Published in final edited form as:
J Prev Interv Community. 2011 January ; 39(1): 65–76. doi:10.1080/10852352.2011.530167.

Using strategic planning and organizational development principles for health promotion in an Alaska Native community

Cécile Lardon, **Susan Soule**, **Douglas Kernak**, and **Henry Lupie**
University of Alaska Fairbanks

SUMMARY

Health promotion aims to support people in their efforts to increase control over factors that impact health and well-being. This emphasis on empowerment and contextual influences allows for a more holistic conceptualization of health and approaches to promoting health that are anchored in principles of community development and systems change. Piciryaratgun Calritllerkaq (Healthy Living Through A Healthy Lifestyle) is a collaboration between a Yup'ik village in rural Alaska and researchers from the University of Alaska Fairbanks. The goal was to improve nutrition, increase exercise and decrease stress. The project utilized elements of organization development and strategic planning to develop a local infrastructure and process and to promote local expertise. The project team developed goals, objectives, action and evaluation plans that integrated local traditions, Yup'ik culture, and research.

Keywords

Health promotion; Alaska Natives; indigenous; rural; organization development; planning

In the community psychology literature health promotion is seen as distinct from prevention in several important ways. Perhaps the most important distinction between the two concepts is how the issue to be addressed is defined. In prevention the issue is, by definition, something negative that is to be prevented from occurring or intensifying. Health promotion, on the other hand, defines health as more than the absence of disease or dysfunction (Green & Kreuter, 1990; O'Donnell, 1989; Pender, Murdaugh, & Parsons, 2002). Indeed, most definitions of health promotion include some explicit statement related to supporting people in gaining increased control over the factors in their lives that influence health (O'Donnell, 1989; Pender et al., 2002).

The shift in perspective from preventing problems to promoting healthy lives allows for a more community development oriented approach to mental and physical health (Phillips, 1988). This is of particular importance to communities that are less connected to health-related infrastructures and/or socioeconomic support systems. Minority and rural communities are often geographically isolated and economically, politically, and culturally marginalized. Consequently, the health and well-being of the members of these communities is influenced by those factors in both positive and negative ways. For example, for the Yup'ik people of western Alaska, the geographic isolation of their communities provided some protection from the loss of culture and language experienced by other Alaska Native communities. Yup'ik is the best preserved indigenous language in Alaska and many traditional cultural practices have survived as well. On the other hand, these geographic

Address correspondence to: Cécile Lardon, Department of Psychology, University of Alaska Fairbanks, PO Box 756480, Fairbanks, AK 99775-6480 (c.lardon@alaska.edu).

distances and cultural differences can make it difficult for a Yup'ik village government to tap into resources controlled by institutions that are not familiar with the particular circumstances of the villages. Water and sewage treatment systems are an example of that. Many rural communities in Alaska still do not have indoor plumbing or only some of the households in a village do. Even communities that have some type of water treatment and distribution system often have difficulty maintaining it. Breakdowns can quickly lead to shutdowns due to cost, climate, transportation, and access to engineering expertise.

In many ways communities, especially small ones, are similar to organizations. In community psychology there is a growing literature on how researchers and practitioners alike can benefit from the organizational literature (Boyd & Angelique, 2007; Hidalgo & Moreno, 2009; Perkins & Bess, 2007). Leadership (Farquhar & Michael, 2005; J. G. Kelly, Azelton, Lardon, Mock, & Tandon, 2004) and systems change models are particularly helpful to community psychologists (Farquhar & Michael, 2005; J. G. Kelly, 2007; J. G. Kelly et al., 2000; D. D. Perkins & Bess, 2007; Williams, 1999).

