Tobacco:
Telling Our Story

Introductory Report
American Indian Community Tobacco Project

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Executive Summary

The American Indian Community Tobacco Project (AICTP) is a unique partnership between the University of Minnesota and the Twin Cities American Indian community and is funded by the Minnesota Partnership for Action Against Tobacco (MPAAT). The American Indian Community Tobacco Project's efforts are primarily focused on the urban Indian population of St. Paul and Minneapolis. The AICTP is addressing tobacco addiction in the American Indian community by designing, conducting and applying research on the issue. More specifically, the AICTP does this by:

- Utilizing research methods that are consistent with American Indian cultural practices and beliefs.
- Identifying the larger social, historical and policy context within which the urban American Indian population has reached disproportionately higher rates of tobacco misuse.
- Developing intervention strategies specific to the American Indian population that take advantage of the traditional strengths of American Indian people.

This report is the first in a series based on the work of the AICTP. This introductory report intends to provide a frame of reference for the tobacco issues in American Indian communities in and around Minnesota. American Indians and Alaska Natives report the highest prevalence of current smoking among the major racial and ethnic groups in the United States. As a result, the health problems associated with or exacerbated by tobacco misuse (including lung cancer, diabetes, and cardiovascular disease mortality) are disproportionately higher for American Indians.

The topic of tobacco can be a sensitive and difficult issue for American Indian communities to discuss, as it is not merely a link to the current health challenges experienced by these communities; it is also connected to the cultural and spiritual traditions practiced by many American Indian communities. Traditional tobacco use encompasses spiritual, ceremonial and cultural American Indian purposes. Tobacco misuse denotes the use of tobacco for non-spiritual reasons. Other terms to describe this use of tobacco are: recreational use, addictive use, habitual use and tobacco abuse. Commercial tobacco in the form of cigarettes, chewing tobacco, cigars, pipe tobacco and snuff are used for this purpose.

This report gives a brief overview of cultural history from an American Indian perspective. Cultural information will ground the reader in historical federal Indian policy and provide a context for the unique legal and political status of American Indians. This report further provides the reader with information about the health status of American Indians. The framework provided may be helpful in providing insights for understanding the high rate of tobacco misuse and its negative impact on the health status of American Indians.

INTRODUCTION

The American Indian Community Tobacco Project (AICTP) is a unique partnership between the University of Minnesota and the Twin Cities American Indian community and is funded by the Minnesota Partnership for Action Against Tobacco (MPAAT). The AICTP partners joined in a vision of addressing the high rate of tobacco addiction by conducting research that fits the reality of American Indians. The partnership relies on the AICTP Steering Council to guide the project. The Steering Council is made up of individuals from the urban American Indian community who are interested in tobacco issues. The Steering Council has final authority on all aspects of the research. Steering Council members meet on a monthly basis and are paid for their time. In addition to the oversight role, Steering Council members are involved in the collection, analysis and dissemination of the research to whatever degree they are willing. The AICTP co-principal investigators are Jean Forster of the University of Minnesota and John Poupart of the American Indian Policy Center. The following mission statement guides the work of the AICTP: *To determine, as a group, what we need to know, how we can learn it, and how to use what we learn to reduce tobacco abuse among young, urban American Indian people.*

Research by the American Indian Community Tobacco Project (AICTP) is primarily focused on the urban American Indian population of St. Paul and Minneapolis and provides the basis for guiding future efforts to reduce tobacco addiction among urban Indian people by:

- Developing intervention strategies specific to the urban American Indian population that take advantage of the traditional strengths of American Indian people;
- Utilizing research methods that are consistent with American Indian cultural practices and beliefs;
- Identifying the larger social, historical and policy context within which the urban American Indian population has reached disproportionately higher rates of tobacco misuse.

The AICTP gathers information from the American Indian community to guide these efforts using:

- Interviews and talking circles held with elders (55 years and older);
- Interviews and talking circles conducted with adults (18 years and older); and
- Surveys and talking circles conducted with youth (11 – 17 years).

This report is the first in a series based on the work of the AICTP. A second, separate report contains a summary of elders' views on tobacco in the American Indian community. The third report will provide the results of interviews with urban American Indian adults. The fourth report will be the results from the Native Youth Tobacco Survey, a survey created

Members of the American Indian Community Tobacco Project pictured: Back row (left to right): Linda Azure, Julie Green, Jean Forster, Patty Thunder Hawk, Jennifer Irving, Audrey Fuller, Loretta Rivera. Front Row (left to right): Kris Rhodes, Lannesse Baker, John Poupart, Hope Flanagan

for and administered to urban American Indian teens. The American Indian Community Tobacco Project intends to produce future reports to consolidate what has been learned about tobacco in the urban American Indian population.

