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Health Promotion in Rural Alaska: Building Partnerships across Distance and Cultures

Cécile Lardon, Elaine Drew, Douglas Kernak, Henry Lupie, and Susan Soule

The Center for Alaska Native Health Research¹ at the University of Alaska Fairbanks is working to build health research partnerships with remote Yup'ik communities in southwestern Alaska. Through a closer look at one of the Center's partnerships, this paper addresses the process and importance of developing a mutual cultural understanding among collaborative partners. By mutually engaging in a process of co-learning from the start, community-campus partners can develop a shared understanding of the project goals, the process of decision making and resource sharing, and realizable expectations for building local capacities and sustainable infrastructure.

Conducting Community-Based Participatory Research (CBPR) for Health in Remote Alaska Native Villages

The Yukon-Kuskokwim river delta region (nearly 41,000 square miles) forms a flat, marshy coastal plain that has supported the Yup'ik subsistence way of life for thousands of years. Yup'ik is the indigenous language, and the culture of the region is one of the most intact of all of the indigenous groups in Alaska. Approximately 100 to 700 residents reside in each of the smaller villages that are accessible only by boat (in summer), snowmachine (in winter), or bush plane (all year). The geographical remoteness of these villages, combined with weather conditions in the region, an underdeveloped telecommunications infrastructure, a less than reliable power supply, and a host of other factors present researchers with significant challenges that increase costs and time needed to complete research. Since strong kinship and personal, face-to-face communication is the social norm, researchers must spend additional time in villages to make themselves known, trusted, and accepted.

Often, past research was carried out in ways that were incongruent with participants' cultural values and practices, resulting in interpretations and intervention efforts that were invalid or ineffective.

Indeed, the success of health research in Alaska is dependent upon local community and village government cooperation. Often, past research was carried out in ways that were incongruent with participants' cultural values and practices, resulting in interpretations and intervention efforts that were invalid or ineffective. Furthermore, investigators rarely included Alaska Natives in the decision making process that surrounded the research effort, and participating communities were rarely informed of the results of the research, contributing to the knowledge drain from Alaska Native communities (Foulks, 1989). That approach, known as "research carpet bagging", is just one factor that led the U.S. Interagency Arctic Research Policy Commission to create the "Principles for the Conduct of Research in the Arctic" (U.S. Interagency Arctic Research Policy Committee), and the Alaska Native Science Commission to adopt the Alaska Federation of Natives' "Guidelines for Research" (Alaska Federation of Natives, 2005). These principles and policies were written to ensure Alaska Native participation in the conduct of research and in the resultant policy and knowledge dissemination and utilization.

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Health among Alaska Natives

Beginning in the latter half of the 20th century, the cumulative effects of various colonizing forces, in conjunction with successive waves of massive population loss (due to infectious diseases contracted from Europeans), gradually caused this mobile culture to settle at permanent village sites. Today, a fairly typical Yup'ik village has a combined elementary and secondary school, local village council, health clinic, post office, church, community center, airstrip, electricity, phones, and satellite televisions. Indoor plumbing and flush toilets are much more common now, but don't exist in every village, or in every household in a village that has a water and sewer system. The general economic pattern is characterized by a mixture of harvesting local resources for commercial and subsistence use with wage employment from public sector positions such as education, administration, and health and social services. Rural villages in Alaska (including those in the Yukon-Kuskokwim Delta) are in an economically difficult situation as many of the modern amenities require monetary resources, while the opportunities for generating money are extremely limited.

Traditionally, the Yup'ik lifestyle has provided several health benefits, such as foods high in n-3 polyunsaturated fatty acids and other nutrients. However, the consumption of traditional foods is in decline in many villages, and many people engage in less physical activity than a generation ago. These changes are associated with rising rates of obesity, heart disease and diabetes (e.g., the incidence of diabetes among Yup'iks has doubled in the last 10-15 years and the number of overweight children has tripled in the last 20 years). Alaska Native leaders have indicated a strong priority to develop increased capacity for health improvement strategies.

