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Luma Issa Al Masarweh  
Brigham Young University - Provo

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Barriers to Native American Women Veterans' Health Care Access on Two  
Reservations: Northern Cheyenne and Flathead

Luma Issa Al Masarweh

A thesis submitted to the faculty of  
Brigham Young University  
in partial fulfillment of the requirements for the degree of

Master of Science

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## ABSTRACT

### Barriers to Native American Women Veterans' Health Care Access on Two Reservations: Northern Cheyenne and Flathead

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Little research has addressed the needs of Native American veterans. This study aims to provide a better understanding of Native American women veterans' experiences using data from the Veteran Administration and Indian Health Services. Fifteen interviews were conducted with special attention to quality and quantity of health and mental health care services available to veterans, the barriers and local contextual factors in accessing and utilizing services, and potential solutions to service gaps for women veterans from two Montana reservations, the Northern Cheyenne and Flathead Confederated Salish and Kootenai Tribes. American Indians and Alaska Natives serve at a higher rate in the U.S military than any other population. Native American women veterans identified many barriers to accessing care, some of which include lack of information regarding eligibility and the type of services available. Many found the application process to be confusing and difficult. Other barriers included distance, cost of travel, and conflict with their work schedule. This research provides important data about Native American veterans who are often underrepresented in survey research and are a rapidly growing segment of the United States military and veteran population.

Keywords: Native American, women, veterans, VA, IHS, barriers to health care access, rural

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## INTRODUCTION

Approximately 12,000 Native Americans served in the United States military during World War I, and that number has continued to increase to this day (U.S. Department of Veterans Affairs 2012b). This long history of military service dates back to the Pre-World War I era. The American Indian population varies by state, with the western region having a large number of American Indians and veterans. For example, the Montana Bureau of Labor and Industry 2010 Report indicates more than 95,000 veterans reside in Montana, making them 12.5% of the entire Montana population (McNay 2011). However, another report by the Department of Veteran Affairs indicates that the number of veterans residing in rural locations is just less than 30% (“Office of Rural Health” 2011).

Veterans residing in rural areas, including Native Americans need primary, secondary, and tertiary health care services to address chronic diseases such as diabetes and hypertension (Sanders, Fitzgerald, and Bratteli 2008). As the Native American veteran population grows, their need to access care from providers such as the Veteran Administration (VA) and Indian Health Services (IHS) clinics and hospitals also continues to grow. Unfortunately, research has indicated that rural veterans experience challenges in accessing the health care they need (Ward et al. 2013) which might explain why Native American veterans have a low rate of seeking care at VA and IHS facilities (Kramer et al. 2009). Although researchers have identified some barriers that American Indian veterans face (Ward et al. 2013), the challenges of recent veterans, especially women veterans living, on reservations with accessing health care, remain unclear even when the VA has implemented changes, not only in primary and specialized care to all veterans, but also in gender specific services for women veterans (U.S General Accounting Office 1992; 1999).

Yet, Native American veterans are twice as likely to be uninsured and to delay seeking care as their non-Hispanic white counterparts (Johnson, Carlson, and Hearst 2010).

The purpose of this exploratory case study is to clarify the challenges and obstacles Northern Cheyenne women veterans experience accessing health and mental health services, offering some additional perspectives from American Indian women veterans from the Confederated Salish and Kootenai Tribes on the Flathead reservation. It also addresses why these challenges persist even with the 2010 Memorandum of Understanding (MOU) between the VA and IHS, which is designed to increase the coordination between these two health care providers serving American Indian veterans (IHS Public Affairs, 2010; Ward et al. 2013). Interviews conducted during 2012-13 with Native American women veterans address experiences accessing health care, as well as indicating to what extent this MOU is being implemented and how it needs to be improved to increase access to and availability of health care services.

Specifically, this study explores and identifies veterans' perspectives about local health and mental health services, focusing on the quality and quantity of health and mental health services available to rural veterans and the barriers to accessing and utilizing these services. In addition to identifying these issues, this research explores the strengths and weaknesses of these available services to better assess needs for improving the health care experience of rural American Indian women veterans in Montana reservation communities. This research is also relevant to other rural and minority veterans attempting to access health and mental health services in the United States. This study will help to corroborate and extend understandings of existing issues, as well as unveil barriers to accessing care for Native American women veterans specifically, and veterans in general, who reside in rural reservation areas. In addition, this study will underscore the inequalities encountered as Native American women veterans seek care and

confront barriers related to racial/ethnic group membership, socio-economic status, and place of residence.

## LITERATURE REVIEW

According to the World Bank, 54,542,564 individuals were reported living in rural areas across the United States in 2012 (World Bank Group 2014). This sizable portion of the population deserves scholars' attention in order to better understand what urban-rural differences persist and why. Studies have shown that health is not only affected by one's daily physical habits and socioeconomic conditions, but also by what scholars in the public health field call "social determinants of health." The World Health Organization (WHO) defines social determinants as "the conditions in which people are born, grow, live, work, and age. These circumstances are shaped by the distribution of money, power, and resources at global, national, and local levels." Thus, the place in which a person is born and lives, affects the kind, quality, and amount of income, employment, quality of health services, education, social ties, etc., that can be accessed. Moreover, differences persist between health statuses or perceived health across the urban-rural spectrum. This can be directly attributed to differences in social determinants of health across urban-rural areas. This notion, that our society and the environment we reside in affects our overall quality of life led researchers to focus on the effect of place on health, (Macintyre and Ellaway 2000; Macintyre, Maciver, and Sooman 1993) and on mental and physical well-being (Atkinson, Fuller, and Painter 2012; Rollero and De Piccoli, 2010a).

Increasingly, the literature on the place of residence and physical and mental health (Kawachi and Berkman, 2003; Wen et al., 2006) reveal that social ties and the relationships people establish with and within their place of residence directly influence their well-being (Rollero and De Piccoli 2010). Additionally, veteran groups within a community allow veterans

to connect with each other, exchange information on veteran benefits, access health services, and even deal with emotional problems related to service. Several other studies have explored the reasons why one's place of residence is such an important indicator for individual health (Eberhardt and Pamuk 2004; Macintyre, Ellaway, and Cummins 2002), finding that residence not only affects health but also affects one's perception of the available or missing health services.

Researchers have identified some of the challenges rural veterans, such as Native Americans, face that prevent or discourage them from seeking care at VA facilities (Friedman et al. 2011). In some rural areas, the VA is often the primary or sole source of physical and mental health care for older rural veterans (Hynes et al. 2007). Descriptive studies have indicated that, more generally, veterans residing in rural locations experience higher rates of physical co-morbidities and lower levels of health-related quality of life (Weeks et al. 2006; Rehman et al. 2005). Surprisingly, Nicholson's (2008) research found that mental health is, in fact, better in rural areas. However, to reach such a conclusion, Nicholson (2008) considered such aspects of rural life as the rural community, social networks, problems with access, and social exclusion. For instance, social networks are composed of a multitude of formal and informal social links between the different members of a group (Nicholson 2008). Social networks can vary depending on their characteristics, such as the number, strength, and importance of the links between group members. Thus, increases in these aspects of networks can increase the degree of belonging an individual feels towards his community. In an overview of social networks and social exclusion, Crow (2004) indicated that fostering a strong and large social network, which directly means stronger social capital, is associated with well-being.

In addition, many studies have provided critical understanding of the services provided and care needed by veterans in rural areas. Specifically, the literature has emphasized characteristics of services, profiles of recipients, access barriers, and use of new technologies. Weeks et al. (2008) suggests that the reasons veterans have for using different types of care and the barriers they may face in accessing them, remain ambiguous. Thus, a needed area of inquiry involves examining the perceptions of rural veterans and their assessment of access to the services they receive (Nicholson 2008). One important area that Nicholson (2008) suggests that is critical is the transportation needed to physically be at the health facility to receive care.

Three previous studies have examined the relationship between travel distance and use of VA services. For example, Burgess and DiFiore (1994) found that as distance to VA facilities increased there was a decline in outpatient services. The second study conducted by Feitz in 1995 examined VA usage rates and travel distance to these facilities. Feitz's results were consistent with those published by Burgess and DiFiore in that distance to VA facilities was inversely proportional to the likelihood of seeking care at these facilities. However, Feitz emphasized the need to explore the idea that having income, and also age, as underlying reasons for this association. Lastly, a study conducted by Mooney et al. in 2000 also examined the issue of distance and travel as a reason why few veterans use VA hospitals for inpatient medical and surgical care. This study found that proximity to a VA hospital is among the determining factors when deciding to seek care at a VA hospital. Additionally, studies have shown that the quality of facilities established by the VA in rural areas, though smaller and less specialized, are similar to those available in urban facilities, easily accessed and close in proximity (Weeks, Yano, and Rubenstein 2002). This suggests that low-quality may not be a factor in why rural veterans are not seeking health care in VA facilities.

The VA has attempted to overcome distance by bringing the health care providers to the rural communities in need. For instance, mobile clinics and satellite psychiatric services have been established in recent years and are shown to be efficient and effective innovations (Weeks et al. 2008; Workman et al. 1997; Wray et al. 1999). Nevertheless, rural veterans continue to delay scheduling appointments for psychiatric care (Cully et al. 2010).

### *Women Veterans<sup>1</sup>*

Women represent the fastest growing segment of the United States military and VA users; the rate of growth has been faster among women veterans than men veterans (Washington et al. 2006; Frayne et al, 2010; Yano et al., 2011). The current projected percentage of US veterans who are women is 10% (“Facts and Statistics” 2011). Recent figures show that women make up nearly 11.6 percent of Operation Enduring Freedom (OEF), Operation Iraqi Freedom (OIF), and Operation New Dawn (OND) veterans (Office of Public Health 2013). In addition, women account for 15% of all active duty military personnel and 20% of all new recruits (Washington et. al, 2006; Yano et al., 2011). As this military population continues to increase so will their enrollment in the VA health care system. Enrollment rates are expected to more than double in the next fifteen years (Mulhall 2009).

Although the VA has recently directed more attention to women’s needs, disparities persist in access and the care provided to male and female veterans (Office of Quality and Safety 2009). Compared to their male counterparts, female veterans generally are more likely to have poor health status, low income, inadequate insurance, higher instances of stress and trauma, and

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<sup>1</sup> This section and the following section on American Indian women veterans include material presented in technical reports to the Western Region VA Rural Health Center related to MT rural health care access studies supported by the VA in 2011-12 (Ward et al. 2012; Ward et al. 2013).

lower levels of VA use among those eligible for services (Washington et. al 2006; Washington et al. 2007). In 2003, the VA mandated that all hospitals and clinics provide gender-specific care in order to address women's unique health needs. Yet Mulhall (2009) reported that only 14 percent of VA women's facilities provide comprehensive primary and mental health care; in fact the number of VA facilities providing gender related care has actually declined since the directive (Mulhall 2009).

As the number of facilities that target the needs of women decreased, the number of women who reported Military Sexual Trauma (MST) increased. Currently, one in five women report MST, and those rates are higher among women than they are among men because of the differences in ratios between men and women in the military (Military Sexual Trauma Support Team 2010). Moreover, 71% of women and 4% of men reported they had experienced sexual assaults. For men, the assault was more likely to occur while out of service; for women, the opposite was true (Murdoch et al. 2004). Most statistics on sexual assault show that a significant number of females had been raped while in the military; however, 81% of military sexual assault against men goes unreported (Innes 2013). Kristen Zaleski, Ph.D., who works with victims of MST-previously through the VA and now in private practice- elaborated on the cause of this under-reporting: "The issue with men being raped, whether civilian or military, is stigma" (Innes 2013).

Importantly, Hayes (2011:S70) reports that the number of women using VA health care has nearly doubled in the past decade: "this group of VA users reflects only 16% of all women veterans alive today," but it compares favorably to the percentage of eligible women veterans using VA services before 2005. Recent data indicates that enrollment in VA care is more than 50% among younger veterans as the VA has increased outreach and services to veterans

discharged from military service in Iraq and Afghanistan (Hayes 2011; Yano et al. 2011). Approximately 57.4% of women who are OEF/OIF/OND veterans have received VA health care. Of this percentage, about 90% had repeat visits to the VA facilities after the initial visit (Office of Public Health and Environmental Hazards 2008). This is an important development given the tightening of eligibility criteria in 2003 that “barred entry to veterans who did not have a service-related problem and who had an above-median income for the geographic region in which they lived” (Oliver 2008:1213).

Of the 1.6 million women veterans identified by the U.S. Census Bureau (“U.S. Summary, 2000” 2002), approximately 11.4% are VA service users (Yano et al. 2003). Researchers have attributed the underutilization of VA services by women veterans to several factors. First, women lack accurate information about eligibility and benefits (Mulhall 2009). For example, Weiss and Ashton (1994) found that one in four female veterans of all ages were unaware of their eligibility for VA health care. In addition, Yano et al. (2003) reported that expansion of the spectrum of services VA provides is poorly understood (Yano et al. 2003; U.S. General Accounting Office 1992; 1999). Additionally, poor communication of how the health care services are organized leaves people wondering if the VA’s multiple venues of health care provision are coordinated or competing with one another (Yano et al. 2003). More recently, according to the National Survey of Women Veterans, about 40% of women veterans who served in recent conflicts in Iraq and Afghanistan believed that only those with service-connected disabilities were eligible for VA care (Washington et al. 2011). In fact, Friedman et al. (2011:S107) asserts that, “this misconception could dissuade some from seeking care.” Mulhall (2009) also pointed out that not only do veterans have to be proactive about obtaining

information on their eligibility, they also have to wade through a myriad of bureaucratic formalities to qualify for services.

