



# NEWSLETTER

SUMMER 2016 / SPECIAL ISSUE



## DIRECTOR'S CORNER

In this special issue we are focusing on the needs of Native Lesbian, Gay, Bisexual, Transgender, and Questioning (NLGBTQ), or Two-Spirit community members. It is with a very heavy heart that I start this letter only a few weeks after the Orlando Massacre, which was a direct attack on our LGBTQ identified friends, colleagues, family members, and leaders. This traumatic event reminds us how important it is to better understand the needs of these community members, and to improve our skills in supporting those clients who identify as LGBTQ. I believe it is crucial to the mission of the National American Indian and Alaska Native ATTC to facilitate the development of a workforce that will be sensitive to the needs of the NLGBTQ/Two-Spirit communities both on and off tribal land.



I would also like to point out the work of the [National Association of Gay and Lesbian Addiction Professionals and their Allies \(NALGAP\)](#), which provides resources to support people working with LGBTQ clients who have behavioral health disorders. SAMHSA has also acknowledged the importance of understanding the needs of the LGBTQ

community by developing a [Center of Excellence for Racial and Ethnic Minority YMSM and other LGBTQ Populations](#) to enhance knowledge and improve skills among behavioral health professionals working with these clients.

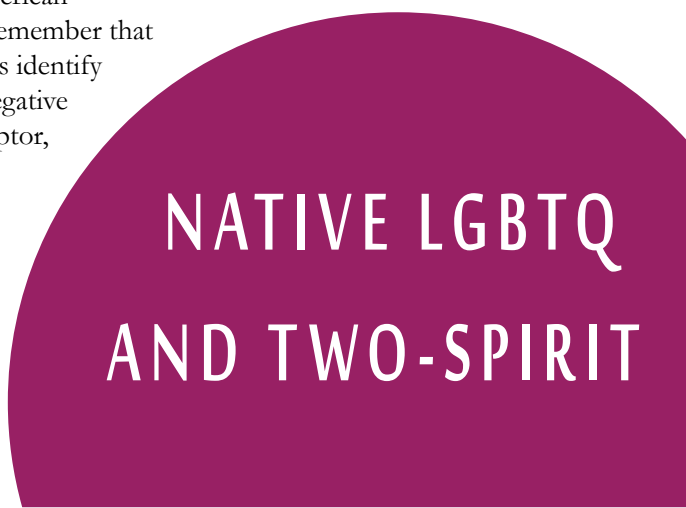
In order for behavioral health professionals to better serve the NLGBTQ/Two-Spirit community, we need to understand the history and the traumas inflicted on the tribal communities in general, and the NLGBTQ/Two-Spirit communities in particular. We explore some of the history of Native LGBTQ perspectives and the concept of "Two-Spirit" in this issue. The term "Two-Spirit" was created in 1990 at the Third Annual Inter-Tribal Native American/First Nations Gay and Lesbian Gathering to describe and honor the traditions of gender in Native American cultures. It is important to remember that not all NLGBTQ individuals identify as Two-Spirit. Some have negative associations with this descriptor, and providers should ask and honor clients' own description of their sexual orientation and/or gender identity.

It was with this in mind that our Center began to develop a NLGBTQ/Two-Spirit-focused

curriculum. Matt Ignacio, MSSW, chaired the committee of content experts for this new curriculum, and Lena Thompson, MPH, and Donna Dorothy facilitated this work. Last year we organized a Training of Trainers (TOT) to pilot the material with an audience of experienced behavioral health professionals who are familiar with the needs of LGBTQ identified clients, and we have been working to implement their feedback.

Our goals for this newsletter are to provide an introduction to the curriculum, the process used to develop it, and an overview of specific issues facing the NLGBTQ/Two-Spirit community. We hope that this curriculum, when published in fall of 2016, will be widely adopted in behavioral health and primary care settings.

