

Setting a Foundation for Innovation

A Good Health and Wellness in Indian Country Progress Report

February 2017



**Urban Indian
Health Institute**

A Division of the Seattle Indian Health Board



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EXECUTIVE SUMMARY

In 2014, the Centers for Disease Control and Prevention launched the Good Health and Wellness in Indian Country (GHWIC) program, a five-year project that funds tribes, tribal-serving health organizations, and Tribal Epidemiology Centers (TECs) to promote chronic disease prevention amongst American Indian and Alaska Native (AI/AN) people. This report examines the strategic assessment and planning work grantees performed in the first two years of GHWIC.

Across Indian Country, twenty-three GHWIC grantees are revitalizing indigenous values to achieve health equity and improve chronic disease prevention through sustainable, culturally-driven interventions rooted in community voice and participation. GHWIC grantees are comprised of two components, and include 11 TECs funded to provide evaluation resources:

- **Component 1 (C1):** Twelve federally-recognized tribes addressing health disparities through community-chosen and culturally-adapted policy, systems, and environmental change activities.
- **Component 2 (C2):** Eleven tribal-serving organizations and TECS providing sub-awards and technical assistance to tribes and tribal-serving organizations in their Indian Health Service Areas.

In the first two years, **C1 grantees engaged in culturally-sound strategic planning to develop a foundation for addressing chronic disease priorities in tribal communities by: 1) forming cross-sector workgroups, 2) completing community health assessments, and 3) selecting community-centered activities.**

Community health assessments (CHA) were completed using methods that reflected indigenous values by prioritizing local voices and engaging with tribal leadership. Health-related physical infrastructure, diabetes, food access, and nutrition emerged as major areas of need across GHWIC communities. By focusing on community strengths instead of weaknesses, these CHA approaches revealed the importance of health program staff members and strong relationships with communities as positive influences on health.

C2 grantees: 1) distributed regional community sub-awards, 2) strengthened coalitions and partnerships and, 3) facilitated regional communities of practice. C2 grantees provided financial resources and technical assistance to tribes and other AI/AN-serving programs in their Indian Health Service Areas. Unlike C1 grantees—who worked within their own communities to implement health improvement strategies—these tribal-serving organizations served as hubs to tribes and agencies region-wide to develop effective and sustainable programs for long-term health and wellness goals.

The sub-award model extended the reach of the GHWIC program to over 113 tribes and organizations serving AI/ANs. With guidance from C2 grantees, sub-awardees implemented diverse policy, systems, and environmental changes to increase the effectiveness and sustainability of their activities and ensure that the impact continued beyond the life of the sub-award. In addition, C2 grantees provided locally-tailored support around evaluation processes and tools and delivered services via multiple avenues, including webinars, site visits, in-person trainings, regular conference calls, and through facilitation of area-wide communities of practice.

The activities described in this report highlight the importance of allowing a flexible, locally-driven assessment and planning period. **By creating collaborative workgroups and allowing the adaptation of health promotion programs to meet local community needs and priorities, GHWIC created a solid foundation for innovative interventions in the years to come to combat health disparities in Indian Country.**

OVERVIEW

This report provides a brief overview of the accomplishments of the first two years of the Good Health and Wellness in Indian Country (GHWIC) program. Component 1 findings presented here focus on the flexible, locally-driven processes and efforts of the twelve tribal grantees. The second section reports on the culturally-sound leadership, training, and resources Component 2 grantees provided to tribes and organizations in support of GHWIC program planning and implementation. Community profiles of two grantees are included to highlight the innovative ways in which the GHWIC grantees adapted health promotion programs to meet local community needs and priorities. The Urban Indian Health Institute (UIHI) acknowledges and honors the work of each GHWIC grantee.

WHY ADDRESS GOOD HEALTH AND WELLNESS?

In tribal communities, good health and wellness were historically rooted in culture, tradition, and community knowledge. Federal policies, institutional practices, and systematic oppression of cultural teachings shaped the current conditions by which tribal communities experience disparities in a wide

range of health outcomes, risks, and quality of life measures. Revitalizing indigenous values with a focus on communal strengths has emerged as a key approach to reclaiming health and balance and achieving health equity. In an era of tribal self-determination, GHWIC seeks to promote tribal health and chronic disease prevention through sustainable, culturally-driven interventions rooted in community voice and participation. The GHWIC program is one of many avenues through which tribal communities and tribal-serving health organizations are leveraging local, regional, and federal resources to create a foundation for innovation in chronic disease prevention.

WHAT IS GHWIC?

In 2014, the CDC's National Center for Chronic Disease Prevention and Health Promotion (NCCDPHP) launched GHWIC as a five-year project to fund tribes, tribal-serving health organizations, and Tribal Epidemiology Centers (TECs). Grantees worked to craft community-driven and culturally-adapted strategies to address health inequities and establish local tribal surveillance and evaluation activities to monitor health promotion efforts.

INDIGENOUS VALUES

Evaluation of the GHWIC program is guided by an Indigenous Evaluation Framework¹ and four adapted indigenous evaluation values listed below. Through this lens, the GHWIC program allowed tribal communities and tribal-serving health organizations to draw upon local tribal knowledge as a means to achieve balance and health equity. Grantees constructed program foundations around four common indigenous values of place, gifts, community, and sovereignty to decolonize approaches to chronic disease prevention.



1. LaFrance, J., & Nichols, R. (2008). Reframing evaluation: Defining an Indigenous evaluation framework. *The Canadian Journal of Program Evaluation*, 23(2), 13.

Healthy lifestyle and chronic disease prevention goals include:

- Reduce rates of death and disability from tobacco use
- Reduce prevalence of obesity through improved nutrition and physical activity
- Reduce rates of death and disability from diabetes, heart disease, and stroke

WHO ARE THE GHWIC GRANTEEES?

Component 1 (C1): Twelve federally recognized tribes addressing health disparities through community-chosen and culturally-adapted policy, systems, and environmental change activities.

Component 2 (C2): Eleven tribal-serving organizations and Tribal Epidemiology Centers providing sub-awards, technical assistance, and resources to tribes and organizations in their Indian Health Service Areas.



