The Power Relations of Healthcare Institutions in Ethnically Divided Societies

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Abstract

Formal healthcare institutions interact with the relationship between ethnic divisions, spatial dynamics, and health in distinctive ways in divided societies, particularly when power is unequally distributed within these healthcare institutions. I thus ask how the distribution of power in formal healthcare institutions effects health in ethnically divided societies, which vary largely in their marginalization and in the spatial distribution of different ethnic groups. I explore this relationship in three distinct cases: Ghana, Romania, and Navajo Nation. While all of these cases are fundamentally different, they all help to shed light on if and how changing formal healthcare institutions alters the health of those residing in these societies, which have varying ethnic and spatial dynamics. I find that in order for formal healthcare systems to engender health changes, governments must recognize the divisions within their society, work to address the power dynamics within formal institutions, and attend to the power dynamics outside of these institutions that permeate the institutions and impede their changes. Doing so may allow ethnic minorities to become actively involved in health-related decision-making processes, which then creates the potential for changes in formal healthcare systems to benefit rather than harm these societies.

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I.   <u>Introduction</u>

Formal healthcare institutions have long been known to contribute to peoples' health, but until recently, peoples' social determinants of health were less frequently explored. These social determinants include peoples' socioeconomic class, gender, race, and ethnic divisions (Daniels, 2007). Ethnic divisions specifically affect peoples' health on a societal level rather than an individual one, making them of particular interest. So, it is then possible that formal healthcare institutions interact with the relationship between ethnic divisions and health in distinctive ways. Additionally, when these ethnic groups have uneven distributions of power in a society, as they often do, the levels of power that these different ethnic groups have within formal healthcare institutions may further complicate the effect that these institutions have on the relationship between ethnic divisions and health. As such, taking into account potential empowerment or disempowerment of diverse ethnic groups is an important facet of institutional design in healthcare.

However, ethnically divided societies vary dramatically in their marginalization, so it is unclear as to how this relationship functions in specific cases. These ethnically divided societies also vary greatly in the spatial distribution of their different ethnicities, which adds an additional layer. For example, a society in which an ethnically marginalized minority is legally confined to a specific area likely experiences different effects from healthcare institutions than one in which an ethnically marginalized minority is not geographically confined. So, different patterns of spatial distributions of groups seem to shape the institutional possibilities for empowerment as well. I thus ask how the distribution of power in formal healthcare institutions effects health in ethnically divided societies, which vary largely in their marginalization and in the spatial distribution of different ethnic groups.

I explore this relationship in three distinct cases. First, I assess if and how Ghana's decentralization of its healthcare system has affected peoples' health using both qualitative and quantitative analysis. While one would expect that decentralization turns over power from a centralized authority to a locale (e.g., a specific region and/or ethnic group), it is not obvious that this is the case, as decision-making power within the healthcare system may not have devolved. Additionally, Ghana is a case of unclear ethnic marginalization in which ethnic groups are located in specific areas throughout the country, meaning that their ethnicity is highly correlated with spatial dynamics. The case of Ghana allows me to then assess if and how changing healthcare institutions lead to health-related changes in a society with ethnic and spatial differences but not necessarily marginalization.

I then assess health on Navajo Nation. The Navajo are highly marginalized by the US majority population, are confined to the borders of the reservation (the largest reservation in the US), and have a healthcare system that has been implemented by the US federal government rather than the Navajo themselves. So, the Navajo are both ethnically and geographically isolated in a unique way. I draw on semi-structured interviews conducted on Navajo Nation in January of 2015 to look at how Western healthcare provision on Navajo Nation (primarily implemented by the US government) interacts with local, traditional forms of healing (primarily implemented by the Navajo that live on the reservation) that have largely been removed from the formal healthcare system to effect peoples' health. I also look at how peoples' health-related choices on the reservation can give me further insight into how local traditional care choices interact with the implementation of external Western healthcare.

Finally, using individual-level data and interviews conducted with healthcare professionals in April of 2014, I explore the case of the Roma in Romania (a systemically marginalized minority)

who likely have no power within their healthcare system, which is also the system used by the greater Romanian population. The Roma have experienced vast changes in the availability of formal healthcare since the fall of communism in 1989, as they are no longer guaranteed fair healthcare treatment (e.g., the state no longer provides the level of services that it did under communism) and have since succumbed to much discrimination in the healthcare system. While not legally confined to specific areas in the country, they often live in isolated Roma settlements outside of cities and in the countryside, thus further isolating them from the majority population and removing any possibility to integrate themselves into society. By using these three cases, I will gain insights as to how power dynamics in formal healthcare institutions interact with ethnic divisions and health, as these three cases are unique manifestations of certain ethnicities' marginalization and their spatial dynamics throughout their respective countries.

At the beginning of each case study I present the historical trajectory of the society in order to provide a better explanation as to how their ethnic divisions, power structures (i.e., marginalization dynamics), and spatial dynamics came to be and why they continue to exist today. I then look more deeply at each case to develop an understanding about how each of their formal healthcare systems affects the health of those living in these ethnically divided societies. While these three cases are all distinctive, they each help to shed light on how changing formal healthcare systems may be insufficient for changing the health of those in ethnically divided societies, especially if those people are marginalized and spatially concentrated. My findings suggest that power structures (which I see manifested in formal healthcare institutions but are likely indicative of power dynamics beyond that of formal healthcare) must be altered in these societies in order to engender health-related change.

II. <u>Ghana</u>

<u>A. The Social Structure of Ghana</u>

Ghana is a case of unclear ethnic marginalization in which numerous ethnic groups have historically coexisted. Its largely heterogeneous population has shaped how both health and the provision of healthcare have evolved over time, how current health behaviors and practices function in different areas, and more. The major different ethic groups are the Akan, Ga-Adangbe, Ewe, Guan, and the Mole-Dagbane. Importantly, these ethnic groups are further divided into subgroups (Table 1) that typically share a common cultural heritage, history, language, and origin (Gocking, 2005; GhanaWeb, 2015). While none of these groups have been specifically marginalized, they have had vastly different experiences in relation to both Ghana's government and those of outside colonizers, which have largely influenced their current circumstances, including those pertaining to health (Morrison, 2004).

It is thus important to understand these ethnic groups, the current relations between them, and their geographic locations to fully understand the ethnic and spatial dynamics that currently exist in Ghana. By developing an understanding of these dynamics, I can establish the necessary context to assess how these dynamics are intertwined with Ghanaians' health, if at all. Once I have developed this necessary context, I then introduce healthcare institutions and their related power relations to assess how they interact with the relationship between Ghanaian's ethnic composition and Ghanaian's health. In order to best parse out this relationship I now look at Ghana's historical trajectory, as ethnicity, health, and healthcare institutions are traceable throughout time.

<u>B. Geography and the Early State</u>

Farming and land cultivation began around 2000 BC in what is now Ghana and complex settlements were established by 1000 AD, many of which were multiethnic (Gocking, 2005). Pre-colonial conditions varied highly by region, and distinct groups began to form when related lineage groups formally associated themselves and elected a leader (Morrison, 2004). While power was centralized within a group, groups became strengthened by interdependency and many expanded, specifically the Akan and Ga-Adangbe (Assimeng, 1999, Morrison, 2004). By the 10th century, both ethnic groups had developed distinct political and social organizations and began taking slaves from other groups, so inter-group relations quickly became hierarchical (Gocking, 2005, Perbi, 2004). For example, much of the Islamic North became an Asante Confederacy (a sub-group of the Akan) governed by military rule (Assimeng, 1999).

While internal dissensions largely decided ethnic and social hierarchies, Europe's external influence might have had an even greater impact. Europe's involvement since 1471 has permanently shaped ethnic relations by heightening the social and ethnic inequalities that existed before. Additionally, Europe's involvement created another layer of inequity in power, as the colonizers took complete control of Ghana. So, Ghana now had an external hierarchy between itself and its colonizers and an internal one between different ethnic groups.

European countries established 110 fortifications on the West Coast of Africa, with 100 in the Gold Coast area of Ghana (Gocking, 2005). Colonization amplified what had begun in pre-colonial times: ethnic groups benefited differentially by their natural resources, areas became further divided, and the North and South grew more distinctive (Morrison, 2004). For example, when the British recognized the Asante as a potential threat to power, they allied with the Fante, another Akan subgroup, to fight against the Asante (Gocking, 2005). Thus, society continued to

stratify by ethnic groups and by regions and now did so more concretely, as both domestic and international forces encouraged these societal rifts.

By the 19th century, the British, Dutch, and Portuguese had taken over the Gold Coast settlements and spread Western institutions, European languages, Christianity, Western educational norms, and more throughout Ghana (Gocking, 2005). Multiple European countries' fractionalized takeover of parts of Ghana only furthered the dissention between ethnic groups and amplified inequalities. For example, the British introduced the Gold Coast area to Western medicine and Christian missions that improved health by increasing longevity and lessening infant mortality ratios (IMR) (Assimeng, 1999). However, while the Gold Coast was given preferential treatment, it likely still did not have any choice in the treatment it received, thus this area still lacked the power of choice. So, the most marginalized ethnic groups and regions (i.e., those in the rural North) likely had no less power relative to the least marginalized ethnic groups (i.e., those in the urban South), as they all likely had no power in relation to Britain. Thus, while groups' statuses still differed, they all lacked power in one form or another.

When groups retaliated against their lack of power from either other ethnic groups or from Britain (i.e., by creating organizations such as the Fante Confederation of 1868), the British only pushed to consolidate power more, as the British took control and decision-making away from Ghanaians and forced them to rely on Britain's presence (Boahen, 1975). In regards to health, the British introduced many public projects during this time, and by the 1870's a medical department was formed with a formal system, lab, and sanitary branch for public health. This was the most formalized healthcare Ghana had seen, but it was highly centralized and had a top-down approach in which Ghanaians were given little to no say in both where the healthcare was offered and what it constituted. For example, many Ghanaians valued the spiritual components

of health and using herbs for healing, but the British system allowed for neither, focusing instead on pathology and physical health (Tsey, 1997). It is thus clear that Britain held power in the healthcare system and in many other realms as well, thus forcing Ghanaians to obey Britain's decisions regardless of their internal preferences.

C. The Colonial State During the 20th Century

Political Structure & Infrastructure

Britain's formal rule brought the next transformation of Ghanaians, which included transforming their healthcare. In the 20th century, Britain claimed the Northern territories in addition to the Gold Coast. In 1902, the North became a protectorate and political unit that had jurisdiction separate from the colony, further emphasizing its inferiority to the South (Gocking, 2005). The North, Gold Coast, and Asante areas then became recognized regions with town councils in urban areas (Gocking, 2005). So, Ghana experienced a slight increase in localized authority during this time although Britain remained heavily involved.

With Britain's exclusive reign on Ghana came less inter-state warfare and less inhumane slave trades, increased law and order, and improved health and living standards (Boahen, 1975). The British installed a piped water supply and built hospitals, dispensaries, and healthcare centers (Boahen, 1975). Yet, these were confined to towns and did not reach rural areas, further contributing to the urbanization that had recently begun and highlighting how spatially defined health and healthcare became. Additionally, the British imposed these healthcare changes, thus giving Ghanaian's no say as to whether or not they wanted these changes, as they may have preferred more traditional practices. Throughout this period, when health conditions worsened, Ghanaians were blamed and what little control they had was taken away, but, when health improved, more Europeans came and there was even less interaction between the colonizers and

the colony, thus further stratifying the two groups (Gocking, 2005). Because Britain had monopolistic control, it became largely disconnected from its colonies and built modern health structures without considering the population's needs. Thus, the British held all of the power in the healthcare system.

The First World War & The End of British Rule

World War I brought more international influences, Western medicine, and a disregard for Ghanaians' needs. A hierarchical class system within ethnic boundaries emerged that was defined most closely with natural resource wealth that could be extracted, meaning that this class system was spatially defined. While ethnic divisions likely influenced health before, the addition of a class system within ethnic groups only heightened inequalities that were already established and created new ones. Thus, spatial and ethnic differences became intertwined at a more granular level than before.

At the end of World War I, the first effort was begun to address the specific health concerns of Ghanaians when the 1920 National Congress of British West Africa (NCBWA) established the West African Medical Service (Boahen, 1975). The congress called for medical reforms, denounced racial discrimination and segregation, demanded modern appliances and up-to-date maternity hospitals, and required that midwives be trained locally rather than abroad (Boahen, 1975). At the conference Ghanaians complained that their current healthcare was not administered fairly to all and that foreign standards and protocols that were not catered to Ghanaians. By 1923, Korle Bu teaching hospital was completed in Accra, Ghana's capital city, and doctors, nurses, public health officials, civil service workers, and health administration could begin training in Ghana (Boahen, 1975). However, the NCBWA failed to spark long-term change and succumbed to Britain's colonization of Ghana. Thus, the NCBWA's failure is

indicative of how the healthcare system and likely other formal institutions were defined by those in power (e.g., the British).

But, the NCBWA's failure only increased Ghanaian's demand for domestic control. The Secretariat for Native Affairs, the Native Administration Ordinance of 1939, and the Native Authority Ordinance of 1944 all strengthened local chiefs' positions and allowed for British indirect rule (Gocking, 2005). The 1946 constitution gave Ghanaians the majority in legislative councils and linked the Ashanti region with the colony proper in Accra, which was the first step in unifying different areas in the country (Gocking, 2005). The Colonial Welfare and Development Act abandoned the principle of economic dependence altogether that had characterized colonial policy by emphasizing self-determination, and, in the realm of health, integrating boards of public health into Ghana's political framework (Gocking, 2005).

However, other territories outside of the Gold Coast were not considered developed enough to merit representation, such as the Northern and Volta areas (Gocking, 2005). So, even though some areas gained local control, this control came differentially to locales based on their status, and the internal hierarchies between ethnic groups became larger as the presence of an external oppressor subsided. However, this external oppressor still had a large presence in Ghana and after World War II when Ghanaians' nationalist demands increased further and boycotts and riots against the British surged, civil society broke down (Gocking, 2005).

D. The Independent State and Health Services

The Nkrumah State

Kwame Nkrumah, a proponent for Ghana's inclusion of all 10 current regions, which are shown in Figure 1, was elected to lead the path to freedom.[1] By 1954, the National Liberation Movement had started, in which there was a call to give each region an effective voice in the central government (Gocking, 2005). This is the first time that Ghana had seen a proactive movement for regional equality. Because this movement was coupled with freedom from the British, most Ghanaian's were in favor of it, as it lowered the power hierarchies both internally and externally.

On March 6, 1957, Ghana gained its independence from Britain and Nkrumah furthered his policies for political integration (Morrison, 2004). In 1958, he held an all-African peoples conference in Accra and established regional assemblies to further his efforts (Gocking, 2005). He paved roads between regions, initiated free primary education, and kick started other infrastructure-enhancing projects to join the disparate regions of Ghana regardless of ethnicity. Health and sanitation conditions subsequently improved, and campaigns against widespread disease, smallpox, tuberculosis, leprosy, and yaws were started (Boahen, 1975). Large sums of money were allocated to improve health measures in rural as well as urban areas, but rural areas remained neglected and suffered from shortages in basic drugs and equipment (Boahen, 1975). By the late 1960's, health standards were increasing but rural areas in all regions continued to lag behind. Importantly, regions in the North are much more rural than those in the South, so even though Nkrumah's state attempted to unify all, the implementation of services varied spatially.

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[1] Ghana's regions are as follows: Ashanti, Brong Ahafo, Central, Eastern, Greater Accra, Northern, Upper East, Upper West, Volta, and Western. While not all of these regions were defined in 1957 when Ghana attained its freedom from Britain, I use this classification for the sake of simplicity and for consistency.

While this unequal service provision may not have been deliberate, it did occur and further stratified the North and South, and the South then had much better measures of human capital.

The Unstable State & Rawlings

Freedom from Western Europe's colonialism seemed to increase local capacity, but it did so differentially by location, as areas catered to during colonialism (i.e., Southern Ghana) had more resources and were thus able to develop more so than other areas. Additionally, Ghana's anti-Western nationalism and its eight governments in 15 years further prevented an equalized increase in local capacity, as there was no stable system in place to enact fair or equal changes in regards to health or other formal systems.[2]

Jerry Rawlings came to power in the 1980's, instituted major restructuring (especially after a return to civilian rule in 1992), and eventually became the first elected president to complete a term in office since Ghana's independence. With his prolonged state, many infrastructural changes were made. These changes further centralized much authority within the federal government, and it was unclear as to whether this centrality would equalize the health of Ghanaians by treating all ethnic groups and regions equally or further stratify it by removing local power. For instance, the Ghana Health Service (GHS) was established in 1996 through Ministry of Health (MOH) reforms, which established national, regional (of which there are 10), and district levels (of which there were 110 in 1996) for health services and remains the primary source of healthcare in Ghana today (Salisu & Prinz, 2009). The GHS's roles are to implement national policies for healthcare delivery, increase access to good quality healthcare services, and

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[2] The eight governments are as follows: the 1966 military coup ousted Nkrumah and established the National Liberation Council, the 1969 Progress Party became Ghana's second republic, the 1972 National Redemption Council presented another coup, in 1975 military control took over, 1979 brought another coup and then the People's National Party and third republic, the 1981 Provisional Defense Council and coup came, and, finally, 1991 saw a return to civilian rule and the fourth republic (Gocking, 2005).

manage resources for healthcare services (Ministry of Health, 2012). The GHS is the most holistic healthcare structure that Ghana has seen, but it remains highly centralized and has not bring about the vast changes in health outcomes that many expected, which I expand upon later.

E. Health in Ghana Today

Remnants of colonial power and the unequal development of districts since Ghana's freedom both likely continue to impede countrywide equality. And, this continued inequality is made worse by both longstanding ethnic and spatial dynamics. Importantly, these many inequalities are likely functions of and contributors to the current formal power structures throughout the country, specifically healthcare institutions (e.g., the GHS).

One example of these health inequalities is the differences in health personnel between regions. The Western Region has one doctor per 24,000 people, the Volta has one per 23,277, the Northern has one per 75,135, and Greater Accra has one per 3,239 (Salisu & Prinz, 2009). The presence of skilled birth attendants is an important indicator for maternal and child health (MCH) specifically (Carlough & McCall, 2005). By 2006, skilled health personnel attended one-half of births, and, while this number continues to grow, few births are attended by someone more highly skilled than a midwife and many healthcare centers that are governmentally mandated to have a midwife do not have the funding to hire one. Many children are delivered by less-skilled birth attendants or relatives, causing both mothers and children to have high risks of mortality and morbidity.

There remain large differences between urban and rural areas as well in regards to human capital, access to care, and the choice to practice traditional medicine rather than Western

medicine.[3] In rural areas there are often far fewer health professionals and higher levels of

poverty and illiteracy. Both poverty and illiteracy impede healthcare advancement because few

people have the necessary skills to enter the medical profession and many patients have little

capacity to care for their own health (i.e., they are unable to read directions for medications).

Over one-quarter of the population lives over 15 kilometers away from a health facility, which

often prevents care, contributes to a reliance on traditional healing and self-medication, and

perpetuates stigma against modern medicine (Salisu & Prinz, 2009). While there have been

attempts to both increase the quality of health services in rural areas and integrate traditional

medicine, formal healthcare remains primarily Westernized, removed from traditional practice,

and of poor quality (Salisu & Prinz, 2009).

In regards to physical health, malaria remains the highest cause of morbidity, with about

one-seventh of the population receiving treatment each year and missing many workdays (Salisu

& Prinz, 2009). Human Immunodeficiency Virus (HIV), diarrheal illness, respiratory infections,

malaria, and perinatal complications account for 50 percent of deaths (Salisu & Prinz, 2009).

Yet, many deaths come from a combination of these two illnesses, with tuberculosis (TB) being

the cause of death for many people living with HIV (PLHIV). There is an increasing burden of

non-communicable disease (NCD) and mental health issues as well, both of which health

systems have little familiarity with.

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[3] Traditional and Western medicine do not have to be mutually exclusive, but, as it will later become evident, the divide between traditional and Western medicine is the most severe in the case of Ghana. Most Roma and Navajo that practice traditional medicine do so in addition to Western medicine, but most Ghanaians that practice traditional medicine only practice this. Unfortunately, I do not have time to expand on traditional medical practice in Ghana, but it is often tied to spirituality and/or witchcraft. Please see Sackey (2002) for a more in depth analysis of Ghanaian's faith-based healing.

It is now clear that Ghana historically experienced a power differential in regards to formal healthcare institutions both between regions and ethnic groups within Ghana and between countries (e.g., Ghana and Britain). Now, a power differential exists between the central and local governments within Ghana. These multiple power dynamics have undoubtedly shaped Ghanaian's health but it is unclear exactly how they have done so and to what exist they continue to do so today. With this historical context, I now look more in depth as to how the current formal healthcare institutions in Ghana shape Ghanaian's health.

F. Ethnicity, Regions, and Health in Ghana

Ghana is a country that has been fractionalized spatially by its ethnicities for centuries and by its political structure since it gained freedom from Britain in 1957 (Chazan, 1982).[4] During Ghana's colonization, regions of the country and its respective ethnic majorities were differentially affected by colonial rule (i.e., the Gold Coast, primarily populated by the Akan ethnic group, received preferential treatment and developed advanced infrastructure) (Morrison, 2004).[5] Since Ghana gained its freedom, the country continues to have many regional and ethnic differences, but it is not clear whether these differences stem from only spatial (as measured by the regions) differences or if ethnic differences remain as well. Importantly, prior work on the social determinants of health finds that ethnic inequalities are a social determinant of health but it is unclear as to whether or not ethnic differences are as well (Daniels, 2008). So, if the ethnicities of Ghana no longer have power differentials and/or the legacy of ethnic differences have been noticeably reduced, it is unclear as to whether or not health will differ by these ethnic

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[4] It is important to clarify early on that Ghana's ethnic fractionalization may be spatially defined whereas the ethnic marginalization among the Navajo and the Roma in the other chapters may be based on ethnicity itself as I said before.
[5] Please refer back to the previous sections for an explanation of Ghana's regions and their dynamics. Ghana has 10 regions, within which are over 200 districts, which I describe later in more depth.

categorizations. I first present health indicators in Ghana split up by both ethnicity and region by using the Ghanaian Demographic and Health Survey (DHS), which I describe in full later, and then discuss how the formal healthcare system has changed in ways that may differentially effect both ethnic and regional health indicators.

Table 2 presents health issues split up by ethnicity, which shows that the Akan ethnic group typically has the most advanced health while the Guan and those in the Other category often have the poorest health.[6] The Ga, Ewe, and Mole ethnic groups have similar levels of health, which lie between the Akan and Guan's levels of health. This trend holds for both indicators that require a health center (e.g., vaccines, level of prenatal care, level of delivery care, treatment for diarrhea) and for those that do not (i.e., recent diarrheal rates). Table 3 then presents health issues split up by region where I find that health levels are more similar across regions than across ethnic groups. The Northern region, which is a largely rural area that was not developed much during the colonial period, typically has worse health than other regions. However, the most urban regions (the Greater Accra region, which houses the nation's capital, Accra, and the Ashanti region, which is home to Ghana's largest city, Kumasi) typically do not have better health than other less urbanized regions. When looking at measures of diarrhea (the primary variable for health that does not require a medical clinic) Greater Accra and Ashanti do not fair better than their neighbors.

