THE EFFECT OF CULTURAL BELIEFS AND CUSTOMS ON NUTRITIONAL ATTITUDES AND FOOD CHOICES OF ALASKA NATIVES LIVING WITH CHRONIC DISEASES IN THE ANCHORAGE METROPOLITAN AREA

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Abstract

Alaska Native and American Indian people are heavily affected by chronic diseases such obesity, diabetes, and cardiovascular disease (Redwood, Lanier, Johnston, Asay, & Slattery, 2010). The presence or severity of many chronic diseases is directly correlated with the type of diet people consume. This study explored how culture influences the understanding of nutritional status and food choices of Alaska native people living in Anchorage, Alaska. Focus groups were held with Alaska Native adults who were living with a chronic disease. Open-ended questions were asked about the participants' culture and food choices. Themes and subthemes emerged through data analysis using the PEN-3 model. Findings from the focus groups indicated that participants believed traditional foods had significant cultural and nutritional value, but there was decreased access to traditional foods in the rural setting. Participants often gave in to the pressures of a busy lifestyle and did not eat as healthy as they would like. Participants were seeking information to improve their diet and health in a culturally effective way conducive to their learning style.

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The effect of cultural beliefs and customs on nutritional attitudes and food choices of Alaska Natives living with chronic diseases in the Anchorage metropolitan area

The United States (U.S.) Census Bureau (2015) reported that as of 2013, American Indians and Alaska Natives (AI/AN) made up 1.2% of Americans, 14.8% of Alaska and 7.9% of the Anchorage population. There are over 200 federally recognized Alaska Native tribes that span through multiple villages in the state of Alaska (Redwood, Lanier, Johnston, Asay, & Slattery, 2010). The Alaska Native and American Indian people are greatly impacted by chronic diseases such as cancer, obesity, diabetes, and cardiovascular disease (Redwood et al., 2010).

Background and Significance

Nutritional choices have tremendous impact on the health of individuals. The World Health Organization (2011) has identified overweight/obesity, hypertension, elevated blood sugar, and elevated blood lipids as the four chief factors responsible for the majority of chronic diseases due to their impact on an individual's metabolism or physiology. There is an abundance of scientific evidence that documents the positive health outcomes for those who consume a healthy diet and maintain a healthy weight. This evidence forms the basis for the nutrition and weight status goals from Healthy People 2020 (U. S. Department of Health and Human Services, 2014). A 2013 cohort study of 5350 adults showed that the typical Western diet, with its emphasis on heavy intake of processed, high-fat content and refined foods, and red meat, was strongly associated with increased risk of disease, unhealthy aging and death (Akbaraly et al., 2013). Similarly, the 2008 INTERHEART study looked at over 15,000 people in 52 countries and demonstrated an association between the presence of chronic disease and consumption of the Western diet. In addition, this study found that individuals received protection against chronic disease development and progression with high vegetable intake (Iqbal et al., 2008).

With increasingly urban lifestyles and adoption of Western eating patterns, diet-related chronic diseases have become more common in populations in the United States and worldwide. The prevalence of diabetes worldwide is currently 6.4% and it is anticipated to rise significantly by 2030 (Shaw, Sicree, & Zimmet, 2010). In the U.S., the overall prevalence of diabetes is almost 10% and is expected to reach over 20% by 2050 (Centers for Disease Control and Prevention [CDCP], 2014). Approximately 40% of U.S. adults over age 20 are considered 'pre-diabetic' and by 2030, over 50% will be obese (Boyle, Thompson, Gregg, Barker, & Williamson, 2010; CDCP, 2014). The prevalence of Type 2 diabetes in the AI/AN population in the U.S. has risen markedly over the past 30 years (Centers for Disease Control and Prevention, 2013). The diagnosis of diabetes in AI/AN adolescents aged 10-19 increased 110% from 1990 to 2009 (Indian Health Service [IHS], 2012). In 2012, the estimated cost related to diabetes in the United States was $245 billion (CDCP, 2014). This amount is anticipated to grow to over $514 billion by 2025 (Institute for Alternative Futures [IAF], 2011a).

Significance to Nursing

In the past 50 years, Alaska Natives in the U.S. have moved away from their traditional eating habits and have adopted a diet that favors a higher fat and protein content and less vegetable and fiber intake. The literature shows that concurrent with the changing nutritional content, overweight/obesity and diabetes have also increased substantially in these populations. It is essential that healthcare providers have a thorough understanding of the perceived barriers Alaska Native patients face when trying to address their particular nutritional needs. Therefore, to effectively influence change, education needs to be done in a way that is meaningful and makes sense to the person receiving the education.

Culture and customs of the ethnic group to which individual patients belong affects how they choose to address their nutritional needs. The culture and customs can also influence the impact of nutrition on the progress of their illness. Awareness of perceived barriers and customs can allow the healthcare provider to present education tailored to the individual and support a patient's self-care effort. Changes in habits, behaviors, and eating patterns can prevent the occurrence of chronic diseases and inhibit the progression, or reverse the effects of chronic diseases (Halpin, Morales-Suárez-Varela, & Martin-Moreno, 2010).

Healthcare providers who work with chronic disease patients will benefit from awareness of the cultural factors that influence food choice and eating habits. Culture-appropriate support and patient-specific education can assist individuals to make the necessary dietary changes to potentially prevent the development or progression of chronic disease and improve overall health. Knowledge of culture-specific variables can empower healthcare providers to confidently tailor guidance to the needs of AI/AN patients in Anchorage.

Purpose of the Study

The purpose of the study was twofold. Firstly, the researcher explored how culture influences the understanding of nutritional status and food choices of Alaska Native populations. Secondly, the researcher identified knowledge gaps that affect the Alaska Native populations' ability to make healthy nutritional choices.

Research question. How do cultural beliefs and customs affect nutritional attitudes and food choices of Alaska Native populations living with chronic diseases in the Anchorage metropolitan area?

Theoretical framework

The PEN-3 cultural model provided the framework for this research project. This model focuses on promoting health and preventing disease with targeted education. PEN-3 is applicable to diverse minority cultural groups and has been used in studies with Chinese-Americans and Chinese immigrants, Hispanic immigrants and adolescents, Native Hawaiians, Afghanis, Iranians, Hmong, Native Americans, Southeast Asian immigrants and others (Acre, 2014; Ka'opua, 2008; Moua, 2006; Owiti, Greenhalgh, Sweeney, Foster, & Bhui, 2015; Saulsberry et al., 2013; Scarinci, Bandura, Hidalgo, & Cherrington, 2012; Shahandeh, Basseri, & Sharifzadeh, 2014; Yick, & Ooman-Early, 2009).

Dr. Airhihenbuwa's PEN-3 model utilizes a 3-dimentional construct that explores a cultural group's (a) cultural identity; (b) relationships and expectations and; (c) cultural empowerment. Each of these three aspects contains three components (Branscum, 2014). The acronym PEN-3 is created from the first common letter of each component in each aspect: 'P' for person, positive, and perceptions; 'E' for extended family, existential and enablers; and 'N' for neighborhood, negative, and nurturers. The dimensions that make up the PEN-3 model are used to plan, implement, and evaluate research in a way that is centered on the culture of the ethnic groups studied (Branscum, 2014; Perez and Luquis, 2014).

The model proposes that it is important for a health care provider to (a) include the person and anyone the person considers as part of their extended family, neighborhood, or community, and (b) identify any roles the person may play or identify with as part of their culture, when attempting to influence the health of that person (Branscum, 2014; Perez, and Luquis, 2014). This is especially relevant for minority populations, who often identify themselves as a family-based unit and include family in every major decision.

According to Branscum (2014), the aspect of relationships and expectations includes perceptions, enablers, and nurturers. Perceptions refer to what helps, or hinders change based on the cultural beliefs and values of the person and their family. Enablers are the pre-existing patterns or structures in the individual or community that impact behavioral change. Nurturers are the individuals in the community, peer group or family that positively influence changes in behavior (Branscum, 2014).

The aspect of cultural empowerment consists of the components positive, existential, and negative. Positive refers to the favorable influences or characteristics that support those in the family or community to adopt a healthier lifestyle (Branscum, 2014). Existential refers to the exclusive behaviors that a certain culture believes in or performs regularly that influence their health (Branscum, 2014). Negative indicates the individual or cultural practices that are unhealthy and damaging to a person's health (Branscum, 2014). Iwelunmor et al. (2013) state that as researchers identify each component of cultural empowerment for a particular cultural group, a strategy can be formed to encourage beliefs that are helpful to health, to acknowledge those that are health-neutral and to work towards correcting those that are detrimental to health.

Using the PEN-3 model as the theoretical framework for this research project allowed the researcher to recognize, and be sensitive to, cultural differences during all stages of the project. The researcher was better equipped to identify and understand health challenges for Alaska Natives by working within this structure. The researcher was able to acknowledge culturally influenced patterns of health for the study populations. With these cultural patterns identified, medical providers can utilize them to positively influence minority health and

empower the patients and families in this ethnic group to reverse and alter the upward trend of chronic disease and illness in their members.

Review of Literature

Chronic diseases are long lasting and have negative impacts on morbidity and mortality. Examples of chronic diseases include cancer, hypertension, hyperlipidemia, obesity, and diabetes. Healthy nutrition and lifestyle behaviors are beneficial for everyone, but more importantly for those with chronic diseases and even more importantly for minorities with chronic diseases. A Canadian based research study conducted from 2005-2011 by Morton et al. (2014) implemented the Complete Health Improvement Program (CHIP). This short-term intervention program focused on making lifestyle and dietary modifications to improve health and reverse chronic disease risk factors. Within the first 30 days of the study, the participants consuming plant-based diets were noted to have significant improvements in their BMI, blood pressure, and lab values (Morton et al., 2014).

There is limited research on the cultural influences of how and why people make food choices. This gap in research is especially evident in the shortage of information regarding those individuals living in circumpolar regions. Minorities are significantly affected by morbidity from chronic diseases (American Dietetic Association [ADA], 2011). Changes mainly in improved nutrition can prevent and reverse many disparities related to chronic diseases in all populations (Esselstyn et al., 2014). More research is needed to determine what cultural values and traditions prevent certain minority groups from maintaining a healthy lifestyle and preventing chronic diseases.

Relationship between Diet and Chronic Disease

Research shows that diet plays a role in the development and progression of chronic disease (Cecchini et al., 2010). Poor eating habits and insufficient physical activity are key reasons for the increase in the number of overweight and obese Americans (CDC, 2015; James, 2009; Rao et al., 2014). Eating a healthful diet and exercising regularly can reduce weight and decrease health disparities associated with chronic disease (U.S. Department of Agriculture [USDA] and Health and Human Services [HHS], 2010). Lack of physical exercise, poor eating habits, and regular intake of food with little to no nutritional value not only leads to obesity, but also can then lead to chronic disease (CDC, 2015).