Figure 2. Map of GHWIC grantees

PARTICIPATING CDC DIVISIONS FROM CDC'S NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION

- Division of Nutrition, Physical Activity and Obesity
- Office on Smoking and Health
- Division for Heart Disease and Stroke Prevention
- Division of Diabetes Translation

COMPONENT 1

WHAT DID COMPONENT ONE GRANTEES DO DURING THE FIRST TWO YEARS?

GHWIC C1 grantees engaged in culturally-sound strategic planning processes to develop a foundation for addressing chronic disease priorities in tribal communities.

Formed community workgroups

- GHWIC encouraged the formation of communities of practice—a convening of people who learn from each other and contribute to a common body of knowledge— and cross-sector workgroups to improve the cultural relevance of programmatic and evaluation activities.
- **The Good Health and Wellness Santa Ana workgroup (GHWSA) at the Pueblo of Santa Ana included representatives from the Wellness Program; Department of Natural Resources; Department of Education, Language, and Culture; and the Native Plant Nursery. Members of the GHWSA collaborate to plan and implement each step of GHWIC planning and implementation.**

Completed tribal community health assessments

- All twelve C1 grantees completed a community health assessment (CHA) to identify needs for chronic disease prevention efforts.
- Some C2 grantees (tribal organizations and TECs) worked closely with C1 grantees and sub-awardees in supporting culturally-rigorous methods to capture local strengths, assets, challenges, and barriers for health and wellness.
- Tailored assessment tools and data collection approaches to integrate local customs and norms, to meet community needs, and ultimately address tribal priorities for health and wellness through community action plans.
- **In their CHA, Winnebago Tribe of Nebraska identified physical environment and community organizations that promoted health as the largest positive health-contributing factors in their community. The greatest self-identified need was for additional policies around smoking and unhealthy foods. This led to a focus on expanding access to health education resources.**

Community of Practice: Project ECHO

In public health, a community of practice is a group of people interested in a common domain. GHWIC fosters a community of practice around chronic disease prevention in Indian Country by leveraging technological tools.

Supported by CDC and UIHI, the University of New Mexico's Project ECHO (Extension for Community Healthcare Outcomes) is being adapted for public health settings. The GHWIC program utilizes Project ECHO to create a community of practice among grantees.

Through videoconferencing and online platforms, grantees share documents, resources, and other items. Project ECHO facilitates joint learning and peer problem solving to grow relationships and foster collaboration between GHWIC partners.

Selected community-centered activities

- Indigenous ways of knowing often draw upon the principles of situational context, community engagement, and strengths-based approaches. C1 grantees applied these indigenous and local values when selecting culturally-adapted and community-responsive activities. C1 grantees engaged in the practices outlined below to select community-centered activities.

Activities rooted in the context and priorities of each tribal community

Developed action plans with activities that best addressed the areas of need identified through CHAs. For example, a top area of need across grantees was physical infrastructure.

Several tribes established community garden activities and invested in traditional and healthy food access programs. For example, the Western Apache Diet Project at the San Carlos Apache Tribal Council was grounded in the distinct culture and regional landscape of the tribe to reconnect the Apache people with ancestral sources of health and a healing food system.

Activities designed and implemented with community buy-in

Used cross-sector workgroups comprised of a variety of local partners to ensure broad input and engagement in the GHWIC program process. Workgroups included tribal governments, health organizations, educational institutions, community health leaders, local organizations, and community members.

The Nez Perce Tribe utilized the Ta'c Wáaq'is Coalition and the Circle of Elders to gather community buy-in for project planning and evaluation activities from 13 tribal and local tribal-serving organizations.

Cultural adaptation and community-driven ideas demonstrated a strengths-based approach

Drew upon indigenous knowledge to address unequal health outcomes in grantee communities.

The Kickapoo Tribe in Kansas partnered with a smoking outreach and education program, *All Nations Breath of Life*, which is a tailored cessation program for tribal communities that uses culturally relevant messaging and program design. The program distinguishes health risks associated with commercial tobacco use from traditional and ceremonial practices and promotes local quit campaigns.

Sault Ste. Marie Tribe of Chippewa Indians

Yellowhawk Tribal Health Center

San Carlos Apache Tribal Council

Fort Peck Community College

Kickapoo Tribe of Kansas

Winnebago Tribe of Nebraska

Red Cliff Band of Lake Superior Chippewa Indians

Navajo Nation

Catawba Indian Nation

Pueblo of Santa Ana

Nez Perce Tribe

Lower Brule Sioux Tribe

COMPONENT 1
GRANTEES

CATAWBA INDIAN NATION

COMMUNITY PROFILE

Each grantee engaged in GHWIC strategic planning to develop culturally appropriate and community responsive interventions to address health inequities specific to their communities. The diversity and innovation of these approaches across C1 grantees is what makes GHWIC a remarkable and impactful investment. Program flexibility and locally-derived evaluation processes drive tribal innovation and reflect a rich diversity found across Indian Country. A community profile of Catawba Indian Nation provides one illustration of how grantees linked community health assessments (CHA) with local areas of need, appropriate targeted outcomes, and community-responsive healthy food activities.

Process for creating a strong GHWIC foundation

Step 1: The Catawba team gathered data from prior assessments, community surveys, key informant interviews with tribal leaders, and the Community Health Assessment and Group Evaluation (CDC CHANGE) Tool to examine distinct community needs and assets. The CHANGE tool helps define areas for improvement to identify policy, systems, and environmental change strategies.

Step 2: This comprehensive approach resulted in a rich assessment that identified five core areas of need: commercial tobacco use, diabetes prevalence, mental health, breastfeeding, and community perceptions of health.

Step 3: Catawba Indian Nation then selected short and intermediate-term outcomes that closely mapped to identified needs and local priorities.

Step 4: Based on findings from community surveys and tribal leader interviews as part of the CHA, Catawba Indian Nation identified access to physical activity and healthy foods as key factors for a healthy community, both of which are strategies for diabetes prevention. They selected outcomes, such as addressing Food Service Guidelines, to improve access to healthy food options in their community. They then developed activities aligned with these outcomes such as establishing and maintaining community gardens, improving vending machine offerings, and expanding running and wellness programs. These activities improve the availability of healthy food and physical activity opportunities to address community priorities.