Second, availability of services and ease in accessing them also influence whether women utilize VA facilities (Vogt et. al 2006). The gender-related care available to women veterans is not centered in one facility, but is dispersed among multiple sites (Mulhall 2009). Therefore, it is not unusual for veterans to travel up to two hours for routine and non-specialized gynecological care. Similarly, 51% of female veterans, especially in rural areas, tend to procure health care services from both VA and non-VA sources. However, the overall quality and continuity of care they received was seldom assessed (Mulhall 2009). Finally, female veterans also are reluctant to utilize health services because of a perceived lack of skills, and sensitivity among service providers to women's health (Vogt et. al 2006). Female veterans reported higher levels of satisfaction with VA health services when they received care from a female health professional at a gender-specific clinic (Mulhall 2009). The VA is also perceived as a system that is not particularly receptive to the needs of women veterans. According to Skinner (2000), one in five female veterans reported that they did not feel welcome at VA facilities.

Among women veterans in general, the top three diagnostic categories in 2009 and 2010 included PTSD, hypertension, and depression (Women Veterans Task Force 2012). Other diagnoses include high cholesterol, low back pain, gynecologic problems and diabetes (Women Veterans Task Force 2012). Significantly, about 31% of women veterans have both medical and mental health issues compared to 24% of male veterans (Women Veterans Task Force 2012). A recent analysis of survey data on health conditions of Montanans (Erickson et al. 2013) indicated that rural women were more likely to experience PTSD than urban women. These findings suggest that the impact of rural residence needs to be examined as well.

In addition to addressing the barriers to VA service use, the new research agenda identified by the Veterans Administration goes beyond descriptive studies on the stress of military life and the health status of veterans and their psychiatric conditions. Goldzweig et al. (2006) identified several gaps in the research on women veterans including three areas that are the focus of this study: utilization patterns of VA and non-VA services, quality of the care and services received, and use of VA services by minority women. Kramer et al. (2009) report that

American Indians and Alaska Natives (AIAN) constitute only 1% of the United States population, but these women and men serve in the military at higher rates than other U.S. populations, often in forward combat units (Bernstein 1991; Holm 1996; U.S. Department of Veterans Affairs [USDA] 2000). Many AIAN women have served with honor and distinction in all branches of the military and are among the growing number of female veterans who are now seeking care at the Veterans Health Administration (VHA). (135)

### *American Indian Women Veterans*

Minority veterans represent a rapidly growing segment of the United States Armed Forces. Their enrollment in the VA health care system is also expected to increase in the next fifteen years (Mulhall 2009). Although little research has addressed the needs of Native American veterans, reports have shown that Native American veterans suffer more from the three most frequent diagnoses than other veterans: post-traumatic stress disorder, hypertension, and diabetes (Kramer et al. 2009). Similarly, among women veterans in general as well as among American Indian women, the top three diagnoses treated by the VA in 2006 included PTSD, hypertension, and depression (Kramer et al. 2009). Since many of these women are members of federally recognized tribes they may also qualify for services from the Indian Health Service (IHS). However, Native American veterans still choose to utilize both the VA and the IHS (Kaufman et al. 2013). Even though these services have improved (U.S General Accounting Office 1992; 1999) they are not utilized at high rates. Kramer et al. (2009), found that Native American veterans used IHS and the VA Health care services only 48% and 25%, consecutively, and only one third of these veterans use both (Kramer et al. 2009).

The missions of the VA and the IHS intersect in providing care to veterans. American Indian women access health care both from the VA and IHS. However, among those using the VA, utilization rates were higher than those using IHS services exclusively. About a third of American Indian women veterans do not access VA services, but the reasons remain unclear. Kramer et al. (2009) conclude that a better understanding of the needs and access barriers among American Indian women veterans would assist both the VA and IHS in providing better services. Research is also needed on the additional service needs identified by the Women Veterans Task Force Report (2012), including higher rates of homelessness among women who are twice as likely to be homeless compared to non-veteran women, more childcare for women veterans who are the primary caretakers of young children, more services for addressing the higher level of service-connected disability ratings among women (55%) compared to men (41%), more services to meet the greater demand for education benefits among recent women veterans, and finally, underrepresentation in memorial services.

In a 2012 report, the VA reported 35,000 enrolled Native American veterans in rural Montana alone (Women Veterans Task Force 2012). These Native American veterans not only face transportation and travel barriers in receiving care, but they also have lower education and lower socio-economic status (SES) (U.S. Department of Veteran Affairs 2012a), as well as other social determinants of health, challenging their access to care and health information. The rural reservation contexts explored in this case study provide an opportunity to identify whether or not, and how, American Indian women veterans experience these barriers given the social factors identified as relevant to health care access and use.

In the following sections, information is provided about establishing eligibility for VA benefits and current collaboration efforts between the IHS and VA as mandated in the 2010

Memorandum of Understanding (MOU) to contextualize the discussion of Native American health care. Additional information provides clarification on key terms used in this study.

*Eligibility at a Glance*<sup>2, 3</sup>

According to the Department of Veterans Affairs any individual who served in the active military service and was discharged or released for any reason other than dishonorable is considered a veteran, and therefore, he or she may be eligible for VA health care benefits. Veterans who served in the Reserves and National Guard who received active duty training only, do not qualify for services. These individuals must serve in active duty to qualify for VA health care benefits. Veterans who enlisted after September 7<sup>th</sup> 1980 and were called to active duty October 16<sup>th</sup> 1981 must serve for two continuous years or serve the full period they were assigned when called to active duty in order to qualify for VA health benefits. Individuals who were discharged because of a disability due to their service, or if they served before September 7<sup>th</sup> 1980, may also qualify for VA health benefits as well. However, because of the complexity of the process, the word “may” is greatly emphasized. Therefore, to determine eligibility, the VA recommends that all veterans who were released under any condition other than dishonorable discharge apply for VA benefits to determine their eligibility and the level of benefits they may qualify for.

Veterans who meet certain conditions may also be eligible to apply for higher levels of benefits, for instance if they were imprisoned due to the war, if they received the Purple Heart Medal or Medal of Honor, if they receive VA pensions or were released after incurring a

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<sup>2</sup> <http://www.va.gov/healthbenefits/apply/veterans.asp>

<sup>3</sup> [http://www.va.gov/healthbenefits/apply/women\\_veterans.asp](http://www.va.gov/healthbenefits/apply/women_veterans.asp)

disability, or if they served in certain operations, etc. The first step to receiving access to VA health benefits is to apply. This usually begins by filling and filing the VA Form 10-10EZ.

Services for women veterans have expanded over the last several decades as women's participation in the military has increased and their needs for health care have been identified (National Center for Veterans Analysis and Statistics 2011). Although women must meet the same eligibility requirements as men, now they are also encouraged to connect with the VA medical center's Women Veterans Program manager who is responsible to advocate and guide women veterans on accessing primary, secondary, and tertiary care to deal with gender-specific health needs as soon as their eligibility level is determined. At a primary health care level, issues related to disease prevention and counseling are mainly addressed. In addition, mental health evaluation is also performed. Assistance regarding mental health issues, especially military sexual trauma (MST), is usually done at a primary level so that veterans are connected with the correct resources and facilities to deal with these issues. Specialized care is also available to women with chronic diseases that need to be monitored and managed. In addition, at this level of specialized care women who need reproductive care are also seen for maternity care, infertility, sexual problems, etc.

*The Memorandum of Understanding (MOU) 2010<sup>4</sup>*

The Memorandum of Understanding (MOU) is meant to provide authority and opportunity for coordinating the efforts and encouraging the collaboration and resource-sharing between both the VA and the IHS health care services. The MOU's goal is to improve the overall

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<sup>4</sup> This section is based on the Memorandum of Understanding Between the Department of Veterans Affairs (VA) and Indian Health Services (IHS) signed on October 1<sup>st</sup> 2010 retrieved from:

<http://www.va.gov/TRIBALGOVERNMENT/docs/Signed2010VA-IHSMOU.pdf>.

health status of Native American Indians across the United States. The 2010 MOU is a continuation and modification of the 2003 MOU between the IHS and the VA.

Both the IHS's and VA's ultimate goals are to increase access and improve the quality of health care through the promotion of patient-centered collaboration and facilitated communication. To do so involves increasing the efforts of the tribal representatives in the Indian health system, as well as the training of IHS and VA staff on appropriate procedures to understand eligibility statuses and referral routes. Moreover, an evident need to improve collaboration and understanding by staff and IHS and VA facilities administrators by establishing standardized mechanisms for access by providers in one system, to the electronic health records in the other system of patients receiving care in both systems, whether it's the IHS or the VA. It is essentially the *sharing* of information, resources, and vision that led to the birth of a new MOU from the old 2003 MOU.

### *Terminology*

This research refers to “access to care” and “utilizing and seeking care.” An important clarification in terminology is needed: “access” or “gaining access to health care services” refer to the first step of application that determines if veterans are eligible and determines the level of VA health care benefits they can obtain. This definition is consistent with Aday and Andersen's (1975) definition of access as “whether or not those who need care get into the system or not” (14). Similarly, Martine (2003) asserts that “access” is a term used to describe the potential or actual entry into the health care system. On the other hand, “seeking” and “utilizing care” at the VA care facilities refer to the second step after receiving notification of eligibility to receive benefits at the VA health facilities and clinics. As Martine (2003) suggests, having access denotes a potential to utilize a service if available. It is critical to make this distinction since each

process is associated with its own barriers and problems. Veterans struggle with the initial step of determining eligibility. Moreover, veterans also struggle later on in the process after gaining access when seeking and utilizing care as they set appointments, travel to facilities, etc.

*Sociological Approach: Social Determinants of Health*

Understanding the relationship between how populations experience “place” and the impact of “place” on health is fundamental to understanding the social determinants of health—including both social and physical determinants (Gornick and Swift 2002).

The World Health Organization proclaimed that several factors have proven to have influential effects on health. These include biological, socioeconomic, psychosocial, behavioral, and social factors (“Social Determinants of Health” 2014). Of these factors, social determinants of health are increasingly the main focus of research, health advocacy, and change. For instance Healthy People 2020 added social determinants of health as one of their goals (Gornick and Swift 2002). The World Health Organization defines social determinants as the influential conditions an individual is exposed to in the environment he or she is born or resides in (World Health Organization 2011). These conditions are responsible for the health inequalities and the avoidable differences in health statuses within and between countries.

This definition of social determinants of health is inclusive of one’s social environment including structural and societal factors, within which discrimination as well as income, education, and gender differences occur. It is also inclusive of the physical environment in which a person previously lived or currently lives. In addition, health service provision, access, quality, and health insurance are also considered a dimension of social determinants of health (“Social Determinants of Health” 2014). Studies have shown that health is not solely affected by one’s daily physical habits and socioeconomic conditions. Social factors are becoming increasingly

significant because they reflect the differential distribution of money, power, and resources at global, national, and local levels (World Health Organization 2011). Thus, the place of residence affects the kind, quality, and amount of income, employment, health services, education, and social ties that persons may access. Moreover, differences can be observed in health statuses (or one's perceived health) across the urban-rural spectrum as to the distribution of resources in these contexts (Macintyre and Ellaway 2000; Macintyre, Maciver, and Sooman 1993).

This view is congruent with the socio-spatial approach, which asserts that the quality of life varies across the urban-rural spectrum due to such social factors as gender, race, social class, power, etc. (Gottdiener and Hutchison 2010). Social problems such as poverty, inequality, and uneven development within settlement space result in unequal access to resources, thus determining one's life chances (Gottdiener and Hutchison 2010). According to the National Center for Veterans Analysis and Statistics (2012), geographic isolation of rural areas generates different circumstances and challenges for rural residents. Rural-urban distinctions can be witnessed in four major ways: demographic composition, social ties and social capital, culture, and infrastructure and institutional support (National Center for Veterans Analysis and Statistics 2012)

Increasingly, research on the place of residence and physical and mental health (Kawachi and Berkman 2003; Wen, Hawkey, and Cacioppo 2006) reveals that the ties and relationships people establish within their place of residence directly influence their well-being (Rollero and De Piccoli 2010). Several studies have explored the reasons that one's place of residence is such an important indicator of individual health. The geographic location in which an individual resides facilitates the creation of interpersonal and social ties crucial to well-being (Wen et al. 2006; Wilson et al. 2007). The negative effects of social isolation on psychological well-being

have been discussed in social research since its emphasis by Durkheim (Durkheim 1951). While social support has been identified as particularly useful in the face of stressful events, dampening cardiovascular reactivity (Kamarck, Manuck, and Jennings 1990), smaller social networks comprised of few close friends result in weak social support and has been linked to depressive symptoms (Barnett and Gotlib 1988). Location not only affects participation in community organizations and involvement in social networks, but it also enhances one's chances of accessing different forms of support that could protect against distress. Moreover, perceived and received support from social networks and other ties contributes to formal or informal access to beneficial health information, as well as reducing negative emotional reactions to stressful events (Kawachi and Berkman 2003).