Producing a report like this is a rare opportunity. The general population has no "frame of reference" about the true nature of American Indians to which it can relate. This report is an attempt to provide a framework to discuss tobacco use among American Indian communities in and around Minnesota. The report defines the various types of tobacco use in American Indian communities and gives a short description of cultural history from an American Indian perspective. This cultural information will ground the reader in the historical federal Indian policy and may be helpful in understanding the high use of tobacco and its negative impact on the health status of American Indians.

Very little information is available to determine why tobacco misuse is higher among American Indians in Minnesota than other ethnic groups. Methodological flaws and distorted cultural worldviews limit the usefulness and validity of published research conducted in American Indian communities. Research findings are typically reduced and taken out of context until they bear little resemblance to the reality or traditions of American Indian people. Rarely are American Indians involved in planning, implementing and interpreting research conducted in their communities. As a result, effective strategies to prevent tobacco misuse among American Indians in Minnesota have yet to be developed.

The AICTP intends to expand knowledge about tobacco use in American Indian communities. More specifically, the AICTP seeks to gain insight into the attitudes and beliefs about tobacco use and misuse, community readiness to address tobacco, and cultural strengths that can be used to reduce tobacco addiction. In addition, it is intended that this knowledge will serve as a basis for developing strategies to reduce the high rates of tobacco addiction in this urban American Indian population.

American Indians & Tobacco

CIGARETTE SMOKING AMONG AMERICAN INDIANS IN MINNESOTA

Tobacco misuse denotes the use of tobacco for non-spiritual reasons. Other terms to describe this use of tobacco are: recreational use, addictive use, habitual use and tobacco abuse. Commercial tobacco in the form of cigarettes, chewing tobacco, cigars, pipe tobacco and snuff is used for this purpose.

The following data on tobacco use among American Indians moved the AICTP to action. American Indian and Alaska Natives report the highest prevalence of current smokers among the major racial and ethnic groups in the United States. Smoking rates among American Indians, however, vary by geographic and cultural factors. For example, cigarette smoking is highest among American Indians in and around Minnesota and lowest among American Indians in the Southwest. According to the Behavioral Risk Factor Surveillance System (BRFSS), 48% of Indian men and 40% of women in this area report current cigarette smoking (Denny, 2003). American Indian youth also report higher tobacco misuse compared to youth from other racial and ethnic groups. The 2001 Minnesota Student Survey, a school-based survey, revealed that American Indian youth are the most likely to have smoked cigarettes in the past 30 days and to be heavy smokers (MDH, 2003).

American Indians in this area have disproportionately higher rates of health problems associated with tobacco misuse as well. In Minnesota, four of the five leading causes of death among American Indians are related to tobacco misuse: cancer, coronary heart disease, diabetes and chronic lung disease (The Great Lakes EpiCenter 2005). American Indians in Minnesota have higher rates of cancer compared to other racial/ethnic groups in the state, and higher rates than American Indians in other parts of the United States; most of the excess is due to the dramatically higher lung cancer rate (IHS, 2004; Seaverson, Perkins et al. 2005; CDC, 2003). Men and especially women in the Northern Plains region have a high rate of diabetes (Gohdes, Harwell et al. 2002; Denny, Holtzman et al. 2003), and 44% of American Indians in this region diagnosed with diabetes also smoke cigarettes (Rith-Najarian, Gohdes et al. 2002). American Indians from this region have the highest cardiovascular disease mortality rates among American Indians in the U.S. (Gohdes, Harwell et al. 2002; Casper et al, 2005).

According to Minnesota birth certificate data, 37% of American Indian births were to mothers who smoked during pregnancy, in comparison to 11% for all races in Minnesota (Great Lakes EpiCenter, 2005). Smoking during pregnancy has been linked to sudden infant death syndrome (SIDS), infant prematurity, low birth weight, asthma and chronic ear infections in children.

However, the topic of reducing tobacco misuse can be a sensitive and difficult issue for American Indian communities to discuss, as tobacco use is more than just a link to the current health challenges experienced by these communities.

TRADITIONAL TOBACCO USE

Tobacco has always had an important role in traditional American Indian life in the upper Midwest. American Indians in what is now Minnesota used, grew, and revered tobacco for many centuries prior to the arrival of Europeans. Ethnographic records suggest indigenous cultures understood the physiological effects of tobacco (Winter, 2000). Tobacco had spiritual, ceremonial and medicinal functions. As a result, it was deeply respected and reserved for important occasions. The beginnings of misuse of tobacco by American Indian people date to the arrival of Europeans (Hall et al, 1995).

