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A Culturally-Relevant, Emergent Approach to Exploring the Needs, Strengths, and Priorities of Tribal Communities in Virginia

Amy Prorock-Ernest
Virginia Commonwealth University

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by

Amy J. Prorock-Ernest

Advisor: Cornelia Ramsey, PhD

Department of Epidemiology and Community Health
Master of Public Health Program
MPH Research Project: EPID 691

Virginia Commonwealth University
Richmond, Virginia

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"It is absolutely essential that the oppressed participate in the revolutionary process with an increasingly critical awareness of their role as subjects of the transformation."
~ Paulo Freire

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Abstract

Little is known about the health of the indigenous peoples in Virginia. When compared to the total U.S. population, indigenous peoples nationwide disproportionately experience disparities in health status across multiple health indicators. Research shows that these disparities are largely due to the inequitable distribution of social and economic determinants present within indigenous communities. Because the indigenous peoples of Virginia are affected by inequitable social and economic conditions, there is reason to believe that health indicators may mirror that of the indigenous population at-large. Outlined in this paper is a framework for exploring the needs, strengths, and priorities of indigenous communities in Virginia. This paper proposes that the use of a culturally relevant methodology, such as Talking Circle, combined with an emergent and community-based participatory approach, will lead to a more authentic identification of the strengths, needs, and priorities of indigenous communities than traditional public health surveillance methodology, as well as build community capacity for on-going engagement.

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Little is known about the health of the indigenous peoples in Virginia. When compared to the total U.S. population, indigenous peoples nationwide disproportionately experience disparities in health status across multiple health indicators. Research shows that these disparities are largely due to the inequitable distribution of social and economic determinants present within indigenous communities (U.S. Commission on Civil Rights, 2004; Jones, 2006; Duran & Walter, 2004; Indian Health Services, 2005; Brave Heart, 2003; Lowe, 2008). Because the indigenous peoples of Virginia are affected by inequitable social and economic conditions, there is reason to believe that health indicators may mirror that of the indigenous population at-large (Virginia Department of Health [VDH], 2008; Virginia Indian Alliance for Life [VITAL]; Waugman & Moretti-Langholtz, 2001).

Outlined in this paper is a framework for exploring the needs, strengths, and priorities of indigenous communities in Virginia. This paper proposes that the use of a culturally relevant methodology, such as Talking Circle, combined with an emergent and community-based participatory approach, will lead to a more authentic identification of the strengths, needs, and priorities of indigenous communities than traditional public health surveillance methodology, as well as build community capacity for on-going engagement. The paper begins with an explanation of the conceptual framework used to explore the health and well-being of indigenous communities in Virginia, followed by an overview of social and economic conditions, as they relate to their influence on health

and well-being, affecting indigenous communities in the Commonwealth. The paper then proceeds to identify the methods of the proposed community assessment, including an explanation of the model on which the methodology of the assessment was developed, as well as a description of the design and structure of the proposed assessment. The paper concludes with a look at potential outcomes of the community assessment process and a brief discussion of the public health implications.

CONCEPTIAL FRAMEWORK: ECOLOGICAL PERSPECTIVE

The ecological perspective (McLeroy, Bibeau, & Glanz, 1988) serves as a valuable conceptual framework for defining and addressing determinants of health at multiple levels of analysis. This approach emphasizes determinants in the intrapersonal, interpersonal, organizational/ institutional, community, and public policy spheres. This paper suggests adding another level of analysis, namely history, to complete the ecological perspective. Refer to Figure 1. McLeroy, Bibeau, & Glanz write, “An implicit assumption of these levels of analysis is that health promotion interventions are based on one’s beliefs, understandings, and theories of the determinants of behavior, and that these [six] levels of analysis reflect the range of strategies currently employed for health promotion programming” (p. 355).

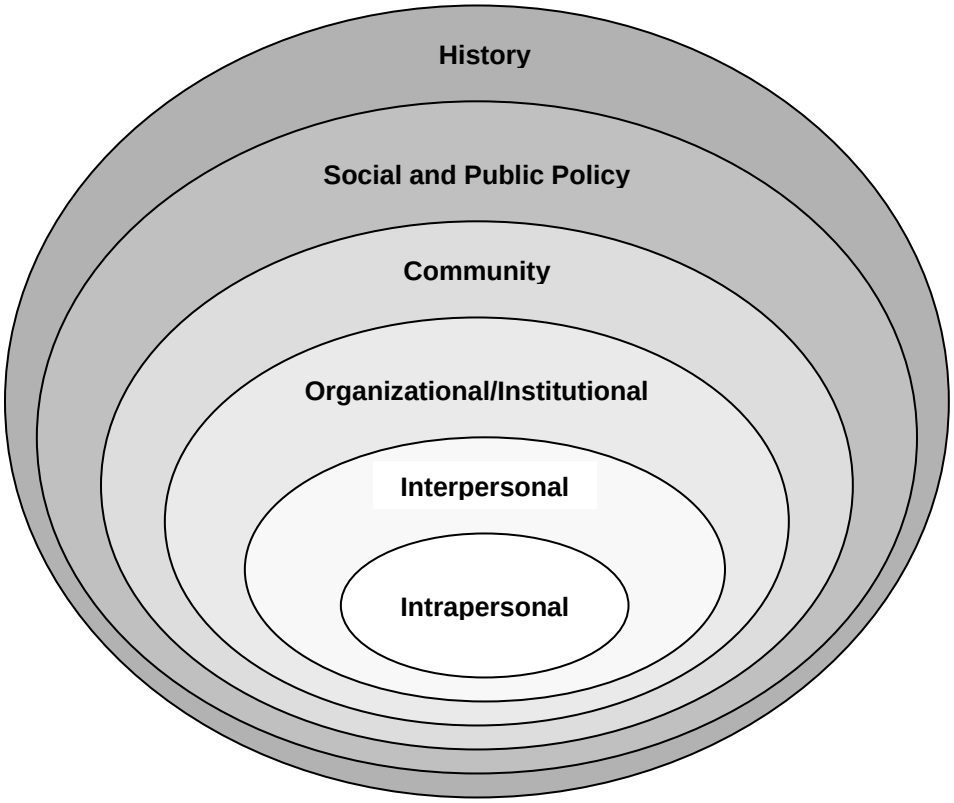
Intrapersonal Health Determinants

Health in the United States has historically been defined as the absence of disease and infirmity. Intrapersonal health determinants, such as genetics and lifestyle behaviors, have largely been viewed as the most influential factors in the attainment and maintenance of good health (McLeroy, Bibeau, & Glanz, 1988; Krieger, 1994). Findings

generated within the field of epidemiology have contributed largely to this belief as personal risk factors, such as diet, exercise, tobacco and alcohol use, etc., have been, and continue to be, linked to poor health outcomes (Link & Phelan, 1995).

