explain that the person who does establish such a relationship has more influence than a person who has a relationship that is simply geographically setting-specific.

Structural Features of Network Analysis

Mitchell and Boissevain discuss several structural features relative to network analysis: anchorage, size, degree, density, and clusters. These structural elements refer to the relationship or patterning of the links in the network in respect to one another (Mitchell 1969:12). Anchorage is a broad generalization of an ever-reticulating set of linkages that stretches within and beyond the confines of any community or organization (Mitchell 1969:12). It is much like a spider s web that reaches out and connects many to self, or self to many, often beyond the local level. An example of this is the notion of Indian self-identification. Within the Indian world, self-identity is enough to be able to

establish lines of communication, however subtle. It is enough for Native people to acknowledge mutual experiences about health and wellness, however exasperating. It is enough to respect origins and world views, however different. It is enough to specify family connections, however extensive. Indian self-identity is even viable enough for individuals to exchange information about access or lack of it to health care, however humorous.

Sometimes, communication is a shared glance or even sign language, such as the story about the Osage lady and Grandpa K. illustrated at the end of the chapter. Many times, acknowledgment is a short greeting. More often, a meeting between two people is responded to with a gentle handshake. The subtle but real links among native people are evident everywhere. It may take place at a social event, such as a health fair, a truck stop for gasoline, or at a public place, such as Wal-Mart, even in a waiting room at a health care facility. It often extends beyond the confines of any community or organization, (Boissevain 1974:35) such as one s own tribal affiliation.

Boissevain has a problem with this structural feature. He argues that the category is too broad since the set of linkages would have to apply to all links within the society. He states, The most important structural criterion of a person s network, whether total or partial, is its size. This is because the other criteria are calculated as a proportion of the total possible or actual links in the network (Boissevain 1974:35). He continues his argument that problems arise when trying to apply an analysis. Analysis of personal and social networks becomes complex because of the potential numbers of combinations or sets of communication lines that are possible. These sets or combinations can multiply

potential contacts in greater proportion to actual contacts.

While Boissevain s critique has merit and may well be problematic in terms of size, and complexity, it nevertheless, is an important part of the analysis simply because such sets of linkages do occur. Native peoples are linked to each other by extensive kinship relations known and unknown. So no matter how extensive such an analysis would be, it is still a valuable part of a kinship network system.

The number of persons who are in direct contact with the anchoring person of a network is the range or degree of the connection (Mitchell 1969). In the story of Grandpa K., his talents were well known in the Indian world especially among the Otoe and Iowa people. He was often called upon to treat people. Relatives would tell other relatives and so on. In this scenario, Grandpa K. was the anchoring person.

It is the number of direct contacts any given person has to another which is no doubt limited. Bossevain says, the degree of a network is the average number of relations each person has with others in the same network (Boissevain 1974:40). This is simply a way to measure the density of a relationship and its connection to a personal or social network.

The degree to which a person s behavior is influenced by his relationships with others often turns on the extent to which he can use these relationships to contact people who are important to him (Mitchell 1969:14). In other words, it is the steps or links from *ego* to others who have influence. How reachable is the person whose influence is sought? Within traditional Indian circles behavior is usually determined by the age and relationship of the persons in the network. The steps can be as simple as one link away

from ego, or as complex as a spider web. Nevertheless, in most cases, if a person wishes something from someone, especially an elder, traditional behavior dictates that he or she bring a gift, serve some coffee, or present tobacco before asking what it is they came to ask. The elder responds in his own time and in his own manner. Proper behavior must be followed. In the Indian world, behavior influenced by relationship (kinship and friendship) is often more important than the extent to which he can use the relationship to contact people who are important to him (Mitchell 1969:14).

Density is where relationships among a set of persons are dense, that is, where a large proportion [of persons] know one another. Then, the network as a whole is relatively compact and relatively few links between persons need to be used to reach the majority (Mitchell 1969:18). This is a measure of *potential communication* and not the *actual* flow of information as Boissevain (1974:37) points out. It is simply that actual transactions or flow of information do not necessarily stem from the denseness of the population. This characteristic, too, has problems. It seems to imply reachability can only occur in a dense population which is an oversimplification (Mitchell 1969).

The idea of where contact, there communication (Boissevain 1974:38) is also a mistaken assumption. People can be in close contact, even be acquainted or related, and not communicate to each other about certain aspects of their lives for a variety of reasons. It seems to depend on the relevance of the subject matter, type of communication desired, and third party relationships. In reality, it is a notion that their perception of the density of their networks, irrespective of its accuracy influences their behavior (Boissevain 1974:38). In other words, people hold back communicating certain things (of a possible

detrimental nature) when they believe what they say will be passed on to others in the network. This is only partially accurate.

Many Native people practice cultural restraints which would make it improper to communicate certain things no matter what the motivation. Cultural restraints involve areas of a person s life that are not open to negotiation or public display, such as, the Osage lady keeping her healing to herself. No one knew for sure how the doctor in the white coat knew who had doctored her, but word got around. If Grandpa K. had been asked if he had healed her, he would have said, No, God healed her. I just helped Him. Sometimes asking questions of an inquisitive nature that do not pertain to the task at hand is met with the reply, *You don t need to know.* Thus, cultural restraints, in one respect, can be interpreted as hampering communication efforts.

Segments or compartments of networks which have a relatively high density (Boissevain 1974:42) are called clusters. People who are identified with this category are those who are more closely linked to each other than they are with the rest of the network (Boissevain 1974:42). Clusters are therefore areas where people share a common bond relatives, friends, neighbors, colleagues, medical professionals, care givers, tribal members, et cetera. Participants in one group can also participate in any other group as long as the groups do not come into conflict. Otherwise, to remain a participant in two or more groups, adjustments in behavior must occur.

For example, I visited a middle-aged Otoe-Ioway man raised in a traditional manner who was a member of an extended family group, a religious group, and a social group all at the same time. As a member of an extended family group, he has certain

responsibilities that differ depending on the role needed at the time son, husband, brother, father, grandfather. These roles do not come into conflict and are compatible with expected group behavior. The man had training in native healing, used to be a member of the tribal council, was a member of the Native American Church, and, at one time, functioned as a Roadman. None of these groups conflicted with each other. They all have links to contacts that may or may not overlap. Since they share a common bond Indianness the chances of conflict are minimal. For the most part, they are compatible groups. The man functioned well in all three groups without compromising behavior, integrity, or standards.

Interactional Characteristics and Social Behavior

In addition to the structural characteristics of an individual s network, as Mitchell points out, there are also interactional characteristics that suggest a type of social behavior between individuals and refer to the nature of the links themselves (Mitchell 1969:12). Boissevain adds, The linkages between persons in a network may be examined in terms of their structural diversity, the goods and services exchanged, the direction in which these move, and, finally, the frequency of interaction (Boissevain 1974:28).

The content of a relationship is the meaning which persons in the network attribute to their relationships (Mitchell 1969:20). Usually, but not always, a person s interaction or connection to the other is only for some purpose or combined interest and

only for a limited time. Mitchell provides some examples of content links as economic assistance, kinship obligation, religious cooperation or it may be simply friendship (Mitchell 1969:20). Persons so linked share meanings in terms of norms, beliefs and values. A role relationship or situation is built-in between those involved in a transaction. The content of the role relationship is determined by the particular role the individual is expected to fulfill. The role can be in terms of assistance (cash or job), service (personal or professional), or traditional behavior (joking or non-interference) (Boissevain 1974).

The personal connection of one to another by choice or obligation that is uneven and not reciprocated in the same manner is called the directional link. These interactions are considered one-way or directional. Such links can be either positive or negative and would include perceived friendships between those who do not view the relationship as equal. An example would be patient physician relationships that require certain professional protocol or tribal member tribal administrator relationships that impose certain obligations.

Within the Indian world among tribal administrators and members, interactions are unequal and usually linked more so by obligation than by choice. When Native people wish to participate in tribal programs and services they must fulfill certain obligations, such as being an enrolled member, proving it, and living within the tribal jurisdiction (usually), and age. Depending on the tribe in question, there may also be other qualifying factors. Thus, obligations to fulfill certain criteria places tribal members in a submissive role with the tribal administration in the position of power. Expectations and the flow of conversation is one way; the relationship is unequal. The tribe provides members with

goods and services which the members cannot return. Members can reciprocate only through voting privileges. Tribal members have power to vote administrations *in* or *out*.

This scenario is complete as far as it goes. There is a kink, however. It leaves out tribal members who are linked by kinship to tribal administrators, further complicating the personal link or connection of one to another by choice or obligation (like the story of Sam, for instance). This may place the administrator member relationship on a personal level which adds another dimension to the directional link to tribal authority. This was the case with Sam. His story is in Chapter Eight.

The Healing Connection: Unintended Consequences

Several elements of social and kinship network systems are illustrated in this narrative. It is an account of two families, traditional healing, and the law. The date is the early 1950s. The setting is Red Rock, Oklahoma, near the Otoe-Missouria Tribal Complex about 35 miles north of the Iowa Tribal Complex. It is a story of a young boy s experience with the art of healing and his grandfather.

> One sunny fall day, as we were playing outside, an old pickup truck drove up with several people in it. I was about eight or nine years old then. We, my brother and sisters and me, all lived with Grandpa and Grandma because our parents worked a long ways away and couldn t come home every night. They came home weekends most of the time and this time, mom was home. We always had visitors so it was not unusual to see strangers arrive. An older man got out and greeted Grandpa.
>
> From that moment on my life got very interesting. I was accustomed to my grandparents speaking Indian. They both spoke their native

language. Grandpa K. was Ioway and Grandma Aas was Otoe-Missouria. We called her that because when we were little we couldn t say Alice! The man who drove up was Osage, as was his family, and Grandpa didn t know that language. They used sign language with a little broken English thrown in. The man brought his wife to Grandpa hoping he could heal her. It was a last resort. The Osage lady had been to those other doctors in the white coats but they couldn t help her. They seemed to think there was no cure for what she had. She was not that big a woman except she really looked big, fat. I don t know what it was, but I heard later she was diagnosed with something called, [1]pleurisy. Her fat was extreme fluid retention.

We all sat outside on a platform and on the grass in the front yard as the discussion took place. Finally, Grandpa indicated he would help her and signed that the family should go home and come back on the fifth day. Treatment for the Osage lady would take four days and four nights. I watched the old pickup drive off and wondered what Grandpa would do. I knew he was an Indian Doctor who had helped others before, so I was sure he could help her. Grandpa asked her some questions through signs and broken English and she answered back the same. I had been taught Indian healing involved treating the whole body mind and all. So I was not surprised when he asked her about her beliefs, or if she had any physical or psychological problems. He even brought up witchcraft. Had anyone given her anything? That s real, you know. Treating the mind, body, and soul it s called holistic medicine. Then he explained what he was going to do, just like the doctors in the white coats do.

This is what he did. It would take five phases, one day for each phase. Phase one was the interview and explanation. Phase two was the cleansing. Each day for four days she would go into the sweat lodge. Several of us kids would also go inside. We needed to help grandpa with the rocks and be a kind of chaperone. She was a lady after all. It was so hot in there we were glad when it was time to come out. We went into the sweat lodge four times a day. That s sixteen times in four days!

1Pleurisy effusion is an inflamation of the membrane surrounding the lungs, lining the rib cage. It makes breathing extremely painful. Excess fluid fills the area between the membrane s layers. It causes shortness of breath and can become infected. It is caused, probably by a viral or bacterial infection, TB, pneumonia, rheumatoid arthritis, cancer, liver and kidney disease, heart failure, chest injuries and drug interactions. Western medical treatment usually consists of antibiotics, anti-inflammatory drugs and pain medication. Sometimes, in extreme cases, a tube is inserted in the chest to drain it (Websters 1998).

> Phase three was medication. Grandpa always collected his own medicines. He always knew just what was needed and where to find them. I always got picked to go help him to gather the various roots, twigs, weeds, and whatever. He d always try to tell me what they were and how they were used, but, you know, an eight year old always thinks he has something better to do. But I respected him and knew he could heal people, so I was happy to go. Wish now I had paid more attention.
>
> Phase four was the healing phase. By this, grandpa meant he was giving the Osage lady confidence that she would be okay. He believed in treating the mind as well as the body. Phase five was the fifth day, the day she would be going home. It was the phase Grandpa called reintroducing her back to be among the well, and back to her family. When her family arrived to take her home they were happy. She had lost all her fluids, was now skinny and well.
>
> Grandpa thanked them for bringing her and when the Osage lady was ready to leave she thanked Grandpa and spoke to a relative who went to their pickup truck. In the back was a box of groceries. The relative brought the box and gave it to Grandma. Then, they got in their truck and headed back to Osage country. That s how it s done. Payment for treatment is not given directly to the doctor but given to the wife and always, it s groceries. We ate good that night.
>
> A few days later we heard the Osage lady had gone back to her doctor in the white coat for an exam. She was happy she was healed. He wasn t. Good news travels fast. A few days later a police car came to our house. They came to arrest Grandpa. They talked really gruff to him and called him *Chief*. Never did understand why white people do that. Grandpa never did understand why he was arrested or the significance of what he had done. All he did was help someone get well. They kept him in jail for awhile. Grandma was beside herself, walkin around speakin Indian and all, sayin *heena*. When the police came, us kids, didn t understand what was going on either. All we knew was they were takin our grandpa away. We were ready to fight. You can t take my Grandpa away. They arrested him for practicing medicine without a license. Buh! Apparently, the doctor in the white coat got mad and reported him to the police (Fields 2002).

Throughout this chapter the discussion has centered on kinship and friendship connections of one to another. Connections are an important component in the pursuit of

health care and was explained using a social network model. The purpose of this type of model was to clarify how individuals influence others through family networks in order to achieve desired results. Kinship and friendship relationships were illustrated using examples of communication, self-identification, personal behavior, and social structures. The size of the network varied from dense to sparse and depended on the frequency of interaction. The stories illustrate how complex relationships can be among the Native population and the effort they make to maintain them. These relationships can be critical for accessing health and nutrition related services.

Chapter Six

American Indian Identity:
An Adventure Through Perceptions

Much literature has already been written about Indian identity and it all seems similar in content (Deloria 1988, 1989; Forbes 2001; Howard 1984; Nagel 1997; Pickering 2001; Sturm 2002, etc.). So when writing this chapter I reflected on the numerous studies and approaches already taken (Barth s studies of group identity and boundaries, e.g.) and wondered how identity might be presented with a somewhat original, or at least alternate, perspective. Identification is functional, useful, and practical. With this in mind the chapter presents how Indian identity is shaped by tribe and self in the present and what effects it has on current health care programs and nutrition services. My hope is to present something of significance and value for potential readers to consider.

Identification (being someone) is important to individuals. Identification (as in belonging to something) is important for people. Identification (as a point of pride) is universal among all groups of people. We all want it and we all do it. The point of identifying begins as an individual, and that is an attribute ascribed at birth a component of being a living entity. The process of identification is a non-ending activity, and should be considered invaluable to our existence.

Identification is ever present. When someone identifies as a nobody, or when other people identify that someone as a nobody, the consequence is much the same. The key to this is simple. How a person identifies self is all that really matters, not how someone else identifies you. You already said you were a nobody. That was how you

identified yourself. For someone else to identify you in the same manner (as a nobody) is moot because you already said it. Identity had already been established. The consequence is the same. Native peoples have been subjected to such practices for a long long time. Although there should be, there seems to be no escape from such identification practices.

In the end, a person is responsible for his/her own identity and what others have to say is of little or no consequence. Indians are a good example of this presumption. They have had millennia of exposure to such identification processes, and surely, . . . had they not identified themselves in the very beginning they would probably be confused by now. . . . *aaay*? But they are not. They appear to have remained who they said they would be from the very beginning. To this day, they remain *Tsis tsis tas, Kâigwu, Ani Yun Wiya, Tsah diks Parí, Bah-kho-je, Jewere-Neutache,* and so on. Identity, Indian or otherwise, seems simple enough. I ask who you are and you tell me.

Where to begin and how much information to include is a challenge many scholars have no doubt pondered. I am no different and the tendency to err on the side of overkill is tempting. Identity boundaries are often invisible to others, but are very much an integral part of self. In an ideal situation, we all desire to identify ourselves in a positive way. It is this image we wish to project to others, in part, because that is how we view ourselves, and partly because it makes us feel good. It is that positive self-image we hear much about these days. Is it real or imagined?

In reality, how others perceive us and our identity may not even be close to how we perceive ourselves. However, identity is an ever-present facet of our existence and it permeates every aspect of our being, even subconsciously. Identity is a strong motivator.

It motivates us to action; it surrounds us when we are outside our comfort zone; it influences our decisions; it can even protect us, and, sometimes, it is a fence we hide behind. None of us can escape this thing called identity, not even Indians. We all identify with something at one time or another, a country, a region, a tribe, an ethnic group, family, kin. Sometimes, we are identified according to context.

Being American or Being Indian?

The Fourth Grade teacher at Perkins Elementary School had noticed something different about two of her young students. Not so much the way they looked, although one was darker than the other, and not so much the way they behaved as they were typical fourth graders doing what fourth graders do. It was the way they talked to each other. Every once in a while, the teacher would catch a word or two she could not quite identify. It sounded like ba, or bah, or buh, or something like that. She asked the children what the word was but they could not tell her. They did not know. They just knew it was an Indian word they grew up with, had always heard and used, and knew how to use it in the right context. She began to listen more carefully and discovered the word was only used in certain settings. She noticed the term was used in circumstances requiring a response to something humorous, silly, surprising, or questionable. In fact, the word the children used was buh an Otoe word shortened from he-nah -hah-buh , which is a word used in response to or as a reaction to some statement of surprise, shock, disbelief, or other exclamation. Intrigued, the teacher began to listen for other Indian

words that might indicate another culture at work. She was surprised to find there were.

Why is this mentioned, and what does it have to do with Indian identity? It has everything to do with Indian identity. After the teacher had asked the children about the word they were using, the children (cousins) went home and told their parents. Their grandpa explained later the boy had felt special in the eyes of his teacher. Special because he was a Indian and that made him feel good, different. He had something unique the others in his class did not have. It set him apart and he liked it. Identity, in this case, began early.

Mainstream society encourages cultural blending so that one culture is not so distinct from another, a practice called assimilation. It is less threatening to the dominant society. Identity boundaries become blurred and this is preferable according to mainstream teachings. Yet we hear parents encourage their children to be unique and independent. Likewise, public services are becoming more and more oriented toward self service and are, therefore, individualistic. It was a surprise when this fourth grader said he felt special being singled-out and identified as an Indian all because of certain words he used with his cousin.

I thought about that for a while and pondered such a reaction in today s society. Being set apart, noticed, or different from the norm seems to have a negative impact on society as a whole. Mainstream activities promote blending together, being like everyone else, minimizing differences, identifying with the masses, and so on. Differences, as such, are still not embraced very well in our society. The federal government s culturally preferred behavior for mainstream society is assimilation, sometimes interpreted as being

American. Rather, would a policy of pluralism, mentioned in Chapter Two, be a positive alternative for accepting culturally distinct identities? Would it even work?

A Pluralistic Paradox

Pluralism is the existence within a nation or society of groups distinctive in ethnic origin, cultural patterns, religion, or the like. . . [and/or] a policy of favoring the preservation of such groups within a given nation or society (Webster 1998). Broadly applied pluralism is the idea that many ethnic groups can coexist side by side, and practice their own distinctive form of culture connected only by the thread of federal authority. Tribal nations easily fit within this definition. Identification is separate and specific. Tribes are able to maintain their own forms of identity based on kinship and traditions. They also identify with the American nation on a broader scale. It is somewhat like a circle within a circle, a nation within a nation.

In this manner and at this level, a Native person can claim dual identities, such as be an Indian or a tribal member, and be a citizen of the United States. More on this later in the chapter about layers of identity, but, at this point, they possess dual citizenship and identification. Perhaps, it is a dualistic notion of identity by ascription and association.

Native peoples identify with the group they are born and enculturated into (ascription), and they identify with the greater society as well (association). Maintaining an identity separated from the rest of mainstream society is a practice not openly accepted or acknowledged in America. It sets them apart, and people perceive that as a threat to

their own existence. Culturally distinct people at one time were considered deviants and thus were supposed to remain separate from the rest of society until they became acculturated or annihilated (Metcalf 1998). It is a notion that ethnicity as a distinct identity would provoke conflict, which must be avoided. Thus segregated neighborhoods were not considered part of a melting pot until the differences disappeared through assimilation and/or acculturation.

It is a pluralistic paradox. Pluralistic because many identifiable ethnic groups (including tribal nations) reside within the territorial boundaries of the United States, and a paradox because we say we accept cultural differences but our behavior indicates otherwise. One only needs to recall comments (speak English when you re in America), some policies (the English Only Bill), and the many hate groups still in existence (KKK, Anti-Semites, Aryan Nation, One Nation, etc.) to realize this is so.

The dominant society would like us to believe we are all equal. If that is true, identification should be within that framework, except the dominant society identifies themselves according to class and status by race and income level. The adage, What s [good] for the goose is [good] for the gander (Kirkpatrick 1993:173) would serve as a reminder. Acknowledgment of social stratification is not very popular among the general public. It is especially noticeable in the medical field. Time and time again we see and hear of people being treated unequally, as a commodity, not as a human being. Often the quality of treatment is based on misconceptions of identity. Almost always treatment is based on the ability to pay. The dollar seems to have more status and identity than a human being. Under that concept, then, Indian identification within the health services

arena becomes a challenge, but that will be discussed in the next chapter.

What I would like to suggest and what the fourth grader s grandpa pointed out is tribalism allows for retention of our culture and for us to remain distinct as a group. As long as we are separate, we maintain our identity. Tribalism provides that (FLR 2002). Tribalism is important because it maintains a closed community which supports and reinforces the culture. Although it is not necessary, there are benefits to cultural separation. Identity is one such benefit. Thus, for the Caddo, it is important to be Caddo, not simply a group among other Woodland Indians, or for Cheyenne to be Cheyenne, not simply categorized Plains Indians.

Individual identity is tied to cultural identity, so if cultural boundaries are blurred or removed, individual identity becomes blurred as well, or at the very least harder to maintain. Cultural boundaries provide a backdrop in which differences or similarities standout. It even includes instances where individuals with different tribal identities live isolated from their tribe in rural areas, or in urban Indian communities, or come together for social events. Such differences can reinforce an individual s own cultural identity. This makes a point about Indian identity, that is, a need for groupings by ethnicity and culture. It is not an academic need but a more basic down-to-earth mentality of separation by self-identification.

Always, literature tries to explain that Indians are disappearing, and interracial marriage is diluting Indian blood to a point where Indians will cease to exist, or at the very least they will look and act like their neighbor. The movement to *generify Indians as all alike is not new (**without individual character or distinctive characteristics.* Webster

1998). It is like removing the distinctive cultures from the Kickapoo, Kiowa, Comanche, Apache, Chickasaw, and so on, and leaving groups of generic Indians in its place. It represents movement more towards a concept called Pan-Indianism.

Pan-Indianism: A Dichotomy At Work

> It unites people ideologically; it is of an old tradition of intertribal alliance to provide structures for action. It is a persisting cluster of core values and related, predictable behavior that gives Indian people a commonality of outlook they do not share with people of European cultural tradition. Today it promotes unity. (Roush 2000).

It *is* Pan-Indianism. Pan-Indianism is a double-edged stone point. On one side, the argument is that it is an explanation of what has happened to Indians since the 1950s and 1960s. It has been written about over and over again from perspectives of federal policy, assimilation, and other major influences. It all makes such good sense, especially to scholars of ethnic identity. It is the idea Pan-Indianism is interpreted from within a researcher's framework in whatever area of study he or she may advocate. In this sense, Pan-Indianism provides light to the ideology that Indians (some Indians anyway) are really not that much Indian anymore, just relics of days gone by.

Pan-Indianism always follows the trend of what real Indians were supposed to be like in prehistoric and historic times. One can only wonder why no one refers to mainstream social attitudes which continued to focus on segregation and civil unrest at the time of relocation. For example, it is the idea that white America was not ready to have

minorities living close by, thus, the Elmer Scott Housing Project for relocated Indian families in Dallas, Texas. This housing project was one of many sites located in major relocation cities across the nation that specifically housed Indians. Perhaps, it was one place from which the non-culturally grounded Indians of today emerged. That point alone could be considered a failure of the original government program to divide and conquer, although it may be difficult for the current generation of bureaucrats to admit. Ironically, instead of isolating Indians into mixed ethnic communities, the government relocated them into urban all-Indian communities. Once there, Native peoples gathered and reaffirmed, or redefined, their Indian identity.

The other edge of the double-sided stone point is that pan-Indianism is arguably not really a new idea at all. Just maybe it belongs to those of us who are willing to try and understand the concept. First of all, Indians are only on reservations because the federal government wanted them there. Before that time Indians tended to roam a wide area in search of adequate living conditions. They often encountered related tribes along the way where they would exchange cultural elements. It was this way even with their enemies. This would occur because of a need to understand what their enemies were all about, even if it was unappealing. Next, there were the marginal groups. These groups lived in areas where it was necessary to identify bi-or tri-culturally. What would such a thing be called by educators today marginal-Indians? Who can really say when it all began? In this case, the definition at the top of this section seems to fit.

Pan-Indianism? It is a source of disagreement, as always. Upon further investigation, it occurred to me such a term is really not saying anything new. It must not

be of too much consequence outside scholarly research or with the authors who use it as I have not heard many Indians use that term outside the classroom. In fact, none of the dictionaries had such a word. Pan-Americanism is there and Webster (1998) defines it as

> any theory or policy of, or movement toward, political and economic cooperation, mutual social and cultural understanding, international alliance, etc. (Webster 1998).