Ceremonial tobacco use varies greatly among tribes in the U.S. and specific ceremonies involving tobacco are not described since American Indians reserve the right to privacy regarding ceremonial practices (Burhansstipanov, 2001). Tobacco is used in traditional ceremonies in a variety of ways. Tobacco can be offered as a gift to the Creator, by placing it on the ground. Burning tobacco is another common spiritual practice. It is believed that the tobacco smoke carries prayers to the Creator. Tobacco can be burned in a pipe, shell, dish or fire. Some American Indian people use tobacco in this way several times a day and others use it only on special occasions. Tobacco is sometimes given to elders or others to show gratitude or honor.

The following story is about the gift of tobacco to the Ho Chunk people as told by Betty Greencrow, an elder from the Ho Chunk Nation.

A long time ago, when the animals and people could talk to each other, one of the little animals went running around telling everyone, "The Earth Maker is coming and he has a special gift for one of us!" The bear proudly said, "It must be for me in honor of my great strength!" Many of the animals added their reasons why they should be the one to get this special gift. The deer said, "It must be for me because I can run so fast!" The eagle said, "It must be for me because I can fly the highest!"

The Earth Maker came and all of the animals gathered around, ready to accept the special gift. The Earth Maker said, "Each one of you have wonderful gifts, but one of my children has nothing and is pitiful. This is the two-legged man. Man doesn't have anything; without this gift, what will become of him? This special gift is tobacco. Man will use this tobacco to ask for the many things he will need in life. When he needs food to eat, he will give tobacco. When he needs shelter and warmth, he will give this tobacco."

Ms. Greencrow generously followed her story with the following comments about tobacco use today.
"We have been instructed on how to use this tobacco. There are many ways such as giving thanks, offering tobacco to someone when asking him a favor, putting out tobacco before a storm, asking forgiveness from the spirit of the animal when hunting for game, presenting tobacco to the spirits. Lots of ways to use tobacco and we teach our children how to put out the tobacco in a special way and what to say. My apologies but this is all I can share about this."

An elder, Chris Mato Nunpa, of the Dakota Wahpetunwan, Pezihuta Zizi Otune or Yellow Medicine Community, shares this teaching about tobacco.
"Tobacco is sacred to most of the traditional Dakota as well as to many other indigenous peoples. Many of the Dakota, Lakota, and Nakota, as well as other indigenous peoples, follow the way of the sacred pipe, in which a special pipe, canduhupayuzapi, is used in all the important ceremonies. Tobacco can be used for invitations and also for requesting help from an elder or from a spiritual leader. It seems that today most of the different Native peoples in Minnesota use tobacco in this way to request help or a favor."

Types of Tobacco
Indian tobacco: This tobacco is not purchased. It comes in the form of a twist/bundle or loose leaf. Each tribe has a unique term for this type of tobacco, which is grown specifically for spiritual use. The Anishinaabe word is asema. The Dakota word is can-sa-sa. The Ho-Chunk word for tobacco is da nee. Among plant biologists, the species of tobacco in this region is referred to by the Latin name *Nicotiana rustica.* Each tribe has traditional teachings and cultural practices for growing, cultivating and sharing Indian tobacco.

Kinnickinick: Kinnickinick is a combination of plant and tree barks (mainly red willow) and is used for spiritual purposes by some tribes. Some people make kinnickinick without tobacco. Traditional teachings describe in detail exactly how and when to collect and prepare this mixture.

Commercial tobacco: These tobacco products are manufactured commercially, processed with many chemicals, packaged and sold in stores. Commercial tobacco products are cigarettes, cigars, chewing tobacco, pipe tobacco and snuff. While mainly used for non-traditional, recreational use, these products are also used occasionally in the traditional manner when Indian tobacco or kinnickinick are unavailable.

AMERICAN INDIAN HISTORICAL PERSPECTIVE

This section contains information about: American Indian culture; the unique legal and political status of American Indian tribes; and health status among American Indians. This information provides the context for tobacco misuse in the American Indian community. The first part of the following section briefly details American Indian culture, oral history, philosophy, and worldview common to Indigenous People in this area. The second part outlines a sequence of political and legal events that highlight the sovereign status of Indian tribes, a status which is totally unlike any other racial or ethnic group in America. The third part provides a brief description of the health status of American Indians.

AMERICAN INDIAN CULTURE

American Indian culture in the United States is very diverse. The American Indian and Alaskan Native population is comprised of members and descendents from more than 560 federally recognized nations. Each of these nations has a unique language, culture, worldview, and government. In addition, each of these nations has a distinct, complicated political or legal history with the United States federal government. Awareness of the cultural complexities and the far-reaching policies imposed by the United States federal government is essential to addressing the multitude of challenges present in American Indian communities.