The focus of this paper is a health promotion project in rural southwest Alaska that utilized organization development principles to promote healthy living. Over the past five years, a team of a university researcher, members of a Yup'ik community, and an expert on health in rural Alaska have developed a model for health promotion that combines elements of strategic planning, capacity building, and community development with Yup'ik cultural approaches to education, training, organizing, and leading. The project, Piciryaratgun Calritllerkaq (Healthy Living Through A Healthy Lifestyle), grew out of a regional study of obesity, diabetes, and heart disease conducted by the Center for Alaska Native Health Research[1] (Boyer et al., 2005; Mohatt et al., 2007). This study included seven villages and the regional hub city in the Yukon-Kuskokwim Delta. One of these participating villages was then invited to collaborate on the health promotion project.

The Host Community And Its Cultural And Geographic Context

The host community of this project is located in the Yukon-Kuskokwim Delta on the west coast of Alaska. It is not on a road system – the village can only be reached by small aircraft, by boat in the summer, and by snowmachine in the winter. There are about 400 people living in the village. Yup'ik is the language most spoken at home and is still the first language children learn. In this, as in others villages, children are taught in Yup'ik through 2rd grade.

The economic base in the host community consists of subsistence hunting and fishing, some commercial fishing, and a few paid positions in government (i.e., Traditional Councils, public safety, the post office, and some state and federal agencies), human services (i.e., health aides, counselors) and education. Although most families still engage in subsistence activities such as fishing, hunting, and berry picking, money is now needed to heat homes, pay for utilities, and fuel fishing boats, snowmachines, and all-terrain vehicles. Traditional subsistence foods are heavily augmented by store-bought foods.

[1]This research was made possible by a COBRE grant from the National Center for Research Resources at the National Institutes of Health (5 P20 RR016430) PI: Gerald V. Mohatt, PhD and by a grant from the National Heart Blood and Lung Institute at the National Institutes for Health (1R21HL083862 - 01A1) PI: Cécile Lardon

The Conceptual Model For Community-Based Health Promotion And Its Application

Piciryaratgun Calritllerkaq utilized a community-based participatory research (CBPR) process of engaging members of the community in identifying the health Piciryaratgun Calritllerkaq (Healthy Living Through A Healthy Lifestyle) issues to focus on and in setting goals for health promotion (Coombe, 1999; Israel et al., 2003; Kline, 1999; Minkler & Hancock, 2003; Minkler & Wallerstein, 2003). Tribal Participatory Research (TPR) (Fisher & Ball, 2003), a model of community based participatory research developed specifically for working with American Indian and Alaska Native communities also emphasizes Tribal oversight, the use of culturally specific assessment and intervention methods, and the importance of training and *employing* community members as staff.

The tripod model for community-based health promotion

For Piciryaratggun Calritllerkaq, these concepts were integrated into 3 core elements – the legs of the tripod: (1) building infrastructure for health promotion, (2) developing local expertise in health promotion and community change, and (3) developing a process that combines elements of strategic planning, program evaluation, and health education with traditional Yup'ik health practices and leadership styles. This approach is consistent with Wallerstein's (2006) model for utilizing empowerment processes to improve health. She presents the following empowerment strategies to produce change on the personal, organizational, and community level: (1) planning and access to information (personal skills); (2) decision-making, use of lay leaders, leadership/advocacy, and organization capacity (community action); and (3) collective actions, effective organization structures, transfer of power, and transparency (healthy public policy).

Local Infrastructure—An infrastructure for health promotion supports the planning, implementation, and evaluation activities that define the project (Duran & Duran, 1999). This includes paid staff positions in the village, a volunteer structure, access to information, a location for the project, and connections to supporting groups and organizations within and outside of the community. Piciryaratggun Calritllerkaq built a local infrastructure by hiring two Yup'ik part-time health promotion team leaders; assembling a Yup'ik Health Promotion Committee (HPC) of 10–15 volunteers that included elders, community leaders, parents, school staff, and local health workers; and establishing an office in the Traditional Council building where the Health Promotion Committee meetings were held. The project office was equipped with a computer, printer, digital camera, web camera, and internet access. Project staff had access to fax and copy machines and to web-based university library resources.