Another social factor that is influential in one's health status is socioeconomic inequality. Historical data shows that as nations around the world witnessed increasing income and wealth inequality, especially between 1973 and 1993 (Karoly 1996; Wolff 1995), economic conditions were accompanied by increases in socioeconomic disparities in health (Moss 2002). In other words, the increase in income inequality, which according to the CDC is influenced by one's social environment, was associated with a gap in health status across social-income gaps. In addition, a number of recent studies examining both the US and Europe affirmed that the growing inequality in income and wealth is associated with a growing gap in mortality rates (Wilkinson 1996; Moss 2002). Because income gaps are more often than not related to racial/ethnic and gender inequality, racial minority groups and minority women are more prone to suffer poor health (Spalter-Roth, Lowenthal, and Rubio 2005).

For example, historical data indicates that gaps in death rates between blacks and whites and between men and women declined in the US between 1960 and 1986 (Moss 2002).

However, when education and income levels were taken into account for these groups, the gaps in mortality rates increased significantly (Moss 2002). Specifically, after 1968 the mortality rate for less educated women was much higher than the rate for women with more education (Pappas et al. 1993; Moss 2002). Moreover, research indicates that in the health system in the U.S, racial minorities experience unequal access to care, treatment, and coverage (Smedley, Stith, and Nelson 2002).

Massey (2007) suggests that for the categories of race, gender, and social status (class), the social mechanisms in place ensure the lack of upward mobility of the “inferior” (i.e., lower status) group members (Massey 2007). For people in these categories, mechanisms of prejudice, discrimination, emulation and adaptation boundaries contribute to exclusion and exploitation (Massey, 2007). Relating Massey’s social mechanisms to the concept of social determinants of health, we find that the WHO meant similar mechanisms when it asserted that the distribution of money, power, and resources at global, national, and local levels create important differences in the circumstances of social groups and communities (World Health Organization 2011). In addition, Brown et al. (2003) suggest that the persistence of a range of social problems among racial minorities emerges from residential and other types of social segregation that separate minorities from economic growth, opportunities and resources.

(Figure 1 about here)

In summary, Figure 1 provides an overview of this research’s theoretical framework regarding the health status of Native American women veterans on the Northern Cheyenne and Flathead reservations. Social determinants of health, in this case participants’ characteristics such as age, gender, ethnicity, educational level, and place of residence, influence access to resources such as health care and service, which influence health status. Figure 1 presents the

social determinants of health care access that produce differences in racial/ethnic, gender, and socioeconomic groups across the urban-rural spectrum, and are useful for studying the experiences of American Indian women veterans residing in reservation communities. This case study explores these issues for Native American women veterans residing in rural reservations in Montana. This population faces social factors identified in Figure 1 as important predictors of access to health care, including racial/ethnic group membership and gender inequality. Also, rural residence affects access to health services, especially because of distance to specialized care (Burgess and DiFiore 1994; Feitz 1995), quality of services, and adequacy of insurance.

## METHODS

“Nature and the world do not tell stories, individuals do.” (Reissman 1993:2)

Constructed individual realities are created through personal narratives, life histories, and family stories which reveal cultural and social patterns (Patton 2002). Along with this constructed bridge comes a call for action: a call to improve conditions of disparity; a call to improve conditions for those left disabled; a call to improve the lives of minorities who served but are left unserved. For this reason I use qualitative methods or semi-structured individual interviews as the primary data collection method for this research. Data were collected for this project as part of a larger project funded by the Emmeline B. Wells grant awarded to Carol Ward in 2012 and with funding from the Veterans Health Administration Rural Research Center in Salt Lake City awarded to Vaughn Call (and a group of sociology and family studies faculty) for a larger project on veterans health care in Utah and Montana.

### *Research Sites*

The American Indian veteran population is especially large in Montana because of the seven reservations located there in addition to the high rate of military participation among Native Americans. The primary site selected for recruiting Native American women veterans in

Montana was the Northern Cheyenne reservation, with the Flathead reservation of the Confederated Salish and Kootenai Tribes providing some supplementary interviews.

*Northern Cheyenne Indian Reservation.* The Northern Cheyenne Indian Reservation is located in southeastern Montana. The federally recognized reservation is approximately 444,000 acres in size, and the population is concentrated around Lame Deer, the capitol of the Northern Cheyenne Nation. The reservation is located around 40 miles east of the site of the 1876 Battle of Little Big Horn. A reported 99% of the land is tribally owned. The membership includes 10,050 enrolled tribal members with approximately 4,939 residing on the Northern Cheyenne Indian Reservation. Approximately 91% of the population is Native American, with 72.8% identifying as Cheyenne. A little more than a quarter of the population's five-years-olds or older speak a language other than English. A few members of the Crow tribe also live on the reservation (Northern Cheyenne Tribe 2013). In addition, the poverty rate in Northern Cheyenne is 42.8%, which is higher than the poverty rate for the state of Montana, 34.2% (Haynes 2011b). The unemployment rate is also higher for the Northern Cheyenne than is the rate for the seven reservations in the state of Montana, 59.8% and 51.6%, respectively (Haynes 2011b). For the two counties, Big Horn and Rosebud, in which the Northern Cheyenne reservation is located, the percentage of veteran's benefits (pension and disability benefits) available is 1.6% and 2.8 %, respectively (Haynes and Young 2011).

*Flathead Reservation.* The Flathead Indian Reservation is comprised of three tribes: the Bitterroot Salish, Upper Pend d'Oreille, and the Kootenai; the reservation was created July 16, 1855. The Salish, Upper Pend d'Oreille became known as the Confederated Salish. The Flathead reservation is located in northwestern Montana, extending to parts of Idaho, British Columbia, and Wyoming (Confederated Salish and Kootenai Tribes official website). Based on

the 2010 census of the Flathead population, 28,324 individuals reside on the reservation. This number is comprised of both Indians and non-Indians. In fact, the census reports a 2:1 ratio of non-Indians to Indians (Census shows growth at 4 Montana reservations, 2011). In addition, the poverty rate for the Confederated Salish Kootenai Tribes on the Flathead reservation is 20.3%, which is lower than the poverty rate for the state of Montana, 30.4% (Haynes 2011a). The unemployment rate is also lower than that of Montana, at 23.7% for Flathead and 51.6% for all seven reservations in Montana (Haynes 2011a). Compared to Northern Cheyenne, the Flathead reservation provides a higher rate of veteran benefits, 3.7% (Haynes and Young 2011).

### *Research Participants*

Participants were recruited using information from veterans groups and a snowball sampling method. A snowball sampling method involves asking research participants to identify other potential participants who are then asked to make the same referrals, and so on (Davis, Powell, and Lachlan 2012). This process of selecting participants provides for purposive sampling, a method for recruiting participants who have the knowledge and experience relevant to the topic being studied. Purposive sampling is also useful for recruiting additional interviewees who can provide relevant data about the patterns and themes identified during preliminary coding. The primary criteria for sample selection included age, type of military service, and type of health care providers and services used. Selecting women who varied on these criteria helped to ensure that the range of relevant experiences of women veterans was represented in the interviews.

The critical steps in each site were establishing a presence with information about the project and finding at least one community member who could help the team move forward with the project. These insiders also helped to identify appropriate ways to proceed and identified

locations for interviews. Initial contacts with women veterans clearly indicated interest in participation and support of the project. Among these key informants were three women veterans of different generations (NC9, NC10 and NC11) who provided important initial insights about the experiences of women veterans, including several barriers that veterans face at Northern Cheyenne.

Individual interviews were conducted with 15 Native American women veterans between 2012 and 2013; 11 at Northern Cheyenne and 4 at Flathead. Interviewees were provided information on the study topics and procedures and were asked to sign a consent form. The interviews ranged in length from 45 to 90 minutes depending on interviewee availability and willingness to talk.

#### *Participant Characteristics*

The women veterans in this study represent a variety of branches of the military: Marine Corps, Army, Navy and Air Force, etc. The participants' ages ranged from 21-45. Marital statuses of the women varied, including single, married, widowed, and divorced. Most of the women had children. Access to health care included the use of VA or IHS, both, or private sources. Thus, these interviews represent a range of experiences with health care providers. Tables 1 and 2 provide demographic information on participants residing on the Northern Cheyenne and Flathead research sites, respectively. From the participants listed in Table 1, NC9, NC10 and NC11 are key informants interviewed in 2010. These initial interviews helped with framing the interview guide to explore access and provision issues.

(Tables 1 and 2 about here)

### *The Interview Process*

Once a participant gave her consent to participate, the interviewer began digital recording, then asked open-ended questions related to the interview guide topics shown in Appendix A. Interviewers were offered a variety of places to hold the interviews that would provide for privacy, such as an office, or a classroom at the Tribal College located in each reservation community. Participants were also given the option to choose a different location that provided similar privacy, such as their home, a nearby restaurant or cafe, or another place.

The interview guide is a critical instrument for the interviewee and the interviewer. The interview guide is not meant to restrict the interviewer and the interviewee, but it helps to ensure consistency in the topics covered across interviews, while allowing room to extend beyond the topics as needed. Trained interviewers were very sensitive to participants' needs and emotions, especially while asking participants for more details or additional information. Generally, women were asked to discuss their health care needs and access to available services. In addition, interviewees were asked about quality and quantity of physical and mental health services accessed, as well as services needed that were inaccessible or unavailable. Major barriers to accessing health services were among the most important topics discussed; and women were asked for their suggestions and recommendations for addressing barriers to accessibility and quality of care. Finally, the community environment, as a contributing factor to accessing or preventing access to health care services, was discussed. Other important topics were community support, or the lack of it, and other social determinants of health care and its access.

## *Coding and Analysis*

Qualitative data analysis occurs in several stages after interviews are conducted. Transcribed interviews are read thoroughly. Open coding of several interview transcripts involves labeling (or creating concepts for) the specific responses to each interview question. Codes are then organized into a coding scheme. Yow (1994) defines a coding scheme as an organized set of labels that identify links between relevant categories and subcategories. For this study, interviews were coded using the coding scheme and the qualitative software program, Dedoose, facilitated consistent use of the coding scheme for multiple interviews.

The goal of more advanced coding was to identify themes, patterns, and relationships among the data items collected. This process *created* more complex concepts for understanding social roles, barriers, processes, institutions, and individual or group experiences. In brief, concepts were created that are valid in the context. I then used these concepts to build a conceptual model showing the relationships between these concepts. The end goal was to relate these concepts to a larger theoretical debate (Leiblich, Tuval-Mashiach, and Zilber 1998).

Figure 2 is a representation of the main codes identified in the coding scheme created to identify IHS and VA barriers to health care services. It provides a visual representation of all codes related to two main areas: veterans' experiences with accessing health care and related barriers, and their personal background and experiences as Native American women veterans. The subcategories in these areas include: (1) VA in general, (2) IHS in general, (3) veteran's personal information, (4) experience prior to enlisting, (5) experience during service, (6) experience post service, and (7) subjects' suggestions and recommendations.

The *VA* and *IHS* categories pertain to general categories and general barriers to access such as lack of knowledge of benefits and available services, unavailability of transportation,

inability to determine eligibility, lack of representatives to aid the veteran, etc. The *VA* and *IHS* categories include codes classifying participants' feelings and attitudes towards the VA/IHS, negatively or positively. The *VA* and *IHS* category also includes participants' evaluations of the quality of services. The third and fourth categories include codes related to participants' personal information and issues preexisting to the participants' enrollment in the military. The *personal information* category includes information regarding health status, tribal affiliation, years in the community, the branch of service, etc. The *experience prior to enlisting* category represents family and community support as well as their story and reason for enlisting. The *experience during service* category includes codes pertaining to the participants' experience as Native American female soldiers as well as types of jobs performed during their service. The sixth and seventh categories are grouped together because they include codes related to experiences after the participant's discharge from the military. The *experience post service* category includes codes related to reasons for discharge, mental health needs, social support post discharge, experiences of female veterans, and perceptions of gender differences in veteran experience. Finally, the participants' *suggestions and recommendations* category represents ideas about how to overcome barriers to access based on their experiences. These codes represent two major categories that yield findings related to (1) key elements of the individual and community context, and (2) barriers to accessing and utilizing health care. Codes from the *experience prior to enlisting* category and *experience during service* category yield findings related to the contextual elements. Codes from the *VA* and *IHS*, *experience post service*, and *suggestions and recommendations* categories yield findings related to barriers to accessing and utilizing health care.

(Figure 2 about here)

Corbin and Strauss (2008) and Berg (2008) advise that the coding process be done in stages. Initially, open coding generates the basic categories that identify the nature of comments, views and experiences of the study's research participants. The researcher can also evaluate the quality of his/her qualitative data to answer the research question. Secondary coding explores the initial codes developed during open coding to create subcategories or sub-codes that reflect the multiple aspects of the views provided in the group interviews.

While the early coding was done by hand, more extensive coding was done with the use of a software program, Dedoose. All transcribed interviews were uploaded to Dedoose. Dedoose allows for multiple coders to view and discuss the coding, as well as add new levels of coding. This was useful when relationships between codes and sub-codes across several interviews were considered or examined. This process facilitated the identification of patterns and themes used to answer questions about the most common needs, experiences, concerns, barriers, and recommendations communicated by Native American women veterans.