Accordingly, health promotion and disease prevention efforts have focused largely on the role of individual behavior and personal responsibility for one's health. Intervention strategies have predominantly targeted changes in knowledge, attitude, and behavior (Duran & Walters, 2004) as they relate to such lifestyle practices as exercise, diet, sexual behavior, and drug, alcohol, and tobacco use (Wallerstein & Freudenberg, 1998).

Figure 1
Conceptual Framework: Ecological Perspective



Even when social influences are incorporated into intervention strategies, such as in the use of peer counseling, the target of change is still the individual (McLeroy, Bibeau, & Glanz, 1988). This perspective assumes that human action is primarily voluntary and conscious (Duran & Duran, 1999, p. 299) and that ill health is a result of personal failure (Krieger, 1994), ultimately leading to a "victim-blaming approach to disease" (Tesh, 1981, p. 379). Crawford warns that this perspective "both ignores what is known about human behavior and minimizes the importance of evidence about the environmental assault on health. It instructs people to be individually responsible at a time when they are becoming less capable as individuals of controlling their total health environment (as cited in McLeroy, Bibeau, & Glanz, 1988, p. 352).

Social Determinants of Health

Public health literature shows, however, that health is influenced by a combination of factors at various levels of influence. While individual-level factors do play an important role in health outcomes, determinants in the outer spheres of the ecological model – organization/ institutional, community, policy, and history - are greater predictors of health status than those spheres in the center – intrapersonal and interpersonal (Link & Phelan, 1995; Adler et al., 2007; Wilkinson & Marmot, 2003). Referred to in the literature as social determinants of health, these determinants include, but are not limited to: socioeconomic status, race, discrimination, housing, education, physical environment, food security, child development, transportation, working conditions, social support, democratic participation, etc. (Brennan, Baker, & Metzler, 2008; Wilkinson & Marmot, 2003). The physical and social environments in which

people live, their ability to make and carry out healthy decisions, their exposure to other social and economic factors that influence health, the levels of stress and coping strategies they engage in have major impacts on health outcomes (Virginia Department of Health, 2008).

The level to which social determinants of health are distributed within a community directly impacts the health of its members. Individuals and communities that have less access to the social determinants of health experience higher rates of illness, disease, and death than individuals and communities with greater access to these determinants (Brennan, Baker, & Metzler, 2008; Wilkinson & Marmot, 2003; VDH, 2008). Disparity in health status and outcomes that is a result of unequally distributed social determinants of health is known as health inequity (Whitehead & Dahlgren, 2007). Health inequities are a result of systemic, avoidable, and unjust social and economic policies and practices that create barriers to opportunity. They are sustained over time and generations and are beyond the control of individuals (NACCHO, 2006). Health inequities do not naturally occur and can be avoided through changes in the institutional, community, policy, and historical spheres of the ecological framework.

A conceptual framework that recognizes the multiple levels of influence on health is valuable in working with disadvantaged groups as access to resources and opportunities needed to be healthy are often beyond the control of such individuals and groups. This is particularly true in working with indigenous communities (Duran & Walters, 2004; Duran & Duran, 1999). Institutional practices, mainstream attitudes and beliefs, and economic policies have a direct impact on indigenous health status. Duran

and Duran (1999) write, “The ecological perspective enables one to recognize that Native peoples are not always the appropriate target of change, although the aim is improved Native American health status” (p. 299).

THE TRIBES OF VIRGINIA

Today, there are approximately 2,500 people on the Tribal registries in the Commonwealth of Virginia, and U.S. Census figures show another 21,638 people of Indian ancestry living in the Commonwealth (U.S. Census Bureau, 2005-2007). The Commonwealth of Virginia formally recognizes eight Tribes whose ancestors and cultural connections can be traced directly to groups documented to have been living in Virginia in 1607 at the time of initial English colonization; six other groups with Indian ancestry are currently petitioning the Commonwealth for Tribal recognition (VITAL). Refer to Table 1.

Table 1
Virginia State Recognized Tribes and Locations

Virginia State Recognized Tribes	
Tribe	Location
• Chickahominy Tribe	Charles City County
• Eastern Chickahominy Tribe	New Kent County
• Mattaponi Indian Tribe	Mattaponi River, King William County
• Monacan Indian Nation	Bear Mountain, Amherst County
• Nansmond Tribe	Norfolk, Chesapeake, Virginia Beach, Portsmouth
• Pamunkey Tribe	Pamunkey River, King William County
• Rappahanock Tribe	Near Indian Neck, King and Queen County
• Upper Mattaponi Tribe	Mattaponi River, King William County

Two of the eight state-recognized Tribes, the Mattaponi and Pamunkey, remain in possession of reservation land that was issued to the Tribes through treaties with England in the late 17th century. Each of the other six Tribes has purchased land in areas closely associated with their ancestry. The land, on which Tribal centers have been constructed, serves as a gathering place for community meetings and events.

Health and Well-Being of Tribal Communities in Virginia

Little is known about the health of the indigenous peoples[1] in Virginia. However, the U.S. Commission on Civil Rights (2004) and other organizations/agencies such as the U.S. Department of Health and Human Services (2001), American Cancer Society, and Indian Health Services (2000; 2005) report national data on the status of Native American health. When compared to the total U.S. population, indigenous peoples nation-wide disproportionately experience disparities in health status across multiple health indicators (U.S. Commission on Civil Rights, 2004; Jones, 2006; Indian Health Service, 2005). For example, indigenous peoples are 770% more likely to die from alcoholism, 650% more likely to die from tuberculosis, 420% more likely to die from diabetes, 280% more likely to die from accidents, and 52% more likely to die from pneumonia or influenza than the U.S. general population (U.S. Commission on Civil

[1] It is important to clarify that while the indigenous peoples of Virginia are referred to collectively in this paper, the indigenous population in the Commonwealth, or anywhere else for that matter, is not a homogeneous group, but rather a diverse group of people with languages, beliefs, traditions, rituals, practices, and ways of life unique to their respective community/tribe. In addition to differences among communities/tribes, differences among community/tribal members are also significant as generations have been shaped by various histories and circumstances.

Rights, 2004, p. 8). The life span of indigenous peoples is approximately 10 years lower than that of the U.S. general population (Indian Health Service, 2000).

The research shows, however, that these disparities in health in the indigenous population are largely due to the inequitable distribution of social and economic determinants within Tribal communities (U.S. Commission on Civil Rights, 2004; Jones, 2006; Duran & Walter, 2004; Indian Health Services, 2005; Brave Heart, 2003; Lowe, 2008). Because the indigenous peoples of Virginia are affected by inequitable social and economic conditions similar to that of the indigenous population nation-wide, there is reason to suspect that health indicators in Virginia's indigenous communities may mirror that of the indigenous population at-large.

A History of Injustice

Since the arrival of European settlers, the indigenous peoples of Virginia have endured oppressive social and economic policies that have had a tremendous affect on the way in which indigenous communities, institutions, families, and persons have developed, function and interact (Egloff & Woodward, 2006; Waugman & Moretti-Langholtz, 2001). These policies have permitted such acts of genocide, dispossession of land, segregation, and cultural assimilation, and have restricted such rights and fundamental freedoms as the right to an "Indian" identity, the right to an education, and the right to observe traditional beliefs and practices.