The health promotion team leaders and the HPC had strong ties to the Traditional Council. As a result, the project received very strong support from local Traditional Council leaders. At various points during the project the local infrastructure also included the three small village stores, the health clinic, the behavioral health office, the village school, and other village programs, offices, and volunteers.

The university-based project principal investigator (PI) provided access to resources outside of the village such as information about other community-based health promotion projects, training in project related skill sets, specialized services available from university staff, and input from experts in community psychology, medical anthropology, and public health. A health promotion specialist who had worked with Alaska Native people for over two decades connected project staff with experts, trainers, and potential mentors from around the state.

The whole project leadership team, consisting of the village-based team leaders and the university-based staff, developed a relationship with staff at the regional Native Health Corporation, especially with the Medical Director, the Diabetes Prevention Unit, and the Community Health Educator Program. Our hope was to develop a model that could be implemented in other villages of the region and to have an impact on regional health policy.

A crucial infrastructure component of Piciryaratggun Calritllerkaq was communication, especially since most of the day-to-day contact between university and village staff was via phone or computer. Since travel in rural Alaska is expensive, long, and dependent on weather conditions, face-to-face contact with the community was limited. During the most active stages of the project the project PI and the health promotion specialist visited the village approximately once per month for 3–4 days, except during the summer when village residents were busy with subsistence activities. These visits by the project PI and the health promotion specialist to the community were the main vehicle for team building, leadership development, defining roles, and skill building. They sometimes also included meetings with the HPC and with the Traditional Council Administrator, and provided an opportunity for university-based staff to interact and get to know other members of the community, learn about local culture and traditions, and better understand the contextual challenges and opportunities village staff were faced with.

About once or twice a year, the team leaders traveled to the university or to Anchorage for training and to access university resources. The team leaders were also invited to conferences and meetings. These occasions allowed the team leaders to meet other researchers and project staff.

Technology plays a crucial role in developing a communication infrastructure that can facilitate collaboration across cultures and languages. The telephone was the primary tool on our project, but e-mail and web-based resources, such as calendars and task management tools, were also essential in sharing ideas and information. Since it is unlikely that the physical infrastructure connecting Alaska’s rural communities to urban centers and university campuses will change much it is vital to utilize every technology available for communication and access to resources. As internet connections in the villages become faster and more reliable video-conferencing will help make collaborating across geographic distances more effective. International businesses have been using video-conferencing quite effectively for years – but they tend to have the advantage of sophisticated equipment paired with fast and reliable connections.

Local Expertise—Developing local expertise and learning from local experts is central to the success of a community-based project (Duran & Duran, 1999; Fisher & Ball, 2003; Kline, 1999; Kreuter, 1992). Most central to the Piciryaratggun Calritllerkaq project was expertise in three key areas: program planning and development, project management, and program evaluation. In March of 2005, the health promotion team leaders, HPC members, and university-based staff came together for an over-night retreat at the Native Health Corporation headquarters in the regional hub city. This retreat introduced the team leaders and HPC members to the strategic planning model specifically developed for community-based groups and organizations ("The Community Toolbox") and gave the team leaders an opportunity to practice group leadership and team development skills. The PI and health promotion specialist, on the other hand, learned more about the priorities and concerns of the HPC, about Yup’ik concepts of health and wellness, and about Yup’ik leadership. The retreat resulted in a vision statement for the project, as well as a first draft of goals and objectives for each of the three focal areas of the project: nutrition, physical activity, and stress reduction.

Following the retreat the team leaders, PI, and health promotion specialist refined the articulation of the goals and objectives and developed action plans including timelines, resources needed, and desired outcomes. This process allowed the project leaders to translate ideas and general goals for the project into specific objectives and plans. The team leaders then continued the planning process in the village with their Health Promotion Committee and debriefed each step with the university team over the phone. As the project unfolded, training shifted from planning to implementation, evaluation, and community development. The goals and objectives articulated at the retreat thus provided the foundation for a planning, implementation, and evaluation process that guided the project through the next four years.

