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Steps to a Healthier Anishinaabe, Michigan

Strategies for Implementing Health Promotion Programs in Multiple American Indian Communities

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American Indians experience significant health disparities compared to the general U.S. population. The Steps to a Healthier Anishinaabe program adopted a unique framework to implement health promotion intervention activities in multiple American Indian communities in Michigan. By enabling each community to tailor interventions to their specific culture and health priorities, the program is characterized by a culturally competent and community-driven approach to decrease the impact of chronic diseases on the health of Michigan's American Indians. This article describes the community-based framework and argues that multisite, community-tailored health promotion programs are a promising approach to reducing health disparities in minority populations.

Keywords: *American Indian; chronic disease prevention; community-based; health intervention; cultural competence; health promotion; Steps to a Healthier Anishinaabe*

The Steps to a Healthier Anishinaabe program, funded by the Steps Program's cooperative agreement through the Centers for Disease Control and Prevention (CDC), has adapted and implemented

several best and promising health promotion practices among eight federally recognized tribal communities in a coordinated effort to reduce the impact of chronic disease on the health of Michigan's American Indians. The disparities in health status between American Indians and the U.S. population as a whole indicate a need for programs that address chronic diseases and conditions such as diabetes, obesity, and asthma. This article describes the strategies used to implement a community-based health promotion program in multiple communities. Each site shared health promotion goals and culturally sensitive evaluation methods, while tailoring intervention activities to their unique strengths and priorities.

▶ BACKGROUND/LITERATURE REVIEW

Literature Review

The American Indian population suffers from chronic diseases and engages in health-risk behaviors at higher rates than the general population (Denny, Holtzman, &

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Cobb, 2003). Within the Indian Health Service (IHS) Bemidji region (Michigan, Minnesota, Indiana, Illinois, and Wisconsin), the age-adjusted death rate for diabetes was 88.9 deaths per 100,000 people which is 6.5 times the rate in the general U.S. population (Indian Health Service, n.d.). The Bemidji region also has the lowest life expectancy at birth of all IHS areas and 10 years fewer than in the U.S. general population (IHS, n.d.).

The present health situation of American Indians is directly related to the history of the United States. Throughout early American history, Indian nations were divided and displaced from their land, disrupting traditional lifestyles and culture. Health problems developed out of substandard living conditions and exposure to Indo-European diseases. As the United States grew, so did the movement to assimilate American Indians to Western educational, cultural, and spiritual practices. In the mid-20th century, Native children were removed from their homes and sent to boarding schools where they were often abused and forbidden to practice their cultural traditions. By the 1920s, assimilation policies led to a decline in the social,

economic, and health status of Native people. Subsequent legislation gave tribes legal rights and assured maximum American Indian participation in directing programs intended to benefit American Indians. The truth tribes encounter again and again in developing health promotion and disease prevention programs is that history impacts health. The mechanisms of historical trauma intrude on present-day American Indian communities as mediators of poverty, interpersonal violence, poor mental health, impaired physical health, and epidemics of chronic diseases (Evans-Campbell, 2008; Jackson, 2006).

Understanding the impact of the historical and contemporary social injustices faced by American Indians is important to designing interventions that respect traditional culture (Struthers, Lauderdale, Nichols, Tom-Orme, & Strickland, 2005). Culture plays a large role in determining an individual's beliefs and behaviors related to health. Minority groups with distinct cultural beliefs and heritages may process health promotion messages differently than the majority for whom most interventions are developed (Brach & Fraser, 2000). The most effective interventions to change individual behaviors acknowledge the influence of culture and are culturally specific (Anderson, Calvillo, & Fongwa, 2007; LeMaster & Connell, 1994).