## FINDINGS

The main topics explored and emphasized in this study include experiences with and barriers to accessing physical health and mental health services from Veteran Administration (VA) and Indian Health Service (IHS) facilities located in or near the reservation service areas. Additional topics include the needs for certain health care and mental health services, and strategies or recommendations Native American women veterans proposed as possible improvements to facilitate access and use of appropriate care for themselves, their families, and other Veterans in their communities.

The findings can be divided into two categories: (1) contextual research elements, which include participant characteristics and socioeconomic and cultural conditions that *indirectly*

influence their needs, access and ability to seek services, (2) barriers to accessing and utilizing health care service, which include VA and IHS shortcomings in disseminating information as well as social determinates of health such as the socio-spatial barriers that *directly* prevent veterans from receiving the care they need and which negatively influences their health status. These can also subdivided into barriers that negatively influence access, e.g., collecting information regarding how to go about determining eligibility and barriers that prevent utilization of services such as unavailability of transportation, funds to travel to the VA facilities, etc.

### *Contextual Elements*

Personal characteristics were found to play a role indirectly in every phase of women's military service as well as life following service: decisions regarding military service, experience in the military, access to health and mental health services and the type of health care services needed after they left the service. For instance, women in this study shared their experiences of being sexually harassed because of their gender and the hostile treatment experienced because of their ethnicity. This led to some veterans' experiences with mental health problems and struggling to make the transition to civilian life upon return. Additionally, as women they had a need for gender-specific services. However, some Native American women veterans who experienced also harassment needed mental health services.

The family history of service, and family and community support for veterans were other examples of important contextual elements. These elements encouraged some women to serve and provided support during and after their service. However, others who faced a lack of family support to enlist faced additional struggles when they returned from service and began the transition to civilian life. For all women in this study the community context included important

messages about the value of service, but few resources that assisted with the transition to civilian life. In fact, many of the research participants reported that women received less recognition for their service as veterans relative to men.

*Reasons for enlisting.* Family and community support were among the strongest motives for many women enlisting. In many families, a history of grandparents, fathers, and brothers serving in the army served as an inspiration for enlisting. In other situations, veterans' family members personally encouraged them to enlist together.

My dad was like "Just go for it, if you can, do it." So I went ahead and did it. It was probably the best thing that I did. I'm grateful I did. I'm proud of my service (NC6)

R2: So, did that help that your older sister was already in the military, that you have family that had been?

I: Yeah, it did.

R2: Did you ever talk to your sister about it?

I: Yeah, I did. She was the one encouraging me to join the army. She was like, "You should join the army, be in the air force," and this and that. (NC7)

In this instance NC6 received support from her father for enlisting. And NC7 was encouraged by her sister to enlist. Similarly, (NC5) from Northern Cheyenne received support from her family as she enlisted with her brother and cousins. FH3 and FH1 from the Flathead reservation had long family histories of service, and eager family members who encouraged enlisting.

There was four of us when we went in: My older brother Joseph, my cousin Hunter, I think you met him, and then my cousin Antwon, and now when they, when they first sent people over, my unit was one of the first ones. I was just proud of that cause they were all pissed! I was the only girl in with them at the time ... because I got sent over and they didn't. They kept volunteering to go with me, but their units wouldn't let them so.... that was cool. They were worried...but, you know. (NC5)

And part of wanting to go into the army, too, I mean I always thought or the military, is because everybody in my family did, my brother, my dad, my grandpa, my uncles. (FH3)

Well, yeah. My cousin and I, we just wanted to go in together. We thought of the Air Force [phone rings], we wanted to do the Air Force. (FH3)

Everyone in my family had been in the military, so it seemed like a good thing to do. (FH1)

In other cases, women talked about the ambivalence or lack of support for their enlisting. For example, Jennifer faced a lack of support because of her mother's beliefs that joining the army was inappropriate for a female.

Mom is Blackfeet, and she felt that it was inappropriate for a woman to join the military. She was afraid of a lot of different aspects of joining the military. And she was mostly just scared. She still doesn't talk about it. She won't talk about it. When I was "away," that's what she says: "when you were away." (FH1)

I: Sounds like your family was pretty supportive, I mean ultimately.

R: Yeah, at first they weren't.

I: Why did they not want you to go in at first?

R: Because of the war, yeah, right after 9/11 and all that was going on. (NC8)

In summary, women who had a family history of several generations serving in the military had more support for enlisting. Family support, regardless of its sources, was a strong reason for Native American women to enlist in the military. However, some women enlisted even if they did not have strong family support because of their interests in seeing the world, getting training, getting a regular pay check or doing something different with their lives.

So I can see the world. I know my brother went in and they were in California and they went straight to where they... Iraq. And was just over there the whole time. At least in the Navy you get to travel around and see different places. (NC8)

I was going to school at Colorado State and I was paying out-of-state tuition. (Inaudible) So I dropped out after two years and bartended for a year and then got tired of it and decided I've got to do something else. I joined the military. (NC8)

Did try school but it was getting kind of expensive for me there, and that wasn't really my calling so it was either get a job or join the military, 'cause I wanted that choice to get paid to go back to school when I was ready 'cause I was basically swimming in debt so that's why I joined the military just because I wanted to have that be paid for and have that experience of being independent and being on my own and making money and providing for myself. (NC3)

Especially coming from a rural...rural Montana, we wanted to get out and do something together. (FH3)

And the military seemed like a good plan. I wanted to serve my country and I thought, it's service... great! (FH1)

Regardless of the presence or absence of family support some women turned to the military as a refuge. NC8 and FH3 joined the military to escape their rural and isolated place of residence and saw the military as an opportunity to explore the world. On the other hand, NC8 and NC3 both tried going to school, but they felt that they needed a change and a chance to

support themselves financially. Another veteran from Flathead (FH1) on the other hand, saw the military as a chance to fulfill the need to serve her country.

*Being a Native American soldier.* The women veterans discussed a variety of experiences in the military; some of those experiences were highly influenced by their ethnicity. Some women believed that their Native American heritage gave them an advantage.

NC6 from Northern Cheyenne expressed that being a Native American resulted in some negative treatment or experiences.

Because it was like a male-dominated MOS, I had my fair share of sexual abuse, you know, sexual harassment. Just kind of because I'm a girl or whatever, and then on top of that, being Native American I kind of got harassed a little bit for being Indian, but it wasn't one of those things that made me cry or anything, it just kind of sucked it up. (NC6)

*Being a woman soldier.* Some women expressed hardship during service because of their gender. For example, some were subjected to sexual harassment because they were female. For instance, NC6 described her negative experience with sexual harassment and verbal abuse due to her gender in a male-dominated field.

I was sexually harassed by my platoon sergeant and he ended up leaving the position. And it wasn't like, "Oh my God, tragic" but "Oh my God, that's sick." But it happens, and thank God that's all it was, it was just verbal harassment, it wasn't physical or anything like that, still it was kind of ugly. (NC6)

Other interviewees were more susceptible to health problems such as Urinary Tract infections (UTI) because the military life in a combat zone provides little consideration for female hygiene, female physiology and female-specific health services. NC3 and NC5 from Northern Cheyenne shared their health problems of severe urinary tract infections (UTIs) and health care access obstacles.

Being one of the first wave of soldiers to go over, and there being nothing there, it really sucked! A lot of the women were getting UTIs and stuff like that because, when you're on convoys, and you gotta... they're not gonna stop for you, you gotta.... it just sucked for the females, and it was so hard to keep yourself clean sometimes. But I had a cool driver and he would always make sure, "You need to stop? You need to?" So I never got a UTI at the time but a lot of them, they did, and they just sucked. It was hard to... and even time when you did stop... washing, it was just dirty all the time because of the sand. So it was pretty rough and you're sitting there washing your clothes in a little bucket, but after a while, now it looks like they've got everything, but it was hard when we first went over. (NC5)

It was a little difficult for health services there, because there was a small town and they didn't have tri-care medical facilities there. We had to go to the nearest medical building, and I remember giving birth to my son, and I was the only woman on the ward doing so, and it was very hard for me getting the attention that I needed as a pregnant woman in that coast guard at that small boat unit. (NC3)

Even though the military is becoming more attentive towards the specific needs of women, this has not always been the case. Several women in our interviews also shared negative experiences with superiors harassing them. In contrast, one woman discussed some positive experiences with being able to demonstrate her strength as a female soldier.

I feel like I had special strength, yeah. I feel I was a little stronger person than some that I had seen around me. Especially women, of course. You know, us women are the more emotional...so I felt like I was a little bit stronger. In fact, no I actually I feel like I was a little stronger than those men, some of those men...you know? (FH3)

Yeah, and I think maybe it's because of that strength I carry, you know, I did notice I got a lot of respect from men. But I'm the type that if they tried to disrespect me I would say something. I'd confront them right then and there. So they...yeah...so I didn't put up with anything. (FH3)

Then when we were in my unit, they always put me at the pacemaker. We'd have to run the airfield and, so I'd be the pacemaker 'cause I'm a woman and I think those officers knew, 'cause those guys are kinda lazyish. (FH3)

Gender can be an influential factor affecting health status. Because of their gender, women veterans faced such as issues having UTIs because of the difficulties of accessing restrooms and practicing good hygiene in the field. Other women were sexually harassed or experienced negative attitudes from their peers. On the other hand, some female soldiers attributed their strength to their gender.

*Transition to civilian life.* As military personnel get discharged, they make a transition to civilian life. About 60% of the women veterans in this study expressed a struggle with the transition to civilian life. One veteran, however, expressed a smooth transition into civilian life (especially when integrating back into society) that was very influential in the development of her personal identity early on in her life. FH3 from Flathead described her transition as a nice one, as she settled back into the Indian community to which she felt she connected.

I actually left Alaska and went to Seattle. My mother was living there at the time. I stayed with her and got a job with an urban Indian center out there: the employment division. So I became the assistant to a director

for the employment division, helping people find jobs, things like that. So yeah, that was a nice transition because I went right back into the Indian community. You know, that connection of who I am. So I felt that belongingness, so it was easier, I think it was. Plus me with the National Guard. That connection. (FH3)

In contrast, most of the Native American women veterans expressed hardship after discharge as they integrated into civilian life. Among the most important issues that women veterans discussed were the difficulties associated with mental health needs that affected making the transition back into civilian life; these issues were shared by approximately half of the women. For example, NC3 and NC7, from Northern Cheyenne experienced several adverse mental health symptoms and a lack of connectivity to the civilian population, making their transition much harder than that of FH3 at Flathead.

I. Do you think it's difficult for female vets to transition back into civilian life?

R. Yeah, it was for me. I know I've got a couple of friends that I served with that they still have it. And it's been years. And I don't know how their personal life is but they told me that they still try to deal with it. I thought that was kind of, I felt for them, but I thought that was "Oh" because I didn't have that hard of a time. I just had a hard time in a different way and stuff.

I. In what ways was it a hard time?

Noises. A lot of it was like noises. Just being home and not trusting and not, I couldn't be in big crowds, I couldn't be I don't know, just a lot of foreign languages. If I heard different languages it was just like I didn't know because I couldn't understand what they were saying, I didn't know what they were saying and I always had to remind myself that I was back home, that I wasn't anywhere else. Loud noises always got to me. A car misfiring or any kind of loud boom or anything just kind of got to me. Took me a while, I just started getting back into hunting again. And that took a while because the sound of a rifle scared me, or certain smells. And seemed like if I tried to talk to people or my family it, I don't if know was just me, but it seemed like they didn't understand. They didn't know what my emotions, my feelings, and I would get frustrated. I think it was just me dealing with it, and I felt like at the time that they were just putting me down, I felt like. ... So it was hard at first and it would affect my jobs... So that was kind of difficult, and then with my kids, that was difficult too. (NC3)

Like I really have, I really wouldn't say that I had bad dreams, but I just kind of have like hard time sleeping and a lot of other things look like my friends, marines, dying. I had lost a lot of brothers, so it was really hard to just like sleep. Even my boyfriend say that you have to wake me up in the middle of night, cuz I would have nightmares. You know even that, I was like I don't like to talk about it. You know, I don't really like to really put myself in the category of needing mental health, I guess. (NC7)

Similarly, other veterans from Northern Cheyenne described their experience with trying to fit back into their civilian lives: culture shock and the lack of connection with civilians around them.

But once I got into school...I felt like didn't fit in, and I just, I don't know... and as like, the Natives, you get like culture shock. You get taken, like when you go away.... there's like no other Natives there. I barely ever [saw] another Native. Like once in great blue moon, you know. Then when we were in Virginia we had a little crew, like there was a couple of us. But the culture shock is so much. And when

you come back, it's different. When you come back, it's like you don't fit in with them, but you don't fit it with civilians either.... Yeah, 'cause you get removed, and you get like, it almost gets, like, silenced in you for so long, for so many years. (NC4)

It seems like sometimes people have a hard time making the transition because they're like, "These people don't really know what I've gone through." (NC5)

Other women veterans at Northern Cheyenne described certain aspects of their experiences in the military, which they considered obstacles in transitioning back to civilian life.