Many studies have recommended a whole-food, high fiber, plant-based diet, low in fat, cholesterol, and refined sugar for those living with chronic disease (Gustafson, 2014; Morton, et al., 2014). The USDA and HHS's Dietary Guidelines for Americans (2010) encourage individuals to manage weight with diet and exercise. Diets should be nutrient dense with fruits, vegetables, whole grains, fat-free or low-fat dairy, and seafood with decreased intake of sodium, saturated fats, trans fats, cholesterol, refined grains, and added sugars (USDA and HHS, 2010). The Dietary Guidelines for Americans is updated and published every five years by the USDA and HHS. The 2015 Dietary Guidelines for Americans, not yet published, continues to focus on and encourage Americans to eat a diet that promotes healthy weight and lifestyle (USDA and HHS, 2015).

Food content can impact health in positive and negative ways. A study conducted by Akbaraly et al., (2013) included 5,350 adults living in London. The results of this study indicated that the typical "Western" diet, with its emphasis on heavy intake of processed, high-fat, refined foods, and red meat, was highly associated with increased risk of disease, unhealthy aging, and death (Akbaraly et al., 2013). Furthermore, a study by Avendano et al., (2009) found

that older Americans had greater incidence of obesity, heart disease, hypertension, diabetes, cancer, and lung disease than older adults in Europe, regardless of economic status. In addition, individuals from lower socioeconomic backgrounds experienced higher incidence of chronic disease and were more likely to be smokers in America and Europe (Akbaraly et al., 2013). Overall, the literature suggests that the health status of the majority of Americans is comparable to the health status of the lower socioeconomic populations in Europe (Akbaraly et al., 2013). Lastly, a study by Yusuf, et al (2004) found that cardiovascular risk for acute myocardial infarction could be decreased 30% if individuals would consume fruits and vegetables regularly; and include prevention strategies that focus on smoking cessation, lowering lipids and regular moderate activity. By consuming healthy, culturally appropriate foods people of all ethnic backgrounds will be more apt to decrease their incidence of chronic disease and prolong their lives.

Studies have found a statistically significant reduction in 1) cancer risk due to nutritional choices; 2) cardiovascular disease risk related to chromosomal variations altered by dietary choices and 3) reversal of DNA methylation and chromatin modification through use of nutrients (Boffetta et al., 2010, Choi and Friso, 2010). Overweight individuals are more at risk to develop type II diabetes, asthma, cancer, hypertension, stroke, coronary artery disease, gallbladder disease, and osteoarthritis (Guhet al., 2009). Dietary choices leading to obesity, chronic disease and death is the result of too high salt intake, low omega-3 fatty acids, high trans fatty acids, and low fruit and vegetable intake (Danaei et al., 2009). Reversing the effects of these dietary habits occurs slowly once a healthier diet is implemented, (Danaei et al., 2009).

Importance of Nutrition in Chronic Disease

A diet with foods that contain large amounts of omega-3 fatty acids, polyphenols, and antioxidants help to decrease inflammation and support weight loss (Wang et al., 2014). In a randomized control trial conducted in the United States over four months, a low fat and plant based, vegan type diets decreased weight, plasma lipid levels, and improved glycemic control for diabetics (Mishra et al., 2013). The randomized control trial implemented group change and used community support to encourage participation and made the aforementioned foods available for consumption (Mishra et al., 2013). Furthermore, another U.S. study found that 198 patients with cardiovascular disease, who consumed a plant-based diet, avoiding all animal products and oils, lost weight, significantly improved their health and showed improvement or stability of their heart disease (Esselstyn et al., 2014). A meta-analysis of 16 research studies completed by Wang et al., (2014) found that literature discussing the cause and effect relationship of fruit and vegetable consumption on cardiovascular disease and cancer found that five servings of fruits and vegetables daily help to promote health, decrease mortality and improve cardiovascular disease. In order to achieve optimal health and reduce chronic disease risk factors, it is prudent to eat the best foods that are shown to reduce those risk factors and being aware of one's own daily dietary consumption. James (2009) found that assessment of one's dietary intake should be done by evaluating dietary patterns rather than single nutrients. With an understanding of cultural eating habits, healthcare providers can more appropriately counsel patients on beneficial and realistic change.

Culture

Since research is conflicting on the inter-relationship between specific nutrients and their relationship to chronic disease, James (2009), suggests studying the eating habits and culture related dietary patterns in order to make national goals and initiatives that are appropriate for

individual cultures and gender. Over the past 30 to 40 years, many people have migrated away from their traditional plant-based diets towards western diets, consequently their incidence of obesity, diabetes and atherosclerosis has risen (Grant, 2012). A qualitative study based in rural India explored beliefs about fresh food, the feasibility of making dietary changes, the processes of household decision-making, and intervention strategies at the household and community level (Daivadanam et al., 2014). Data gathered from focus groups found that decisional balance was the strongest item that impacted behavioral change. Findings from this study suggest that households were more likely to adopt a dietary or lifestyle change when the seriousness of their family member's chronic disease outweighed the inconvenience of lifestyle modifications. For example, a common barrier identified in this study was the factors that influenced food choices. Overall, Daivadanam et al., (2014) found that nutrition choices within a family household were based heavily on the cost and accessibility of food and family priorities. Diet along with respect and cultural awareness are important factors when doing research studies. Recognizing how to respectfully interact with different cultures and learning what is important to them when they are considering any kind of change will help them make positive change.

A study that investigated the interactions of Australian Aboriginal people found that the best system for chronic disease management included interventions that involved the community, had excellent communication, was flexible to adapt to the people's needs, and built on current knowledge of what they considered to be acceptable and doable (Liaw et al., 2011). Lastly, a study completed in New Mexico discovered that Native American families want family-centered care with effective communication, and culturally appropriate services with providers who understand their culture-specific needs; providers should not assume, should listen to them, and ask questions as appropriate (Garwick et al., 2002). More studies are needed to determine how

cultural food choices affect obesity and chronic disease or if community, socioeconomic status, or access to food choices leads to the increasing incidence of obesity and chronic disease (James et al., 2012; Larson et al., 2009).

Alaska Native Population

According to the CDC (2014), Alaska has the largest number of American Indians and Alaska Natives in the United States. In 2013, 14.3% of all American Indians and Alaska Natives (AI/AN) lived in Alaska, which was 14.7% of Alaska's population (CDC, 2014). Of those AI/AN living in Alaska, 7.9% resided in the municipality of Anchorage (CDC, 2014; United States Census Bureau, 2013).

Family and community are important aspects of the of Alaska Native culture. Parents and other elders teach the younger generations about their culture and traditional values through storytelling (Ayunerak, Alstrom, Moses, Charlie Sr., & Rasmus, 2014). The newer generations are taught western social values through schooling which conflicts with the traditional values being taught by their elders (Ayunerak et al., 2014). The increasing impact of western societal values on the traditional lifestyle of AI/AN is evident primarily in the youth. Children are no longer being strengthened mentally and physically with the necessary chores associated with contributing to the survival of a family in a collective subsistence way of life (Ayunerak et al., 2014). Fostering Yupik children to be successful in the western school system needs to be taught in conjunction with traditional cultural values. These traditional values have been and are being passed down from generation to generation as a means to preserve the Yupik culture (Ayunerak et al., 2014). This strategy is equally important for all Alaska Native children. Unfortunately, western society has shown it not only impacts the traditional lifestyle of AI/AN people, but it

also affects their health. Many poor eating habits adopted from western culture leads to chronic disease among native people.

Health status. American Indians and Alaska Natives experience higher incidences of chronic disease than other minority populations (Redwood et al., 2010). The top five disease-related causes of death in AI/AN people are cancer, heart disease, diabetes, chronic liver disease and chronic lower respiratory disease (Redwood et al., 2010). Research in these areas over the past several years has resulted in the following.

The incidence of diabetes has and is projected to continue to climb in the Alaska Native population, increasing at more than twice the rate than the non-native population (Redwood, 2010; Shaw, Brown, Khan, Mau, & Dillard, 2013). A study by Yuan, Bartgis, and Demers (2014), found that AI/AN people were more likely than non-AI/AN people to be diagnosed with diabetes. This study also found AI/AN were more likely to die from complications related to smoking cigarettes, binge drinking, and alcohol consumption. Literature suggests, however, that although heart disease among Alaska Native people is lower than the rates among Caucasians currently, the incidence is rapidly catching up to Caucasian rates (Johnston, Day, Veazie, & Provost, 2011).

Across the United States, the incidence of obesity is increasing among all ethnic groups and is an important risk factor for the development of chronic disease. Alaska Natives are much more likely to be obese and use tobacco than other residents of Alaska (Redwood et al., 2010). Alaska Natives experience higher mortality from cerebrovascular disease and cancer, while other ethnic groups have higher mortality rates of heart disease and diabetes (Redwood et al., 2010; Shaw et al., 2013). Mortality rates from heart disease and cancer for AI/AN males remain constant but are increasing for females (Plescia & Bauer, 2014). In regards to overall death rate,

AI/AN people experience 50% more times the mortality rate than non-Hispanic Caucasians (Plescia & Bauer, 2014). The leading causes that contribute to this 50% rate include diabetes, intentional and unintentional injury, and chronic liver disease. AI/AN people also have an overall greater incidence of death from gallbladder, stomach, liver, and kidney cancer than Caucasians, with Alaska having the highest rate of death from lung, colon, and esophageal cancer (White et al., 2014).

Traditional versus Western diet. Traditional Alaska Native foods vary from culture to culture depending upon the geographic location of the tribe within Alaska and availability of foods at any given time of year. Traditional diets include items such as meat, blubber, seal oil, walrus, whale, salmon, fish, caribou, moose, ducks, geese, swans, cranes, wild greens and berries (Johnson, Nobmann, & Asay, 2012). Other traditional foods include marine mammals, sea ducks, shellfish, and whale oil (Fall, 2013). A study by Bersamin et al. (2006), surveyed residents in six remote villages located within the Yukon-Kuskokwim River Delta in Western Alaska regarding their recollection of food they had eaten the previous 24 hours. The study included people ranging in age from 14 to 81 and found that the younger the person, the more likely they were to eat western foods like pizza and chicken strips. Types of convenience foods such as these are readily available either through "bush orders" or at the local store if the community has one. Similarly, the study found that elders or village residents over the age of 40 consumed most of their diet from traditional sources (Bersamin et al., 2006). Although publications on the attitudes of Alaska Native people toward changing dietary practices are few, the available literature suggests that western foods can account for 76% or more of the current Alaska Native diet (Johnson et al., 2012). However, to maintain optimum health status, the best diet for Alaska Native people is to consume a diet primarily composed of traditional foods, limit

the amount of western food, and supplement their diet with available fruits and vegetables (Bersamin et al., 2006). If the younger Alaska Native population continues to rely on western foods instead of traditional foods to fulfill their dietary needs, the incidence of chronic disease will likely continue to increase.

