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## Healthy Native Community Fellowship: An Indigenous Leadership Program to Enhance Community Wellness

Rebecca Rae

*University of New Mexico*, rrae@salud.unm.edu

Marita Jones

*Healthy Native Communities Partnership*, marita.jones@hncpartners.org

Alexis J. Handal

*University of New Mexico*, ajhandal@salud.unm.edu

Marge Bluehorse-Anderson

*Healthy Native Communities Partnership*, marge.bluehorse-anderson@hncpartners.org

Shelley Frazier

*Healthy Native Communities Partnership*, shelly.frazier@hncpartners.org

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# Healthy Native Community Fellowship: An Indigenous Leadership Program to Enhance Community Wellness

## Abstract

The Healthy Native Communities Fellowship (HNCF) is a grassroots evidence-based mentorship and leadership program that develops the skills and community-building capacities of leaders and community teams to improve health status through several intermediate social and cultural mechanisms: (a) strengthening social participation (also known as social capital or cohesion); (b) strengthening cultural connectedness and revitalization of cultural identity; and (c) advocating for health-enhancing policies, practices, and programs that strengthen systems of prevention and care, as well as address the structural social determinants of health. This leadership program uses a community-based participatory research (CBPR) approach and participatory evaluation to investigate how the work of local American Indian and Alaska Native leaders (fellows) and their community coalitions contributes to individual, family, and community level health outcomes.

## Keywords

American Indian, Alaskan Native, Indigenous leadership, community health and wellness, community capacity, participatory evaluation, community based participatory research

## Acknowledgments

HNCF would like to acknowledge and thank the Alumni Fellows for their contributions, dedication, and commitment to improving the health and wellness of communities throughout Indian Country. The Fellowship is an enriched experience because of your shared knowledge, wisdom, and openness to overcome challenges through collective leadership. This article is dedicated to the Alumni Fellows, thank you for your leadership.

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## Authors

Rebecca Rae, Marita Jones, Alexis J. Handal, Marge Bluehorse-Anderson, Shelley Frazier, Kristine Maltrud, Chris Percy, Tina Tso, Frances Varela, and Nina Wallerstein

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## Healthy Native Community Fellowship: An Indigenous Leadership Program to Enhance Community Wellness

American Indian and Alaska Native (AI/AN) communities face many health challenges, including experiencing some of the highest levels of health disparities of any group in the US. Many of these health challenges are preventable, and are related to behaviors and social determinants resulting in obesity, physical inactivity, poor diet, substance abuse, and injuries (King, Smith, & Gracey, 2009). The Healthy Native Communities Fellowship (HNCF) emerged from the Indian Health Service (IHS) Prevention Task Force and its National Health Promotion and Disease Prevention (HP/DP) Program to support the goal of building healthier communities and a coordinated, systematic approach to enhancing preventive health practices and policies at the local, regional, and national levels. In 2003, the IHS developed a 10-year strategic plan to improve the quality of life for AI/AN by reducing health disparities through prevention initiatives that improved healthy behaviors, primarily through developing and implementing effective HP/DP programs (Jones et al., 2010). As one prevention effort, the IHS launched the HNCF in 2005 as a one-year leadership and mentorship program for AI/AN urban and tribal communities with the understanding that building the skills and capacities of those most affected by the issues creates catalysts for positive community change.

HNCF structurally transitioned in 2007 to a 501c3 national non-profit organization called Healthy Native Communities Partnership, Inc. to broaden the reach of wellness efforts throughout Indian Country. The non-profit provides capacity building, leadership development, partnership, and networking training (see [www.hncpartners.org](http://www.hncpartners.org)) to Native communities across Indian Country. Retaining active collaboration with the Shiprock Area IHS HP/DP Program (located in Northwest New Mexico), the Healthy Native Communities Partnership has been responsible for coordinating the successful implementation of many local, regional, and national Indigenous community health promotion programs and projects. The non-profit includes the HNCF, Just Move It, the Native Health Communications Center, and the Native Wellness Resource Network's Creating Community Circles for Change. This article focuses specifically on the HNCF, as one program offered by the Healthy Native Communities Partnership.

The HNCF is an evidence-based mentorship and leadership program that starts from an Indigenous strengths focused core to enhance skills and community-building capacities of leaders, community teams, and co-mentored teams in order to improve health status through several intermediate social and cultural mechanisms, such as:

1. Increasing social participation (also known as social capital or cohesion);
2. Strengthening cultural connectedness and revitalization of cultural identity; and
3. Advocating for health-enhancing policies, practices, and programs that strengthen systems of prevention and care, as well as address the structural social determinants of health.

The five core principles of the HNCF are:

1. To build community connectedness and care for each other in strong and healthy relationships,

2. To regenerate and heal the community by cultivating cultural and spiritual resources,
3. To nurture talents and leadership that enhance the quality of community life,
4. To develop effective strategies to tackle problems that threaten the community, and
5. To cultivate and create opportunities to heal negative family and community conditions.

Though many leadership programs currently exist, at the time of HNCF's conception there were no Native-specific leadership programs available. The creation of HNCF thus filled this gap in leadership programs by addressing the specific cultural and community needs of diverse tribal communities throughout Indian Country.

The purpose of this article is to showcase how participatory evaluation has enabled an iterative development of the HNCF leadership and mentorship program as an action-learning cycle. Together with the University of New Mexico's Center for Participatory Research (UNM-CPR), and HNCF fellows, HNCF uses a community-based participatory research (CBPR) and participatory evaluation framework to conduct a process and outcome evaluation that has changed with fellowship needs over time. During the past 10 years, HNCF evaluation has evolved from an early focus on formative curriculum development and individual transformations of fellows and fellowship teams, to a greater concentration on enhancing coalitions within home communities and supporting community change and policy outcomes. We will first present the literature that supports an Indigenous<sup>1</sup> leadership initiative, and then provide an overview of the HNCF program and curriculum and the participatory evaluation theory of change and methods. Finally, we will discuss the results for fellows, teams, and community and policy changes, along with challenges and successes, to showcase learnings that can be applied to mentorship and leadership programs among other diverse communities nationwide.

### **Background Literature**

The fellowship begins with a one-year commitment to hands-on, collaborative learning that is grounded in Native cultural, spiritual, and intellectual perspectives over the course of three weeklong learning sessions. Over the course of the year, fellows learn new skills and enhance their capacity to support actions in their communities that increase social participation and strengthened cultural connectedness, as well as new programming, practices, and policies. HNCF's conceptual model (Figure 1; Wallerstein, Rae, Handal, & Jones, 2011) illustrates the hypothesized relationship between three intermediate outcome categories that improve community well-being. For example, participation in support groups, such as walking clubs, can enhance physical activity as well as strengthen cultural connectedness through traditional patterns of behavior and, by virtue of shared participation, a greater sense of community. This community connectedness can lead people to collectively advocate for changing conditions, such as improved access to healthy traditional foods. Access to traditional foods can involve youth learning from

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<sup>1</sup> In this article, we use all three terms, American Indian and Alaska Native (AI/AN), Native, and Indigenous to describe the First Peoples of the United States. AI/AN has been used by the US census to characterize the

Elders, enhanced reservation employment with new markets, and, in terms of the policy, can involve community leaders promoting farm-to-school programs.