The definition continues under the term *pan-* the cooperation, unity, or union of all members of (a specified nationality, race, church, etc.). How quaint. Is that not already how Indians are identified by the uninformed? Looking further, Webster (1998) identifies other groups in much the same manner. The list includes Pan-African, Pan-Arabic, Pan-Asiatic, Pan-European, Pan-Islamic, and Pan-Slavic. There was no entry for Pan-Indian, or Pan-American Indian. So, as it can be understand within that context, the concept of Pan-Indianism, then, are those tribal groups who cooperate and are unified, and members of those groups are called Pan-Indians. . .*buh?*

Pan-Indianism is a term many Indians seem to resent primarily because they do not realize the significance of the term, nor do they much care. For the most part, many Native people do not have a problem with themselves or the standard of living they endure. But if the term must play a role, let it be fair in perspective. By this I mean, Pan-Indianism can be used with ethnocentric overtones, that is, to prove or disprove a point.

Pan-Indians are often identified as individuals with multiple or unverifiable Indian descent. They identify as Indian but cannot belong to any specific tribe because they are unable to fulfill membership guidelines for tribal membership. Often they were raised in urban Indian communities in large cities with little cultural knowledge of any specific tribal

group. However, they have idealistic notions of Indian behavior, customs, and traditions they perceive as Indian. Often the core values are a mixture of tribal traditions that blend parts of many tribal customs into one which is then presented to the general public as Indian.

Max is Indian (34, single, part-time sales). He says he is and I believe him. What makes Max an Indian is self-identification and the fact he can now prove it. He looks a little bit like one, but more than that he says he is. He is not sure of his descent, but knows he carries the blood of several tribes. His mother and step-father never took an active interest in his heritage since at that time there was no benefit to being Indian. It was not beneficial to be Indian until tribal sovereignty became an issue. So, like many others, Max s folks suppressed it. When Max grew up he took an active interest in his heritage and decided to trace his ancestry, and learn as much as he could. By this time being Indian was popular and beneficial. It took Max a long time and finally, he was able to substantiate at least the BIA minimum standard, and qualified as Indian for the Indian Health Service. When visiting with him one day I discovered he had a multitude of health problems. He showed me his leather beaded bag full of pills and explained how many of which pills he had to take daily and for which ailments. I was astonished. He even jokingly called himself the Medicine Man. What he was weary of most, though, was not the quantity of pills he had to take during the course of twenty-four hours, nor the many ailments he was plagued with, but every time he went to the clinic they questioned his Indian identity, always, every single time.

Max is like many other Indians who have no single formal tribal affiliation. Their

identity is a blending of traditional components of many native cultures. Raised in the city, Max associates with other Indians of mixed ancestry. Such associations provide a unified Indian identity for becoming ethnically distinct as Indian. To the general public such identity also serves to raise the social consciousness of Indians who then become a type of generic image. Carried to its logical conclusion, then, it is this type of generic Indian the general public desires to promote and identify with.

Couldn t find a wife from my tribe, we re all related

Pan-Indian identity can also be a result of Native people living in states with multiple tribal groups. Oklahoma is an excellent example. Mentioned in an earlier chapter, Oklahoma has over sixty tribes. Some sources indicate there are as many as sixty-seven tribes. While there may be similarities, no two tribes are exactly alike.

Many Oklahoma tribes are clan structured. A clan is defined as a group of related individuals who can trace their ancestry back to a single ancestor. Sometimes that single ancestor is said to have been an animal, such as, a bear (Murray 1992). Thus, a mutual identity with bears, which are then identified as relative, emerges.

Over the years tribes have lost some of their clans through a variety of circumstances, often through death or merging. When membership reaches a point where the remaining members cannot continue to function as a clan they will often be merged with other clans, strengthening them. More often, a clan will simply be discontinued because its purpose has ceased.

It was explained to me in this manner. The Iowa tribe used to have a Snake Clan. It performed a duty for the Ioways. Unclear, but it may have had something to do with their pipe. There were not enough clan people left to use it according to custom. Thus, the purpose for the clan was gone, so the Snake Clan was not replenished. God must have known that no pipe, no use, no clan. In 1937, an automobile accident took the lives of the last two members of the clan two young girls too young to have had any children. The Iowa recognized this as God s plan and discontinued the clan. Clans serve a purpose. When they fail to serve a purpose anymore, it is best to just let them go.

Reducing the number of clans within a tribe can put marriage rules at risk of being altered or abandoned. At one time a tribe s marriage rules or customs dictated who their members could marry and a reduction in the number of clans would reduce the number of eligible marriage partners. Most clan customs stated persons could not marry within their clan or within their moeity (other closely related clans). They were to find marriage partners from outside their clan. This became difficult since less clans meant persons were often related, and marriage to them would be incest. It boiled down to this. Either they followed the rules and looked for some eligible person to marry within another clan or they looked outside the tribe for a marriage partner, or face the consequences. In any case, the impact of this has long term consequences for the tribe, the clan structure, and individual identification. As a result, the potential for Native peoples in Oklahoma to interact and marry someone of another tribe is much greater than it would be for Native persons who live in more isolated tribal-specific areas, such as, the Navajo people in New Mexico.

The Navajo reservation encompasses a four state area (Arizona, New Mexico, Utah, and Colorado). They have a very large land base. Not surprising, Navajo residents have less direct contact with other tribal groups on a daily basis than do Native people who live in Oklahoma. As a result, interaction between residents would tend to be with other Navajo, not with outsiders. Therefore, the opportunity to follow traditional marriage rules is far greater as there are more eligible marriage partners to choose from within the tribe. Thus, there is more Navajo identity and less multiple tribe identity. This means persons with ancestry from more than one tribe sometimes face more challenges in defining their identity than others living isolated from many tribal groups. How one identifies oneself in these instances often depends on cultural upbringing, marriage rules, and clan structure.

In the Beginning Identity was with Family

In the beginning a child is born and is taught the things he or she needs to know in order to be part of a family unit. It is only the beginning of circles within circles of becoming a human being. Along the way a child learns how to be Ioway, or Otoe, or Osage, or Apache, and . . . American, but that is only a beginning, until, in the end, multiple layers of identity have emerged. We all have layers of identity. It is not so simple to be a human being today. Sometimes, identity is as simple as identifying with family and country. Other times identity is more complex. For Native peoples it is more complex.

Eric (45, extended family, construction) was born into a large extended family.

As a young child he was told he was related to the bear clan and taught those ways. He is a card-carrying member of the Iowa Tribe of Oklahoma. He identifies as Ioway, although his lineage is more complex than that. He is also descended from the Cheyenne, Seminole, and Otoe-Missouria tribes. On occasion, he identifies with those groups as well. He also identifies as Indian when the situation warrants. Finally, Eric is an American who works hard to support his family. He pays taxes, and fought for his country many years ago. He even earned the status of warrior from his tribe on his return.

Eric has multiple layers of identification--circles within circles. There are five layers that expand one upon the other: family, clan, tribe, Indian, and American. Why is this important? Simply put, how you identify yourself to others is determined by the world around you. If you are the center of the universe, as many Native peoples believe they are, then your identity reflects those perceptions. So if you belong to the bear clan, that is part of your extended family group and your behavior will reflect that. The bear then becomes your relative and is integrated into your world view. Extending the concept one more layer (to the next circle), Eric identifies as Indian (as generic as that is) to other Indians and is comfortable doing that. Other Indians acknowledge that identity. It is a sign of acceptance by the group, a type of external ascription.

American identity is the last circle. It is the broadest category of identification in this example. It is the layer of identity that obviously includes many people from many backgrounds. It is the circle where identity allows the greatest possible connection to others on a larger scale. It is the level where people have the potential to relate on

common ground and yet have little in common other than being American. American Indians do this all the time. The complex management of layered identities seems to be second nature to many Native peoples. They have had years of perfecting this.

I am Bah-kho-je. Who are you?

Bah-kho-je, is the Ioway (*Ai yuwe)* word for gray snow or dusty ones (Wright 1951). I have been told at one time they were even referred to as gray noses. Over time, the more popular and currently accepted interpretation has become *gray snow.* This descriptive label came about because their noses, heads, even hands were dusted with soot falling from the fires burning inside their lodges. Neighboring tribes noticed this and began to call them by that name.

The extensive amount of grey-white ash was due to the type of wood they burned inside their lodges. Blackjack was plentiful and burned at about the same rate as cottonwood, except cottonwood was aromatic, burned hot, and left a slow burning core that would last for hours. Thus, it became the more popular choice of wood to use. There was a consequence to burning this species of wood, though.

Cottonwood produces lots of smoke and white ash which settles on everything, including the occupants heads, noses, hands, and clothing. In fact, everything inside the lodge would be covered with ash. Even the snow covered ground outside and around the lodges would be dusted with a layer of soot, enough to turn the ground into a hazy light gray. Not only ashes fell, but smoke permeated everything as well.

Empirical knowledge validates the truth of this claim since the author spent several summers and one winter break living in a tipi during ethnographic field schools. And, yes, even during the hot Oklahoma summers, fires were built inside lodges. Fires lower humidity, smoke keeps away the mosquitoes, and rain or drizzle evaporates. Aside from smelling like a chimney, it is not all that unpleasant.

Identity Labels: Mixed Messages?

Lack of non-Indian concern over seeking the native s view of himself and his society seems to have guided a one-sided understanding and left us with an abundance of non-Indian perceptions and labels of who Indians are. Native societies had little use for such labeling. While native groups had names and descriptions for themselves and others it was not based on stages of civilization nor development, but, rather, on perceptions and social relationships, such as, the Ioway called Otoe, *Relative;* Pawnee referred to Arapahoe as *One Braid*; Osage thought of Ponca as *Song Makers*, and so-on.

Most native groups refer to themselves simply as the people. It is no different than how we refer to ourselves. For example, the Cheyenne name, *Tsis tsis' tas* means the people, the real people, our folks, etcetera. Originally, the term, Cheyenne, was thought to have come from the French word, *chien* (dog), referring to their warrior society, the Dog Soldiers.

Many Native people use the term Indian more or less as a generalization. When asked they usually identify themselves first by using their tribal name, such as Ponca,

Kiowa, Iowa, Kickapoo, Comanche, Otoe, and so on, and second, as Indian. In a recent conversation with a Pawnee professor on how he identifies himself to others, he says he replies according to who is asking. To other Pawnee, he says he is Skidi and names his relatives; to other tribes and non-Indians he identifies as Pawnee, and sometimes he says he is just an Indian guy, to others he is just a human being and to students he is the instructor. It all depends on context (Fields 2002).

Non-Indian efforts to identify Indians can be understandably difficult. For example, many phenotypically identifiable Native people (often the younger brown ones) identify an Indian as a person having at least some amount of Indian blood and physical traits. Most Native people say an Indian should at least be raised with Indian values. They explain that an Indian should have dark hair, dark skin, and dark eyes. They say this partly because most brown Indians often face discrimination simply because others identify them as different. I have heard Indians say, if you look Indian, you have no choice. You cannot pick and choose when to be Indian like light-skinned Indians can.

What if All Us Indians Were to be Shot at Dawn
Would You Show Up?

If all Indians were to be shot at dawn and a light-skinned Indian could pass for white would he or she line up with the brown ones to be shot? Or would the light-skinned Indian blend into mainstream society and just disappear? Light-skinned Indians have a choice, they can blend into either group; brown ones do not. They cannot blend into white society. The point here is brown Indians must be Indian whether or not it is convenient or advantageous; whether or not they were raised with traditional values; whether or not they want to be, and whether they like it or not. What if some brown Indians just simply don't wanna be Indn no more? It is not so easy to do that when you are idenifiably Indian. It just does not work that way. You are who you are. Phenotypic features place you in a category that you have no control over. Once again, race is an ascribed status. Either way, it works like this.

You are a person, a human being. You were born into a particular group of people. You did not ask to be born into it, but you were. You had no choice. It is who you are. You identify with that group; you always have. It is an ascribed status which carries with it certain perceptions, expectations, and images by self and others. Through time, you grow, you learn, and you hear what others think about who you are. Others identify you as being part of a particular group as well, but it is often based on what you look like, not based on who you say you are. They continually identify you based on preconceived notions of how they think you should behave according to the images and perceptions that have been ingrained in them from birth. Who am I talking about? You

and me, it could be anyone and everyone.

Ascribed racial categories are not dispositive of personal identification. The point is all people are born into a particular category. They have no choice whether to be born American Indian, Middle-Eastern, African, Mexican, Asian, or Anglo. Such a lack of choice, though, does not mean someone cannot choose to identify with a different group or become acculturated into that group if they make the effort. It just means they cannot choose who their parents are or how they are raised. A case in point, there are black Muslims; black Jews; black Indians; white Indians, and so on. Some of these people have chosen to identify with such groups based on personal preference. Regardless, they have the option to change their minds at any time and leave that identity behind and search for another; none would be the wiser.

So what about persons of Indian ancestry who do have light skin, brown hair, and blue eyes? Are they any less Indian? Not necesarily. Cultural behavior, recognition by others in the tribe, and fullfilling tribal guidelines are often more important than blood degree. Tribal identification does not need to be based on blood quantum levels, but most tribes do include that feature in their guidelines. Its usefulness depends on who is asked. Some say it is a way to regulate tribal membership. Others say it dilutes cultural authority Sometimes what is more important is proving descent.

Of particular interest would be what impact minimal blood tribal members have on tribal sovereignty and tribal governments in the future. Ultimately, the danger lies within the tribal groups themselves. When does tribal representation cease to be bound by traditional cultural constructs and become less recognizable due to external influence?

With each generation of multiracial influence, traditional world views can become obscured. At what point does a tribe cease to be recognizable as a distinct entity? Or does it? For example, a group of field school students visited the Cherokee Nation tribal heaquarters a while back. The Tribal Operations Director, of 1/2 Cherokee descent, was our guide. He explained to us what impact minimal blood members had on his nation.

During the tour, our guide noticed how impressed we were of the newly constructed buildings, the programs and services offered to its tribal members, and future plans to expand economic development into the gaming and resort industry. We marveled at how organized and industrious they were and wondered how their members could all be of one accord. A comment was made by our professor, a native person, We have nothing like this. We can't even reach an agreement on anything (Fields 2002). The Director took us aside and explained that while this is indeed impressive, it is a result of minimal bloods who are the majority tribal members. They do not live here and they cast their votes by absentee ballot. They are the Cherokee who have little or no contact with, nor knowledge of, Cherokee culture. They are the 1/256 and 1/1024 bloods whose focus is economic development (translated as money in the bank), not traditional cultural values. He went on to explain. The fullbloods? They are up in the Cookson Hills. They are the ones who speak and live traditional Cherokee. They are outvoted everytime. They have little say in what happens within the Cherokee political arena their home. So you might say the tribe is run by absentee or non-Cherokee Cherokees. He then warned our professor. This is what happens when the blood degree is reduced to such a drastic extent or eliminated altogether. This is what we have done. Don t let your

tribe do this. Cherokee tribal membership requires only that proof of descent be established. The amount of blood degree is not important nor necessary.

At this point an explanation is in order concerning absentee enrolled tribal members who claim Indian identity. While it may be odd to discuss Indianness from this perspective, as this chapter points out Indian identity is not that simple. To truly have Indian identity one ought to be connected in some way to the Indian community they claim identification with and exhibit culturally identifiable traits. However, there are people who are enrolled tribal members who do not culturally identify with their tribe for one reason or another, such as, for the economic benefits, or the prestige such identity supposedly brings. This is what the Cherokee director was talking about.

You Say You re Indn? Prove It

Misidentification, misinformation, and stereotyping of America's Indigenous peoples all began when the local inhabitants discovered a lost and bewildered Columbus on their shores and when he mistakenly identified them as Indios. Such identification has endured and persists to this day. Who an Indian is has been a topic for debate in books, classroom lectures, movies, and so on, for decades. In addition, stereotyped terms such as, *primitive, heathen, pagan, savage*, and *uncivilized* have persistently been used to describe and identify Native peoples. The multitude of misinformation concerning Indian identity fuels much confusion, especially to non-Indians. Such influence can even be found among some Native peoples themselves.

Many non-Indians tend to assume if one is physically identifiable as an American Indian, they automatically belong to some tribe somewhere. This is untrue. Physical characteristics, including lineage, do not automatically qualify an individual for tribal citizenship. Is it any wonder confusion exists over Indian identity? It would appear that culture is not a factor in identification of Native individuals or tribal groups.

How much impact this has on individuals who identify as Indian today is yet unknown but the subtle sometimes unasked question, *Who are you*? is evident everywhere in literature, the media, academics, government documents, legal matters, even in tribal services and programs, like health care, where identity is dependent upon tribal membership. Tribal membership is necessary for full access to tribal resources. The basis of such ongoing confusion appears to be an overwhelming curiosity over identifying who an Indian is. Attempts by federal and state authorities to identify Indians has been an ongoing process ever since European contact. Native peoples never had this problem. They always knew who they were and who their neighbors were. Furthermore, affiliation with a tribe never became an issue. It is also apparent Native people were never asked about tribal membership. Then, when asked, they had to provide proof.

American Indians are the only ethnic group in America required to prove their heritage in some way. For example, an American Indian must provide proof of Indian identity when obtaining medical care from Indian Health Service providers, or when purchasing tribal license plates, or when voting in tribal elections, and even when applying to a college or university. Any program federally or tribally sponsored or funded requires proof of Indian ancestry and proof of tribal membership. Not only that but definitions of

Indian differ depending on which programs a person participates in.

As a result Native peoples must contend with a multitude of definitions daily depending on circumstances. According to some definitions, a person can be born of full-blood Indian parents and still not be an Indian. Then again, according to many Native groups a person with no Indian ancestry can indeed be Indian. An example of such a paradox is the story of Mr. Barnes.

Mr. Barnes stood there in line along with the other Otoes ready to receive his allotment. He had protested to the leaders who had come to get him and his family saying, he was not Otoe, he was a whiteman. He was not eligible to receive any land. The leaders rebuked him and asked, Do you not live with us? Have you not learned our ways, our language? We say you are Otoe. You are entitled to receive land as much as we are. So here he was standing in front of the agent assigning land allotments. The agent protested Mr. Barnes right to receive land as he determined Mr. Barnes was not an Indian. The Otoe leaders stepped up and said he was. Give him some land; he is Otoe. Somewhat agitated and with an attitude of indifference and disdain the agent assigned Mr. Barnes an allotment. Today, his heirs (Indian and non-Indian alike) are eligible for tribal membership and full benefits (adult, Otoe, M, maintenance).

The Non-Indian Indian

Written and traditional oral histories have recorded many non-Indians as acculturated and accepted within tribal societies. Even captives (Indian or non-Indian) were often fully accepted by and adopted into their captors groups. It was not uncommon for some Indians to accept non-Indians who lived within their communities and adopted their ways as being Otoe, Iowa, Kiowa, and so on. It did not matter if they had Indian blood, physical characteristics or not. What mattered was culturally acceptable behavior. This was so with Mr. Barnes. Although rare today, it is still true. Within the Otoe community, there is an elderly Anglo woman who was the wife of an Otoe tribal member. She has been part of the Otoe community for over 30 years. Even though her husband has long since been deceased she still identifies as Otoe and is still recognized as Otoe by that community. Although such plausible identity is not recognized as valid by federal policy, this Indian view is still accepted today among many tribal groups. There are problems associated with relying on phenotypical identity though. One is the inference a person of Anglo descent *cannot be* Indian and is based on biases and discriminating attitudes. This behavior is due to misuse and abuse of opinions of who Indian people *should* be based on ill-conceived concepts of Indianness.

Sometimes self-proclaimed, knowledgeable individuals are subject to ridicule, and/or disbelief by the general population if they identify with Native people and do not look stereotypically Indian. Much of this is a result of Anglo misconceptions passed down through time requiring that Indians (1) prove who they are through verifiable descent (Indians did not require proof); (2) have phenotypic Indian features (some Indians have

light skin and brown hair); or (3) do specific Indian things (Indians never had checklists); and (4) stereotypes. These misconceptions permeate Indian and non-Indian viewpoints alike and are partly a result of government regulations of what constitutes Indianness.

Even Native people may be suspicious of those who say they are Indian but do not exhibit culturally appropriate or acceptable behavior. Several comments to this effect have been heard over the course of my fieldwork and the reaction has always been the same. One Native person interviewed responded to my questions concerning Indian identity and recognition in the following manner.

> When you meet another Indian, you say, well, I ll see. There are certain unconscious things [behavior] we react to. Within a range, of course. Like all people, Indianness is not monolithic. There s a wide range. Even though I look . . . like an Indian. I m not fullblood [great grandmother was Mexican, mother is Kiowa]. I m Kiowa. My dad is Pueblo. But I m not Pueblo. How would I know someone was an Indian? If somebody told me they were Indian. And if they didn t look Indian. I really would reserve judgement. I d wait. And as I m talkin to them, or maybe we d do things, or whatever, I d just be aware of the way they handled things and what they did. If they handled things that was within a consistent given (and make allowances for quirks . . . .It s not like they re held to some rigid checklist or somethin , because my own relatives wouldn t make it). It raises my suspicions. When someone knows all about Indians in, kinda, an encyclopedia sense. It kinda makes me suspicious. Because every Indian I know. . . . They don t know everything. You ask them about the Navajos. They ll say, *Yeah, I met a couple of em* ; or, *They came to visit me one time. We had a good time talkin ; but, I jus met a couple of em*. . . . . See? You get somebody [else]. You say, Navajos. And then they will tell you about their migratory routes and tell you about their language. And I m sittin there and I m wonderin . . . . There s two different responses here. See, if I want to know about the Navajo . . . . (To me the Indian approach is,) [if] you want to know about the Navajos, really, you go ask a Navajo. And the next time I m around a Navajo I ll ask em, *Well, what do you guys do*? or *What's your religion*? or *What about this*. . . . And even an Indian would have the sensibilitiy to say, *If you can, tell me about your*

> *religion. Tell me what you can tell me. I m curious. If you can t, well I understand that too.* Then, I d watch other behavior and if it got too many things stacked up [against them], I would think and say, maybe, to someone who asked, *You know, they re not an Indian* (Lujan 2000).

It Seems Indians Will Just Not Go Away

Through time the federal government has continuously attempted to extricate itself from Indian business matters. To accomplish this goal government policymakers initiated periods of extermination, termination, and assimilation for purposes of decreasing the numbers of Indians they were responsible for. This action would result in opportunities for the federal government to obtain the last vestiges of remaining Indian land. But, it seems, Indians will just not go away! For example, the Iowa Tribe reported a total of 488 members as of June 2002. This is an increase of ten newly enrolled members since June 2000 (Iowa Tribe 2002:4). McNickle states in *Native American Tribalism* (1973) that Indian populations have not declined but increased from 250 thousand in 1850 to 700 thousand in 1967. The 1990 census shows yet another increase in the native population to approximately 2.9 million: 1,873,536 self-declared and 1,175,173 tribally enrolled members (Russell 1993). Additionally as of the 2000 census another increase of twenty-six percent was recorded (Knight Ridder 2001).

> The number of people identifying themselves as American Indians and Alaska Natives increased 2.5 million, and if included with new mixed race categories grew to 4.1 million overall. This marks a 26 percent increase. . . (Knight Ridder 2001:1).

Reasons for this increase vary because of: new categories; mixed blood self-identification instead of census worker identification; increased awareness of what the census means for tribal revenue; and even television commercials. Another reason appears to be that more and more individuals are taking pride in who they are and are seeking information from elders about their heritage and identity.

> Before I reached the age of twelve my mother sat me down and had a talk with me. In school, we had been learning about Indians in Oklahoma history. I came home and was talking about Indians when my mother said, 'I think you should know something, you are an Indian' she told me. I remember being surprised and wondering what she meant. I didn't look like an Indian. I didn't ride a horse, I had never seen a buffalo. None of these things I learned about Indians in school seemed to apply to me. She explained that she was 'half-Choctaw,' and that my grandmother, . . . , known to me as muma, was a full-blooded Choctaw (Davis 2003:1).

Others want to identify as Indian for purposes of obtaining government services like health care, education, and money they think such identification brings. As head of the Oklahoma State University American Indian Student Association one year, Jake, a native student (Choctaw), thought a good way to find Indian students on campus, increase membership, and get other native students involved with Indian activities would be to go where the BIA was handing out education checks. As he approached the long line, he noticed most of the people waiting did not appear phenotypically Indian. Nevertheless, he forged ahead and asked several students if they would be interested in getting involved in Indian activities and attending the association meetings. Those asked declined his offer and simply stated they were not interested in Indian activities; they were not *real* Indians. They only identified as such to get the money that Indians always got from the federal

government

Certain policies make it fairly easy to do this. Although this is changing, many academic institutions do not require anything more for identification purposes than marking the right place on a form, thus, becoming another Indian in the eyes of the academic community. Although no tribal membership or CDIB roll numbers are required, the University of Oklahoma does require tribal identification in order for students to be eligible for certain benefits. The admissions application form line number twenty states, WHICH GROUP BEST DESCRIBES YOU? There are five boxes each labeled with a racial category: 1. White, 2. Black, 3. Hispanic, 4. Asian or Pacific Islander, and 5. American Indian or Alaska Native--

> indicate tribe of enrollment: _____
> For the purpose of eligibility for programs and services designated for Native American/Alaska Native students, documentation of tribal/village membership/affiliation will be required. CDIB cards are not sufficient evidence of tribal membership (OU Admissions 2005:n.p.).

And, I thought all Indians needed for proof of Indianness was a CDIB card! . . . *Buh*? It is not so easy to be Indian these days. It is equally confusing for Indians to be officially recognized by state and federal governments.