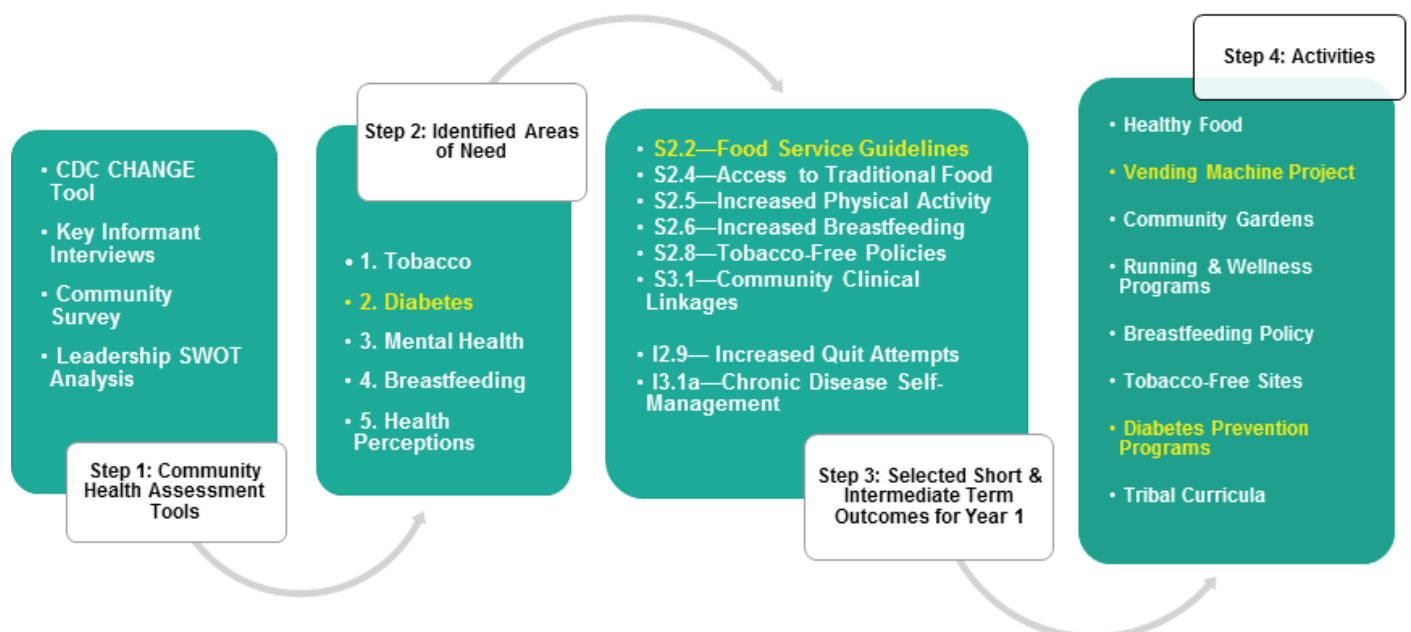


Figure 3: Process for creating a strong GHWIC foundation

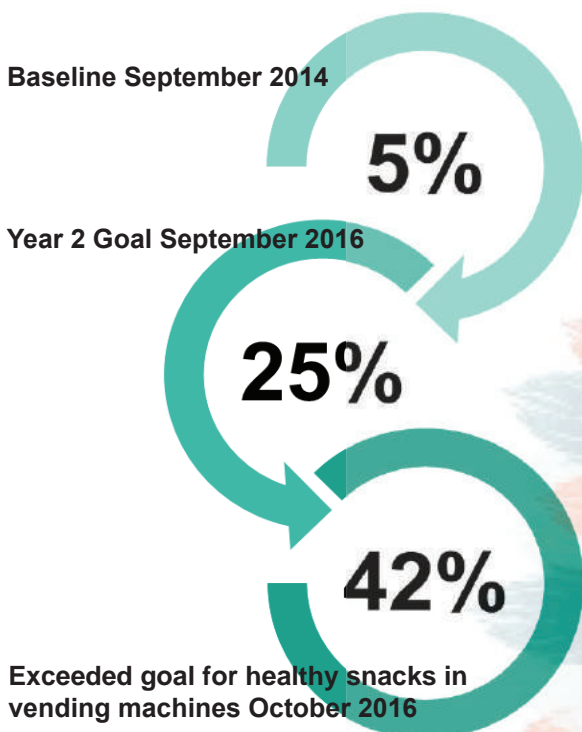
ACTIVITY SPOTLIGHT: CATAWBA VENDING MACHINE PROJECT

Vending machines at various tribal buildings are among the most visible and accessible food sources. As such, Catawba Indian Nation worked closely with the vendor, community members, and stakeholders to identify healthier snacks to stock in the machines. The process included a community “Healthy Snack” taste test and tracking of monthly sales data to identify which snacks could be offered as viable sales options.

As a result of a successful demonstration project with one machine in 2016, plans expanded to offer healthy options in other machines on the reservation. As shown in Figure 4 below, the Catawba team nearly doubled their intended goal of having 25 percent of snacks in the vending machine meet healthy nutrition guidelines. Catawba is also working to implement policies for healthy food served at meetings and social events.

For this project, Catawba addressed a lack of access to healthy foods in and around tribal offices and other tribal buildings on the reservation. In keeping with indigenous principles, community was involved at every stage of the project, including participation in the community taste testing, focus groups with tribal leaders, and surveys with the Boys and Girls club, tribal employees, and community members.

Figure 4. Proportion of snacks in vending machine that met healthy nutrition guidelines



Next steps to extend and sustain project benefits

- 1** Replicate process for increasing healthy snacks in additional vending machines and in a second tribal building.
- 2** Inform policies and guidelines for healthy food and drink access in vending machines and other venues.
- 3** Develop tribal Memorandum of Understanding supporting guidelines for stocking healthy snacks in vending machines across the reservation.

“

...people rated the new snacks higher than expected, which may indicate more people willing to eat healthier snacks if they were easily accessible.

”

”

Placing the most liked items with a reasonable price increased likelihood they would sell well.

”

WHAT DID WE LEARN?

Component 1 grantees used a range of techniques and tools for assessing community health areas of need. This flexibility encouraged tribal grantees to incorporate indigenous methods based upon local community philosophies, values, and cultural norms.