Finally, Table 4 presents the number of districts within each region with certain ethnic majorities in order to provide some initial comparisons. The Akan group, which typically has better health than others, is primarily in the Western, Central, Eastern, Ashanti, and Brong Ahafo regions, meaning that they are primarily in the South where Britain gave preferential treatment.

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[6] Groups in the Other category are the few districts in which a minority ethnicity (e.g., Grussi, Gruma, Hausa, Mande, or Dagarti) holds a majority.

The Ga and Guan groups are much smaller majorities that are also mostly in the South of Ghana. The Ewe are primarily in the Volta region in the east of Ghana and the Mole are largely in the North, where health outcomes are worse. Those in the Other category are mostly in the North as well, meaning that most districts that have a minority as a majority are located in the rural North.

G. The Push for Decentralization

Ghana's evident spatial and regional fractionalization is thus associated with differences in health outcomes. As previously stated, healthcare institutions also play a large role. Ghana is a unique case in that the way in which healthcare is administered has changed drastically, both over the past couple of decades as the country has decentralized in the past 60 years since Ghana gained its independence from Britain. The power dynamics within the healthcare system are of particular interest, as some regions and/or ethnic groups may have more power than others, and because the way in which decentralization has occurred may have actually placed much of the power in the hands of Ghana's central government. Thus, while Ghana no longer suffers from British control in regards to healthcare, it may still suffer from a centralizing healthcare administration that removes power from all local areas.

Ghana has followed many international organizations' (i.e., USAID) push for countries to decentralize public services (i.e., health) to local governments.[7]According to these organizations, decentralization helps to improve health throughout the country, meaning that ethnic and regional disparities should go away due to a redistribution of power and decision-making on the local level. Ghana and many other countries have become dissatisfied with the central government's public service delivery, so they are changing their institutions mostly through

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[7] I do not go into Ghana's motivation for decentralization, as it may politically motivated in addition to being motivated by public services or the lack there of. For more on this theory, please see Ayee (2012). Because most countries and agencies publicize decentralization as a cure for poor public service provision, I use this motivation here for the sake of simplicity.

political restructuring. The international organizations that originally advocated for decentralization state that smaller governments, if properly structured and steered, are inherently more efficient and accountable to the needs of their people than large central governments (Saltman et al., 2006).[8] Because Ghana cannot change its ethnic structure but it can change its institutional one, decentralization is then a potential mechanism through which Ghanaian's health can potentially start becoming equalized.

However, over the past decade, while countries are singing the praises of decentralization, there are mixed findings. International institutions, governments, and civil society organizations have tried to make sense of countries' decentralization results, but there are a lack of comprehensive empirical frameworks that isolate the affect of a country's decentralization on public service delivery and outcomes. This study provides an example of this empirical framework, using Ghana as a natural experiment (because it has recently undergone vast decentralization) and focusing specifically on formal healthcare delivery as an example of a public service.[9]

Definitions of Decentralization

While Ghana is politically decentralized and the GHS is administratively decentralized, these are not the only types of decentralization that countries can experience. Decentralization comes in numerous forms and multiple can be present in a given country: delegating funding power, devolving power (political decentralization), and deconcentrating power (administrative

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[8] This paper refers to efficiency as achieving maximum productivity at minimal expense (i.e., minimal cost) and refers to accountability as being responsible to another entity for one's actions.

[9] In addition to direct health benefits that high-quality health service delivery provides, there may be indirect effects as well. If decentralization does increase development and thus peoples' wellbeing, then health may improve indirectly. However, this paper focuses solely on direct effects.

decentralization) (Crawford & Hartmann, 2008; Craig & Porter, 2003). Ghana has primarily devolved, giving more political power to the districts but keeping funding mechanisms and administrative tasks within the central government. Once Ghana devolved its districts politically, it then deconcentrated the GHS, handing over administration and implementation to the districts. It is critically important to design and discuss decentralization for each country individually, so I do not aim to cover all three types of decentralization in this analysis (Craig & Porter, 2003). Rather, I focus on political and administrative decentralization, because this is what has occurred in Ghana, while referencing the benefits and consequences that could stem from financial decentralization throughout this text.

Within each type of decentralization there is then jurisdictional and functional decentralization (Ahmad et al., 2005). The former being the separation of power between tiers of government and the latter being the separation of powers between the government and service providers (Ahmad et al., 2005). In the case of Ghanaian health provision at the district level, I am concerned with both. The local government structure must have power separate from the central government and the health system must have power separate from the local government and in order for decentralization of health services to occur. So, jurisdictional and functional decentralization must exist in order to assess if and how decentralization has improved peoples' health.

Now that I have laid the groundwork for the different types of decentralization, I will discuss the benefits and consequences of decentralization. Once I discuss decentralization's potential effects in the context of Ghana, I present an empirical analysis that attempts to isolate the effect that decentralization has in Ghana. But, it is only through first assessing the many

nuances of decentralization and how it is manifested in Ghana that I can set up this empirical strategy.

Benefits of Decentralization

To begin, I outline the potential benefits of decentralization that many international organizations have publicized. There are two main issues related to decentralization and health that I focus on throughout the discussion: efficiency and accountability, both of which contribute to the quantity and quality of healthcare services provided.

First, local governmental control can increase the efficiency of public service provision (Ayee, 2012). For healthcare, this means that services can be provided more cost-effectively to patients.[10] Managing complex, large organizations often leads to problems of scope, so decreasing organizations' size and subsequently creating smaller markets should increase cost efficiency (Saltman et al., 2006). Once these smaller markets form, there is a high potential for vertically integrated healthcare to succeed (e.g., primary care is provided at the local level, secondary care at the district level, and tertiary care at the region level) in such a way that minimizes costs (Saltman et al., 2006). Additionally, if there are more healthcare centers and clinics that provide primary care, the GHS can lower costs by treating illnesses at early stages or preventing them altogether. This increase in local control also means that the GHS can set up clinics in rural areas, both increasing access for patients (e.g., removing transportation barriers) and decreasing the time it takes to receive treatment.

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[10] Yardstick competition may lead to increased efficiency as well; wherein providers compete for patients, but this mechanism likely operates better through local governments themselves rather than through healthcare (Bardhan, 2002).

For this to occur, at least two stipulations must hold. First, technology in local areas must be on par with the technology used for primary care at the level of the central government.[11] Advances in technology have made it easier to provide public services in smaller markets, so this stipulation may be the easiest to meet if funding is provided (Bardhan, 2002). Second, all personnel must be properly trained in both technology and healthcare practices (Saltman et al., 2006). If healthcare has been operating from a central government, locals in rural areas likely do not have the proper technical training to provide healthcare, so they must be trained by the GHS when decentralizing care. If both technology and training are up to par, then healthcare can be efficiently provided at the local level and health disparities between regions and ethnic groups can be mitigated.

However, efficiency is not the only important facet of decentralization. Local management must have autonomy (and thus power) while maintaining accountability (Burki et al., 1999).[12] This means that all hospitals and corporations must be able to make some of their own decisions regarding patient care, services provided, etc. that reflect their locale's preferences and do not only implement protocols from the central government. When providers have autonomy and healthcare is carried out efficiently, then local providers can meet local health needs much better than centralized governments can because they understand what these local health needs are (Channa & Faguet, 2012; Habibi et al., 2003). For example, because of Ghana's ethnic and regional fractionalization, decentralized healthcare systems can cater to specific ethnic group's and specific regions' health concerns and preferred health practices (e.g., traditional

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[11] This does not mean that technological capacity must be the same for the healthcare sector at the local and national level. It only requires that primary care (or other care provided at a local level) be provided using comparable levels of technology to that of the central government.
[12] I define autonomy as being empowered by making administrative decisions at the local level (Saltman et al., 2006).

medicine or Western care) better than a centralized government can (Grossman & Lewis,

2014).[13] However, for these local health needs to be met, local health services must couple their

autonomy with accountability. They cannot make decisions themselves, but must take into

consideration the needs of the local community. When healthcare providers do cater to local

needs, the increased autonomy that decentralization brings can be highly beneficial.[14]

Consequences of Decentralization

However, decentralization is not often carried out in such a way that all of these

stipulations are met.[15] According to the subsidiary principle, healthcare should be assigned to the

lowest level that can provide it efficiently (Craig & Porter, 2003). Many countries, including

Ghana, have taken this to mean the local level, but the local level may not have the capacity to

provide healthcare efficiently, especially due to Ghana's existing power differentials.

Decentralization is often not cost efficient because as more and more levels of healthcare are

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[13] It is important to note that I do not mean that the GHS must incorporate traditional care into formal healthcare services, as this is an area of much contention. Rather, I mean that the GHS operating on a local level may allow for it to be more attentive to how patients view health and thus be more sensitive in the care that it offers.

[14] The benefits of healthcare decentralization may extend beyond healthcare itself. When patients' health needs are better met, patients are often more satisfied with their local government. Because GHS is a public program, when patients are more satisfied with its services, individuals may increase their political involvement (Ahmad et al., 2005). Additionally, when local government becomes directly involved in healthcare the local government often becomes involved with community development as a whole and collaborates with other social services because the government sees the benefits from this collaboration (Saltman et al., 2006; Craig & Porter, 2003). So, by decentralizing healthcare in a way that is both efficient and gives providers autonomy in such a way that ensures accountability to the needs of locals, health and community development both have the potential to improve. Most importantly, this means that when power is redistributed so that local areas can make decisions for themselves and have the capacity to do so, decentralizing healthcare can improve both peoples' health and other facets of society.

[15] Additionally, districts may only be able to make marginal changes in the healthcare system and if the margin is only a fraction of the whole (e.g., the central government), then the potential for marginal changes decreases as the size of the whole decreases (e.g., as the central government gets smaller) (Prud'homme, 1995). However, this argument is beyond the scope of this paper.

created, transaction costs increase and care is increasingly disjointed (Saltman et al., 2006). With many levels within the healthcare system, principal and agent problems then emerge because there is often no coordination or collaboration when there are too many parties involved (Bardhan, 2002).

Once GHS services are made autonomous at a local level, they often do not collaborate. They neither collaborate with localities or other GHS providers (i.e., horizontal collaboration) nor with higher tier GHS providers or government (i.e., vertical collaboration) (Prud'homme, 1995). This problem is largest for rural areas, as these areas often start with no infrastructure in place for health services and must invest in human resources, physical capital, and more and may not have open lines of communication with more experienced health providers. In short, healthcare decentralization often does not always minimize costs.[16]

From this inefficiency often stems ineffectiveness and inequality. The tiers of healthcare provision create hoops for patients to jump through and could make receiving care confusing, so many actually receive less care, making it ineffective. For instance, one study found that when decentralization occurred across low and middle-income countries, vaccination rates actually decreased for some areas (Khaleghian, 2003). Additionally, decentralization often leads to increases in inequality within healthcare, as rural areas or those with low levels of resources lack the capacity to provide adequate care (Saltman et al., 2006).[17] Additionally, as stated earlier, local healthcare may cater to the many different ethnicities in Ghana. However, local

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[16] Healthcare may also become more ineffective because more tiers of government and public services often bring more unfunded mandates, so GHS facilities may not be compensated for services they are expected to provide. And without funding, they often lack the resources and incentives to provide them. However, because this concern has to do with fiscal decentralization, I will not discuss it further.

[17] This issue can potentially be corrected for by cross-subsidies (Saltman et al., 2006). However, because my focus is on political rather than financial decentralization, I will not expand on this point further.

governments are often not attentive to the social rights of minorities, so ethnic minorities may actually benefit most from the central government providing care (Saltman et al., 2006).[18] In sum, decentralization often leads to inefficiency rather than efficiency, from which stems ineffectiveness and inequity in care in a country in which power differentials exist.

In addition to issues of efficiency come issues of autonomy. While one benefit of decentralization is the autonomy of both healthcare providers and local governments, both entities are often given too much choice and are not held accountable to local needs, so power is redistributed in a harmful way. The central government must provide local providers with technical skills, high levels of information, and the capacity to deliver care in order for locales to have the substantive autonomy necessary to cater to the health needs of those in their communities (Saltman et al., 2006). When this does not occur, providers' autonomy becomes largely detrimental because they do not have the necessary skills to provide healthcare.

And, when there is no accountability to other sectors of health or government, autonomy goes unchecked, which is harmful. Even if providers are accountable to their community (one of the benefits of decentralization), they are often not accountable to the political system or to larger healthcare structures (Crawford & Hartmann, 2008). With decentralization, patients and providers may increase their collaboration but the healthcare system and the government often do not, which leads to poor communication of information and creates negative externalities (Crawford & Hartmann, 2008). With more tiers in the health system, less is communicated

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[18] Please see the chapter on the health of the Roma for a closer look at how central governments may provide the best healthcare for ethnic minorities. During communism, the Roma were guaranteed healthcare, jobs, etc. by the state. But, since Romania has broken free from communism, has privatized, and has ultimately decentralized, the Roma's health has worsened. In the chapter on the Roma I do not have sufficient time to explore the connection between Romania's decentralization and the health of the Roma, but it is an important potential mechanism to be mindful of.

between the national and local level, so local healthcare facilities are often left with little direction (much less any potential for the larger community development that I mentioned earlier), which the central government is often unaware of. Thus, while the central government has the capacity to meet local needs, it may not know what those needs are because the necessary communication structures do not exist, as local providers infrequently communicate with higher-tier structures about the type of training they need (Bardhan, 2002). So, neither the central government nor local governments are able to effectively improve peoples' health.

If the central government continues to provide funding within its decentralization, as it is in Ghana, then this lack of accountability and full local autonomy often result in the central government and higher tier GHS structures overinvesting in unnecessary healthcare infrastructure (i.e., machines for technical care) and underinvesting in necessary healthcare infrastructure (i.e., human resources) (Bardhan, 2002). There is little political will for the central government to do otherwise and little capacity in which local citizens can make or advocate for change (Akin et al., 2005). What the central government does invest in is used only in urban areas where advanced care is located, so rural areas go unaddressed (Crawford & Hartmann, 2008). So, while there are now GHS facilities in rural areas, they have neither the physical nor human capital to meet all of their patients' health needs.

Additionally, with increased local autonomy and no accountability often come two issues related to funding: (1) low quality and quantity of fiscal policy and (2) increased bribery and local elite capture (Malesky et al., 2014).[19,20] First, there is often stagnant resource mobilization

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[19] Privatization is not a feasible alternative because private organizations and people often have even less political clout than local governments and even weaker bargaining power. For an extended discussion on privatization and decentralization, please see Saltman et al. (2006).

at the local level and little citizen participation due to both a lack of accountability and little sense of ownership that was previously discussed (Kis-Katos & Suharnoko-Sjahrir, 2014).[21] This can lead to low levels of local funding, subsequent low levels of resources, and then insufficient healthcare provision, which only reinforces citizens' lack of confidence of and investment in the local system. Additionally, when there is neither frequent communication between levels of government nor oversight, it becomes easy to hide large levels of corruption, so bribery becomes common and funding is often ill spent (Crawford & Hartmann, 2008; Fan et al., 2009). When spending is up to the discretion of local elites (the ones holding all of the power) that are not accountable to a larger structure, they often spend on their own health priorities (i.e., modern health facilities) rather than the citizens' priorities (i.e., preventative healthcare) (Malesky et al., 2014). And when funding is spent poorly, the quality of service delivery then decreases (Malesky et al., 2014). In sum, the two primary potential benefits from decentralization, efficiency and accountability (which is closely tied to autonomy), often do not hold.

The resulting combination of inefficiency, lack of autonomy and accountability, funding issues, and more then lead to low amounts of resource prevision and continued high interjurisditional disparities in public service delivery and quality (Prud'homme, 1995).[22] And when full decentralization occurs, there is then no mechanism to redistribute public services or to reallocate human or physical capital, so inequalities continue to grow (Prud'homme, 1995).

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[20] As I said earlier, Ghana has not experienced fiscal decentralization, so the problems I explain here are specific to an area in which other forms of decentralization have occurred but financial decentralization has not. So, the issues associated with fiscal decentralization are then likely different than those I present here.

[21] This issue is amplified for regions with complete financial decentralization, as increased control may not come with any increases in funding (Saltman et al., 2006). Again, because all levels of the GHS still received federal funds, I do not expand on this further.

[22] Inequalities between districts can be beneficial if it stimulates competition because then local governments are responsive (Akin et al., 2005). However, Ghana has little interjurisdictional competition so this likely does not hold.

These growing inequalities then leave policy makers with no clear direction, as some districts and regions are thriving while others are failing.[23] So, even if power has been redistributed from a central to a local level in Ghana, this power has been redistributed disproportionately, which may only create more inequalities.

Decentralization itself is then not inherently bad, but its design and implementation is often flawed, as seen in the case of Ghana (Craig & Porter, 2003). The effects of decentralization are contextual, and there may be an institutional optimum for each country in regards to the numbers of governmental tiers within healthcare provision that are necessary for local levels to have the capacity and power to improve health evenly for different ethnic groups and regions (Blind Review). In order for this capacity to become a reality, cost efficiency and accountability must hold. Only when this happens does decentralization have the potential to benefit a nation.

Ghana's Decentralization

Since 1988 Ghana has experienced significant decentralization, going from 65 districts (also known as Metropolitan, Municipal, and District Assemblies (MMDA)) within 10 regions in 1988 to 216 districts in 2014, which is the level of analysis that I use in my empirical analysis.[24] These 216 districts contain 1,300 urban, zonal, and town and area councils (Grossman & Hartmann, 2008; Ayee, 2012). However, the urban, zonal, and town and area councils are largely

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[23] As I said earlier, Ghana cannot change its ethnic make-up but it can change its institutional one. This means that while decentralization may contribute to inequalities between ethnic groups, it directly does so through contributing to the inequalities between districts and regions. For this region, I only refer to the direct inequalities that increase across space.

[24] While 70 percent of district assemblies are made up of elected officials, 30 percent are appointed by the president, including the district chief executive who holds the most power (Grossman & Hartmann, 2008). While the interworking of Ghana's electoral system is beyond the scope of this paper, it is important to keep in mind that a good amount of those in power were directly appointed and not voted on by local citizens.

ineffective and inefficient and sub-district structures have fallen, so most districts centralize within their district borders, meaning that power has actually not devolved (Grossman & Hartmann, 2008).

At the district level, the most prevalent healthcare institution is the GHS, which was established in 1996, and as the country has decentralized so has the GHS's healthcare delivery. This is a common pattern, with many countries reforming their healthcare system and decentralizing it alongside political reform, thus making this case study relevant on the international arena (Saltman et al., 2006). The GHS is the implementing body of the Ministry of Health (MOH), which is a line ministry. This means that each district is responsible for implementing GHS protocols and programs mandated by regional and national MOH authorities, which still partially fund the districts (Ayee, 2012). So, the GHS must respond to federal funding priorities and implement programs that have been decided upon at a national level and is not fully devolved.

The districts do have an opportunity to create and implement their own programs. Each district has a five-year development plan that includes health, but there is often little talk about health and what healthcare reform is enacted is primarily infrastructure based (i.e., the building of hospitals) rather than compositionally based (i.e., assessing what type of care is most needed) (Crawford & Hartmann, 2008). Districts then carry out MOH policies and they create few of their own. The sub-district structures are responsible for promoting healthy lifestyles, public health (i.e., sanitation), etc., but because the sub-district structures are largely ineffective, public and preventative health is often not carried out (Ayee, 2012).

In sum, the GHS is a vertically integrated deconcentrated department, so Ghanaian

healthcare is decentralized in implementation but not in funding. Districts carry the bulk of the responsibility in carrying out national and regional protocols and programs that are funded through the central government. Thus, the GHS is administratively not fiscally decentralized, which is an important distinction.

H. Decentralization and the Health of Ghanaians

Now that I have set up the institutional and ethnic backdrop of Ghana and have presented the arguments for and against decentralization, I now test for whether decentralization helps or hurts Ghanaian's health and how it does so. By measuring district-level decentralization (in addition to what region a district is in) and ethnicity in regards to health, I am able to measure whether the effect of decentralization on health is explained by spatial dynamics alone or of ethnic differences remain. Importantly, I can measure whether or not a district has decentralized in 1989 and/or in 2004, but I cannot measure how power was transferred, if at all, meaning that I cannot fully model how decentralization effects health and that if I obtain inconclusive results, they may be attributable to this unobservable characteristic.

Data

My primary source for quantitative analysis is Ghana's Demographic and Health Survey (GDHS), which is conducted by the Ghana Statistical Service and the GHS and is meant to provide information on fertility, family planning, and health in Ghana (Ghana Statistical Service, 2009). The survey is part of a worldwide program coordinated by the Institute for Resource Development in over forty countries in Africa, Asia, and Latin America (Ghana Statistical Service, 2009). The survey began in Ghana in 1988 and has been conducted at five-year intervals since then, with the 2008 data being the last released survey as of April 2015, and I use the five surveys conducted in 1993, 1998, 2003, and 2008 due to data coding errors in 1988. The timing

of this survey is ideal because Ghana began to decentralize in the late 1980's, going from 65 to 110 districts and then decentralizing again in 2004 going to 138 districts.[25] I am thus able to assess how health has changed in Ghana since the decentralization that occurred in both 1989 and in 2004.

The survey is a nationally representative sample conducted at the household and individual level and interviews women ages 15-49 and men ages 15-59 (Ghana Statistical Service, 2009). I use data collected at the individual level based on women's interviews but that also includes information about the household, specifically her children and their health. In regards to health-related variables, women were asked whether or not they received a tetanus shot during pregnancy, whether or not the child received a Bacillus Calmette-Guerin (BCG) vaccine (referred to as child vaccinations from now on), a measles vaccine, all three diphtheria, pertussis, and tetanus (DPT) vaccines, all three polio vaccines, the highest level of prenatal and delivery care the woman received (e.g., doctor, nurse, midwife, birth attendant, unprofessional, or none), and whether or not that diarrhea was treated by either a doctor or at a clinic or hospital. My independent variables of interest (e.g., whether or not the district divided) are measured by whether or not a woman's district divided in 1989, 2004, or both, the ethnic majority in the district, and the region the district is located in for reasons previously described.[26]

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[25] While Ghana had 216 districts as of 2015, I use the 138 district classifications due to data availability. While this may seem like a limitation, it is likely that decentralization does not impact health immediately, so being able to measure very recent decentralization may not be telling in relation to health outcomes.