### **Social Participation**

Research shows that when strong community partnerships and coalitions are formed among different community sectors, health outcomes can dramatically improve (Butterfoss, 2007; Butterfoss & Kegler, 2002). Strengthening community conditions requires supporting capacity building in communities to create social capital, social cohesion, and social networks for increased resources and a stronger sense of both community and culture (Berkman & Glass, 2000; Mignone, 2003; Surkan, O'Donnell, Berkman, & Peterson, 2009). Social capital, social cohesion, and social networks are associated with health outcomes such as maternal health and child nutrition, stress, cardiovascular disease, obesity, reproductive health and sexually transmitted diseases, mental health, and health behaviors (Ferlander, 2007; Giordano & Lindstrom, 2010; Kawachi & Berkman, 2000; Lindsay, Sussner, Greaney, & Peterson, 2009; Mignone & O'Neil, 2005; Poortinga, 2006; Poundstone et al., 2004; Teufel-Shone, 2006). Social participation has also been linked to empowerment, which—through specific interventions with patients, youth, people with HIV/AIDS or other conditions, or in poor communities, for example—has contributed to improved health outcomes (Wallerstein, 2006; Wiggins, Hughes, Rodriguez, Potter, & Rios-Campos, 2014).

### **Cultural Connectedness**

A related concept that affects health is cultural connectedness, defined as “systems of belief, values, customs, and traditions that are transmitted from generation to generation through teachings, ecological knowledge and time honored land-based practices” (McIvor, Napoleon, & Dickie, 2009, p. 7). Considerable evidence demonstrates that connection to culture, history, and tradition has a positive impact on the health of Indigenous populations (King et al., 2009; Whitbeck, Adams, Hoyt, & Chen, 2004), including connection between land and health, use of traditional healing and medicine, traditional food and cultural practices, and connection to language (McIvor et al., 2009; Milburn, 2004). Populations and communities who confront historical injustices and suffering use connections to culture and history to heal from discrimination, loss of identity and the breakdown of cultural belief systems, and negative trauma resulting from assimilative policies (Gone, 2009; King et al., 2009; Kirmayer, Sehdev, Whitley, Dandeneau, & Issac, 2009). Methodologies and practices of observation and experiential learning are critical; therefore, it is important that Native-focused services and/or programs center on holistic approaches that include the spiritual, emotional, physical, and intellectual aspects of health (Absolon, 2010; Durie, 2004). A holistic approach addresses factors beyond specific individual health problems by considering a person's well-being as something that is connected to their social ties and community (Edgerly, et al., 2009; Hurst & Nadar, 2006).

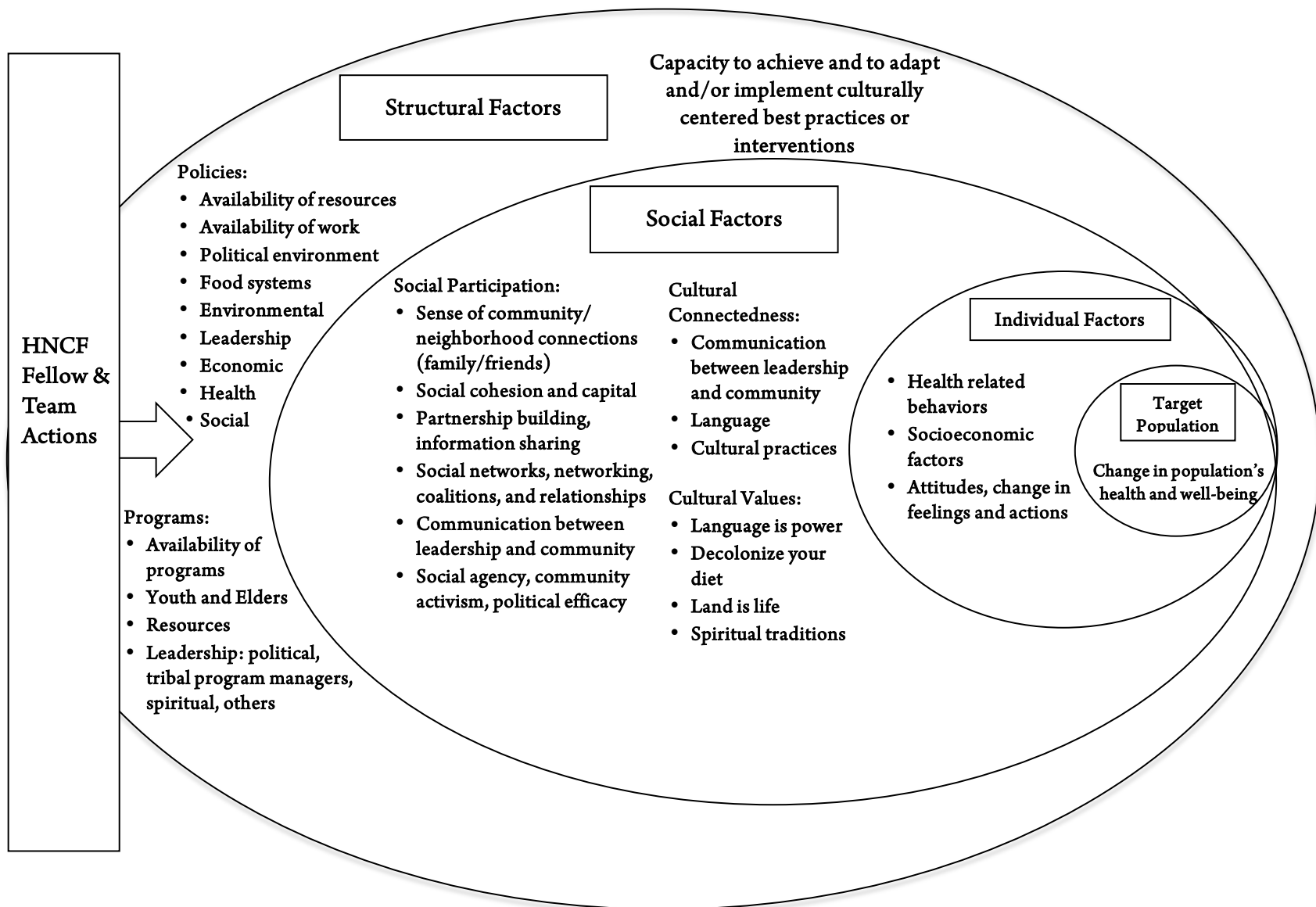


Figure 1. HNCF Community Change Conceptual Model: What Are We Evaluating? (Adapted from Poundstone, Strathdee, & Celentano, 2004).

Cultural connectedness has been particularly important for HNCF to strengthen the work happening on the ground in Native communities, as it shapes individuals' beliefs and behaviors towards their health, with growing evidence suggesting that culturally specific interventions are most effective (Mead, Gittelsohn, Roache, Corriveau, & Sharma, 2013; Mohatt et al., 2007; Saewyc, Tsuruda, Homma, Smith, & Brunanski, 2013; Saksvig, et al., 2005).

The related concept of cultural centeredness, proposed as an essential component of interventions that are effective and sustainable, recognizes culture not just as a set of beliefs, but as peoples' agency, knowledge, and voices to initiate and direct the changes needed in their community (Duran, Wallerstein, & Miller, 2007; Dutta, 2007; Hall, 2001). Two recent Institute of Medicine (IOM) publications promulgated this understanding of culture as an important leverage strategy for prevention and health promotion efforts to reduce health disparities (IOM 2012; 2013). A complementary consensus report from the Office of Behavioral and Social Science of the National Institutes of Health called for culture to be recognized as a multi-dimensional ecology, based on both historical and socio-political realities as well as power relationships between disadvantaged communities and dominant society (Kagawa-Singer, Dressler, George, & Elwood, 2015). Not only does the report demand greater attention be paid to histories and stratification as parts of culture, but it also calls for recognition of the mistaken view that a Western scientific model is sufficient for understanding Native communities.

### **Structural Factors: Policy and System Changes**

Structural factors such as social determinants related to poverty, under-resourced neighborhoods, institutional racism, lack of health prevention services, and/or the need for health promotion policies are core risk factors that inhibit well-being in Native communities. Freudenberg (2014) has described a model in which illness is produced as a consequence of corporate strategies<sup>2</sup>; yet, there are innovative opportunities to reduce chronic disease through pairing regulatory oversight with primary care prevention strategies (Freudenberg & Olden, 2010). He has explained, for example, that the food industry has created a profit-making junk food market based on sugar subsidies and the manipulation of taste buds that favor salt, sugar, and fats. Many fellow teams have concerned themselves with obesity and have promoted strategies for improving school nutrition and using traditional foods to counter the overselling of junk food. In week two of the fellowship, for example, the fellows are offered social marketing skills to integrate into their strategies for nutritional and other community changes.