Methods reflect tribal community philosophies and values

GHWIC promotes tribal program development that is respectful of local knowledge systems and community strengths for making sustainable change. Grantees used various techniques for conducting community health assessments (see Figure 5). Eight grantees described using some form of community survey for their assessments and seven included secondary sources of data. Five grantees chose the CDC CHANGE tool. Guided by indigenous principles, grantees used a variety of assessment techniques including in-person surveys, focus groups, forums, or interviews. Given the unique cultural and social constructs of AI/AN communities, a “one-size-fits-all” approach could not reflect the diversity of circumstances and priorities across all tribal sites. Multiple data sources and flexible tool development allowed grantees to document and make visible the needs and health influences of their communities.

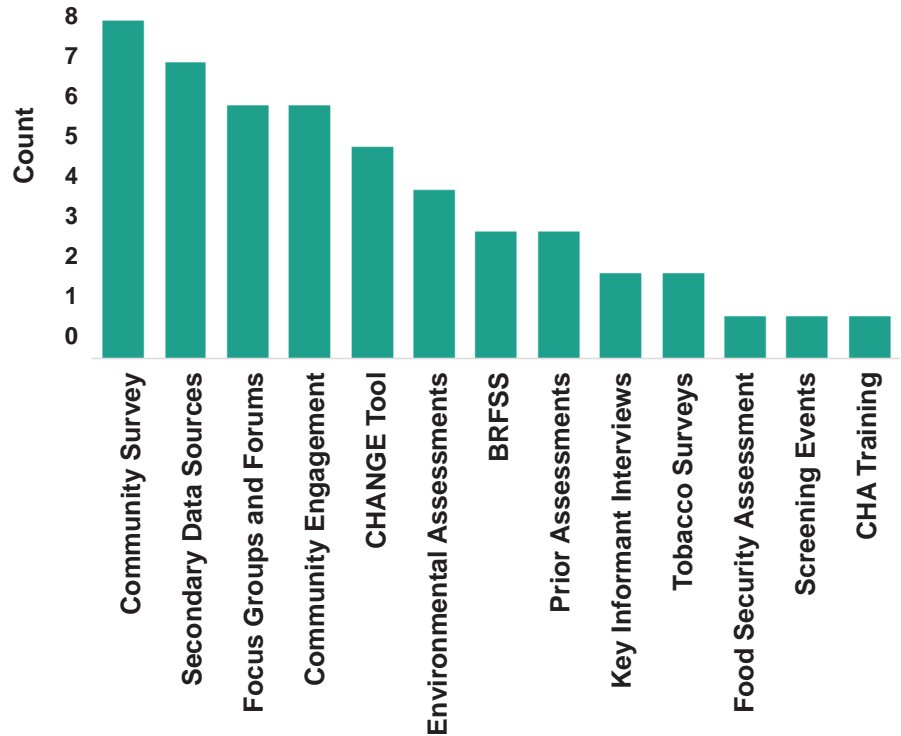


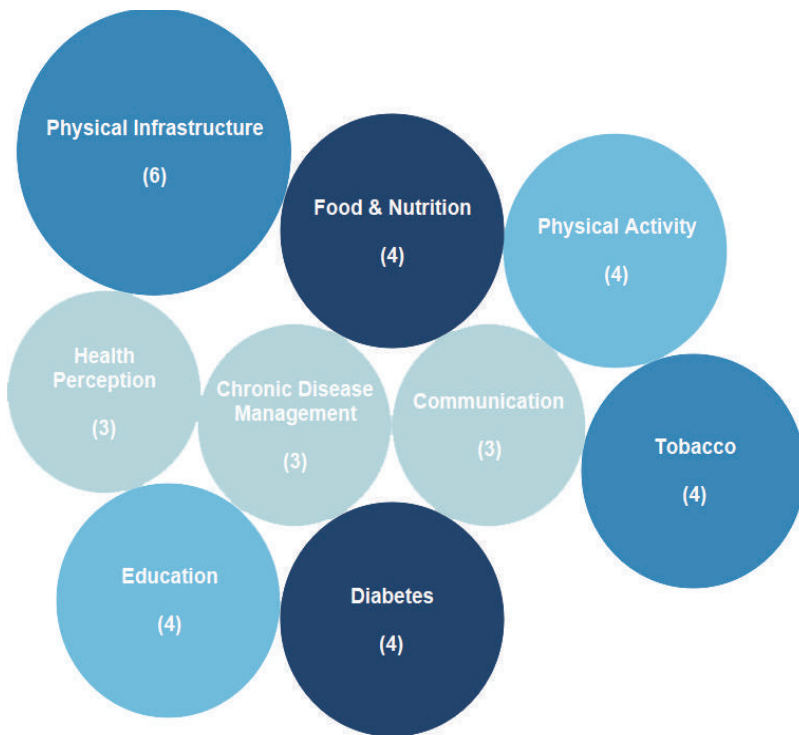
Figure 5. C1 Grantees Reporting CHA Technique

Areas of need identified

Component 1 grantees identified several areas of need through community health assessments. Figure 6 highlights the top nine areas. Half of the grantees, (6/12 sites) cited a need for physical infrastructure improvements such as community centers, sidewalks and parks, emphasizing the critical role of the physical and structural environment in supporting health. Opportunities for physical activity can be limited without safe and accessible spaces for exercise classes, walking, or biking. One grantee noted problems with unsafe drinking water as a priority need for addressing health and wellness in their community.

“
A location in the community that is consistently available for exercise classes needs to be identified.

”
“
... [one] children’s program does not have policies governing the foods and beverages provided to children participating in their program and typically offers food with low nutritional value.



Although fewer grantees listed diabetes prevention or food and nutrition as their top community needs, those that did discussed these topics with intensity and detail. The prevalence of diabetes and a need to provide additional services to people with diabetes concerned a third of the C1 grantees. In particular, more education for diabetics and expansion of preventative services to youth were noted as important goals. Issues with access to healthy foods, lack of policies around high-fat and high-sugar foods, and a need to improve eating habits were also described as urgent issues throughout several community health assessments. Re-establishing healthy traditional diets and strengthening food sovereignty practices and policies emerged as key activities.

Figure 6: Top C1 Grantee Areas of Need

Circle size represents # grantees (in parenthesis) who identified an area of need; darker color indicates intensity of reference to an area of need.

Strengths connected to outcomes

Grantees also used strengths-based CHAs to identify positive influences and challenges to health. Overall, the quality of staff members was most commonly cited as a positive influence on health goals and outcomes. Strong relationships between program staff and communities were essential elements for the success and long-term impact of health promotion and disease prevention efforts. Interestingly, finding and retaining quality staff was equally cited as a common challenge. While certain environmental aspects supported healthy activity—such as access to fruits and vegetables—many grantees noted unhealthy environments and gaps in critical infrastructure as major challenges.