Regards,  
Anne Helene Skinstad





# CREATING WELLNESS FOR LGBTQ AND TWO-SPIRIT INDIVIDUALS

*By: Rick Haverkate, MPH;  
Sault Ste. Marie Tribe of Chippewa Indians*

*Photo: Shutterstock*

It's the year 1992. A guy named Bill Clinton is running for President, and he and his young wife seem to actually like folks like me. I think they've actually held formal campaign meetings and talked about ways to improve our lives. I can't believe it's true. Someone – albeit a saxophone playing politician that no one outside of Arkansas has ever heard of – but someone who has a serious chance of becoming President of the United States of America, is actually talking about gays and lesbians, and HIV/AIDS, and he's saying these things publicly with major news reporters and cameras present. I have this strong feeling that this decade is going to become known as the “Gay 90s.” I'm in my late 20s, a member of the Sault Ste. Marie Tribe of Chippewa Indians; I've lived my whole (closeted) life in small towns on the shores of Lake Superior. Now I'm heading off to Hawai'i to earn my master's degree in public health (MPH), and it looks like I might actually have some reason to believe that the American dream also belongs to me. I've wanted out of my small town, full of good people with seemingly trivial minds, for years, and now my chance has arrived.

By the time I started my MPH in the fall of 1992 I'd been a community health educator for my own tribe, served in a state-wide tribal role in American Indian health promotion and disease prevention, and even taken a national part in HIV/AIDS education and prevention for people of color. However, I'd always felt like a fraud. Sure, I could talk about the science of HIV; I knew the transmission routes; I could demonstrate

how to roll a condom on a banana and even how to stretch a dental dam over a plastic anatomically correct model. I could convince my Native mentors and leading HIV/AIDS advocates that I was a true public health professional. But I was still the emperor wearing his new clothes. I was naked out there in front of everyone. It was just a matter of time, I thought, until someone called me out. Out as gay. Out as not “Indian enough.” Out as not actually close enough to HIV/AIDS to be able to proselytize about prevention, treatment, care, or cultural competency. I barely had any real sexual experience let alone direct knowledge of the prime venues for HIV exposure like bathhouses, big city nightclubs, parks, or the injection drug world. Working as a health educator brought me close to the great public health thinkers and Indigenous traditionalists, but also brought me terrifyingly close to my insecurities about my homosexuality and my ultimate outing to my co-workers and family. How, I thought, could I keep fostering HIV/AIDS prevention while advocating for more acceptance of people who identify as gay, lesbian, bisexual, transgender and/or Two-Spirit (LGBT2-S), and not be forced to accept my sexuality? Until the time I left for graduate school – just after the country learned that Bill Clinton was the Democratic nominee for President – I had come out to only a small handful of friends. When the Gay 90s got into full roar after that 1992 election, and after I'd been exposed to the Aloha of Hawai'i and found a new Ohana of LGBT2-S, did I have the courage to fully



come out. I learned shortly afterward that I'd offended many of my close friends by not trusting them enough to share one of the very basic parts of my humanness with them. They felt betrayed. I had been afraid that I would be cast off if I came out, but instead of the screenplay I'd created in my own mind – where I scolded them for not accepting my gayness – they were now scolding me for not accepting their unconditional love. How shamefully divine.

Popular and progressive western culture has a knack for portraying the gay community as affluent, young, upwardly mobile and blemish free. According to them, people in the gay community drive fancy cars, wear expensive clothes, take frequent and extravagant vacations, carouse at hip restaurants, rarely work, and always live the hi-life. I find it odd that in these pictures, gay individuals seem to be surrounded by look-alike friends, yet inexplicably have no identifiable family joining in the festivities. These distorted images of the “gay lifestyle” use mostly gay white men, and it seems only in the last 15 years have women and people of color been shown in gay-positive advertisements or on magazine covers. Even worse is the fact one rarely sees our transgender and Two-Spirit siblings in the media. The affirming side is that I do often see the LGBT2-S community represented in a positive light, but not dissimilar to the general public, we don't frequently see full inclusion of our diversity. In my opinion LGBT2-S folks are seen as having three positions in popular culture: (1) white, male, and privileged; (2) colorful Mardi Gras oddities; or (3) sex- and drug-addicted pedophiles. A welfare-receiving, evangelical church attending, multi-ethnic enrolled tribal member from a small northern town like me just doesn't appropriate any of these positions. This became more and more clear as I progressed through my education and my career. However, the bigger – and less egoistical – part of my story are the chapters where I witness others bringing care, compassion, acceptance, resources, education, treatment, and capacity to Native LGBT2-S people and their communities across the country. An integral portion of this success story are the champions who saw the big picture and explained to me the business of linking history, culture, health statistics, politics, human nature, language, and common sense to eventually arrive at inclusive public health policy.



