# *Using Traditional Practices to Support Change*

**WASHINGTON STATE**

## THE HEALTH CONCERN

King County is the most urban county in Washington state, and Seattle is the largest city in King County and the state. The county's population is predominantly non-Hispanic White (73.4%) with 11.2% of its residents being Asian/Pacific Islander, 5.3% African American, and 3.5% Hispanic. Although Native Americans comprise only 1.1% of the population of the county,[1] this promising practice was developed to address the significant disparity in infant mortality for the Native American population.

Despite an overall drop in Sudden Infant Death Syndrome (SIDS) rates in the state and King County, the rates of SIDS and infant death continued to be higher in American Indians and Alaska Natives than in other populations. In 2003, the overall infant mortality for King County was 5.1 deaths per 1,000 live births. The 5-year average, 1999-2003, was 14.9 deaths per 1,000 live births for American Indians and Alaska Natives compared to 4.5 deaths per 1,000 live births for White infants (Washington State Department of Health, Center for Health Statistics, linked birth-infant death files). A Health Status of Urban American Indians and Alaska

[1]King County Budget Office. *The 2004 King County Annual Growth Report*. (2004). Downloaded on October 27, 2006, from http://www.metrokc.gov/budget/agr/agr04

*The Health Concern Continued*

Natives (2004) report states that SIDS was the leading cause of infant death among children born to American Indian/Alaskan Native (AI/AN) mothers living in the service areas of Urban Indian Health Organizations (UIHO).[2] The rate of SIDS was 157% higher when compared to the overall rate for all children combined.

King County has promoted safe sleep position since the mid-1990s. According to data from the Pregnancy Risk Assessment Monitoring System (PRAMS), in a *Public Health Data Watch* report, 76% of mothers placed infants on their back to sleep in 2001, compared to 43% in 1996. The report suggests that the safe sleep campaign correlates with the changes in behavior and may in part account for the decline in SIDS mortality.[3] The message and related behavior changes may not have been embraced, however, in the AI/AN communities in King County. Therefore, one strategy is to develop culturally relevant messages about back sleep position and safe sleep environment for use with families, caregivers, and communities. Other strategies include protecting and improving women's health *before* conception in order to identify risks and treat medical problems (see http://www.metrokc.gov/HEALTH/news/00082201.htm).

## THE STRATEGY

Since the mid-1990s, Washington state has used multiple approaches to reduce a baby's risk of SIDS. A coalition, Communities for Infant Sleep Position, spearheaded by the SIDS Foundation of Washington, includes 59 public and private agencies. The goal of the coalition is to get every parent, childcare provider, and healthcare professional to follow the American Academy of Pediatrics (AAP) recommendation: Put healthy infants to sleep only on their backs. In 1997, Mona Lee Locke, wife of Washington Governor Gary Locke and a mother herself, was the spokesperson for the coalition and starred in TV and radio messages that aired frequently throughout the year. Disparities in infant mortality for American Indians and Alaskan Natives led the SIDS Foundation of Washington to convene a meeting with leaders and members of the AI/AN community to identify approaches to disseminate safe sleep messages. From that process, the Native American Women's Dialog on Infant Mortality was formed to address this concern.

Native American Women's Dialog on Infant Mortality is a collaboration between Native American women, Public Health Seattle & King County, and allies. This network, currently sponsored by the SIDS Foundation of Washington, includes American Indian organizations and community members representing the diverse number of tribes in the community. Many American Indian and Alaska Natives relocated to Seattle during the Termination and Relocation era of the 1950s. Some tribes represented in the group include Duwamish, Muckleshoot, Suquamish, Port Gamble S'Klallam, Cowichan,

[2]Urban Indian Health Institute (UIHI). (2004). *The Health Status of Urban American Indians and Alaska Natives: An Analysis of Select Vital Records and Census Data Sources, March 16, 2004*. Available from UIHI, a division of the Seattle Indian Health Board, www.uihi.org/reports/2004HealthStatusReport.pdf

[3]Barkan S, Solet D, Carson K, Carlos M, Spahr S. Racial Disparities in Infant Mortality: An Update King County, 1980-2002. *Public Health Data Watch*. (2004);1(1), 16 pages.

*The Strategy Continued*

Comanche, Lakota, Nez Perce, Haida, and Kootenai. Leah Henry-Tanner, a Nez Perce tribal member, coordinates this group.

Members recommended using American Indian traditions to connect with women. Cradleboard classes were a logical approach to disseminate SIDS risk reduction information and teach American Indian traditions. The cradleboard, a traditional child-rearing practice, is a board or frame to which an infant is secured with blankets or straps. Cradleboards are used for infant transport and sleep. They provide a safe sleep environment for infants. This traditional practice was a cultural protective factor in the past, and this approach provides an opportunity to return to traditions that had long kept American Indian babies safe. A baby's mother, aunt, grandmother, or a friend usually makes the cradleboard. Many new AI/AN mothers, however, lack the monetary resources and knowledge of traditional practices needed to make a cradleboard. To

address this problem, the SIDS Foundation of Washington, with funding from the CJ Foundation for SIDS, initiated a program to provide a cradleboard instructor, supplies, and SIDS/safe sleep information to AI/AN pregnant women and family members.