Cultural factors, such as acculturative stress and collective trauma, have often been implicated as contributors to behavioral health problems in American Indian and Alaska Native communities (Duran & Duran, 1995). Research on culture and chronic disease indicates that an understanding of cultural beliefs and perceptions of disease are critical for a number of reasons. For example, individual perceptions of the cause of an illness and its symptoms serve as guideposts for self-monitoring, self-management, and the treatment seeking process (Schoenberg, Amey, Stoller, & Drew, 2005). Similarly, cultural beliefs and traditions related to healthy living can form a strong basis for encouraging and strengthening healthy behaviors (Stephanich et al., 2005). Also, research has shown that a detailed understanding of the local cultural context is central to health assessment and program development (Schulz et al., 2005).

The Center for Alaska Native Health Research (CANHR)

CANHR seeks to examine the factors contributing to rising rates of obesity, diabetes and heart disease among Yup'ik people in Alaska utilizing a collaborative research model that involves tribal and community leaders and groups. The original funding for CANHR included three research projects related to obesity, diabetes, and heart disease: a genetics study, a nutrition and physical activity study, and a study of cultural and behavioral factors linked to these diseases (the Cultural Understanding of Health Project). (A fuller description of CANHR and its research can be found in Boyer et al., 2005.)

The Cultural Understanding of Health Project of CANHR

The Cultural Understanding of Health Project had three goals: (1) to document a Yup'ik

definition of health and wellness that can guide research, evaluation, and interventions; (2) to examine the relationships between cultural-behavioral health, nutrition, and weight in a Yup'ik sample; and (3) to translate these research findings and make them useful to participants through a community-based health promotion program. The focus of the rest of this paper is the third goal, which involves a health promotion project currently underway in one Yup'ik village.

A Brief History of the Project

In 2004, Cécile Lardon and her colleagues conducted a series of focus groups in two villages participating in the CANHR study and with Yup'ik employees of the regional tribal health corporation. These focus groups formed the basis for a cultural definition of health and wellness (Wolsko, Lardon, Hutchison, & Ruppert, in press) and, subsequently, the development of a Yup'ik Wellness Questionnaire for use in the CANHR study (the development of this questionnaire will be published separately).

During a CANHR data collection trip in the spring of 2004, Cécile Lardon approached Henry Lupie, the then Tribal Administrator of one of the participating villages, about the possibility of working with that village to develop a regional model of health promotion based on the data collected by CANHR. In the summer of that year, the Tribal Council discussed the proposal and voted to permit the health promotion to take place in their community. No formal plans for how to conduct health promotion with Yup'ik people existed at the time. Rather, the plan was to develop the intervention approach and its evaluation in collaboration with members of the host community.

Work began in the fall after the fishing and hunting seasons were over and subsistence food gathering was completed. Originally, the project was staffed by one part-time team leader from the village along with Cécile Lardon (the project principal investigator at the university in Fairbanks), and Susan Soule (a part-time health promotion specialist in Anchorage). The first step was a community presentation of the research findings pertaining to that village. We presented a PowerPoint slide show that summarized the results of several health indicators (e.g., cholesterol, weight, percent body fat), nutrition, physical activity, questionnaires (e.g., stress, coping, and social support), as well as some basic information about health and the health indicators used in the study. The presentation was given in Yup'ik by a Yup'ik language specialist who had translated most of CANHR's research materials and thus knew how to translate scientific terms used in the study. Following the presentation was a discussion about the data. For example, what did community members make of the differences in nutrition between elders and young adults? Why are some elders not eating much traditional foods? Why are girls gaining weight so much earlier than boys? The participants then identified key topic areas from the presentation and articulated what they would like to see addressed in a health promotion project.

We were able to add a second team leader position, and the two leaders began meeting every 3-4 weeks with a health promotion committee made up of 10-15 volunteer members from the community including several elders, community leaders, former members of a now defunct community wellness team, and others. The staffing of the team leader positions and the membership of the committee has changed over time, but eventually we built an

experienced leadership team (Douglas Kernak and Henry Lupie) and a core group of about nine people. Soon after the community presentation, the committee identified three focus areas for the project: Increasing traditional Native food in the diet, increasing physical activity, and decreasing stress. An important step was naming the project Piciryaratgun Calritllerkaq (Healthy Living Through A Healthy Lifestyle). There was a retreat for the whole health promotion committee in March of 2005 and there were several two-day training sessions for the team leaders in Fairbanks and Anchorage provided training in computer skills, project planning, implementation and evaluation.