Photo: Shutterstock

*“From beginning to end we must think of and honor those who have not made it this far; those who struggled with their identity and their illness. We need to acknowledge our love for them and grieve their passing, remembering them always.”*

These heroes in public health taught me that we all have a part to play, no matter the feelings of inadequacy that creep into our thoughts, in keeping our rainbow communities educated and healthy. We are all responsible for taking up the charge and playing our role. Over the many years spent working in tribal communities, and for other government and non-government agencies at the state and national level, whether helping to gather data, building resources, designing curricula, or developing policy, I've tried to keep mindful of the need to address the individual and the key factors that contribute to Two-Spirit challenges related to substance use. There is a lack of knowledge and lack of ease that healthcare providers, educators, law enforcement and even parents have in providing services for the LGBT2-S community members who are voluntarily and involuntarily seeking services. I know what it's like to be victimized by bullies, to be silently aware of my differences and the exclusionary practices of schools, places of worship, the workplace, and social activities. Many of us who work in HIV/AIDS prevention and education self-identify as LGBT2-S, yet I cannot begin to know what it's like to live as a lesbian or a transgender individual. I wonder, then, just how many heterosexual primary care providers can empathize with their LGBT2-S patients? I don't mean to suggest that heterosexual healthcare providers cannot perform top-notch wellness care for LGBT2-S people, but my advanced practice nurse friends tell me, for example, that a very high percentage of women who identify



as lesbian and transgender are excluded from health care and screenings that heterosexual women receive. Fewer pap smears are performed on lesbians, perhaps because they may feel it unnecessary. A study in the *Journal of Urban Health* suggests that lesbian women do not follow the recommendations for screening programs like cervical cytology tests and mammograms to the same extent as heterosexual women (Kerker, Mostashari, and Thorpe, 2006).

A qualitative study based on stories featured in the *Scandinavian Journal of Primary Health Care* states that many lesbians feel forced to disclose their sexuality when in a vulnerable situation such like a pelvic examination, because the doctor insisted on an explanation upon finding a combination of a sexually active life, no contraception, and no possibility of pregnancy to be illogical. Some study participants had been given medical information aimed at heterosexual activities; others had received prescriptions for contraceptives or had had pregnancy tests taken, even after revealing a long-standing lesbian orientation. A few participants did not see the need to inform their healthcare professionals about their lesbian orientation; other histories displayed a lack of confidence in the health authorities, or a reluctance to disclose out of embarrassment (Bjorkman and Malterud, 2009).

None of this is to say that the healthcare professionals were not acting with anything but the most sincere desire to provide optimal medical services. However, these stories begin shed

light on just how much work still needs to be done to bring our health



delivery systems in-line with the full continuum of our Native LGBT2-S communities.


When individuals grasp they are transgender, they may have questions about how to begin the transition process. Some may seek the steps involved in transition and look for the best and up-to-date information about their transition. For many, the thought of going to see a healthcare provider is very frightening for an array of reasons. They may wonder, “What if the doctor doesn’t support me in my transition? What if the therapist tells me I’m not ready? How do I know whether or not the counselor is really qualified to help me?”

As Native LGBT2-S people we’ve learned to overcome many obstacles on our way to self-fulfillment and we’ve had to learn a combination of systems to get adequate healthcare. Many of us first experienced doctors, nurses, and psychologists through the Indian Health Service (IHS) or in a tribally run healthcare system. Depending on who is telling their story the federally operated healthcare delivery run on many reservations has nearly as many fans as it does foes. The idea of the federal government providing a fully integrated system of care may seem counterintuitive to some, but the IHS has been doing wonderful things for American Indian and Alaska Native (AI & AN) communities for over 50 years by bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion.

A much newer exemplary system that has been gaining traction since the mid-1980s, through the practice of tribal sovereignty is the provision 100 percent tribally-managed healthcare wherein a tribe takes over all aspects of a health system with control over programs, services, functions or activities that the IHS would otherwise provide. The Tribal Self-Governance Program provides Tribes with the flexibility to manage program funds to best fit the needs of their citizens and Tribal communities.

Tribal self-governance has allowed many tribes to expand their array of services to Native LGBT2-S individuals at a pace quicker than federal policies have allowed, providing access to HIV screening and prevention activities, specialized services for transgender individuals, and the development of innovative and profound risk reduction curricula that may never have been approved through more stringent federal operational procedures. However, in the past seven years the federal government has rapidly increased their response to the special needs of AI & ANs and the unique needs of the LGBT2-S community through targeted disease management, increased funding for community-based

Photo: Shutterstock



participatory research, and policy development. An example of this is the innovative Section 1557 of the 2010 Affordable Care Act (ACA) that prohibits discrimination in federally-funded health programs based on race, national origin, age, disability, and sex. The law makes it clear that transgender people are protected by this law – including health insurance coverage.

