

# Native Health Initiative Program Plan and Evaluation Strategy

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# **Native Health Initiative (NHI)**

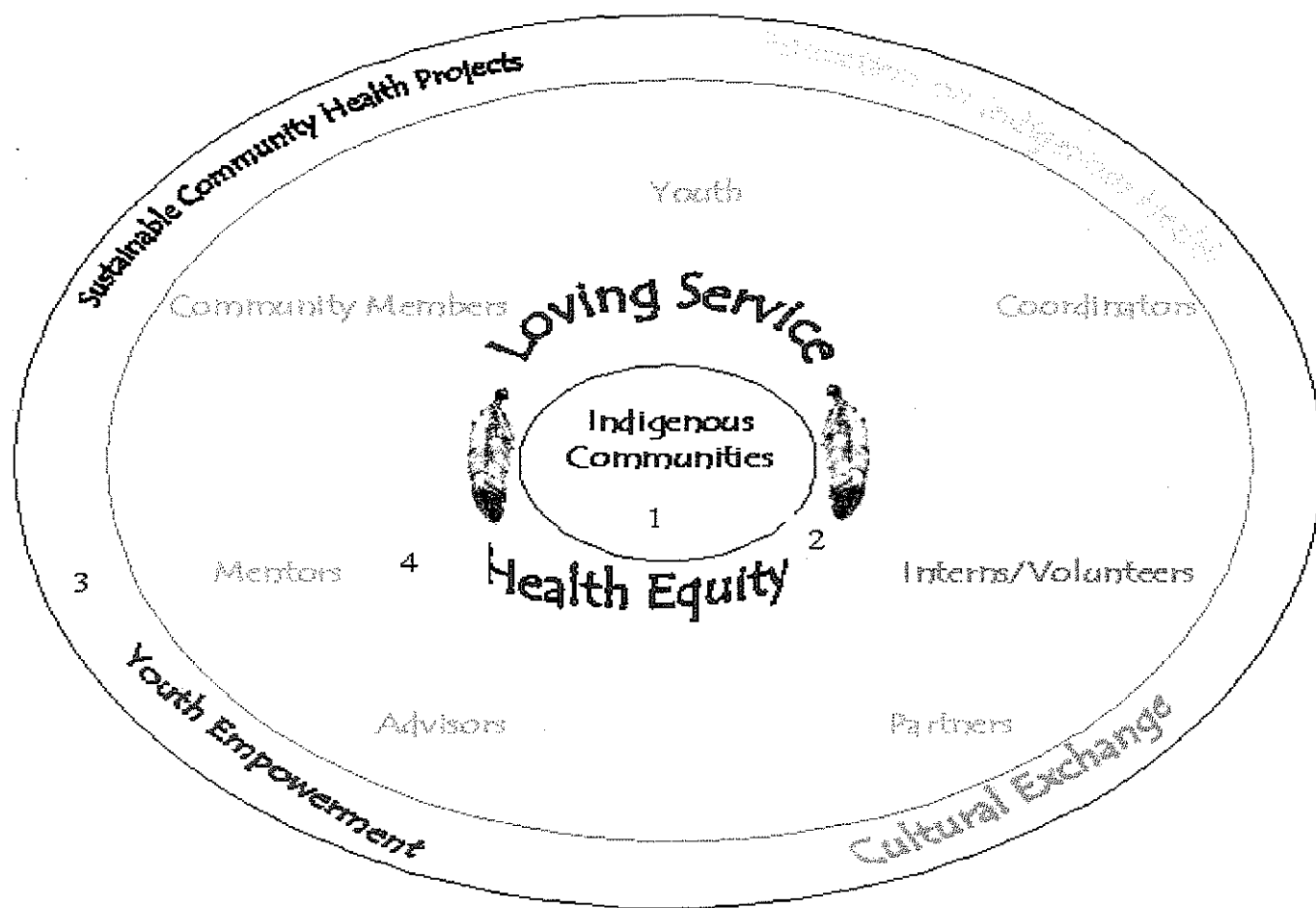
## **Program Plan and Evaluation Strategy**

### ***A Manual for Program Leaders***

Anthony Fleg, 2007

# The Native Health Initiative Circle of Healing

*Addressing health inequities through loving service*



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## **I. PROGRAM PLAN**

### **A. PROGRAM CONTEXT**

#### **1. American Indians and their health in the United States**

##### ***a. Overview***

American Indians and Alaska Natives (AIAN) are heterogeneous groups of peoples whose ancestors were the original peoples of the Americas and who maintain tribal affiliation<sup>i</sup> with one of the 569 federally recognized tribes or more than 300 state recognized tribes in the United States (Note 1). In all, this group represents more than 200 indigenous languages, with approximately 10% of AIAN households speaking a language other than English at home. Current estimates suggest that the AIAN population consists of 4.1 million people, approximately 1.5% of the U.S. population<sup>ii</sup>. While AIAN are often associated with reservations, land appropriated for tribes by the U.S. government, the majority live in cities and towns where indigenous peoples are the minority. Overall, AIAN are more likely to live in poverty (26% vs 13%), less likely to have a high school education (66% vs. 75% in 1990), and twice as likely to be unemployed than the average American citizen<sup>iii</sup>.

##### ***b. Indian Health Service***

Federally recognized tribes enjoy a government-to-government relationship with the United States. Through treaties, congressional laws (Synder Act of 1921, Indian Health Care Improvement Act of 1976), and court decisions the U.S. government agreed to provide health care for AIAN, a duty currently carried out through the Indian Health Service (IHS). A program under the Department of Health and Human Services (DHHS), the IHS cares for 1.8 million AIAN and describes itself as the “principal Federal health care provider and health advocate for Indian people.<sup>iv</sup>” However, the IHS is poorly under-funded; a review that compared the IHS to mainstream health plans, accounting for other forms of coverage and payments fund AIAN

health care, revealed that the IHS expenditure of \$1,385 per user was 52% of the \$2687 it would take to provide benefits similar to what the average plan offers<sup>v</sup>. For those moving off their respective reservations, problems of access to care mirror those seen in other minority populations. Currently, the IHS allocates less than 1% of its budget to providing urban AIAN health care, despite the fact that more than 50% of the AIAN population live in these settings, suggesting that the government's promise of health care is an absent one for many AIAN<sup>vi</sup>.

**c. Health status**

*Today, Native Americans continue to experience significant rates of diabetes, mental health disorders, cardiovascular disease, pneumonia, influenza, and injuries. Native Americans are 770 percent more likely to die from alcoholism, 650 percent more likely to die from tuberculosis, 420 percent more likely to die from diabetes, 280 percent more likely to die from accidents, and 52 percent more likely to die from pneumonia or influenza than other Americans, including white and minority populations<sup>vii</sup>.*

This quote, part of a U.S. Commission of Civil Rights briefing on Native American health disparities, was part of a larger survey by the Commission which found that equal access to health and healthcare to minority populations was not given the same federal protection as equal access to housing, education and employment<sup>viii</sup>. While the numbers are shocking, the trends toward poorer health amongst AI citizens, communities, and Tribes has persisted since European contact.

While the diseases themselves, and the explanations for the disparities have changed over these centuries, the AI have consistently lived sicker and died younger than the average American<sup>x</sup>. A recent study examining the differences in health between population groups in the U.S. broke the population into "Eight Americas." One of the eight, labeled *Western Native Americans*, had a male/female life expectancy of 69 and 75 years, respectively. In contrast, Asian Americans, the longest-living subset, live 83 and 88 years; In other words, the healthiest Americans live close to a decade and a half longer than American Indians<sup>x</sup>.

Looking at the leading causes of death in 2002 using Centers for Disease Control (CDC) data, a few differences between AIAN and the U.S. population are evident: diabetes and unintentional injuries are higher on the AI list, as are markers of substance abuse and mental health. Regarding the latter, three of the top ten causes of death (liver disease, suicide, homicide) for American Indians are known to be associated with substance abuse and mental health conditions, while they are absent from a similar list for the U.S. population.

*Table 1: 2002 CDC Mortality Data for the United States – Top 10 leading causes of death*

<b>U.S. population</b>	<b>American Indian population</b>
1. Heart disease	1. Heart disease
2. Cancer	2. Cancer
3. Stroke	3. Unintentional Injuries
4. COPD	4. Diabetes
5. Unintentional injuries	5. Stroke
6. Diabetes	6. Liver Disease
7. Influenza/pneumonia	7. COPD
8. Alzheimer's	8. Suicide
9. Kidney disease	9. Influenza/pneumonia
10. Sepsis	10. Homicide

The CDC office on Minority Health has identified a “disproportionately high prevalence” of health inequalities in four areas: mental health, substance abuse, obesity and sudden infant death syndrome)<sup>xi</sup>. Of the twelve Indian Health Service (IHS) areas, ten identified mental health as the top health problem in 2001<sup>xii</sup>.

## 2. American Indians and their health in North Carolina

### a. Overview

Vibrant Pow Wow culture...American Indian churches...Communities where Indigenous culture and traditions are practiced. These are not the first things most people think of upon hearing the words *North Carolina*, even to those who live in the state. In fact, many North Carolinians, like residents of other Eastern states, are entirely un- aware of the presence of American Indians in their midst<sup>xiii</sup>.

More than 100,000 American Indians (AI) from eight recognized tribes live in North Carolina, giving it the largest American Indian population east of the Mississippi<sup>xiv</sup>. However, as seven of the eight tribes are state recognized and therefore not eligible for designated land or services (e.g. health care) from the federal government, North Carolina's American Indians are less visible and less distinct from the larger population than in other states. The history of segregation in the south also contributed to the "hiding" of one's Indian identity, as anonymity was a tool for survival. This unique socio-historical milieu leads to an equally unique Indigenous culture in the state. Dr. Stanley Knick, professor at UNC-Pembroke says, "Probably, very little that you learned in school about American Indians is true, especially for the Indigenous population of North Carolina and the southeastern United States<sup>xv</sup>."

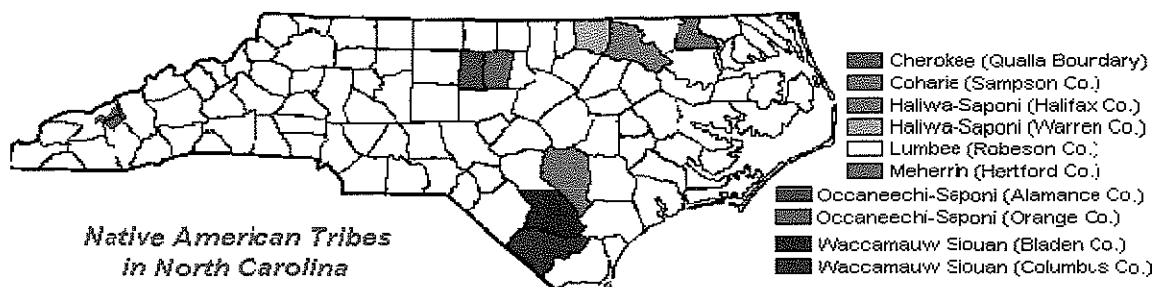


Figure 1: American Indian tribes of North Carolina. The Sappony tribe, located in Person county, north of Orange county, is an additional state recognized tribe that is not depicted on this map.



## **b. Health status**

The health of the AI population in North Carolina is difficult to assess, given the current paucity of data<sup>xvi</sup>. However, all indications suggest that Indigenous persons in North Carolina fare worse on determinants of health (e.g. economic status, education level), health care (e.g. access to care, rates of uninsured), and health outcomes (e.g. rates of chronic and infectious disease) than other citizens of the state<sup>xvii</sup>.

A report in 2005 from the North Carolina Department of Health and Human Services, AI had higher rates of diabetes, hypertension, asthma, and arthritis than African Americans or Whites<sup>ii</sup>. Age-adjusted mortality rates for American Indians from chronic disease were 2.44 times higher for diabetes and 1.55 times higher for kidney disease when compared to the White population. Similar disparities existed in infectious diseases (e.g. 2.13 times higher death rate from HIV) and injury/violence (e.g. death rates 3.70 times higher from homicide and 2.05 times higher from motor vehicle injuries).

On quality of life measures, AI had poorer functional status on all five measures when compared to Whites and African Americans, and reported disproportionately high rates of problems with access to health care. Of note, many of these disparities persisted even after controlling for socio-economic status. The report concludes with a dismal statement, "For most of the measures presented here, American Indians in North Carolina experience substantially worse health problems than whites." However, we should remember that the AI "data gap," an embarrassing result of misled priorities, continues to serve as an impediment to health equity amongst North Carolina's Indigenous peoples.

## **c. Lack of data and infrastructure**

Many of the Tribes in NC do not know the extent of the health problems that exist within their communities and do not have the infrastructure to begin the process of providing services and assistance. A directed effort is needed to document the health priorities in American Indian communities in North Carolina, and a means to which these areas can be effectively addressed<sup>xviii</sup>.