This probably sounds fairly straight forward to the average Euro-American, but it may be a particularly difficult task for Yup'ik people. Any western planning process assumes that a) we can see far enough into the future to establish meaningful goals, b) we know enough about what is likely to occur between now and then to make a plan, and c) we can control events and our surroundings enough to move toward the end goal. Unfortunately, these assumptions are not congruent with Yup'ik culture. Until about the middle of the 20th century Yup'ik life was guided by the seasons and the availability of fish, game, and plants. It made no sense to develop plans for, let's say, a hunting trip since the weather and other conditions could change very rapidly and very drastically. This is not to say the people were unprepared – they could not have survived without careful preparation – just that few things required detailed action plans far ahead of time. Even today, most Yup'ik people's decisions regarding activities such as trips and social events are fluid and often made on short notice. The Yup'ik way is to take things one day at a time, as one of our team leaders explained. It was therefore crucial to develop a shared understanding of our goals, objectives, and action plans that allowed for more fluidity than would be expected in western cultures.

Related to planning and evaluating was the need to develop and support culturally appropriate and effective leadership and team building. The significance of this was not a lack of leadership in the community, but rather issues related to age, status, culture, and style (Duran & Duran, 1999; J. G. Kelly, Azelton, L.S., Lardon, C., Mock, L.O., Tandon, S.D., & Thomas, M., 2004; Kline, 1999). For example, the health promotion team leaders were a man in his early to mid 30s and a man in his late 50s to early 60s. Both team leaders came to the project with significant community leadership experience. On the Piciryaratggun Calritllerkaq project they defined their roles as leaders with each other, based not only on their individual skills, experience, and interests, but also in relation to Yup'ik age norms. Furthermore, several of the Health Promotion Committee members were elders and respected community leaders. The younger team leader needed to define his role and leadership style in ways that respected his elder co-worker and committee members. On the other hand, the PI and the health promotion specialist are both Euro-American women with graduate degrees; the PI is unmarried and does not have children. These characteristics do not fit into defined traditional Yup'ik gender and social roles and, therefore, needed to be defined within the context of the project (J. G. Kelly, Azelton, L.S., Lardon, C., Mock, L.O., Tandon, S.D., & Thomas, M., 2004).

Technical training for the health promotion team leaders included computer training at the university, in the village by the PI and/or health promotion specialist, and over the phone as needed. The team leaders improved their computer skills in word processing, using spreadsheets to organize data and budgets, accessing and finding information on the internet, using e-mail, and creating project materials such as PowerPoint presentations, posters, brochures, certificates, forms for data collection, and reports. These skills were crucial to the every-day operations of the project but also connecting the project to resources outside of the village. Probably one of the most effective uses of computer skills was a PowerPoint

presentation one of the team leaders gave to a Yup'ik audience at a regional health conference. In his talk, the team leader combined images from the project with text and an oral presentation style similar to traditional Yup'ik story telling.

Finally, health education for the team leaders, the HPC, and for the community took several forms. Throughout the course of the project, the team leaders provided health education to their community. They identified materials appropriate for their audience and developed their own posters and handouts when they needed to. Along the way, they also became more knowledgeable about the research process. This made them more critical consumers of health research and also more empowered collaborators on this and future research projects (Duran & Duran, 1999; D. Perkins & Wandersman, 1990; Stoecker, 1999).

One important skill the PI had to develop was to be able to understand something from two cultural perspectives simultaneously. Most Yup'ik people are experts in this area. For example, Yup'ik hunters use both traditional knowledge of their local ecology and information based on western science. For the PI it remained difficult to understand how Yup'ik communities function in a very complex cultural space in which change is both embraced and resisted with seemingly equal force.