The concept of "cultural competency" reflects the importance of incorporating culture into health promotion and is a necessary feature of interventions intended to reduce health disparities (Betancourt, Green, Carrillo, & Park, 2005). Culturally competent interventions are "designed to take into account cultural beliefs and values to increase the likelihood that health promotion messages will be heard and heeded" (Brach & Fraser, 2000). Lack of cultural tailoring has been proposed as a potential explanation for the dearth of notable successes in community-based health promotion programs (Merzel & D'Afflitti, 2003). To maximize cultural competency, program planners must strive to involve community members in all stages of program planning, implementation, and evaluation; communities are best able to define their culture and health needs (Anderson et al., 2007).

Understanding the local culture is also important in designing a culturally competent evaluation. Understanding the local culture can help evaluators learn which evaluation methods are feasible and appropriate (Butterfoss & Francisco, 2002). For example, many American Indian communities value qualitative outcomes more than quantitative ones as indicators of success (LaFrance, 2004). The acceptance and sustainability of a program, as well as perceptions of beneficence, can be central components of evaluations in American Indian communities (Richmond, Peterson, & Betts, 2006). Lack of cultural competence in designing and conducting evaluations in American Indian communities can be a significant barrier to collecting data

that are valued and used by the community to strengthen and expand programming.

Another barrier to the success of health promotion programs within American Indian communities is that they are often limited in scope, focusing on a limited number of individuals within one community. Designing and evaluating a culturally competent health promotion program across multiple communities present the opportunity to increase the program's reach, especially when working with minority populations (Straw & Herrell, 2004). Much of the literature focuses on implementing the same intervention at multiple sites. However, allowing each site to prepare and implement intervention activities can help to ensure cultural competency and is a promising strategy for improving the success of community-based multisite health promotion programs. This approach is minimally represented in the literature, with a few notable exceptions.

Giard and colleagues (2005) evaluated a multisite study that allowed each site to adapt a basic intervention strategy to accommodate their strengths and regional context. The study was implemented in nine sites, with standardized data collection methods across all sites. Similarly, Dewa and colleagues (2002) conducted a multisite evaluation in which six mental health programs were granted funding for individual projects with the stipulation that they also participate in an evaluation orchestrated by an independently funded multisite coordination team. Each site followed a multisite evaluation protocol in addition to independent evaluation activities. Each site selected its own staff, and the multisite team provided technical assistance and expertise.

Although culturally competent, multisite health promotion programs are a promising strategy for reducing health disparities, limited examples exist in the literature of successful health promotion programs implemented with priority populations (LeMaster & Connell, 1994). As SenGupta, Hopson, and Thompson-Robinson (2004) argue, "there is obvious need for more available reports and literature on examples of culturally competent evaluation theory and practice" (p. 15). The *Steps to a Healthier Anishinaabe* program provides an example of culturally competent health promotion programming using a community-based framework. Furthermore, it adds to the body of literature regarding the issues involved in implementing a general health promotion grant in multiple communities. As such, the *Steps to a Healthier Anishinaabe* program contributes a unique perspective to health promotion practice.

Project Overview

Changing health behaviors and health outcomes are formidable tasks. The *Steps Program* is focused on

helping Americans live longer and healthier lives by focusing on obesity, diabetes, and asthma and the mediating factors of poor nutrition, lack of physical activity, and tobacco use. The program specifically prioritizes groups that are at increased risk for these diseases, including minority populations (CDC, n.d.a).

The *Steps to a Healthier Anishinaabe* program is coordinated by the Inter-Tribal Council of Michigan (ITCM), a private nonprofit agency with 501(c)(3) status. Founded in 1966, the ITCM is a consortium of 12 federally recognized tribes in Michigan. Its mission is to help promote the health, well-being, and quality of life of Indian people in Michigan. A team of experienced personnel at ITCM oversees the *Steps to a Healthier Anishinaabe* program, led by the ITCM project manager who provides ongoing technical assistance and coordinates trainings for tribal staff.

The majority of funds are subcontracted to 8 participating tribes. These tribes design and implement interventions for their particular community's needs. This community-based model is ideal in this setting, particularly because it accommodates for the varied infrastructure and capacity of the tribes.