> The Federal government, State government and the census Bureau all have different criteria for defining Indians for statistical purposes, and even Federal criteria are not consistent among Federal agencies. For example, a State desiring financial aid to assist Indian education received aid only for the number of people with one-quarter or more Indian blood. For preference in hiring, enrollment records from a Federally recognized tribe are required. Under regulations for law and order, anyone of Indian descent is counted as an Indian. If the Federal criteria are inconsistent, State guidelines are even more chaotic. In the course of preparing this report, the Commission contacted

> several States with large Indian populations to determine their criteria. Two States accept the individual s own determination. Four accept individuals as Indian if they were 'recognized in the community' as Native Americans. Five use residence on a reservation as criteria. One requires one-quarter blood, and still another uses the Census Bureau definition that Indians are who they say they are [AI Policy Review Commision] (25 USC 13 1977:89).

Non-Qualifying Identifiable Indians

So what about Native peoples who do not qualify for tribal membership under all these stipulations? There are Native peoples who cannot become members of a tribe for various reasons. Such reasons include unverifiable descent, non-enrollment, insufficient minimum blood degree requirements, or errors and omissions in government documents and processes. Sometimes individuals resort to other ways of identification, such as, pan-Indianism which was discussed at length earlier. Tribes also contribute to this dilemma as do some individuals. Consider the following situation:

Emily (22, single, cashier) identifies herself as Ioway but she is not an enrolled member of the Iowa Tribe. In fact, she is not an enrolled member of any of the five tribes she is descended from. She is also unsure of her blood degree. Emily says she is 1/8 Iowa, 1/8 Shawnee, 1/8 Cheyenne, 1/16 Otoe, and has some Creek blood but she does not know how much. Her mother is Iowa, Otoe-Missouria, and Shawnee, and is on the Shawnee roll. Her father is enrolled Cheyenne and has Otoe descent. Since the Iowa Tribe reduced their blood degree qualifications from 1/4 to 1/8 in 2002, Emily should be eligible for membership except for one unmet requirement. She has no parent enrolled

as an Iowa tribal member. Emily has grandparents who were and she can trace her lineage on the Iowa side back three generations. But rules are rules and since no parent is an enrolled member, she does not qualify.

At one time, the Iowa tribal council overlooked this ruling and opened the rolls for a brief time to anyone who qualified by blood degree and lineage. Persons with 1/4 blood degree who could prove Iowa descent were then eligible for membership. Presently, there are members on the tribal roll who would not qualify today because they have no enrolled parent. It was an oversight in the regulations, it was said. In the past, as in the present, the Otoe and Ioway consider themselves closely related. These two tribes were (and still are) culturally the same. At one time they shared overlapping geographic boundaries and spoke mutually understandable Siouxan languages. In fact, many of the Otoe enrolled members have Iowa lineage. Ironically, many parents with Ioway lineage are on the Otoe-Missouria tribal rolls.

To confuse the issue even more, when the time came for parents of Ioway and Otoe descent to enroll their children with a tribe, the families chose to enroll their children in both tribes. It worked like this. During the reservation era, families with several children (the first generation of enrollment) were unsure of the future of their tribes. To ensure there would be children who would belong to at least one tribe, the boys were enrolled in the Iowa tribe and the girls were enrolled in the Otoe tribe. Occasionally, it worked in reverse, boys would be enrolled Otoe and girls would be enrolled Ioway. It was simply personal preference.

So today there are siblings who are on different tribal rolls and some of their

children (the second generation) cannot enroll their children (the third generation) in the Iowa tribe because the parent is an offspring of a male or female who was enrolled Otoe. The lineage is the same; the blood degree is the same; but they cannot qualify for Ioway membership. The circle backfires. Imagine the conflict and confusion of sibling rivalry between brother and sister enrolled in two different tribes. Such a custom is not exactly in accord with kinship practices and extended family relationship obligations. Perhaps, one day the council will reconsider this qualification.

How Much White *Blood You Got*?

So where did the blood degree concept come from anyway? During the early 1700s, a series of laws were developed by the Virginia colonies to promote and maintain social distance between white colonists and the rest of the population. These laws denied civil rights to any negro, mulatto, or Indian . . . [who] were treated as legally inferior persons (Forbes 2001:1). This was only the beginning. Other colonies and, then states, followed this precedence using blood quantum as a way of determining who could have the privileges accorded to white persons (Forbes 2001:1).

In other words the blood degree concept was introduced by early white colonists as a way to discriminate and separate minority populations from the local Euro-American communities. It was a racist concept that allowed white privileges based on ' how much *white* blood you got? In its origination, "how much *Indian* blood you got? was never the issue. Through time, laws were also passed prohibiting mixed race marriages which

meant that "a part-Indian of one-eighth American [Indian] ancestry and seven-eighth European ancestry would not have acquired sufficient European 'blood' to be accorded the legal privileges of whiteness (Forbes 2001:2).

As time passed, so too, did the racist use of the blood quantum perspective. Virginia's laws in 1866 stated that "every person having one-fourth or more Negro blood shall be deemed a colored person, and every person not a colored person having one-fourth or more Indian blood shall be deemed an Indian (Forbes 2001:2). It is quite likely, this is where the BIA got the concept of one-quarter blood degree in use today.

The use of blood degree levels were also used to regulate the numbers of immigrants allowed in the United States. Immigration laws placed quotas on the national origins of persons who would be allowed entry into America. Such laws influenced the BIA's policy of identifying Indians eligible for tribal enrollment.

Towards the end of the nineteenth century terms used in tribal enrollment, such as full-blood, half-blood, and so on were simply extensions of racist concepts, and a step towards terminating tribal identity. How much white blood an Indian could prove was much more important than any degree of Indian ancestry as it entitled an Indian citizen to greater privileges, including being able to have wardship restrictions removed, being able to sell property, acquire the right to vote in state and federal elections, and so on (Forbes 2001:3).

It is no wonder many Native persons at that time exaggerated their degree of white ancestry. Consequently, this is another reason tribal rolls today are often inaccurate. Native persons with no white ancestry (who could not prove it) were declared

incompetent and were, thus, restricted persons. The Bureau of Indian Affairs controlled their financial lives. Conversely, it was believed that Native persons who could prove enough white ancestry could be declared competent. When a person became competent (or was white enough) from a federal perspective, it was expected they would no longer be an Indian.

In this manner a tribe would eventually terminate itself out of existance. Forbes put it like this. The recording of blood quantum is both a product of white racism and of white social science theories of a racist nature, and also a product of a plan wherein Native nations are expected to vanish when the white blood quantum reaches a certain level (above three-fourths, for example) (Forbes 2001:3). A reverse irony occurs at this time as well. The irony is Indians, tribes, and nations are still here, going strong and do not seem to be going anywhere anytime soon, blood degree, blood quantum or not.

Analyzing the Blood Quantum Quandary

> Set the blood quantum at one-quarter, hold to it as a rigid definition of Indians, let intermarriage proceed as it had for centuries, and eventually Indians will be defined out of existence. When that happens, the federal government will be freed from its persistent Indian problem' (Limerick 1987:338).

Historical evidence has shown the reasons for defining, redefining, and identifying Indians by various methods were all economically stimulated because governments must have money to operate. Tribal nations are no different. They need money too.

Tribal membership denotes dollars from the federal government allocated to tribal

treasuries for their use in tribal economic development. There are economic benefits to tribes based on the number of members they have. In order to increase federal monies granted to tribes, tribal membership must increase. This compels tribes to alter membership guidelines. They do this by lowering their blood degree levels, for example, from one-quarter to one-eighth and so on. Results of this procedure are evident in tribal membership doubling almost overnight. The federal government did not anticipate tribal administrators lowering their blood degree levels in order to increase their membership. This practice consequently increased the number of members the federal government would now have to acknowledge--an unintended consequence of federal policy.

Native peoples thus fall into a trap of playing the blood quantum game. Since the blood degree concept was adopted by tribes as a means of determining tribal membership more and more Native individuals focus on that aspect when identifying themselves to other Native people. Comments like I'm more Indian than you are not uncommon. Policies like this tend to pit one person against the other.

> While one-quarter degree of blood has been the norm used in defining *Indian-ness*, the quantum has varied from place to place, one-half blood was the standard utilized in the case of the Mississippi Choctaws and adopted by the Wheeler-Howard Act; one sixty-fourth was utilized in establishing the Santee rolls in Nebraska. It is hardly unnatural, under the circumstances, that federal policy has set off a ridiculous game of one-upmanship in Indian Country: I'm more Indian than you' and You aren't Indian enough to say (or do, or think) that' (Jaimes 1992:136).

Some tribes only require proof of Indian ancestry. In the example mentioned earlier about the visit to the Cherokee Nation complex, the Cherokee Nation of Oklahoma Registration Application of 1993 allowed anyone who could prove descent from the

original tribal rolls to apply and be accepted for Cherokee membership, no matter what the blood degree was. This is still true today. Economic necessity forces tribes to make such changes for tribal growth and financial stability. This causes tribal membership to be composed of culturally non-Cherokee Cherokees who have more voting power and authority over the local grassroots, full-blood Cherokee who may have a different idea of how the tribe should be run.

Amy (23, single, student) identifies herself as Cherokee by showing her CDIB card. In actuality she has had little interaction with the Cherokee Nation and was raised white with western values. She uses her Indian identification card in order to gain access to education and health assistance as well as to gain entry into minority job markets. Her CDIB card states she is 1/512 Cherokee. This concentration on blood quantum levels takes away from cultural things that are just possibly more important in determining Indian identity than *How Much Blood You Got* (Feraca 1990:28). One person explained it this way.

> To me, personally, being an Indian is not a racial thing. And it s not a blood thing. I personally call it the blood quantum game. I have no part and do not participate in any of the blood quantum thing. You know, to me, to use a scientific word, it s stupid! Someone will say, I m a fullblood, you re half. What I say counts twice as much as you. How can you have twice as much Indianness by virtue of blood? You know genetics are such a funny thing. Indians used to never worry about this. In my family my great great grandmother was a Mexican captive. Big deal. She was raised in a [Kiowa] family. She was a Kiowa. And she was raised by her family and that was her family. Those people were simple, direct people; by simple, I mean elegance. If you said, I adopt this person. She is my daughter. Then all your brothers and sisters [and] all your relatives say, That's our [sister,] niece . That s our relative. And it s done. Completely. No worry, no quibbling about blood and all these things. My great great grandfather was like a chief in the tribe and his mother was

> from the north. So, he wasn t a fullblood Kiowa. Well, why was he [like a chief?] Cause that [blood] kinda stuff didn t matter (Lujan 2000).

When individuals cannot qualify for tribal membership under any of these definitions the general population often considers them not Indian. It is hard to imagine there are Indians who are not Indians even if only from a federal perspective. Culture, group association, and acceptance at one time were considered more important qualities by tribal societies when determining identity more so than the quantity of Indian blood coursing through their veins.

Tribes are allowed to set tribal membership criteria, but only under certain federal guidelines. Whatever the criteria, authentification and verification of Indian ancestry for purposes of federal programs and services remain a major concern today because federal regulations make it so. So why be concerned with tribal membership? Without tribal affiliation an Indian cannot qualify for tribal programs and services. So how do they contend with all this? One method used by many Native peoples is humor.

> I m forever being asked not only my tribe, but my percentage of Indian blood. I ve given the matter a lot of thought, and find I prefer to make the computation based on all of me rather than just the fluid coursing through my veins. Calculated in this way, I can report that I am precisley 52.5 pounds Indian about 35 pounds Creek and the remainder Cherokee 88 pounds Teutonic, 43.5 pounds some sort of English, and the rest undetermined. Maybe the last part should be described as human. It all seems rather silly as a means of assessing who I am, don t you think? Ward Churchill. (Jaimes 1992:123).

Will The *Real* Indian Please Stand Up?

Attempts at clarification are ongoing. Non-Indians persistently describe, define, and identify Indians from their own perceptions usually without asking Native people who they are. Notorious in this ongoing attempt at clarification of Indian identity is the federal government and its subsidiaries (the Bureau of Indian Affairs, Department of the Interior, Congress, Indian Health Service, and so on). There is a consistent effort on their part to describe, define, and identify Indians from legal and congressional standpoints which varies considerably according to context. Alas, these efforts have failed to reach agreement about identifying such groups of people.

Herein lies a dichotomy: on one hand, federal and state governments wish to decrease the number of Indians they must deal with via tribal governments by making it more difficult to be officially recognized as Indian, such as, through proof of Indian blood, ancestry, and single tribal membership. On the other hand, these same authorities seem to embrace Indian identity under the guise of culture by continuing to foster misconceptions of identity through such visible activities as tourism (Red Earth, Gathering of Nations, and so on). It would appear not to be left up to Native peoples to decide who an Indian is except maybe from within the context of their own social group.

Much effort and energy has been dedicated by many to identifying Indians. For now answers will differ considerably. One key depends on whose viewpoint is used and whose interest suffers. Nevertheless, Indians (individually and as a group) remain in the limelight, become curiosities, and eventually research projects. If there is one thing most Indians are aware of it is who they are. Indians are individuals who belong to a society

distinctly different from one another with elements from that culture identifiable to each other but not necessarily identifiable to all.

> People can tell just by looking at us what we want, what should be done to help us, how we feel, and what a real Indian is like . . . . it becomes impossible to tell truth from fiction or fact from mythology. Experts paint us as they would like us to be. Often we paint ourselves as we wish we were or as we might have been. The more we try to be ourselves the more we are forced to defend what we have never been (Deloria 1989:1-2).

Some of the identification practices discussed in this chapter shift the focus away from traditional cultural values and lifeways and towards economics. With practices such as these, there will soon be Indians who are not Indian who cannot meet a tribe s minimum blood degree standards; and non-Indians who are Indian with no minimum blood degree standards to meet. The practice of multiple methods and regulations for identifying Native peoples stems from Anglo misconceptions and controversies surrounding the complex understanding of tribal sovereignty. If tribes did not believe they had certain inherent rights to regulate their internal and external affairs (to the extent of their territorial boundaries) no tribal services or programs, vis-a-vis health care and nutrition services would be relevant or even possible. Throughout it all, there is one thing Native peoples know for sure. Nothing involving them ever stays the same. Indian and Indianness are descriptions of individuals whom Native peoples await to meet, perhaps someday. This in mind, will the *real* Indian please stand up?

Part IV

The Political Economy of Indian Health and Nutrition

The Indian Health Service and other related programs (chapter 7)
You are what you eat (chapter 8)

Chapter Seven

The Long Road to Indian Health Care

> Native Americans, from the sixteenth through the mid-twentieth century, experienced a new set of afflictions which decimated their populations. Epidemics such as smallpox, rubella, influenza, malaria, yellow fever, and cholera ravaged Native American societies, creating societal disorganization (Campbell 1989:1).

Ill health continued to plague Native societies throughout the initial stages of European contact, and by the time of the reservation era, Native peoples had experienced centuries of culture change, including a decline in health status (Campbell 1989:2). Federally organized medical treatment appeared around the time Native groups were forced onto reservations. Whether by design or accident, this medical help would be too late for some of these groups. In those days and in those places, new diseases claimed thousands of Native lives. In fact, whole populations had been decimated. American Indians were thus subjected to rapid changes in settlement pattern, social organization, diet, and ideology (Campbell 1989:2). Such rapid changes gave rise to health problems rarely experienced by Native populations prior to contact. One glaring example is diabetes.

Before 1940, very few cases of Type II diabetes were recorded. Today, it is a serious health problem affecting Native peoples to a much greater extent than other population groups. One of the research participants (middle-age, Ioway, M, sales) told me that he was perplexed about how he could have been diagnosed with diabetes. He has been under a doctor s care for some time now and part of his health exams have always included blood tests for diabetes. It seems for years his glucose levels were fine, well

under the level to be diagnosed with diabetes. Then, one day, suddenly, his blood test confirmed a glucose level consistent with Type II diabetes. He cannot figure out what he did different to cause a positive test for diabetes. He thinks it is not a medical problem at all, but an environmental one.

Reasons for Type II diabetes have been attributed to changes in diet, food availability, activity output, and medical intervention (Campbell 1989:9). Diabetes has now reached epidemic proportion and is the seventh leading cause of death among Native peoples. Although medical studies have indicated Native Americans have a genetic predisposition towards Type I diabetes, Type II diabetes is believed to be directly related to rapid social change and government intervention (Campbell 1989:9). Studies indicate that most of the newly introduced diseases, such as, diabetes, fetal alcohol syndrome, bacterial meningitis, otitis media, mental disorders, and substance abuse are connected with poverty and social disadvantage. Campbell continues, Treatment . . . is retarded by lack of services, lack of prevention strategy, and cultural insensitivity [by] many health service providers (Campbell 1989:10). Other studies have also shown that among minority populations the age group most neglected and under served are the Native American elderly (those over age 75).

Shelly (elderly, Ioway, F, retired) is an exception to this study, somewhat. She is an elderly Iowa tribal member who has been struggling with progressive degenerative arthritis in both legs for a many years. Her granddaughter and grandson help her go places as do her children when needed. Shelly participates in the senior meals program at the complex when she can get there and seems to do well with the prescriptions she

receives from the health clinic, or so she says, but I think she just tolerates the system. As a security officer at the Iowa Tribe casino, I have seen her come frequently to play bingo and she always appears in a good way (pleasant), but I know she must be in pain. She can barely walk. I have asked her several times how she is doing (health-wise) and she always answers, I m doing fine. I saw her the other day while visiting someone in the hospital. She had finally received authorization for knee implants and was about to be prepped for surgery. The surgery was successful. On a later visit, she was optimistic at the prospect of being able to soon walk with no pain, at least on that leg. She plans to get the other knee operated on as soon as she is well enough and the doctor authorizes it.

The elderly tend to suffer more from poor nutrition and higher rates of disease associated with poverty and a lower standard of living than do younger Native or other minority populations. Could it be that federal subsidy and commodity programs promote these conditions? Reasons given for this situation are that elderly Native people frequently live alone, are isolated, and have limited financial resources. When examined from a cultural perspective, we see that many traditionally raised elderly Native individuals find it difficult (if not impossible) to complain or otherwise make their presence and/or condition known to mainstream physicians who see them as outsiders. Often, they prefer to seek a traditional Indian doctor.

Traditional Indian doctors are private practitioners. They practice traditional medicine passed down from generation to generation. In a sense, this means one s belief system is essential to successful treatment. In this view, traditional successful healing is reflective of the willingness of the patient to participate. Native peoples know where these

doctors are and visit them when the occasion presents itself. At some point in their lives, many Native people have come into contact with traditional doctors. Such doctors are invisible to the general public for good reason since most healing is attributed to miracles or skills that are God given. Those who have witnessed or taken part in traditional doctoring are often reluctant to tell non-Indians about such events because of their belief in healing powers of Western medicine.

In modern times, such Western beliefs appear to overshadow traditional Native behavior. Indian doctors have experienced reprisals for practicing traditional medicine. I was told several years ago about a traditional Indian doctor (Grandpa K.) who was arrested for practicing medicine without a license. See the story, The Healing Connection. in Chapter Five. In this case, apparently, having a license overrides one s ability to heal. Native doctors attend to the whole being in mind, body, spirit, and illness. Its cause and prevention, in other words, is very holistic. Western medicine focus on a cure, not always a cause. Physicians expect immediate cash payment for services rendered. Native traditional views do not require payment, which is part of the tradition.

As an Ioway elder (M, retired) explained, Indian doctors were not responsible for cultivating the medicines they used. They could use them because they had knowledge of their curative powers. What is remarkable is where and how they got the knowledge to begin with. The interviewee said even his grandfather could not recall where he got his information. He would use the medicines, but did not claim credit for them. Thus, no payment should ever be received. That does not mean there was no compensation.

Compensation is given, not because of the medicine but because of the knowledge.

That is what makes Indian doctoring unique. Anyone who does otherwise and receives direct monetary payment is not a traditional Indian doctor. Compensation comes in the form of food, since everyone needs food. Only one meal s worth of food is acceptable. The food would usually include some flour, coffee, meat, and possibly bread and fruit, enough for one meal. Sometime after the doctoring, the food would be delivered to the doctor s wife when the doctor was not at home. She would prepare it for the next meal. It was considered a blessing. No explanation was necessary because the doctor knew where the food came from. It is not a form of open barter but a silent understood practice. In other words, compensation was rendered as an esoteric gesture of respect, honor, and thanks. The food payment was for the doctor s time, knowledge, and effort, not the medicine.

> Like grandpa used to say. They are only a half-assed doctor. That s the difference. The white man insists on being paid and will sue you and take what you own for his doctoring. Indians don t want no part of that western practice. They have no responsibility for the plants. That s God. Yet the white doctor insists to be paid for them. They give no credit except to themselves. That s what grandpa said about white doctors (adult, Pawnee-Yuchi, M, law enforcement).

No wonder accounts of healing are not shared with non-Indians.

Health care providers do not target elderly Native people for health care services because they are not among the visible population, have limited access to transportation, and are the least likely to spend what little income they have on health care. As a result, they have limited access to these resources (Campbell 1989). Mobile health clinics would be one solution to this problem except the cost and practicality often prevent such services. Presently, the Iowa Tribe has no such mobile clinic, and none are planned for the

near future. It is too expensive to operate. However, they do provide transportation for doctor s visits.

Federal medical health services did not begin with desires to treat ailments of the Indian elderly, or other members of the Native population after European contact, or from westward expansion. Such services developed slowly over time due to their increased exposure to non-Indians and their unfamiliar diseases. Federal health care for American Indians began with the Office of Indian Affairs.

The Office of Indian Affairs and Federal Health Care for Indians

Historically, health care for Native peoples was rooted in federal policies stemming from treaties, legislative acts, and executive orders.

> The provision of health services to members of federally-recognized tribes grew out of the special government-to-government relationship between the federal government and Indian tribes. This relationship, established in 1787, is based on Article 1, Section 8 of the Constitution, and has been given form and substance by numerous treaties, laws, Supreme Court decisions, and Executive Orders (Grim 2002:1-2).

Although not often specifically stated in all treaties or negotiations, health care was considered necessary for fulfilling other treaty provisions and to preserve friendly relations with tribes (Whitecrow 1984). The relationship between the federal government and tribal governments is complex. Treaties ratified between federal and tribal governments were and still are contracts. Contracts are formal agreements between two or more parties. Treaties provided for exchanges of one thing for another, such as, land exchanged for

services, and so on. Johnson and Rhoades state, Indian tribes gave up their land in return for payments and/or services from the U.S. government (Johnson and Rhoades 2000:75). It is that simple.

> The cession of most of the lands of the United States by the Indians, codified in hundreds of treaties, forms the basis for the federal government s provision of health care to Indians and for the intensely held belief that these services are not provided free. Many treaties identified health services (and other considerations) as part of the federal government s payment for Indian land. In effect, the tribal leaders indeed paid in advance for health services for their people, the premium being paid in the form of land. As a result, members of Indian tribes have a prepaid health program, and the federal government has the obligation to continue its payment (Johnson and Rhoades 2000:74-75).

The federal government is not in the business of giving anything away for free.

Initially, Indian health care provided by federal agencies was minimal and focused primarily on protecting military personnel and other white populations from diseases by dispensing vaccines to Native peoples. The notion that Indian people would be protected from diseases was secondary. Its purpose was to keep fort personnel and dependents healthy not to protect Native people. Considering the alternative for Native people (inevitable exposure, debilitating illness, extensive treatment, and sure death), vaccinations were deemed the sensible thing to do at the time.

> During the early 1800s, health care efforts were aimed at preventing the spread of contagious diseases such as smallpox. Services were provided to Indians often with an eye towards the value to the non-Indian communities. With responsibility assigned to the War Department, it is not surprising that attention focused primarily on Indians residing in the vicinity of military posts (Pfefferbaum, et al. 1996:376).

The first round of medical care was dispensed to Native peoples living near forts

for treatment of smallpox. For fort physicians, time away from treating fort personnel in order to treat sick Indians, and the space to put them, posed a challenge. Indians living at or near forts were the most vulnerable to the newly introduced communicable diseases since they came into contact more frequently with the personnel and dependents who lived there. At that time, smallpox vaccine was readily available, highly effective, and forts were well supplied. Thus, because of smallpox s epidemic nature and smallpox vaccines were readily available and effective, smallpox vaccination was one of the first organized health-care efforts. Vaccinating the Native population was an important public health measure and provided additional incentives in providing health care to Indian persons (Johnson and Rhoades 2000:74).

Federal health care for Indians gradually expanded over time, beginning in the early nineteenth century and continuing into the first half of the twentieth century. Today, the Indian Health Service (IHS) is the primary provider of medical services for American Indians. It was not always so.

> The first congressional appropriation explicitly providing for Indian health care was not made until 1832; $12,000 was designated to hire physicians and provide vaccinations. Increasingly, treaty agreements provided medical services and supplies in exchange for land and promises to remain on reservations, establishing a precedent for the creation of a separate system of health care for Indians (Pfefferbaum, et al. 1996:376).

Originally, the primary responsibility for dealing with Indians fell under the War Department. So, in 1824, the Office of Indian Affairs was established. However, it soon became apparent that placing Indian affairs within the War Department was inappropriate and in 1849 the office was transferred to the newly created Bureau of Indian Affairs (BIA)

within the Department of the Interior (Johnson and Rhoades 2000).