Patterns of disease with change in diet. Many traditional Alaska Native foods contain high amounts of animal fat including omega-3 fatty acids, eicosapentaenoic acid (EPA), and docosahexaenoic acid (DHA) (Bersamin et al., 2008). Alaska Natives, who consumed the majority of their food from traditional sources, had higher intake of omega-3 fatty acids, and lower intake of saturated fats (Bersamin et al., 2008). Blood studies have shown that Alaska Natives who have a diet compiled mainly of traditional foods, have higher high-density lipoprotein (HDL) levels and lower triglyceride levels compared to those who consumed a primarily western diet (Bersamin et al., 2008). The traditional Alaska Native diet, if eaten almost exclusively, provides enough omega-3 fatty acid protection to protect against heart disease. Much of this protection is lost when Alaska Natives consume and incorporate a larger portion of their nutritional intake from western culture. The end results of such decisions put Alaska Natives at a greater risk of developing cardiovascular disease, as well as other chronic diseases (Bersamin, 2008). Furthermore, the consumption of traditional foods has also been linked to tighter controlled glucose tolerance levels, improved lipid profiles and a lower occurrence of obesity in western Alaska (Johnson et al., 2012). In an effort to better understand the consequences of food choices; a few researchers have begun to investigate what contributes to health issues of Alaska Natives and why these factors are important to the overall health of this population.

Shaw et al. (2013) conducted a study focusing on type II diabetes and identified resources and roadblocks to managing their diabetes. In an effort to provide the most effective care to Alaska Natives, researchers conducted a recent study in Anchorage, Alaska (Shaw et al., 2013). The study sought to identify and understand the social and psychological barriers to the management of Type II diabetes (Shaw et al., 2013). As a result of the study, four themes were identified that were integral in helping patients manage their diabetes, and included 1) knowledge and education; 2) support from others with the same disease; 3) spirituality; and 4) self-efficacy (Shaw et al., 2013). Barriers identified by the researchers included a lack of knowledge about nutrition and diet, dietary restrictions that caused social difficulties, and medical co-morbidities (Shaw et al., 2013). The study identified two major participant needs that were not being met; 1) the support from family and friends to abide by the dietary requirements, especially during food-centered social gatherings, holidays and community events; 2) education for family and friends to understand the dietary requirements for diabetes (Shaw et al., 2013). To overcome this lack of support, patients often isolated themselves and did not attend their usual gatherings (Shaw et al., 2013). The Shaw report concluded by recommending that all family members be included in the health education efforts for diabetic patients. Increasing community awareness about diabetes and encourage people to view it as a community issue were also recommended (Shaw et al., 2013). A successful nutritional education program should incorporate all of these components and place a primary focus on the importance and nutritional value of traditional foods.

Importance of diet for Alaska Natives. All over Alaska, western foods are becoming a larger part of many Alaska Native diets and replacing their traditional balanced subsistence diet. This trend occurs more frequently the closer Alaska Native people live to a metropolitan area

(Bersamin et al., 2008). Within the municipality of Anchorage, there are a multitude of fast food restaurants, sit down restaurants, grocery and convenience stores. This abundance of prepared food is a drastic contrast compared to a traditional village life. Currently, there is little research about whether Alaska Natives can feasibly consume a primarily traditional diet while living in the city. Furthermore, there is little known if and what barriers exist that may complicate or impede the consumption of a traditional diet. Therefore, more research is needed to determine how and what can be done to encourage and support Alaska Natives living in a metropolitan area to consume more of a traditional diet and how choosing not to do so will result in health disparities (Bersamin et al., 2006; Bersamin et al., 2008).

Methods

Focus Group Design

The experiential structure of a focus group, which is based upon within-group similarities rather than differences, is well suited for a study investigating shared customs and culturally defined practices (Curtis & Redmond, 2007). Focus groups are especially helpful during an exploratory qualitative design project where there is little known about the topic of interest (Curtis & Redmond, 2007; Redmond & Curtis, 2009; Sagoe, 2012).

According to Curtis & Redmond (2007, p.27), focus groups are "appropriate if the purpose is to explore the views, feelings, and experiences of a homogenous group". Curtis and Redmond assert that the use of focus groups is "appropriate when the researcher has no interest in generalising [sic] beyond the population of interest and where the shared beliefs, opinions, attitudes and perceptions - and not necessarily their underlying dimensions - are the focus of inquiry" (p.28). This study investigated the Alaska Native culture, practices, and traditions in

relation to dietary habits. A focus group design was chosen for this project because it is complementary to the cultural traditions and customs of the target population.

The Alaska Native culture typically values group participation, interaction, and cohesion. For this cultural group, the unit is the family and group/community rather than the individual (Pewewardy, 2002; Tsoukalas, & Satterlund, 2010). This population has strong and longstanding tradition in which individuals rely heavily on storytelling and direct word of mouth conversations to share information and experiences (Tsoukalas & Satterlund, 2010). Alaska Natives are familiar with the concept of the traditional 'talking circle' (Craciun Research, 2012). Alaska Native individuals are expected to place importance on reciprocal obligations, thus making participation in group conversations a give and take interaction (Tsoukalas, & Satterlund, 2010). In the published literature, marketing studies have found that the group/community orientation of the Alaska Native population is particularly suited to focus group participation (Craciun Research, 2012).

Focus group questions. The focus group questions utilized in this project were adapted from Dr. Delores James's 2004 study on the eating habits of African-Americans (Appendix A). Dr. James's research examined the cultural factors influencing nutritional choices made by the African-American population. The questions from her study have been written in a format that is culturally neutral with language and content that can be applied to a variety of cultural groups. The researcher was given permission from Dr. James to adapt the original study questions for use in this project (Appendix B).

Open-ended questions were integrated into the study design to maximize individual participation and capture as many variations in response and opinion as possible (Magilvy & Thomas, 2009) (Appendix C). All of the questions were written at a Flesch-Kincaid sixth grade

reading level to limit confusion and ensure all participants would clearly understand all of the question contents (U.S. National Library of Medicine, 2013).

International Review Board Process. An IRB application was completed and submitted to the University of Alaska, Anchorage IRB for approval. Upon receiving IRB approval, the researcher began posting flyers to advertise for study participants. Advertising was done in six locations throughout the Anchorage metropolitan area to maximize the possibility of a diverse project population.

Focus group meetings. Four focus group meetings were held during a six month period. The focus groups were held in various community group and meeting rooms to ensure a comfortable, quiet, and private setting. Two focus groups were held on the north side of town at a coffee shop, one focus group was held in a restaurant meeting room on the south side of town and one focus group was held in a church meeting room in midtown. Each focus group consisted of three to six participants and lasted approximately one hour. The researcher provided refreshments during each focus group session and each participant received a $20 gift card at the end of the focus group discussion.

Participants

Inclusion criteria. The target population for this project included adult Alaska Native individuals over 18 years old who had been diagnosed with a chronic disease for at least six months. For this project, chronic disease diagnoses included the following in isolation or in combination: diabetes, obesity, hypertension, and hyperlipidemia. Furthermore, all participants resided in the Anchorage metropolitan area for a minimum of six months, spoke English and self-identified as being Alaska Native.

Participant recruitment. Purposive sampling was used to gather study participants. Recruitment occurred at a variety of Anchorage-based community and social centers, and churches that were regularly attended by Alaska Native people. The researcher received permission to hang signage and post flyers to solicit study participants (Appendix D). There were six participants gathered using the posted flyers. Therefore, the additional recruitment method of snowball sampling was used to obtain the additional 14 project participants.

Data Collection, Analysis, and Management

Data collection. During all four focus group discussions, the primary researcher acted as the moderator. The researcher received assistance from another graduate-level nurse practitioner student who took observational notes during all four focus group sessions. Both the researcher and the graduate student assistant held current CITI certificates from the University of Alaska, Anchorage. A standardized script was developed and used for moderating all of the focus groups (Appendix E). The script included introductory comments, description about informed consent, the six study questions with prompts to encourage thorough discussion, and conclusion comments. The script was used as a guide to ensure that the same information was given to all participants and that each study question was asked in the same order. Permission was obtained to adapt a script for moderating focus groups from JoAnn Kauffman, President of Kauffman & Associates, Inc. (Appendix F). Kauffman & Associates is a Native American, woman-owned business that provides marketing research, grant and proposal management, communications and business support for federal, state, regional and tribal governments (Kauffman & Associates, 2015).

The primary researcher occasionally provided prompts to encourage participants to consider different aspects of each question and to provide clarification (Redmond & Curtis,

2009). The primary researcher paraphrased and summarized main points that were brought up in response to each question. Aside from note taking, the project assistant did not actively participate in any of the focus group discussions; instead, observed participant interactions and non-verbal 'conversation'.

With prior consent from participants, each focus group was digitally recorded using two recording devices. An additional recording device was used as a backup in the event that the primary device malfunctioned. Each subject had a 'first name' identification card in front of them to allow the primary researcher to speak to them by name and enable the note-taker to track who was speaking and associate non-verbal cues with specific individuals. The identification card was later used to match the digital recording to the correct participant. The note-taker created a diagram that mapped the seating arrangement for each focus group to assist the researcher during transcription and data analysis. After each focus group, using a systematic analysis process, the primary researcher and the note taker discussed ideas, interpretations, and themes heard throughout the focus group. Similarities and differences were also discussed comparing the current group to prior focus group data.

Data analysis. All data was collected and analyzed by the primary researcher. The primary researcher transcribed all of the audio recordings within a week of completing each focus group. The audio recordings were transcribed into electronic documents using tape-based analysis (Krueger, 2006; Krueger & Casey, 2014; Onwuegbuzie et al., 2009). Using Tape-based analysis, the moderator typed the transcript word for word excluding words or phrases that were not related to the focus group discussion such as when someone entered the room in the middle of a session. The primary researcher used the typed transcripts, notes from the note-taker, and

information discussed in the debriefings to analyze the data. Taped-based analysis was chosen because it increases the level of rigor while minimizing the risk of error (Krueger, 2002).

The researcher listened repeatedly to each recorded discussion and focused on participant responses to the questions. The transcript was matched to the written notes from the note-taker to maximize the use of nonverbal communication. Once the full recording was transcribed and integrated with the written notes, the new document became the unit of analysis.

To analyze the focus group transcripts, the researcher followed the systematic analysis process outlined by Krueger (2005). Two transcripts were printed, one was cut up and the other was used for reference. Participant quotes were cut up individually and then arranged and sorted by focus group question, looking for emerging themes. The cut up quotes were then rearranged into different sections that focused around similar topics and ideas. A highlighter was used to highlight main thoughts or strong recurring themes. Once the majority of the quotes were separated into themes, they were further separated into subthemes. Once all the quotes were separated into piles of themes and subthemes, the researcher identified words that were representative of the theme and subthemes. Participant quotes were then used and integrated into the findings section of this paper as exemplars of the study findings.