I think years, just years of trying to deal with it. Being in the military, I can't speak for everybody, but you kind of learn to hold your emotions in. Or hold your thoughts in because before I could be able to talk but after I came home, after the military, and it took years to let those out, to let my thoughts out or my feelings out, and not hold everything inside. I would say some really good friends that went through the same, that were there with me. Just us talking and keeping in contact with each other and dealing with it. That's about it. I know I was asked if I wanted to go see a counselor or something, but I said no because I felt no because they weren't there. They don't know. They might know how to deal with it or help you deal with it but I wanted someone that was actually there that knew what I was actually talking about. So I guess years and those good friends and sometime some smells and some noises bother me now still but not as bad as it was before. I mean it was bad and now just hearing about the war I want to go back in and I want to go and say, "Well I can deal with it this time." Because that was my first time and I was, "Yeah, I can do it." It brings back memories. (NC2)

Women from Flathead also shared the same struggles transitioning as women veterans at Northern Cheyenne.

That's one of the issues. I don't really want to talk about it, it's kind of a, "That was then, this is now," process. But also I felt like, after I got out, I made the decision to get out. I knew that there was.... and this is a hard thing to say... that there was no place in society for the person that I was. Not really. ...I mean... they are not exactly advertising for highly trained killers in the newspaper. Which is probably a good thing... But I had to figure out where that balance was. And it took a long time to put that away... (FH1)

You know, some aspects of it are great — the training, the discipline, the self-discipline, understanding how to give direction, leadership; all of those things are great qualities. But... I always thought if people really knew what I was doing overseas... that wouldn't be such a great thing. People want to say, "Oh, good! Good! Let's support the Veterans!"... I didn't feel like a victim... I don't like that! (pause) Yes, support us with health benefits! Say thank you- that's great! You're welcome! I did put my butt on the line for eight years! (FH1)

R. It was definitely different. Because, I mean, you don't have NOBODY, like.... When you wake up there you know what you're gonna do, what's expected, where you're to be, where you're to report and all this then you kinda get what you're going to do for the day from there. But basically (when you're out) it's like, wake up and not know what you're going to do. Nobody's gonna tell you what you're gonna do. I. And is that difficult or just weird? Like did you feel a little bit lost, or you liked it?

R. Yeh I felt lost. I know like, what helped too is, about the same time that I got out, like four of my buddies got out of like the Marine Corps and stuff, the Marine Corps and the Army, and they all felt the same way so we all kinda hung out a lot.... We did a lot of partying. Like ... hard partying. Like, days-on-end partying! (FH2)

NC 3 and NC1 described the experiences they had seen among friends and relatives who were veterans and needed mental health care:

I've had experiences with male cousins that needed help 'cause they were in Afghanistan; they had PTSD, and there weren't very much outreach programs out there for them. I know it's harder for people who have those issues to come out especially when there's not much support especially in the Native American community. It's just like you come home, you're a warrior now, get back to work and get back to life and that's kind of how it's been for a while. I hope that changes. I hope they have a facility that they can automatically have them come check in and get evaluated, and have classes to have them start at so they can slowly get out of being in a war zone, active duty, to civilian. I think it's more difficult for people that have been in war. And I think they need something like that. (NC3)

I have a cousin who is suffering from PTSD and he's a marine veteran and just out of pride and gossip he doesn't go down here and he can't afford to go to Sheridan to get the proper care to even have a counselor listen to him. He doesn't even want to do that. And from male to female, from experience, females are a little bit more open in our community, being it's OK to talk to a family member or someone who can help you get referred. Or even walking down [to the clinic] for support to get help. (NC1)

A veteran (FH2) from Flathead also had friends and family struggling with mental health needs such as PTSD after they came back:

I. Do you have close friends or family that are aware that you might be in a little bit of a rough situation?  
R. Um hmm (yes). Well from my baby's dad...he's PTSD. (FH2)

A veteran (NC1) from Northern Cheyenne discussed obstacles for why veterans prolong seeking care or avoid accessing mental health care services.

I. What are some things that hold people back [from getting mental health services]?  
R. Pride. Admitting that there is a problem. Covering it up with substance abuse or drug abuse or just not taking notice to it—riding it out until something bad happens. Blowing up, anger—that's what I meant. Like, out of anger or emotionally crumbling because they can't handle day-to-day situations. (NC1)

I. So, what could be some things the VA could do to help?  
R. If there was a VA representative that was accessible from day-to day to where someone could feel that they could walk in and even ask a question knowing that there is confidentiality... But in small communities you deal with gossip, so not being sure if your story is confidential. Sometimes even people are so prideful that they don't even want to be seen going into Behavior Health. (NC1)

For some women veterans, especially those who served in the 1990s, getting help for anxiety disorders or other mental health needs was not something they did. They preferred to get help from other veterans rather than from professionals.

I think years, just years of trying to deal with it. Being in the military, I can't speak for everybody, but you kind of learn to hold your emotions in... And it took years to let those out, to let my thoughts out or my feelings out and not hold everything inside. I would say some really good friends that went through the same, that were there with me - just us talking and keeping in contact with each other and dealing with it. That's about it. I know I was asked if I wanted to go see a counselor or something but I said no because I

felt no because they weren't there. They don't know. They might know how to deal with it or help you deal with it, but I wanted someone that was actually there that knew what I was actually talking about. (NC2)

It's hard. When I got back I had trouble sleeping and stuff like that because... but, when I'd go to the doctor, all they'd do is just give you lots of pills and you know, send you out the door. I went back.... they gave me these really potent sleeping pills and stuff like that... I ended up going back and telling them you know, I can't take these and I had like all these different medications and he's like "who put you on these?" Kinda like that, and I was like, "You did" [laughter] He's like, "Oh, well," and starts crossing off a couple of the prescriptions. I'm like, "Ok, we're not coming back here again." (NC5)

I think that some of those people with those disorders wouldn't want to come out and talk about it. A lot of our tradition and stuff were very private, we're private people, and unless there's a gathering everybody lets that privacy go and we kinda let it go and you know, this is the issue at hand and whoever is doing the meeting this is what we're doing to help, to benefit everybody, I think that would be more beneficial. (NC3)

### Other women veterans sought help but were denied benefits.

Yeah, I would. I did apply actually, for benefits for depression, because they said when I got out, they said, "Oh, you're depressed." (pause) It's been, like, a huge struggle! Basically what my experience was, it goes to Fort Harrison, and someone who doesn't know me stamps it with a stamp that says, "Denied" and I get a letter in the mail that says, "By the way, you've been denied." (FH1)

After returning, Native American veteran women faced a problem with making the transition into civilian life and forming connections with family members, neighbors, and other members of their community who were unfamiliar with the military way of life. Many of the veterans not only struggled with simple daily life tasks, but also returned suffering mental health problems. Because of the ambiguity surrounding the VA enrollment process, as well as the negative stories other veterans shared about being denied access to VA healthcare, the veterans faced yet another form of struggle. If the VA enrollment process were easier and simpler, veterans would be better able to address mental and physical issues such as PTSD as soon as they returned. As veterans deal with their health issues, it becomes easier for them to transition into civilian life.

*Community Support for Veterans.* Veterans from both reservation communities described the support for veterans. The following comments are typical and reflect the women's perceptions of the level of support and care for veterans in their reservation communities:

I: Did you feel like people were being supportive when you first got back?

R: Yeah, when I was in and when I got back.

I: Yeah, it seems like everyone is really proud of the veterans. (NC2)

The tribe's helped out a lot like with just, medical, personal shopping and stuff. (NC5)

Our community really supports our veterans. It doesn't matter which branch or whatever. (NC6)

Well I think this community does pretty well, you know. There are little events going on for veterans, like the powwow. (FH3)

It was cold out, I remember. Cause I went with the honor guard. We stood along the highway and waited for him to come through and drive through. But every community even along the highway 93. You'd see people out from their houses. And you'd see people's lights in their houses blinking. Oh, it's gonna make me cry. He's just a baby. I mean, how old was he when he came back home? I want to say he was maybe 21. (FH3)

Like within any, with any tribal community it just always seems like there's really great support. There's always something going on with veterans. Usually it is a Powwow. Bring 'em and honor them. (FH3)

Women from both Northern Cheyenne identified support for veterans by their communities.

Their communities fostered a sense of pride and respect for the men and women who served their county by taking action to provide resources, plan honoring events, and by lining up on highways to welcome returning veterans.

However, some women also mentioned that they felt women received less acknowledgement or recognition for their service compared to men. Some believe it may be related to their greater involvement in combat, but others indicated that women veterans are less visible. Because of this publicity and recognition, male veterans were much more connected than female veterans.

I do notice that the male vets are, uh how would I put it? They're more known or whatever and the female vets, they're kind of looked like as - I don't know, I have heard a couple people say that they believe that there shouldn't be any female vets, that it should all be male because female vets aren't actually out there on the front line fighting. I'm just like, "Um I was a frontline medic." So we were out there just as much. And I don't know if that's how everybody feels, but I've heard it said. When they do, what is it called, announce the vets or name them, they really don't name any females. It's all males. And I was just like "hello!" So that's what NC1 and I were talking about. We were hoping that we would start meeting regularly and start helping each other out and getting involved like that they might start recognizing us, so hopefully that would work. (NC2)

At Northern Cheyenne women recognized that there was a lack of connection among them. However, they also have been attempting to connect with one another to provide support and aid to one another.

I've been trying to get with all my friends and everything and trying to get a reunion going and I figure that might help us to all get together. It's been years and kind of see where each other is and be able to at least from there keep in contact with each other. Some are doing really good and some aren't. And like I said, I know there's a couple that just they haven't moved on and they were there longer so, I think that's why. (NC2)

Proves it right there, that there's a disconnect with us women veterans. (FH3)

In contrast to her previous statement, FH3, at Flathead, also mentioned her experience with community functions that enabled her to connect with another local woman veteran who was on the reservation.

So we met at a Powwow. In fact I think it was a veteran's Powwow. And we just hooked up just like that, became best friends, best friends and we just had so much similarities and that's how I found out about, with somebody saying, "Oh, you gotta meet so and so," and we were just really a great circle of friends. She passed away last year. (FH3)

Diverse opinions on the matter of community support for women veterans were provided in the interviews. However, three facts are clear. Native American communities at both Northern Cheyenne and Flathead are very supportive of their veterans. However, women find themselves less recognized for their service compared to men, which leads them to be less connected with other female veterans and more isolated from other women veterans who could be resources in accessing health care.

### *Barriers to Accessing and Utilizing Health Care*

As the purpose of this research is to improve our understanding of Native American women veterans' experiences with using VA and IHS through identifying the barriers in accessing and utilizing health and mental health care services available to Native American women veterans, possible barriers were explored during the interviews. Figure 2 presents several barriers found in our analysis. Primary among these are distance from VA facilities, availability

of transportation, and cost of transportation or travel to the specialized VA facilities. Many of the research participants reported long wait times or scheduling problems at the VA facilities, which conflicted with their work schedules. Another barrier was the lack of information and the inability to complete the required paper work. Therefore, not knowing where to look, what to look for, and even how to look for information in relation to eligibility, enrollment, and seeking care was an issue many of the women repeatedly faced.

*Access: Lack of information on eligibility and benefits.* Upon discharge, transitioning into civilian life is not the only struggle Native American women veterans' experience. Many interviewees expressed problems accessing care at the VA, due to the lack of information on benefits, eligibility, and the enrollment process. Approximately three-fourths of women in this study discussed the problems they had with accessing VA healthcare due to the lack of information regarding qualifications and what the VA had to offer.

The VA, I don't know what's offered there. You know, we don't have anything like, anything in the media that shows, "Well, hey, you guys can have this and that." And it's not really emphasized to us Native Americans, being that we live in a rural area, so it's just hit or miss. If you lose out, you lose out, like no big deal. And I think the VA clinics around here.... I don't even know where they're at! I mean, I think they offer some in Sheridan maybe, or Billings. And usually it's too far; it's like what's the point when we can just go to Lame Deer [IHS clinic] if it's for medical purposes, or any other medical issue. You just go to Lame Deer and you get what you get, you know. (NC6)

I. Have you ever used the VA?

R. No.

I. Never?

R. No, it's just too hard. Like paperwork wise, and just trying to get to where I need to go for that kind of stuff. It's easier to just go down here [to the IHS clinic] than to get the VA benefits.

I. Where's the closest VA that you would have to go to?

R. I think it's in Billings ...I think, so it's more of a hassle. (NC5)

What information is there? You have no information! You have no access. You don't really know. And when you come in to get it it's a really uncomfortable experience. (FH1)

In addition, FH1 from Flathead mentioned the issue of obtaining the correct documentation. Understanding the requirements and the process for filing the needed paperwork to seek care was very hard for many women.

Actually I ran around like a crazy person trying to find every single record of every single thing trying to pinpoint.... they still don't even look at it most of the time. They are just like.... and that is what I've heard from other people over and over again. (FH1)

Some took the challenge to learn about the application and enrollment process and helped to file the paperwork needed to gain access to VA healthcare services. However, some were denied access or heard that other fellow veterans were denied. These experiences, which were shared among veterans, discouraged some from putting in the time and effort to get the proper documentation to apply for VA benefits.