The Bureau of Indian Affairs was directed to administer all programs and services related to promoting western-style civilization of Native peoples. Such services and programs included futile efforts at relocation, education, housing, food, and health care. Even religious conversion was included in their objectives. The BIA s role was not separated from political policies of assimilation. Hospitals were not built to isolate sick, infectious Indians or to furnish a sanitary place to practice medicine, but were built to civilize sick Indians hoping to remove them from tribal influences (Campbell 1989). The Bureau only took charge of treating diseases as part of their civilization programs. Medical treatment was only incidental to the whole package of assimilation policies of that era to begin with (Brod and LaDue 1989; Johnson and Rhoades 2000). Medical personnel began treating reservation diseases created by conditions (social and economic) generated by BIA policies (Campbell 1989).

Health needs increased as tribal dependence increased. Reservation life only compounded health problems through inadequate diet, lack of exercise, unclean water, unsanitary conditions, and exposure to white settlers. Vaccinations must not have reached the Ioways living in enforced poverty conditions (Gordon 2001:1) near the Presbyterian Mission in Kansas in time to prevent exposure and death as the following report suggests:

> With the exposure to the emigrant traffic, cholera and smallpox broke out among the Indians. Some fifteen Iowa Indians died of cholera at the mission in June 1849. In 1850 cases of smallpox were followed by another onslaught of cholera. With these epidemics, the Indians shunned contact with the white emigrants and the missionaries, fearing that more disease would befall them (Native American Heritage Museum 2004).

The concept of an Indian person s right to health care was beginning to be recognized in Indian policy (Pfefferbaum, et al. 1996:381). However, it was not until 1921 that Congress focused on these conditions and enacted the Snyder Act (PL 67-85) which authorized funds for the

> benefit, care, and assistance of the Indians throughout the United States for the following purposes: General support and civilization, including education . . . For relief of distress and conservation of health. For the employment of . . . physicians. . . . For suppression of traffic in intoxicating liquor and deleterious drugs (25USC13 1921).

The act authorized the Bureau of Indian Affairs to continue providing health care to Native peoples and to expend such moneys as Congress may from time to time appropriate for the benefit, care, and assistance of the Indians for among other things relief of distress and conservation of health (25USC13 1921; Pfefferbaum, et al. 1996:382). In addition, the health needs of Native peoples would now be met by the Division of Indian Health within the Bureau of Indian Affairs. However, even with this added authority funding was still difficult. Recruitment and retention of qualified, experienced help remained a problem. The health status of Native peoples remained poor, with high infant mortality and excessive deaths from infectious diseases, particularly diarrhea, pneumonia, and tuberculosis (Johnson and Rhoades 2000:75).
Costs and services were by this time rising way beyond the capabilities the Bureau could manage, so in 1926, the Secretary of the Department of the Interior turned to the U.S. Public Health Service (USPHS) for assistance (Whitecrow 1984).

The first congressional review into living conditions of reservation inhabitants was authorized by the Snyder Act. The review consisted of several reports. One significant

report (the Meriam Report) took two years to prepare. Lewis Meriam published his report in 1928 under the title, *The Problem of Indian Administration*. His report recommended several areas for correction. These were tribal self-government, education, health, and reservation development (Whitecrow 1984:4). The report also recommended an increase in support from states. It was a scathing indictment against the federal government s responsibility, policy, and procedures in overseeing Indian living conditions. Meriam reported Native peoples were having to endure deplorable living conditions, deficient diets, and poor health (Pfefferbaum, et al. 1996).

At this point, it is necessary to make some comments in order to keep a few issues in proper perspective. First, the definition of deplorable living conditions, et cetera, is value-laden. It may or may not reflect how Native peoples view their own living conditions. Using traditional housing (tipis, earth lodges, and grass huts) and utilizing the natural environment (medicines, cooking, scraping hides outdoors) were culturally preferred and accepted living arrangement which fit their world views and worked well for centuries. Criticizing such practices without considering aspects of Native adaptations is an ethnocentric perspective.

Second, if overcrowding, unsanitary conditions, and lack of proper food was evident, as the report suggests, then why are Native peoples living on reservations in the first place? Had they been left alone to operate within their own world views and cultural systems, they might have faired much better. As I recall, it was not their choice to relocate. Ultimately, the report is indeed a scathing indictment against federal practices. Conditions improved somewhat for Native peoples in 1934 with the enactments of the

Indian Reorganization Act and the Johnson O Malley Act (JOM). The Johnson O Malley Act enabled states and other political subdivisions to provide for the health, education, and welfare of Indian people through a system of contracts and grants-in-aid (Whitecrow 1984:4). This act was in response to the Meriam Report s criticism that the Indian Bureau s standards were inferior to those of state agencies (Pfefferbaum, et al. 1996:383). It was the idea that Indians should receive services from local entities used by other citizens rather than special federal programs operated specifically for Indians (Pfefferbaum, et al. 1996:383). However, the JOM act was implemented during the Depression and World War II when states were unwilling and often unable to afford it. As a result, the federal government had to increase its role in providing these services.

The Iowa Tribe participates in a series of programs funded through grants including a Tribal Management Grant, Community and Child Care Development Block Grants, and the Bison Land Grant project and contracts such as BIA-638 contracts, Title VI-A, VI-C, and JOM programs. The JOM program provides educational assistance for all Native children attending public schools in the form of school supplies, clothing, hot meals, and tutoring assistance within an expanded service area (Schurz 2003).

The Public Health Service (USPHS) continued to assist with health care services throughout the 1940s, even though the BIA Indian Health division still maintained primary responsibility (Whitecrow 1984). With the onset of the termination era during the 1950s, questions were raised concerning what to do about Indian health care. Who would be responsible for addressing the health needs of Native individuals?

Debates began between two federal agencies, the Bureau of Indian Affairs (BIA)

and the Health, Education and Welfare (HEW), over which agency would take over responsibility for Indian health. Eventually, a bill was passed authorizing transfer of the Division of Indian Health to HEW. So, in 1955 the Division of Indian Health was transferred to HEW s Public Health Service to be re-designated as the Indian Health Service (IHS). It has remained there ever since (Whitecrow 1984).

The Indian Health Service

> The IHS provides a comprehensive health services delivery system for American Indians and Alaska Natives with opportunity for maximum tribal involvement in developing and managing programs to meet their health needs (IHS 2002).

The goal of the Indian Health Service is finding a way to increase the quality of health care, provide professionally trained staff, and ultimately turn over management to tribal governments for self-operation. As a first step to reaching this goal, the Indian Health Service s operation was divided into three phases: Phase I (1955-1962); Phase II (1963-1969); and Phase III (1970 - present). Phase I established reasonably competent and high-quality medical care (Johnson and Rhoades 2000:76). This required extensive renovation of health facilities, recruiting of health professionals, and consultation with physicians to arrange for hospital and clinical services when such was not available at an Indian Health Service facility.

Phase II expanded the management of health programs, provided formal training of health professionals, and established criteria for research on the health care delivery system

expecting that new technology and methods would enable IHS to provide more cost-effective and efficient health service. The third and final phase began the transition of the first two phases and introduced the Community Health Representative program. Now, for the first time, tribes could assume management of funded, health care programs (Johnson and Rhoades 2000). The Iowa Tribe began their CHR program sometime during the late 1970s to provide basic health care services to all eligible Indian persons residing in the tribe s service area.

Throughout all this well-intentioned and well-placed health care ideology and effort, unintended consequences began to develop. It was hoped that with Indian health care housed under the Public Health Service three objectives would occur: (1) the health status of Native peoples would improve dramatically, (2) preventable diseases would be controlled, and (3) increased medical knowledge would significantly lower chronic diseases like tuberculosis and trachoma. It did in part, but soon American Indians began to suffer from other more modern physical and social ills, such as alcoholism, drugs, diabetes mellitus, carcinoma, heart disease, violence, and physical abuse (Campbell 1989). Attempts to solve these health problems prompted the federal government to pass the Indian Self-Determination and Education Assistance Act in 1975 (PL 93-638). The act gave tribes two options: 1. to administer and operate their own programs under IHS guidelines or, 2. to remain with the direct health system administered by the Indian Health Service (IHS n.d. a).

One year later (1976) the Indian Health Care Improvement Act (PL 94 437) was passed to specifically address issues concerning tribal planning and management of the

quality and quantity of health care services. The act supported the Indian Self-Determination Act with a goal to provide the best possible health services in order to elevate the health status of Native peoples to the highest possible level and to encourage maximum tribal participation in planning and managing those services (IHS n.d. a).

Unfortunately, policy does not always dictate reality and goals are not always realized, and, thus, the health status remains low for Native people as compared to the national average. Concern over poor health status spurred the Iowa Tribe to develop a comprehensive health plan funded by a Tribal Management Grant prepared in September 1989. The report determined that

> The Indians residing in the Iowa tribal service delivery area experience a high incidence of endocrine, nutrition, and metabolic disorders disease; a high level of substance abuse problems, and alarmingly large number of circulatory system problems and infective and parasitic diseases among the Indian population (Lincoln 1989:12).

The report further stated that forty-one percent of the health problems were directly related to alcohol and substance abuse (Lincoln 1989). Since this report was prepared, the tribe has made some inroads into correcting these health issues. With receipt of a small tribal action grant, the tribe focused on a plan to curtail alcohol and drug related problems (Lincoln 1989). The Substance Abuse Program offers education and counseling in areas of DUI and drug abuse (Autaubo 2004).

Health care standards that had improved over the past thirty years are now being eroded by present-day federal policy. Present policies are intent on reducing or eliminating much needed funding for facilities, sanitation, and Indian child welfare. The trend today seems to be towards the private sector providing these services (Campbell

1989). Tribal services and programs are almost entirely funded through grants based on current federal policy. If funding were to be reduced or eliminated, the effect on tribally operated programs and services would suffer immensely, especially those that are health-related.

The Indian Health Service has taken an all-inclusive approach to health services and programs designed to meet the needs of Native peoples. It provides (to the extent resources allow) special initiatives in traditional medicine, elder care, women s health, children and adolescents, injury prevention, domestic violence and child abuse, health care financing, state health care, sanitation facilities, and oral health (IHS 2002). Also included are food commodity programs and/or counseling in environmental health, health education, mental health, and nutrition. Other community services are offered for social well-being, and environmental improvements (Johnson and Rhoades 2000).

The Indian Health Service promotes nutritional care as part of its health care program. Rhoades (1989:10) suggests that those considered at nutritional risk infants, pre-school children, adolescents, pregnant and lactating women, the elderly and chronically ill sound nutritional practices are essential. Further, the Indian Health Service considers nutritional care an important part of the health services delivery system. Emphasis is placed on including as much nutrition education into every health and social service, and food assistance program as possible (Rhoades 1989).

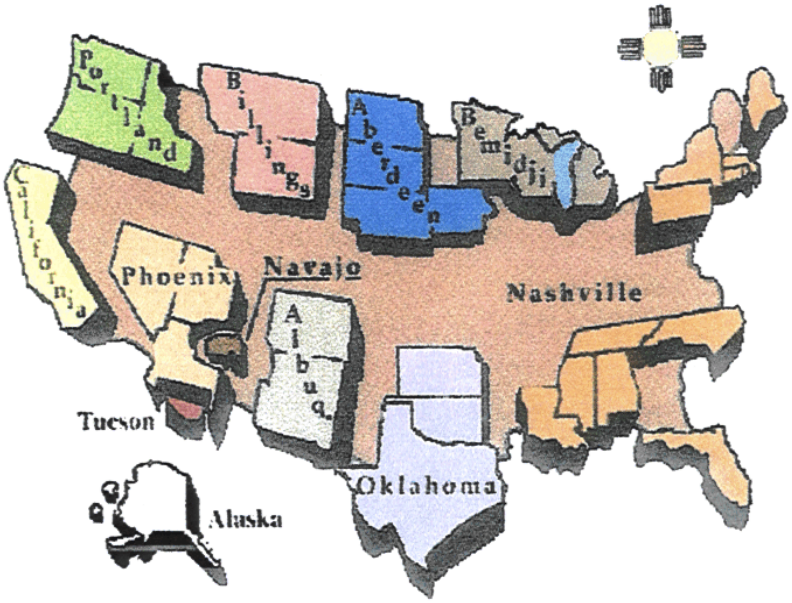
The Iowa Tribe is also concerned about providing nutritious meals and education on nutrition. They do this through Title VI (A and C) programs. For example, the tribe provides at least one meal per day, at noon, Monday through Friday, for all Native seniors

and disabled family members living in Payne and Lincoln counties. The noon meal can be enjoyed at the Iowa Tribal grounds in the White Cloud Building or it can be delivered to a homebound person s home (Autaubo 2002). As a resident in Perkins, I often see the tribal van driving around the community. It frequently pulls into the driveway of a housebound elderly tribal member who lives just down the street from me to deliver her noon meal. I have wondered what the elderly do about meals on the weekends? I asked one of the kitchen staff and she said the kitchen was closed on weekends and she guessed that family members prepared food for their elderly relatives. There will be further discussion regarding nutrition and food commodity programs in the next chapter.

Organization of the Indian Health Service

Three parallel organizations answer to the IHS Headquarters in Rockville, MD: (1) the Indian Health Service Area Offices; (2) Tribal Governments; and (3) Indian Operated Urban Programs (Johnson and Rhoades 2000). The Indian Health Service is organized into areas by region. There are twelve Area Offices in the United States (see map 1): Aberdeen, SD; Anchorage, AK; Albuquerque, NM; Bemidji, MN; Billings, MT; Nashville, TN; Phoenix, AZ; Portland, OR; Sacramento, CA; Tucson, AZ; Window Rock, AZ; and Oklahoma City, OK.

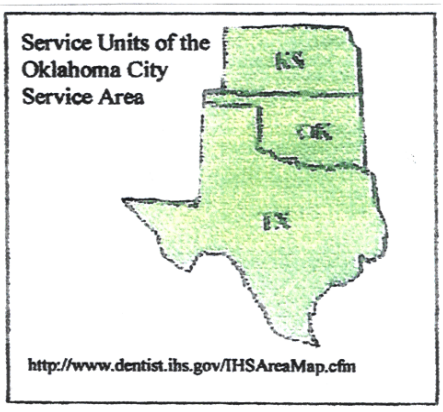
IHS Regional Map



IHS is organized as 12 Areas operating over 500 facilities located in 35 States

Map 1

www.info.ohs.org/Map



Map 2

Typical with most organizations, complexity is the norm not the exception, and the Indian Health Service is no different. As one of eight agencies of the Public Health Service, the Indian Health Service with almost fifteen thousand employees, unique goals, emphasis on complete community-based care, and diverse sovereign tribal nations is one of the most complex organizations of its type (Johnson and Rhoades 2000).

A service unit is a facility with administrative staff who are responsible for the administration, coordination, and implementation of health programs for Indians in a specific geographic region (IHS n.d.). Service units are usually centralized at hospitals with several outlying clinics providing medical services to the local Native community. They usually consist of medical and dental services included with other community and environmental services at the local level (Johnson and Rhoades 2000). Smaller service units may only have a minimal staff consisting of a part-time physician, physician s assistants, nurse practitioners, and other support staff.

As of 2002 there were 49 hospitals, 236 health care centers, and 133 ambulatory services located throughout thirty-five states all providing health care services to more than 550 Indian tribes/nations. During this time the IHS operated 66 service units, and tribes operated 84 service units (IHS n.d. a). Much of the structure and changes were brought about by the passage of the Indian Self-Determination and Education Assistance Act and the Indian Health Care Improvement Act.

The Oklahoma City Service Area

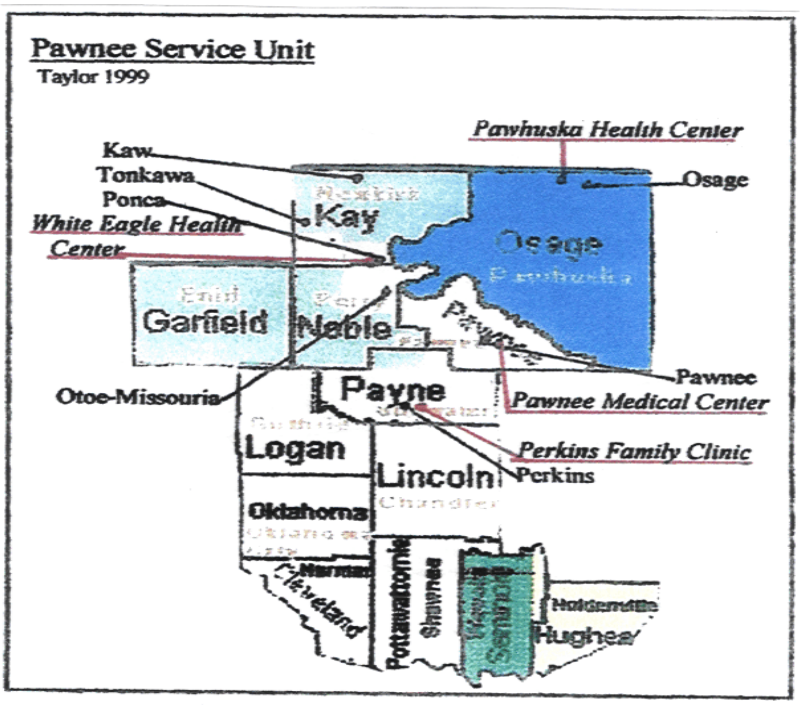
The Oklahoma City Area services the largest population of Native people in the United States. For example, during 1998 over 303, 000 American Indians health needs were met. By comparison the Tucson Area serviced only two tribes with a combined population of slightly less than 28,000 (Johnson and Rhoades 2000). In addition, forty health centers located within the Oklahoma City Service Area are managed by tribal compacts and other Indian organizations (IHS n.d. a). The director representing this area coordinates the required health services with the service units and applicable tribal governments. The director is responsible for delivering these services to those individuals who qualify (IHS n.d. a).

The Oklahoma City Service Area oversees twelve service units (see map 2) in three states (Oklahoma, Kansas, and part of Texas). Eight of the twelve units are located in the state of Oklahoma (Clinton, Lawton, Claremore, Tahlequah, Tishomingo, Talihina, Shawnee, and Pawnee). Two service units are sites for my research. They are located in Pawnee (map 4) and Shawnee (map 5), Oklahoma.

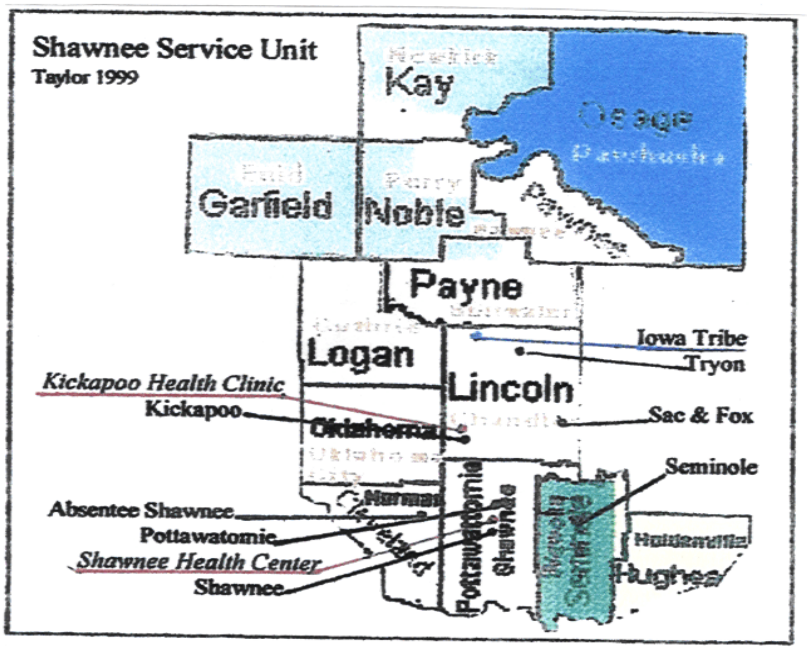
The Pawnee Service Unit is about 37 miles northeast of the Iowa tribal complex. The six counties represented in this unit are Garfield, Noble, Kay, Osage, Pawnee, and Payne counties. Perkins is located in Payne County four miles north of the tribal complex. The tribes/nations residing within this service unit are the Otoe-Missouria, Osage, Kaw, Tonkawa, Ponca, and Pawnee. Three medical facilities make up this service unit: the new Pawnee Health Center in Pawnee; the White Eagle Health Center south of Ponca City, and the Pawhuska Health Center in Pawhuska. Only two tribes in this service

unit (Pawnee and White Eagle) are close enough to the Iowa tribal complex to be accessible to the Indian residents of Perkins and Tryon.

The second service unit is the Shawnee Service Unit located in Shawnee and is approximately 36 miles south of the Iowa tribal complex. The Shawnee Health Center is one of the busiest and largest health centers for Indians in the Oklahoma City Area (IHS n.d. a). The Kickapoo Tribe also operates a small health clinic which is closer to the tribal complex than Shawnee is; it is about 21 miles southwest of the complex. The Shawnee Service Unit consists of seven counties: Cleveland, Hughes, Logan, Lincoln, Oklahoma, Potawatomie, and Seminole. The small township of Tryon is located in Lincoln County, seven miles southwest of the tribal complex. Tribes/nations residing in this service unit are the Shawnee, Absentee Shawnee, Sac and Fox, Kickapoo, Potawatomi, Seminole, and the Iowa.


Pawnee Service Unit
Taylor 1999
Pawhuska Health Center
Kaw
Tonkawa
Ponca
White Eagle Health Center
Osage
Kay
Garfield
Noble
Pawnee
Otoe-Missouria
Payne
Pawnee Medical Center
Perkins Family Clinic
Perkins
Logan
Lincoln
Oklahoma
Cleveland
Pottawatomie
Shawnee
Seminole
Holdenville
Hughes

Map 3


Shawnee Service Unit
Taylor 1999
Kay
Garfield
Noble
Payne
Logan
Lincoln
Oklahoma
Cleveland
Pottawatomie
Shawnee
Seminole
Hughes
Iowa Tribe
Tryon
Kickapoo Health Clinic
Kickapoo
Sac & Fox
Absentee Shawnee
Pottawatomie
Shawnee Health Center
Shawnee

Map 4

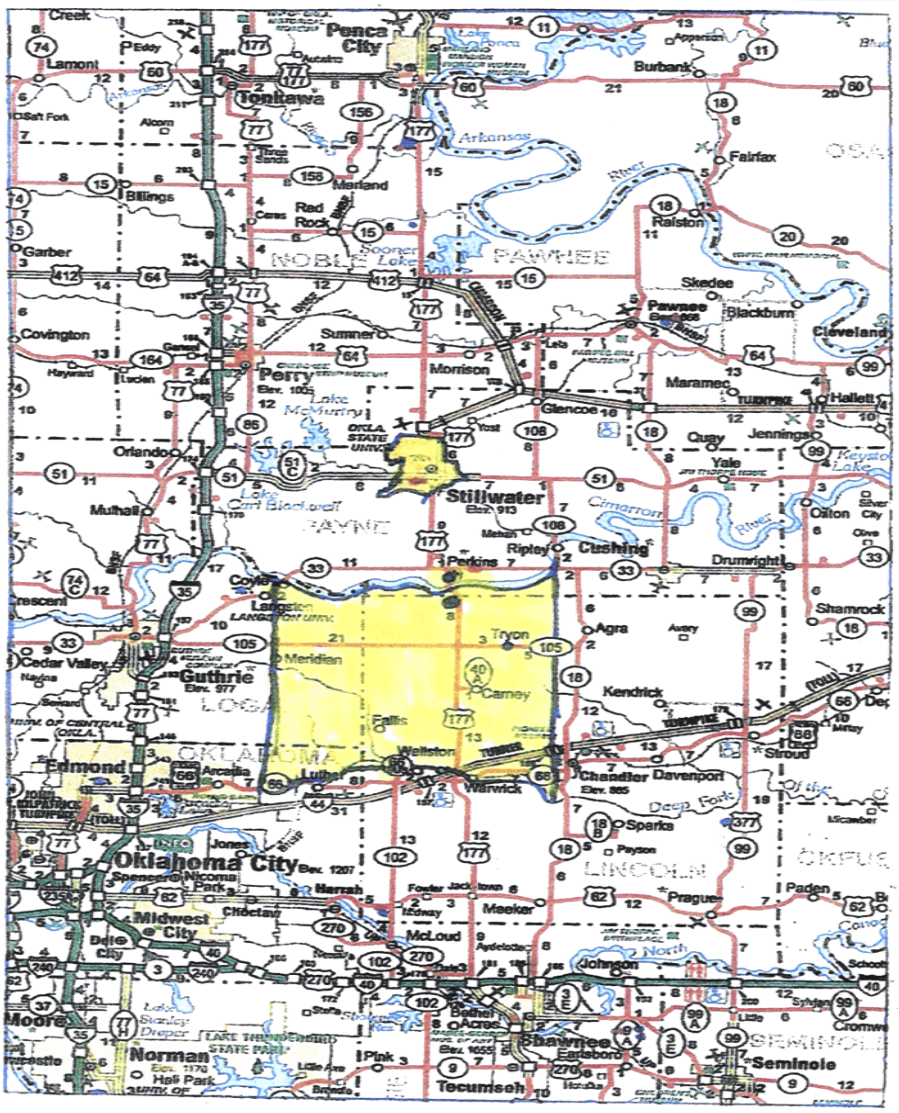
Tribal Governments and Health Services

With the passage of the Indian Self-Determination Act in 1975 many tribes including the Iowa Tribe were able to directly participate in programs under the direction of the Indian Health Service. Thus, they would have some involvement in meeting their own needs. This included the ability to enter into contracts for any government operated programs or services (Whitecrow 1984) including contracts for health care. Rhoades said the following about such legislation:

> This legislation strengthens and enhances the I.H.S. long-standing policy of giving Indian people maximum opportunity to become meaningfully involved in the programs serving them. Specifically, the law gives the Indian tribes and Alaska Native groups the option of managing and operating health care programs in their communities. It also authorized assistance, if needed, for any tribe or group wanting to develop or improve the capabilities to take advantage of this option (Rhoades 1989:v).

