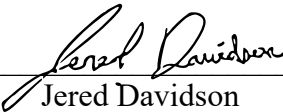
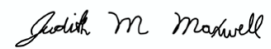


LIVING ACROSS TWO WORLDS: POLITICAL AND CULTURAL BARRIERS TO
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To be a modern Navajo is to live in two separate worlds, contemporary and traditional. This thesis investigates the complicated political and cultural relationship that exists between these worlds and its implications on Navajo health. Chapter 1 explores many of life's most significant challenges on the reservation, such as limited access to healthy food and infrastructure that contribute to disproportionate rates of chronic illness among Navajo individuals. Chapter 2 establishes that the Navajo Nation is a sovereign and independently governed entity geographically surrounded by and governmentally and financially linked to the United States. Chapter 3 describes how the Navajo Nation internally manages an annual budget of over \$1 billion that covers the operational costs of governmental offices and programs crucial to the Navajo people's wellbeing. Chapter 4 discusses traditional Navajo healing practices and how incorporating cultural elements into treatment plans can improve health outcomes and help to bridge the divide between Navajo patients and modern providers. The fifth and final chapter showcased how the Navajo Nation acted with autonomy to beat the odds and successfully overcome political and cultural barriers to slow the spread of COVID-19 on the reservation. This thesis illustrates that many problems are best solved with intimate personal knowledge of Navajo life and culture that state and federal entities fail to possess. Overcoming political and cultural barriers requires a partnership with surrounding state and federal governments that capitalizes on meaningful participation from the Navajo Nation's citizens and leaders. Internal decision-making and cultural competency are part of the solution for a diverse set of complex problems facing the Navajo Nation.

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INTRODUCTION

Frank Tabaha declined his doctor's recommendation for a life-saving foot amputation. Navajo tradition required that he "die whole" to allow his spirit unimpeded passage to the next world. Frank and his physicians had reached a critical impasse. After consulting with a medicine man back home on the reservation, Frank consented to the operation under the condition that the hospital would release the amputated limb for a special Navajo unifying ceremony.

I took an interest in the Navajo Nation after hearing a series of incredible stories from my friend, Devin Tabaha, Frank Tabaha's nephew when we worked together in a hospital the summer before I started college. Devin grew up on the Navajo Reservation near Window Rock, Arizona and now lives off the reservation working in a state-of-the-art orthopaedic facility in Phoenix. He offered a unique perspective on both sides of the cultural divide that exists between Navajo patients and modern doctors. Conversations with Devin and other Navajo individuals shed light on the most pressing issues the Navajo face today and inspired this report.

The Navajo word Diné translates literally to "the people," and can be used to describe those who make up the largest Native American Tribe in the United States. The Navajo Nation is expansive, with over 300,000 individuals, over half of which live on 25,000 square miles of federally recognized land across Arizona, western New Mexico, and southeastern Utah. The Nation's people, however, have an understanding that their land extends much further. Growing up just outside of Phoenix, Arizona, I often found myself on this land, whether that be running through tribally operated landscapes with my school's cross-country team or hiking within the San Francisco Peaks. Despite this, I

knew very little about the people that call these areas home, their unique culture and history, and the struggles they face today. This thesis describes the two worlds, modern and traditional, in which the people of the Navajo Nation live today and investigates the political and cultural barriers to healthcare delivery on the reservation.

CHAPTER 1

The Politics of Poverty on the Navajo Nation: Food Deserts and Infrastructural Deficiency

A Brief Historical Component

The tumultuous history between the United States and the Navajo Nation is a complicated story of war, betrayal, hardship, and resilience. Initial contact with the Navajo was made by the Spanish, who had a significant influence on Navajo culture and life. The Spanish were responsible for bringing a variety of livestock to the Navajo, such as “horses, sheep, cattle, and goats,” which ultimately became agricultural staples among native people of the American southwest (Iverson, 2002, p. 23). Despite this, tensions steadily rose and culminated in several battles between the two groups. The Navajo succeeded several times in raiding Spanish and Pueblo settlements for livestock in the late 1700s and early 1800s (Carey, 2014). In 1805, however, Spanish armies killed over one hundred women, children, and elders taking shelter in a cave near Canyon de Chelly (Iverson, 2002, p. 23).

Decades later, following a victory in the Mexican-American War and the treaty of Guadalupe Hidalgo, the United States decided to expand into the southwest aggressively. General James H. Carleton ordered Colonel Christopher “Kit” Carson to destroy Navajo homes, crops, and livestock before forcibly marching them to the Bosque Redondo reservation in New Mexico as part of the 1864 scorched earth campaign (Sumrak, 2012). Those who survived the march were subjected to horrible conditions in an unfamiliar land and were expected to adopt “American cultural values” such as farming, Christianity, and the English language as a part of the “federal Indian assimilation policy”

(Bosque Redondo, 2019). After years of hardship and famine, the Navajo negotiated with the United States government and signed the Treaty of Bosque Redondo in 1868. This treaty officially established the Navajo Reservation and allowed those remaining at Bosque Redondo to return to their homeland. The United States formally established the Navajo Tribal government in 1923 following the discovery of natural resources beneath reservation land (Thompson, 2016).

The Navajo Nation Today

According to several social and economic standards, many racial and ethnic minorities in the United States fare worse than their white counterparts. Native American populations face a unique set of problems; this chapter's primary objective is to address what these issues are in the context of the Navajo Nation. Elements of this chapter were inspired by conversations I had with Nashonna Frank, a member of the Navajo Nation who studied nutrition at Arizona State University and is now working towards a Masters in Public Health with a focus on caring for Indigenous populations.

Many Diseases Disproportionately affect Navajo Populations

“Native American people experience higher disease rates and lower life expectancy than any other racial or ethnic group in the country” (Spector, 2017, p. 160). Those among the Navajo Nation are no exception to this unfortunate reality. According to the National Indian Health Board, Navajos have a mortality rate that is over 31% higher than the United States average. While the leading cause of death on the Navajo Reservation is unintentional injury, obesity and diabetes, cardiovascular disease, and alcohol-related illnesses follow closely behind (Indian Health Service). Almost all of

these problems arose following first contact with European settlers, and, despite recent efforts to improve Navajo health, annual reports show marginal progress at best.

Obesity and the Navajo Food Desert

To better understand why the Navajo Nation faces high accounts of obesity and related health complications, it is necessary to investigate the evolution of common dietary practices among Navajo individuals. While Navajos have adopted a diet that consists of a large portion of processed foods, this has not always been the reality. In fact, meat, corn, wheat, squash, melons, and a variety of winter vegetables were staples of the traditional Navajo diet (Oski, 2010, p. 238). A series of events that began with the U.S. government's forced Navajo resettlement in the mid 19th century catalyzed the shift from this healthier, more natural diet. Fascinatingly, Krehbieh-Burton of the University of Southern California's Center for Health Journalism mentions how the "traditional" Navajo Taco was actually created out of necessity when the Bureau of Indian Affairs would selectively ration out several dietary staples such as flour, salt, pepper, and lard (p. 1). Nashonna mentioned how fry bread, a famously popular yet unhealthy piece of Navajo cuisine, was also developed out of necessity from the same scarcely provided rations. Navajo More recently, Navajos have struggled to secure ample sources of healthy food within reasonable driving distance from their homes.

Several studies focusing on healthy food insecurity among rural populations use the term "food desert" to describe the conditions on Native American reservations. While the term food desert is defined broadly among researchers, on the Navajo Reservation, it typically refers to the "type and quality of foods rather than the number and size of food stores available to residents" (Walker, Keen, and Burke, 2010, p. 1). According to the

Diné Policy Institute, the Navajo Nation would be more accurately classified as a “food swamp” due to the “abundance of processed, high caloric, energy-dense foods” (p. 53). A study conducted by this same organization in 2014 found that 60 percent of Navajos surveyed felt they did not have access to fresh produce or natural and organic foods (Diné Policy Institute, 2014, p. 16). While this is a massive number of individuals, roughly 180,000, further research into travel times for the average Navajo grocery shopper provides a clear explanation for this measure. 65 percent of Navajos surveyed indicated that they traveled “off-reservation” to shop for food; the shortest distance traveled for those individuals was 155 miles, and the longest was upward of 230 (Diné Policy Institute, 2014, p. 17). It is also important to note that several of these shoppers are regularly traveling across state lines to secure groceries on a week-to-week basis. Nashonna discussed how her grandfather regularly spends hours traveling from his small Navajo community of Dennehotso, Arizona to get groceries for his family. Most others opt to purchase their food at more accessible, albeit far less healthy convenience stores and gas stations much closer to their homes. While this problem is not unique to the Navajo Nation, the large size of their reservation and a lack of proper infrastructure exacerbates the issue.

The Consequences of Life in a Food Desert

With rates of nutrition-related illnesses such as diabetes and heart disease being among the highest in the nation, the health consequences of the scarcity of healthy food options are apparent among Navajos. Diabetes, in particular, has become an increasingly prominent problem. A study conducted in 1990 found that just under 23% of Navajos were diabetic, and, remarkably, roughly one-third of those individuals were unaware of

their condition (Will et al., 1997, p. 1). Unfortunately, since then, these numbers have not decreased in size, with the Indian Health Service (IHS) now estimating that one-third of Navajos are diabetic or prediabetic, and 90% of those with prediabetes are not aware they are at risk (Noble, 2017). Diabetes disproportionately affects Navajo individuals; according to the CDC, just 10.5% of the United States population at large has diabetes (Centers for Disease Control and Prevention, 2020, p. 2). Navajo youth may be at particular risk when it comes to diabetes and related health conditions. A study from Dabelea et al. (2009) found that Navajo children with type 1 or type 2 diabetes had higher incidences of unhealthy behaviors, such as smoking and inactivity, and evidence of depression (p. 144).

Heart disease has also progressively become a massive issue both on the Navajo Reservation and across the United States. Higher rates of diabetes are correlated with increased incidences of cardiovascular disease. Among diabetic Navajos, 25.3% also had heart disease, and an additional 8.5% were experiencing some form of vascular illness (Hoy, Light, and Megill, 1995, p. 1). Not only was coronary heart disease once uncommon for the Navajo Nation, but so were the majority of associated risk factors. Several studies during the 1960s and 1970s found that hypertension, cigarette smoking, and sedentary lifestyles were far more uncommon among Navajo individuals in the first half of the 20th century (Mendlein et al., 1997, p. 2103). Cases of hypertension, in particular, have risen among Navajo patients. According to Percy et al. (1997), rates of hypertension in the Navajo Nation were once low before rising substantially during the 1970s, and, as of 1997, approximately 17% of Navajo individuals were affected by the disease (p. 2115). In 2014, the National Heart Lung and Blood Institute, which is a part of

the National Institute of Health, estimated that high blood pressure affected 25% of those aged 31-55 and 51% of those aged over 55 in the Navajo Nation (Partners in Health and the Navajo Nation, 2014). Chapter 5 of this thesis details how these health complications contributed to a more severe COVID-19 outbreak on the reservation.