Data management. All original recordings were retained on a digital recorder, locked in a file cabinet, and stored at the residence of the primary researcher. A backup copy of each recording was made and stored until all transcriptions were completed and then the recordings were permanently erased. To maintain privacy, individual identifiers were deleted from the typed transcripts and subjects were tracked by their unique numerical code (P1-P20). Prior to project completion, the original recordings, transcripts, code key, and paper documents remained secure in a locked file cabinet in the researcher's home. After completion of this project, all

items will be secured at the University of Alaska Anchorage, School of Nursing office for three years, and will then be permanently destroyed.

Ethical Considerations

Prior to the recruitment of any participants the researcher received approval from the UAA Institutional Review Board. Participation was completely voluntary. There was no emotional or physical risk to any project participant. There were no individual benefits for participating. Prior to the commencement of any focus group discussion, written informed consent was obtained from each subject after they had been given a verbal and written description of the project (Appendix G). Additionally, each participant was given a written consent to take with him or her that included the researcher's contact information.

Findings

Participants

Twenty Alaska Native adults aged 28 to 67 years participated in the four focus group discussions. There were six male and fourteen female participants (see Table 1). There was at least one male in each of the four focus groups. All participants spoke English and had resided in Anchorage for at least six months prior to the focus group discussions. Each participant had at least one of the following chronic diseases: obesity, diabetes, hypertension, or hyperlipidemia. To maintain anonymity, each participant was given a code number (P1 to P20) that correlated to each individual's comments. During each focus group, most of the participants shared their ideas for each question. While some participants spoke more than others, there was active discussion from each project participant.

Table 1

Participant Demographics

Variable	Category	Number of Participants	Percentage
Age (years)	18-29	2	10%
	30-39	4	20%
	40-49	5	25%
	50-59	5	25%
	60-69	4	20%
Gender	Male	6	30%
	Female	14	70%

Themes

Three themes and ten subthemes emerged during data analysis (see Table 2). The themes are listed from most prevalent to least prevalent. Culture was the first theme that was evident from the analysis. The subthemes that emerged under this theme were traditional foods, subsistence lifestyle, and togetherness. The second theme identified by the researcher was Adaptation. The subthemes associated with the Adaptation theme were accessibility, convenience, and competing priorities. The final theme that emerged from the data was Requesting Information. The subthemes that arose from the Requesting Information theme were food labels, food preparation, information seeking, and learning.

Table 2

Themes and Subthemes

Themes	Subthemes
Culture	Traditional Foods
	Subsistence Lifestyle
	Togetherness
Adaptation	Accessibility
	Convenience
	Competing Priorities
Requesting information	Food labels
	Food preparation
	Information seeking
	Learning

Culture. This first theme emerged because participants repeatedly spoke about their culture, the way they were raised, and how the foods they grew up eating impacted their life. The participants discussed that they mainly ate a traditionally based diet and foods they learned to eat when they were growing up. Traditional foods held special meaning to them because these were the foods their ancestors depended on. Furthermore, growing up, participants described how their family activities incorporated hunting and fishing for these special foods. As participants grew older, their traditional foods brought back the favorable memories of times spent with family members involved with subsistence activities and eating traditional foods. The subthemes under this theme further explained the traditional lifestyle of the Alaska Native participants.

The subtheme of traditional foods evolved when all participants spoke regularly about the importance and significance of traditional foods in their culture. Traditional foods refers to

foods that have been consumed for generations by Alaska Native people. These foods have cultural, spiritual, and nutritional value. Seventy-five percent of participants stated that traditional foods were important and this is what they grew up eating. These foods reminded the participants of home and the lifestyle they used to live. P2 said "I think about the way I grew up a long time ago, we ate quite healthy because we ate a lot of wild game, birds, fish; natural foods." P5 stated that eating healthy meant eating subsistence foods such as fish and moose meat, P4, P6, P9 all agreed. P10 stated "We grew up on it [traditional foods] and look at our people, they are strong. Now, we're living in a society where it's not readily available anymore. In our family, we don't have it so we don't eat it. That plays a big role in what we choose to eat." P7 stated "Now we have big houses and mortgages and cannot afford to take our families out to the villages."

The subtheme of subsistence lifestyle emerged during all four focus groups when the topic of exercise came up. Subsistence lifestyle is the way of life for many people who grew up in an Alaska Native village. Traditionally, Alaska Native people who live in villages need to work all year round to provide food for their family. Their active lifestyle included hunting, fishing, gathering, and processing meats and animal hides. All pieces of the hunted animals were used to make clothing and tools. Hunting was very laborious. All of the harvested animals had to be carried by individuals, butchered, skinned and processed. All of these activities were time consuming and required extensive physical exercise. P1 stated, "we ate good food back then but we were also putting in a lot of energy to do what we were doing." P2 said, "It wasn't just hunting, it was preparing the food, hauling the food, storing the food. Our foods are naturally lean so we had to add oil in our diet such as seal oil or fish oil to add to our foods so we could

get healthy fats. Today, we are still eating white flour and other bad fatty foods and also eating seal oil, eating the way we historically did".

The subtheme of togetherness evolved when participants from all four focus groups shared that they liked to learn about things they did together as a group. In Alaska Native villages, all community members work together and depend on each other to survive. Community members help provide food for each other and look after one another. Alaska Native people work together as a community in many things they do, therefore, prefer to learn nutrition and health related topics together. P15 said "good nutritional information comes from a cooking class that is held in my apartment building for a group of us". P1 said "playing basketball with friends helps with motivation to be healthy". P7 said "growing up, there was a community garden where everyone did gardening together and everyone had fresh vegetables." P12 stated "In order to survive in rural Alaska, the whole village needs to work together. This togetherness spills over into all aspects of our lives".

Adaptation. The non-traditional metropolitan environment that participants were currently living in greatly affected their current eating patterns. Participants' spoke about a lack of accessibility to their traditional, healthy foods, the impact current advertising had on their food choices, how convenient it was to eat unhealthy, and how hectic and demanding their current lives had become compared to the traditional environment they grew up in. The advertisements on television and fast food restaurants located on every corner contributed to their perception that convenience foods were very accessible. Their current environment was discussed as having a significant impact where the unhealthy foods were available and easier to prepare and eat than healthier foods, or traditional foods. In addition, the participants expressed frustration with the shelf life of healthier foods purchased in Anchorage compared to the store bought foods with

preservatives or to the way they preserved foods in their village. Participants shared that fresh fruit and vegetables from the store were only good for a few days, if they were not eaten, the food was wasted and thrown away. This went against their cultural practice of not wasting their foods. Alaska Native peoples are not a wasteful group of people and have been taught by their elders to use all parts of the animals, fish, birds and plants by preserving them for future use. Therefore, participants perceived that buying and throwing away perishable foods, is culturally and morally wrong.

The subtheme accessibility pertained to how readily available unhealthy foods were and the affordability and decreased access participants had to healthier foods. The foods that were most accessible, realistic to purchase, and easiest to prepare were identified as convenience foods. The convenience foods were mostly processed foods that participants in all four focus groups contributed to being unhealthy. P13 said that unhealthy foods were more accessible to grab on the run "if it wasn't there, I couldn't grab it." Accessibility to fresh fruits and vegetables because of cost and spoilage was apparent through comments from twelve participants. "Fresh produce goes bad so quickly, so you have to buy it the day you are going to eat it, and that is sometimes not doable." The participants shared that when they wanted to eat healthy fruits and vegetables, they either didn't have any when they wanted it or it was spoiled. In this sense, participants felt that healthy fruits and vegetables were not accessible when needed. P13 said "I try but so much gets wasted. Then pretty soon, I just stop buying it." Additionally, participants discussed the lack of accessibility to traditional foods frequently. P16 said "it is difficult to eat healthy because you cannot hunt in Anchorage." P18 said "I grew up eating the native food like fish, seal oil, greens, and berries off the land but now, here, I just go get whatever." P3 said

"living in the city makes it difficult to eat healthy." Cost and spoilage was a big factor for participants to be able to have access to healthy foods.

The subtheme of convenience emerged during each of the four focus groups. There were many comments and discussions about foods that were more convenient to eat on the run. Foods identified by participants were typically considered unhealthy and were able to stay fresh for a long time. Comments from participants that centered on eating at fast food chain restaurants were included into this subtheme. Overall, participant comments dealt with the idea that even though some foods were not a healthy choice, the foods were seen as quicker and more convenient to grab a quick meal than one that was homemade. P3 said "It's more work to eat healthy, you have to actually prepare the food somehow. You can't just go to the freezer section and grab a box of TV dinner, its more work." P13 said "In the mornings, I used to eat shakes and it was healthy and my knees stopped hurting, for some reason I stopped and now I just grab a coffee and go, I go without the shake knowing I'm hurting myself." P13 stated "It's hard to eat healthy when there is easily accessible foods to grab on the run. If it wasn't there I wouldn't grab it." P11 agreed saying "Yeah, there is a McDonalds on every corner."

The subtheme of competing priorities was a strong subtheme that was mentioned by the majority of the participants in regards to not having enough time to prepare and cook healthy meals. With the busyness of city life, the participants struggled between their priorities of cooking a healthy homemade meal or attending local activities and appointments. Seventeen participants stated they were too busy to eat healthy, and that unprocessed foods take longer to prepare and cook. P10 stated "We don't have time to eat proper. We get so involved with so many different things going on, we say, Oh I'll just grab this, and not take the time in the day to eat a healthy meal." P34 said "It's a lot of work, it takes a lot of effort to cook and shop and look

and be picky and read labels." P33 stated "It's the time. I have four kids with activities, working full time, depending on the day, if they have to be dropped off or picked up, appointments, it's just crazy juggling everything." P31 responded saying "then the next thing you know it's time to cook supper and what are you going to cook?"

Requesting information. This final theme emerged based upon comments participants made about what they didn't know and what they would like to know about health, nutrition, and eating healthier. The primary researcher observed knowledge gaps in food label nutritional information during the focus group discussions. There was a variety of opinions and comments in regards to food labels during the focus group. Some participants seemed to know what they were looking at and why while others didn't appear to understand fully what the nutrition label information meant. All twenty participants spoke about wanting more education regarding nutrition and food labels; some wanted additional information for themselves and some wanted it for younger generations. Many participants stated it would be helpful to have information about how to prepare and cook urban store bought foods. There were discussions within each focus group about the way participants wanted to receive educational information and how best that information could be understood. Participants also discussed what experiences they have had that did not help their learning. Each subtheme arose during discussions with the participants on what they wanted to learn more about and how they learn best.