Thus, today under Indian Self-Governing regulations, tribes are able to not only contract for health care services but can develop their own programs, health care facilities, and operate their own clinics under the auspices of the Indian Health Service. Many have done so, including the Sac and Fox, Kickapoo, Pawnee, Ponca, and the Iowa (map 5).

Iowa Tribe Service Area



Map 5

Taylor 1999

Health Programs and Services of the Iowa Tribe of Oklahoma

> The [Iowa Tribe] Health Department provides a diversity of services including direct patient care through the Perkins Family Clinic and home visitation, basic patient care and transportation through the Community Health Representative Program (Autaubo 2004).

The Iowa Tribe of Oklahoma took advantage of the opportunity to develop their own health care services after self-governing regulations were enacted. Concern over available, accessible, and beneficial health care prompted this action. So, during the late 1970s, four health care programs were initiated. Health services offered to tribal members at that time were (1) a CHR program funded by a BIA 638 contract; (2) a contract physician provider agreement; (3) a tribal alcohol prevention contract program; and (4) agreements with the IHS for outpatient care through the Shawnee and Pawnee Service Units (Lincoln 1989). Today, the tribe has expanded these health and human service programs and added new ones, such as, its own staffed health clinic, a new fitness center, massage therapy, a Well Woman/Well Baby Clinic, and a Family Caregiver Program.

The Iowa tribe says it takes its health programs seriously and desires to employ the most qualified personnel available. Sometimes, it is not that simple. Finding experienced qualified personnel to staff their programs is a challenge. The tribe has an Indian hiring preference with a focus on hiring their own tribal members first. This is a good economic strategy. However, often a search reveals no tribal member is qualified. This is unfortunate as it would decrease tribal dependency on others and increase tribal involvement in their tribe s health care decisions. The tribe does have various educational programs available to assist tribal members in becoming qualified, but very few seem able

or are interested in completing the process. For this reason, most professional positions are filled with other experienced Indians or non-Indians.

Ideally, these programs should be staffed with experienced, well-qualified personnel. For example, the Iowa Tribe hiring criteria recommends that the fitness instructor should have a bachelors degree in fitness and wellness, CPR/First Aid certification, and be able to lift up to 50 pounds. The LPN must be fully certified and licensed in the State of Oklahoma, and should have completed training in CPR and First Aid. The Substance Abuse Prevention Program Coordinator (SAPPC) should have a master s degree in sociology, psychology or other related field and, ideally, five years professional experience. He or she also needs to be certified in CPR and First Aid.

The Iowa Tribe s health programs are organized and managed under different guidelines and classifications. For example, the Health Department is responsible for health services; Tribal Assistance Programs manage several financial awards for emergencies and unexpected expenses; and, the Human Services division oversees social services and other sub-programs. Social Services administers BIA 638 contracts. A BIA 638 contract is the result of the Self-Determination and Education Act (P.L. 93-638) mentioned earlier. The Act allocates certain funds to tribal governments for administering federally contracted programs and services. Eligibility for these programs is once again dependent upon Indian identity. As a result, tribal membership and residence location becomes an issue. A tribal member (Iowa or otherwise) must reside within the tribe s service area before being able to participate in these services.

The Client Services Representative program provides health care services to

housebound and disabled persons by a licensed Client Services Representative (CHR). The representative helps clients coordinate medical appointments and will pick up medications when needed. The CHR also distributes supplemental commodity items to qualifying families and the elderly on a first come, first served basis. Transportation services are also available on a limited basis to those who have none. Other duties of the Client Services Representative include medical referrals, immunizations, and child safety restraint education. The program offers a wide variety of services to any Indian resident living within the Iowa tribe s service area, but only if they qualify (Autaubo 2002).

The contract physician service contracts with a local physician (Medical Doctor or Doctor of Osteopathy) to provide medical services to qualifying participants. For the Iowa Tribe, a physician is contracted by the Shawnee IHS service unit. In the past, the tribe s contracted physicians have been located in Stillwater and even Perkins, for a time.

During my research, I found that most of my contacts preferred to use a health clinic in the nearby city of Stillwater whenever possible because at one time that was where the IHS contract doctor was located. Patients have since become familiar with the facility and the doctors, and are now used to going there. Thus, changing physicians and facilities is frustrating and inconvenient. More recently, the tribe opted to provide its own physician and health clinic, and subsequently purchased the small doctor s office in Perkins. This move was such a success that for convenience and expansion the tribe purchased a larger building just outside the city limits. They retained the original name of Perkins Family Clinic.

Andrew is sixteen and a student descended from three tribes. He was recently

enrolled in the Pawnee Nation, but lives in the Perkins Indian community. One day last summer, he complained of a sore toe. His dad took him to the Perkins Family Clinic. It seems he had an in-grown toenail that finally hurt so much he could ignore it no longer, and besides, it was beginning to look infected. The doctor looked at it, said it was nothing, and proceeded to look for a medical instrument to remove it. He could not find one so he took his pocket knife out of his pocket, wiped off the blade on his pants, and removed the in-grown portion of the toenail. Andrew s dad went into a rage. He told the doctor he did not understand why he would not use a medical instrument even if the procedure was not so serious. As the dad feared, the toe became infected and Andrew had to return to the clinic, wait for the doctor, get a shot, and, now a prescription for some antibiotics. All this was unnecessary had the doctor followed procedure.

Sometime later, Andrew s brother, Cody (also Pawnee and a student), was rushed to the same clinic to see the same doctor. Cody is in the ninth grade at the Perkins/Tryon High School and he plays football. Well, he used to play football until his weight increased and his health declined. During football practice one day, he suffered from dehydration and heat stroke. Alarmed, he was rushed to the Perkins clinic. After about three hours, he finally got to see the doctor. By this time, he was feeling really sick. Blood tests were taken. In the end, he was diagnosed with diabetes. His parents enrolled him in the Iowa tribe s diabetes and nutrition clinic, which he attended for awhile. Today, he says he is eating a better, more balanced diet, although I think he cheats. It has been very difficult for him to give up some of his favorite foods. Oh, the doctor? He does not practice medicine at the Iowa Tribe s health clinic anymore. The clinic is

advertising for a new physician to take his place. Meanwhile, visiting physicians come to the clinic once or twice a week and a nurse practitioner takes care of the small stuff.

The Perkins Family Clinic is open to the public but subsidized services are only for qualifying individuals, such as Iowa tribal members, other tribe s members, other Indians, and yes, even non-Indian employees classified as full-time. For awhile, the clinic was only staffed by a physician s assistant (PA) until a licensed physician could be found. This proved to be an interesting dilemma for one individual who needed immediate medical attention.

Jesse (middle-aged, Cherokee-descent, M, construction) has high blood pressure and gets anxiety attacks every so often. He was low on medication and feeling very anxious one day. His wife took him to the clinic. The Physician s Assistant told him she could not see him because he was not Indian. This only increased his anxiety and his wife (who is Indian) tried to calm her husband and find out why the PA said she could not help him.

As it turned out, the Physician s Assistant was not certified or qualified to assist non-Indians. I thought the clinic was open to non-Indians, too. Apparently, the clinic is open to the public when a qualified medical doctor is present. In the event the Iowa Tribe s clinic (Perkins Family Clinic) is not able to treat an Indian patient or the treatment is beyond the physician s skills, referrals to specialists in the nearby city of Stillwater or the IHS service area in Shawnee or Pawnee is available. When needed, patients can be referred to Oklahoma City or Tulsa. The family clinic is not used by all the Native residents in the Perkins Tryon area for a variety of reasons. Some of the Native residents

have health insurance from their employers.

Bev (young adult, F, accounting) is Otoe, Ioway, and Pawnee. She works for the tribe and has tribal health insurance. Her husband, a non-Indian, also works for the tribe and has tribal health insurance. Because they are full time tribal employees, their insurance is paid. It would seem they would have no worries about affordable health care. That is not the case. They have three children, all in need of some kind of health care. They are not covered on their parents health insurance because it is too costly. The children are enrolled Pawnee tribal members, so their only health care option is an Indian Health Service facility. They have the Pawnee benefit package. In order to use it, they must travel the thirty-three or so miles from Perkins to the Pawnee Health Center any time they need to see a doctor, dentist, or pick up medications.

I accompanied Bev one day as she took one of her sons to the doctor. It was quite time consuming. She took time off from work, her son took time out of school, and I tagged along. After arriving at our destination and checking in with the receptionist, we sat down and waited. There were several people waiting another mother with two young children, an elderly couple, a middle-aged couple and a young woman all Indian. We watched as people came and went. After about an hour, the nurse took Bev and her son into the exam room. More people came and went. They were gone about thirty minutes. Bev returned and said that once the nurse took them into the exam room they had to wait another fifteen minutes for the doctor. When the doctor did examine her son, he only stayed about five minutes. They waited until the nurse brought her son s prescriptions.

Next, we went to the pharmacy, turned in the prescription and had to wait what

seemed like another thirty minutes for the medicine. The pharmacist told Bev he did not have one of the prescriptions and she would have to come back the next day for it. We left. By the time we reached Perkins, and home, it was late and even I was frustrated. The next day, her father drove the thirty-three miles back to pick up his grandson s medicine. Bev could not afford another day off work. Later, she told me if there was any way she could afford it, she would enroll her children in her health insurance and not be bothered with the frustrations of the Indian Health Service.

Others travel the extra distance to use the IHS facilities in Shawnee and Pawnee or the other tribal health clinics in White Eagle and at the Kickapoo health complex. Sometimes, families must use several types of health care facilities. This is usually the result of varying types of insurance coverage.

Some families utilize more than one health clinic due to differing qualifications of family members. *Annie and Alex live in Perkins and are both employees of the Iowa tribe. Alex (young adult, M, supervisor) is one-half Otoe and one-half Ioway. He is an Otoe tribal member. His wife, Annie (young adult, F, cashier) is a Ponca tribal member. Her blood degree is 7/16 Ponca, one-half Pawnee, and 1/16 Omaha. They have two little boys who are enrolled in the Pawnee Nation. Alex is a full-time employee and the tribe pays for his health insurance. He uses the Perkins Family Clinic. Annie works part time and does not qualify for tribal health insurance. She uses the Ponca Tribe s health clinic in White Eagle, about forty miles north of Perkins. Their sons have the Pawnee benefit package and must go to the Pawnee Medical Center for services. It is about thirty-three miles northeast of Perkins.*

Another reason given for seeking health care away from the Iowa Tribe s health clinic is the difficulty the clinic has had in keeping the same physician for an extended period of time. Since the turnover in physicians has been frequent, patients have preferred to use medical facilities in Stillwater. It was hoped, with the newly expanded health clinic, the present physician would remain for a while. He did not. The tribe is trying to get the former physician to return to the Perkins clinic a few days per week. It was rumored that he quit working for the tribe because of internal conflicts with the staff.

The tribe recently introduced a new diabetes program whose primary goal is to provide support, information, and educational programs for families who have diabetes. Nutrition education and special luncheons are also provided to those who participate in the program. An important part of this program is to promote knowledge about the prevention of diabetes (Autaubo 2002).

Lewis (elderly, Ioway, M, laborer) was diagnosed with diabetes. He was told to get some supplies a blood glucometer and test strips. So he did. He went to the local Walgreen s and purchased the required supplies, went home, and began to use them. A few days later, Lewis found out he was eligible to receive the same supplies from the tribe at no charge. It was too late to take the purchased item back for a refund. Now he has two glucometers a spare in case one breaks. In addition, he was eligible to take part in the tribe s diabetes program which provides quarterly newsletters, diabetes support groups, nutrition education, special luncheons, Heartland Share Promotion and distribution, and an annual camp (Autaubo 2002).

The Iowa Tribe also operates a drug and alcohol prevention program. The former

substance abuse program has now been expanded to include families, not just youth, who must deal with problems associated with drugs and DUI. Part of the program includes educational and psychological counseling. The program is not limited to tribal members or Indians but is open to the community for a fee. There is now a new Tribal Youth Program that not only looks at drug and alcohol abuse but has added another element gang involvement. The program s purpose is to provide an alternative to youths idle time by sponsoring various activities, such as, foot races, basketball tournaments, and so on. (Autaubo 2002).

The tribe operates a Title VI nutrition program that provides meals once per day, Mondays through Fridays, for American Indian elderly and disabled (Autaubo 2002). This meal is provided at the tribal complex s White Cloud Center. Title VI is a program based on the Title III Federal Older Americans Act. However, the focus is on Native Americans age 55 and above. Disabled persons or homebound elderly can have their meals delivered as long as they live in the tribe s service area (Autaubo 2002).

A fitness program is located in the newly constructed gym at the tribal complex. It is open all week and staffed with a certified physical fitness instructor. Activities at the center include a dry sauna, free weights, aerobic equipment, and a small pool. The pool can be used for water aerobics or swimming laps when the air jets are turned on. When the workout is finished, a massage therapist is on duty to ease the pain. Massage therapy is available once a week and open to the public. These programs are available at no charge to tribal members and employees, but there is a small fee for all others.

Other Health Related Programs Offered by the Iowa Tribe

In tough times, people need assistance. The Iowa tribal administration recognizes this and, thus provides financial assistance to its tribal members as educational incentives and for emergencies. Eligibility for any of these programs is varied and depends upon the assistance desired. Applications must be completed and approved by the stated deadlines before any awards are distributed. The assistance is a monetary award and is dispensed once or twice per year. The awards range from $50 per year for prescriptions to a one time award of $5,000 for burial expenses. Other types of aid include elder assistance, including hearing aids, dental, and eyeglass assistance as well as prescriptions, and critical illness. Non-health related assistance is also available for household rent or utilities, education completion, and school expenses (Sine 2002).

Human services include vocational rehabilitation, child protection, and a youth shelter. The Eagle s Nest is the Iowa Tribe s temporary emergency youth shelter for abused children. Access to this program is open to any and all Indian children regardless of residence or tribal membership (Schurz 2003). Social services include Indian Child Welfare services, child care development, and counseling on family preservation.

The WIC (Women/Infant/Children) clinic is a program that focuses on food supplements and nutrition education for pregnant, post-partum, and nursing mothers. It also includes children up to age five (Cherokee Nation n.d.). In order to participate, women must be at nutritional risk and meet income guidelines. These clinics focus on well-baby development and early childhood care and nutrition, as well as pregnancy care. Supplemental food vouchers are provided for participants, as is information on health,

nutrition, and child care education. The Iowa Tribe contracts these services from the Sac and Fox Nation (Winchester 2003). There will be discussion of more nutrition and food commodity programs in the next chapter.

The Color of Medicine, Economics, and Health Care

> The clash of divergent civilizations was also reflected in the fundamental difference between traditional Indian people with their own highly developed treatments and often strange and foreign treatments of government physicians. Although the relation between medicine man and physicians was considerably more complex than usually portrayed, Indians often reacted to foreign medicine with fear and hostility. Many government physicians made little attempt to understand or analyze the Indian s own historically rich and highly successful traditional medicine (Pfefferbaum, et al. 1996:378).

Sally was an elderly Creek woman who was not feeling very well. On one visit to the Indian Health Clinic, she was diagnosed with hypertension. The physician prescribed pills and explained they needed to be taken once a day, every day. Her daughter (adult, Creek, F, sales) took her to the clinic s pharmacy, and after waiting what seemed like hours, she received her pills. The daughter instructed her elderly mother once again that she must take one pill every day. It would make her feel better. A week went by and the elderly woman still did not feel any better. Her daughter asked if she had been taking her pills. The elderly woman replied she had not. Why? They will make you well. The elderly mother then showed the daughter the pills. They were red. Her daughter then knew why her mother had not taken any of the pills.

In Creek culture, the color red signifies death. The logic is, why take a pill that is

something the color of death? How can that help you recover? In the end, the pharmacist would not change the pills for the elderly woman until she made another visit to the doctor and was given another prescription. Was all that hassle necessary just to feel better? The following is an account of what another individual went through just to get a prescription filled.

> I remember getting a prescription filled for high blood pressure one time. The pharmacist at the Indian clinic gave me a different brand. I questioned him and asked for the specific brand I was prescribed. He said he didn t have any. The generic brand was the only one he had. Take it or leave it. So, I took it. I couldn t afford to pay for the one my doctor prescribed from a regular pharmacy. You d think I could get what my doctor prescribed. Anyway, I took what the pharmacist gave me and went home. Next day, I took one of the pills. Soon after I started feeling strange, nervous, fidgety. I couldn t sit still and I paced back and forth, back and forth. I was breathing fast, my heart was pounding, and I was dizzy. I couldn t think clearly. My wife took me to the hospital emergency room. And, after an hour or so, the doctor said I had had an allergic reaction to the blood pressure pill I took. He said I should take only the pills prescribed by my doctor. Buh! I would ve if they d given em to me. They cost $90 for a month s supply and that s only for one prescription. I have three. I don t have that kind of money. I have Indian health care. I thought they were supposed to help us get healthy! (middle-aged, Pawnee, M, management).

Why is it when patients go to an Indian Health Service facility they face such difficulties, and often do not get the medicines prescribed? Here is the sequence. A doctor or physician s assistant makes a diagnosis, prescribes medication, and the patient goes to the clinic s pharmacy to get it filled. The pharmacist fills the prescription with another brand, not with what the doctor requests because that is all he has. Strange, as I always thought physicians prescribed what they wanted their patients to have, not what pharmacists had on hand. Several contacts I spoke with are convinced the medicines at

Indian health clinic pharmacies are surplus medicines. Quite simply, they believe the pharmacist fills the prescription with whatever brand he has on hand. The idea, it appears, is as long as the type and dosage is correct, the brand does not matter.

Money, Medicine, and the Madness of it All: The Circle Shrinks

> An individual may be regarded as within the scope of the Indian health and medical service program if he is regarded as an Indian by the community in which he lives as evidenced by such factors as tribal membership, enrollment, residence on tax-exempt land, ownership of restricted property, active participation in tribal affairs, or other relevant factors in keeping with general Bureau of Indian Affairs practices in the jurisdiction (42 CFR 2002:58319).

Once again, in order to participate in health care services and programs an individual of Indian descent must provide proof of Indianness. Not only that, but as stated above, tribal affiliation, and even residence location, play an important role in whether or not health care or other services are provided and paid from tribal funds. While being an eligible "Indian" is essential in order to receive tribally funded services, access to and participation in some tribal programs may also be limited by age, gender, and income.

Ironically, for fear of contradicting myself and after emphasizing that only eligible "Indians" may receive health care from participating providers, there are three situations when non-Indians *can* receive Indian health care services. These circumstances are: (1) for purposes of controlling certain contagious diseases (only when a non-Indian is a member of an eligible Indian's household); (2) when an eligible Indian is guardian of a

non-Indian child under 19 years of age; and (3) when a non-Indian woman is pregnant with an eligible Indian s child (Iowa Tribe 2001).

Jean (middle-aged, F, housewife) is the non-Indian spouse of an Otoe tribal member living in the Perkins Indian community. She tells me all of her children were born at the Pawnee Indian Hospital, and at no cost. Not only that, but before regulations changed in the mid-1960s she was also able to use Indian health services. This was one period when the Indian Health Service was beneficial to her and her husband.

Operating revenue for the Iowa Tribe is derived from a variety of sources. Sources stem from enterprises, grants, taxes, and trusts. They are divided into four categories: Enterprise Funds, General Funds, Special Revenue Funds, and Fiduciary Funds. Enterprise Funds are revenue from the Bingo/Casino, Gallery, Mini Mart, Smoke Shop, and Trucking Company. General Funds include five categories: (tribal) taxes, trusts, payroll, federal management, and medical benefits (Roubidoux 2002). General funds are designated for all services and programs to tribal members including health services and human service programs. Unused assets from the general fund are held in trust by the federal government for use by the tribe at a later date.

Special Revenue Funds are all grants and awards that are received by the tribe. They are used for specific purposes based on the award (Roubidoux 2002). Funds are received from the Department of the Interior, Health and Human Services (HHS), Indian Health Service (IHS), Department of Education, Housing and Urban Development (HUD) Environmental Protection Agency (EPA) and Federal Emergency Management Agency (FEMA). While the Treasurer s Report of 2002 does not specify exactly where these

special funds go, it seems self-explanatory. For example, HHS and IHS funds would go to health and human services programs. HUD funds would go to tribal housing. Fiduciary Funds are trust funds from the (federal) Government Services Trust and the Minor s Trust and are held by the federal government in trust for the tribe for later use (Iowa Tribe 2002; Roubidoux 2002).

As a result Indian identity and physical needs are both critical factors in assessing who qualifies for tribal services. However, qualifying is only part of the process. Receiving the funds is yet another side of the health care participation process.

> When an Iowa Tribal Health Service clinical provider determines that a patient needs health care not available from the clinic or one of the regional Indian health care facilities, they will write a referral . . . . And, although patients are *eligible* for contract care based on the clinical physician s referral, they may not be *authorized* to receive it at the expense of the Iowa Nation Health Service, due to lack of funds (Iowa Tribe 2001:5).

Most funding for patients is issued on a first come, first served basis. Tribal and federal funds are limited and allocated for specific procedures. For example, high risk pregnancy, life threatening emergency care, and cancer treatment are the top three medical conditions on the Iowa Tribe s Inpatient and Outpatient Medical Priority Lists. It was surprising to me that the least priority item on the outpatient list was an organ transplant.

Funds may not always be available when patients need them. Once the budget becomes depleted patients must seek alternative financial arrangements elsewhere. Examples of other arrangements include private insurance, public health services, loans from banks, relatives, and friends, et cetera. Otherwise, they must do without until the next fiscal year budget is approved. Then the cycle begins again.

Ron (middle-aged, Otoe, M, service industry) needed knee surgery. His knee had been hurting for quite some time. He knew it was only a matter of time before he would acquiesce and have it operated on. Finally, the time arrived when he could stand it no longer. It was time. He visited his doctor who gave him a referral to a specialist. Since he had health insurance where he was employed, in addition to the Pawnee Benefit Package, he felt his share of the surgical cost would be minimal. Perhaps, the entire procedure would be covered. At least, that is what he was hoping. After a multitude of tests, he finally had the surgery. It was successful. Even the physical therapy, difficult as it was, was somewhat successful. Then the bills came. His employee insurance paid for most of the surgery, but the Pawnee Health Plan denied any payment. The plan spokesperson said the surgery was not a priority procedure. Now, he is facing one more bill for the next few years. When I asked him about it. He replied, he was not really all that surprised.

The payor of last resort is what the IHS calls their medical priority system. It is an IHS requirement that patients must deplete all financial resources available to them from other sources, such as private insurance, state and other federal programs before IHS will pay anything (42 CFR136 2002). Reasons for denial of medical services stems from a combination of things, such as medical inflation, Native populations increase, and more importantly, limited competitive pricing and options (42 CFR 136 2002). I never would have suspected that a medical policy would focus on denial of service as a priority sequence of payment. Can this be yet another unexpected consequence of being an Indian? Considering the history of Indian-Federal relations, I am not all that surprised.

The following story is an account of such frustration a tribal member felt when denied medical payments from the IHS because of lack of funds.

> I always hear people say we get free health care. Bah! I remember once about ten years or so ago I woke up in the middle of the night, bleeding from my nose. So much blood, everywhere. I filled up two bowls not including what I swallowed. Man, it really scared me. I was rushed to the emergency room at Stillwater Medical Center for treatment. While lying in the emergency room waiting for the doctor, and still bleeding, a candy striper came in and pleasantly asked how I was doing. Buh! I thought that was a stupid question, I m bleeding to death. How do you think I feel? The doctor couldn t stop the bleeding at first and even commented he didn t know how to stop it. That sure made me feel good! After [cauterizing] it and stuffing large quantities of gauze up my nose, the bleeding was finally stopped and the doctor informed me I had ruptured an artery and had begun to hemorrhage. He added that if he couldn t have stopped it soon, I would have bled out. He explained my blood pressure had gotten so high I just exploded. Well, after they got the bleeding under control, they sent me home with orders to rest and not get so stressed out. They said that s what caused my blood pressure to go up so high in the first place. Yeah, sure, don t get stressed. I only thought my problems were over. Because I have this IHS Pawnee benefit package that entitles me to emergency medical services, I thought the fees and all would be taken care of. After all, I am a card carryin Endn. About a month later, I get this bill from the medical center saying the IHS would pay nothing for the services and would I send them a check for the full amount? This bout caused another rupture! I called [IHS] and asked why not? I m eligible! First, they said they didn t consider my nose bleed a life or death emergency situation even when I explained I could have bled to death because I was hemorrhaging. Then, they said they didn t have any more money in their budget since they had spent it all on providing rehab to repeat alcoholics. Now, where s the justice in that I ask? So, I had to pay over $2500 for doctor bills that the IHS says I m entitled to but won t pay because some guys repeatedly choose to drink too much and then there s no money left to help me. And I don t have any insurance! What a system. It just don t make no sense at all (adult, Pawnee, M, machinist).

Where Will It End? Opening The Circle

So what is the future of health care for Native peoples? Will participation in health care programs continue to be done on a first come, first served basis? Will services still continue to be based on a negative pay system? Just how much money is necessary and how long can the federal government procrastinate in providing the health services to which it has obligated itself? Certainly, health care is a complex issue not easily solved. Native peoples are entitled to health care through treaty obligations. So far that has not changed. However, only time will tell. Will the federal government ignore or abolish treaty obligations just to balance the budget? Or, will it, once again, reinterpret Native peoples? Health care is costly, not only for Native peoples, but for everyone government agencies and the general public alike.