This quote from North Carolina Joint Task Force on Indian Health summarizes the current structural dilemmas regarding AI health – a lack of data and a lack of health infrastructure.

Regarding the issue of data, for the majority of North Carolina's eight recognized Tribes, the best answer to "What does your Tribe's health look like?" would be "Not sure." In fact, literature on the health of the state's indigenous population is almost non-existent, with the exception of the Eastern Band of Cherokee (who have data due to having IHS services and funding) and the Lumbee (who have data due to the fact that they are the largest Tribe in the Eastern U.S.).

Health infrastructure, insofar as it relates to clinics, home health services, and public health programs that have an AI focus are also non-existent for most of the AI communities in the state. Thus, AI largely rely on county and state-run health services, with similar barriers to care as seen with other rural, minority, and lower socioeconomic populations in the state – transportation issues, cost of care/medicines, absence of health resources (e.g. sources of healthy food, gyms, sidewalks) and fear of discriminatory health care settings.

### **3. HOW NHI BEGAN**

In multiple attempts to find volunteer opportunities in American Indian communities as a pre-medical student, I consistently ran into dead ends. This happened for a variety of reasons – a lack of an infrastructure within academic institutions for such opportunities, a similar lack of infrastructure within Tribal communities, the rural and isolated nature of many AI communities, and the historical scars from exploitative outsiders and researchers that made AI communities wary of bringing volunteers into their midst.

In my case, it was not until 2002, the third year of my quest to volunteer, that I convinced an Indian Health Service staff member to send out a request on my behalf, stating that “Anthony is offering his time for the summer to work on a health related project – is anyone interested?” One program responded - the Navajo Nation Health Education Program in Tuba City, Arizona, located in the heart of the Navajo Reservation. With minimal communication as to what I would be doing or whether I was even welcome there, I boarded a plane June 22<sup>nd</sup>, headed to Arizona. On the first day there, I was asked to sign extensive paperwork stating that I would not publish or present anything that I did or saw during my time there, opening my eyes to level of mis-trust amongst Indigenous persons, the result of the long history of exploitation and discrimination they had endured<sup>xix</sup>.

Returning to Chapel Hill to begin medical school in August of 2002, I began to wonder how a summer opportunity like mine could be replicated. With the added impetus of a foreign medical student posting a message to U.S. medical student internet list-serves in 2004, looking for an opportunity to volunteer in American Indian communities, the work on building a program to connect AI communities with health professions students began.

With only a vague idea of what such a program would look like that, I contacted the North Carolina Commission of Indian Affairs to propose the project. This led to a November 2004 meeting at the Commission, where I discussed my idea, and more importantly, listened to

the opinions and expressed health needs cited by Commission members. The overall sense from the meeting was that such a project was both needed and did not currently exist, with the recommendation to follow-up with community-level AI health leaders to work toward creating such a program.

A few months later, in January 2005, with the support of a prominent minister in the Pembroke community, home of the Lumbee Nation, we sat in a church – the minister, a representative from the Commission, and community health leaders from various tribes. In this, and ensuing meetings, we agreed upon a name for the project – the Native Health Initiative - and developed four principles to guide our work.

Ambitiously, with a \$0 budget, we looked to begin projects in the summer of 2005, leaving me to recruit volunteers while the community partners thought about how to “host” volunteers, and how to effectively use the time and talents of the volunteers.

There were many things that stood out from these initial events, many of which went against the stereotypes and fears that I brought into this project. First, there was an inherent sense of trust in the good of the project, and of me as an outsider. Second, there was a desire to see more done in AI health, but a lack of infrastructure and resources (e.g. human and capital) that stood in the way. There was also a sense of urgency regarding the ill-health of American Indians, yet a sense of hopelessness from feeling that their health needs were neglected from the non-Indian, health, academic, and political communities. Fourth, the leaders expressed a need for youth outreach to help them live healthier and receive encouragement and information regarding health careers. Fifth, there was a very visible excitement among the community leaders at the potential for a unified purpose to drive such a project, despite the absence of infrastructure and funding. And maybe most striking, given the stereotype of the “stoic Indian Chief” was the humor that pervaded each of these conversations.

#### **4. WHY NHI BEGAN: THE UN-MET NEEDS AND UN-TAPPED RESOURCES**

##### ***a. American Indian Health in North Carolina – The Needs***

Unlike many needs assessments, which focus on the “deficits” and “deficiencies” of communities and populations, the needs we identified in North Carolina with regard to AI health primarily focus on entities beyond the Indigenous population. The AI population in North Carolina is largely invisible to policy makers and health care systems, comprising only 1% of the state’s population, and with few persons lobbying on their behalf. The primary needs we identified were the lack of health data, inequities in social determinants of health, inequities in health and health care outcomes, few existing AI health interventions, minimal avenues for health professions students to learn about AI culture and health, and the under-representation of AI in health professions.

##### ***Paucity of data***

As mentioned above, there is little data on the health of the AI population in NC, and data at the level of the tribes is non-existent. Addressing the “data gap” was recently cited by the North Carolina American Indian Health Task Force as a priority.<sup>iii</sup>

##### ***Inequities in social determinants of health***

Despite the lack of data, we know is that AI in North Carolina are more than twice as likely to be unemployed and to live in poverty, and much more likely to have low educational attainment when compared with white North Carolinians<sup>xx</sup>. Adding these barriers to health to the effects of racism and historical trauma on Indigenous peoples in this country, we would expect that the health of the AI population in North Carolina suffers accordingly.

##### ***Inequities in health and healthcare outcomes***

Also mentioned above, available data suggest that American Indians live sicker and die younger than other citizens of the state. This is an ethical issue as much as it is a medical/health issue, as the vast majority of differences in health and healthcare are preventable and correctable. Of note, the health of American Indians appears to correlate closely with African Americans and Latinos in NC, evidence for the presence of larger inequities disproportionately affecting minorities in the state.

### ***Inadequate levels of interventions aimed at AI health***

The reality of poor health is compounded by the current situation in which there is little collaboration between tribal communities and health professions students or their respective Universities. Indeed, no programs exist that offer students the opportunity to volunteer in any of North Carolina's American Indian communities. Not surprisingly, the same is true nationally, where there are few programs/internships in AI health or AI communities for the health professionals of the future. Barriers include the history of exploitative research efforts targeting AI communities, brought back to the forefront in 2004 with the misuse of blood samples from the Havasupai tribe by Arizona State University.<sup>xxi</sup> Indigenous people are wary of participating in research. Second, as a small percentage of the population, AI health is often not on the political or public health agenda, even in the realm of minority health. At the University of North Carolina, for example, there are no AI faculty on the health side of campus (nursing, dentistry, medicine, allied health, social work, public health) and, thus, conversations regarding minority health occur without Indigenous input; as expected, the resulting programs and initiatives, from our experience, systematically ignore and forget the state's first people.

### ***Lack of opportunities for health professions students to learn about AI culture/health***

The lack of attention to the health of AI communities breeds ignorance and *cultural incompetence*, both of which contribute to health inequities. Here at UNC-Chapel Hill, there are

no American Indian faculty within the medical school, and no courses that address American Indian health in either the pre-clinical or clinical years. In fact, to my knowledge, the only teaching in the entire medical school on American Indians occurs in once class period during a Social Medicine selective on health disparities that 10-15 second-year students have the chance to take. On a larger scale, despite the large presence of American Indians in NC and the reality that UNC is one of four campuses in the U.S. to have all of the core health professions schools on one campus, there is a glaring absence of American Indians at UNC – zero American Indian faculty on the health side of campus, and zero courses in American Indian health.

Using Microsoft's *Live Search* on November 6<sup>th</sup>, 2007 and the search words "American Indian" and "service learning," the first thirty items were reviewed. Interestingly, while we found that some programs did allow students to visit American Indian communities, with others allowing Tribal communities to take leadership in the program/project, NHI's model was unique from all thirty in the following ways: (1) student-driven project, (2) focuses on change on the campus on which it is situated, (3) loving service and health equity as foundations for the project, (4) funding - I am making an assumption that since the programs I found are by either Universities or Foundations, that these programs have much more financial capital than NHI, (5) bringing students from beyond the University at which the project is located, (6) bringing students from abroad to volunteer, (7) summer internships - the programs I found have spring break trips or short activities, but not summer internships, and (8) tribe directed projects - not a single one of the programs talked about tribe-directed programs/projects.

Whether faced with a Lumbee patient in the clinic or being in a position to advocate for the needs of the Cherokee, clinicians fall short, and will continue to do so, in working to eliminate health inequities simply because they, and their academic institutions, have little understanding of American Indians and their needs.

### ***Lack of AI in health professions***

Finally, while we do need to increase the understanding of AI culture and health for tomorrow's clinicians, we also need to increase the numbers of AI health professionals. In many tribal communities, there are no Indigenous health providers and many of these tribes have yet to produce a health care provider. This has obvious implications for both the quality of care given, and for the difficulty in encouraging youth to choose health professions. In a recent NHI event, A Day into Health, where high school students from across the state came to UNC to learn about health careers, one participant confessed, "It is real hard when you don't have anyone that looks like you [in the health fields]...it can make you become discouraged and just want to give up and do something else."

AI comprise 0.9% of the U.S. population but only 0.3% of those graduating in dentistry and public health doctoral programs, and 0.6% of those becoming physicians<sup>xxii</sup>. In other words, in order to match their proportion in the population, our system needs to produce at least 200% more AI dentists and doctors of public health and 50% more AI doctors. When we consider estimates for the near future which predict a doubling of the AI population (as a percentage of the U.S. population) by 2050, it is clear that the lack of AI health providers is a critical concern, and a necessary point of action in working toward health equity for America's Indigenous peoples.



### **Initial Poor health status of AI population**

[an issue that is isolated, either “kept on the rez” (Federally recognized tribes) or an enigma due to “data gaps” (State recognized tribes). It is also left out of the realm of education in health professions, and is often left out of conversations/programs on Minority Health]

+

Substandard education that most AI students receive, along with the negative experiences with substandard health care systems, and few role models leads to very few AI students choosing health careers

+

Health professions students learn nothing about AI culture or health issues



AI communities get poor health care, at the hands of clinicians that do not fully understand AI culture or AI health, and who have limited ability/desire to advocate for AI communities and issues.



### **Continued Poor health status of AI population**

(a result of all of the above factors – ignorant health professionals, substandard health care for AI population, few AI as health professionals)

Figure 2: Schematic of the perpetuation of AI health inequities, and the multiple levels at which interventions are needed to achieve health equity

### ***b. American Indian Health in North Carolina – The assets***

NHI's initial assessment could have ended by simply highlighting the health inequities and needs. However, we recognized that *asset mapping* must complement this traditional *needs mapping*. By mapping the assets of a community, we can begin to create programs that utilize these resources, creating invested and empowered communities that will, in turn, create sustainable, culturally-appropriate solutions to their social and health issues. Our mission, as a project is therefore not “What can we do for the communities,” but instead, “What we can do to help communities in their efforts to do for themselves.”

In North Carolina's AI community, NHI identified two unique assets as critical resources. First, in AI communities, a strong social network exists based on families, tribal communities (e.g. a geographic location where a subset of the tribe lives) and tribal identity. These networks have allowed NHI to find housing for students and establish trust and support in ways that would not be possible in many populations.

Second, a strong sense of “preserving the traditional way” exists amongst the AI communities that parallel much of what medical and public health professionals preach as solutions to health problems. For example, there is a push to teach youth about traditional tobacco, the sacred plant used in ceremonial and medicinal ways, as a way to curb smoking rates in this group and reclaiming the image of tobacco from the cigarette companies that have depicted their product as connected to AI and sacred tobacco. (See figure 3) Similar strategies exist for addressing diabetes (e.g. invoking the traditional diet), substance use and mental health (e.g. use of sweat lodge ceremonies and “Oneness” with the Creator), and other conditions. NHI seeks to incorporate these and other assets of our partner communities to teach a way of health consistent with, and built upon, tribal values and their traditional ways.

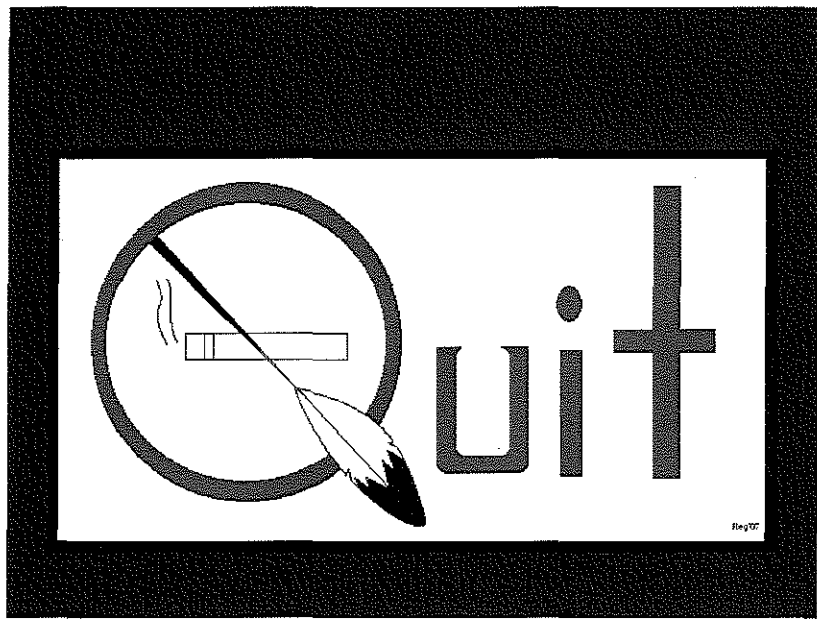


Figure 3: Healing from within.