Description of the Steps to a Healthier Anishinaabe Communities

The Anishinaabe are the people of the Three Fires: the Ottawa (Odawa), the Potawatomi, and the Chippewa (Ojibwa). As descendants of the Algonquin Indian nation, the Anishinaabe share common cultural traditions and dialects (Benton-Benai, 1988). The 8 communities in the *Steps to a Healthier Anishinaabe* program are located mainly in rural areas of Michigan. To ensure the privacy of the tribal communities, sites will not be identified by name or through citations.

All *Steps to a Healthier Anishinaabe* tribes operate under elected tribal chairpersons and officials. Tribal enrollment for the *Steps to a Healthier Anishinaabe* tribes ranges from 500 to more than 20,000; the average population size is approximately 2,500. The infrastructures of the tribes' health care systems are highly varied. Some operate full health care facilities which include medical, dental, pharmacy, and vision services, whereas the more recently recognized tribal communities are still developing their health care capacity and offer only primary medical services with one or two health care providers and several community health technicians.

These communities face significant barriers to nutritious eating and physical activity. For example, through experience and interactions with tribal members over many years, ITCM staff has learned that many of these reservation-based communities lack access to fresh fruits and vegetables that are available

in large grocery stores. Tribal members must often rely on nearby gas stations for food staples. In addition, few sidewalks, trails, or parks exist, making access to physical activity a challenge. Severe winter weather conditions lasting 6 months of the year or longer further restrict outdoor activity for these populations.

► STRATEGIES/INTERVENTION APPLICATIONS

Program Framework

The ITCM has experienced success coordinating previous health promotion programs by using a community-based framework and believed this design would be the most appropriate for the *Steps to a Healthier Anishinaabe* program. The community-based framework involves five core strategies: (1) use a tribal coordinator in each community; (2) develop a community action plan in each tribe; (3) adapt best practice interventions to be culturally appropriate and tribe specific; (4) provide ongoing technical assistance; and (5) respect tribal sovereignty. The description of intervention activities presented here comes from quarterly reports, annual meetings, training sessions, and personal communication with tribal coordinators.

Use a tribal coordinator in each community. The first step of the tribal community-based framework is to provide each tribe with adequate funding to hire a full-time staff person to serve as the tribal coordinator. Many tribal coordinators have background or experience in health education; some have degrees in dietetics or exercise science, whereas others are registered nurses or community health representatives. The tribal coordinators are hired by the tribes and become employees of the tribal health clinics. Given their knowledge of health promotion and local culture, tribal coordinators are well suited to develop appropriate intervention activities for their community. In addition, tribal coordinators take the lead role in completing data collection tools and reports and maintaining communication with ITCM staff.

Develop a community action plan for each tribe. The second component of the tribal community-based framework is the creation of a community-centered planning tool, the community action plan (CAP). Although all of the 8 *Steps to a Healthier Anishinaabe* communities face common barriers to healthy behaviors and experience disproportionately high rates of chronic disease, each is unique in available resources, infrastructure, and community priorities. Due to the diversity of the communities, attempting to implement one

standard action plan for all 8 tribes to follow would be unwise. Instead, ITCM created a CAP template that outlines the overarching goals and objectives of the *Steps to a Healthier Anishinaabe* program and provides a framework for incorporating evidence-based practices. Tribal coordinators enlist a multidisciplinary team of professionals and community members to assist in developing and implementing the CAP. This collaboration results in a community-centered approach to primary prevention and health education driven largely by community values and priorities.

Adapt best practice interventions to be culturally appropriate and tribe specific. In developing their CAPs, tribal coordinators use best practices for disease prevention and health promotion. However, many of the existing evidence-based interventions do not specifically focus on the needs of American Indians. To contend with the lack of culturally specific best practices, best practice interventions are adapted to include culturally appropriate materials and incorporate tribal-specific norms and values.