The regulations make illegal the practice of categorically excluding all gender transition-related health care from coverage, common in private health insurance plans, as well as in state Medicaid, Indian Health Service, and CHIP (Children's Health Insurance Program) programs. Instead, plans will have to cover services for transgender people if they offer those services to non-transgender people or if denying the service is based on a discriminatory reason instead of a valid reason, such as a scientifically supported reason. Due to their special political nature, tribes and their self-governed healthcare facilities are not obligated to comply with this federal law, but many hope that our sovereign tribal nations will enact their own policies that reflect the intention of the ACA and provide health services that include all of us without discrimination based on gender identity or sexual orientation.

The fact that a federal policy of non-discrimination that protects our Two Spirit siblings is now written into a law covering all 50 states is nearly incomprehensible. Thinking back to the hiding and “passing” that so many of us did for decades, and then to the fall of 1992 when a presidential candidate openly talked about the LGBT2-S community, up to the present day when the President speaks of us in his State of the Union Address and presses for full inclusion of all Americans at every level of society, I am deeply moved and duly grateful.

I recently read a wonderful book that described one man's scientific conclusion about our connectedness to each other as human beings and to every living thing, every weather system, every single person, place or thing in the Universe. “Described by his contemporaries as the most famous man in the world after Napoleon, Alexander von Humboldt was one of the most captivating and inspiring men of the early nineteenth century.” And he just happened to be gay. According to the author Andrea Wulf, in her book entitled, “The Invention of Nature: Alexander von Humboldt's New World” (Wulf, 2015), von Humboldt saw the earth as one great living organism where everything was connected, conceiving a new vision of nature that still influences the way that we understand the natural

world. As a scientist he began collecting organic and inorganic specimens and calculating their dimensions early in his life. But the author, Andrea Wulf, writes of von Humboldt's theory, “Of course nature had to be measured and analyzed, but he also believed that a great part of our response to the natural world should be based on the senses and emotions...nature has to be experienced through feelings.” This is not a new concept for Native people. We've had a lifetime of teachings from our elders regarding this truth. But many people are not taught to be as connected to the earth as we are. This idea of connectedness means that our efforts to heal, our actions that cause harm, our good intentions that create harmony, and the things we leave behind after we pass through this realm leave remnants that affect the Universe and all that dwell in it for ever. “Humboldt found connections everywhere. Nothing, not even the tiniest organism, was looked at on its own. ‘In this great chain of causes and effects,’ Humboldt said, ‘no single fact can be considered in isolation.’ When nature is perceived as a web, its vulnerability also becomes obvious. Everything hangs together. If one thread is pulled, the whole tapestry may unravel.”

I hope that some small part of the efforts we make today in creating wellness for Native American LGBT2-S people will live on and establish new dreams and new realities for those that come after us. I hope that all of us find ways to share our knowledge, but that sharing must come with understanding and compassion and empathy, and only then will positive change come about. For lasting effects that truly travel through the webbed network of our world knowledge must be shared, imported, exported and made available to everyone. Our talents and even our tribulations must be turned into guiding lights that in turn become the matter of dreams and tangible products. My favorite quote is fitting to this writing: “Fortunate are the old men who plant trees under whose shade they will never sit.” (Anonymous)

From beginning to end we must think of and honor those who have not made it this far; those who struggled with their identity and their illness. We need to acknowledge our love for them and grieve their passing, remembering them always. But like Maude said to Harold when she was facing the end of her life and he called out, “Don't leave me, Maude, I love you” and her poignant and powerful answer was, “Oh Harold, that's wonderful. Go and love some more” (Higgins and Ashby, 1971).

---

## References

Kerker BD, Mostashari F, Thorpe L. Health Care Access and Utilization among Women Who Have Sex with Women: Sexual Behavior and Identity. *J Urban Health*. 2006 Sep; 83(5): 970–979. Published online 2006 Jul 30. doi: 10.1007/s11524-006-9096-8

Wulf A. (2015). *The Invention of Nature: Alexander von Humboldt's New World*. New York, NY: Alfred A Knopf.