Since time immemorial, in this Western hemisphere, lived the people often referred to as Native American, American Indian, Indian and sometimes respectfully by their true, native tribal name, such as Anishinaabe, Dakota, Lakota, or Ho-Chunk, among others. The native peoples of this land had a way of life, a society, long before contact with Europeans. "Walking in the footsteps of my ancestors" was the mantra by which most American Indian elders abided, for they were the keepers and teachers of wisdom and information

from previous generations. Oral history was the crucible for Indian beliefs and way of life. Indian language, song, stories and legends were never written or recorded, but were handed down orally from one generation to the next. The elders were responsible for acquiring and preserving knowledge for the younger people and future generations. The devotion demonstrated by elders throughout the years ensured American Indian people continued access to a unique cultural identity.

An Anishinaabe elder from the Lac Courte Orielles Tribe, Eugene Begay, shared his thoughts on how Indian people were identified by how they believe and practice spirituality.
"Religious and spiritual beliefs define the way people viewed the world. For instance, the understanding of the Creator evolved from the Anishinaabe oral history, culture, perspective and conception of the world. The Anishinaabeg believe that everything is spiritual, since all people see the world around them within a spiritual context. Everyone, in some way or another, is connected to the Great Spirit."

American Indian language is very important to spiritual identification. The way the Indians view the world, how we accept nature and other life around us, is part of the spoken language. American Indian language fluency opens the door to understanding American Indian spirituality and ways of life. According to Mr. Begay, "*there are five Anishinaabe words for love. The love we have for our Creator is a different word than the words of love that we have for our wives and mothers. You can see how language is important for understanding our relationships and our spirituality."*

American Indian elders, when discussing the challenges within their communities, have consistently shown a deep and abiding focus on the children. Many times they express the need for young American Indian people to find their emotional and spiritual strength in the traditional American Indian values. At an elder's forum sponsored by the American Indian Policy Center, an elder said this about the younger generation.

"They need to recover physically, or start getting the proper rest, the proper diet and exercise of their body to feel good. Next one is spirituality, because spirituality determines our attitude, our thinking, our behavior. We need to be naturally alert, learning as much as we can about life and the way to live. And emotionally, we need to be able to have some management of our emotions like anger and frustration that affect how we think, feel and all those things. When we take care of ourselves, that's what we're taking care of – our emotions, our intellect, our physical being, our spiritual, so that we are a good, solid, healthy person spiritually. Those are things that the children should know. I smoke cigarettes and that's not good for me – for our health, for our muscles especially. A long time ago, a guy my age would still get out there and run and chop wood. I can't do that. I weigh too much, I smoke too many cigarettes, I drink too much coffee. So I'm not really a good example of what a warrior's physical, mental and spiritual capabilities are. I just sit here and think about it."

American Indian cultural values have little utility in contemporary capitalist society, but define the spiritual, mental, and social framework of American Indian existence and identity. Several key factors help explain the cultural dynamic of American Indian people:

- Non-materialism is the basis for values of American Indians
- Power is spiritual, non-hierarchical, and shared by all
- Indians tend to be mission-driven, putting community and family before self-interest
- Indians are steeped in the traditions of oral history
- Indians tend to be visionary people
- Shared responsibility is often for the common good

American Indian history, as reported and compiled by non-Native people, often begins at the time of European colonization. This occurs, in part, because non-Native writers know little about the time before. Although the history of North America post-colonization is a dark and troubled one for American Indians, it is only part of the context for discussing who Indians are as a people. The origin of American Indians as distinct peoples is rooted in the centuries before colonization. American Indians are the only people who can tell this story, learned from the traditions and oral history of their people.

"Tobacco can be used for invitations and also for requesting help from an elder or from a spiritual leader.

POLITICAL AND LEGAL CONTEXT

Each tribe has its own distinct history in dealing with the various European groups who colonized this land. Because it is beyond the scope of this report to address each tribe's individual encounters, this section focuses on federal policies that impacted and continue to impact all American Indian people living in the United States.

Shifting federal policy has shaped contemporary issues in American Indian communities. Many legal professionals versed in American Indian law divide these shifts into the following seven periods (Canby, 1988).

- Establishment of Federal Role (Colonial Times to 1820)
- Removal (1820-1850)
- Movement to Reservation (1850-1887)
- Allotment and Attempted Assimilation (1887-1934)
- Indian Reorganization (1934-1953)
- Termination (1953-1968)
- Self-Determination (1968-Present)

Establishment of Federal Role (Colonial Times to 1820)
During this time, Europeans were colonizing North America. Although much has been written about the "settlement", this is only a euphemism for a much darker and violent time in history. The British Crown dealt formally with American Indian tribes as foreign sovereign nations, but land theft from and violence toward Indians on the part of individual colonies and colonists were already the informal policies of what would become the United States (Canby, 1988; Clinton 1991).