The heightened rates of diabetes and cardiovascular disease, among other ailments, in the Navajo population, are directly correlated to a shift from traditional foods to more processed commodity foods with large amounts of additives and unnatural ingredients. Kopp (1986) discusses how federal food programs are quick to “shun traditional foods” and question their legitimacy (p. 2). According to Kopp and several others, if traditional Navajo foods, which are actually quite healthy, were made more available and not delegitimized by the federal government, the Navajo would be able to use their knowledge of those foods to develop and maintain proper diets more easily. Efforts from some Navajo schools, grassroots movements, and food programs such as Community Outreach and Patient Empowerment (COPE) are committed to providing students with more natural, healthier, and traditional alternatives to fast food (Murphy, 2018).

The Effects of Poor Infrastructure

Despite experiencing much higher case numbers of serious chronic diseases than the national average, various factors place significant limits on access to healthcare among Navajo. The Navajo Nation shares many of the same problems that other majority rural communities face concerning accessibility of care, many of which revolve around infrastructure. Physical hospital and urgent care locations are often far away, and Navajo communities are often limited in terms of transportation methods. The Navajo Nation

covers almost 27,000 square miles of land, an area larger than the state of West Virginia, yet its population is restricted to just “five hospitals, seven health centers, and fifteen clinics” (King et al., 2017, p.1). Additionally, access to primary care is in short supply on the reservation, with Navajo individuals traveling upwards of eighty minutes, on average, to visit their closest providers (Arizona Department of Health Services, 2019).

It is reasonable to assume that having more access to primary care would help to increase the overall health of a population. Still, those with less barriers to primary care are likely to require fewer emergency medical services during their lifetime as well. A study of over 230,000 insured American citizens showed a direct correlation between a higher number of barriers to primary care and emergency department utilization (Cheung et al., 2012, p. 7). When emergency medical services are required, a lack of well-maintained infrastructure often necessitates the costly use of helicopters for air transport (National Indian Health Board).

Roads

The large majority of roads within the Navajo Nation, almost 80%, are unpaved, rendering travel difficult on a daily basis and sometimes even treacherous during periods of inclement weather (National Indian Health Board). It is not just healthcare access that is limited by the absence of proper roadways. According to Linn (2018), poorly maintained roads also contribute to “unemployment, illiteracy, and crimes against women and children.” Roads that travel through areas without lighting or street signs often become nearly impassable, making it difficult for school bus drivers to pick up children, law enforcement to respond to calls, and emergency services to care for the sick or injured. Additionally, Nashonna described how improperly marked roads without proper

lighting or agricultural fencing lead to many preventable accidents. Unfortunately, the Navajo Division of Transportation estimated that \$7.8 billion would be necessary to address pavement deficiencies and upgrade the current road system. The current NDOT annual budget stands at just \$68 million, meaning a project dedicated to revitalizing Navajo roads would take roughly 116 years to complete (Navajo Nation Council, 2019, p. 2). Crumbling roadways are one of several infrastructural problems faced by the Navajo Nation.

Water

Thirty-eight percent of Navajo households do not have access to running water in their homes (Gies, 2016). A lack of funding and low population densities in several areas of the reservation contributes to the Navajo Nation's infrastructural shortcomings (Nania et al., 2014, p. 63). Because of the absence of proper infrastructure, water must be hauled in by water trucks regularly. These households that rely on water trucks are limited to just ten to twenty gallons of water per day (Bureau of Reclamation, 2007). To give some context to this number, the median United States shower alone uses roughly sixteen gallons per use. On average, Arizona residents use 120 gallons of water per day, and this number is much higher within several of the valley's zip codes (Arizona Department of Water Resources). There is a stark contrast between the luxurious Scottsdale spa resorts and golf courses that maintain thousands of acres of grass year-round and the relatively barren lands of the Navajo Nation where the vast majority of households still rely on outhouses. Incredibly, the economic burden of transporting water to the Navajo Nation every month is massive. It costs \$133 per 100 gallons of water trucked onto the reservation, while Phoenix residents pay less than \$2 for the same amount of piped tap

water (Nania et al., 2014, p. 63). Chapter 5 discusses how the Covid-19 pandemic illuminated the Navajo Nation's immense water access problem when individuals struggled to take proper public health precautions.

Access to Power and The Digital Divide

Access to power has always been a significant problem for the Navajo Nation. Despite recent progress to connect more reservation homes to the electric grid, a substantial number of individuals live without what most consider to be a vital resource. In fact, roughly 60,000 Navajos live without power in their homes (Gallucci, 2019). This scarcity of power access has significant ramifications; those without it can not refrigerate perishable foods, complete homework assignments, or apply for job opportunities. The cost of connecting a single residence to the electric grid is substantial due to homes being spread out over large areas, hovering around \$40,000 per installation (Morales, 2019). Recent efforts, such as "Light Up Navajo," have helped eliminate the power shortage in the Navajo Nation by connecting hundreds of homes to the power grid or providing solar panels to residences within a short period. Unfortunately, the second stage of the Light Up Navajo effort, staged to take place from April 6th to June 26th of 2020, was postponed due to Covid-19 (American Public Power Association, 2020). The inability to access electricity also contributes to a phenomenon referred to as "the digital divide."

The digital divide is defined broadly as the gap between those with and without access to the internet, computers, or other information and communication technology. Unequal access to technologies results in unequal participation in society, further reinforcing existing inequalities (Dijk, 2017, p. 3). An undersupply of affordable broadband access in the Navajo Nation has been a known hindrance to development for

over a decade. Recently, the COVID-19 pandemic and the rise of telemedicine has further proven how vital internet access is to the health of Navajo families and the entire country. This past summer, President Jonathan Nez of the Navajo Nation discussed his estimated 300 million dollar plan to provide broadband internet to the over fifty-five Navajo communities currently without any form of access (Eggerton, 2020). Despite advocates' claims that this is an essential cost with the potential to rapidly elevate Navajo health, acquiring these funds is a complicated and lengthy process.

Case Study: The Bennett Freeze and Government's Role in the Navajo Nation's Infrastructural Shortcomings

Infrastructural problems in the Navajo Nation could be a product of broad federal policy. In 1868 the United States government initially established the Navajo Reservation on traditional Navajo lands. Fourteen years later, President Chester A. Arthur allotted the Hopi Tribe land overlapping with areas already settled by many Navajo people (Navajo Thaw Implementation Plan). Although the two tribes lived amongst one another relatively peacefully, after discovering coal and uranium beneath the disputed areas, tensions over land use between the two groups steadily grew. The *Healing v. Jones* Supreme Court decision of 1962 ultimately established that parts of this land would be part of a "joint use area" for both tribes (*Healing v. Jones*, 1962). This decision, however, did little to lessen tensions between the groups. In July of 1966, former Commissioner of Indian Affairs Robert L. Bennett issued a development ban on over a million acres of land within the Navajo Nation in an effort to promote negotiations between the Hopi and Navajo (Moore, 1993, p. 223). This "Bennett Freeze" halted development entirely for a massive portion of the Navajo Nation, preventing the installation and repair of roads,

water pipes, and gas lines. It was not until 2009 that the Obama Administration officially repealed the development freeze in its entirety.

Removing the freeze was a significant victory for the Navajo Nation, particularly those residing in the western region most affected by it. Despite this victory, many Navajo leaders still feared the road to development would be a long and arduous battle. “No resources or plans for recovery were attached” when the freeze was lifted, and the 20,000 individuals that live in the former frozen area remain without water, electricity, and adequate infrastructure (Krist, 2020). The shortage of federal government response prompted the rise of grassroots movements, such as the Navajo Thaw Project. Current Navajo President Jonathan Nez instituted the Navajo Thaw Implementation Plan, a large-scale community effort to finally secure federal resources needed to make a lasting impact on the affected region.

Conclusion

The problems that face the Navajo Nation today are extensive, and more will be addressed in the upcoming chapters of this thesis. These obstacles, however, have been met with an impressive amount of local and community efforts that seem to expand each year. Where federal programs have repeatedly come up short, grassroots movements have proven to be effective catalysts for change. The following chapter will investigate the Navajo Nation’s unique relationship with the United States federal government.

CHAPTER TWO

Two Nations in One: Navajo Government Structure, Voting and Elections, and the Role of the Federal Agencies

Introduction

Federally recognized tribes in the United States are unique in that they are fundamentally nations within nations. This chapter will address exactly what that means in the context of the Navajo Nation. Subsequently, it will investigate the modern Navajo government structure along with voting rights and elections on the reservation. Ultimately, the chapter concludes with a brief discussion of the three federal agencies most central to the remainder of this project.

The Question of Sovereignty

It is critical for this project to clearly establish what the Navajo Nation is and understand its relationship with the United States federal government. There exists a somewhat substantial level of confusion among non-natives regarding the degree of independence held among tribal nations. Sovereignty is defined broadly as “the supreme political authority of an independent state” (Austin, 2017, p. 21). The Navajo Nation, and all other tribes within the United States, are not sovereign according to this definition not because they do not self govern but rather due to their lack of statehood. Instead, federally recognized tribes are described as “domestic dependent nations” whose sovereignty is ultimately controlled by the United States government (Austin, 2017, p. 20-21). In the early nineteenth century, a series of court cases established the existing status of independence for modern-day tribes.

The first and arguably most principal legal action involved a land ownership dispute between current lessees of Thomas Johnson, who had purchased property directly from the Piankeshaw Tribe, and William McIntosh, who obtained a land patent for the same area from the United States government. The Supreme Court ultimately sided with McIntosh, stating that the European Doctrine of Discovery granted the first “Christian European nation” to discover a land occupied by non-Christians with the ultimate rights to that land (“The Doctrine of Discovery, 1493,” n.d.). Therefore, the United States, and no other nation or group, held the rights to this land and all other lands occupied by Native people in exchange for “bestowing upon them civilization and Christianity” (*Johnson v. McIntosh*, 1823, at 573). This landmark decision ultimately eliminated the sovereign status of Native tribes, making them no longer able to sell or trade their lands to anyone other than the United States government. Instead, tribes maintain only the “right to occupancy” of their lands (*Johnson v. McIntosh*, 1823, at 563). While this decision stripped Native people of the title to their land, they remained able to “retain possession” of their lands and use them “according to their own discretion,” at least until Christian settlers might decide to acquire this land through “purchase or conquest” (*Johnson v. McIntosh*, 1823, at 574 and 587).