A revered traditional symbol, the eagle feather is depicted in a logo aimed at smoking cessation, without demonizing tobacco (e.g. the use of traditional tobacco) altogether. Designed by Shannon Fleg

## **B. PROGRAM MISSION**

### **1. Principles**

At initial meetings that brought together community leaders (health workers, ministers), a liaison from the North Carolina Commission of Indian Affairs, and NHI coordinator Anthony Fleg, our group came up with the name of the project and developed four principles to guide NHI's work:

Figure 4: Four guiding principles to NHI and its work

- (1) educating health professions students about health equity, about health inequities in American Indian communities and in U.S. society, and doing so within an interdisciplinary, holistic model of health
- (2) creating tribe-directed sustainable health projects,
- (3) fostering cultural exchange and sincere, loving interactions between all involved in the "NHI Family"
- (4) youth empowerment toward healthy living, becoming health leaders in their communities, and toward health careers.

### **2. Framework and program theory**

A gestalt of these four principles was that we would use health equity as our gold standard for our work, doing so through the "loving service" of community and student volunteers. While this does not fit neatly in a linear description of our *raison d'être*, it speaks to the circular nature of Indigenous culture in which all aspects of life are related, interwoven, and not always amenable to Western (linear) explanations. More recently, we have coined the idea that the principles are "*how* we accomplish NHI's mission" while the framework of loving service and health equity are "*why* we work to accomplish NHI's mission." We think it will be helpful to explain the reasons behind the "*why*" components driving our work:

### **Why health equity?**

Health equity differs in three fundamental ways from the biomedical model that dominates the literature under the titles *health disparities* and *health inequalities*. First, the issue of our ethical stance. Disparities and inequalities simply denote a difference in health and disease, taking no ethical position on these differences. Health inequities, however, suggests that such disparities and inequalities are, by definition, unjust.

Second, the scope of our work is critical to the ultimate success in eliminating differences rates of health and disease. Health inequities broadens the scope from the disparities model, which often focuses on a specific disease within a specific population, and instead seeks to understand the common inequities in health and healthcare that affect certain segments of the population disproportionately (See figure 5). We believe that this shift in language is critical if we are to address the underlying causes of health inequalities – we must recognize them as unjust and search for the root causes of the injustices across populations.

Third, we must know what we are holding as our goal in this work. The biomedical framework points out the disparities/inequalities, but as a curse of its ethical neutrality, it posits no corresponding answer regarding the solution. NHI feels that health equity is a critical gold standard by which we must work, pointing to the goal of restoring justice by the elimination of systematic inequalities in health.

Fact: For most chronic diseases, prevalence rates are elevated in American Indians (AI) in NC, comparable to the rates for African Americans (AA).

### **Disparities/inequalities (biomedical) approach**

Question: Why are AI experiencing high rates of chronic disease in NC

Intervention: Study AI health, tailor program to address AI risk factors

Endpoint: ????

### **Health equity approach**

Question: What social and health inequities, shared by AA and AI are leading to similarly high rates of disease?

Intervention: Study both groups, looking for social and health determinants of health that can be addressed

Endpoint: When health equity is achieved (e.g. rates of disease for AA, AI are equivalent to other North Carolinians)

Figure 5: Framework is everything: An example illustrating the differences in the disparities/inequalities approach to the health equity approach, and the effect this has on the question asked, the intervention planned, and the endpoint for the intervention

### **Why loving service?**

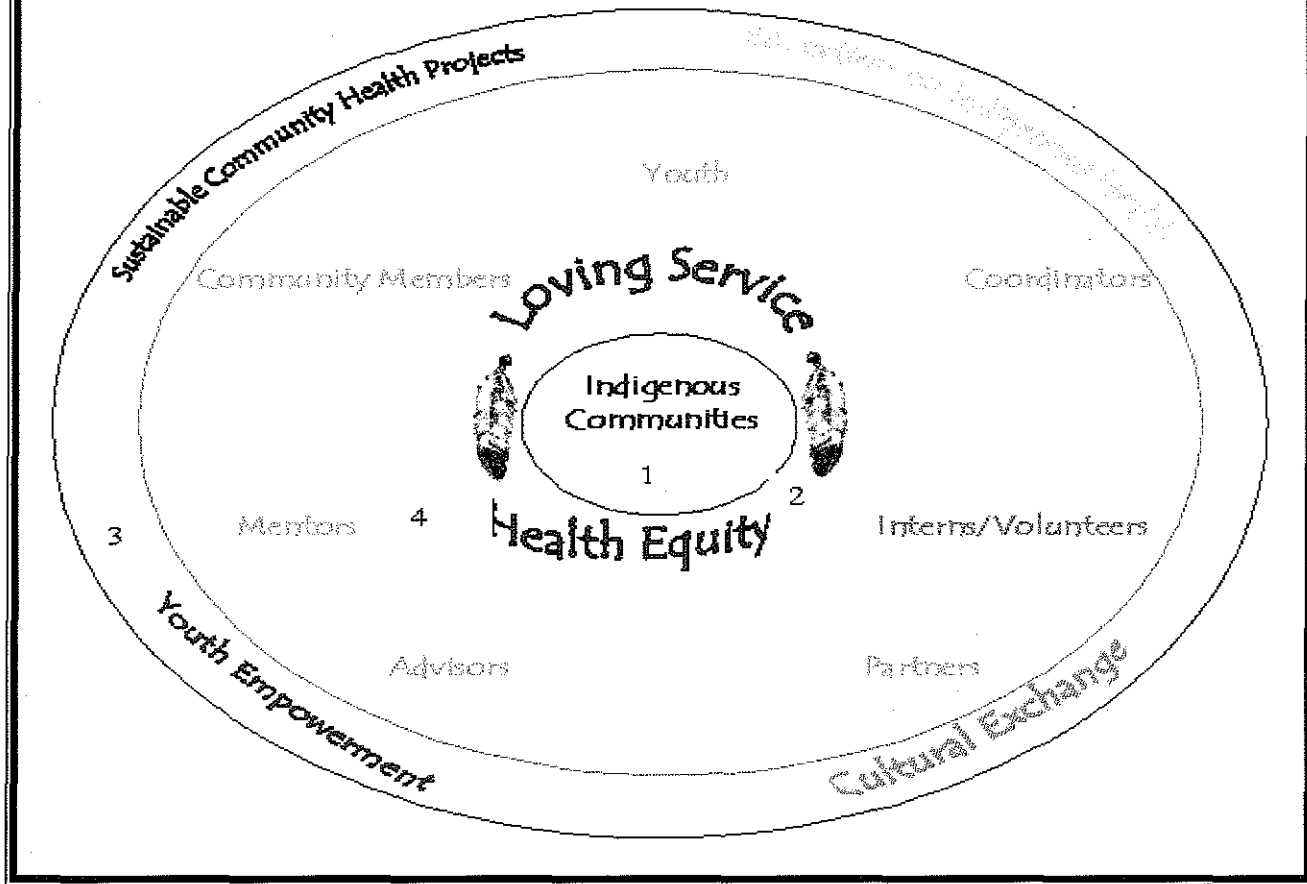
First, it is important to understand that Indigenous culture values, above degrees and titles, relationships with others. Congruent with this, NHI could not expect to enter as a guest to these communities as an academic or volunteer program, but rather as a group seeking to build relationships, a group whose work was grounded in “loving service” and not merely intellectual interest.

We decided that unlike other programs working with AI communities and those initiatives attracting foreign volunteers, we would not charge for our internships, and would instead use “loving service” as our funding source. Volunteers from the tribal communities offer meals and places to stay in the tradition of the hospitality of Indigenous culture while the NHI coordinators and interns offer their time and talents, sharing of their own cultures. Congruent with this philosophy, we invited each person into the NHI as equals, forgoing a hierarchy of coordinators vs. interns, community members vs. students. The sincere friendships and cross-cultural connections that are made with this approach provide the support and foundation for our work.

Thus, in lieu of a logic model, NHI created a pictorial representation of its work, known as the NHI Circle of Healing.

# The Native Health Initiative Circle of Healing

*Addressing health inequities through loving service*



NHI Circle of Healing:

## 1 – Community-driven model – *Where we do our work*

Autonomy given to Indigenous health leaders to design projects, and using community-expressed needs to direct NHI's programming. Accordingly, our projects and efforts take place primarily in Indigenous communities.

## 2 – The framework for NHI – *Why we do this work*

\*Loving Service – Our foundation is love, requiring us to serve as equals, with open hearts and minds to create the NHI family – NHI is a human project, based on the relationships and sincere love for one another, and is not merely an academic endeavor!

\*Health Equity – Our belief is that health disparities are, by definition, unjust, and are therefore health inequities. We seek health equity (e.g. the elimination of health inequities) as the ethical and practical foundation for our work

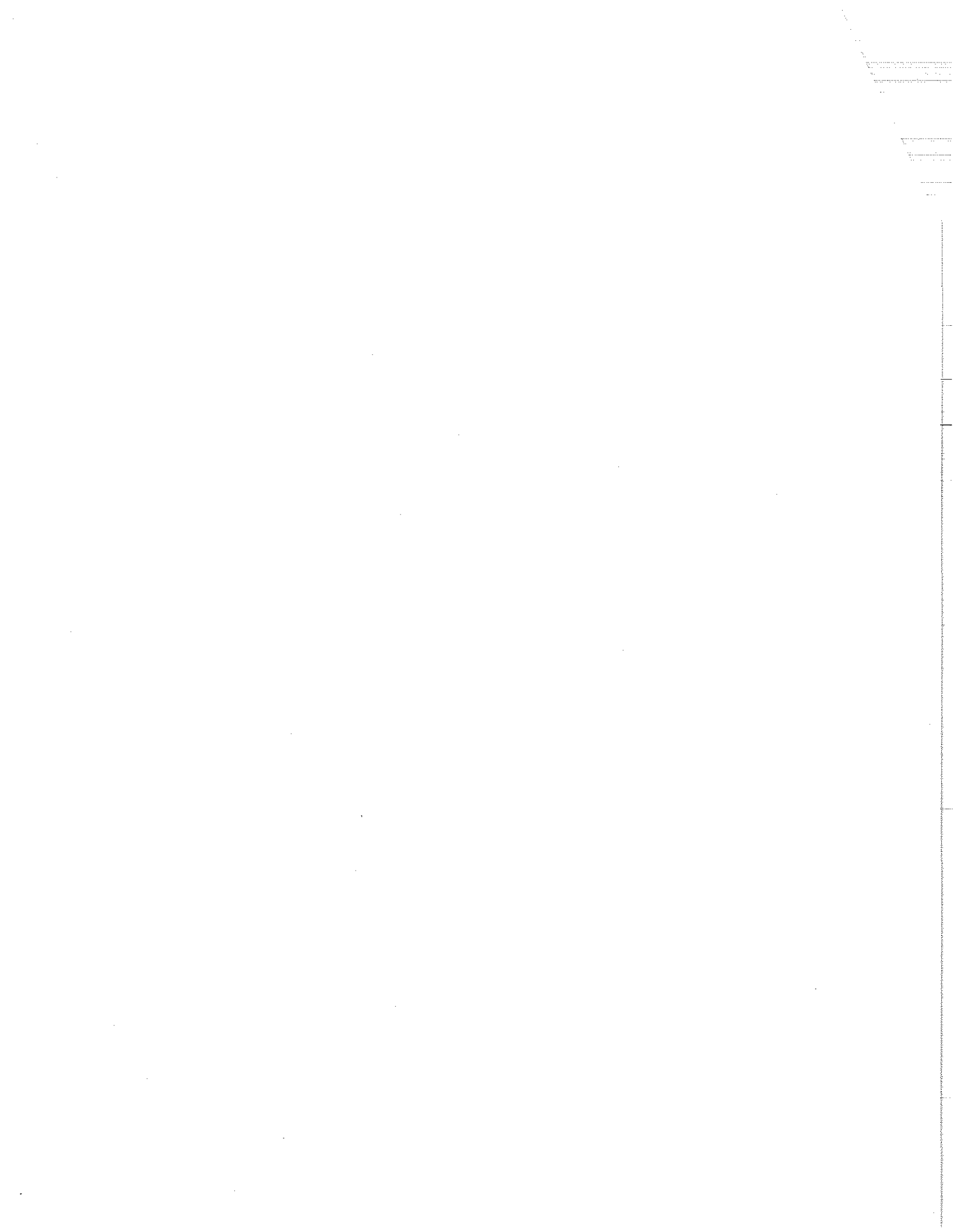
## 3 – The principles of NHI – *How we do this work*

From an initial community meeting, four principles were identified, acknowledging that all NHI entities have talents to give and things to learn. We approach "health" in the most holistic, interdisciplinary sense of the term, feeling that cultural, historical, spiritual, and other aspects of life are integral to understanding and addressing Indigenous health concerns in a meaningful way.