Removal (1820 – 1950)
During this time, there was increased friction between Europeans and Native tribes as Europeans continued to demand more land. To address this conflict, Native tribes were "removed" from their lands and forced to relocate further west (Canby, 1988; Clinton 1991).

Movement to Reservation (1850 – 1987)
In addition to removal policies that came about as a result of European expansion and continued desire for more land, the federal government established additional policies that created reservations for Native tribes that served to confine Native tribes to certain geographical areas (Canby, 1988).

Allotment and Attempted Assimilation (1887 – 1934)
The cornerstone of the Allotment and Assimilation Era was the General Allotment Act of 1887, also called the Dawes Act. Originally, the tribe generally owned reservation land communally. This Act remains one of the most significant federal statutes in the field of Indian law, because it delegated authority to the Bureau of Indian Affairs (BIA) to allot parcels of tribal land to individual Indians, with large amounts of tribal land that were not allotted being opened for homesteading by non-Indians (Canby, 1988).

The primary goal of this era was assimilation by means of allotment and several other policies—from forcibly removing American Indian children from their homes and placing them in BIA boarding schools to suppression of Native religious practices. During this time, Indian people were also granted United States citizenship through the Indian Citizenship Act of 1924—a move by the federal government that further promoted assimilation (Canby, 1988; Clinton, 1991). These policies, grounded by the Dawes Act, had the intended effect of, as then President Theodore Roosevelt said about the Dawes Act, "a mighty pulverizing engine to break up the tribal mass. It acts directly upon the family and the individual."

As the quote above and many other well-documented policies of the United States federal government illustrate, the assaults on indigenous languages, values, traditions and religious practices were specifically designed to make American Indians less Indian. American Indians were forbidden from practicing traditional ceremonies (Clinton, 1991). People wishing to continue honoring the Creator in their age-old traditional ways were forced underground. The religious freedom so acclaimed in American history never included American Indian religious and spiritual practices.

Indian Reorganization (1934 – 1953)

In the first major positive swing in federal policy toward American Indians, the time of Indian Reorganization came about as a result of the Meriam Report of 1928 (Clinton, 1991; U.S. Commission on Civil Rights. 2004). This influential study publicized the deplorable living conditions on reservations, and recommended that health and education funding be increased; that the allotment policy end; and that tribal self-governing be encouraged. The most significant contribution of the Meriam Report was to promote exercising powers of self-government in the adoption of tribal constitutions and the granting of federal charters.

The Indian Reorganization Act was passed in 1934 and incorporated some of the recommendations of the Meriam Report. Perhaps the most important provision was that which ended the practice of allotment and indefinitely extended the trust period for existing allot-

ments still in trust. It also restored tribal ownership to any surplus lands that had not already been acquired by third parties. The Act also authorized tribes to develop self-governing structures, although always subject to the approval of the Secretary of the Interior (Canby, 1988; Clinton, 1991). The Act's "encouragement of tribal self-government enjoyed a more limited success [than the provisions preventing further erosion of the tribal land base]; the tribal constitutions adopted under the Act were suggested by federal authorities and followed the non-Indian pattern of divided executive, legislative and judicial authority. They were consequently unsuited to tribal needs and conditions" (Canby, 1988).

Termination (1953 – 1968)

Prior to the 1950s, most American Indians resided on reservations, or in nearby rural towns. In the Termination Era of the 1950s and 1960s, the federal government passed legislation (HCR-108) to terminate its legal obligations to Indian tribes, resulting in policies/programs that attempted to assimilate Indian people into the mainstream of American society (Poupart, 2003). This philosophy produced the Bureau of Indian Affairs (BIA) Relocation/Employment Assistance Programs which encouraged Indian families living on impoverished Indian Reservations to "relocate" to various cities across the country, i.e., Twin Cities, Milwaukee, Los Angeles, Chicago, etc. (Sandefur, 1996). BIA Relocation offered job training and placement, and was viewed by Indians as a way to escape poverty on the reservation. The American Indian and Policy Review Commission found that in the 1950s and 1960s, the BIA relocated over 160,000 American Indians to urban centers (IHS, 2003). At the same time, American Indians returning from military service in World War II and the Korean Conflict often stayed in the urban areas rather than return to their reservations (Poupart, 2003).

The Twin Cities area is home to one of the major populations of urban, off-reservation American Indians in the United States, estimated at about 33,000 by the United States Census, or about 41% of all American Indians in Minnesota (2000 U.S. Census as enumerated in American Indian plus one other race). The majority are Anishinaabe (Ojibwe or Chippewa), Lakota, Dakota (Sioux) or Ho-Chunk (Winnebago), reflecting the indigenous people of Minnesota and Wisconsin, but many are affiliated with other tribes.