The effects of four centuries of oppressive social and economic polices can still be seen in Tribal communities today (VITAL; Waugman & Moretti-Langholtz, 2001). For example, the majority of Virginia's indigenous population resides in rural areas, on

lands closely associated with their ancestry. *The Virginia Health Equity Report 2008* reports that rural areas are more likely to be in high poverty census tracks than non-rural areas (Virginia Department of Health, 2008). Also, indigenous peoples in Virginia remain largely uneducated in comparison to other minority groups, not graduating from high school more than any other race or ethnicity and least represented in graduates from college or technical schools (VITAL; Gruss & Wells, 2008; Waugman & Moretti-Langholtz, 2001).

Racial Integrity Act of 1924

One policy in particular is worth mentioning as its effects have rippled across multiple spheres of the ecological model for nearly three-quarters of a century. *The Racial Integrity Act of 1924*, spearheaded by Walter Ashby Plecker, the first Registrar of Vital Statistics in Virginia, made it illegal for any indigenous person to be listed as "Indian" on any official record, including birth records, marriage licenses, and death certificates. Anyone who was unable to prove him/herself as "white" was classified as "colored" on all official and public documents (Waugaman & Moretti-Langholtz, 2001). Plecker went to such lengths as to alter numerous birth certificates of indigenous peoples changing, without proof, their race from "Indian" to "colored" (Wood, 2007). This piece of legislation resulted in what became termed *documentary genocide* or *eugenic homicide* as it sought to "deny the existence of the surviving Indian population in the Commonwealth of Virginia" (Waugaman & Moretti-Langholtz, 2001, p. x). This harsh and restrictive policy was not repealed until 1968 when it was deemed unconstitutional by the U.S. Supreme Court.

The effects of this piece of legislation are still evident today. First, it weakened the family and community structure, as well as threatened the practice of traditional beliefs and customs. To escape the repressive policies, many families left Virginia and settled in surrounding states. Some families chose to stay and fight the injustice, and others "simply melted into the background" and waited for things to change (Waugaman & Moretti-Langholtz, 2001, p. 27). Some families even changed their last names so as to create a new "white" identity in an attempt to avoid the harsh restrictions placed on those newly labeled as "colored". It is reported that it is not an uncommon occurrence for indigenous peoples today to not know of their indigenous heritage until a father or mother is on the deathbed. "In some families, it was a secret they were afraid to reveal" (p. 27).

Second, indigenous children were not allowed to attend white schools, and were not accepted in many black schools. Most of the current Tribes in Virginia established their own schools which provided up to a seventh-grade education for those children who were able to attend. Many indigenous children, however, were unable to attend because of obligations at home or in the fields (Wood, 2007). There was a strength in the segregated schooling, however, as children had the opportunity to learn about indigenous history, beliefs, and traditions from Tribal elders (Egloff, Woodward, 2006; Waugaman & Moretti-Langholtz, 2001). High school education was not available to indigenous children in Virginia, so children were sent out of state to complete high school. This was another factor that contributed to the weakening of the family and community structure, as well as loss of traditional beliefs and practices. Public schooling was not made

available to indigenous peoples until 1963, despite the passage of *Brown v. Board of Education* nine years earlier (Wood, 2007).

Third, there are currently 562 Tribes federally recognized by the U.S. government – not one of the Virginia Tribes has, yet, been extended this recognition. Part 83 of Title 25 of the *Code of Federal Regulations***,** "Procedures for Establishing that an American Indian Group Exists as an Indian Tribe," mandates a rigorous process requiring the petitioning tribe to satisfy seven mandatory criteria, including being "identified as an American Indian entity on a substantially continuous basis since 1900" and comprising a "distinct community" that has existed from "historical times until the present" (U.S. Department of the Interior: Indian Affairs).

Because of the widespread modification of official documents as a result of Plecker's *Racial Integrity Act*, the indigenous Tribes of Virginia have experienced barriers in meeting the federal recognition requirements. As such, the indigenous peoples in Virginia are ineligible to receive health services through the Indian Health Services (IHS), as well as funding for other social and economic services. Much of what we know about the health status of indigenous peoples nation-wide is derived from health records maintained by the IHS. Given the ineligibility for services offered through IHS, there does not exist a centralized collection of records for indigenous peoples in Virginia that can be used to assess health indicators.

Fourth, because of the harsh consequences associated with claiming indigenous ancestry, many indigenous peoples to this day do not identify as "American Indian/Alaska Native" when filing official paperwork. This has a direct effect on

population-based data sets, as well as public records, that are often used for research purposes.

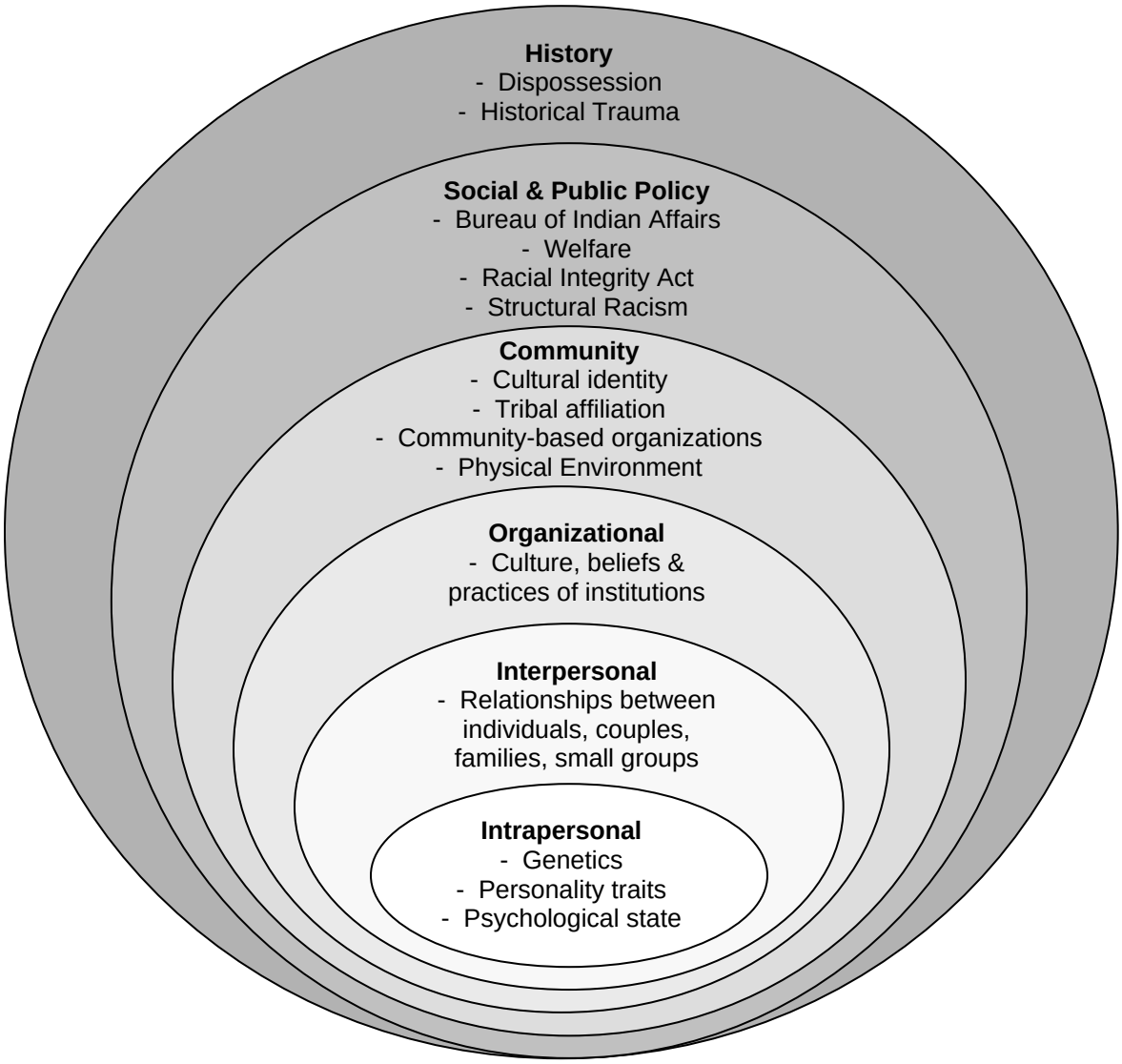
An Ecological Perspective of Health as Applied to Virginia Tribal Communities