Culturally based process—Developing a culturally based process for health promotion was closely linked to building infrastructure and developing local expertise and was critical to the success of the project (Andersen, Belcourt, & Langwell, 2005; Duran & Duran, 1999; Israel et al., 2003; Matias-Carrelo, Chavez, Negron, Canino, & Aguilar-Hoppe, 2003; Minkler & Hancock, 2003). Everyone associated with Piciryaratggun Calritllerkaq functioned within the context of cultural and institutional settings that made their own demands on processes like hiring staff, providing access to resources, and approving research protocols. The process for Piciryaratggun Calritllerkaq was defined in the interaction between the university researchers, village-based team leaders, and the Health Promotion Committee. This process was further influenced by the climate, the distance between the university and the village, the geographic isolation of the village, the limitations of the existing infrastructure, and the annual life cycles at the university and in the village (e.g., course schedules and subsistence season). The face-to-face encounters by the PI, the health promotion specialist and the team leaders were, by far, the most crucial element in developing a process that could move the project forward. Being in the same room for an extended amount of time enabled team members to communicate in multiple ways, making use of verbal and nonverbal cues. Meetings over the phone where team members had to rely on spoken language were often difficult and intended messages were lost frequently. Luckily, the length of the project allowed for enough time to develop trusting and respectful relationships that greatly helped overcome these barriers to communication.

Much of the process in the first year of the project focused on finding common interests, defining a purpose and mission for the project, and finding ways to communicate and work with each other. As the project progressed the PI and health promotion specialist moved increasingly into a support role, and the team leaders took on increasing responsibility for the planning and implementation process in the village. This made it easier to also shift day-to-day decisions about project activities to the team leaders who knew the circumstances much better and had to live with the consequences of the decisions. All major decisions (e.g., changes to the goals, objectives, or action plans) were made jointly by the PI, the health promotion specialist and the team leaders.

In the beginning of the project the team leaders were responsible for all project-related activities, such as organizing the spring and fall traditional foods potlucks, leading the Yup'ik dance group, or signing out snowshoes to community members. One of our goals

was to recruit community members to take on project leadership roles (e.g., someone to take over the Yup'ik dance group once it got started, someone to organize women's gym night, or someone to coordinate volunteers for potlucks and other activities) so that the team leaders could focus more on coordinating all of the activities rather than implementing them. This, unfortunately, did not happen.

DISCUSSION

We used the metaphor of a tripod for our model because the legs of a tripod are interdependent; the tripod can not stand if one leg is missing or weak. Too many community projects have demonstrated that a process that is imposed on the setting without at least some adaptation to the local culture is bound to fail. Similarly, a process without a supporting infrastructure cannot sustain even the best planned efforts. Leadership is required to build and maintain both process and infrastructure but leadership also needs to be supported by a process and an infrastructure. The two team leaders of Piciryaratggun Calritllerkaq were experienced and complemented each other in their skill sets. They were quite successful in both creating an infrastructure in the village and tapping into support systems outside of the village. This web of relationships to other individuals and organizations has been shown to be a crucial aspect of successful community leadership in other communities (Glidewell et al., 1998; Saegert, 1989; Tandon, Kelly, Mock, Tolman, & Brydon-Miller, 2001). But despite a successful collaboration with the PI and the health promotion specialist (i.e., a process for working across geographic distances and organizational cultures) it remained difficult to reliably engage other community members in the project. The success of all project-related activities remained the burden of the two team leaders, although others assisted and participated.

Our experience with Piciryaratggun Calritllerkaq points to the need to understand the leadership models and systems change mechanisms in social settings before attempting to engage in any interventions. This may seem obvious but there rarely is enough time to do this right, nor is it always seen as necessary. Although all four members of the leadership team of Piciryaratggun Calritllerkaq were experienced and appreciated the importance of leadership and change mechanisms it took us about two years to have a conversation about the meaning of volunteerism in Yup'ik culture. Nor surprisingly, volunteers are recruited quite differently in Yup'ik communities than in Euro-American communities. One important difference is the much more indirect nature of Yup'ik requests for anything. Of course our Yup'ik team leaders knew about this cultural value but it took a conversation about how each one of us became involved in various community projects and activities to truly understand the connection between what were trying to do and how we needed to go about it in this particular cultural context.