Urban Indians are often geographically dispersed with clusters of Indian families found in lower income areas, but in general, Indians are found throughout the metropolitan region. Urban Indians often remain connected to Indian cultural practices and attend pow-wows and other social events, thus maintaining Indian cultural ties. Some move frequently between city and reservation. This persistence in holding on to one's heritage, in light of the difficulties of federal policy and government intervention, is a significant factor affecting the health of many urban Indians (Forquera, 2001).

It is believed that the need to conduct ceremonies in secret and begin utilizing commercial tobacco to "hide in plain sight" was a fac-

The failure of the federal relocation policies is shown by the economic and social hardships experienced by American Indians in the Twin Cities. Urban American Indians are more likely to live in single parent households (56% vs. 46%) and more likely to be below the federal poverty level (35% vs. 29%) compared to the general population (U.S. Census, 2000 cited in Poupart, 2003). Unemployment rates in Minneapolis are higher for American Indians than any other racial/ethnic group. American Indian women are least likely to get adequate prenatal care. Almost 70% of all American Indian children who started ninth grade in 1996 dropped out of school before their classmates graduated in 2000 (Poupart, 2003). These problems put the American Indian population in a highly stressful situation. High tobacco misuse among the younger population group is but one debilitating factor. Yet for the past 20 years, Congress has allocated just over 1 percent of the federal annual appropriation for the Indian Health Service to serve this growing urban population (Forquera, 2001).

Self-Determination (1968 – Present)

In another major federal policy shift, the Self-Determination Era began in the 1960s and continues today. This period has been characterized by expanded recognition and application of the powers of tribal self-government and by the general exclusion of reservations from state authority (Canby, 1988). Then President John F. Kennedy promised that "[t]here would be no change in treaty or contractual relationships without the consent of the tribes concerned. No steps would be taken to impair the cultural heritage of any group" (Clinton, 1991). The changes in policy reflected in Kennedy's statement become evident when examining four key pieces of legislation from this era: the Indian Civil Rights Act of 1968, the Indian Self-Determination and Education Assistance Act of 1975, the Indian Child Welfare Act of 1978 and the Indian Religious Freedom Act of 1978.

The Indian Civil Rights Act of 1968 imposed upon the tribes most of the requirements of the Bill of Rights and amended a previous law "so that states could no longer assume civil and criminal jurisdiction over Indian country unless the affected tribes consented at special elections called for that purpose" (Canby, 1988).

The Indian Self-Determination and Education Assistance Act of 1975 authorized the secretaries of pertinent federal agencies to enter into contracts under which the tribes themselves assumed responsibility for the administration of federal Indian programs (Canby, 1988).

The second piece of legislation, the Indian Child Welfare Act of 1978, was enacted to protect Indian children from arbitrary and unilateral removal from their homes. In laying the foundation for the act, The United States Congress found "that an alarmingly high percentage of Indian families are broken up by the removal, often unwarranted, of their children from them by non-tribal public and private agencies and that an alarmingly high percentage of such children are placed in non-Indian foster and adoptive homes and institutions…" (Indian Child Welfare Act, 25 U.S.C. § 1901(4) (1978).

The Indian Religious Freedom Act of 1978 provides that:

[I]t shall be the policy of the United States to protect and preserve for American Indians their inherent right of freedom to believe, express, and exercise the traditional religions of the American Indian, Eskimo, Aleut, and Native Hawaiians, including but not limited to access to sites, use and possession of sacred objects, and the freedom to worship through ceremonial and traditional American Indian rites. (American Indian Religious Freedom Act, Pub.L. 95-341, § 1, Aug. 11, 1978, 92 Stat. 469 (codified as amended at 42 U.S.C. § 1996 (1994)).

All of the previously mentioned federal statutes have had a tremendous impact on American Indian people. However, this act has specific relevance to the discussion about the use and misuse of tobacco among American Indians, specifically in this region of the country where tobacco was and continues to be an important part of American Indian religious practices. Prior to this legislation, there was virtually no protection for American Indians against persecution and/or prosecution for practicing their religions. This lack of protection, combined with the federal government's policies on termination and assimilation, led to many religious ceremonies and practices being carried out underground. In addition to continuing American Indian religious practices in secret, commercial tobacco began to be substituted for traditional American Indian tobacco as a means of further protection from prosecution. American Indian people utilizing commercial tobacco instead of traditional American Indian tobacco were less likely to be punished for participating in their religion if it appeared to onlookers that they were using commercial tobacco. It is believed that the need to conduct ceremonies in secret and begin utilizing commercial tobacco to "hide in plain sight" was a factor in the inculcation of commercial tobacco into American Indian cultures in this region.