A team approach that strengthens coalitions or organization in order to transform structural conditions is part of the HNCF curriculum. The "fellow team" approach enables leaders to strengthen both their community-building capacities (through social ties and cultural connections), and their community and inter-organizational organizing capacities (by building advocates' capacities to challenge unhealthy conditions) (Lasker & Weiss, 2003; Minkler, Garcia, Rubin, & Wallerstein, 2012; Wolff, 2000). As mentioned above, increased social participation and cultural connectedness can be linked to changes in health outcomes. Community organizing and community-based participatory research also can directly impact policy change at the local as well as regional and state levels for improved health (Bell &

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<sup>2</sup> Freudenberg reviewed six industries (tobacco, alcohol, gun, oil and gas, pharmaceutical, and food) that use lobbying, product development, and marketing strategies to sell product, without necessarily considering health effects. While some of these may be obvious health hazards, others have complex intersecting systems and networks that put profits over health.

Standish, 2005; Cacari-Stone, Wallerstein, Garcia, & Minkler, 2014; Minkler et al., 2012; Minkler et al., 2014; Themba-Nixon, Minkler, & Freudenberg, 2008). HNCF fellows gain skills to engage with policy makers, and, at the same time, can become policy-brokers themselves in order to change specific policy environments. This outcome of procedural justice, whereby community members gain a policy voice, has been named in the CBPR literature as a key component of acquiring distributive justice or equal access to services, programs, and resources (Gonzalez et al., 2011; Minkler, 2010). By supporting teams working with their community coalitions and organizations, the fellows serve as catalysts or change agents taking action to promote change in prevention programs, policies, and practices throughout the community to address their issues of concern (Collie-Akers, Fawcett, & Schultz, 2013; Fawcett et al., 1995). Such actions aimed at structural change ultimately enhance collective empowerment, which literature has identified as associated with improved health (Wallerstein, 2006).

Starting from the literature and adding public health leadership models, the HNCF built upon the fundamentals of “transformation, legislation and politics, trans-organization, and team and group dynamics” (Wright et al., 2000, p. 1204), adapting them to fit an Indigenous framework. These fundamentals of within-team and across-team relationships are emphasized in the fellowship for fellows to support each other and work with others to transform their communities, including changing behaviors, community norms, and policies in order to support health. From these models and from the World Health Organization (WHO) healthy communities guidelines (WHO, 2000), the curriculum adopted facilitative tools that asked fellows to construct healthy community visions, identify tribal programs across multiple sectors with which they could collaborate, and strengthen their communication, leadership, strategic planning, and policy skills. Visioning that focuses on a future based on core values (Gilkey, 1999)—paired with effective collaboration and communication—increases communities’ capacities to sustain collective efforts and tackle challenges, and also provides opportunities to shift the leadership structure from a hierarchical one to horizontal power sharing (Avery, 1999; Alexander, Comfort, Weiner, & Bogue, 2001; Raelin, 2006). HNCF included Brazilian educator Paulo Freire’s (1970) empowerment and popular education methodology, emphasizing its belief in the capacity of community members to come together to analyze their issues and develop strategies to promote community well-being. The Freirian methodology uses a continuous reflection and action cycle that starts with listening to community issues, engaging community members in dialogue, deciding and implementing action strategies, and then reflecting on their actions, including barriers and facilitators to change, which, in turn, starts another cycle of listening, dialogue, and action (Wallerstein & Auerbach, 2004). This listening, dialogue, action, and reflection cycle was incorporated into the HNCF Medicine Wheel. The fellowship also drew from Indigenous historical traditions within Native communities of storytelling around both the life cycle of childhood, adolescence, adulthood, and the wisdom of Elders, as well as collaborative group decision-making and diversity of knowledges taught within the community, which were also built into the curriculum that followed the HNCF Medicine Wheel (Dapice, 2006).

### **HNCF Program and Curriculum**

The mission of HNCF has been to support community health advocates and teams working in Native communities to build their skills and capacities in leadership, partnership, and networking practices,





The Action Learning Space emphasizes co-developing and implementing interventions for specific community outcomes with support from distance learning opportunities, such as webinars, monthly coaching calls, mentoring, and technical assistance. HNCF promotes “learning community” networks of fellow teams from across Indian Country, which, working on the same issues, share wise practices, challenges, and together problem-solve to overcome barriers to their work. Using a generative co-creation approach, the learning activities are adjusted each year to reflect the unique knowledge and goals of fellow teams and communities, all with the goal of accelerating community change.

The yearlong fellowship is grounded in a multi-dimensional curriculum that utilizes the Medicine Wheel as its overall framework for outlining four directions of learning, skill building, and practice (Jones et al., 2010). This Indigenous-centered curriculum is grounded in Native holistic philosophy that incorporates core-learning principles, culture, history, tradition, and the spiritual, emotional, physical, and intellectual aspects of health. Many tribes utilize medicine wheels (how they are portrayed vary amongst tribes) for teachings on spirituality, cardinal directions, life cycles, and environmental cycles. It therefore fits within the holistic health paradigm that includes collaborative leadership capacity and skills, Freirian empowerment, and Native teachings and knowledge.

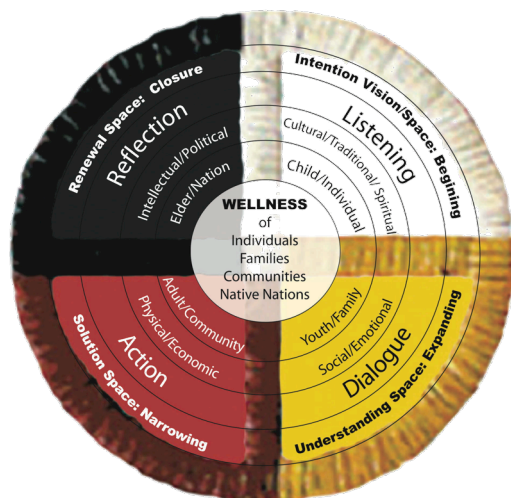
The HNCF Medicine Wheel is a dynamic model that acknowledges the various factors that influence health and wellness based on public health and health promotion science, and promotes community health action based on the principles of community-based learning (Jones, Varela, Frazier, Tso, Bluehorse-Anderson, & Percy, 2012; see Appendix). Each direction of the Medicine Wheel (East, South, West, and North) focuses on developing skills and practices based on different levels, such as areas of health or wellness, stages in the life cycle, and emphases within Freirian listening, dialogue, and action cycles. For example, the East direction includes cultural and spiritual traditions, child and individual perspectives, and listening. The South direction incorporates social and emotional growth, youth and family perspectives, and dialogue, etc.

The Medicine Wheel (Figure 3), which is at the center of the HNCF Curriculum Framework, has 4 concentric rings:

- The outer ring represents the cycles of group interaction and group process to promote community engaged learning and action,
- The second ring represents the community action and natural learning processes of Paulo Freire,
- The third ring represents the Indigenous dimensions of wholeness and wellness,
- The inner ring represents the life course development of community members, and

- The center circle, which holds the space for the goal: wellness for individuals, communities, and American Indian, Alaska Native, and Hawaiian Native Nations.<sup>3</sup>

HNCF fellows complete their “Fellowship Journey” around the Medicine Wheel in one year, learning and practicing new skills and tools while strengthening capacities (of themselves, their team, their “home team” or wellness coalition, and community) along the way.