[26] While I originally included basic demographic covariates in my analysis as well, I removed them when I collapsed my data at the district level. Collapsing my data allows me to measure the change in health over time in each district, which is my primary variable of interest. However, that means that indicators such as a woman's marital status are also conglomerated at the district level (e.g., I measure the percent of women married in that district). While this is not inherently bad, if I kept these variables in the model, I would capture the relationship between the percent of women married in the district and the percent change in health outcomes, which has little

Once I analyze this data for all five GDHS surveys, I append the datasets so that I have

the district averages for each variable across the five surveys. For example, I measure the

percentage of women that received a tetanus shot during pregnancy, on average, for each district

from 1988-2008. This allows me to look at how different health indicators vary by district over

time. But, I am also able to stratify the sample by years so that I can measure the percentage

change in women in each district getting tetanus shots and other health indicators within districts

over time.

Descriptive Statistics

Because I previously described how peoples' health in Ghana varies by ethnicity and by

region (Tables 2 and 3), I now focus on peoples' changes in health over time as Ghana

decentralized, which I display in Table 5. Overall, the percentage of women receiving tetanus

shots during pregnancy, the percentage of children receiving their child vaccinations, measles

vaccines, DPT vaccines, polio vaccines, and being treated for diarrhea increased over time. The

percentage of children receiving DPT treatment decreased in 1998 but then increased

consistently from 2003-2008. However, the percentage of women receiving high levels of

prenatal and delivery care decreased over time.

In Tables 6-11 I then split up how these health indicators have changed by ethnic group

over time. I find that districts with an Akan majority saw similar trends in health overtime as the

entire DHS survey sample. Districts with a Ga majority have inconclusive health trends with

many variables fluctuating over time such as the percentage with high levels of birth care

fluctuating between 64 percent to 71 percent to 44 percent to 67 percent of the district. Districts

with an Ewe majority saw a decrease in many health indicators in 1998 and then an increase in

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theoretical backing. However, if I kept my data at the individual level, women's marital status
would be an important predictor of some health decisions (i.e., contraceptive use).

2003 and 2008. Districts with a Mole majority also have inconclusive health trends with fluctuating increases and decreases over time. Districts with other majorities (e.g., minority majorities) saw more positive health trends over time than other districts. Because ethnic groups do have health trends that vary from the overall country-level health trends, it is important to continue to split up ethnic groups in this way. However, there are likely many confounding variables that influence this relationship between ethnicity and health, which I can better assess through regression analysis.

I also split up health trends over time by region and find that health variables vary over region over time as well. However, when comparing regional health changes over time as compared to areas with similar ethnic concentrations (Table 4) and those respective ethnic health changes over time, there seem to be differential effects by region and ethnicity. For example, the Ga ethnic group primarily populates the Western and Central regions, but health indicators for these regions and for the Ga all vary. Thus, it is important to continue to measure regions and their ethnic make up over time separately when assessing health.

Methodology and Concerns

I use ordinary least squares (OLS) regression to assess if and how decentralization and ethnicity affect the health outcomes and health-related decisions made by women in Ghana from 1988-2008. By measuring whether or not decentralization occurred in a woman's district, I am able to isolate the effect of institutional change, and by measuring the ethnic majority in the district I am able to isolate the effect of ethnicity while also controlling for a woman's location in the country. Importantly, by measuring health variables that require a visit to a healthcare provider (i.e., prenatal care), multiple visits to a healthcare provider (e.g., a child receiving all three polio vaccines), and no visits to a healthcare provider (e.g., diarrhea incidence), I am able

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to see how decentralization, ethnicity, and regions differentially affect different types of health and health choices.

Self-reporting is a large issue, as women's responses are likely biased upwards about heath precautions (i.e., their child's vaccines) and are likely biased downwards about health issues or illnesses (e.g., diarrhea). However, because these interviews were not conducted in a healthcare setting, self-reporting bias is likely smaller than in other health related studies. Women may have also moved districts, so the effect of decentralization may not hold. For instance, if a woman lived in an urban area when she had her child, a nurse or doctor may have delivered the child and the child may have received all of his/her vaccines. But, if she then moved to a rural area, the survey will not capture that this high level of birth care actually occurred in a more urbanized or more advanced area. However, most internal migrants in Ghana do stay within their same region, which mitigates some of this effect (Ackah & Medvedev, 2010).

Empirical Model and Results

I conduct OLS regression analysis to assess the effect that decentralization, spatial dynamics, and ethnicity all have on the change in health outcomes between 1993 and 2008, as this allows me to assess the long-term effects of decentralization (Table 12 shows the results for one specific health outcome, the change in measles vaccinations from 1993-2008).[27] I am able to control for whether or not districts split in 1989 and in 2004, so I create variables for the district splitting in 1989, 2004, and at both times to assess whether or not there are differential effects depending on when and how many times the district decentralized.

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[27] While results do fluctuate some by health outcome, I am not concerned with specific coefficients and significance levels, but with the broader effects that decentralization, ethnicity, and region have on health, so I only show one set of regression models here.

I first run regressions controlling for district decentralization in 1989, 2004, or 1989 and 2004:

(1) $Health\_Change_i = \alpha + \beta_1 District\_Divide_i + \varepsilon_i$

where $Health\_Change_i$ are the different changes in health variables over time from 1993 to 2008, $District\_Divide_i$ is three variables for the district dividing in 1989, 2004, or both, and ε_i indicates the error term, which captures unobservable characteristics. I find that there is no statistically significant relationship between decentralization measures and changes in health. However, as previously stated, the ethnic majority and region that the district lies in may also be important in the relationship between decentralization and health. So, I then run regression 1 with ethnic and then regional effects:

(2) $Health\_Change_i = \alpha + \beta_1 District\_Divide_i + \beta_2 Ethnicity_i + \varepsilon_i$

(3) $Health\_Change_i = \alpha + \beta_1 District\_Divide_i + \beta_2 Region_i + \varepsilon_i,$

where $Ethnicity_i$ is a dummy variable for the ethnic majority in the region and where $Region_i$ is a dummy variable for the region that the district is in. Here, I find that decentralization is still not a statistically significant predictor of health changes over time and that some ethnicities and regions are statistically significant predictors of changes in health but not all are. Finally, I regress decentralization, regional identifiers, and ethnic majorities all in the same regression:

(4) $Health\_Change_i = \alpha + \beta_1 District\_Divide_i + \beta_2 Ethnicity_i + \beta_3 Region_i + \varepsilon_i,$

and while I find no statistical significance for decentralization, some ethnic groups and regions remain statistically significant, meaning that ethnic difference still may impact health even when ethnic marginalization is unclear. Additionally, because regional and ethnic effects remain significant in the same regression, I conclude that regional (e.g., spatial) dynamics do not entirely absorb ethnic effects as I measure them.

While this lack of statistically significant findings in relation to decentralization may seem problematic, it is interesting that Ghana's decentralization, which includes decentralization of the healthcare system, does not effect changes in health outcomes in a statistically significant way. Additionally, I measured health outcomes that required one visit to a health facility (i.e., a tetanus shot during pregnancy) and that required multiple visits to a health facility (i.e., a child's measles vaccines) and found no different effects from decentralization. This may mean that decentralization did not effect any change in health. However, this may not be the case. I am not able to measure health outcomes that do not require a health facility, so decentralizing the healthcare system may have engendered behavioral health changes that I cannot measure.[28] Additionally, while I can measure decentralization, I cannot measure exactly how the healthcare systems changed within each district. For example, if the district splitting into two districts only caused the healthcare system to now centralize within its new borders, then people would experience no real change in healthcare provision, as it would still be provided at a central location likely not tailored to the peoples' needs. I also cannot measure the power structures within the formal healthcare system, so it is unclear if and how decentralizing healthcare shifted the power dynamics. While these now smaller healthcare systems may allow for more local direction and decision-making, they may not. Thus, there are many other factors at play that are integral to the relationship between decentralization and health that I am unable to measure. But, this does not lessen the value of these regressions, as my results make it clear that decentralization did not lead to changes in some health predictors requiring healthcare facilities.

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[28] While I originally measured diarrheal incidence (an indicator that does not require a healthcare facility), which I still report in descriptive statistics, I am not able to include this in regression analysis due to data coding errors.

It is not surprising that the ethnic majority of the district and the region that the district lies in do not contribute to changes in health. These indicators have likely not changed during this short time period, so I do not expect there to be large changes in health associated with them. So, I then regress the ethnic majority of the district against health outcomes in 2008, the region that the district lies in against health outcomes in 2008, and the ethnic majority of the district and the region that the district lies in against health outcomes in 2008 (i.e., equations 2, 3, and 4 where *Health_Change$_i$* becomes *Health_2008$_i$*). I find that regions are statistically significant predictors of child vaccinations, measles vaccinations, level of birth care, and diarrheal treatment rates while ethnicity is a statistically significant predictor for only child vaccinations and diarrheal treatment. However, in all of these specifications, only some ethnic majorities and regions are statistically significant, so there is no clear association between ethnic and spatial dynamics and health. Regional specifications explain between 10 and 15 percent of the variation in health outcomes and ethnic specifications explain between five and 10 percent of the variation in health outcomes, so it is possible that regional effects are more telling than ethnic effects, but this is not necessarily the case.

I. Implications

It is thus unclear if and how ethnic and spatial dynamics and changing healthcare institutions affect health in Ghana. It may be that these indicators are not important predictors of health outcomes and the change in peoples' health over time, but it is more likely that they have effects on health that I am unable to measure. There are four primary ways in which decentralization may be contributing to changes in health in ways that I am unable to quantify. First, decentralization has occurred in Ghana both politically and administratively but my empirical analysis is not able to separate out these two forms of decentralization, which may

impact health differently. Second, as mentioned previously, decentralization may affect health behaviors more so than health indicators that require visits to a healthcare center due to potential increases in public health efforts in decentralized healthcare systems or through other mechanisms. Third, these new districts may have simply recentralized on a smaller scale, thus preventing true decentralization. Fourth, I am unable to assess if and how power dynamics have changed within the healthcare system as decentralization has occurred, which likely affects the relationship between decentralization and health.

In regards to regions and ethnicity, only some ethnic majorities and regions were statistically significant predictors of health-related changes, so it is important to more closely study individual ethnic groups and regions to better assess how they interact with health. Of particular interest are the power dynamics among ethnic groups and between regions, which may differentially affect how decentralization affects health (i.e., if the Greater Accra region has more power in relation to other regions, then decentralization in this region may improve health more so than decentralization does in other regions because Greater Accra may be best able to cater health services to its inhabitants). These many immeasurable factors likely mean that the effects from healthcare institutions, ethnicity, and regions are not easily predicted and are more nuanced than many theories expect (i.e., that decentralization improves health) and than my empirical analysis is able to capture.

III.   The Navajo

A. The Social Structure of Native American Indians (NAI)

NAI are classified as those whose ancestors lived in America before Europeans arrived and who are recognized as NAI by their tribe or community. Once recognized, they receive legal, judicial, and administrative identification by the Bureau of Indian Affairs (BIA), which results in them having access to federal services that are distinct from those available to the majority American population, including healthcare (Kickingbird, 1983). This means that their healthcare system is fundamentally different from that of the United States (US) majority population and is primarily enforced by the federal government.

In the 2010 census, NAI and Alaskan Natives numbered over five million, growing over 25 percent since 2000 (US Census Bureau, 2010). There are currently 556 recognized NAI tribes, which are often treated homogenously by the government and have striking human capital disparities compared to the majority population (US Census Bureau, 2010). The Navajo tribe, which I focus on in my analysis, is the second largest NAI tribe in the US, with most of the Navajo living on Navajo Nation, the tribe's reservation. Only about 20 percent of NAIs live on the 279 federal and state reservations, 50 percent are in urban areas although their urban migration has decreased since the 1970's, and the remaining 30 percent are in non-reservation, rural areas (Snipp, 1997). 75 percent of NAI live in the Western US and only greatly populate 12 cities, predominantly in poor suburbs (Rhoades, 2001; Snipp, 1997). Their population's continued growth in numbers and geographical dispersion combined with their unique legal and political status should signal to the healthcare system that it must increase its knowledge of the history and demography of this group in order to fully understand their differences from the

majority population and the heterogeneity within them in order to provide adequate healthcare (Snipp, 1997).

B. Origins and Historical Background

Prehistory and the Rise of the Nation-State

The NAI originally descended from Asia 12,000-14,000 years ago and developed into many distinctive tribes (Deloria & DeMallie, 1999). Importantly, many of these groups have their own language and cultures and exhibit their own medical traditions, including the Navajo (Deloria & DeMallie, 1999). Colonizing Europeans began recognizing tribal political identity in the 1700's but quickly began to deliberately take all of the NAI's power away when the nation-state formed later that century (Kickingbird, 1983).

The US majority population enacted colonialist expansionist policies carried out through military annihilation (Heart & DeBruyn, 1998). As land became valuable to the US, the NAI were forced to resettle elsewhere, which is how the reservation system developed (Heart & DeBruyn, 1998). Frontiersmen overtook land, forced the NAIs onto barren soil (which caused them to lose their subsistence economy), and geographically isolated them from social and economic opportunity; they were completely marginalized (Rhoades, 2001; Sarche & Spicer, 2008; Duran & Duran, 1995). These actions are often referred to as cultural genocide, as the US threatened the integrity and viability of NAI societies (Duran & Duran, 1995).

The 19th Century

In 1824 the first steps were taken to formally recognize the NAI by creating the Office of Indian Affairs, which later became the Bureau of Indian Affairs (BIA) (Heart & DeBruyn, 1998). The Office of Indian Affairs fell under the department of war, so NAI were only given episodic healthcare, primarily vaccinations if they lived near a military fort (Rhoades, 2001). While NAI

were now legally recognized and granted legal access to services, their practical access to federal services remained minimal (e.g., they had *de jure* but not *de facto* access). They had no active role in the care that they received and were forced to accept whatever federal forces gave them, which did not often include traditional health practices that were ingrained in NAI societies.[29]

In the 1830's, the Supreme Court declared the tribal lands as 'domestic dependent nations,' so Indian Affairs were switched to the department of the interior, which had more obligations to provide healthcare and other services (Kickingbird, 1983; Rhoades, 2001). However, the government decided that NAI would forcibly secede the rights to their land as payment for services, including health (Rhoades, 2001). The BIA forced adherence to these services and forced the NAI to assimilate. They did this through boarding schools that taught US dominant cultural values, language, and dress, which mandated the NAI to cooperate by threatening them with threats of incarceration and cutting off rations and supplies (Heart & DeBruyn, 1998). The 1887 Dawes Allotment Act then fully confined NAI to reservations and granted them meager amounts of land and welfare payments (Heart & DeBruyn, 1998; Bartley et al., 1998). By attacking the language, family, and historical systems of the NAI by relocating them and forcing their assimilation, the US attacked the core of NAI identity and spatially confined them, thus both confining them by both their geography and by their ethnicity (Duran & Duran, 1995).[30]

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[29] These traditional practices include participating in sweat lodges for spiritual healing, using herbs, balms, and purgatives as cures for ailments, and only speaking positively about peoples' health (e.g., not giving patients negative health information) (Kim & Kwok, 1998; Carrese & Rhoades, 1995). The US federal government provides neither access to sweat lodges, herbs, balms, and purgatives in formal healthcare settings nor respects the Navajo's want for only positive information. I explain the divide between traditional and Western medicine in more depth later when speaking about the Navajo specifically.

[30] The NAI's relocation is also problematic in that many NAI tribes are attached to their land in a cultural and spiritual sense (Low, 1992). While I do not have time to expand on this facet

The 20th Century

While the US continued to ignore the oppression experienced by the NAI, they did begin increasing federal services in the 1900's. In 1911, the first funding for NAI health was issued and in the 1921 Snyder Act was passed, which provided continued authority for federal Indian programs, including health (Rhoades, 2001). However, this mandate lacked funding, physicians, and a general knowledge of the health issues and diseases faced within NAI communities (Rhoades, 2001). When the US continued to expand programing but saw little results, they instituted the 1934 Indian Reorganization Act to restore tribal government to many reservations (Snipp, 1997). While this act attempted to give NAI sovereignty, it still did so within the structure of the US governmental and did not permit the NAI to have full autonomy or power.

As extending federal services to reservations did not improve the plight of NAIs, the government began establishing departments within the BIA for service delivery (Rhoades, 2001). In 1955, the US created a Division of Indian Health, which became the Indian Health Service (IHS) in 1968 (Rhoades, 2001). The US's rationale was that after peoples' health was on par with US averages and tribal identity was eliminated, there would be no need for the IHS and it would be removed, so it was created as a temporary program (Heart & DeBruyn, 1998). The IHS established basic clinical services, developed relationships with local governments and communities, extended management and training programs to community members, established a Health Programs Systems Center to research and ensure proper functioning of IHS centers, and more (Rhoades, 2001). In theory, the IHS increased access to care and quality of care, provided tribes with a range of health experts, and heavily involved itself in communities by giving power back to the NAIs (Rhoades, 2001).

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specifically, it is important to keep in mind that the NAI's attachment to their land likely adds another layer to the issues associated with their relocation.

However, the IHS came with many problems as well. The NAI were considered to have access to this healthcare if they lived within a 90-minute drive of an IHS center (Rhoades, 2001, Call et al., 2006). The centers were set up in 35 states with 12 regional offices, 492 ambulatory service centers, and 49 hospitals (Rhoades, 2001). They were mostly staffed by rotating physicians, so patients could not develop a relationship with doctors and doctors often could not come to understand the context they were working in (Rhoades, 2001). Additionally, many areas did not have physicians, so the level of care provided was limited (Rhoades, 2001).[31] Thus, formal healthcare systems first stripped the NAI of their traditional health practices and subsequently provided inadequate care in a biomedical setting as well.

C. Self-Determination

By the 1970's NAI gained more control of health services through the creation of the National Indian Health Board and American Indian Health Care Association (Rhoades, 2001). The US started moving towards self-determination for the NAI, directing the IHS to provide funding but turning management over to the tribes (Kickingbird, 1983). Individual tribe and intertribal organizations were created at the local level and the Indian Self-Determination and Education Assistance Act was established at the national level to further these efforts (Snipp, 1997; Rhoades, 2001). Mandates were created for the health sector specifically in the 1976 Indian Healthcare Improvement Act, which was meant to ensure the health of NAI and achieve maximum participation of NAI in IHS services (Rhoades, 2001). This act established a benefit package for in and outpatient care; dental, preventative, and mental health; and substance abuse issues (Rhoades, 2001).

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[31] Urban areas lacked healthcare centers entirely, so urban Indian community leaders began meeting in the 1960's to develop volunteer-based programs, and the Urban Indian Health Program was established. There are now 34 urban programs, some of which are only outreach programs (Rhoades, 2001).

The relationship between the US and NAI was redefined in 1977 as a trust relationship, meaning that the US had the duty and the power to raise the standard of living and social wellbeing of the NAI people (Kickingbird, 1983). However, it was unclear how this relationship would pertain to health (Kickingbird, 1983). The US affirmed the importance of native healing in relation to Western, modern medicine and invited traditional healers to clinics to speak with IHS staff and created liaisons between native healers and biomedical physicians (Rhoades, 2001). While this relationship was formally established, it largely ignored community assets and traditional medical approaches, thus still keeping power within the hands of the US government, which prioritized a Western medical approach (Duran & Duran, 1995).

The 1993 Indian Tribal Justice Act switched the power for Indian affairs from the US government to a compact between the government and Indian nations (Kickingbird, 1983). However, only the federal government shared power, not the states, making the power dynamic unnecessarily complex. While this relationship was itself confusing, it also impinged on the design of health programs, as states that had reservations could not have a say in how health services were structured on the reservation (Kickingbird, 1983).

NAI tribes' full sovereignty was recognized in 1994, which gave the tribes a dual status of both political independence and being in a trust (Kickingbird, 1983). The paradox of sovereignty and the responsibility of being in a federal trust often bled over into both the design and implementation of health programs, as it was never clear how much control NAI had over the federally established healthcare centers (Kickingbird, 1983). By 1996, tribes operated 12 out of the 49 IHS hospitals and 379 out of the 492 ambulatory centers, so most NAI tribes were providing some of their own health services (Rhoades, 2001). But, it is still unclear how much

power the NAI tribes had within these systems when they were created and how much power they currently hold.

D. Health Among NAI Tribes Today

While there has been a clear movement of power from the federal to tribal level, there remain many issues that have evaded the legal changes. Within healthcare, there is much racial discrimination, cultural misunderstanding, miscomprehension of family and work responsibilities, and a disregard for religious practices, so many NAI do not trust healthcare providers (Call et al., 2006). Because the workers do not fully understand cultural context, they often do not provide culturally sensitive service and overtones of paternalism remain (Duran & Duran, 1995; Call et al., 2006). From a practical standpoint, many living on reservations have transportation difficulties getting to facilities and many facilities have depleting resources, so many have poor access to care (Call et al., 2006; Rhoades, 2001). From a federal funding standpoint, $1,914 is spent per patient per year while $3,803 is spent on health for prisoners (Sarche & Spicer, 2008). Thus, IHS centers have poor funding and infrastructure in addition to services that ignore cultural context.

Almost 30 percent of NAI have no health insurance, compared to about 15 percent of the US population. Many purchase private insurance if they can afford it, but among the poor, about 60 percent rely solely on IHS care (Snipp, 1997). The IHS centers remain understaffed, having two psychiatrists and four psychologists per 100,000 people, about one-seventh of the US average (Sarche & Spicer, 2008). This lack of infrastructure, among other reasons, contributes to higher rates of domestic violence, trauma, mental disorders, substance abuse, suicidal behavior, and alcoholism than the US population (Sarche & Spicer, 2008). Additionally, diabetes, chronic liver disease (mostly due to alcoholism), and injuries from accidents are over three times the US

average and death from tuberculosis, pneumonia, suicides, homicides, and heart disease are higher than the US average as well (Sarche & Spicer, 2008). Almost 40 percent of children are overweight or obese (twice the US rate for being overweight and three-times the US rate for being obese) and almost 70 percent of people have untreated dental decay (Sarche & Spicer, 2008).

It is thus clear that NAI experience many health inequalities in relation to the US majority population. These inequalities are undoubtedly tied to their ethnic and spatial isolation and to their marginalization. And, their marginalization is likely compounded by the US exerting a healthcare system on them that removes the opportunity for the NAI to practice traditional medicine, have a healthcare system that is familiar to them, and more.

The way in which the US has interacted with each NAI tribe and on each reservation is distinctive, as it was not until the US invaded these native peoples that they were collectively termed NAI (Berkhofer, 2011). Rather, they each had (and continue to have) their own identity as Navajo, Cherokee, etc. I thus focus on one tribe, the Navajo, in order to best understand how the power dynamics of the formal healthcare system that I previously described manifests in a specific ethnic and spatial context. I focus more specifically on the Navajo living in Navajo Nation, as focusing on a reservation adds a layer of spatial isolation that is different for the NAI residing elsewhere. I draw on interviews that I conducted in Navajo Nation over January of 2015, which allow me to gain invaluable insights into the power dynamics of the IHS, as I was able to gain the perspective of Navajo and non-native biomedical healthcare providers, psychologists, traditional healers, and more.

