Our Wellness Journey: Following the Path of Traditions in Building Healthier American Indian/Alaska Native Communities

The Balanced Budget Act of 1997, enacted by Congress in August 1997, provided $150 million to the IHS over a five-year period (from FY 1998 to FY 2002) to establish grants for the "prevention and treatment" of diabetes in AI/ANs. The entities eligible to receive these grants included IHS, tribes and tribal organizations, and urban Indian organizations. The IHS distributed this funding to over 300 IHS programs, tribal organizations, and urban Indian organizations through a process that included extensive tribal consultation, a distribution methodology for eligible programs, and a formal grant application. These programs were allowed to use this funding to design programs and activities according to local priorities and needs. Subsequent legislative activity has increased the funding to $150 million per year and extended the *Special Diabetes Program for Indians* through 2008.

Selected results from our evaluation show that 67% of grant programs have chosen to focus on primary prevention, such as, offering exercise and nutrition programs to prevent the onset of diabetes. Prior to the *SDPI*, AI/AN communities had few resources to devote to primary prevention of diabetes. Diabetes grant programs have also afforded tribes the opportunity to address diabetes and obesity prevention where it needs to be addressed – at the tribal community level.

Availability of diabetes primary prevention programs for children and youth increased from 10% before *SDPI* to 73% after *SDPI.* Weight management programs for children and youth increased from 18% to 60%; nutrition education programs for children and youth increased from 39% to 83%; and community-based healthy eating programs for children, youth, and families increased from 13% to 75%. Physical activity programs for children and youth have also increased: community based programs from 10% to 71%; school-based programs from 22% to 53%; walking and running activities from 20% to 64%; fitness classes from 15% to 54%, and playgrounds built or improved from 10% to 31%. Such programs have addressed access to nutritious foods in many remote rural reservation school settings and increased opportunities for physical activity in both school and community-based settings.

Many local nutrition programs have focused significant portions of their teaching on traditional native diets and native practices. In the *SDPI*, we have found a significant number of programs using traditional practices. For instance, a 41% increase in the number of programs offering traditional food and nutrition services and activities with *SDPI* has been noted. 10% of programs offer traditional food classes for Head Start and early childhood programs; 14% offer traditional food classes for families. 24% of programs offer traditional games for children and 25% offer them for adolescents. Traditional and cultural approaches to diabetes and obesity prevention targeted at children and youth are offered through story-telling (21%), talking circles (12%), traditional medicine practices (4%), traditional healers (5%) and traditional practices (8%). Promotion of a healthy lifestyle through these traditional approaches often accompanies a resurgence of cultural pride and an acknowledgement that tribal traditions provide a way to physical, mental, and spiritual well-being.

For AI/AN children and youth and those who care for them, new, emerging health challenges of chronic diseases, such as diabetes and overweight, are urgent public health concerns. To improve AI/AN child health, we will need to complement the focus on individual behavior with approaches that not only create supportive environments that encourage healthy choices but also promote healthy child development. Adopting these approaches will require collaboration and partnerships with the many individuals and institutions that affect the lives of AI/AN children and their families. This is the path we must follow if we are to reduce and eliminate the disparities in health that so clearly affect AI/AN children and their families.