So what can be done? Is there any better solution to the health care dilemma? Given my limited knowledge of the intricacies of health care funding, I would, nevertheless, like to offer at least one alternative or addition to the present system. That suggestion would be something similar to a bank debit card system.

A certain amount of money would be credited to a debit card that could be used for health care purposes. All eligible Native people would have access to a card that would be used like a debit card. Once again, there is a catch-22 dilemma. Eligibility is a factor. By requiring proof of Indian identity, eligibility could be based on combined descent and recognition.

The card could be used to pay for discounted medical, dental, prescription, or other qualifying health services at a medical facility of an individual s choice after a

reasonable deductible has been met. Major medical expenses would be prioritized and eligibility renewed annually. Any funds not used could be rolled-over to the next year and would accrue interest. Admittedly, such a solution may present an oversimplification of the existing complex system.

At present, the structure of an affordable, accessible health care plan cannot be agreed upon for the general public, let alone for Native peoples. Nevertheless, this would be a beginning. Maybe in the decades to come a more logical, equitable system will be developed that is affordable to everyone.

> The development of general public health policy in this country has been slow and has followed the pattern of other industrialized countries. Three stages of development of health policy have been identified: (1) public apathy and reliance on charity; (2) public provision of services when not adequately provided by the private sector; and (3) replacement of private and charitable programs by public services and public financing (Pfefferbaum, et al. 1996:391).

There is yet another, fourth, stage of development yet to be unfolded. Until then, Native peoples will continue to make do with what they have. They have resilience, resourcefulness, and decades of cultural tradition to rely on.

Chapter Summary

This chapter provides an overview of the development of the Indian Health Service and the efforts by federal agencies and policies to put it in place and make it work. Overtime treaties and policies were the tools used to formulate policies and procedures that enabled health care services. Health care provisions for Native people has been a

gradual process. It started with vaccinations against smallpox. The chapter opens with a discussion of diseases new to the Native population since European contact.

The overview continues with how tribal governments in Oklahoma are able to offer health care, and what the impacts are on tribal members who choose to participate in these services. For clarification purposes, there is an explanation of the Iowa Tribe s programs and services, such as health, nutrition, and social services relative to the research. Personal accounts throughout the chapter illustrate the complexities and frustrations participants have had with access to medications and participation in health care. Maps of the Service units (Pawnee and Shawnee), areas, and regions are also included to provide a visual aid as a helpmate to the reader. The chapter ends with a suggestion for a possible solution to the Indian health care dilemma.

Chapter Eight

The Indian Side of Health and Wellbeing

This chapter presents health and wellness from a Native viewpoint. It is a chapter about access to food products and nutrition services, and whether these choices help or hinder participation in health care resources. Attitudes sometimes justify the choices people make when deciding on which food items to purchase, and is reflected in participants comments and stories throughout the chapter. Topics reflected within the chapter are food programs, affordability factors, and challenges of accessing quality versus quantity food products. Examples of traditional foods are included, as are interesting insights into food preparation techniques.

During the course of interviewing subjects for the dissertation, I discovered an interesting and unexpected turn of events regarding the Indian side of health, food, and economics. What I discovered was a distinct difference between what was presumed as ideal and what was practiced as real when it came to native peoples pursuits of wellness and well-being. According to health care information, good health is a result of following and maintaining a medically sanctioned diet and appropriate nutrition programs truly an ideal philosophy of wellness.

The medical community encourages people to take an active part in whatever the accepted, or ideal, practice of becoming healthy currently is. Native peoples would not argue the wisdom of this philosophy, either. However, they have a different way of going about the business of living according to their own world view and economic situation, which may be at odds with following such advice. Often native people are less influenced

by a doctor or other health care provider, or the media.

The popular position is that a nutritious diet and frequent exercise may provide a healthier, more active lifestyle, and, perhaps, even longer life. For a variety of reasons, such advice often falls on deaf ears among Native peoples. In fact, food choices may simply be based on attitude and justification than on economics or a determined effort to count calories, calculate cholesterol, reduce fat consumption, and, the latest craze, limit carbohydrates. One frustration the research participants commented on during the interview process was that their doctors and nutritionists advised them to stay away from certain foods because they would harm them only to be told later those foods were acceptable to eat and, in fact, were good for them. Eggs are one such example.

> Once upon a time, eggs were considered the perfect food. They are an excellent source of protein, iron, and phosphorous, and eggs are high in important nutrients, such as vitamins B12, D, E, riboflavin, and folate. In addition they are inexpensive and low in calories (70 per egg). But they have an Achilles Heel. The yolk has more cholesterol per ounce, by far, than any other food (Bird 1999:n.p.).

In the 1960s, public health officials recommended consuming only one egg per week. Later, the *American Heart Association* raised that limit to three eggs per week. By the late 1980s the egg limit was increased to four per week. Eleven years later in 1991, the *New England Journal of Medicine* revealed a case study of an 88-year-old man who ate 25 eggs a day and had normal cholesterol and no clinically significant heart disease (Bird 1999:n.p.). Lastly, in two Harvard University studies completed in 1998, diabetics who ate one or more eggs a day had a much higher rate of heart disease . . . compared to those who consumed one egg or less per week (Bird 1999:n.p.). The debate continues.

One lady put it this way.

> I remember when one of the first national studies about eggs . . . twenty years ago . . . stated that eggs were bad for you. . . . I m very healthy and considering that I love eggs, I never paid much attention to what scientists of the day were talking about. . . . Then came. . . another study. . . . This study claimed that egg yolks were bad, but that the whites were good and could be eaten as much as desired. . . . To add insult to injury, I had been eating only egg whites and those commercial egg substitutes for about a year when they came out with still another study about eggs. This one stated that the yolk wasn t so bad and the white wasn t so good. Give me a break. . . . I have since heard of still another study in which it was concluded that once a week eggs (whites too) are fine in most diets. . . (Dorfman 2001:1).

Such confusing and often contradictory recommendations are prevalent in health and diet books. In addition, the recently revised nutritional guidelines create confusion as well. As the egg example demonstrates, if you wait long enough, the guidelines will change. The ever-present media is also guilty of disseminating conflicting information and constantly reminds us of positive and negative lifestyle options. Sometimes, these images have a greater influence on the choices we make than we would like to admit. Thus, from a reality perspective, attitudes about diet and nutrition, and justification for certain actions, often play a more significant role in cultural behavior than a doctor s advice. At best, doctors can only recommend nutritional choices, as their medical training is limited in that area.

Attitudes and Justifications

How Far Can You Stretch a Dollar?

Native peoples, like many others, make choices in health care and spend their income on medical bills, food, et cetera based on certain attitudes and justifications. I will explain further. In the community where I live and conduct research, my contacts and/or their spouses work. Some are receiving Social Security payments in addition to paychecks. No one in my research group is on welfare or living entirely on fixed incomes, such as, Social Security or pensions. They are also not elderly (over age 75). Their income levels vary quite a bit depending on the number of paychecks in the household and if children are present. These individuals, whether they recognized or admitted it, tended to purchase food items and pay bills according to personal attitudes of how they justified purchases and expenditures. This type of behavior plays an important role in the choices people make, especially when accessing health care.

The research participants were very aware of their income, the limitations it imposed on spending, the concept of paying bills on time, and saving for a rainy day. They were also quite aware of what the medical profession advises about eating better quality foods and exercising regularly in order to reach a higher level of health and fitness. In addition, several individuals made sporadic attempts to follow those rules of the game, but for one reason or another never made them a routine.

The medical community, including the Iowa tribe s health personnel, would continually hammer away at individuals attempting to get everyone to conform to a medicalized, Western lifestyle. By medicalized, I refer to medical problems that are

cultural or environmentally constructed into traditional native societies, such as tobacco use and eating frybread. The following scenario should further clarify what I mean:

Joe (middle-aged, Pawnee, machinist) and his wife do not make much money and never have. They have three grown children with families of their own. All their lives, they have had to make a dollar stretch about four different ways. There were medical emergencies from time to time, some serious, some not so serious. Early on, medical care was often provided by the Indian Health Service, but that was not always convenient or even approved. So private doctors were sought and used whenever manageable, and the medical bills accumulated. Unavoidably, sometimes, bill payments were postponed. All in all, clothes had to be mended and cleaned, food had to be purchased and prepared, and a car (when there was one) had to be repaired. Not only that, but when the children were small they wanted things, just like their classmates. All these things cost money, which the family could ill afford. Meanwhile, mainstream media influences are ever present.

This is how the capitalist system works in Indian country. A family goes to the grocery store to buy food. More often than not, what money there is needs to be stretched until the next payday. With several mouths to feed, the shopping list tends to be full of items that can be purchased in bulk or stretched to last over several meals. An example would be beans and ham hocks, or sacks of enriched white flour for biscuits or bread, potatoes, ground beef for chili, and so on. After two or three months of consuming budget food items, they get tired of this type of diet and, affordable or not, become influenced by advertisements for high dollar and fast-food items. They decide it is time for

a change. Joe s wife, Jean, tells me.

> Boy, we sure get tired of eatin the same food all the time. At least, I do. I am so tired of fixing biscuits and gravy that I d rather skip breakfast. We eat beans a lot. Sometimes, we get ham hocks to add some flavor. Good thing, because no matter how many times we have this, my husband says he never gets tired of it, especially if I make biscuits to go with it. I fix chili a lot too and then I make corn bread. My husband says I can stretch a $20 bill a long ways. Got to or we won t be eatin . Once in awhile, my husband says, That s it! I can t stand it any more, we re gettin steak for dinner tonight (middle-aged, Otoe, F, housewife).

Never mind that food brokers purchase specific locations to shelve their products in grocery stores because they know it will influence consumers choices and increase sales or fill volume quotas. Never mind that grocery items conveniently placed at eye level and arm s reach are oriented to raise sales. Never mind whether food items are healthy or reasonably priced. The food industry spends millions of dollars each year to promote their products, which include foods that are high in refined sugar, fat, and cholesterol. For grocers and food brokers, it is the profit line that counts. Brenda told me she has a hard time shopping with her kids because they re always reachin for that food item that s advertised on TV. It always costs the most, and I can t afford it. Why do they always put the cheaper foods on the highest shelf anyway? Makes you really have to search for it (adult, Pawnee, F, food service).

For the consumer, the family, what does matter is providing enough food to last between paychecks. Counting calories or focusing on purchasing foods low in fat, cholesterol, or sugar, does not matter most of the time. And, while stretching a dollar might just help a family make ends meet, there comes a time when attitude supercedes practicality and that is where choice enters the picture.

Given a tight budget, there may be one month when a bill is left unpaid or maybe the family will get a windfall or tax refund, and then they go to the store to buy groceries. This time, they choose beef steaks, pork chops, processed pot pies, packaged cookies, fresh fruit, and soda pop, all the really good tasting highly processed foods available at the market. Little thought is given to the potential results of overspending or health consequences. They do this because it just tastes good and as Jean s husband says: We ve sacrificed for three long months living on beans and ham hocks. We deserve to go out. Besides we just got our tax refund check (middle-aged, Pawnee, M, machinist).

When the sun comes up tomorrow, ask me then

So what is the basis for such reasoning and attitude? For the most part it is live for today, not for tomorrow. What seems difficult for mainstream society and the medical community to understand is many Native people spend their entire life operating at the lower end of the economic spectrum, and often cannot see a way of increasing their standard of living without some form of divine intervention. Besides, since life is short, why not treat yourself to something nice once in a while. Many native people do not make such a conscious effort to consider the future and their place in it. They simply live for today, not for next month, or next year. What is the basis for such reasoning, logic, and attitude? Grandpa M. says, It s good enough just to get through today (middle-aged, Ioway, M, maintenance).

Ironically, one day while attempting to explain discretionary income, choices in

food items, and access to medical facilities within the field of American Indian health care, it occurred to me that the Native people who were my research subjects went about their lives oblivious to scientific studies or research efforts. Not surprisingly, they seemed more concerned about their own welfare than any attempts at scholarly research concerning diets. What I found interesting was a disregard for diet recommendations. They were living one day at a time with nothing but a fleeting thought of tomorrow. Not that tomorrow is not important, it is. However, it appears not to be as important as the present because tomorrow may never come. This is a key concept is native philosophy. Here is how a research participant expressed it.

> It s like tomorrow is a part of today and you can t separate it. Because if you live for tomorrow, it s like today s not important. There s a real difference in thinking between white people and Indian people. When I was young and asked about tomorrow, my grandpa used to tell me, When the sun comes up tomorrow, ask me then. In the meantime, it s all I can do to just get through today. For some of us it s still like that. It s like pulling up to McDonald s window to order. You re supposed to already know what you want. There s no time to read the menu or decide. That s always frustrated me. It s like you re living the future in the present. That s the difference between white people and Indian people. That s how I see it (middle-aged, Ioway, M, maintenance).

He continued, explaining that it seems as if mainstream society is supposed to already know what they want to eat, or how the day will turn out. Thus, they focus on future events or plans as if today is no longer important. The focus on tomorrow increases as it gets later in the day. Somehow, non-Indians tend to speak of events to occur tomorrow while they are still in the present as if today s events are unimportant. In a sense, it is like merging today with tomorrow as if they were one and the same, or at least a continuation of the present. Everyday in mainstream society, life appears like that. For

the most part many Native people live for today because life is tough enough. Why complicate it with plans for tomorrow that may never take place? The situation just may get worse.

Native people are aware of the future. They know certain things must take place at a future time, like a buffalo hunt or the Sun Dance, or a doctor s appointment, and that they will occur in seasons yet to come. Native people know these events will happen, and when that time comes, the designated ceremonies will occur. Native people are certainly aware there is a tomorrow, and at the appropriate time, specific events will take place. Events take place when they are supposed to, not before. The key factor is that Native people do not live that event before its scheduled occurrence. This concept is a subtle part of culture and may be one explanation for Indian time.

By contrast, mainstream society plans events, such as cruises, six months or more in advance, saves for retirement, and sets aside money for IRAs and 401Ks with expectations those events will occur later. Then, they live the present as if the future were already here. Do we not live each day in terms of what we will do tomorrow? What if tomorrow never comes? This is a big philosophical difference between Indians and non-Indians. Sadly, today, many native people are also caught up in the idea of living in the future, thereby lessening differences between mainstream society and native people.

Affordable vs. Natural: Quality or Quantity?
Your Choice

Food choices are directly linked to good health, but good quality food is expensive. Sadly, today, the more natural the food, the more expensive it is, unless one has the time and space to grow his or her own. In its natural state, natural food products contain more nutrients than the highly processed foods on the market today.

Economics and attitude also play an important role in the quality of one s health and well-being. Often after an individual receives his or her monthly income check and pays the bills, there is not much money left for food. Numerous studies indicate the basis of good health begins with a diet high in nutritional value. Calories high in nutritional value tend to stem from quality foods. For example, bananas are high in potassium and carbohydrates.

The Health and Human Services Department currently suggests dietary guidelines for healthier living. They suggest eating a variety of fruits (bananas, apples, oranges) and vegetables (broccoli, cauliflower, brussels sprouts, beans), whole grain products, low fat dairy products, and lean meats. Foods low in nutritional value serve only to provide empty calories which often have no nutritional significance and have been known to cause health problems, such as high cholesterol, hypertension, and obesity. These foods include bacon, non-lean meats, butter, and deserts laden with sugar. Popular food items that come to mind are Cokes, french fries, and Krispy Kreme Donuts. Although they taste good, they do nothing to increase a person s health status. These are only a few items that can either enhance the health status of an individual or significantly lower it and put one at

risk for disease.

A person s income level influences their choice of food items. Thus, both health status and food item choices are linked to budgetary limitations. It is a disconcerting cycle for someone on a low or fixed income. How much money can one afford to spend on food products when other issues, such as medical care, are equally pressing?

In an effort to address these issues a foundation, called the Thakiwa Foundation, One People s Vision, was developed by Sauk community members as a grassroots effort of individuals and families working together for the health, wellbeing, and happiness of our people (Thorpe n.d.). The Foundation supports two major efforts: the *Enatowey-akwe*, which focuses on reintroducing the Sauk language; and the Thakiwa Agricultural Project, established in 1995, which focuses on the unnatural state of foods on the market today. This project successfully reintroduced traditional Sac and Fox foods of corn, beans, and squash. It established land use and management demonstration sites, and provided model gardens and a seed bank (Grant and Wilson 1995). The directors of this project, Jimmy Wilson and Austin Grant, Jr., Sac and Fox members, teach others how to grow and preserve these traditional foods. Their objective is to see more and more families taking an active interest in growing their own healthier and more natural foods, hopefully, at a lesser cost than purchasing them at the market today. The project also provides access to information and assistance with gardens to all native people who are interested in growing traditional foods as part of their diet. Although budgetary constraints have set the project on hold for the moment, it has already been somewhat successful. Future plans are to continue with

> direct assistance to families in their efforts to increase their food self-sufficiency through: generating fresh food and livestock; developing vegetable and fruit gardens/markets/cooperatives; increasing buffalo and cattle herds; preventing soil erosion; planting family and cooperative gardens; and building ponds (Grant and Wilson 1995).

Just gimme the damn cheese. I wanna go home!

As mentioned earlier, one of the primary factors contributing to poor health among native peoples often begins with what is eaten, that is, one s dietary intake. Usually, what is purchased and eaten is based on economics, availability, and personal taste. How much food does it take to feed a family of, say, six, and how much will it cost? The answer? Food items are often chosen based on the premise of purchasing the most product for the least amount of money, such as bulk food items. Bulk foods are usually high in refined sugars and carbohydrates, fats and starches, and only provide empty calories that contribute to obesity. The ease, quickness, and prevalence of relatively inexpensive fast food places like McDonald s does not help either.

Food is costly. People on low or fixed incomes are often faced with a dilemma when choosing which food products to buy. Very simply, it means choosing between quantity or quality with whatever money is available. It then becomes a challenge to purchase as much as possible of the highest quality food product for the least amount of money.

Native people may receive assistance through programs that help families purchase needed food items, if they qualify. Assistance is available from various government

agencies. One food program includes food stamps at $71 per person/per month (FNS/USDA n.d.). Other programs are at no cost to participants, but they must qualify. These include WIC programs, and food commodities. In any case, whichever program is chosen, eligibility becomes a major issue, whether the participant is Indian or non-Indian.

Case Study Number One.

Sam was an old man, a full-blood Pawnee, and here he was standing in line for some commodity cheese. He had driven the thirty-three miles or so to go to the Pawnee Health Clinic. While he was waiting for the doctor, he overheard people talking about the excess commodity cheese that was available from his tribe. Most everyone there at the clinic had gotten their share. They knew Sam was a tribal member, so they asked if he had gotten any cheese yet. There was plenty to go around. So they told him to go get some. After thinking about it, Sam realized that appointments did not really mean very much since names were called from a sign-in sheet. He decided to go and get some cheese. Even though he was eligible to get his commodities only from the Sac and Fox tribe, he thought, Why not? The Sac and Fox have a satellite distribution center in the town of Cushing, which is where he, his wife, and granddaughter live. The last time he went there they did not have any cheese. So there he was, standing in line at the Pawnee distribution center one more time while his wife and granddaughter waited in the car. However, he was disappointed.

A converted kitchen at the Roam Chief Building in the Pawnee tribal complex served as the commodity distribution center. As Sam neared the center, he saw there were still plenty of cheese blocks remaining. He thought, All that cheese. How come

they got so much and my distribution center didn t get any? Strange. Surely, I can get one block of cheese. He smiled at the thought, glad he had driven to the clinic that day. He had not wanted to make that long drive but decided he could not put it off any longer. He really needed to see the doctor about his diabetes and renew his prescription.

Finally, Sam was at the head of the line. Since he knew the men handing out the cheese, he joked with them and asked, Some cheese, please. During the conversation Sam casually mentioned they did not have any cheese where he got his commodities and had heard his tribe had received a surplus of block cheese. Sometimes, the federal government did that. It would seem there is a logistics problem with the distribution of commodities as food commodities are never assigned to centers on an equal basis, but on a random basis. He never understood why one tribe would get a whole room full of some food items and another tribe would get none. Strange, he reflected again. He had traveled a long way, but had thought, It ll be worth it.

He told the men he had heard there was some surplus cheese and had come to see about getting some. The men said they would like to give him some cheese, but since he was not eligible at this center, he would have to go and see the tribal administrator and get his permission. They could not break the rules, but they were sure he would get the authorization, and, besides, they were accountable for every block of cheese handed out. They were not too concerned since the men knew Sam had kinship connections, and, after all, he was a tribal member.

Sam understood and headed over to the tribal administrator s office. Confident he would get the authorization, he entered the office. After greetings, Sam told him he

heard they had an excess of cheese, and he wanted some. The tribal administrator said he could not give him any. He was ineligible. Acting every bit like a tribal administrator, he said, Rules are rules. Can t break em. Not even for you. Again, Sam said, he knew he was ineligible here at the Pawnee tribal complex but believed that the tribal administrator could authorize it. After all, there was so much cheese. He needed some and it would just go to waste otherwise. Words were exchanged, and finally, Sam said, Son, I m tired. My feet hurt, and it s gettin late. Just gimme the damn cheese, I wanna go home! (middle-aged, Pawnee, M, machinist).

The kinship connection? Sam was the tribal administrator s father and was surprised at his son s refusal. He scolded his son in a manner consistent with traditional kinship behavior. Somewhat hurt, angry, and disillusioned, Sam left his son s office disgusted and shaking his head. How could his son treat him like that? He was unable to understand why his son would not share so much cheese with others and just let it spoil like that. It was not like he asked for something they did not have. He was asking for something they did have. His son had the power to authorize the request but responded in a negative way, a way that was hurtful to him. Sam sensed that and it both saddened and angered him. The tribal administrator could have used his power and authority to do good by sharing the surplus. Instead he refused. His actions violated traditional behavior which placed a value on sharing with others in need.

Such non-traditional behavior has far reaching consequences. There had been so many blocks of cheese delivered to the tribe all of which could not be distributed. All eligible tribal members authorized to receive blocks of cheese had all they wanted and all

they could use. In fact, many of the recipients had even given away blocks of cheese to their relatives living outside the distribution region, and there was still plenty of cheese. Kinship connections are strong in Indian communities and communication is quick. It did not take long for everyone to know about the excess cheese. It would be hard not to know. No doubt others would have been grateful for a block or two. It was a much sought after food commodity. Healthy or not, everyone liked it.

Cheese is a perishable food. Without refrigeration cheese cannot be safely stored for a very long time before it spoils. When fuzzy green and white mold begins to grow, that is a pretty good indicator to get rid of it. What happened to the leftover cheese? It was rumored that it was stored in a corner of the converted kitchen until it spoiled. Then, a hole was dug and all the leftover cheese was buried. This event was an embarrassment to the tribal administrator and a source of ridicule for everyone involved. In time, the embarrassment subsided and the ridicule died as the incident just faded away and no one talked about it anymore. Cheese is not good for diabetes, anyway.

Traditional kinship behavior has always been consistent with sharing excesses with those in need. The tribal administrator could have given some cheese to Sam and even given the surplus to any other tribe who had none if he had wanted to. That would surely have been a display of respect for traditional values. However, there is a hidden qualification, a catch. Federal guidelines for food distribution programs restrict the sharing of federally funded food commodities. Food commodities are assigned by region and cannot be shared. The case study cited above gives the impression that letting food spoil is compatible with federal policy.

So what about Sam? Sam lived outside his tribe s jurisdiction and in another tribe s area. He had to get his commodities there. And the cheese? No, Sam never got his cheese from the tribal administrator or from the commodity distributors. But he did get his cheese two blocks. When Sam returned to the clinic, his friends asked if he had gotten any cheese. Surprised that he never got any and that his son refused to authorize it, they sent one of their own relatives home to get the cheese. Since they received more cheese than they really needed, or could use, and following traditional behavior, they shared what they had with him. In the end, although his own son refused his request, Sam still got his cheese.

Tribal participation in food commodity programs is based partly on treaty negotiations between the federal government and certain tribes/nations. At the individual level, recipients are able to choose whichever food program benefits them the most. But first, they must qualify. To qualify, tribal membership is required and recipients must reside within a region serviced by a commodity food program sponsored by a tribe. With that in mind, residence location becomes an integral factor in determining eligibility. Although residing within the resident s tribal jurisdiction is not necessary, it does determine where the recipient will receive the commodities. This was the issue that Sam faced.

Food Commodities and the Origin of Frybread

Food Distribution Programs on Indian Reservations (FDPIR) are administered by the federal government. They regulate food commodities to low-income households living on Indian reservations, and to American Indian households residing in [Oklahoma] that contain at least one person who is a member of a Federally-recognized tribe (FNS/USDA n.d.). In the Perkins Tryon area, there is no food commodity distribution center. The Iowa tribe chose not to have its own. It was not that they could not establish their own center, it was simply not cost effective. It was more cost effective to contract with another tribe for that service.

The Iowa tribal administration contracted with the Sac and Fox Nation in Stroud, Oklahoma, to provide food commodities to the Indian communities of Perkins and Tryon. The Sac and Fox Distribution Center is located approximately 32 miles southeast of the Iowa tribal complex. Under contract, they have been providing food commodities for the residents of the Perkins Tryon Indian communities since the early 1970s. At that time, as a support system for the main distribution center and a convenience to the customer, satellite distribution centers were developed. Most satellite centers are only temporary and are usually housed in trucks, which are easier and more convenient to the distributor and the customer. For a while, a food distribution truck was sent to the Iowa tribal complex once a month. It was convenient, but the selection of food items was poor. Eventually, the food truck project was abandoned since participants found alternative ways to get to Stroud for their commodities.