Cécile and Susan began fairly regular (about every 4-6 weeks) trips to the village. These trips involve two full days of travel (a bit less for Susan) and about three days in the village – weather permitting. In fact, several trips have had to be rescheduled due to bad weather and last minute decisions about travel have had to be made based on the weather report for the Kuskokwim Delta.

Over the past two years, we have developed a model for health promotion that combines elements of strategic planning and community development with Yup'ik cultural approaches to education, training, organizing, and leading.

The Conceptual Model for Community-Based Health Promotion and Its Application

Over the past two years, we have developed a model for health promotion that combines elements of strategic planning and community development with Yup'ik cultural approaches to education, training, organizing, and leading. This model is continually being revised and refined based on what we have learned. Most of the mutual learning related to the project happens in informal conversations; usually when we can meet face-to-face, but sometimes in phone conversations. We have all needed to be flexible and patient with each other and with people we have brought in to help with a particular aspect of the work.

Piciryaratgun Calritllerkaq has three equally important elements: developing local expertise, developing a local infrastructure, and developing a process. Developing local expertise includes training in a variety of skills related to the project, including health education, computer skills, and program management, as well as training in research. Of equal importance has been educating the university staff in Yup'ik culture and local customs. For example, in a recent conversation about increasing community participation in the project, Cécile, Douglas and Henry educated each other about common practices and challenges community change agents face and local norms related to participation and volunteerism.

Second, the development of a process for health promotion focused on clarifying roles, communication, and growing local support for the project. We have all stressed the importance of being true partners who share decision-making. We also each have unique roles in our partnership (based on our expertise, experience, age, and gender) and in our respective social settings. Not surprisingly, it has taken some time to fully understand what we each bring to the project and to develop a partnership based on who we are. Given that funding for the project comes from the National Institutes of Health (NIH) through the university, there are some inherent power inequalities that can only be corrected by funding the project with grants that come directly to the community. Over time, some responsibilities have shifted from the

researchers to the team leaders (e.g., follow-up data collection on several health indicators including cholesterol, blood pressure, percent body fat, and survey data). Similarly, the content of many of our conversations with each other has shifted from training and planning sessions to interactions that are focused much more on identifying issues that need attention and problem solving.

The team leaders and the health promotion committee have developed action plans for 14 objectives related to eight goals. Implementation has begun on several action plans; others are close to implementation. Each action plan also includes an evaluation specific to each objective.

Communication is a vital component of any working relationship, and is especially important when people work across cultures and geographic distances. Cécile and Susan have traveled to the village approximately eight times per year to guarantee a minimum of face-to-face time not only with the team leaders, but also with the health promotion committee and other community members. In addition, we have held weekly phone conferences that have helped enormously, but have some challenges including unreliable phone service in the village and lack of visual cues. The phone and email are essential in bridging the times in between visits, but they put Douglas and Henry at a disadvantage since English is not their first (or primary) language. Written language, especially, is easily misunderstood.

Third, developing a local infrastructure for health promotion and community change has involved local staff and a project office in the community hall where the tribal council offices and other community programs are located. Technology has been extremely important in a number of ways. Computers, internet access, phones, and a fax machine help connect the team leaders to resources and people outside the village. For example, Douglas and Henry have utilized the internet to locate materials for health education and to research and select necessary equipment (e.g., pedometers). We have also experimented with web-based video conferencing to be able to see each other during our weekly meetings, but the connection has not been good enough to make that work. Equally important have been the relationships we have developed with local and regional tribal organizations, state agencies, and others who may be able to provide some support. Frequent contact with the Tribal Council is especially important, as are connections to the regional tribal health corporation. Douglas and Henry were awarded a small community grant from the health corporation to support efforts to increase physical activity. At an Alaska Native Health Research Conference that was held in Anchorage earlier this year, Douglas and Henry were able to connect with a representative from the Indian Health Service who continues to serve as a wonderful resource.

Some of the collaborative mechanisms that have been most useful on all levels of collaboration include:

- ♦ Regular and direct contact about research planning, dissemination of findings, and applications at local and state policy levels.

Given that funding for the project comes from NIH through the university, there are some inherent power inequalities that can only be corrected by funding the project with grants that come directly to the community.