**Figure 3. HNCF Medicine Wheel Model.**

Each direction of the Medicine Wheel is highlighted in each of the three face-to-face weeklong retreats, which incorporate personal support, cultural sharing, and community wellness skill development taught in a cyclical way. Between each of the face-to-face retreats, fellows try out their new skills back in their home communities (Action Learning Space), and maintain connections with each other via “Fellow Space,” which includes custom webpages, and the “Fellowbook” blogging site, where they can share their stories and challenges, individual and team coaching calls with HNCF staff, and skill-based webinars. Fellowship teams are also required to work with a home team to share the skills, tools, and knowledge they gain throughout their fellowship year.

The HNCF curriculum framework has been developed and refined yearly through an iterative process to reflect input and learnings from the fellows, HNCF staff, and learning teams. The first few years of the fellowship helped establish the key principal tools and lessons in the curriculum, based on the experience of what was useful and meaningful to the fellows. HNCF staff and the learning team took feedback from the fellows, observed implementation at the fellowship retreats of what tools or lessons sparked the most

<sup>3</sup> The HNCF program is open to fellows from all AI/AN/NH Nations, although to date no Native Hawaiian teams have applied.

interest, and observed from blog posts what tools fellows used most in their communities to solidify and focus the tools and lessons in the curriculum.

In recent years, HNCF developed an additional second year curriculum for a small group of alumni teams, which offers two face-to-face retreats to focus on interventions and evaluation, with coaching and support within the Action Learning Space and network-building across sites. From 2005 to 2010, the fellowship held four face-to-face weeklong retreats, and, in 2011, the fellowship was streamlined to allow more fellows to participate, to reduce costs, and to offer a Year 2 fellowship for alumni teams. That year, the fellowship moved from a one-year model to a two-year model, and the first year was cut back to three face-to-face weeklong retreats. Since 2011, a Year 2 fellowship has been available to a few alumni teams to deepen their development of interventions and evaluation designs. Year 2 fellows attend two face-to-face weeklong retreats, with the second retreat scheduled alongside Year 1's third retreat for shared learnings amongst the two cohorts. The second year fellowship is not reported on in this article.

In its current iteration, week one of the curriculum focuses on:

1. Observation and listening skills to hear hidden voices in community,
2. Conduct a Building Healthy Communities Survey as a strategy to listen to communities,
3. Implement a Community Rez Cafe to explore community connectedness, and
4. Practice strategies to build collaborative leadership for community wellness.

Week two incorporates skills that:

1. Strengthen communication skills to create effective dialogue in the team and community,
2. Develop a community wellness plan, and
3. Develop effective community wellness strategies.

During the third week Fellows learn:

1. To keep track of community wellness work,
2. Understand the tribal and federal policy process,
3. Strengthen collaborative and ethical leadership practices, and
4. Develop new resources for community wellness.

A complete list of tools and skills learned during each of the three retreats is further highlighted in the HNCF curriculum framework (see Appendix).

### Methods: HNCF Participatory Evaluation Design

The HNCF “learning team” of university and consultant evaluators partnering with HNCF staff has used a “participatory evaluation” framework to co-create the evaluation design, participate in data collection, and apply analysis of learnings to iteratively inform curriculum developments and overall program changes (Springett & Wallerstein, 2008). Participatory evaluation is a process of mutual reflection, whereby stakeholders participate in evaluation design, implementation, and interpretation, and identify lessons learned from training and field practice in order to inform future actions (Coombre, 2012). Shared evaluation and research practices help:

- a. Establish trust with under-resourced and disenfranchised communities,
- b. Enhance cultural-centeredness of evaluation methods based on community strengths,
- c. Build community leader capacity in evaluation, and
- d. Build capacity for changes in policies, programs, and practices at the community level (Hicks et al., 2012; IOM, 2012, 2013; Wallerstein & Duran, 2010).

Working with principles of CBPR, the learning team supported internal evaluation capacity building among the HNCF staff to ensure that new directions for the program and evaluation methods were grounded in mutual decision-making (Hoole & Patterson, 2008; Israel, Eng, Schulz, & Parker, 2012; Minkler & Wallerstein, 2008).

In the first few years, the curriculum and evaluation focused on the individual skill development, healing, and transformation of fellows as change agents, along with changes in team cohesiveness and capacities—although some self-perceived community changes were captured (Jones et al., 2010). The learning team, with input from the HNCF staff, created measurement tools that were used to track changes that occurred over the yearlong fellowship at the individual, team, and community levels. Data collection methods included team interviews (conducted during weeks 2 and 4), end of week evaluations, and analyses of blog posts. A coding sheet (see Appendix) was developed to analyze the qualitative data from the interviews and blog posts. The coding sheet was essential for tracking uniform community changes over time. The coding sheet helped categorize the fellows’ learnings, actions, and success stories that they shared via the interviews and blogging on Fellowbook.

As the fellowship evolved over the years to seek greater impacts on community wellness, the evaluation also increasingly focused on community actions and impacts—these are outlined in Figure 4, which describes the HNCF Evaluation Model. The hypothesis was that the HNCF intervention (of weeklong retreats coupled with coaching and network building in between) have supported changes in fellows’ confidence, knowledge, and use of community mobilizing and listening skills, which then link to their abilities in order to work better as a team. Additionally, this can be linked to their actions and capacities; thereby fostering multi-sector and multi-level community changes towards social and health equity.