The word cloud in Figure 7 illustrates that many of the identified positive influences centered around communal impact, represented here by larger sized font based on word counts such as “health”, “community”, and “tribal” in C1 grantee reports and documents. Programs and policies aimed at supporting chronic disease patients, reducing smoking of commercial tobacco, and improving physical activity were regularly mentioned. The strength of the relationships between health programs and communities stood out consistently across multiple grantees.



Figure 7. Top 100 Words in C1 Positive Influences

COMPONENT 2

WHAT DID COMPONENT TWO GRANTEES DO DURING THE FIRST TWO YEARS?

Component 2 grantees provided financial resources and technical assistance to tribes, tribal health organizations, and other AI/AN-serving programs in their Indian Health Service Areas. Unlike C1 grantees—who worked within their own communities to implement health improvement strategies—C2 grantees represented hubs serving tribes and organizations region-wide to develop effective and sustainable programs for long-term health and wellness goals. Specifically, C2s effectively extended the reach and scope of GHWIC resources while building local capacity for culturally sound leadership, training, evaluation, technical assistance, and program planning. For instance, C2s helped at least 157 communities complete community health assessments and action plans in the first two years (see below for specific examples). They worked with each unique setting to incorporate sustainability elements into interventions and program implementation based on the four domains that the CDC recommends for chronic disease prevention:

- Epidemiology and surveillance
- Policy, systems, and environmental (PSE) changes
- Community-clinical linkages
- Health systems and interventions

Distributed regional community sub-awards

- Disseminated Requests For Proposals (RFPs) through on-line, phone, and in-person outreach.
- Sub-awarded small grants to tribal communities and urban Indian health programs.
- A total of 101 tribes and tribal organizations were awarded grants in Year 1 with an additional 113 grants awarded in Year 2.
- **Great Lakes Inter-Tribal Council (GLITC) awarded small grants to three tribal communities and one urban Indian health program across the Bemidji area of Wisconsin, Michigan, and Minnesota.**

Strengthened coalitions & partnerships

- Supported local and regional coalition-building. C2 staff and resources supplemented coordination of workgroups, development of cooperative agreements, and regional meetings to strengthen networks between sub-awardees, Tribal Epidemiology Centers, and key partnerships.
- **Inter Tribal Council of Arizona (ITCA) conducted on-site visits with 13 communities to negotiate Memorandums of Agreement and establish cross-sector community health coalitions to guide GHWIC efforts.**

Facilitated regional communities of practice

- Coordinated peer networks and co-learning between C1s and sub-awardees to share stories of success and discuss challenges in order to inspire new ideas and cross-tribal collaborations.
- **Alaska Native Tribal Health Consortium (ANTHC) funded five Tribal Health Organizations (THOs) annually. THOs attended six Community of Practice (CoP) videoconference meetings and at least one in-person training per year. CoP meetings and in-person trainings supported site-relevant skills development, technical assistance, and information sharing between sub-awardees.**
- **Inspired by a success story related to navigating the CDC's National Diabetes Prevention Program (DPP) recognition process, a THO new to DPP conducted a site visit to learn from another tribal community how best practices could be incorporated into the DPP planning process.**

Depending on sub-awardee needs, the C2s also provided one or more of the following services.

Tailored workplans to local needs and priorities	CHA design and implementation	Served as connection to TECs and resources	Supported Community Action Plans
<p>Engaged in meetings, trainings, and/or site visits with sub-awardees to help identify local health priorities, define a scope of work aligned with community needs, and draft detailed workplans reflecting local priorities.</p> <p>Albuquerque Area Indian Health Board (AAIHB) facilitated culturally-adapted trainings designed to meet the unique context, culture, and set of local health priorities of each community. Sub-awardees selected from a broad range of assessment tools and resources to adapt those best suited for documenting community needs.</p>	<p>Helped adapt standardized tools to assess community health needs, provided local or regional supplementary data, and/or training on CHA techniques to tribes within the service area.</p> <p>California Rural Indian Health Board (CRIHB) adapted the CDC CHANGE tool questions regarding tobacco use to better address traditional use and cultural significance of tobacco amongst sub-awardees. The modifications targeted local strategies for prevention of commercial tobacco use and exposure.</p>	<p>Provided technical assistance for culturally responsive assessment implementation, including CHAs. In some cases, C2s directly conducted assessments to support sub-awardees restrained by time and resources.</p> <p>Southern Plains Tribal Health Board (SPTHB) supported the work of 13 sub-awardees in Year 2 through trainings and TA via its partnership with the Oklahoma Area TEC. Cultural components were incorporated into classes and programs, including traditional games, storytelling, basketmaking, and traditional versus commercial tobacco use.</p>	<p>Supported workplan implementation to ensure participation and uptake of new and continued GHWIC programs and interventions.</p> <p>Rocky Mountain Tribal Leaders Council (RMTLC) used a variety of trainings and conferences to ensure that medical providers were able to work in a culturally sensitive manner, and to increase tribal participation in Native Diabetes Lifestyle Balance Programs, a pre-diabetes prevention program that uses evidence-based lifestyle interventions to increase weight loss and physical activity.</p>

“

...[P]rograms and activities aim to complete tasks *with* tribal communities, rather than to do work *for* Tribes. This approach will build sustainability and strengthen skills and knowledge that will promote community health and wellbeing.

”

“

...[O]ur service to our Tribal partners includes the following values: honoring culture and involving community members; recognizing community knowledge and positive health trends; being a resource to community; and honoring tribal sovereignty and self-determination.

”

NORTHWEST TRIBAL EPIDEMIOLOGY CENTER, A DIVISION OF NORTHWEST PORTLAND AREA INDIAN HEALTH BOARD

COMMUNITY PROFILE

C2s worked directly with area C1s and sub-awardees to integrate sustainability elements into programs and strategies focused on policy, systems, and environmental (PSE) changes. They also fostered peer-to-peer communities of practice, and supported integration of locally-relevant measures into workplans, building capacity for long-term health goals. This community profile illustrates how the Northwest Tribal Epidemiology Center (NWTEC), a division of Northwest Portland Area Indian Health Board, built productive tribal relationships to expand GHWIC strategies across the Northwest region through the Wellness for Every American Indian to Achieve and View Health Equity project (WEAVE-NW).