E. Health Issues Facing Navajo Nation

   Navajo Nation is a semi-autonomous territory situated in Northeastern Arizona, Southeastern

Utah, and Northwestern New Mexico and is home to about 300,000 Navajo (Henson et al.,

2008). It is the size of West Virginia, making it the largest reservation in the US. While its size

may allow for more autonomy, its isolation and historical past have forced it to become

dependent on US federal programs. This dependency has led to multiple issues for its inhabitants

ranging from poor educational attainment to poor job opportunities, but I focus specifically on

health. Navajo Nation is home to multiple health issues ranging from physical ailments to mental

and emotional trauma and more, many of which are related to behavioral choices. Importantly,

many aspects of health are worsening over time, which contradicts the advertised increases in

health that are expected to come from Navajo Nation's recent self-determination policies and

emphasis on tribal decision-making (Henson et al., 2008). Thus, power, both formal and

symbolic power still may rest within the US federal government.

   In regards to behavioral physical health, nutrition is poor starting from a young age, with

people, on average, consuming less than one serving of fruits and vegetables per day (Ballew et

al., 1997). School administrator Stuart Noggle says that when he grew up in Navajo Nation,

meals were healthy, and now kids are getting pizza and "it [isn't] pizza once a week, [it's] pizza

every day." Physical activity and exercise are on the decline with neither young children nor

adults receiving recommended amounts of exercise, something that has contributed to the large

increase in diabetes mellitus type two over the last few decades. 22.9 percent of Navajo have this

chronic condition and for those over the age of 20, the rate is four times higher than the US

average (Will et al., 1997). Other physical health concerns have remained an issue over time,

including dental care, which is not provided at local clinics (David, 2015; Glasses, 2015). In

2004 only about 25,000 Navajo out of the reservation's 300,000 received dental services

(Roubideaux, 2003). And, even for services that are offered at local clinics, locations are

clustered and centralized, so many Navajo lack true access for physical healthcare and other care.

One of these other aspects of care is mental and behavioral health issues, which are arguably

less addressed on the reservation than physical health concerns. Depression and anxiety loom

large, with some providers claiming it to be the largest health issue the tribe faces (David, 2015).

The reservation also has high stress levels and what is presumed to be under diagnosed

depression and anxiety, which likely contributes to incredibly high suicide, alcoholism, drug

usage rates (Jim, 2015; Henson et al., 2008).[32] Between 1999-2001, 20 people per 100,000

committed suicide on the reservation, double the US average, and suicide rate on the reservation

was triple the US average as of 2013 (Wilson et al., 2007; Clichee, 2013). While these three

behavioral health issues have always been present on the reservation, providers claim that they

are beginning to become more common and appearing at a younger age, 13 or 14 years old.

Valley High School in Sanders, Arizona, which is on the border of the reservation, had two

suicides in a student population of 300 in 2014 (David, 2015; Speen, 2015).

Additional health concerns that are pronounced among the Navajo relative to the US

population include high rates of domestic violence, with many women being physically and

emotionally abused, and high rates of teen pregnancy, with about 8 percent of high school

females getting pregnant during 2014 (Lee, 2015; Speen, 2015). In a 1998 study, researchers

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[32] By stating that the reservation has high stress levels and under diagnosed anxiety and depression, I do not mean to say that the mental health issues here can be reduced to those of psychopathology. Instances of trauma differentially influence each person, so anxiety and depression should be seen as examples of a potential outcome of historical trauma but not the only one (Wilson et al., 2007).

found that 179 out of 341 women reported at least one instance of domestic violence and 56 reported regular violence (Fairchild et al., 1998).

It is evident that health issues on Navajo Nation are many and nuanced, so it is critical to develop a better understanding as to how their health interacts with their ethnic and spatial isolation and with the formal healthcare institutions. The power dynamics between the healthcare system and its patients are of particular interest, as are the health-related choices that Navajo patients make on a daily basis. By looking more closely at both of these facets of health, I am able to shed light on the power dynamics at play within the IHS today.

F. The Causes of Health Issues

First, to truly understand how power and control within the IHS are intertwined with the Navajo's ethnic and spatial identity, I need to go beyond the distribution of power within the healthcare system itself because broader historical issues shape individual behavior in ways that would otherwise be hard to see. By first viewing the Navajo's healthcare institutions against the backdrop of historical oppression, I am best able to parse out how the Navajo view these institutions and thus respond to them.

Historical Issues & Mental Health

The Navajo have experienced much historical trauma, defined as the intergenerational psychological consequences of genocide, ethnic cleansing, and forced acculturation (Whitbeck et al., 2004). The Navajo were forced to go on the Long Walk in 1864 and relocate from their tribal land to a reservation that US forces created, which subsequently created land disputes. Government officials then used education as the primary method by which to Westernize the Navajo, so many were forced into boarding schools until the mid-twentieth century to acculturate

Navajo youth (Adams, 1995). By instilling in children Westernized ways of thinking and living, children were robbed of a traditional Navajo childhood (Heart & DeBruyn, 1998).[33]

Then, in 1974, the Navajo and the Hopi were forced to move off of each other's land in the Navajo-Hopi Land Settlement Act. The US government moved over 15,000 people during this relocation, provided them with new homes on the edge of the reservation, and promised to revitalize their new communities. But, revitalization did not occur and 15,000 Navajo have lived the last four decades in polished houses in largely destitute towns. Poverty in communities on the reservation ranges from 27 percent to 65 percent and while unemployment ranges from three percent to 40 percent, survey data has found that 54 percent are unemployed, indicating that many unemployed, discouraged workers are considered to be out of the labor force (Clichee, 2013).

In relation to health, this economic destitution may contribute to high levels of stress and self-destructive behaviors due to peoples' anger and oppression (Heart & DeBruyn, 1998). Heart and DeBruyn (1998) say that the Navajo's accumulated historical trauma has contributed to their current internalized oppression and unresolved grief because this oppression and grief is often experienced throughout generations. The Navajo's historical trauma still exists today and often materializes in depression, anxiety, substance abuse, domestic violence, and homicide and suicide (Heart & DeBruyn, 1998; Wilson et al., 2007).[34] Thus, the trauma the Navajo experienced may continue to lead to people's loss of spirit and onset of mental health issues.

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[33] Culture and traditions may be a filter for psychic trauma, which I expand on later (Wilson et al., 2007). This potential healing mechanism emphasizes the critical importance of children having the opportunity to be raised in traditional settings, which boarding schools did not allow.
[34] Internalized oppression has come about in the Navajo through a process over many centuries. They endured systemic genocide within Western society and had Otherness forced upon them, which caused them to internalize the discursive Western practices that reproduced their original oppression (Poupart, 2003)

Isolation & Physical Health

Peoples' mental health issues that are intermixed with historical trauma are a large concern on the reservation, but it is not the only health issue stemming from the Navajo's historical stressors. The Navajo's historical trajectory has been both mentally and physically destructive, as the reservation has become incredibly geographically isolated and closed off.

To start, making doctors' appointments is often a large ordeal because people remain isolated and often do not have reliable transportation (Lee, 2015). Because of their poverty, many are not able to save money for gas to drive a long distance to a doctor's appointment, so they often do not go. Many then rely on family members and friends for transportation if gas money is tight, which is often also unreliable and causes people to miss their doctor's appointments (Glasses, 2015). Waiting lists at IHS and 638 facilities can be up to three months and while local clinics often have shorter waits, they are unaffordable for most, so many patients are forced to wait months before rescheduling an appointment, which often further disincentivizes getting primary care (Glasses, 2015).

Many acknowledge the need for outreach programs due to these transportation issues, which sparked the Community Health Representative (CHR) program (Glasses, 2015). Remote areas have the highest elderly population, and the elderly often do not have their own transportation and rely on CHRs to conduct home visits (Morgan, 2015; Glasses, 2015). Other programs exist through specific hospitals but require specific types of insurance, so they are not accessible (Clichee, 2013).

People's isolation results in very few receiving primary care, which ultimately results in many being taken to the hospital in an ambulance for a preventable illness. In 2013, the ambulatory care sensitive (ACS) discharge rate (per 1,000 Medicare enrollees) was 96 for the

Navajo but only 66 for the US (Clichee, 2013).[35] The ACS rate indicates the level of conditions

treated through ambulatory services such as asthma attacks and complications related to diabetes

that could have been prevented if adequate primary care resources were available and accessible

for those patients (Clichee, 2013). So, the high ACS among the Navajo indicates that many

issues requiring ambulatory services could have been prevented by primary care (Clichee, 2013).

 Thus, the Navajo's difficulty with accessing healthcare resources is at least partially

attributable to their isolation, which largely stems from historical processes (e.g., the BIA's

actions). These historical processes also created the formal healthcare institutions present on the

reservation today, which I turn to now.

G. Institutional Issues

History and Institutions

 Importantly, the way in which people respond to formal healthcare institutions is based on

peoples' history, which is harshly evident on Navajo Nation. One behavioral health counselor,

Samantha Lee, says that the forced relocation of the Navajo brought on a feeling of

institutionalization, so patients now believe that programs are meant to assimilate them into the

majority population (Lee, 2015; Heart & DeBruyn, 1998).[36] Lee claims that "our people have

already experienced the long walk, the boarding schools, the shipping to the state of Utah and

those foster care placement homes...so the idea of institutionalizing individuals...it's a scary part

for a lot of people." One traditional healer says that what outsiders may see as modern facilities

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[35] Issues related to high ambulatory usage are similar among the Roma, which are discussed in the next chapter. However, this does not mean that Roma and Navajo patients using ambulances at high rates come from the same causal mechanisms.

[36] Granted, relations between the US government and Navajo Nation used to be considered guardian-ward rather than government-government (Henson et al., 2008). However, I will now operate within the timeframe of government-government relations, which have existed since the mid-twentieth century.

that will improve peoples' health, many Navajo see as imposing facilities that will deteriorate peoples' health (Jim, 2015). For instance, there is a large lack of nursing homes on the reservation, with many elderly patients relying on CHRs to make home visits (Lee, 2015). And while it looks like the reservation needs more nursing homes, Lee says that nursing homes make people feel like they are being institutionalized, so they avoid them (Lee, 2015). So, while it seems as if people are responding to institutions (or the lack thereof), people may actually be responding to the power dynamics first put in place by historical structures. Because structural, historical issues are still present, modern day health services are being offered in ways that people see as paternalistic, so they do not always respond well to them. As a result, the US healthcare system may be continually losing its legitimacy for the Navajo people.

Healthcare System

The healthcare system itself is a set of institutions encompassing IHS facilities, Tribally-Operated 638 health programs, and private clinics. Yet, how they serve the population is shaped by structural shortcomings, such as limited resources, and peoples' perceptions of what the services actually are. As previously mentioned, the IHS plays a large role in the healthcare that is available on the reservation. The IHS was originally built as a temporary program meant to deal with acute diseases until the health of Native Americans achieved that of the larger US (Henson et al., 2008). As chronic health issues developed and overall health did not improve, people realized IHS's imperialistic features and inattention to the needs of the Navajo (Byers & Hubbard, 1997). To correct for this, many hospitals have recently transitioned from IHS facilities to 638 Programs (Henson et al., 2008). These 638 hospitals have more autonomy than standard IHS facilities, allowing them to cater their services more specifically to their population (Henson

et al., 2008).[37] However, they still receive pressure from federal funding priorities to continue with the programs that existed when hospitals were designed as IHS facilities (Henson et al., 2008). Private clinics exist as well, but these cater to those of higher socioeconomic status, which are mostly educators and hospital staff members (Begay-Piechowski, 2015).

One overarching issue is that primary care, the main service provided on Navajo Nation, has recently become more convoluted and harder for patients to navigate due to institutional changes (David, 2015). The switch from IHS services to 638 status or private clinics means that patients are now more responsible for their own healthcare, but many patients do not fully understand the differences (Clichee, 2013). The IHS provided comprehensive healthcare for patients, including free pharmaceutical referrals and vaccinations for anyone with a Certificate of Indian Blood (CIB) (David, 2015; Hute, 2015). Now, clinics see many patients that do not know how the new process works (i.e., that they need to go and purchase medication at a pharmacy) (David, 2015). This means that while the US may have transferred power of choice over to the Navajo, the US has not increased the Navajo's capacity to make informed choices, thus the US federal government still holds the power while making it seem as though they do not.

Additionally, people often do not feel connected to their doctors because there is much contracting out for providers, so many do not feel comfortable around them, which lessens peoples' incentives to use primary care regularly (Glasses, 2015; Begay-Piechowski, 2015).[38] There is a high turnover rate for doctors in the hospitals and there are only 32 providers per 100,000 people in opposition to 85 per 100,000 people in the US (Clichee, 2013). This high

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[37] Please see the chapter on Ghana's decentralization for a discussion of fiscal decentralization and its potential consequences.

[38] One Navajo provider believes that patients get a sense that he understands Navajo culture and language, so they are more receptive to him than to others (Glasses, 2015). Having more Navajo providers is a potential solution to this issue, but raising solutions to these issues is beyond the scope of this paper.

turnover rate and the need for more providers creates low morale and patients say that healthcare

providers often come off as rude and inattentive (Clichee, 2013). Patients assume they will see a

different doctor each visit, so they are not able to build relationships or rapport with their

doctors. Because healthcare facilities are now more autonomous, providers have low levels of

collaboration between hospitals, among specialty departments throughout the reservations, and

even within the same hospital between different departments (Lee, 2015; Begay-Piechowski,

2015). For instance, behavioral health providers are not aware of other behavioral health services

on the reservation and some doctors are not sure what all services are available to their patients,

which may make patients feel like doctors are not fully invested in them (Lee, 2015).

Perceptions of the Healthcare System & Traditional Care

Beyond the infrastructure of the healthcare system, people's perception of the healthcare

system plays a large role, specifically the Navajo's perception of how much power they have

within the system to practice their traditional beliefs. For example, people's culturally shaped

beliefs play a role in determining whether or not explanations for medical treatment within

formal healthcare institutions make sense for patients (Jim, 2015; Wilson et al., 2007). It is not

only the institution providing medical treatment that matters, but also how people react to the

institution. While the IHS may provide primary health services, it may do so in a way that

Navajo see as imposing and that disregards their traditional beliefs.

The conception of health itself is debated on the reservation, with Western doctors claiming

that health is biologically and socially constructed while traditional practitioners say that health

is the balance of natural order and that sicknesses often come from a spiritual imbalance (Henson

et al., 2008; Rickmann et al., 2004). One school nurse says that there has not been a change in

tradition, but there has been a change in how things are done on the reservation (Hute, 2015). For

instance, many families believe in and practice traditional healing but formal healthcare institutions follow Western biomedicine. Alta Begay-Piechowski, who is Navajo and a school psychologist, says that "there's people that live way in the remote areas and a lot of them...are afraid of going to the hospital...so it kind of goes back to how you're raised and what you believe about healthcare." So, many families still do not use the Western care that is available because it is both unfamiliar to them and it is not what they consider to be healthcare.

Traditionally, Navajo do not talk about someone's death because when you do, you sentence that person to death spiritually (Jim, 2015). Western doctors have become known for talking about death with patients that have fatal conditions, which makes others, even ones that are not ill, fear the healthcare system (Jim, 2015; Begay-Piechowski, 2015). This does not mean that the Navajo need to completely abandon Western healthcare, but it does mean that healthcare needs to become legitimate to them by allowing them to have more power and choice (Henson et al., 2008).[39]

Traditional practitioners that I spoke with believe that Western doctors claim that what Western medicine is not able to comprehend or diagnose is trivial (Jim, 2015). However, Navajo conceptions of health to not believe these issues that are not diagnosable are trivial. Traditional practitioners also believe that health is a combination of physical, mental, and spiritual elements, so the majority of the time the body can heal itself through the mind, which is based in spirituality (Jim, 2015; Coleman, 2015).[40] One psychologist claims that if you are stable

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[39] Here I refer to legitimacy in a practical rather than a normative sense. For healthcare to be effective, the Navajo must be receptive to it. For a more normative argument of healthcare system legitimacy, please see Norman Daniels' *Just Health Care* (1985) and *Just Health: Meeting Health Needs Fairly* (2007).

[40] Traditional approaches to health are an example of an expression of indigenous culture and cultural identity, which I previously mentioned was largely absent in youth (Henson et al., 2008).

emotionally, you are going to be healthy physically (Begay-Piechowski, 2015). And, even if you

are not able to cure your physical ailment, being emotionally and spiritually prepared for what is

to come is just as, if not more, valuable (Begay-Piechowski, 2015). This is commonly referred to

as the beauty way (*hozho*), a natural balance that includes being at peace with yourself and in

your spiritual journey (Lee, 2015). Tina Coleman, a traditional practitioner, says that "a lot of the

Western medicine...can't cure or...correct the balance of a lot of the natural things that happen to

the human body." So, even if Western care can health the physical parts of an illness, it is often

insufficient in addressing the entirety of the illness.

While Western and traditional medical belief systems may seem in opposition, they do

have the potential to work together, as many patients use traditional medicine as a supplement to

Western medicine, or vise versa (David, 2015). However, the type of medicine that is prioritized

varies greatly depending on who is talking. Patients say that they do not see conflicts with

practicing both types of care, with 62 percent of patients in Western hospital facilities saying

they have used a traditional healer and 39 percent saying that they do so regularly (Kim & Kwok,

1998).

However, care is rarely integrated in a formal environment and the IHS has traditionally

not encouraged integration (Henson et al., 2008).[41] Fort Defiance Indian Hospital in Fort

Defiance, Arizona has now combined traditional and Western medicine, traditional practitioner

staff members often collaborate with doctors, and there is now a Hogan on site for traditional

Thus, reintroducing traditional medicine may be a pathway to reinstating young people's cultural
identity. However, this paper is not based in solutions, so I will not go into it further.
[41] I previously mentioned that IHS facilities began having liaisons for patients that preferred
traditional medicine, but these facilities did not fully integrate traditional care within the formal
healthcare system.

ceremonies (Coleman, 2015; Jim, 2015). Harrison Jim is one of the traditional practitioners

working with Fort Defiance Indian Hospital:

> I have to work alongside the psychologists and what I encourage is that let's not use the
>
> medication first, let's try to use our traditional ceremonies first to find, to restore balance
>
> and harmony in the individual first and if all else fails then we can refer to using the
>
> medication...I say that nine out of ten kids that I've worked with didn't need to be on
>
> medication, all they needed to have was a restoration of balance and harmony in the
>
> individual. - Harrison Jim

So, this hospital has, at least at some level, combined traditional and Western health practices in

such a way that allows the patient to have integrated care. However, other hospitals still only

provide Westernized care (Lee, 2015). So, while collaboration may be possible, it is uncommon,

thus further revealing how little power the Navajo have in their healthcare.

H. Individual Choice

People's behaviors (their demand for both healthcare and good health) may be a function of

the power dynamics within healthcare institutions (the supply of healthcare, type of healthcare,

and the resources for good health). Some providers blame patients and their choices for their

poor health the providers see, but peoples' behaviors are a function of the opportunities available

to them as well as longstanding ethnic and spatial dynamics (Glasses, 2015). For instance,

providers may think that patients have poor eating habits but, in reality, peoples' traditional

methods for growing healthy food were taken away the Navajo being relocated to areas with

barren soil, and it is now much cheaper to buy processed foods at convenience stores rather than

driving one hour to a grocery story. People may not have true choice or, rather, people's choices

are not independent of the set of options from which they have to choose. I now explore the potential pathways through which this personal choice operates.

Parental Choice

Some providers claim that people simply make poor choices and are not compliant with formal healthcare systems (Glasses, 2015). They state that people do not want to be responsible for their healthcare and they do not want to leave their community to get necessary treatment (Glasses, 2015). Providers claim that parents are not involved in their children's lives, make poor parental choices, and do not supervise their kids (Glasses, 2015; Coleman, 2015; David, 2015). In focus groups, many Navajo patients say that there are problems with poor parenting and a lack of role models on the reservation (Clichee, 2013). Thus, both some patients and some providers say that the problems people have begin in the home.

But, if I look more broadly, I can better see possible causes of what seem to some observers to be parental deficiencies. Many parents are forced to be absent while their children are at home because they have jobs that are far away (Lee, 2015). Because the reservation is rural and isolated, many commute an hour or more to work, so there is limited time available for parents to be with their kids. Many schools programs that used to be catered to parents (i.e., their work schedules, location in relation to the school, etc.) have ended because of funding (Speen, 2015; Hute, 2015). For instance, schools used to have a parent liaison to communicate with parents about their children and a bus to transport sick children back home due to long distances from home to school but when funding ran out, they ended both programs (Speen, 2015; Hute, 2015). Parents were immediately expected to be available to pick up sick children and to communicate regularly with teachers. Both of these tasks seem reasonable, but parents were not used to them

and had not been expected to do them before. When the parents did not do them, they were seen as bad parents.

Additionally, many families live with their extended family. Coleman says that in the ACU, kids may not be sure who to look up to and may receive less discipline from grandparents and other caretakers as opposed to parents (Coleman, 2015; Clichee, 2013). She says that the Navajo highly value living with extended family, respecting kinship ties, and honoring elders, so many Navajo leave the reservation as young adults and return towards the end of their life, as they want to be with family and return to their roots (Coleman, 2015; Clichee, 2013). This often results in kids having many influences, none of which may be particularly strong. Additionally, Coleman says that kids do not often identify with their immediate family specifically because they have so many different influences.

Youth Choice

Because of the parent's long commutes, low parental involvement in the schools, and families' living situations, many professionals claim that the youth have no role models, which then leads to their poor choices (Glasses, 2015; Dennis, 2015; Lee, 2015). Providers claim that if kids do not have someone to look up to, they cannot be expected to take their health into their own hands (Glasses, 2015).

And without these role models, kids often have neither a strong cultural identity nor strong ties to their Navajo Background. Coleman says that many Navajo youth have lost their cultural identity, "they think they're white kids. That's how their mentality is," and that is the source of their poor choices and actions. When kids do not have a strong Navajo identity (family and community identity is known as *K'ei*), Coleman claims that there is no way to understand why the reservation is the way it is, how history plays a role, or how they can reclaim a culture that

has been pushed aside by the US government, which has robbed them of their power (Coleman, 2015).[42] Without this identity these kids see themselves as severely disadvantaged, unlucky white kids (Coleman, 2015). They see that 46.7 percent of kids are living in poverty without seeing why (Rickmann et al., 2004; Bergsma et al., 2012). Coleman and others say that if Navajo youth perceive themselves to be white, they have no sense of place or belonging and feel powerless (Rickmann et al., 2004). If they see themselves as white, then their life on the reservation is incomprehensible. And, without a sense of place, they do not respect themselves, others around them, or elders, because they feel they do not have an identity that deserves or merits respect, which leads them to make poor choices. Thus, the US cannot isolate kids' choices from their society.

