Gun Violence on Indian Reservations:
An Advocacy Campaign to Collect Data and Raise Community Awareness

Edith G. C. Wolff, JD, MPH, Kellogg Foundation Fellow, Center for American Indian and Alaska Native Health, Johns Hopkins School of Hygiene and Public Health, Baltimore, Maryland

Executive Summary

The problem that will be addressed in this paper is gun violence on Indian reservations. The rates of fatal gun injuries on reservations are alarmingly high, but the rates of non-fatal gun injuries (which one would expect, based on national trends, to be higher than rates of fatal injuries) are unknown simply because such information is not routinely collected. In reservation communities, which tend to be small and rural, the major stakeholders in this discussion are: gun owners and gun users; children and parents; young males, in particular; and tribal government officials. The author proposes a campaign that advocates: 1) the establishment of a surveillance system to collect accurate data on both fatal and non-fatal gun injuries on reservations; and 2) the use of those data to raise community awareness about the problem of gun violence. It is anticipated that these two steps would lead to the organization and mobilization of tribal government and citizen groups to begin to discuss both legal and programmatic methods of addressing the public health problem of reservation gun violence.

Statement of the Problem

The total numbers of reservation gun injury deaths do not at first seem large, but categorical examination and comparison to national mortality rates reveal their significance and indicate both the existence of a serious problem and the need for solutions. Though data on gun injury morbidity are incomplete, the gun mortality data may serve as an indicator and allow us to make estimates about non-fatal gun injuries. Incomplete though the data may be, the information we have

is enough to tell us that we need to explore the facts more fully and address the problem of gun violence on reservations.

Addressing the problem of reservation gun violence is a complicated task in many respects. The social, economic, political, and legal facets of reservation life intertwine to form a complex weave. It is unwise to approach the problem of violence, in any of its forms, without a thorough understanding of this weave and all its threads. Also, it is essential to act in full partnership with the community involved and not to approach communities with preconceived ideas or plans. The first step is to examine the existing facts and the community resources that might be brought to bear to alter those facts in the future.

In the case of gun violence on reservations, however, all the facts are not available. The first part of this advocacy campaign, then, would be to determine the total number of gun injuries in Indian Country, fatal and non-fatal. Given national

trends, it is likely that the number of non-fatal gun injuries far outstrips the number of those that are fatal. In a nationwide survey, non-fatal gun injuries were found to occur at 2.6 times the rate of fatal injuries. For people age 15 to 24 (the highest risk group among Native Americans, also) and African Americans, the ratios of non-fatal to fatal were 4.1:1 and 4.3:1, respectively.[1] Although these figures could not be directly applied to reservations, they give an indication of the magnitude of the problem of non-fatal gun injuries. They indicate, too, the need to implement a surveillance system to gather accurate data on non-fatal gun injuries on reservations to complete our understanding of the toll of gun violence. This would require the cooperation of health care facilities both on-reservation and in contiguous counties where reservation residents living near tribal boundaries might go for care. Those health facilities would need to agree to keep and submit data for all gun injuries, fatal and non-fatal.

The second part of the advocacy campaign would entail using the collected data to raise awareness at the tribal government level and in the reservation community. This would require working with the tribal council and organizing community-wide meetings and/or specific focus groups involving affected or interested parties. The third step (outside the scope of the advocacy campaign) would involve using the tribal government and community meetings to assess options for addressing the problem and working with community members to design an intervention cooperatively. This advocacy campaign does not go so far as to suggest which prevention tools any given tribe might choose, since that choice must come from the community itself after deliberation and group process. Rather, this campaign proposes to fuel the process whereby a community could, informed by the necessary data, be empowered to make its own choice.

Epidemiologic Context

From 1991 to 1993, there were 591 firearm related deaths (out of 5,210 deaths from all types of injuries) among American Indians and Alaska Natives living in the Indian Health Service Areas.[2] While those deaths that were deemed intentional (suicides, homicides, and some of undetermined intent) had lower rates than for the demographic category U.S. All Races, those that were unintentional occurred at a rate almost 3.5 times higher than for the U.S. population as a whole.[2] More recent unconfirmed (and disputed) figures indicate that between 1992 and 1996, homicides on reservation "increased by a shocking 87 percent."[3] Regardless of the accuracy of that figure, the figures taken as a whole indicate that gun violence is taking a heavy toll in Indian Country.

To understand what is happening in Indian communities with regard to gun related deaths, it is necessary to break down the figures as much as possible. This was recently done by the Indian Health Service in the Richard Smith article, cited above. Of the gun related deaths during the studied period, 12.4% were unintentional, 52.5% were suicides, and 33.3% were homicides (with 1.9% undetermined as to intention). In most cases (64.6%), the type of gun used was not known, so the authors could not generalize about this parameter; but of those that were known, 15.1% were handguns and 20.3% were shotguns or rifles.