Recount from the ecological perspective that an interplay of factors at multiple levels – or spheres – influences our health and well-being. Figure 2 builds upon the ecological model presented earlier in the paper by including examples of determinants of health in each of the spheres as relevant to indigenous communities. The ecological perspective serves as a valuable conceptual framework for identifying both risk and protective factors at various levels of influence, as well as identifying various levels for intervention. To demonstrate the various levels of influence on health, the following section briefly identifies potential risk and protective factors within each sphere of the ecological model as they pertain to the indigenous population in Virginia.

Historical Trauma

We will start with the outer most sphere of the ecological model: history. Past events shape and form current reality. Therefore, a historical context is crucial to understanding present day circumstances affecting indigenous peoples and communities (Weaver & Yellow Horse Brave Heart, 1999; Duran & Duran, 1995; Duran, 2006). Historical trauma refers to the "cumulative and collective emotional and psychological wounding during the life span and across generations, resulting from a cataclysmic history of genocide (Lowe, 2008, p. 231). When trauma is not dealt with in previous generations, not only is the unresolved trauma passed on to subsequent generations, it accumulates, becoming more severe as it is passed down (Duran, 2006, p. 16). Lowe (2008) writes, "The effect

Figure 2
An Ecological Perspective of Health as Applied to Indigenous Communities



of historical trauma results in numerous symptoms that affect the psychological, social, economic, intellectual, political, physical, and spiritual realms of Native American people" (p. 231). The indigenous peoples of Virginia have experienced widespread genocide, both decimation in numbers, as well as loss of indigenous identity and traditional ways of life, and, as such, are potentially affected by such historical trauma.

Social and Public Policy

There is a deep history of oppressive social and economic policies that have had a tremendous affect on the way in which indigenous communities, institutions, families, and persons have developed, functions, and interact; perhaps the greatest of which has been addressed previously, *The Racial Integrity Act of 1924*. Arguably the most well known policy issue affecting Virginia's Tribes today relates to the pursuit of federal recognition on behalf of six of Virginia's eight state recognized Tribes. Since 1999, six Virginia Tribes have been petitioning the federal government for federal recognition. Federal recognition will make the six pursuing Tribes eligible for funding in such areas as housing assistance and education, as well as promote economic development opportunities that will enable the Tribes to become self-sustaining and provide economic development in their surrounding communities (VITAL). As such, there are also six groups with Indian ancestry currently petitioning the Commonwealth of Virginia for Tribal recognition (Virginia Council on Indians, [VCI]).

Community

The greatest strength in indigenous communities can arguably be found at the community level. Despite a long history of hardships, including past policies that deliberately sought to diminish indigenous cultural identity, a strong thread of renewed hope is woven through indigenous communities in the Commonwealth (Waugaman & Moretti-Langholtz, 2001). Since the 1980s, Tribes have worked diligently to retain and reclaim cultural traditions (Wood, 2007). Recently, non-reservation Tribal centers have emerged as symbols of unity, similar to those on the reservations. Tribal centers serve as

gathering places for such events as Tribal council meetings, dances, dinners, exhibits, adult education classes, and craft guilds. Efforts are also being made to preserve the heritage of native dancing through dance groups and the teaching of native dances to children and adults. Increasingly popular Tribal powwows enable indigenous Tribes to meet with the public and demonstrate crafts, dances, and share oral histories (Egloff & Woodward, 2006, p. 70). Conversely, as indigenous communities are seeking to strengthen cultural identity and Tribal affiliation, a risk factor at the community level still remains community-level political disempowerment (Duran & Walter, 2004).

Organizational / Institutional

As has been eluded to earlier in the paper, public organizations and institutions have been, and continue to be, unresponsive to the needs of the indigenous communities in Virginia. This is due, in part, to both the lack of understanding of public organizations and institutions of how best to meet the needs of indigenous communities, as well as reluctance on behalf of the indigenous peoples to trust a formal establishment that has had a history of harmful practices. However, there are a number of indigenous-based non-profit organizations that have emerged to meet the needs of their people. These include, but are not limited to: United Indians of Virginia, American Indian Society, and The Mattaponi Healing Eagle Clinic.

Interpersonal and Interpersonal

As the community level of the ecological model has been identified as a strength within indigenous communities, so also is the family unit. “Family represents the cornerstone for the social and emotional well-being of individuals and communities” (Red Horse, 1981, as cited in McGoldrick et. alt., 1996). Family in indigenous culture extends beyond the nuclear familial bonds known in Western culture and is traditionally defined by relationship, rather than in terms of blood (McGoldrick et. alt., 1996). Generally, the indigenous culture is less individualist and more systemic (Duran & Duran, 1995), which explains, in part, why Western approaches are often unsuccessful in working with indigenous peoples.

Within each of the spheres are determinants that affect health at the intrapersonal level. Successful health promotion and disease prevention efforts must consider individual health in terms of its context. Intervention strategies that address only the intrapersonal level run the risk of failure or limited success.

METHODS

Comparative Approaches to Planning Models

Initially developed for program planning within human service organizations, the dimensions of Netting, O’Connor, and Fauri’s (2008) emergent approach to interpretive planning are well suited for use in the community assessment process and compliments the ecological model discussed earlier. Interpretive planning and emergent approaches were developed in response to the short-fall of rational planning models to address the complexity of some social problems, especially within the context of multiculturalism and globalization (O’Connor & Netting, 2007, p. 57).