I hear stories from other people. It just doesn't...it just seems like it's a headache and just a pain in the butt. And...it's hard to receive it, to get it. I don't know. It's just not out there to...I don't know. Like I said, I didn't really think of it or pay attention to it or even know it was available, kind of, in this area. (FH3)

And so it just was like... a mess! Like trying to navigate the system. And then if you call, they are just very impatient! They're like, "What do you need help with?!" (FH1)

In some cases, if women didn't ask about how to access healthcare for themselves, they never got it; and it was always a difficult process to ask for care.

You got to take care of your own to make sure that you are up to par in deployment status...And see, some aren't necessarily ignorant to the fact of, "Well I'll get it when I need it." Some need to take that initiative to ask; spread the word. And we can't get it through the IHS, but it's not a provider through the Army. (NC1)

But they don't advertise it. They don't let people know about it. You kinda have to search it out. And I'm like...I lost track of that lady, but she tried to really help me get that benefit. (NC1)

It took me like six months to go through the whole process of filling out the paperwork and sending more paperwork in. It only took them about six weeks to deny me. And now we are in the process of re-doing a claim. I'm seeing a pretty good therapist for combat vets in Polson. She does a lot of good work. (FH1)

In contrast to these negative perspectives, some veterans shared some positive experiences when they were aided in obtaining what they needed to access care at VA facilities.

R. But when I needed them, when I really needed them, I came up here and they always came through for me.

I. That's great.

R. Even right now, like for mental, for just trying to deal with.... I should have got that right when I got out, but I didn't. And they, yeah they always look, they always write to me, they're always checking on me, they're always...

I. That's good. So you feel like they've been pretty good to work with then?

R. Yeah, I feel like they saved my life. They really saved my life at one point. They did. Because it was getting too crazy, and I just had to like... I didn't know where to turn to, and I knew that I had VA benefits, and I turned to them. And they immediately, like that day, saved my life! But you have to make your appointments ... and you have to, you can't be late. But they helped me out. The VA helped me out so

much! Ever since I've been out.... I was on unemployment, and then I went to school, but I don't think I was there long enough to even get my VA checks... and then, it took a while to get whatever, but I was in Boise and I was sick over there and I just went to the VA! And I was in Washington and the nearest one was Walla Walla. (NC4)

Another veteran received help from older veterans or officials at the Tribe who had a better grasp of the paperwork process as well as more experience with maneuvering within the system.

The Tribe's helped out a lot like with just, medical, personal shopping and stuff. But like VA [pause] that is a lot of paperwork just to go for one checkup or you know, something. (NC5)

So I was living over in Cherokee. Kind of during transition after the economy crashing and I just stayed with some folks over there. But, he was an old Vietnam veteran. Him and his wife and they took me on like a daughter. So I stayed with them. So they used it all the time. At the Veteran's Hospital. So they got me to sign up and I did. That's how I found out about it. They were so like, "Yeah, you need to go. Come on, we'll take you." And if it wasn't for them, I probably wouldn't have done anything or looked into it. (FH3)

It is important to recognize that not all veterans are able to connect with other veterans who have mastered the VA enrollment process, nor are they able to dedicate the time to learn the enrollment process. Some veterans neglect mental and physical health issues because they lack access to VA health care. Women discussed how the military administration educated them on successfully seeking employment after discharge, but failed to educate them about VA and IHS health care benefits.

I: Did they give you much information when you got out? On how to get benefits?

R: Ahhh no not really. They mainly talked about how to get a job and stuff like that. And coping with being in the real world and stuff.

I: Transitioning back to civilian life.

R: They really did not talk about medical. They made sure that there is nothing wrong with you medically before you got out. So you can't go back and blame it on them. So if something does happen. But I don't know if the medical center or the VA benefits are better than IHS. Some things at IHS are not the best (NC8)

*Utilization: Distance to VA services.* A major barrier to seeking and utilizing care shared by every interviewee was distance and travel. Native American women veterans reported difficulty in going to VA facilities because of the lack of availability of transportation, their inability to drive, the cost of the commute, or their unwillingness to spend many hours

commuting and waiting in VA waiting rooms. Distance and travel were mentioned by two-thirds of the interviewees as important barriers to seeking care.

To have to go into town you have to worry about gas, you have to worry about food, if you take a driver, that kind of thing. (NC6)

I. So about how long does it take to get to the nearest one?

R. An hour and a half to Sheridan. About six hours to Helena. So I could see where it would be (ugh) it could be really hard for an elderly couple to say I can go up and maybe VA can pay for it if they don't get referred by IHS. To where they would have to pull out of pocket if they didn't have a job or social security. How are they going to find the gas money? (NC1)

I: Where are the places off the reservation that you can go to?

R: Billings, over 100 miles away. (NC1)

It's just...it's so far to drive! (FH3)

To some interviewees the issue of travel to VA facilities was a new experience since in the past some funds had been provided for VA trips by tribal programs. A van funded by the VA provided some help with travel to VA clinics and other services.

I. Are there any other barriers and challenges to getting services from the VA?

R. Yeah, just travel. The Tribe used to help, like when we had appointments and stuff. They would give us gas vouchers and stuff like that, but now they had to shut that down because some of our programs, they got cut because of the budget and stuff like that. So, now if we have to go out of town for anything you have to get your own gas and get your own ride. I have a vehicle, but they, my family, the rest of them, they don't. I got a lotta miles on my ride.

I. And, have you seen other friends or people in the community that this has been a big problem?

R. Yeah. The Tribe tries to help with that. A lot of people don't have a vehicle so if people gotta go to Billings, we have this transit bus on Saturdays that will take whoever they can squeeze on there, and they'll go up to Billings and they'll take them to Wal-Mart and stuff like that. (NC5)

Other veterans felt that VA healthcare for women was simply inaccessible for them.

Yeah, I wasn't really aware of that until there was a women's health fair that was going on over here and they were set up. And I was like, "Really?" And they were like "Yeah, sign up!" I never did sign up. But the thing is, is that it's just...it's so far to drive! (FH3)

Some veterans mentioned that the local van (that provides transportation to VA services) was too limited to provide transportation to the services they needed. One younger veteran identified problems for older veterans related to travel and reimbursement, as well as getting medications they needed:

But with the older veterans, complaints of travel; how to get reimbursed; how do I get it; waiting on social security and time of the month; when at the beginning of the month when they really need help or run out of medication—how they can find a doctor to prescribe them maybe blood pressure medication that they

could get at the IHS. It just comes down to convenience and with VA benefits that's really hard to come by. (NC1)

In summary, the distance barrier can be attributed to various reasons such as the rurality of Montana, age of the veteran, and lack of transportation. Identified in most interviews, this barrier was detrimental to utilizing care.

*Access and utilization: Support from tribal VA representatives.* A number of the women veterans identified the need for more assistance from the Tribal VA representative in learning about VA benefits and the process of qualifying, which is critical for successful access. While some had attempted to get help from this source, a number of the women were not able to get the assistance they needed.

If there was a VA representative that was accessible from day-to-day to where someone could feel that they could walk in and even ask a question knowing that the confidentiality is HIPPA, like the IHS. But in small communities you deal with gossip, so not being sure if your story is confidential. Sometimes even people are so proud that they don't even want to be seen going into the [mental health office]. (NC1)

A representative for questions and out there. I meant, you can't get enrollment up at a college if you don't put it out there, the dates, get a representative out there. The same with the VA. There has to be awareness. There has to be someone active in the community within the community members getting out there, getting to know people being visible: the clinic; flyers; tribal building. (NC1)

And then their advocate is supposed to tell us what we can access and stuff. I haven't seen him. I don't know. From what I've heard, he just kind of tells you and gives you a bunch of paperwork. (FH2)

The difficulty in scheduling appointment at the VA is related to the utilization of services. This issue became relevant once veterans successfully accessed the VA health care system. NC2 discussed how her work schedule clashed with that of the tribal representative, which prevented her from scheduling any appointments or accessing any information she needed through him.

Yeah, because with my work schedule and everything and by the time I get off work or the times I have days off I just, you know, it just happens to be that they're not in or [the Tribal Rep] just happens to be out so like I said, we just keep missing each other. (NC2)

In the past, tribal support facilitated VA access through financial assistance or by providing veterans with transportation. However, with recent financial cuts and few resources,

this option was less available. As a result veterans must continue to struggle to overcome the access and distance barriers on their own.

*Utilization: Women's health care.* Another barrier that prevents many women from seeking care at VA facilities is the lack of services targeting the needs of women and health care needs for service-related conditions, as well as other health needs, such as specialized care for reproductive health.

I. So, at the VA in Billings, do they have a women's center or a place where you can get women's healthcare?

R. The only thing that I think I have a problem with ... is like getting my yearly "paps".... I'm still trying to get it! And I've been trying since March! Those are booked like...

I. Oh really, you just can't get an appointment?

R. And if you miss it, you don't get another one for like three months... (NC4)

As NC5 from Northern Cheyenne mentioned earlier, women suffer UTIs as a result of the harsh military conditions. Similarly, FH1 from Flathead, discussed health problems related to serious back, hip, and pelvic pain due to the heavy weights they were required to carry.

I think there are certain concerns for women coming out of service. You've got a lot of pressure on your pelvis, a lot of pressure on your hips, you've got a lot of back problems coming out of the military. The other women I'd talk to said, "Yeah, my back hurts all the time." That's a lot of weight to be carrying. (FH1)

Many of the women we interviewed were working mothers. Because of their situations, women veterans found it difficult to set appointments between work and childcare. In addition, they had to take into consideration the time and cost of travel to VA facilities.

OK, childcare. If I don't have enough leave I can't seek to find childcare in order to go to an appointment. And if there's not enough leave accumulated I can't get that paid. I'd have to sacrifice – [take] unpaid leave - to seek medical care. (NC1)

The women in this study identified conditions that made accessing health care difficult. These were related to both their experiences as women in the military and their situations as veterans who are working women and mothers.

*Access and utilization: Choosing local health services (HIS) over VA services.* Because of the barriers in access and utilization of care at VA facilities, a substantial proportion of Native

American women veterans in this study expressed a greater desire to pursue, or continue to pursue, care at IHS clinics. As veterans failed to gain access, due to the lack of assistance from VA representatives and lack of information dissemination by the VA, they also failed to utilize the VA services. Thus, many sought services from the local IHS health care facilities. These clinics were considered easier to access and utilize due to their close proximity and because veterans were able to acquire information about IHS services. Because of this ease and familiarity, women chose to seek care at less specialized facilities such as IHS rather than seek care at more specialized facilities such as the VA facilities, leaving many of their health needs unmet.

I don't even know what [VA] resources are available there; you never hear of anything. I don't know. I've never had to because we have the IHS clinic, which is less than mediocre healthcare that we're offered, but it's just something we're used to, you know, something we've grown up with so we make the most of that (NC6)

FH2 from Flathead, drew the same conclusion as the women from Northern Cheyenne regarding the VA.

[The VA's] a lot out of the way... and right now, like with school, and work and everything, it's like... and then to go to them you've got to schedule like a whole day just to like go there and put up with their B.S. and all their stupid running around crap, and you just get tired of it, so... (FH2)

Because of the inconvenience of traveling to the VA, women would sacrifice quality and specialized care at the VA facilities for less specialized services at the IHS clinics. Some also avoided seeking mental health counseling because of their fear of a lack of confidentiality, and also a fear of the stigma of seeking mental health counseling.

I don't know which one is better. I know they cut down on a lot of things at the IHS with people. The budget with them... (NC8)

I: Ok, and then how are the services here on the reservation? How do they work?

R. From compared to a Band-Aid and pain reliever, to someone who will sit down and hear your symptoms, to getting the proper care. (NC1)

In sum, due to the barriers associated with accessing and utilizing VA services, some Native American women veterans found themselves sacrificing quality and specialization, as well as leaving their mental and physical health needs unmet.

*Women veterans' recommendations.* Women were also asked to identify a number of recommendations that, based on their experience, would be helpful for improving access to care at VA facilities. When discussing barriers due to the lack of information, many women suggested a more proactive role for the Veteran Administration in assisting veterans in accessing the needed information for their eligibility and the required paper work to understand what is needed to ensure access to healthcare.

I know they had a class when we got out, but you don't always get all that stuff. They're just kinda like, here's everything, give you all the paperwork and here it is. Go do it. And I wish they would have something here that would be so useful. You know, you can get your VA medical insurance here. A lot of ...veterans here that have families, like 99% of them do, and that would be helpful if they did that, said here's your medical tier, your educational, here's something if you want to get a job too beforehand. That would be great if they had that, you know, training...I would totally go and I know a lot of people would go cause that's just something we need to have cause you forget that. You come back to the reservation and you think, "What do I need to do again to get all my paperwork done?" You know, it's a lot, a lot of paperwork you have to do one by one by one ... and you have to figure out yourself so it would be nice to get some support cause I know people who could use the help. (NC3)

The women veterans addressed the specific needs of reservation communities for improved technology and coordination with organizations on reservation communities.