Higgins C (Producer), Ashby H (Director). (1971). *Harold and Maude [Motion Picture]*. United States: Paramount Pictures

Bjorkman M, Malterud K. (2009). *Lesbian women's experiences with health care: A qualitative study*. *Scandinavian Journal of Primary Health Care*, 27(4), 238–243. <http://doi.org/10.3109/02813430903226548>.

# The Two-Spirit Purpose

By: Apacuar/Tutmalria Larry Kairaiuak (Yup'ik)

Photo: Shutterstock



It is said that we have always been. We, as in, the Two-Spirit people within Indigenous communities, although some may not acknowledge the members of the Indigenous Lesbian, Gay, Bisexual, Transgendered (LGBT) and other non-heterosexual members of the tribal community. Two-Spirit people was first coined in the 1990's and quickly embraced by indigenous LGBT people, mostly in urban areas as a means to proudly declare their indigenous identity along with their sexual identity or orientation. It is said that the term recognizes both male and female spirits in one individual.

Historically, we have been able to find specific terms from over 100 indigenous communities in the United States that describe or acknowledge the existence of our Two-Spirit relatives. The recognition of our community has been diminished because of unfortunately outside non-traditional influences. It is not by accident that the Two-Spirit community starting finding like-minded individuals and reinvigorated its own community.

During the AIDS epidemic in the 1980's, obviously many people were misinformed about the disease and the unknown of the epidemic. Society in general, saw this as the Gay disease which negatively impacted our community. With people getting infected and dying, naturally the LGBT community stepped up and rose to take care of their own and demanded changes in the healthcare system. No one in the general Native community and let alone, the healthcare programs stepped up until a group of LGBT individuals in the San Francisco Bay area saw that our Two-Spirit community were not adequately treated and served in the Native healthcare system. Ron Rowell, (Choctaw) was one of

those brave men and women who stepped up and founded the National Native American AIDS Prevention Center (NNAAPC), a program that provided capacity-building assistance to tribes, state health departments, tribal and non-tribal healthcare services in culturally responsive treatment for American Indians, Alaska Natives and Native Hawaiians. NNAAPC expanded its treatment advocacy work to preventive HIV/AIDS programs.

During this time, many urban Two-Spirits began talking and meeting informally in North America. This effort sparked the mobilization of local groups in forming Two-Spirit organizations to support each other, culturally relevant activities and events, advocacy and voice in the broader LGBT communities and ensure that they are at the table in any discussions or programs that impact our community. Today, there are close to 20 known groups that host local gatherings as well as international gatherings, local Native events, and support broader Native social, political and educational endeavors. Thus, fulfilling a role of Two-Spirits in contemporary indigenous communities.

*The concept now often referred to as "Two-Spirit" existed in many Native American cultures long before the arrival of Europeans. These communities recognized that all people have within them a natural duality of masculine and feminine traits, as the goal of mankind was to become androgynous, allowing for a natural balance as seen in nature. Some women may have more innate masculine traits than most women, while some men may have more innate feminine traits than most men. In some Native American teachings, this fluidity of gender identity is referred to. These people were not only honored and encouraged to fill the roles that suited them best, but also seen as special and/ or holy, being born with the ability of viewing the world from more of an androgynous manner. Some Two-Spirit women were warriors, while some Two-Spirit men took care of children. Men and women were seen as equals, both serving as leaders and healers.*

- Sean A. Bear

# HONORING OUR RELATIONS: INCREASING KNOWLEDGE ON NATIVE LGBTQ/TWO-SPIRIT WELLNESS

By: Lena Thompson, MPH

Photo: Shutterstock



The National American Indian and Alaska Native ATTC is excited to be in the final stages of developing a Native American LGBTQ/Two-Spirit curriculum. The intent of the curriculum is to help increase providers' knowledge and their ability to respond to the challenges of Native LGBTQ/Two-Spirit people. Our goal has been to develop the curriculum in the spirit of collaboration and in partnership with other efforts to mobilize and restore harmony and balance for all Native people, including Native LGBTQ/Two-Spirit individuals.