Dimensions of Rational Planning and Prescriptive Approaches

Rooted in a Western paradigm, the rational model is driven by the positivistic assumption that knowledge about social reality is hard and concrete (Netting & O'Connor, 2003, p. 79). It is "pragmatic, problem-solving, seeking to apply the models and methods of the natural sciences to the study of human affairs" (O'Connor & Netting, 2007, p. 61). It "extends to include the idea that most decisions can be made through a series of well-defined steps that follow a predictable or fixed linear sequence, moving toward a predetermined goal" (Netting, et al., 2008, p. 13). Thus, planning is prescriptive in approach, following a predetermined, standard linear logic model that "starts at the beginning, continues with a middle, and ceases in an ending process" (O'Connor & Netting, 2007, p. 66). This approach is largely facilitated by an outside expert and implemented in a top-down manner (O'Connor & Netting, 2007; Netting, et al., 2008). Rational planning has functioned as the traditional planning model used within the United States and, for the most part, is required of those seeking funding for outcome-based programming. It has also become the "gold standard" for many international funding sources (O'Connor & Netting, 2007).

Netting et al., write that while prescriptive approaches may be "helpful in many situations, they are not sufficient in the face of the complexity of some social problems" (Netting, et al., 2008, p. 128). This is particularly true when working with a group of people whose beliefs and actions are shaped by a worldview that differ from that of a Western paradigm (O'Connor & Netting, 2007), as well as with disadvantaged and/or oppressed groups of people such as indigenous communities in Virginia.

Dimensions of Interpretive Planning and Emergent Approaches

Interpretive planning is founded on a different set of assumptions. Interpretive planning acknowledges there is no single reality, but rather a multiplicity of realities, "constructed internally and externally by individuals and groups" (Netting, et al., 2008, p. 227), and that while there is no fixed order, there is directionality that allows for the unexpected to present itself (p. 134). The emergent model is not expert driven, but rather relies on a collaborative approach to mutually define and understand the problem and work toward a solution. The process is less about reducing and more about broadening, less of an assessment of a problem and more of an understanding of the problem in all of its complexity. Interpretive planning is an on-going process of discovery and creating, each step influencing the next, the design and structure emerging as people and communities interact together (O'Connor & Netting, 2007; Netting, et al., 2008). It is "very attentive to the context bound nature of language and cognition. It protects the cultural nuances that influence both what is seen to be an acceptable problem and a viable solution to the problem" (O'Connor & Netting, 2007, p. 70); thereby respectful of the worldview of cultures that differ from that of the Western paradigm. Table 2 identifies four dimensions of interpretive planning and emergent approaches, their corresponding functions, and application within the ecological model. The dimensions of interpretive planning are congruent with key principles associated with the more well-known community-based participatory research (CBPR) (Israel, Schultz, Parker, & Becker, 1998; Israel, Schultz, Parker, Becker, Allen, Guzman, 2008).

Table 2

Dimensions of an Interpretive Planning Process

Dimension	Function	Ecological Spheres Addressed
Engagement	• Assures that multiple perspectives are heard, and reinforces their validity • Collaborative approach facilitates mutual goal setting, plans, and processes • Less of an assessment of a problem and more of an understanding of the problem in its complexity	• Interpersonal • Organization / Institution • Community
Discovery	• Integrated sources of knowledge (e.g., formal and informal; quantitative and qualitative)	• Intrapersonal • Interpersonal • Organization / Intuition • Community • Social and Public Policy
Sense-making	• Continual process of discovery and creating; thus analysis is viewed as a broadening, not as a reducing, process • Compromise and consensus-based decision-making • Multiple dimensions with many embedded circles spiraling toward a planning product	• Intrapersonal • Interpersonal • Organization / Intuition • Community • Social and Public Policy • History
Unfolding	• Build on what was learned and attends to continual learning • Unfolding is both the process and product of program design • Iterative – assumes continual revisioning	• Interpersonal • Organization / Institution • Community

Adapted from Netting, et al. (2008, p. 136).

Interpretive Planning and Emergent Approach as Applied to Community Assessment

Conventional community assessment approaches are largely built on the positivistic assumptions of rational planning models. Needs are identified through a reducing process using "objective" data relevant to the topic of interest. Typically, conventional health assessment focuses on "traditional" indicators such as morbidity and mortality (Hancock & Minkler, 2005, p. 142), determinants of health within the

intrapersonal sphere of the ecological model. The assessment is usually *on* a community, rather than *by* and *for* a community, and is primarily facilitated by an outside expert. McKnight and Kretzman (2005) assert that this narrowly defined approach to assessment all too often results in a "deficiency-oriented" understanding of the community.

An emergent approach to community assessment, however, provides for less of an assessment of a pre-defined problem and more of an understanding of the problem in all of its complexity (O'Connor & Netting, 2007). Hancock and Minkler (2005) write that community members know from their own experience that health is much more than the absence of illness or dysfunction (p. 142). An emergent approach to assessment allows for 1) a culturally-relevant definition of health and well-being, and 2) a collaborative identification and understanding of the problem, as well as a shared understanding of the solution and its design. "The problem is defined when the participants in the investigation process say it is, and it may change when new information emerges" (O'Connor & Netting, 2007, p. 69). This is an assessment truly *by* and *for* the community. The dimensions of an emergent model as applied to assessment compliments the ecological perspective as it allows for exploration of determinants of health in various spheres of the ecological model.

Goodness of Fit

Health promotion and disease prevention efforts rooted in a rational planning model have demonstrated limited success in indigenous communities. Its prescriptive

approach does not allow for consideration of social, cultural and historical factors relevant to the indigenous worldview, which, as O'Connor and Netting (2007) note, has the potential to oppress, rather than benefit. Duran and Duran (1999) suggest that "anchoring health promotion and disease prevention efforts within Native American control and in Native American social, cultural, and spiritual knowledge" is vital to the success of such efforts (p. 291). An emergent approach to community assessment answers this call and is well suited for working with indigenous populations for a number of reasons, including but not limited to: 1) allows for the community to be the unit of analysis rather than the individual; 2) focuses on community assets rather than deficits; 2) compliments the indigenous worldview that conceptualizes time as spatial rather than linear, as well as honors process or content thinking; 3) minimizes to the greatest extent possible the reigns of colonialism; 4) minimizes pathologizing and honors a culturally rooted naming process; and 5) increases community empowerment and individual and community capacity for on-going community engagement.

Methodology

Talking Circles

The Talking Circle was chosen as the methodology for the community assessment process because of its cultural and spiritual relevance. In Native American culture, the Talking Circle is a traditional way of bringing indigenous peoples together in a quiet, respectful manner for the purpose of sharing information, offering support, and solving problems (Becker, Affonso, & Blue Horse Beard, 2006). Rooted in traditional storytelling and religious ceremonies, Talking Circles offer a place where stories of life

experiences are shared in a respectful, egalitarian, and non-confrontational manner, in a context of "complete acceptance" by participants. "The Talking Circle is a sacred reminder of the interrelationship, respect, and clarity that come from opening oneself up to the energy of the Circle of Life when stories of life experiences are offered. Native Americans have long used the Circle to celebrate the sacred interrelationship that is shared with one another and with their world" (Lowe, 2008, p. 232). The Talking Circle can be a powerful means for bringing healing both to the individual and community.