Health in American Indian Communities

The American Indian and Alaskan Native population has long experienced a poorer health status than the general United States population. When compared to the general U.S. population, American Indians have a lower life expectancy, higher infant mortality rate, and a disproportionate burden of acute and chronic diseases. Higher rates of chronic conditions such as diabetes, cardiovascular diseases and cancer plague American Indian communities. Attempts to address these health disparities are leading community members, tribal leaders, and health care providers to identify factors contributing to poor health. Tobacco is identified as a key contributor to disease and death in American Indian communities.

Lack of immunity to communicable diseases, warfare, forced relocation, confinement to small land bases or reservations, destruction of food sources and extreme poverty contributed to the severe decline in the health status and decimation of many post-colonial American Indian nations. Often times, health care services necessary to address newly introduced diseases and living conditions were not available to American Indian communities. The provision of federal resources for health care in American Indian communities grew out of a series of administrative actions and policies which were adopted by the federal government throughout the previously summarized periods of Indian affairs. The administrative actions most notably include treaty negotiations; the establishment of the Bureau of Indian Affairs; the Snyder Act of 1921; the Transfer Act of 1954; the Indian Self–Determination and Education Assistance Act of 1975; and the Indian Health Care Improvement Act of 1976.

Some American Indian nations received medical services from treaty negotiations when they were asked to cede lands to the United States government. Early health care provisions under treaty negotiations were typically delivered by the Department of War when American Indian communities became a health risk to neighboring settlements or military posts. An official policy for the federal provision of health care to American Indian communities did not begin to emerge until the BIA established a small health program after it was transferred to the Department of Interior in 1849. Although the U.S. Congress appropriated funds for the BIA health program, the health status of American Indians continued to decline. As a result, Congress enacted the Snyder Act of 1921, which served as the initial legislative authority for the provision of health programs for American Indians and Alaska Natives. Federal Indian policy changed abruptly in the early 1930s. These changes can be attributed, in part, to the release of the Meriam Report, an influential study issued in 1928 by the Brookings Institute. The report brought attention to the severe and hopeless conditions faced by American Indians as a result of historic federal policies imposed to address what was broadly defined as the "Indian Problem." The report described the extreme poverty, devastating epidemics, inadequate food, and insufficient education ravaging Indian communities.

The following was printed in 1928 in the Meriam Report on the health status of American Indians.

> The health of the Indians as compared with that of the general population is bad. Although accurate mortality and morbidity statistics are commonly lacking, the existing evidence warrants the statement that both the general death rate and the infant mortality rate are high…the prevailing living conditions among the great majority of the Indians

> are conducive to the development and spread of disease. With comparatively few exceptions, the diet of the Indians is bad…The housing conditions are likewise conducive to bad health…The inadequacy of appropriations has prevented the development of an adequate system of public health administration and medical relief work for the Indians…The hospitals, sanatoria, and sanatorium schools maintained by the Service, despite a few exceptions, must be generally characterized as lacking in personnel, equipment, management, and design (U.S. Commission on Civil Rights. 2004).

The grim realities about the health status of American Indians, especially those captured by publications such as the Meriam Report, fueled debates and public dissatisfaction with the ability of the BIA to deliver appropriate and adequate health services to address the growing health crisis in American Indian communities. The debate raged until the health responsibilities of the BIA were transferred to the Public Health Service, currently the United States Department of Health and Human Services (USDHHS), in 1954. American Indian communities began to assume an active role in the delivery and management of the health care programs within their communities during the mid-1970s. The Indian Self-Determination and Education Assistance Act of 1975 encouraged American Indian communities to contract with the BIA and Indian Health Service (IHS) to assume responsibility for programs, including health programs, historically delivered by these federal agencies. One year later, in 1976, Congress passed the Indian Health Care Improvement Act. This legislation expanded health care priorities in American Indian communities, set a goal of raising the health status of American Indians and Alaskan Natives to that of the general population, and funded health programs for American Indians residing in urban settings.

Although the health status of American Indian people has improved since the transfer of the IHS to the USDHHS in 1954, multiple health challenges presented in the Meriam Report persist in American Indian communities nearly 80 years following the release of the report. The health of American Indians continues to be well below the health status of the general population.

The following was printed in 2004 in an article in *US News and World Report.*

> [t]he health status of the more than 2.5 million tribal members is worse than that of any other U.S. minority or majority group. Native Americans have a life expectancy of 71, roughly 5 years less than all others. They face higher maternal and infant mortality rates and are many times more likely to die from tuberculosis, diabetes, and alcoholism. During flu season, they die far more often. Indian teenagers kill themselves at a higher rate. The rate of kidney failure from diabetes is staggering; heart disease is rising. Native American cancer patients have the poorest survival rates of any group (Healy, 2004).