The National AI & AN ATTC contracted with six content experts who wrote each of the six modules in the one-day training. We are grateful for the thoughtfulness that these people put into developing the modules and are humbled by the amount of time that they all spent coming together to review the curriculum in its entirety. The ATTC would like thank Clinton Alexander—mikwamibissa (Anishinaabe – White Earth Ojibwe Nation); Michaela Grey, MPH (Diné); Apacuar/Tutmalria Larry Kairaiuak (Yup'ik); Wendy Schlater (La Jolla Band of Luiseno Indians); and Nazbah Tom, MA (Diné). Karen Simons (Dumna/Kechayi Yokuts Tribe of California) also provided invaluable consultation for the team. These members represent tribal nations across the United States and offer expertise in a variety of areas including LGBTQ/Two-Spirit advocacy, HIV prevention, domestic violence, substance abuse prevention, cultural preservation, behavioral health, and tobacco use prevention. Finally, the curriculum would not have been possible without our team lead, Matt Ignacio, MSSW (Tohono O'odham). Matt recruited each of the content experts, organized our meetings and coordinated the curriculum. He also contributed modules of his own and kept us going with his positive attitude and spirit.

## Training Modules:

Each of the training modules builds upon the previous module to tell a story about the challenges faced by Native LGBTQ/Two-Spirit individuals, protective factors within the population, and steps providers can take to best serve Native LGBTQ/Two-Spirit individuals. The following is a brief overview of each of the modules:

- Introduction – This module introduces participants to the curriculum, sets house rules, and defines key concepts.

- Cultural Factors Affecting Native LGBTQ/Two-Spirit Individuals – Participants will learn about historical trauma and about the cultural and historical challenges faced by the Native LGBTQ/Two-Spirit community.
- Native LGBTQ/Two-Spirit Identity Affirmation – Participants will learn about the issues Native LGBTQ/Two-Spirit clients may face as they maintain and develop identities and go through the coming out process.
- Native LGBTQ Related Health Issues – This module provides information about health-related issues faced by Native LGBTQ/Two-Spirit individuals including minority stress, HIV/AIDS, violence, and suicide.
- Substance Use in Native Communities – Participants will be exposed to data and information about substance use disorders in Native communities.
- Multicultural Counseling and LGBTQ Affirming Treatment Approaches — Participants will learn practical approaches to multicultural counseling and LGBTQ Affirming Treatment Approaches with focus on Native-specific approaches.
- Relapse Prevention – This module offers Native-specific strategies for preventing relapse with Native LGBTQ clients.

## Future Steps:

The Native American LGBTQ/Two-Spirit curriculum was pilot-tested in June 2015 to an audience of Native American providers on land governed by the Viejas Band of Kumeyaay Indians near San Diego, California (*see photo, back page*). Content experts and ATTC staff are currently incorporating feedback and finalizing trainer notes. Training of trainer sessions are projected for late 2016.



# BEST PRACTICES FOR TREATING OF NATIVE TRANSGENDER WOMEN

*for Indian Health Service and non-Indian  
Health Service Health Care Providers*

*By: Michaela Grey, MPH  
Contributors: Matt Ignacio, MSSW;  
Renaë Gray; Sasha James*

*Photo: Shutterstock*

According to the Centers for Disease Control and Prevention Fact Sheet HIV Among Transgender People in the United States, transgender women are at high risk for HIV infection. In a 2010 report comparing HIV infections and gender categories, the highest numbers of new HIV infections were reported among transgender women.<sup>1</sup> High rates of substance and alcohol use, violence, stigma, discrimination, sex work and incarceration are some factors that all contribute to higher risk for HIV infection.<sup>1</sup> Specifically, American Indian, Alaska Native and Native Hawaiian (hereafter, 'Native') transgender women also experience culturally-specific challenges such as limited or non-existent access to hormone therapy at Indian Health Service facilities, discrimination from health care providers with limited knowledge of the needs of transgender patients and limited access to transgender-specific HIV prevention messages, particularly in rural/reservation communities. In an effort to prevent the spread of HIV among all Native people, including transgender individuals, it is incumbent for all health care providers and staff to receive more comprehensive gender-identity trainings, administer changes to overall agency protocols inclusive of and to reflect the needs of transgender community members and eliminate any discrimination towards transgender people.

The Center of Excellence for Transgender Health at University of California San Francisco defines the term transgender as "across gender" or "beyond gender"; this is a umbrella, community-based term that applies to a variety of cross-gender behaviors and identities including cross dressers (those who wear the clothing of the other sex), the gender queer person (those who feel they belong to either both genders or no

gender) and transsexuals (those who take hormones and have the gender confirmation surgery).<sup>2</sup> Although transgender people are often categorized with the lesbian, gay, and bisexual community (i.e. 'LGBT Community'), it is important to note the term, "transgender" may not be a classification of sexual orientation.