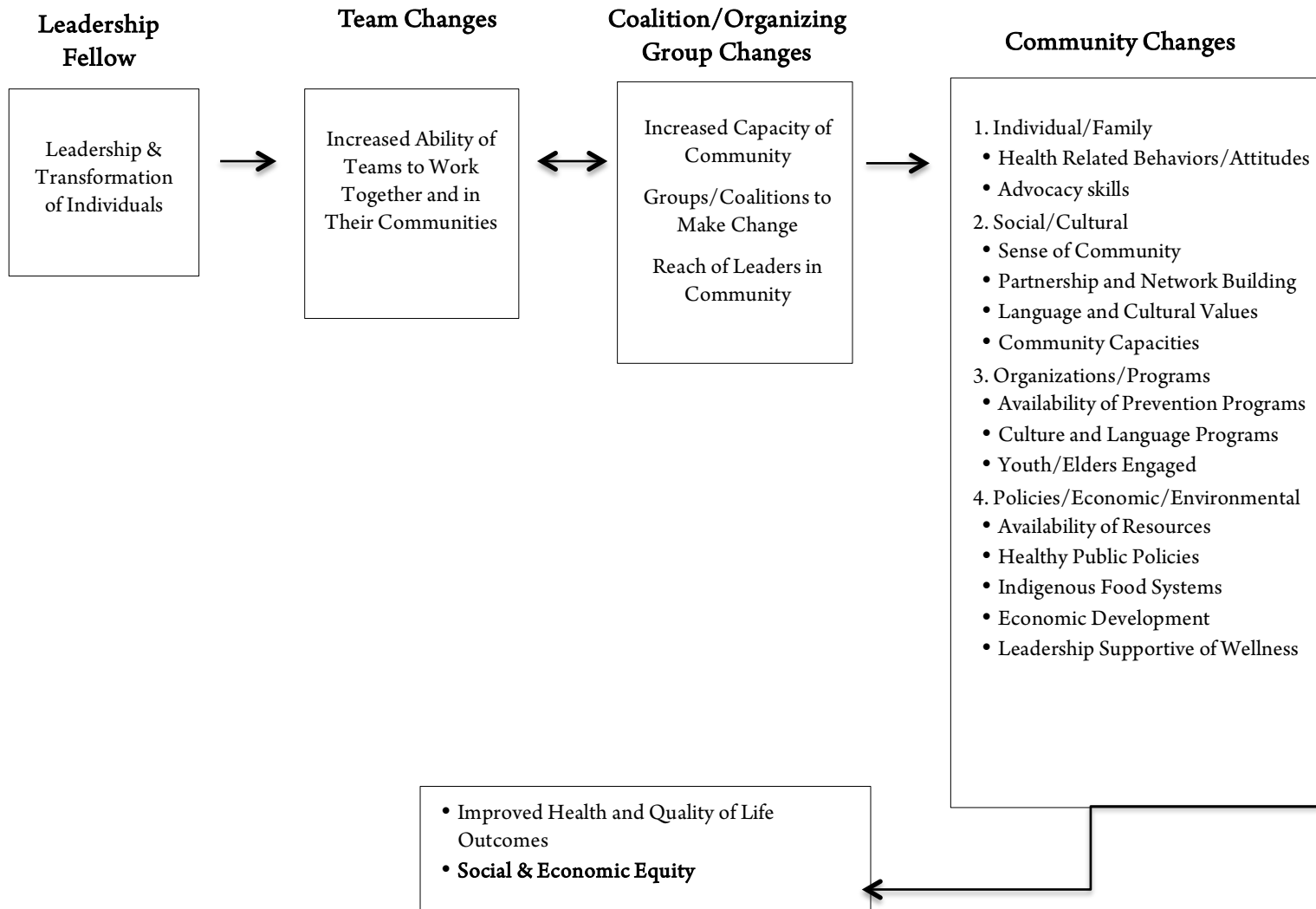


Figure 4. HNCF Evaluation Model.

In 2009, the fellowship had been in place for four years, long enough to begin to learn about the trajectory of the fellows over time and to identify the impact of the HNCF on participating individuals, teams, and communities. A retrospective internet-based assessment of the first four years (2005-2008) allowed the alumni to report with their own documentation and in their own voices about the lasting impact of the fellowship on their use of skills and on their actions to create health and well-being within their communities over time. Questions ranged across the potential levels of impact on individuals, teams, and communities and included positive work or personal changes attributed to the fellowship, use and scope of reach of HNCF skills and tools, continued collective work of HNCF teams and connections to other teams, primary and secondary issues being currently worked on in the community, community-level changes, and the need for ongoing alumni support or technical assistance. Results from the retrospective survey helped develop a plan for an ongoing and more comprehensive longitudinal evaluation, with the recognition that the fellowship has the capacity to make community changes that could impact health outcomes.

In addition, the survey drew from the RE-AIM framework (RE-AIM, 2016), which is an evaluation methodology that captures the “Reach” and “Effectiveness” of programs, as well as the extent of their “Adoption,” “Implementation,” and “Maintenance” in new settings. In our retrospective survey, we captured the scope of the “Reach” of the fellows in and across communities, including with whom the fellows connected directly and how broadly a program’s impact may filter through to others in a community. We also asked about effectiveness—including extent to which they used HNCF skills—levels of new partnerships and networks, and impacts on policies, programs, cultural participation, and community-level changes.

In 2011, the learning team conducted two case studies with two communities to assess potential for policy and program changes within communities that had active fellow teams or different teams from the same community over several years. The HNCF curriculum by this time had expanded to include more direct Community Wellness Planning leading teams to identify specific targets for policy and program change. The case studies focused therefore on multi-level community changes, and examined the interaction between healthy individual behaviors and attitudes, changed social cohesion, participation, and cultural connectedness, and, finally, transformed systems at the structural level—such as healthier policies and socio-economic conditions, new wellness programs, and organizational practices to support conditions for people to become healthier (as outlined in the conceptual model in Figure 1).

Several instruments (focus group guide, interview guide, and questionnaire) and methods were tested to “listen” to the community to assess their knowledge of HNCF and their participation in community actions and wellness. An advisory committee of alumni fellows was a key partner in the development of the instruments; they provided input and recommendations to ensure the instruments were culturally relevant and community friendly. Alumni fellows from the two participating communities were also trained in data collection and were critical of the success of the case studies. They planned, coordinated, and recruited community members to participate in the focus groups, interviews, and questionnaire. Conducting the focus groups, interviews, and questionnaire in the two case study communities provided an opportunity to directly ask community members about what contributes to community health and wellness. These “listening sessions” generated rich dialogue amongst the participants and captured meaningful data. The data collected were compiled into individualized reports (for participating communities) that categorized the strengths, concerns, and recommendations of various themes such as

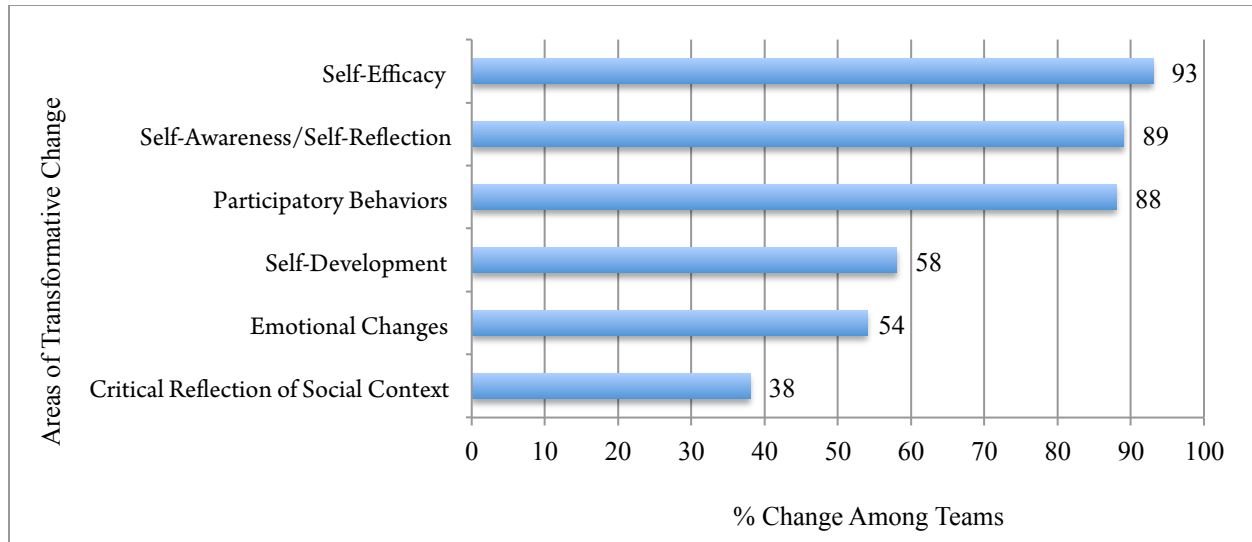
community health and wellness, sense of community and participation, youth, Elders, leadership, cultural knowledge, practices, and connectedness. While these learnings were useful for the fellows, HNCF and the learning team recognized the data collection process and analysis was laborious and could be a challenge for communities to implement. For sustainability purposes, HNCF simplified the process by pulling three questions from the focus group: What does a healthy community look like to you? How do you think community participation contributes to a healthy community? And how do you think connection to core values and culture contributes to a healthy community? We also modified the method into a “Rez Café” activity, a tool that fellows learn in week one of the fellowship. This tool, along with the modified questionnaire, has since been added to the curriculum as “listening tools” for engaging community members and capturing what matters to them.

## **Results**

The HNCF began in 2005 with its inaugural fellowship and has now served 309 individual fellows and 119 teams, representing 19 states and all 12 Indian Health Services Areas, with another 20 alumni fellows in Year 2. The four-year retrospective survey of “Reach” from fellows indicated an average of 294 community members reached per fellow. Assuming this average reach for all years, HNCF has reached approximately 91,000 community members (through 309 fellows). Preliminary data presented here comes from eight years of data collected from the Year One fellowship. Up to this point, the evaluation had focused on transformation of fellows as change agents, including healing, self-confidence, use of new listening and community mobilizing skills, changes in fellow team cohesiveness and capacities, and perceived community changes (Jones et al., 2010). In 2011, HNCF Year 2 fellowship was launched at which time the opportunities for tracking community wellness and health changes were enhanced and the fellows began to concentrate more on community level changes. As the HNCF changed, over a two-year period (2010-2012), the individual and the team levels data seemed to follow a consistent change pattern, though there is new emphasis on community change outcomes.