The Talking Circle remains an integral part of Native American tradition to this day. The ceremony has become accepted as effectively providing for self-expression, conflict resolution, and development of community cohesion (Nebelkopf, E., & King, J., 2003). Talking Circles have been used successfully for health promotion and disease prevention and management for such issues as HIV/AIDS and Hepatitis C Virus education (Lowe, 2008), breast cancer prevention and treatment (Becker et al., 2006), diabetes education and management (Struthers, Hodge, Geishirt-Cantrell, & DeCora, 2003), and smoking cessation (Daley, James, Barnoskie, Seagraves, Schuphach, & Choi, 2006).

Design and Structure

As mentioned previously, in planning with an emergent approach, specific goals and objectives cannot be pre-determined in the same manner as traditional, prescriptive approaches. "The best that can be expected is the creation of benchmarks to watch how emergence is occurring" (Netting et al., 2008, p. 160). Benchmarks can serve as

significant activities agreed upon by all stakeholders that are based on what should be known, or what should happen, in order to move from one stage of the plan to the next.

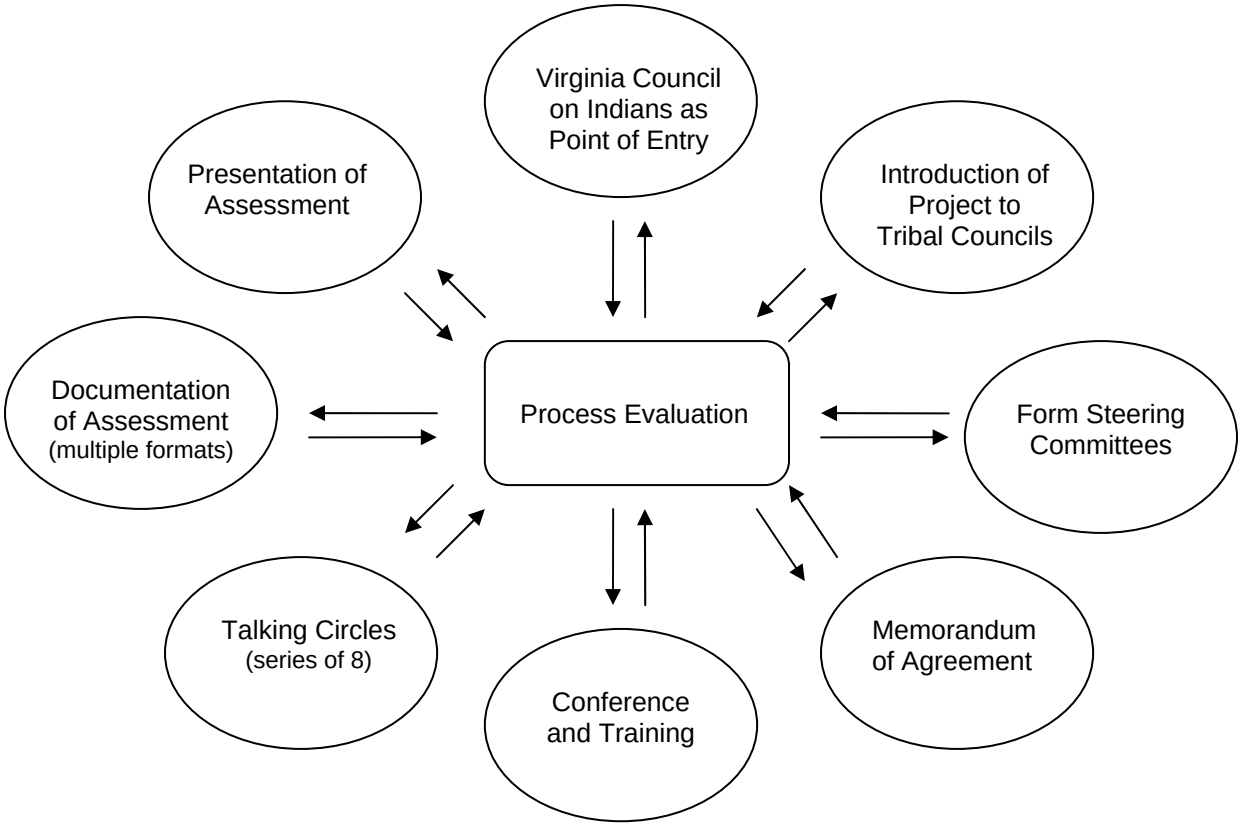
The following section identifies a number of potential benchmarks that have been envisioned to create a framework for the assessment process. However, the timing, order, and specific content of the benchmarks will emerge as individuals and communities begin to interact with it. Figure 3 is a visual representation of the proposed framework of the community assessment process. Remember, that an emergent design is not linear and there is not pre-determined order. It does not consist of a clear beginning and end, however, there is directionality. It proceeds from one point to the next "in responsive fits and starts, stopping where someone thinks it is important or interesting to do so, sometimes backing up or starting over again, and then continuing in an approximate direction" (Netting et al., 2008, p. 133).

Community Entry

Community entry is an important initial phase in any collaborative effort and involves building trust between community members and outside stakeholders, as well as establishing a basis for collaboration (Balcazar, Keys, & Suarez-Balcazar, 2001). While this is an important initial phase in any collaborative effort, it is of even greater importance when working with communities whose worldview differs from that of outside stakeholders, and especially where disparate power dynamics are at play. In Native American culture, respect for the traditional political structure is vital to gaining access to the community. The Tribal Chief, Council and Elders are the decision-makers

and gate-keepers into Tribal communities. The first three benchmarks of the community assessment process are sensitive to this notion.

Figure 3
Benchmarks



Community Entry: Introduction of Project to Virginia Council on Indians

The Virginia Council on Indians (VCI) was selected as the point of entry and lead organization to coordinate this project for reasons that will be identified later in this section. The Council, established in 1983 through a mandate set forth by the General

Assembly, serves as an advisory board to the Governor and the General Assembly of the Commonwealth of Virginia. The Council's main role is to suggest ways in which the Commonwealth's indigenous population may reach its fullest potential as citizens (Virginia Council on Indians, [VCI]).

The Council is comprised of 11 members which include the Chief of each state recognized Tribe, or a delegate from the Tribe appointed by the Chief, two Indian members at-large appointed by the Governor, and one non-voting member from the senior staff of the Governor, appointed by the Governor. All Council members work on a volunteer basis. The Council holds monthly meetings, open to the public, to discuss issues pertinent to the indigenous population in the Commonwealth (VCI).