The subtheme of nutrition information was a large topic of discussion in all focus groups. Nine participants said they received their nutritional information from the backs of food packages. There was no consistency between what they looked for on the nutrition label. Some participants felt that their focus should be on carbohydrates while others focused on calories as a primary concern. Overall, the consistency among participants was that they were conscious of

the important nutrients that affected health but did not have a majority focus of a primary ingredient. P5 stated, "I look at the sugar", P3 stated "I look at calories and fat", P7 stated "I look at protein, sodium and calcium", P6 and P20 both stated "I look at carbs", P12 stated "I calculate carbohydrates and proteins", and P4 and P9 both stated "I look at calories". P16 stated "I look at the side of the bag or box but usually only when I'm bored."

Some comments led the researcher to believe that the participants did not have a clear understanding about what healthy food was and wasn't. P11 said "sugar is a bad influence but can be good" when discussing sugar in processed foods. P14 said "I feel like anything can be unhealthy if you consume too much of it, doughnuts are not the most healthy but if you eat one, you can eat other things to offset it." Two related participants, P10 and P11 were discussing a popcorn diet where a friend ate only popcorn for two to three years which was healthy because he had self-control and lost a lot of weight. These comments led the researcher to believe more education was needed surrounding nutritional information.

The sub theme of food preparation was evident from the interest that the majority of participants had in learning more about how to eat healthier. Sixteen participants expressed their desire and interest in wanting more nutritional education for themselves. P8 wanted to learn "how to use the produce, you know, the good stuff, in ways that are not time consuming and they are tasty and that are going to preserve it [the produce]. See how you can freeze them yourself and can them and dry them and do all these things with them that can make them last longer." P4 stated "yeah" and P6 stated "exactly" both agreeing that food preparation education would help them as well. P18 said "If they [healthcare providers] can compare the fresh and the canned and tell them what is the difference and where all the nutrients are lost when they cook them and process them."

The subtheme information seeking emerged from the information participants felt they needed to be able to eat healthier and stick to a healthy diet. Six participants had a lengthy discussion about wanting education on how to avoid eating when stressed. P7 stated "I think that the thing that would be the most helpful for me is to have a health provider discuss deeper issues that would cause me to overindulge in food and not stop. You know, there are deeper things like addictions or stuffing down your feelings or stress or someone broke my heart. Those kinds of things and knowing what to do and how to get out of that loop." P6 stated "having a nutritionist or provider talk to you about what or why you are eating when you are. That would be more helpful than just saying here is a food guide pyramid, follow this." P3 stated they wanted "a list of alternatives, with examples like instead of eating chips, have a bag of carrots available".

Six participants felt strongly that they wanted more education that was centered on the younger generations. P4 said "I think my life would have been different if there was awareness. If there was education from elementary school, processed food is bad not just convenient. If I knew from an early age that fresh fruit was better or vegetables were better or if my dad knew. We had boxed chicken. We didn't know it was bad. So it's not that we don't care it's we don't know." P19 wanted more education for younger children also stating "I like commercials, even with the little kids. Sitting there with a grandkid and they see something and all of a sudden they say I want that kind! If they see something that is nutritional then they might want to try it. So, advertising, maybe if South Central Foundation or Alaska Native Medical Center did a commercial about healthy eating, it would capture everyone's attention." P18 stated "Maybe if you catch the new moms, because a lot of children nowadays would rather have pizza and fast food and French fries. If you try to catch them and educate them early about healthy food. A lot of babies are having babies and it's just easier for them to just grab the easy stuff to cook and

give in to your child's wants rather than giving them a healthy 3 course meal." P2 agreed stating "also in the villages I wish they would quit having the children grow up on soda. I understand it is a lot cheaper than milk or juice but it's really not good."

The last subtheme that emerged from the focus group data was learning. Ten participants spoke specifically about being visual and interactive learners. The participants voiced that they learn best when they are in the office and could discuss and look at menus or recommendations with a healthcare provider. P17 said "We learn in person than over the phone. When you have someone call you they seem to be in so much of a hurry and their questions are just pop pop pop! It goes by so fast so I just didn't care after that." P2 stated it would be helpful to have "a daily reminder that I could just look at because I am a visual person, I need to look at things. It would help if there was something in front of me every day." P1 stated "a newsletter or something like that that would be created with little questionnaires about how you get your vitamins and proteins and exercise." P7 said "I spoke with a nutritionist once and they wrote a timeframe of what you should eat and when your snack has to be a dairy and you eat this many proteins. You know, you can say that until you are blue in the face but until I see it and you can give me a schedule, I am more of a visual person and I need examples of what to eat." P8 agreed saying "Yeah, one that's easy for me to understand… instead of a chart that's this big [motioning a small chart] instead of trying to decipher it, it's like, I just give up!" P12 wanted more guidance to eating healthy stating "I think, teach us to how to put it [eating healthy] into practice. Instead of giving us a brochure on diabetes and her are all the things that contributed to you having diabetes, maybe have along with the brochure, a grocery list, or a recipe, with a colored picture. Make it tangible so you can see it. It would go from this is what you do to this is why, and this is what you get." Four other participants from the P12's focus group unanimously agreed. Later on

when discussing information learned from medical appointments, P12 stated "I'm a very visual learner, so any provider needs to take into account that people are looking at, seeing, in taking, and gearing something from their perspective, so you could be coming from a nutritionist perspective and what I take home could be something totally different. Then they read their notes and say what the nutritionist told me and it was surprising to see that I took a totally different message home with me. It's not enough to just give somebody the information. For me, I have to see it."

Discussion

The results of this study have provided valuable information for healthcare providers on how culture affects the nutritional status and food choices of Alaska Native adults with a chronic disease. Using the results of this study will help healthcare providers educate Alaska Native patients in a way that is effective and most valuable for this population. This study has outlined common barrier that impact how Alaska Natives make food choices and how such barriers affect the ability to eat a healthy diet. From the collected data, suggestions for improving patient education effectiveness for this patient population and the implications for advanced practice nursing will be explored. The study limitations will be reviewed and recommendations will be suggested for future research projects.

In general, Alaska Native people have a strong connection with their culture and family heritage. This population places a high value upon family and community connections and traditions passed down through generations by their elders. Overall, participants in this study voiced their desire to see more nutrition and dietary education available for children and young mothers who need to teach their children healthy eating habits from birth. The participants wanted the younger generation to learn how to eat healthy before they learn too many unhealthy

eating habits. Half of the participants felt that there was not enough education that explained how to read nutrition labels. Furthermore, there was great confusion about what participants should be focusing on when they look at food labels when they make their food choices. The participants who were forty years or older voiced that they ate mostly traditional foods growing up, but over the years, in their villages, they had been exposed to some western foods such as soda, Tang, white bread, rice, and chips. These foods have remained part of their diets after they moved into the city and some were difficult for them to eliminate from their diets.

Participants in each focus group commented on being visual and interactive learners. The participants voiced their desire to have healthcare information face to face with their healthcare providers along with a visual aid to help remind them or help them to choose healthier foods. The participants suggested a handout or menu lists that outlined foods that were considered healthy to grab on-the-go. Participants felt such strategies would help support patients with busy lifestyles. Other ideas participants spoke about were having handouts available at clinics that included sample menus with healthy meals and snacks, nutrients and calorie counts.

Southcentral Foundation has made some of these visual aid items available for Alaska Native patients and are currently available in their clinics. A few of the participants wanted to also see television or radio commercials from local healthcare organizations. The participants believed that currently children are asking for and choosing what they eat based on what they see on television. Participants stated that healthcare sponsored commercials could help create an increased awareness and entice Alaska Native adults and children to make better choices and eat healthier diets. The participants tagged this idea as a visual aid and indicated that these ideas would serve as a constant reminder to eat healthy to stay healthy.

Each focus group discussed how communication and learning styles impacted their food choices and disease management ability. The majority of project participants stated that they did not learn as well over the phone as they did in person. The participants felt rushed during office visits and felt that they did not have time to absorb the information and ask questions. When healthcare information was given out over the phone, participants reported being able to listen for the first couple of minutes and then confessed how overwhelmed they were and how they had trouble paying attention. The participants suggested and agreed that it would be more meaningful for them if test results, diagnoses, or any new health related information was done during a face to face office visit with a healthcare provider rather than over the telephone. Being respectful to the learning and communication preferences of Alaska Native patients could prove to have a great impact upon the ability of healthcare providers to build relationships and empower their Alaska Native patients. Adopting a culturally focused approach would help Alaska Native patients feel more comfortable and encourage them to become more actively engaged in their healthcare.

During the four focus groups, the researcher noted that there seemed to be differences in socioeconomic statuses between the participants. Participants made various comments concerning their ability to afford and budget to buy regular food and fresh fruits or vegetables. Another aspect of a difference in socioeconomic status became apparent when participants discussed their ability to access a vehicle to transport them to the store or to medical appointments. Some participants spoke of needing a ride and not having a vehicle. The first two focus groups appeared to be evenly distributed with mainly middle class individuals while the third focus group of participants seemed to be composed of participants of higher socioeconomic means. The fourth focus group appeared to have had participants in the lower socioeconomic

class. Variances in socioeconomic status resulted in different responses. For example, the lower socioeconomic status participant's main barriers to eating healthy was more about affordability, while those who made more money tended to be too busy taking kids to sports and appointments to cook a healthy meal. Whether affordability was a factor or time or education, the results would be different if they were separated.

Nursing Implications

This study's results have provided a great deal of insight and information that impact nursing practice. The participants in the study felt that a delivery approach that was more understanding of their culture would be more effective and conducive to improving learning and overall health status. Alaska Native peoples have a more relaxed lifestyle than the western world. They take their time to process information and thoughtfully consider outcomes and alternatives throughout a discussion. Sometimes, the cultural differences are not always understood or considered within the healthcare setting. Often, for example, Alaska Native people need extra time to process health information. Many Alaska Native people must translate English conversations into their native dialect, interpret the meaning of the message in their primary native language, and then find the equivalent English words that best describe their thoughts and feelings. Healthcare providers can often misinterpret the time delay as a lack of interest in their health, a lack of intelligence, or an inability to understand what is being said.

Healthcare providers play a vital role in patient education. The effectiveness of healthcare teaching can have a great impact on long-term health outcomes. The study participants stated many times that they learned best in person where they can look at their results or charts and discuss them with their provider. Participants from all focus groups agreed that having the

healthcare provider explain medical information over the phone was not optimal for them and described how, at times led to confusion and disengagement.