Chief Justice John Marshall authored this case and two others in a series of legal actions known as the Marshall trilogy, which established the degree of sovereignty tribal governments operate under today. The two later decisions in the trilogy, *Cherokee Nation v. Georgia* (1831) and *Worcester v. Georgia* (1832) determined that recognized tribes are domestic dependent nations able to self-govern without interference from state or federal governments (Fletcher, 2014). All three cases continue to impact modern tribes in the

United States, but the *Johnson v. McIntosh* (1823) decision also had a great deal of influence internationally. While the resolution did place massive limitations on indigenous people's land rights, Marshall's ruling has helped establish "certain property rights entitled to judicial protection" for Native groups in the United States, Australia, New Zealand, and Canada (Watson, 2011, p. 509). Despite this, *Johnson v. McIntosh's* basis in the highly prejudicial Doctrine of Discovery, a Papal Bull laid out by Pope Alexander VI in 1493, spurred on several major international initiatives in the last two decades.

In 2007, the United Nations Declaration on the Rights of Indigenous People defined the rights of native people to "maintain and strengthen their own institutions, cultures and traditions, and to pursue their development in keeping with their own needs and aspirations" (United Nations, 2006). Upon its initial presentation in 2007, all U.N. states, excluding the United States, Canada, New Zealand, and Australia, were in favor of the declaration. Since then, these remaining four nations have reversed their position and are now supporting the memorandum. However, when the Obama administration ultimately endorsed the resolution in 2010, it was deemed "aspirational," and notable provisions such as obtaining free and prior consent from Indigenous peoples before developing on Native land have been repeatedly neglected (Joffe, 2015, p. 2; Davis, 2016). While unfortunate legal injustices regarding tribal land ownership rights persist today, initiatives such as this remain as steps in the right direction.

The Basis of The Modern Navajo Government

Despite the Navajo Nation not existing as a sovereign state by most definitions in and of itself, its people maintain the right to occupy and govern their lands according to

their own needs. The Navajo government structure is similar to that of the United States federal and state systems, with a few unique caveats. Like government at the federal and state level, the Navajo Nation is organized into executive, legislative, and judicial branches.

The Executive

The president of the Navajo Nation acts as the chief executive officer of the executive branch and is responsible for enforcing laws, negotiating contracts, appointing members of the administrative bureaucracy, and serves as the primary representative of the Navajo Nation in its correspondence with external governments and private firms (Wilkins, 2003, p. 131). Voters elect a president and vice president to four-year terms with two-term limits. Candidates for president must be over thirty years of age, members and residents of the Navajo Nation, and, until recently, they were required to have the ability to speak and read Navajo fluently. The Navajo language proficiency requirement was reversed in 2014 following several allegations from political rivals concerning popular candidate Chis Dechene's ability to speak and understand Navajo, resulting in his ultimate disqualification (Fonseca, 2014). The importance of Navajo language proficiency among providers in tribal healthcare facilities is detailed in Chapter 4. The COVID-19 pandemic showcased the significance of having a capable and efficient executive branch. After experiencing the highest national rates of the virus in May of 2020, current president Jonathan Nez was tasked with containing the spread and coordinating relief efforts. Specifically, the Coronavirus Aid, Relief, and Economic Security, or CARES Act, supplied the Navajo Nation with over 700 million dollars in aid, most of which the Nez administration opted to spend on critically essential projects

involving water, electricity, and broadband telecommunication services (Smith, 2020). This action is addressed further in the subsequent chapter on tribal finance.

The Legislature

The primary differences between the Navajo Nation government structure and that of Arizona lie within the legislature. The Navajo Nation legislature, or council, is a unicameral system like the state of Nebraska, meaning it has just one chamber rather than the two we observe at the federal and state government levels. Just over a century ago, the Navajo Reservation was divided into 110 chapters that are now responsible for electing twenty-four individuals who act as council delegates (“The Three Branches of the Navajo Nation Government,” n.d.). Representatives are up for re-election every four years by the voters within their respective precincts; they are not subject to term limits. The Navajo Council is responsible for enacting and amending laws, appropriating the annual tribal budget, and establishing all standing committees, among other essential duties (Wilkins, 2003, p. 116). In addition, the legislature elects a Speaker of the Navajo Nation Council every two years who has the duty of presiding over the council and acts as the tie-breaking vote when necessary.

The Judiciary

The Navajo Nation Judiciary is the most complex court system of all United States tribal nations, and, despite being the youngest of the three branches, its firm grounding in traditional Diné customs and legal values garners it by far the most respect (Wilkins, 2003, p. 137 and 139). Navajo judges can serve for life once appointed, so long as they remain in good standing, and work within the Navajo Supreme Court, Family Court, or District Court. Peacemaker Courts are a unique aspect of the Navajo legal

system; they act as alternative justice systems that “reflect the culture, traditions, and values of the Navajo people and their conception of justice” (Wall, 2003, p. 539). More specifically, tribal judges emphasize central Navajo doctrines referred to as *k'é and hózhó*, which refer broadly to the ideas of kinship and harmony (Austin, 2007, p. 1). Such Peacemaker Courts act as complementary systems to other Navajo courts and practice a unique form of adjudication focused more on personal wholeness than punishment alone (Nielson, 1999, p. 108-109).

After Peacemaking Courts began to show a record of success following their official implementation in the early 1980s, several Navajo leaders started to question the efficacy of federally imposed judicial practices on the reservation. Explicitly, according to Bluehouse and Zion (1993), the failure of the Bureau of Indian Affairs Court and corresponding legal code, first adopted in 1959, showcased the “failure of legal structures and methods imposed on Indians by non-Indian outsiders” (p. 328). More recently, courts in cities far outside the reservation have been looking to find ways to apply traditional Navajo justice to modern judicial systems. In Brooklyn, New York, the Red Hook Community Justice Center is the Nation’s first multi-jurisdictional community court that emphasizes the peacemaking and restorative justice methods rooted in Native American tradition; since its inception, the center has documented rates of recidivism that are 10% lower than those of conventional courts in the area (Humphries, 2019).

A Brief History of Native U.S. Citizenship and Tribal Voting Rights

The Navajo, and many other indigenous groups, have the unique position of being citizens of both their own independently governed tribes and the United States at large. Until the passage of the 1924 Indian Citizenship Act, which granted “all noncitizen

Indians born within the territorial United States” citizenship, the majority of Native American individuals could not engage in political processes at the federal level (Stein, 1972, p. 257). Despite this landmark action from then-President Calvin Coolidge, the Navajo people remained unable to participate in state elections until multiple decades later when Arizona, New Mexico, and Utah became the final three states to grant indigenous people voting rights in 1956. An extensive volume of activism and legal action took place to secure indigenous voting rights in the southwest during this roughly thirty-year period, much of which is overlooked in teachings and discussions surrounding the civil rights movement (McCoy, 2016, p. 293). Unlike several other racial or ethnic groups in the United States, despite possessing full U.S. citizenship, tribal nations have sought to remain somewhat separate from the federal and state political establishments (Wilkins, 2003, p. 177).

The Navajo Nation has routinely seen impressive rates on voter turnout for their internal elections in recent times, with over 66% of registered voters participating in the 2018 General Tribal Election (Navajo Election Commission, 2018, p. 9). In 2020, Navajo voters demonstrated the impact they can have on the outcome of a national election as well. Navajo and Hopi citizens in Arizona cast almost 60,000 ballots in an election Joe Biden narrowly won by just over 10,000 votes (Fonseca and Kastanis, 2020). This heightened voter turnout among native groups likely played a significant role in the historically Republican stronghold of Arizona flipping for the Democrats in 2020. Despite this unprecedented occurrence, a substantial number of voting barriers exist for those living on the Navajo Reservation.

Barriers to Voting and Political Participation on the Navajo Reservation

Voting has never been a simple task for those living on reservations. While there is an increasing level of activism against voter suppression in Black and Hispanic communities, the same cannot be said regarding barriers to the indigenous vote. The rural communities inhabited by the Navajo are remote and lack formal addressing programs, with residences instead being regularly “described in terms of landmarks, crossroads, and directions” (Ferguson-Bohnee, 2020). Furthermore, as discussed in the first chapter of this report, most roads are unpaved, exist without official names, and frequently become impassable during periods of inclement weather. For these reasons, the United States Postal Service does not deliver mail to the vast majority of Navajo residents, who instead rely on shared P.O. boxes that may be far from their homes or in a separate county all together (The Native American Voting Rights Coalition, 2018, p. 101). For these reasons, all mail, election-related or not, often never reaches many Navajo individuals’ hands.

Despite registering to vote being more straightforward than ever before for most United States citizens, the process remains highly arduous for those living on remote reservations. A lack of broadband access on the Navajo Reservation massively restricts most resident’s ability to register online or receive political news. For those with some degree of access to the internet, Arizona requires that all individuals hoping to register remotely have both a state-issued I.D. and a residential address logged with the Department of Motor Vehicles (Ferguson-Bohnee, 2020). This makes the option of online voter registration entirely unavailable for most Navajo individuals. Moreover, surveys conducted by the Native American Voting Rights Coalition (2018) found that offices that provide in-person voter registration may be long drives away or exist without the translation services required by the majority of Navajo elders (p. 93). Such counties

may be non-compliant with Section 203 of the Voting Rights Act (1975), which “protects the voting rights of language-minority Americans” by providing them with voting materials and voting assistance in their language.

The Federal Role on The Reservation

Indigenous groups vote in both tribal and federal elections because of the unique form of dual citizenship they possess by living within two separately governed nations. Despite this, the “domestically dependent” status of tribal nations renders them inextricably connected to the United States federal government. A series of agencies located thousands of miles from reservation land have the responsibility of maintaining the “government to government” relationship that exists between the United States and all federally recognized tribes. The following subsections will briefly address three of the most central federal agencies, which will be routinely mentioned in this thesis’ remaining installments.