Although Piciryaratggun Calritllerkaq was quite deliberately developed around some core concepts related to organization development, it also became clear early on that these concepts would need to be adapted to a very different cultural context. Perhaps one of the most striking examples was the need to adapt the ideas of strategic planning to a culture in which planning does not come naturally. In Western culture people are often reluctant to change a plan once it is made. In fact, leaders in organizations often have to be strongly encouraged to revisit their plans every so often. In Yup'ik culture, on the other hand, plans are seen as flexible from the start, more like general guidelines than a roadmap. Consequently, we revisited our goals, objectives, action plans and evaluation plans quite frequently, and there was rarely the expectation that they would be followed in exactly the way we wrote them down. At some point during the project we did find a good equilibrium between planning and flexibility that allowed us to stay directed and focused while also adapting to our ever-changing circumstances.

In the end, there is very little evidence that Piciryaratggun Calritllerkaq changed the behavior of individual members of the host community. We have some anecdotal evidence of a few individuals who now walk more or spend more time gathering berries. But the project had not gathered enough momentum for enough individuals to make significant changes in the way they exercise and eat. What the project did accomplish, however, is to lay the foundation for future community initiated projects. The village-based team leaders partnered with the university-based staff to develop a model for initiating and leading change that is congruent with the local culture. The product of that collaboration was seen by the team as the most valuable outcome of the project. If utilized by the community the legs of the tripod can support projects that address a variety of issues, including water, energy, and subsistence issues.

REFERENCES

Andersen SR, Belcourt GM, Langwell KM. Government, politics, and law: Building healthy tribal nations in Montana and Wyoming through collaborative research and development. American Journal of Public Health. 2005; 95(5):784–789. [PubMed: 15855453]

Boyd N, Angelique H. Resuming the dialogue on organization studies and community psychology: An introduction to the special issue. Journal of Community Psychology. 2007; 35(3):281–285.

Boyer BB, Mohatt GV, Lardon C, Plaetke R, Luick BR, Hutchison SH, et al. Building a community-based participatory research center to investigate obesity and diabetes in Alaska Natives. International Journal of Circumpolar Health. 2005; 64(3):281–290. [PubMed: 16050322]

The Community Toolbox. 2005. from http://ctb.ku.edu/

Coombe, CM. Using empowerment evaluation in community organizing and community-based health initiatives. In: Minkler, M., editor. Community organizing and community building for health. New Brunswick: Rutgers University Press; 1999.

Duran, B.; Duran, E. Assessment, program planning, and evaluation in Indian country. In: Huff, RM.; Kline, MV., editors. Promoting health in multicultural populations: A handbook for practitioners. Thousand Oaks: Sage; 1999. p. 291-311.

Farquhar SA, Michael YL. Building on leadership and social capital to create change in two urban communities. American Journal of Public Health. 2005; 95(4):596–601. [PubMed: 15798115]

Fisher PA, Ball TJ. Tribal participatory research: mechanisms of a collaborative model. American Journal of Community Psychology. 2003; 32(3–4):207–216. [PubMed: 14703257]

Glidewell, JC.; Kelly, JG.; Bagby, M.; Dickerson, A.; Tindale, RS.; Heath, L., et al. Theory and research on small groups. New York, NY US: Plenum Press; 1998. Natural development of community leadership; p. 61-86.

Green L, Kreuter M. Health promotion as a public health strategy for the 1990s. Annual Review of Public Health. 1990; 11:313–334.

Hidalgo MC, Moreno P. Organizational socialization of volunteers: The effect on their intention to remain. Journal of Community Psychology. 2009; 37(5):594–601.

Israel, BA.; Schulz, AJ.; Parker, EA.; Becker, AB.; Allen, AJI.; Guzman, R., et al. Critical issues in developing and following community based participatory research principles. In: Minkler, M.; Wallerstein, N., editors. Community based participatory research for health. San Francisco: Jossey-Bass; 2003.