Participants knew the value of looking at nutrition labels but could not verbalize what they should be looking for. Further education on food labels and nutrients needs to be incorporated into regular guidelines. Many participants stated they do not know what to look for on the labels and others only look for one or two items rather than all nutrients together. For example, two of the participants who were diabetic only looked at carbs when viewing nutritional labels while other participants only looked at calories or fat or sugar. None of the participants could verbalize why they look at those items specifically. All of them had received information about nutrition labels at some point but they did not have a comprehensive perspective when looking at the ingredients. There was confusion surrounding which ingredients should be of particular focus for them. Healthcare providers need to be aware of such confusion as this lack of clarity had a significant impact of the participant's ability to make health food choices.

All four focus groups voiced concern for the younger age groups and young mothers in that participants wanted to encourage a focus of healthy food choices be steered towards younger patients. All age groups have different needs and levels of education regarding interpreting nutrition labels and general discussion during healthcare visits would be beneficial.

Participants in each focus group shared that sometimes they eat or overeat due to depression, stress, or other psychosocial reasons. The participants were requesting to have conversations initiated by the healthcare provider at each visit regarding stress, depression, or other reasons they may be overeating. In addition to the regular screening questions, the participants voiced that they would like to have specific discussions about psychosocial concerns

that they may be facing and the implications such situations have on their eating habits. The participants shared that they would like to understand why they are feeling the way they are, how to overcome those feelings, and why they are tied to eating unhealthy or overeating. They also voiced that they would like to learn how to avoid eating or overeating when they are having these feelings. Primary care providers who work without counselors, and nutritionists need to regularly incorporate stress management, addiction, and depression screening inquires. The study participants tied such challenges to their unhealthy eating and difficulty with chronic disease management. Healthcare providers need to be cognizant of these complex psychosocial needs that are not often vocalized by their Alaska Native patients. Chronic disease management with Alaska Native people should include the incorporation of a strong cultural component including collaboration with other healthcare management team members to address emotional, social, and psychosocial domains of the patients' disease experience. Such a coordinated approach is important to provide sensitive and culturally specific care to Alaska Native patients who have chronic disease care needs.

Limitations

There were a few study limitations identified by the researcher. The first limitation was that while there was a wide range of ages in all focus groups, the 30 years and younger age group was under represented. Participant's ages ranged from 28 to 67 years old. Generational differences were apparent in the way the participants spoke and answered the focus group questions. There was a difference in the way they grew up, their healthcare knowledge, and their comfort level with preparing store bought foods. The older participants had grown up eating more traditional foods, while the younger participants had moved to the city at an earlier age and had been exposed to western store bought foods earlier in life. The older participants

spent more of their early years, living a subsistence lifestyle than the younger participants. The older participants' healthcare knowledge was more based on what they learned from their elders and what they learned growing up in their village while the younger participants had a mixture of knowledge passed down from their elders mixed with education from school and their healthcare providers. It was noted that the younger participants were more comfortable buying, storing, and cooking store bought foods than the older participants. Completing more focus group studies with each generation better represented could provide a great variety of perspective than what was generated in the study data from this inquiry. Identifying educational needs across generations would provide a more comprehensive view of existing gaps in current knowledge about food choices and chronic disease management.

It was difficult to recruit participants for this study. As a result, the sample size for this study was small. Therefore, the limited number of participants may not be representative of the larger Alaska Native population. Furthermore, the researcher did not ask participants to identify what type of Alaska Native they were, what region they were from, how long they had lived a traditional lifestyle in their village, or how long they had lived in Anchorage. Alaska Native people have differences in their culture that could affect responses and therefore not completely be representative of the larger population. While there are many similarities in cultural values throughout Alaska, there are differences in the types of foods they prefer, how they hunt for foods, mannerisms, and potentially how they prefer to receive healthcare information. When conducting focus groups, different preferences may emerge depending on the region the participant is from or how long they have lived in a rural setting.

Recommendations

The findings complied from this study have not been reported in any previous published literature. Therefore, more work done in this area could only further increase healthcare provider's knowledge and success in dealing with this healthcare topic and patient population. The study sample was small and involved participants from a variety of age groups. As a result, the researcher would recommend repeating further focus group studies where the focus group sessions are separated into three different generations, i.e. X generation (those born 1965-1984), Millennials (born 1985-2004), and Baby Boomers (born 1946-1964). The upbringing, life experiences, learning styles, motivational styles and education levels all present unique challenges that would enrich knowledge on this topic and therefore warrant a more thorough investigation. The needs and understanding of an older adult, as hinted in this investigation, are different from the needs and understanding of a late teenager. Separating focus groups by ages would provide information on the cultural preferences, experiences, and needs unique to each age group thus maximizing outcomes for individuals across all generations. Gathering data from a larger sample from each of the generational age groups would allow researchers to collect opinions from a greater variety of the population that would increase the representative preferences unique to the issue of chronic disease management.

A second recommendation would be to further investigate issues that were noted during this investigation such as; socioeconomic challenges, transportation capacity, fresh foods access, and regional differences within this population. Such an investigation would help expand the knowledge and highlight the experiences, struggles, and individual group needs to better promote health. Educational teaching sessions could then be tailored to fit the needs of individuals.

The researcher noticed a difference between participants in the level of knowledge and understanding about dietary requirements. The researcher did not have enough data to evaluate

whether the lack of participant knowledge and understanding was related to the educational status. Therefore, in the future, questions that explored participant educational level would be important to assist educators to evaluate and develop educational material that would maximize patient understanding. Furthermore, healthcare providers could use such information to help guide their patient conversations and accommodate for learning differences.

Future research studies could also focus on the type of learning styles that are most effective when teaching Alaska Native adults about healthcare information. Studies currently available on this topic are greater than ten years old and primarily focus on the learning styles of school aged or college age participants. Determining the effective learning styles for Alaska Native adults can assist healthcare providers in both outpatient and inpatient settings deliver healthcare information that is culturally appropriate and meaningful.

The Alaska Native culture is family centric with a focus on community and group interactions. Participants felt that their engagement and learning would be greatly enhanced if their learning encounters could include and take place in their community amongst family. Some educational opportunities to support community and family values for this population could include cooking classes that teach how to shop, prepare, store, and preserve store bought foods. Many of the participants voiced frustration and helplessness when speaking about how expensive store bought foods were and how quickly fruits, vegetables, some meats spoil. When using non-traditional foods, participants voiced their desire to learn how to cook quick healthy meals. Additionally, participants wanted to learn about the nutritional benefits of key ingredients in different recipes they cooked. Using these techniques along with cultural consideration and individualized patient education, healthcare providers can better tailor their health message in a way that is beneficial and culturally appropriate for Alaska Natives.

Based on conversations with the research participants, a beneficial project for the future would be to discuss and develop sample menus that outline locally available healthy foods and meals within the urban setting. The creation of sample menus could be incorporated into a cooking class which participants were interested in attending. Investigations that focused on knowledge deficits and understanding of preparation experiences would help individuals incorporate healthier foods into diets while actively involving participants. Such actions could help change current food choices and cooking practices and lead to improved health outcomes. The Southcentral Foundation has developed some handouts and provide some classes for their patients that include topics pertaining to choosing healthy snacks, however, it is unknown how expansive the program is and the number and type of Alaska Native patients this program has included.

Lastly, if more healthcare providers were aware of patient's visual and behavioral cues and tailored their healthcare teachings and conversations accordingly, there could be a greater opportunity for increased learning. To improve the effectiveness of interactions between healthcare providers and their Alaska Native patients, more attention needs to be focused on the length of healthcare visits. Increasing appointment time slots would allow many Alaska Native patients the parameter required to meet the patient's needs. Healthcare providers can benefit their Alaska Native patients most by using face-to-face interactions for health related conversations and allowing the patient to ask questions and fully absorb the information instead of using telephone conversations. Teaching with visual aids and demonstrations produce the best outcomes with Alaska Native patients. This culturally respectful approach would take longer than a current average appointment time, however, it would encourage partnership and

collaboration between Alaska Native patients and their healthcare providers to move towards successful planning for their improved health.

Conclusion

Findings from this study suggest that Alaska Natives living in Anchorage continue to have a strong connection to their culture including their desire to eat traditional foods. The study results indicate that Alaska Natives living away from their village setting do not have easy access to their traditional foods and are not as active as they once were compared to when they were living their traditional subsistence lifestyle. Alaska Native adults continue to value and recognize the health benefits of their traditional foods and lifestyle after moving away from their village. Regrettably, moving away from their rural villages and into the urban settings has depleted the accessibility to the highly valued traditional food choices. Recognizing these challenges to eating healthy, healthcare providers can help Alaska Native patients develop strategies to address these cultural considerations.

The majority of the participants indicated that they were visual, interactive learners who learned by watching and doing. Health education needs to be taught using this model and needs to be presented in a more culturally appropriate manner to maximize the message and level of acceptance. This type of learning style is supported by a study conducted by Steven Aragon (2004) who found that most American Indian and Alaska Native students in a postsecondary program learned best by watching and listening. In that study this method of instruction was referred to as a "watch-then-do or listen-then-do". Aragon strongly encouraged that educators allow the learner to watch and listen to what is expected, then think about what they just watched, before they are expected to begin to do what is desired (Aragon,). Furthermore, the study found that when the education was delivered in a logical and thorough manner, Alaska

Native and American Indian students performed better. Changing the way targeted healthcare information is presented to this population is paramount to enhance learning outcomes. Listening with empathy to the Alaska Native patients and allowing for periods of silence while they process the information and gather their thoughts will lend itself to a more trusting relationship and improved outcome. All healthcare providers can be more effective in their conversations with Alaska Native patients by bringing them into the office for most health related conversations and discussing at each visit possible psychosocial problems that may be affecting them. It is also beneficial for healthcare providers to modify their own communication style by slowing down their approach and spending more time, speaking with a lower tone of voice and at a slower rate, explaining topics thoroughly and simply, and giving extra time for their patients to process the information and ask questions.

Understanding Alaska Native culture and traditions are a very important first step so healthcare providers can help initiate change when requesting Alaska Natives to consider making changes to their diet and food choices. Learning more about the uniqueness of the cultures of Alaska Native peoples would improve the relationship and interactions between both providers and patients. A trusting and open relationship can promote trust and enhance the desired healthcare message. Providing educational information about the different Alaska Native cultures, communication styles preferences, and the importance subsistence food choices have on health status can provide non-Native health care providers with effective strategies and better prepare them to work more effectively with their Alaska Native patients.

The U.S. Fish & Wildlife Service Region 7 (Alaska Region) conducts an Alaska Native Relations training for all of their employees. This training is mandatory and covers lectures on all Alaska Native culture groups, the laws affecting Alaska Natives and those who work with

Alaska Natives, subsistence, and cross-cultural communication. Alaska Native elders are active participants in the class, and the instructors are all Alaska Native employees of the U.S. Fish & Wildlife Service. The training is conducted at the Alaska Native Heritage Center to facilitate a more traditional setting. The curriculum was developed by a team of Alaska Natives (Appendix H). Developing a similar training that is available for health care providers would be of great benefit to improve health outcomes for Alaska Native patients.