Integrating Sustainability Measures

Step 1: WEAVE-NW worked closely with two sub-awardees to develop CHAs and provide training on implementation of the local health assessments. Based on CHA results and/or areas already identified by their tribal leadership, all sub-awardees identified community-responsive areas of need.

Step 2: WEAVE-NW then supported tribal Community Project Workplans, emphasizing sustainability in scope and structure. For example, WEAVE-NW sub-awardees developed detailed workplans outlining the timeline and responsibilities for all tasks, integrating process evaluation benchmarks to ensure successful implementation based on the needs that arose. In addition, sub-awardees completed a Program Sustainability Assessment Tool (PSAT) in their last year, the results of which will be incorporated into their final workplan activities.

Step 3: Trainings and regional gatherings fostered inter-tribal opportunities where sub-awardees and C1s learned from each other and created a common body of knowledge as they developed PSE strategies and practices. WEAVE-NW facilitated interactions with organizations that could support local GHWIC planning and project activities, strengthening key partnerships and coalitions. Peer-to-peer interactions and monthly coordination calls reduced tribal staff isolation and encouraged exchange of ideas, inspiration, and cross-tribal collaboration—all essential components for building a community of practice.

Step 4: Sub-awardees implemented workplans resulting in 14 new policies, 16 health systems improvements, and 21 environmental changes. In Year 2, four sub-awardees expanded GHWIC projects with outside grants and two secured additional tribal funds.

Wellness for Every American Indian to Achieve and View Health Equity (WEAVE-NW)

- Offered services to 43 tribal communities located across the Pacific Northwest - Idaho, Oregon, and Washington
- Provided technical assistance to Component 1 grantees: Yellowhawk Tribal Health Center and Nez Perce Tribe
- Supported 5 sub-awardees in Year 1 and 11 sub-awardees in Year 2

Program Sustainability Assessment Tool

WEAVE-NW promoted the use of a tribally-adapted Program Sustainability Assessment Tool (PSAT) amongst sub-awardees. The adapted tool was developed by the Center for Public Health Systems Science at Washington University in St. Louis.

The tool measured a program's capacity for sustainability across eight domains:

- Strategic Planning
- Environmental Support
- Funding Stability
- Partnerships
- Organization Capacity
- Program Evaluation
- Program Adaptation
- Communications

Through the assessment process, sub-awardees gained a better understanding of how programs and their community benefits could be maintained over time. Assessments ensured that gaps were not created by the short-term funding of sub-awards and helped tribal communities identify areas of need when transitioning out of direct funding.

As a GHWIC regional resource hub, WEAVE-NW had an increased opportunity to connect sub-awardees and C1s to additional resources and projects at NWTEC beyond WEAVE-NW, providing public health skills and relevant data as needed to support local GHWIC efforts and long-term program planning and implementation.

ACTIVITY SPOTLIGHTS:

Two activity spotlights illustrate how WEAVE-NW created spaces for partnership and collaboration that led to improved, sustainable programs throughout the region.


WEAVE-NW ANNUAL GATHERING

WEAVE-NW leveraged their role as a C2 grantee and created the WEAVE-NW Annual Gathering which brought together sub-awardees from across the Northwest region and established communities of practice, coalitions, and partnerships. These gatherings provided sub-awardees with critical trainings on program planning, PSE strategies, and sustainable practices. Participants could meet and interact face-to-face to strengthen their partnerships, share knowledge, and ultimately leave a deep-rooted and lasting impact on their work in their communities and across the region.


QUINAULT INDIAN NATION GARDEN & CSA

After attending a WEAVE-NW Annual Gathering, representatives from Quinault Indian Nation expanded their community garden. The existing garden was so successful that demand exceeded the amount of produce harvested. Through participation in a roundtable discussion with another sub-awardee of WEAVE-NW, Quinault representatives learned about a Community Supported Agriculture (CSA) model. The discussion sparked a collaboration with local farms to supplement the community garden with locally-sourced produce. As a result, 27 tribal families received weekly CSA produce boxes for five weeks. By focusing on PSE changes and integrating sustainable principles into programs, Quinault Indian Nation and WEAVE-NW were able to expand the garden program beyond its original scope.

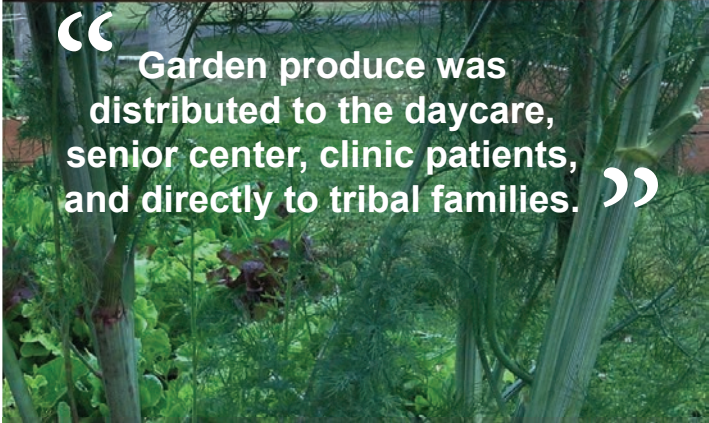
WEAVE-NW created a foundation for meaningful GHWIC program planning, implementation, and evaluation. By focusing on establishing trusting relationships with sub-awardees and area C1 grantees, new policies, health systems improvements, and environmental practices laid the groundwork for sustainable change in health and wellness efforts. These PSE improvements all work together to alter the social determinants of health for communities.



“ I absolutely loved the collaboration with other tribes. I look forward to seeing ... the policies the other tribes discussed. ”



“ Garden produce was distributed to the daycare, senior center, clinic patients, and directly to tribal families. ”



WHAT DID WE LEARN?

Sub-awards extended reach of the GHWIC program

C2 grantees established and maintained regional tribal relationships by awarding small grants, providing site-specific technical assistance in program planning and implementation, facilitating culturally-sound evaluation activities, and creating spaces that fostered peer support and communities of practice. Collectively, the C2 grantees served to effectively amplify the potential for positive GHWIC impact on tribal communities beyond the reach and scope of the national CDC initiative.