Food commodity recipients have explained that this is how it works. The

participant applies, qualifies, and, when accepted, is assigned to a region near his or her residence where a food commodity program is established. Every six months, participants must re-qualify. After qualifying and before receiving any food, the recipient first goes to the office to check-in. The quantity of food is determined by family size. If there are six family members, they receive an allotment of sixteen or so cans from each category (fruit, vegetable, meat, dry-goods, et cetera).

At the office, the recipient is told what is available from a master list sent by the Stroud Distribution Center. The recipient s choices are marked on their list to be presented to the distributors at the warehouse or truck (when the truck was used). They said, it was always interesting to see how much of the recipient s list would actually be filled with the marked food items.

> I remember years ago we d go to the tribal complex for our commodities. A truck would be waitin at the north end of the complex and in the back we could see cases of food. We d give the guy our list with the foods we wanted. Then he d disappear in the back of the truck and a little while later would come back with cases of canned goods. Depending on what we qualified for, we d get ten or twelve or more cans of fruit, vegetables, and meat, and sacks of dried goods like flour, cornmeal. Some of us even got boxes of farina. We took our supplies to the car and sorted through it. Usually we got corn instead of green beans, peaches instead of pears, and pork instead of beef. Some sort of arrangement like that. We never seemed to get what we ordered. And there would be a whole bunch of it. Thinking back, it must ve been a sight for sore eyes. All us people in the parking lot with different kinds of canned goods we got but didn t want. We d walk from car to car and ask if anyone wanted to trade peaches for pears, or pork for beef, and so on. So that s how we d get a variety of foods, by exchanging them for what we wanted. It worked most of the time. Sometimes, though, it didn t, and we d end up with twelve or fifteen cans of spinach or something we had no use for. But always it got put to good use. We never wasted any. Food was food, and well, someone would eat it.

> Oh, yeah, and we always gave some of our commodities to other family members who weren t eligible to get any. It was also a good time to visit and find out how Aunt Tilly was doin after her hip operation; or how little Johnny hurt his arm; and how was grandpa s blood pressure lately. Quite a little flea market back then. Found out later the truck was loaded with leftover foods from the main distribution center. All we got was the food no one else wanted. So that s why we never got what we ordered. Buh! Must ve made some people upset because less and less people were comin to the food truck every month and finally it just quit comin . Next thing I knew, we were told we had to go to Stroud to get our food (adult, Pawnee, F, food service).

Ideally, the food list would be filled with what was requested. In reality, the truck often did not have what was on the list, so the list would be filled with whatever was on the truck. This was one reason why many of the recipients told me they tried to arrive at the distribution truck as early as possible.

The distribution office had a list of foods that should have been on the truck, but it never seemed to be accurate. One reason for this was the Stroud distribution center may not have put some of the listed food items on the truck. For example, some of the products may have already been given out at the main distribution center before the truck was loaded, or the list may have simply been outdated. In the end, no one really knew what was loaded on the truck. Even those in charge were not really sure, Emma explained.

> That s why we d end up with, maybe, 14 cans of asparagus and two cans of beets. And someone else would end up with 24 boxes of farina. We were eligible for 16 cans of each category and they would ask us what we wanted. Then, when you got to the truck, they would fill the order with as much of your request as possible and supplement with other foods from the same category, like corn for potatoes. That s why you tried to get there early because there was a better chance you would get what was on your list (adult, Otoe, F, retail).

If recipients were early enough, they could take home a variety of goods, like canned potatoes, corn, green beans, spinach, peaches, pears, and even luncheon meat. Bulk products came in boxes or sacks, such as powdered milk, bleached white flour, macaroni, rice, and so on. What was most surprising was that coffee, tea, and sugar were not commodity options. I thought those products would have been a major food item.

Almost always there was oatmeal. Always there were boxes and boxes of raisins. Several comments were made about how much they liked homemade oatmeal-raisin cookies. It is no wonder with the large quantities of flour, oatmeal, and raisins that the recipients received. Food was mostly homemade from scratch. The household cooks were clever, creative, and skilled. With commodities such as these, they had to be. Another comment was that it seemed as if the food coordinators did not really care if the distributed foods actually contributed to a healthy diet.

> They didn t care if the food was starchy or fatty. They didn t care if you had diabetes or high blood pressure. Food was food, and it didn t matter if it was helpful or harmful to your health. I think what we got was pretty close to the rations that were distributed on reservations years ago. I think that s why fry bread came along. You got a lot of flour and lard and we had to be creative. Thus, frybread (middle-aged, Pawnee, M, machinist).

Most of the frybread I have helped make was prepared outside in anticipation of a feast of some kind or for a family dinner. Fry bread, the Indian staple, is made by the dump-and-pour method a little salt, some sugar, and a measure of yeast or baking powder, which is then added to flour, and mixed with warm water to a malleable consistency, i.e. dry enough to handle, wet enough to stick together.

Originally, commodity flour was used for this process. However, with the

appearance of self-rising flour, many Native people use that instead, although it is not on the list of commodity items. Self-rising flour saves time and there is no measuring of yeast or baking soda. The flour mixture is placed in a bowl and set out to rise. Later, the raised dough is made into round, thin patties. Once flattened, the dough is placed into hot grease to fry.

Outside, frybread is cooked in a tub of grease that has been heated over an open fire. Inside, grease is heated in a large cast iron skillet. With either method, frybread is cooked until it reaches a medium brown color and a rather firm consistency. One caution is worth mentioning. I found out the hard way. Do not poke the frybread with a fork! It creates a hole where grease can enter and this will make the frybread soggy. Otherwise, frybread can be eaten with anything, even as a desert with cinnamon sprinkled on top, yum! At feasts where I have attended and helped cook, frybread has been eaten with traditional meals of corn soup, chicken and hominy, and boiled beef.

Canned Beef or Frozen Buffalo: Decisions, Decisions, Decisions

Variety and availability of food products in the commodity food program have changed. In the past, recipients had very little choice in the products they received. Canned goods and dry goods were just about the only food items distributed to participants. Today, according to the USDA Food and Nutrition Service (FNS), the types of commodity foods available to participating families is broad and varied. Ideally,

participants choose from a variety of food products which are intended to provide a balanced diet. The food package includes:

> " frozen ground beef and chicken; canned meats, poultry and fish
> " canned fruits and vegetables; canned soups; and spaghetti sauce
> " macaroni and cheese; pastas; cereals; rice; and other grains
> " cheese; egg mix; and nonfat dry and evaporated milk
> " flour; cornmeal; bakery mix; and crackers; low-fat refried beans; dried beans; and dehydrated potatoes
> "canned juices and dried fruit; peanuts and peanut butter; corn syrup; vegetable oil; and shortening (FNS/USDA 2004).

Although commodity food items have improved and now include frozen meat and fresh fruit, in reality, the majority of commodity food items given to recipients of this program contain little nutritious value and can still be harmful to individuals. For example, canned processed meat contributes to colon cancer, the high fat content of cheese and lard, and the high salt content of canned goods contributes to high blood pressure and heart disease both prevalent diseases among the Native population. It is strange how the federal government fails to meet American Indian nutritional needs.

As mentioned earlier, there are many food programs available to help low income families. However, participation is limited to a single program. Choosing a food program that meets all of a family s needs can prove to be challenging. For example, an individual who chooses to participate in the food commodity program is no longer eligible to receive assistance from WIC programs or food stamps. Accepting food commodities over other food programs will provide food items at no monetary cost, but a high dietary cost.

Today, recipients who decide to participate in the food commodity program have choices. They can choose fresh fruit instead of canned fruit, or some combination of the

two. For example, bags of apples and oranges are a nutritious favorite among children, so parents occasionally choose this commodity item over canned fruit even though they receive less.

Participants also have a choice between canned meat and frozen meat. In the past, beef and pork were all canned. Recipients who choose canned meat receive a larger supply of beef and pork than they would receive of frozen beef, buffalo, and chicken. Those who choose frozen meat receive five cut up chicken fryers, one five-pound roll each of ground beef and ground buffalo; whereas, others would receive the alternative of one case each of canned pork and canned beef. It is a tough decision, and once again the choice is between quantity or quality.

Food items lacking within the commodity food program include packaged goods. No convenience foods are available in this program. Cookies must be baked from scratch, and oatmeal-raisin cookies are still favorite treats, as mentioned earlier. Sugar and salt are not a part of the program, nor is coffee or tea, but even more amazing, butter is. Participants can choose between less butter or more vegetable oil.

_____Case Study Number Two.

Sarah (cashier) is a single parent on the Iowa tribal rolls and listed as the head of the house. She has three minor children living with her in her elderly mother s house. The house was built by the tribe for tribal elders. It has four bedrooms and one bath. Often, other relatives stay with them, and, typical of cultural behavior, Sarah feeds them when she can. Her mother helps care for the children while Sarah works and often fixes their meals. Neither Sarah nor her mother would hear of denying family or anyone else a

meal.

Sarah goes to the Sac and Fox food distribution center to get her commodities once a month. Often, it is her only source of groceries. She knows food stamps and the WIC program would provide food for her and her family. However, with the nearby Perkins market she would receive more food on the commodity program.

Sarah lives in Perkins and it takes her about 35 minutes to drive to the center. Always she hopes her car will make it. It is a concern to her to have to drive so far, especially if she has to take her children with her as she often does. She worries her car will break down, and, with the cost of gasoline so high today, she worries she will not have enough gas money to get there and back. Relatives are not always available to take her. She lives a day-to-day existence.

Sarah has told me that before she goes to the center she must call and make an appointment. Only so many people are allowed inside the distribution center at any given time, usually ten to twelve persons. When she gets to the food center, she checks in with the receptionist in the waiting room. It is like having an appointment with the doctor. She is handed a checklist and told to mark the items she needs. The quantity she will receive is based on the size of her family. It is calculated on an equation of so many items per so many family members residing under one roof. Obviously, the more family members living at the residence, the more food items assigned to the head of household.

As Sarah awaits her turn to shop she notices the other people waiting to do their shopping. There is an elderly woman with a teenager, a young couple with a baby, and several single women of varying ages. She is glad she came early and that her mother

was available to watch the children this time. Finally, it is her turn and she pushes the shopping cart to gather the items on her list. She had to substitute a few cans of corn for peas, and decided that this month she would get the canned fruit instead of fresh fruit because it would go further. It was tougher deciding on the meat allowance frozen or canned? Finally, she opted for the frozen meat. Somehow, she would stretch it to last the entire month. She even had a few cans left over from last month. Maybe that would work. She checked out her groceries, pleased with how much food she had gotten and bagged them, loaded them in the car, and headed for home.

In Those Days and In Those Places

Prior to relocation, the American Indian diet was based on natural foods acquired and consumed seasonally. Plains Indians were accustomed to natural foods like buffalo, wild game, fruits and nuts, roots, corn, squash, et cetera. What they could not find or grow, they received through trade.

In those days and in those places, the Ioways were a semi-sedentary people who used the natural environment to their advantage. They gathered seeds, nuts, roots, and berries in season. They planted crops, such as corn, beans, squash and pumpkins. Their crops were not planted as modern gardens are today in neat rows free of weeds, but in bottom lands, near streams, intermixed with the natural environment. Often crops were planted two or three together. In that way, the crops would replenish the soil and support each other. In addition, if a disease wiped out one crop, at least there would be others to

rely on. Fish from nearby streams were integrated into their diet as were clams and mussels. Once the meat was extracted and eaten, the shells were used as tools. Their diet was not a diet that solely relied on vegetables and fruit. In fact, at one time meat was their primary staple. Hunters hunted buffalo, deer, and elk. Boys often searched for rabbits and caught turtles. These foods provided a well-balanced, complete diet.

One example of a primary staple is the buffalo. Buffalo contains more protein and less fat than beef (see chart 1), which currently contains lots of antibiotics. This is why buffalo meat is becoming more and more popular as a food source. In fact, not far from where I live, the Iowa tribe is raising buffalo as part of their agricultural program. So is Junior. He has fifteen buffalo.

Nutrient Composition
per 100 grams of cooked lean meat
USDA Nutrient Data Base

Species	fat grams	calories Kcal	cholesterol Mg
Bison	2.42	143	82
Beef	9.28	211	86
Pork	9.66	212	86
Chicken (skinless)	7.41 (skinless)	190 (skinless)	89

Chart 1 USDA.gov

Junior (adult, M, law enforcement) is a mixed-blood of Anglo, Otoe-Missouria, Ioway, and Pawnee descent. He is a Pawnee tribal member who lives in the Perkins Indian community. He leases an eighty acre former allotment across the highway from the Iowa tribal complex. He started raising buffalo about five years ago, after purchasing a bull he named Butch, and two cows. Gradually, he purchased more buffalo cows until he reached a total of eight adults. Within the last two years, seven baby buffalo have been born. Each spring, we anxiously wait to see how many new calves will

be joining the group. As of spring, 2005, he is expecting four more buffalo calves. Junior hopes to build a small herd and be able to market them somewhere. He talks about opening a small BBQ stand and serve ribs and buffalo burgers. He makes the best traditional Indian frybread for miles around. He tells me his ribs and frybread should be especially popular during the summer powwow season.

Times have changed and so have diets. Traditional diets for the Ioway people consisted of a variety of foods that were hunted, grown, and gathered. In good years, it was a very complete diet with all the essential nutrients the Surgeon General says are important for a long and healthy life. In lean years, it was a bit tougher to maintain a complete healthy diet, but Native women (Ioway women included) were industrious and thrifty and knew there would be lean times, so excess foods were preserved the old-fashioned way. They dried it.

In the past, Native peoples preserved foods naturally by drying. Drying foods preserved nutrients and allowed for easy storage, efficient use, and convenient portability. This practice is still done today in some households. Many Native people still preserve some of their foods in this old-fashioned way. While visiting one day, Lewis shared his memories of making dried meat. Back then, it was called stripped meat because pieces of meat were pulled away before it was eaten.

> My mom made the best dried meat. When I was young I d come home from school and find strips of meat hanging everywhere: over door frames, on drying racks, anywhere a strip of meat could be laid out to dry. Today beef is used, but in the old days the men went and got buffalo. I hear buffalo can still be found if you know where to look for it. Well, anyway, after the meat was cut into wide strips, Mom would pound the daylights out of it. Then, it was laid out to dry. Once the meat was dried, it would

> keep for months. Women did this in the old days and it would last through the cold winter months or through hard times. They called it stripped meat because we had to pull strips off of it before we could eat it. Mom would give this to us kids to take to school for lunch. Best thing about this food was it was portable. It sure kept your stomach from growling (adult, Otoe, M, supervisor).

Food preparations were successfully managed without the help of modern appliances or technology. All it took was a little time, labor, and creativity, something most of us today shy away from, except Emma s momma. She always made her sand plum and persimmon desert the same way, by hand. Emma fondly reminisced how she made it. It was the best dessert. I was ready to try some when she finished her story:

> Momma used to make us dessert. She said it was the way her momma made it. Sometimes, my sisters and I helped. During the late summer months, she d ask us kids to go find persimmons and sand plums. It was hard to leave playing and go pick fruit in the hot sun but we knew what momma would make for us. When she got the fruit all together, she would press out the juice to use for later and dry the fruit. Then, she would pound the dried fruit into a powder, mix it with commodity flour and fruit juice. Next she rolled it out and put it into a pie shell and sprinkled it with cinnamon. Then she d bake it. It smelled so good. And taste? It was the best dessert I ever ate. I can still smell it when I close my eyes (adult, Otoe, F, retail).

As I inquired about what foods were prepared and consumed back in the old days, I was told about another food that was used for dual purposes. The Otoe call it *wasunýe,* or journey food. It was called journey food because it was portable and easy to take along when going somewhere. It also kept for a long time, was a good source of protein and energy, and it tasted good. They would make it when the ingredients were plentiful, usually after a hunt or during autumn. Once it was prepared, it was wrapped and stored in bundles for later use. Then, when they had to move camp or go somewhere they would

have food already prepared to take with them. It was an easy, portable food that anyone could use. In fact, I helped make this during a field school one summer. It really does taste good. There was another use for it as well. The Native American Church used this food as a type of sacrament in their meetings. They still use it today.

When Nellie (adult, Ioway, casino worker) was a little girl she used to watch her mother make *wasunýe*. Ground beef (or buffalo) was mixed with molasses and pecans or walnuts (whichever nut meats were available). It would be rolled out, spread in a cookie sheet, and baked. When it was cool enough, the procedure would begin all over again. The mixture would be ground, molasses and nuts would again be added, and it would be spread in a pan and baked. This process would occur at least three times, until finally after the third baking and cooling, the dried mixture would be stuffed into a meat grinder and ground into a fine powder. The powder was then wrapped in personal-sized bundles and stored for later use. Nellie said she used to take it to school for lunch. When times were tough and food was scarce, this provided good nutrition and would get her through the day.

In those days and in those places, food was preserved naturally. Most of the foods took time to prepare. Today, we operate at such a fast pace no one takes the time to make foods from scratch anymore because we have other things to do with our time. So, today we eat fast foods and frozen dinners. Grocery stores and food producers have found ways to package food items for our convenience in a variety of ways. So, if we do decide to cook from scratch we can conveniently get a box of pre-mixed ingredients to quickly make our favorite cake, or scalloped potatoes, or fajitas, or even fry-bread! They

are all full of sugar, salt, and lots of preservatives.

Additives and unnatural preservatives in food, and crop hybridization were not necessary in the old days. Those processes are primarily intended to increase the shelf life or growing season of a product, not its nutritional value. Besides, it is more economical for the producer. Native peoples had natural ways to preserve their foods. It was not necessary to keep food products for such a long time as we seem to think we need to do, today. So, now we can fill up our pantries and freezers with all kinds of favorite boxed and canned foods that will probably keep fresh well into the next decade.

I wonder how long the box of frybread I saw in the grocery store the other day would last? Yes, even Indians have gotten into the act, and now if you are pressed for time, or not sure how to make that fried bread you heard so much about, you can go to your grocers and buy it off the shelf. Everything is there, just add water. You can even read about the origin of frybread, romantically stereotyped as it is. Just in case you were curious, it is on the back of the box.

> When the Buffalo were all gone from the prairies and the plains tribes were confined to the reservations, the starving Indians were issued commodities to survive. . . . out of the wheat flour that was so alien to their cook fires these ingenious people created a wonderful new concept for bread. . . . Indian Fry Bread. . . . (Woodenknife 2004).

Review of the Chapter

Throughout this chapter I have explained the challenges that Native peoples face when attempting to feed their families. Economics has much to do with food selection. The chapter includes sections on nutrition, economics and food accessability issues. Overall, families struggle to make the best decisions on food selection based on economics and limited choices. The result is Native heads-of-households experience difficulties in providing their families with nutritious quality food at affordable prices. The inability to provide healthy nutritious foods puts families at risk for disease and illness.

Food programs are available to help families but there are qualifications and other restrictions making access to such programs a challenge. Two case studies provide interesting examples of access to food products through commodity programs. Growing traditional Native crops is one solution if time and space permit. One Native group is providing the ways and means to see this a reality by attempting to teach how to grow traditional foods. Old habits die hard, and it is often easier to justify purchasing non-nutritious, fast foods than it is to prepare a more expensive quality meal.

Part V

Conclusions

Chapter Nine

The End of the Road

It was around dinner time when I heard the sirens. They got louder and louder. Looking out my window I saw an ambulance drive by my house and stop down the street. It was dusk, about 6:15 p.m., and cold. My police scanner indicated that someone had passed out and fallen. Curious to know who it was, I ventured outside. An elderly Otoe woman I had met years earlier lived in the house where the ambulance now parked. She lived there with her grown son and two grandsons. A grown daughter, her husband, and two granddaughters had also recently moved in. Temporarily, they said. The house is not that big. I wondered where they all slept. Soon the tribal police pulled up along with the Perkins police and some volunteer firemen. I figured the elderly woman had died. The ambulance drivers put someone inside the ambulance and drove off. The family followed close behind.

At one time, I worked with the daughter s husband at the casino until he was laid off. So, when he returned from the hospital, I felt comfortable asking him what had happened. It was not the elderly woman but his wife (the elderly woman s daughter) who had passed out. Poor eating habits and excessive alcohol consumption had eventually led to diabetes. Complications of her diabetes then led to kidney failure. She needed dialyses treatment every few days and because their car had quit, she was not able to get to the hospital for treatments. A few days later, I saw her. She said she was weak but alright. It had sure scared her.

They use Indian health services and, for treatment, she must go all the way to the

IHS-approved Shawnee Medical Center instead of the closer Stillwater Medical Center. For a while, when Indian health service funding was plentiful, she was allowed to go to the Stillwater facility. But that did not last long and, within a few months, she was told she had to return to Shawnee for treatments.

Soon after her hospitalization, they borrowed a used car until they could pay for it over time. At least, now they could get to the medical center for treatment. The husband found another job and they moved out of the elderly woman s home, relocating to Shawnee. The husband is Shawnee and Otoe. I heard they moved in with some of his relatives. I see the car around town every once in awhile.

This story ties together what I have been writing about in my dissertation. Social, political, and economic networks interconnect and are activated on the local level. As a result of inter-agency cooperation, tribal and city police both responded to the emergency call, as did city volunteer firemen. Dialysis treatment is expensive. Without Indian Health Services and with no health insurance, it is doubtful that the patient would have received any treatment at all. Prognosis for a long life would certainly be curtailed. Proof of Indian identity and tribal membership was required for health services and since the patient was a card-carrying member of the Otoe Nation, and her ailment was one of the listed priority medical procedures, she was accepted into the program. In other words, she had proof of Indianness and was sick enough to qualify. Her emergency occurred at the beginning of the fiscal year when the IHS had a full bank account. Without an extended family network and with a high cost of living, it is anyone s guess where the patient, her husband, and their children might have ended up.

Research Summary: Pulling it All Together

This dissertation began with a story and ends with a story. Stories and first person accounts give the teller a voice. Native voices provide meaning and substance, emphasis and realism to sometimes traumatic events. It is an outlet for others who can identify with similar difficulties associated with acquiring and maintaining health. The reader is allowed a glimpse into the real world of Native people on their terms. An ethnographic approach provides a measure of reality to the study, and gives insight into how they view their world. It is important that Native voices be heard.

Native people have seen and experienced a myriad of changes directly affecting their lives and health since colonization. By presenting a Native viewpoint, it is hoped the reader will gain an understanding of how complex Indian identity is, its importance in the Indian world, and how it is tied to access and participation in health care services. It is why I have used this approach.

I have also incorporated a second, more theoretical approach, political economy set within a historical context. It provides a means to explain how and why tribal governments are able to do what they do for their members, their community, and their future. I find that both approaches complement each other and provide a measure of understanding and clarity to the dissertation.

The political economy of tribal governments begins with an overview of sovereign issues. I provided the background and justification of the federal taking of land in exchange for services. At one time, Indian tribes/nations were dealt with on a nation-to-nation basis with power and control being somewhat equal. Quite simply, tribes had land

and Europeans wanted it. Through time, an enormous amount of land was transferred from tribal nations to the federal government through treaties, policies, agreements, and laws. In exchange for the federal acquisition of Indian land, concessions and reparations had to be negotiated. Negotiations included federal responsibility for providing health, education, and human services to Native people who were affiliated with a tribe. Service delivery took time to develop placing tribes in a tenuous position. For a while, their ability to provide goods and services for their people was severely curtailed.

At this point, I argued that health care for Native people was segregated by policy and legislation. Separated from the general population, health care was provided primarily as a preventive mechanism to curtail the spread of infectious diseases. Later, it was offered as a civilizing tool. Today, many tribal governments, through asserting their sovereign rights, have begun to develop new ways of providing programs and services for their people through taxation, gaming, and retail outlets. These ventures have been successful as evidenced by the increased availability of health and human services to tribal members and, police and fire protection to rural communities. All these activities are evidence of renewed sovereign strengths by tribal governments. Tribes now have a voice in their own destiny and are being heard. As a result compatible legislation and policy has been passed providing avenues for economic development. Tribal administrations have the potential to provide more health care options to tribal members than ever before. All they need now is to implement them.

I continued the historical overview of tribal governments with a focus on jurisdiction issues pertaining to the land status of Indian country within the state of

Oklahoma. Indian country in Oklahoma with its posted tribal boundaries are no less Indian reservations than in other states that have official reservation status. Thus, tribes in Oklahoma have the same sovereign abilities as other states who have tribes/nations residing within their borders. The significance of this for access to health care services stems from Oklahoma s unique relationship to the many diverse tribes residing here. Confusion over jurisdiction boundaries results in confusion over resource allocation. I learned how complex this issue is and the problems associated with it.

Due to the many tribes dispersed throughout the state, health care resources tend to be fragmented over a wide area. This leads to friction when facilities lack a wide range of resources and are inconveniently located. Transportation to a health care facility then becomes tedious and time consuming. As a result, tribal members who must travel great distances to receive specialized care, may ignore seeking any health care at all.

I also explain Native American internal perspectives from a world-system framework. Applying a world-system theoretical perspective in the area of tribal governments and health care has been a challenge. Indian tribes and nations (as growing peripheral governments) provided land (a raw commodity) to the federal government. In return, the federal government (as a core area) provided goods and services (as promised by treaty negotiations) to tribal governments. As a result of this transfer, some of the goods and services have taken the form of money, health care, education, and food commodities. Such goods and services filtered down to tribal members through designated channels set up by their tribal administrators. These channels have enabled tribal administrations to develop business enterprises which provides the means, motives,

and opportunities to fund programs and services, including health care, benefitting tribal members with limited success.