- Co-authorship of research presentations, reports, publications, data descriptions, and other relevant materials to the community (in Yup'ik and English).
- Power sharing — Decisions about the goals, implementation, and evaluation of the project are made jointly.
- Knowledge sharing — Learning from each other about health, culture, change mechanisms, local ecology.
- Workshops and training to build local capacity and self determination.
- Building linkages to other tribal health entities in Alaska
- Collaboration with other biomedical research efforts in Alaska and circumpolar north to share protocols and methodologies.

Closing Thoughts

Community-centered health promotion offers all participants a number of benefits that go well beyond the health issue being addressed, but are just as important. Researchers gain a much deeper and more culturally-based understanding of the health issue(s) to be addressed – and they gain that understanding within the social, economic, geographic, and political contexts in question. A simple example is the interactions between the location of the village, the price of fuel, opportunities for earning money, the shelf-life of various foods, and cultural preferences for foods as they relate to the actual food intake of a particular group of people and, consequently, expressions of health and chronic disease. Researchers also have the opportunity to better understand the mechanisms for change in their partnering community and can be of more help in suggesting specific strategies for behavior change. Community partners, on the other hand, can gain better access to information about health issues (especially in situations where data are being collected from their community) and about approaches that have worked in other communities. Learning research and program planning/evaluation skills is important for community members to function as full partners in a community-campus partnership and to be more critical consumers of research outside of that partnership.

Of course, there are responsibilities that come with any true partnership. In community-centered health promotion and CBPR, it is vital that all partners understand the cultural and organizational systems they operate in, including the limitations and constraints of those settings. For example, Douglas, Henry and the health promotion committee had to understand the limitations of the university bureaucracy in relation to hiring staff. Cécile and Susan had to understand that hiring decisions in the village are made based on an assessment of the “whole person”, as opposed to a narrow set of job qualifications used by the university. Together, we had to develop a process for hiring staff that could work in both contexts.

In community-centered health promotion and CBPR, it is vital that all partners understand the cultural and organizational systems they operate in, including the limitations and constraints of those settings.

It is important to point out that we are not making a distinction between *knowledge* and *beliefs* (i.e., the researchers have knowledge of health, and the community partners have beliefs about health). We are assuming that all partners come to the table with some shared knowledge and some unique knowledge about the issues at hand. By engaging the CBPR process through this lens of shared expertise, we can promote healthier communities through co-learning partnerships that are both respectful and more sustainable over time.

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Elaine Drew is an Assistant Professor at the University of Alaska Fairbanks. She moved to Alaska in 2004 after completing her PhD in anthropology at the University of Kentucky. Occupying a joint appointment in CANHR and the Department of Psychology, Elaine is teaching courses in medical anthropology and social science research methods while building a research program on health disparities among Alaska Natives. Currently, she is developing projects to examine the cultural and political economic factors shaping chronic disease risk among Yup'ik Eskimos in remote Alaska villages, including a project on diabetes risk and Yup'ik body image and a project on gestational diabetes with Yup'ik women.



Douglas Kernak is a health promotion team leader of Piciryaratgun Calritlerkaq. As an Americorps volunteer he developed and implanted a recycling program in his community. He has served on the tribal council, search and rescue group, the volunteer fire department, and is currently one of the board members for the utilities company. He is the father of three children and is a commercial fisherman. Douglas learned many subsistence life skills from his mother, brother, uncle and through his lessons he learned from himself as well. He has been a health promotion leader since February 2005.



Henry Lupie is a health promotion team leader of Piciryaratgun Calritlerkaq. He has served his community in many ways: As a member of the Tribal Council, the Tribal Administrator, He has also taught Yup'ik as a first language in both the B.I.A. School System and then the State operated school, between 1972 thru 1987. Henry is the father of 3 children and the grandfather of 5. Henry has been Commercial fishing since the mid-1960's. Henry has been a health promotion team leader since October of 2005.



Susan Soule received her M.A. in psychology from Goddard College in 1974. She has worked with the rural communities of Alaska since 1979 when she moved to the village of Aniak where she lived and worked as director of the Kuskokwim Community Counseling Center. In 1987 she accepted employment with the State of Alaska Division of Mental Health as their Rural Services Director. She continued her career in state government for 18 years, working primarily with Native villages on prevention of substance abuse and suicide and on the development of a network of trained village-based counselors. Since her retirement from state government in 2005 Ms. Soule has worked in Alaska and abroad as a consultant and trainer in the areas of community health promotion and suicide prevention.

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