## 4 – The people of NHI – *Who does the work*

Like any family, NHI relies on each of its 7 "family members" to carry out its work. Of note, we seek partnerships, both within and beyond Indigenous communities, with the belief that NHI is a collective, inclusive effort toward health equity and loving service.





### **3. Goals and Objectives**

#### **Goals:**

NHI will strive to accomplish the following goals, which are aligned with the framework and principles of the program:

- To increase health and pre-health professions students' knowledge of American Indian culture and health
- To increase health and pre-health professions students' understanding of health inequities and the framework of health equity.
- To increase partnerships between American Indian communities and health and pre-health professions students
- To increase AI communities' health capacity and programming
- To increase the health literacy within AI communities
- To increase understanding of "loving service" for its ability to mobilize resources to work for social justice

#### **Objectives:**

In keeping with its mission and goals, NHI's objectives are best divided by participant category. Since we foster an environment in which all participants are both giving and receiving, we have grouped the objectives accordingly. Percents correspond to the % of individuals expected to achieve each objective.

Receiving – Corresponding to the non-hierarchical structure of NHI, along with a model of service that is the reciprocal exchange between equals<sup>xxiii</sup>, our objective is for all groups within NHI to receive equally, in the following ways:

- 1) *Will report new friendships as a result of their work with NHI (75%)*
- 2) *Will report a sense of camaraderie within NHI, of which they are a part (75%)*

- 3) *Will report feeling rewarded and appreciated for their efforts, by all NHI participant categories (75%)*

Giving – Each participant category will lend their unique talents to the program, and will also be expected to gain skills appropriate for their position.

### **NHI Coordinators**

- 1) *Will report increased knowledge of the framework of health equity and loving service as a framework for addressing health inequities (100%)*
- 2) *Will report an increased awareness of American Indian culture and health, particularly with regard to the local American Indian Tribes (100%)*
- 3) *Will report increased self-efficacy in their ability to translate health equity and loving service into service (100%)*
- 4) *Will show ability to transmit the framework, principles, and project areas of NHI, both through recruitment of volunteers and the following year's coordinators (100%)*

### **NHI Advisors**

- 1) *Will report increased knowledge of the framework of health equity and loving service as a framework for addressing health inequities (100%)*
- 2) *Will report an increased awareness of American Indian culture and health, particularly with regard to the local American Indian Tribes (100%)*
- 3) *Will report ability to support NHI Coordinators, through giving direction, assisting with infrastructure (e.g. funding, networking), and troubleshooting (75%)*

### **NHI Interns**

- 1) *Will report increased knowledge of the framework of health equity and loving service as a framework for addressing health inequities (75%)*

- 2) *Will report an increased awareness of American Indian culture and health, particularly with regard to the local American Indian Tribes (100%)*
- 3) *Will report increased self-efficacy in their ability to translate health equity and loving service into service (75%)*

#### **NHI Mentors**

- 1) *Will report increased knowledge of the framework of health equity and loving service as a framework for addressing health inequities (75%)*
- 2) *Will report increased self-efficacy in their ability to translate health equity and loving service into service (75%)*
- 3) *Will report direct benefits to their community as a result of collaboration with NHI (75%)*

#### **NHI Community Volunteers**

- 1) *Will report increased knowledge of the framework of health equity and loving service as a framework for addressing health inequities (75%)*
- 2) *Will report increased self-efficacy in their ability to translate health equity and loving service into service (75%)*
- 3) *Will report being able to share talents, wisdom, and or energy that directly improved the work NHI is doing (75%)*

#### **NHI Youth**

- 1) *Will report increased knowledge of the framework of health equity and loving service as a framework for addressing health inequities (75%)*
- 2) *Will report increased self-efficacy in their ability to translate health equity and loving service into service (75%)*
- 3) *Will report increased desire for one or more of the following as a result of their involvement with NHI (100%)*
  - *Taking leadership to better their community*
  - *Living healthier and making healthier decisions*

- *Attending post-secondary education*
- *Becoming a health professional*

**NHI Partners**

- 1) *Will report increased knowledge of the framework of health equity and loving service as a framework for addressing health inequities (75%)*
- 2) *Will report an increased awareness of American Indian culture and health, particularly with regard to the local American Indian Tribes (100%)*
- 3) *Will report increased programming as a result of collaboration with NHI (100%)*

## **C. PROGRAM PARTICIPANTS**

NHI is a partnership and “family” of seven entities – Coordinators, Advisors, Mentors, Volunteers/Interns, Community Members, Youth, and Partners. We will briefly describe the role of each element in NHI, the responsibilities and important qualities for each position, and will describe the role of that position in our work in North Carolina, the NHI pilot project. As with other sections of this manual, the set-up of NHI-NC is an example of how NHI projects could be run.

### ***1. NHI Coordinators***

NHI Coordinators are an important component of NHI, serving to connect the individual pieces of the NHI puzzle and turn them into a collective NHI Family. While no higher than anyone else in NHI, Coordinators have much of the responsibility for the ultimate success (or failure) of NHI. Since our NHI mentors are often the leaders of many efforts in their communities, it would be impossible to expect them to spend the time required to recruit students, develop programming and advocacy efforts, and make partnerships and collaborative efforts to the extent that NHI requires.

NHI-NC:

We began with one coordinator, Anthony Fleg, a medical student at the University of North Carolina (UNC) at Chapel Hill. In the first summer of work, we expanded to three coordinators with the addition of Shannon Fleg (a Navajo public health educator) and Sabina Fattah (a 2005 volunteer who is a Norwegian medical student). Sabina took the role of “International Coordinator” since our project had a connection with an international medical

student organization. In the 2007-8 school year, in preparation to transition into a new stage of NHI's existence in which the initial coordinators will no longer be running the project, we have begun a search for undergraduate and graduate students who can run the project. In our search, we are heavily targeting Indigenous students, and those from diverse health professions, hoping that the NHI Coordinators will reflect the interdisciplinary approach of the project, along with our feeling that American Indians should be involved in leading the project.

#### Responsibilities of NHI Coordinators

- Recruit summer interns
- Arrange summer internships with Indigenous health leaders
- Initiate NHI programming on the campus to speak to the needs of the AI population in your state/community.
- Advocate for AI issues in the academic and political realms
- Secure funding for NHI programming
- Establish and maintain partnerships with campus, tribal, and other organizations

#### Characteristics of a successful NHI Coordinator

- Passionate about addressing health inequities, improving health for the Indigenous population, and doing so through a grounding in the principles of equity and love.
- Previous experience as a volunteer with NHI or other organization working with Indigenous health
- Understanding of Indigenous culture, history, and health.
- Has the ability to lead with authority while simultaneously creating a "team" approach
- Willing to roll up sleeves, and lead by example of "loving service"
- Ability to network amongst many different types of people, in many different forums

- Intrinsic: good smile, great sense of humor, lots of patience and flexibility

Additional advice:

Having multiple Coordinators is beneficial, and is critical to avoid burnout.

- 2) As the project expands, so should the number of NHI Coordinators, though more than 4-5 might create inefficiency and logistical problems.
- 3) Of the Coordinators, it is preferable to have at least 1 Indigenous member, and preferably, and AI student from one of the local tribes.
- 4) Of the Coordinators, it is preferable to have 2-3 health professions represented
- 5) You may decide to adopt a more formal leadership structure (e.g. president, vice-president, treasurer, etc), and may be forced to do so (e.g. to be recognized as a student group, many schools will require such positions to be filled)

## **2. NHI Advisor(s)**

NHI, once established at a school, will benefit greatly from having a dedicated advisor. We prefer to use this term over “faculty advisor”, knowing that for various reasons, the best NHI Advisors may not be University faculty, or even University employees. Like the Coordinators, the faculty advisor is part of the NHI Family, a dedicated member of the team. An advisor with experience in working with ambitious student-run projects will provide needed guidance and direction for the project. Since he/she/they will remain at the university longer than the Coordinators, they are an essential part of the continuation of the project. In addition, as a part of the academic institution, an advisor has the ability to make connections, raise funds, and bring the project attention and recognition. At the same time, since NHI coordinators do most of



the logistical work for NHI and the Mentors direct much of the work to be done, an advisor must be willing to forgo much of the decision-making in the project.

## NHI-NC

For two years, NHI was un-affiliated with no official connections to UNC. Our un-official advisor, was a UNC staff person, Danny Bell (Coharie/Lumbee). Mr. Bell is very well-connected with the AI tribes and leaders in this state, more so than anyone else on campus, and being a UNC employee, understands the perspective of both the Tribes and UNC. Partially because there are no AI faculty on the health side of our campus, Mr. Bell, who runs the UNC American Indian Studies program, became our unofficial advisor in the first years of the project. However, since he is not a faculty member, our official recognition by UNC as a student group in the fall of 2006 meant that we had to choose a faculty member as an advisor. We approached Dr. Adam Goldstein, a family physician well-known for his passion for service work and mentorship of the Student Health Action Coalition (S.H.A.C.). Dr. Goldstein was instrumental in the formation of a partnership between S.H.A.C. and NHI, with NHI becoming a project under S.H.A.C.'s umbrella by November, 2006, an example of the positive influence that an advisor can have on the growth of the project.

In the 2006-7 school year, we have made a concerted effort to recognize both Dr. Goldstein and Mr. Bell in our work, treating them both as advisors. While we don't consider any of our Mentors officially as Advisors, we see the potential good for the project of having an Advisor who is not a part of the University community (e.g. a Tribal leader who brings the community and Indigenous perspective to the advisor position). However, in each specific project or question we have, the Coordinators turn to whoever is most qualified to answer the question, a duty often falling upon our Mentors and community volunteers.

## Responsibilities of NHI Faculty Advisor

- Help Coordinators set goals and agenda
- Aid in transitioning Coordinators and Mentors
- Provide connections to academic realm, as necessary (e.g. funding contacts)

## Characteristics of a successful NHI Faculty Advisor

- Passion for service work and/or health equity work
- Ability to *lead* without being *in control*
- Experience in leading similar student projects
- Experience in serving as a volunteer for similar projects
- Flexibility
- Behind-the-scenes leadership style

### Additional advice:

- 1) Faculty Advisors who are Indigenous, particularly from the a local Tribe, are preferable.
- 2) Having more than one advisor is a possibility, especially in a case where stipulations prevent a well-qualified advisor from having that official role.
- 3) Though not a part of NHI-NC, having an advisor who is not a part of the campus community, presumably a Tribal member/leader, would add a community perspective to this position

### **3. NHI Mentors**

Working under a community-driven model of service, NHI relies on the energy and expertise of its Mentors to carry out its work. More specifically, the summer internships that are

a backbone of NHI's programming, require the commitment of the Mentors. While NHI does extend its non-hierarchical concept to all involved, we also make it clear to the Mentors that they are in charge of their projects and their interns. A goal of NHI is to ultimately have community-level leadership for the project, which would most likely involve Mentors as the governing body.

## NHI-NC

Our mentors have served as the backbone for the summer projects. They range from clinicians to ministers, educators, and tribal leaders. We have attempted to create a community amongst the mentors themselves, an effort that has proven difficult. We have also created "Project Proposals" for the Mentors to help them clarify what they want their communities to get out of the volunteers' work, and to help the Coordinators understand what students would be best-suited for a particular project. In NC, we have also asked the Mentors to find housing for the students in their communities, preferably with host families.

## Responsibilities of NHI Mentor

- Direct and guide volunteers
- Are given the "voice of the community", a power which they must wield with care
- Assist in providing and promoting cultural exchange between volunteers and community
- Assist in finding housing for students

## Characteristics of a successful Mentor

- Passionate about improving their community
- Able to work well across lines of disciplines, race/ethnicity, culture, and age
- Enjoy teaching
- Willing to listen to students' opinions, concerns, etc.

- Supportive and encouraging

#### **4. NHI Interns and student volunteers**

NHI relies on the efforts of students in two senses. First, students are the ones providing services to the partner communities (NHI principles #2 and #4). Equally important, however, is the need for students to be engaged in working with, and learning about AI communities to be capable of taking care of, and advocating for, the AI population and other populations that face systematic health inequities (objectives #1 and #3). There are four unique aspects of the interns/volunteers in NHI, compared to places where they have volunteered before NHI.