Yeah, like I said before, I think they should have a training, here or somewhere on the reservation, and do training for them and have everybody sit down and they could have the guy do a speech or a talk and have everybody introduce themselves and tell what they've done, and then maybe have a briefing and tell about the services that they have, give everybody an outlook, cause not everybody have internet services. We don't even have cell services, so it's difficult to even do that. The reservation life is so backwards. That's what's so difficult for us young people, for young Veterans. It's so difficult to raise a family, to get a good job, to do all this when you don't have those resources. So I think it would be good if the VA understood that - that these reservations are backwards on their technology. It would be good to have a gathering like this to have a feast or something like that and have a talk and get the word out, let the tribal council know, "Hey this is what's going on," [and] the boys and girls club and these other organizations on the reservation. Let them know that there's an agenda going on for the veterans, free meal, talk about some services. That will be pretty useful. I think that would be so helpful here. (NC3)

Yes, you have to go out and initiate what you need and go seek your help, but I think if there was readily available through our agency to go and talk and have someone spread the word within the different age groups or one individual who was, I guess what I'm saying is, not just a job, more of caring, taking the time to get to know the vets because if we don't come together for a meeting or if an elder does not call one like at the log cabin a couple weeks ago, well like May, that there is really nothing. And if you don't take

notice, you don't want to seem being judged or pushy saying, "Hey, it looks like you're needing help." Or "I heard you need a ride" and not being an immediate family member. It's not quite as comfortable approaching someone who you know is in need but I guess the initiative to taking that step of having someone be there to say "Hey, I'm here if any of you need help feel free to call me, email me, send a representative for you to come get an application or help you fill it out." Because I know social security comes down once a month, down here, but to have maybe a tribal member be the representative or position, start with volunteering, putting the word out to where people could get the proper care. It just comes down to people listening, someone who wants to take that time. (NC1)

Women veterans expressed interest in having an advocate from within the community who is willing to raise awareness for different issues while crossing different gender, age, and ethnic boundaries.

Maybe if there was gender specific, maybe if we had that option of having a male and female. It comes down to pride. No one wants to admit they're sick. (NC1)

There has to be awareness. There has to be someone active in the community within the community members getting out there, getting to know people, being visible: the clinic; flyers; tribal building. (NC1)

In addition, because of the lack of connection between generations and groups of veterans, many women were unaware of other veterans' needs.

[At a recent meeting] there was a viable question that a few of the older vets had, and it's like I didn't know that they felt like this. I didn't know that they didn't have a ride. I didn't know that it was such a big deal that they knew they needed help and they just didn't know where to turn. A representative... It's still old school around here with that generation and the older, baby boomers, of that generation are the ones who are in need right now. And it's more mental health, with the younger generations, with the younger soldiers: life or limb, they know where to go right now but ones that have the hidden scars, I feel, don't. (NC1)

Because of the negative encounters with personnel at the VA health care facilities, some veterans suggested easier access to the VA staff and friendlier personnel.

Like maybe if one day, once a month or something, someone would set up in the IHS or something... the VA.... so the vets that go in don't have to use IHS, they can use the VA, and have somebody there with the paperwork, and like an office off to the side...(FH2)

Maybe just have somebody a little bit friendlier... when you call in and ask a question... they don't cover everything under the Q and A. (FH1)

Another veteran, concerned about the scarcity of opportunities and resources in reservation communities, suggested the following:

I think it's crazy, 'cause a lot of veterans are not working and it's hard for them and many are homeless and it's just really tough. What I would like to see, just recently I started thinking about this...there needs to be some sort of plan and legislature push to give the veterans their own health insurance. I mean that makes more sense....You give everybody that doesn't work Medicare and Medicaid. What about us? You know,

we served this country. We did, you know, our part. And we're having a tough time out in the world. You know, a lot of them are having a tough time. The least you could do is let us be eligible for certain federal health insurance. (FH3)

## DISCUSSION

This research revealed several patterns and themes in the experience of Native American women veterans attempting to access and seek care at VA facilities and local health care providers located in the reservation areas. Some of these patterns and barriers were consistent with previous research focusing on female veterans (Mooney et. al 2000), especially studies discussing the lack of available resources to determine benefits and eligibility (Mulhall 2009; Weiss and Ashton 1994). This research went beyond this general theme of a lack of information and revealed several other conditions: lack of help from VA representatives, and difficulties in obtaining the appropriate documentation for eligibility in applying for VA benefits. Veterans not only found hardship in gaining access to VA health care, but they also shared their struggles with utilizing this care once they were declared eligible.

While Figure 2 identifies the major barriers emerging from my analysis, Figure 3 builds on Figure 1 by including the barriers and contextual factors emerging from my analysis and displayed in Figure 2. Figure 3 is a conceptual model that provides an overview of the specific characteristics or experiences that are linked to social determinants of health and how they may negatively influence access to and utilization of health care, Even though this research does not provide data on the health status of participants, Figure 1 and 3 present barriers that prevent provision of health care when needed which could negatively influence veterans' overall health status. The final figure represents a sociological approach that draws on women's perceptions and experiences to identify specific barriers that prevent them from fully accessing and utilizing VA benefits. That influences whether and to what extent they receive the care they need and the quality of these services. One or more barriers or elements identified in Figure 3 is sufficient to

discourage and even prevent veterans from attempting to access VA benefits and seek care at the VA facilities, which then results in their turning to local IHS clinics. Although IHS clinics are accessible and familiar to these women, they lack the resources to provide sufficient physical health and mental health care to meet the range of Native American women veterans' needs.

(Figure 3 about here)

In summary, as Native American women veterans return to rural reservation communities, the first barriers they face are related to access. The lack of information on obtaining eligibility and types of services available combined with the lack of support from tribal VA representatives, unavailability of the services targeting their needs as females and the VA's reputation of denying eligibility statuses to veterans led many Native American women veterans to fail to gain access. However, when they do gain access to the VA they are faced with utilization barriers. Because of their rural residence these veterans struggle with needed transportation, especially with the lack of financial support by the VA or the Tribe to provide funds for transportation. Hours spent commuting and waiting at the facilities led many veterans not only to prolong seeking care at the VA facilities and prefer using this time working, it also led them to turn to the IHS clinics. Even though these services are considered adequate to meet primary health care needs, they are unable to meet more advanced health care needs

As shown in Figure 3 the lack of transportation, lack of funds, and the unwillingness to spend several hours on the road and in waiting rooms, are among the travel-related barriers interviewees shared as they attempted to seek care at Billings, Sheridan, or Helena VA facilities and clinics. Previous research on veterans found that distance to VA facilities negatively affects the seeking of care at those facilities (Burgess and DiFiore 1994; Feitz 1995). This study suggests that this issue persists, as veterans continue to struggle with it. Although tribal programs

have been supportive in aiding veterans in overcoming the travel barrier, the issue with distance was expressed in most interviews. Because of the hardships associated with accessing and utilizing the VA health care services, many of these veterans sought health care at local IHS facilities and clinics which were accessible, but provided lower quality primary care. Thus health issues that required secondary and tertiary care were ignored.

Figure 3 also shows that Native American women veterans' utilization of VA health care is influenced by social determinants of health, such as conditions emphasized in the socio-spatial perspective, specifically, uneven development within the reservation context that result in unequal access to resources, thus determining one's life chances. The findings indicate a lack of VA healthcare resources on reservations because of their rural location and a lack of communication between the IHS and VA, regardless of the MOU, as well as the absence of a tribal VA representative. The analysis revealed that many participants did not receive information about the different types of services being offered and whether these services can be sought at the IHS or VA facilities, thus indicating the failure of the MOU agreement. Moreover, my analysis also revealed a lack of information due to the absence of tribal VA representatives.

An important aspect of this study is that the research sites are unique. Native Americans serve at a higher rate in the military than any other minority group in the U.S (U.S. Department of Veterans Affairs 2012b; Kramer et al. 2009). In the case of members of the Northern Cheyenne and Flathead tribes, this can be attributed to the positive cultural meanings of military service, the family and community support provided to service and veterans, and the opportunities offered in the military. These communities have a deep appreciation for tradition and service. The socio-spatial perspective adds understanding to the social conditions associated with accessing health care with its focus on the rural locations of the study populations and key

features of those locations; such features include both positive and negative influences on access to needed resources such as health care. For example, the American Indian tribes included in this study have special relationships to the federal government, which provide for education, health care and other institutional resources. Additionally, special agreements between the IHS and VA are intended to improve health care access. Nevertheless, the communities in this study, like many other reservations, experience health care and resource shortages, as well as high rates of poverty and unemployment. Veterans in both reservation areas struggle with finding employment, affording health care services and transportation. The socio-spatial perspective also emphasizes the distance of these populations from needed resources such as VA facilities compared to IHS clinics. VA facilities located in urban cities such as Helena, Fort Harrison, Sheridan and Billings are hours away from the Northern Cheyenne and Flathead reservations. Consequently, distance limits the access of rural residents to resources such as specialized VA health care facilities because of their urban location.

Being Native American in some cases meant negative treatment by their peers or superiors while serving. Other women drew on their ethnic identities as strengths during their service. Additionally, some felt a cultural barrier and unfamiliarity when seeking care at the VA facilities, thus, leading them to seek care at more familiar settings such as the IHS.

Gender-specific needs have been neglected and left untreated as well. Gender is an important determinant of health for women in this study both during and after their service. Research shows that MST for women is on the rise and the number of facilities that target the needs of women has decreased (National Center for PTSD Fact Sheet: Military Sexual Trauma, 2010). Women participants shared their experiences of harassment related to their ethnicity and gender while serving. They also shared their struggles to deal with mental health problems and

transition into civilian life. That combined with the lack of gender specific services and mental health services available to them led many to neglect their mental health issues. In addition, when women compared themselves to men in their communities, they often felt less supported and recognized for their services, and less connected with their peers. This lack of connection can negatively affect their health since they miss out on opportunities to connect and share information regarding VA benefits and aid with transportation and other beneficial resources.

Among the many suggested solutions was an increase in outreach by the VA to help Native American veterans with understanding eligibility for benefits and the services available. In addition, other suggestions included increased patient advocacy and local service officers in reservation communities to help with obtaining eligibility for services, and improved coordination of the VA with other health providers to ensure appropriate general physical, mental and gender-specific care is available. This includes IHS, tribal health, and other local clinics and hospitals. In summary, attention to the availability and quality of services must be dedicated.

This research reveals major themes that support previous research. Native American veterans in rural areas struggle with the transition into civilian life due to trauma and the inability to relate to civilians in their communities. As they struggle with accessing mental health services; mental health issues often remained untreated and neglected. Others refused to deal with these needs because of the stigma attached to mental health problems and the lack of family and community support upon return. To facilitate access to health and mental health services an evident need for a VA tribal representative must be met. Because of the absence of a representative many veterans miss the opportunity to learn about VA benefits, and the process of qualifying and scheduling. To overcome the barriers associated with distance and travel, veterans

in this study suggested that transportation be provided and that resources be allocated to aid veterans, especially older veterans make their appointments by providing a mode of transportation.

Unfortunately, simply providing transportation is insufficient to address the needs of women veterans; when women are able to gain access and have the transportation to overcome the travel and distance barriers, they are met with a lack of services targeting their needs as women. Even though the VA has been improving gender-specific specialized care, women's needs remain unmet either because of unavailability or lack of information. Therefore, more extensive efforts are needed to ensure that all facilities provide gender-specific services and that there is sufficient information on the types of services needed.

The findings of this study suggest that the rural environment and the distance from the larger cities where the larger VA facilities are located is very influential in veterans' ability to receive care. The location of VA facilities primarily in urban areas reflects social determinants of health related to socio-spatial patterns that increase access and utilization for some groups and create barriers for others.

The rurality of reservations and the Native American women veterans' preferences to reside in reservation communities surrounded by family, community members, and others who share their ethnic beliefs and lifestyle also influence their health care access. Specifically, these institutional constraints interact with social and cultural conditions, which represent social determinants of health.

## CONCLUSION

This exploratory study was conducted as part of a larger research effort to clarify the challenges and obstacles American Indian women veterans living on the Northern Cheyenne reservation experience when attempting to access health and mental health services. It also

offers additional perspectives from American Indian women veterans from Flathead regarding their access to the VA and other experiences with health care. These Native American women veterans served in different branches of the military, in different periods of time and different locations. The findings presented provide important insights into the experiences and perspectives of Native American women veterans residing in rural areas. The findings can also form the basis for solutions to the problems of access, quality, availability, and barrier elimination to improve access and health provision at the primary, secondary, and tertiary levels. The data presented are relevant to stakeholders including health officials, health care providers, veterans, and veteran's advocates in the development of viable, efficient, and effective solutions to overcome the presented barriers.

Aside from barriers to accessing and seeking care that directly influence the health status of participants in this study, contextual elements were identified that also indirectly influence the health status of participants. These contextual elements and barriers are considered critical components of the social determinants of health and the socio-spatial perspective. This study's findings are consistent with previous literature related to effects of place of residence for both physical and mental health (Kawachi and Berkman 2003; Wen, Hawkey, and Cacioppo 2006) in that the rural settings in which Native American women veterans reside in influence the amount and type of health care resources they have access to as well as the amount of support they receive from their tribal community. This emphasizes the need to examine all environmental components of rural communities as social determinants of health. Rural community support, social networks, problems with access, and social and geographic exclusion are all characteristics of place that must be examined to assess how they directly and indirectly influence well-being (Nicholson 2008). Additionally, this study suggests that the unique histories and cultures of rural

communities affect the meanings given to military service and may differ for men and women, and certain types of health care may have local meanings that impede or inhibit their use.