Though the overall number of 591 deaths may seem small, one must keep in mind the relatively small size of the American Indian and Alaska Native population as a whole, and, more importantly, the effect of underreporting of deaths and misre-porting of race on death certificates. The fact that "Firearm-related deaths accounted for 11.3% (591/5210) of all injury deaths, making this the **second leading cause of injury death** after motor vehicles"[2] (emphasis added), though, demands attention. The figures in the report by Smith have also been aggregated by sex, and show much higher rates for males than females both overall and within each category of intention and cause of death. Overall, the report showed that males "accounted for 86.8% (513/591) of all firearm-related deaths."[2] It is noteworthy that, of the intentional deaths, a large number were gun-related: in 53.1% (310/584) of suicides and 36.8% (197/535) of homicides, the means used was a gun.[2]

The figures are consistent with statistics released by the Centers for Disease Control and Prevention (CDC) in 1996 which showed that, between 1979 and 1992, firearms were the predominant method used in suicides for both male and female Native Americans, and were a significant method used in homicides (the majority for male victims, but not for female victims).[4] The study did not address unintentional injuries and deaths. The report emphasized that, overall, violence is a significant health threat in Native American communities: from 1990-1992, homicide and suicide combined ranked as the fourth leading cause of death for Native Americans, exceeded only by heart disease, cancer, and unintentional injuries.[4]

The CDC study showed that the group most at risk for homicide were young males, age 15 to 24 years. Although over the study period, the homicide rate actually declined, it was still higher than the overall U.S. rate and the second leading cause of death for males in this age group.

It should be noted, however, that although firearms are a significant factor in homicide patterns on reservation, they are used less than in the population as a whole. In the U.S. population, 63% of homicides involved the use of firearms, as compared to 38% for Native Americans in IHS Areas (this figure varied by IHS Area).[4]

Suicide was an increasing problem during the study period, 1979 to 1992, with 2,394 victims and a 19% increase over the duration of the period. Suicide was the eighth leading cause of death for Native Americans from 1990 to 1992 (although it ranked higher for younger age groups). Firearms were the main means of suicide for both males (59%) and females (41%).[4]

It might be possible to form hypotheses about the situation on specific reservations if data were collected by reservation.

Sociocultural Context

It is difficult, if not impossible, to define the sociocultural context on Indian reservations as a whole. This is because each tribe has a unique history and culture. It may be valid, though, to try to understand some general trends, demographics, and shared experiences among tribes. It might then be possible to take some general gun policy ideas and adapt them, as appropriate, to different community settings.

Indian communities vary widely in location, size, and socioeconomic status. In 1980, there were Native Americans living in every state, but 44% lived in four states: Arizona, California, New Mexico, and Oklahoma.[5] Of the total Indian population, only 23.9% lived on reservation, a fact which would have a significant impact on any gun injury initiative aimed at reducing gun deaths and injuries through the use of Indian legal authority (such as legislation by a tribal council and enforcement by tribal police). Although some tribes and reservations are quite large, the average reservation population is 1,924, and half of all reservations have fewer than 602 inhabitants. Half of Alaska Native villages have populations of less than 214. The size of native communities must be taken into account both in understanding the statistics and in devising a plan to address the problem. Obviously, it is crucial to know the community well.

In addition to these facts, it is important to understand that the demographics of Indian populations are different from those of the population as a whole. Some information about the overall demographic context on reservations can be gleaned from the Indian Health Service publication, *Trends in Indian Health*.[6] This is a compilation of statistics gathered by the Indian Health Service, an Agency of the U.S. Public Health Service, on an ongoing basis. It contains quantitative information about the makeup of the American Indian and Alaska Native populations and their health status indicators (birth and death rates, health status, and services provided).

The IHS service population consisted, in 1997, of 1.43 million people. The Indian population, overall, is younger than the U.S. All Races population, with a median age of 24.2 years as opposed to 32.9 for U.S. All Races. Indians have lower incomes, overall, than the general population, with a median household income of $19,897 as compared to $30,056 for U.S. All Races; 31.6% of Indians live below the poverty level, compared with 13.1% of U.S. All Races.[6] There are differences, also, between on- and off-reservation Indians. Those living on reservation tend to have higher percentages of people under 20 and over 60, as compared with Indians living in contiguous counties.[5] This is significant in light of the fact that gun violence is more of a threat to younger Indians, especially young males.

The political, cultural, and economic environments vary considerably, but there are some common trends. Politically, most tribal governments are based on a democratic model, with tribal councils, court systems, chairpersons, and, often, a tribal police force. It is important to understand, in any given tribe, the structure of the government if one is to design a public health intervention with a legal arm requiring enforcement (for example, a gun control law). It is also necessary, though, to understand the tribe's particular history and the political undercurrents that could affect community efforts.