When these perceptions that youths hold preclude a notion of cultural identity, they, as stated earlier, are even more influenced by the outside world than other youth that do have a cultural or societal identity. And the most constant and formal institution in their lives that exerts influence is the education system. I focus specifically on the school's role in health education as it relates to sexual health although there are many other issues that could be expanded upon here. Health education in the school system is not effectively designed and is only taught at the high school level. Abstinence is the only sex education program due to a restrictive school board policy although there are high rates of teenage pregnancy (Speen, 2015). On the reservation, about 35 percent of births are to women 19 years and younger as compared to only 27 percent of all births in Arizona (Curley, 2008). Many providers recognize that health education needs to occur at a younger age because many have already become sexually active by high school (David, 2015).

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[42] Higher levels of cultural identity are found to lower instances of depression, which I will further explore at a later section, but is something to keep in mind in the context of youth health choices (Rickmann et al., 2004).

One provider suggests that elementary schools could start explaining what it means to have a meaningful relationship in order to begin the conversation about sexual health in an appropriate way (David, 2015).

Respondents say that another issue is that families are not talking about what it means to have a meaningful relationship. Families often do not talk about sexual health, as talking to "cultural natives about those types of things...you're not supposed to talk about that" (David, 2015). Thus, while sexual education is falling behind in the school system, it is also a concern within the home. Outside of the home and school, one larger structural issue at play here is the lack of other things to do on the reservation (David, 2015). While high rates of teen pregnancy may largely be the fault of school programming and parental guidance, it could also be the fault of a lack of stimuli on the reservation (Clichee, 2013).

Youth are initiating sexual relationships at younger and younger ages and David recently had two pregnant teenage girls come in to the clinic that had each had three or four sexual partners (David, 2015). One worry is that sexually transmitted diseases (STD) will spiral out of control soon, as Chlamydia currently effects 525 per 100,000 people on the reservation and only 400 out of 100,000 people in the US (Clichee, 2013). While rates of other STDs are currently lower than the US average, providers worry that they will increase soon if sexual health is not addressed (David, 2015).

Thus, youth choices are influenced by their parents' choices, their perceptions of their cultural identity, the education system, and the resources on the reservation, all of which are deeply intertwined with the power that the Navajo have in relation to the US majority. Without this power, peoples' choices in relation to health are also severely constrained, especially when

coupled with the Navajo's ethnic and spatial isolation. I now turn to a discussion of health outcomes in order to further assess how institutions interact with peoples' health in this context.

I. Health Outcomes

Alcohol & Drug Usage

A health choice that youth often make is to abuse alcohol and drugs. There is rampant alcoholism and high rates of drug usage on the reservation, with many youth initiating this behavior at a young age, often in conjunction with the risky sexual behavior mentioned earlier (David, 2015; Noggle S., 2015; Speen, 2015). School administrator and former teacher, Stuart Noggle, stated the following when asked about his interactions with students in regards to alcohol:

> I've had students, my first year back, I'd ask them, hey what do you want to be when you graduate? And they would jokingly say, I want to be an *adlnee...adlnee* is Navajo for drunk, professional drunk, and I stopped asking that question my first year. –Stuart Noggle

He also claims that he has seen many of his students choose that lifestyle, making it even more evident that many issues on the reservation that seemingly only effect adults are starting to reach youth in ways that have long-term effects on them throughout their lives. By eighth grade, 36 percent of youth on the reservation have tried alcohol and by twelfth grade 64 percent have while in the greater US only about 30 percent of those underage have reported drinking alcohol in the past month (Curley, 2008; Department of Health Services, 2007). Alcohol related deaths are 17 times higher among Native Americans than the US majority population (Henson et al., 2008). Some school educators claim that drugs and alcohol are so easily accessible now and alcoholism is socially acceptable, so there is no deterrent to using them (Goodheart, 2015).

It can take the Navajo police force up to four hours to respond to a call, so if someone is caught with alcohol or drugs at school, teachers do not always go through the hassle to call them, so there are few consequences for students (Speen, 2015). Living with large extended families and youth's lack of respect have ramifications for drug usage as well, as youths often use their grandparent's prescription drugs, an emerging problem on the reservation (Speen, 2015). Because there are no consequences within the education system or within the family, youths are deterred by neither the education system nor society to refrain from drugs and alcohol. Additionally, respondents said that their lack of cultural identity and subsequent confusion might even encourage them to participate to mentally escape their situation.

These issues continue to compound to adulthood. There is often no hope for people, no job market, no economy, and transient working conditions at best (Noggle S., 2015; Lee, 2015; Begay-Piechowski, 2015). The historically grounded lack of economic opportunity that came out of forced relocation has contributed to stressors and internalized aggression and oppression, so people then likely drink to escape (Lee, 2015). As mentioned earlier, unemployment is incredibly high, at an estimated 54 percent, and income per capita ranges from $6,500-$14,600 by community, which is half of the Arizona and US average (Clichee, 2013). While only one-fifth of the population has access to alcohol by geography (selling alcohol is illegal on the reservation), bootlegging is rampant and the legal consequences are low, with prison sentences for bootlegging being as low as eight hours (Clichee, 2013). This bootlegging is evident as Navajo Nation is the number one county for alcohol expenditures in the state of Arizona but very few people actually live on the border towns that have liquor stores (Clichee, 2013). These high rates of alcoholism then contribute to further poverty and unemployment, domestic violence,

assault, and poor behavior, which only perpetuate the cycle of alcoholism, so there is little incentive to quit (Clichee, 2013).

Even if there were incentive to quit, there is little opportunity to do so. There are few treatment centers for alcoholism and few alcohol education programs.[43] David says that when patients come to the emergency room for alcohol related issues, doctors rehydrate them and send them on their way, not asking more about why they are drinking or referring them to a program (David, 2015). The primary reasons people do go to behavioral health centers are for court and state mandated programs (Lee, 2015). There are few programs available and existing programs are in centralized locations and are often perceived to be for intensive psychological issues, not for people with drinking problems. The significance of alcoholism is thus drastically underplayed in the formal healthcare system.

These issues involving healthcare are problematic, but likely originally stem partially from peoples' history, isolation, and other long run issues. If people are destitute and continually drink, there is little reason for doctors to think that alcoholism is out of the ordinary and are more likely to dismiss it. Additionally, respondents said that alcoholism remains a taboo topic for many traditional Navajo, so there is no open talk of alcoholism in families and treatment centers often do not offer family therapy (Jim, 2015). Thus, alcoholism becomes incredibly individualized and treatment often blames the victim, which reduces the issue to the individual, the exact opposite of what should be done.[44,45]

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[43] This lack of alcohol education compounds with high rates of teen pregnancy (an issue discussed earlier) to present a larger issue. In Navajo Nation 2.3 percent of pregnant women drink as opposed to 0.9 percent of US women, but 3.8 percent of pregnant women in Navajo Nation drink under the age of 18, thus emphasizing the lack of health education programming in both the school and healthcare systems (Roubideaux, 2003).

[44] This distinction between individualized care versus community care is important to keep in mind throughout this chapter and will be discussed in full later (Noggle, 2015).

Nutrition

Nutrition is another health outcome that seemingly comes from behavioral choice but that must be understood in an institutional context. When the government began providing commodity foods to the reservation, making other foods relatively more expensive, people's diets started to deteriorate (Jim, 2015). Traditional food served as both a diet and a lifestyle based on food production, which provided a strong foundation for people's health (Byers & Hubbard, 1997). Traditional meals that incorporated vegetables and homegrown ingredients have become far less common and modern commodity foods and fast food have become the norm, as Jim describes:

> ...Those canned goods come in commodity where the government brings nonperishable...food, and my people started to depend on that...so why do I need to tend to my cornfields? ...The body is becoming weak, the body is becoming vulnerable...it has a lot to do with physical and mental, you have that satisfaction that you got the corn, you prepared it for yourself and your family...it makes you feel good and strong...so it all comes down to where everything is at the ready made...and we have become lazy, our physical has become lazy, our mental and our spirit became lazy. -Harrison Jim

Many, including Jim, say that big food industry takes advantage of the reservation. In fact, the Wal-Mart in Gallup, New Mexico, about 50 minutes from the reservation, is the highest producing Wal-Mart in the US for sodas with the average person on the reservation consuming 1.6 sodas per day (Noggle S., 2015; Begay-Piechowski, 2015; Clichee, 2013). There are 113 fast

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[45] Another critical component of Westernized care that does not align with traditional Navajo views is the focus on the individual, as the Navajo typically separate the individual less from the family and community than Westerners do (Dinges et al., 1974). While I do not have time to expand upon this point, it is important to keep in mind that there are problems specifically tied to Western individual-based patient care.

food restaurants per 100,000 people on the reservation as compared to 70 per 100,000 in the US (Clichee, 2013). There is little incentive for people to grow their own nutritious food or buy healthy food when it is cheaper to go to the grocery store and buy processed food (Clichee, 2013).

This problem becomes even more complex when taking into account issues of transportation and isolation. Many people have to drive between one and two hours to a grocery store, so they often buy processed food in bulk that will last multiple weeks and have long shelf lives (Clichee, 2013). Most Supplemental Nutrition Assistance Program (SNAP) recipients spend their benefits at convenience stores, as all communities live within a ten minute drive of one but very few live within even 45 minutes of a full grocery store (David, 2015; Clichee, 2013).

Like many other health issues on the reservation, poor nutrition starts at a young age. School breakfast and lunch programs do not emphasize healthy eating and almost the entire student population is on free or reduced lunch services, so there is ample opportunity for the school to incentivize healthy eating (Hute, 2015). While a healthy meal choice is offered in the school systems, kids are always given a choice for pizza, which they choose (Noggle S., 2015). CHRs say that teens are often sitting on the couch during home visits drinking energy drinks, which are included in SNAP and likely contribute to poor health (Morgan, 2015; Clichee, 2013).

In recent years, teachers have seen the biggest health concerns for young students transition from poor dental care to obesity and type two diabetes, which was previously considered to be a chronic condition found only in adults (Noggle I., 2015).[46] 39 percent of Navajo Nation is

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[46] To be clear, dental care has not improved on the reservation, with providers claiming that access to dental care is still a large issue (Glasses, 2015). Rather, obesity and diabetes rates have increased so much that they tend to overshadow the Navajo's lack of dental care.

considered overweight while 33 percent are obese, approximately 7 percent higher than the US

population (Clichee, 2013).

Physical Fitness

In conjunction with poor nutrition, many people have low levels of physical fitness and there

are high levels of vitamin D deficiency, largely a result of lack of sunlight exposure (Glasses,

2015). In schools, less than 30 percent of kids have daily physical education classes and only 34

percent meet the recommended amount of physical exercise (Navajo County, 2003).[47] Noggle

has seen that this lack of exercise at a young age has become an issue in recent decades:

> When a teacher in school would say, 'do you want to go to the gym and play basketball
>
> today,' we were like 'yeah, let's go for it,' and when I tried that as a teacher...the kids
>
> wanted to play on their phone, play on their computer, whatever, they just wanted to sit...
>
> I'm just wondering where that shift has come from, our students are so sedentary and
>
> uninterested in doing things that kids normally do out here. -Stuart Noggle

There is little focus on going outside for kids and there are few wellness centers or programs in

the area. There are no recreation or fitness facilities on the reservation for a population of

300,000 and there is one wellness center in Window Rock, which most do not have access to due

to transportation and cost barriers (David, 2015; Clichee, 2013). There are some playgrounds

near public housing facilities, but they are often dangerous and are frequented by dogs, snakes,

gangs, and drunks (Clichee, 2013). Many kids, when asked if they want to go outside or play

basketball, would rather sit and play videogames (Noggle S., 2015). Thirty percent of females

say they have no daily physical activity and 24 percent of males do not, and both genders

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[47] According to the Center for Disease Control, children and adolescents needs one hour or more
of physical activity per day, which is what I use to define the recommended level of physical
activity (Centers for Disease Control and Prevention, 2015).

average over two hours a day in front of a screen (Clichee, 2013). A CHR says that when she does home visits and students are home, they're always playing videogames or watching TV (Morgan, 2015).

From the outset, it may seem counterintuitive that people say they want to engage in physical activity in survey data because physical health behaviors are poor (Clichee, 2013). But, when looking deeper, it becomes evident that how people are situated (i.e., not being physically active) is relative to their institutional environment and the larger opportunities surrounding them. When people live in a physically isolated environment away from modern wellness facilities or other venues for exercise, there are few opportunities to be active.

Mental & Behavioral Health

The largest area of contention for health outcomes is likely mental health, where chronic stress and depression are highly prevalent (Rickmann et al., 2004). There is poor communication between doctors and behavioral health practitioners at the same hospital, there are incredibly long waits at behavioral health centers, and there is a large misunderstanding of behavioral and mental health in general (Lee, 2015). Lee states the following when asked about this type of health and its treatment in a formal medical setting:

> Medical people tend to ignore the behavioral health part because...it's kind of like a scary thing. We get called to the emergency room and as soon as somebody starts becoming agitated or anxiety or depression...it becomes [my] patient...I can't understand them with an elevated alcohol level just like [the medical doctors] can't. I think it's totally just a misconception about behavioral health and mental health professionals, that we can fix anything, you know. -Samantha Lee

Western doctors thus do not fully understand that behavioral and mental health issues are something that cannot be solved easily with standard Western care. Western doctors often see mental health issues as psychiatric problems rather than spiritual or emotional imbalances, so patients are not responsive to services (Noggle, S., 2015; Jim, 2015). When Jim began working at Fort Defiance Indian Hospital, the first thing he did was rename the 'adolescent psychiatric care unit' the 'house of hope for adolescents,' which got doctors to stop calling it 'the loony bin' and got patients to be receptive to the services offered (Jim, 2015). By altering the framework of mental health to be emotional health rather than a disorder, people stopped neglecting this component, which had been hugely detrimental (Begay-Piechowski, 2015; Jim, 2015).

Once people started acknowledging emotional and mental health, it became readily apparent that many issues were overlooked by the formal healthcare system. Many neglect the importance of traumatic issues and the grief and shame that occurred both historically and early in peoples' lives (Lee, 2015). Behavioral health counselors say that diagnosed mental illnesses remain very low on the reservation due to lack of services and because many do not want to be treated and have families that accept peoples' mental disabilities and don't seek treatment (Lee, 2015). There are many stressors on the reservation creating emotional disabilities that were often ignored by the US government that date back to historical issues of dispossession, impoverishment, and denial of Navajo identity (Begay-Piechowski, 2015; Henson et al., 2008). Historically, the survivors-child complex comes into play, which is often manifested in anxiety, depression, guilt, and self-isolation that requires community wide healing to address (Heart & DeBruyn, 1998). Additionally, strong family ties often lead to people remaining in depressive

states of grief long after losing loved ones.[48] Now that these issues are recognized, the Navajo

are beginning to realize that their shared history is not simply historical, but that it requires

ongoing group survival in the realm of mental health (Coleman, 2015).

One large emotional health issue related to shame is domestic violence (Lee, 2015). Most

women report verbal and physical violence with sexual violence only being reported if other

forms of violence were reported as well (Fairchild et al., 1998). People do not often admit to

being in an abusive relationship and multiple interviewees said that they knew women currently

in abusive relationships that believe the violence is normal (Hute, 2015). Lee states "[her

behavioral health center] also [has] a domestic violence class for survivors, [the teacher] gets no

patients for the survivor class. For my domestic violence class for angry individuals, those

people are court ordered, they're here every week, my class fills up." So, most domestic violence

relationships are ongoing and are only acknowledged if legal issues arise. Many partners and in-

laws also encourage reconciliation after violence occurs, which further normalizes it and makes

it too shameful to admit to (Hamby, 2004). The shame is experienced by the perpetrator too, as

Lee says that perpetrators often become angry precisely because they do not want to talk about

their shame (Lee, 2015). Thus, there is an insufficient perception of mental health and wellbeing

and there are not enough facilities to address the concerns that people have acknowledged on the

reservation.

In close, people suffer from poor health comes across health sectors and the cause cannot

be pinpointed to any particular issue. When health issues look like they come from peoples'

choices (i.e., alcoholism), they likely come from formal healthcare institutions inadequately

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[48] Due to high rates of alcoholism, homicide, and suicide, the Navajo are just more likely than
others to experience many losses of loved ones throughout their life (Heart & DeBruyn, 1998).
One doctor recently saw a depressed patient that lost his brother 15 years ago who has never
gotten mental health treatment (David, 2015).

addressing peoples' mental health issues, which are often the consequence of historical issues. Sometimes, the pathway is not even that simple. While it is not possible to fully parse out causality, it is important to understand how complex the relationship is between the Navajo's health and its many influences to truly appreciate how nuanced health among the Navajo is.

J. Implications

The health outcomes of Navajo people are clearly affected by many factors. Their health is attributable to historical and present day geographic and ethnic isolation and the power dynamic between the US federal government and the Navajo people. This power differential permeates all of society including within healthcare institutions, as the Navajo have little to no power. Importantly, the Navajo often see their lack of power in healthcare decisions and respond accordingly (i.e., by practicing traditional medicine rather than Western medicine and coping with behavioral and mental health issues on their own with alcohol). While it is not clear how to better the health and the overall wellbeing of the Navajo residing on Navajo Nation, it is important to continually draw out how the Navajo interact with the federal government in healthcare institutions and in other formal institutions as well. Doing so allows me and others to understand how the situation on the reservation formed and is continually reproduced today.

IV.   <u>Romania</u>

<u>A. The Social Structure of the Roma in Romania</u>

In Romania, the Roma are a distinct, marginalized ethnic group that officially number 600,000, three percent of the population, but likely breach two million, over nine percent of the population (The World Factbook, 2015; WHO, 2013). Many Roma do not identify as such due to ensuing discrimination and many others do not have necessary paperwork (because they are a stateless people) and are not registered with the government, making the Roma incredibly difficult to identify. Their ethnic identity is a source of much discrimination throughout Europe, specifically in Romania, where their population is the highest and where there are many predominantly Roma towns throughout the country, making them very spatially isolated.

In fact, Romania could not join the EU until 2007 largely due to its human rights violations against the Roma (Rat, 2014). The legal solutions that have come since to benefit the Roma in order to allow Romania's entrance into the EU have not all been met with practical change. For example, Romania's strategy for including the Roma has been largely ineffective and Romania's programs funded through the EU have been suspended because the Romanian government did not make its payments (Economist, 2012).

In fact, the Roma may be the most severely marginalized of my three cases (as opposed to Ghanaians and the Navajo) in the sense that they are not legally spatially separated from society (meaning that they do not have their own institutions as the Navajo do) but they are also not integrated into society at large (as Ghanaians largely are). Their informal and often unrecognized isolation is something that I attempt to draw out throughout this chapter, as it likely compounds the effect that discrimination (both within and outside of the healthcare system) has on the Roma.

History & Nation-States

While the Roma have a distinctive history, many are unaware of their slavery past, as the communist leader, Nicolae Ceauşescu, disposed of their history as a myth by claiming that the Roma had always been treated as equal to other Romanians (Fonseca, 2011). The Roma are originally from Northern India and arrived in Eastern Europe in what is now Romania by the 11th century (Crowe, 1996). Since their arrival, they have been a diverse and nomadic group without unified leadership (Lee). Most were free until the Ottoman Empire gained power and the Protestant Reformation took place, at which point they became slaves (Crowe, 1996). There are conflicting theories as to the history of their slavery, as some believe they were originally slaves in India, others claim they were only slaves beginning in the 14th century, and others claim that even in the 14th century they were filling a void in social structure and were part of the working class (Fonseca, 2011; Lee; Crowe, 1996).

Notwithstanding the debate of their origins, the Roma experienced much intolerance in Europe beginning in the 16th century when nationalistic nation-states formed because the Roma were not indigenous to any of these states (Hajioff & McKee, 2000). They were systematically excluded from citizenship where states had drawn ethnically exclusionary boundaries and were seen as an undesirable social group (Hajioff & McKee, 2000; Lee). During the 18th century, the Ottoman Empire regained its earlier power and defeated the Hungarians, so Transylvania, where modern-day Romania is located, fell under Ottoman control (Crowe, 1996). During this time, some of the Roma were seen as spies to the Ottomans, which further restricted their lifestyle and trading opportunities that had already been restricted due to their marginalization, and they were

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forced to become nomadic, thus removing any hope of them integrating into society (Crowe, 1996).[49]

Russia's entry into this region provided some impetus for change as all peasants were emancipated in 1864 and there was no longer pressure from the Ottoman Empire to be nomadic (Crowe, 1996; Lee). However, the Roma remained deeply impoverished social outcasts, lived in isolated areas, and were often not granted land along with their freedom (Crowe, 1996; Glajar, 2011; Lee). Additionally, for the next few decades, the Roma did not gain citizenship or inclusion within the nation-states in which they resided and without any international oversight, the Roma remained isolated from each society in which they lived.

The World Wars & The Communist State

With the World Wars came international oversight from outside of Eastern Europe that forced Romania and neighboring governments to recognize the Roma's rights, including the right to health. For instance, after World War I, the Paris Minorities Treaty of 1919 forced Bucharest to recognize the rights of postwar minorities (Crowe, 1996). However, the Romanian constitution neither guaranteed nor enforced Roma rights, so these international mandates had little practical effect. During the inter-war period, Roma life varied greatly by region and by year. In 1928 the Liberal Party saw more gains for the Roma but the 1929 depression was, as previously described, followed by a nationalistic period that oppressed the Roma because they were not considered to be native to Romania (The World Bank Group, 2014). Thus, there was not a sustained period of an adequate level of Roma rights that would have allowed for human capital accumulation, and their situation soon worsened further.

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[49] Nomadic groups typically have low access to healthcare, lack health information, and have poor maternal and child health (MCH) indicators, so the Roma's forced nomadic state is of critical importance (Sheik-Mohamed & Velema, 1999).

Romania entered the Third Reich by 1940 and was ruled by military authoritarianism

through fascist rule (Crowe, 1996). When Adolf Hitler prepared to attack the Soviet Union, he

needed a stable ally in the East, so he became greatly invested in Romania. The Nazi state

imposed harsh policies against the Roma and began removing the Roma from Romania as the

Nazis removed the Jews from Germany (Crowe, 1996). Between 25,000-36,000 Roma were sent

to camps in Transdneister in an effort to maintain a nationally ethnic Romanian population and

government that was not populated by 'outsiders' (e.g., the Roma) (Glajar, 2011).

In 1947, the Allied-Romanian peace treaty was signed, which ended World War II in

Bucharest and offered modest protection against discrimination for minorities (Crowe, 1996).

Directly after, the People's Republic, run by the Romanian Workers' Party, came to power. The

communist state in Romania, which began in 1947, was initially sensitive to Roma mistreatment

and some even say it was a Roma cultural-political renaissance (Crowe, 1996). But sensitivity

quickly turned into forced conformity and the Roma were coerced into adopting Romanian

language, customs, and lifestyles, meaning that their ethnic difference was largely ignored and

seemingly integration-based policies became largely ineffective (Lee). For instance, the

government took Roma people's horses and wagons and forced them to settle on the edge of

villages instead of in the countryside (Lee). So, they were forced to at least partially assimilate to

the working class, which robbed them of their livelihoods and was largely detrimental. Many

Romanians thus wrongly assumed that assimilation rids discrimination, and well-intended

welfare programs (i.e., moving the Roma into villages) imposed a culture of dependency by

forcing assimilation and a loss of the Roma's identity (Glajar, 2011; Fonseca, 2011; Lee). The

Roma thus suffered from a lack of recognition during this time by larger society ignoring their

ethnic difference, which, rather than helping to integrate the Roma, only further marginalized them.