Although the VA has recently directed more attention to women's needs by expanding services for women in VA facilities, disparities persist in access and the care provided to male and female veterans (Office of Quality and Safety 2009). Thus, while the overall number of facilities targeting the needs of women has decreased, the number of minorities and women serving in the military and those reporting MST are increasing (Mulhall 2009; National Center for PTSD Fact Sheet: Military Sexual Trauma, 2010). Similarly, women in this study communicated several barriers to seeking care in both the IHS and VA facilities, which include the need to educate and inform all veterans about determining eligibility, and the types of VA and IHS mental and health services available to them. The findings indicate that the VA continues to face substantial problems in making needed information available to veterans in rural areas as well as informing all veterans of the MOU which aims to coordinate veteran care between the VA and IHS and outline service provision responsibility. Both the IHS and VA must address barriers of distance so that even when veterans are informed and educated they are able to travel as needed to access available care.

Additionally, this research aspires to shed light on a neglected population that is underrepresented in qualitative and quantitative research so that potentially unique issues of health care provision and access are better understood. Since Native American women veterans are part of a fast growing minority segment of the military with growing health needs, the findings of this study may help health care providers better address unmet needs. Another area that remains understudied is mental health problems, such as PTSD treatment, and the lack of community and family support to veterans, women specifically, who continue to need treatment.

Initiatives are needed to overcome social stigma among Native American veterans about seeking care for mental health problems such as PTSD, depression, or anxiety (Women Veterans Task Force 2012).

Finally, the barriers for accessing and seeking care are multidimensional. Though there is substantial family and community support and recognition for veterans at both Northern Cheyenne and Flathead, resources are inadequate to aid veterans in finding employment, accessing VA benefits, or obtaining educational benefits. Therefore, the scarcity of resources and opportunities on the reservation, in addition to the difficulty of accessing VA information and health care, along with veterans' reluctance to get some types of care, result in multiple factors that can prevent or inhibit veterans from getting the care they need and deserve.

Policy implications of this research involve increasing the efforts of tribal VA representatives for rural, reservation communities as well as establishing unified training for IHS and VA staff on appropriate procedures for informing veterans about benefits, their eligibility for services, and their statuses. Additionally, both VA and IHS staff need training that will improve collaboration and standardize mechanisms for accessing an integrated electronic records system between IHS and VA; such a system is needed to facilitate sharing patient records between providers without inconveniencing patients. Therefore, several policy and logistical changes are needed to establish a more effective and efficient system for sharing resources.

Moreover, this research raises several questions for future inquiry. For example, future research could address a more effective method of information dissemination regarding use of different types of insurance by rural veterans and community members, including American Indian veterans. Additionally, research on social determinants of health, such as age, should examine available options for rural aging veterans and community members as well as the

resources available as they explore and plan for retirement. There is an increasing need, based on the findings of this study, to clarify generational differences in accessing VA and other sources of health care as well as to identify the unique barriers and needs facing each generation.

Finally, efforts should continue to be dedicated by the VA to the needs of women and minorities and to ensure that mental health services are available in rural locations.

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## APPENDIX

### *Topics for Native American Women Veteran Health Care Needs Interviews*

The interview discussion will include the topics shown below. They may not be covered in the order shown – the list is primarily used to suggest the types of things we would like to discuss. The main purpose is to have a discussion in which everyone can contribute by discussing experiences, views, etc.

Participation is voluntary, and all information shared is confidential. Each person will be asked to sign a consent form for participation in the group interview.

The interviewer will encourage the discussion to address relevant topics.

- √ Level of need and types of health and mental health services accessed.
  - current needs for health services?
  - mental health services?
  - experiences with accessing these services?
  - service providers used to meet your needs?
  - where service providers are located?
- √ Quality and quantity of health and mental health services accessed (or changes).
  - frequency of need for health services now?
  - mental health services?
  - types and amounts use now?
  - services needs changed?
  - assess quality of the services you receive now? In the past?
- √ Barriers/challenges related to accessing services (e.g., transportation) and problems with service delivery.
  - barriers or challenges in accessing the services you need?
  - other problems seen or experienced in the delivery of health services or mental services?
- √ Needs for services not accessible or available.
  - needs not met through local or other services providers you are familiar with?
- √ Community conditions that affect access to services.
  - conditions or circumstances in the local community or area that affect the provision of services you need?
  - would telemedicine help to improve your access to health or mental health services?
- √ Recommendations for addressing service delivery and other problems identified.
  - recommendations to address the problems you have identified?
  - other improvements you would like to see either in the types of services provided or improvement to access?

Table 1. Northern Cheyenne Veteran Characteristics.

Code Name	Reservation	Years in community	Age group	Branch of service	Employment status	Education	Marital Status	Number of minor children
NC1	Lame Deer	6-10 years	31-40	Reserves	Full-time: project manager	4 years of college	Separated/Divorced	2
NC2	Lame Deer	3-5 years	31-40	Army	Part-time: program assistant	Some college	Separated/Divorced	2
NC3	Lame Deer	1-2 Years	21-30	Coast Guard	Unemployed	Some collage	Married/cohabitating	1
NC4	Lame deer	1-2 Years	21-30	Navy	Student	Some high school diploma. GED	Separated/Divorced	2
NC5	Lame Deer	16+ Years	21-30	Army	Stay at home	Some high school diploma. GED	Married/cohabiting	4
NC6	Ashland	16+ Years	31-40	Army	Full-time: Donor relations clerk	Some college	Married/cohabiting	2
NC7	Ashland	16+ Years	21-30	USMC	Unemployed	Some high school diploma. GED	Separated/Divorced	0
NC8	Billings	6-10 years	31-40	Navy	Student of nursing	Some college	Single	0
NC9	Missing	Missing	Missing	Army	Store attendant	Missing	Missing	Missing
NC10	Missing	Missing	Missing	Navy	Student	Some high school diploma. GED	Missing	Missing
NC11	Missing	Missing	Missing	Missing	Missing	Missing	Missing	Missing

Table 2. Flathead Native American Veteran Characteristics.

<b>Code Name</b>	<b>Reservation</b>	<b>Years in community</b>	<b>Age group</b>	<b>Branch of service</b>	<b>Employment status</b>	<b>Education</b>	<b>Marital Status</b>	<b>Number of minor children</b>
FH1	Saint Ignatius	1-2 years	31-40	Army AD	Student	Some college	Married/cohabiting	2
FH2	Polson MT	3-5 years	21-30	No answer	Student & full-time community support specialist	Some college	Single	1
FH3	Polson MT	3-5 years	41-50	Army	Full-time Journalist	4-year college degree	Single	1
FH4	Pablo, MT	3-5 years	31-40	USMC	Student & part-time work	2-year degree	Single	2

Figure 1. Overview of the Theoretical Framework

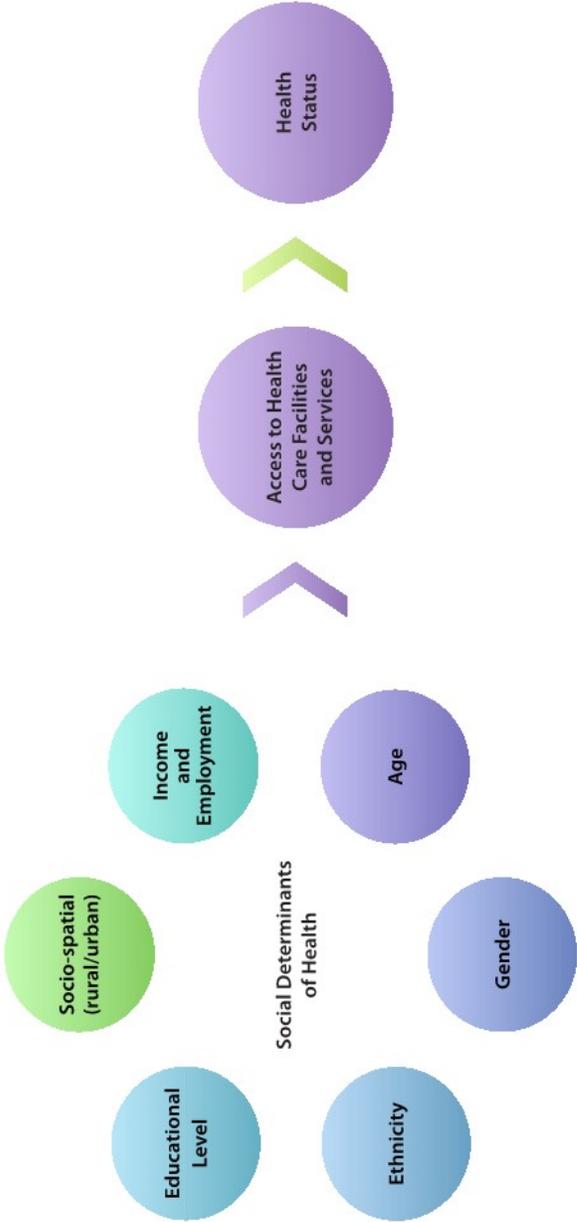


Figure 2. Coding Scheme for Major Themes: Accessing Health Care from Different Providers, Veteran Characteristics and Contextual Elements Affecting Experiences with Accessing Health Care.

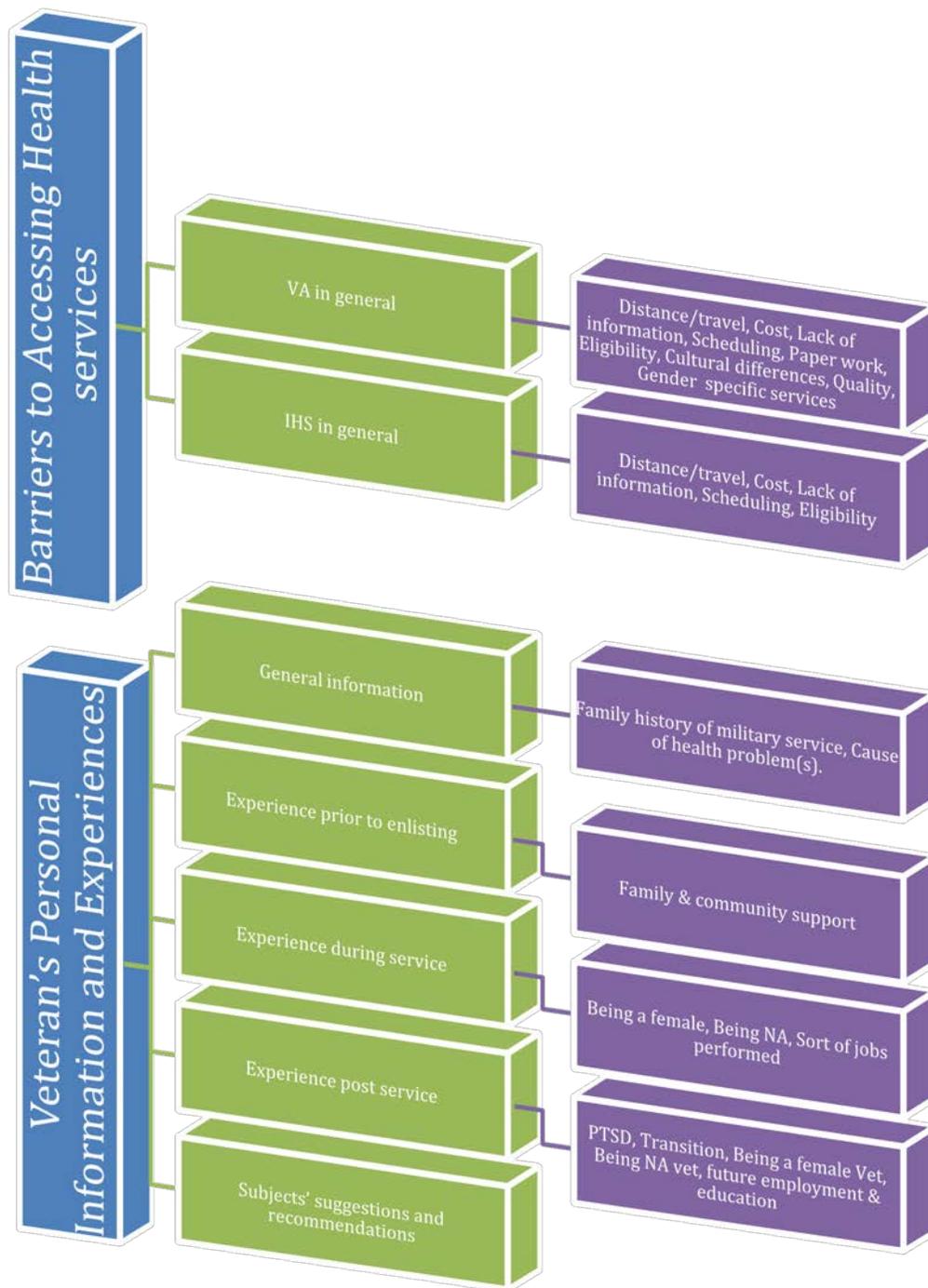


Figure 3. Overview of Social Determinants of Health Access and Health Status.