Culturally, all tribes are unique, and the tribe's culture and history will have a great impact on how the proposed coalition-building stage of the problem-solving approach will proceed. It will be crucial to know, for example, if the tribe one is working with is matriarchal or patriarchal, what the clan structure is, what the importance of family is and what the religious values are. Family, clan, and religion are often the most dominant cultural determinants in tribes that are more traditional. Even in more acculturated tribes, these factors can have a powerful influence.

Although, economically, Indians, as mentioned above, are worse off than the population as a whole, this is not true for every tribe. There are tribes that are wealthier due to ownership of a successful commercial operation (such as a gaming operation) or other resources (such as land, water, or any number of valuable minerals). These tribes would have more to spend on health care and interventions and might also have a very different political structure than poorer tribes. For example, they could have better health care facilities, more to spend on data collection, and more attorneys or lobbyists to help design and implement legal interventions. They could have more to spend on educational initiatives or longer term projects.

Advocacy Coalition Building

Indian communities have changed dramatically over the centuries as a result of, among other things, evolving Federal Indian policies and changing demographics. The changes during this century alone have been remarkable. Although there may be exceptions, many tribes retain their basic traditional social structures and values.

The stakeholders would be all those who are affected, in any way, by gun use, violent or non-violent. Gun ownership is widespread on many reservations, especially rural ones, so one group of stakeholders would simply be gun owners and users (for example, hunters and ranchers). Many of these would undoubtedly defend their gun ownership on the usual grounds of necessity, tradition, and rights, and resist any proposed restrictions. There might also be political opposition to what could be seen as a movement by whites to disempower Indians once again. Tribes whose reservations are more urban, however, might have a different perspective, especially if they are plagued by urban gun violence. Parents and families in all Indian communities might be a gun control effort's best allies, since youths are so disproportionately represented among the victims of gun violence. Another group of stakeholders would be tribal government officials, who would have to address the difficult policy issues, and tribal police, who would be called upon to enforce any legal resolution. Health professionals, a

potentially strong group of allies, would have an interest in seeing a reduction in gun injuries and deaths.

In seeking allies among the stakeholders and in the community in general, the public health practitioners and community activists would be well advised to start with the tribal elders and the tribal council. These tribal leaders can have a great influence on the community's readiness to acknowledge a problem and on its acceptance of an intervention. This level of influence is based in history and the leadership role of tribal elders, who often functioned as a council, in making important decisions in the community. Obviously, tribal council members can effect or influence the passage of legislation.

The resources to be used in such an effort will vary from tribe to tribe. Some wealthier tribes might have more monetary and physical resources[7], but tribes that are not as wealthy might have resources that are less tangible, such as community cohesion. Among the resources to be identified or sought are: tribal elders; tribal council members; tribal media; health professionals; youth and family groups or organizations; community boards; schools; tribal social services; tribal law enforcement; domestic violence groups; experts to gather, compile, and interpret data on fatal and non-fatal injuries (for example, to test a biostatistical hypothesis); and individuals or families personally affected by gun violence. In addition, material resources such as money and meeting places and, again, media conduits will need to be identified.

It will be important to decide which allies are most important and which adversaries the most formidable. It is likely, in this case, that among the most important allies will be the tribal council, tribal elders, health professionals, and parents and families. The most difficult and powerful adversaries will most likely be young men whose arguments will be based on necessity and rights. This is the group, of course, that has the highest rate of gun injury deaths. A cohesive coalition of allies will have to decide how to address the arguments of this latter group.

Objectives

The objectives of the advocacy campaign will be:
1) to create a complete database about all gun injuries (fatal and non-fatal); and, with that data,
2) to raise awareness in the reservation community about the impact and cost of gun violence.

The targets of change will be the rates of both fatal and non-fatal gun injuries. The agents of change will be the community itself, its citizens, government (possibly via a legislative or policy approach), police, and the health care facilities used by that community, both on and off reservation. More specifically, the health care facilities will begin the process of awareness raising by collecting complete data and making it available to the community. These data will be used in the community meetings, focus groups, and meetings with tribal leaders.

Community groups, health professionals, and tribal leaders may have different approaches to addressing the problem of gun violence. In the face of this public health threat, the tribal council, in league with health professionals, might consider exploring the option of gun control. However, though gun control seems a logical approach to gun violence on reservations, it also raises many difficult legal and political questions. Many of these questions are faced by any community considering this option, but some are peculiar to reservations because of their unique legal status as semi-sovereign nations that deal with the United States on a different basis than states. Although a tribal government would have the jurisdiction to pass gun control legislation to apply to its own territory and citizens, it is difficult to gauge what kind of reception such a law would receive on different reservations. The community, however, may want to link a legal campaign to a social one, such as a safety campaign to raise awareness and effect change in the community as a whole.