In 1965, Nicolae Ceaușescu came to power and harshly discouraged ethnic identities in an effort to promote the ethnically homogenous Romanian state, thus further ignoring Roma differences (Crowe, 1996). For example, each geographical zone was given an industry or agricultural product that the government saw as fitting, which reinforced attempts to deal with the Roma as the state saw fit (i.e., forcing them to work in manufacturing rather than farming) and furthered their dependency on the state (Fonseca, 2011). Ceaușescu blamed the Roma's marginalization on the pre-communist governments, claiming that his regime allowed them to integrate into greater society by giving them jobs within their respective geographic zones (Crowe, 1996). However, by 1977, 48 percent of Roma women remained unemployed and 32 percent of Roma men did, which was much larger than Romanian's unemployment overall (Crowe, 1996). Thus, the communist regime was not effective at fully integrating the Roma into society, but because they were legally treated the same as other Romanians, the Ceaușescu regime continued to ignore their unique situation.

There were few state-run development projects for the Roma during this time and most were seen only as a quick fix that did not target long-lasting resentment or prejudices (Crowe, 1996). For instance, the Propaganda Section of the Central Committee gave Roma land and other physical assets, encouraged their participation in the labor force, and encouraged them to attend school and healthcare appointments, and different ministries then worked with local and county officials to ensure attendance (Crowe, 1996). However, none of these programs looked at Roma people's health behaviors, schooling preferences, traditional employment choices, and more, so they were not culturally appropriate for the Roma. So, for many, their situations did not improve

and when an economic downturn came in the late 1980's, the Roma were hit even harder than the majority population and many were forced to find illegal ways to survive (The World Bank Group, 2014). The Roma thus had little power in Romania during this time and were forced to accept the treatment that the Romanian government said they should receive, which was often unsuitable for them.

The Post-Communist State

The Romanian people overthrew Ceaușescu's communist regime in the December revolution in 1989. After this revolution, Romania instituted a semi-presidential republic that proclaimed democratic freedoms to all, including rights for all national minorities (Crowe, 1996). The Roma supported this notion until they created their own groups, such as the Democratic Union of the Romanies in Romania (DURR). They began writing Romani publications, producing television stations, conducting translations, and increasing their cultural presence, among other services (Crowe, 1996, Fonseca, 2011).

However, with this increase in freedom also came an increase in violent nationalism and the Roma experienced resurgent discrimination (i.e., unfair medical treatment) (Oocities, 1998; Crowe, 1996). Because of this, they began selling goods outside of the formal economy, but communism had looked down on personal initiative, and people still reacted to this, which sparked further violence against them (Fonseca, 2011). While the situation for most improved after communism, it likely declined for the Roma because they no longer received state benefits. Thus, while their ethnic difference had been ignored during communism, it was now addressed too attentively, with the Roma experiencing much blatant discrimination and violence.

There were many serious attacks on Roma settlements, mostly in rural areas, where children were burned, beaten, murdered, and maimed (Fonseca, 2011). In addition to the Roma's

informal discrimination largely being ignored by the public eye is the harsh brutality that they experience by police forces, which includes torture of the Roma and mistreatment of detainees, violent police raids, racial intimidation and harassment involving the illegal use of weapons that often cause death (Toma, 2014). As both informal and police attacks became more common, the press stopped covering them, so many did not know it was happening (Fonseca, 2011). In 1991, the International Labor Organization (ILO) declared Romania an area of continuing ethnic violence, and Romania experienced a massive emigration of the Roma out of Romania (Crowe, 1996). However, only .02 percent of Roma that apply for asylum are accepted, and Romania has historically refused to take these Roma back, so Germany began paying Romania to take back the Roma coming from Romania (Fonseca, 2011). When Romania was inducted into the Council of Europe in 1993, the Romanian government claimed that attacks on Roma had no ethnic considerations (Fonseca, 2011). So, not only do the Roma continue to experience violence, the violence exhibited towards them has gone unrecognized by the government as targeted ethnically based violence (Fonseca, 2011). In fact, former Romanian President Traian Basescu gave the first apology to the Roma in Romania in 2007 when he apologized for Romania having sent the Roma to World War II death camps, thus only acknowledging Romanian's past discrimination towards the Roma and ignoring the discrimination and violence they still face (Reuters, 2007).

C. Problems & Policies in Contemporary Romania

Domestic & International Efforts

Lack of documentation remains a large problem for the Roma in receiving many social and public services (i.e., non-contributory health insurance), and the government has no incentive to correct for the problem (Fonseca, 2011). The government has initiated broad ordinances, mostly due to outside pressure, including national plans to combat discrimination,

national Roma action plans, and the national strategy for improving the situation of the Roma (Danova-Russinova, 2006). These efforts consist of vague statements, do not address funding mechanisms, and often do not acknowledge discrimination in certain public sectors (e.g., education) (Danova-Russinova, 2006). Many strategies claim they will work on behalf of the Roma by collaborating with Roma leaders and with NGO's, but they have not followed through. Additionally, mandates that could potentially benefit the Roma, such as the national plan for equality between men and women, are not catered to the Roma. So, these mandates have little effect on them, as the Roma likely need these national plans to be catered to their situation to be effective (Danova-Russinova, 2006).

As Romania began to try to gain entrance into the European Union (EU), it was forced to create an ordinance for preventing and punishing all forms of discrimination (Danova-Russinova, 2006). However, this was only targeted at individuals, not communities, and has had little effect. Romania has produced mostly Band-Aid solutions to improve their chances of entering the EU, which are based on not persecuting national minorities (meaning that they only have a negative responsibility to do no harm to them rather than a positive responsibility to better their situation) (Lee).

International action, as I stated before, has attempted to curb the Roma's vast marginalization, but it is often not specific enough. EU directives for racial equality, employment equality, the Commission Against Racism and Intolerance, and the Convention for the Elimination of All Forms of Discrimination Against Women are not targeted to the Roma specifically (Danova-Russinova, 2006; Danova-Russinova, 2006). Additionally, the Geneva Convention protects stateless people but the Roma are no longer considered stateless even if they are not recognized as citizens in Romania (Fonseca, 2011). International efforts are informed by

the Romanian government's reports but Romanian representatives often downplay discrimination. So, international reports that go to the country often state vast discrimination in education, law enforcement, court systems, housing and society, health, employment, and more that the government largely ignored (Danova-Russinova, 2006).

Nongovernmental Efforts

Over time, Roma community leaders and NGOs have become more involved, as a national network of local Roma experts serve as a mechanism through which to support vulnerable groups. There has also been increased transnational, regional, and international cooperation. However, only 14 percent of the Roma (26 percent in rural and 7 percent in urban) say they have benefited from EU, WorldBank, or other NGO or donor groups (Surdu & Surdu, 2006). Additionally, these groups often operate separate from formal institutions, meaning that they are unable to address the root causes of the problems faced by the Roma. For example, health-related NGOs can provide stigma-free care to the Roma, but they cannot often alter how the Roma are treated within the formal system, which the Roma cannot always avoid. Roma groups continue to report no change in the Romanian government's attitude towards the Roma, no change in living environments, continued inadequate accommodation if evicted from settlements, discriminatory social aid, segregated education, and more (Danova-Russinova, 2006).

The Roma have experienced vastly different treatment from formal government structures as the Romanian government has changed. For example, before the communist state, the Roma were deliberately discriminated against, during the communist state the Roma's ethnic difference was ignored and they were forced to assimilate, and after the communist state the Roma were once against discriminated against but often in such a way that goes unaddressed by

formal government. Additionally, while they remain a marginalized ethnic minority, their spatial distribution throughout Romania continues to shift. Originally nomadic, they were forced to move to the edges of cities as an assimilation tactic and are now dispersed in shantytowns on the edges of cities, in rural villages, and in the countryside. Their ever-changing treatment both ethnically and geographically likely contributes to the way in which they interact with the formal healthcare system, which I turn to next.

D. Health Among the Roma in Romania

The Roma's historical and modern-day discrimination contributes to many current issues for the Roma ranging from low education levels to their high involvement with rural agriculture rather than a modern sector economy to their geographic isolation to poor health outcomes (Greenberg, 2010; Nicoara, 2011). I focus specifically on the Roma's health because exploring their health allows me to get at both institutional (e.g., issues stemming from the health system) and behavioral (e.g., issues stemming from peoples' choices) issues in ways that other sectors do not. Within health, I look specifically at maternal and child health (MCH) because it opens up to me a demographic (i.e., pregnant women), who are the most marginalized Roma (e.g., they experience multiple levels of poor power dynamics) because their ethnically induced inequality is reinforced by gender-specific structures that further limit Roma women's opportunities to enjoy adequate standards of health (Danova-Russinova, 2006; WHO, 2013). The Roma's discrimination and social exclusion thus intersects race, gender, and spatial related issues in unique ways that I now explore (WHO, 2013).

By utilizing qualitative analysis and interviews conducted in Romania with healthcare providers over April of 2014, this chapter explores how power dynamics in modern day healthcare institutions interact with the Roma's distinctive ethnicity and spatial isolation in

Romania. By integrating interviews with doctors and public health researchers in Romania with national and international documents, I am able to see how these mechanisms (e.g., the relationship between healthcare, ethnicity, and geographic isolation) are operative on both a national and local scale. Additionally, by drawing on data from a prenatal survey conducted in Romania on an individual level, "Advancing Maternal and Child Health in Romania: an integrated assessment of the determinants of pregnancy outcomes" (the MAIA study), I am able to further assess how Roma women's health choices compare to those of non-Roma women in Romania, thus further drawing out the ways in which the Roma's health differs from that of the majority.

Roma women's discrimination by race, class, and gender is inextricably tied to their health, which I first show by presenting the health issues and health status of Roma women in Romania. Few studies split up the health of the Roma by gender, which is something this study expands on through using the MAIA data, but I first provide background here on Roma health as opposed to non-Roma health for both genders.

Importantly, the Roma in Romania have worse health outcomes than the Roma in Hungary or Bulgaria, two comparable Eastern European countries in which the Roma officially number between three and five percent of the population (Masseria et al., 2010). In a recent study, 47 percent of Roma women in Romania that were sampled evaluated their own health condition as poor (WHO, 2013). Many of these women had issues ranging from hypertension to diabetes at much higher rates than the majority population (WHO, 2013). They have a higher rate for other chronic conditions as well and are more likely to have illnesses stemming from unhygienic living conditions than other Romanians (Masseria et al., 2010).

In regards to MCH, one gynecologist, Dr. Claudiu Marginean, says that Roma women have premature births much more often than other women, likely because they start having children at a younger age and have more children as well (Marginean, 2014). In his experience, Roma women typically have three or four kids while Romanian and other minority women typically have one or two (Marginean, 2014).[50] He says that the Roma also start having kids much earlier, around ages 12-15, while Romanian women at large start having kids at age 24 (Marginean, 2014; WHO, 2013). While most Roma women in Romania have heard of contraceptive methods, many use abortion as their primary form of contraception with 78 percent of women having had an abortion and most women having at least two (WHO, 2013).[51]

Roma women's health behaviors are different from the rest of the population as well with the Roma women generally having poorer diets and smoking more (Vivian & Dundes, 2004). This is especially important for MCH, as the Roma have over five times the odds of continuing their smoking during pregnancy than non-Roma women (Meghea et al., 2012).

Roma women report that they are highly discriminated against in the formal healthcare system with 71 percent of Roma women sampled in a WHO study claiming that medical staff have discriminated against them based on their ethnicity and many also claim that medical staff have disregarded their traditional views on health (WHO, 2013). Reports by the World Health Organization (WHO) state that the Roma are more likely to experience discrimination in the healthcare system than their counterparts and that doctors use discretionary practices against

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[50] The other predominant ethnic minorities in Romania are Hungarian, German, and Ukrainian, all of whom have demographic characteristics more similar to Romanians than the Roma (The World Factbook, 2015).

[51] During communism, abortion and all forms of contraception were outlawed, which likely largely attributes to the high rate of abortions today throughout the country (Stephenson et al., 1992). Rates may be especially high among the Roma due to their lack of access to healthcare institutions and modern contraception, which I discuss later.

them (WHO, 2013). This discrimination may encourage Roma women not to go to a healthcare provider when necessary, which further contributes to their poor health. The stark divide between medical providers and Roma patients then likely increases tensions between the Roma's traditional views and more Westernized views of both health and family roles within healthcare (Zeman et al., 2003). For example, the Roma have distinctive views on surgery (e.g., avoiding it when possible) and the source of disease, which do not always align with Western care (Vivian & Dundes, 2004). Additionally, they typically rely much more on their family for health guidance and supervision than the majority population, which medical providers do not often fully appreciate or understand (Vivian & Dundes, 2004).

Thus, Roma women's health issues are many and nuanced and are inextricably tied to their systemic lack of power to make decisions within the healthcare system. While the Romanian government has, in recent years, removed legal barriers to the Roma's advancement, including health, it has been minimally proactive at best and has often ignored the Roma, only perpetuating the Roma's inferior health status. I now outline the historical marginalization the Roma experienced and continue to suffer from, Roma women's interactions with the health system, and the health related choices that Roma women must make in order to better understand the nuanced relationship between these factors.

E. The Historical and Legal Framework for the Roma in Romania

Formal Frameworks

First, I recall the historical and structural features that I expanded upon the previous section, as healthcare systems often need to be seen against the backdrop of historical trajectories in order to fully understand why and how they operate the way that they do. Because the Roma were originally migratory they have always been a minority in Romania, often leading to their

marginalization (Hajioff & McKee, 2000). Dating back to the Austro-Hungarian Empire in the Transylvania region of Romania, the Roma were made inferior to the majority population because they were nomadic and were not seen as part of a particular nation-state (Rat, 2014). They are commonly referred to as Gypsies, a derogatory term that became popularized by the Nazis and is still the most commonly used label for this group (Rat, 2014).

During Romania's communist regime, it seemed that the Roma's condition actually improved as the government ostensibly provided all people with jobs, homes, etc. Roma poverty rates were very low during this time. In 1988, about 16 percent of Roma were very poor and 13 percent were poor, but by 2000 over half of Roma were very poor and another 23 percent were poor (Ladanyi & Szelenyi, 2002). However, as the Roma's situation was improving (according to statistics) during communism, Ceaușescu wanted a purely Romanian state without any minorities, so the Roma experienced ethnic genocide and authorities tried to strip away their ethnic identity and traditional practices (Lee). With this loss of identity, they became much more dependent on the state's provisions, which had devastating ramifications after the communist regime fell in 1989.

Since the fall of communism the Romanian government has stopped providing services equally for the Roma and has taken mostly passive action, removing legal barriers for the Roma's advancement rather than addressing their needs proactively. For example, the decade of Roma inclusion in Romania removed many legal barriers but was met with poor national enforcement (Danova-Russinova, 2006). Additionally, while there have been legal changes in regards to the Roma, there have been no legal changes for Roma women specifically, which I previously mentioned suffer from more marginalization than men. There is a lack of understanding about the notion of multiple forms of discrimination, so policy makers may

misunderstand that the Roma suffer from ethnic, social, and class discrimination in policy initiatives, which likely have compounded effects (WHO, 2013). There is also little political will in the Romanian government (e.g., the powerful) to take the positive action needed to better the Roma's situation and because there are no longer legal barriers to the Roma's advancement, the burden is largely placed on the Roma themselves (e.g., the powerless) to fix it (WHO, 2013).

Because the burden for Roma advancement has largely been placed on them (e.g., no one is acting to actively assist them) and because their discrimination continues today (e.g., people are acting actively to marginalize them), there is little opposition against further isolating and marginalizing the Roma. Since the fall of communism in 1989 Romania has failed to emphasize equality and many Roma have been exiled by city governments to shantytowns. In the city of Cluj specifically the Roma were moved between an old military fortress and a waste dump, where they began working once they lost their government jobs provided by the communist regime (Rat, 2014).

Informal Frameworks

The Roma often live with extended families, further isolating them from their surrounding areas. The Roma's physical and social isolation has indirectly contributed to their poor health, both mentally and emotionally. Their isolation has had direct negative health effects as well (e.g., chronic disease) due to poor environmental factors and poor hygiene (Rat, 2014). For example, the Roma often live in one or two bedroom houses and lack basic facilities, including electricity and running water (WHO, 2013). Because the Roma often live with extended family (who likely smoke, as the Roma smoke at much higher rates than the majority population) and live in poorly ventilated areas (thus heightening the consequences of SHS exposure), pregnant women then

have an even greater chance of being exposed to SHS than others and thus also have a greater risk for continuing to smoke during pregnancy (Meghea et al., 2012; Marginean, 2014).

Roma women's historic marginalization and current isolation is amplified by traditional practices and roles that do not align with Romanian society as a whole. The most applicable traditional practice for MCH is gender roles. In a recent study, 63 percent of Roma women in Romania said that they had fewer rights than Roma men did (WHO, 2013). Most of these women said that gender differences stem from both differences in the current social status between men and women and from traditional attitudes (WHO, 2013). First in regards to social status, Roma women are generally less educated than Roma men and 23 percent of Roma women have no formal education while only four percent of all Romanian women do not (Danova-Russinova, 2006; WHO, 2013). Additionally, Roma women, especially single mothers, tend to be economically worse off than Roma men (Danova-Russinova, 2006). Roma women's lack of education and income then causes healthcare costs to affect Roma women disproportionately compared to Roma men or other women in Romania, which increases the risk of them being excluded from healthcare, specifically MCH care (Danova-Russinova, 2006).

In regards to traditional gender roles, even when Roma women do receive care, patriarchal roles come into play in ways that harm women's health. A very high percentage of Roma women are married or have a partner, and while this is not initially indicative of a larger issue, the women said that they were often married because there is a large social stigma attached to having children out of wedlock and to losing one's virginity before marriage (WHO, 2013). So, women marry very early, often in their teens through arranged marriages (WHO, 2013; Timmerman, 2004). Roma women also claim to value their husband being sexually compatible with them and being the same age as them less than Romanians do (WHO, 2013). Because Roma women often

marry out of attached social stigmas against not doing so, Roma women often associate marriage and family with traditions and obligations rather than choice. As an example of the husband's superiority in these partnerships, Dr. Marginean has noticed that in his medical practice husbands rarely give up smoking during their wife's pregnancy even though the doctors say it is better for both mother and child for him to quit (Marginean, 2014). Thus, the wife's needs may be inferior to the husband's wants. These gender roles are then indicative of further power dynamics within Roma society, as Roma women are marginalized by men in addition to being marginalized by Romanian society as a whole.

Dr. Marginean says that ties to tradition are evident not only in romantic and gendered relationships but also between youth and elders. In his clinic, he sees that young women cannot stand up to older Roma women (Marginean, 2014). Many of the older Roma women refuse to see the problems associated with having children very young and with high fertility rates (i.e., premature birth, preeclampsia, fetal macrosomia) (Marginean, 2014; Salihu & Wilson et al., 2007). So, while younger Roma are beginning to see health issues to be associated with longstanding structures (i.e., marriage, high fertility rates), they often do not have the power to act against these structures, thus perpetuating the cycle.

F. Issues Involving the Healthcare System

MCH in Romania

Policies towards the Roma and tradition within Roma society in Romania largely contribute to how the modern day provision of public services functions for the Roma, but first it is important to spell out how these issues are related to service provision for all Romanian women. Gynecologists often take on a narrow role in MCH, with many seeing issues indirectly related to MCH as irrelevant. Dr. Magdelena Ciobanu, a pulmonologist that works with pregnant women,

says that this prevents pregnant women from asking for help during their pregnancy from their gynecologist, which causes women to take on a primarily passive role rather than an active one. Specifically, Dr. Ciobanu says that gynecologists are not involved in smoking cessation because they do not see it as part of their field although prenatal smoking is shown to lower birth weight, increase the risk for preterm birth, and result in long term health complications for both mother and child (Ciobanu, 2014; Bhatti, 2014; Been et al., 2014; Webb, 2013). Dr. Marginean says that there are no specific programs for Romanian women to quit smoking, much less pregnant ones and/or Roma (Marginean, 2014). So, many women continue to smoke during pregnancy, partially because service provision occurs in silos.

Providers are also uninvolved in mental health (Ciobanu, 2014). Dr. Alexandra Ciuntea, a psychologist in Romania, says that there is still a large misunderstanding towards mental health that is largely considered to encompass only serious mental illnesses, which stems from the mentally ill being confined to asylums during the communist regime (Ciuntea, 2014). This disregard for mental health is a large problem for pregnant women, specifically because prenatal stress, anxiety, and depression are very common, so women often do not receive the care that they need. With this context for MCH in Romania, I now turn to the situation of Roma women specifically.

MCH in Romania for Roma Women: Insurance

Dr. Christina Rat, a sociology professor, claims that Roma women get even less care from doctors than others, so they suffer from a multiple deprivation of health-related services (Rat, 2014). She claims that they suffer from both physical and monetary barriers as well as social and cultural ones, which are often combined (Rat, 2014).

To begin, the Roma experience a systemic barrier to healthcare access through a lack of health insurance coverage (Danova-Russinova, 2006). Romania has a National Health Insurance Fund (NHIF), meaning that they have a universal healthcare system (Vlădescu et al., 2008). In order to receive subsidized or free healthcare from the NHIF, people must be eligible for social assistance, which requires personal identity documents and approval by authority. The Roma often have no paperwork and are discriminated against by authority, as previously described, so they do not always receive the subsidized care that they are qualified for by their income (Danova-Russinova, 2006; Rat, 2014). Only 34 percent of the Roma population had registered with Romania's health insurance system after its first year whereas 75 percent of the population had (Danova-Russinova, 2006).