A comprehensive analysis of HNCF between 2006 and 2012 (highlighted in Figure 5) showed that, out of 97 teams, 93% reported increased confidence (self-efficacy) and 88% improved their participatory behaviors to work with others to improve wellness policies, programs, and practices in their communities. HNCF had a deep impact on fellows’ confidence and self-awareness, which can be linked to their abilities to work together as a team with the actions and capacities to foster community changes. The stories shared through the blogs, interviews, and end-of-week evaluations were of personal journeys and transformation, increased confidence in the use of new skills, taking greater leadership roles, and working cooperatively with team and home team members, other current HNCF teams, alumni HNCF teams, co-workers, community members, and families.





**Figure 5. Analysis of Self-Reported Change Among HNCF Fellow Teams.**

At the individual fellow level, a trend developed wherein the fellows experienced internal changes in the earlier part of the fellowship year and, in the latter part of the year, the changes shifted more towards external changes. Key indicators of internal changes were self-awareness and self-reflection; external change indicators included self-efficacy, self-confidence, and intention, as well as participatory behaviors and use of skills. One fellow profoundly expressed an internal change by saying:

I find myself stepping ahead more; there are a lot of things I would not have done if I weren't a part of HNCF. I feel like a much stronger person, who can meet the challenges that lie before me. (Blog entry, 2008)

Self-development can be a challenging, but rewarding experience, as expressed by one fellow:

It [the fellowship] has changed my life. I am so very grateful to be included in this growth experience. I have not wept so much in my life (growth can be painful) and I am looking forward to many positive lifestyle changes for myself and my community. (End-of-week evaluation, 2009)

Another fellow reflected on an external change:

It has changed me so much!! I have become a better leader! I have learned to use my voice. I have learned to step out of my comfort zone and challenge myself. I did that with all the activities we learned. (End-of-week evaluation, 2012)

Similar to the trend described above of moving from internal to external changes, the fellow teams also shared their experiences of focusing more on internal collaboration at the beginning (i.e., communication among themselves, commitment, trust, and discovering the value of working together), and then moving towards more external orientation—the gathering of additional skills, tools, and confidence, as the fellowship year progressed. One fellow team member shared some key skills that the team had learned together by saying:

We are also brainstorming how to get our community excited about attending meetings. So often we put on our "work mask" and refrain from sharing too much of ourselves. Last week we learned it is okay to drop the mask and share our passions! It leads to a deeper level of communication (including listening!) and connectivity amongst team members. (Blog entry, 2009)

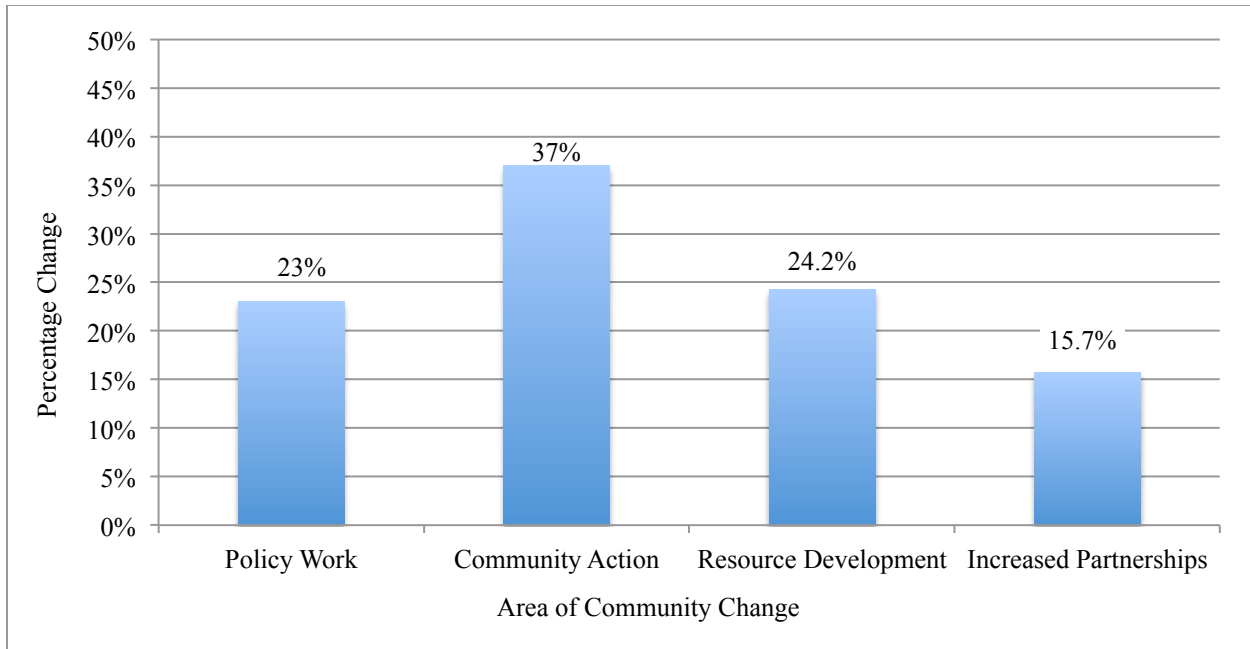
As teams gained more experience working together their capabilities and capacities as a team also grew and one team shared the following as an example:

Our team has become more outspoken and politically savvy. The fellowship provided an opportunity to explore controversial ideas out loud and to craft a plan to execute ideas at home. (Team interview, 2006)

It was when teams reached a certain level of confidence that they can began to focus on becoming change agents in their communities.

Without strong collaborative leaders, change in communities is difficult to achieve. As the fellowship evolved to seek greater impacts on community wellness, the evaluation increasingly focused on community actions and policy impacts. This emphasis on community and policy change was reinforced with the addition of Community Wellness Planning into the curriculum. Annually, the evaluation tracked fellows' community change efforts in multiple areas outlined in the codebook, but the following four areas were noted most often: policy efforts, resource development, community actions, and increased partnerships. Though specific policy work was tracked separately, these four areas together strengthen policy-makers and policy environments within a tribe or urban AI/AN community to be more directed towards community social participation and wellness.

Community change efforts were tracked over time using the codebook (Appendix) and, while various capacities were tracked, Figure 6 highlights the overall percentage of community change efforts that fellows made in the four main issue areas, based on the comprehensive analysis of data from 2006-2012. The percentages were computed by dividing the total of each issue area by the total change efforts highlighted in Table 1. Fellow teams often reported that they addressed wellness change efforts through policy (tribal resolutions to support wellness), community actions (wellness events, culturally-based programs), resource development (in-kind contributions, grants) and increased partnerships and coalitions.



**Figure 6. Overall percentage of community change by four main issue areas.**

As indicated in Table 1, a high percentage of fellow teams' community efforts were directed towards impacting chronic disease prevention and youth development. In addition, 49% of community changes focused on impacting the renewal of language and culture and 40% focused on community coalition changes. Significantly, 41% of actions more generally focused on organizational tribal governance improvement, a direct assessment of changes within policy environments.