The Bureau of Indian Affairs

The Bureau of Indian Affairs, or the BIA, acts as the primary federal agency responsible for protecting the trust assets of Native Americans and sustaining the relationship between tribal and national governments (“Bureau of Indian Affairs,” n.d.). The BIA is housed within the Department of the Interior, and its inception in 1824 makes it among the oldest federal agencies in the United States. Former Secretary of War John C. Calhoun initially created the bureau to manage trade and treaty relations with tribes within the United States’ interior (“Bureau of Indian Affairs,” n.d.). Today the BIA has grown to be massive in size, with twelve regional offices, almost one hundred field offices, and roughly ten thousand employees (McCarthy, 2004, p. 16). As the largest and

most general of all the federal agencies related to Native American populations, the BIA is responsible for the crucial tasks of administering federal laws, maintaining infrastructure, and enhancing tribal governance. Ultimately, however, the most central role of the BIA, involving the management of tribal lands and funds, was established through the series of Supreme Court decisions under Chief Justice John Marshall, alluded to earlier in this chapter (McCarthy, 2004, p. 19).

The Bureau of Indian Education

Like the Bureau of Indian Affairs, the Bureau of Indian Education, or the BIE, is also a division of the United States Department of the Interior. Formerly known as the Office of Indian Education Programs, the BIE was renamed in 2006. A number of significant legislative actions have shaped the BIE into what it is today. In particular, since the Indian Reorganization Act of 1934 and the Education Amendments Act of 1978, BIE tribal schools have been able to teach native culture and history and receive federal funding directly (“Bureau of Indian Education,” n.d.) As of 2020, the BIE school system includes 184 elementary and secondary schools that serve just under 50,000 students and employ over 5,000 teachers, administrators, and other support personnel (“Bureau of Indian Education,” n.d.). These numbers account for the vast majority of students and staff that learn and work in tribal school systems.

The Indian Health Service

The Indian Health Service, or IHS, is an agency located within the Department of Health and Human Services with the responsibility of providing health-related services to federally recognized indigenous tribes throughout the United States (“Indian Health Service,” n.d.). Since its establishment in 1955, the IHS now cares for over two million

Native Americans, employs over 4,500 healthcare professionals, and operates under an annual budget of roughly six billion dollars (“Indian Health Service,” n.d.). Despite having a history riddled with underfunding and sporadic budget cuts, the IHS has managed to better the health of Native Americans to a significant degree since its inception (Bergman et al., 2002, p. 571-572). In spite of this, the Indian Health Service still has a long way to go in its pursuit of making meaningful and lasting improvements to indigenous health in the United States. (I go much further into detail on the IHS in the following installment on tribal budgets and healthcare finances).

Conclusion

The roles of these federal agencies have periodically evolved and expanded over the last few decades, and an increasing emphasis on hiring Native American administrators and staff has improved their ability to understand and assist federally recognized tribes. However, these agencies have repeatedly struggled to properly secure the finances necessary to carry out their obligations to indigenous groups. The third chapter of this report will examine Navajo revenue sources, tribal financial management, and the expansion of Indigenous health care autonomy.

CHAPTER THREE

Follow the Money: Navajo Revenue Sources, Tribal Financial Management, and Growing Indigenous Healthcare Autonomy

Introduction

In Chapter 2 of this report we established the status of the Navajo tribe as a domestic-dependent nation that is inextricably connected to the United States but entirely sovereign in the manner that it administers its internal governmental operations. To better understand the most pressing issues facing the Navajo people, an investigation into tribal finance is critical. This chapter discusses Navajo Nation revenue sources, how the Navajo government manages its finances, and the shifting landscape of the largest financial sector on the reservation, healthcare.

Navajo Revenue Sources: A Federal Obligation

A unique government-to-government relationship exists between tribal nations and the United States federal government. Three major court cases, known as the Marshall Trilogy, established that this trust relationship deals with self-governance, land, social services, and the overall welfare of Native peoples. (“Federal Funding and Unmet Needs in Indian Country,” 2003, p. 3). The financial connection between tribes and the U.S. government is not a one-way arrangement of money passing from the federal government to the reservations. Contrary to popular belief, Indigenous populations pay significant federal, business, and sales taxes. Also, as elaborated in Chapter 1, while income earned and goods purchased on federal tribal lands are not taxed, such areas are staggeringly underdeveloped requiring most tribal residents to travel far outside reservations to collect income and buy essential products. In 2003, a study found that

almost \$42 were returned to the state of Arizona through sales taxes Native groups paid on goods purchased off reservations and taxes imposed on tribal businesses for every dollar the state spent tribes (“Federal Funding and Unmet Needs in Indian Country,” 2003, p. 4). Additionally, while it is the obligation of the federal government to provide the Navajo Nation with the resources necessary for effective self-governance, the tribe also utilizes funding from a number of their own assets including minerals, agriculture, and ranching.

Internal Revenue Case Study: The Rise and Fall of Coal

Coal and uranium deposits were discovered underneath Navajo land several decades after the U.S. government established the reservation, and what was once considered worthless acreage suddenly became enormously valuable to many external interests. It was not until 1985, however, that the Supreme Court decision *Kerr-McGee v. Navajo Nation* held that tribes are able to tax non-tribal persons or entities doing business on tribal lands (p. 1). Following this landmark case, coal quickly became a major revenue source for both the Navajo Nation and a number of other tribes throughout the Southwestern United States. For the Hopi, revenues from royalties and leases pertaining to coal processing made up upwards of eighty percent of their annual operating budget as recently as 2018 (Randazzo, 2019). The Navajo Generating Station, in particular, was once the largest generator of coal-fired power in the west, and it employed upwards of 700 Indigenous people who quietly played a major role in the meteoric growth of the Phoenix area (Randazzo and Silversmith, 2019). This contribution to Arizona energy independence is ironic given the fact that a substantial percentage of Navajo households do not have access to electricity in any form. Despite this, due to falling natural gas and

renewable energy prices, the plant was deemed uneconomical and subsequently shut down entirely in 2019 (Pyper, 2019). While opponents of the Navajo Generating Station's closure cite the economic harm associated with terminating 700 Navajo jobs on a reservation with an unemployment rate regularly standing at upwards of 50%, others, both on and off the reservation, feel no amount of revenue or employment makes up for the decades of damage done to Navajo "land, water, air, and health" by such plants (Curley, 2017). The shutdown of the Navajo Generating Station and associated Kenyata Mine cost the Navajo Nation an estimated \$30 to \$50 million per year in revenue forcing the Navajo Council to tap into external funding reserves when allocating annual operating budgets (Smith, 2019).

Tribal Financial Management

The Navajo Nation Annual Budget

The Navajo Nation Council and President are responsible for allocating an annual budget of over \$1 billion crucial for maintaining the government offices and programs that are critical to the wellbeing of the Navajo people. As with many modern governments, the Navajo budget is broken up into a general fund responsible for covering the core administration and governmental operational costs, and several special-purpose funds designed to finance a number of specific programs and agencies. Despite receiving some legislative backlash, Navajo President Jonathan Nez approved the 2021 budget on December 10, 2020, after line-item vetoing a series of additional funding requests for a number of Navajo Nation programs ranging from the Navajo Election Commission to the Navajo Child Advocacy Center. (The 24th Navajo Nation Council, 2020, p. 2). In total, the Navajo Nation Fiscal Year 2021 Budget was roughly \$1.25 billion, with a general

fund of just under \$170 million, the majority of which was received by the Executive, Legislative, and Judicial branches for regular administrative costs (The Navajo Nation Fiscal Year 2021 Budget Summary, 2020).

The remainder of the budget, accounting for over \$1 billion, is placed in the hands of the Executive Branch to be administered to specified tribal programs such as the Navajo Division of Transportation, the Department of Health, the Department of Diné Education, and the Division of Social Services, all four of which receive upwards of \$100 million each year (The Navajo Nation Fiscal Year 2021 Executive Branch Budget Summary, 2020). These programs are then responsible for allocating their funds internally, and regularly struggle to meet the needs of the Navajo People. As discussed in Chapter 1, the Navajo Division of Transportation (NDOT) is able to allocate just \$68 million a year to transportation infrastructure such as roads and bridges, when the total infrastructural needs in these areas are estimated to be greater than \$7.9 billion in cost (Navajo Nation Council, 2019, p. 2). While funding shortages have proven to be a problem, independent sources have also uncovered cases of troublesome financial mismanagement.

Mismanagement of Federal Funds: The Navajo Housing Authority

A recent development involving internal mismanagement of funds occurred when the Navajo Housing Authority (NHA) was granted more than \$1.5 billion dollars over a 17 year period following the adoption of the Native American Housing Assistance and Self-Determination Act (NAHASDA) of 1998 (Harris and Wagner, 2016). This funding came as a welcome surprise to countless multigenerational Navajo families that have gone years without even a semblance of adequate housing. While running water and

electricity are considered luxury items on the Navajo Reservation, as discussed in Chapter 1, the majority of Navajo homes are also small and dilapidated despite regularly accommodating sizable multigenerational families. Despite a number of large and exciting promises, few projects ever materialized, and subsequent investigations by the U.S. Department of Housing and Urban Development (HUD) uncovered that the NHA had squandered hundreds of millions of federal dollars on projects that never housed anyone and were eventually demolished; other completed projects remain plagued by construction related defects (Harris and Wagner, 2016). Further investigation showed former Navajo President Peterson Zah and former Navajo Council delegate Ervin Keeswood received \$342,000 and \$700,000 respectively from the NHA for their consulting roles during the six-year period from 2011 to 2017 (Balcom, 2017). However, this large and unfortunate failure on the part of the Navajo Housing Authority should not discredit the Navajo Nation's ability to manage its resources internally. Recent events have demonstrated that the Navajo Nation is capable of efficiently and effectively allocating and utilizing large sums of federal funds for desperately needed projects, even during a time of crisis.