Without this insurance, the Roma must pay unnecessarily high costs for healthcare procedures (WHO, 2013). Compounding the issue of high costs, a lack of insurance, and discriminatory procedures, bribery is very common in the Romanian healthcare system, which Roma women often cannot afford to participate in, so the Roma are often redirected to other medical providers, who sometimes refuse to see them (WHO, 2013). Many providers set aside specific time slots for Roma women at the end of the day, so they may not be seen, and many maternity wards remain segregated by Roma and non-Roma, so they receive inferior care (Danova-Russinova, 2006; WHO, 2013). Seventy percent of Roma women in Romania say that the birth and maternity benefits that they should be provided from the state are inferior to the benefits they actually receive and half of Roma women have either never seen a gynecologist or have only seen one during pregnancy (WHO, 2013; Danova-Russinova, 2006). Additionally, providers often use derogatory language towards the Roma in consultations and strike Roma off their patient lists even when they have health care coverage on the grounds that they are dirty

and noisy (WHO, 2013). In sum, many Roma feel discriminated against by medical personnel and say that doctors seem uninterested in the Roma as patients, do not prescribe the cheapest drugs, and charge for services that are usually free (WHO, 2013).[52]

Partially because of their poor experience in formal healthcare settings (and also their rural location), the Roma often use the ambulance, which is free of charge (Rat, 2014). However, because the Roma often do this and it is not always for medical emergencies, the ambulance rarely comes, likely because providers think it is a false alarm. The European Roma Rights Centre (ERRC) recently published a report titled "Ambulance Not On The Way: The Disgrace of Healthcare for Roma in Europe," which begins with an account of a Croatian man calling emergency medical providers when his wife went in to labor (Danova-Russinova, 2006). They told him to put his wife in a wheelbarrow and wheel her to the medical center and when the providers arrived over an hour later, the child was stillborn (Danova-Russinova, 2006).[53]

MCH in Romania for Roma Women: Poor Resources

To improve the Roma's (specifically Roma women's) health in Romania, the government has implemented a health mediator program stationed in Roma communities throughout the country (Rat, 2014). The program caters to the Roma being predominantly in rural areas and being isolated from the formal healthcare system. The health mediators are trained Roma women, which specifically fits women's MCH needs. However, the program suffers from

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[52] The Roma often experience discrimination in other services as well. For example, a commune council in Romania decided that people with horses but not land (e.g., usually the Roma) use the horses to steal, so horse-owners are no longer allowed to receive social assistance (Danova-Russinova, 2006). The reason that the Roma do not have land is also often due to discriminatory processes, thus showing how multiplicative the issues stemming from the Roma's marginalization often are.

[53] I in no means attempt to generalize the situation of Roma women in Romania to other areas and/or countries. However, it is important that the Roma in surrounding Eastern European countries seem to treated similarly as those in Romania.

insufficient training modules and difficult working conditions, which largely lower the effectiveness of the program (WHO, 2013). Additionally, the program calls for one mediator per 500 Roma but the program currently has far fewer mediators and cannot find health mediators at the replacement rate (WHO, 2013). Additionally, the program is removed from the public health system, so it does nothing to address the larger issues mentioned earlier regarding the Roma's lack of healthcare insurance, their discrimination in the formal sector, and more (Danova-Russinova, 2006). Thus, the program is minimally effective at best.

MCH in Romania for Roma Women: Perceptions

Roma women understandably often view both the formal healthcare system and the health mediator program in a negative light, often relying on their informal community for medical care because they have more power within this community and it is familiar to them. Their reliance on this informal system is heightened by their traditional views, which healthcare workers often fail to understand. For example, in regards to traditional gender roles, Dr. Rat said that many Roma prefer to have a male gynecologist, likely reflecting more traditional gender views, which providers to not cater to, which then discourages Roma women from attending prenatal appointments (Rat, 2014). Also, the Roma often consider staying in the hospital other than for childbirth to be associated with death (Hajioff & McKee, 2000). However, the healthcare providers often do not understand these rationales and view the Roma's hesitancy towards hospitalization as being irresponsible (Hajioff & McKee, 2000). In sum, Dr. Rat claims that the Roma have come to distrust the medical system largely due to traditional practices, often involving gender issues, so they often do not want to go to healthcare professionals (Rat, 2014). There is then a mutual suspicion of providers towards Roma patients because they see them as

irresponsible and of the Roma toward their providers because the Roma see them as unfamiliar and as misunderstanding their situation.

G. Individual Choice

Descriptive Statistics

To further parse out the relationship between the power within formal healthcare institutions and the health of Roma women in Romania, I use a quantitative framework that measures Roma women's health behaviors at an individual level. As I said before, when the Roma do not go to formal healthcare institutions, providers perceive this as an individual choice, but when viewing their lack of attendance in light of their discrimination and marginalization, it is unclear what the cause of their behaviors are. While women's behaviors are clearly influenced by women's interaction with the health system, it is important to also look at health indicators that do not require a health system, as doing so can potentially isolate the effect of how healthcare institutions and their power structures effect Roma women's health behaviors beyond the formal system and/or how power structures outside of the healthcare system in greater society effect the Roma's health behaviors.

To look more closely at women's behavioral health choices, I use data from the MAIA project. This study was conducted as Babes-Bolyai University's Center for Health Policy and Public Health in Cluj, Romania in the Community and Behavioral Health department from 2012-2014 at five public hospitals. The MAIA questionnaire was given to pregnant women ages 18 and older and contains demographic and socioeconomic, pregnancy, mental health, and smoking indicators. Women's smoking behaviors are the primary variables that I use to assess women's health behaviors. The survey has over 1,300 observations but only 28 are Roma. While this

number is too small to do many statistical tests on, it is still helpful in explaining Roma women's health and demographics in reference to the overall Romanian population.

Using this data allows me to delve into women's health-related choices more directly than qualitative evidence alone does. Because the data only captures women that are 18 years and older, it misses many teen pregnancies, which make up approximately 10 percent of Romania's live births and are disproportionately Roma pregnancies (The World Bank Group, 2014). In a study in Bulgaria, over half the births ages 13-16 were Roma, which is highly disproportionate to the entire population (Hajioff & McKee, 2000). While I cannot make a statement concerning young teen births, it is interesting that even when excluding very young segments of the population, the Roma are still more likely to be younger mothers than other Romanians, so they may have kids for a longer time than their counterparts (Hajioff & McKee, 2000). While fewer Roma women are married than expected, almost all are married or with a partner (Table 1). When looking at the cross tabulations in Table 5, only one Roma woman is single and she is in the oldest age bracket while there are single women throughout age brackets for non-Roma women. Dr. Marginean says that the Roma typically have more kids than other Romanians, which the survey shows as well with almost half of Roma women having two or more children but only about 15 percent of the entire survey having two or more children (Table 2).

Of particular interest is that almost 75 percent of the survey wanted their pregnancy while less than 30 percent of the Roma did (Table 2). While prior studies have shown that most Roma women have heard of modern contraceptives, the most common form of contraception among the Roma is still abortion, with Roma women in Bulgaria reporting an average of over two abortions per woman, meaning that unwanted pregnancy estimates are likely skewed (Hajioff & McKee, 2000). Romanian women said that their high abortion rates tie back to traditional gender

roles because women are often the only caregivers in the family and when they feel that they cannot raise another child, they have an abortion (WHO, 2013).[54]

Measures of Roma women's mental health are of particular importance as well. Mental health is often not treated in a formal health setting because psychologists are uncommon and mental health is likely worse for the Roma than others. So, mental health is largely uncorrelated with a certain level of healthcare provision. Women's stress levels were evaluated using the Perceived Stress Scale (PSS), anxiety through the State-Trait Anxiety Inventory (STAI), depression through the Edinburgh Postnatal Depression Scale (EPDS-R), and social support through the Social Network Support Scale, which was modified from the Lubben Social Network Scale (LSNS-6). High and low levels of stress, anxiety, and social support are split according to the mean response level in the survey whereas depression is split using an established threshold for the Romanian context.[55] The Roma have higher levels of stress and anxiety than the majority population and the strongest relationship is among depression, with Roma women having high levels of depression over 35 percent more often than non-Roma women. Roma often have much lower levels of social support as well, with over 50 percent more Roma having low guidance, 25 percent more having low friendship, about 45 percent having low comfort and welfare, etc. (Table 4).

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[54] It is not clear as to why Roma women have abortion as opposed to using modern contraception. It may be that these methods are too expensive or that due to their low involvement in the formal healthcare system, they are unaware of them, but this topic is beyond the scope of this paper.

[55] Splitting mental health indicators at the mean level may seem irrelevant because half will be in either category. However, this distinction does allow me to compare Roma observations to the non-Roma's distribution, which is telling.

Health Behaviors

This quantifiable data is particularly useful for examining behavioral health choices for the Roma. Prenatal smoking is an important indicator because it neither directly requires a health facility nor indirectly requires one because Romanians that have quit smoking recently say that they did so on their own without advice from a medical practitioner (Irimie, 2013). While about 30 percent of the survey was a current smoker or recent quitter (as opposed to never having smoked or having quit over six months before their current pregnancy), over half of the Roma were (Table 3). Of these smokers in the whole survey, about half in the sample had reduced their smoking and the other half had recently quit. However, of recent Roma smokers, about 15 percent smoke the same amount as before, 65 percent of the Roma had reduced their smoking, and about 20 percent quit entirely. These high smoking rates among Roma women and their high continued smoking during pregnancy are often accompanied by large amounts of SHS exposure, as the Roma live with at least one smoker over 30 percent more than to the non-Roma women in the survey do, so they experience heightened direct and indirect health effects from smoking (Table 4). It is important that the health indicators operative outside of a formal setting (e.g., smoking) are worse for the Roma because that means their health is not solely the outcome of public healthcare provision. While this claim may seem obvious, it is important to look at how power outside of the formal healthcare system may be operative here.

H. Implications

I cannot draw any causal conclusions about why Roma health indicators that both require formal healthcare settings (which I looked at qualitatively) and that do not (which I looked at quantitatively through smoking) are worse than the majority population's indicators. However, it is important that Roma women's health both within and outside of formal healthcare is

fundamentally different from other Romanian women's health. Additionally, when I run chi-squared tests to ensure that the Roma and Roma women's health in the sample are fundamentally different from the non-Roma, I that they are different in a statistically significant way and that their differences are not due to random selection (Table 7). These differences likely point to how power dynamics both within formal healthcare institutions and in greater society effect Roma women's health and their everyday health behaviors, which are also compounded by the Roma's ethnic and spatial isolation and discrimination.

The case of Roma women's health is particularly telling because the Roma are marginalized to a great extent in Romania and remain both socially and physically isolated from greater society. However, by law they receive healthcare treatment equal to that of the majority population, likely making them the most marginalized of the three cases because their ethnic differences are largely ignored in formal, law-making settings, which serves to heighten the discrimination that they experience. Additionally, their marginalization likely permeates the formal and informal healthcare sector, other institutions, and larger society as a whole, thus worsening Roma women's health from all directions.

V.   Conclusions

Through using three distinctive case studies that each exhibit varying forms of ethnic marginalization and spatial dynamics, I find that the distribution of power in formal healthcare institutions is critically important for peoples' health. While each case study exists in its own context, each works to shed light on the larger question of if and how formal healthcare systems operate in ethnically divided societies.

Ghanaians are both ethnically and spatially stratified and in this case I find that changing the healthcare system alone does not necessarily significantly affect health. While this may mean that altering the way in which healthcare is administered is unimportant, it more likely means that this change in structure must be accompanied by a change in the distribution of power within this system. If Ghana decentralizes its healthcare system by only centralizing on a smaller level (i.e., centralizing within each smaller district rather within each original, larger region), then certain ethnic groups and/or geographic areas may not actually regain power, meaning that peoples' health will not change as a function of formal healthcare institutions changing. However, it is important for future work to study power dynamics in Ghana's formal healthcare system more directly, as I am unable to measure if and how power has shifted within this system. It is also important to more closely look at the hierarchies of ethnicities and regions within Ghana, as this is largely thought of as a thing of the past, especially since Ghana gained its freedom from Britain in 1957 and united as one country.

I find that the Navajo, who are both ethnically and spatially isolated from the rest of society within the confines of Navajo Nation, are very much affected by the healthcare system on the reservation (e.g., the IHS). When the US federal government took away the Navajo's power of choice in their healthcare, the governments forced them to practice Westernized health and

prohibited them from deciding for themselves what kind of health and healthcare they should receive. Interestingly, as the IHS has changed its structure and has attempted to put more power in the hands of the Navajo through 638 programs, it is unclear as to whether or not this has actually changed the power dynamic on the reservation. Peoples' health has not substantially improved with these changes, likely because the 638 programs claim to be more attentive to the Navajo's needs and wants but the program still operates through the federal government, responds to government incentives and funding pressures, and likely holds informal powers due to its association with the IHS. However, it may be that even if power has shifted more towards the Navajo in their healthcare, power has not shifted in other realms. For example, the historical oppression that the Navajo faced has implications today, with the Navajo still being spatially isolated, enduring untreated historical trauma, and more. So, it is important to consider the power dynamics that exist within these societies outside of the formal healthcare sector, as these power structures likely interact with power dynamics within the healthcare system.

The Roma in Romania undergo marginalization similar to that of the Navajo, but they are neither legally geographically isolated nor given healthcare separate from that of the majority population. While it may seem at first glance that the Roma then fare better than the Navajo, this is likely not the case, as their marginalization and discrimination is largely unrecognized by the Romanian government (i.e., they often live in shanty towns on the outskirts of cities but their situation is often considered by the government to be due to their own free will because they are not legally bound to these areas). In regards to health, doctors often discriminate against them in a formal setting. But, because there are no protocols against this (e.g., there are no negative responsibilities to do no harm) and because there are no protocols actively incorporating the Roma into the majority society (e.g., there are no positive responsibilities to do good), active

discrimination against them continues. It thus seems as though most are blind to the power

dynamics within the formal healthcare system as all patients are regarded as equal by law.

However, it should be clear by now that the Roma are not treated equally, with the Roma having

little to no power either within the healthcare system or outside of it. While there are a few

programs that work to aid the Roma (largely international rather than national programs), these

often work by introducing new programs such as NGOs rather than working within the systems

that the Roma are forced to participate in every day. Thus, Romania does not seem to be altering

the power structures within the healthcare system, which is arguably the most important formal

system in which to treat people equally.

Implications

As these three cases rightly show, there is no panacea for redistributing the power within

healthcare systems in such a way that benefits all ethnic groups in a divided society. However,

these cases do shed light on common themes (i.e., a disregard for peoples' traditional health

beliefs) that indicate broad measures that could work to better the plight of these ethnic groups if

catered specifically to each of these contexts.

As the Roma and Navajo cases show, it is critically important to first recognize the

marginalization and isolation that ethnic minorities experience. By the Roma's discrimination

being ignored, issues of power within the healthcare system are not even noticed by the majority

population. In Navajo Nation, the US government formally addresses the Navajo's situation even

though the government's actions are largely insufficient.

All three cases show that even once different ethnicities and their situations are

recognized, the government cannot decide on its own how to best cater to each group. For

example, Ghana has decentralized drastically over the last 25 years, but it has likely not done so

with the intentionality of redistributing power when it did so. Thus, although governments can formally recognize different ethnic and spatial dynamics, they often do so in a way that ignores the needs and wants of these groups. This manifests in Ghanaians receive healthcare on a local level that is decided upon by a federal level and the Navajo are not allowed to incorporate traditional healing practices with Western medicine in most formal settings.

Finally, as the Roma and Navajo cases show, there are likely substantial differences in power outside of formal institutions that permeate the healthcare system, which most are unaware of. So, even if power is redistributed within these healthcare systems, ethnic minorities likely do have power in other spheres, which could make redistributed power in healthcare less effective or entirely ineffective. Importantly, I do not find this to be as evident in Ghana, where ethnic and spatial division exists but where ethnic marginalization may not. This may indicate that Ghana and other ethnically divided societies that have unclear marginalization may be able to focus more so on formal healthcare institutions (or other institutions) themselves without addressing larger power differentials throughout society.

In sum, the governments of divided societies must recognize the division within them, work to address the power dynamics within formal institutions rather than merely changing or reformulating these institutions, and attend to the power dynamics outside of these institutions that may permeate them and impede their changes. It is important to note that these stipulations seem to largely place the decision-making in the hands of the federal governments and/or the more powerful. While it is not the role of only these governments to make changes, when large power differentials exist, they may be the only ones with the capacity to do so and the current situations may be largely their own doing (i.e., they are responsible for the present situation). However, once they begin addressing the issues of power that I previously mentioned, it is

necessary for the marginalized and/or divided groups to actively participate as well. Once these

groups have the power to have their voices heard, they then must be more actively involved in

decision-making processes than they are now (i.e., how to integrate traditional care in Western

healthcare practices). Once these groups take on an active role and are equally valued in the

formal healthcare system and in larger society, there then may be potential for changes in formal

healthcare institutions to benefit rather than harm all people in divided societies.

Ch. 1: Ghana

Table 1: The Ethnic Groups of Ghana			
Ethnic Group	**Percent of Population**	**Ethnic Sub-Groups and Neighboring Groups**	**Additional Information**
Akan	44	Asante, Fante, Ahanta, Guan, Bono, Akyem, Akwamu, Kwahu, Akuapem, Sefwi, Nzema	Live mostly in the forested regions.
Mole-Dagbani	16	Grusi, Gurma	Live mostly in the North and are Islamic.
Ewe	13	Singular group that lives among the Akpafu, Lolobi, Likpe, Sontrokofi, Nkonya, Avatime, Logba, Tafi	Live in the Volta region.
Ga-Adangbe	8	Ga, Shai or Adangbe, Ada, Krobo	Live in cosmopolitan areas and have largely undergone 'Akanization.'
Guan	19	N/A	Highly dispersed from the North to the South of Ghana.

Table 2: Ethnicity and Health						
	Akan	Ga	Ewe	Guan	Mole	Other
Vaccinations						
Tetanus Shot During Pregnancy	84.0%	83.8%	83.6%	75.2%	85.4%	77.2%
Child Vaccine	86.8%	90.1%	84.5%	83.8%	83.9%	79.5%
Measles Vaccine	65.6%	57.9%	57.5%	67.6%	60.5%	64.6%
DPT Vaccines	73.9%	66.0%	69.2%	42.5%	64.9%	54.0%
Polio Vaccines	66.7%	62.5%	61.9%	38.9%	55.6%	49.4%
Highest Level of Prenatal Care						
Doctor or Nurse	18.6%	15.6%	15.5%	25.0%	18.1%	25.9%
Midwife, Birth Attendant, Unprofessional, None	81.4%	84.4%	84.5%	75.0%	81.9%	74.1%
Highest Level of Birth Attendant						
Doctor, Nurse, Midwife	62.5%	65.1%	48.0%	21.2%	38.9%	41.0%
Birth Attendant, Unprofessional, None	37.5%	34.9%	52.0%	78.8%	61.1%	59.0%
Diarrhea						
Had Diarrhea Recently	72.2%	81.3%	78.2%	90.0%	76.1%	86.9%
Treated Diarrhea	60.1%	46.8%	32.2%	74.3%	61.3%	59.1%

Table 3: Region and Health										
	Western	Central	Greater Accra	Volta	Eastern	Ashanti	Brong Ahafo	Northern	Upper East	Upper West
Vaccinations										
Tetanus Shot During Pregnancy	83.4%	83.2%	79.5%	82.1%	82.2%	84.9%	86.7%	75.2%	83.4%	87.1%
Child Vaccine	80.6%	87.0%	87.1%	79.2%	88.1%	87.9%	85.0%	75.2%	89.5%	90.7%
Measles Vaccine	60.4%	60.6%	48.9%	56.0%	64.3%	70.5%	65.0%	55.9%	72.9%	68.1%
DPT Vaccines	71.9%	68.4%	63.4%	68.1%	63.4%	76.7%	75.6%	42.4%	66.8%	70.0%
Polio Vaccines	65.2%	60.1%	59.8%	61.8%	56.9%	71.8%	69.5%	34.2%	59.2%	60.2%
Highest Level of Prenatal Care										
Doctor or Nurse	16.9%	15.7%	13.8%	19.1%	14.6%	22.3%	20.5%	23.7%	16.1%	20.0%
Midwife, Birth Attendant, Unprofessional, None	83.1%	84.3%	86.0%	80.9%	85.4%	77.7%	79.5%	76.3%	83.9%	80.0%
Highest Level of Birth Attendant										
Doctor, Nurse, Midwife	61.1%	61.7%	58.6%	39.7%	61.8%	63.0%	60.1%	27.6%	53.1%	40.1%
Birth Attendant, Unprofessional, None	38.9%	38.3%	41.4%	60.3%	38.2%	37.0%	39.9%	72.4%	46.9%	59.9%
Diarrhea										
Had Diarrhea Recently	77.4%	75.4%	76.2%	75.9%	72.9%	75.8%	76.4%	85.6%	76.1%	77.9%
Treated Diarrhea	64.2%	53.6%	51.1%	26.8%	44.3%	62.7%	60.8%	63.3%	66.7%	70.2%

Table 4: Ethnicity and Region	Western	Central	Greater Accra	Volta	Eastern	Ashanti	Brong Ahafo	Northern	Upper East	Upper West
Akan	39	42	3	1	31	55	28	0	0	0
Ga	1	0	9	0	12	0	0	0	0	1
Ewe	1	0	4	33	5	1	3	0	0	0
Guan	0	1	0	1	0	2	0	0	0	0
Mole	0	0	0	0	0	2	4	20	13	15
Other	0	0	1	4	1	3	7	15	7	11

Table 5				
Conditional Correlations				
	1993	1998	2003	2008
Tetanus Shot During Pregnancy	.78	.83	.84	.88
Child Vaccine	.74	.86	.87	.95
Measles Vaccine	.47	.62	.68	.77
DPT Vaccine	.72	.53	.69	.75
Polio Vaccine	.50	.53	.68	.74
High Prenatal Care Level	.26	.19	.12	.15
High Birth Care Level	.55	.56	.36	.66
Diarrhea Treated	.54	.51	.52	.66

Table 6				
Conditional Correlations: Akan				
	1993	1998	2003	2008
Tetanus Shot During Pregnancy	.82	.82	.85	.88
Child Vaccine	.77	.90	.89	.95
Measles Vaccine	.49	.62	.78	.81
DPT Vaccine	.75	.65	.75	.80
Polio Vaccine	.55	.64	.74	.80
High Prenatal Care Level	.28	.15	.10	.15
High Birth Care Level	.64	.71	.44	.67
Diarrhea Treated	.61	.57	.54	.66

Table 7				
Conditional Correlations: Ga				
	1993	1998	2003	2008
Tetanus Shot During Pregnancy	.86	.82	.57	.97
Child Vaccine	.81	.90	.89	.97
Measles Vaccine	.53	.63	.51	.65
DPT Vaccine	.73	.65	.72	.63
Polio Vaccine	.52	.64	.67	.63
High Prenatal Care Level	.14	.15	.25	.16
High Birth Care Level	.63	.71	.37	.87
Diarrhea Treated	.17	.57	.46	.57

Table 8				
Conditional Correlations: Ewe				
	1993	1998	2003	2008
Tetanus Shot During Pregnancy	.75	.83	.92	.85
Child Vaccine	.77	.75	.90	.96
Measles Vaccine	.51	.47	.72	.57
DPT Vaccine	.79	.39	.81	.74
Polio Vaccine	.53	.39	.79	.74
High Prenatal Care Level	.19	.24	.07	.14
High Birth Care Level	.49	.28	.47	.69
Diarrhea Treated	.28	.18	.32	.51

Table 9				
Conditional Correlations: Guan				
	1993	1998	2003	2008
Tetanus Shot During Pregnancy	.71	.65	1.00	.64
Child Vaccine	.71	1.00	1.00	.64
Measles Vaccine	.43	1.00	1.00	.28
DPT Vaccine	.71	.35	.00	.64
Polio Vaccine	.57	.35	.00	.64
High Prenatal Care Level	1.00	.00	.00	.00
High Birth Care Level	.57	.00	.00	.28
Diarrhea Treated	.33	1.00	1.00	.64