Provide ongoing technical assistance. ITCM provides technical assistance to the participating tribes to develop the CAP, complete progress reports, and collect data. The ITCM project manager also facilitates linkages and locates resources through other health promotion agencies, such as the YMCA, Michigan Asthma Coalitions, Blue Cross Blue Shield of Michigan, and the Michigan Diabetes Outreach Networks. For example, representatives from these organizations are invited to attend annual program meetings to network with tribal staff which then leads to collaboration at the local level.

Respect tribal sovereignty. American Indian tribes are sovereign nations; as such, they exercise their rights to work on a government-to-government basis with state and local agencies. Tribal sovereignty is often overlooked or misunderstood by agencies that assume state and local laws apply on tribal land. As part of the *Steps to a Healthier Anishinaabe* program, ITCM ensures respect for the sovereignty of the participating tribes through all aspects of programming. For example, the *Steps to a Healthier Anishinaabe* program structure allows for advocacy and policy development within the local tribal community. Furthermore, ITCM uses caution when reporting program outcomes to protect the privacy and respect the authority of the tribes. For example, formal agreements which recognize the Behavioral Risk Factor Survey (BRFS) data collected through this project as the property of the tribes were signed prior to conducting the survey; results from the survey can be shared only with permission of the tribal councils.

Example Intervention Applications

Data from quarterly reports completed in Year 4 of the program indicate more than 11,600 people participated in intervention activities conducted by the 8 *Steps to a Healthier Anishinaabe* tribal communities. The specific intervention applications identified, modified, and implemented by the *Steps to a Healthier Anishinaabe* communities were varied and unique. Examples which illustrate the potential for this community-based approach include the casino team member wellness program, “Tribe to Tribe Walking Challenge,” and promotion of traditional tobacco use.

Casinos are one of the largest employers in Indian Country in Michigan; most *Steps to a Healthier Anishinaabe* communities have at least one casino on their reservation. The tribal coordinator in one community worked with casino management to create a comprehensive employee wellness program in five casinos. The program incorporates health screenings, education, nutrition and fitness consultations, individual and group exercise programs with incentives, tobacco cessation counseling, and healthy meal options in the employee cafeterias. More than 350 people participated in wellness activities in the program’s 2nd year—twice the Year 1 participation. The tribal coordinator was formally acknowledged by casino management for the success of the healthy menu options in the cafeteria. In three of the five casinos, the wellness program has been extended to the community, allowing even more tribal members to benefit from the program.

Another interesting example is a community-based physical activity intervention that promoted friendly competition between the *Steps to a Healthier Anishinaabe* communities. The Tribe to Tribe Walking Challenge was a 17-week program involving most of the *Steps to a Healthier Anishinaabe* tribes. Participants recorded the number of steps they took daily using pedometers and an online logbook. The average total number of steps taken per participant of each tribe was computed, and the tribe with the highest number of average steps per participant was declared the winner at the Annual Michigan Indian Olympics. The winning tribe averaged more than 1.2 million steps per participant. The program was widely popular and created a community norm encouraging walking. At the conclusion of the program, several tribal coordinators reported that community members continued to track their steps.

By incorporating community values in their work, tribal coordinators have also been able to focus on health issues which have been historically challenging to address, such as tobacco use. Tribal coordinators initially approached this issue by developing community-level

interventions focused mainly on increasing smoking cessation and reducing exposure to secondhand smoke. However, this approach received significant resistance.

Tribal coordinators found that a more culturally appropriate way to address the issue was to promote the traditional uses of sacred tobacco, or Semah, and discourage abuse of commercial tobacco. To do this, one tribe designed and displayed banners throughout tribal property with educational messages about Semah; another tribe provided trainings for health care providers on Semah. One tribal coordinator helped to write a policy to include education on sacred tobacco use in a diversion program for youth who violate tobacco laws. In addition, several tribes coordinated tobacco education with cultural events, and invited members who follow a traditional lifestyle to talk about Anishinaabe teachings related to the use of sacred tobacco.