Internal Management Success: CARES Act Federal Funding

The COVID-19 Pandemic provided the Navajo Nation with new and unexpected challenges that required outside aid in the form of the federally instituted Coronavirus Aid, Relief and Economic Security (CARES) Act Hardship Assistance Program, which allocated \$714 million in addition to the annual budget. The Navajo Nation Council and President Jonathan Nez opted to spend portions of these funds on a variety of infrastructural projects desperately needed to slow the spread of COVID-19, all of which

have exceeded expectations. Nez approved \$130 million for safe drinking water projects, \$44.2 for powerline and electrical line extensions, \$53.2 million for broadband expansion in schools and public facilities, and an initial thousand dollars in hardship assistance stimulus checks to all Navajo individuals (“Navajo Nation President Approves \$475 million in CARES Act Funding,” 2020). Thus far, tribally managed programs have effectively utilized this funding to spur on a variety of successful projects. The Navajo Tribal Utility Authority (NTUA) has already been able to connect over 700 homes to the electrical grid, a number that far surpasses their initial goal of 500 residences (“713 Homes Now Connected to Electric Grid,” 2021). Additionally, 42 free wifi hotspots and 82 new internet broadcast stations were recently completed, enabling many Navajo families to access the internet from their homes for the very first time (Becenti, 2020). The NTUA was also able to use CARES Act funding to repair or replace 62 water well pumps and construct an additional 60 new bathrooms, 101 cistern water systems, and 98 septic systems (Fast, 2020). While the COVID-19 pandemic helped to further uncover the severity of the Navajo Nation’s infrastructure problems, it also has also highlighted the tribe’s ability to effectively manage a budget in a time of extreme urgency. Importantly, appropriations for healthcare-related programs and projects exceed those of any other sector, and internal tribal oversight has repeatedly shown to be an effective method of resource management. The final chapter of this report addresses how the Navajo Nation successfully slowed the spread of COVID-19, distributed needed PPE and other medical supplies, and rapidly vaccinated significant portions of their unique patient base.

Federal Programs and Growing Indigenous Healthcare Autonomy

The IHS and Federal Insurance Programs

In Chapters 1 and 2 we discussed the unique dual nature of citizenship for federally recognized Native groups. This reality becomes even more apparent when observed in the context of healthcare. All Navajo patients are eligible to receive care from the Indian Health Service (IHS), but the IHS is not healthcare. The Indian Health Service receives an annual budget determined by Congress each year that it allocates amongst tribal healthcare facilities and programs. For this reason, the IHS critically provides programs and facilities with funding to ensure tribal affiliates can access primary care, which is a treaty right; however, all programs affiliated with the IHS typically contribute to healthcare costs only after all other payment options have been exhausted (Engle, 2020). These payment options come in the forms of “Medicare, Medicaid, the State Children’s Health Insurance Program (CHIP), the Department of Veterans Affairs, and private insurance companies” (“The Indian Health Service, An Overview,” 2016, p. 11). Additionally, health coverage outside of IHS is required for the majority of specialty care that takes place at off-reservation facilities (“Public Health Services on the Navajo Nation,” n.d.).

Evidently, despite the existence of the Indian Health Service and associated health care facilities and programs, Medicaid or other forms of insurance are still a necessity for all Navajo individuals. In the last several years, access to public health insurance options has increased significantly. Specifically, the Affordable Care Act expanded Medicaid in 2015, resulting in 440,000 Native Americans becoming eligible for the service (Duan and Price, 2017). Many Navajo-dominated areas, such as McKinley County, New Mexico, have rates of Medicaid enrollment that are over 50% of the total population (Galewitz, 2018). Despite this, access to Medicaid varies for Navajo individuals depending on their

state of residence. A 2014 study by the U.S. Department of Health and Human Services found that it should be possible for the Navajo Nation to operate its own Medicaid agency, ensuring equal care for all tribal members across state lines (“President Shelly Signs NDOH Act into Law,” 2014, p. 1). This information helped to spur on a series of concerted efforts to create such an agency, all of which have stalled in the last year. Medicare also plays an important role in Indigenous health, with almost a third of Native Americans enrolled in Medicare falling below the age of 65 due to their disproportionate numbers of chronic health complications (Engle, 2020). When more Navajo individuals are insured, they have more flexibility in where they receive care, which may be outside of IHS contracted facilities; this reduces the burden on already underfunded and overworked tribal hospitals and clinics (Shinn and Martin, 2020). Additionally, when tribal hospitals and clinics are able to bill insurance programs and companies, they have a greater available budgetary surplus to care for some of the poorest, most disenfranchised individuals who may not be insured.

IHS Budgetary Shortfalls

The IHS is tasked with providing Native Americans with healthcare equivalent to the rest of the national population, but it is widely considered the payer of last resort, relying heavily on external sources of revenue from both public and private insurance alongside its annual congressionally appropriated budget. In 2014, third-party insurers accounted for upwards of 20% of operating budgets for IHS providers, a number which has grown following Medicaid expansions with the implementation of the Affordable Care Act (Boccuti, Swoope, and Artiga, 2014, p. 7). The reason for this is simple, the Indian Health Service is chronically underfunded, and it has been since its inception

within the Department of Health and Human Services over half a century ago. To provide some context, in 2017, the IHS spent \$4,078 per individual, compared to the \$10,692 spent by the Veterans Health Administration, the \$13,185 spent by Medicare, and the \$8,109 spent by Medicaid (“Indian Health Service: Spending Levels and Characteristics,” 2018, p. 10-16). In the last decade, the IHS has seen regular annual budget increases, but these increases serve simply to “meet mandated obligations and cover inflation costs,” with little spending to actually expand on the services IHS is supposed to provide to Indigenous people (“Fiscal Year 2017 Indian Country Budget Request,” 2016, p. 51). The National Congress of American Indians (2016) estimates that an additional two billion dollars per year for the IHS would be necessary to achieve health equity for federally recognized tribal nations over a 12-year period (p. 52).

How the IHS Allocates Funds on The Navajo Nation

Despite funding shortages, the IHS still manages a congressionally determined budget of over \$6 billion. The smooth and timely allocation of these funds is critical to ensuring the daily function of the vast majority of tribal health facilities. Funding is either allocated directly by the IHS itself from its twelve federal offices located in Washington D.C. or to on-reservation facilities that manage their own care through a series of self-determination contracts (“Federal Funding and Unmet Needs in Indian Country,” 2003, p. 45). Since the late nineteen seventies, tribes themselves have garnered ever-greater autonomy from the federally managed Indian Health Service. More recently, in the 16-year span from 2003 to 2019, tribal IHS budget management increased from just over 50 percent to roughly 60 percent (Murrin, 2019, p. 1). This change is a welcome one for Indigenous patients, doctors, and officials who feel tribally managed healthcare is “more

responsive to the needs of individual tribal members than a far-removed federal system” (“Federal Funding and Unmet Needs in Indian Country,” 2003, p. 40). Two pieces of major legislation are responsible for this ongoing shift to tribal healthcare management, the Indian Self Determination Act of 1975 and the Indian Health Improvement Act of 1976. Both of these statutes and their subsequent amendments have called for “maximum participation of Indians in the planning and management of healthcare services” steadily limiting the role of the IHS over time (Joe, Swift, and Young, 2003, p. 4-5).

The Modern Navajo Healthcare Landscape: Rising Independence in Management

As the largest federally recognized tribe in the United States, Navajo Nation health is managed by the Navajo Area Indian Health Service (NAIHS), one of twelve regional administrative units of the IHS. This NAIHS branch is located outside Washington D.C. and is responsible for directly allocating funds to five hospitals interspersed throughout the 25,000 square miles of Navajo Reservation. As discussed in Chapter 1, these federal hospitals are tasked with serving growing numbers of a population suffering disproportionately from chronic health problems. Additionally, these locations are often difficult to reach, understaffed, underfunded, and generally mismanaged (Levingston, 2016, p. 3). Contrastingly, as we have seen across the United States, however, more autonomy is steadily being given back to the tribe itself, whose leadership feels they do a better job of managing their own patient populations. The Navajo Department of Health (NDOH), an urban health program in Flagstaff, Arizona, and five additional tribal healthcare corporations round out the Navajo healthcare landscape and are operated directly by the Navajo Nation with the use of federal funds and private donations (Indian Health Service: Navajo Nation, n.d.). One of the primary

purposes of the NDOH is to provide “culturally acceptable” healthcare alternatives to the federally managed IHS programs and facilities (Indian Health Service: Navajo Nation, n.d.).

Conclusion

The Navajo have gradually gained more autonomy managing healthcare dollars, and greater monetary independence has allowed tribal entities to provide much needed finances to an increasing number of facilities that emphasize cultural competence in care. Chapter 4 investigates how such care can increase patient compliance and improve overall healthcare outcomes.

CHAPTER FOUR

A Cultural Intersection: Modern Medicine Meets Traditional Ways

Introduction

Frank Tabaha declined his doctor's recommendation for a life-saving foot amputation in an urban hospital. Navajo tradition required that he "die whole" to allow his spirit unimpeded passage into the next world. Frank and his doctors reached a critical impasse. Finally, after consulting with a medicine man at home on the reservation, Frank consented to the operation under the condition that the hospital would release the amputated limb for a special unifying ceremony. This story was told to me by Devin Tabaha, a friend and former coworker who grew up on the Navajo Nation and now works at a state-of-the-art orthopaedic surgery center in Phoenix. In addition to Devin, this chapter features insights from Dr. Peter Siepel, a surgeon based in Globe, Arizona and Nashonna Frank, a Navajo Native pursuing a Masters in Public Health, who both specialize in treating Indigenous populations. My research and conversations with them demonstrate how cultural literacy is an essential prerequisite for effective health care delivery and public policy on the Navajo Reservation.

Traditional Navajo Healing Traditions

Background

To begin to understand the role Navajo culture plays in modern Navajo health, it is important to first learn more about Navajo healing traditions. The Navajo religion is present throughout Diné history, and its traditions remain a major component of tribal culture and life. Health and healing are deeply rooted in Navajo religious customs, and a number of highly trained specialists carry out a variety of distinct "diagnostic, curative,

and restorative practices” (Lewton and Bydon, 2000, p. 481). For example, hand tremblers diagnose the problem and determine the ceremony necessary to correct it, herbalists treat illness with specific herbs, and singers lead chants and oversee troupes of dancers throughout healing ceremonies (Donovan, 1997). While these singers, called *Hataalii*, spend years learning the many details and meaning behind each ritual chant, prayer, and myth, some aspects of Navajo curing rituals are uncontrollable and unpredictable, like sickness itself (Parezo, 1983, p. 11). Additionally, there is no fixed ceremonial calendar, institutionalized priesthood, or official certification system for Navajo healers (Parezo, 1983, p. 11; Donovan, 1997). While Western medicine, or biomedicine, typically categorizes and treats physical and psychological ailments separately, a strong psycho-physical connection exists within Navajo traditional healing (Moulton, 2011, p. 2-3). This connection is related to the concept of *hózhó*, which refers to the balance and harmony in a person’s life; all illness is caused by “improper contact with inherently dangerous powers” that force an individual to move away from this balance and toward disharmony (Parezo, 1983, p.12). Only a series of methodically carried out rituals and ceremonial practices can restore this equilibrium in a sick individual.