Lastly, increasing the duration of appointment times would allow healthcare providers to take the needed time to communicate effectively and would encourage more meaningful discussions and successful partnerships. Patients who believe that their healthcare provider listens to them and values their culture are more likely to build relationships, trust their provider, and therefore, be more likely to consider advice. Achieving a strong trusting relationship between Alaska Native patients and their healthcare providers, will improve dietary plan adherence and ultimately health outcomes for patients with chronic disease.

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Appendix A

Dr. James' Focus Group Questions

Concepts of Healthy Eating

1. What comes to mind when you think of eating healthy? (Probe: What makes a food healthy or unhealthy?)

2. What comes to mind when you hear the words 'eating habits of blacks/African Americans? (Probe: Do most blacks/African Americans eat a healthy or unhealthy diet? Are they interested in eating a healthier diet?)

Barriers and Motivators to Healthy Eating

3. What factors in your life make it difficult for you to eat a healthy diet? (Probe: What about when you eat out?)

4. Which foods are the most difficult to limit or give up from your diet? (Probe: Do these foods have any special meanings to you?)

5. Which foods do you think would be the most difficult for most blacks/African Americans to limit or give up? (Probe: Do these foods have any special meanings?)

6. Which foods or food groups would be the most difficult to add to your diet? (Probe: Why?)

7. What are the main reasons that prevent many blacks/African Americans from eating healthier foods?

8. What would motivate you to improve your eating habits? (Probe: Why?)

9. What factors would motivate most blacks/African Americans to change their eating habits? (Probe: Why?)

Nutrition Education Channels

10. Where do you get most of your nutrition information? (Probe: What type of information do you usually get? How do you use the information?)

11. What groups in the African American community would be receptive to changing their eating habits? (Probe: Why? Where should we start?)

12. What type of information do you need to help change your eating habits?

13. Where do you think other blacks/African Americans get their nutrition information? (Probe: What would be the best way to educate African Americans about health issues?)

Appendix B

Permission Email from Dr. James

James,Delores Corinne Suzette
To: alison armour
Re: Your culturally sensitive model study

Hi Allison,

You have permission to use the focus group guide. I would request that you put me in the acknowledgement.

If you do not have enough for each group, I recommend that you use triads (3 per group) rather than larger focus groups.

Hope this helps.
Dr James

Sent from my iPad

Appendix C

Project Focus Group Questions

Concepts of Healthy Eating

1. What comes to mind when you think of eating healthy?

- Prompt: What makes a food healthy or unhealthy?
- Prompt: Do most Alaska Natives eat a healthy or unhealthy diet?
- Prompt: Are they interested in eating a healthier diet?

Barriers and Motivators to Healthy Eating

2. What factors in your life make it difficult for you to eat a healthy diet?

- Prompt: What about when you eat out?
- Prompt: What about other Alaska Natives?

3. Which foods are the most difficult to limit or give up from your diet?

- Prompt: Do these foods have any special meanings to you?
- Prompt: What about for most Alaska Natives?

4. Which foods do you think would be the most difficult to add to your diet?

- Prompt: What makes them difficult to include?

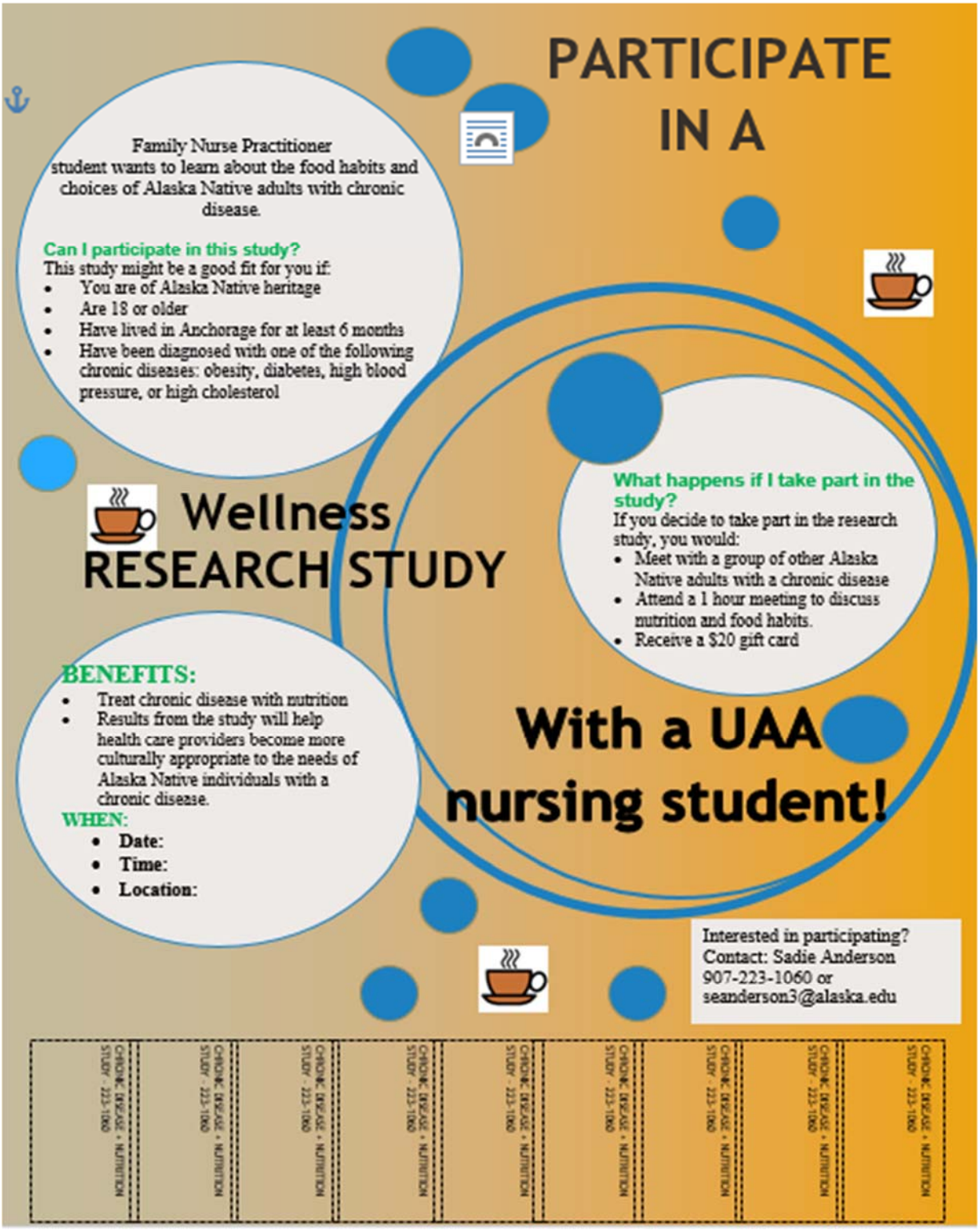
5. Where do you get most of your nutrition information?

- Prompt: What type of information do you usually get?
- Prompt: How do you use it?

6. What type of information would help you make better choices about what you eat?

Appendix D

Project Flyer



Appendix E

Focus Group Script

Hello. My name is [-----], from the University of Alaska, Anchorage Family Nurse Practitioner program. Accompanying me today is [-----], a fellow student. We are here today to conduct a focus group with Alaska Native individuals with chronic disease to understand how culture affects diet and nutrition choices.

A focus group is a guided discussion in which all participants are encouraged to respond to a series of broadly worded questions on a particular topic. We are very interested in hearing about what everyone in the group thinks and there are no wrong comments or responses. My role as moderator is to keep the discussion on focus and to make sure that nothing is misunderstood. It is not to participate in the discussion.

The purpose of today's focus group is to help determine what kinds of issues you, and other members of your community with chronic disease, face regarding the choices you make about your diet and nutrition. We have invited you here today because of your experience with chronic disease. We value your opinions and encourage your honest and complete feedback in response to our questions, and we are thankful that you've agreed to come to this group to share your thoughts and perspectives. While we encourage your full participation to help us understand how you make your decisions about your diet, there are no negative consequences for choosing not to respond to any questions during the course of this group.

We want to remind you that what you tell us today will be sorted based on the themes and topics we identified. No names or identifying information will be associated with anyone's particular responses or appear on any presentation or report. With your consent, we will be using a recording device to ensure that we preserve a complete and accurate record of what is shared in

this group. Today's recording and any notes will be kept secure and only the two student researchers will have access to them. There is a time limit on how long these are kept and then they will be destroyed. Are there any questions? [Moderator answers any questions].

You received the Informed Consent form when you arrived. Everything I have just described is written on this Informed Consent form. We invite you to ask any questions you have regarding the Informed Consent process at this time. [Moderator answers any questions]. If there are no other questions, we ask that you sign the form to express your written consent to participate in this focus group and place it in this manila envelope. I will sign this form as well. You will receive a copy of this statement for your records, which contains within it the contact information for the persons responsible for this project, should any questions arise after we leave here today. [Moderator collects consent forms].

To get us started, we'd like to have you briefly introduce yourself. I will begin.

[Moderator will once again give her name. After the moderator has completed her introduction, she will gesture to the person to her immediate left who will then be asked to introduce her or himself. When introductions have been completed, the note taker will turn on the recorder and the moderator will begin the focus group.]

[Focus group questions will be asked. Prompts will be used to help participants clarify their responses, to encourage further depth, and to ensure that participants touch on all of the salient points addressed by the question.]

This concludes our questions. We are very thankful for your time and your thoughtful responses. We ask that you observe and respect the confidentiality of all participants.

Appendix F

Permission Email from J. Kaufmann

Jo Ann Kauffman
To: alison armour
Focus Group Script

Dear Alison,
Certainly, you have my permission to use or modify our focus group script for moderators. I am glad you found it helpful.

Jo Ann Kauffman, President
Kauffman & Associates, Inc.
W: 509-747-4994 C: 509-768-8557
www.kauffmaninc.com •
Joann.kauffman@kauffmaninc.com

"We Do Work That Matters"

GSA Contract Holder

Appendix G

Consent

Consent Form

Researcher:
Sadie Anderson, UAA School of Nursing
(907) 223-1060

School of Nursing, University of Alaska Anchorage

Description:

I am asking you to be part of a focus group talking about how culture affects diet. If you agree to take part, you will be a member of a group that will include several adults from the Anchorage area. The meeting should last approximately one hour.

Voluntary Nature of Participation:

Your participation in this study is voluntary. You may stop at any time and you do not have to answer any questions you do not want to. Nothing will happen to you if you choose not to answer any questions or if you decide not to participate.

Confidentiality:

I would like to record the focus group. This will help to keep the researcher's notes accurate. Recordings and paperwork will be kept in a locked file cabinet. Only the researcher will have access to them. It will not be possible to identify you from any of the data. Your name or any other information that can identify you will not be attached to any of your responses, or to any reports or posters describing the results of this study.