Through this model, C2s served as hubs to sub-awardees and C1 grantees for networking and local capacity-building to develop strengths-based approaches for GHWIC health and wellness program planning and implementation. As liaisons and translators, C2s empowered communities to control the flow of information while meeting CDC's required program milestones and evaluation goals.

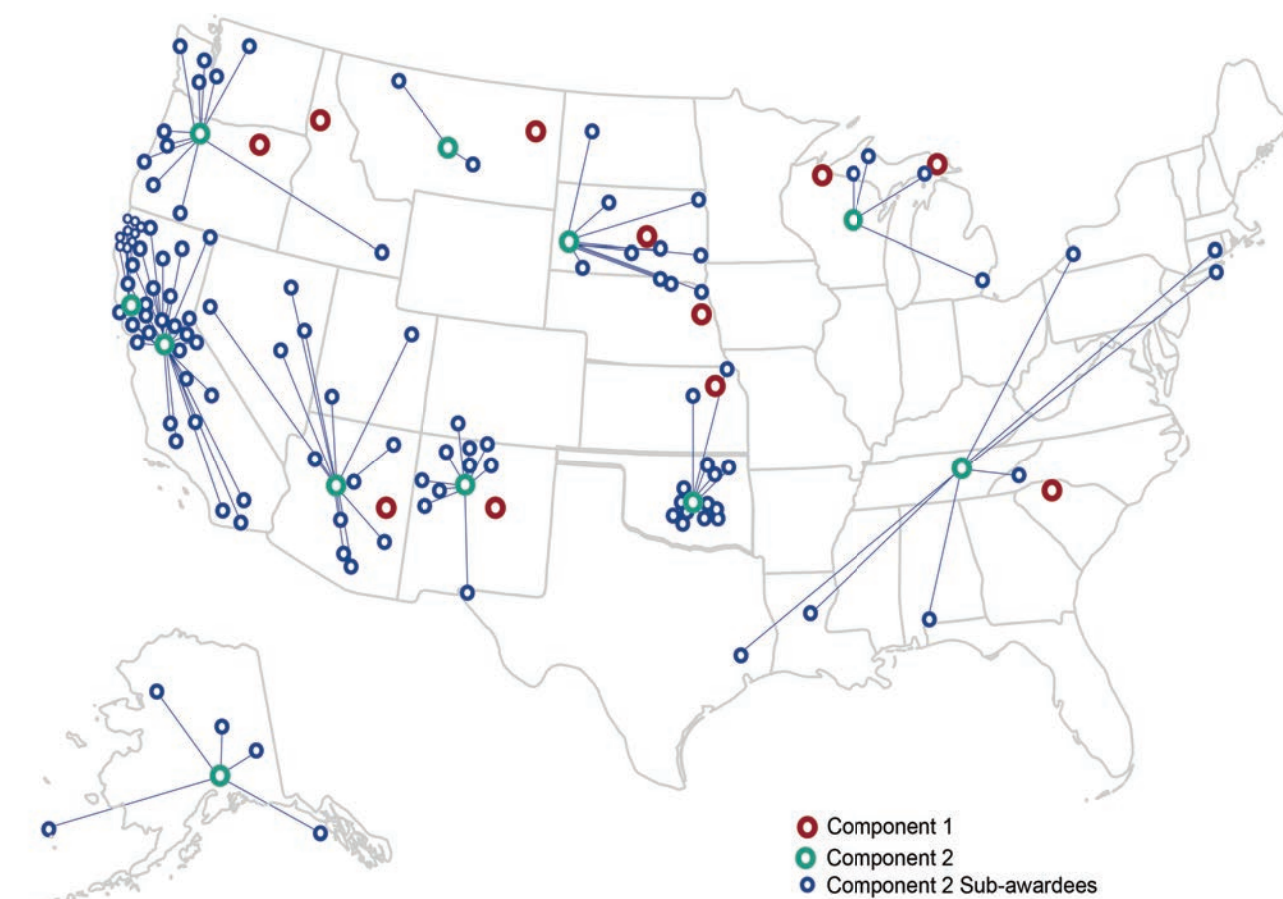


Figure 8. Map of GHWIC Grantees and C2 Sub-Awards

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We brought the nine sub-awardees together, in-person, on a quarterly basis. Sub-awardees saw similarities in their community health assessments and they identified ways in which they could share resources and asset[s] to further the goals of the grant. They identified resource gaps that they could work on together. Synergy between the sub-awardees is a significant accomplishment.

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Evaluation processes and tools met the unique context of each community

A central component of supporting sub-awardees through the CHA process was the development, adaptation, or selection of culturally-sound assessment tools. Some used standardized forms for community surveys such as the CDC CHANGE tool or the Behavioral Risk Factor Surveillance Survey (BRFSS). Others used policy scans and community engagement tools such as focus groups, which allowed for greater local guidance and qualitative analysis of findings. For instance, sub-awardees of the United Indian Health Service, Inc. (UIHS) used skills gained through quarterly trainings to implement their community health assessments. These sub-awardees talked directly with community members through forums and interviews, and developed workplans in response to the expressed needs of their communities.

About half of the C2s provided secondary data and/or training on CHA techniques to their sub-awardees and to other tribal partners within the IHS Area that did not receive GHWIC sub-awards. Often, standardized evaluation tools were tailored or adapted with the assistance of C2 grantees to better meet the needs of tribal communities served. For example, the Great Plains Tribal Chairmen’s Health Board (GPTCHB) provided sample templates, including one modeled from the CDC CHANGE guide, to create culturally-relevant CHAs and action plans. Another adaptation comes from the Albuquerque Area Indian Health Board (AAIHB), which adapted CHA trainings by including AI/AN content experts from local partner organizations. They also included interactive sessions to create collaborative learning spaces in alignment with local traditions, incorporated cultural imagery and customs, and emphasized action-oriented and strengths-based evaluation. Through these methods, AAIHB sought to balance western methodologies of research and evaluation with indigenous ways of knowing.

“Our approach has been to not promote one canned process or tool (i.e., MAPP, CHANGE Tool), but instead we provided options for our Tribal partners to choose from to honor Tribal sovereignty and self-determination and that will be more relevant to their context.”