Table 10				
Conditional Correlations: Mole				
	1993	1998	2003	2008
Tetanus Shot During Pregnancy	.73	.94	.91	.87
Child Vaccine	.74	.81	.83	.96
Measles Vaccine	.46	.72	.46	.81
DPT Vaccine	.73	.50	.57	.72
Polio Vaccine	.45	.50	.57	.68
High Prenatal Care Level	.19	.36	.14	.11
High Birth Care Level	.33	.42	.14	.65
Diarrhea Treated	.50	.49	.49	.87

Table 11				
Conditional Correlations: Other				
	1993	1998	2003	2008
Tetanus Shot During Pregnancy	.64	.85	.72	.82
Child Vaccine	.43	.93	.81	.87
Measles Vaccine	.25	.71	.63	.89
DPT Vaccine	.43	.52	.56	.63
Polio Vaccine	.25	.52	.55	.59
High Prenatal Care Level	.35	.29	.18	.23
High Birth Care Level	.32	.51	.30	.47
Diarrhea Treated	.56	.54	.62	.64

Table 12

VARIABLES	(1) % Measles Change	(2) % Measles Change	(3) % Measles Change	(4) % Measles Change
Divide_1989	0.056	-0.011	0.121	0.059
	[0.109]	[0.107]	[0.106]	[0.103]
Divide_2004	0.007	0.010	0.002	0.056
	[0.091]	[0.087]	[0.088]	[0.084]
R_Western			-0.485**	-0.411
			[0.215]	[0.275]
R_Central			-0.213	-0.146
			[0.212]	[0.275]
R_GtrAccra			-0.496*	-0.357
			[0.276]	[0.319]
R_Volta			-0.252	0.194
			[0.235]	[0.290]
R_Eastern			-0.619***	-0.575**
			[0.206]	[0.271]
R_Ashanti			-0.307	-0.308
			[0.203]	[0.260]
R_BrongAhafo			-0.453**	-0.475*
			[0.209]	[0.248]
R_Northern			-0.137	-0.121
			[0.217]	[0.200]
R_Uppereast			-0.172	-0.138
			[0.242]	[0.227]
R_Upperwest			-	-
E_Akan		0.362		0.421*
		[0.222]		[0.212]
G_Ga		0.196		0.441
		[0.262]		[0.277]
E_Ewe		0.031		-0.159
		[0.241]		[0.266]
E_Guan		-0.145		-0.303
		[0.421]		[0.403]
E_Mole		0.474**		0.325
		[0.235]		[0.294]
E_Other		0.629**		0.412
		[0.245]		[0.294]
Constant	0.267**	-0.022	0.561***	0.212
	[0.105]	[0.217]	[0.204]	[0.333]
Observations	90	90	90	90
R-squared	0.003	0.199	0.212	0.384
Adj R-Squared	-0.0199	0.120	0.101	0.238

Standard errors in brackets
*** p<0.01, ** p<0.05, * p<0.1

Figure 1

Ch. 3: Romania

Table 1

Demographic Characteristics	Non-Roma		Roma	
	N	%	N	%
Age				
18-27	229	27.8	9	56.25
28-30	224	27.2	2	12.50
31-34	187	22.7	2	12.50
35-44	184	22.3	3	18.75
Education				
High School or Lower	579	44.1	27	96.4
Undergraduate or Higher	735	55.9	1	3.6
Ethnicity for the Survey				
Romanian	1,104	81.2		
Hungarian	224	16.5		
Roma	28	2.1		
Other	4	0.3		
Current Residence				
Rural	423	33.0	16	84.2
Urban/Suburb	859	67.0	3	15.8
Living Arrangement				
Married	1,141	86.3	13	50.0
With Partner	154	11.7	12	46.2
Other	27	2.0	1	3.8
Monthly Income				
$0-216	144	11.1	11	44.0
$217-464	311	23.9	12	48.0
$465-928	514	39.6	1	4.0
$929-1,547	257	19.8	0	0.0
$1,548-2,166	39	3.0	1	4.0
Over $2,166	34	2.6	0	0.0

Table 2

Reproductive History & Health Behaviors	Non-Roma		Roma	
	N	%	N	%
Unwanted Pregnancy				
Wanted Pregnancy	970	74.2	7	26.9
Wanted Pregnancy Later or Did Not Care	277	21.2	11	42.3
Unwanted Pregnancy	61	4.7	8	30.8
Other Children				
First Birth	99	17.2	3	20.0
One Child	391	67.8	5	33.3
Two or More Children	87	15.1	7	46.7

Table 3				
Smoking	Non-Roma		Roma	
	N	%	N	%
Smoking Status				
Recent Smoker	361	29.1	13	54.2
Never Smoker	878	70.9	11	45.8
Of Prior Smokers				
Smoking Same	12	3.3	2	14.3
Smoking Reduced	150	41.1	9	64.3
Quit After Pregnant	169	46.3	3	21.4
Quit Before Pregnant	34	9.3	0	0.0
Other Smokers in the Home				
Yes	428	40.3	16	76.2
No	634	59.7	5	23.8
Exposure to Secondhand Smoke				
Yes	604	49.3	16	69.6
No	620	50.7	7	30.4

Table 4				
Support Characteristics	Non-Roma		Roma	
	N	%	N	%
Advice & Guidance				
Low	248	19.0	19	70.4
Medium	483	36.9	6	22.2
High	579	44.2	2	7.4
Friendship				
Low	364	27.8	15	55.6
Medium High	945	72.2	12	44.4
Sense of Comfort & Welfare				
Low	205	15.8	17	63.0
Medium	410	31.7	4	14.8
High	679	52.5	6	22.2
Amount of Help				
Low	267	20.5	15	57.7
Medium	479	36.9	6	23.1
High	554	42.6	5	19.2
Recognition of Talent & Skill				
Low	237	18.3	16	59.3
Medium	364	28.2	7	25.9
High	691	53.5	4	14.8
Closeness & Emotional Stability				
Low	324	24.87	18	66.7
Medium	452	34.69	5	18.5
High	527	40.45	4	14.8

Table 5

Cross Tabulations

Non-Roma

| Age | Marital Status | | |
	Married	With Partner	Other
18-27	168	52	6
28-30	203	15	4
31-34	176	10	0
35-44	164	16	3

Roma

| Age | Marital Status | | |
	Married	With Partner	Other
18-27	4	4	0
28-30	0	2	0
31-34	1	1	0
35-44	2	0	1

Table 6

Cross Tabulations

Non-Roma

| Residence | Smoking Status | |
	Recent/Current Smoker	Not a Recent/Current Smoker
Rural	261	135
Urban	592	215

Roma

| Residence | Smoking Status | |
	Recent/Current Smoker	Not a Recent/Current Smoker
Rural	4	9
Urban	3	0

Table 7

Chi Squared Tests

| | Smoking Status | |
	Recent/Current Smoker	Not a Recent/Current Smoker
Non-Roma	361	878
Roma	13	11

Chi-Square = 7.1, p=.008

| | Social Support: Guidance | | |
	Low Guidance	Medium Guidance	High Guidance
Non-Roma	248	483	579
Roma	19	6	2

Chi-Square= 44.8, p=.000

Bibliography

1. Ackah & Medvedev 2010
2. Ahmad, J. K., Devarajan, S., Khemani, S., & Shah, S. (2005). Decentralization and service delivery. *World Bank Policy Research Working Paper*, (3603).
3. Akin, J., Hutchinson, P., & Strumpf, K. (2005). Decentralisation and government provision of public goods: The public health sector in Uganda. *The Journal of Development Studies*, *41*(8), 1417-1443.
4. Assimeng, J. M. (1999). *Social structure of Ghana: A study in persistence and change*. Ghana Publishing Corporation.
5. Ayee, J. R. (2012). The political economy of the creation of districts in Ghana. *Journal of Asian and African Studies*, 0021909612464334.
6. Ballew, C., White, L. L., Strauss, K. F., Benson, L. J., Mendlein, J. M., & Mokdad, A. H. (1997). Intake of nutrients and food sources of nutrients among the Navajo: findings from the Navajo Health and Nutrition Survey. *The Journal of nutrition*, *127*(10), 2085S-2093S.
7. Bardhan, P. (2002). Decentralization of governance and development. *Journal of Economic perspectives*, 185-205.
8. Bartley, M., Blane, D., & Davey Smith, G. (1998). Introduction: beyond the Black report. *Sociology of Health & Illness*, *20*(5), 563-577.
9. Been, J. V., Nurmatov, U. B., Cox, B., Nawrot, T. S., van Schayck, C. P., & Sheikh, A. (2014). Effect of smoke-free legislation on perinatal and child health: a systematic review and meta-analysis. *The Lancet*.
10. Begay-Piechowski, A. (2015, January). Interviewed by K LeMasters and J Fugate. Mental Health on Navajo Nation.
11. Bergsma, L., Delgado, S., Kizer, E. (2012). Navajo County Community Health Status Assessment. *Navajo County Public Health Services District*.
12. Berkhofer, R. F. (2011). *The white man's Indian: Images of the American Indian from Columbus to the present*. Vintage.
13. Bhatti, L. (2014, May 6). Interview by K LeMasters. WHO Involvement with Smoking Behaviors and Exposure for Pregnant Women.
14. Blind Review
15. Boahen, A. A. (1975). *Ghana: Evolution and change in the nineteenth and twentieth centuries*. London: Longman.
16. Burki, S. J., Perry, G., & Dillinger, W. R. (Eds.). (1999). *Beyond the center: Decentralizing the state*. World Bank Publications.
17. Byers, T., & Hubbard, J. (1997). The Navajo Health and Nutrition Survey: Research that can make a difference. *The Journal of nutrition*, *127*(10), 2075S-2077S.
18. Call, K. T., McAlpine, D. D., Johnson, P. J., Beebe, T. J., McRae, J. A., & Song, Y. (2006). Barriers to care among American Indians in public health care programs. *Medical care*, *44*(6), 595-600.
19. Carlough, M., & McCall, M. (2005). Skilled birth attendance: what does it mean and how can it be measured? A clinical skills assessment of maternal and child health workers in Nepal. *International journal of gynecology & obstetrics*, *89*(2), 200-208.

20. Centers for Disease Control and Prevention (2015). Health of American Indian or Alaska Native Population. FastStats.

21. Channa, A., & Faguet, J. P. (2012). Decentralization of health and education in developing countries: a quality-adjusted review of the empirical literature.
22. Ciobanu, M. (2014, April 10). Interview by K LeMasters. Smoking Behaviors Among Pregnant Women: Ministry of Health Perspective.
23. Ciuntea, A. (2014, April 11). Interview by K LeMasters. MAIA Project Data Collection.
24. Clichee, D. (2013). Tehootsooi Medical Center Community Health Needs Assessment. *For Defiance Indian Hospital Board, Inc.*
25. Coleman, T. (2015, January). Interviewed by K LeMasters and J Fugate. Traditional Healing on Navajo Nation.
26. Craig, D., & Porter, D. (2003). Poverty reduction strategy papers: a new convergence. *World Development*, *31*(1), 53-69.
27. Crawford, G., & Hartmann, C. (Eds.). (2008). *Decentralisation in Africa: a pathway out of poverty and conflict?*. Amsterdam University Press.
28. Crowe, D. M. (1996). *A history of the Gypsies of Eastern Europe and Russia*. Palgrave Macmillan.
29. Curley, P., (2008). Navajo Nation Needs and Assets Report. Navajo Nation Regional Partnership Council.
30. Daniels, N. (1985). *Just health care*. Cambridge University Press.
31. Daniels, N. (2007). *Just health: meeting health needs fairly*. Cambridge University Press.
32. Danova-Russinova, S. Ambulance Not on the Way: The Disgrace of Health Care for Roma in Europe. Budapest: European Roma Rights Center; 2006.
33. David, K. (2015, January). Interviewed by K LeMasters and J Fugate. Biomedicine on Navajo Nation.
34. Deloria Jr, V., & DeMallie, R. J. (1999). *Documents of American Indian Diplomacy* (Vol. 1). Norman: University of Oklahoma Press.
35. Department of Health Services (2007). Office of Adolescent Health.
36. Dinges, N. G., Yazzie, M. L., & Tollefson, G. D. (1974). Developmental intervention for Navajo family mental health. *The Personnel and Guidance Journal*, *52*(6), 390-395.
37. Duran, E., & Duran, B. (1995). *Native American postcolonial psychology*. SUNY Press.
38. Economist (2012). Romania's Roma: Where is Europe's Roma Policy?
39. Fairchild, D. G., Fairchild, M. W., & Stoner, S. (1998). Prevalence of adult domestic violence among women seeking routine care in a Native American health care facility. *American Journal of Public Health*, *88*(10), 1515-1517.
40. Fan, C. S., Lin, C., & Treisman, D. (2009). Political decentralization and corruption: Evidence from around the world. *Journal of Public Economics*, *93*(1), 14-34.
41. Fonseca, I. (2011). *Bury me standing: the gypsies and their journey*. Vintage.
42. Ghana Statistical Service (2009). Ghana demographic and health survey 2008. *Accra, Ghana: Ghana Statistical Service, Ghana Health Service, and ICF Macro*.
43. Glajar, V. (2011). Chapter Twelve Framing the Silence: The Romanian Jewish and Romani Holocaust in Filmic Representations1. *Local History, Transnational Memory in the Romanian Holocaust*, 225.
44. Glasses, D. (2015, January). Interviewed by K LeMasters and J Fugate. Biomedicine on Navajo Nation.
45. Gocking, R. (2005). *The history of Ghana*. Greenwood Publishing Group.
46. Goodheart, T. (2015, January). Interviewed by K LeMasters and J Fugate. The Schools and Health on Navajo Nation.

47. Greenberg, J. (2010). Report on Roma education today: From slavery to segregation and beyond. *Columbia Law Review*, 919-1001.

48. Grossman and Hartmann

49. Grossman, G., & Lewis, J. I. (2014). Administrative Unit Proliferation. *American Political Science Review*, *108*(01), 196-217.

50. Habibi, N., Huang, C., Miranda, D., Murillo, V., Ranis, G., Sarkar, M., & Stewart, F. (2003). Decentralization and human development in Argentina. *Journal of Human Development*, *4*(1), 73-101.

51. Hajioff, S., & McKee, M. (2000). The health of the Roma people: a review of the published literature. *Journal of Epidemiology and Community Health*, *54*(11), 864-869.

52. Hamby, S. L. (2004). Sexual Victimization in Indian Country: Barriers and Resources for Native Women Seeking Help. *Retrieved October*, *1*(2004), 2004.

53. Heart, B., & DeBruyn, L. M. (1998). The American Indian holocaust: Healing historical unresolved grief. *American Indian and Alaska Native Mental Health Research*, *8*(2), 56-78.

54. Henson, E., Taylor, J. B., Curtis, C., Cornell, S., Grant, K. W., Jorgensen, M., ... & Lee, A. J. (2008). *The state of the Native nations: conditions under US policies of self-determination*. New York: Oxford University Press.

55. Hute, L. (2015, January). Interviewed by K LeMasters and J Fugate. Schools and Health on Navajo Nation.

56. Irimie, S. (2011). Global Adult Tobacco Survey. *Ministry of Health Romania*. Bucharest, Romania.

57. Jim, H. (2015, January). Interviewed by K LeMasters and J Fugate. Traditional Healing on Navajo Nation.

58. Khaleghian, P. (2004). Decentralization and public services: the case of immunization. *Social Science & Medicine*, *59*(1), 163-183.

59. Kickingbird, K. (1983). *Indian sovereignty*. The Institute.

60. Kim, C., & Kwok, Y. S. (1998). Navajo use of native healers. *Archives of Internal Medicine*, *158*(20), 2245-2249.

61. Kis-Katos, K., & Suharnoko-Sjahrir, B. (2014). The impact of fiscal and political decentralization on local public investments in Indonesia.

62. Ladányi, J., & Szelényi, I. (2002). The Nature and Social Determinants of Roma Poverty. *Review of Sociology*, *8*(2), 75-96.

63. Lee

64. Lee, S. (2015, January). Interviewed by K LeMasters and J Fugate. Behavioral Health on Navajo Nation.

65. Low, S. M. (1992). Symbolic ties that bind. In *Place attachment* (pp. 165-185). Springer US.

66. Malesky, E. J., Nguyen, C. V., & Tran, A. (2014). The Impact of Recentralization on Public Services: A Difference-in-Differences Analysis of the Abolition of Elected Councils in Vietnam. *American Political Science Review*, *108*(01), 144-168.

67. Marginean, C. (2014, April 18). Interview by K LeMasters. Smoking Behaviors Among Pregnant Women: Gynecology Perspective.

68. Masseria, C., Mladovsky, P., & Hernández-Quevedo, C. (2010). The socio-economic determinants of the health status of Roma in comparison with non-Roma in Bulgaria, Hungary and Romania. *The European journal of public health*, 20(5), 549-554.

69. Meghea, C. I., Rus, D., Rus, I. A., Holtrop, J. S., & Roman, L. (2012). Smoking during pregnancy and associated risk factors in a sample of Romanian women. *The European Journal of Public Health*, 22(2), 229-233.

70. Ministry of Health (2012). *Agencies: Ghana Health Service*. Ministry of Health: Republic of Ghana.

71. Morgan, S. (2015, January). Interviewed by K LeMasters and J Fugate. The CHR Program on Navajo Nation.

72. Morrison, M. K. (2004). Political parties in Ghana through four republics: a path to democratic consolidation. *Comparative Politics*, 421-442.

73. Navajo County 2003

74. Nicoara, M. (Director & Producer). (2011). *Our School* [Documentary] Romania: One World Romania.

75. Noggle, I. (2015, January). Interviewed by K LeMasters and J Fugate. Alcoholism on Navajo Nation.

76. Noggle, S. (2015, January). Interviewed by K LeMasters and J Fugate. Education on Navajo Nation.

77. Oocities (1998). Timeline of Romani History.

78. Perbi, A. A. (2004). *A history of indigenous slavery in Ghana: From the 15th to the 19th century*. Sub-Saharan Pub & Traders.

79. Poupart, L. M. (2003). The familiar face of genocide: Internalized oppression among American Indians. *Hypatia*, *18*(2), 86-100.

80. Prud'Homme, R. (1995). The dangers of decentralization. *The world bank research observer*, *10*(2), 201-220.

81. Rat, C. (2014). Interview by K LeMasters. A Sociological Approach to the Roma in Romania.

82. Reuters (2007). Roma Urge Romania to End Discrimination.

83. Rhoades, E. R. (Ed.). (2001). *American Indian health: Innovations in health care, promotion, and policy*. JHU Press.

84. Rickmann, T. R., Wadsworth, M. E., & Deyhle, D. (2004). Cultural identity, explanatory style, and depression in Navajo adolescents. *Cultural Diversity and Ethnic Minority Psychology*, *10*(4), 365.

85. Roubideaux, Y. (2003). Trends in Indian Health: 2002-2003 Edition. *US Department of Health and Human Serivces. Indian Health Service. Office of Public Health Support. Division of Program Statistics.*

86. Sackey, M. B. (2002). Faith healing and women's reproductive health. *Institute of African Studies Research Review*, *18*(1), p-5.

87. Salihu, H. M., & Wilson, R. E. (2007). Epidemiology of prenatal smoking and perinatal outcomes. *Early human development*, *83*(11), 713-720.

88. Salisu, A., & Prinz, V. (2009). Health care in Ghana: March 2009. *Vienna: Austrian Centre for Country of Origin and Asylum Research and Documentation*.

89. Saltman, R., Bankauskaite, V., & Vrangbaek, K. (2006). *Decentralization in health care: strategies and outcomes*. McGraw-Hill International.

90. Sarche, M., & Spicer, P. (2008). Poverty and health disparities for American Indian and Alaska Native children. *Annals of the New York Academy of Sciences*, *1136*(1), 126-136.

91. Sheik- Mohamed, A., & Velema, J. P. (1999). Where health care has no access: the nomadic populations of sub- Saharan Africa. *Tropical medicine & international health*,

4(10), 695-707.

92. Snipp, C. M. (1997). The size and distribution of the American Indian population: Fertility, mortality, migration, and residence. *Population Research and Policy Review*, *16*(1-2), 61-93.

93. Speen, C. (2015, January). Interviewed by K LeMasters and J Fugate. Schools and Health on Navajo Nation.

94. Stephenson, P., Wagner, M., Badea, M., & Serbanescu, F. (1992). Commentary: the public health consequences of restricted induced abortion--lessons from Romania. *American Journal of Public Health*, *82*(10), 1328-1331.

95. Surdu, L., & Surdu, M. (2006). Broadening the agenda: the status of Romani women in Romania.

96. The World Bank Group (2014). Adolescent Fertility Rate. Data.

97. The World Factbook (2015). Romania. Central Intelligence Agency.

98. Timmerman, J. (2003). When her feet touch the ground: conflict between the Roma familistic custom of arranged juvenile marriage and enforcement of international human rights treaties. *J. Transnat'l L. & Pol'y*, *13*, 475.

99. Toma, A. (2014, April 10). Interview by K LeMasters. Smoking Behaviors Among Pregnant Women: Practitioner Perspective.

100. Tsey, K. (1997). Traditional medicine in contemporary Ghana: A public policy analysis. *Social Science & Medicine*, *45*(7), 1065-1074.

101. US Census Bureau (2010). American Indian and Alaskan Native.

102. Vivian, C., & Dundes, L. (2004). The crossroads of culture and health among the Roma (Gypsies). *Journal of nursing scholarship*, *36*(1), 86-91.

103. Vlădescu, C., Scîntee, G., Olsavszky, V., Allin, S., & Mladovsky, P. (2008). Romania: Health system review. *Health systems in transition*, *10*(3), 1-172.

104. Webb, Douglas. (2013). *Tobacco Control for Health and Development*. [Issue brief]. HIV, Health, and Development, United Nations Development Program, New York, NY.

105. Whitbeck, L. B., Chen, X., Hoyt, D. R., & Adams, G. W. (2004). Discrimination, historical loss and enculturation: Culturally specific risk and resiliency factors for alcohol abuse among American Indians. *Journal of Studies on Alcohol and Drugs*, *65*(4), 409.

106. Will, J. C., Strauss, K. F., Mendlein, J. M., Ballew, C., White, L. L., & Peter, D. G. (1997). Diabetes mellitus among Navajo Indians: Findings from the Navajo health and nutrition survey. *The Journal of nutrition*, *127*(10), 2106S-2113S.

107. Wilson, C., Gilliland, S., Moore, K., & Acton, K. (2007). Peer Reviewed: The Epidemic of Extreme Obesity Among American Indian and Alaska Native Adults With Diabetes. *Preventing chronic disease*, *4*(1).

108. World Health Organization (2013). Roma Health Mediation in Romania: Case Study. Copenhagen, WHO Regional Office for Europe.

108. Zeman, C. L., Depken, D. E., & Senchina, D. S. (2003). Roma health issues: a review of the literature and discussion. *Ethnicity & health*, *8*(3), 223-249.