Potential Benefits and Risks:

Being part of this study will take about one hour of your time. If you decide to take part, your willingness to share your experiences and knowledge may help healthcare providers in the future. Healthcare providers teach good eating habits to adults. Information from this study could make the teaching more specific for people in your culture. There are no anticipated risks or benefits to you from taking part in this study.

Compensation:

To thank you for being part of the study, you are offered a $20 gift certificate to Wal-Mart.

Contact People

Please call Sadie Anderson, Family Nurse Practitioner student, at 223-1060 with questions about this study. Please contact Sharilyn Mumaw, Research Integrity & Compliance Officer, at (907) 786-1099 if you would like to know more about your rights as a person in the study.

Signature

Your signature below means that you have read the information above and agree to take part in this study. If you have any questions, please feel free to ask them now or at any time during the study.

Signature_____ Date _____

Print Name _____

A copy of this consent form is attached for you to keep.

Appendix H

US Fish and Wildlife Society Alaska Native Relations Training Agenda

Alaska Native Relations Training

USFWS Region 7 – February 29 – March 4, 2016, Alaska Native Heritage Center, Anchorage, AK

Elders

Anna Nageak, Inupiaq, Anuktuvuk Pass
Pete Abraham, Yup'ik, Togiak
Elliot Roger Lind, Alutiiq, Chignik Lake
Wilson Justin, Ahtna Athabascan, Chistochina
Trimble and Mary Gilbert, Athabascan, Arctic Village

Guest Speakers

Dr. Stephen J. Langdon, Professor Emeritus, Anthropology, University of Alaska Anchorage
Judge David Avraham Voluck, JD, Sitka Tribe of Alaska
Reverend Dr. Michael Oleksa, Intercultural Communications Professor
Jack Dalton, Traditional Yup'ik Storyteller
Dr. James Fall, Statewide Program Manager-Research, ADF&G, Division of Subsistence
P.J. Simon, President, Allakaket Village Tribal Government
Dr. Jeffrey Brooks, Sociocultural Specialist, Bureau of Ocean Energy Management
Dr. Michael Koskey, Assistant Professor, Cross-Cultural Studies, UA Fairbanks
Marlene Zichlinsky, Native American Program Policy Analyst, U.S. Fish & Wildlife Service

Teaching Cadre

Crystal Leonetti, Yup'ik, Alaska Native Affairs Specialist
Orville Lind, Alutiiq, Tribal Liaison, Office of Subsistence Management
Joanne Bryant, Gwich'in Athabascan, Community Liaison, Arctic National Wildlife Refuge
Ernest Nageak, Inupiaq, Alaska Native Affairs Specialist, Barrow FES Office
John Mark, Yup'ik, Refuge Information Technician, Togiak NWR, Quinagak
Jack Lorrigan, Tlingit/Haida/Tsimshian, Former USFWS, Tribal and Community Liaison, BSEE
Patty Schwalenberg, Ojibwe, USFWS Contract, Executive Director of Chugach Regional Resources Commission/Alaska Migratory Bird Co-Management Council

MONDAY (1-5 pm) – *Moderator Crystal Leonetti, Yup'ik, Alaska Native Affairs Specialist*

Class begins at 1:00 pm at the Athabascan Ceremonial House

1:00 MOMENT OF SILENCE for Alaska Native Leaders Sidney Huntington, Alice Petrivelli, and Etok Edwardson

1:10 CLASS INTRODUCTION

Welcome, Introduction and Purpose of the Training – Patty Schwalenberg, Executive Director, Chugach Regional Resources Commission/Alaska Migratory Bird Co-Management Council

Welcome to Alaska Native Heritage Center – Yaari Walker, Siberian Yup'ik Author, Teacher

Housekeeping/Logistics, Introduce Instructor Cadre, Overview of the Week - Crystal Leonetti, Yup'ik, Alaska Native Affairs Specialist, and Patty Schwalenberg

1:40 WHAT TO EXPECT THIS WEEK– Regional Director

1:50 RECOGNITION – Geoff Haskett, USFWS Regional Director, Region 7

2:00 WORDS FROM ELDER, LONG-TERM USFWS EMPLOYEE – Pete Abraham

2:20 PARTICIPANT INTRODUCTIONS

4:00 ***BREAK***

4:15 WHAT IS AN ALASKA NATIVE ELDER? – ANR Cadre Members

4:45 Optional: Meet with an Elder or work on an Alaska Native Craft *(Introduction to Athabascan Beading – Joanne Bryant, Smoking Fish – Jack Lorrigan) Joanne will provide a historical overview of the Athbascan art of beadwork and its importance to her culture.*

TUESDAY (8-5 pm) – *Morning Moderator Ernest Nageak, Inupiaq, Alaksa Native Affairs Specialist, Barrow FES Office*

8:00 INTRODUCTION OF ELDERS

8:30 NATIVES OF ALASKA: CULTURAL GROUPS AND HISTORY – Dr. Steve Langdon, Professor Emeritus, Anthropology Department, University of Alaska-Anchorage

9:30 ***BREAK***

9:45 NATIVES OF ALASKA: CULTURAL GROUPS AND HISTORY *(continued)*

10:45 ALASKA'S NATIVE ORGANIZATIONS - Crystal Leonetti

Federally Recognized Tribes, ANCSA Corporations, Regional Native Non-Profits, Commissions and Co-Management Councils, and other organizations

11:15 WALKING TOUR OF THE ALASKA NATIVE TRADITIONAL HOUSES
This is an outdoor walking tour, so please bring appropriate outwear

12:00 ***BREAK*** *- After the Walking Tour, this break provides additional time for students to continue touring the facility, visit with an elder or other class participants, or take a short rest prior to the video.*

12:30 ***LUNCH (Provided)*** **- VIDEO - ALASKA TRIBES: THE STORY OF FEDERAL INDIAN LAW IN ALASKA** This video is essential to review prior to the next session on American Laws and Alaska Natives.

Afternoon Moderator Jack Lorrigan, Tlingit/Haida/Tsimshian, Former USFWS, Tribal And Community Liaison, BSEE

1:30 AMERICAN LAWS AND ALASKA NATIVES – Judge David Voluck
What are the federal laws that impact Alaska Native peoples; and how does USFWS implement them while ensuring respect is given to Alaska Native peoples?

2:30 ***BREAK***

2:45 AMERICAN LAWS AND ALASKA NATIVES - *(continued)*
Judge Voluck's presentation will include a 15" period where students can ask questions or time for those wishing additional information

3:45 OPEN FORUM – for issues, questions, ideas that have arisen throughout the week. As a class or in small groups with elders

4:15 Meet with an Elder or work on an Alaska Native craft *(family members are welcome to participate in this portion of the training)*

WEDNESDAY (8-5 pm) – *Morning Moderator John Mark, Yup'ik, Refuge Information Technician, Togiak, NWR, Quinhagak*

8:00 CROSS CULTURAL COMMUNICATION - Reverend Dr. Michael Oleksa, Inter-Cultural Communications Professor

9:30 ***BREAK***

9:45 CROSS CULTURAL COMMUNICATION Discussion, Questions – Crystal Leonetti with Reverend Dr. Michael Oleksa

11:15 WILDLIFE LAW ENFORCEMENT IN ALASKA

How differences in communication make an officer's job more difficult . . . or easier. A video and a discussion.

Noon – 2:00 POTLATCH - ***Lunch Provided***
#ShareYourPlate Video, Athabascan Dance Group and Traditional Yup'ik Storyteller Jack Dalton *(see potlatch agenda in training folder)*

Afternoon Moderator Orville Lind, Alutiiq, Tribal Liaison, Office of Subsistence Management

2:15 SUBSISTENCE AND ALASKA NATIVE WAYS OF LIFE – Panel Presentation:

Dr. James Fall, Statewide Program Manager - Research, Alaska Department of Fish & Game, Division of Subsistence; PJ Simon, President, Allakaket Village Tribal Government; Wilson Justin, Athabascan Elder; Anna Nageak, Inupiaq Elder; and Elliott Roger Lind, Alutiiq Elder; moderated by Crystal Leonetti
This session includes a 15" period for questions

3:30 ***BREAK***

3:45 VILLAGE PROTOCOL – Teaching Cadre

When I enter a village, what should I do, where should I stay, where do I get food, what if someone offers me Native food or asks me to take a steam with them, what else should I know?

4:30 Meet with an Elder or work on an Alaska Native craft *(family members are welcome to participate in this portion of the training)*

THURSDAY (8-5 pm) – *Morning Moderator Joanne Bryant, Gwich'in Athabascan, Community Liaison, Arctic NWR*

8:00 TRIBAL CONSULTATION – Crystal Leonetti, Yup'ik, Alaska Native Affairs Specialist

8:30 ***CONSULTATION ROLE PLAY EXERCISE*** **–** Dr. Jeffery Brooks, Sociocultural Specialist, Bureau of Ocean Energy Management

9:15 ***BREAK***

9:30 NAVIGATING CO-MANAGEMENT AND COLLABORATIVE MANAGEMENT – ***How Best Can we Work with Tribes?*** – Dr. Michael Koskey, Center for Cross-Cultural Studies, UAF; Patty Schwalenberg, Executive Director, CRRC/AMBCC; and Stewart Cogswell, OSM-USFWS

10:30 TRADITIONAL ECOLOGICAL KNOWLEDGE/INDIGENOUS KNOWLEDGE –
Dr. Michael Koskey, Center for Cross-Cultural Studies, UAF
What is TEK and how do we best utilize it at USFWS? – How "to do" TEK

11:45 ***LUNCH*** **- Duck-In Movie**
Optional for those students bringing their lunch and wishing to stay on site during the lunch hour

Afternoon Moderator Ernest Nageak, Inupiaq, Alaska Native Affairs Specialist, Barrow FES Office

1:15 GROUP WORK
Discuss with Elders traditional knowledge and collaborative relationships. Ask questions, think beyond limitations, ask "what if?" imagine the most ideal scenario and discuss in your groups

2:00 REPORTS – Each group reports on the MOST USEFUL information - 1 min. soundbites!

2:30 NATIVE AMERICAN POLICY – Marlene Zichlinsky, Native American Policy Analyst and Facilitator, U.S. Fish & Wildlife Service

3:30 ***BREAK***

3:45 ALASKA NATIVE RELATIONS POLICY – Crystal Leonetti & Patty Schwalenberg

4:00 CLOSING CIRCLE – Crystal Leonetti, Yup'ik, Alaska Native Affairs Specialist

Participants share their biggest learning moment or something they'll do differently in their daily work

5:00 EVALUATIONS AND END OF TRAINING – *Students are welcome to take their beadwork projects home*