Despite these persistent challenges, the IHS, the primary agency responsible for the delivery of health care services to American Indians, remains severely under-funded. Current funding of IHS is approximately $2.6 billion. For people receiving Indian health system services, this translates to health care funding at approximately 60% of the level enjoyed by people in mainstream health plans (Indian Health Service). The budget shortfall further translates into many facilities lacking the resources, space and equipment to deliver the most modern medical care. In addition, recruitment of physicians and personnel to work in these inadequate, often isolated facilities remains an imposing challenge. Gains made in the health status of American Indian communities can be attributed mainly to increased access to health services and public health measures which decreased morbidity and mortality from infectious disease.

Unfortunately, health gains among Indians have slowed or ceased all together in recent years as disease patterns have changed. Injuries, chronic disease, and behavioral related diseases have emerged as new challenges (Indian Health Service).

Minnesota is consistently ranked among the healthiest and most livable states in the country. Despite these achievements, the American Indian population in Minnesota continually fares far worse than most other Minnesotans on numerous social and economic measures related to health.

- According to the 2000 U.S. Census, more than one in four American Indians in Minnesota lived below the poverty level in 1999, compared with only one in seventeen non-Hispanic Whites. In 1999, the federally defined poverty line was an annual income of less than $13,290 for a family of three (MDH, 2005). In addition, one in six American Indians compared to roughly one in twenty non-Hispanic whites in Minnesota lacked health insurance in 2004.

- Behavioral differences, such as the high rate of tobacco abuse, may contribute to the growing list of disproportionate health burdens for American Indians. American Indians in Minnesota have an infant mortality rate (12/1,000) more than two times higher than their white peers (5.2/1,000).

- Injury and violence disproportionately affect American Indians more than any other racial and ethnic group in Minnesota. The overall injury related mortality rate is nearly three times higher for American Indians than the white population. In addition, American Indian males ages 18 to 19 years have suicide rates six times higher than any other age or population group.

- Diabetes mellitus is a serious disease significantly impacting the health of the American Indian population. Wide regional variation exists in diabetes prevalence rates for American Indians in the United States. Data from the IHS outpatient database indicate that American Indians in Minnesota not only have the highest rates of diabetes, but that diabetes prevalence is increasing among American Indian children, adolescents and young adults. Diabetes prevalence nearly doubled between 1990 and 1998, increasing from 8 to 15 per 1,000 among American Indians under age 35 living in Minnesota, Wisconsin, and Michigan.

- Cardiovascular disease (CVD) refers to a wide variety of conditions. These conditions may include coronary heart disease, stroke, high blood pressure and high blood cholesterol. While mortality rates from CVD are generally lower in Minnesota than the nation as a whole, American Indians are 33 percent more likely than the state population and 44 percent more likely than the total U.S. population to die from CVD.

- Although the overall cancer incidence rate in Minnesota is similar to the nation, American Indians in Minnesota are twice as likely to be diagnosed with and die from cancer. The reasons for this disproportionate burden are not well understood; however, it may be associated in part to the higher prevalence of smoking in this population.

- In Minnesota, four of the five leading causes of death among American Indians are related to tobacco misuse: heart disease, diabetes, cancer, and chronic lung disease (MDH, 2003).

CONCLUSION

The topic of tobacco is a sensitive and difficult issue to discuss as it has connections to the cultural and spiritual traditions practiced by many American Indian communities. Many non-Native people confuse tobacco use for cultural or spiritual reasons with tobacco addiction. The traditional use of tobacco is separate from the addictive use of commercial tobacco products, such as cigarettes, cigars, and chewing tobacco.

It is well known that abuse of tobacco products negatively impacts health status. Health conditions directly linked with cigarette smoking, such as cancer and chronic lung disease, are prevalent in American Indian communities. In addition, chronic conditions such as heart disease and diabetes are exacerbated by the abuse of commercial tobacco products. Despite clear evidence of a link between cigarette smoking and poor health status, the rate of tobacco abuse in American Indian communities, especially in and around Minnesota, remains disproportionately high. Attempts to address these high rates of tobacco misuse will have to take into account the unique histories, cultures, worldview and reality of American Indian communities.

As discussed throughout this report, many factors contribute to health care disparities among American Indians, including the historical relationship between tribes and the federal government. Although health outcomes for American Indians have improved in the past several decades, Indians continue to experience serious health disparities. In describing and moving toward the elimination of the existing health disparities, we must recognize that health care for American Indians is more than medical treatment. It involves a holistic approach. In addition, we must consider how numerous social and cultural barriers, such as lifestyle decisions, socioeconomic status, education, housing, economic opportunity, and racial bias and discrimination, as well as empowerment through self-determination and self-governance, interact and contribute to the current health status of the American Indian population.

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