VCI was selected as the point of entry and lead organization for this project for a number of reasons: 1) its established infrastructure; 2) its representation of the eight state recognized Tribes in Virginia; 3) its inclusion of non-state recognized groups in Virginia; 4) its composition of the Chief from each respective Tribe; and 5) its mission is in support of the purpose of the proposed community assessment.

The Council consists of at least two committees that serve to carry out particular functions assigned to, or developed by, the Council. There is a VCI recognition committee that reviews petitions from non-state recognized groups per their request for Tribal recognition. There is also a VCI advisory committee which serves to organize an annual conference for the indigenous peoples of Virginia. May it meet the approval of the Council; an additional committee may be developed to oversee the implementation of the community assessment process.

Also, there exist a number of indigenous-based non-profit organizations that have been developed throughout the years to serve the indigenous peoples of Virginia. A number of the Tribal Chiefs represented on the Council also serve on the boards of these non-profit organization; thus, opening the door for possible collaboration with organizations already serving the indigenous communities in Virginia.

Community Entry: Introduction of Project to Tribal Council

As previously mentioned, Tribal Councils and Tribal Elders are the decision-makers in their communities, as well as the gate-keepers, making it essential to have their support for the project. Their acceptance, support, and blessing are vital in encouraging "buy-in" from community. The details of how the Tribal Councils will be presented with the community assessment framework will emerge in the process. Ideas include Tribal Chiefs introducing the project to their respective Tribal Councils, or maybe a specific meeting to introduce the project to the Tribal Councils collectively. Tribal Councils will be asked to discuss the benefits and risks of participating in such a project and come to a decision as to whether their respective Tribes will participate.

Implementation of Process: Memorandum of Agreement with Participating Tribes

It should come as no surprise that there is a strong potential for mistrust of outsiders. Generally, social research and interventions facilitated by outsiders have left many indigenous individuals and communities feeling exploited and mistrustful (Duran & Duran, 1999). Salois, Holkup, Tripp-Reimer, & Weinert (2006) identify a number of problems that have, and continue to, result from outsider-controlled research with Tribal communities: (a) research projects identifying problems without benefit to the

participating Tribe, (b) the publication of sensitive cultural material, (c) the exploitation of Native American communities to further investigators' academic careers, and (d) the misrepresentation of findings derived from the cultural misinterpretation of data (p. 507).

It is unknown if and what past research has been done with Tribal communities in Virginia, and, accordingly, the outcomes of those endeavors. Regardless of past research experiences, there is foreseeable mistrust of outsiders based upon historical experiences previously noted. The purpose of the Memorandum of Agreement is to openly address the potential historical distrust, as well as discuss parameters of the collaboration and community assessment process (i.e. what are the benefits to participating Tribes, who owns the material that emerges, expectations for potential publication, the process for decision-making, etc). Whether this agreement is documented in writing or pledged to via another medium is at the discretion of either the Council or each participating Tribe.

Implementation and Process: Formation of Steering Committees

This community assessment has the potential to become a fairly involved project, both at the state level, as well as at the tribal level, requiring a considerable degree of coordination to oversee the planning and implementation process. As mentioned previously, may it meet the approval of the Council, a sub-committee will be formed at the state level to coordinate activities among the participating Tribes and, may it meet the approval of each participating community, a committee will be formed at the community level to oversee the planning and implementation of the assessment process at the local level.

Conference and Training

Eduardo Duran is a Native American psychologist who has worked extensively with indigenous populations throughout the United States. Duran is currently the Director of Health and Wellness for the United Auburn Indian Community, Northern California. Duran writes in length about the persistent *soul wound* (Duran, 2006) as a result of historical trauma that deeply impacts indigenous peoples of today. He warns that successful interventions in indigenous communities are not possible unless they address the socio-historical factors that have had a devastating effect on the dynamics of indigenous communities (Duran & Duran, 1995). Duran has extensive experience in working with indigenous communities to develop approaches for exploring the needs, strengths, priorities, and resources within indigenous communities in a manner that empowers communities and increases individual and community capacity to address identified problems within the community.

With agreement from the Council, Duran will be invited to be the key note speaker at a week-long conference and training. The conference is intended to draw together indigenous communities of the Commonwealth for teaching and discussion on such topics as community healing, community building, and capacity building, as well as begin to stimulate discussion regarding a community assessment. Trainings will be held for Council and Tribal committees in learning how to use the Talking Circle as a tool for exploring the needs, strengths, and priorities of their respective communities. The conference will be hosted at a location agreed upon by the Council sub-committee. Time permitting, and dependent on interest, perhaps Duran can visit some of the Tribal communities in Virginia.

Talking Circles

Perhaps more so with this stage than any of the others, the details will emerge during the process of planning with the Council and Tribal committees. Currently, there is a series of eight Talking Circles planned; this, of course, can change to accommodate the desires of the Council and Tribal committees. Whether each Talking Circle will occur over the span of a few hours, a day, a weekend, etc, will be decided by the Council and Tribal committees. Decisions will also be made regarding the format of each Talking Circle (e.g., town-hall style, small groups). The Tribal committees, each of whom received training from Duran, will be responsible for hosting the Talking Circles in their respective communities.

Meaning and Context of Talking Circle

Through the use of a Talking Circle methodology, information pertaining to the needs, strengths, priorities, and resources present within Tribal communities can be collected via a culturally and spiritually relevant way. Talking Circle methodology includes the use of story-telling, a traditional practice within the indigenous culture. McKnight & Kretzmann point out that while "institutions learn from studies, communities learn from stories" (as cited in Hancock & Minkler, 2005, p. 146).

> Studies are usually data-rich and, with the important exception of community-based participatory approaches to research, tend to be carried out by academics and professions working *on* rather than *with* communities. The data are analyzed to yield information, but the knowledge that is acquired is seldom transferred to the community; and as a result, there is little increase in wisdom, Stories, in

> contrast, represent the accumulated and almost folkloric wisdom of a community. Stories contain knowledge that can be adapted and applied by other communities but seldom contain information in the form of hard data. If one accepts that knowledge is power and that stories are a means of transferring knowledge between and within communities, the empowering potential of stories as a source of information about health becomes apparent (Hancock & Minkler, 2005, p. 147).

Discussion topics for each Talking Circle will emerge from the process. Such topics many include a visioning process where communities define health as related to their belief system, envision what their community would like according to their definition of health, identify current community condition, and brainstorm actions that could bridge the discrepancy between current status and envisioned healthy community.

It is important for the dialogue of each Talking Circle to be documented. Council and Tribal committees will decide on the most appropriate manner for this to documentation. A cultural guide that clearly defines the meaning and parameters of the language and process will be essential in analyzing the content documented during the Talking Circles. Duran & Duran (1995) write, “To assume that phenomena from another worldview can be adequately explained from a totally foreign worldview is the essence of psychological and philosophical imperialism” (p. 25). Caution will be taken not to pathologize identified community struggles and hardships. This should be mitigated through the use of a cultural guide in the analyzing process. Who will serve as the cultural guide(s) will emerge through the process, probably following the training with

Duran. Throughout the series of Talking Circles, content analysis of the documented material will be carried out to identify themes that occur during the discussions in each of the Tribal communities. It will be important for community members to have the opportunity to review and respond to the analyzed material to ensure documented material accurately represents content discussed during the Talking Circles, as well as facilitate feedback and generate ideas for future Talking Circles.