Recommendations for Action

Define the Issue or Concern:* Initially, the public health practitioner will need to work with the tribe (most likely the tribal council and/or elders) to define the issue. This may well be the most difficult step of the process, in that there may be disagreement over what the issue really is, and there may be great hurdles to clear in terms of willingness to promote gun violence awareness. However this part of the process is essential in that it is here that the groups involved must agree on what problem to address: all of gun violence or, for example, gun violence as it affects youth. It may be effective here to use the national NEISS data study, cited above, to show the ratio of non-fatal to fatal injuries. This could help reveal the true magnitude of the problem (assuming the same patterns hold true on their reservation) and convince tribal elders that such data need to be collected.

Collect Background Data: Once the issue or concern is identified, the health professionals can begin to collect data at the various health facilities. The surveillance system would be established in such a way as to document both fatal and non-fatal gun injuries. To give a complete picture of what is happening with guns on the reservation, the data collected should include information that has previously been recommended for a Firearm Fatality Reporting System: type of death (homicide, suicide; unintended, undetermined); information about the victim (age, race, sex, and drug/alcohol involvement); information about the shooter (the same as about the victim, plus relationship to victim); information about the circumstances of the shooting (date, time, location, community, whether it occurred during the commission of a crime); and involvement of emergency medical services.[8] Additional infor-

---

mation could include the result of the shooting (death or specified injury), the type of gun, and, although this would be more difficult to define and calculate, the cost of the response and care given. An information sheet could be designed for use at health facilities and filled out for each case.

Surveillance: Surveillance would take place at all health facilities where gunshot injuries were treated. Those places would be tribal and IHS clinics and, also, clinics and hospitals in contiguous counties. It would be important to design a data form, such as the one suggested above, to ensure the uniform collection of information about gun injuries and the related circumstances. Also it would be important to make sure that the form was user-friendly to assure compliance.

Coalition Building: Although this step is fourth in the model, one could argue that, in fact, it commences at the beginning of the process and continues throughout. In other words, it is necessary to begin coalition building when defining the issue or concern. Some coalition support is necessary to acquire accurate background data, and the coalition must be even stronger to organize and begin the surveillance process. As the model's steps progress, the coalition should be building and becoming stronger within the community in order to conceive of a workable, acceptable plan and, then, to implement it successfully. It might, then, be more accurate to show this step not as fourth, but as an ongoing part of the continuum.

After the surveillance step is well underway, public health practitioners would begin to work with the existing coalition on building community support and extending the coalition network so that a sustainable plan could be devised at the community level. This would involve working with community groups at centers or schools, and at the tribal council level, sharing the data, and starting the process of creating a "shared vision."[9] This may be more or less difficult, depending on the cohesiveness of the community. Because so many reservations are so small, it would be possible for the public health practitioner to work with many segments of the community and gain an understanding of what groups work well together. On the other hand, small Indian communities present their own problems in terms of coalition building. One particular problem is the clan and family structure that can engender friction and complicate the process of coalition building.

Strategic Plan: It would be important to make the plan community-based, as opposed to community-targeted. There are many reasons for this, but foremost is that, in Indian Country, a community targeted project set up by someone who is not a community member has bleak prospects for sustainability. Therefore, even though there is the potential for the project going in a direction not necessarily envisioned by the public health practitioner, it is essential that the ideas for change come from within the community. The public health practitioner can offer guidance, experience, and ideas, but the community must develop the intervention in its own way. This is best achieved through the action of community institutions

and groups that are already in place. These would most likely be the tribal council; tribal elders; tribal police; community boards; school groups, such as the PTA; other groups addressing the needs of children, such as 4-H; the community newspaper or radio (native language and English); and local health professionals, such as community health representatives (CHRs).

The tribal council should be consulted early on for its support. The tribal council plays a very large role in tribal affairs and community change. If the council is not convinced of the need for change, or even discussion of the matter, it will most likely not happen. This institution, although based on a democratic model, has its roots in Indian tradition:

> Indian tribes . . . were once primarily judicial in the sense that the council, whether it was that of a village, a league of tribes, or a simple hunting band, looked to custom and precedent in resolving novel and difficult social questions that arose . . .. The task of the council, when it had a difficult question to resolve, was to appeal to that larger sense of reality shared by the people of the community and to reach a decision that people would see as consonant with the tradition.[10]

This may still be said to be true, although the workings of tribal councils can be complex. Nevertheless, it would be advisable, early on in any project involving guns and gun control, to know and work with the tribal council.

In addition, if there is a tribal newspaper or radio program, it should also be used to raise public awareness about gun violence. The use of native language radio would be effective in reaching the older generation, but it would also be important to get messages out in English since that is now the first language of many younger Indians. The tribal media could focus on gun violence in general, highlight stories about individual deaths or injuries, follow the council's discussions on the issue, and, if one were designed, promote a safety campaign. It could disseminate information about the data once they were collected, in a way that citizens would understand. It could announce times, locations, and agendas for community meetings or focus groups to discuss intervention strategies.