First, students must understand that NHI operates under the guidance of our American Indian constituency, whose concerns and ideas for programs take precedence over the interests of the volunteers themselves. Second, especially for those doing projects in American Indian communities, they must understand that the NHI coordinators, while there to support the students, have no authority over the projects themselves. In other words, each student's NHI Mentor is the one to whom questions, ideas, and concerns should be directed.

Third, NHI's loving service framework makes us a "human" project, as opposed to a "student" or "academic" project, and interns/volunteers are expected to get away from seeing their work as research, as an academic endeavor, but instead to see it as service between two equally needy parties. Related to this, volunteers/interns are expected to share of themselves and give of themselves in their work. A fourth aspect that students must grasp is that NHI is more of a collective, a family, than a organization with strict hierarchy. Thus volunteers are told that they are NHI, and should feel comfortable speaking about our work, representing NHI as no less, and no more than any other person involved in the project. In fact, we discourage

volunteers and interns from directing persons to the NHI Coordinators for answers to “What is NHI?”, instead encouraging them to answer these queries themselves.

NHI volunteers fall into two primary categories – those that commit to large amounts of time working with, and often living in, AI communities, and those volunteering on a more limited basis. Both groups are needed, especially as NHI expands its programming at a given site. Recruiting interns involves contacting many organizations across diverse fields of the health professions, both undergraduate and graduate, and in diverse geographic locations. For shorter-term volunteers, diverse groups representing the health and pre-health professions students are places where we recruit students. In both cases, the use of list-serves has proved to be the single most effective way to recruit volunteers.

#### NHI-NC

We began in the summers of 2005 and 2006 with interns as the basis of the project. At this point, we did not have a strong presence on the University’s campus, and focused the majority of our energy on running the summer programs. In 2007, we have expanded greatly in the academic realm, and accordingly, have recruited volunteers to work on one-day events (lectures, health fairs, youth empowerment workshops) and projects (semester-long projects in American Indian communities, creating a clinical course in the medical school). In addition, we have expanded the summer internships to include 27 students, up from the 9 interns we had in each of the first two years.

#### Responsibilities of NHI Interns/Volunteers

- Take direction from appointed NHI mentors with regard to the project
- Commitment to learning about all that is “beneath the surface” - health inequities, AI culture, loving service, etc.

- Commitment to adding to NHI in some way
- Commitment to creating projects in a way that allows the community to sustain them.

#### Characteristics of a successful NHI Intern/Volunteer

- Commitment to loving service and health equity
- Flexible and creative
- Energetic
- Comfortable with being an outsider (racially/ethnically, culturally, and geographically)
- Eager to learn about areas that they might not be familiar with – health inequities, community-directed work, American Indian culture
- Respectful of communities
- Cognizant of the issues of power and privilege that exist between themselves and those they are working with

#### Additional advice:

- 1) Volunteers who have requirements to meet (e.g. for a paper, for a practicum) must understand that NHI will always put the requirements and interests of the community as first priority.
- 2) Along with #1, we will not allow volunteers/interns to bring their own research questions to NHI, unless they were developed in conjunction with our American Indian partners (Mentors, Tribes, communities)
- 3) One of the best ways to encourage a feeling of the NHI family is transparency – for instance, the 2007 summer interns, working along with the Coordinators and Mentors, will decide how to allocate the funds available for the summer's work.

## 5. NHI Community volunteers

The community volunteers are the un-sung heroes of NHI, providing much of the intangible and in-kind support of NHI interns, from places to stay, home-cooked meals, invitations to social gatherings and religious events, and a loving, Indian version of southern hospitality. Our volunteers also serve to assist NHI mentors and interns run the projects. From the perspective of NHI, the organization, our community volunteers are the pulse to the relevancy of our work – if community members are not willing to be a part of NHI, it suggests that NHI’s work needs a thorough diagnosis and resuscitation to be more effective and relevant in the eyes of the community.

### NHI-NC

Our project relies on community volunteers in each of our projects, but particularly, for the summer internships. There are intangibles that these volunteers provide, such as invitations for meals, sharing of their homes (e.g. serving as host families), and supporting the projects themselves. While NHI does not directly recruit these volunteers, we do make every attempt to contact them to show our appreciation, and to recognize them in various ways.

### Responsibilities of NHI Community Members

- Collectively, will help to house and feed students
- Support the NHI projects in their community
- Invite Interns to participate in their community’s functions (e.g. church services, Tribal council meetings, social events, etc)

### Characteristics of a successful NHI Community Member

- A strong pride in their community and Tribe

- Willingness to volunteer
- Interest in sharing their lives and culture with others

## **6. NHI Youth**

Young people have much to offer their communities, and it is a mission of NHI to incorporate youth into our work in a variety of ways. If we are successful in this, we will accomplish NHI's principle #4: youth empowerment toward healthy living, becoming health leaders in their communities, and toward health careers. Thus, in addition to reaching out to youth, NHI must empower AI youth so that they can use their talents to reach out to others.

### **NHI-NC**

While our first two years of work involved considerable amount of youth-directed work, it has proven difficult to get NHI Interns to empower AI youth in a way that allows these young people to become leaders and educators in the realm of health. In the third year, we have begun to see a change in this, through a variety of strategies. We held a "Day into Health," bringing AI high school students to UNC to learn about health professions, and to develop health projects that NHI then works with them to carry out. Also, we have developed Youth Project Grants, open to AI and non-AI youth to create, and get funded for, projects that meet health needs in their communities. We will also incorporate youth in our NHI orientation for the summer interns, hoping to model the outcome we hope to see – putting young people in positions of leadership in the projects carried out.

### **Responsibilities of NHI Youth**



- Learning material asked of them
- Helping their community with the material they have learned
- Working to recruit other youth to become leaders

#### Characteristics of a successful NHI Youth

- Excited to learn, excited to lead
- Passionate about improving their community
- Strong sense of pride in their Tribe

### **7. NHI partners**

Interestingly, from a initiative that listed almost no partnerships for the first two years of the project, NHI has begun to not only develop partnerships, but to see these partners are integral to our work. While many of the partners may never meet our AI communities, or even the Interns or Mentors, there is a critical part of NHI's work done through these partnerships. In North Carolina, and the Eastern U.S., one of the primary benefits and functions of partnerships is the attention that it brings to AI health inequities, attention, as mentioned above, that this population rarely receives. Partnerships also bring added agendas and complexities, and should be approached with a clear understanding of the role both parties will play.

#### NHI-NC

As mentioned, NHI strategically avoided partnerships for the first two years of its existence. In hindsight, looking at the two primary opportunities for partnerships during this time, this was a smart approach. The North Carolina Commission of Indian Affairs, while authoritative, would have brought political barriers and issues of concern toward NHI's mission in the

communities we serve. Partnering with the University of North Carolina, meanwhile, would have brought great scrutiny from our communities regarding the sincerity of our work, and the agenda driving it.

However, in the third year of NHI, now with more to bring to the table, and with the looming question of how to make this project sustainable, building partnerships became a priority. NHI partners now include a student-run service organization on UNC's campus, which will serve as a permanent home on the campus for NHI. Organizations aligned with health equity (Association of Clinicians for the Underserved, American Medical Student Association and their Health Equity Campaign, Justice Speaks), loving service (the Gesundheit Institute), service learning (APPLES service learning program at UNC-CH, Carolina Center for Public Service), and minority health (UNC Minority Student Caucus, UNC Health Care Access to Professions) and others now stand as organizations with which we can turn to as allies, and organizations which we can work with to bring attention to AI health inequities.

#### Responsibilities of NHI Partners

- Establish clear, common points of interest with NHI
- Include NHI in their work, as appropriate

#### Characteristics of a successful NHI Partner

- Understands, and appreciates the need for collaboration
- Understands, and respects, NHI's commitment to our communities
- Willing to push NHI, willing to be pushed by NHI (in the sense of constantly expanding – becoming more knowledgeable, developing new programs, reaching new populations, forming new collaborative projects)

## **D. NHI ACTIVITIES**

The more that NHI can do, working in diverse realms to develop a multi-faceted approach to addressing health inequities through loving service, the more effective the project will be.

In our pilot project in North Carolina, our 4 focuses are health interventions, community based participatory research, advocacy, and collaborative efforts. Following the description of these areas is a chart with examples of projects from each realm. (For a more detailed look at NHI projects from 2006-7, see appendix C)

### 1. Health interventions

Our health interventions have focused on health education and youth empowerment, building on the assets of the host communities under the direction of tribal leaders (NHI mentors). Examples of such projects are seen in Figure 7. However, there is a second level of intervention which reflects the idea that sincere service work acknowledges that both parties – the “giver” and “receiver” – are equally changed and improved by the act of service. Thus, the clinical experience our volunteers gain, often working with AI health care providers, is an intervention of its own right, with NHI volunteers gaining the ability to practice more culturally appropriate care, and in the process, becoming better healers for all of their future patients.

### 2. Community Based Participatory Research

Another important element of our work, especially given the data gap facing NC’s Indigenous peoples, is research. NHI conducts research using the Community Based Participatory Research (CBPR) framework, believing that the most relevant and empowering

research will be that which is driven by our community partners. CBPR, which stresses equity of power at all stages of the research process, has also proven an effective means for building community capacity in the communities with which we work, as very few AI communities have contact with research, and almost none have ever been engaged in the research process.

NHI strives to go a step further in the CBPR realm, recognizing that the majority of such work has not shifted the powerful driving force – funding – away from the control of academic institutions. This is a slippery slope on which to tread, especially if we are proposing a true shift of power in line with CBPR's principles. As long as the purse strings are not distributed equitably, the communities lack the control over the research process. Thus, NHI has pledged to pay our researchers in all projects such that community researchers receive at least 50% of the funds going to reimburse the researchers.

An exciting project set for summer 2007 illustrates the power of CBPR to empower and build capacity – two of our tribal partners have proposed to their tribal councils to conduct “Assessing the Health of Our People” projects in which the community would work with NHI interns in coming up with the questions to be asked, the methods for data collection, and ultimate power and ownership over the data once collected. This has already created a sense of excitement and empowerment for communities who have often felt invisible to the health community, and who often express their frustration that “they just don't care enough about Indian people to know what our health is,” in reference to the lack of data on the tribes. These projects are critical for another reason – the data that is collected will be vital for understanding the health of these tribes and will provide impetus for gaining programming and funding to address the health needs of these communities.

### 3. Advocacy

Advocacy has become increasingly important for NHI, realizing that inequitable systems will never produce health equity. At UNC, NHI is involved in various efforts to address the lack of emphasis on AI health, but also to work on behalf of other populations being left out of the conversations and programs. We have found great opportunity in pushing for the language and mindset of health equity in place of the current health disparities approach. In the latter, underserved groups and their advocates are forced to shout louder than the others for their specific issue in order to be heard. However, a health equity framework suggests that all of this shouting is not necessary, nor is it fruitful, since the social, political, educational, and economic inequalities underlying the inequalities in health are shared by these groups, and therefore deserve a unified approach in addressing them.

### 4. Collaborative Efforts

A fourth aspect of NHI's efforts has been focused on collaborative projects, creating connections with other organizations to increase the capacity for service work, and to further the work of health equity. For instance, this spring NHI will host American Indian high school students from around the state in Chapel Hill for an event called "A Day into Health," which will seek to empower and inspire students toward becoming health leaders in their communities, and toward choosing health careers. This project stems from a collaboration between NHI, the eight recognized tribes and four North Carolina urban-American-Indian associations, the American Medical Student Association, the Carolina Center for Public Service and various student groups in the UNC-CH schools of nursing, medicine, dentistry and public health.

## **E. NHI RESOURCES/FUNDING**

NHI operates on a model where resources are mostly non-monetary, coming in the form of the volunteer efforts and social capital of our students and community members. To be a bit more radical, we like to say that “love is our funding source,” and truthfully, this is correct. In the summer of 2007, for instance, we estimate a cost of bringing 26 volunteers to N.C., 18 of which required housing, that monetary costs would exceed \$30,000 for the summer. However, we will likely spend less than \$2,000 in currency, the rest being supplied by the love of our Interns, Mentors, Community Members (including host families), and Partners. We will describe the efforts of NHI-NC herein, beginning with a look at NHI’s financial principles (approved by NHI Coordinators, Interns and Mentors in 2007), and then will turn to NHI-NC as an example of successful funding of a project given limited financial resources.