## THE ACTION

The Native American Women's Dialog on Infant Mortality's network advertises the cradleboard classes. An American Indian outreach worker, employed by the SIDS Foundation of Washington, serves as a cultural broker. She contacts partner organizations for help with recruitment for classes. Additionally, pregnant women receiving services in various Native American health centers are invited to participate.

The classes are held in Seattle and surrounding areas and are taught by the cultural broker who is of an older generation than the mothers and brings the wisdom of life experience and tradition. About 10 cradleboards are made in each class. The cradleboard and SIDS/safe sleep instructors are American Indian women who take a traditional approach in their teaching. Class starts with a talking circle. This traditional activity is appreciated by women in the class. They can meet their classmates and share their parenting experiences. Some have had an infant death, and the talking circle offers an opportunity to discuss their experience. "Many of our mothers have had a loss and the talking circle makes them feel close to the group," reported Keri Wagenaar, former Executive Director, SIDS Foundation of Washington. Additional concerns raised include difficulty with housing, transportation, gentrification, and institutional racism, reports Henry-Tanner. SIDS risk reduction and safe

*The Action Continued*

sleep messages are delivered with respect, with no criticism of past practices.

The cradleboard is made in one class. The cost to produce 10 to 20 cradleboards is approximately $1,000 to $1,500 per class. The funding from the CJ Foundation for SIDS initially covered this expense. There is no charge to attendees for materials.

The cradleboard classes bring generations together. Many urban American Indian women do not have mothers and grandmothers available to teach Native traditions. "Within the city, there is no one place for Native women to meet. During the classes, they reach out to each other and feel a sisterhood," states Henry-Tanner.

## WHY IT WORKS

Working with a cultural broker has been a key to the success of the cradleboard project. "Leah, our American Indian outreach worker and coordinator of the Native American Women's Dialog on Infant Mortality group, is key to our success. She is our point person for the program," says Wagenaar. "Our attendees report that they appreciate help with the cradleboard and hearing safe sleep messages from an American Indian." Initial funding from the CJ Foundation for SIDS was used to create the program. Currently, the program is continued through the United Indian of All Tribes Foundation. This continuation speaks to the success of the program.

## THE NCCC PERSPECTIVE

The NCCC Perspective
The National Center for Cultural Competence (NCCC) chose this promising practice because it exemplifies key values of culturally competent health promotion that include the following:

- Demonstrates respect for the cultural values, beliefs, and practices of the intended audience. Culturally competent health promotion supports and honors those practices and beliefs that are protective or benign, and respectfully helps identify and change those beliefs and practices that have a negative health impact;
- Ensures meaningful involvement of community members and key stakeholders in determining need and designing, implementing, and evaluating the approach. Community partners play several key roles including:
  - providing the cultural perspectives of the intended audience
  - providing credibility to the effort within the community
  - bringing expertise (e.g., knowledge of health beliefs and practices, language, and preferred sources of information for the intended audience)
  - bringing community resources to support health promotion efforts (e.g., access to local media outlets or other dissemination points and local financial or in-kind support for activities);
- Uses cultural brokers in creating and implementing the approach; and
- Chooses formats that address audience preferences.

*The NCCC Perspective Continued*

Additional NCCC resources on cultural and linguistic competence in health promotion follow:

- ***Infusing Cultural and Linguistic Competence into Health Promotion Training***
  http://www.11.georgetown.edu/research/gucchd/nccc/projects/sids/dvd/index.html
- ***A Guide to Choosing and Adapting Culturally and Linguistically Competent Health Promotion Materials***
  http://www11.georgetown.edu/research/gucchd/nccc/documents/Materials_Guide.pdf

  *En español:* http://www11.georgetown.edu/research/gucchd/nccc/documents/Materials_Guide_Spanish.pdf
- ***Bridging the Cultural Divide in Health Care Settings: The Essential Role of Cultural Broker Programs***
  http://www11.georgetown.edu/research/gucchd/nccc/resources/brokering.html

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## ABOUT THE NATIONAL CENTER FOR CULTURAL COMPETENCE

The NCCC provides national leadership and contributes to the body of knowledge on cultural and linguistic competency within systems and organizations. Major emphasis is placed on translating evidence into policy and practice for programs and personnel concerned with health and mental health care delivery, administration, education, and advocacy.

The NCCC uses four major approaches to fulfill its mission including (1) Web-based technical assistance, (2) knowledge development and dissemination, (3) supporting a *"community of learners,"* and (4) collaboration and partnerships with diverse constituency groups. These approaches entail the provision of training, technical assistance, and consultation and are intended to facilitate networking, linkages, and information exchange. The NCCC has particular expertise in developing instruments and conducting organizational self-assessment processes to advance cultural and linguistic competency.

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