The strategic plan, then, would consist of the following steps:

- build an initial coalition of health professionals interested in this health problem and work with them to collect background data and establish a surveillance system to collect complete data on gun injuries, both fatal and non-fatal;
- undertake surveillance using both tribal health facilities and health facilities in contiguous counties;
- continuing the process of coalition building, introduce tribal council and tribal elders to data and discuss the impact of gun violence in the community;
- facilitate the organization of community groups and

focus groups to discuss the data and interventions, working toward a shared understanding.

Eventually, after a strong and diverse coalition has been built and awareness has been raised sufficiently, the community can then proceed, possibly with the help of the same public health practitioner, to consider interventions and the feasibility of various approaches. Then, it would go on to organize implementation of the chosen approach or approaches, and evaluate their impact on the problem. This process can be ongoing and cyclical, but needs to be community-based to be sustainable.

Implementation: Feasibility of this ongoing plan depends on the thoroughness of the approach of the public health practitioner and the willingness of the community to recognize gun violence as a threat to its health. Much will depend on both the timing of the effort and, importantly, on the nature of the relationship of the public health practitioner to the community. Of course, there will be opposition to efforts to control gun use. However, it could be that in such small communities grassroots efforts will meet with more success if they come from representative community groups and are not imposed by an outside organization.

It will be necessary to allow sufficient time for the project to take hold. Data gathering will take time, especially considering the relatively small numbers of gun incidents overall. Once the data are gathered, it will take additional time to raise public awareness. There is a tradition, in many tribes, of true democracy at public meetings: everyone speaks his or her mind before any decision is taken. The democratic process in tribal councils and public meetings is time consuming. Therefore, the public health practitioner pursuing this sort of change must be prepared to spend months, even years, seeing it through to realization.

The task of making gun use and ownership safer becomes more difficult and complex when the setting is an Indian reservation. Aside from cultural differences, this difficulty also stems from the unique legal status of reservations, which affects their relationship with the Federal government and with the states within which they lie. The jurisdictional questions, which are not examined here, are complex and would need to be explored by tribal counsel if gun control were all or part of that tribe's solution to the problem of gun violence.

Evaluation: This advocacy campaign involves only data collection improvement and public awareness raising, so the evaluation stage of the process would involve only those two steps. It is hoped that the campaign would spur another campaign or project to use those data and that new awareness to design actual interventions.[11] Depending on the hypothesis being tested, one could even go so far as to calculate Disability Adjusted Life Years (DALY) or some other measure indicating the greater extent of the loss to the community. For purposes of this campaign, however, we need evaluate only the first two steps.

Evaluation of the effectiveness of the campaign would involve identifying and calculating process, outcome, and impact measures. The time frame might vary from one community to another, depending on their sizes, but could take at least three years, since most Indian data are collected and analyzed in three year periods, due to small numbers. One would begin by measuring the effectiveness of the data collection system (how accurately and completely were the data forms filled out?). As to the next step of the campaign, it will be more complicated to measure community awareness. This may need to be done by looking at other indicators such as community participation in various meetings; media coverage; resources generated; and members' satisfaction ratings.[9] It might be worthwhile to organize a community survey with basic questions about the data and the impact of gun violence on the community to see if the data have been understood. If the responses indicated an understanding of the need for community action, that might be a measure of the success of the campaign.

Conclusion

This advocacy campaign must be understood to be the first part of a larger campaign for change. These first steps, however, must be taken carefully or the later steps of actual social or legal change cannot be undertaken successfully. First, to understand what the actual impact of gun violence is in the community, health professionals must collect accurate data. Next, those data must be shared with the community in an organized and sensitive manner so as to further effective coalition-building. Once those steps have been taken, the community, in the various fora, can discuss options for addressing the problem. It would be inappropriate to choose those options at this point without having the data. In addition, in order to be effective, the ideas for change must come from the community itself. In terms of implementation, it may be important for public health practitioners to start on a small scale on a reservation that might be more receptive to the idea of gun violence as a health problem. Then, if the program were a success there, its results could be disseminated and generalized* to other reservations that might then be more open to hearing about programs that have worked elsewhere.

This way of approaching the problem may be more time consuming and may go in directions the public health practitioner would not choose. However, if the problem-solving approach were community-targeted and a solution were imposed on the community, the changes would most likely not be sustainable. Therefore, it is best to take the slower road and, as a public health practitioner, act as a team member in working with an Indian community to devise solutions to this pervasive problem. □

*Dissemination and Generalization are two additional steps Richard Smith is considering including in his problem-solving model.