The Role of Diagnosis in Navajo Traditional Healing

Diagnosis plays a role in most if not all global healing systems, and traditional Navajo healing is no different. However, the Navajo do not consider diseases in terms of the symptoms they produce or body parts with which they are associated; instead, illnesses are classified by their causal agents, and diagnosticians are tasked with finding the origin of an ailment that ultimately determines the manner in which a patient is

treated (Milne and Howard, 2000, p. 545). While illness can stem from an individual encountering and subsequently being contaminated by animals, foreigners, or other natural phenomena, it may also originate following contact with the ghost of a deceased person, the violation of a taboo, or the offense of a deity (Moulton, 2011, p. 82). For this reason, the afflicted individual may have no way of knowing the cause of their health problem on their own. Hand-trembling is the most common method of diagnosis in Navajo tradition. In this process, the hand-trembler, most often a woman, offers prayers to the Gila Monster Spirit, who knows of all illnesses, and their hands begin to tremble vigorously, illustrating in their motions the diagnosis for the person's illness (Palmer, 1974, p. 25; Milne and Howard, 2000, p. 549). When the diagnostician is aware of the cause of the condition, they are then able to notify the patient and their family of the necessary healing ceremony; they may also recommend a specific trusted medicine man or woman to preside over the service (Palmer, 1974, p. 25).

Navajo Ceremonies

Singers, Prayer, and Song

Healers in Navajo are referred to by a number of terms in English, including chanters, singers, or medicine men/women, and conduct ceremonies that may last under an hour or up to several days (Moulton, 2011, p. 82). Unlike hand tremblers, Navajo singers are overwhelmingly male; however, female healers do exist and are incredibly knowledgeable, often spending far greater periods of time training as apprentices before their official initiation into the practice (Schwarz, 2003, p. 65). Milne and Howard (2000), mention that, although many ceremonies focus on addressing a specific illness, others may be administered prophylactically to enhance "health, the quality of social

relationships, and financial well-being” (p. 545). Devin noted that while ceremonies are most often performed in traditional Diné homes called hooghans, they can also take place in whichever structure an affected individual may live. Regardless of the underlying ailment, each ceremony centers around retelling portions of the Navajo creation story that typically depict people overcoming a problem or regaining balance (Moulton, 2011, p. 83). The medicine man or woman will say prayers or sing songs associated with the Navajo Holy People, or the *diyin dine'e*, who manifest themselves in the form of natural elements and powerful animals; the patient will repeat these prayers verbatim until they ultimately become one with these spirits (Milne and Howard, 2000, p. 546). It is important to note that by speaking or singing these prayers the singer actually assumes “control of a supernatural power and personifies the deity who created the song” which allows them to restore balance, or *hózhó*, in the patient’s life (Moulton, 2011, p. 83). A substantial amount of preparation is required for each ceremony, much of which involves the creation of sandpaintings critical to calling supernatural spirits into the patient’s hogan or residence.

Sand Paintings

Depending on the length of the given ceremony, multiple sandpaintings may need to be created to act as “ceremonial membranes” that the “evil of man and the good of deity” penetrate; once inside the patient's home, these forces neutralize one another (Parezo, 1983, p. 14). These paintings depict specific deities determined to be associated with a person’s illness, and such spirits are then drawn in by their own appearance in the artwork. These images may vary in complexity, but the choice in painting ultimately comes down to “the singer’s knowledge and power, the success of the painting in the

past, etiological factors, and the sex of the patient” (Parezo, 1983, p. 15). The number of artists and the amount of time a composition takes to complete largely depends on the intricacy and size of the piece. While smaller, more simple, sandpaintings may be completed by one or two artists in under an hour, larger, more elaborate, illustrations may require upwards of 30 laborers working for more than 10 hours (Reichard, 1990, p. xxxv). Despite this labor-intensive and time-consuming operation, not everyone is allowed to help with the creative process. Only important relatives of the patient, artists, healers, and apprentices are permitted to assist with sandpainting (Parezo, 1983, p. 15). Designers exclusively use taut strings to form straight lines when creating these images, the rest is done completely freehand. However, this process is not carried out at whim, the placement of figures and ritualistic designs must follow strict rules or risk the ceremony failing to cure the patient entirely (Parezo, 1983, p. 16). While sandpaintings are the most central aspect of Traditional Navajo healing ceremonies, healers utilize a number of other methods to restore hózhó in their patients.

Herbalists

Navajo people have been using plants as natural remedies to do anything from cleansing and rejuvenating otherwise healthy individuals to treating those with chronic illnesses (Dempsey, n.d.). Like hand tremblers, Navajo herbalists are also primarily women, and a substantial number of these practitioners are trained in and actively implement both practices (Milne and Howard, 2000, p. 549). Navajo medical ethnobotany is incredibly expansive and comprehensive, with countless bodily systems and associated ailments being accounted for. Wyman and Harris (1941) describe Navajo herbal treatments for a great number of illnesses associated with everything from the

circulatory system to the genito-urinary system (p. 55-63). Their work also includes extensive documentation on herbal treatments for everything from mental health problems to injury from venomous animals (Wyman and Harris, 1941, p. 59 and 65). Herbalists prepare and utilize plants in a number of ways such as tea mixtures, powders, and ointments; regardless of the method of administration, all remaining plant products are returned to mother earth in the form of an offering following their ceremonial use (Dempsey, n.d.). Unfortunately, traditional Navajo practitioners such as hand tremblers, singers, and herbalists have been historically disregarded by non-Indigenous policymakers and healthcare providers.

Improving Healthcare Outcomes by Bridging the Cultural Divide

Lack of Navajo Patient Trust and Compliance

Based on all available evidence, prior to the arrival of European diseases, the Navajo people were generally a “well-fed and robust” population who effectively managed their health-related problems by utilizing traditional Navajo healing systems (Trennert, 1998, p. 4-7). When the United States government began to take control of Indigenous health during the mid 19th and 20th centuries, more effort was focused on assimilating “uncivilized” Native groups than actually treating their medical problems (Trennert, 1998, p. ix). For many years, federal programs actively delegitimized Native healers and traditional practices that were viewed as barriers to medical progress on reservations (Trennert, 1998, p. ix). While such programs have made significant headway with respect to Native cultural acceptance, a disconnect remains between Indigenous patients and many of the doctors that treat them in hospitals and clinics on and off-reservation land. Numerous studies and the conversations I have had with Dr. Peter

Siepel, a surgeon who serves a large indigenous patient base in Globe, Arizona, and Navajo Native Devin Tabaha have demonstrated that Arizona tribes and the Navajo patient population are no exception to this reality.

Dr. Seipel practices orthopaedics in northeastern Arizona where a significant number of his patients are Indigenous. He estimates that somewhere between 10 and 15 percent of the Native patients he encounters in his clinic will refuse treatment, most of whom tend to be among the older generations. Devin Tabaha, who grew up with his family on the Navajo reservation and currently works as a surgical technologist in an urban hospital in Phoenix, attributes this to an overall lack of trust among Indigenous populations. While a number of historical occurrences may explain this mistrust, Devin mentioned that his own grandparents have associated hospitals and being told what to do by white outsiders with the boarding schools they were forced to attend in their youth. Both Devin and Dr. Seipel stressed the importance of developing lasting trusting relationships with Indigenous patients over time. When doctors are able to establish positive reputations within extended Navajo families, their diagnoses gain far more credence, and subsequent outcomes are more positive. A number of authors have focused on the most effective methods of establishing trust between Navajo patients and providers, most of which centers around providing culturally competent care.

Establishing Trust through Cultural Competence

When cultural differences are not considered in medical practice, there exists a higher likelihood of “patient dissatisfaction, misdiagnosis, and suboptimal outcomes” (Carrese and Rhodes, 2000, p. 1). While there is an abundance of evidence that cultural competence improves patient outcomes, basic cultural awareness is not sufficient to

bridge the gap between Indigenous patients and providers. Instead, steps must be taken to actively incorporate traditional values into modern medical practice. Dr. Lori Arviso Alvord, a graduate of Stanford University School of Medicine and the first female board-certified Navajo surgeon, writes about effectively linking traditional tribal health practices and the latest advances in Western biomedicine in her critically acclaimed memoir, *The Scalpel and the Silver Bear*. Dr. Alvord discusses the importance of patient mindset in healing, stating that it is “hard to heal a person who does not believe they will get well” (Alvord, 1999, p. 94). Many Navajo feel diseases such as cancer are caused by an “evil action or bad deed” from the ill person; family members will occasionally drop their loved ones off at distant hospitals out of fear they will contract the illness themselves, further lowering the morale of an already frightened patient (Alvord, 1999, p. 90-94). Through the incorporation of a traditional sing from a Navajo healer or hataalii, Dr. Alvord was able to better prepare a Navajo patient with breast cancer mentally and spiritually to fight off her disease (Alvord, 1999, 91-104). Healthcare delivery should be tailored to meet patients’ “social, cultural, and linguistic needs;” culturally competent healthcare providers not only have increased patient respect and improved health outcomes, but they also may incur “lower costs and fewer care disparities” (“Becoming a Culturally Competent Healthcare Organization,” 2013, p. 3).

A culturally competent approach to Indigenous health care should begin at the initial consultation and follow through the remainder of the treatment process. For Navajo populations, the specific manner in which providers relay information is critical to effective patient communication and compliance. Devin explained how certain members of his family would immediately dismiss the suggestions of physicians who

directly and blatantly informed them about the severity of their illnesses. This incredulity makes sense, however, considering that the discussion of negative information in this manner is considered a violation of traditional Navajo principles. Carrese and Rhodes (2000), note that physicians should establish patient trust by taking actions such as facilitating the involvement of family members and traditional healers and communicating in a respectful and unhurried manner always with a positive focus in mind (p. 93-94). Specific suggestions from Navajo informants in this study include protocols such as making references to hypothetical third parties and recounting the entirety of the patient's story relative to the symptoms they present (Carrese and Rhodes, 2000, p. 94). While such methods have proven to be effective within samples of Diné patient populations, it is important to note that there is significant variation within Navajo culture, and each patient should be addressed on a unique basis. Additionally, large numbers of Navajo patients, and elders in particular, rely on the Navajo language for everyday communication. A lack of Navajo language proficiency among healthcare providers is an obvious barrier to effective healthcare distribution.