Implemented diverse policy, systems, and environmental changes

The examples in the box below are just a small sample of the myriad projects implemented with the sub-awards from C2 grantees in Year 2. In conjunction with the community health assessment and action plan assistance provided by the grantees, these activities met specific needs in the sub-awarded communities. As the examples below highlight, many of the sub-awardees built sustainability into their activities to ensure that the impact continued beyond the life of the sub-award.

Policy	Systems	Environment
<p>Southeast Alaska Regional Health Consortium, a sub-awardee of ANTHC, implemented a policy to support breastfeeding in a tribal health facility by creating a taskforce and staff trainings developed from the Baby-Friendly Hospital initiative to promote and support breastfeeding.</p> <p>One Albuquerque area sub-awardee is working towards establishing a food distribution system and policy to increase access to traditional and/or healthy foods from a community garden and beekeeping program.</p>	<p>Lake County Tribal Health Consortium, a sub-awardee of CRIHB, implemented a health and wellness “prescription” system into an existing clinical Electronic Health Records (EHR) system.</p> <p>Port Gamble S’Klallam Tribe, a sub-awardee of NPAIHB, improved clinical linkages by bringing together the health clinic, behavioral health, social services, and tribal administration to create a case management team for clinic patients.</p>	<p>Greenville Rancheria Tribal Health Program, a sub-awardee of CRIHB, increased compliance for a smoke-free tribal workplace policy by developing signage addressing the harms of commercial tobacco.</p> <p>Lower Brule Head Start, a sub-awardee of GPTCHB, worked with the Lower Brule Sioux Tribe (LBST) Parent Advisory Committee to renovate playground equipment and coordinate supplemental programming that is age-appropriate and encourages moderate to vigorous physical activity amongst children.</p>

Regional hubs provided locally-tailored support

C2s served as regional hubs by providing technical assistance (TA) to sub-awardees and tribes in their IHS Service Areas. C2s used multiple avenues to deliver services, including webinars, site visits, in-person trainings, and regular conference calls.

Implementation support in the form of assistance with strategic planning, CHAs, policy consultation, and other activities made up the largest segment of C2 technical assistance work in the first two years. Many sub-awardees received support for community health assessments in the form of secondary data and community health profiles. Other capacity building efforts included site visits, regular check-ins, and ad-hoc activities. C2s also provided a substantial number of subject-specific trainings (a total of 38 separate training subjects over the first two years) on topics ranging from food sovereignty to traditional native games. Substantial work was done to create useful resources, engage communities, and evaluate sub-awardee progress. The range of content areas and service delivery methods highlights the extensive effort involved in providing support responsive to each community and their particular needs, and illustrates the relationship-building contributions of the C2 sub-award/technical assistance model.

For example, United South and Eastern Tribes, Inc. (USET) offered 59 different trainings on program planning, evaluation, implementation, and partnership building. By sharing resources interdepartmentally, using volunteers, and leveraging the evaluation skills and experience of USET staff, sub-awardees received direct support in tailoring CHA tools, performance measure selection, program planning, and developing activities.

GHWIC expanded the partnering of C2 expertise and services with C1 and sub-awardee community knowledge of local systems. C2s managed the administrative burden of federal funding while sub-awardees focused on community engagement and programmatic activities, expanding the scope and reach of GHWIC initiative throughout Indian country.

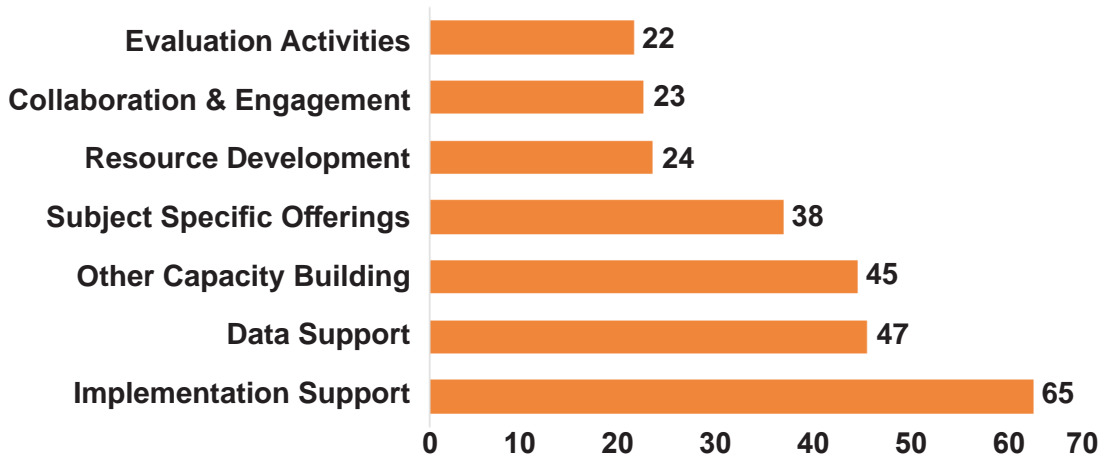


Figure 9. Type of Technical Assistance Provided to Sub-Awardees

COMPONENT 2 GRANTEES

Northwest Portland Area Indian Health Board
Great Plains Tribal Chairmen's Health Board
Alaska Native Tribal Health Consortium
Rocky Mountain Tribal Leaders Council
Albuquerque Area Indian Health Board
Southern Plains Tribal Health Board
California Rural Indian Health Board
United South and Eastern Tribes
Great Lakes Inter-Tribal Council
Inter-Tribal Council of Arizona
United Indian Health Services

LOOKING FORWARD

Beyond meeting the technical requirements of the cooperative agreement, the assessment and planning activities described in this report highlight the importance of allowing a sufficient assessment and planning period. By creating collaborative workgroups and allowing for a wide range of CHA techniques, GHWIC set a sound foundation for innovative interventions to combat health disparities in Indian Country.

The Catawba Indian Nation and Northwest Tribal Epidemiology Center examples demonstrate the flexibility of these processes undertaken across grantee sites to gain deeper understanding of local needs and apply these findings in planning and interventions to promote health and well-being of each community. GHWIC has strengthened relationships across Indian Country to promote collective action and effective programming through culturally responsive and regionally coordinated efforts led by Component 2 grantees.

“

[Our nation] is a community with a proud past and a clear connection to its heritage and culture.

”

Contact Us

Please contact the Urban Indian Health Institute with your comments by emailing info@uihi.org, calling (206) 812-3030, or visiting us online at www.uihi.org.



Seattle Indian Health Board
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