References

1. Annest J, Mercy J, Gibson D. National estimates of nonfatal firearm-related injuries. *JAMA*. 1995;273:1749-1754
2. Smith R, Handler A. The role of firearms in American Indian deaths. *IHS Primary Care Provider*. 1997;22:109-111
3. Indian Reservations Witness Violent Crime Crisis. Join Together Online [Internet Source]. Nov. 25, 1997
4. Wallace L, David J, et al. Homicide and Suicide Among Native Americans 1979-1992. Atlanta, Georgia: National Center for Injury Prevention and Control; 1996.Violence Surveillance Series, No. 2
5. Rhoades E. American Indian and Alaska Native Health, (unpublished), Center for American Indian and Alaska Native Health, Johns Hopkins University, 1997
6. *Trends in Indian Health* 1996. Rockville, MD: Indian Health Service, US Department of Health and Human Services; 1997
7. Egan T. Backlash growing as Indians make a stand for sovereignty. *The New York Times*, March 9, 1998
8. Teret, S, Wintemute G, Beilenson P. The firearm fatality reporting system: a proposal. *JAMA* 1992;267:3073-3074
9. Altman D, Balcazar F, Fawcett S, Seekins, T, Young, J. Public health advocacy: creating community change to improve health. Stanford Center for Research in Disease Prevention in Cooperation with The Kaiser Family Foundation. 1994:2
10. Deloria V, Lytle C. *Americans, American Justice*. Austin, TX: University of Texas Press; 1983
11. Teret S, Wintemute G. Policies to prevent firearm injuries. *Health Affairs*. 1993;Winter: 96-108

Capacity-Building:
Public Health Concepts and Planning for American Indian and Alaska Native Communities

Maha Asham, MD, MPH, Director, Community Health Training; Everett R. Rhoades, MD; and George Brenneman, MD, all from the Johns Hopkins Tribal Education Program, Center for American Indian and Alaska Native Health, Department of International Health, School of Hygiene and Public Health, Johns Hopkins University, Baltimore, Maryland

Two major factors continue to stimulate the need for local health planning activities among Indian tribes. First, the Indian Health Care Improvement Act of 1976 provided the opportunity for each tribe to develop its own health plan as a way of estimating the unmet health needs of that tribe. Many tribes, having no health planner, hired consultants to develop their respective plans, sometimes with minimal participation of tribal health care workers. Even now with the availability of health directors and planners working for many tribes and Indian Health Service (IHS) service units, most would benefit by moving the planning process into a more participatory mode utilizing local health care workers. The second major impetus is the dramatic increase in the complexity of providing health care and establishing priorities for resource allocation. These two factors, and perhaps others, dictate intensified local training and involvement of health care workers in health planning.

Conceptual Framework

The Johns Hopkins University School of Hygiene and Public Health has created the John Hopkins Tribal Education Program (JHTEP). This program was designed to increase the capacities of tribes to pool their inherent strengths in gathering and analyzing technical health data and in formulation of local policies and activities leading to specific health interventions.

The JHTEP is based upon several important concepts. A basic premise is that tribes are often more capable of sound health planning than they realize, and can do most such planning quite adequately themselves. This, in turn, should increase the effectiveness of consultants when they are required. Demonstration to the tribe that the principles of epidemiology and statistical analysis are well within their reach "demystifies" these tools and their application to the process of health planning. Another premise is that the greatest teaching effectiveness could be achieved by utilizing a team of instructors, working with a cross section of local disciplines (not all of whom need be the customary mix of health care workers, who often function independently of one another). Thus, separate and diverse disciplines learn to pool expertise, share experiences, and build a much broader and stronger basis for tribal program design and planning.

It was decided that capacity and team building could take place in a setting in which the local group actually carried out

its ongoing planning. Equally important was the idea that the group would find it much more pertinent and worthwhile to learn these concepts using morbidity and mortality data from its own community. One expected outcome was that the university team would take away nothing but their experiences, and that all data, information, and other products, and especially the process, would remain in the community. (See Table 1.)

Development, testing, and evaluating the application of these concepts were made possible with funds generously provided by the Educational Foundation of America, and the Center for American Indian and Alaskan Native Health ("the Center").

Table 1. Program Goals

1. To strengthen the capacity of tribal and IHS health workers in local health planning through community-based training in community health practice, planning, and disease prevention.

2. To introduce participants to planning principles that will enable effective, efficient, and economical local planning.

3. To encourage integration of strategies for prevention and self-evaluation into local health care delivery systems.

4. To assist tribal leaders and local health workers in coordination and application of available resources to address health priorities determined by the tribes themselves.

Program Content

The centerpiece of the education initiative, *"Capacity-Building: Public Health Concepts and Planning for American Indian and Alaska Native Communities,"* is a one-week long course taught by three of the Center's community health experts, working as a team. During this week the instructors provide daily instruction and facilitate interaction and discussion. This provides an excellent opportunity to use the advantages of team teaching as well as one-on-one instruction.

In addition to formal presentations, there are class exercises during which participants collect and analyze local morbidity and mortality data, examine the sources of, and inherent weaknesses in, various data, organize these data in such a way that priorities can be set, and present the results of team deliberations. Continued daily analysis of local, regional, and national health data by the three faculty members permits intense personal instruction over the course of several days. Planning principles that enable more effective, efficient, and economical local planning are reviewed and discussed.