The Navajo Language and the use of Translators in Healthcare

As recently as 1983, 91% of Navajo individuals were fluent in the Navajo language; since then this number has decreased significantly, with less than half of the tribal population speaking fluently today (Denetclaw, 2017). Despite this notable decline, Navajo remains the most widely spoken Indigenous language in North America with roughly 150,000 speakers in total. Despite the existence of a strong modern revitalization effort and the success of Navajo language immersion schools scattered across the reservation, there remains a very clear generational gap in language proficiency between

older generations and Navajo youth (“Examining Efforts to Maintain and Revitalize Native Languages for Future Generations,” 2018, p. 28). Devin stated that effective and meaningful communication with Navajo elders, who often use the Navajo language as their primary mode of communication, is critical because these groups are also the most likely to be skeptical of non-Navajo doctor’s treatment plans. Both Devin and Dr. Seipel spoke about the growing use of Indigenous translators in healthcare facilities both on and off the reservation and the remarkable effectiveness of this practice. Geri Kinsel-Begay, a Navajo interpreter at Flagstaff Medical Center, discussed the importance of “bilingual storytelling to create a cultural bridge between Navajo elders and providers” (Sevigny, 2016). These translators are especially critical for explaining diseases and procedures to patients and families that are not typically described in the Navajo language to patients and families. Nashonna illuminated that there is a significant amount of regional variation in the Navajo language, depending on where someone grew up on the reservation they may pronounce words and phrases differently or practice alternative cultural traditions. Nashonna feels those who grew up speaking the Navajo language and practicing traditional Diné customs understand best how to incorporate these elements into modern healthcare delivery. When tribes act with genuine autonomy, they can often avoid making the same mistakes as a far removed federal system with a less nuanced understanding of vast and complicated Indigenous language and spiritual practice.

Conclusion

Providers and policymakers alike should seek to gain a deeper understanding of their patients’ unique cultural perspectives and proceed to utilize an “intensive, systematic, and imaginative empathy” to guide clinical communication, research and

education, and healthcare policy (Carrese and Rhodes, 1995, p. 829). This same study from Carrese and Rhodes (1995) found that well-meaning federal congressional actions such as the Patient Self Determination Act of 1990, which emphasized the practice of advance care planning, violate traditional Diné values and are likely harmful to Navajo patient populations who think about matters related to sickness and death differently than the general population (p. 828-829). Those living in the traditional Navajo world with intimate knowledge of Indigenous culture are better equipped than Congress or federal offices in Washington D.C. to solve certain complex healthcare issues on the reservation. Chapter 5 documents the success the Navajo Nation has had managing Navajo health during the COVID-19 pandemic, while federal agencies and programs have fallen short.

CHAPTER FIVE

A Healthcare Success Story: Navajo Self Governance and COVID-19 Mitigation

Introduction

In the spring of 2020, the COVID-19 pandemic shocked the entire world. The Coronavirus quickly ravaged through cities and towns across the United States, filling ICUs, prompting the shutdown of countless businesses, and catalyzing abrupt change in daily life. News reports avidly documented viral spikes in metros across the country, where many of the nation's most bustling areas struggled to keep up with rapidly surging case numbers and deaths. In May of 2020, the Navajo Nation received an uncharacteristic amount of national press for quietly surpassing New York City as the country's most infected area per capita (Silverman, Toropin, and Sidner, 2020). The Navajo government and tribal health officials have since taken unprecedented measures to successfully slow the spread of the virus in an effort to protect the lives and culture of the Navajo people. Their successes throughout the pandemic illustrate what the Navajo tribal government can accomplish when allowed to act autonomously as a sovereign nation.

The COVID-19 Pandemic's Unique Impact on the Navajo Reservation

The Navajo people deeply value community, and it is common for extended multigenerational families to live in close proximity to one another. This unique aspect of Navajo life promotes the passing down of cultural knowledge, language, and traditional values. Unfortunately, tight-knit communal living was also conducive to the rapid spread of the Coronavirus from young, healthier individuals to their older, more vulnerable family members (Gutman, Rodriguez, Shakya, 2020). The COVID-19 pandemic also highlighted the infrastructural deficiencies and health disparities on the reservation

discussed in Chapter 1 of this thesis. Upwards of 30% of Navajo residents have access to clean running water in their homes, and even fewer have electricity (Gies, 2016; Gallucci 2019). Nashonna has closely followed the outbreak on the Navajo Nation as her family and friends continue to fight through the pandemic. She described how it is impossible to expect those with a scarcity of clean drinking water to take part in hygienic practices such as frequent hand washing. Additionally, Nashonna acknowledged that the Navajo Reservation's status as a food desert leads to excessive crowding in the small number of reservation grocery and convenience stores where viruses can spread and later be transmitted to families. According to Donavon Tabaha, Devin's brother who lives and works on the reservation, despite the best efforts of Navajo political and public health officials, hearing critical information about the virus early on in the pandemic was incredibly challenging for those without internet access. For a period in the spring of 2020, the Navajo Nation not only had the highest number of COVID-19 cases per capita, but its population's disproportionate share of preexisting health conditions drastically heightened the threat of the outbreak on tribal land (Hedgepeth, Fears, and Scruggs, 2020).

The frightening reality of the pandemic's impact on the reservation became clear for siblings Devin and Donavon Tabaha when both of their parents became infected with COVID-19 in the early fall of 2020. They were treated at Gallup Indian Medical Center, a Navajo Area Indian Health Service (NAIHS) facility in Gallup, New Mexico. Devin explained the hectic nature of the initial viral outbreak and how limitations in hospital space necessitated the use of several local hotels where patients could quarantine and receive treatment. While Devin and Donavon's father continued to take steps toward

making a full recovery, numerous respiratory comorbidities caused their mother's condition to deteriorate rapidly. Ultimately, the relatively small NAIHS hospital in Gallup lacked the resources necessary to treat Mrs. Tabaha, and she was transported to Albuquerque, New Mexico, where her health status finally began to improve. Devin explained that while tribal health facilities have increasingly adopted culturally competent care practices, such as utilizing Navajo translators and healers to improve patient trust, being treated by strangers in unfamiliar off-reservation medical centers that lack these accommodations is often difficult for older Navajo patients. As a healthcare professional himself, Devin was able to communicate what the doctor had to say in a way that his mother understood and was comfortable with. Mrs. Tabaha has since left the ICU and is back at home recovering with her family on the reservation, where she has utilized several additional traditional treatment recommendations from Navajo healers and herbalists. Tragically, many Navajo elders do not recover, and in their death, they take with them their abundance of unique cultural knowledge and expertise (Morales, 2020). Despite her improving health, long-standing reservation lockdown ordinances and travel restrictions have prevented Devin from visiting his mother since she initially fell ill.

The Navajo Government's Response to the COVID-19 Pandemic

Following large early case numbers, the Navajo Nation government has done an outstanding job slowing the spread of COVID-19 and protecting the most vulnerable people in their population. The tribe began preparations for the virus months before discovering the reservations first case first and quickly reacted when infections rose by implementing temporary mask mandates, stay-at-home orders, and curfews (Curtis, 2020). President Jonathan Nez recognizes these measures, along with heightened testing

and contact tracing, for the decline in COVID-19 cases on the reservation throughout the summer of 2020 (Giuliano, 2020). Nashonna, described the Nez administration's response to the pandemic as being an exciting sign of a positive shift toward greater public health awareness on the Navajo reservation. Nez's use of social media apps such as Facebook and Instagram to spread information about the pandemic's rapidly progressing stages impressed Nashonna and a number of her younger Navajo peers. Donavon Tabaha also feels the tide is turning for Diné health education; he mentioned noticing signs alongside popular roadways encouraging frequent hand washing and the use of masks from the earliest stages of the pandemic. Those who can access the internet can watch live town halls hosted by Nez and several Navajo public health officials. Additionally, Donavon acknowledged how traditional medicine men have begun to use social media platforms to post recommendations for herbal remedies and prophylactics to help with COVID-19. Despite facing many unique barriers to healthcare distribution, the Navajo Nation has acted autonomously from surrounding governments and managed to outpace the state of Arizona in terms of testing and response throughout the entirety of the pandemic (Curtis, 2020).

How the Navajo Nation Acting Autonomously to Slow the Spread of COVID-19

In many ways, the actions taken by the Navajo government contrasted those of neighboring states. Even when case numbers across Arizona, New Mexico, and Utah remained in the single digits, the Nez administration and the Navajo Department of Health began taking action to protect their more vulnerable population. Quickly following the discovery of the first positive case in Maricopa County in late January of 2020, President Nez released a statement encouraging Navajo residents to begin to take

precautions against COVID-19 (The Navajo Nation, Office of the President and Vice President, 2020). Arizona Governor Doug Ducey did not release a public disclosure until over a month later, on March 2nd, when officials noted the “risks of contracting the virus were low” (Curtis, 2020). By this time, the Navajo Nation had already established a COVID-19 Preparedness Team including members from the Office of the President and Vice President, the Navajo Department of Health, the Navajo Nation Division of Public Safety, and several other vital governmental organizations (The Navajo Nation, Office of the President and Vice President, 2020, p. 2).

Additionally, President Nez recognized the unique differences within the Navajo patient population and stressed the importance of utilizing “Community Health Representatives to inform Navajo elderly people and those living in remote areas” about the virus (The Navajo Nation, Office of the President and Vice President, 2020, p. 2). As case numbers rose throughout March and early April, the Navajo Nation declared a state of emergency, implemented a series of curfews, and mandated the use of masks in public spaces; Governor Ducey implemented no such restrictions state-wide (Curtis, 2020). After experiencing record high case numbers on the reservation in the late spring, the curve began to flatten throughout the summer for the Navajo, while cases steadily rose across greater Arizona (Hlavinka, 2020). The Navajo Nation’s early prioritization of testing helped the tribe become a national model for effective COVID-19 response.