Kelly JG. The system concept and systemic change: Implications for community psychology. American Journal of Community Psychology. 2007; 39(3):415–418. [PubMed: 17406971]

Kelly JG, Azelton LS, Lardon C, Mock LO, Tandon SD. On community leadership: Stories about collaboration in action research. American Journal of Community Psychology. 2004; 33:205–216. [PubMed: 15212179]

Kelly JG, Azelton LS, Lardon C, Mock LO, Tandon SD, Thomas M. On community leadership: Stories about collaboration in action research. American Journal of Community Psychology. 2004; 33:205–216. [PubMed: 15212179]

Kelly, JG.; Ryan, AM.; Altman, E.; Stelzner, SP.; Rappaport, J.; Seidman, E. Handbook of community psychology. Dordrecht Netherlands: Kluwer Academic Publishers; 2000. Understanding and changing social systems: An ecological view; p. 133-159.

Kline, MV. Planning health promotion and disease prevention programs in multicultural populations. In: Huff, RM.; Kline, MV., editors. Promoting health in multicultural populations. Thousand Oaks: Sage; 1999.

Kreuter MW. PATCH: Its origin, basic concepts, and links to contemporary public health policy. Journal of Health Education. 1992; 23:135–139.

Matias-Carrelo LE, Chavez LM, Negron G, Canino G, Aguilar-Hoppe S. The Spanish translation and cultural adaptation of five mental health measures. Culture, Medicine, and Psychiatry. 2003; 27:291–313.

Minkler, M.; Hancock, T. Community-driven asset identification and issue selection. In: Minkler, M.; Wallerstein, N., editors. Community-based participatory research for health. San Francisco: Jossey-Bass; 2003.

Minkler, M.; Wallerstein, N. Introduction to Community based participatory research. In: Minkler, M.; Wallerstein, N., editors. Community based participatory research for health. San Francisco: Josey-Bass; 2003.

Mohatt GV, Plaetke R, Kleijka J, Luick BL, Lardon C, Bersamin A, et al. The Center for Alaska Native Health Research Study: A community-based participatory research study of obesity and chronic disease-related protective and risk factors. International Journal of Circumpolar Health. 2007; 66(1):8–18. [PubMed: 17451130]

O'Donnell M. Definition of health promotion: Part III: Expanding the definition. American Journal of Health Promotion. 1989; 3(3):5. [PubMed: 10292073]

Pender, NJ.; Murdaugh, CL.; Parsons, MA. Health promotion in nursing practice. 4th ed. Upper Saddle River, NJ: Prentice Hall; 2002.

Perkins D, Wandersman A. "You'll have to work to overcome our suspicions:" Benefits and pitfalls of research within community organizations. Social Policy. 1990 summer;21(1):32–41.

Perkins DD, Bess KD. Community organizational learning: Case studies illustrating a three-dimensional model of levels and orders of change. Journal of Community Psychology Exploring the intersection of organization studies and community psychology. 2007; 35(3):303–328.

Phillips S. Health promotion, community development, and participation: An approach to Native health education. Canadian Family Physician. 1988; 34:1625–1627. [PubMed: 21253037]

Saegert S. Unlikely leaders, extreme circumstances: Older Black women building community households. American Journal of Community Psychology. 1989; 17(3):295–316.

Stoecker R. Making connections: Community organizing, empowerment planning, and participatory research in participatory evaluation. Sociological Practice. 1999; 1(3):209–231.

Tandon, SD.; Kelly, JG.; Mock, LO.; Tolman, DL.; Brydon-Miller, M. From subjects to subjectivities: A handbook of interpretive and participatory methods. New York, NY: New York University Press; 2001. Participatory action research as a resource for developing African American community leadership; p. 200-217.

Wallerstein, N. What is the evidence on effectiveness of empowerment to improve health?. Copenhagen: WHO Regional Office for Europe (Health Evidence Network report; 2006.

Williams L. Participatory research, knowledge, and community based change: experience, epistemology, and empowerment. Research in Community Sociology. 1999; 9:3–40.