A fellow shared an example of a tribal policy improvement:

We presented to the chapter on our involvement with the fellowship. We were able to share our vision and goals on what our community can be like in a healthy sense. The chapter officials were in support of our initiative and willing to show it through a resolution. They all seemed very inspired by our enthusiasm. (Blog entry, 2006)

**Table 1. Community Changes by Issue Area Years 2006 to 2012**

<b>Issue Areas</b>	<b>Policy Work</b>	<b>Community Actions</b>	<b>Resource Development</b>	<b>Increased Partnerships</b>	<b>Total Changes</b>	<b>Percentage<sup>a</sup></b>
<b>Youth Development</b>	8	36	19	11	74	76%
<b>Chronic Disease Prevention</b>						
Physical Activity	8	23	11	7	49	51%
Diabetes	6	10	12	3	31	32%
Healthy Foods	9	10	6	6	31	32%
Tobacco Use	7	4	5	1	17	18%
Healthy Weight/Obesity	2	2	5	2	11	11%
Cancer	1	3	3	3	10	10%
Nutrition	0	5	4	0	9	9%
Indigenous Food Systems	1	3	1	0	5	5%
Cardiovascular Disease/Stroke	0	3	0	0	3	3%
Renewal of Language and Culture	3	36	5	4	48	49%
Organizational/Tribal Governance Improvement	32	1	1	6	40	41%
Community Capacity/Coalitions	17	3	10	9	39	40%
Mental/Behavioral Health	4	2	3	2	11	11%
Substance Abuse	4	12	8	2	26	27%

<b>Issue Areas</b>	<b>Policy Work</b>	<b>Community Actions</b>	<b>Resource Development</b>	<b>Increased Partnerships</b>	<b>Total Changes</b>	<b>Percentage<sup>a</sup></b>
<b>Suicide Prevention</b>	2	8	4	2	<b>16</b>	<b>16%</b>
<b>Other</b>	8	4	10	13	<b>35</b>	<b>36%</b>
<b>Older Adults/Elders</b>	1	11	7	3	<b>22</b>	<b>23%</b>
<b>Environmental Health</b>	6	5	5	4	<b>20</b>	<b>21%</b>
<b>Injury and Violence Production</b>	4	5	5	3	<b>17</b>	<b>18%</b>
<b>Public Safety/Crime Prevention</b>	4	4	4	5	<b>17</b>	<b>18%</b>
<b>Maternal and Child Health</b>	1	7	3	3	<b>14</b>	<b>14%</b>
<b>Women's Wellness</b>	1	8	4	1	<b>14</b>	<b>14%</b>
<b>Access to Health Care</b>	4	3	1	1	<b>9</b>	<b>9%</b>
<b>Men's Wellness</b>	0	4	3	0	<b>7</b>	<b>7%</b>
<b>Adolescent Health</b>	0	2	1	0	<b>3</b>	<b>3%</b>
<b>Total Number of Teams</b>	<b>97</b>					

*Note.* <sup>a</sup> The percentage was calculated by dividing the total changes by the total number of teams. The total changes represent the total number of HNCF teams that impacted change in that category.

Another example of a significant policy change is reflected in this fellow's statement:

[We] helped tribal schools remove sodas from Bureau Indian Education schools and replaced with juices and water dispensers. Finalized policy so tribal employees could be excused from work for an hour for fitness [and] exercise, led to increase in use of fitness center, even tribal administration is involved and being more physically active. (Team interview, 2009)

Over the fellowship years, many fellows documented community actions such as seeking out resources to sustain their wellness efforts or to create new programs and/or infrastructure. In 2012, a fellow team shared:

[They] got a grant from someone who was identified from Circle of Influence activity [HNCF tool] at our coalition meeting. The grant is for a walking trail that is about 1 mile and connects the two reservations. (Team interview, 2012)

Fellows were often so inspired and motivated after the fellowship retreats that they actively incorporated the skills and learnings into their community wellness efforts, with one noting that their team:

Created Food Coalition after returning from Scottsdale [retreat one], had four community events, changed the food process for our summer camp to whole foods, no preservatives. (Team interview, 2010)

Another team of fellows stated:

[They] submitted a three-year Community Wellness Plan, complete with goals, funds used, and departments responsible to our legislative council last August. Also we've obtained funds for the Culture Center's culture camps for the next two years. (Retrospective survey, 2009)

Through the blogs, the evaluation results showed that the fellows focused more on their community actions as the years progressed. Also, due to the growing longevity of the fellowship and increasing interconnectedness between fellowship teams within and across communities, a new change indicator was added around bridging, bonding, and linking within and across communities. This indicator has the potential power to capture enhancements in cultural connectedness, social support, partnerships, and supportive policy environments that contribute to community wellness.

## **Discussion**

Overall, the evaluation of HNCF as an Indigenous leadership program has shown impressive results in the both "Reach" of the fellows and fellow teams within their communities and their "Effectiveness" at all levels (RE-AIM, 2016). Evaluation results over time showed a trend for both individual and team level changes of moving from internal self-development and group cohesion, to external effectiveness of becoming leaders and advocacy teams engaged in community actions and changes in policies, actions, and partnership participation. Fellowbook blogs became an even more important method for sharing self-described changes at the individual, team, and community levels, and there were more details shared because of the real-time feature of blogging. The longevity of this program has allowed us to offer several

lessons that we think may be useful for other leadership programs working to support communities from strengths-based and culturally-based perspectives, even as they deal with both historic and current social and health inequities.

### **Lesson One: Use Participatory Evaluation as Iterative Co-Learning**

Participatory evaluation as an application of community-based participatory research allowed for continuous re-thinking of curriculum and capacity to respond to needs of the fellows, fellow teams, and communities over time. In early years, the learning team would participate with HNCF staff in semi-annual curriculum reframing retreats. One initial challenge was an over-ambitious agenda of activities in each retreat. Process evaluation from fellows during the retreats and team interviews allowed for the staff to streamline each year to focus on tools that fellows found effective in practice for initiating community health changes. As the HNCF curriculum became more settled, fellow alumni and board members joined in these retreats on an annual basis, thus expanding stakeholder involvement in evaluation at the same time as recognizing the strength of the curriculum framework that revolved around the Medicine Wheel.

Participatory evaluation was rooted in a continual “listening, dialogue, action” model, which paralleled the Freirian popular education framework within the curriculum. This co-learning evaluation model, while it fostered quality improvement and a natural evolutionary process, also demanded tremendous flexibility from the HNCF staff to be responsive. Thus, recognition that HNCF wanted to have greater community impact led both to creating the Community Wellness Planning framework for greater Year 1 emphasis on community action and policy change, and to offering a Year 2 program for fellow teams to work on their own community indicators and change targets. The learning team also iteratively adopted multiple methods as needed (i.e., conducting the retrospective survey which enabled documentation of large-scale reach of HNCF into communities, and the case studies, which resulted with new tools for the fellows to assess changes in their own communities).

### **Lesson Two: Be Sensitive to the Reality of Community Challenges**

While many positive changes occurred, the fellows often expressed challenges with finding the time and enough support to practice HNCF skills in their own communities and with sustaining a commitment to their own personal changes. These challenges included their own overload at work, with fellows expressing that they sometimes felt that leaders in their community did not support them, and a general feeling of not being sufficiently confident after one year. HNCF staff recognized that many of the tools and practices learned throughout the fellowship involved shifting the paradigm of leadership from a traditional hierarchical stance to a horizontal stance of leadership from the grassroots. Related to this shift was the realization that the fellows needed and wanted ongoing support after finishing the fellowship. This understanding had two effects: strengthening coaching and the Action Learning Space during the intervals between retreats in Year 1, and creating a variety of technical assistance mechanisms, including invitations to participate in a Year 2 program (for the teams that could), or to begin to form regional networks of teams to support each other. The challenges of health and social issues within each

community are significant and the shift in the last 4 years to focus on supporting changes in organizational practices, community policies, and regional coalitions are examples of approaches to building a social movement as a long-term commitment.

### **Lesson Three: Importance of an Indigenous Cultural-Centered and Connected Model**

Over the years of HNCF, the Medicine Wheel framework and the commitment to Indigenous life experience, which includes spiritual traditions, history, and knowledge, has shaped a curriculum that honors fellows' distinct community origins and supports their growth as individuals, team members, and community change agents. This core has never changed, though specific curriculum and program activities have been added or dropped. The consistency created a foundation for how HNCF made decisions and supported the fellows, alumni, and board members as equal partners in each step of the program. While the specifics of the Medicine Wheel or life cycle varies by tribe, by reporting on HNCF, we hope that other Indigenous communities will be inspired to incorporate their own histories, knowledge, and traditions in their leadership programs.