Evaluation Framework

Due to the unique program design and context, evaluation methods and data collection tools required special adaptation as well. A number of data collection tools were used to provide both process and outcome information; some of these tools include the BRFSS, the Youth Risk Behavior Survey (YRBS), Personal Assessment (PA) forms, and Decision-Maker Survey. Each tool was adapted or designed to make it uniquely suited for the *Steps to a Healthier Anishinaabe* program. Using standard data collection tools allow data to be aggregated for reporting and makes it possible to speak about the impact of the *Steps to a Healthier Anishinaabe* program as a whole, as well as within each specific community.

BRFSS. All *Steps Program* communities are required to participate in the BRFSS and the YRBS. Although the BRFSS has been conducted in Michigan since 1988, the representation of American Indians in the sample has never been sufficient to produce meaningful data (CDC, n.d.b). To implement the BRFSS in the *Steps to a Healthier Anishinaabe* communities, special consideration of the cultural and political dynamics of the tribes was required.

To obtain tribal membership lists for the annual survey, ITCM had to receive approval from tribal councils. By conducting several site visits, which included detailed presentations and discussions with tribal councils and the provision of strict confidentiality agreements, ITCM gained permission from six of the eight tribes to use their tribal membership lists for the 2006 survey. The other two tribes employed convenience sampling strategies to collect phone numbers for tribal members. One example was the “coffee can” strategy which involved placing

boxes in well-trafficked areas on tribal property to solicit tribal members who would volunteer their phone numbers for the sample. Another strategy was a mass mailing to tribal members requesting them to submit their phone numbers for the survey; self-addressed postage-paid envelopes were provided for their reply. Small incentives were offered for both the “coffee can” strategy and the mass mailing.

All phone number lists were sent to the survey contractor who cleaned the sample and randomly assigned the numbers to replicates of 25 within each tribal community; the sample was released for calling in replicate groups. Telephone interviews were conducted with tribal members aged 18 years and older.

In addition to unique sampling strategies, the ITCM tailored the BRFSS questionnaire by adding questions on traditional native lifestyles and beliefs. Furthermore, survey interviewers were provided cultural training by ITCM staff. The purpose of the training was to ensure culturally appropriate communication between interviewers and respondents. For example, interviewers were trained to recognize speech patterns common among the priority population.

In 2006, a total of 569 surveys were completed with all eight tribes. As part of the agreement with the tribes, survey results are disseminated to the communities through presentations and reports to tribal councils and boards of health. When sample size permits, tribe-specific analyses are conducted and provided to each tribe. In the final year of the project, ITCM will also disseminate results from the BRFSS through multiple media outlets to increase awareness of community health issues.

YRBS. Implementation of the YRBS required coordination with the Michigan Department of Education (MDE) to ensure that the survey adequately sampled American Indian youth in the participating communities. ITCM identified the counties where tribal lands were located. MDE oversampled high schools in the priority counties to increase the probability that American Indian youth would be included in the sample. Within randomly selected high schools, either class subjects or class periods were randomly selected to administer surveys. The MDE provided each high school with the 99-item, self-administered, anonymous questionnaires. Local parental permission procedures were conducted by the schools before survey administration.

In 2007, 19 high schools were included in the YRBS sample. Of the 1,763 students who completed the questionnaire, 8.7% reported being American Indian. Due to a small sample size overall, the survey data were

not weighted. However, almost every survey question had enough responses from American Indian youth to provide data for the group, which is a significant improvement from the YRBS data collected prior to the *Steps to a Healthier Anishinaabe* program which frequently failed to report results for American Indian youth (Michigan State Board of Education, 2000).