The following subject matter forms the core of the training:

- The unique Federal-Indian relationship and its impact on past and future American Indian and Alaska Native (AI/AN) health care and services.
- The special aspects of general AI/AN and specific tribal health conditions and indicators.
- Basic epidemiological principles and statistical tools.
- Assessment of local community health needs and priorities through analysis of existing local health status and health care utilization data.
- Determination of local health needs and priority health problems through application of basic epidemiology and statistics.
- Concepts of planning, monitoring, and evaluation of a health program.
- Drafting a local health plan, based on identified priorities, that can be used in tribal comprehensive planning.

An essential component of the training is the establishment of an ongoing relationship through postworkshop consultation with the Center. This includes assisting the local group in producing a written report to each community with a comprehensive synopsis of the action plan and further recommendations for resources or strategies for implementation. It was found that this relationship assists tribes to optimize existing resources and health services to carry out the health plan; aids in identifying additional outside resources; helps tribes track progress in carrying out the health plan; and provides "troubleshooting" for the inevitable problems and barriers to progress.

Participants

Participants are selected by the local community, in consultation with the faculty. A wide range of disciplines (e.g., health planners, administrators, program directors, nurses, health board members, community health representatives, and other tribal and IHS personnel with an interest in health planning) are represented. Communities are encouraged to include personnel not ordinarily considered to be part of the health care team, such as safety and law enforcement, who often have important insights into community health practices. The size of the group is deliberately kept within a workable number, generally up to 25 participants. This permits small "break out" sessions, which provide a better environment for discussion and closer instructor-participant interactions.

In each instance care is taken to secure the approval of local political bodies (Tribal Health Boards and Tribal Councils) prior to planning and conducting a course. Once approval is obtained, a preliminary session is held with prospective participants to discuss the content of the course and to begin collection of local health data from appropriate Federal, state, and regional health entities. In many instances the assistance of the IHS Area epidemiologist proves to be invaluable in providing information, discussion, and instruction.

Course Evaluation

Course evaluation and pre- and posttest scores from each of the five training sites that have participated have shown favorable ratings and gains in knowledge of public health concepts and use of epidemiologic and statistical tools in analysis of local data, setting health priorities, and formulating health plans. Feedback and lessons learned from each workshop, as well as experience gained, have been continuously integrated into a curriculum package tailored to address basic epidemiology and community health planning principles for American Indian health workers and professionals working in Indian communities.

Health improvement plans were drafted to address priority health problems, formulate local policies, and plan interventions in all five sites. Course faculty continue to provide technical assistance as requested by participating communities. One tribe requested assistance from the Center's faculty to prepare a final report documenting the developed plans for presentation to the local tribal council and for grant solicitation. All tribes continue to communicate with the Center's faculty.

The leading health problems in most Indian communities (e.g., diabetes, injuries, adolescent risk taking behaviors, etc.) involve a complex array of associated socioeconomic risk factors. Thus, measures that will demonstrate reduction of the impact of these conditions will be long range and will require years of follow up. Measures of the success of this course, therefore, are based on the local adoption and implementation of principles taught in the course.

Discussion and Conclusion

The course has been successfully conducted in five local communities (comprising 17 tribes) across the nation. Participants have indicated their intention to adopt relevant techniques and dynamics into their own departments/programs. A number of intangible yet valuable benefits attributable to this training by a team of instructors in the local community have been identified. The course has served to facilitate, strengthen, and enhance interdepartmental and interdivisional cooperation and team building in each site. It has proved to be a very valuable focal point around which a variety of health workers and health programs could come together for mutual support and planning. A number of participants have remarked that interdepartmental cooperation was materially increased as a result of the process. Another common comment is that participants were pleasantly surprised to find that their initial fears that they would be attending just another "planning session" were quickly replaced by enthusiasm for the process. All elements of the formal presentations, including the background materials on the origins of Indian populations and the special government-to-government relationship were thought to be important and useful.

We believe that it is possible to establish long term, ongoing relationships with other university centers, and that continued development of local, interdisciplinary approaches may become "permanent." Each group has expressed appreciation for the attitude of the Center's faculty in dealing with them as colleagues and equals. This supports the conclusion that the most important elements of the JHTEP are the collegial style of the faculty, the determination that ownership of the process would truly reside with the community, reliance on the utilization of tribal-specific data, and the willingness to remain available for subsequent consultation. The reaffirmation of the participants' own competence and capabilities was another intangible yet, we believe, very valuable contribution to the health programs in each community.