Indian Health Service (IHS) is an important access point for basic health care for Native people. Native transgender women also access IHS services for primary health care in modifying their bodies to affirm their female gender identity. In June 2013, the National Pharmacy & Therapeutics Committee (NPTC) released a formulary brief on hormone therapy for those diagnosed with gender dysphoria disorder.<sup>3</sup> Although the diagnosis gender dysphoria disorder is controversial as it has negative connotations within the transgender population, the formulary brief provides Indian Health Service (IHS) health care providers treatment guidelines for administering hormones to Native transgender men and women. The NPTC formulary brief makes estradiol (female hormone) and spironolactone (testosterone blocker) tablets available for Native transgender women.<sup>3</sup> IHS health care providers (or outside provider, if unavailable) willing to manage hormone therapy for Native transgender women can submit their prescriptions to the IHS pharmacy for filling. Due to unforeseen limitations (i.e. funding), some IHS local formularies may not stock estradiol or spironolactone tablets.

Unfortunately, when prescription hormone therapy is not provided by a local, trusted medical provider – in this case IHS - transgender patients may have to acquire hormone medications and related supplies (i.e. sterile syringes) through



untrained, unsupervised contacts, often through social networks, posing serious health threats, not limited to over/under medication, unmanaged side effects, overdose and death. Furthermore, if sterile syringes are necessary for hormone injections and there is no access to sterile injection equipment, transgender patients may have no other option but to re-use or share injection equipment, placing them at very high risk for HIV and other blood-borne disease infections (e.g. Hepatitis C).

In addition to obtaining hormone prescriptions, Native transgender women experience a number of obstacles when accessing either routine or emergency health care. Obstacle number one is the legal name assigned to some Native transwomen is incongruent with their gender presentation. IHS health clinics regularly use birth names to identify their patients, which is typically congruent with the gender presented, but is not the case for a Native transwoman. Sitting in a waiting room and presenting as female while answering to a male birth name makes Native transwomen uncomfortable in health clinic settings (S. James, personal communication, March 13, 2014). To allay anxieties surrounding this issue, clinic administrators may implement the following:

1. Obtain direct feedback from representatives or community leaders from the local Native transgender community when making any agency changes to accurately reflect the needs of the local transgender community
2. Amend patient demographic and intake forms to allow patient to identify a "Preferred Name"
3. Train all health care staff to use preferred name identified by patient, use appropriate pronouns (e.g. "she", "him", "her", etc...) associated with preferred name
4. Amend patient demographic and intake forms to be gender inclusive, including categories for:
  - "Transgender (Male-to-Female)"<sup>3</sup>
  - "Transgender (Female-to-Male)"<sup>3</sup>
  - "Other" (with a blank line to complete)<sup>3</sup>
5. Ongoing staff education on issues of gender-identity and transgender health needs

Making these changes to patient demographic forms may ease transgender patient's anxiety about entering the clinic for either routine or emergency health care. Additionally, making these changes is a way to begin restoring and building trust between transgender community members and IHS health care staff, ultimately, improving the overall community health and reducing HIV infection rates.

Beyond the front desk, health care providers should be aware of key health issues Native transwomen face. Beyond hormone therapy, health issues specific to Native transgender women are high rates of substance & alcohol use, survival sex in exchange for money or a home and/or victims of intimate partner violence. According to the Center of Excellence for Transgender Health at University of California San Francisco, health care providers can employ the following tips while treating Native transgender women,

- Honor the preferred gender identity and use appropriate pronouns (i.e. female preferred name warrant the use of female pronouns)<sup>3</sup>
- Make time for introductions between provider and patient. Introductions allow time for providers to ask about preferred name, pronouns and transition status (i.e. pre or post gender confirmation surgery)<sup>3</sup>
- Respect the gender identity of your transgender patient, which includes treating her body as if it belongs to her. Transgender women are not defined by their anatomy. That is, although she presents as female, a Native transgender woman's body may have traits, characteristics or residual elements that do not affirm their preferred gender identity<sup>3</sup>
- Treat the medical issue at hand. Transgender patients still require routine health screenings (i.e. cancer preventative screenings, STD screenings, cardiac testing, etc.). Health care providers still need to administer health exams that encompass breast exams for cancerous or benign nodules and prostate exams for Native transwomen patients<sup>3</sup>
- During every medical interview, assess sexual history, sexual risk, and HIV status with all transgender patients. Encourage transgender patients to test for HIV regularly, properly use condoms and other safe practices