### Financial principles of NHI

- 1) We trust that Creator will give us exactly what we need to sustain our work, nothing more and nothing less.
- 2) Money must never become our primary funding source – instead, we will use sincere partnerships to mobilize loving service on the part of NHI student and community volunteers to fund our project
- 3) Of money that is appropriated for stipends, at least 50% must go to community members’ hands (e.g. when receiving a grant)
- 4) All awards won on behalf of NHI, for work done with NHI, will be donated back to NHI
- 5) We will operate with transparency in the area of finances, making collective decisions on how funding is to be spent together, amongst Coordinators, Interns, and Mentors.
- 6) We will do our absolute best to ensure that costs are not incurred
  - by host families
  - by Interns at NHI Orientation, NHI retreat, and NHI closing ceremonies

- by partner organizations

7) We will not charge Interns to volunteer with NHI, but will instead welcome them as partners in our work, knowing that they will “pay” our partner communities and NHI through their loving service

### ***Social capital – initiating and maintaining NHI***

Indigenous communities, as expressed by an Occaneechi elder John Blackfeather, “will be your best friend, if you can get into the door.” Thus, from the outset, the most important resources for NHI have not been monetary. We relied on the “opening of the door” by those in the AI community to begin discussions about forming the project, and have since realized the wealth of resources that the AI community can offer such a partnership-oriented project. Since the creation of a project such as ours rested not only on the presence of social capital, but also on the openness of these resources to us, outsiders of the community, it is worth mentioning the aspects of our initial proposal and plan that allowed NHI to form.

First, the importance of a truly collaborative process in program formation. What stood out to us most from those first meetings was the level of trust that tribal leaders gave to the project. In many ways, it was good that we came to the table without a grant hanging over our heads, free from political and University ties, and without pre-set goals and objectives. Our open agenda allowed us to sit down as people who shared a common interest in what could come from our working together.

Second, we recognized the importance in such community work of working through “gatekeepers” of communities, which in the case of our first meeting in Pembroke was not a clinician, but a well-known minister. It is critical to respect the social structure and leaders of communities, as defined by the communities themselves, in order to earn their respect and trust.

Third, we came to the table with a culturally sensitive view of the interaction. As *outsiders*, we should be ready and accepting of suspicion from Indigenous and other peoples who have endured trauma, exploitation, and all out attempts of extermination at the hands of *outsiders* to their communities. Though we did not have explicit conversations about these issues, we were clear to present the plan for the program in a way that made explicitly clear our intentions, the ownership of the project, and which respected the autonomy of the communities we were working with.

Finally, we cannot forget to mention the very simple aspect of bringing a sincere desire to work for positive change – members of the Commission and the tribal leaders have since recalled feeling, as stated by a minister in Pembroke that above all, there was a “good vibe that this was project that could really help our communities.”<sup>xxiv</sup> AI leaders, such as Missy Brayboy have long felt that their communities are ready and eager for change. “We are a people eager for information, eager to know how we can live healthier. We just lack the information and the resources for knowledge many times,” she reminded NHI Interns at the 2007 NHI Orientation.

### ***Monetary capital – it’s role in the NHI model***

While not the foundation of NHI’s programming, monetary funding is useful in expanding NHI’s programming. We will briefly mention the ways which NHI-NC is funded, by school year.

2004-5 – We received \$0.00 funding to run the first summer’s program, which involved 9 students (5 from NC, 2 from other states, 2 from overseas). We established an agreement of “reciprocity” whereby volunteers would work in the community, and the community would provide free housing, preferably with a host family. The orientation, mid-summer retreat, and closing ceremonies were similarly funded by in-kind donations of supplies and food from NHI coordinators, student volunteers, and community volunteers.



- 2005-6 – Still un-affiliated with other organizations, we relied on a few private donations and a generous gift from the Medical Association of Norway (thanks to the efforts of one of our 2005 volunteers) to collect \$1600 to fund 9 summer volunteers (6 from NC, 3 from overseas) and 6 spring volunteers (all from Norway). Again, communities housed students, leaving them to pay only their living expenses. With the money we were able to fund the NHI retreat and provide small grants to our community partners for the running of the projects.
- 2006-7 – In the beginning days of the school year, NHI began an ambitious attempt to build partnerships with three primary goals: (1) becoming financially sustainable, (2) finding a “permanent home”, either on campus or in the AI community, and (3) broadening the scope and influence of our work. With the addition of a spring event, “A Day into Health” for AI high school students, 26 summer volunteers (13 from NC, 8 from other states, 5 from overseas), additional programs (Youth Project Grants, Community Project Grants), and presenting at multiple conferences, we knew that we would need to secure funding.

At this point, through grants, awards, conference scholarships, and donations we have \$4000 in funds for our programs. Though our partnerships are too numerous to list, one is worth mentioning. The Student Health Action Coalition (S.H.A.C.) is a student-run, interdisciplinary program on UNC’s campus, hosting projects that range from building houses (Health-for-Habitat), caring for the homebound elderly (Mobile SHAC) and running a free clinic. Their infrastructure, both in human and monetary capital, met NHI’s three goals, and we have become a project of S.H.A.C. In the negotiations, NHI and S.H.A.C. were clear as to how the partnership would work, and we were assured both our autonomy as a program, and the support from S.H.A.C. We believe that partnerships such as this one can greatly enhance the long-term prospects of a student program, providing a source of recruiting volunteers, assuring leadership from year-to-year, and relieving some of a program’s funding burden.

## **II: PROGRAM EVALUATION**

For NHI to become an agent for change at the University and Tribal, attention to rigorous evaluation is critical. We feel that all parties involved with NHI – Coordinators, Mentors, Advisors, Interns/Volunteers, Community Members, Youth and Partners – must be engaged in constant evaluation of NHI in two domains. First, the NHI's implementation of projects and programs to address health equity through loving service require constant evaluation. Second, the process through which NHI carries out its work is critically important, and must be evaluated with equal rigor. To carry out evaluations in these areas, NHI has developed five core principles for evaluation:

- 1) All NHI projects, regardless of size, require evaluation
- 2) All NHI projects should be evaluated by both community and student interests
- 3) The parameters for evaluation should prioritize the community's input
- 4) For some projects, it may be necessary to have a dual-evaluatory approach, with separate mechanisms for evaluating the project from the community and students' perspective
- 5) Loving service and health equity will be our framework through which we will carry out evaluations of our work

This section will clarify the strategies for evaluating NHI in these areas.

## **A. IMPLEMENTATION EVALUATION**

NHI has an approach oriented in loving service and health equity, both of which require effective projects to be multi-dimensional, and all of which require evaluation regarding the effectiveness of the projects themselves. NHI-NC has become active in many fronts (see Appendix C), from creating change in medical school curriculum, organizing summer health internships, and

carrying out collaborative projects with partner organizations. This creates a challenge for NHI, for evaluation does not center on a single “core” project, but instead on our ability to work toward the NHI principles, within the NHI framework of loving service and health equity. In addition, while many student programs find it effectively to carry out evaluations at the beginning and end of the school year, NHI, whose most formative work is in the summer, must adopt a more fluid, flexible time table for evaluation.

## **IMPLEMENTATION EVALUATION STUDY DESIGN**

This evaluation is divided into the two segments of NHI’s programming – summer internships/projects and school-year projects.

### **Summer internships/projects**

#### *Phase 1: Beginning of the summer evaluation*

In Phase 1, we will use two primary inputs to determine the appropriate projects for the summer. The first piece of data are the NHI Summer Internships Applications, which give a detailed view of the prospective volunteers. Second, the Project Proposals are turned in by our NHI Mentors, giving their initial thoughts on the projects for the summer, and addressing logistics (e.g. housing for interns). Using both sources of information, we will have a good qualitative survey of both the knowledge of interns around issues of health inequities and American Indian culture, and an idea of the goals for the summer’s projects. While we have not chosen to do so, there is opportunity herein to implement more quantitative assessments of both NHI volunteers and community partners before the summer begins, especially on

parameters expected to change during the course of the summer's work, though such evaluations would require Institutional Review Board approval.

### *Phase 2: End of summer evaluation*

Like the beginning of summer evaluation, the end of summer evaluation will rely heavily on two measures. First, an extensive survey will be completed by NHI Interns, using a mix of open-ended questions, closed-ended questions, and Likert scale-graded questions. Secondly, a similar survey will be used for both NHI mentors and NHI community members (e.g. host families). Quantitative measures will also be incorporated into this stage of the evaluation, measuring such items as those listed below:

- Number of projects initiated vs. Number of completed projects
- Number of NHI volunteers – full-time vs. part-time
- Number of NHI volunteers at orientation, retreat, and closing ceremony
- Number of host families
- Number of youth engaged
- Number of youth empowered and trained to become “youth health leaders”

## **STUDY METHODS**

NHI Summer Internship Applications: The application will gauge prospective volunteers' competency on the four NHI principles and the larger scope of the NHI framework.

NHI Project Proposal Form: This assesses the initial capacity of the community partner, along with outlining the goals for the proposed projects.

NHI Summer Internship Evaluation Form: This will be completed by the summer's volunteers at the end of their summer's work, and will elicit their perspectives on the logistics, projects, organization, and effectiveness of NHI. There will also be questions to ascertain the growth of volunteers during the summer.

NHI Summer Projects Evaluation Form: To be completed by NHI Mentors, this form will elicit their opinions on the logistics, projects, organization, and effectiveness of NHI, this will serve as part of the communities' evaluation of NHI.

NHI Community Perspective Evaluation Form: Given to community members active in the projects, including host families and those actively involved in the projects and/or support of the volunteers, this will comprise part of the communities' evaluation of NHI.

Focus Groups and Interviews of participants: During the summer, beginning at NHI Orientation, NHI Coordinators will gauge the potential for projects and then the progress of the projects through multiple interviews and conversations of varying degree of formality.

Summer Implementation Goals and Strategies Report: A document produced in the Phase 1 evaluation, this will help guide all involved in the summer internships. Serving as a key component to the initial Phase 2 evaluation, a section will be added during this latter phase, discussing the progress toward stated goals and strategies, along with progress relating to NHI core principles and framework.

## **DISSEMINATION PLAN**

Internal Communication:

NHI Coordinators will compile the evaluations, making the results and comments available to all NHI entities in a timely manner.

External Communication:

NHI Coordinators will also handle the communication of results beyond NHI. Specifically, American Indian communities where NHI has not yet worked, prospective NHI Partners, and potential funders will be included in this dissemination process. If appropriate, local media, professional conferences, and NHI-authored articles are additional avenues for communicating the results.

**SCHEDULE FOR NHI IMPLEMENTATION EVALUATION: Stages 1-2**

Evaluation	PHASE 1 - Beginning of Summer	PHASE 2 - End-of-summer
Dates	Completed annually within two weeks of NHI Orientation	Completed annually within one month of NHI Closing Ceremony
Objective(s)*	<ol style="list-style-type: none"><li>1. Enhance NHI programming (communities' perspective)</li><li>2. Enhance NHI programming from Interns perspective</li><li>3. Enhance NHI's effectiveness in working toward NHI core principles</li></ol>	<ol style="list-style-type: none"><li>1. Enhance NHI programming (communities' perspective)</li><li>2. Enhance NHI programming from Interns perspective</li><li>3. Enhance NHI's effectiveness in working toward NHI core principles</li></ol>

	and framework	and framework
Tasks	1. Review Summer Internship Applications and Project Proposals 2. Coordinators, working with NHI entities, will establish goals and strategies for summer – Summer Implementation Goals and Strategies Report (SIGSR) 3. Disseminate results	1. Review SIGSR 2. Gather data from NHI entities (Mentors, Coordinators, Interns, etc.) through evaluation forms 3. Complete SIGSR 4. Disseminate results

\* All objectives developed by a coalition of NHI Coordinators, Advisors, Mentors, and others interested/invested in the particular realms being discussed.

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### School-year projects

#### *Phase 1: Beginning of the school-year evaluation*

The Phase 1 assessment will include an evaluation of existing activities, in addition to goal development for the upcoming school year. The former will rely on the *NHI May Report: End-of-year Assessment* from the previous school year, while the latter will involve completion of the *NHI September Report: Goals and Strategies*. This evaluation will be completed by NHI



Coordinators, in conjunction with Advisors, Mentors, and others interested and invested in the activities during the school year. More community-level input during Phase 1 will enhance the effectiveness of the year's programming, and will be elicited to the extent possible.

#### *Phase 2: End of school-year evaluation*

At the conclusion of the school-year, the NHI Coordinators, along with NHI Advisors, Mentors, and others, will use the *NHI September Report: Goals and Strategies* to evaluate the NHI programming for the school year. The result, the *NHI May Report: End-of-year Assessment*, will evaluate the year's projects on the basis of two criteria: stated goals and strategies from the September report, and the NHI core principles and framework.

## **STUDY METHODS**

*September Report: Goals and Strategies* : The application will gauge prospective volunteers' competency on the four NHI principles and the larger scope of the NHI framework.

*May Report: End-of-year Assessment*. This assesses the initial capacity of the community partner, along with outlining the goals for the proposed projects.

*NHI Volunteer Evaluation Form*: For designated events/projects, NHI will distribute evaluation forms for NHI volunteers

*NHI Event/Program Evaluation Form*: For designated events/projects, NHI will give evaluation forms to attendees, NHI partners, and others involved to assess the event/program.

Focus Groups and Interviews of participants: Throughout the school year, NHI Coordinators will gauge the potential for projects and then the progress of the projects through multiple interviews and conversations of varying degree of formality.