In sum, while data and evaluation have historically been used against AI/AN communities with much documentation of research abuse (Burhansstipanov, Bemis, & Petereit, 2008; Cacari-Stone & Avila, 2012; Reverby, 2009; Walters, Beltran, Huh, & Evans-Campbell, 2011), the HNCF leadership program demonstrates a highly integrated participatory evaluation listening approach that is congruent with fellowship values and educational methodologies. Moreover, it works to strengthen the capacity of the program to make a difference across Indian Country. As HNCF staff and fellows have gained skills by sharing what works and what is not working in their communities, this builds their own capacities to not only implement an effective program, but also to track and realign their own practice with their goals; thus, supporting tribal and AI/AN ownership and sovereignty.



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## Appendix

### HNCF Curriculum Framework and Community Change Coding Sheet

#### Healthy Native Communities Fellowship CURRICULUM FRAMEWORK

<b>Week 1: Core Skills</b>	<p><u>Forming a Community Wellness Group</u></p> <ul style="list-style-type: none"> <li>• Community and Cultural Capacity</li> <li>• Starting A Community Wellness Group</li> <li>• HNCF Coalition Guide: How Well Does Our Community Wellness Group Work?</li> <li>• Community Wellness (Coalition) Assessment</li> </ul> <p><u>Collaborative Leadership Skills</u></p> <ul style="list-style-type: none"> <li>• Traditional Gift of True Colors</li> <li>• Basics of Facilitation</li> <li>• Creating Our Own Medicine Wheel</li> <li>• Facilitative Leadership</li> <li>• "35" - A tool for narrowing</li> </ul>	<p><u>Listening to Community Voices</u></p> <ul style="list-style-type: none"> <li>• Deep Listening</li> <li>• Community River of Life</li> <li>• Community Core Values</li> <li>• Community Rez Cafe</li> <li>• Community Snapshot</li> <li>• 6 Pre-Requisites for Community Change</li> <li>• Talking Journey: Circle Conversation</li> <li>• Community Listening Tool</li> </ul>
<b>Week 2: Core Skills</b>	<p><u>CWP Process and Tools</u></p> <ul style="list-style-type: none"> <li>• Vision Workshop Method</li> <li>• 4-Directions of Wellness</li> <li>• Choosing the Focus                             <ul style="list-style-type: none"> <li>- Naming the Change: Result Statement</li> <li>- Setting Priorities: Setting a Focus</li> </ul> </li> <li>• Choosing what to Track                             <ul style="list-style-type: none"> <li>- Experience Statements</li> </ul> </li> </ul> <p><u>Creating a Community Wellness Plan</u></p> <ul style="list-style-type: none"> <li>• Partners with a Role to Play                             <ul style="list-style-type: none"> <li>- Circle of Influence</li> </ul> </li> </ul>	<ul style="list-style-type: none"> <li>• Story behind the Baseline                             <ul style="list-style-type: none"> <li>- "5 Why's?"</li> </ul> </li> <li>• What works Strategies Workshop</li> <li>• Implementing CWP                             <ul style="list-style-type: none"> <li>- Action Planning Workshop</li> </ul> </li> <li>• Using Web Based Tools to Keep Track</li> </ul> <p><u>Collaborative Leadership</u></p> <ul style="list-style-type: none"> <li>• Nature of Human Beings</li> <li>• Dealing with Difficult Group Dynamics / Conflict Resolution</li> <li>• Community Action                             <ul style="list-style-type: none"> <li>- Open Space</li> </ul> </li> </ul>
<b>Week 3: Core Skills</b>	<p><u>Keeping Track with CWP</u></p> <ul style="list-style-type: none"> <li>• Keeping Track                             <ul style="list-style-type: none"> <li>- Whole Community Change (population)</li> </ul> </li> </ul> <p><u>Collaborative Leadership</u></p> <ul style="list-style-type: none"> <li>• Medicine Wheel Assessment - Fellowship Journey</li> <li>• Key Messages for Media &amp; Advocacy</li> <li>• Appreciative Inquiry</li> <li>• Build Collaborative Leadership</li> <li>• Understanding Leadership Styles</li> </ul>	<p><u>Policy Orientation</u></p> <ul style="list-style-type: none"> <li>• Policy Awareness: Developing Fact-sheets</li> <li>• Federal Policies and Native Nations</li> <li>• Overview: How to influence policy</li> </ul>



**Table A1. Definitions of Coding**

	<b>LOW:</b> <b>Thinking/Talking</b> <b>without initiating action</b> <b>(especially collective</b> <b>action)</b>	<b>MEDIUM: Initiation of</b> <b>Footprint/Actions</b> <b>without completion of</b> <b>product</b>	<b>HIGH: Action with</b> <b>Product/Output</b>
<b>Community Actions/Footprints</b>			
Having a Vision Statement, Mission Statements, Goals	Talking	Initiation of Process/Actions in process	Completed documents with input
Writing a Plan (Planning Efforts)	Talking	Initiation of Process/Actions in process	Completed documents with input
Having an Evaluation Plan	Talking	Initiation of Process/Actions in process	Completed documents with input
Community Surveys	Talking	Developing Survey, pilot-testing	Implementing survey and analyzing
Community Outreach	Talking	Initiation of Process/Actions in process	Completed documents with input
Use of fellowship skills (deep listening, facilitation, action planning, conflict resolution, etc.)	Talking about using skills	Using skills and sharing them with others to accomplish goal	Teaching skills and disseminating to others
<b>Healthy Policies and Practices</b>			
New policies proposed and adopted (organizational, public, governmental)	Talking and Identifying need	Action steps to adopt: meetings, consensus, research, starting to use media	Testimonies, Factsheets, Media campaign, written resolutions presented, policy adopted
New organizational practices proposed and adopted	Talking and Identifying need	Action steps to adopt: meetings, consensus, research, starting to use media	Testimonies. Factsheets, Media campaign, written resolutions presented, policy adopted
<b>Strengthened Community Capacity</b>			
Community Leadership	Talking		Evidence that new leaders have emerged
Responsive political leadership	Talking		Evidence that political leadership has embraced healthy community issues

	<b>LOW: Thinking/Talking without initiating action (especially collective action)</b>	<b>MEDIUM: Initiation of Footprint/Actions without completion of product</b>	<b>HIGH: Action with Product/Output</b>
Community participation	Extending invitations to groups considered before as hidden voices	Increased participation from sectors	Active involvement of new sectors/co-creation of events
Increased partnerships	Extending invitations to groups	Increased participation from sectors	Active involvement of new sectors
Wellness & Community Events	1 event	2-3 events	4 or more is high
<b>Strengthened Community Capacity</b>			
New & More Resources	Talking about and researching grants and other resources	Writing 1-2 grants or leveraging resources from 1-2 sources	Writing 3 or more grants or leveraging 1 or more sources of funds, in-kind donations or grants
Communication and Dialogue	Talking about the need to communicate and talk more	Engaging in new dialogue	Establish communication structures with broader community
New & Improved Programs	Talking about need and planning for new programs	Improved components of existing programs	1 or more new programs
Community Power	People talking about need for more collective power	People starting to act as a group in change process; including community strengths as part of vision and actions	Evidence that team/home team is acting in more powerful way; using sovereignty as tool to make change
Language and Culture including events, community identity, history & values (community river of life)	Talking about importance of language and culture, etc.	1-2 community cultural events and actions, i.e., use of collective river of life	3 or more community cultural events and actions; and/or establishing a structure(s) to institutionalize cultural transmission
Sustainability	Discussions of importance of developing plans for sustainability	Starting actions about institutionalizing within structures or need for new resources	Finding mechanism for institutionalizing programs or efforts

Note. Decision-rule: If something specific, then code higher. If less specific, code lower.