For more information, please contact Dr. Maha Asham at 621 Washington Street, Suite 5505, Baltimore, MD 21205; telephone (410) 955-6931; fax (410) 955-2010; or e-mail *masham@jhsph.edu.* □
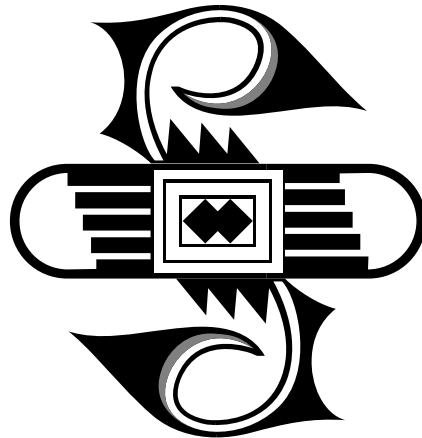
Training Opportunity: American Society on Aging, "New Ventures in Leadership" program

An executive leadership program targeting minority practitioners, administrators, researchers, and students working in aging in order to promote solutions to service delivery problems affecting minority elders. The 12-month leadership development curriculum consists of seminars, development and implementation of a special project, and related activities under the guidance of assigned mentors from the American Society on Aging (ASA). Agencies can sponsor attendees (estimated cost is $6-7000), secure funding from a local source, or apply for a limited number of available scholarships. For more information, contact the ASA's Office of Diversity Programs at (415) 974-9630.

Pat Stenger Memorial Award

At the National Indian Council On Aging (NICOA) biennial national meeting held in August in Bismarck, ND, the first Pat Stenger award was given to the Trenton Indian Service Area (TISA). This award was established in memory of Dr. Pat Stenger, geriatrician and the first IHS Senior Clinician for geriatrics, who established the Elder Care Initiative in 1995. In keeping with Dr. Stenger's vision for Indian elder care, the award was established using memorial gifts given to NICOA in his memory. The award will be given every two years, at the NICOA national meetings, to a tribal program serving Indian elders. Programs will be honored for achievement and creativity in providing services to Indian elders in innovative and effective ways.

TISA, the first recipient of this award, provides comprehensive care to 380 seniors through a coordinated service delivery system for the Trenton Community Clinic. TISA, with a staff of ten people, serves a total of 6400 square miles of non-reservation lands in Montana and North Dakota. Since many of the communities in the area have a largely non-Indian population, TISA must not only provide service directly, but advocate with other agencies on behalf of Indian elders.

Under the leadership of Cynthia LaCounte, Director of CHRs and Elder Services, who accepted the award on behalf of her staff, TISA has been tremendously effective in meeting the goals set by their Board of Directors (tribal council). For example, in 1992 TISA was charged with finding funding for construction of a senior center in Trenton. Using monies from a wide variety of sources, including $10,000 raised by seniors and community members, they broke ground for the new Senior Center in June of this year.

It is very appropriate that TISA be honored with the first Pat Stenger Memorial Award. Their program exemplifies the dedication, resourcefulness, and caring for which Dr. Stenger was known throughout his career in Indian aging.

TISA has expressed its willingness to be available for advice or help to other programs serving Indian elders. Contact Cynthia LaCounte, Director, CHR/Aging Programs, Trenton, ND, 58853; telephone (701) 774-0303; or fax (701) 774-3953.

The International Year of the Older Person (IYOP)

The United Nations (UN) General Assembly has designated 1999 as the International Year of the Older Person (IYOP), and the observance will be officially launched on October 1, 1998. The theme for the year is "Towards a Society For All Ages." The Federal Administration on Aging (AoA) is the lead for this effort in this country. Jeanette Takamura, Assistant Secretary for Aging in the Department of Health and Human Services, has encouraged "tribal organizations to begin planning for the IYOP in their own communities."

Think of this as a way to gain additional energy and publicity for our efforts in developing programs for Elders. It may be an additional "hook" as we submit ideas to funding agencies. The IYOP may, at least, help us to raise the visibility of Indian elders, both nationally and internationally.

For more information, contact Marla Bush, International Coordinator, Administration on Aging at (202) 619-3996; fax (202) 619-7586; or e-mail: *Marlab@ban-gate.aoa.dhhs.gov*. You may contact the AoA for general information about the IYOP and to report your activities commemorating the event. These will be publicized on the AoA website and in Aging Update. You may also use the following websites: AoA International Year of Older Persons at *http://www.aoa.dhhs.gov /international*, or UN International Year of Older Persons at *http://www.un.org/esa/socdev/iyop/htm.*
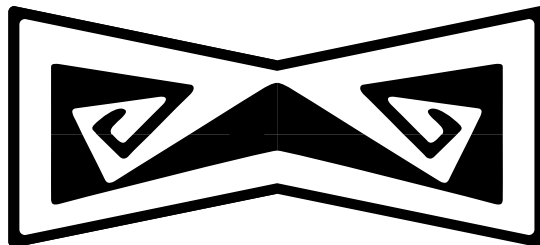
Change of Address or Request for
New Subscription Form

Name _____ Job Title _____

Address _____

City/State/Zip _____

Worksite: ☐ IHS ☐ Tribal ☐ Urban Indian ☐ Other

Service Unit (if applicable) _____ Social Security Number _____

Check one: ☐ New Subscription ☐ Change of address

If change of address, please include old address, below, or attach address label.

Old Address _____

THE IHS PRIMARY CARE PROVIDER