COVID-19 Testing Success

The high relative case numbers in the late spring of 2020 can likely be attributed in part to the Navajo Nation’s preemptive rigorous testing protocols. In May, the Navajo Department of Health administered tests at a higher rate per capita than any other state in

the country (Giuliano, 2020). Midway through June, 25% of the Navajo population had received at COVID-19 test compared with 8% of the national public and just 5% of the Arizona residents (Lakhani, 2020). By September, the Navajo Nation had tested more than 50% of its population living on the reservation, continuing to vastly out-test surrounding states Arizona, Utah, and New Mexico on a per capita basis (Johns Hopkins Coronavirus Resource Center, 2020; Pfeiffer, 2020). In an interview with Sacha Pfeiffer of National Public Radio's "All Things Considered" (2020), President Nez accredited this significant testing effort for allowing Navajo public agencies to effectively track and subsequently contain viral hot spots throughout the reservation on a consistent basis. When case numbers began to rise to peak levels across the country in the winter of 2020, the Navajo Department of Health accurately identified communities where the virus was spreading and actively took further steps to reduce transmission ("73 Navajo Nation Communities with Uncontrolled Spread of COVID-19," 2020). Case numbers continued to decline across the reservation in the early months of 2021. As recently as March 23rd, the Navajo Nation, a former global hotspot, reported the second-to-lowest numbers of new cases across all U.S. states and territories (Mendez, 2020). The most significant factor in this reduction of cases lies in how the Navajo government quickly and effectively allocated COVID-19 vaccinations.

Vaccination Success on the Reservation

The Navajo Department of Health began planning and setting goals for vaccinating the tribal population before receiving their first allocations of doses. Halfway through February, the tribe massively exceeded their initial vaccine rollout goals, having already administered upwards of 100,000 doses of the vaccine, effectively immunizing

roughly 24,000 individuals (Silversmith, 2021). Not only has the Navajo Nation surpassed their own expectations regarding vaccine rollout, but they have also managed to outpace surrounding states and the U.S. at large. By March, 22.4% of New Mexico, 17.1% of Arizona, 12.2% of Utah, and 15.3% of the United States had received at least one shot of the COVID-19 vaccination compared to 26% of the Navajo population (Krisst, 2021). On March 22nd of 2021, the Navajo Nation had administered 191,000 COVID-19 vaccines, fully vaccinating over 76,000 people, and, for the first time since September, saw a day go by without a single additional positive case (Onneweer, 2021). The Navajo Nation contains several isolated communities without access to functioning roadways or electricity. Their populations, who suffer disproportionately from a number of chronic illnesses, have a long history of mistrust in non-Navajo medical practices and personnel. Despite this, Navajo health organizations were able to oversee a successful vaccine rollout by recognizing their unique population's needs in ways no external government agency could.

The Importance of Self-Governance in Managing the Pandemic

Tribal healthcare autonomy was critical to successful pandemic response on the reservation. From the early stages of the pandemic, Navajo President Jonathan Nez and other health officials compared the virus to the monsters that plagued the Navajo people in their traditional creation stories (Jones, 2020). By framing the Coronavirus in the Diné perspective in press conferences and radio announcements, Navajo leadership better equipped their population to take on the challenges that lay ahead, just as they had done with tremendous resiliency for generations. The Navajo Nation also took a personalized and systematic approach to vaccine education and administration, establishing

widespread trust in the process. Like many other groups in the United States, Native American populations have historically been wary of vaccinations, which makes sense considering the medical and research abuses committed against Indigenous people following European colonization (Hodge, 2012, p. 431). Navajo Area Indian Health Service Chief Medical Officer Loretta Christensen emphasized the importance of utilizing community health representatives, who know families and homes personally, to reach out to isolated populations on the reservation, homebound elders, and persons with disabilities (Krisst, 2021). President Nez stressed that having Navajo doctors and healthcare providers available to discuss the vaccine and answer questions in the Navajo language over the radio and at weekly town halls is also critical to building extensive confidence (Kaur, 2021).

Not only did the Navajo take a personalized approach to communication throughout the pandemic, but they utilized their tribal autonomy to strategically determine which groups in their unique population base should receive priority in their vaccination rollout. Many tribes across the country, including the Navajo Nation, expanded their initial phases of vaccine distribution to include individuals much younger than the CDC's nationally recommended age of 75 due to lower life expectancies and a higher prevalence of dangerous pre-existing conditions in their populations ("Interim Considerations for Phased Implementation of COVID-19 Vaccination," 2021). Tribes also prioritized the vaccination of those who held significant cultural and community value. These groups often consisted of revered members of tribal communities, such as Native language teachers and Indigenous spiritual leaders (Kaur, 2021). Donavon discussed how the Navajo Nation inoculated their traditional medicine men and other

uniquely essential healthcare workers on the reservation. He felt this action not only protected a significant aspect of Navajo culture but helped to legitimize the vaccine in the eyes of tribal elders and his own parents, who might have previously been skeptical about receiving their doses. The success of the COVID-19 response and vaccine rollout on the Navajo Nation and Indigenous communities across the country shows what is possible when tribal governments can act as autonomously as true sovereign nations.

Grassroots Internal Response

A number of grassroots movements emerged across the Diné reservation to work alongside the Navajo government and tribal healthcare agencies. Grassroots strategies are effective because they are “dynamic,” “vigilant,” and operated internally by tribal members themselves who understand the needs of their communities best (Hardy, Saul, and Thompson, 2020). Nashonna and Donavon recognized such organizations’ efforts in our conversations about Navajo life both before and after the pandemic first reached reservation land. The Yee Ha’ólníi Doo Navajo & Hopi Families COVID-19 Relief Fund is operated by Navajo and Hopi Natives who can target their most vulnerable populations in ways no externally driven organization can. On their website, they provide information regarding all aspects of COVID-19 in the form of colorfully illustrated educational flyers and pamphlets; they also actively distribute food, water, and PPE to far removed families on the reservation (Navajo & Hopi Families COVID-19 Relief Fund, n.d.). Another notable grassroots campaign, Defend Our Community, is run by a group of Navajo women and focuses on protecting Diné elders in the remote community of Leupp, Arizona. Through word of mouth communication, Defend Our Community was able to compile an extensive list of names and directions to the homes of elders in need of

essential items like water, non-perishable food items, toilet paper, and disinfecting wipes (“Defend Our Community - Leupp Elder Care Packages,” n.d.). Devin emphasized the importance of organizations like this on the reservation, describing their personalized and family-oriented approach to be an excellent way of reaching isolated communities who otherwise are often overlooked by larger outside organizations and governments.

Conclusion

Despite being located within the United States, members of the Navajo Nation practice their own traditions, speak their own language, and face a unique set of barriers with respect to healthcare delivery. During the COVID-19 pandemic, the Navajo Nation successfully managed their population’s health, outpacing external governments in preparation and response. Tribal health agencies recognized what made those on the reservation more vulnerable to the Coronavirus and utilized their intimate knowledge of Navajo culture to effectively disseminate information and provide care.

Final Observations: Moving Forward

The Navajo Nation was federally recognized as a tribe within the United States Southwest in 1923, but the Navajo people settled this land centuries before any United States colonization efforts. To be a modern Navajo is to live in two separate worlds. The Navajo Nation is an impoverished region within the boundaries of the wealthiest country on earth, and it is composed of individuals with alternative perspectives on life, sickness, healing, and death. This thesis investigated the complicated political and cultural relationship that exists between these worlds and its implications on Navajo health. In many important ways, the Navajo Nation is better equipped than a far removed federal system to solve some of its biggest problems.

The first chapter explored many of life's most significant challenges on the reservation, such as limited access to healthy food, infrastructure, and healthcare facilities that contribute to disproportionate rates of chronic illness among Navajo individuals. The United States government has historically contributed to Navajo health problems by delegitimizing traditional foods in favor of less healthy selectively rationed alternatives. More recently, federal programs have routinely failed to adequately address these underlying problems, while certain tribally operated community-based initiatives have found success.

The second chapter established how the Navajo Nation is a sovereign and independently governed entity geographically surrounded by and governmentally and financially linked to the United States. In addition to voting in United States Federal and State elections, Navajo citizens democratically elect representatives to service within a tribal government composed of executive, legislative, and judicial branches. Failures of

the United States Bureau of Indian Affairs Court and corresponding legal code on the reservation prompted the use of Navajo Peacemaking Courts that found success incorporating Navajo culture and restorative justice into the tribe's legal system.

The third chapter described Navajo revenue sources and tribal financial management. The Navajo Nation internally manages an annual budget of over \$1 billion that covers the operational costs of governmental offices and programs crucial to the Navajo people's wellbeing. Self-governance is not a simple cure-all to the complex and layered problems of poverty on the Navajo Nation, and in years past, there have been instances of waste and corruption. However, growing Indigenous health care autonomy has demonstrably allowed tribal health facilities to successfully provide more culturally competent care.

The fourth chapter discussed traditional Navajo healing practices and how incorporating cultural elements into treatment plans can improve health outcomes and help to bridge the divide between Navajo patients and modern providers. Navajo Natives, Devin Tabaha and Nashonna Frank, and Dr. Peter Seipel, a surgeon who regularly treats Indigenous patients in Northern Arizona, stressed the importance of integrating traditional healers and language translators into medical practice to better develop patient trust and compliance, leading to more successful treatment.

The fifth and final chapter showcased how the Navajo Nation acted with autonomy to beat the odds and successfully overcome political and cultural barriers to slow the spread of COVID-19 on the reservation, outpacing the response of surrounding states and the country as a whole.

This thesis illustrates that many problems are best solved with intimate personal knowledge of Navajo life and culture that state and federal entities fail to possess. Overcoming political and cultural barriers requires a partnership with surrounding state and federal governments that capitalizes on meaningful participation from the Navajo Nation's citizens and leaders. The successes of the Navajo government, tribal health programs, and grassroots movements throughout the pandemic illustrate what the Navajo Nation can accomplish with self-determination. Internal decision-making and cultural competency are part of the solution for a diverse set of complex problems facing the Navajo Nation.

Frank Tabaha consented to his urban doctor's recommendation for a life-saving foot amputation after consulting with his medicine man back on the reservation and learning of a unifying ceremony that would allow him to die whole and pass unimpeded to the afterlife. Devin has told me that Frank is living happily on the reservation, having recovered from his gangrenous foot infection and subsequent operation. Frank's amputated limb was ceremoniously wrapped in a blanket and buried in a family grave. When Frank eventually passes away, he will be covered in another blanket and buried alongside his limb, making him whole and able to travel on to the next world. Had Frank undergone the amputation without the unifying ceremony, he, after his passing, would have been stuck in limbo in this world, creating mischief and haunting his family on earth. Cultural competency saved Frank's life and provided peace of mind to his loved ones as well.

It is with gratitude and respect that I dedicate this thesis to my friend, Devin Tabaha, and his family on the Navajo Nation.

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