## **DISSEMINATION PLAN**

### Internal Communication:

NHI Coordinators will compile the evaluations, making the results and comments available to all NHI entities in a timely manner.

### External Communication:

NHI Coordinators will also handle the communication of results beyond NHI. Specifically, American Indian communities where NHI has not yet worked, prospective NHI Partners, and potential funders will be included in this dissemination process. If appropriate, local media, professional conferences, and NHI-authored articles are additional avenues for communicating the results.

## **SCHEDULE FOR NHI PROCESS EVALUATION: Stages 1-2**

|  |                          |                    |
|--|--------------------------|--------------------|
|  | <b>PHASE 1</b>           | <b>PHASE 2</b>     |
|  | Beginning of School Year | End-of-School Year |
|  | Evaluation               | Evaluation         |

|               |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                |
|---------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
|               |                                                                                                                                                                                                                               |                                                                                                                                                                                                                                                |
| Dates         | Completed annually by<br>September 15th                                                                                                                                                                                       | Completed annually by<br>May 15th                                                                                                                                                                                                              |
| Objective(s)* | <p>1. Enhance NHI programming (communities'perspective)</p> <p>2. Enhance NHI programming from Interns perspective</p> <p>3. Enhance NHI's effectiveness in working toward NHI core principles and framework</p>              | <p>1. Enhance NHI programming (communities'perspective)</p> <p>2. Enhance NHI programming from Interns perspective</p> <p>3. Enhance NHI's effectiveness in working toward NHI core principles and framework</p>                               |
| Tasks         | <p>1. Review previous school year's Phase 2 report</p> <p>2. Contact NHI entities to establish goals and strategies for summer</p> <p>3. Complete NHI September Report:Goals and Strategies</p> <p>4. Disseminate results</p> | <p>1. Review Phase 1 report</p> <p>2. Gather data from NHI entities (Mentors, Coordinators, Interns, etc.), using evaluation forms, focus groups, etc.</p> <p>3. Complete May Report: End of Year Assessment</p> <p>4. Disseminate results</p> |

\* All objectives developed by a coalition of NHI Coordinators, Advisors, Mentors, and others interested/invested in the particular realms being discussed.

## **B. ENGAGEMENT PROCESS EVALUATION**

The engagement process, whereby Tribal communities, organizations, and citizens are brought into the planning and development of programming is a critical aspect of NHI, as depicted by Indigenous Communities sitting in the center of the NHI Circle of Healing. Thus, engagement process evaluation is a critical complement to implementation evaluation for NHI. As stated by Dehar et al, “Process evaluation fulfills the need for information on program implementation, which is important in interpreting program outcomes, and informing future efforts in similar areas”<sup>xxv</sup>. for NHI serves a unique and critical purpose for our ultimate effectiveness in partnering with, and engaging communities to address health inequities. Moreover, we are concerned mostly with the evaluation of “process” in two arenas. First, recognizing the history of exploitation and injustices at the hands of outsiders, we will carefully review the process by which we engage, interact with, and partner with Indigenous communities. We know that our work, however well-intentioned, will be ineffective if not carried out with attentiveness to detail, and consideration of the socio-historical context in which we are operating. Secondly, NHI will evaluate the organizational and administrative processes, looking for ways to streamline our efforts, develop effective partnerships, and run NHI efficiently and effectively.

### **ENGAGEMENT PROCESS EVALUATION STUDY DESIGN**

#### **Phase 1: Beginning of the summer process evaluation**

At the beginning of the summer, NHI will review the *Summer-2 Process Evaluation Report* from the previous summer as a means for compiling specific process goals and

strategies for the current summer's projects. This report, authored by NHI Coordinators, Mentors, and Advisors, along with others interested and invested in NHI's Summer Internships, will be called the *Summer-1 Process Evaluation Report*.

#### Phase 2: End of summer process evaluation

At the conclusion of the summer, NHI will review the processes regarding both interactions between students and communities, and more administrative/organizational aspects of NHI. This report, authored by NHI Coordinators, Mentors, Interns, and Advisors, along with others interested and invested in NHI's Summer Internships, will be called the *Summer-2 Process Evaluation Report*.

#### Phase 3: Beginning of school year process evaluation

This evaluation will utilize the findings from the *School year-3 Process Evaluation Report* from the previous school year to draw up process goals and strategies for the present school year. This report, authored by NHI Coordinators, Mentors, Advisors, along with others interested and invested in NHI's school year programming, will be called the *School year-1 Process Evaluation Report*. Mid-year and end-of-year goals will be elucidated in this report.

#### Phase 4: Middle of school year process evaluation

The process evaluation in Phase 4 will review the *School year-1 Process Evaluation Report*, particularly its mid-year goals. The goal of this report will be to identify the effective process elements, while correcting and improving less-than-optimal process elements. This report, authored by NHI Coordinators, Mentors, Advisors, along with others interested and invested in NHI's school year programming, will be called the *School year-2 Process Evaluation Report*.

### Phase 5: End of school year process evaluation

At the conclusion of the school-year, the NHI Coordinators, along with NHI Advisors, Mentors, and others, will complete the *School year-3 Process Evaluation*, using the *School year-1 Process Evaluation Report* and *School year-2 Process Evaluation Report* to aid in the *evaluation criteria for a particular school year*. Moreover, Phase 5 will include recommendations for the upcoming summer (Phase 1) and following school year (Phase 3) projects and evaluations.

## **STUDY METHODS**

*Beginning of summer Process Evaluation Report:* Written by NHI Coordinators, Mentors, and others, this will outline the process-oriented goals for the summer, taking into account the Process Evaluation Reports from the previous summer.

*End-of-summer Process Evaluation Report:* Written by NHI Coordinators, Mentors, and others, this will evaluate the summer's work, making recommendations for the following summer's work.

*School year-1 Process Evaluation Report:* Written by NHI Coordinators, Mentors, and others, this will outline the process-oriented goals for the school year, taking into account the Process Evaluation Reports from the previous school year.

*School year-2 Process Evaluation Report:* Written by NHI Coordinators, Mentors, and others, and taking into account the *School year-1 Process Evaluation Report*, this will assess progress, making recommendations for the 2<sup>nd</sup> semester of the school year.

*School year-3 Process Evaluation Report:* Written by NHI Coordinators, Mentors, and others, this will evaluate the school year's work, taking into account the previous two Process

Evaluation Reports. This document will also make recommendations for the following summer's work

## **DISSEMINATION PLAN**

### Internal Communication:

NHI Coordinators will compile the Process Evaluation Reports, making the results and comments available to all NHI entities in a timely manner.

### External Communication:

NHI Coordinators will also handle the communication of results beyond NHI. Specifically, American Indian communities where NHI has not yet worked, prospective NHI Partners, and potential funders will be included in this dissemination process. If appropriate, local media, professional conferences, and NHI-authored articles are additional avenues for communicating the results.

### **SCHEDULE FOR ENGAGEMENT PROCESS EVALUATION: Stages 1-2**

|       | PHASE 1                        | PHASE 2                       |
|-------|--------------------------------|-------------------------------|
|       | Beginning of Summer Evaluation | End-of-summer Evaluation      |
| Dates | Completed annually before      | Completed annually within one |

|              | NHI Orientation                                                                                                                                                                                                                                                   | month of NHI Closing Ceremony                                                                                                                                                                                                                                    |
|--------------|-------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|
| Objective(s) | <ol style="list-style-type: none"> <li>1. Enhance NHI programming (communities' perspective)</li> <li>2. Enhance NHI programming from Interns perspective</li> <li>3. Enhance NHI's effectiveness in working toward NHI core principles and framework</li> </ol>  | <ol style="list-style-type: none"> <li>1. Enhance NHI programming (communities' perspective)</li> <li>2. Enhance NHI programming from Interns perspective</li> <li>3. Enhance NHI's effectiveness in working toward NHI core principles and framework</li> </ol> |
| Tasks        | <ol style="list-style-type: none"> <li>1. Review previous summer's Phase 2 report</li> <li>2. Contact NHI entities to establish goals and strategies for summer</li> <li>3. Complete Phase 1 Process Evaluation Report</li> <li>4. Disseminate results</li> </ol> | <ol style="list-style-type: none"> <li>1. Review Phase 1 report</li> <li>2. Gather data from NHI entities (Mentors, Coordinators, Interns, etc.)</li> <li>3. Complete Phase 2 Process Evaluation Report</li> <li>4. Disseminate results</li> </ol>               |



**ENGAGEMENT PROCESS EVALUATION SCHEDULE: Phases 3-5**

|               | PHASE 3                                                                                                                                          | PHASE 4                                                                                                                                                                                                               | PHASE 5                                                                                                                                       |
|---------------|--------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------|-----------------------------------------------------------------------------------------------------------------------------------------------|
|               | Beginning of school year evaluation                                                                                                              | Middle of school year evaluation                                                                                                                                                                                      | End of school year evaluation                                                                                                                 |
| Dates         | Completed annually by September 15th                                                                                                             | Completed annually by January 1st                                                                                                                                                                                     | Completed annually by May 15th                                                                                                                |
| Objective(s)* | 1. Assess process measures from previous school year<br>2. Develop process measures for current school year<br>3. Develop mid-year process goals | 1. Assess progress, using Phase 3 goals for the mid-year and end-of-year<br>2. Develop recommendations for improved process performance in the 2nd semester of the school year<br>3. Refine end-of-year process goals | 1. Assess progress, using Phase 3 and 4 documents<br>2. Develop recommendations for improved process performance in the following school year |
| Tasks         | 1. Develop School year-1 Process Evaluation Report<br>2. Dissemination of results                                                                | 1. Develop School year-2 Process Evaluation Report<br>2. Dissemination of results                                                                                                                                     | 1. Develop School year-3 Process Evaluation Report<br>2. Dissemination of results                                                             |

\* All objectives developed by a coalition of NHI Coordinators, Advisors, Mentors, and others interested/invested in the particular realms being discussed.

### **III. Discussion**

NHI is a novel, effective model for loving service as a way to address health inequities. It represents a different model for service in many ways – from the transfer of power to communities, use of love to mobilize resources to work for social justice, and bringing students from abroad to learn about health inequities in the United States. Before sharing our conclusions from this initial project, we will discuss the limitations and barriers to our work in NHI-NC.

#### Limitations

While we have surpassed many of our expectations in the pilot project here in North Carolina, the project has faced barriers and limitations that are worth noting. First, making a dent into health inequities is difficult – though we have many projects that are addressing health inequities, showing that we are affecting change is a challenge. In terms of “hard outcomes”, such as reduced rates of diabetes in a given Tribe, NHI can work to educate and empower, but cannot expect such immediate results. Second, developing comprehensive, sustainable programming with little AI health infrastructure is not easy – in many communities, NHI is one of the only influxes of labor and energy toward AI health, posing a barrier to the sustainability of our work. Efforts carried out on UNC’s campus, meanwhile, is done without AI health faculty or programs. Third, youth empowerment is hard to guarantee with short-term volunteers – while we have emphasized the importance of youth empowerment to our NHI Interns, we recognize the difficulty in asking people from various cultures and backgrounds, with varying degrees of interest and ability in working with youth, to empower youth in their short time in the community. Fourth, finding host families is a logistical headache – when the numbers of NHI Interns swelled, we did not realize how difficult it would be to find housing for them. Not only are we asking families to give up their privacy to complete strangers, but we also must understand the

importance of privacy in American Indian culture, particularly toward outsiders. Fifth, maintaining sincere, loving partnerships with AI communities and NHI Mentors is challenging – with communities spread out through the state, varying use of technology (e.g. email), and busy lives, it has proven difficult to gather and sustain community leadership within NHI. Sixth, partnership building must be done with caution – We have realized the power of partnerships, both to do great things, and to create tension; playing the political game in terms of aligning NHI with specific partners, is something to do with care, and with the input of community members.

Despite these limitations, NHI continues to pave a new road, an example of the power of sincere, love-driven service to heal wounds from the past and health inequities of the present. Sadly, we are the only volunteer project in the United States bringing foreign students to learn about, and address health inequities in this country. We are also the only project bringing U.S. students to work in Indigenous communities to address such injustices through Tribe-directed projects. And of the programs doing work in American Indian health, NHI is unique in that it receives little monetary funding, is a student-initiated project with no full-time staff, and is not a program of a large institution (University, Indian Health Service). Thus, we do not see our work in North Carolina as a success, as there is a need for such work across the country. Instead, NHI-NC is a sign that success is possible, and possible without large grants and benefactors. NHI-NC, to the contrary, shows that committed students, engaging in sincere, loving partnerships with American Indian communities, can begin to address health inequities in a powerful way.