Documentation of Assessment

In the months following the last scheduled Talking Circle, each participating Tribe will put together a final report documenting the themes that emerged during the process. The Council and Tribal committees will decide which format of media, or combination thereof, is most appropriate. Also, the decision will be made regarding who will be involved in the creation of the report (i.e. a collaborative process, a committee function, etc.).

Presentation of Assessment

At an event decided upon by the Council and Tribal committees, there will be a formal presentation of the documented report. Community feedback is vital to the refinement and personalization of the assessment report. Each Tribe will have ownership of all documentation and reports.

Evaluation

In rational planning models, evaluation typically occurs at the end of a program to assess whether the program was effective in meeting the goals set by the outside

"experts". In emergent planning models, however, evaluation is formative, oriented toward monitoring the process as it unfolds (Hardina, 2002, p. 270). Important to evaluation in emergent planning is its ability to provide feedback throughout the process, as feedback allows for continual adjustments to be made. Formative evaluation assesses short-term desired outcomes (how and where progress is happening), unanticipated consequences, barriers, unpredicted effects, ripples beyond the hoped-for-results, as well as opportunities for critical learning and informing changes as needed (Netting et al., 2008, p. 160). Interpretive planning and implementation focuses on continuous learning and changing (p. 156). As a cultural guide will be important in the content analysis of documented materials from the Talking Circles, a cultural guide will also be essential in monitoring the process as it unfolds.

OUTCOMES

The desired outcomes of the community assessment process are five-fold: 1) documentation of the needs, strengths, and priorities of Tribal communities in Virginia as identified by Tribal members; 2) Tribal ownership of project; 3) increased community empowerment to address public health concerns; 4) increased individual and community capacity in and among the Tribes, with focus on such dimensions as leadership, citizen participation, & skill building; 5) increased capacity within the public health system to work with Tribes in Virginia.

In a seminal article, Marti-Costa and Serrano-Garcia (1983) argue that, far from being neutral or objective, community assessment is an ideological process that can serve political purposes ranging from system maintenance and control to the promotion of

social and structural change. Community assessment is an initial step in community organizing and community building. Although direct community organizing is beyond the scope of the model identified in this paper, the proposed emergent, community-based participatory approach, in combination with culturally-relevant methodology, has the capacity to facilitate community empowerment and build individual and community capacity that are foundational to any community organizing and community building effort.

Duran & Duran (1999) write that an important aim of health promotion and disease prevention efforts in indigenous communities should be the empowerment of individuals and the community. Wallerstein and Bernstein (1994) define community empowerment as "a social-action process in which individuals and groups gain mastery over their lives in the context of changing their social and political environment" (p. 142). To Brazilian educator, Paulo Freire, community empowerment starts when people listen to each other, engage in participatory/liberatory dialogue, identify their commonalities, and construct new strategies for change (Wallerstein and Bernstein, 1999, p. 143). The emergent CBPR approach combined with Talking Circle methodology proposed in this paper was chosen for its role in bringing community members together to engage in dialogue, raise consciousness of a shared living experience, and facilitate community participation in decision-making around problem definition and proposed solutions.

Closely related to the concept of community empowerment is the concept of community capacity. Community capacity defined as "the characteristics of communities that affect their ability to identify, mobilize, and address social and public health

problems" (Goodman et al., 1998, p. 259) and includes many of the elements described in the proposed approach to community health assessment in the indigenous peoples of Virginia.. Community capacity has many dimensions: active community participation, leadership, rich support networks, skills and resources, critical reflection, a sense of community, an understanding of history, the articulation of values, and access to power (Goodman et al., 1998). Community capacity as an outcome of this project will focus on the cultivation of leadership, rich and invested community participation, and the development of individual skills and community resources.

LIMITATIONS

The first and foremost glaring limitation of the community assessment framework proposed in this paper, is its development by an outsider of the indigenous community. Much of the knowledge relayed in this paper was gathered through articles and books about the indigenous population in Virginia, as well as in drawing from health promotion and disease prevention efforts that have been implemented in indigenous communities elsewhere. Some of the author's knowledge also comes from personal interactions with indigenous persons from indigenous communities in Virginia; however these interactions were limited and not directly related to this project. The author recognizes her own Western worldview as the lens through which this proposal was presented.

An additional perceived limitation may be the proposal's lack of mention of potential stakeholders outside of the indigenous community. This seeming oversight was intentional. While a workable partnership with organizations and institutions outside of the indigenous community is inevitable, the appropriate timing for this to occur is beyond

the prediction of this author. This decision must be made by the communities participating in the assessment process, and it may be that each community has a different timing for this partnership to occur.

Another limitation is the limited understanding of indigenous communities in Virginia including the lack of health data. Because of this limitation, health promotion or disease prevention effort must start from step one. Even in 2009, the public health community still does not have the knowledge or skills to appropriately engage indigenous communities in Virginia. A strength of the emergent and CBPR approach is that it provides the "roadmap" for the development of culturally relevant, community-specific health promotion/disease prevention process which is guided by the indigenous communities.

PUBLIC HEALTH IMPLICATIONS

Community assessment and surveillance are essential public health functions and foundational to health promotion and disease prevention efforts; however, traditional public health models and methodologies are inadequate in working with indigenous populations. As mentioned previously, conventional community assessment typically focuses on morbidity and mortality, determinants of health within the intrapersonal sphere of the ecological model. Accordingly, health promotion and disease prevention efforts have focused largely on the role of individual behavior and personal responsibility for one's health. This perspective neglects to consider the social and economic environment that influences determinants of health in the intrapersonal sphere. Use of the ecological model allows public health professionals to recognize that while improved

health status in indigenous communities is the aim of health promotion and disease prevention efforts, indigenous peoples are not always the appropriate target of change.

Also, the role of community assessment is greater than the mere information that it provides. Community assessment should be a process *by* and *for* the people in a manner that fosters community empowerment and builds individual and community capacity for on-going engagement. The process of empowerment is central to, and indeed forms the core of, the WHO's (1986) definition of health promotion:

> Health promotion is the process of enabling people to increase control over, and to improve, their health. To reach a state of complete physical, mental and social well-being, an individual or group must be able to identify and to realize aspirations, to satisfy needs, and to change or cope with the environment. Health is, therefore, seen as a resource for everyday life, not the objective of living.

A culturally relevant, emergent approach to community assessment compliments the ecological perspective as it allows for exploration of determinants of health in various spheres of the ecological model in a manner that facilitates community empowerment and builds individual and community capacity for on-going community engagement. This approach is beneficial to the field of public health as it strives to fulfill its responsibilities and commitment to the public well-being.

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