Health care clinics and emergency departments that amend patient demographic forms to accommodate Native transgender patients make it easier for a health care provider to a) identify transgender patients and b) assess her transition status. By implementing afore-mentioned tips as best practices, IHS providers exhibit increasing cultural sensitivity in treating Native transwomen. Additionally, making these changes is a way to begin restoring and building trust between transgender community members and IHS health care staff, ultimately, improving the overall community health and reducing HIV infection rates. "I would like to enter the (IHS) clinic and feel welcomed. The girls [Native transwomen] won't go off the rez [reservation] to see the doctor for pills [treatment]."

## References

1. Centers for Disease Control and Prevention. (2013). *HIV Among Transgender People*. Retrieved from [http://www.cdc.gov/hiv/pdf/risk\\_transgender.pdf](http://www.cdc.gov/hiv/pdf/risk_transgender.pdf)
2. Center of Excellence for Transgender Health, University of California San Francisco. (2011). *Primary Care Protocol for Transgender Patient Care*. Retrieved from <http://transhealth.ucsf.edu/trans?page=protocol-00-00>
3. Indian Health Service National Pharmacy & Therapeutics Committee. (2013). *NPTC Formulary Brief -Gender Dysphoria*. Retrieved from <http://www.ihs.gov/nptc/documents/NPTCFormularyBrief-GenderDysphoria.pdf>



# INCLUSIVENESS AND THE AMERICAN INDIAN AND ALASKA NATIVE CULTURE

By: Mary K. Winters, MEd

American Indian and Alaska Native tribal communities value families as a critical and continuing source of community strength. A cultural tradition of acceptance and inclusion, as well as reliance on individuals and families to pass along such traditions, is at the core of Native communities. It has been well documented that the experiences of colonization and recurring cultural trauma since European contact has had lasting, negative impacts on the lives of American Indian and Alaska Native individuals, communities, and tribes. Native researchers and others agree that addressing this problem requires legal and policy changes, but also the engagement of individuals, families, and communities, to protect and support the health and well-being of all community members.

Individuals who may be particularly vulnerable within the Native population are those who identify as LGBT. Thus, the support of family, significant others, and community members can make a big difference regarding social and health outcomes. Without strong support, many LGBT individuals feel they must hide who they are from others, and are more likely to

experience the effects of victimization at work, school and in the community. Unfortunately, loss of friends, family violence, drug and alcohol use, and discrimination can be resulting consequences.

Readers may be interested in several resources about LGBT issues and the AI & AN community.

**General AI & AN perspective:** [Walking in Two Worlds: Understanding the Two-Spirit and LGBTQ Community.](#)

**School Issues:** [GLSEN, the Gay, Lesbian & Straight Education Network](#)

**Family Issues:** [Family Acceptance Project.](#)

**Legal Perspectives:** [Lambda Legal.](#)

**Health Issues:** [John Steever, MD, "Lesbian, Gay, Bisexual, Transgender, and Questioning Youth: Special Focus on Native American Population."](#)



Curriculum pilot June 2015. Pictured from left, back row: Donna Dorothy, Wendy Schlater, Clinton Alexander, Michaela Grey, Matt Ignacio, Anne Helene Skinstad, Larry Kairaiiak; front row: Kate Thrams, Lena Thompson, ThankGod Ugwumba, Nazbah Tom.

Be aware of how you treat others and yourself, as to not influence or change something that was created to be beautiful, into something molded by angry hands, words, or looks. The Creator sends a precious child, with a loving and open spirit into the world to be loved and nurtured into a loving and kind being. Be not the influence that changes an innocent child into a pained and bitter adult.

- Sean Bear

## Newsletter Editorial Board and Contributors

Anne Helene Skinstad, PhD, Managing Editor  
Kate Thrams, BA, Editor  
Mary K. Winters, MA, Contributing Editor  
Sean Bear Sr., BA, CADC, Contributor

Rick Haverkate, MPH, Contributor  
Larry Kairaiiak, Contributor  
Lena Thompson, MPH, Contributor  
Ryan Red Corn, Buffalo Nickel, Design

Michaela Grey, MPH, Contributor  
Matt Ignacio, MSSW, Contributor  
Renae Gray, Contributor  
Sasha James, Contributor