PA form. The PA form is a pre and post assessment tool that was developed specifically for the *Steps to a Healthier Anishinaabe* program. The PA form was developed to measure change at the individual level. An individual-level measure was important for the evaluation because of the smaller scale and reach of the *Steps to a Healthier Anishinaabe* program compared to the relatively large state- and county-wide projects participating in the initiative. The 13-question form gathers information about health behaviors and beliefs related to health care and disease prevention and is administered to participants in selected interventions.

The PA form was developed by project staff using mostly standardized questions from existing validated survey instruments, such as the BRFSS and YRBS. In addition, new questions were added to address objectives of the *Steps to a Healthier Anishinaabe* program and other state-specific preventive health programs. A draft instrument was piloted using a convenience sample of American Indian community members.

At the request of tribal coordinators, in Year 3 of the *Steps to a Healthier Anishinaabe* program, the PA form was revised for use with children aged five through 12. The tribal coordinators expressed concern that some questions from the standard PA form were confusing or not applicable to youth. The Youth PA form was created with similar content as the standard PA form, but it contained fewer questions, larger print, and pictures which illustrate each question and response option. Youth respondents were given assistance or guidance from adults when completing the form.

The PA allows compilation of outcome data across all tribes and analysis of data from a single intervention or within a single community. In Year 4 of the program, a total of 612 matching pre- and postintervention PA forms were completed. Outcomes that can be measured include vigorous and moderate physical activity, average daily servings of fruits and vegetables, knowledge of recommended health screenings, and belief in the importance of health screenings.

Decision-Maker Survey. ITCM has found support from tribal leaders to be critical, particularly for community- or policy-level interventions, because they affect

decisions about community priorities and resource allocation which, in turn, affect health behavior and health outcomes. The Decision-Maker Survey is administered annually to key stakeholders in each community including tribal council members, tribal health board members, health program administrators, and health care providers.

The survey explores knowledge, awareness, and beliefs related to chronic disease prevention. Question types are primarily closed-ended with Likert-type scale response options or number ranking. A few open-ended opinion questions are asked about community needs and strategies for change. All of the questions were developed using information from health promotion literature distributed by the Indian Health Service, the American Lung Association, and the National Heart Lung and Blood Institute. A draft instrument was pilot tested using a convenience sample of American Indian community members.

In Year 4 of the program, a total of 155 surveys were completed by decision makers from all 8 *Steps to a Healthier Anishinaabe* communities. Survey data indicate that the majority (62.9%) of respondents rank health care as the single most important service area for using tribal funds when compared to economic development, education, environment, housing, law enforcement, safety, and transportation. Furthermore, access to health care and diabetes were identified as the most important health care issues in their communities.

► RESULTS

Valuable lessons have been learned from the *Steps to a Healthier Anishinaabe* program. This experience has implications for practitioners conducting health promotion programs with American Indian communities, and for those developing, implementing, and evaluating health promotion programs which have multilevel or multisite designs.

First, the community-based framework used by ITCM enabled several American Indian communities to carry out the goals and objectives of one health promotion cooperative agreement in multiple sites. ITCM functioned as a coordinating center for the larger program operations, providing guidance to the tribal coordinators in designing and implementing their CAP and ensuring fulfillment of funding requirements.

Second, employing a full-time tribal coordinator to manage the program from within the tribal health clinic enabled *Steps to a Healthier Anishinaabe* interventions to be integrated into other health programs and allowed for the coordination of resources within the existing

infrastructure. Both of these features increase the likelihood that *Steps to a Healthier Anishinaabe* interventions will have sustainability beyond the duration of the cooperative agreement.

Finally, the evaluation of a program involving so many diverse communities requires flexibility and creativity. Standard local data collection tools were created and customized for the purposes of the program. Furthermore, traditional sampling methodologies had to be examined in light of the need to sample a specific population within varied geographic areas. Permission to use tribal membership lists to conduct the BRFSS was an extraordinary accomplishment and extended the tribes' ability to monitor the health of their members. The unique relationship between ITCM and tribal leadership and the dedication of the tribal coordinators in communicating with tribal councils about the program were key components of this process.