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## **Appendix A: NHI projects, July 1st 2006- June 28th 2007**

\*Tribes abbreviated as W-S (Waccamaw Siouan), L (Lumbee), T (Tuscarora), S (Sappony), C (Cherokee), O (Occaneechi), Co (Coharie)

### INTERVENTIONS

#### *Toward American Indian Community*

- Education on traditional tobacco and diabetes at Pow Wows, 2007 (L, O)
- Home visits with local clinicians for homebound elders, 2006 (T)
- “Empowering youth to health” @ Tuscarora Dear Clan Project summer camps, 2006 (W, T)
- Academic enrichment at the Boys and Girls club, 2006 + 2007 (L)
- Health education instruction at Indian Education, 2007 (L)
- Creation of a work-study course for UNC-P students to work at the Healing Lodge
- Organization of a youth rally sponsored by the Healing Lodge (L)
- “A Day into Health”, a workshop for high school students, with Carolina Center for Public Service, Minority -Student Caucus, and NC Health Care Access Program as co-sponsors, April 2007 (Co, S, L)
- Service trip to Louisiana, working with New Orleans’ residents and schools, along with Houma nation, May 2007
- Understanding substance abuse – “Learn it, teach it” presented by Shannon Fleg to youth attendees at NC Native American Youth Organization conference (done in the capacity as NHI Coordinator and UNC employee), 2007
- Empowering American Indian youth camp counselors: “Excellence in Leadership”, June 2006 and 2007 (S)
- Inspiring youth to excellence – volunteered with Outward Bound, S.T.E.P., Phoenix Academy, Hargraves Community Center, and DNA Day, 2006-7
- Youth project grants, spring 2007

#### *Toward NHI summer interns*

- 2006 NHI orientation – two days of learning in Pembroke, NC on American Indian health, culture, and history, largely taught through guest speakers. In addition, training on health inequities and loving service
- 2006 NHI internships – teaching ourselves through service!
- 2006 NHI retreat – trip to Cherokee, NC to meet with various health leaders in the Cherokee community, along with visits to cultural sites
- 2006 NHI Closing Ceremony – community gathering in Pembroke, NC allowing students to share what they have learned about themselves, and what the community has taught them

#### *Toward Health Professions students/community*

- Health inequalities workshop - partnered with Carolina Center for Public Service to teach 2-hour workshop for their Public Service Scholars, October 2006
- Community Asset Mapping Workshop - partnered with Carolina Center for Public Service to teach 2-hour workshop for their Public Service Scholars, March 2007
- “Health issues in North Carolina’s American Indian population” –Lecture by Dr. Ronny Bell at the UNC medical school, with traditional Navajo food served, November 2006
- “Cultural competency in working with rehabilitation and those with disabilities” – Lecture by Shannon Fleg as guest lecturer in UNC allied health class, October 2006

- Health and healthcare inequities in American Indians” – Lecture by Anthony Fleg as guest lecturer in UNC School of Medicine course Racial and Ethnic Disparities in Health: What do we know and what can we do?, April 2007
- “What is NHI?” – Brief presentation by Anthony Fleg at UNC School of Social Work (to social work students), April 2007
- “The importance of culture in healing: a case study of an Ethiopian family at odds with medical staff,” presented by Anthony Fleg as part of Cultural Crossroads lunch lecture series at the school of medicine
- Created “Tools and Links on Health Inequities” page on NHI website

### RESEARCH

- “Tobacco use statistics and American Indian youth – Which numbers can we trust?” (summer 2006)
- “Evidence based brochure – development of a Family Component brochure focusing on traditional and non-traditional tobacco related to tobacco addiction.” (summer 2006)
- “How are American Indian and Latino pre-health students at UNC being mentored?” –research project conducted in conjunction with NC-HCAP program
- Tuskegee project – “Uncovering the truth about a hero in medicine”
- Diabetes: A context and novel approaches to prevention in the Eastern Band of Cherokee
- Stand tall, Sing, Dance: Photovoice project with the Occaneechi Band of the Saponi Nation

### ADVOCACY

- Creation of American Indian health course within UNC School of Medicine, to be implemented in 2008-9 school year (to be the first AI health course on UNC’s campus, the first AI health course in the state of NC, and possibly the first course on AI health working in non-federally recognized Tribal communities in the United States (done in the capacity of a MPH student practicum)
- Advocated for inclusion of American Indians in 2007 Minority Health Conference on HIV/AIDS – succeeded, and “hosted” The Healing Lodge and their presentation on a faith-based health ministry to address HIV/AIDS and STIs.
- Worked to set-up, and run, AI recruitment weekend for prospective AI graduate students at Chapel Hill (done in the capacity of graduate research assistant)
- Worked to set-up, and run, AI “Welcome Back” reception in Sept. 2006 for students, faculty, and staff in the AI community at UNC (done in capacity of graduate research assistant)
- Advocating for the hiring of the first AI faculty on the health side of UNC’s campus – conversations with faculty, acceptance speech, letter to school administrators
- Leading efforts to include AI and other “invisible” populations in UNC’s recruitment and programming efforts in the realm of Minority Health

### COLLABORATIVE EFFORTS

- Merging with Student Health Action Coalition (S.H.A.C.) to become the first American Indian health outreach program at UNC-CH, Nov 2006
- Partnering with APPLES service learning program to create “alternative spring/fall break” trips to AI communities in NC for 2007-8 school year, Feb 2007
- Worked with private donor to begin set-up for NHI College Scholarships, to be offered as 4 scholarships for \$3000 each, beginning in 2007-8 school year
- Partnered with UNC Minority Health Project in presenting Minority Health Videoconference, “Does Racism Make Us Sick?”, June 2007

- Collaborated with Carolina Indian Circle and multiple minority student groups to moderate the session, “PC terms for minorities”, Nov 2007
- “Kinaalda - the Navajo rite of passage for women” discussion led by Shannon Fleg, for an event sponsored by the Carolina Women’s Center, Nov 2007
- “Four directions: poetry from four women”, sponsored by the Women’s Center. Shannon Fleg was one of the four presenters, reading poems about AI spirituality and awareness, Feb 2007
- Co-facilitator at “Into the Community”, an event to orient students to community work at UNC, sponsored by CCPS and Campus Y
- “American Indian spirituality” – a lecture at Shaw University co-facilitated by Shannon Fleg and Vivette Jeffries (Occaneechi), Feb 2007
- “What it means to be American Indian.” on WCOM radio - Shannon Fleg served as co-host with Vivette Jeffries, April 2007
- Partnered with NC-HCAP to provide volunteers for “Health on the Block” health fair, March 2007
- Consulting with AMSA’s Health Equity campaign on the development of student projects informed by, and aimed at achieving health equity, Jan 2007 -
- Partnering with AMSA on creation on a module on “How to create a medical school course to address health inequities”, March 2007 -
- Consulting with ACU on the creation of a student arm of its organization, with NHI as a model project
- Partnering with medical students in U.S., Canada, and Norway to establish NHI projects to be initiated/supported/loved by NHI.

Additional work:

**Conference presentations (posters or presentations) on “Native Health Initiative: a partnership to address health inequities through loving service”**

- Association of Clinicians for the Underserved (Sept. 2006),
- Minority Health Conference (Feb 2007), NC Unity Conference (March 2007),
- American Medical Student Association (March 2007),
- Community-Campus Partnerships for Health (April 2007).

**NHI trainings (attended)**

- Health Justice Institute, January 2007
- UNC Faculty Development Institute on service learning, April 2007
- Loving-kindness meditation, May 2007
- Undoing Racism Workshop by the People’s Institute for Survival and Beyond, June 2007

**NHI “Love Diplomacy” efforts, in solidarity with Indigenous struggles for justice**

- April 2007 - Visit to Mohawk community, and “Caldonia Reclamation Site”, Caldonia, Toronto. Sacred tobacco presented on behalf of NHI Injustice: Canadian government’s encroachment on Six Nations land
- May 2007 - Visit to Houma Nation, Louisiana. Attended Tribal Council Meeting and visited with Chief Brenda and other tribal members. Tobacco presented. Injustice: Lack of assistance in the wake of Hurricane Katrina
- April/June 2007 – Visit with Nansamond tribe, Virginia at two Pow Wows. Injustice: Racist nature of Virginia’s “400 year celebration” in 2007
- June 2007 – Attended dedication ceremony at Occaneechi tribal grounds, along with helping to prepare the grounds for the ceremony, Mebane NC. Injustice: Encroachment of local township on traditional village of the Occaneechi tribe

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- <sup>i</sup> Census Bureau, Census 2000 Brief: Overview of Race and Hispanic Origin, 2000.
- <sup>ii</sup> Census Bureau, Census 2000.
- <sup>iii</sup> Surgeon General's Report. Fact sheets: Native American Indians. 1999. Accessed 11/8/06 at <http://mentalhealth.samhsa.gov/cre/fact4.asp>.
- <sup>iv</sup> U.S. Department of Health and Human Services. Indian Health Service fact sheet.
- <sup>v</sup> LNF Work Group. Level of need cost funded model: A study to measure the costs of a mainstream package of health services for Indian people. Accessed 11/8/06 at [http://www.ihs.gov/NonmedicalPrograms/LNF/Dld\\_files/p1sum.pdf](http://www.ihs.gov/NonmedicalPrograms/LNF/Dld_files/p1sum.pdf).
- <sup>vi</sup> Dickerson D. National American Indian and Alaska Native Heritage Month. November 2006. Accessed 11/8/06 at [http://www.healthyminds.org/naian/Dickerson\\_article.pdf](http://www.healthyminds.org/naian/Dickerson_article.pdf).
- <sup>vii</sup> U.S. Commission on Civil Rights. Native American Health Care Disparities Briefing: Executive Summary. 2004. p. 5.
- <sup>viii</sup> U.S. Commission on Civil Rights, *The Health Care Challenge: Acknowledging Disparity, Confronting Discrimination, and Ensuring Equality* September 1999, p. vii (hereafter cited as USCCR, *The Health Care Challenge*).
- <sup>ix</sup> Jones DS. The persistence of American Indian health disparities. *Am J Pub Health*. 2006; 96: 2122-2134.
- <sup>x</sup> Murray CJ, Kulkarni S, Ezzati M. Eight Americas – new perspectives on U.S. health disparities. *Am J Prev Med*. 2005; 29 (5S1).
- <sup>xi</sup> CDC Office of Minority Health: American Indian and Alaska Native Populations. Accessed 11/8/06 at <http://www.cdc.gov/omh/Populations/AIAN/AIAN.htm>.
- <sup>xii</sup> Indian Health Service. Trends in Indian Health 1998-1999. 2001. Accessed 11/9/06 at [www.ihs.gov/PublicInfo/Publications/Trends98/trends98/asp](http://www.ihs.gov/PublicInfo/Publications/Trends98/trends98/asp).
- <sup>xiii</sup> Miller BG. *Invisible Indigenes: The politics of nonrecognition*. 2003. U of Nebraska Press. p. 1-2.
- <sup>xiv</sup> CensusScope: United States American Indian Population. Accessed 10/1/07 at [http://www.censusscope.org/us/map\\_nhindian.html](http://www.censusscope.org/us/map_nhindian.html).
- <sup>xv</sup> Knick, S. Lecture to Native Health Initiative. June 29<sup>th</sup>, 2007.
- <sup>xvi</sup> NC Dept. of Health and Human Services. Recommendations for improving American Indian health in North Carolina. March 14<sup>th</sup>, 2005.
- <sup>xvii</sup> Gizlice Z, Houston S. Health risks and conditions among American Indians in North Carolina. NCPH SCHS studies. 2004: 1-14.
- <sup>xviii</sup> The NC Department of Health and Human Services' Secretary and Commission of Indian Affairs' Joint Task Force on Indian Health. Recommendations for improving American Indian health in North Carolina. 2005. p. 3.
- <sup>xix</sup> Walters, KL, Simoni JM. Reconceptualizing native women's health: a stress coping model. *AJPH*. 2002; 92(4): 520-4.
- <sup>xx</sup> State Center for Health Statistics and the Office of Minority Health and Health Disparities. North Carolina Minority Health Facts 2005: American Indians. 2005: 1-12.
- <sup>xxi</sup> Oates M. Havasupai file \$25M suit vs. ASU. *Arizona Daily Sun*. February 28<sup>th</sup>, 2004. Accessed 5/1/07 via <http://www.irbforum.com/forum/read/2/52/52?PHPSESSID=49c0e23e847cba67883d0b8b85b56cbd>.
- <sup>xxii</sup> Mitchell DA, Lassiter SL. Addressing health care disparities and increasing workforce diversity: the next step for the dental, medical, and public health professions. *Am J Public Health*. 2006; 96:2093-7.
- <sup>xxiii</sup> Remen, R. In the service of life. *Insight Out*. 2001 Spring. p. 5.
- <sup>xxiv</sup> Cumings, M. Personal conversation. June 29<sup>th</sup>, 2006.

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<sup>xxv</sup> Dehar, Casswell, Duignan. Formative and Process Evaluation of Health Promotion and Disease Prevention Programs. *Evaluation Review*, Vol. 17, No. 2, 204-220 (1993).