In terms of economic development within a world system that links core and peripheral regions, networks exist on both internal and external levels. Networks foster a consumer producer relationship in two ways: first, internally, between tribal governments and tribal members. The tribe produces health care services and nutrition programs through its economic enterprises. Tribal members as consumers participate in tribal programs and services which are linked back to the federal government by way of policies that dictate identity and consumer qualifications.

The second relationship is external, between tribal governments and the federal government. Tribes, again as producers, provide natural resources and the federal government, as broker, regulates, refines, and redistributes them within the market economy which filters the resources back to the consumer who pays higher prices for using them. Either way, these networks are connections linked by economics and politics between core and periphery areas.

Accordingly, in a world-system approach, tribal governments would be connected to a larger core region within a global economy that provides economic opportunities for producing goods and services to its people. Since no nation, today, is isolated from the larger world influence it is no surprise that tribes have been motivated by such notions of economic development. Thus, it is easy to see why it appears tribes may fit within a certain global niche that places them in a peripheral role as economic entities within the larger income producing nation. Whether tribal governments are economically self-

sufficient within the world economic system is a matter of individual opinion. While tribes have changed through time, just as other governmental entities have, many tribal nations have continued to maintain traditional behavior and world views while adopting elements of mainstream economic and political views.

What motivates tribes to enter the world market says much about their perception of sovereignty. On a broader scale their participation is minimal and its impact is all but non-existent. Nevertheless, tribes are captive entities within an economic system that dictates the cycles of the production of goods and services. For example, the federal government sets standards for food production which are often too high for small farms or tribal businesses to meet. Only large agribusinesses can compete and make a profit. They do this through amassing large tracts of land where they grow grains, crops, et cetera, that are then sold on the global market. As is often the case, there are surpluses. Surplus foods are redistributed to the poor, farmers, and to Native peoples as food commodities by the federal government. The federal government buys farmer s surplus produce so that they do not suffer heavy economic losses for overproduction.

The United States distributes surplus food to Native populations, the rural and urban poor, and to subsidize Third World countries. I have since learned that subsidies to Third World countries are received at a cost. Third World governments pay for them. The impact on the local economy is disastrous. The local farmers must compete with the price of the subsidy and lower the cost of their product. Guess what? The local farmers are put at economic risk. So, how does that help the Third World country that requested their help? In the end, the impact of subsidizing is felt on both countries local economies

which is reflected in higher food prices.

In Oklahoma, what agricultural land is held by tribes is very fragmented. There are no contiguous tracts of land large enough to compete with agribusinesses in a global market. Tribes who do have land available for agricultural pursuits, tend to raise livestock, such as cattle or buffalo instead of crops. Crops are time consuming and are at the mercy of inclement weather and equipment malfunction. More economic opportunities exist at the local level for tribes in raising livestock than in farming. Raising livestock is less labor intensive and provides a means of self-sufficiency, albeit limited. However, growing crops would enable tribes to provide less expensive and more nutritious foods for their members. In my research I only found one group, the Thakiwa Foundation, a Sac and Fox organization, who was attempting to do this. At present, the Iowa Tribe has future plans for growing crops. Although, not yet profitable, their cattle and buffalo enterprises are doing well.

So, just how self-sufficient is the Iowa Tribe? Based on empirical knowledge, if it were not for the tribe s economic development, taxes, and numerous grants, it would not be very self-sufficient. But because tribal operating funds are derived from these sources, I believe the Iowa Tribe is somewhat self-sufficient. There is room for improvement. If the tribe were to begin a gardening program and grow crops for the local market, it would make a big step towards self-sufficiency.

Tribal social networks operate within the scope of capitalism, economics, and politics through a linking relationship with the federal government not much different than a tribe s links to its members. For example, the Iowa tribe provides social services to their

members through formal (tribal newspaper) and informal communication channels. Tribes also negotiate with the federal government for goods and services that are then distributed to qualified tribal members.

Networks are not the exclusive domain of a world economic system, but are also reflected in kinship ties. At the individual level I focused on the utilization of social networks for health care and other social needs and continued to develop the concept of Indian identity. Social networks reflect kinship ties. I also examined various structural features and interactional characteristics of social network analysis. Kinship connections are an important part of social networks, especially in the area of social services, such as health care and nutrition services.

Kin relationships are an invaluable source of help because family responsibilities are usually strong. Native people are networked into extended family structures. There are always lots of relatives around, especially when a pot of stew is on the stove. But more than that, when a ride to the dentist s office or medical clinic is needed someone is always around to provide transportation. When it is necessary to visit the pharmacy or a doctor s clinic, which can often take an entire day, having a relative available to help is often the only way some individuals can access tribal services.

When a relative is not available, a neighbor or close acquaintance can often be of assistance. Some friendships are strong. Close acquaintances are sometimes accepted as family, complete with all its expectations. As a close acquaintance of a Perkins Native family, I have been accepted as a family member and included in their family and social activities. They have called upon me for transportation, and even babysitting. When they

were sick, I ran errands, cooked, and mowed the lawn. It works both ways. They have also done the same for me. The friendship is strong and lasting. I have learned quite a bit about kinship connections and Indian identity while living here.

Kinship connections are also a factor in identity. In the Indian world, who you say you are is sometimes more important than the CDIB card in your wallet. How one counts his kin is not all that unique among Native peoples. Most Native peoples have more than one mother, or a grandmother who is younger than they. It is not all that strange to Indians, as it is to non-Indians. This is because the relationship of one to another is not based on the biological connection, but on other factors, like social organization. Even today, such kinship ties are maintained and changed very little.

However, for participation in health care and other tribal services, proof of Indian identity and tribal membership is mandatory. Tribal governments know all about this. It is part of being sovereign. Being sovereign has responsibilities. Providing for tribal members is one such responsibility.

A long time ago it was not necessary to prove who you were, and health care was part of the cultural norm. Tribes had doctors, and if you were sick, he (or she) would do what was necessary to cure you or at least alleviate your symptoms. Today, it is not that simple. Health care is tied to Indian identity. Indian identity is linked with tribal membership, and tribal membership is connected to tribal sovereignty. Tribal sovereignty means having an ability to provide health and human services for tribal members. Tribes must have funds to do this. They use a variety of ways to accomplish this. Receiving grants is one way, economic development is another.

Qualifying for tribal membership is only part of the difficulty of gaining access to Indian health services. Membership in a tribe does not automatically qualify an individual to receive health care. One of the research participants thought the notion of receiving any services paid for by the Indian Health Service was a joke. He was unsuccessful in getting them to pay for anything. The bottom line in participation in Indian health services rests upon economics. I was surprised to learn there was never enough money to meet everyone s health care needs.

So, after spending all that time proving Indian citizenship, what do you get for all that effort? If you qualify, you can get health care, dental care, eye exams and glasses, consultation with a dietician, food commodities, a diabetes test and a blood sugar monitor, a massage, a fitness routine, physical therapy, and even surgery. You get all this and prescriptions too, that is, if you do not mind getting whatever is available at the pharmacy. It is all available at no charge, if you cannot afford it. There is a catch, right? Yes, there is. Only if you qualify for access to these resources, and, according to most of my research participants, qualifying for some of these services and programs can be a nightmare.

I considered the political economy of Indian health and nutrition beginning with a historical overview of the Indian Health Service (IHS). Implementation of health care policies took shape gradually. Initially administered by the BIA, it was soon evident needs far outweighed any ability to provide adequate health care. So, in 1955, the Division of Indian Health was transferred to the HEW agency and subsumed under the Public Health Service. It has remained there ever since. Health care improved over the years and in

1988 opportunities opened for tribes to operate their own health care programs and facilities. Several tribes in my study did that. Three were the Kickapoo, Ponca, and Iowa. The Pawnee Tribe preferred to remain with the Indian Health Service and now have a brand new facility.

The method for IHS funding was the most surprising thing I learned during my research. It is based on a system called the Payor of Last Resort. Again, this means all other funding available to an individual must be exhausted first before IHS will pay anything, and then only if there are funds remaining in their budget. I had always assumed that since Native peoples were entitled to prepaid health care, they always got it. Since the stated goals of the Indian Health Service are to provide the best quality of health care possible to all Native peoples, it was disturbing to find this was not entirely true. It is ironic how IHS funding levels do not allow the agency to achieve its primary goals. Only qualified individuals have access to Indian health services.

This leads me to conclude that Indian health services are accessible only if a Native person is a card carrying member of a federally recognized tribe; only if he or she is diagnosed with a priority medical problem; only if he or she can get a referral for the medical procedure; only if he or she has enough patience to wait for approval of the procedure; and only if he or she is lucky enough to have the procedure completed early in the fiscal year, October 1st to September 30th. That is when funds become available for payment to individual accounts, but only after other financial resources are exhausted. Such an individual beneficiary is indeed fortunate. What is the future of health care for Indians? Only time will tell. One suggestion is to implement a personal health care card

that functions like a debit card to be used by tribal members for health care.

From a nutritional perspective, You are what you eat is an old adage heard frequently. There is some truth to it. American society lives off fast foods and junk foods. The results are evident in diet deficiencies. Consequently, our health suffers. We become subject to obesity, diabetes, fatigue, hypertension, stress, hypothyroidism, hypoglycemia, immune system failure, insomnia, and a host of other modern-day maladies. Native people are no different. They like junk foods as well as anyone. They also suffer the same consequences of a diet deficient in nutrients.

Access to nutritional food products becomes a challenge due to cost. Limited funds require creativity when planning meals. Programs are in place that can help alleviate the high cost of foods. Food stamps, WIC, and commodity food programs are a few ways to reduce costs. However, participation in these programs requires some qualifications. For food commodity programs, a qualification is proof of Indian identity. Purchasing foods in bulk is another way to get by until the end of the month. But, as pointed out earlier, some bulk and commodity food items are not very nutritious. Making ends meet is a challenge and those who can qualify and participate in food programs will be able to reduce their food expenses.

So what about the future of the health care industry for Native people and the general population? Are improvements in access and delivery on the horizon? A political economy of health approach can explain historical and political influences that shape decision making and distribution of health care and provide suggestions for improvement.

Our health care systems, including health care for Indians, is in dire need of repair,

reform, and revision. Presently, the Social Security System is under scrutiny and at risk of being restructured for lack of funds. It is in dire need of repair. Policies affecting the environment, such as the example of Tar Creek, need to be examined and reformed if industry refuses to clean up after itself and continues to put a population at risk for illness and disease. Policies affecting health and nutrition, such as surpluses from agribusinesses need revision to reflect economic factors consistent with the local economy.

Affordable health care means accessible health care. Accessible health care means a healthier population overall. This includes Indians and non-Indians alike. Future research can provide solutions or applications that can influence policy makers to make the necessary changes for the betterment of society. The consequences of not addressing these issues can result in entire populations being at risk of having to depend on the federal government for assistance which it can ill-afford. How can the system be redefined for better access with regard to proof of Indianness, location of services, and adequate funding for services provided?

Results of the Research

Results of my dissertation research were interesting and somewhat unexpected. I expected most Iowa and non-Iowa tribal members would participate in federal and tribal sponsored health care services. Most did not. I expected a few families would have private health insurance, and would also qualify and use Indian health services. They did not. Naively, I expected that if Native people qualified for health care services they would

all receive them with funding not a factor. This also was not so.

What I learned was Indian health care services are allocated based on certain criteria: Indian identity, tribal membership, residence location, seriousness of the medical condition, timing, and funding.

Indian identity:	recipient must prove descent from an allottee or ancestor
tribal membership:	recipient must be a member of a federally recognized tribe
residence location:	recipient must live within a tribe s jurisdiction
medical treatment:	recipient must have a priority medical condition
timing:	recipient must apply early to be accepted for treatment
funding:	recipient must be accepted when funds are available

In my research, participation in health care programs varied by household, and depended on how each tribal member defined his or her need, where he or she lived, and how the tribe defined its service area. Out of twenty households in the study, eighteen qualified for Indian health care. Two did not. Although these two households could prove Indian identity, they could not qualify for tribal membership because their blood degree was too low. They receive health care from the US Public Health Service.

Five households participate in federally-sponsored IHS health services from the Pawnee and Shawnee Health Centers. One household participates in health care services from the Ponca Tribe s White Eagle Health Center. Four households utilize the Iowa Tribe s Perkins Family Health Center. Six households must utilize a combination of services, that is, children and spouses all use different health care facilities due to differing qualification criteria. The last two households have private health insurance from their employers, and although they qualify for Indian-related health care services, they opt not to participate because of dissatisfaction with the quality of care.

All the recipients of tribal and Indian health services access multiple forms of health care. The majority of services used include medical care, dental and eye care, and pharmacy services. Three participants took advantage of the diabetes clinics, and one is currently undergoing physical therapy at the Perkins Family Health Center for an injury. Another participant was approved for contract surgery and physical therapy at a Stillwater facility. Only two participants use the gym at the tribal complex, occasionally. Visits to the nutritionist occurs on an irregular basis, mostly through referrals from the diabetes clinic.

Exploring Indian identification was an interesting exercise in kinship relationships and somewhat expected. No big surprises here. None of the Native persons in my study were full-blood Ioway. However, nine were full-blood Indian with Ioway descent, plus a combination of Otoe, Pawnee, Ponca, or Shawnee descent. Only four mixed-blood individuals had no Ioway descent. They identified themselves as Comanche; Yuchi Pawnee, Sac and Fox, and Shawnee.

Five individuals mentioned they had some non-Indian ancestry as well (Anglo and/or Mexican). But they were reluctant to admit it, because from their perspective, they viewed themselves mostly as Indian. Two individuals were full-blood but were descended from so many tribes that qualifying for tribal membership posed a problem. They could not document their descent, thus, when they sought health care from an IHS facility, they were denied. Indian identity is connected to tribal membership and is the primary means for access to any Indian health-related services.

Residence location is important for access to health care services. Of the twenty

households in the study, twelve live within the Perkins city limits. Six households live within the Iowa Tribe s jurisdiction. Three heads-of-households, moved from Perkins to the small town of Carney, another Ioway Indian community eight miles south of the tribal complex (see figure 1). Two households live in the country on original allotments. Only one household was contacted who lives in the Indian community of Tryon. She works for the tribe providing meal services for the elderly. Other potential contacts from there were always unavailable. Two households moved out of the tribe s jurisdiction. One single parent moved to Nebraska, returned, and moved in with her grandfather in Cushing (another small city twenty miles east of Perkins), and towards the end of my research, one family moved out of the area to Comanche country (near Lawton in southeastern Oklahoma) to be closer to family.

When asked, all research participants identified themselves by the tribe they were members of even though they may have resided near relatives of another tribe. Often they had more cultural ties to other Indian communities than the one they held membership in, such as a mixed-blood Otoe tribal member living among the Ioway in Perkins.

Contributions From The Study

On a local level this research study contributes to knowledge and understanding about health care practices of tribal members residing in the Indian communities of the Perkins Tryon area of central Oklahoma. On a larger scale it provides additional insights into what choices people make when determining health care resources.

This research (1) expands existing data concerning health issues on personal and societal levels; (2) increases knowledge of existing political systems of mainstream government and domestic dependent nations from perspectives of core and peripheral areas; (3) offers insights into the multiplicity of kinship relationships in a social network system in terms of health care access and participation; (4) strengthens awareness of economic hardships individuals face in terms of health care options; and (5) creates cultural understanding of issues related to health care participation and problems of access.

The resulting research data is not limited to those communities but can be applied to other ethnically diverse areas as well. It stands to reason, then, that answers to certain questions, as, what affects a population s access to health care? and what explains environmental influences that contribute to certain overall health conditions? could benefit a variety of communities, not simply a few specific ones.

Throughout the research and writing of this dissertation I thought about how Native people could use this study for their benefit. After reading it, they should be able to identify with some of the stories which may remind them of their own experiences. It could validate the study for them. Reading the text would be useful for expanding their knowledge of tribal governments, federal policies, and health care processes within a world economy. In addition, it could be an incentive, for the Ioways anyway, for beginning a farming or gardening project that would benefit everyone.

Nothing New Under the Sun After All

Negative images of supposedly second-rate health care are still vivid in the minds of many older Native peoples who pass their experiences along to the younger generation. I was told a story of what one research participant s elderly mother endured around 1964, simply to have a boil lanced (middle-aged, Otoe, M, counselor).

> Momma told of a time when she had a boil on her back. Nothing serious but it became painful. She wanted to lance it a simple procedure she was well acquainted with, but she could not reach it. No one was around to help her, so she decided to go to the then Pawnee Indian Hospital and ask them to lance the boil. No big deal, she thought. She told the doctor what she wanted. The doctor wanted to give her a pill and let the boil dissipate over time. She was adamant, NO! and repeated she wanted him to lance it. Period! The doctor proceeded to gather his tools (scalpel, needle, gauze). He explained he wanted to numb the area first before lancing it. She said it was not necessary as it already hurt. Insisting this was procedure, the doctor inserted the needle anyway. The point broke off under her skin. Then they told her they could not remove it because there was no surgeon on duty. She would have to come back the next day to have it removed. Angry and disgusted, she left the medical center and drove home. She only wanted a boil lanced. How big a deal is that? Now her back hurt like crazy. Finally, she asked her husband to go get an elderly Indian neighbor who sometimes did doctoring. The neighbor came and not only easily lanced the boil but removed the broken needle point as well, applied a bandage, and that was it. Weeks later she received a letter from the Pawnee Indian Hospital asking why she never came back and for her to sign the enclosed disclaimer so they would not be liable if she became infected. Talk about adding insult to injury, in the end, she threw the letter away.

Such horror stories like this are not uncommon. They reflect times past about inadequate facilities, uncaring physicians, and the substitution of brand name drugs for generic ones. Distrust occurs when generic drugs are said to be just as effective as brand named drugs, only cheaper. The reality is they are not the same. They do not work in the same manner. Another research participant explained that there is an image of quality that name brand

drugs represent. They just work better. Besides, that is what the doctor prescribed. The subtle distrust that generic drugs are of lesser quality stems in part from horror stories, such as a bad reaction after taking the medicine. Misinformation also occurs when pharmacists say generic drugs are no different and patients are later informed by the physician that there is a big difference between the two. The decision of whether to take generic drugs or try to purchase the more expensive brand name drug is tough. Cost is always a factor. Experiences like these may cause many Native peoples to shy away from Indian health care unless they have no choice. Even though improvements have been made, uncaring attitudes by medical professionals often remain. It is probable such attitudes still persist and influence whether or not Indian health services will be sought.

When generic drugs are substituted for brand name drugs, and when physicians apply band-aid solutions to illnesses, they cause negative psychological effects on those who utilize Indian Health Centers. One research participant (middle-aged, Ioway, F, sales) commented, I must not be good enough for the real drugs because they always give me generic ones. Never mind that they are cheaper. I am always returning to the clinic because they never seem to find out what s wrong with me. Never mind that the treatment was only a temporary fix. That is how it was in those days and in those places. My research indicates, it has changed very little today.

The psychology of mind over matter is a strong influence. The mind can make you sick; the mind can make you well. External influences do make a difference in a person s health and well being. Holistic health care treats the whole being (mind, body, and spirit). It leaves nothing to chance. Many people believe this. Maybe non-belief is why some

people are always sick and do not seem to get well. This would be especially so if negative images are continually reinforced by health care professionals. This fosters a misconception that hoping for a cure is remote. Yet, ironically, we patiently sit and listen while a person complains about always going to the clinic, always seeing a doctor, always getting pills, and still, they are ill. We rarely hear that individuals are ill because they failed to take care of themselves. The next time a funeral takes place, go and listen. You will not hear that the person died because he or she did not take care of himself or herself. Always, it will be something else that caused the death.

It is all about the little guy who is trying to survive in a world economy whose focus is on obtaining low-wage employees and participating in some conspicuous consumption. It is all about self identity, family, and survival. It is all about world views, the world economy, and survival. It is about survival, and survival is all about maintaining good health and good nutrition so you can live as long as you are supposed to. It is about connections to others and connections to self. Connections are a tangled web linked to the quality of life. Who can measure the quality of life? More to the point, who should? In the end, others will decide our fate. There is nothing new under the sun after all. In the final analysis, everything remains the same.

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Appendix A

Questionnaire for Health Care Participants

Interview Date: _____
Interviewee Name/No: _____

1. How many family members are there in your household? _____
   a) Ages. _____ b) Gender. _____ c) Relationship. _____
   Comments: _____

2. Who is the main wage earner in the family? _____
   Comments. _____

3. Are you descended from more than one tribe? Y N
   Which one(s)? _____
   _____Comments: _____

4. If you are descended from more than one tribe who determined which tribe you would belong to and why? Self: _____ Parent(s): _____ Other: _____
   Don t know: _____

   What were the determining factors? _____

5. Do you interact more with the tribe you are enrolled in or another? Y N
   Comments: _____

6. Are your spouse and children also enrolled tribal members? Y N
   Which tribe(s)? _____
   Comments: _____

7. If you had the opportunity to belong to all the tribes you are descended from would you? Y N
   Comments: _____

8. Do you live within your tribe s jurisdiction? Y N
   Don t Know _____
   Comments: _____

9. Are you employed? Where? _____ Y N
   Comments: _____

10. Do you have private health insurance? Y N
What type? Blue Cross. _____ Medicare. _____ Medicaid. _____
Other. _____
Comments: _____

Does it include family members? Y N
Comments: _____

11. Do you have health benefits from your place of employment? Y N
Does it include family members? Y N
Is there cost to you? Y N
Comments: _____

12. Do you consider yourself and your family to be healthy? Y N
Comments: _____

13. Have you or your family had any serious health problems or concerns within the past 2 yrs? Y N
Comments: _____

14. Do you use any method to promote your health and prevent disease, i.e., diet or exercise? Y N
Comments: _____

Does your family? Y N
Comments: _____

15. Have you or other family members visited a physician within the last
6mos _____? 12 mos _____?
For what reason? _____

16. Do you and your family visit a physician regularly for routine checkups? Y N
Comments: _____

17. How far do you live from health care facilities?
within 1 mile _____ 1- 4 miles _____ over 4 miles _____
Stillwater _____ Pawnee _____ ____Shawnee _____
Other _____
Comments: _____

18. What type of transportation do you have to access health services, such as family vehicle, tribal shuttle bus, friend or relative? _____
Comments: _____

19. Do you use any specific Indian Health clinic or tribal health clinic for medical services? Y N
Which one? _____
Where is it located? _____
Comments: _____

20. Do you have a private physician? Y N
How often do you see him/her? _____
Comments: _____

21. Which do you prefer: an Indian Health Service (or Tribal Health clinic) contract physician, or a private physician? _____
_____ Why? _____

22. Do you use or have you considered alternative health care, such as, non-western style medicine? Y N
Comments: _____

23. Do you have any difficulties communicating your concerns with the health service provider you use, such as, communicating with the physician about your illness or understanding the treatment? Y N
Comments: _____

24. What are the most difficult problems you have encountered when attempting to access or participate in health care services? For example, do cultural and language differences cause problems when trying to communicate with the physician? Or does a lack of health insurance, no transportation, high medical costs, or not knowing where or who to go to keep you from seeking help? Y N
Comments: _____

25. Do you use any tribal sponsored health care programs or services? Y N
_____ Which tribe s services or programs? _____
What services? _____
Comments: _____

26. Does it meet your needs? Y N
How? _____
_____ What would make it more accessible or suitable? _____
Comments: _____

Appendix B

Questionnaire for Health Administrators

Interview Date: _____
Tribe/Nation: _____
_____Administrator: _____

1. What health programs and services do you offer qualified participants?

2. What is the criteria to become qualified? (Tribal membership guidelines)

3. Are health care services available to non-tribal members or non-Indians as well as tribal members?

   Y N

   What services? _____
   Comments: _____

   Is transportation also available to non-tribal members or non-Indians? Y N
   Comments: _____

4. Must participants live in the Iowa tribal jurisdiction in order to receive health care?

   Y N

   Comments: _____

5. Why did the tribe decide to purchase a health clinic? _____
   Where is it located? _____

   _____Is it convenient to participants? Y N
   Comments: _____

6. Is the physician a Bureau of Indian Affairs contract doctor? Y N
   Comments: _____

7. What qualifications were you looking for when you hired the clinic physician?

8. Do you have a nutrition program? Y N
   Is it successful? Y N
   How old it is? _____
   How does it work? _____

9. Do you have an exercise program? Y N

Is it successful? Y N
How old is it? _____
How does it work?_____

10. Do you believe your health services and programs meet the needs of the participants? Y N
How?_____

11. Are there costs involved for the participants? Y N
What kind of costs? _____

12. Do you plan to add more services? Y N
What? _____
Comments: _____

13. Do you plan to add a dental clinic? Y N
When? _____
Comments: _____

14. What were the determining factors for providing health care services initially?

15. Do you advertise your health services? Y N
To: tribal members _____ other tribes _____ general public _____
other _____
Comments: _____

16. Do you focus your health care services and programs to any particular age group(s), such as children, elderly? Y N
Comments: _____

17. How are your health care services structured (or modeled after)? _____
_____

Appendix C

Questionnaire for Health Clinic Staff

Interview Date: _____
Interviewee Name/No: _____

1. What services are offered to Native peoples?

    a. Medical
    b. Dental
    c. Eye Clinic
    d. Psychological Services
    e. Diabetic Clinic
    f. Pharmacy

2. How are the services defined?
    Comments.

3. What is the criteria for accepting patients?
    Comments.

4. What medical personnel are employed?

    a. Physician
    b. Psychologist
    c. Pharmacist
    d. Physician s Assistant
    e. Nursing staff
    f. Other

5. Do you accept non-Indian patients?
    Comments.

6. How long has this health facility been in service?
    Comments.

7. What are the hours of operation?
    Comments.