► DISCUSSION AND CONCLUSIONS

American policy has neither adequately addressed the consequences of a mutual history and the complexity of the present need nor planned for the holistic health of the culturally rich and diverse American Indian population. These actions created a legacy of disparity in overall health and quality of life for this population. A significant body of literature argues for conducting culturally competent programs to address health disparities in priority populations. Relatively less information is available on designing and implementing multisite, multilevel programs which use culturally competent interventions that are tailored for communities.

The community-based framework used by ITCM for this project is similar to other evaluation studies of community health initiatives (Dewa et al., 2002; Giard et al., 2005). In their article, Giard et al. (2005) describe how "a common set of elements and treatment attributes defined the intervention at each site, but the details of the implementation varied widely according to the agencies' strengths and the regional contexts" (p. 416), indicating that one intervention was tailored for use at each site. The *Steps to a Healthier Anishinaabe* program expands this approach. Each tribal coordinator has flexibility to develop an action plan that addresses the overarching goal and objectives of the program, while incorporating interventions that are appropriate for his or her unique community.

The community-based design of the *Steps to a Healthier Anishinaabe* program also ensures that interventions are culturally competent. As Anderson and colleagues (2007) noted,

Communities are themselves the best ones to define what constitutes their culture and their community. In this way, the traditions, values, strengths, and needs of community members become the basis for appropriate interventions. As a result, methods and strategies consistent with the values and traditions of each community more likely will be used effectively to reduce and eventually eliminate health disparities. (pp. 56S-57S)

Furthermore, the community-based framework supports change that is largely driven by people within the community, rather than by external agents. This is particularly important as it relates to American Indian sovereignty, given the history of programs that have been forced on Native people by outsiders who “know what’s best” for them.

One of the greatest benefits of the multisite design is the number of people the program is able to reach. With the majority of funds subcontracted to the communities, *Steps to a Healthier Anishinaabe* is able to impact many more people than if funding were to be spent by a single tribal community. However, having the majority of program activities planned and implemented in multiple sites at the community level has limitations. Due to the nature of the multisite design, the success of the program is highly sensitive to situational factors within each community. For example, turnover in tribal coordinators can delay intervention activities and create the need for frequent training of new staff on cooperative agreement requirements.

As Dewa and colleagues (2002) argue, multisite evaluation “affords an opportunity to examine diverse programs using a common metric” (p. 175). A strength of the evaluation design for this program was the application of standard local evaluation tools, which allow the communities to be evaluated individually and in aggregate. The local evaluation tools also provide an opportunity to document change that is occurring at multiple levels of the socioecological context.

Due to the unique design of this program, reporting outcomes using the national evaluation instrument is complicated. The scope of the *Steps to a Healthier Anishinaabe* program is very different from the scope of other *Steps Program* communities. In addition, the evaluation was aligned with the *Steps Program* evaluation plan, which focuses largely on outcomes and quantitative measurement of change. Many of the tribal communities involved in the *Steps to a Healthier Anishinaabe* program are very small compared to other *Steps Program* communities. Small communities translate to even smaller sample sizes, and quantitative measurements are

not always ideal for assessing outcomes. As LaFrance (2004) learned, “tribal populations in the programs being evaluated are often not large enough to put faith in statistical models; as a result statistical analysis is usually limited to descriptive summaries” (p. 46).

Consistent with findings from previous projects with American Indians, more qualitative methods would be useful and informative for program purposes and may also have more value to the community (Richmond et al., 2006). The success of this program may be more meaningfully captured through anecdotes and success stories than surveys and assessments.

Overall, the ITCM’s experience with the *Steps to a Healthier Anishinaabe* program illustrates that a community-based framework holds promise for coordinating health promotion programs with multisite and multilevel designs. This framework presents one promising method for the challenges of identifying and implementing evaluation designs which capture the rich and diverse experiences and outcomes achieved in local communities.

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